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De-escalation of aggressive behaviour in healthcare settings: Concept analysis

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ABSTRACT

Background: De-escalation is the recommended first-line response to potential violence and aggression in healthcare settings. Related scholarly activity has increased exponentially since the 1980s, but there is scant research about its efficacy and no guidance on what constitutes the gold standard for practice.
Objectives: To clarify the concept of de-escalation of violence and aggression as described within the healthcare literature.
Design: Concept analysis guided by Rodgers' evolutionary approach.
Data sources: Multiple nursing and healthcare databases were searched using relevant terms.
Review methods: High quality and/or highly cited, or otherwise relevant published empirical or theoretical English language literature was included. Information about surrogate terms, antecedents, attributes, consequences, and the temporal, environmental, disciplinary, and theoretical contexts of use were extracted and synthesised. Information about the specific attributes of de-escalation were subject to thematic analysis. Proposed theories or models of de-escalation were assessed against quality criteria.
Results: $N = 79$ studies were included. Mental health settings were the most commonly reported environment in which de-escalation occurs, and nursing the disciplinary group most commonly discussed. Five theories of de-escalation were proposed; while each was adequate in some respects, all lacked empirical support. Based on our analysis the resulting theoretical definition of de-escalation in healthcare is "a collective term for a range of interwoven staff-delivered components comprising communication, self-regulation, assessment, actions, and safety maintenance which aims to extinguish or reduce patient aggression/agitation irrespective of its cause, and improve staff-patient relationships while eliminating or minimising coercion or restriction".
Conclusions: While a number of theoretical models have been proposed, the lack of advances made in developing a robust evidence-base for the efficacy of de-escalation is striking and must, at least in part, be credited to the lack of a clear conceptualisation of the term. This concept analysis provides a framework for researchers to identify the theoretical model that they purport to use, the antecedents that their de-escalation intervention is targeting, its key attributes, and the key negative and positive consequences that are to be avoided or encouraged.

What is already known about the topic?

- De-escalation is frequently recommended as the first line intervention for imminent violence.
- De-escalation comprises a range of short-term psychosocial interventions aimed at reducing or eliminating aggression and violence.
- There is a lack of clarity about what precisely de-escalation entails and how best it should be implemented.

What this paper adds

- De-escalation is a collective term for a range of interwoven staff interventions, comprising verbal and non-verbal communication, self-regulation, assessment, and actions, whilst maintaining the safety of staff and patients.
- Models of de-escalation are either linear or cyclical, the former aligning with the assault cycle theory, and the latter with current research on event sequencing in inpatient aggression.
- Administration of PRN medication, and de-escalation itself, both

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appear to play an important role in unfolding incidents involving or potentially involving aggression.

1. Introduction

Violence and aggression by patients in healthcare settings is a global problem (Iozzino et al., 2015) with those working in mental health and medical emergency departments most at risk (Bowers et al., 2011; Phillips, 2016). Aggression can be verbal, physical, or sexual; the most commonly experienced by healthcare staff is verbal (Iennaco et al., 2013), but around a third of nurses in mental health settings have experienced physical violence (Spector et al., 2014). Violence causes short- and long- term physical and psychological harm for staff victims, and has been linked to burnout (Galián-Muñoz et al., 2014), decreased productivity, increased absenteeism (Gates et al., 2003), and interrupted patient care (Roche et al., 2010). The financial costs are significant: in the UK, £178 million, approximately half of all annual mental health nursing resources, are used to address and contain conflict (those things that patients do to threaten staff and patient safety e.g. aggression, absconding, self-harm) (Flood et al., 2008). Violence prevention, therefore, should be a priority. There is currently insufficient evidence to determine the safety and efficacy of intrusive and coercive interventions including seclusion and restraint (Nelstrop et al., 2006), and in the US the National Association of State Mental Health Program Directors have concluded that 'every episode of restraint or seclusion is harmful to the individual and humiliating to staff members' (Haimowitz et al., 2006, pg. 31). Professional guidelines recommend that coercive measures should not be considered as first-line interventions for potentially violent incidents (Haimowitz et al., 2006; Khwaja and Beer, 2013; Institute for Health and Care Excellence, 2015), and endorse de-escalation instead, with more restrictive measures being used only in the event of its failure to avert violence.

