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Nurses and Consumer Consultants Perspectives on the Implementation of a Novel Violence Risk Assessment and Intervention Framework

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ABSTRACT

Interventions to prevent aggression and reduce use of restrictive practices are essential for recovery-oriented mental health nursing care. This study explored how nurses can best enhance employment of a structured risk assessment instrument paired with an aggression prevention protocol. Fourteen nurses with responsibilities for reducing restrictive practices attended focus groups, and three consumer consultants working with mental health nursing staff participated in one-to-one interviews. The focus groups and interviews were designed to elicit recommendations to assist nurses use of the violence risk assessment instrument and apply the protocol interventions. Thematic analysis was used to analyse the data. Four themes were interpreted from the data. Theme one: The nurses are experiencing incredible difficulty talking about how they can be supported. Theme two: 'calming the farm': The need to self-regulate, with the subthemes: (1) some nurses may need support to 'calm the farm' and (2) if you can't 'calm the farm' another nurse may need to step in. Theme three was the need for robust training and education and the final theme was: The need for 'decompressing' before leaving the shift. Participants suggested while some nurses were very skilled at regulating their emotions while intervening to prevent violence, some had difficulty, or were not aware of their emotional state, and may need support from colleagues when intervening. Suggestions for enhancing the application of aggression prevention interventions include use of mental wellness check-in forms, engaging in clinical supervision and safety huddles at the end of the shift to assist nurses to decompress before leaving.

1 | Introduction

Aggression in mental health units poses many challenges and causes much concern for staff, consumers and their families, carers and supporters, as well as mental health services (Cusack et al. 2018; Le Bel et al. 2014). Aggression sometimes results in the use of restrictive practices, including restraint and seclusion (Daguman et al. 2024), even though these practices can cause harm and recommendations to reduce or eliminate their use have been made.

Contemporary mental health care requires nurses to work collaboratively with consumers to use evidence-based practice and although much research has been conducted on violence risk assessment, which is a pre-requisite for violence prevention, there is less focus and evaluation of intervention efforts (Maguire

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et al. 2022). To address this practice gap, a structured prevention protocol was developed, the Aggression Prevention Protocol (APP, Maguire et al. 2019), which is linked to a risk assessment of imminent aggression instrument, the Dynamic Appraisal of Situational Aggression (DASA, Ogloff and Daffern 2006), together forming the DASA + APP. This paper explores the perspectives of nurses and Consumers Consultants working in mental health services on how to enhance risk assessment and intervention (e.g., the DASA + APP) and identify the supports nurses may require to assist adoption in clinical practice.

1.1 | Background

Validated short-term violence risk assessment instruments paired with structured nursing intervention have been shown to lessen the incidence of aggression and reduce the use of restrictive practices in mental health units (Abderhalden et al. 2008; Griffith et al. 2021; Maguire et al. 2019; van de Sande et al. 2011). The assessment and management of aggression is a core clinical activity; however, restrictive practices are often relied upon to prevent harm and contain aggression. These practices have been criticised due to their potential to cause harm and there is little evidence they provide benefits to consumers (Roychowdhury and Adshead 2014). Risk assessment practices have been criticised when they are locally derived as opposed to validated, for not leading to reduction in aggression, and for being limited in predictive efficacy (Callaghan and Grundy 2018; Maguire et al. 2019; Ryan et al. 2010). They have also been criticised for lacking consumer involvement or active engagement; in many circumstances, consumers may be unaware that a risk assessment has been completed (Ahmed et al. 2021; Eidhammer et al. 2014; Lantta and Anttila 2022). An exception is recent work exploring the perspective of consumers regarding aggression in mental health units and the acceptability and application of the short-term violence risk assessment instruments (Lantta et al. 2016; Välimäki et al. 2022).

