School of Nursing

How mental health nurses can use recovery-focused care to reduce aggression in the acute mental health settings

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DECLARATION

To the best of my knowledge and belief, this thesis contains no material previously published by any other person except where due acknowledgment has been made.

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (2007) – updated March 2014. The proposed research project received human research ethics approval from the Curtin University Human Research Ethics Committee, Approval Number HR132/2015. The research study received human research ethics from the South Metropolitan Research Ethics Committee, Approval Number 2016-210.

Signature ……

Date 7th January 2022 ……...

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ABSTRACT

This hybrid thesis consists of eight chapters and reports on research that explored how mental health nurses can use recovery-focused care to reduce aggression. The focus of the research was the acute mental health setting where aggression is a common occurrence that impacts both consumers and health professionals.

Background: Globally, the use of recovery-focused care is recognised as evidence-based best practice to care for people with mental disorders (also referred to as consumers in this thesis). Working collaboratively with the consumers (Roper, Grey, & Cadogan, 2018), mental health nurses can use recovery-focused care to support the person to experience connectedness, hope and optimism about the future, identity, meaning in life, and empowerment (Leamy, Bird, Boutillier, Williams, & Slade, 2011). Yet, how mental health nurses engage consumers at risk of aggression in co-production and their use of recovery-focused care in the acute mental health setting remains relatively unexplored.

Aim: The research aimed to explore key stakeholders' (mental health nurses and consumers) beliefs of how recovery-focused care can be used to reduce aggression in the acute mental health settings. It explored consumers' beliefs about the causes of aggression and their understanding of recovery-focused care and the knowledge, skills, attitudes and beliefs that mental health nurses hold regarding the use of recovery-focused care with consumers at risk for aggression.

Methods: A two-phase sequential exploratory mixed methods research design was used. Phase 1 comprised two qualitative studies using semi-structured interviews to collect data from mental health nurses (study 1a) and with consumers (study 1b). All stages of the research process in Phase 1, from participant

recruitment, data collection, coding, analysis, interpretation, and writing up of the findings were guided by the grounded theory method (Charmaz, 2006). Phase 2 involved two studies that followed the steps of Q methodology to determine: a) the knowledge and skills (Phase 2a) and b) beliefs and attitudes (Phase 2b) components of recovery-focused care provided by mental health nurses to reduce aggression.

Results: Twenty-seven mental health nurses participated in Study 1a (Publication 3) which explored mental health nurses' perspectives on how recovery-focused care could be used to reduce aggression. Data analysis generated five categories and they were: (i) identify the reason for the behaviour before responding; (ii) being sensitive to the consumer's trigger for aggression; (iii) focus on the consumer's strengths and support, not risks; (iv) being attentive to the consumer's needs; and (v) reconceptualise aggression as a learning opportunity. These categories provided an understanding of the strategies that mental health nurses could use to increase the consumers' self-regulatory ability.

In Study 1b (Publication 4), 31 consumers were interviewed about the causes of aggression and how mental health nurses can use recovery-focused care to reduce aggression in the acute mental health settings. The analysis of data contributed to five categories 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. These categories captured the consumers' perspectives of recovery-focused can be used clinically to promote self-management of their aggression risks.

In Phase 2, 40 mental health nurses participated in Study 2a (knowledge and skills) and 58 mental health nurses participated in Study 2b (beliefs and attitudes). Factor analysis of the Q sorts provided by the participants in Study 2a revealed five factors: (I) acknowledge the consumers' experience of hospitalization; (II) reassure consumers who are going through a difficult time; (III) interact to explore the impact of the consumer's negative lived experiences; (IV) support co-production to reduce triggers for aggression; and (V) encourage and support consumers to take ownership of their recovery journey. These factors explained the knowledge and skills components of recovery-focused care used by mental health nurses to reduce aggression. The findings of this study were discussed in Publication 5.

Similarly, factor analysis of the Q sorts provided by the participants of Study 2b revealed five factors that explained the beliefs and attitudes of mental health nurses that influenced them to use recovery-focused care. These factors implied that mental health nurses are likely to use recovery-focused care when aggression is triggered by the consumer's (I) dynamic lived experience; (II) intense reactions; (III) distressing thoughts; (IV) dysregulating emotions; and (V) ineffective communications..

Conclusion: Theoretically, the significant findings of this research provide evidence-based knowledge for mental health nurses to understand how they can translate the use of recovery-focused care clinically to reduce aggression. Pragmatically the significant findings can support mental health nurses with more interactive clinical strategies to acknowledge consumers as experts by lived experience and to work collaboratively with them to reduce aggression. The recommendations and suggestions for future research are presented and if

implemented, may assist in reducing the use of restrictive practices and nurture a truly recovery-focused culture of care in acute mental health settings.

LIST OF PUBLICATIONS

Publication 1

Lim, E., Wynaden, D., & Heslop, K. (2017). Recovery-focussed care: How it can be utilize to reduce aggression in the acute mental health setting. *International Journal of Mental Health Nursing, 26*(5), 445-460. doi: 10.1111/inm.12378

Publication 2

Lim, E., Wynaden, D., Baughman, F., & Heslop, K. (2021). Realising the potential of Q methodology in nursing research. *Collegian, 28*(2), 236-243. doi: 10.1016/j. colegn.2020.08.004

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Lim, E., Wynaden, D., & Heslop, K. (2019). Changing practice by using recovery-focused care in acute mental health settings to reduce aggression: A qualitative study. *International Journal of Mental Health Nursing, 28*(1), 237-246. doi: 10.1111/inm.12524

Publication 4

Lim, E., Wynaden, D., & Heslop, K. (2019). Consumers' perceptions of nurses using recovery-focused care to reduce aggression in the acute mental health including forensic mental health settings: A qualitative study. *Journal of Recovery in Mental Health, 2*(2/3), 21-34. https://jps.library.utoronto.ca/index.php/rmh/ article/view/32741/25119

Publication 5

Lim, E., Wynaden, D., Heslop, K. (2021). Using Q methodology to explore mental health nurses' knowledge and skills to use recovery-focused care to reduce aggression in acute mental health settings. *International Journal of Mental Health Nursing, 30*, 413-426. doi: 10.1111/inm.12802

ASSOCIATED AWARD, CONFERENCE AND PEER-REVIEWED PRESENTATIONS, AND POSTER PRESENTATION

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Lim, E., Wynaden, D., & Heslop, K. (2016). Reducing aggression in the acute mental health setting using recovery-oriented mental health practices: A systematic search and review. Presented at the Curtin University Mark Liveris Student Research Conference, Perth, Australia (1st September 2016).

Lim, E., Wynaden, D., & Heslop, K. (2017). Recovery-focused care: How it can be utilized to reduce aggression in the acute mental health setting. Presented at the Curtin University Mark Liveris Student Research Seminar, Perth, Australia (1st October 2017).

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GLOSSARY OF ABBREVIATIONS

ACMHN	Australian College of Mental Health Nurses Inc
AMHS	Acute Mental Health Settings
APA	American Psychological Association
CINAHL	Cumulative Index of Nursing and Allied Health Literature
CIOMS	Council for International Organizations of Medical Sciences
DSM	Diagnostic and Statistical Manual of Mental Disorders
EBSCO	Elton B. Stephens Company
EC	Ethics Committees
Et al.	Et Alii (And Others)
E.g.	Exempli gratia
EMBASE	Excerpta Medica Data Base
EV	Eigenvalues
HR	Human Research
JBI	Joanna Briggs Institute
MEDLINE	Medical Literature Analysis and Retrieval System Online
MHNs	Mental health nurses
N	Number
NHMRC	National Health and Medical Research Council
NSW	New South Wales
PCC	Population/Concept/Context
PhD	Doctor of Philosophy
P.	Page
P	Participant
PRN	Pro Re Nata
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
PsycArticles	Psychological Articles
PsycINFO	Psychological Information Database
PubMed	Public/Publisher MEDLINE
Qual	Qualitative
Quan	Quantitative
RFC	Recovery-focused care

SPSS	Statistical Package for the Social Sciences
SIC	Intentionally so written
WA	Western Australia
WRAP	Wellness Recovery Action Plan
WERP	Wellness Enhancement and Recovery Program
Z	Standard normal distribution

SECTION A

Chapter 1 – Introduction and background

Chapter 2 – Literature review

CHAPTER 1

INTRODUCTION AND BACKGROUND

1.1 Introduction

This hybrid thesis presents the findings of research that explored how the use of recovery-focused care (RFC) by mental health nurses (MHNs) can reduce the risk for aggression of people admitted to acute mental health settings (AMHS). The thesis is comprised of traditional thesis chapters and five peer-reviewed publications. The 6th Edition of the American Psychological Association (APA) publication manual has been used throughout this thesis to guide the presentation and referencing style.

The use of RFC (also known in some countries as recovery-oriented care/practice) is important to the global effort to reduce or eliminate the use of restrictive practices in mental health settings, which are often used to manage aggression (Gooding, McSherry, Roper, & Grey, 2018). RFC acknowledges the consumer's lived experience and its impact on their presenting behaviours and encourages MHNs to work collaboratively with the person to promote both their clinical and personal recovery (Slade, 2013).

The research was conducted in Australia and in line with Australian mental health policy, the term 'consumer' is used throughout the thesis to refer to a person who identifies as having a current or past lived experience of mental disorder. It is also used to refer to a person who is utilising or has utilised a mental health service. (Commonwealth of Australia, 2017; Western Australian Mental Health Commission, 2015). The researcher is aware that in other countries, terms such as service user, patient or client are used.

Chapter 1 details background information that provides support for this research. This includes information on mental health recovery, the impact of aggression on consumers and health professionals, together with the role that MHNs play in reducing the risk for and managing aggression when it occurs.

1.2 Background

The emergent concept of 'recovery' from a mental disorder can be traced back to the beginning of the 20th century with the birth of the consumer-survivor movement in mental health, the process of deinstitutionalisation, the introduction of new psychotropic drug treatments, the widening legal conceptions of consumer rights, and the intellectual critiques associated with the antipsychiatry movement (Fakhoury & Priebe, 2002; Tomes, 2006). The concept of 'recovery' as defined by the consumer-survivor movement, was a shift away from the traditional medical model of clinically managing and preventing relapse of mental disorders, towards health professionals collaborating and supporting consumers to achieve their personal goals while taking increasing responsibility for their health and wellbeing (Slade, 2009b). The radical restructuring of mental health services which began in the United States of America referred to as deinstitutionalisation, shifted the care and treatment for people diagnosed with mental disorders from psychiatric institutions to mainstream general health care services and community-based mental health services (Fakhoury & Priebe, 2002). The premise for restructuring the mental health system was based on human rights and equality issues, reducing mental health stigma and discrimination, and problems with the chronic overcrowding in psychiatric institutions (Kalucy, Thomas, & King, 2005; Ryan, Marks, & Heffernan, 2018).

While the shift from institutional to community-based living was viewed as intrinsically more therapeutic for consumers, there was a lack of systemic planning or adequately placed community-based services to support their care and treatment (Fakhoury & Priebe, 2002; Lamb & Bachrach, 2001). Many consumers experienced a significant loss of the quality of life associated with community resistance, severe fragmentation of services, and insufficient and inadequate social and housing opportunities (Lamb & Bachrach, 2001). Inevitably, the consumer-survivor movement was born to advocate for the need to provide more residential, vocational, educational, and social supports to meet the needs and wellbeing of consumers (Anthony, 1993; Davidson & Schmutte, 2020; Fakhoury & Priebe, 2002; Jacobson & Curtis, 2000; Myers, 2010).

The consumer-survivor movement in the United States of America allowed individuals to share the accounts of their recovery and laid the foundation for the recognition that people diagnosed with a mental disorder can and do recover when they receive appropriate support and care (Anthony, 1993; Carpenter, 2002). Globally and successively, compilations and syntheses of recovery accounts, many of which were shared by accomplished mental health professionals began to emerge (Carpenter, 2002; Slade, 2009b). The centrality of their accounts was having hope, identity, meaning, and personal responsibility, and this contributed to the understanding of recovery as a personal journey to experience personal health and self-growth to live a contributing and satisfying life (Coffey et al., 2019; Horsfall, Paton, & Carrington, 2018; Slade et al., 2011; Slade & Longden, 2015). The recovery promulgated by the consumer-survivors is known as ‘personal recovery’ and is different from the traditional ‘clinical recovery’ which primarily focuses on

the reduction or remission of psychiatric symptoms (Davidson & Schmutte, 2020; Park et al., 2014; Penas, Moreno, Uriarte, Ridgway, & Iraurgi, 2017).

The concept of recovery although originating in the United States of America is now a familiar part of the language of mental health policy, service provision, and research worldwide (Buchanan-Barker & Barker, 2008; Ellison, Belanger, Niles, Evans, & Bauer, 2018; Kartalova-O'Doherty, Stevenson, & Higgins, 2012; Nakanishi et al., 2021; Ramon, Healy, & Renouf, 2007). There are many empirical models of recovery, such as the Recovery College (R. Perkins, Repper, Rinaldi, & Brown, 2012), Recovery Star (4th Edition) (Triangle Consulting Social Enterprise Limited, 2021), the Wellness Recovery Action Plan (WRAP) (Copeland Center, 2020), and the Wellness Enhancement and Recovery Program (WERP) (Tierney & Kane, 2011). These models aim to support people to rebuild their confidence in living with a mental disorder, experience social connectedness, learn skills that they need to live meaningfully in the community, and ultimately regain control over their mental disorder and live productive lives (Copeland Center, 2020; R. Perkins et al., 2012; Pledger, 2018).

1.2.1 The recovery movement in Australia

In Australia, the Human Rights and Equal Opportunity Commission launched a national inquiry into the human rights of consumers and published the Burdekin report (Burdekin, 1993) demanding the rights of consumers be upheld by mental health services. As a result of the national inquiry, the National Mental Health Strategy was introduced in 1992 and implemented through a series of five-year National Mental Health Plans (Commonwealth of Australia, 1992, 1998, 2003, 2009, 2017). The strategy aims to promote the mental health and wellbeing of the

Australian community through: a) the promotion of mental health; b) early intervention and treatment for consumers; c) reducing the impact of stigma and discrimination towards consumers and their families; d) promoting mental health recovery, and e) assuring the rights of consumers to participate meaningfully in society (Commonwealth of Australia, 2017; Whiteford & Buckingham, 2005).

The Australian National Mental Health Strategy has resulted in significant shifts in where and how mental health services are delivered. Most consumers receive care and treatment in their local community with the support of community-based mental health services, non-government organisations and community support services (Australian Government, 2011). They only access inpatient services if they become acutely unwell, can no longer be supported in the community, or are deemed to be a risk to self or others (Australian Government, 2011). It is also an ongoing priority of the Australian National Mental Health Strategy for the Australian Government to have a sustainable, skilled, and appropriate mental health workforce to provide recovery-focused mental health services for people accessing mental health care (Australian Government, 2011). Importantly, this workforce now includes peer support workers who have lived experience of living with a mental disorder (Byrne, Roennfeldt, Wang, & O'Shea, 2019).

1.2.2 Recovery-focused care (RFC)

RFC is a clinical approach used by health professionals that supports consumers to achieve their personal recovery alongside clinical recovery (Coffey et al., 2019). RFC care is a strengths-based approach that uses hope-promoting strategies to support the person to have active involvement in their care and treatment, for example self-determination, shared decision-making, and choice

empowerment (Laitila, Nummelin, Kortteisto, & Pitkänen, 2018; Park et al., 2014; Slade et al., 2014; Wyder et al., 2017). Co-production, a term now embedded in Australian mental health policy, refers to the partnership where consumers and health professionals share responsibility in problem identification, designing and delivering the solution and evaluating the outcomes in care delivery (Clark, 2015; Kidd, Kenny, & McKinstry, 2015; Roper et al., 2018). Co-production supports the consumer to improve their mental health literacy, realise or develop their existing strengths and resources, achieve self-growth, and facilitate social connectedness to assist them to live meaningfully in their community following discharge from hospital (Cambers, 2016; Coffey et al., 2019; Jacob, Munro, & Taylor, 2015; Waldemar, Esbensen, Korsbek, Petersen, & Arnfred, 2018).

The principles underlying RFC outlined by the Australian Government support: a) that consumers can recover from mental ill-health; b) that care is person-centred and uses an evidence-based approach; c) that the unique circumstances and experiences of each individual are acknowledged; d) that a range of factors impacts the person's level of wellbeing; and e) care uses a trauma-informed approach (Australian Government, 2013). While the use of RFC is now viewed as important to support consumer recovery, how it has been implemented clinically has been identified as problematic (Cleary, Horsfall, O'Hara-Aarons, & Hunt, 2013; Coffey et al., 2019; Le Boutillier et al., 2015; McKenna, Furness, Dhital, Ennis, et al., 2014). There are few guidelines to support health professionals to implement RFC clinically and how its use may reduce aggression in AMHS remains relatively unexplored (Coffey et al., 2019).

1.3 Aggression in the acute mental health setting

The AMHS is a specialist mental health setting that provides voluntary and involuntary (under designated Mental Health Acts) inpatient care and treatment for people experiencing an acute phase of their mental disorder (Australian Government, 2020). Internationally, aggression in AMHS is a major problem and it is estimated 75% to 100% of mental health professionals will encounter aggression during their work-life (Chambers, Kantaris, Guise, & Välimäki, 2015; Iozzino, Ferrari, Large, Nielssen, & de Girolamo, 2015; Olupona, Virk, Ishola, & Akerele, 2017). Aggression is defined as any behaviour that can inflict harm to others, for example verbal abuse (including shouting or swearing); physical assaults (such as hitting, kicking, and spitting); or intentionally causing damage to property (Dickens, Picchioni, & Long, 2013).

Duxbury (2002) identified three primary reasons why a person may be aggressive when hospitalised in the AMHS. These are: 1) internal factors, for example, the person's symptoms associated with their mental disorder, personality disorder, and/or substance abuse; 2) external factors such as the ward structure, restrictiveness of the environment, crowding, and noise; and 3) situational factors, for instance ineffective or miscommunication, or getting involved in a conflict with staff or other consumers. More importantly, the consumer's lived experience for example, being involuntarily admitted to AMHS under a Mental Health Act and being subjected to coercive care and treatment have also identified as a potential reason for aggression (Schmidt & Uman, 2020; Tingleff, Bradley, Gildberg, Munksgaard, & Hounsgaard, 2017; Watson, Thorburn, Everett, & Fisher, 2014).

Frequent episodes of aggression in the workplace can erode the quality and safety of health care and impact the consumer's wellbeing and satisfaction with the

treatment they receive (Hills, Lam, & Hills, 2018; Lantta, Anttila, Kontio, Adams, & Välimäki, 2016). For example, an AMHS may be minimally furnished to decrease the risk for consumers who may be aggressive in injuring themselves or others. This can also make the environment feel less homely and conducive for the consumer to self-regulate their behaviour effectively (Greenwood & Braham, 2018). Additionally, there may be a lack of privacy, limited outdoor access, and locked doors, all of which can make the consumer feel disempowered, frightened, uncomfortable, and unsafe (Cutler, Sim, Halcomb, Moxham, & Stephens, 2020; Greenwood & Braham, 2018; Lamanna et al., 2016; Slemon, Jenkins, & Bungay, 2017).

Frequent episodes of aggression in this setting can substantively increase health care expenditure due to medical and legal costs, higher staff ratios, or the use of security guards to maintain safety (Grossi et al., 2015; Heckemann, Hahn, Halfens, Richter, & Schols, 2019; Morphet et al., 2014; Tattoli, Bosco, Grattagliano, & Di Vella, 2019). To counter this, services may adopt a risk-averse approach towards aggression resulting in a low threshold of tolerance for the presence of any disruptive behaviour and emotion (Slemon et al., 2017). When the consumer's risk for aggression escalates, health professionals try to communicate with the person to de-escalate the situation. However, if the person's behaviour passes the threshold of tolerance, the use of restrictive practices such as pharmacological interventions, physical restraint, or seclusion may be used to manage the escalating situation (Barr, Wynaden, & Heslop, 2018; McKenna, McEvedy, Maguire, Ryan, & Furness, 2017; Muir-Cochrane, O' Kane, & Oster, 2018; Ziaei, Massoudifar, Rajabpour-Sanati, Pourbagher-Shahri, & Abdolrazaghnejad, 2018). Yet, the use of restrictive practices can increase the consumer's level of anxiety, distress, and fear of losing control of the immediate situation (Papadopoulos et al., 2012; Wilson, Rouse, Rae, & Kar Ray,

2017). Negative experiences when accessing mental health services can significantly impact the consumer's overall satisfaction with health care provided and may discourage them from seeking help in the future and hinder their recovery journey (Malky, Wahab, El-Amrosy, & Fiky, 2016; Papadopoulos et al., 2012).

1.3.1 The links between consumer lived experience and aggression

There is increasing evidence that the consumer lived experience can be a trigger for aggression and that this experience is not always assessed or fully understood by health professionals (Muskett, 2014; Vidal, Reynolds, Praglowski, & Grados, 2020). For example, a person may have a higher risk for aggression if they have experienced trauma, such as childhood neglect, sexual abuse, domestic violence, social discrimination or stigma (Horsfall et al., 2018; Paterson, McIntosh, Wilkinson, McComish, & Smith, 2013; Starnino & Sullivan, 2016). As a result, lived experiences associated with feelings such as anger, fear, and shame may be expressed as aggression (Horowitz, Guyer, & Sanders, 2015; Starnino, 2016).

If the consumer's lived experience is not accurately assessed, health professionals may believe that internal factors are the underlying cause of the person's aggression and use practices such as pro re nata (PRN) medications to manage the situation (Dawood, 2013; Dickens, Piccirillo, & Alderman, 2013; Tomagová, Bóriková, Lepiešová, & Čáp, 2016). The use of restrictive practices may further traumatise the person and intensify their level of risk (Ashcraft & Anthony, 2008; Fletcher et al., 2017; Kuivalainen et al., 2017; Wilson et al., 2017).

MHNs place emphasis on building therapeutic relationships (Chambers, 1998; Zugai, Stein-Parbury, & Roche, 2015) and they spend more time engaging with consumers than other health professionals (Jonker, Goossens, Steenhuis, &

Oud, 2008; Llor-Esteban, Sánchez-Muñoz, Ruiz-Hernández, & Jiménez-Barbero, 2017; Vandecasteele et al., 2015). The nature of the nurse-consumer engagement allows MHNs the ability to obtain an accurate assessment of the person's lived experience and to identify strategies to best support the person and their recovery. Those nurses who have an accurate understanding of the consumer's lived experience are more likely to practice RFC and support the individual to instil hope, build a positive sense of self-identity, and regain self-regulation of their thoughts and emotions, thus reducing their risk for aggression and the potential use of restrictive practices (Davidson, O'Connell, Tondora, Lawless, & Evans, 2005; Slade, 2013). Improved mental health literacy along with the ability for a consumer to self-manage personal triggers for aggression can also increase their self-esteem, sense of control and promote recovery (Kidd et al., 2015; Walsh & Boyle, 2009).

However, there is currently a lack of research evidence on how MHNs practice RFC with consumers at risk of aggression supporting the need for this research (Cleary et al., 2013; McKenna, Furness, Dhital, Ennis, et al., 2014). Without this evidence, MHNs are less likely to focus on interpersonal interventions such as anger management strategies, sensory modulation, distraction techniques, and environmental modification to encourage the consumer to self-regulate or de-escalate their behaviour and risk for aggression (P. Cusack, McAndrew, Cusack, & Warne, 2016; Jalil, Huber, Sixsmith, & Dickens, 2017; Kuivalainen et al., 2017; Laiho et al., 2013).

1.4 The need for this research

There is now an impetus for all health professionals to address human rights issues, social inequities, and the loss of entitlements of citizenship in the

deinstitutionalisation model for people with mental disorders (Arboleda-Flórez, 2008). This has led to the worldwide movement to further reduce or eliminate the use of restrictive practices for consumers admitted to AMHS (Cambers, 2016; Tingleff, Bradley, Gildberg, Munksgaard, & Hounsgaard, 2017). There is also a need to achieve an improved understanding of the consumer lived experience and its impact on the person, the care they receive, and to personalise care and treatment (Horsfall et al., 2018; Park et al., 2014; Peebles et al., 2009; Sykes, Brabban, & Reilly, 2015).

Due to their continuing presence in the clinical environment, MHNs are uniquely positioned to get to know consumers at a personal level, engage them in co-production, and use RFC (Jeffery & Fuller, 2016; Perlman et al., 2018; Santangelo, Procter, & Fassett, 2018). However, as previously stated, there is a lack of evidence-based knowledge to guide MHNs to practice RFC, and particularly when the consumer is at risk for aggression (Coffey et al., 2019). Existing literature highlights that MHNs either lack the confidence to practice RFC or believe it is not suitable to use with consumers at risk for aggression (Coffey et al., 2019; Harris & Panozzo, 2019; Le Boutillier et al., 2015). Therefore, research that provides evidence-based insights into how MHNs believe they can reduce aggression through the use of RFC is a key factor in supporting changes in care in AMHS.

1.5 The purpose of the research

The purpose of this research was to obtain an in-depth understanding of how RFC can be used to reduce aggression in the AMHS.

1.6 Aim and objectives of the research

The research aimed to explore MHNs and consumers' beliefs of how RFC can reduce the risk of consumer aggression in AMHS. The objectives were to:

1. Scope peer-reviewed literature on the use of RFC to reduce aggression in AMHS;
2. Explore MHNs' understanding of RFC and how it can reduce aggression;
3. Explore consumer's perceptions of the causes of aggression occurring in AMHS;
4. Examine consumers' understanding of RFC;
5. Generate empirical evidence relating to MHNs' attitudes and beliefs central to the use of RFC; and,
6. Identify factors that influence MHNs' knowledge and skills to use RFC with consumers at risk for aggression.

1.7 The significance of the research

The use of RFC to support the recovery of consumers is now recognised as best practice in all mental health policies and standards in Australia (Australian Department of Health, 2010; Australian Government, 2011; Commonwealth of Australia, 2017, 2019). Yet, there is no clear clinical practice guidelines to guide health professionals to use RFC in the AMHS, with the risk for aggression identified as a barrier to its implementation (Harris & Panozzo, 2019). As such, this research was significant as it supports the strategic intent of the Fifth Australian Mental Health and Suicide Prevention Plan (Commonwealth of Australia, 2017) to provide better care and treatment for people with mental disorders.

