DISMISSING DE-ESCALATION TECHNIQUES AS AN INTERVENTION TO MANAGE VERBAL AGGRESSION WITHIN MENTAL HEALTH CARE SETTINGS: ATTITUDES OF PSYCHIATRIC HOSPITAL-BASED NIGERIAN MENTAL HEALTH NURSES

Oyeyemi Oyelade, MN student
University of KwaZulu-Natal
E-mail: yemilad13@gmail.com

Amanda April Heather Smith, MN
University of KwaZulu-Natal
E-mail: smitha1@ukzn.ac.za

Mary Ann Jarvis, MN
University of KwaZulu-Natal
E-mail: Jarvism@ukzn.ac.za

ABSTRACT

The risk of violence within mental health care settings is high. Although literature does indicate certain mental illness symptoms, and or labels, as associated with increased risk for violence there is no definitive causative factor. Interrelated environmental factors directly influence verbal aggression and risk of violence. Specifically, lack of, or inadequate, mental health care legislation and policy, and practitioner attitudes, knowledge and skills are noted as core influential factors. The purpose of this study was to present de-escalation techniques, as an intervention, and describe the response of psychiatric

UNISA university of south africa

Africa Journal of Nursing and Midwifery
https://upjournals.co.za/index.php/AJNM/index
Volume 19 | Number 2 | 2017 | #731 | 18 pages

https://doi.org/10.25159/2520-5293/731
ISSN 2520-5293 (Online), ISSN 1682 5055 (Print)

hospital-based Nigerian mental health nurses. A qualitative approach using content analysis of audio recorded pre- and post-intervention focus group discussions was adopted. The intervention – one oral and visual presentation of de-escalation techniques – bisected focus group discussions. The objective for the pre-intervention focus group was to facilitate participants' descriptions of current experiences and practices towards verbal aggression and violence management in order to inform and contextualise the intervention, specifically the relevant application of information within the intervention. The objective of the post-intervention focus group discussion was to describe participants' responses to the intervention. Purposive sampling of nurses at unit or ward manager level yielded eight participants who attended both focus groups and the intervention. Results indicate that participants felt betrayed by all role players within the mental health care service system, were disappointed that de-escalation techniques were considered evidence-based practice, and hopeless about their introduction. Participants' fears for their safety are suggested to have informed a more militant approach to the management of aggression, an approach perceived by participants to strengthen nurses' control over their own and patients' physical and emotional welfare. A review of Nigerian mental health legislation to set the context for human rights of both nurses and mental health care patients is recommended. In addition, a need exists for further research utilising a participatory action research approach. Such an approach will allow the participants to reflect, develop self-awareness, understand and respond to a specific context.

Keywords: de-escalation, intervention, Nigerian mental health nurses, verbal aggression and violence

INTRODUCTION AND BACKGROUND

Current research argues the risk of violence within health care, specifically mental health care, settings is high (Chukwujekwu & Stanley, 2011:163; Itzhaki, Peles-Bortz, Kostistky *et al*., 2015:407; Pompeii, Dement, Schoenfisch *et al*., 2013:58). International (Itzhaki, *et al*., 2015:407; Nelson, 2014:1373; Price, Baker, Bee *et al*., 2015:447) and sub-Saharan African (Chukwujekwu & Stanley, 2011:163; James, Isa & Oud, 2011:130; Mitchell, Ahmed & Szabo, 2014:148: Ukpong, Owoeye, Udofia *et al*., 2011:46) studies report the prevalence of workplace violent incidences against mental health nurses as ranging between 49.5% and 96.7%, or three times that of other health care workers. This broad prevalence range has been linked to limited reporting facilitated by differing reporting policy and procedure, and mental health nurses perceptions of violent incidents as 'typical' and 'part of the job' (Jack-Ide *et al*., 2012:50; Ukpong *et al*., 2011:48).

There is/are no definitive causative factor/s of violence within mental health care settings (Bader, Evans & Welsh, 2014:180; Chukwujekwu & Stanley, 2011:163;

Papadopoulos, Ross, Stewart *et al*., 2012:425). Literature does link certain mental illness symptoms, and labels, as greatly influencing risk for violence (Bader *et al*., 2014:180; Nestor, 2014:1974). However, current research clearly argues that interrelated environmental factors, specifically lack of, or inadequate, mental health care legislation and policy (Drew, Funk, Tang *et al*., 2011:1664; Papadopoulos *et al*., 2012:434; WHO, 2013:10), and practitioner attitudes, knowledge and skill (Bader *et al*., 2014:185; Björkdahl, Hansebo & Palmstierna, 2013:397; Papadopoulos *et al*., 2012:435; Mitchell *et al*., 2014:148) directly influence risk of violence within these settings.