1.2 | Risk Assessment and Intervention

This paper focuses on the DASA (Ogloff and Daffern 2006; Daffern and Ogloff 2020), an instrument designed to assess the risk of imminent aggression, to prompt early intervention and to reduce restrictive practices (Moscovici et al. 2024). The DASA is comprised of seven dynamic items that are scored as either present or absent over the past 24 h, the score is summed to produce a score that can be interpreted according to three risk bands, low (DASA 0), moderate (DASA score of 1–3) and high (DASA score of 4–7). By assessing the level of risk as measured by the DASA, nurses can identify who might be likely to engage in aggression (Maguire et al. 2018) and who is less likely. This can help prompt early intervention for consumers who need attention and increase liberties for consumers who are not at risk.

An Aggression Prevention Protocol (APP; Maguire et al. 2019), which is comprised of seven commonly used nursing interventions (one-to-one nursing, distraction, empathic validation [reassurance], de-escalation, limit setting, close observations and Pro Re Nata [PRN] medication) was developed to work in tandem with the DASA (together known as the DASA + APP). When paired with the DASA, the APP is designed to provide structure to nursing practice by encouraging early intervention and reserving the more restrictive interventions (limit setting, close observations and PRN medication) for people assessed within the high risk DASA band. Studies exploring the DASA + APP have shown reductions in aggression, use of restrictive interventions, and use of PRN medication when the DASA + APP is used together to assess and intervene (Griffith et al. 2021; Maguire et al. 2019).

Despite promise in the reduction of both aggression and the use of restrictive practices, a critical task is to ensure nurses can action the APP interventions, some of which are complex clinical activities (Maguire et al. 2024). For example, de-escalation requires a range of skills including sound knowledge of the influence of trauma on memory and regulation; the aetiology and an understanding of voice hearing; as well as skills such as the ability to emotionally self-regulate, validate distress, reinforce autonomy, set limits and problem-solve (Price et al. 2024).

When consumers are presenting as irritable and disagreeable (a state assessed by DASA; Daffern and Ogloff 2020), they may be reluctant to engage in the APP interventions (Maguire et al. 2022), and nurses may also be impacted by the threat of aggression, which may influence their ability to respond (Stevenson et al. 2015). Against this background, the aim of this study was to explore the use of DASA + APP and how nurses might be supported to apply the DASA + APP in practice, with nurses who are responsible for the reduction of restrictive practices in their workplace and with Consumer Consultants so that consumer perspectives are elicited.

2 | Methods

2.1 | Design

An exploratory approach was used in this study adopting a descriptive qualitative design with focus groups to collect data with nurses who are responsible for the management of aggression and reduction of restrictive practices, and one-to-one interviews with Consumer Consultants who are employed to provide consultation with consumers and advocate for service improvement across the state of Victoria, Australia. This study is reported using 'Enhancing the QUAlity and Transparency Of health Research' (EQUATOR) network recommendations for qualitative research, using the 'Consolidated criteria for REporting Qualitative research' (COREQ) checklist (Tong et al. 2007). This study was approved by Swinburne University of Technology Human Research Ethics Committee (Project ID: 6648). Data were collected from August to October 2024.

2.2 | Participants

Purposeful sampling was used to identify mental health nurses with expertise and roles related to the management of aggression and reduction of restrictive practices. In the state of Victoria, there are nurses employed into a role titled 'Clinical Nurse Consultant: Reducing Restrictive Interventions'. Nurses employed in these roles work with multi-disciplinary teams in the

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mental health units to reduce the use of restrictive practices (seclusion and restraint). There is also a forum called the Victorian Prevention of Clinical Aggression (VPCA) forum. The VPCA forum includes representatives from public health services in Victoria who have leadership or training roles in their organisation related to the prevention and management of aggression. These participants were selected because they have expertise in assessing and applying nursing interventions to prevent and manage aggression and to reduce the use of restrictive practices.

Purposeful sampling was also used to identify Consumer Consultants with lived experience who work in mental health settings across the state of Victoria as part of a multi-disciplinary team. These participants were selected due to their role advocating for people with mental health needs and their families and ensuring that mental health services are responsive to their needs (Scholz et al. 2017).