Issues such as potential staff injury, compassion fatigue, and high staff turnover suggest the need for an investigation into how the risk of aggression can be reduced with more interactive and collaborative ways in AMHS (Baby, Glue, & Carlyle, 2014; Itzhaki et al., 2015; Pekurinen, Välimäki, Virtanen, Kivimäki, & Vahtera, 2019). Health professionals frequently involved in managing aggression, for example MHNs, are more likely to experience burnout leading to extended periods of sick leave, worker's compensation claims, and ultimately withdrawing emotionally from their work or resigning from the profession (Edward, Ousey, Warelow, & Lui, 2014a; Itzhaki et al., 2015; Pekurinen et al., 2019). The custodial role ascribed to MHNs in the AHMS by other health professionals, the organisational culture, or the acuity or staffing levels can also impact on MHNs ability to develop a therapeutic relationship with consumers in their care. This can lead to MHNs experiencing lower job satisfaction and a higher level of stress resulting from regular exposure to aggression in the workplace (Baby et al., 2014). Therefore, the findings of this research may provide practical and evidence-based guidelines and clinical interventions to support MHNs to be more therapeutic in this acute care environment and identify ways they could empower consumers to self-manage their risk for aggression.

There is now a global movement to eliminate the use of restrictive practices and address human rights issues such as stigma and discrimination which are commonly experienced by consumers (United Nations General Assembly, 2007; World Health Organization, 2017). As such, this research is significant as it investigated the use of more effective and therapeutic ways of caring for consumers who are at risk for aggression and generated meaningful findings that can be used to inform clinical practice. The findings can also be used to inform policy and practice

related to the management of aggression and contribute positively to workforce wellbeing and consumer recovery.

Lastly, previous studies have highlighted a dearth of evidence from key stakeholders' (consumers and MHNs) regarding their understandings of how the risk of aggression can be reduced by using RFC (Harris & Panozzo, 2019). Therefore, it was anticipated that the findings of this research would uncover new knowledge and understanding in this important area and add to the knowledge base in this subject area that few studies have explored (Coffey et al., 2019).

1.8 Assumption underlying the research

The researcher is a MHN with more than 15 years of experience working in acute mental health including forensic mental health settings in Australia and Singapore. So before commencing the research, the researcher documented his beliefs and attitudes towards how RFC could be used to reduce consumer aggression so any assumptions that may bias the research could be identified. Researcher assumptions were:

1. Mental health policy promotes the use of RFC in mental health practice;
2. RFC encourages consumers to practice self-care and reduces the use of restrictive practices to manage aggression;
3. There is a lack of research evidence regarding how MHNs can use RFC for consumers at risk for aggression;
4. MHNs do not generally consider the impact of the consumer lived experience on their risk for aggression;
5. There is a lack of academic and clinical preparation relating to how MHNs can practice RFC with consumers at risk for aggression;

6. Most MHNs do not believe that aggression can be reduced with the use of RFC;
7. Without clear guidelines, MHNs develop their subjective beliefs and attitudes toward the use of RFC to reduce aggression;
8. Without the academic and clinical preparation of how RFC can be used to reduce aggression, MHNs have varied levels of knowledge and skills of how this approach can be implemented clinically; and
9. The concept of RFC and aggression are being investigated in this study primarily using the MHNs' lens.

1.9 Limitations of the research

While this research was undertaken in Australia, the generalisation of findings to the other English-speaking countries with similar health care systems may be limited due to local policies and care directions. MHNs who participated in this research were recruited nationally through the Australian College of Mental Health Nurses Inc. (ACMHN) and this is a potential sampling bias. This recruitment strategy may have potentially provided a population of MHNs who had more knowledge and interest in RFC. The MHNs may also have a more informed knowledge and understanding of the causes of aggression and the impact of using restrictive practices on consumers' personal recovery outcomes. Lastly, the researcher did not measure the effect of MHNs using RFC on the rate of aggression in the AMHS as this was outside the scope of the study. Further research is needed in this area to clinically validate the research findings reported in this thesis.

1.10 Definition of terms used in thesis

The following are definitions of terms that have been frequently used in this thesis.

Acute mental health setting	Specialist mental health service that provides voluntary and involuntary (under Mental Health Act) short-term inpatient care and treatment for people experiencing an acute phase of their mental disorder (Australian Government, 2020).
Consumer	Any person who identifies as having a current or past lived experience of a mental disorder. It is also used to refer to a person who is utilising or has utilised a mental health service (Government of Western Australia, 2015).
Health care services	Generic term for a broad array of services and places where health care is provided (Christensen & Fagan, 2018).
Health professional	Health practitioner that has the skills and qualifications to be registered by their national professional board to practice (Australian Health Practitioner Regulation Agency, 2021).
Lived experience of a mental disorder	The experience of a person who identifies oneself either as living with or has lived with a mental disorder (Commonwealth of Australia, 2017)
Mental health nurses	Registered nurses who work in the area of mental health. May have specialist postgraduate qualifications in mental health nursing (Australian Government, 2021).
Mental health recovery	

a. Clinical recovery	The elimination of symptoms, restoration of social functioning, and return to a normal state of health and wellbeing (Slade, 2009a).
b. Personal recovery	A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles… [and] a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness (Anthony, 1993).
Q methodology terminology	
a. Concourse	The shared knowledge surrounding any topic communicated in ordinary conversation, commentary and discourse of everyday life (Brown, 1993; Van Exel & de Graaf, 2005).
b. Q set	A subset of statements selected from the concourse to provide a comprehensive representation of all the statements in the concourse (Brown, 1993).
c. Q sort	The unique arrangement that each participant rank-ordered the statements based on their point of view on the topic (Paige, 2014).
d. Subjectivity	A concept referring to the expression of the individual or groups' point of view (Burke, 2015).
Recovery-focused care (Also known as recovery-oriented care/practice)	A clinical approach that allows health professionals to support consumers to achieve their personal recovery alongside their clinical recovery (Coffey et al., 2019).

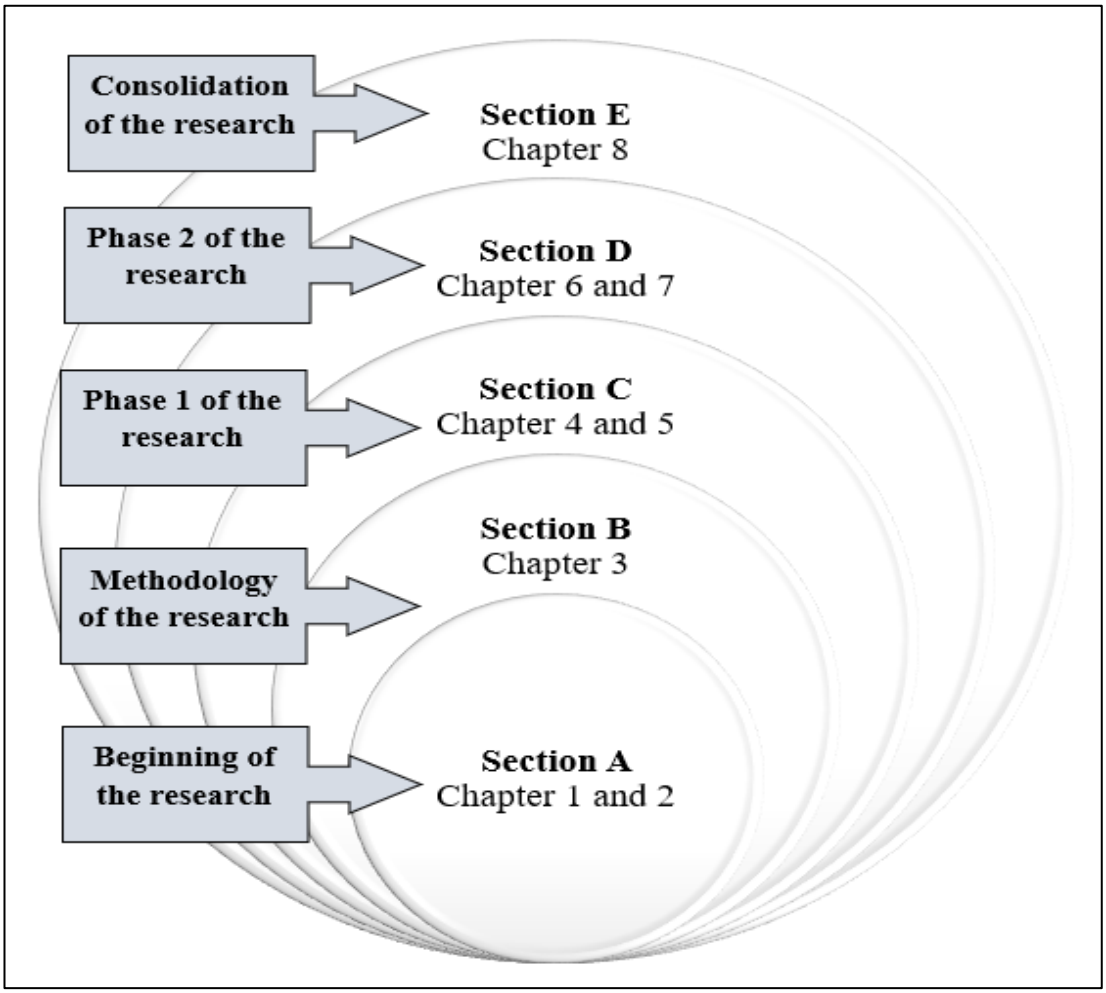
a. Co-production	A relationship where consumers and health professionals recognise that both parties are active participants and have mutual responsibilities in care decisions, planning, and delivering care (Slay & Stephen, 2013).
b. Empowerment	The level of choice, influence, and control that a person living with a mental disorder can exercise over their own life (World Health Organization, 2010).
c. Partnership	A process in which both the health professionals and consumers engage in a working alliance and share power to solve problems and achieve mutually common goals (Shanley & Jubb-Shanley, 2007).
d. Self-determination	The ability of an individual to make their own decisions confidently (Piltch, 2016).
e. Shared decision-making	A collaboration between the consumer and health professionals to bring together the individual's values, goals and preferences with the best available evidence about benefits, risks and uncertainties of treatment to reach the most appropriate decisions for that person (Australian Commission on Safety and Quality in Health Care, 2019).
Risk assessment	The identification of early warning signs of aggression so that strategies are implemented to de-escalate or eliminate the risk level (Maguire, Daffern, Bowe, & McKenna, 2017).
Restrictive practices	
a. Restraint	The use of force to restrict the physical movements of a person who is being provided with treatment or care at an authorised hospital (Chief Psychiatrist of Western Australia, 2021).

b. Seclusion	The confinement of a person who is being provided with treatment or care at an authorised hospital by leaving the person at any time of the day or night alone in a room or area from which it is not within the person's control to leave (Chief Psychiatrist of Western Australia, 2021).
c. Zero tolerance	A stance that aggression will not be tolerated under any circumstances, and that there will be a non-negotiable restriction imposed whenever that behaviour occurs in the mental health service (Morphet, Griffiths, Beattie, Velasquez Reyes, & Innes, 2018).
Trauma-informed care	An approach to care that recognises the high prevalence of experiences of assault and abuse among people accessing mental health services and takes care to avoid practices or discussions that may trigger memories of previous experiences of trauma (Victorian Government, 2020).

1.11 Organisation of the thesis

This thesis is organised into five sections with a total of eight chapters. Figure 1.1 provides an overview of the organisation of the chapters into sections.

Figure 1.1 Overview of the organisation of the chapters into sections



Five peer-reviewed journal articles are presented in accordance with the copyright policy of each journal.

Chapter 2 presents Publication 1 – A scoping review of the peer-reviewed literature on how RFC is used to reduce aggression in the AMHS. This chapter also consists of an updated search of the literature from the time of the article's publication.

Chapter 3 covers the methodology for the research including the overview of the philosophical justifications for using a mixed methods research approach. This chapter also describes Phase 1 and 2 of the sequential exploratory mixed methods research, Publication 2 which detailed the steps taken to complete a Q methodology

studies in Phase 2, ethical considerations, informed consent, and data storage and management.

Chapter 4 presents Publication 3 – The qualitative study using semi-structured interviews (Phase 1a) with MHNs to obtain an in-depth understanding of their perspectives of using RFC and how it can be used to reduce aggression. The participants and recruitment strategy, data collection, and data analysis, results, discussion, and relevance to clinical practice are also included.

Chapter 5 presents Publication 4 – The qualitative study using semi-structured interviews (Phase 1b) with consumers to explore their perspectives of the causes of aggression and their understanding of RFC. The research design and method, data collection, data analysis, findings, and discussion are also presented.

Chapter 6 presents publication 5 – the Q methodology study (Phase 2a) to determine MHNs' knowledge and skills of using RFC to reduce aggression. The overview of the step taken to set up the study, findings of the study, discussion of the findings, and implication of findings to clinical practice are also included.

Chapter 7 describes the Q methodology study (Phase 2b) that explored MHNs' beliefs and attitudes toward using RFC to reduce aggression.

Chapter 8 is the final chapter of this thesis and presents an overview of the completed research, discussion of significant findings, recommendations around mental health policy, mental health services, mental health nursing workforce, and suggestions for further research in this area. This chapter ends with the concluding statements.

1.12 Chapter precis

This chapter provided the background to the research and discussed the origin of the concept of 'recovery' informing the need for health professionals to use RFC. The impact of aggression in the AMHS on care delivery, health professionals, and consumers was also included, highlighting the need and purpose for the research in the Australian context. The significance of the research, the aim, and objectives, definition of terms along with a summary of the organisation of the thesis were outlined. Chapter 2 presents the scoping review of literature on how MHNs can use RFC to reduce aggression in the AMHS. It also includes an updated search of the literature from the date of publication of the scoping review to 31st December 2020.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

Chapter 2 presents Publication 1 – a scoping review of the literature on how MHNs can use RFC with consumers at risk for aggression in AMHS. An updated search of the literature from the time of publication to 31st December 2020 is also included.

Initially, the researcher set out to conduct a systematic literature review to determine how MHNs can use RFC to reduce aggression in the AMHS. However, when the search for literature to guide the systematic review was performed in March 2015, the researcher was unable to find any peer-reviewed literature related to the topic under investigation. The lack of peer-reviewed literature highlighted the gap in knowledge in this area further supporting the need for this research.

Following discussion with his supervisors about the findings of the first literature search, the researcher conducted a scoping review of the literature to locate primary research papers that could be used to construct an overall impression of how MHNs could use RFC to reduce aggression. Conducted in April 2015, the second search included papers that met the inclusion criteria of: (i) adult mental health; (ii) applying RFC in the mental health settings; (iii) using RFC to reduce aggression; and (iv) promoting recovery for consumers with a history of being aggressive.

The findings contributed evidence on how MHNs can use RFC with consumers to reduce their risk for aggression. They also highlight the importance of understanding the impact of the consumer's lived experience on their level of aggression risk. More research is needed to expand the breadth and depth of

knowledge resulting from this review and to build the evidence base on how the use of RFC reduces the risk of aggression in AMHS. This is important as it supports consumer empowerment, collaboration, and engagement in care and may further reduce or eliminate the use of restrictive practices in AMHS.

2.2 Publication 1 reference

Lim, E., Wynaden, D., & Heslop, K. (2017). Recovery-focussed care: How it can be utilized to reduce aggression in the acute mental health setting. *International Journal of Mental Health Nursing, 26*(5), 445-460. Doi: 10.1111/inm.12378

Note: Publication 1 uses spelling, pertinent terminology, and referencing in accordance with the requirements of the journal and the country of publication. Permission to include the article in the thesis in the presented format was obtained from the Editor (see Appendix 1)

Author's contribution

All co-authors have consented to their work being included in the thesis and they have accepted the candidate's contribution as indicated.

Author's contribution

Mr Eric Lim	90%	Signature	
Emeritus Professor Dianne Wynaden	6%	Signature	
Associate Professor Karen Heslop	4%	Signature	

Higher Degree Research Thesis by Publication

Curtin University

STATEMENT OF ORIGINALITY

We, the PhD candidate and the candidate's principal supervisor, certify that the following text, figures and diagrams are the candidate's original work.

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SPECIAL ISSUE

Recovery-focussed care: How it can be utilized to reduce aggression in the acute mental health setting

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2.3 Updated review of literature

Since the publication of the scoping review in 2017, there has been an increased global movement to use RFC to enhance consumer engagement and promote human rights issues in mental health care (McSherry & Maker, 2020). This has led mental health services in many countries to focus on reducing or eliminating the use of restrictive practices and to facilitate a recovery-focused culture of care that is consumer-inclusive (Gooding et al., 2018; World Health Organization, 2017). As such, the researcher was expecting in the updated search of the literature to find more nursing research dedicated to this area.

An updated search was completed in February 2021 to identify articles that were published between 2015 and 2020. The same search terms, electronic databases, and inclusion and exclusion strategies as demonstrated in the method section of Publication 1 (see p. 45-46) were employed. No additional articles were identified that specifically explored the use of RFC for consumers at risk for aggression except for those published by the researcher.

Despite the paucity of nursing research, RFC is best practice for MHNs to use to prevent the risk for aggression and to support consumers in their transition from inpatient care to community living (Laitila et al., 2018; Olasoji, Plummer, Shanti, Reed, & Cross, 2020; Reid, Escott, & Isobel, 2018; K. A. Thomas & Rickwood, 2016). Yet, there remains a lack of clinical guidelines to guide MHNs to use RFC clinically within a culture of care that remains in many countries inherently risk-aversive for managing aggression (McKenna et al., 2017; McKeown et al., 2020; Muir-Cochrane, Grimmer, Gerace, Bastiampillai, & Oster, 2020; Riahi, Thomson, & Duxbury, 2016). Many MHNs may find it difficult to use RFC with consumers at risk for aggression, leading to its inconsistent use within AMHS (Harris & Panozzo,

2019). The lack of published evidence in the five years since the initial review suggests that clinical practice does not reflect the intent of the current national mental health legislations and policies.

In summary, MHNs therapeutic relationships with consumers are the foundation of their care delivery (Chambers, 1998). This premise places them in a strategic position to accurately assess and support consumers to effectively self-manage their aggression risk (Chambers et al., 2015). However, the updated search of the literature revealed the need for more research in this area to build an evidence-based practice in mental health nursing, reiterating the need and significance of this PhD research.

2.4 Chapter precis

This chapter presented a scoping literature review conducted in 2015 that built an understanding of how MHNs can use RFC with consumers at risk for aggression. However, an updated review of literature from 2015 to 2020 identified no additional articles in this subject area and substantiated the need for more research.

Section B (Chapter 3) of this thesis presents the methodology guiding the research. The chapter provides an overview of the philosophical justifications for using mixed methods approach to obtain an in-depth and accurate understanding of how MHNs can use RFC to reduce aggression. The major paradigms in nursing research, the researcher's position within the pragmatist paradigm to conduct the research, and the process of designing sequential exploratory mixed methods research are covered. Ethical considerations and data storage and management are also presented.

SECTION B

Chapter 3 – Methodology

CHAPTER 3

METHODOLOGY

3.1 Introduction

Chapter 3 presents the methodological considerations that were completed for this research. The philosophical justifications for the researcher's position as a pragmatist to use a mixed methods approach are discussed alongside the design of the two-phase sequential exploratory mixed methods research. This chapter includes Publication 2 which described the steps involved in conducting the Q methodology studies completed during Phase 2. In addition, the ethical considerations and data storage and management completed for the research are presented.

3.2 An overview of the major paradigms in nursing research

The term 'paradigm' is used in research philosophy and refers to the researcher's beliefs and knowledge about the world (Creswell & Creswell, 2018; Polit & Beck, 2018). According to Houghton, Hunter, and Meskell (2012), a researcher's paradigm is made up of their ontology (beliefs about reality), epistemology (the relationship between the researcher and what can be known), and methodology (how to carry out the research relative to the question and context). Therefore, it is important for researchers to make explicit their paradigm to provide an understanding of the theoretical framework underpinning the purpose and conduct of their research, as well as the philosophical assumptions underlying the use of either a qualitative, quantitative or mixed methods approach (Creswell & Creswell, 2018; Polit & Beck, 2018; Weaver & Olson, 2006; Zukauskas, Vveinhardt, & Andriukaitienė, 2018).

Every researcher's paradigm is influenced by their professional discipline orientations, research communities, advisors and mentors, and past research experiences (Creswell & Creswell, 2018). While there are different beliefs and knowledge about the world, four major paradigms are universally recognised by researchers: i) Positivism, ii) postpositivism; iii) constructivism; iv) transformative; and v) pragmatism (Creswell & Creswell, 2018; R. Hall, 2013). An overview of the four major paradigms, their key assumptions, and the founders of the schools are presented in Table 3.1.

Table 3.1 The five major research paradigms, their key assumptions, and the founders of the schools

Major Paradigms	Key Assumptions	Founders of the Schools
Positivism	• Focus on objectivity and natural sciences. • Believe that all methodological and even conceptual problems can be solved exclusively by applying experimental research approaches. • Reduce ideas into variables for testing hypotheses and research questions. • Develop knowledge based on empirical observations and measurements.	• Auguste Comte
Postpositivism	• Use of more integrated research approaches to for measurement and knowledge production. • Focus on scientific reasoning to generate a more comprehensive explanation of a phenomenon. • Collect data to either support or refute a theory.	• Karl Popper • Max Weber • Thomas Luckmann • Peter Berger

Constructivism	• Seek understanding of the work in which people live and work. • Explore the multiple and varied meanings of participants' experiences. • Obtain insights into the historical and cultural norms that operate in participants' lives. • Generate or inductively develop a theory or pattern of meaning.	• Yvonn Lincoln • Egan Guba • Norman Denzin
Transformative	• Aim to address the important social issues such as empowerment, inequality, domination, suppression, and alienation of marginalised individuals in the society. • Seek to intertwine research inquiry with politics and a political change agenda. • Collaborate with participants to design questions, collect data, analyse information, and share the benefits of the research. • Provide a voice for participants to raise their consciousness or advance an agenda for change to improve their lives.	• Donna Mertens
Pragmatism	• Focus on actions, situations, and consequences rather than causes and effects. • Seek to solve real-world practice problems and questions. • Use of pluralistic approaches to collect and analyse data to derive knowledge about the problem. • Provide a philosophical underpinning for mixed methods studies.	• William James • John Dewey • Charles Sanders Peirce • Herbert Mead

(Adam, 2014; Appleton & King, 1997; Creswell & Creswell, 2018; Fox, 2008; Howell, 2015; Mertens, 2010; Parvaiz, Mufti, & Wahab, 2016)

The researcher took a pragmatist approach to the research. The pragmatist paradigm originated from the work of William James (1842-1910), John Dewey (1859-1931), Charles Sanders Peirce (1839-1914), and Herbert Mead (1863-1931) (Parvaiz et al., 2016). The main characteristic of pragmatism is that researchers are not immersed in the quantitative and qualitative rhetorical debate but embrace the plurality of methods to strengthen the research processes to produce meaningful results for their participants (Houghton et al., 2012; Kaushik & Walsh, 2019). Nevertheless, pragmatism is not a rejection of the positivist and constructivist paradigms. Rather it highlights the importance of drawing from the strengths and minimises the weaknesses of both (Johnson & Onwuegbuzie, 2004) to explore diverse perspectives and uncover relationships that exist between the intricate layers of the multifaceted research questions (Ingham-Broomfield, 2016; Shorten & Smith, 2017; Weaver & Olson, 2006).

Pragmatists are focused on 'what works' to answer the research questions in the pursuit of deeper understanding to solve practical real-world problems (Biddle & Schafft, 2014; Biesta & Burbules, 2003; Maarouf, 2019). As such, the emphasis is placed on the research problem as the determinant for the epistemology, ontology and axiology of the research rather than the method (Revez & Borges, 2018). For the pragmatists, truth is considered fallible, provisional or revisable and is only considered truth while it works best (Nowell, 2015). The pragmatist paradigm, therefore provides the methodological justification for many researchers in the use of mixed methods approaches with the aim to find workable solutions, gain a greater understanding of the world, and solve the problems of individuals and society (Nowell, 2015).

With more nurses in the frontline of health care, nurse-led research is increasingly being recognised as a critical gateway to improve the quality of clinical care (Curtis, Fry, Shaban, & Considine, 2017; Siedlecki & Albert, 2017). Nurse-led research is also a cost-saving and efficient way to evaluate the effectiveness of nursing care, generate evidence that has the potential to lobby and inform policy change, and contribute knowledge to the advancement of evidence-based practice (Berthelsen & Hølge-Hazelton, 2017; E. Cusack, Killoury, & Nugent, 2017).

The need to address complex real-life issues found in today's health care environment has seen many nurse researchers abandoning the so-called 'qualitative-quantitative paradigm war' as it is no longer of contemporary relevance and have turned to the use of mixed methods approaches to effectively address the complexity of the issues in nursing practice (Bressan et al., 2017; Corry, Porter, & McKenna, 2019). This phenomenon can be summed up by Corry et al. (2019) who stated that "patterns of events and behaviours can only be demonstrated through numerical calculation. However, because meanings cannot be measured, only understood, qualitative approaches are needed to uncover people's understandings and motivations" (p. 5). As such, the pragmatist paradigm is increasingly becoming popular among nurse researchers who are tailoring qualitative and quantitative research methods to answer innovative research questions of clinical practice (Kettles, Creswell, & Zhang, 2011).

By drawing from the strengths of both qualitative and quantitative research approaches, nurse researchers are empowered with a rigorous research design to broaden the understanding of the multifaceted dimensions of health care issues and enhance the knowledge translation into clinical practice (Chiang-Hanisko, Newman, Dyess, Piyakong, & Liehr, 2016). The use of mixed methods approaches has also led

to increased collaborative research endeavours involving nurses, doctors, health consumers, public health experts and other health disciplinary researchers (Kettles et al., 2011).

In this current research, the researcher's use of a mixed methods approach in the mental health area was partly driven by theoretical models that acknowledge the importance of consumer perspectives, contextual influences on disparities in the delivery of mental health services, and the dissemination and implementation of evidence-based practices (Palinkas et al., 2011). It supports the increasing recognition of the importance of incorporating the experiences and motivations of consumers and their family/carer to inform or co-produce or co-design service delivery (Corry et al., 2019).