Nigeria, like 64% of low and low middle income countries (LIMIC), has no mental health legislation (Westbrook, 2011:403; WHO, 2013:10). Nigeria continues to use the *Lunacy Act* (1958) as amended from the *Lunacy Ordinance* formed in 1916 (Wesbrook, 2011:403). The label used – lunatic– and detainment and confinement procedural elements within the *Lunacy Act* (1958) facilitate the diminished status of the mentally ill person, increasing the risk of abuse (Westbrook, 2011:404; WHO, 2012:5). The belief that a mentally ill person is a lunatic affects service delivery, with the Nigerian *Lunacy Ordinance* and *Lunacy Act* suggested to indirectly facilitate negation of human rights (James *et al*., 2011:133; Westbrook, 2011:397). James *et al*. (2011:133) report that the reaction of Nigerian mental health nurses towards violence has made violence reoccurrence inevitable.

De-escalation techniques, non-physical interventions for the management of violence and aggression, are internationally recognised as an evidence-based psychosocial approach of verbal aggression management (Björkdahl *et al*., 2013:397; Bowers, 2014:36; Price *et al*., 2015:447; Richmond, Berlin, Fishkind *et al*., 2012:17). In essence, current literature supports the view that the use of de-escalation techniques represents the use of current best evidence in the management of aggression and violence. Price *et al*. (2015:447) describe de-escalation techniques as typically encompassing non-provocative communication to find solutions to the aggressors' concerns. A communication approach that emphasises the expression of understanding and respect for one another's opinion in the face of anger (Richmond *et al*., 2012:20). These techniques entail the use of verbal and non-verbal clues to prevent the occurrence of violence to curb or reduce the gravity of occurred violence (Björkdahl *et al*., 2013:397; Loewenstein & McManus, 2014:171; Mc Andrew, Chambers, Nolan *et al*., 2014:215; Richmond *et al*., 2012:17). Communication techniques required in de-escalation involve establishing verbal contact and initiating discussion in a friendly rather than accusatory manner (Richmond *et al*., 2012:2). The ability to listen carefully, understand the needs of a mentally ill person and provide suggestions on the way forward are essential to mental health nurses' practice (Loewenstein & McManus, 2014:171; Richmond *et al*., 2012:19). A punitive approach and failure to engage early with de-escalation to prevent aggression progression can trigger further incidences of aggression (Loewenstein

& McManus, 2014:171; McAndrew *et al*., 2014:216). Training of mental health nurses in the use of verbal de-escalation techniques has been embraced in Europe (Björkdahl *et al*., 2013:396; Mc Andrew *et al*., 2014:212; Price *et al*., 2015:447), in America (Richmond *et al*., 2012:17) and in South Africa (Mitchell *et al*., 2014:147), but it seems to not feature in Nigerian psychiatric hospitals (Westbrook, 2011:403).

PROBLEM STATEMENT

Verbal aggression and violence within mental healthcare settings, including Nigeria, persist (Chukwujekwu & Stanley, 2011:163; Nelson, 2014:1373; James *et al*., 2011:130). Studies related to Nigerian mental health nurses' verbal aggression and violence management practices have emphasised that improvement of practice is essential (Chukwujekwu & Stanley, 2011:166; James *et al*., 2011:133). Improvement of mental health nurses' practice is related not only to the presentation of specialised training, but also mental health nurses' decisions to accept or reject new knowledge (Björkdahl *et al.*, 2013:403; Mc Andrew *et al*., 2014:215; Price *et al*., 2015:453).

THE PURPOSE OF THE STUDY

The purpose of this study was to present a verbal aggression intervention strategy to hospital-based Nigerian mental health nurses and to describe their responses.

METHODOLOGY AND DESIGN

A qualitative approach using content analysis of audio recorded pre- and post-intervention focus group discussion was adopted. The intervention – one oral and visual de-escalation techniques presentation – bisected the pre- and post-focus group discussion. Within the focus group discussions, the term 'psychiatric patient' rather than 'mental health care user' of 'service user' was used in keeping with local mental health care terminological choices.

The objective for the pre-intervention focus group was to facilitate psychiatric hospital-based Nigerian mental health nurses' descriptions of their current experiences and practices towards verbal aggression and violence management. Semi-structured questions, 'How do you manage aggressive psychiatric patients in your unit?', 'How effective has this been?', facilitated narratives of personal experiences and informed the clinical application examples used in the intervention to enhance its relevance and accessibility (Bowers, 2014:36; Price *et al*., 2015:452). The objective of the post-intervention focus group discussion was to describe psychiatric hospital-based Nigerian mental health nurses' responses to the intervention – visual and oral presentation of de-escalation techniques – as an evidence-based practice for reducing verbal aggression and averting violent behaviour displayed by mentally ill

persons admitted for treatment. This second focus group discussion was facilitated by three semi-structured questions: 'Was the use of de-escalation techniques clear?', 'Could you incorporate it (de-escalation) into your practice?', 'What barriers do you envisage?'.