An email describing the study was sent to all eligible participants introducing the nature and purpose of the research. Informed consent was via electronic consent forms, where participants returned the signed consent form via email, prior to attending either the focus group or one-to-one interview. Five business days before the focus groups/interviews the participants were emailed a summary of the DASA + APP and asked to read this prior to the focus group/interview. The Consumer Consultants were also sent a brief video briefly describing the DASA + APP to ensure they were provided with an overview of how the DASA + APP is applied in practice. Four focus groups with a total of 14 nurses ($n = 11$ Clinical Nurse Consultants and $n = 3$ members from the VPCA forum) and three one-to-one interviews with Consumer Consultants were conducted. Participants were from 11 different public health services and one private service across Victoria: eight based in metro and four based in rural Victoria. Twelve nurses were from area mental health services and two were from forensic mental health. All were familiar with the DASA, but not all were familiar with the APP. The nurses worked across a variety of settings including child and adolescent mental health, acute mental health, acute forensic mental health and emergency departments.

2.3 | Data Collection

Data were collected using Microsoft Teams as the online conferencing platform informed with a focus group/interview guide. The focus groups and interviews began with a brief orientation to the DASA + APP provided by the researchers. The researchers inquired if participants were familiar with DASA + APP before seeking feedback about application in practice (e.g., 'How can nurses best engage consumers about the DASA + APP?', 'How can nurses use the Aggression Prevention Protocol interventions to increase safety for everybody on the unit?', 'What support might be required to best apply the DASA + APP in practice?'). TM facilitated all focus groups with assistance from TF in two groups, BM and MD in one group each. TM, BM and MD all conducted one interview each with a Consumer Consultant. The focus groups lasted from 50 to 58 min (the focus group size ranged from a low of two participants to a high of nine). Interviews lasted from 45 to 56 min. The focus groups and interviews were all audio-recorded and transcribed verbatim for analysis. The letter (P) indicates a nurse from a focus group and (I) an interview with a Consumer Consultant.

2.4 | Data Analysis

The thematic analysis was undertaken according to the steps outlined by Braun and Clarke (2019). After the audio recordings were transcribed, TM listened to the audio recordings against the transcripts and corrected any text that was inaccurate. Transcripts were then subject to analysis by TM and TF. After familiarisation with the data, initial codes were generated, where similar accounts were identified and assigned codes using Microsoft Word (computer aided data analytic software was not used). The codes were then discussed together by TM, BM, and TF. The codes were then organised into potential themes and reviewed in relation to the coded extracts, followed by the full dataset. TM, BM and TF then considered and identified the final themes. Revisions were made to the codes and/or themes following discussion. The writing up of the results was the final phase in writing this manuscript. Authors TM and BM are mental health nurses and MD is a psychologist. All researchers have qualitative research experience.

2.5 | Rigour

Rigour was established by using a reflexive and systematic study design. The participants were recruited because they were considered the most appropriate to answer the research questions. The study was designed and conducted by researchers who have experience in mental health and risk assessment. Authors TM, BM and MD are forensic mental health clinicians and researchers. Review of transcripts alongside the audio-recording ensured accuracy. Analysis and theming of the data were done in collaboration, and the use of quotes demonstrates the themes.

3 | Findings

Four themes were interpreted from the data. Theme one: The nurses had incredible difficulty talking about how they could be supported. Theme two: 'calming the farm': The need to self-regulate, with the subthemes: (1) Some nurses may need support to 'calm the farm' and (2) If you can't 'calm the farm' another nurse may need to step in. Theme three: The need for robust training and education. The final theme was: The need for 'decompressing' before leaving the shift.