3.3 The application of mixed methods approach to this research

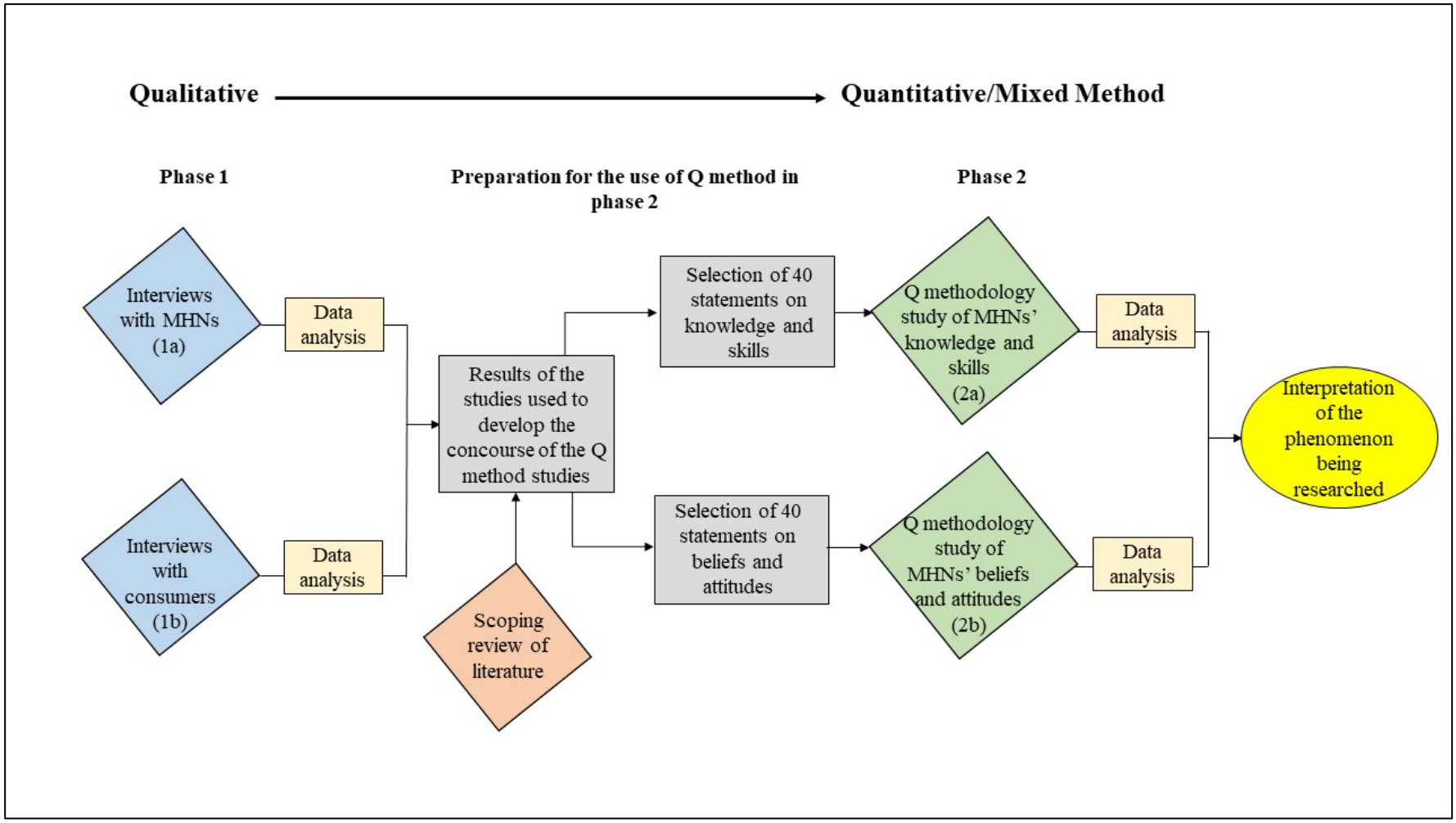
With RFC now endorsed as best clinical practice in health policy internationally (Australian Government, 2013; Government of Ireland, 2020; Hong Kong Special Administrative Region Government, 2017; United Kingdom Department of Health, 2014), there is an expectation for MHNs to pragmatically translate this clinical approach to all aspects of care delivery (Santangelo et al., 2018). Nevertheless, the review of literature in Chapter 2 demonstrated that there is currently a lack of research evidence (Lim, Wynaden, & Heslop, 2017) to support the mental health nursing workforce to develop and advance their use of RFC with consumers at risk for aggression. The lack of research evidence in this area also highlighted the need for the researcher to use both qualitative and quantitative approaches in this current research to gain an in-depth and accurate understanding of the perspectives and experiences of MHNs and consumers on how RFC can reduce

aggression. Additionally, existing literature revealed that there is a difference in opinions between MHNs and consumers about what constitutes RFC in the AMHS. For instance, MHNs viewed the promotion of a safe and conducive environment as facilitating RFC whereas consumers regard it as having a high quality nurse-consumer therapeutic relationship and being involved routinely in their own care and treatment (Aston & Coffey, 2012; Cleary et al., 2013). As such, it was crucial for the researcher to select the most appropriate research methods to generate an in-depth and accurate understanding of the subject area.

A sequential exploratory approach (Creswell, 2009) was utilised to guide the researcher to design the two-phase sequential exploratory mixed methods research for generating an in-depth and accurate understanding of how MHNs can use RFC to reduce aggression. This approach is used when little is known about a phenomenon under investigation and typically begins with a qualitative phase followed by a quantitative phase (Andrew, Halcomb, & Brannen, 2009). It is also used when a researcher wants to test elements of the findings resulting from the qualitative phase or to generalise qualitative findings to different sample populations (Creswell, 2009).

In this research, both qualitative and quantitative/mixed method data were equally prioritised. Phase 1 used a qualitative semi-structured research approach and consisted of Phase 1a) study with MHNs, and Phase 1b) study with mental health consumers. Phase 2 used Q methodology and consisted of Phase 2a) MHNs' knowledge and skills of using RFC to reduce aggression and Phase 2b) MHNs' beliefs and attitudes of using RFC to reduce aggression. Figure 3.1 detailed the phases in the two-phase sequential exploratory mixed methods research, which comprised qualitative studies (Phase 1) followed by Q methodology studies (Phase 2).

Figure 3.1 Phases in the two-phase sequential exploratory mixed methods research



3.4 Phase 1a and b of the two-phase sequential exploratory mixed methods research

Phase 1 (1a and 1b) used an application of the grounded theory method (Charmaz, 2006) but it was never the intention to develop a substantive theory which is often the outcome when researchers use the grounded theory method. However, the method guided all stages of the research process from participant recruitment, data collection, coding, analysis, interpretation and writing up of the findings in both studies. As grounded theory focuses on identifying key social and psychological experiences, this method was deemed appropriate to explore the issue under investigation.

A description of the qualitative research process (participant recruitment, data collection, data coding, and analysis) common across both studies is now presented to prevent duplication of this information in Chapter 4 (Phase 1a MHNs – Publication 3) and Chapter 5 (Phase 1b consumers- Publication 4) where each study is presented.

3.4.1 Recruitment of participants in Phase 1 qualitative studies

In Phase 1 (1a and 1b), purposeful and theoretical sampling, techniques widely used in grounded theory (Lavrakas, 2008) was used to recruit participants. In Phase 1a, a homogenous population of MHNs from all states and territories in Australia who were members of the Australian College of Mental Health Nurses (ACMHN) was invited to participate in the research. Purposeful sampling ensured participants were representative of the participant population and had knowledge in the area being researched (Lavrakas, 2008). After initial data analysis, theoretical sampling was employed to seek participants with specific and different experiences

to ensure data were rich and comprehensive. The decision to recruit members of the ACMHN was also driven by the need to seek out MHNs with specific and extended experiences directed by theoretical sampling as data analysis progressed. Invitations were sent to MHNs via an email advertisement sent by the ACMHN to their members and those who were interested to participate contacted the researchers to arrange an interview.

Similarly, in Phase 1b, purposeful sampling was used and consumers from the South Metropolitan Mental Health Service in Western Australia were invited to participate. Potential participants were provided with the information sheet and those who were interested contacted the researcher to arrange an interview. Theoretical sampling was also used following initial data analysis to target specific consumer experiences to add to the richness of data collected. These included people experiencing their first admission to a hospital and consumers who had a long history of admissions to mental health services. The inclusion criteria for consumers who agreed to participate in the research were: i) people with a lived experience of mental disorder; ii) 18 years or older; iii) had the experience of being hospitalised in the AMHS, and iv) being able to give informed consent.

3.4.2 Data collection in the two qualitative studies

Semi-structured interviews were used to collect data from participants in both Phase 1 studies. All interviews were digitally audio-recorded and used interview guides developed by the researcher in consultation with his PhD supervisors. After each interview, the digital-audio recordings were transcribed and new concepts that emerged from the interviews were used to guide the development of questions for subsequent interviews based on theoretical sampling.

3.4.3 Data coding and analysis in the qualitative studies

According to Charmaz (2006), there are two phases in grounded theory coding and they are 1) initial coding which involved naming each word, line, or segment of data followed by 2) focused coding which involved using the most salient categories to sort, synthesise, integrate, and organise the data.

In the research, initial coding was done by reading and cataloguing each of the transcribed verbatim interviews into smaller segments of information according to their identifiable categories and sub-categories and assigning labels to them (Creswell, 2013). Categories of particular significance for example, with a large amount of consolidated data, were used for comparison with the other codes to build emerging categories (Charmaz, 2006; Meabh & Robert, 2015). In focused coding, data collected from subsequent interviews were reduced to codes and compared with the emerging categories. Similar codes were consolidated into the emerging categories and those that did not fit were used to form new categories and subcategories. When no new category was formed from subsequently collected data, the researcher was confident that the core categories were well-formed and descriptions rich and expansive so data saturation was achieved. As previously stated, the results of research conducted in Phase 1a and b follow in Section C (Chapters 4 and 5) along with further descriptions of the methodology included in the publications.

3.5 Preparation for the use of Q methodology in Phase 2

After completing Phase 1 of the two-phase sequential exploratory mixed methods research, the generated data of both qualitative studies were subsequently

used to inform the design of the data collection tool for conducting the Q methodology studies completed in Phase 2.

The use of Q methodology to conduct research in Phase 2 required the researcher to first prepare a comprehensive list of statements (known in Q methodology as the concourse) (Brown, 1996; Van Exel & de Graaf, 2005), that communicated the knowledge, skills, attitudes, and beliefs of MHNs regarding the use of RFC to reduce aggression. Due to the lack of literature surrounding the phenomenon being researched, data from the scoping review of the literature (Chapter 2) and Phase 1a and b findings were also used to develop the concourse. The 80 statements of the concourse and how the positive and negative statements were identified from the findings is presented in Appendix 2.

After the concourse was developed, a set of 40 statements that best represented the beliefs and attitudes of MHNs and another 40 statements that best represented the knowledge and skills of MHNs to use RFC to reduce aggression were selected. The researcher's supervisors cross-checked all the statements and ensured that they were credible and correct to represent the phenomenon being researched. The two sets of selected statements known as Q sets (Van Exel & de Graaf, 2005), were entered into FlashQ (Hackert & Braehler, 2007) which is a computer software designed for conducting Q methodology research, for developing the data collection tool to be used in Phase 2. The developed data collection tool consisted of Part A – the Q methodology study of MHNs' knowledge and skills to RFC to reduce aggression, and Part B – the Q methodology study of MHNs' beliefs and attitudes to use RFC to reduce aggression.

3.6 Phase 2 of the two-phase sequential exploratory mixed methods research

Both studies in Phase 2 followed the same process for data collection, recruitment of participants, data analysis, and data interpretation. A detailed description of the steps taken, from the preparation of the data collection tool through to data interpretation using Q methodology, is presented in Publication 3 titled: 'Realising the potential of Q methodology in nursing research'.

3.6.1 Publication 2 reference

Lim, E., Wynaden, D., Baughman, F., & Heslop, K. (2021). Realising the potential of Q methodology in nursing research. *Collegian, 20*(2), 236-243. Doi: 10.1016/j. colegn.2020.08.004

Note: Publication 2 presents the use of Q methodology and its application to nursing research and work presented in this thesis. The spelling, pertinent terminology, for example, use of word client instead of consumer and referencing used in the article is in accordance with the requirements of the journal and the country of publication. Permission to include the article in the thesis in the presented format was obtained from the Editor (see Appendix 3).

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Realising the potential of Q methodology in nursing research

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3.7 A summary of Phase 1 and 2 of the sequential exploratory mixed methods research

In summary, Phase 1 of the sequential exploratory mixed methods research consisted of two qualitative studies that explored the MHNs' and consumers' perspectives regarding the causes of aggression and how they believed RFC could reduce aggression in AMHS. The data gathered in Phase 1 studies were then integrated with the data of the scoping review to develop the concourse and this was then used to prepare the data collection tool used in Phase 2 of the research. In Phase 2, Q methodology was used to investigate the knowledge, skills, beliefs, and attitudes of MHNs for using RFC to reduce aggression in the AMHS.

3.8 Ethical considerations in the mixed methods research

The ethical considerations completed to conduct the research will now be detailed. All research involving human participants must conform to high scientific and ethical standards to protect the liberty and welfare interests of every individual participant (Council for International Organizations of Medical Sciences (CIOMS), 2019; World Health Organization, 2019). Internationally, there are several well-known ethical principles and guidelines which researchers use to guide the ethical conduct of their research such as the International Ethical Guidelines for Health-Related Research Involving Humans of the CIOMS and the Declaration of Helsinki Organisation of the World Medical Association (World Health Organization, 2019).

In Australia, the National Statement on Ethical Conduct in Human Research 2007 (Updated 2018) of the National Health and Medical Research Council (NHMRC) (hereafter refers to as the National Statement) is used to guide researchers to identify and address the ethical issues that are associated with research involving

human participants, for example clinical trials, health service research, population health research, and family studies (NHMRC, 2018; Polonsky & Waller, 2011). The National Statement is organised around the ethical values of respect, research merit and integrity, beneficence, and justice (NHMRC, 2018).

Before research can be undertaken, researchers are required to complete an ethics application and submit it to be reviewed by the lead ethics committee where the research is being conducted (NHMRC, 2018; Polonsky & Waller, 2011). This process ensures that the risks and benefits of the proposed research are appropriately balanced, the strategy for recruitment is fair, and that voluntary, informed consent will be sought from each participant unless a specific waiver is obtained in some situations during the ethical review (Bracken-Roche, Bell, Macdonald, & Racine, 2017). Ethics approval to conduct the research covered in this thesis was obtained from Curtin University's Human Research Ethics Committee (HR132/2015); (see Appendix 4), and South Metropolitan Health Service Human Research Committee in Western Australia (EC00265); (see Appendix 5).

3.8.1 Obtaining informed consent from research participants

Obtaining informed consent from participants was crucial to uphold the ethical value of respect, protect their human rights, ensure that they had the right to self-determination, and the right to full disclosure of the risks and benefits of the research (Cannon & Delahoyde, 2020; Manton et al., 2014; Polit & Beck, 2018). Informed consent is obtained when a participant voluntarily agrees to participate in the research and has fully understood the nature of their participation and what will be done with data collected from them (Nieswiadomy & Bailey, 2018). Therefore, full disclosure of the description of the study, what is expected of their participation,

the person's right to refuse to participate, to withdraw without penalty, and any potential risk and benefits must be clearly stated in information sheets given to participants to promote self-determination (Polit & Beck, 2018).

In this research, all potential participants of the qualitative studies were provided with an information sheet (see Appendices 6 and 7) that outlined the study, the voluntary nature of their participation, their rights as participants, how their confidentiality would be maintained as well as their rights to withdraw from the research at any time without penalty. A copy of the informed consent form used with MHNs is presented as Appendix 8, and a copy of the informed consent form used with consumers is presented as Appendix 9. All the participants in this study provided informed consent. MHNs who volunteered in the Phase 2 Q methodology studies were informed that their consent to participate was provided if they completed the questionnaires and submitted their answers electronically (Appendix 10). No participants in any phase of the research withdrew their consent to participate. While adverse event protocols were developed for the research, no adverse events were reported during any stage of the research process.

3.8.2 Working with vulnerable populations – Mental health consumers

When mental health consumers participate in research it is essential to ensure that the research is informed and relevant to consumer priorities and care needs (Morse, Forbes, Jones, Gulliver, & Banfield, 2019). Mental health consumers are considered a vulnerable population in the National Statement. Therefore, it is important that they are fully informed about the research they are being asked to participate in and are well enough to provide voluntary informed consent (Gordon, 2020). They are also a vulnerable population due to a common shared lived

experience of trauma and so require stringent ethical considerations and practice to avoid them experiencing any potential for harm during the research (Siriwardhana, Adikari, Jayaweera, & Sumathipala, 2013).

Consumers who volunteered to participate in Phase 1 qualitative study were all assessed by their treating team as being well at the time of their participation to provide informed consent to participate. They were also required to acknowledge that they have read and understood the information sheet and signed a consent form before they were interviewed. No consumer participants involved in this research experienced distress or asked to withdraw from the study.

3.9 Data storage and management

All information and data collected from this research, including the Q sorts, demographic data, digital audio recordings, transcripts and field notes are stored on the secure Curtin University research drive allocated to PhD students, and only the researcher and his supervisors have access to this drive. The hard copies of the signed informed consent forms and completed demographic information sheets are stored in a key-and-lock secured filing cabinet, in the researcher's office at Curtin University, Western Australia. All digital data and hard copy materials will continue to be stored securely on the research drive and locked cabinet for seven years from the completion of the research and then destroyed in line with the retention and disposal procedures of the Western Australian University Sector Disposal Authority and the Western Australian Government at that time. All the final submitted manuscripts of the publications are stored in the Curtin University Institutional Repository (espace).

3.10 Chapter precis

This chapter provided the philosophical justification for the researcher's position within the pragmatist paradigm to design sequential exploratory mixed methods research. The phases completed in this mixed methods approach were described along with specific research components of Phase 1 (recruitment of participants, data collection, coding, and analysis), preparation of the use of Q methodology in Phase 2, and Publication 2 to explain the research process of the Q methodology studies conducted in Phase 2. Additionally, ethical considerations, informed consent and data storage and management were detailed to demonstrate that the research was designed and conducted in a safe and ethically responsible manner. Phase 1a and b studies are now presented in Section C (Chapters 4 and 5) of this thesis.

SECTION C

Sequential Exploratory Mixed Methods Research – Phase 1 Qualitative Studies

Chapter 4 – The qualitative study with mental health nurses (Phase 1a)

Chapter 5 – The qualitative study with mental health consumers (Phase 1b)

CHAPTER 4

THE QUALITATIVE STUDY WITH MENTAL HEALTH NURSES (1a)

4.1 Introduction to phase 1a study

Chapter 4 presents the findings of a qualitative exploratory study with MHNs (Phase 1a) using an application of the grounded theory method. In the AMHS, MHNs often have to balance the therapeutic role and the provision of empathetic care with the potentially incompatible task of managing risk and ensuring safety and security for consumers and colleagues (Berring, Pedersen, & Buus, 2016; Wilson et al., 2017). This balancing role can influence MHNs' ability and willingness to use RFC (Delaney, Cleary, Jordan, & Horsfall, 2001; Koukia, Madianos, & Katostaras, 2009). Therefore, it was crucial to explore the experiences of MHNs to obtain insights into how they believe RFC can be implemented successfully to reduce consumer aggression in this setting.

4.2 Publication 3 reference

Lim, E., Wynaden, D., & Heslop, K. (2019). Changing practice by using recovery-focused care in acute mental health settings to reduce aggression: A qualitative study. *International Journal of Mental Health Nursing, 28*(1), 237-246. Doi: 10.1111/inm.12524

Note: Publication 3 uses spelling, pertinent terminology, and referencing in accordance with the requirements of the journal and the country of publication. Permission to include the article in the thesis in the presented format was obtained from the Editor (See Appendix 11).

Author's contribution

All co-authors have consented to their work being included in the thesis and they have accepted the candidate's contribution as indicated.

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ORIGINAL ARTICLE

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

Eric Lim, Dianne Wynaden and Karen Heslop
School of Nursing, Midwifery and Paramedicine, Curtin University, Perth, Western Australia, Australia

4.3 Chapter precis

Publication 3 reports on one of the few studies that have explored MHNs' perceptions of how the use of RFC can reduce the risk of consumer aggression. The five categories identified demonstrate that MHNs have positive attitudes toward the use of RFC and believed its use is effective in reducing the risk of aggression in AMHS. However, the results of the study highlight that some MHNs require additional education and training to translate RFC to clinical practice. For example, when MHNs lack confidence, experience and/or expertise in using RFC they may resort to more restrictive management strategies when faced with consumer aggression. Therefore, ongoing education and training of MHNs to utilise RFC is important and will also assist in reducing or eliminating the use of restrictive practices in AMHS.

The findings of this study recommend practice changes in aggression risk assessment to focus on better understanding the consumer's lived experience and how it impacts the person's level of aggression risk. This is supported by existing literature which identified that individuals who have experienced traumatic experiences tend to have a lower threshold to stress. This can significantly increase their level of risk for aggression when faced with challenging situations (Grattan et al., 2019; Muskett, 2014; Vidal et al., 2020).

MHNs who understand the impact of a person's lived experience on their presenting behaviour, are more likely to use RFC to reduce the risk for aggression (Langeland, Wahl, Kristoffersen, & Hanestad, 2007; Ness, Borg, Semb, & Karlsson, 2014) and not make assumptions that the aggression is solely related to the person's psychiatric symptoms (de Girolamo et al., 2016; J. Duxbury, 2015; Maguire, Daffern, Bowe, & McKenna, 2019). The therapeutic engagement between the MHN

and consumer will increase the individual's level of confidence and trust to collaborate more effectively (Hallett, Huber, & Dickens, 2014; Jacob, 2015; Paterson & Duxbury, 2007; Ward, 2011), support the person to self-manage their challenging behaviours, and facilitate personal recovery (Serin, Chadwick, & Lloyd, 2016).

In summary, MHNs believe RFC can facilitate improved consumer and workplace outcomes for all health professionals by reducing aggression through the assessment of the person's lived experience and working in co-production to promote self-management of challenging behaviours that can lead to aggression. Chapter 5 follows and presents Phase 1b study with consumers to explore their perceptions of the causes of aggression and how when MHNs use RFC it can reduce aggression and facilitate consumer recovery (Publication 4).

CHAPTER 5

THE QUALITATIVE STUDY WITH MENTAL HEALTH CONSUMERS (1b)

5.1 Introduction to Phase 1b of the research

Chapter 5 presents research that explored mental health consumers' understandings of the causes of aggression and how RFC can reduce aggression in AMHS. The findings highlight the importance of engaging consumers in research and co-production to develop knowledge and understanding drawn from their lived experience that promotes improvements to care (Horgan et al., 2018) and facilitates consumers' mental health recovery (Zugai et al., 2015).

5.2 Publication 4 reference

Lim, E., Wynaden, D., & Heslop, K. (2019). Consumers' perceptions of nurses using recovery-focused care to reduce aggression in the acute mental health including forensic mental health settings: A qualitative study. *Journal of Recovery in Mental Health, 2*(2/3), 21-34. https://jps.library.utoronto.ca /index.php/rmh/article/view/32741/25119

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All co-authors have consented to their work being included in the thesis and they have accepted the candidate's contribution as indicated.

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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

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5.3 Chapter precis

The findings presented in Publication 4 illustrate the importance of facilitating a therapeutic environment where consumers can contribute actively to their care and treatment. This environment also empowers consumers to participate in research and talk about the uniqueness of their lived experience, recovery process, and existing strengths and capabilities that can impact the risk of aggression (Cleary et al., 2013; Davidson, Drake, Schmutte, Dinzeo, & Andres-Hyman, 2009; Marynowski-Traczyk, Moxham, & Broadbent, 2015; O'Connor & Delaney, 2007). The findings highlighted the important roles that peer support workers play in supporting MHNs to create a recovery-focused environment, thus should be better supported by health care organisations to reach their full potential, for example be meaningfully employed and collaborate with health professionals (Byrne et al., 2019). Previous studies have shown that when strong therapeutic alliances were present with consumers, MHNs displayed a higher level of therapeutic optimism for allowing the person to self-regulate their aggression risk (Happell & Koehn, 2011; Procter et al., 2017; Salzmann-Erikson, Rydlo, & Wiklund Gustin, 2016; Seed & Torkelson, 2012). It can also reduce the use of restrictive practices in these acute care settings (Greenwood & Braham, 2018; McCann, Baird, & Muir-Cochrane, 2014; Meehan, de Alwis, & Stedman, 2017; Pulsford et al., 2013; Vargas, Luis, Soares, & Soares, 2015).

In summary, the findings of Phase 1 research contribute evidence from both nurse and consumer perspectives of how RFC can be used clinically to reduce aggression in AMHS. However, there remains a lack of understanding of how MHNs can translate this understanding to the use of RFC clinically. Section D of this thesis explored this issue in Phase 2 of the sequential exploratory mixed methods research

which examined what MHNs perceived as the critical knowledge and skills of RFC for reducing aggression (Phase 2a, Chapter 6), and the shared beliefs and attitudes that motivate MHNs to use RFC with consumers at risk for aggression (Phase 2b, Chapter 7).

SECTION D

Sequential Exploratory Mixed Methods Research – Phase 2 Q Methodology Studies

Chapter 6 – The Q methodology study of mental health nurses' knowledge and skills of using recovery-focused care to reduce aggression (Phase 2a)

Chapter 7 – The Q methodology study of mental health nurses' beliefs and attitudes of using recovery-focused care to reduce aggression (Phase 2b)

CHAPTER 6

THE Q METHODOLOGY STUDY ON MENTAL HEALTH NURSES' KNOWLEDGE AND SKILLS OF USING RECOVERY-FOCUSED CARE TO REDUCE AGGRESSION (2a)

6.1 Introduction

Chapter 6 presents Phase 2a research which identified MHNs' knowledge and skill components of RFC and how these can be used to reduce aggression in AMHS. In the clinical environment, nurses build therapeutic relationships with consumers and promoting their recovery is a central premise of these interactions (Wilson et al., 2017; Zugai et al., 2015). As it has been identified that MHNs lack guidelines on how to implement RFC, many MHNs have developed their own subjective knowledge and skills of how the use RFC with consumers who are aggressive. Therefore, it was important for the researcher to explore the knowledge and skill set of RFC that MHNs believed assists them clinically to reduce aggression. Publication 5 below provides the findings of this research.

6.2 Publication 5 reference

Lim, E., Wynaden, D., Heslop, K. (2020). Using Q methodology to explore mental health nurses' knowledge and skills to use recovery-focused care to reduce aggression in acute mental health settings. *International Journal of Mental Health Nursing, 30*(2), 413-426. Doi: 10.1111/inm.12802

Note: Publication 5 uses spelling, pertinent terminology, and referencing in accordance with the requirements of the journal and the country of publication. Permission to include the article in the thesis in the presented format was obtained from the Editor (See Appendix 13).