One group of eight participants attended the pre-intervention focus group, the intervention, the post-intervention focus group, and one confirmation of data meeting.

The intervention – oral and visual de-escalation techniques presentation – was subjected to two forms of content validity: content validity based on a review of current evidence-based practice literature (Björkdahl *et al*., 2013:396; Bowers, 2014:36–37; Richmond *et al*., 2012:17–25), and face validity via presentation to an expert panel. The expert panel composition included two clinical specialist mental health nurse academics, one hospital based clinical specialist mental health nurse and one specialist nurse educator academic who is also a mental health nurse. Written feedback was reviewed by all three researchers and the presentation modified to include evidence of sub-Saharan African use of de-escalation techniques.

RESEARCH SETTING AND POSITIONING THE RESEARCHERS

The researchers sent letters requesting involvement and support for the proposed research to five Nigerian psychiatric hospitals. The research setting was the only psychiatric hospital to respond. The participating hospital, like other Nigerian psychiatric hospitals, has two distinct sections: a main hospital that offers mental health care, and an annex, separated from the main psychiatric hospital by 18 kilometers that provides forensic mental health care services. The main psychiatric hospital, not the annex, was the research setting for this study.

In this psychiatric hospital, wards are, for the purpose of nursing management, divided into two units. Each unit consists of between two and eight, thirty-bedded wards. The first unit has an assessment focus, although treatment can and does occur, and includes: emergency assessment mental health care (one mixed gender thirty-bedded ward, and a mixed gender thirty-bedded assessment ward for National Health Insurance Scheme (NHIS) patients. The NHIS patients are people who work for, and are provided with health care by, the Nigerian government. In addition, this unit includes an outpatient assessment department accessed by approximately eighty people per day for follow-up care. The second unit focuses on treatment rather than assessment, although assessment is part of the treatment process, and includes: drug addiction care (two thirty-bedded wards, one male and one female), and general psychiatric treatment (three male and three female wards each with a bed capacity of thirty). In these general psychiatric treatment wards, one male and one female ward are considered to be for long-term care. Throughout both units, all wards,

child and adolescent mental health care and psychogeriatric mental health care are incorporated within adult mental health care services. Each ward has between twenty and twenty-five nurses working over three different shifts per 24 hour day. Bed occupancy is commonly between twenty and twenty-five patients per ward. Taking into account absenteeism, leave and administrative roles the nurse patient ratio is usually 1:10 for every shift. Unit managers are mental health nurses who are responsible for all the wards within their unit. Each ward has a ward manager and a deputy ward manager, both mental health nursing posts. The ward manager liaises directly with the unit manager to facilitate implementation of directives related to service delivery. Typically, a total of twenty security officers, all male, are allocated across all wards for the morning shift and to the hospital entrance and exit routes during the other shifts.

The Nigerian researcher completed her undergraduate training in Nigeria, and was placed within the research site hospital as a student nurse, about six years prior to this research study. Although some of the participants remembered the Nigerian researcher as a previous student nurse, this seemed to reassure them of her ability to relate to their working context rather than hinder their willingness to participate. Both South African researchers have working experience in South African psychiatric hospitals, specifically acute assessment units, and continue to work collaboratively with local psychiatric hospitals to improve mental health care outcomes.

POPULATION AND SAMPLING

Invitations to Nigerian stakeholders to participate began in July 2014. As previously stated, only one psychiatric hospital responded and it became the research site. Purposive sampling, in consultation with hospital nursing management, was used to access the target population; hospital-based mental health nurses providing in-patient care at unit and ward management level. Unit and ward managers were targeted due to their position of authority to implement directives in the management of psychiatric care, specifically emergency care responses, such as an incident of escalating aggression or violence. Both unit managers and all eleven ward managers were invited to participate (N= 13). Both unit mangers agreed to participate. Due to lack of availability, six ward managers agreed to participate, two (2) sending deputy ward managers instead. A total of eight participants (n=8) participated and included two (2) unit managers, four (4) ward managers and two (2) deputy ward managers.

ETHICAL CONSIDERATIONS

Final negotiations regarding time, place and potential participants occurred after full ethical approval was granted from the Nigerian psychiatric hospital's research ethics committee (31st August, 2015), and the University of KwaZulu-Natal's Human and

Social Sciences Research Ethics Committee (3rd September, 2015). Data collection commenced on the 5th October 2015. The study held minimal risk for participants, and mental health nurses are not considered a vulnerable population in the same way that mental health care patients are. However, several ethical considerations were highlighted within the 'participant information sheet'. Firstly, that complete confidentiality could not be assured due to the group nature of data collection, although requests that each participant maintains group confidentiality were made. Secondly, it was acknowledged that participants' recounting experiences of violence management or exposure may result in uncomfortable emotional responses and a counselling referral pathway was established with hospital management. This did occur for one participant, who had been a victim of a violent encounter with a mental health care patient two days prior to data collection. This participant was counselled and offered access to the supportive counselling services pathway, but refused stating that the chance to talk within the focus group, and after, was sufficient.