3.1 | Theme One: The Nurses Are Experiencing Incredible Difficulty Talking About How They Can Be Supported

The nurses in this study found it very difficult to talk about what support they might need to enhance the application of the risk assessment and intervention such as the DASA + APP. Instead, they were almost completely oriented towards how they could support the consumer. Even with several prompts, the nurses kept talking about consumer needs, as demonstrated by the following quote:

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> I think, like I said, I think I always think of a consumer...
>
> (P4)

> Some of my very first things would be really listening, trying to establish what some of the concerns and the issues are and trying to navigate through how to resolve that and actually asking questions to that consumer, well what helps you?
>
> (P2)

Because the DASA + APP is designed to be an early intervention process, participants were thinking about using the DASA + APP to inform the intervention approach that the consumer might prefer by working to understand what they would like in terms of intervention approaches and what might be most effective. Participants also spoke about using the DASA + APP to guide discussion with consumers regarding assessment and intervention.

> Talk about what their flashpoints are, ...what are the triggers, what are their early warning insights around aggression
>
> (P14).

> Maximizing the choices, so be maximizing transparency, openness about the process and highlighting personal preference
>
> (I1)

3.2 | Theme Two: 'Calming the Farm': The Need to Self-Regulate

After reluctance to talk about what support nurses might need, what was discussed by the nurse and consumer consultant participants was what nurses need to regulate their emotional state when they are going into a situation where aggression might be imminent and they need to apply intervention strategies:

> Needing to regulate yourself before you go into the situation
>
> (P14)

Nurses may be feeling anxious/overwhelmed when approaching certain situations, as there is often a certain sense of pressure that nurses need to be able to intervene even if they may not have the skills to do so.

> Just because you are the contact nurse, you shouldn't feel pressured to be the one that has to deescalate the situation, especially if you feel that you don't have the skills or the experience to do so... And negative situations occur because, nurses feel it's their responsibility to de-escalate someone when they may not have the skillset to do so
>
> (P11).

There was also acknowledgement that many nurses are fearful or have been traumatised in their job, and the impact this has on being able to regulate oneself when intervening.

> We've got a bunch of clinicians who have been traumatised as hell by the job they're in and told that that is what you signed up for...It's about getting people to act better and be more aware of their behaviour, so much as it is being more aware of the fact that they are affected. They're allowed to be affected, but as much as they are taught to help consumers regulate themselves, they need help regulating themselves as clinicians
>
> (I3)

There was concern that sometimes nurses might be reluctant to engage with consumers when they are elevated. This may be due to fear or reflection on past experiences where harm was caused.

> As soon as the name's mentioned, staff freeze. It's past trauma around really significant events; assaults that staff have experienced
>
> (P7)

> If you want to know why someone's cheesed off, then just ask. They'll probably tell you. But often people are afraid to ask
>
> (I2)

When nurses do not feel safe, this can influence how they approach situations in the workplace, and how they apply interventions to prevent and manage aggression.

> One of the biggest factors (when intervening) is fear for their own safety. I see this with the more junior workforce coming through, that fear response taking over rather than a practiced calmed approach
>
> (P7)

In this regard, there is a need to ensure nurses are equipped with the knowledge and skills they need to intervene to prevent aggression. It is also important that they feel safe in their workplace so they can remain calm and in control, particularly when faced with difficult situations and engaging consumers who are at risk of engaging in aggression.

3.2.1 | Subtheme One: Some Nurses May Need Support to 'Calm the Farm'

Nurses who can calmly approach consumers who are at risk of aggression were viewed by participants as very skilful.

> I have so many examples of people who just get it because they have the knack. They seem to be able to wander into some of the most tense, terrifying situations, and they just talk their way out of it, cool

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> as a cucumber, and you get a brilliant outcome., and no need for restrictive intervention. Some people just have that knack.
>
> (I3)

While some nurses were recognised as very skilled in intervening effectively to de-escalate a situation, there was acknowledgement that for other nurses, support from their colleagues was required to assist them to approach the situation in a calm and considered manner. This is where participants described spending time working with other staff members to assist them to relax, or ease tension before they engage with a consumer and apply interventions.