Author's contribution

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ORIGINAL ARTICLE

Using Q-methodology to explore mental health nurses' knowledge and skills to use recovery-focused care to reduce aggression in acute mental health settings

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6.3 Chapter precis

The five factors identified in the findings reported in Publication 5 provide evidence of the knowledge and skillset components of RFC that MHNs believed are essential to reduce aggression in consumers admitted to AMHS. As there are currently no clinical guidelines in this area (Cleary et al., 2013; Gilburt, Slade, Bird, Oduola, & Craig, 2013; Le Boutillier et al., 2015; McKenna, Furness, Dhital, Ennis, et al., 2014), the findings provide evidence-based information that can assist in this development.

The findings of Phase 2a highlight the important role that MHNs have to facilitate therapeutic environments that support consumers (P. Barker & Ritter, 1997; Chambers, 1998; Happell et al., 2019). For example, MHNs' ability to walk alongside a distressed person to support them following admission (Coffey et al., 2019; Cutler, Sim, Halcomb, Stephens, & Moxham, 2020; Ness et al., 2014; Slade, 2013). The findings support the reduction or elimination of the use of restrictive practices, acknowledge human rights issues in this area, and encourage MHNs to work in co-production with consumers to reduce the risk for aggression in AMHS.

Chapter 7 presents Phase 2b study which used Q methodology to investigate the beliefs and attitudes that MHNs identified as central to the use of RFC to reduce aggression. The work is presented as a traditional thesis chapter. The findings of Phase 2b explain the beliefs and attitudes of MHNs that may influence them to use RFC to reduce aggression.

CHAPTER 7

THE Q METHODOLOGY STUDY ON MENTAL HEALTH NURSES' BELIEFS AND ATTITUDES TO USE RECOVERY-FOCUSED CARE TO REDUCE AGGRESSION (2b)

7.1 Introduction

Chapter 7 presents the findings of the Phase 2b study that identified the beliefs and attitudes that MHNs characterised as central to the use of RFC to reduce aggression. This work is presented as a traditional thesis chapter as parts of the findings from this study have been used in Publication 2 to illustrate the use of Q methodology in this thesis. Therefore, the work could not be presented in a peer-reviewed journal publication.

7.2 Background of the study

The presence of aggression in AMHS remains a common problem that can significantly impact the health and wellbeing of both staff and consumers (Bimenyimana, Poggenpoel, Temane, & Myburgh, 2016; Dickens, Piccirillo, et al., 2013; Oyelade & Ayandiran, 2018; Pulsford et al., 2013). Although all health professionals encounter aggression, MHNs are the health professionals most often exposed to aggressive acts and the frequent victims of aggression in AMHS (Baby et al., 2014; Frauenfelder, Müller-Staub, Needham, & van Achterberg, 2013; Kynoch, Wu, & Chang, 2009). The frequent exposure to aggression can negatively impact MHNs' personal and professional wellbeing, such as sustaining a physical injury, decreased confidence in their clinical knowledge and skills, and experiencing symptoms that are comparable to a person with post-traumatic stress disorder such as

fear, guilt, anger, anxiety, grief and shame (Dickens, Piccirillo, et al., 2013; Jacobowitz, 2013; Jalil et al., 2017; Verhaeghe et al., 2016). These negative aftereffects identified in previous research correlated with increased feelings of higher job stress, reluctance to go to work, and decreased job satisfaction (Baby et al., 2014; Bilici, Sercan, & Izci, 2016; Itzhaki et al., 2015).

The frequent exposure to aggression also influences MHNs' beliefs about the causes of aggression and their attitudes which may determine how they respond to potential or actual aggression (Bowers, 2014; McCann et al., 2014; Pulsford et al., 2013; Tomagová et al., 2016). For example, previous studies found that MHNs commonly believed most aggression was caused by internal triggers, such as auditory hallucinations and paranoid delusions (Dawood, 2013; J. Duxbury, 2002, 2015; Papadopoulos et al., 2012). These beliefs were present even though there are other prominent interpersonal and situational factors that may have been the triggers for aggression. Beliefs held about the causes of aggression also influence MHNs' management of aggressive incidents. For example, whether they use verbal de-escalation, encourage the consumer to try to self-regulate their behaviour, use PRN medications or implement more restrictive interventions to mitigate the risk of the aggression (Camuccio, Chambers, Valimaki, Farro, & Zanotti, 2012; Gaynes et al., 2017; Pulsford et al., 2013). Nevertheless, little is presently known about MHNs' beliefs and attitudes towards the use of RFC with consumers to manage potential or actual aggression. This lack of evidence-based information provided the justification for conducting Phase 2b study.

7.3 Method

The Phase 2b study utilised Q methodology and followed the same methodological process previously outlined in Chapter 6 (Phase 2a Q methodology study). Participants were also recruited from the Australian College of Mental Health Nurses but there were more participants in the Phase 2b study (n=58) than Phase 2a study (n= 40).

7.4 Findings

7.4.1 Results

A total of fifty-eight MHNs participated in Phase 2b of which 54 were registered nurses (93.1%) and four were enrolled nurses (6.92%). Most participants were working in acute mental health inpatient settings (77.6%) and had ± 5-10 or more years of experience in nursing (84.5%). The demographic characteristic of participants is presented in Table 7.1.

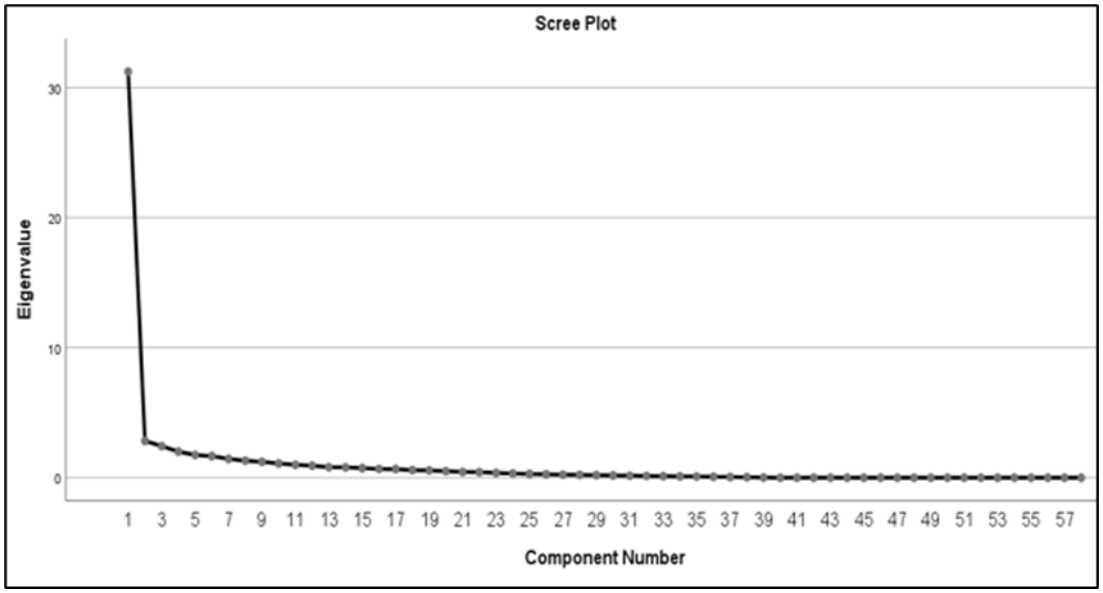
Table 7.1 Demographic characteristic of participants

Demographic characteristics of participants (n= 58)	
Gender	**Number of participants:**
Male	20
Female	38
Age group	
20 to 29 years	9
30 to 39 years	9
40 to 49 years	18
50 to 59 years	15
60 years or older	7
Role	
Enrolled nurse	4
Registered nurse	33
Clinical nurse	7
Nurse specialist/manager	9
Others:	
Nurse educator	4
Clinical nurse consultant	1

Setting working in	
Acute mental health inpatient	43
Forensic mental health inpatient	2
Mental health rehabilitation inpatient	3
Community mental health	7
Others:	
Mental health education	3
Years of nursing	
1 to 3 years	9
4 to 6 years	7
7 to 9 years	3
10 years or more	39
Highest nursing qualification	
Certificate	1
Diploma	16
Bachelor	31
Masters	8
Doctorate	2

The analysis of participants' Q sorts yielded 10 factors with a generated Eigenvalue (EV) of greater than 1.0 (1.0-31.2) and was put through the SPSS scree plot test (Figure 7.1) to determine the number of factors to be retained.

Figure 7.1 Scree plot test



(Lim, Wynaden, Baughman, & Heslop, 2021)

Despite that only factors 1 and 2 contributed to the gradient before the elbow of the slope, the researcher deemed that factors 3 to 5 may be theoretically or substantively important to the study hence including them for factor analysis (Lim et al., 2021). These five factors accounted for 69.4% of the variance that encompassed participants' beliefs and attitudes about how RFC could reduce aggression. Table 3 illustrates the factor loadings of the participants and the factors.

Table 7.2 Factor loadings of the participants and the factors

	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5
P1	.561		.439	.323	
P2	.723				
P3	.481	.449			
P4	.537		.301	.330	
P5	.501				.526
P6	.322	.590			
P7	.588				
P8	.425			.389	.429
P9					
P10	.403		.415		
P11	.618		.346	.326	
P12	.637				
P13	.450			.357	
P14		.431	.524	.333	.369
P15			.400	.479	.434
P16					
P17				.837	
P18	.450			.543	.428
P19	.456	.459	.416		
P20			.369		
P21		.745			
P22					.504
P23		.324	.420		
P24	.350	.472			
P25	.493	.377	.407		.308
P26					
P27	.413		.434		.391
P28	.793	.309			
P29	.542	.557			
P30	.484	.426		.464	

P31	.594		.300		
P32	.428		.411	.426	
P33	.478	.400		.369	
P34		.523			.477
P35				.387	
P36	.503				.314
P37	.567		.343	.399	
P38	.331	.506		.465	
P39	.423		.433	.449	
P40	.545				
P41	.803				
P42	.483			.346	
P43	.570	.325			
P44	.410	.307		.460	
P45	.341		.559		
P46					
P47					
P48	.416	.375			
P49	.469				
P50	.447		.397		.320
P51			.855		
P52	.396				
P53	.589		.487	.329	
P54	.561				
P55	.301	.700			
P56	-.401			-.410	-.376
P57			.578	.321	
P58					-.781

The 40 statements of the Q set, their z-scores, and the retained factors are presented in Table 7.3.

Table 7.3 The 40 statements which formed the Q set, retained factors, and z-scores

Q set	z-score				
Positive statements about beliefs	**Factor I**	**Factor II**	**Factor III**	**Factor IV**	**Factor V**
1. The consumer should be involved in the planning of their care and treatment to reduce aggression.	.87404	.92866	.55039	1.45902	.28893
2. Every consumer endeavour to achieve recovery when admitted to hospital.	.37214	-1.59530	-.53653	1.42670	.06942
3. A consumer who achieves personal recovery has a lower risk for aggression.	.18110	-.13874	.67543	-.06625	-.95677
4. It is important to display positive attitudes when intervening to reduce the consumer's potential for aggression.	-1.22513	1.19727	1.74096	2.82896	-1.14322
5. It is empowering to support the consumer to self-manage their behaviour.	.29264	-.54379	-.03851	.88424	1.63174
6. A consumer usually has a reason for displaying aggression in the acute mental health setting.	-.33754	.58858	.58651	.32462	1.86897
7. Aggression is triggered by the consumer's negative experience in the hospital.	1.20129	.64016	.28034	-.25615	-.47544
8. Nurses need to put themselves in the consumer's shoes when intervening to manage aggression.	1.16799	-2.71113	.58083	-.55863	.13016
9. A consumer can learn about their strengths and weaknesses to self-manage their risk for aggression.	.81354	.31512	.30256	-.05647	-.37689
10. Risk of aggression is reduced when the consumer understands their strengths and vulnerabilities.	.58137	.55195	.31702	.35435	1.66463
Negative statements about beliefs					
11. A distressed consumer should never display dysregulated behaviour such as aggression in the hospital.	36652	-.28690	-.62114	.22523	-.14674
12. Providing recovery-focused care is not suitable for the consumer with an acute mental disorder.	-1.78975	.01455	-.87382	-.33087	.52338
13. A consumer with an acute mental disorder cannot control their behaviour in the hospital.	.89906	-.03489	.33133	.75545	-1.26038
14. Nurses need to exercise control over the consumer in the hospital.	-.45101	-.40971	.32131	-.21350	.65804

15. A consumer with an acute mental disorder is too unwell to collaborate in their care and treatment.	-1.51013	.43366	.06032	.67178	-.59475
16. A consumer is aggressive if they have an acute mental disorder and/or drug and alcohol abuse.	.84854	-.31579	-.20040	-.97733	-.91878
17. Aggression is not allowed in the hospital regardless of the consumer's lived experience.	1.41893	1.52608	-1.11194	-2.31620	-1.31901
18. A consumer who is admitted to hospital does not have resources and/or family and carers to support their recovery journey.	-.71404	-.33739	.86441	-.58358	-.18567
19. A consumer who is non-compliant with care and treatment has a high risk for aggression.	-1.10860	2.28794	-.07511	.75017	-1.65084
20. It is impossible to build a therapeutic relationship with the consumer with a high risk for aggression.	-.59625	-1.63335	-1.76171	-.06445	.97501
Positive statements about attitudes					
21. It is important to respect the consumer's feelings and thoughts when reducing their level of risk for aggression.	.43443	1.77524	1.48330	-1.82157	.72643
22. It is important to listen to the consumer's reason for being aggressive before responding.	.86229	.61221	1.05048	-.98748	.87144
23. Being attentive to the consumer's lived experience can reduce their level of risk for aggression.	.91522	-.08358	.21690	.06933	.60041
24. It is imperative to support the consumer to self-regulate their level of risk for aggression.	1.29221	-.13243	.05043	1.03527	.45281
25. It is important to meet the consumer's needs when they are experiencing a personal and/or mental health crisis.	.89719	.62232	-.06883	-.05744	-.30303
26. Nurses should see each consumer's episode of aggression as an individual experience.	1.25667	-.94629	-.06687	1.21003	.89984
27. A consumer should be supported to express their negative emotions in the hospital.	-.29375	.31739	-.34995	.09809	1.79878
28. The consumer's aggression can be a response to their negative lived experience.	1.40194	-.32934	.18988	.37477	-.66955

29. Nurses should encourage the consumer to take responsibility for their behaviour.	-.03460	.99532	-.19039	-.15430	-.06142
30. Nurses should display optimism and offer choices for the consumer to self-regulate their behaviour to reduce their potential for aggression.	-.14447	.46264	.11253	1.33336	.32836
Negative statements about attitudes					
31. A consumer should not interfere with the clinical decisions about their care and treatment.	.21158	-1.42644	.01612	-.57504	-1.39539
32. It is not possible to facilitate both therapeutic and restrictive care at the same time.	-1.67195	.24122	-.09125	.27156	.49352
33. Nurses do not need to get to know the consumer personally to identify their triggers for aggression.	.43842	1.00639	-4.77307	.78948	-.56930
34. A consumer has too many requests when they are in the hospital.	-1.04414	-.22577	.00757	-.93451	.13680
35. There is nothing that the consumer can offer to their treatment and care when they are in the hospital.	-.77923	-.02756	-.16962	-1.27127	-.00303
36. It is difficult to trust the consumer to use their strengths and abilities to reduce aggression.	.50898	-.60332	.83067	-.82381	-.40118
37. It is impossible to support the consumer to achieve their recovery goals in the hospital.	-1.90930	-1.73679	.17740	.30622	-.79056
38. It is irrelevant to explore the consumer's strengths and life achievements when they are in the hospital.	-1.31495	-.37929	.01546	-1.08978	.18086
39. It is difficult to assess the consumer's triggers for aggression.	-1.44508	.50554	-.33139	-1.58629	1.45244
40. A consumer with a high risk for aggression should not be in the hospital.	-.86619	-1.12444	.49841	-.44371	-2.53005

7.4.2 Interpretation of results

7.4.2.1 Factor I emphasised that aggression is triggered by the consumer's dynamic lived experience

Factor I contributed to 53.8% of the variance and consisted of the 15 statements (see Table 7.4). While participants did not accept aggression as part of the job (-2), their ranked-ordered statements 7, 17, 23, and 28 highlighted that aggression was most likely triggered by the consumer's dynamic lived experience such as being admitted to hospital or going through a life crisis.

Table 7.4 The 15 statements which significantly loaded onto factor I

	Items ranked at +4
17.	Aggression is not allowed in the hospital regardless of the consumer's lived experience +4
28.	The consumer's aggression can be a response to their negative lived experience +4
	Items ranked higher in Factor I array than in other factor arrays
7.	Aggression is triggered by the consumer's negative experience in the hospital +3
24.	It is imperative to support the consumer to self-regulate their level of risk for aggression +3
26.	Nurses should see each consumer's episode of aggression as an individual experience +3
8.	Nurses need to put themselves in the consumer's shoes when intervening to manage aggression +2
23.	Being attentive to the consumer's lived experience can reduce their level of risk for aggression +2
25.	It is important to meet the consumer's needs when they are experiencing a personal and/or mental health crisis +2
	Items ranked lower in Factor I than in other factor arrays
15.	A consumer with an acute mental disorder is too unwell to collaborate in their care and treatment -3
32.	It is not possible to facilitate both therapeutic and restrictive care at the same time -3
39.	It is difficult to assess the consumer's trigger for aggression -3
4.	It is important to display positive attitudes when intervening to reduce their potential for aggression -2
34.	A consumer has too many requests when they are in the hospital -2
	Items ranked at -4
12.	Providing recovery-focused care is not suitable for the consumer with an acute mental disorder -4

37.	It is impossible to support the consumer to achieve their recovery goals in the hospital -4

Participants' interpretations of statements 12 and 37 strongly indicated their positive attitudes toward the effectiveness of promoting RFC to reduce aggression in AMHS. Their rank-ordered statements 15, 26, and 39 highlighted that RFC allowed MHNs to obtain insights into the consumer's personal challenges and needs when admitted to the hospital, hence they viewed each consumer's episode of aggression as an individual experience. Participants' responses to statements 8 and 23 indicated that the understanding of the person's lived experience allowed MHNs to plan and implement more sensitive and attentive care to reduce the person's risk for aggression. This was supported by this group's interpretations of statements 24, 25, and 34 that they would try to meet the requests and needs of a consumer experiencing a personal and/or mental health crisis so that the person felt supported to effectively self-regulate their emotions and behaviours.

7.4.2.2 Factor II emphasised that aggression is triggered by the consumer's intense reactions

Factor II contributed to 4.9% of the variance and consisted of the 13 statements (Table. 7.5) which indicated that aggression was displayed when a consumer is reacting strongly to their current situation.

Table 7.5 The 13 statements which loaded significantly onto factor II

	Items ranked at +4
19.	A consumer who is non-compliant with care and treatment have a high risk for aggression +4
21.	It is important to respect consumer's feelings and thoughts when reducing their level of risk for aggression +4
	Items ranked higher in Factor II array than in other factor arrays

32.	It is not possible to facilitate both therapeutic and restrictive care at the same time +3
24.	It is imperative to support the consumer to self-regulate their level of risk for aggression +2
28.	A consumer' aggression can be a response to their negative lived experience +2
	Items ranked lower in Factor II than in other factor arrays
2.	Every consumer endeavour to achieve recovery when admitted to hospital -3
30.	Nurses should display optimism and offer choices for the consumer to self-regulate their behaviour to reduce their potential for aggression -3
5.	It is empowering to support the consumer to self-manage their behaviour -2
14.	Nurses need to exercise control over all the consumer in the hospital -2
25.	It is important to meet the consumer's needs when they are experiencing a personal and/or mental health crisis -2
35.	There is nothing that the consumer can offer to their treatment and care when they are in the hospital -2
	Items ranked at -4
8.	Nurses need to put themselves in the consumer's shoes when intervening to manage aggression -4
36.	It is difficult to trust the consumer to use their strengths and ability to reduce aggression -4

The participants' responses for statements 2, 5, 8, 19, 25, 30, and 32 suggested that consumers may display aggression if they were adjusting to the loss of freedom and autonomy, in denial of the need to be admitted to hospital, and not ready to collaborate with MHNs to share responsibilities of their care and treatment. As such, MHNs need to maintain a safe environment and allow the consumer to have some personal space to sort out their negative thoughts and feelings. This is supported by the participants' rank-ordered statements 14 and 28, which offered their views that the individual was not dangerous or threatening but was feeling upset when displaying dysregulated behaviour. As such, RFC provided MHNs with opportunities to support the consumer to self-determine or engage in shared decision-making for their care (-2), and in doing so validated the person's thoughts and feelings (+4). The display of trust in the consumer's strengths and ability to self-regulate their level of risk for aggression (-4) may encourage the individual to collaborate more effectively as their emotional and mental state improved (+2).

7.4.2.3 Factor III emphasised that aggression is triggered by the consumer's distressing thoughts

Factor III contributed to 4.2% of the variance and consisted of 14 statements (Table 7.6). The rank-ordered statements 4, 11, 16, 21, 22, and 40 highlighted participants' opinions that aggression was often triggered by the consumer's distressing thoughts.

Table 7.6 The 14 statements which loaded significantly onto factor III

	Items ranked at +4
4.	It is important to display positive attitudes when intervening to reduce their potential for aggression +4
21.	It is important to respect consumer's feelings and thoughts when reducing their level of risk for aggression +4
	Items ranked higher in Factor III array than in other factor arrays
18.	A consumer who is admitted to hospital do not have resources and/or family and carers to support their recovery journey +3
22.	It is important to listen to the consumer's reasons for being aggressive before responding +3
36.	It is difficult to trust the consumer to use their strengths and ability to reduce aggression +3
3.	A consumer who achieved personal recovery have a lower risk for aggression +2
8.	Nurses need to put themselves in the consumer's shoes when intervening to manage aggression +2
40.	A consumer with a high risk for aggression should not be in the hospital +2
	Items ranked lower in Factor III than in other factor arrays
11.	Distressed consumer should never display dysregulated behaviour such as aggression in the hospital -3
16.	A consumer is aggressive if they have an acute mental disorder and/or drug and alcohol abuse -2
27.	A consumer should be supported to express their negative emotions in the hospital -2
29.	Nurses should encourage the consumer to take responsibility for their behaviour -2
	Items ranked at -4
20.	It is impossible to build a therapeutic relationship with the consumer with a high risk for aggression -4
33.	Nurses do not need to get to know the consumer personally to identify their triggers for aggression -4

Participants agreed with statements 18 and 36 and indicated that the lack of access to personal coping mechanisms and closeness to family and/or carers can affect the person's ability to self-regulate their emotions and behaviour effectively. This was reinforced by participants' disapproval with statements 27 and 29 that implied that it is unrealistic to encourage a distressed individual to take control and responsibility for their behaviours. Therefore, the participants believed that RFC provided MHNs with the opportunity to build therapeutic relationships and walk alongside the consumer (-4) and support the person to achieve their goals of personal recovery (+2). The display of empathetic attitudes for a distressed individual (+2) is more likely to empower the person to talk about their lived experience (-4) and this is important to reduce their level of aggression risks.

7.4.2.4 Factor IV emphasised that aggression is triggered by the consumer's dysregulating emotions

Factor IV contributed to 3.5% of the variance and consisted of the 16 statements (Table 7.7). This group strongly disagreed with statements 17 and 21 but agreed with statements 13 and 40, which contributed to their opinions that consumers with an acute mental disorder were a risk for aggression if they are dysregulating emotionally.

Table 7.7 The 16 statements which loaded significantly onto factor IV

	Items ranked at +4
1.	A consumer should be involved in the planning of their care and treatment to reduce aggression +4
4.	It is important to display positive attitudes when intervening to reduce their potential for aggression +4
	Items ranked higher in Factor IV array than in other factor arrays
2.	Every consumer endeavour to achieve recovery when admitted to hospital +3

26.	Nurses should see each consumer's episode of aggression as an individual experience +3
30.	Nurses should display optimism and offer choices for consumers to self-regulate their behaviour to reduce their potential for aggression +3
13.	A consumer with an acute mental disorder cannot control their behaviour in the hospital +2
40.	A consumer with a high risk for aggression should not be in the hospital +2
	Items ranked lower in Factor IV than in other factor arrays
35.	There is nothing that the consumer can offer to their treatment and care when they are in the hospital -3
38.	It is irrelevant to explore the consumer's strengths and life achievements when they are in the hospital -3
39.	It is difficult to know what is important in the consumer' personal lives -3
16.	A consumer is aggressive if they have an acute mental disorder and/or drug and alcohol abuse -2
18.	A consumer who is admitted to hospital do not have resources and/or family and carers to support their recovery journey -2
34.	A consumer has too many requests when they are in the hospital -2
36.	It is difficult to trust the consumer to use their strengths and ability to reduce aggression -2
	Items ranked at -4
17.	Aggression is not allowed in the hospital regardless of the consumer's lived experience -4
21.	It is important to respect the consumer's feelings and thoughts when reducing their level of risk for aggression -4

Participants' interpretations of statements 16, 18, 26, 38, and 39 highlighted the importance of MHNs acknowledging the uniqueness of each consumer's strengths and weaknesses to self-manage their level of risk for aggression. When the person is dysregulating emotionally, MHNs should spend time with the person to identify the reason for their presenting behaviours and to explore what they may need to support them to prevent future episodes of aggression. The group's rank-ordered statements 1, 2, 4, 30, 34, 35, and 36 highlighted that when MHNs fully explored the consumer's strengths and weaknesses, they were more likely to display a higher level of trust, therapeutic optimism, and positive attitudes to collaborate with the person.

7.4.2.5 Factor V emphasised that aggression is triggered by the consumer's ineffective communications

Factor V contributed to 3.0% of the variance and consisted of the 15 statements (Table 7.8). They rank-ordered statements 27 and 39 higher in this factor and revealed their views that the consumer displayed aggression if they are unable to share thoughts and feelings with others.