DATA COLLECTION

Data collection, facilitated by the Nigerian researcher, occurred over two consecutive days, data confirmation occurred on day four. Data collection was facilitated by the Nigerian researcher, to reduce social desirability bias that can occur with 'outsiders'.

As is Nigerian custom, snacks and liquid refreshments were provided at each encounter with the researcher. The pre-intervention focus group discussion followed a non-recorded 'meet and greet' session where the researcher shared details of her own nursing career in Nigeria to build rapport, and confirmed that all participants had received and understood the information sheet before asking participants to sign an informed consent. Once the pre-intervention focus group began, audio recording was used and the session lasted one and a half hours. On day two, participants received the intervention – an oral presentation, facilitated by the use of power point visuals, on de-escalation as an evidence-based practice for verbal aggression and violence prevention management. This was immediately followed by the post-intervention focus group, which lasted one hour. The final meeting on the fourth day confirmed data collection through member checking of written transcriptions of both focus group discussions and lasted one and a half hours, approximately 45 mins focused on confirmation of transcribed data and a further 45 minutes retelling narratives explored in the pre-intervention focus group.

DATA ANALYSIS

Data analysis followed the content analysis process of Elo and Kyngas (2008:13). The Nigerian researcher transcribed verbatim the pre- and post-intervention audio recorded focus group discussions. All three researchers independently listened to

the audio recordings while simultaneously reading the typed transcript to ensure accuracy. Each researcher independently implemented content analysis of the raw data. A meeting followed of all three researchers and final themes and categories were reduced and reframed.

MEASURES TO ENSURE TRUSTWORTHINESS

Credibility began with a process to validate the appropriateness, clarity and completeness of the content of the de-escalation techniques intervention presentation. The Nigerian researcher attended a presentation related to the concepts of anger and violence within mental health care at a higher education institution in South Africa. All three researchers, two considered specialist clinical mental health nurses, designed the de-escalation intervention presentation before it was presented to the mental health nursing expert panel described previously under methodology and design. The Nigerian researcher kept in daily contact with one South African researcher throughout the data collection process through electronic media of video chat and debriefing was done. In addition, the original audiotapes were provided to both South African researchers. The process of member checking of the transcribed data facilitated confirmation of the transcribed data and provided proof that data collection occurred.

Dependability of the study data was facilitated by consistent language use. As English is the only official language in Nigeria, the pre- and post-intervention focus group discussions and the presentation of the de-escalation techniques intervention occurred in English. The use of audio recording of the pre- and post-intervention focus group discussions ensured that the researchers did not misinterpret the participants' own wording. Both South African researchers received copies of the audio recordings and transcribed raw data, and were able to check the dependability of the transcriptions by the Nigerian researcher. The data analysis process of Elo and Kyngäs (2008:109) was used by each of the three researchers to independently analyse the raw data. In addition, this completed study was evaluated by two external examiners who were provided with copies of transcribed raw data.

MEASURES TO ENSURE TRANSFERABILITY

Transferring recommendations from this study to other mental health care settings, in and outside Nigeria, will depend on the reader's assessment of the suitability of the study to their context. This is facilitated by rich and thorough descriptions of the study background, research setting, methodology, data collection, sample size and extracts from raw data.

RESULTS

Participants' demographic data

Table 1 provides the participants' gender, managerial position within a unit, and years of experience. Gender demographics were representative of hospital statistics where female nurses accounted for the majority (75%) of ward manager positions (2011 Nigerian national statistics reported more female nurses than males (www.nursinworldnigeria.com)).

Table 1: Demographic characteristics of participants

Participants Gender	Current Unit and / Ward	Management position	Years of service
Female	Unit 1: Assessment	Unit manager	22
Female	Unit 2: Treatment	Unit manager	26
Male	Long-term care ward	Ward manger	30
Female	Female drug addiction ward	Deputy ward manager	11
Female	Out Patient Clinic within Emergency Assessment ward	Deputy ward manager	15
Female	National Health Insurance Scheme assessment ward	Ward manger	19
Female	Emergency Assessment ward	Ward manager	15
Female	Male drug addiction ward	Ward manager	19

The eight participating nurse managers reported high levels of mental health care nursing experience, from eleven to thirty years. All eight participants had a diploma in general and mental health nursing. At the time of data collection, one had completed, and seven were pursuing, a Bachelor of Nursing Science degree.

