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Consumers' Perceptions of Nurses Using Recovery-focused Care to Reduce Aggression in All Acute Mental Health Including Forensic Mental Health Services: A Qualitative Study

Lim, Eric[1]
Wynaden, Dianne[1]
Heslop, Karen Dianne[1]

[1] School of Nursing, Midwifery and Paramedicine, Curtin University, Perth WA

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Psychiatric Nursing, Recovery-Focused Care, Aggression, Forensic Mental Health

Abstract

Recovery-focused care is now the preferred model of care that health professionals can utilize to support people with a mental illness to achieve their personal and clinical recovery. However, there remains a lack of practice guidelines and educational opportunities to support nurses to use recovery-focused care with consumers who may become aggressive.
Objective: This paper reports the findings of research conducted with consumers to obtain their perception of how nurses can use recovery-focused care to reduce aggression in all acute mental health including forensic mental health services.
Research Design and Methods: Thirty-one people diagnosed with a mental illness participated in this study. The constructivist grounded theory method guided data collection, coding, and analysis to generate categories that described the consumer perspective.
Results: Five categories emerged, and these were: 1) see the person as an individual with a unique lived experience, 2) dialogue to explore the reason for the behaviour, 3) use positive communication to encourage self-management, 4) promote personal comfort to de-escalate the risk for aggression, and 5) travel alongside the person to co-produce strategies for reducing aggression.
Conclusion: The findings may be tested in future research to translate recovery principles into acute mental health settings. They can also be incorporated into nursing

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Corresponding Author: Lim, Eric, School of Nursing, Midwifery and Paramedicine, Curtin University
GPO Box U 1987, Perth, WA 6845. Email: boonchuan.lim@postgrad.curtin.edu.au

education and professional development training to increase understanding of consumer perspective of recovery-focused care in all acute mental health including forensic mental health services.

Introduction

The use of recovery-focused care (RFC) by health professionals is endorsed in mental health policy in many countries as a way to support people with a mental illness to be fully involved in decisions about their care.[1,2,3] RFC is based on the premise that having a mental illness is only one aspect of the person's life, and empowering and supporting them to mobilize their strengths and resources can assist them to build a positive sense of self-identity, find meaning and purpose in life, and foster hope for the future.[4,5,6] Central to RFC is the philosophy that recovery from mental illness is not an absence or reduction of symptoms, but a personal change in the person to take control and responsibility over their life.[7,8] Health professionals need to use RFC in all acute mental health settings including forensic services,[9] as this will move the focus of care from the traditional medical model approach to a model that empowers consumers to be more involved in their own care and that supports their recovery journey.[10,11,12]

In all acute mental health settings, nurses have a continual presence in the ward environment and are uniquely positioned to support consumers to achieve their personal recovery goals.[13,14,15] However, the occurrence of aggression can impact on nurses' willingness and ability to establish a therapeutic relationship with the person.[5,16,17] Aggression is dysregulated behaviour that manifests as, or results in, threats or injuries to self or others, or damage to objects or property.[18,19,20] Previous research that examined the triggers for aggression grouped them into 1) person-related factors such as the person's mental illness, personality, or substance abuse, 2) environment-related factors such as layout, space, location of ward, type of regime, or organizational routines, and 3) interpersonal factors such as interactional methods and staff variables.[18,21,22,23]

The consumer's lived experience when admitted to an acute mental health setting can also trigger aggression, but it is not an interactional factor routinely recognized by health professionals as a potential trigger for aggression. Nevertheless, the literature highlights that consumers can feel helpless, vulnerable, frustrated, and anxious about their future, which may all be precusors for aggression.[24,25] Consumers who developed negative feelings during admission are more likely to use ineffective communication styles, which can lead to a greater likelihood for interpersonal conflicts.[18,21,26,27] Assessing and having an understanding of the person's lived experience is important to the provision of nursing care.[28] However, a thorough asessment by health professionals to gain an informed understanding of the person's lived experience is currently not routine practice.[29] Consequently, challenging behaviours that were triggered by the impact of the consumers' lived experience may be viewed by nurses as resulting solely from the consumer's mental illness, leading nurses to focus on behavioural and symptom management.[30] They may also be less optimistic to use therapeutic engagement

strategies, such as positive communication, verbal de-escalation, or anger management to support consumers to self-regulate their own behaviours. Hence, they may implement more restrictive practices, such as enforced medications, restraint, and selcusion.[20,30,31,32,33] However, choosing these restrictive options to manage aggression is in direct opposition to the philosophy of RFC.[34]

Nurses who use RFC can obtain a more person-centred assessment of consumers' triggers for aggression, and thereafter support them to utilize their own coping mechanisms to reduce their potential for aggression.[35,36,37,38] This will facilitate the therapeutic relationship and increase consumers' involvement in their care to minimize the intensity of their negative feelings.[11,39] As there is a lack of practice guidelines on how to embed RFC within contemporary nursing practice,[40] its use is currently dependent on the knowledge, skills, and confidence of each nurse to practise RFC. This paper contributes to literature in the area and reports the findings of a qualitative study which explored consumers' perceptions of how nurses can use RFC in all acute mental health settings to reduce the potential for aggression.