Table 7.8 The 15 statements which loaded significantly onto factor V

	Items ranked at +4
6.	A consumer usually has a reason for displaying aggression in the acute mental health setting +4
27.	A consumer should be supported to express their negative emotions in the hospital +4
	Items ranked higher in Factor V array than in other factor arrays
5.	It is empowering to support the consumer to self-manage their behaviour +3
10.	Risk of aggression is reduced when the consumer understands their strengths and vulnerabilities +3
39.	It is difficult to know what is important in the consumer's personal lives +3
14.	Nurses need to exercise control over all the consumer in the hospital +2
20.	It is impossible to build a therapeutic relationship with consumer with a high risk for aggression +2
	Items ranked lower in Factor V than in other factor arrays
13.	A consumer with an acute mental disorder cannot control their behaviour in the hospital -3
31.	A consumer should not interfere with the clinical decisions about their care and treatment -3
3.	A consumer who achieved personal recovery have a lower risk for aggression -2
4.	It is important to display positive attitudes when intervening to reduce their potential for aggression -2
16.	A consumer is aggressive if they have an acute mental disorder and/or drug and alcohol abuse -2
28.	A consumer's aggression can be a response to their negative lived experience -2
	Items ranked at -4
19.	A consumer who is non-compliant with care and treatment have a higher risk for aggression -4
40.	A consumer with a high risk for aggression should not be in the hospital -4

This is consistent with participants' negative responses about statements 3, 13, 16, 19, 28, 31, and 40 that a person may use aggression to communicate their negative feelings and personal needs when hospitalised. The participants' rank-ordered statements 4, 14, and 20 revealed beliefs that MHNs need to take control and find ways to establish a nurse-consumer therapeutic relationship, as statements 6 and 19 ranked higher in this factor indicated that a consumer is more likely to reveal their reason for aggression when there is a therapeutic alliance. When MHNs knew the reason for the person's aggression, they are more likely to support them to learn about their strengths and vulnerabilities (+3) and be empowered to regain self-management of their behaviour (+3) as their mental states improve.

7.5 Discussion

The use of Q methodology allowed the researcher to examine and quantify the beliefs and attitudes shared by MHNs towards the use of RFC to reduce aggression in AMHS. The findings illustrate that MHNs believe that they would more likely use RFC if they knew the consumer well and empathised with their lived experience of being admitted to the AMHS. For example, the loss of freedom, feeling of unsafety, or low self-worth and self-esteem (Cutler, Sim, Halcomb, Stephens, et al., 2020). MHNs who viewed aggression as an outward expression of one's deeply personal and unique experience of going through a difficult time (Anthony, 1993; Olasoji et al., 2020; Slade, 2013) were more likely to display a higher level of therapeutic optimism to collaborate with the person and support them to self-regulate their thoughts and emotions (Bowers, 2014; Ness et al., 2014; O. Price & Baker, 2012). These nurses are also more likely to use RFC to reduce the risk of aggression, supporting the consumer to achieve self-growth, personal healing,

and self-manage their behaviour (McKenna, Furness, Dhital, Park, & Connally, 2014a).

The finding that mental health nurses' beliefs that aggression is often triggered by the consumer's lived experience are supported by the cognitive vulnerability-stress model (Gibb & Coles, 2005). The cognitive vulnerability-stress model proposes that vulnerable individuals are more likely to lose control of their emotions and behaviours due to their social cognition and interpretation of stressful situations (Harwood, 2017; Kaite, Karanikola, Merkouris, & Papathanassoglou, 2015; Muir-Cochrane, Barkway, & Nizette, 2014; Thibeault, Trudeau, d'Entremont, & Brown, 2010). Due to the repeated activation of the fight or flight mechanism, individuals with a lived experience of trauma experience are likely to be hypersensitive and hyperaroused by strict routines and ward practices, ineffective communication styles of health professionals, the lack of personal space, and unmet needs (Abate, Marshall, Sharp, & Venta, 2017; Kar, 2019; Paterson et al., 2013; Procter et al., 2017; Schmidt & Uman, 2020). As such, many individuals who become aggressive when admitted to the hospital have a lived experience of trauma (Grenyer et al., 2013). This highlighted the importance of MHNs using trauma-informed principles central to RFC with these consumers (Muskett, 2014).

The findings also identified MHNs believe that the use of RFC would increase if they had more time to spend one-on-one with consumers in the clinical setting. This would enable them to learn more about the person's strengths, weaknesses, and the impact of their lived experience on their presenting aggression risk. Getting to know the consumer at a personal level is crucial for MHNs to establish a therapeutic nurse-consumer relationship with an individual and foster co-production to reduce aggression (Clark, 2015; Roper et al., 2018; Slay & Stephen,

2013). MHNs who see the consumer as a partner when addressing a clinical situation such as aggression, are more likely to focus on the person's strengths and abilities, thus using interpersonal interventions as opposed to the use of medication or restrictive practice. This nurse-consumer therapeutic alliance where both parties share equal responsibilities to reduce aggression, also enables MHNs to personalise care to meet the individual's needs, so that they could participate more actively in the care and treatment (Bora, Leaning, Moores, & Roberts, 2010; Boyle, 2004; Motteli et al., 2019; Oades, Crowe, & Nguyen, 2009).

Existing literature supports that aggression is more likely to be reduced when consumers experience supportive relationships that enable them to begin their personal recovery journey (Fletcher et al., 2018; Ness et al., 2014; Procter et al., 2017). Consequently, these MHNs are likely to see the assessed aggression risk as an opportunity to motivate and coach the consumer to learn or identify more effective ways of managing their risk for aggression. This approach is significantly more effective to support the person to build a positive sense of self-identity, finding strengths and resilience to deal with daily life challenges, and fostering hope for the future (Horsfall et al., 2018; McKenna, Furness, Dhital, Park, & Connally, 2014b; Ness et al., 2014; Slade, 2013). When there is trust and rapport with MHNs, the consumer may share more openly about their thoughts and emotions and collaborate actively in their care and treatment even if their psychiatric symptoms persist (Edward, Welch, & Byrne, 2018; Spaulding, Montague, Avila, & Sullivan, 2016).

7.6 Implication to clinical practice

Mental health nursing is a discipline that emphasises building therapeutic relationships with consumers, supporting them to restore their health and wellbeing,

and adapting to the associated life changes and broader psychosocial needs of living with a disorder (P. Barker & Ritter, 1997; Chambers, 1998; Happell et al., 2019). Therefore, collaborating with consumers to navigate stressful situations in the clinical environment and supporting them to achieve personal recovery is considered the essence or cornerstone of mental health nursing (Jeffery & Fuller, 2016; Perlman et al., 2018; Santangelo et al., 2018). Yet, MHNs due to the philosophy of care at the service may be required to prioritise safety over fostering positive experiences for the consumers to reduce the impacts of their lived experiences on their level of aggression risks (R. Barker, 2012; Muir-Cochrane & Duxbury, 2017; Slemon et al., 2017). Consequently, supporting consumers to begin their recovery journey is often a secondary goal, rather than being the foundation of nursing care (R. Barker, 2012).

Research evidence generated from this study should be translated into the existing policies to ensure a consistent assessment of the consumer's lived experience. If MHNs assessed the consumer's lived experience and the impact on their aggression risk, they are likely to adopt a trauma-informed, compassionate, and empathetic perspective of the consumer and their presenting behaviours (Cutler, Sim, Halcomb, Stephens, et al., 2020; Smith & Garcia, 2012). The display of more positive beliefs and attitudes is likely to motivate them to use RFC and promote a more supportive and conducive milieu for the person (Coffey et al., 2019; McKeown et al., 2016). Understanding of the consumer's lived experience may also lead MHNs to develop a higher level of therapeutic optimism for traveling alongside the individual and delay the use of restrictive practices to support them to self-regulate their level of aggression risks (Bowers, 2014; Muskett, 2014; Procter et al., 2017).

Evidence-based knowledge derived from this study when translated to clinical practice can motivate MHNs to use more encouraging and supportive

communication styles to engage with the consumer. This is important for the person to experience a more positive sense of self and their current situation (Chronister, Chou, Kwan, Lawton, & Silver, 2015; Pledger, 2018; Slade, 2013; Sommer, Gill, & Stein-Parbury, 2018), thus gain or regain strengths to overcome the identified triggers for aggression. The use of a more encouraging and supportive communication style can also make the individual feel that they are being understood and validated to reduce the negative thoughts and feelings, and regain control of their behaviour to reduce their level of aggression risks. (Gaillard, Shattell, & Thomas, 2009).

7.7 Chapter precis

Chapter 7 presented the findings of Phase 2b study on the beliefs and attitudes that increased the likelihood of MHNs using RFC to reduce aggression. The five generated factors provided insights into the beliefs and attitudes components of RFC that the majority of MHNs shared that can promote the use of RFC to reduce aggression in the AMHS.

Chapter 8, the final chapter of this thesis presents an overview of the five completed studies, discussion of the research findings, recommendations around nursing education, professional development, clinical practice, policy directions, need for further research, and concluding statements.

SECTION E

Chapter 8 – Discussion: Overview of findings, significance of findings, recommendations and conclusion

CHAPTER 8

DISCUSSION: OVERVIEW OF FINDINGS, SIGNIFICANCE OF FINDINGS, RECOMMENDATIONS AND CONCLUSION

8.1 Introduction

Aggression remains a challenging and complex clinical and workforce issue. Health professionals and particularly MHNs who are repeatedly exposed to aggression in AMHS may experience personal injury, trauma, burnout and as a result, leave the profession. From the consumer perspective, human rights issues have now highlighted the need to reduce or eliminate the use of restrictive practices which are often employed to manage aggression. Consumers who are involved in or witness aggression may experience trauma which may impact their level of mental wellbeing and health outcomes (Muskett, 2014). These factors emphasise the importance of mental health professionals using a range of recovery-focused interventions to reduce the risk of aggression. This is particularly relevant for nurses who have the closest and most frequent interactions with consumers. Chapter 8, the final chapter of this thesis provides an overview of the completed research, discussion of significant findings, recommendations and suggestions for further research in this important area of health care.

8.2 Overview of findings

A scoping review of the literature along with four research studies that engaged key stakeholder groups (MHNs and consumers) explored how the use of RFC by MHNs can reduce aggression in the AMHS. A summary of key findings from the scoping review and the four studies is outlined in Table 8.1 below.

Table 8.1 Overview of the key findings of four research studies and scoping review of the literature

Scoping review of literature	A review of 35 published articles identified four key components of RFC that MHNs can utilise to reduce aggression: (i) Seeing the person and not just their presenting behaviour; (ii) Interact, don't react; (iii) Co-production to achieve identified goals; and (iv) Equipping the consumer as an active manager of their recovery.
Phase 1a **Qualitative study with 27 MHNs to explore how RFC can reduce aggression**	Five important categories were identified by the MHN participants using semi-structured interviews – (i) Identify the reason for the behaviour before responding; (ii) Being sensitive to the consumer's triggers for aggression; (iii) Focus on the consumer's strengths and support, not risks; (iv) Being attentive to the consumer's needs; and (v) Reconceptualise aggression as a learning opportunity.
Phase 1b **Qualitative study with 31 consumers to explore the causes of aggression and how RFC can reduce the risk of aggression in AMHS**	Consumer participants identified the following categories as important to reduce the risk of aggression: (i) See the person as an individual with a unique lived experience; (ii) Dialogue to explore the reason for the behaviour; (iii) Use positive communication to encourage self-management; (iv) Promote personal comfort to de-escalate the risk for aggression; and (v) Travel alongside the person to co-produce strategies for reducing aggression.
Phase 2a **Q methodology study with 40 MHNs to identify the knowledge and skills components of RFC**	Factors analysis identified five factors that encompassed MHNs' knowledge and skills components of RFC – (i) Acknowledge the consumer's experience of hospitalization; (ii) Reassure consumers who are going through a difficult time; (iii) Interact to explore the impact of the consumer's negative lived experience; (iv) Support co-production to reduce triggers for aggression; and (v) Encourage and support consumers to take ownership of their recovery journey.
Phase 2b **Q methodology study with 58 MHNs to identify the beliefs and attitudes components of RFC**	Factor analysis identified five factors that explained the beliefs and attitudes held by MHNs that influenced them to use RFC. They believed aggression is triggered by consumers' – (i) Dynamic lived experiences; (ii) Intense reactions; (iii) Distressing thoughts; (iv) Dysregulated emotions; and (v) Ineffective communication.

In summary, the scoping review and four completed studies contribute empirical evidence from MHNs and consumers regarding how RFC can be used to reduce aggression, lower the rates of restrictive practice usage and promote consumer recovery. The findings also highlight that while aggression is a common, challenging, and destructive experience for both consumers and staff, research into how RFC can reduce aggression remains relatively unexplored. Therefore, the research findings reported in this thesis add to knowledge and understanding in the area and the significance of the findings will now be discussed.

8.3 Significance of research findings

8.3.1 The use of a sequential exploratory mixed methods research design

The use of a sequential exploratory mixed methods research design added to the trustworthiness of the overall research findings. Phase 1 qualitative studies with MHNs and consumers allowed the researcher to obtain an in-depth understanding of stakeholder perceptions regarding the triggers of aggression and how they believed RFC can reduce aggression. The findings from the scoping review of the literature and Phase 1 studies were then utilised in the development of a concourse for Phase 2 studies using Q methodology. This process ensured that the 80 statements of the concourse used in Phase 2 studies with MHNs were broad, comprehensive and representative of key stakeholder beliefs (Coogan & Herrington, 2011; Van Exel & de Graaf, 2005). Therefore, the researcher was confident that the completed Q-sorts and generated factors in Phase 2 studies were accurate representations of MHNs' knowledge, skills, beliefs, and attitudes regarding the use of RFC to reduce aggression.

The novel use of Q methodology is viewed as significant to the findings of this research, as it allowed the researcher to explore new dimensions, for example MHNs and consumers' shared perspectives of factors that influenced how RFC can reduce aggression in clinical situations. The knowledge and understanding generated by this methodology add to the body of knowledge of other researchers in this area (Cleary et al., 2013; McKenna, Furness, Dhital, Ennis, et al., 2014; Simpson et al., 2016).

8.3.2 The involvement of key stakeholders in the research process

The significance and trustworthiness of the findings were also enhanced by the collaborative relationship (co-production) between the researcher, MHNs and consumers (Phase 1), and the co-design of the Q methodology studies completed in Phase 2 (Jackson-Blott, Hare, Morgan, & Davies, 2019). Co-production allowed the exploration of consumers' beliefs and understandings about the causes of aggression. It enabled the researcher to compare similarities and differences between consumer and MHNs' beliefs and with existing literature regarding established triggers for aggression (J Duxbury & Whittington, 2005). The engagement empowered consumers to be active partners in research affecting their care, the development of evidence-based practice and how this knowledge can be translated clinically (Fusco, Marsilio, & Guglielmetti, 2020). Consumer involvement in research supports mental health policy directions to foster co-production where consumers are actively involved in all aspects from service planning to clinical care (Arboleda-Flórez, 2008; T. Hall et al., 2019; Mfoafo-M'Carthy & Huls, 2014; Vijayalakshmi, Ramachandra, Reddemma, & Math, 2013). Similarly, Happell et al. (2018) concluded that "the grounds for consumer participation in research are based on human rights,

democratic and participative citizenship, and diversifying research to arrive at more complete and valid knowledge" (p. 1231). This research empowered consumers to have a voice (Chambers et al., 2017) and reinforced the importance of consumer involvement in all aspects pertaining to mental health care (Scholz, Gordon, & Happell, 2017).

8.3.3 The use of RFC by MHNs in AMHS

Before this research, how MHNs believed RFC could reduce aggression in AMHS was not well documented. This was highlighted in the findings of the scoping review of the literature (Publication1). Additionally, it was surprising that the subsequent updated review of the literature conducted several years later prior to submission of this thesis, revealed that a paucity of literature in this subject area remained. It was identified in this study, that while MHNs understand policy directions and the principles of providing RFC along with its importance to consumer recovery, their use of RFC clinically appears to remain limited. This clinical translation of mental health policy failure continues, despite consumers emphasising that RFC facilitates meaningful engagement with MHNs and this engagement provides support that is central to their level of wellbeing (Lim, Wynaden, & Heslop, 2019b). This finding is consistent with other research that found consumers had a lower level of aggression risk when they were supported to experience a more positive sense of self even when their psychiatric symptoms persist (Serin et al., 2016). Working in co-production with MHNs, consumers can be empowered to self-manage their triggers for aggression, better understand the impact of their lived experience on their behaviour, and reduce their stress sensitivity, emotional dysregulation, and uninhibited behaviours assisting them to more

effectively engage in decisions about their care (Arboleda-Flórez, 2008; Grattan et al., 2019; Laitila et al., 2018; Muskett, 2014; Vidal et al., 2020). However, while mental health policy sets directions regarding the importance of using RFC in clinical settings, the workplace reality of shorter lengths of stay, higher levels of acuity, and existing nurse-consumer ratios compromises the amount of available time for MHNs to engage in meaningful therapeutic interventions with consumers. If RFC is to be implemented clinically in all mental health settings, then workforce preparation, adequate allocation of staff, and time to work in co-production effectively with consumers must be prioritised.

When MHNs practice RFC, they can more accurately assess how the consumer responds to stress, for example, being away from friends and families, disruptions to their work and lifestyle, and loss of autonomy following admission (Kaite et al., 2015; Procter et al., 2017). This research provides important insights into the uniqueness of each consumer's triggers for aggression many of which are not related to their presenting mental disorder. An increased understanding of the consumer's lived experience enables MHNs to implement therapeutic care to support the individual to cope with the negative feelings and thoughts, learn about their own strengths and weaknesses, and increase their ability to self-manage their personal triggers for aggression (Caldwell, Sclafani, Swarbrick, & Piren, 2010; Slade, 2013; Solomon, Sutton, & McKenna, 2021).

An increased appreciation for and employment of peer support workers in AMHS may also enhance health professionals' awareness of the human rights issues, the impact of lived experiences, and the resulting triggers for aggression. The findings highlight that mental health consumers can collaborate well with researchers as evidenced by their participation in Phase 1b study. The benefits of having peer

support workers in clinical settings have been demonstrated in previous research to improve consumers' sense of empowerment, support them to develop self-management skills, validate their lived experiences, and reduce their feeling of being stigmatised (Byrne, Roennfeldt, O'Shea, & Macdonald, 2018; Kilpatrick, Keeney, & McCauley, 2017). The emersion of peer support workers in teams working in AMHS is an important strategy for facilitating the translation of RFC clinically and for supporting consumers to achieve self-regulation of their behaviour, reduce the impact of their lived experience, and de-escalate their level of risk for aggression.

8.3.4 Who is responsible for managing aggression in the AMHS?

Traditionally MHNs have been the group of health professionals who most frequently experience and manage aggression in the AMHS (Baby et al., 2014). However, this role routinely places MHNs in conflict with their central role of developing therapeutic relationships with consumers which is central to the delivery of RFC. In translating the principles of RFC to clinical care, a cultural shift is needed in AMHS to view aggression prevention and management as a multidisciplinary responsibility. A multidisciplinary approach to preventing and managing aggression increases the range of interventions available for supporting consumers to de-escalate their level of aggression risk, and/or to regain control of their behaviour (Edward, Ousey, Warelow, & Lui, 2014b; Happell & Koehn, 2011; Jeffery & Fuller, 2016; Muir-Cochrane et al., 2018). A multidisciplinary approach also ensures that all team members are educated on the causes of aggression and related assessment processes. Procter et al. (2017) claimed that almost 90% of the consumers admitted to the AMHS are individuals who have experienced multiple trauma in their life. The high prevalence of trauma and known impact on the level of risk for aggression

necessitates that an assessment of a consumer's lived experience be incorporated as part of structured aggression risk assessments routinely used in the AMHS. Multidisciplinary ownership of managing aggression should also focus on the reduction in the use of the restrictive practice to minimise traumatisation or re-traumatisation of the person (Fletcher, Hamilton, Kinner, & Brophy, 2019; Fletcher et al., 2017).

8.3.5 Collective view of the world

Collectively, both the MHN and consumer participants in Phase 1 studies highlighted that consumer who experienced a more positive sense of self were likely to better self-manage their triggers for aggression (Bird et al., 2012; Chisholm & Petrakis, 2021; Sommer et al., 2018; Waldemar et al., 2018). This study provided the opportunity for consumers to articulate the reasons for their aggression and identify self-management strategies. This account from people who have a lived experience of aggression adds strength to research evidence, by emphasising that aggression in the clinical environment is not always a dysfunctional phenomenon that a consumer displays deliberately but also a normal human protective or communicative response when a person is distressed (Baby, Gale, & Swain, 2018; Verhaeghe et al., 2016). This emphasises the need for MHNs to 'walk in consumers' shoes' and to develop effective communication with them so that an accurate and comprehensive assessment of a consumer's potential for aggression occurs (J. Duxbury, 2015; J. Duxbury et al., 2019; Muir-Cochrane & Duxbury, 2017; B. Price, 2015).

The findings showed that MHNs did not perceive that the use of restrictive practices were necessary to reduce aggression (E. Perkins, Prosser, Riley, & Whittington, 2012; Walker & Tulloch, 2020; Wilson et al., 2017). Collectively

MHNs and consumer participants shared that the risk for aggression was reduced when they spent more time interacting with each other and worked together to address the consumer's clinical concerns or issues. Through co-production, MHNs can support consumers to learn more effective ways to manage their negative thoughts and emotions (Lim, Wynaden, & Heslop, 2019a; Lim et al., 2019b; Singh et al., 2007; Wilson, Rouse, Rae, & Kar Ray, 2018). By working in co-production with consumers and avoiding the use of restrictive practices, MHNs align their practices with the human rights law. Specifically, Article 15 of the Convention on the Rights of Persons with Disabilities (United Nations General Assembly, 2007) emphasises the rights of people with mental disorders to be free from any form of unpleasant or degrading care and treatment (McSherry & Maker, 2020).

In summary, this section presented the significance of findings from the current research and highlighted contributions to existing knowledge on how RFC is used in the AMHS. The strengths and importance of i) using the sequential exploratory mixed methods research design to achieve the stated objectives and ii) having the involvement of key stakeholders (MHNs and consumers) to co-design this research were discussed. The next section discusses recommendations based on the findings of this research.

8.4 Implications of findings, recommendations, and suggestions for further research in the area

This section presents the implications of findings and recommendations in the areas of mental health policy, mental health services, the mental health workforce, the profession of MHN along with suggestions for further research in the area.

8.4.1 Mental health policy

8.4.1.1 Aggression management and the use of restrictive practices

The findings demonstrate that current mental health policy in the areas of managing aggression and the use of restrictive practices, for example, restraint and seclusion need to be revised within the frameworks of recovery and working in co-production with consumers. Both MHNs and consumer participants reported their belief that consumers have the capability and resources to self-manage their identified triggers for aggression with effective support from health professionals (Cornaggia, Beghi, Pavone, & Barale, 2011; Felton, Repper, & Avis, 2018). Yet, existing mental policies in the area of aggression training continue to place emphasis on risk minimisation, risk aversion, and a zero-tolerance to aggression in many clinical environments (Ash, Suetani, Nair, & Halpin, 2015; Le Boutillier et al., 2015; Wyder et al., 2017).

Future policy and programs for preventing and managing aggression should focus on improving health professionals' awareness and understanding of the impact of the consumer's lived experience on their aggression risk and how RFC can encourage them to self-manage triggers lessening the need for the use of restrictive practices. When a consumer is assessed as 'being a risk for aggression', policy directives in many health services currently place priority on health professionals managing the consumer's psychiatric symptoms, presenting behaviours and the physical environment to prevent an aggressive incident from occurring. This may lead to the health professional focusing on containment and control of the person, rather than strengthening the individuals' capability and resources to overcome and/or self-manage the identified triggers for aggression (Cornaggia et al., 2011; Felton et al., 2018). This approach can escalate an individual's level of risk for

aggression particularly if the person has a lived experience of trauma, resulting from childhood abuse and neglect, dysfunctional relationships, domestic violence, sexual abuse, and social and economic hardship (Buchanan, Stefanovics, & Rosenheck, 2017; Grenyer et al., 2013; Paterson et al., 2013; Stinson, Quinn, & Levenson, 2016).

8.4.1.2 Implementation policies that support working in coproduction

Implementing the policy directions of working in co-production with consumers will foster the use of RFC and increase consumer involvement in all decisions about their care. This can be further supported by embedding peer support workers in all mental health settings to support consumers and work within the multi-disciplinary team.

8.4.2 Mental health services

8.4.2.1 Eradicating terms that are stigmatising and do not support the use of RFC

Terms such as 'locked wards', 'forensic setting' 'high dependency', and 'involuntary admissions' are currently used in many mental health services to describe consumers and AMHS. It is assumed that consumers who meet the criterion for involuntary admission to mental health services as stipulated under relevant Mental Health Acts (Government of Western Australia, 2013) are a risk to self or others and that their psychiatric conditions impacted on their ability to make decision for themselves and manage their behaviour. These terms are potentially stigmatising and can expose the person to social and structural stigma (strict and regimental care and treatment) and self-stigmatisation (Livingston, Rossiter, & Verdun-Jones, 2011) which can impact on their ability to interact effectively with the health care services.

Subsequently, health professionals often assume power and control of consumers in these circumstances and this custodial practice and disempowerment of people with mental disorders is supported by mental health law (Ash et al., 2015; Bulgari, Ferrari, Pagnini, de Girolamo, & Iozzino, 2018; Felton et al., 2018; Koukia et al., 2009; Olupona et al., 2017). Consequently, the use of use restrictive practices to maintain the order and safety of the unit may be viewed in this context as 'a part of working with consumers who are acutely unwell' (Baby et al., 2014).

Both the MHN and consumer participants consistently stressed throughout this research the importance of co-production and how it can maximise the potentials of both parties to reduce aggression (Bovaird & Loeffler, 2013). If co-production is enshrined in policy directives for preventing and managing aggression, the stigma associated with admission to AMHS and the use of restrictive practices can be reduced (Shefer, Henderson, Howard, Murray, & Thornicroft, 2014).

8.4.2.2 Placing the responsibility of managing aggression with the multidisciplinary team

By placing the responsibility of preventing and managing aggression in AMHS with the multidisciplinary team, the professional development of all mental health professionals working with consumers in the AMHS would be supported. Shared responsibility will allow MHNs to experience less conflict between their custodial/therapeutic roles and allow them to implement RFC more easily in AMHS as part of their routine care. Multidisciplinary management of aggression presents an array of options for preventing aggression and early intervention of potential aggression improving the AMHS environment and consumer care.

8.4.3 Upskilling the mental health nursing workforce

The findings have significant implications for MHN leadership, management, and education to nurture a recovery-focused mental health nursing workforce. As discussed, both MHN and consumer participants regarded RFC as an effective strategy for MHNs to use to reduce aggression. This highlights the need for nursing leadership to establish clear directions for the MHN workforce and ensure that practices in the AMHS remain evidence-based, innovative, and contemporary (McKenna, Furness, Dhital, Park, et al., 2014; Wynaden & Heslop, 2019).