PRE-INTERVENTION FOCUS GROUP DISCUSSION DATA

As displayed in Table 2, participants' current verbal aggression and violence management experiences and practices generated two themes: betrayal, and power versus powerlessness, each with categories.

Table 2: Pre-intervention focus group themes and categories

Themes	Categories
Betrayal	Home – hospital transit Deliberate harm Ineffective response Heightened threat
Power versus powerlessness	Asserting authority through intimidation Questionable practice

The theme of betrayal emerged early in the analysis process; its categories linked to the second theme of power versus powerlessness and its categories. This link highlighted the influence of personal experience, predominantly fear, on current practices and participants' hopelessness that emerged in the post-intervention focus group.

Theme 1: Betrayal

Participants stated that the potential for aggression and violence began during the admission process, specifically transportation of the patient from home to hospital, *home–hospital transit*. Participants emphasised that aggression against professionals was a result of patients' anger at perceived betrayal by families and community members who deceive and restrain the patient to facilitate admission. The 'harsh' measures used by family members to bring the acutely ill patient to the hospital were believed to increase the risk of violence against nurses who became targets of the patients' anger on admission.

> Some of them are told they are only going out on a stroll and will find themselves in the hospital.
>
> They come very wild because of maltreatment and not because of illness.
>
> Some of them come in chains.
>
> The patients are brought in tied with a rope like an animal.

The theme of betrayal also manifested in descriptions of participants' belief that patients deliberately harm nurses. Participants referred to feeling betrayed by mentally ill patients they were trying to help, their attempts at caring resulting in patients' intention to *deliberately harm* them (the nurses).

> I thought she is my friend, but she rose up and suddenly gave me a heavy slap. She later admitted that her intention was to kill me if not for rescuers.
>
> I tried to intervene by settling it, but the patient turned back and held my neck.

> They (patients) also take the advantage of the size and height of the nurse. Patients find it easier to attack small statured nurses.
>
> They attack junior nurses more. Even if bold, they still attack to see how he/she will handle the situation.

Another form of betrayal emerged from participants' responses. This related to betrayal of workers' right to a safe working environment in the form of *ineffective response*. Participants expressed that in cases of escalating aggression they have no means of being rescued other than to shout for help or run away.

> I had to shout for attention of other nurses on the ward.
>
> I had to call for help using intercom.
>
> Nobody came to help, l was alone and could not shout.
>
> We had to run away in search of help.

Assistance from hospital structures, including co-workers, was presented as unpredictable.

> I don't know what happened, the doctor holding one of the legs left it. Then the person also holding her other leg also left it and ran away. The patient then stood up and everyone ran away.
>
> … a doctor was around and ran out with a promise that he will look for more hands to support me. [Chorus group interruption] Hum! and did he come back? [Participant] Hum! Never. He did not come back.

One participant's narrative highlighted the ineffectiveness of 'alarm or alert response systems'.

> They all came together in group to attack me. Before l know what is going on, the patients just broke the louvers and said he would kill me if l don't open the gate. I immediately called the attendant at the other end of the gate to please open the gate immediately and quickly. But he thought l was joking. Thank God for intercom, so I called one of the consultant that stay in the compound to notify him of the situation of my unit. So he called and ordered that the gate should be opened, so they all left and he also came later to rescue me. After then, any patient that is admitted in drug unit is made to sign that they will not abscond from the hospital again.

And limited maintenance of what has been installed to raise the alarm.

> We had it, all got spoilt and they never repair.

Ineffective response was presented by participants to result in *heightened threat of injury*, including the severity of injuries sustained by nurses.

> She made second attempt to slap or strangulate me.
>
> Patient was angry and came to grab my penis. Then they carried me. The pain was so severe.
>
> For three days I lost sense of hearing.
>
> I was so traumatised that l sustained neck injury. I got home and was so traumatised that I could not sleep despite analgesics.
>
> The nurse was brutally injured and was admitted; afterward she had some off days to rest.
>
> They have killed many.

Theme 2: Power versus powerlessness

Participants' perceptions of their own powerlessness and their need to establish power within the clinical environment resulted in the first category of *asserting authority through intimidation*. Intimidating patients, specifically verbally aggressive patients and patients with a history of violent behaviour, through numerical strength, weight and height, was believed to be a violence prevention approach.

> When they see we are many, they behave themselves.
>
> The height and size of the nurse can be intimidating to the patient and will make them watch their actions.

Half of the participants verbally agreed with another participant who stated:

> If they know you will not take nonsense, they will behave well. Patients are usually scared when there are many nurses who are experienced.