Research Design and Methods

Ethics approval to conduct the research was obtained from Curtin University Human Research Ethics Committee—approval number HR132/2015, and one health service in Western Australia. Grounded theory methodology[41] guided the process of data collection, coding, and analysis to generate categories that accurately interpreted participants' perspectives of how nurses can use RFC to reduce aggression.[42] The researchers did not set out to develop a substantive theory but used grounded theory methodology to guide data collection, analysis, and write-up of findings. This is to ensure that the emerging categories were grounded in the participants' social and psychological process of the studied phenomenon.[42,43,44] The use of the constant comparative method of analysis central to grounded theory also ensured that each participant experience was compared with others and all participant experiences were captured.

Data Collection

Data were collected by the first author from June to October 2017 using semi-structured interviews and three focus groups with consumers. Consumers identified by their treating team as being able to participate in the research were given an information sheet by their case manager. The information sheet outlined the details of the study and what their participation involved. Individuals who told their case manager that they would like to participate gave their permission for the research team to contact them and were given time to ask any questions they had prior to their involvement in the research. All participants provided written consent to be interviewed and to have their dialogue digitally recorded. An interview guide, which included a brief explanation of RFC, was used to guide data collection.[45]

Purposeful sampling was initially used in line with grounded theory methodology to recruit participants who 1) were 18 years or older, and 2) had experience of being hospitalized in an acute mental health setting, including forensic mental health settings. Theoretical sampling was then employed as the categories started to emerge through concurrent data collection and analysis.[46] This enabled different or expansive experiences of the phenomenon under investigation to be captured, for example younger participants (age 18 to 24) who had limited admissions to hospital, and people who had been hospitalized regularly during their lives and had seen many changes in care during this time.

Data Analysis

All interviews were transcribed verbatim by the first author and were checked by the second and third authors to ensure that data were accurate and detailed in descriptions of participants' experiences. The constant comparative method of analysis central to grounded theory was used to code each interview data, compare data between participants, and to build categories.[43] The coding procedure outlined by Charmaz was employed—initial coding and focused coding constructed the analytical categories.[47] In initial coding, data were analyzed line-by-line and in segments and assigned labels to build initial codes.[48] In focused coding, initial codes that were most significant were used as provisional categories for comparisons with new interview data to consolidate the emerging categories.[44,46] Validation of the coding process and emerging categories was obtained through checking of data and coding by the second and third authors. Data analysis ceased when all the categories were well-developed and rich in participants' experiences.[49]

Findings

Thirty-one people diagnosed with a mental illness participated in this study. Participant demographic data is presented in Table 1. The individual interviews lasted between 10–48 minutes (mean = 17 minutes) and the focus groups lasted between 30–45 minutes (mean = 40 minutes).

Table 1. Demographic Data of Participant

Total number of participants	31 (%)
Gender: Male Female	 14 (45) 17 (55)
Age groups: 18 to 24 25 to 34 35 to 44	12 (39) 3 (10) 3 (10) 6 (19)

45 to 54 55 to 64 65 and above	6 (19) 1 (3)
DSM Group: Mood Disorders Substance-related Disorders Post-Traumatic Stress Disorder Schizophrenia and Other Psychotic Disorder	 16 (52) 4 (13) 5 (16) 6 (19)

Many participants described aggression occurring in all acute mental health settings as a form of maladaptive behaviour that some consumers displayed when they were overwhelmed by the intensity of their emotions during hospitalization: “When people are in distress, they can feel helpless and trapped [in the ward environment]” (P12). The behaviour also occurred when nurses did not take time to explore and address the consumers’ lived experience: “Sometimes they [consumers] think that [nurses] don’t care” (P7) and “[the negative emotions] can start bottling up and it is going to get to a point where the bottle is full and then they explode [become aggressive]” (P10); “They want to express themselves, but they can’t, so it will be expressed by acting up and throwing things” (P11). There was a consensus among participants that RFC was effective for reducing aggression and five categories and their subcategories that defined consumers’ perceptions about the use of RFC were identified. They are listed in Table 2.