The lack of consistent use of RFC to reduce the risk for aggression underscores the importance of having nurse leaders with advanced recovery-focused knowledge and specialist mental health nursing skills to facilitate a reflective mental health nursing workforce for example, through the provision of clinical supervision (Driscoll, Stacey, Harrison-Dening, Boyd, & Shaw, 2019; Snowdon, Leggat, & Taylor, 2017). With the guidance of an experienced member of the profession, a MHN may achieve a richer and deeper reflection of their clinical, organisational, developmental, and emotional experiences surrounding the use of RFC in the AMHS (Bifarin & Stonehouse, 2017; E. Cusack et al., 2017; Driscoll et al., 2019; Snowdon et al., 2017). MHNs can be supported to achieve personal and professional growth, thus experiencing a higher level of self-efficacy to reduce aggression using RFC (M. Thomas & Isobel, 2019). Nurse leaders with advanced recovery-focused knowledge and specialist mental health nursing skills can also act as role models, mentors, and coaches to encourage MHNs to use RFC in the clinical environment (Wynaden & Heslop, 2019).

The need to develop a knowledgeable and skillful mental health nursing workforce for the AMHS is paramount to ensuring a more open and interactive

AMHS (Horgan et al., 2021). However, with the nursing shortage and increasing patient acuity, many AMHS are filled with casual and/or agency nurses who have no specialist mental health qualifications (Cowin et al., 2003; Usher, Baker, Holmes, & Stocks, 2009). There is a need for governments to support postgraduate qualification in MHN and credentialing of MHN by the ACMHN will facilitate an improved skillset for nurses working in AMHS (Happell, 2006; Horgan et al., 2021; Lakeman, Cashin, Hurley, & Ryan, 2020).

Nurse academics must ensure that RFC is incorporated into nursing curricula and that all nurses have the advanced skillset to manage aggression in all health settings. This will assist in the recruitment of a future MHN workforce as many nurses are currently frightened to work in this area of nursing due to the threat of exposure to aggression. Nurse academics and clinical educators must ensure new knowledge is incorporated into aggression prevention and management programs, for example, RFC, a range of de-escalation methods, and more effective communication strategies (Bowers et al., 2015; Heckemann et al., 2015) that support MHNs to work collaboratively with consumers. Advances in the use of virtual reality technology that mimic real-life aggressive incidents for MHNs to practice RFC without exposing them to potential consequences of encountering aggression in the real world (Liaw et al., 2020; Mendez et al., 2020; Rim & Shin, 2021; Rourke, 2020) may reduce fear and stigma amongst health professions. The enhanced awareness of their own performance can support MHNs to reflect and learn about their own strengths and flaws, and thereafter consciously and purposefully improve their knowledge and skills (Freshwater, 2002; McAllister, Robert, Tsianakas, & McCrae, 2019; Oates, 2017; Videbeck, 2020). This will significantly increase the confidence of MHNs to engage consumers in co-production and use RFC in the AMHS.

8.5 Suggestions for further research in this area

The following suggestions for further research in this area are made:

1. The findings generated in this research have not been evaluated clinically and are based on consumers' and MHNs' beliefs and understandings of the subject area. Therefore, further research to evaluate the clinical efficacy of the findings should be undertaken. This evaluation would include how RFC reduced the use of restrictive practices in AMHS.
2. Further research should focus on the accurate assessment of the consumers' lived experiences and their impact on their risk for aggression. The research should focus on facilitating co-production, the identification of triggers for aggression, and empowering consumers' self-regulatory behaviours.
3. Further research should examine how the custodial role often assigned by the mental health team to the nursing profession in AMHS impacts on MHNs' ability to practice RFC clinically.
4. Further research in the area of virtual reality technology can better prepare health professionals to work with consumers at risk for aggression. This safe innovative training can build confidence and expertise to use interpersonal interactions. Its effectiveness can be evaluated clinically.
5. Further research that explores how health professionals, particularly MHNs can work more collaboratively with peer support workers to better assess and understand the impact of the consumers' lived experience on the presentation of aggression in AMHS.

6. Further research should evaluate the impact of MHNs with specialist postgraduate education in the area on consumer aggression and the use of restrictive practices in AMHS.

8.6 Concluding statement of thesis

In conclusion, this research used a sequential exploratory mixed methods research design to achieve the stated aims and objectives of the research. The knowledge, skills, beliefs, and attitudes components of RFC shared by the majority of MHNs were obtained and provided research evidence that presents in-depth and accurate understandings of these factors. This research demonstrates how mixed methods can explore new dimensions of a complex clinical issue and generate insights and knowledge that are useful for advancing evidence-based practice. More importantly, this research highlighted the value of involving key stakeholders (MHNs and consumers) to explore issues that are critical to improving their experiences in the AMHS. It is through their generous contributions in both Phase 1 and 2 that critical insights and knowledge of how RFC can be used by MHNs to reduce aggression were achieved. While the centrality of nursing perspective through the research may be viewed as a limitation, the findings of this research demonstrate that MHNs believe that RFC can be used to reduce aggression when translated into the mental health policy, mental health services and professional preparation of the mental health nursing workforce. More research clinically on the work presented in this thesis is needed to further promote the use of RFC to manage aggression in AMHS.

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4. Curtin University Human Research Ethics Committee (HR132/2015).
5. South Metropolitan Health Service Human Research Committee in Western Australia (EC00265).
6. Information sheet for the qualitative study with mental health nurses in Phase 1.
7. Information sheet for the qualitative study with consumers with a mental disorder in Phase 1.
8. Informed consent for the qualitative study with mental health nurses in Phase 1.
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11. Permission to include the format of the article in the thesis in Chapter 4.
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14. Email from Curtin University Human Research Ethics Committee- Ethics application ID 5984 - Exemplary ethics application - use for training purposes.
15. Top downloaded article (2017 – 2018): Recovery-focussed care: How it can be utilized to reduce aggression in the acute mental health setting.
16. Top downloaded article (2018 – 2019): Changing practice using recovery-focused care in acute mental health settings to reduce aggression: A qualitative study.

17. Email from Charles R. Mauldin, PhD- Thanks for great Q work.
18. Strategies that mental health nurses can utilize to reduce aggression in acute mental health settings through cultural change. – Oral presentation abstract for the 3rd NUS-NUH International Nursing Conference and 20th Joint Singapore-Malaysia Nursing Conference 2015.
19. Reducing aggression in the acute mental health settings using recovery-oriented mental health practices: A systematic search and review. – Oral presentation abstract for the Curtin University Mark Liverlis Student Research Seminar 2016.
20. Recovery-focused Care: How it can be utilize to reduce aggression in the acute mental health setting. – Oral presentation abstract for the Curtin University Mark Liveris Student Research Seminar 2017.
21. Using recovery-focused care to reduce aggression in the acute mental health settings? – Oral presentation abstract for the Australian College of Mental Health Nursing, Western Australia Branch Symposium 2018.
22. Consumers' perceptions of nurses using recovery-focused care to reduce aggression in the acute mental health including forensic mental health settings: A qualitative study. – Poster for the Nursing and Midwifery Leadership Conference 2019.

Appendix 1

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Appendix 2

The 80 statements of the concourse and how the positive and negative statements were identified from the findings

Findings of the literature review	Positive statements	Negative statements
Component 1: Seeing the person and not just their presenting behavior The first component highlighted the importance of 'seeing the person and not just their presenting behaviour' (Cruce et al. 2012; McKenna et al. 2014b; Russinova et al. 2011; Rydon 2005; Wright et al. 2014). This is particularly important for nurses when completing an assessment with the consumer to fully explore and understand their unique lived experience. It also allows the nurse to assess the impact, for example, that personal or family trauma, previous hospitalizations, or substance abuse problems might have on the person's presenting symptoms and behaviours (Isobel & Edwards 2017; Kirst et al. 2016; Watson et al. 2014). Previous negative experiences of hospitalization might make the consumer relive these unpleasant memories and display heightened emotions, high levels of anxiety, or become easily frustrated (Parkes et al. 2015; Russinova et al. 2011). It could leave them feeling reduce the risk for aggression if the person is unable to successfully self-regulate their escalating behaviour. These strategies should be as least restrictive as possible and be sensitive to the unique lived experience of the consumer, for example, guided by the principles of trauma-informed care (Isobel & Edwards 2017; Kirst et al. 2016).	Nurses explore the impact of the person's lived experience of having a personal and mental health crisis Nurses assess patients' past and present trauma to determine their level of risk for aggression	Patients must not display dysregulated behavior such as aggression when admitted to hospital
Component 2 (assessment/planning): Interact, don't react 'Interact, don't react' is the second category identified from the literature, and while clinical recovery stabilizes the person's		

psychiatric symptoms (Department of Health and Ageing 2009), clinical judgments based on accurate assessment can support the person's personal recovery journey, even during the acute phase of their illness (Aston & Coffey 2012; Kogstad et al. 2011; Tunner & Salzer 2006; Walsh & Boyle 2009; Williams & Tufford 2012). 'Interact, don't react' creates an environment that allows the consumer a voice in their recovery journey and to be able to talk openly about their concerns, feelings, and needs (Aston & Coffey 2012; Billsborough et al. 2014; Boardman & Roberts 2014; Hamann et al. 2009; Happell 2008; McCloughen et al. 2011; Young et al. 2008). It establishes a healthy platform for the nurse to listen and to obtain a greater knowledge and understanding of the person's capabilities and strengths (Mancini 2007; Young et al. 2008). This component emphasizes the importance of effective communication skills, such as listening, attending, showing interest, empathy, and giving feedback. It also allows the nurse to strengthen the therapeutic alliance with the consumer, and to continue to assess their ability to increasingly self-manage their behaviours (Rydon 2005). 'Interact, don't react' empowers the consumer and allows them to continue their personal recovery (Goodwin & Happell 2006; Green et al. 2008; Rydon 2005). The nurse continues to engage with the consumer to identify strategies to further decrease trigger/antecedents for aggression, while increasingly involving them in the planning of their care (Goodwin & Happell 2006; Happell 2008). This component reduces the risk for miscommunication and negative situations that can precipitate reactions, such as aggression. It portrays to the consumer the nurse's sense of calmness and enthusiasm to collaborate with them (Aston & Coffey 2012; Bowers 2014; Day et al. 2005; Tunner &	Respecting the people's feelings and thoughts is important when reducing their level of risk for aggression Every person should be involved in the planning of their own care and treatment	People with an acute mental illness are unable to communicate their needs and preferences in care People with an acute mental illness cannot self-manage their own behavior Nurses cannot establish therapeutic alliance with people who have a higher risk for aggression

Salzer 2006). In this component, the nurse continues to explore, clarify, and negotiate with the person how they can continue to more effectively self-regulate their responses and begin to build a range of self-management strategies to respond appropriately to future challenging situations (Bowers 2014; Day et al. 2005; Padmore & Roberts 2013). 'Interact, don't react' changes the distribution of power in the consumer–nurse relationship that currently exists in many mental health settings (Goodwin & Happell 2006; Green et al. 2008; Happell 2008; Padmore & Roberts 2013; Rydon 2005). It encourages the person to assume greater responsibility for the management of their presenting behaviours and make decisions about their care (Mancini 2007). It places emphasis on positive interactions, which decreases the potential for aggression and escalating situations (Boardman & Roberts 2014; Hamann et al. 2009; McCloughen et al. 2011). For nurses, 'interact, don't react' encourages self-reflection on their skills and practice routines, and builds increased confidence to work collaboratively with consumers during the acute phase of their illness (Dusseldorp et al. 2011).	Nurses are able to support people identify their own coping mechanisms to reduce aggression is effective to reduce aggression All nurses know how to collaborate care with patients with an acute mental illness	Nurses should assume control of the patients whom they are caring for
Component 3: Coproduction to achieve identified goals 'Coproduction to achieve identified goals' was the third component identified in the literature. Coproduction is a term increasingly appearing in mental health literature, and portrays the consumer as having equal influence in making decisions about their care (Eriksen et al. 2012; Saruwatari 2009; Slade 2009). Consumers should be acknowledged as an expert of their illness, and their expertise should be utilized during periods of hospitalization (Aston		Patients should not interfere with the clinical decisions about their care and treatment

& Coffey 2012; Goodwin & Happell 2006; Happell 2008; Happell & Harrow 2010; Hughes et al. 2009; Kogstad et al. 2011; Mancini 2007; McKenna et al. 2014b). Even during the acute phase of hospitalization, they can continue to have a good understanding of their recovery goals and utilize coping strategies to positively manage their mental distress (Lakeman 2010; Lloyd & Carson 2011; McKenna et al. 2014b; Rydon 2005). Therefore, nurses practising 'coproduction to achieve identified goals' will support the person to improve their mental health knowledge and broaden their self-management strategies (Mancini 2007; Mancini et al. 2005; Russinova et al. 2011; Slay & Stephen 2013). For instance, during hospitalization, the consumer might be at risk of aggression due to frustration, negative feelings, and a loss of sense of control over their life (Aston & Coffey 2012; Happell 2008; Kogstad et al. 2011; Stanhope et al. 2013). Nurses practising coproduction can support them to try new ways to control these feelings (e.g. distraction (thinking of something else), reapprasial (thinking from an alternative perspective), or moderating facial expression/body posture) can assist them to assume more responsibility over their recovery trajectory (Aston & Coffey 2012; Bowers et al. 2014; Goodwin & Happell 2006; Happell 2008; Kogstad et al. 2011; McKenna et al. 2014b). Supporting the consumer to build on their existing strengths can also transform the way they view themselves (Hughes et al. 2009; Mancini 2007; McCloughen et al. 2011; Robins et al. 2005). 'Coproduction to achieve identified goals' also ensures the consumer's personal recovery is central to all care delivery (Hughes et al. 2009; Mancini 2007). The literature highlights that recovery trajectories are consumer determined as their health improves and they begin their personal recovery	All patients endeavor to become independent when admitted to hospital Patients who achieved their personal recovery will self-regulate their own risk for aggression Nurses have the skills to involve people in their own treatment and care during the acute phase of their mental illness	Persons with a mental illness do not have the strengths and ability to collaborate care and treatment for themselves

journey (Alexander et al. 2016; Bryant et al. 2008; Green et al. 2008; Rydon 2005). This component also supports the person to establish a positive self-identity and to begin to prepare for discharge (Billsborough et al. 2014; Mancini 2007; Rydon 2005; Walsh & Boyle 2009).		
Component 4: Equipping the consumer as an active manager of their recovery The last component identified was conceptualized as 'equipping the consumer as an active manager of their recovery'. When evaluating the person's current effort to self-regulate and manage their risk for aggression, nurses should provide positive feedback on their achievements. This increases the consumer's confidence to master their symptom management, which is a significant achievement in their recovery (Green et al. 2008; Hackman et al. 2007; Mancini 2007; McKenna et al. 2014a; Polit et al. 2011; Robins et al. 2005; Tee et al. 2007). Similarly, Cruce et al. (2012) stated 'motivational strategies with feedback, for instance confirming behavioural improvements, also contributed to symptom control' (p. 667). Consumers who are able to contribute to their mental health outcomes have more confidence to increasingly self-manage their behaviours, and when supported by nurses, further reduces their risk for aggression (Aston & Coffey 2012). Nurses displaying positive attitudes towards the consumer's potential to self-manage their behaviours also minimizes the use of restrictive practices (Markoff et al. 2005; Robins et al. 2005). Watson et al. (2014) surmized that 'even as a practice of last resort, the threat of force can cause distress and undermine recovery' (p. 535). Equipping the	Nurses should maintain positive attitudes towards patients who display aggression Provide positive feedback to support patients achieve self-management of their own behaviour	Nurses do not know how to support patients self-manage their own behaviours

consumer as an active manager allows them to consolidate new coping strategies and to practice these within a safe environment before returning to the community (Cruce et al. 2012; Day et al. 2005; Fukui et al. 2014; Happell & Koehn 2011; Hungerford & Fox 2014; Tsai et al. 2010; Young et al. 2008). It ensures that the nurse provides a balance between providing support and allowing the person to develop autonomy as their health improves (Bryant et al. 2008). Consumers striving to self-manage their behaviours gain better insight into their strengths (Cruce et al. 2012) and their ability to participate more effective in making decisions about their care (Hamann et al. 2009). This outcome can also increase nurses' confidence and professional competencies to utilize RFC in acute mental health settings (Aston & Coffey 2012; Cleary et al. 2013; Williams & Tufford 2012).	It is important to help patients learn new coping strategies to manage their own behaviours	Nurses are unable to deliver both therapeutic and restrictive care for aggressive patients
Findings from Study 1a		
Category 1: Identify the reason for the behaviour before Responding Participants reported there is usually a reason why consumers become aggressive when hospitalized. However, as nurses are pressured to maintain safety in the acute care environment, at times, they may respond to challenging/ escalating behaviours with interventions directed at controlling or reducing that behaviour. Yet, the nurse's response may not identify, acknowledge, or address why the consumer's challenging/escalating behaviours occurred or how to prevent it from reoccurring. Practising RFC ensured the nurse gave 'the person a chance to talk and get to know them, work with what they feel is most important, the most pressing things in	People usually have a reason for displaying aggression in the acute mental health settings It is important to listen to people's reason for their behavior before responding	People with mental illness and/or drug and alcohol abuse are aggressive

their life' (P1), 'work with them [the consumers] to identify some stressors, triggers, why they become aggressive, then all of that [needs to be] coordinated back to [assessing the cause of their presenting] behaviour' (P13). Having knowledge and understanding of common triggers for aggression assisted nurses, to identify timely and appropriate interventions and support the consumer to mitigate the risk of aggression: 'it is really important because the more information you get [about them], the better the decision you can make. [You need to] talk to them and ask them what their point of view is?' (P16). Participants explained that prior to responding, nurses should seek to identify the reasons for the escalating behaviour, for example, previous personal trauma or use of restraint during hospitalization: 'they see the person with [lived experience] rather than just a person who is verbally abusing them' (P12). This knowledge can motivate nurses to show more appreciation of the causes of the behaviour and provide time for the person to try and self-regulate their behaviour, rather than intervening to manage the situation. This approach allowed nurses to: 'Break [down] barriers [in communications] and misunderstandings of what's going on exactly at the time. If you know they are in personal crisis or have a decompensation in mental or emotional state, being locked in a small area with fourteen or fifteen other people who are very unwell, and you are saying "no" to all their requests, I mean obviously all those things can lead to aggression as well' (P13)	Nurses are aware of how the patients' past and present trauma can impact on their level of risk for aggression	Nurses do not need to explore the patients' personal life when they admitted to hospital Nurses do not have the skills to assess the impact of patients' personal issues on their level of risk for aggression Nurses are not equip with skills to support patients self-regulate their level of risk for aggression Patients often have too many requests when they are admitted to hospital
Category 2: Being sensitive to the consumer's triggers for Aggression The second category was being sensitive to the consumer's triggers		

for aggression. Participants noticed that when consumers are first admitted to hospital they are often experiencing negative thoughts and feelings which may increase their risk for aggression: 'The main causes for aggression are [when the consumers] haven't been in a hospital before, and when they [are] locked up they are scared, they are anxious. They don't know what is going on, they think they are locked up in jail, they think they can't get out, they don't know what's happening. So I think the triggering factors are usually more to do with staff not being on guard to see what's happening not giving [the person] enough attention [and] time to explain what's going on' (P14) Participants explained that this group of consumers had often experienced previous trauma, such as 'childhood sexual assault or adult abuse' (P3), 'domestic violence, and a lot of other stressors that they had not talked about, so they can take a long time for them to trust us ' (P1). Due to their previous trauma, they experienced difficulties in expressing themselves because it is 're-traumatising having them tell their story over and over again' (P12), resulting in emotional dysregulation and a 'lowering of their frustration tolerance, especially when they are in situational crisis or have a decompensated mental state' (P13). Practising RFC made nurses more sensitive to the person's triggers and to take time to assist them to feel safe within the unfamiliar hospital environment: 'obviously, they [the consumers] feel that they are not in control, they get scared if they have trauma in the past. [So if we intervene the wrong way and] restrain and sedate somebody, we can actually make them quite agitated and paranoid' (P12)	Aggression can be triggered by the patients' lived experience of being in the hospital Nurses are sensitive to the patients' feelings when reducing aggression	Nurses do not give patients enough attention and time to explain themselves when reducing aggression Nurses do not know how to provide trauma-informed care to help patients cope with their level of risk for aggression Aggression is aggression regardless of their trigger
Category 3: Focus on the consumer's strengths and support,		

not risks Participants stated that most consumers have acquired personal strengths, coping mechanisms, and established families and carers' support to manage their mental illness and life challenges. There was a consensus that, even during the acute phase of their illness, the person was still able to utilize their resources to self-regulate their behaviours. Work on a strength-based approach, assess what they [the consumers] are good at, what they like, or what lights them up and what motivates them. Even if they don't have anything [at present] because they are depressed, there is always something in the past [lived experience]. You could use it to collaborate with the person to find ways to resolve the problem (P1) Participants highlighted that, when practising RFC the nurse needed to focus on the consumer's strengths and support, not their risks, and encourage them to self-manage their behaviour thus reducing their potential for aggression: 'give the power all back to the person so that they will experience respect and [regard for their] human rights. Sometimes what [the person] needs is just for you to give them one or two minutes and a little bit of attention [encouragement]. They can often de-escalate properly on their own' (P5), 'If you can instil trust and hope [for the person], then the crisis [potential for aggression] can be managed in a positive way that is empowering and helps the person get back to being in control of their own behaviour' (P11).	Nurses can focus on the patients' strength and support person them self-regulate their own level of risk for aggression	People who are admitted to hospital do not have resources and/or family and carers to support their recovery journey There is nothing that patients can offer to the nurse-patient collaboration when admitted to hospital Nurses do not have trust and/or confident in patients' strengths and ability
Category 4: Being attentive to the consumer's needs Participants described that, when people are highly aroused or		

distressed following admission, they often became preoccupied with personal issues, and these increased their level of distress. They described how the consumers' static risk factors, such as having a past experience of trauma, sexual abuse, exposure to violence, or treatment in the community and hospital, could intensify their potential for aggression. This was important as practising RFC could possibly address these static risks when the consumer was 'under the influenced or withdrawing [from drugs and/or alcohol] admitted involuntarily or brought in by the police' (P5) or 'highly paranoid or extremely manic' (P8). Addressing the person's needs allowed the risk to be mitigated and 'to come to that win-win resolution' (P13) of reducing aggression, and at the same time, making the person feel supported was a critical focus of RFC. These needs varied and 'could be [something like] asking for a cup of tea, asking for a phone call, or asking to go out for a cigarette, asking for a different meal to what they ordered. . . making the environment more conducive for them, rather than trying to control the person' (P11). Another participant provided this example: 'In the ward, [consumers] will be knocking on the window, they will be knocking on the door. They have obviously got issues that need resolving and I think we need to ask questions: What can I do to help you? What can I do to make you feel safer? What can I do to make you feel better because this is a really bad situation that you are in? Getting them to come and have a discussion about where to from there, and actually getting them to discuss from a whole admission perspective what we can do to assist them and support them to get discharge into the community [is important]' (P12). Another dimension of this category was the disruption to familiar routines or lifestyle that people experienced when hospitalized:	People are more likely to become aggressive when they have unmet needs Recovery-focused care can reduce the impact of patients' static risks such as past trauma on their risk for aggression Addressing the patients' personal needs is effective to reduce aggression Nurses need to put themselves in the patients' shoes when reducing aggression	Facilitating recovery-focused care is impossible when a person is under the influence of drug and alcohol or psychiatric symptoms Nurses should use restrictive interventions to reduce aggression no matter regardless the reason Nurses are not prepared to communicate therapeutically with people who present with a higher risk for aggression Nurses do not find out what the patients want to achieve during their admission to hospital

'They [the consumers] might have a cat or a dog something at home, they might be quite worried and quite distressed and quite agitated. They don't know who is going to feed the cat or the dog. I think [the cause of aggression] is about how we engage with people' (P3). Using RFC meant that: 'Aggression management is really based on what the particular individual need, there is no blanket rules, there is nothing. It really is what that individual needs at that time and lots of individual's express a lot of different behaviours. It is about knowing the [consumer], knowing what can indicate aggression, intervene early, communicate and making sure that they have the information that they need, making sure that they are aware of who they can come to when they need help' (P15)	People may become aggressive because of the disruption to their familiar routine or lifestyle when hospitalized Aggression management is about what the person need at that time of crisis Getting to know a person is the most effective way to intervene early and reduce aggression	Nurses do not provide patients with the information about how to cope with their level of distress
Category 5: Reconceptualize aggression as a learning opportunity The last category identified was reconceptualize aggression as a learning opportunity. Some participants recognized that, while aggression is unwelcomed in the acute care environment, it contributed to 'a great learning opportunity' (P11) for the consumer to improve the ' understanding their own ability, strengths and vulnerabilities' (P20). It allowed them to self-regulate their behaviour and lessen the risk of future aggression. When using RFC nurses reflected on and provided feedback to consumers regarding 'their strengths, positive things, useful things, their success and triumphs' (P23), 'help them [the consumer] remember the positive strategies to deal with the anger before it escalate into an episode of aggression' (P16). Nurses who reconceptualize aggression as a learning opportunity assisted the person 'to regain hope and find	Aggression is a great learning opportunity for patients to understand their strengths and weaknesses Supporting patients to understand their own ability, strengths and vulnerabilities can lessen the risk of future aggression	Nurses do not like to provide feedback to patients regarding their strengths, positive things, useful things, their success and triumphs

meaningful and purpose in life' (P 21). 'It is validating [for the person]. I think you [nurses] will help build a stepping stone for that person's ongoing recovery because afterwards you can reflect with them and say look, that was some crisis but with a bit of support you will be able to get it [self-regulation] back. We can end it with a positive outcome.' (P11)	Nurses always reconceptualise aggression into a learning opportunity for the patient Nurses know how to support patients reflect and learn how to self-manage their own behavior	
Findings from Study 1b		
Category 1: See the person as an individual with a unique lived experience Participants explained that nurses needed to see the individual with a unique lived experience, personal traits, and differences despite having the same psychiatric diagnosis as others 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 just part of their mental illness: "there was a kid who they [nurses] said he threatened a staff member when he just waved a sunscreen bottle [outward expression of his emotions] when talking to her and wasn't actually being aggressive" (P14). Participants conveyed that nurses needed to "not take everything as a sign of aggression and pay attention to [patients' lived	Nurses see each patient as a individual with a unique lived experience, personal traits, and differences Nurses can assess the patient's lived experience to know the reason for the aggression	Nurses do not acknowledge the things that are happening in patients' personal lives

experience]. Stop ascertaining how they [patients] 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).	Patients should be allowed to express themselves naturally when admitted to hospital Listening to patients' story for admission to hospital reduced their level of risk for aggression	Patients who do not follow rules and regulations have higher risk for aggression
Category 2: Dialogue to explore the reason for the behaviour Participants perceived that nurses were quick to identify patients as being potentially aggressive when they expressed negative emotions, and this had an impact on nurses' willingness to interact with the person. Instead of responding to the behaviour as a threat of aggression, 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		Nurses are less likely to interact therapeutically with patients who have a higher risk for aggression Nurses are more likely to use physical and chemical interventions to reduce aggression

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's react 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 patients in a dialogue when they are 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 hospitalisation]. This will probably support the individual to skip a few steps towards their [personal] recovery" (P10).	It is more recovery-focused to regard people who display aggression as feeling upset rather than being aggressive	Using medication to reduce aggression is more effective than using interpersonal interventions to reduce aggression Nurses do not know how to work collaboratively with patients who have a higher risk for aggression
Category 3: Using positive communication to encourage self-management Participants stressed the importance of nurses using positive communication to support them to self-manage their behaviour. When de-escalating the person, 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	Nurses have positive communication skills to support patients self-manage their behavior	

of 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. Lets' 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 people who experienced therapeutic communication with nurses during their personal crisis 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. Bring them into the comfort room where it is private and away from 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-	The use of positive words can empower the person to take responsibility of their behavior Nurses use therapeutic communications to support patients re-evaluate their own strengths and ability during a crisis Nurses can use positive reinforcement to encourage the person self-manage aggression	Nurses do not acknowledge or involve patients as the recipient in their own the care and treatment Nurses often do not communicate therapeutically to a person who have higher risk for aggression Nurses do not support patients to learn and utilize their own strategies to self-manage their own behaviour

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 adjustment to their familiar lifestyle and daily routines during 176ospitalized, 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 hospitalisation] 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 that structure and routines of the ward environment, they highlighted how little gestures 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	Little gestures of care are important to patients during their admission to hospital Offering choices and being optimistic in the person's strengths is important to support individuals self-regulate their own behaviours	Nurses do not know how to how to support patients make adjustment to their familiar lifestyle and daily routines during hospitalized

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 hospitalised] 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 people 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 an acute mental health setting as a personal journey of trialling clinical and personal strategies to identify ways to 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 people 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 become "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 people are in distressed" (P8). Many participants highlighted that nurses could use this time as an opportunity "to work alongside patients and try		Recovery-focused care is not suitable for people with an acute mental illness People who lose control of their own behavior should not be involved in their own care and treatment Nurses do take the opportunity and coach patients to develop

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 patients] all work together [engaging in co-production], we can achieve desirable outcomes and reduce [the risk] for aggression" (P6).		effective strategies to reduce aggression Nurses do not need to collaborate with patients to reduce their level of risk for aggression

Appendix 3

Permission to include the format of the article in the thesis in Chapter 2

Eric Lim

From: Barron, Fiona (ELS-SYD) <F.Barron@elsevier.com>
Sent: Monday, 14 December 2020 8:50 AM
To: Eric Lim
Cc: Lisa McKenna (L.McKenna@latrobe.edu.au)
Subject: RE: Seeking your permission to use the first page of the article published in Collegian in my PhD by publication thesis

Dear Eric

Professor Mckenna has forwarded your request to me

Would you mind including the abstract with a link to your paper too please

https://doi.org/10.1016/j.colegn.2020.08.004

I also include a copy of the title page of your paper.