Participants reported that engaging the patient in discussion rather than issuing a warning may present the nurse as 'soft' and easily conquered. Dialogue was rejected by participants in favour of commands.

> They also capitalize on the level of firmness and permissiveness of nurses.

This attitude of asserting authority is suggested to lead to descriptions of nursing practice that were categorised as *questionable practice*.

> Thank God l was proactive, I quickly took the chair and pinned her to the bed with it.
>
> I also put on a bold face and remove one of my shoes as if I want to attack her (the patient).
>
> Another method we use is distracting them and covering their head with counterpane.
>
> I learnt some developed countries, l believe, have gun to cause temporary paralyses for aggressive patient, also electro-conductive belt, those are the things we need.

> Recently the hospital started using ex-military men for crisis management, but patients went to court that they were mal-handled and the hospital stopped it. We need it.

The information gleaned from the pre-intervention focus group provided the Nigerian researcher an opportunity to identify the participants' attitudes and practices towards displays of aggression by the psychiatric patients in their setting. This information was used to inform the de-escalation presentation, as through video-chat calls the researchers were able to have access to the data gathered and discuss the need for emphasis to be placed on practice benefits of de-escalation, specifically safety.

Post-intervention focus group discussion data

As displayed in Table 3, participants' comments during the post-intervention focus group were all encapsulated by one theme – that of hopelessness. Hopelessness emerged to express participants' responses to the possible implementation of de-escalation as an aggression management strategy. Categories within this theme represented participants' substantiation of their rejection of de-escalation.

Table 3: Post intervention focus group theme and categories

Hopelessness	Heard it before Relationship dependent Crisis team

Participants indicated having heard of de-escalation previous to this intervention and discounted its value to them. In essence, it was mostly perceived as irrelevant to participants' context. This context was reported, and linked to the stages of anger, as almost always involving a patient who is out of control.

> I was surprised when you talked about the use of restrain and de-escalation in western world because l feel there is a more sophisticated approach they have that you can introduce to us.

> Talking to them does not usually yield positive result in every situation, physical restraint might be needful to prevent possible damage that may arise from aggression.

> We also use de-escalation approach but it does not yield positive results.

> The way their relations behave with them before they bring them is somewhat traumatising. The way they treat them at home before bringing them is usually annoying and they would have been so upset by maltreatment before bringing them down here that the issue of de-escalation at that time cannot work.

> … but some, especially with drug cases, there is nothing you can do to make them calm apart from physical restraint and sedation.

> Thank you for your presentation you were able to compare the traditional approach with the de-escalation approach. The approach is not new to us, but it can only be used on the ward after a relationship has been established with the patient, but not in emergency or assessment that is the entry point of the hospital, in such unit de-escalation cannot work. But on the ward de-escalation and traditional approach has to go hand in hand. The two are effective depending on the situation at hand.

As illustrated in the last extract, there was acknowledgment that the nurse-patient relationship could mediate the effectiveness of de-escalation. However, the nurse-patient relationship was perceived by participants as requiring time to develop. The possibility of communication strategies used within de-escalation to build rapport with a patient in that moment of verbal aggression was rejected. Participants' responses indicated their belief that the effectiveness of de-escalation was *relationship dependent*.

> De-escalation may not be possible always if a nurse that the patient can listen to is not on duty, then what is going to happen?

> De-escalation technique is possible in ward setting, but it depends on the level of relationship the nurse has built with patients over time.

> It can only be used on the ward after a relationship has been established with the patient.

> A nurse that is closer to a particular patient may find it easier to de-escalate the patient aggression.

Descriptions of aggressive and violent incidence reported in the pre-intervention focus group were returned to as justification of de-escalations' lack of value. Descriptions suggested that participants perceived themselves as moving from *crisis to crisis* in attempts to combat the re-occurrence of aggression, and prevent injury to self in what was perceived as an uncaring environment.

> They have killed many.

> So many have sustained injury.

> If she had killed me, nothing would have been done.

Participants reminded the researcher of their comments within the pre-intervention session, indicating that there was a need for more staff, at least a crisis team to essentially assist with restraint and sedation. Participants wanted a crisis team that would come to their aid. Descriptions seemed to suggest being rescued was the focus rather than being assisted.

> Physical restraint might be needful to prevent possible damage that may arise from aggression.

> She then asked me to narrate the story which l did and she immediately called for the file of six men, who were previously interviewed to serve as crisis intervention team for immediate employment
>
> They employ the crisis intervention team so that they will be readily available to intervene by preventing aggressive patient from harming the nurses or co-patents.

This desire for a crisis team was reiterated in the group meeting held for confirmation of data.

> You were able to capture all we said but don't forget the issue of crisis intervention team. You did not mention it. We need them to rescue in case of aggression, [Chorus answer] Yes. We really need that.