Table 2. Consumers’ Perceptions About the Use of RFC

Categories	**Subcategories**
1. See the person as an individual with a unique lived experience	• Recognizing different triggers for aggression • Respecting the individuality of each consumer • Empathizing with the consumer’s feelings
2. Dialogue to explore the reason for the behaviour	• Focusing on the consumer’s reason, not their behaviour • Cultivating a therapeutic relationship
3. Use positive communication to encourage self-management	• Focusing on the consumer’s strengths • Promoting self-management of behaviour
4. Promote personal comfort to de-escalate the risk for aggression	• Implementing care for a consumer holistically
5. Travel alongside the person to co-produce strategies for reducing aggression	• Understanding recovery in mental illness • Focusing on the consumer’s personal recovery

Category 1: See the Person as an Individual with a Unique Lived Experience

Participants explained that nurses needed to see each consumer as an individual with a unique lived experience, personal traits, and differences despite having the same psychiatric diagnosis as other consumers in their care*:* "Everyone is human and we all have our own [lived experience] and no two people are the same" (P13);

> "Everyone is different, and we are not all going to be coming in with the same [personal challenges]. We have all got a different situation [leading up to the acute admission], so [nurses] need to acknowledge that everyone has got different things going on [in their lives] and to [acknowledge] each person individually" (P12).

Participants perceived that nurses who did not have an appreciation of them as individuals with unique lived experiences could easily misjudge their behaviour as only related to their mental illness: "There was a kid who they [nurses] said he threatened a staff member when he just waved a sunscreen bottle [an outward expression of his emotions] when talking to her and wasn't actually being aggressive" (P14).

Participants conveyed that nurses should "not take everything as a sign of aggression and pay attention to [the consumers' lived experience]. Stop ascertaining how they [consumers] should behave [when they are admitted to the hospital]" (P13); "Be open-minded and [respect] that everyone [expresses themselves differently] when they are in a bad mood" (P9). Many participants claimed that being accepted as an individual maintained their self-esteem and reduced the intensity of their negative emotions during hospitalization: "When you are in a hospital facility [away from family and carers], you need help and assistance [to cope with the negative emotions] and having nurses who are understanding and open-minded is probably the best things" (P9), because "when they take time to listen to my story [exploring lived experience], it is easing to my mind [de-escalating the potential for aggression]" (P7).

Category 2: Dialogue to Explore the Reason for the Behaviour

Participants perceived that nurses were often quick to identify and judge consumers as being potentially aggressive when they expressed negative emotions, and this had an impact on nurses' willingness to interact further with the person. Instead of responding to behaviours such as frustration as an aggression threat, nurses needed to take the opportunity to have a dialogue with the person and ask "What's troubling you and how can we help you? It is [usually] you need to take this medication and if you don't do it then we will inject you [give you an intramuscular sedative injection]" (P27). Another participant spoke about his experience:

> "They [nurses] don't communicate properly. They will take an aggressive approach and kind of hands-on grabbing me, dragging me in there [to seclusion], sedating me, and say "here's the medication and this is what

> we are doing because you are aggressive". I think if they communicate, they would have helped me manage my situation a lot better. My opinion is that if nurses can communicate better rather than just dosing medication when [an individual is expressing intense emotions], they can mitigate the [negative emotions] and the situation would work out a lot better." (P6)

Participants identified that nurses needed to initiate a dialogue with them to explore the reason for their behaviour before judging the person as being aggressive because "people who get identified as angry when they might just be upset are just going to get angrier and more rebellious if you [nurses] say to them that they look angry" (P26);

> "Everyone reacts differently to [being called aggressive], so maybe [the nurse should] sit with them and have a conversation to find out the reason behind the behaviour. Once they [nurses] have the reason, they can help the person [co-producing coping strategies] by asking 'What to do about it or what would be helpful for you?'" (P12).

There was a consensus among participants that engaging consumers in a dialogue when they were distressed allowed nurses to "validate the person's feelings" (P5); and "figure out what are the deeper issues that need sorting for the person [during hospitalization]. This will probably support the individual to skip a few steps towards their [personal] recovery" (P10).