Best wishes and good luck with your thesis!

Fiona

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Realising the potential of Q methodology in nursing research

Eric Lim[a,*], Dianne Wynaden[a], Frank Baughman[b], Karen Heslop[a]

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Mixed methods
Clinical research
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ABSTRACT

Background: Mixed methods research designs are becoming increasingly popular in nursing complex clinical issues and to generate knowledge useful to improve the quality of nursing p clients' health outcomes. Q methodology is one such research design that combines the streng qualitative and quantitative approaches to examine scientifically peoples' subjectivity toward area.

Aim: This paper aims to provide an introduction to Q methodology and outlines the steps t conducting research on clinical issues.

Methods: A clinical example of nurses caring for clients with a risk for aggression is used t how Q methodology was used to examine this subject area. The five sequential phases of Q-me integrate both approaches in a continuous interaction in a single study design, enabling res explore the breadth and depth of factors that influence participants' responses towards the t investigation.

Findings: Q methodology is a unique mixed methods design as it does not require the researche time triangulating two or more research approaches into one single study or to conduct a qual a quantitative study separately. The unique characteristics of Q methodology can be advant nurses who have complex clinical workloads but also want to conduct research. Moreover, Q me does not require a large sample size, hence it is resource- and cost-effective.

Discussion: Q methodology allows both nurse clinicians and nurse academics to explore new d of staff and clients' subjectivity which is important for the development of evidence based pr

Conclusion: Adding Q methodology to the nursing research repertoire can facilitate nurse res expand clinical research opportunities, to improve client care and to build capacity in early ca researchers.

1. Introduction and background

The increasing complexity of health care, along with the importance of advancing innovations in nursing practice, has led nurses to conduct research while balancing their clinical roles and responsibilities (Chiang-Hanisko, Newman, Dyess, Piyakong, & Liehr, 2016; Siedlecki & Albert, 2017). The need for nurses to conduct research is driven by the fact that nurses are well-positioned in the clinical settings to identify clinical problems in need of solution (Siedlecki & Albert, 2017). For this reason, mixed methods research approaches are appealing, as they allow nurses to generate knowledge that captures the multi-faceted dimensions of a particular clinical issue, and broaden their understanding of its impact on both the p and client outcomes (Chiang-Hanisko et al., 2016).

Q methodology is a ready-to-use mixed methods approach that nurses can use to conduct both profess client focused research. Q methodology was developed chologist William Stephenson in 1935 (Roberts, Harget Jakoi, & Lehrich, 2015), and is an inverted technique o vailing R methodology, which is a generic name for met use 'by-variable' factor analysis (Watts & Stenner, 2012a) participants are transposed as the 'units of analysis' and t ables as the 'samples', so that a 'by-person' factor analy performed to quantify the similarities and differences o jectivity in a group of people (McKeown & Thomas, 2013 Newman, 2011; Watts & Stenner, 2012a, 2012b). The ter tivity' is used in Q methodology, and refers to the intern qualities of a person, for example beliefs, attitudes, knowl

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E-mail address: eric.lim@postgrad.curtin.edu.au (E. Lim).

From: Eric Lim <eric.lim@curtin.edu.au>
Sent: Thursday, 10 December 2020 7:50 PM
To: Lisa McKenna <L.McKenna@latrobe.edu.au>
Subject: Seeking your permission to use the first page of the article published in Collegian in my PhD by publication thesis

Dear Professor McKenna (Editor-in-Chief),

How are you and I hope that you are well.

I am currently writing up my PhD thesis by publication, and would like to include a copy first page of the article that we have published in the Collegian titled: "Realising the potential of Q methodology in nursing research" to show the examiners that it has been published (see attached for example of what I wish to use).

Hope that we can get your permission to do so.

Thank you.

Warmest regards,
Eric

Appendix 4

Curtin University Human Research Ethics Committee

MEMORANDUM

Curtin University

To:	Prof Dianne Wynaden School of Nursing, Midwifery and Paramedicine
CC:	Boon Chuan Eric Lim
From	Professor Peter O'Leary, Chair HREC
Subject	Ethics approval Approval number: HR132/2015
Date	09-Jul-15

Office of Research and Development
Human Research Ethics Office

TELEPHONE 9266 2784
FACSIMILE 9266 3793
EMAIL hrec@curtin.edu.au

Thank you for your application submitted to the Human Research Ethics Office for the project: 5984

Facilitating cultural change in acute mental health inpatients settings: How do mental health nurses' beliefs, attitudes, knowledge and skills influence the rate of consumer aggression?

Your application has been approved by the Human Research Ethics Committee at Curtin University at their meeting on 7/07/2015

The committee commend you on the quality of your application.

Please note the following conditions of approval:

1. Approval is granted for a period of four years from **09-Jul-15** to **09-Jul-19**
2. Research must be conducted as stated in the approved protocol.
3. Any amendments to the approved protocol must be approved by the Ethics Office.
4. An annual progress report must be submitted to the Ethics Office annually, on the anniversary of approval.
5. All adverse events must be reported to the Ethics Office.
6. A completion report must be submitted to the Ethics Office on completion of the project.
7. Data must be stored in accordance with WAUSDA and Curtin University policy.
8. The Ethics Office may conduct a randomly identified audit of a proportion of research projects approved by the HREC.

Should you have any queries about the consideration of your project please contact the Ethics Support Officer for your faculty, or the Ethics Office at hrec@curtin.edu.au or on 9266 2784. All human research ethics forms and guidelines are available on the ethics website.

Yours sincerely,

Professor Peter O'Leary
Chair, Human Research Ethics Committee

Appendix 5

South Metropolitan Health Service Human Research Committee in Western Australia

Government of **Western Australia**
South Metropolitan Health Service

South Metropolitan Health Service
Human Research Ethics Committee (EC00265)

06 December 2016

Professor Dianne Wynaden
School of Nursing, Midwifery and Paramedicine
Curtin University
GPO Box U 1987
Bentley WA 6845

Dear Professor Wynaden

Project Title: ***Exploring Recovery-Orientated Mental Health Practice in Nursing Care to Reduce Aggression.***

REG Number: **2016-210**
HREC Meeting: **8 November 2016**

The ethics application for the project referenced above has been reviewed by the South Metropolitan Health Service (SMHS) Human Research Ethics Committee (HREC). In reviewing this project, the Committee has considered whether the protocol meets the requirements of the NHMRC's National Statement on Ethical Conduct in Human Research (National Statement).

The SMHS HREC considers that the research meets the requirements of the National Statement and resolved at the meeting to approve the project

This approval is valid to **6 December 2019** and on the basis of compliance with the 'Conditions of HREC Approval for a Research Project' (attached).

The nominated participating site(s) in this project is/are:

- **Fiona Stanley Hospital**
- **Fremantle Hospital**

Documents
Protocol version 2 ,dated 17th November 2016
Interview Guide_MHNs_version 2, 17th November 2016
FSHMHN_Invitation_MHNs_Version 2, 17th November 2016
Interview/focus group_MHNs_version 2, 17th November 2016
consent_interview/focus group_MHNs_version 2, 17th November 2016
Interview guide_consumer_version 2, 17th November 2016
FSHMHN_Invitation_conumer_version 2, 17th November 2016
Interview/Focus group Version 2, 17th November 2016
Consent_interview/focus group_consumer_version 2, 17th November 2016
Q Methodology version 2 , 17th November 2016
Demographic data questionnaire(mental health nurses) version 1 dated 17th November 2016

Research Ethics and Governance
South Metropolitan Health Service
Locked Bag 100, PALMYRA DC WA 6961
Telephone: 08 6151 1180
Email: SMHS.REG@health.wa.gov.au
www.southmetropolitan.health.wa.gov.au

Demographic data questionnaire(consumers) version 1 dated 17th November 2016

If additional sites are recruited prior to the commencement of, or during the research project, the Coordinating Principal Investigator is required to notify the HREC. Notification of withdrawn sites should also be provided to the HREC in a timely fashion.

This letter constitutes ethical approval only. This project cannot proceed at any site until separate site authorisation has been obtained from the Chief Executive, or delegate, of the site following Site Specific Assessment by a Research Governance Officer. For further information about obtaining site authorisation, refer to the WA Health Research Governance Framework available at http://ww2.health.wa.gov.au/Health-for/Researchers-and-educators/Research-governance

The SMHS HREC is registered with the National Health and Medical Research Council (NHMRC) and operates according to the NHMRC's *National Statement on Ethical Conduct in Human Research (2007)*.
Should you have any queries about the HREC's consideration of your project, please contact the HREC Administrative Officer on 6151 1180. The HREC's Terms of Reference, Standard Operating Procedures, membership and standard forms are available from the SMHS Research Ethics & Governance Unit or from the website:
http://ww2.health.wa.gov.au/About-us/South-Metropolitan-Health-Service/About/Human-Research-Ethics-and-Governance

Yours sincerely

DR PHILLIP CLARINGBOLD
Chairman | South Metropolitan Health Service Human Research Ethics Committee

Appendix 6

Information sheet for the qualitative study with mental health nurses in phase I

Appendix 3.

Government of **Western Australia**
Department of **Health**
South Metropolitan Health Service

Curtin University

INFORMATION SHEET FOR INTERVIEW/FOCUS GROUP DISCUSSION (MENTAL HEALTH NURSES)

Practice change in acute mental health inpatient settings: Facilitating recovery-oriented mental health practice in nursing care to reduce aggression.

Investigators: Professor Dianne Wynaden, Mr Eric Lim, Dr Karen Heslop, Dr Ajay Velayudhan, Ms Jane Murdock, Ms Sharon Delahunty

Nature and Purpose of the Project
Mental health recovery is important for all people admitted to acute care settings. This project aims to increase mental health nurses (MHNs) ability to provide recovery-focused care to consumers in the acute care environment. Therefore it is important that we talk to you to gain insight into what you believe are the important principles for nurses to incorporate into their care.

The findings will increase MHNs' knowledge and understanding of how to facilitate recovery-oriented practice. This information sheet outlines what we would like you to do if you are going to participate in this study. If you have any questions after reading this information sheet, we are happy to answer these for you.

What the Project will Involve
If you agree to participate in this research, you will be asked to take part in an interview or focus group where we will ask you to talk about your experiences in facilitating recovery-oriented mental health practice in the acute care settings. A semi-structured interview guide will be used to facilitate the interview/focus group discussion which will take approximately 30 to 45 minutes and you will have an opportunity to express your ideas and opinions around how nurses translate recovery principles into daily practices and reduce aggression. The interview/focus group will be digitally recorded so we can focus on our interview with you during this session. Only the researchers will hear the interview and your confidentiality will be maintained at all times in any reports/documents resulting from the interviews.

Benefits
You may experience some benefit from participating in this project and increase your knowledge and insight in the facilitation of recovery-oriented mental health practice. You may also find it is very useful to reflect on recovery-oriented practices which may be utilised in the acute mental health inpatient settings to reduce aggression. It is hoped that the results of this project will upskill mental health nursing practice to facilitate recovery for the acutely ill consumer while reducing aggression.

Discomfort and Risks
There is no perceived risk for participating in this project. The discussion will allow you to share your opinions on current practices to reduce aggression, and potential ways to align practices with national standards of care. If you experience any discomfort during the project you may opt not to answer any question, answer it in another time, or discontinue.

Voluntary Participation and Withdrawal from Project
Your participation is entirely voluntary. Participation or non-participation in this project will not in any way interfere with your clinical role and function at Fiona Stanley Hospital Mental Health Services. You can withdraw from the study at any time up until data is submitted for publishing in peer-reviewed journals and reports. After that time it will not be possible to delete any one person's data. Prior to participating in this study, you will be asked to sign a consent form.

Privacy, Confidentiality and Disclosure information
At all times your confidentiality and privacy will be maintained and no information that might identify you will be used in any publications. Only the researchers will have access to the information and it will be stored in locked cupboards and password protected research drive at Curtin University for seven years.

This study has been approved by the South Metropolitan Health Service Human Research Ethics Committee – approval number 2016-210. If you should have any complaints or concerns about the way in which the

being conducted, you may contact the Chairman of the South Metropolitan Health Service Human Research Ethics Committee on 6151 1180.

This study has also been approved by the Curtin University Human Research Ethics Committee – approval number HR132/2015. If needed, verification of approval can be obtained either in writing to the Curtin University Research Ethics Committee, c/- Office of Research and Development, Curtin University, GPO Box U1987, Perth, 6845 or by telephoning 9226 2784 or by emailing hrec@curtin.edu.au.

Thank you for taking the time to read this information sheet. If you have any questions or enquire about this study, please feel free to contact Professor Dianne Wynaden on (08) 92662203 or email at d.wynaden@curtin.edu.au.

Professor Dianne Wynaden

Appendix 1.

Government of **Western Australia**
Department of **Health**
South Metropolitan Health Service

Curtin University

Exploring recovery-oriented mental health practice in nursing care to reduce aggression.

Investigators: Professor Dianne Wynaden, Mr Eric Lim, Dr Karen Heslop, Dr Ajay Velayudhan, Ms Jane Murdock, Ms Sharon Delahunty

SEMI-STRUCTURED INTERVIEW/FOCUS GROUP STUDY FOR MENTAL HEALTH NURSES

INTERVIEW GUIDE

This interview guide will be used in this study to guide the researcher to ask questions reflecting the objectives of the study. The researcher will meet up with the participants 15 minutes before the discussion starts to build rapport and to explain the purpose of the study and answer additional questions participants may have. The researcher will explain to participants that they will be informed of the outcome of the study and that the researcher is happy to conduct a presentation to present the findings of the study to their organization.

Question guide:

1. What do you understand about the term recovery-oriented mental health practices?
2. Can you share about your experience in facilitating recovery-oriented mental health practice in the acute mental health settings?
3. What were some of the challenges that nurses may face in facilitating recovery-oriented mental health practices in this setting?
4. Why do you think people become aggressive in the acute mental health settings?
   Clues: patient factors, environmental factors, interactional factors
5. What do you think is needed for an aggressive consumer to experience recovery-oriented care?
6. How can aggression be prevented or handled better?
7. When a person become aggressive, generally do you think the incident is handled well?
8. What are important things that nurses can do during the management of aggression:
   a. To know the person and not just the presenting behaviour?
   b. To interacting to the person and not reacting to the presenting behaviour?
   c. To co-produce (hint: collaborate, partner, working together) to facilitate care delivery?
   d. To equip the person and prepare them for their recovery journey?
9. Is there anything you would like to us to know about facilitating recovery for consumer in the acute setting?

After the interview, the researcher will spend 5 minutes to 'debrief' the participant to ensure that they are not experiencing any distress resulting from the focus group discussion.

Appendix 7

Information sheet for the qualitative study with consumers with a mental disorder in phase I

Government of **Western Australia**
Department of **Health**
South Metropolitan Health Service

Curtin University

INFORMATION SHEET FOR INTERVIEW/FOCUS GROUP DISCUSSION

Practice change in acute mental health inpatient settings: Facilitating recovery-oriented mental health practice in nursing care to reduce aggression.

Investigators: Professor Dianne Wynaden, Mr Eric Lim, Dr Karen Heslop, Dr Ajay Velayudhan, Ms Jane Murdock, Ms Sharon Delahunty

Nature and Purpose of the Project
Mental health recovery is important for all people admitted to acute care settings. This project aims to increase mental health nurses (MHNs) ability to provide recovery-focused care to you when hospitalised. Therefore it is important that we talk to you to gain insight into what you believe are the important principles for nurses to incorporate into their care.

The findings will be incorporated into an educational package that nurses working at the service will complete to increase their knowledge and understanding of how to care for you using recovery-oriented practice. This information sheet outlines what we would like you to do if you are going to participate in this study. If you have any questions after reading this information sheet, we are happy to answer these for you.

What the Project will Involve
If you agree to participate in this research you will be asked to do two things. Firstly, we will invite you to take part in an interview or focus group where we will ask you to talk about your experiences when hospitalised and things that could have made the experience more positive for you. The focus group interview will take approximately 30 to 45 minutes and you will have an opportunity to express your ideas and opinions around your experiences being hospitalised and your interactions with MHNs. The interview/focus group will be digitally recorded so we can focus on our interview with you during this session. Only the researchers will hear the interview and your confidentiality will be maintained at all times in any reports/documents resulting from the interviews. Secondly, we will ask you to complete a survey about what you think are the causes of aggression in the hospital settings. This will take approximately 10 minutes to complete and you will be required to put a tick in the box that best represents your answer. At the end of the survey, you receive a $10 gift card to thank you for your time in participating in the discussion and acknowledging your contribution.

Benefits
You may not get any benefits from participating but your ideas will be used in the educational program which will influence the way in which MHNs will care for future people when hospitalised. You may feel empowered to speak out and have your voice heard about service delivery and to be involved in service improvements. You may experience some benefit and satisfaction from participating in this research.

Discomfort and Risks
There is no perceived risk from participating, but the experience may bring back some memories which could upset you. If this occurs, you can ask to stop the interview and arrangements will be made with your team and treating doctor for follow-up support. Following the interview, the researcher will contact you to ensure you are feeling okay.

Voluntary Participation and Withdrawal from Project
Your participation is entirely voluntary, and will in no way influence the treatment you receive at Fremantle Mental Health Services. If you decide not to participate you will still receive the same standard of clinical care from your mental health team. You can withdraw from the study at any time up until data is submitted for publishing in peer-reviewed journals and reports. After that time it will not be possible to delete any one person's data. Prior to participating in this study, you will be asked to sign a consent form.

Privacy, Confidentiality and Disclosure information
At all times your confidentiality and privacy will be maintained and no information that might identify you will be used in any publications. Only the researchers will have access to the information and it will be stored in locked cupboards and password protected computer at Curtin University for seven years.

This study has been approved by the South Metropolitan Health Service Human Research Ethics Committee – approval number 2016-210. If you should have any complaints or concerns about the way in which the study is being conducted, you may contact the Chairman of the South Metropolitan Health Service Human Research Ethics Committee on 6151 1180.

This study has also been approved by the Curtin University Human Research Ethics Committee – approval number HR132/2015. If needed, verification of approval can be obtained either in writing to the Curtin University Research Ethics Committee, c/- Office of Research and Development, Curtin University, GPO Box U1987, Perth, 6845 or by telephoning 9226 2784 or by emailing hrec@curtin.edu.au.

Thank you for taking the time to read this information sheet. If you have any questions or enquire about this study, please feel free to contact Professor Dianne Wynaden on (08) 92662203 or email at d.wynaden@curtin.edu.au.

Professor Dianne Wynaden

Appendix 6.

Government of **Western Australia**
Department of **Health**
South Metropolitan Health Service

Curtin University

Exploring recovery-oriented mental health practice in nursing care to reduce aggression.

Investigators: Professor Dianne Wynaden, Mr Eric Lim, Dr Karen Heslop, Dr Ajay Velayudhan, Ms Jane Murdock, Ms Sharon Delahunty

SEMI-STRUCTURED INTERVIEW/FOCUS GROUP STUDY FOR CONSUMERS

INTERVIEW GUIDE

This interview guide will be used in this study to guide the researcher to ask questions reflecting the objectives of the study. The researcher will meet up with the participants 15 minutes before the discussion starts to build rapport and to explain the purpose of the study and answer additional questions participants may have. The researcher will explain to participants that they will be informed of the outcome of the study and that the researcher is happy to conduct a presentation to present the findings of the study to their organization.

Question guide:

1. Can you share your experience of being hospitalised in the acute mental health settings
2. What were some positive experiences of your encounter with nurses in this setting?
3. Did you have any negative experiences of interactions with nurses?
4. What do you understand about the term aggression?
5. Why do you think people become aggressive in the acute mental health settings?
   Clues: patient factors, environmental factors, interactional factors
6. How can aggression be prevented or handled better?
7. When a person become aggressive, generally do you think the incident is handled well?
8. What are important things that nurses can do during the management of aggression:
   a. To know the person and not just the presenting behaviour?
   b. To interacting to the person and not reacting to the presenting behaviour?
   c. To co-produce (hint: collaborate, partner, working together) to facilitate care delivery?
   d. To equip the person and prepare them for their recovery journey?
9. What do you understand by the term mental health recovery?
10. What are important things that nurses can do to demonstrate that they are facilitating recovery-oriented mental health practice while you are hospitalised?
11. Is there anything you would like to us to know about facilitating recovery for you in the acute setting?

After the interview, the researcher will spend 5 minutes to 'debrief' the participant to ensure that they are not experiencing any distress resulting from the focus group discussion.

Appendix 8

Informed consent for the qualitative study with mental health nurses in phase I

Government of **Western Australia**
Department of **Health**
South Metropolitan Health Service

Curtin University

Practice change in acute mental health inpatient settings: Facilitating recovery-oriented mental health practice in nursing care to reduce aggression.

Investigators: Professor Dianne Wynaden, Mr Eric Lim, Dr Karen Heslop, Dr Ajay Velayudhan, Ms Jane Murdock, Ms Sharon Delahunty

CONSENT FORM FOR INTERVIEW/FOCUS GROUP DISCUSSION (MENTAL HEALTH NURSES)

Name of Participant: _____

Date of Birth: _____

Thank you for participating in this interview/focus group discussion to explore you experiences experiences in facilitating recovery-oriented mental health practice in the acute care settings. Information gathered will be used solely by the researchers for its intended purpose and data published will not disclose your identity. Please read the following statements carefully before you sign the consent form.

Declaration by Participant

1. I agree voluntarily to take part in the above project
2. I am over 18 years of age.
3. I have been given a copy of the Information Sheet and Consent Form, have read and fully understood the purpose and aims of this project, and what is required from me if I agree to participate.
4. I agreed to have the interview digitally recorded.
5. I have had the opportunity to ask questions and I am satisfied with the responses I have received.
6. I understand that I am free to withdraw from the project at any time up until findings are published.
7. I agree that the research data collected can be published in peer-reviewed journals and reports as long as my identity is kept confidential.
8. I agree that the findings or results from the project can be shared with staff at the health service at the completion of this research.

Signature by Participant	Signature by Researcher
Signed _____	Signed _____
Dated _____	Dated _____

Appendix 9

Informed consent for the qualitative study with consumers with a mental disorder in phase I

Government of Western Australia
Department of Health
South Metropolitan Health Service

Curtin University

Practice change in acute mental health inpatient settings: Facilitating recovery-oriented mental health practice in nursing care to reduce aggression.

Investigators: Professor Dianne Wynaden, Mr Eric Lim, Dr Karen Heslop, Dr Ajay Velayudhan, Ms Jane Murdock, Ms Sharon Delahunty

CONSENT FORM FOR INTERVIEW/FOCUS GROUP DISCUSSION

Name of Participant: _____

Date of Birth: _____

Thank you for participating in this interview/focus group discussion to explore you experiences being hospitalised and your beliefs about the causes of aggression. Information gathered will be used solely by the researchers for its intended purpose and data published will not disclose your identity. Please read the following statements carefully before you sign the consent form.