DISCUSSION OF RESEARCH RESULTS

Global movements have highlighted the maltreatment of the mentally ill, in particular those in psychiatric hospitals in LIMIC counties, leading to the development, and recommended use, of international policies and tool kits (WHO, 2012:47). Although these policies and tool kits include consideration for safety of mental health care practitioners, it is argued that study participants perceived themselves as forgotten. Participants' experiences and resultant fear, and possible persistent symptoms of trauma, have resulted in a belief that a militant approach is the only valid response, specifically within an acute mental health assessment care environment. The expressed desire for the involvement of armed forces to strengthen the capacity for nurses' control is contrary to Bowers' (2014:37) suggestion that de-escalation techniques require expressions of empathy and respect. This militant approach is argued to reflect participants' emotional trauma. Although participants claimed to 'know de-escalation techniques', it is argued that participants were unable to 'hear' due to a pervasive fear based on previous violent experiences. This is in keeping with the findings of Hallett and Dickens (2015:326) where participants chose seclusion and medication when, according to good clinical practice, de-escalation techniques would have been preferable. The reality of the occupational risks to mental health care nurses is reported in current literature. Yoshizawa, Sugawara, Yasui-Furukori *et al*. (2016:11) report that mental health nurses are prone to occupational hazards that inflict both physical and psychological injury, and a resultant estimated 37% probability of depression linked to occupational stress. What was clear in this study was participants' certainty that de-escalation techniques, specifically referenced as 'talking to the verbally aggressive patient', was not appropriate. This certainty and rejection of evidence-based practice within mental health care are reported by Gallo and Barlow (2013:101), who argue that evidence-based practice in mental health can fail to recognise the lifelong nature of learning, and we would add, the pervasiveness of own clinical experience learning in the acceptance or rejection of evidence-based

practice. Participants' experiences within this study are suggested to be the core of their rejection of de-escalation techniques, and based on the belief that de-escalation techniques, specifically talking and listening to the aggressive mentally ill person, these experiences have the potential to increase the likelihood of their subjection to violence and injury.

CONCLUSIONS AND RECOMMENDATIONS

A necessity exists for the development of Nigerian mental health legislation that will facilitate policy development aligned with the WHO (2012) rights-based approach and negate aspects of the current Nigerian *Lunacy Act* (1958). Recognition and enactment of the right to a safe work environment are critical and argued as core to the mental health nurses' investment in change. Price *et al*. (2015:453) suggest that although knowledge of de-escalation techniques and participant confidence to manage aggressive behaviour have the most significant impact on satisfaction with training, there is insufficient evidence that training in de-escalation techniques enhances practice performance. These authors further report participants' desire for 'live' demonstrations that incorporated broad case study presentations, feedback on actual clinical interactions, and 'real time' inclusion of the entire unit/ward team. It is recommended that further research utilising a participatory action research approach is required. Such an approach will address the persuasiveness of clinical experience, allow the participants to reflect, develop self-awareness, understand and respond to their specific context, while taking into account tensions related to participants' fear and safety and best practice guidelines derived from evidence-based practice.

REFERENCES

Arnold, E.C. & Boggs, K.U. 2015. *Interpersonal relationships: Professional communication skills for nurses*. 7th edition. Missouri, U.S.A: Elsevier Health Sciences. ISBN 978-0-323-24281-3

Bader, S., Evans, S.E. & Welsh, E. 2014. Aggression among psychiatric inpatients: The relationship between time, place, victims, and severity ratings. *Journal of the American Psychiatric Nurses Association*, 20(3):179–186.

Björkdahl, A., Hansebo, G., & Palmstierna, T. 2013. The influence of staff training on the violence prevention and management climate in psychiatric inpatient units. *Journal of Psychiatric and Mental Health Nursing*, 20(5):396-404. DOI: 10.1111/j.1365-2850.2012.01930.x

Bowers, L. 2014. A model of de-escalation. *Mental Health Practice*, 17(9):36–37.

Chukwujekwu, D.C. & Stanley, P.C. 2011. Prevalence and correlates of aggression among psychiatric in-patients at Jos University Teaching Hospital. *Nigerian Journal of Clinical Practice*, 14(2):163–167.

Drew, N., Funk, M., Tang, S., Lamichhane, J., Chávez, E., Katontoka, S., Pathare, S., Lewis, O., Gostin, L. & Saraceno, B. 2011. Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis. *The Lancet*, 378(9803):1664–1675.

Elo, S. & Kyngäs, H. 2008. The qualitative content analysis process. *Journal of Advanced Nursing*, 62(1):107–115. DOI: 10.1111/j.1365-2648.2007.04569.x

Gallo, K.P. & Barlow, D.H., 2012. Factors involved in clinician adoption and non -adoption of evidence-based interventions in mental health. *Clinical Psychology: Science and Practice*, 19(1):93–106.