Category 3: Use Positive Communication to Encourage Self-management

Participants stressed the importance of nurses using positive communication and supporting consumers to self-manage their behaviour. When de-escalating a situation, nurses should "take things slowly and [think about the] words that they [nurses] want to say, carefully. Use positive words to empower the individual to take responsibility for their behaviour and ask the person to try not to [behave aggressively] again" (P8);

> "When giving medication, say positive things like, "This is going to help you, this is going to work for you. Let's give it a go. You can let us know later if this works for you [encourage self-management]. Explain what this medication does to help them feel better, not just stick a needle to sedate them" (P9).

"Be more empathetic and provide positive avenues for the person to take control of their own behaviour and move them toward recovery in mental health" (P18). Participants claimed that when they engaged in therapeutic communication with nurses during the time they were experiencing a personal crisis, they were more encouraged to re-evaluate their own strengths and ability to self-manage their behaviour: "If nurses can use positive reinforcement, they will encourage the person to re-focus on the main issue [that triggered their aggression] and this can motivate them to gain an in-depth understanding of how they can deal with it" (P5); "When they find out the cause of the

aggression, they will move on to identify how it is affecting their life so they may manage it themselves in the future " (P10). Another participant provided this example:

> "If [nurses] noticed that the person is aggressive, go talk to them about it instead of telling them what to do as it can be antagonistic because they are in that moment where their mind is racing at one hundred miles an hour. All they are thinking about is I want to hit this, I want to throw this, I want to hit everybody. Sit them and ask them "What is wrong right now, what do you need from us, what can we do to help you, what do you usually use to calm down?" Try various suggestions and it is about getting them to utilise their own strategies [to self-manage] and they will learn about their [own strengths and potentials] on that day." (P9)

Category 4: Promote Personal Comfort to De-escalate the Risk for Aggression

Most participants spoke negatively about having to make adjustments to their familiar lifestyle and daily routines when hospitalized, and how this increased their risk for aggression. They explained that "it is just human nature that [people] tend to get frustrated as they don't have their own belongings and stuff" (P6); "They cannot get what they want, and this reinforces their feelings of being neglected, so they will do something and try to get it" (P15); "It is quite suppressing [during hospitalization] and I feel like I am living in the moment. Every day is the same and it feels like deja vu" (P3). While participants accepted the structure and routines of the ward environment, they highlighted how little gestures on the part of nurses could make a positive difference to their experience: "It was raining, and they got me some blanket and gave me a cup of tea which was really nice and reduced my frustration of being hospitalised" (P5); "They [nurses] are reassuring and approachable even when I can be quite demanding. When I am upset, they showed that they are really here to help you and offered me choices: Can I get you a blanket? Can I get you a pillow, a drink, a tea, a coffee?" (P21). One participant provided an example of how increasing her level of comfort reduced her risk for aggression:

> "I came in after a traumatic event and was very upset and unwell. I didn't like [to be hospitalized] so I have been pretty aggressive and being blatantly rude to the nurses. [However] they were really nice, sat me down, got me a tea, and talked to me. They treated me like a human being [promoting level of comfort] instead of just treating me as another number and all these actions made me feel that [nurses] actually do care, so it calmed me down (P11)."

Category 5: Travel Alongside the Person to Co-produce Strategies for Reducing Aggression

Participants described their admission to hospital as a personal journey that allowed them to trial clinical and personal strategies to identify ways they could achieve their

recovery goals. There was a consensus that this journey was “just like a trial run, give another shot, give another shot when you get knocked down, keep on going” (P2); “is not overnight” (P14); “it takes a long time” (P15); “[recovery] is hard work, so having nurses [travelling alongside] can help make [consumers] feel like they have to do it alone” (P17). Most participants described recovery as a personal journey to find the strengths that “will come from within themselves” (P2) but the process could potentially increase their risk for aggression if they became “fearful of not knowing what is going to happen” (P5); “impatience [to overcome their life challenges] and probably lost control a little bit [of their self-control]” (P7); because “waiting [for positive outcomes] is the worse feeling especially when [they] are distressed” (P8).

Many participants highlighted that nurses could use this time as an opportunity “to work alongside [consumers] and try to coach them to develop effective strategies to reduce aggression because they are in wiser position [clinically]” (P2), rather than to implement more restrictive practices that could potentially impact on their personal effort to achieve recovery. As one participant stated:

> “Personally, I was here because of a particular reason which would be somewhat difficult for nurses to truly understand how I feel. If we [nurses and consumers] all work together [engaging in co-production], we can achieve desirable outcomes and reduce [the risk] for aggression” (P6).