Declaration by Participant

1. I agree voluntarily to take part in the above project
2. I am over 18 years of age.
3. I have been given a copy of the Information Sheet and Consent Form, have read and fully understood the purpose and aims of this project, and what is required from me if I agree to participate.
4. I agreed to have the interview digitally recorded.
5. I have had the opportunity to ask questions and I am satisfied with the responses I have received.
6. I understand that I am free to withdraw from the project at any time up until findings are published.
7. I agree that the research data collected can be published in peer-reviewed journals and reports as long as my identity is kept confidential.
8. I agree that the findings or results from the project can be shared with staff at the health service at the completion of this research.

Signature by Participant	Signature by Researcher
Signed _____	Signed _____
Dated _____	Dated _____

Appendix 10

Information sheet for the Q methodology study with mental health nurses in phase II

Recovery-Focused Care in Reducing Aggression

Nature and Purpose of the Project

Mental health recovery principles are now embedded in national mental health policy. However, their translation to clinical practice remains limited, particularly in acute mental health settings. It is proposed that mental health nurses (MHN) who practice from a recovery framework will better support clients in their personal recovery. This framework increases clients' level of decision-making and empowers them to engage in self- management strategies. The framework can enhance interactions between MHN and clients and has the potential to reduce aggression, which is common in acute care settings.

The purpose of this project is to understand nurses' beliefs, attitudes, knowledge, and skills to facilitate recovery-focused care to clients who have a higher risk for aggression. The results from this project will be used to guide the development of an educational program for MHN on translating recovery-oriented principles to clinical practice. This proposed educational program is expected to upskill MHN to deliver recovery-focused care in the acute care setting.

Before you decide whether to participate, please read the following pages, which will provide you with information about what is involved, and the potential benefits of participating in the project. When you have read the information sheet we are also happy to answer any questions you may have.

What the Project will Involve?

You are taking part in the Q-methodology survey of the research. By completing the questionnaires Part 1 - Attitudes and Beliefs and Part 2 - Knowledge and Skills, it indicates that you have understood the information sheet and consented to participating in this research. You will not be able to delete your work after you have submitted your answers electronically.

Once you have entered the questionnaire, you will receive a sorting instruction to sort 40 statements relating to the delivering of recovery-focused care in the acute mental health settings to reduce aggression. You are required to sort the statements and the process of sorting will take approximately 30 minutes to complete.

Benefits

You may experience some benefit from participating in this project and increase your knowledge and insight in the facilitation of recovery-focused care. It is hoped that the results of this project will upskill mental health nursing practice to facilitate recovery-focused care for the acutely ill clients while reducing aggression.

Discomfort and Risks

There is no perceived risk for participating in this project. The survey questionnaires will allow you to share your opinions on current practices to reduce aggression, and potential ways to align practices with national standards of care. If you experience any discomfort during the project you may opt not to answer any question, answer it in another time, or

discontinue.

Voluntary Participation and Withdrawal from Project

Your participation is entirely voluntary. However, you will not be able to withdraw their data from the study after it has been submitted as data will be de-identified at this time and no names will be collected. If you have any questions or enquire about this project, please feel free to contact Mr Eric Lim on (08) 9416 3679 or email at eric.lim@curtin.edu.au.
This project has also been approved by the Curtin University Human Research Ethics Committee – approval number HR132/2015. If needed, verification of approval can be obtained either in writing to the Curtin University Research Ethics Committee, c/- Office of Research and Development, Curtin University, GPO Box U1987, Perth, 6845 or by telephoning 9226 2784 or by emailing hrec@curtin.edu.au.

Privacy, Confidentiality and Disclosure information

At all times your confidentiality and privacy will be maintained and no information that might identify you will be used in any report, presentation or publication resulting from the research. Thank you for taking the time to read this information sheet. All data collected in this project will be stored on a computer research drive that is password protected in Curtin University. After the completion of the project, all data will be kept for seven years and then completely destroyed using the retention and disposal procedures of Curtin University. As you have consented to permit the researchers to use the provided data for the research project, the results will be published in peer-reviewed journals. If you have any questions please do not hesitate to contact me or one of the other researchers listed above.

If you agree to taking part in this research, please complete: Part 1 and, then Part 2

Appendix 11

Permission to include the format of the article in the thesis in Chapter 4

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Institution name	Curtin University
Expected presentation date	May 2021
Requestor Location	Curtin University 15 Longshaw Cct Canning Vale, 6155 Australia Attn: Curtin University
Publisher Tax ID	EU826007151
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Appendix 12

Permission to include the format of the article in the thesis in Chapter 5

Eric Lim

From: Davidson, Larry <larry.davidson@yale.edu>
Sent: Thursday, 10 December 2020 10:43 PM
To: Eric Lim
Subject: Re: Seeking your permission to use the first page of the article published in the Journal of recovery in mental health n my PhD by publication thesis

You certainly have my permission, and congratulations!
Larry

--
Larry Davidson, Ph.D.
Professor of Psychiatry and Director
Program for Recovery and Community Health
School of Medicine, Yale University
(http://medicine.yale.edu/psychiatry/prch/)

Senior Policy Advisor
Connecticut Department of Mental Health and Addiction Services
(http://www.ct.gov/dmhas/site/default.asp)

Director
New England Mental Health Technology Transfer Center
https://mhttcnetwork.org/centers/new-england-mhttc/home

Editor
American Journal of Psychiatric Rehabilitation

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New Haven, CT 06513
U.S.A.
(p) 203-764-7583
(f) 203-764-7595

From: Eric Lim <eric.lim@curtin.edu.au>
Date: Thursday, December 10, 2020 at 4:16 AM
To: "larry.davidson@yale.edu" <larry.davidson@yale.edu>
Subject: Seeking your permission to use the first page of the article published in the Journal of recovery in mental health n my PhD by publication thesis

Dear Professor Davidson (Editor-in-Chief),

How are you and I hope that you are well.

I am currently writing up my PhD thesis by publication, and would like to include a copy of the first page article that we have published in the Journal of recovery in mental health titled: "Consumers' perceptio using recovery-focused care to reduce aggression in all acute mental health including forensic mental h services: A qualitative study" to show the examiners that it has been published (see attached for exam wish to use).

Journal of Recovery in Mental Health Vol. 2 No. 2/3 Winter/Spring 2019
ISSN: 2371-2376

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

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

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

KEYWORDS
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 education and professional development training to increase understanding of

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

Hope that we can get your permission to do so.

Thank you.

Warmest regards,
Eric

Regards

Eric Lim | RN, CertTL, DipNurs, BN, GradDipTh, GradDipFMH, MNurSt, PhD candidate, MACMHN

Unit Coordinator for CRIT3000 Complex Nursing Practice 1
& GMED3008 Applied Bioscience for Complex Conditions
Deputy Unit Coordinator for MEDS6013 Research and Evaluation in Health,
MENT3000 Behavioural Perspective of Mental Health Wellbeing,
& CRIT3001 Complex Nursing Practice 2

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Appendix 13

Permission to include the format of the article in the thesis in Chapter 5

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Institution name	Curtin University
Expected presentation date	May 2021
Requestor Location	Curtin University 15 Longshaw Cct Canning Vale, 6155 Australia Attn: Curtin University
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Appendix 14

Email from Curtin University Human Research Ethics Committee- Ethics application ID 5984 - Exemplary ethics application - use for training purposes

From: Human Research Ethics Committee <hrec@curtin.edu.au>
Sent: Tuesday, October 13, 2015 4:05:38 PM
To: Eric Lim <boonchuan.lim@postgrad.curtin.edu.au>; Dianne Wynaden <D.Wynaden@curtin.edu.au>; Karen Heslop <K.Heslop@curtin.edu.au>
Subject: RE: Ethics application ID 5984 - Exemplary ethics application - use for training purposes

Dear Dianne, Eric and Karen

The ethics office is putting together some training materials/exemplar ethics applications to be used as examples to assist other researchers to understand what information the HREC need to be provided with to consider and approve an ethics application.

As your ethics application for the approval of HR132/2015 "*Facilitating cultural change in acute mental health inpatients settings: How do mental health nurses' beliefs, attitudes, knowledge and skills influence the rate of consumer aggression?*" was considered to be an exemplary ethics application we were hoping you might provide your permission for your application to be used as an example to other researchers.

Could you kindly please advise if you are happy for this to occur? If not, please let me know. This will not be used for training purposes, unless all investigators consent.

Many thanks.

Kind regards
Mandy Downing
Research Ethics Officer | Office of Research and Development
Curtin University
Tel | +61 8 9266 9223
Fax | +61 8 9266 3793

Email | hrec@curtin.edu.au
Web | http://curtin.edu.au

Appendix 15

Top downloaded article (2017 – 2018):

Recovery-focussed care: How it can be utilized to reduce aggression in acute mental health settings

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International Journal of Mental Health Nursing

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.

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- Your research generated immediate impact and helped to raise the visibility of *International Journal of Mental Health Nursing*.

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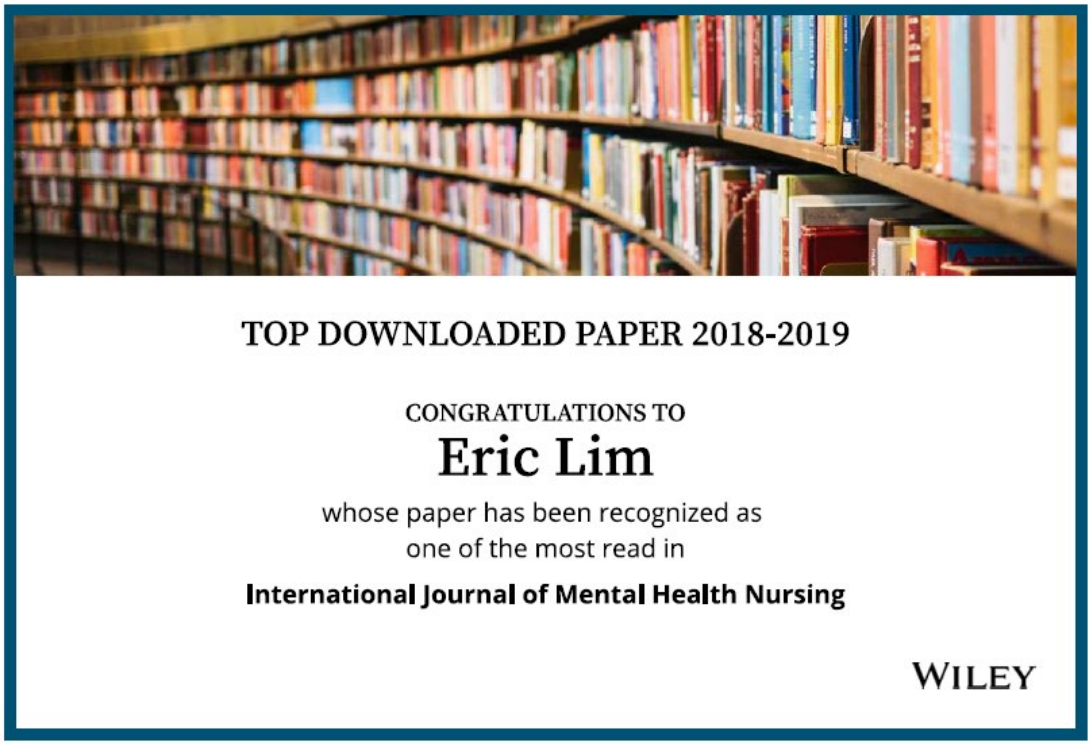

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CONGRATULATIONS TO

Eric Lim

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Appendix 17

Email from Charles R. Mauldin, PhD- Thanks for great Q work

From: Charles Mauldin <chazmauldin@gmail.com>
Sent: Monday, 26 October 2020 1:12 AM
To: Eric Lim
Cc: Steven Brown
Subject: Thanks for great Q work

Eric,

I posted this to the ListServe, and Steve Brown reminded me your colleagues might not be subscribers. Please share this as appropriate.

Congratulations to you and your colleagues, Dianna Wynaden and Karen Heslop for Q work of exceptiona value.

You won me over immediately when you expressed your five factor interpretations as strategies, as goals t be reached. I quote you directly:

(I) acknowledge the consumers' experience of hospitalization;

(II) reassure consumers who are going through a difficult time;

(III) interact to explore the impact of the consumer's negative lived experiences;

(IV) support co-production to reduce triggers for aggression;

(V) encourage and support consumers to take ownership of their recovery journey.

Your five operant factors reveal the natural formation of a collaborative system, comprised of five complementary strategies, each one a movement forward necessary to the overall goal for collaboration t achieve mental health recovery of "consumers" in an acute mental health inpatient setting.

What we see: For each of your factors, the nurses with high pure loadings comprise a set of natural advocates for that strategy. Each set of nurses is attuned to what might be called the "forensic tactics" for accomplishing that strategy. Together, these "specialists" reflect the operation of a dynamic collaborative system in which nurses must deal with acute mental health in-patient cases. In naming your factors, you've captured your way of expressing each strategy. For factor IV, for example, the term, "co-production to reduce triggers for aggression" expresses joint-responsibility of the nurse and the consumer for successfu dealing with aggression. Got it!

It's valid to think of these nurses as a team of human resources, qualified members of a team of specialist all necessary to accomplish the mission of mental health recovery in acute mental health situations.

I do not have access to your factor arrays, nor to details of your interpretations, but I know, in principle what they will reveal – what I've called the "forensic tactics" for the strategies. For each factor array, the distinguishing items express the "forensic tactics" for that movement. Across the factors, the consensus items express "forensic tactics" for achieving the common mission.

You accomplished that with Q method, with the vision for and expert design of your Q study, and with the constructive support of your nurse participants. From their own points of view, your participant nurses hav expressed a dynamic blueprint for success, as well as the priorities of team members for collaboration.

It's up to your leadership team to grasp, support, amplify, and leverage such focused energies to enable group progress. The leadership challenge, as always, is to create and sustain operations that enable such teams to work effectively and efficiently.

In your in-patient operations, I know you deal every day in a lived-experience "laboratory" for gaining mastery of those processes. The team and the organizational operations together comprise the "social machinery" on which progress depends.

In the modern world, we see many other venues that face the same general challenge you face, helping people who are in acute forms of emotional and physical crisis. In many other venues, solution-seekers and problem-solvers have much of value to learn from your research.

Thanks for the work you are doing.

Warm regards,

Charlie

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Appendix 18

Strategies that mental health nurses can utilize to reduce aggression in acute mental health settings through cultural change –

Oral Presentation Abstract for 3rd NUS-NUH International Nursing Conference and 20th Joint Singapore-Malaysia Nursing Conference 2015

Abstract ID: ABS 1176

STRATEGIES THAT MENTAL HEALTH NURSES CAN UTILIZE TO REDUCE AGGRESSION IN ACUTE MENTAL HEALTH SETTINGS THROUGH CULTURAL CHANGE

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This study is a systematic literature review to identify strategies that mental health nurses can utilize to reduce aggression in acute mental health settings through cultural change. A three-step search strategy was used to eliminate bias. Keywords were: ('recover$' AND 'consumer participat$' OR 'consumer consult$' OR 'user involve$' AND 'mental health' OR 'mental illness' AND 'psychiatric nurs$' OR 'mental health nurs$'). Databases searched were Cochrane Library, EMBASE (Ovid); EBSCOhost CINAHL PLUS with full text; Grey Literature Report; Joanna Briggs Institute Library; MEDLINE, PubMed; PsycINFO; PsycArticles; ProQuest nursing and allied health source; ProQuest Dissertations and Theses Global; Scopus; and Science Direct. The reference list of the included papers were searched to locate additional papers relevant to this review. All included articles were assessed for quality using JBI quality assessment tools.

Thirty-three research papers and one thesis were included for data extraction in this review. Six strategies were identified and they are: 1) Create a positive consumer perception of recovery-orientation; 2) Provide a truly safe, holistic and stigma-free "haven" for consumers; 3) Develop a interpersonal partnership with consumer; 4) Use recovery language in daily interactions; 5) Enthusiastically engage consumers in positive partnership; and 6) Operationalise consumers' strength and potential for personal recovery.

This study is one of the components in a PhD by publication research. Findings from this systematic literature review will be combined with two other studies into an educational package to help mental health nurses facilitate recovery and reduce rate of aggression in the acute mental health inpatient settings.

Appendix 19

Reducing aggression in the acute mental health settings using recovery-oriented mental health practices: A systematic search and review –

Oral Presentation Abstract for Curtin University Mark Liverlis Student Research Seminar 2016

Reducing Aggression in the Acute Mental Health Settings Using Recovery-Oriented Mental Health Practices: A Systematic Search and Review

Presented by:	Eric Lim, School of Nursing, Midwifery & Paramedicine
Course:	Doctor of Philosophy
Supervisor:	Professor Dianne Wynaden, School of Nursing, Midwifery & Paramedicine
A/Supervisor:	Dr Karen Heslop, School of Nursing, Midwifery & Paramedicine

Brief Introduction: Aggression remains a common adverse event in acute mental health services. When people with a lived experience of mental illness are highly aroused by their symptomatology and become aggressive, health professionals can utilise strategies, ranging from the least restrictive interpersonal and de-escalating approaches, to the more restrictive restraints and seclusions. The choice of strategies is usually determined by health professionals to protect the individual, others under their care and themselves. Health professionals who practice within the recovery-oriented framework, may choose to utilise strategies such as self-determination, shared decision making, and choice empowerment, which will support people with mental health issues take increased responsibility for their wellbeing, build on their existing capabilities, strengths, resourcefulness, and autonomy to regain or maintain their self-identity in their community.

Aims: The aim of this literature review was to identify how health professionals can translate the principles of recovery-oriented mental health practice (ROMHP) to clinical practice and reduce aggression.

Methods: The Joanna Briggs Institute Reviewers' Manual 2014 (JBI) guided the systematic search of the literature, quality appraisal and data extraction of papers for a narrative review. Data analysis was completed using the constant comparative analysis central to grounded theory methodology, and similar ideas were grouped together into emerging categories.

Findings: Four overlapping but distinctive components emerged from the literature that encompasses the principles of ROMHP: 1) Knowing the person and not just the presenting behaviour; 2) Interact, don't react; 3) Co-production to identify and achieve goals; and 4) equipping the consumer for recovery to reflect the fundamental nursing process model of assessment, planning, implementation and evaluation.

Significance: Health professionals incorporating these components to their clinical practice will build a therapeutic alliance with the consumer, enhance assessment and

care planning, and to support consumer recovery and involvemennt of the family/carer in this process.

Appendix 20

Recovery-focused care: How it can be utilize to reduce aggression in the acute mental health setting – Oral presentation abstract for Curtin University Mark Liveris Student Research Seminar 2017

Recovery-focused care: How it can be used to reduce aggression in the acute mental health setting.

Presented by:	Mr Eric Lim, School of Nursing, Midwifery & Paramedicine
Course:	Doctor of Philosophy
Supervisor:	Professor Dianne Wynaden, School of Nursing, Midwifery & Paramedicine
A/Supervisor:	Dr Karen Heslop, School of Nursing, Midwifery & Paramedicine

Brief Introduction: Consumer aggression is common in the acute mental health inpatient setting. Mental health nurses can utilize a range of interventions to prevent aggression or reduce its impact on the person and others who have witnessed the event. Incorporating recovery-focussed care into clinical practice is one intervention, as it fosters collaborative partnerships with consumers. It promotes their engagement in decisions about their care and encourages self-management of their presenting behaviours. It also allows the consumer to engage in their personal recovery as their mental health improve. Yet there is a paucity of literature on how nurses can utilize recovery-focussed care with consumers who are hospitalized and in the acute phase of their illness.

Aim: The aim was to report the findings of a scoping review of the literature to identify how recovery-focussed care can be utilized by nurses to reduce the risk of consumer aggression.

Methods: The Joanna Briggs Institute Reviewers' Manual 2014 guided the systematic search of literature, quality appraisal and data extraction for a narrative review. Data analysis was completed using the constant comparative analysis central to grounded theory methodology, and similar ideas were grouped together into emerging categories.

Findings: Thirty-five papers met the inclusion criteria for review. Four components were identified as central to the use of recovery-focussed care with consumers at risk of becoming aggressive: (i) seeing the person and not just their presenting behaviour; (ii) interact, don't react; (iii) coproduction to achieve identified goals; and (iv) equipping the consumer as an active manager of their recovery.

Significance: The components equip nurses with strategies to decrease the risk of aggression, while encouraging consumers to self-manage their challenging behaviours and embark on their personal recovery journey. Further research are being carried out to evaluate the translation of these components clinically in the acute care setting.

Appendix 21

Co-production: Using recovery-focused care to reduce aggression in the acute mental health settings? – Oral presentation abstract for Australian College of Mental Health Nurses, Western Australia Branch Symposium 2018

Title: Co-production: Using Recovery-Focused Care to Reduce Aggression in the Acute Mental Health Settings?

Author: Mr Eric Lim, RN, MNurSt, Professor Dianne Wynaden, RN, RMN, PhD, & Dr Karen Heslop, RN, PhD

Contact details: eric.lim@curtin.edu.au

Oral paper: Category: Research

Abstract:
Aggression is common in the acute mental health settings and nurses can utilise a range of interventions to manage or prevent aggression. One intervention is recovery-focused care, where nurses establish a collaborative partnership with the individual displaying aggression to identify more person-centred and least restrictive interventions. Nurses using recovery-focused care can support the person actualise their existing strengths and potentials, to self-manage current and prevent future incidences of aggression. They can also maintain or protect the person's self-esteem and hope after losing control of their behaviour to support personal recovery. Yet, there is currently no practice guide for nurses utilise recovery-focused care with consumers who have a high risk for aggression. A scoping review of the literature was completed to explore how nurses can utilise recovery-focussed care to reduce aggression. Four components were identified as central to nurses who want to use of recovery-focussed care to reduce aggression. They are: (i) seeing the person and not just their presenting behaviour; (ii) interact, don't react; (iii) coproduction to achieve identified goals; and (iv) equipping the consumer as an active manager of their recovery. Further research is currently being carried out to translate these components clinically in the acute care setting.

Learning objectives:

- Discuss how nurses may utilise recovery-focused care to reduce aggression
- Explore some of the positive outcomes of utilising recovery-focused care to reduce aggression

References:

Lim, E., Wynaden, D., & Heslop, K. (2017). Recovery-focussed care: How it can be utilized to reduce aggression in the acute mental health setting. *International Journal of Mental Health Nursing, 26*(5), 445-460.

Appendix 22

Consumers' perceptions of nurses using recovery-focused care to reduce aggression in the acute mental health including forensic mental health settings: A qualitative study –

Poster for the Nursing and Midwifery Leadership Conference 2019

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

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ABSTRACT

Introduction/Background

Recovery-focused care is now the preferred model of care that nurses can provide for people with a mental illness (consumers) to support them achieve their personal and clinical recovery. However, there remains a lack of research evidence to support nurses to translate this knowledge clinically and achieve a consistent approach to provide recovery-focused care for consumers who may become aggressive.

Aim/Purpose of the project

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.

Methods/Process/Who is being studied

Individual and focused group interviews were conducted with consumers diagnosed with a mental illness in acute mental health settings. The constructivist grounded theory method guided data collection, coding, and analysis to generate categories that described the consumer perspective.

Results/Outcome

Thirty-one consumers participated in this study and data saturation was reached. 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.

Recommendations/Conclusion

The research provides insights into the consumer perspective of potential causes of aggression, and how nurses can use recovery-focused care to reduce the risk of aggression in all acute mental health settings. The findings are currently being tested in research to generate deeper knowledge and understanding of how nurses can provide recovery-focused care for consumer who may become aggression. They can also be incorporated into nursing 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.

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

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Background

Recovery-focused care (RFC) is endorsed by mental health policy as best practice that health professionals can use to support people with a mental illness (hereafter refers to as consumers) to regain autonomy and build a positive sense of self when admitted to hospital.[1] RFC is facilitated by health professionals actively involving consumers in their care decisions and mobilise the person's strengths and resources to take control and responsibility over their life.[2]

Nurses have a continual presence in the ward environment and are uniquely positioned to facilitate RFC and support consumers to achieve their personal and clinical recovery goals. However, aggression is common in all acute mental health including forensic mental health services and its occurrence can impact on nurses' willingness and ability to use RFC. Aggression in mental health settings is often conceptualised by health professionals as dysregulated behaviour that manifests as, or results in, threats or injuries to self or others, or damage to objects or property.[3]

Currently, there is a lack of practice guidelines on how nurses can actively involve consumers in their care decisions and facilitate RFC to reduce aggression. If nurses can facilitate RFC, they may support consumers to actualise their coping mechanisms to reduce their risk for aggression.

Purpose: To obtain consumers' perception of how nurses can use recovery-focused care to reduce aggression in all acute mental health including forensic mental health services.

Methods

- Data were collected by the first author from June to October 2017 using semi-structured interviews
- 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 hospitalised 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

Data collection and analysis

- Thirty-one people diagnosed with a mental illness participated in this study
- Individual interviews lasted between 10–48 minutes (mean = 17 minutes)
- Focus groups lasted between 30–45 minutes (mean = 40 minutes)

Total number of participants	31 (%)
Gender:	
Male	14 (45)
Female	17 (55)
Age groups:	
18 to 24	12 (39)
25 to 34	3 (10)
35 to 44	3 (10)
45 to 54	6 (19)
55 to 64	6 (19)
65 and above	1 (3)
DSM Group:	
Mood Disorders	16 (52)
Substance-related Disorders	4 (13)
Post-Traumatic Stress Disorder	5 (16)
Schizophrenia and Other Psychotic Disorders	6 (19)

Demographic data of participants

Analysis

- 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
- The coding procedure outlined by Charmaz was employed—initial coding and focused coding constructed the analytical categories[4]
- 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

Findings

- 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 hospitalisation
- 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

Categories	Subcategories
1. See the person as an individual with a unique lived experience	• Recognising different triggers for aggression • Respecting the individuality of each consumer • Empathising 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

The five categories and subcategories that defined consumers' perception about the use of RFC

Discussion

Consumers perceive that nurses who use RFC to reduce aggression in all acute mental health including forensic mental health services are more likely to:

- Explore the consumer's past and present lived experience during assessment to gain an understanding of the person's presenting behaviours and potential for aggression[5]
- 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.[6]
- Display a higher level of therapeutic optimism about consumers' potential to self-regulate their behaviour

Conclusion

The research provides insights into the consumers' perspectives of how nurses can use RFC to reduce the risk of aggression in all acute mental health settings. As RFC is now viewed internationally best practice for support people with a mental illness achieve their personal and clinical recovery, 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.[7]

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END