Hallett, N. & Dickens, G.L. 2015. De-escalation: A survey of clinical staff in a secure mental health inpatient service. *International Journal of Mental Health Nursing*, 24(4):324–333.

Itzhaki, M., Peles-Bortz, A., Kostistky, H., Barnoy, D., Filshtinsky, V. & Bluvstein, I. 2015. Exposure of mental health nurses to violence associated with job stress, life satisfaction, staff resilience, and post-traumatic growth. *International Journal of Mental Health Nursing*, 24(5):403–412.

Jack-Ide, I.O., Uys, L.R. & Middleton, L.E. 2012. A comparative study of mental health services in two African countries: South Africa and Nigeria. *International Journal of Nursing and Midwifery*, 4(4):50–57.

James, B.O., Isa, E.W. & Oud, N. 2011. Patient aggression in psychiatric services: The experience of a sample of nurses at two psychiatric facilities in Nigeria. *African Journal of Psychiatry*, 14(2):130–133.

Loewenstein, K. & McManus, M. 2014. 'Don't Tell Me to Calm Down!': De-escalation of the agitated patient in a hospital setting. In Gallo, K. & Smith, L.G (eds,), *Building a culture of patient safety through simulation, an interprofessional learning* model, 171-186. New York: Springer Publishing Company. ISBN: 978-0-8261-6007-5.

Mc Andrew, S., Chambers, M., Nolan, F., Thomas, B. and Watts, P. 2014. Measuring the evidence: Reviewing the literature of the measurement of therapeutic engagement in acute mental health inpatient wards. *International Journal of Mental Health Nursing*, 23(3):212–220. DOI: 10.1111/INM.12044

Mitchell, A., Ahmed, A. & Szabo, C. 2014. Workplace violence among nurses, why are we still discussing this? Literature review. *Journal of Nursing Education and Practice*, 4(4):147–150. DOI: 10.5430/jnep.v4n4p147

Nelson, R. 2014. Tackling violence against health-care workers. *The Lancet,* 383(9926): 1373–1374.

Nestor, P.G. 2014. Mental disorder and aggression: Personality dimensions and clinical features. *American Journal of Psychiatry*, 59(12):1973–1978.

Papadopoulos, C., Ross, J., Stewart, D., Dack, C., James, K. & Bowers, L. 2012. The antecedents of violence and aggression within psychiatric in-patient settings. *Acta Psychiatrica Scandinavica*, 125(6):425–439.

Pompeii, L., Dement, J., Schoenfisch, A., Lavery, A., Souder, M., Smith, C. & Lipscomb, H. 2013. Perpetrator, worker and workplace characteristics associated with patient and visitor perpetrated violence (Type II) on hospital workers: A review of the literature and existing occupational injury data. *Journal of Safety Research*, 44:57–64.

Price, E., Baker, J., Bee, P. & Lovell, K. 2015. Learning and performance outcomes of mental health staff training in de-escalation techniques for the management of violence and aggression. *The British Journal of Psychiatry*, 206(6):447–455. DOI: 10.1192/bjp.bp.114.144576

Richmond, J.S., Berlin, J.S., Fishkind, A.B., Holloman, G.H., Zeller, S.L., Wilson, M. P. & Ng, A.T. 2012. Verbal de-escalation of the agitated patient: Consensus statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. *Western Journal of Emergency Medicine*, 13(1):17–25. DOI: 10.5811/westjem.2011.9.6864

Ukpong, D.I., Owoeye, O., Udofia, O., Abasiubong, F. & Ukpong, S. 2011. Violence against mental health staff: A survey in a Nigerian psychiatric hospital. *The Psychiatris*t, 35(2):46–49.

Westbrook, A.H. 2011. Mental health legislation and involuntary commitment in Nigeria: A call for reform. *Washington University Global Studies Law Review*, 10(2):397–418.

World Health Organization. 2012. WHO quality rights tool kit: Assessing and improving quality and human rights in mental health and social care facilities. World Health Oganization, Geneva. Retrieved from http://apps.who.int/iris/bitstream/10665/70927/3/9789241548410_eng.pdf (Accessed 05 November 2013).

World Health Organization. 2013. Mental health action plan 2013–2020. World Health Organization. Retrieved from http://www.who.int/mental_health/publications/action_plan/en/ (Accessed 15 October 2015).

Yoshizawa, K., Sugawara, N., Yasui-Furukori, N., Danjo, K., Furukori, H., Sato, Y., Tomita, T., Fujii, A., Nakagam, T., Sasaki, M. and Nakamura, K. 2016. Relationship between occupational stress and depression among psychiatric nurses in Japan. *Archives of Environmental and Occupational Health*, 71(1):10–15.