Discussion

This qualitative study contributes evidence on consumers’ perceptions of how nurses can use RFC to reduce aggression in all acute mental health inpatient settings. All participants interviewed displayed positive attitudes toward nurses who used RFC and explained how they believe this model of care can reduce aggression in the clinical environment. Participants highlighted their feelings of being validated and valued as a person as two important components of RFC. Many participants indicated that RFC supported them to achieve personal recovery and mitigated the impact of their lived experience on their risk for being aggressive when hospitalized. This is supported by Antonysamy, who reported that consumers who achieved personal recovery were less likely to display aggression, and the need for nurses to use restrictive practice, such as restraint, during hospitalization was therefore reduced.[50]

Participants identified that nurses who used RFC explored the consumer’s past and present lived experience during assessment to gain an understanding of the person’s presenting behaviours and potential for aggression. The literature suggests that consumers who displayed aggression when admitted to hospital tend to have a history of physical abuse, psychological trauma, or neglect and social discrimination.[35,51,52,53] These negative lived experiences can be reactivated by the interpersonal and environmental factors that exist within all acute mental health inpatient settings and the person’s response to these circumstances may trigger aggression.[55,] When admitted to the hospital, it will take time for this vulnerable group to build a trusting relationship with

nurses and fully disclose their lived experiences.[15,28,54] As they have not previously always be able to voice their concerns, they may continue to choose to utilize aggression to express their needs and preferences unless their interactions with nurses can build their trust to begin to self-manage their behaviours.[35,55,56] Therefore, nurses must explore each consumer's lived experience and assess the intent of the person's presenting behaviours.[35,57,58,59] When nurses have an increased appreciation of the impact of lived experience on the consumer's presenting behaviours, they are more likely to talk to the individual, give the person time, and be open and available to help the individual cultivate a sense of safety, trust, and closeness.[60] Lantta et al. stated that nurses who recognized the reason behind the person's presenting behaviours were able to more accurately interpret the person's potential for aggression. These nurses were also more confident to use interpersonal and alternative strategies to de-escalate the situation.[58] They were also more sensitive toward the consumer's individuality and used trauma-informed and person-centred care to help the person feel acknowledged and validated.[57,60,61,62]

In this study, participants highlighted that nurses who used RFC were more likely to implement micro-affirmations, which are little gestures of care, such as offering food, drink, touch, and physical comfort to help consumers to self-regulate their level of risk for aggression.[60,61] The display of unconditional feelings of warmth and consideration toward these consumers helps them maintain a positive sense of self and address the impact of their negative feelings when admitted to hospital.[60] The feeling of being valued by nurses as a person experiencing a personal or mental health crisis was identified by participants in this study as empowering for building their hope and confidence. This allowed them to take ownership and responsibility of their behaviour, and ultimately their personal and clinical recovery as their mental health improved.[63]

There was a consensus among participants that nurses who used RFC displayed a higher level of therapeutic optimism about consumers' potential to self-regulate their behaviour.[17,64,65,66] They also conceptualized consumers' aggression as a learning opportunity and travelled alongside them to help them to identify better ways of expressing their emotions and needs. These nurses chose this strategy rather than the use of restrictive practices.[54,67] Through co-production, nurses can empower consumers to self-determine or share the decisions about their own care and treatment and increase their awareness of their existing coping mechanisms and resources that they have not yet used.[28,54] This assists persons to achieve self-growth and actualization of their strengths to overcome the impact of their lived experiences on their behaviour when hospitalized.[19]

Limitations

Several limitations are acknowledged in this qualitative study. Firstly, the transferability of findings may only be possible to consumers who have experienced care and treatment in wards that have similar climate, structures, level of staffing, and culture of care delivery. Secondly, the involvement of the treating team to identify people who are

suitable to participate in this study may have potentially introduced a selection bias in determining some participants over the others as shown in their demographic data. However, this was an essential step to ensure that the participants are clinically well enough to understand the nature of this study and their expected involvement, and to make an informed decision to participate. Despite these limitations, the five categories identified in this research were rich and in-depth in the participants' experience and contributed valuable insight into patients' perceptions of how nurses can use RFC in all acute mental health inpatient settings to reduce aggression.

Conclusion

The research provides insights into the consumer perspective of potential causes of aggression, and how nurses can use RFC to reduce the risk of aggression in all acute mental health settings. Despite the limitations, the findings contribute to the understanding of the consumer perspective of how nurses can support the personal recovery journey. As RFC is now viewed internationally as the preferred model of care for people with a mental illness, the findings may be tested in future research to translate recovery principles into all mental health settings. The findings can also be incorporated into nursing education and professional development training to increase understanding of consumer perspectives of recovery-focused care in all acute mental health settings, including forensic mental health services.

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