De-escalation: A methodology to reduce coercive measures in clinical psychiatry. A project based on Action Research Principles.


This paper briefly presents a PhD project about de-escalation in clinical psychiatry in Region Zealand, Denmark. 2012 – 2015.

The study investigates whether coercive measures and violence can be reduced in psychiatric wards when staff uses a deescalating approach, as the patient's behaviour is escalating. The study is based on action research principles and the objective is to identify, characterize and test deescalating methods that can "... redirect a patient towards a calmer personal space ..." (National Institute for Clinical Excellence, 2005). Successful de-escalation might prevent violence, and if a patient experiences rapid assistance, the use of coercive measures might be reduced.

De-escalation is the collective term for a range of psychosocial interventions to reduce stress and anxiety in escalated and violent situations. De-escalation is a complex, interactive process, which guides the patient toward a calmer personal space (ibid: 24 - 25), through the use of specific communicative techniques and psychosocial interventions and by a staff focus on having control of the situation and not the patient.

De-escalation in a psychiatric context is a relatively new phenomenon in Denmark. Denmark has no official professional guidance on handling violence, as the National Health Service in GB (NICE guideline for the management of disturbed / violent behaviour in psychiatry (ibid)). This NICE guideline recommends de-escalation as a preventive intervention.

NICE identifies various theoretical approaches to de-escalation and points out that these are not substantiated scientifically and can be contradictory (ibid: 24 - 25). According to NICE it is not known whether de-escalation affects the use of coercion. Following, nurses must act on intuition in clinical situations, without evidence of efficacy. NICE recommends further research in order to examine whether de-escalation techniques minimise the use of coercive measures.

Coercion in Danish psychiatry
A major national effort to reduce the use of coercion in Danish psychiatry (Danske Regioner, 2008; Sundhedsstyrelsen, 2011) has failed to affect the use of coercive measures. The number of coercive
measures has over the last 10 years remained unchanged. About one fifth of patients submitted to a psychiatric hospital are involved in some form of coercion.

**Aim and research questions**
The study investigates how de-escalation affects the use of coercive measures in a psychiatric context. The objective is to identify, describe and test verbal and nonverbal de-escalating methods, which support the interactive process whereby the patient is directed to a calmer personal space and support the self-control of the aggressive patient.

1. How does the research literature describe verbal and nonverbal deescalating methods?

2. How do health professionals handle deescalating behaviour without any use of coercive measures?
   a. How do mental health workers act in aggressive and threatened situations?
   b. What factors does the patient experiences as calming down /escalating?
   c. What motivates mental health workers to use de-escalation?

3. What impact has the application of evidence-based knowledge on the practice of de-escalation in clinical practice?
   a. How does de-escalation affect violence and the use of coercive measures in a psychiatric ward?
   b. How does de-escalation affect the relationship between the patient and the mental health worker?

4. What kind of de-escalating, redirect the patient to a calmer personal space?

**Design and Methodology**
The project is designed as an exploratory, descriptive and implementing study that develops and tests actions of de-escalation in a psychiatric ward in Region Zealand. The project further evaluates affects on incidence of violence and coercive measures.

Strategies from different qualitative methods are combined in order to answer the overall research aim: To understand the deescalating approach.

The theoretical framework underpinning the practical research study is the social science and principles of action research (Reason and Bradbury, 2008).

The study and the process are partly conducted in close collaboration with co-researchers.

**Data collection**
Data is created through different sources; a literature search, a textual analysis and case studies. In view of this data actions for de-escalation is developed and implemented in the acute admission ward in Zealand.

Throughout the project the following data is collected:
BVC (Brøset Violence Checklist (Björkdahl et al., 2006; Woods and Almvik, 2002)), SOAS-R (Staff Observation Aggression Scale (Nijman et al., 2005, 1999), registered coercion, patient complaints and registered injuries among staff.

**Participants**
The study involves staff employed in psychiatric wards and patients admitted to psychiatric wards in Region Zealand.

In order to anchor the research project in clinical practice throughout the research process, an advisory group and workgroups are established. These groups contribute throughout the project. The advisory group includes representatives from the external level, the managerial level and the operational level.

**Study setting**
The clinical study is carried out at one acute admission ward in the Zealand Region of Denmark. The ward has a long history based on tradition of toughness and cultural routines including emphasize and control and the use of physical restraint. The study is carried out from December 2012 – December 2015.

**Expected outcome**
Since the project uses an action research methodology it has no a priori structure for what kind of deescalating method will be developed. But hopefully the outcome will be a qualified guide-line of de-escalating methods that can: "... redirect a patient towards a calmer personal space", and a description of de-escalation based on verbal and nonverbal psychosocial interventions.

**Approval and ethics**
The project is carried out in accordance with the Declaration of Helsinki II principles. There are no risks, disadvantages or discomfort associated with the project to the involved participants. Informed consent of the involved participants is obtained during the project. Participants are informed orally or in writing of the purpose, methods, anticipated benefits, potential risks of the study and opportunities to discontinue. All material is confidential and publication of results is done in a way, so that it is not possible to recognize individuals. The project is reported to the Data Committee. The project has been submitted to the local Research Ethics Committee, which has estimated that the project does not fall under the notification obligated for biomedical research.

**References**

Preliminary Timetable

2012 Preparing the study
• Entering the field
• Identifying core values
• Literature search

2013 Preparing the actions
• Identifying the typical aggressive incidents (Textual analysis)
• Review on de-escalating
• Conducting
• Entering the field
• Conducting working groups and co-researchers
• Identifying core values
• Preparing actions

2014 Implementing the actions
• Implementing the actions
• Following the baseline data

2015 Analysing the result
• Building a theory
• Writing the thesis.