The term de-escalation was first used in discourses about violence prevention in health and social care in the mid-1980s (e.g. Infantino and Musingo, 1985; Kaplan and Wheeler, 1983). It had occurred in the health literature before this to describe a tailing off of any one of a range of behaviours or situations towards eventual extinction, for example "opiate use" or "crisis". However, in the context of violence, the term had largely been used in scholarly works to describe geo-political conflict resolution (Azrael, 1978); specifically the reduction of western military involvement overseas (e.g. Darling, 1969; Tierney, 1969) and negotiation of opponent concessions through unilateral action in nuclear arms discussions (Wall, 1977). By the late 1970s the term was used in the context of police training in the management of domestic violence (Bell, 1979). In healthcare, use of the term has grown and has supplanted other terms for aggression management, such as 'control and restraint' which was an approach utilised in training programmes first in prisons and subsequently in mental health services in the UK and Canada which focused on self-defence, the use of pressure points, and martial arts-influenced holding and restraint techniques (Ryan, 2010).

From a public health perspective de-escalation has been defined as the main form of secondary violence prevention, occurring in the face of imminent aggression. This is in contrast to primary prevention which involves steps that are taken to prevent or reduce the likelihood that violent behaviour will be initiated, and tertiary actions which aim to reduce the impact of violence during its occurrence and in its aftermath (Paterson et al., 2004). De-escalation is described as a psychosocial intervention, which should be used as the first-line response to violence and aggression (National Institute for Clinical Excellence, 2005). *Pro re nata* (as required; PRN) medication can be used as part of a strategy to de-escalate (National Institute for Health and Care Excellence, 2015), however there are risks, including increased morbidity and inappropriate use (by staff and patients), which are not associated with psychosocial de-escalation (Hilton and Whiteford, 2008).

Several writers have provided conceptual and operational definitions of de-escalation in healthcare settings (e.g. Clinical Resource and Audit Group, 1996; Cowin et al., 2003; Institute for Health and Care Excellence, 2015). Some writers argue that de-escalation qualities are innate (Kindy et al., 2005) while others purport that their use and effectiveness develops through experience (Johnson and Hauser, 2001), or can be learnt through role-modelling and education (Beech and Leather, 2006; Kaufman and McCaughan, 2013; Pestka et al., 2012). However, despite these differing perspectives, Bowers (2014, p. 36) notes that there are currently 'no systematic descriptions about what de-escalation is'. Furthermore, it is unclear whether definitions of de-escalation in healthcare have changed or evolved over time.

The aim of this paper was to conduct a concept analysis of de-escalation in healthcare in order to provide clarity for researchers, educationalists, and clinicians about the issue. An improved understanding of the concept has the potential to inform the theoretical underpinnings of de-escalation and help embed de-escalation principles in health care and educational culture with the ultimate aims of improving violence prevention and reducing the incidence of inappropriately restrictive interventions.

2. Methods

Concept analysis is a form of literature review which aims to clarify concepts that are important in academic discourse but which lack definitional clarity (Tofthagen and Fagerstrøm, 2010). For the purpose of this review Rodgers' (2000) evolutionary method was used. This method involves setting contextual parameters for the time span of the review, the discipline(s) to which it is intended to apply, and the environment in which it occurs. Unlike Walker and Avant's (2005) method, the primary focus of the evolutionary approach is not to construct fictitious model, borderline and alternate cases of the concept; instead, the process is inductive so 'real world' exemplars are identified. The aim of an evolutionary analysis is to provide a starting point for ongoing development of the concept as it evolves in usage (Rodgers, 2000). This involves identification of the component attributes of the concept that constitute a 'real' definition of when and where it is used, how, and by whom: (i) 'surrogates' are terms used interchangeably with the concept; (ii) 'antecedents' are actions and events that precede the concept; (iii) 'consequences' are those that follow; (iv) 'attributes' are the component characteristics of the concept; (v) 'context', describes the temporal, disciplinary, environmental, and theoretical contexts of the concept. The latter point addresses Paley's (1996) concern that concept analysis fails to provide theoretical context. Finally, by providing clear details, we have addressed Draper's (2014) criticism that concept analyses typically lack explicit inclusion and exclusion criteria, and do not describe the data extraction process.

2.1. Data sources

We searched multiple databases (AMED, BNI, CINAHL, Embase, Medline and PsycINFO) from 1980 to April 2017. This period was selected as extensive internet searching failed to reveal mention of de-escalation in the healthcare context prior to 1980. The search terms used were: "de-escalat*" or deescalat*" or "conflict resolution" or "talk down" combined with "violen*" or "aggress*" or "assault*".

2.2. Data selection and analysis

Included papers were discursive, contextual, or theoretical accounts, empirical research studies, or literature reviews that used the term de-escalation or a synonym in the article title or abstract. Other literature about the de-escalation of violence or aggression without explicit mention of the term were also considered for inclusion. Exclusion criteria were non-English language papers, and those not within the health and social care context. Papers that mentioned de-escalation, but did not describe any of the components of de-escalation required for the concept analysis, were also excluded. Additional