> I do a fair bit of individual work with people essentially calming the farm before they go and have conversations and get them to focus on what is the outcome you want from this particular intervention or this particular interaction
>
> (P6)

When nurses were entering a situation in a heightened state, it impacted their ability to effectively interact with the consumer, and in some instances could also adversely affect the situation.

3.2.2 | Subtheme Two: If You Can't 'Calm the Farm' Another Nurse May Need to Step in

There was recognition that there may be occasions when another nurse needed to intervene to take over the situation, when perhaps the nurse 'didn't have the knack to intervene effectively with a certain consumer' (I1), or was not able to regulate their emotions.

> A lot of the staff I find don't actually have the wherewithal to go, I need to step away for five minutes and just regulate myself. They just continue and then it becomes this really icky situation
>
> (P14).

> We had a situation, the ANUM was getting so triggered, she came back into the office, she was so dysregulated, she was almost hysterical and everyone else was getting stressed and we had to ask the nurse to get off the ward because they were causing everyone else to be stressed. So, if you imagine them trying to set limits with a patient or regulate them, it just doesn't work
>
> (P13)

One of the participants had started using a wellness plan to support nurses in identifying their emotions and early signs of stress. The wellness plan was also introduced as a strategy to acknowledge the high levels of stress that can be present among the nurses, who work in very challenging environments.

3.3 | Theme Three: The Need for Robust Training and Education

Participants emphasised the need for good quality education and training programmes that assisted nurses to enhance their skills in aggression prevention interventions such as de-escalation.

> Robust training packages where you can maybe role play and undertake some more of those complex challenging situations
>
> (P2)

In particular, participants where really keen to see simulation-based training included where possible, to practice their intervention skills in a safe setting.

> We do something called simulation training...we have an actor come in and they pretend to be a patient... and then the staff will practice deescalating and then we do a group debrief and unpack it afterwards and all hate it because it's role play. But afterwards always say I feel much so much more empowered because they know that the actor can really, really push it
>
> (P13)

Having good quality training where nurses could practice as close to reality as possible was seen as a way of increasing confidence and skill building.

3.4 | Theme Four: The Need for 'Decompressing' Before Leaving the Shift

The final theme relates to a need for self-care and reflection to reduce stress and tension at the end of shift before going home. While it was acknowledged that people are keen to leave their shift and return to their personal lives as soon as possible, it was considered important to take a moment either by themselves or with the team to reflect on the shift.

> We focus on just wanting to get home, whereas a lot the time processing how you felt and how you approach something from an emotional point of view yourself can really impact how you deal going forward in other situations
>
> (P7)

Having the time to reflect as a team was also viewed by some of the participants as a positive strategy when done safely. Reflection could help with reviewing practice such as intervening to prevent aggression and debriefing people before ending the day's work.

> An end of shift huddle 10 minutes before everyone goes home. So, you're finishing together and sharing positives and strengths from the shift. It can boost people's confidence
>
> (P13)

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> There was a protected 15 minutes for the team to sit down and discuss the shift, talk about what went well, what could be improve upon. You've got to have a culture where people feel safe. It was carried out very safely and people came away feeling very positive. It was also a moment to decompress
>
> (P2)

Previous experiences of not having time to debrief had resulted in some participants being hypervigilant when completing personal tasks like grocery shopping after a shift.

> I remember going to a supermarket straight after a shift and being still so hypervigilant, someone might be walking up behind me, and I'd be ready to turn around and check
>
> (P11)

Some participants spoke of taking stress home from work after a shift and the need to switch from the professional to the personal self.

> When you go home, you try not to take that home with your family, you can get angry. I used to take it out of my teens until one of them said, geez, mum, I only asked you for an apple and you just lost it... I had to check with myself and go, right, I need 20 minutes before I change from nurse to mum
>
> (P4)

> If I had that delegated time 10 minutes before leaving for the day to debrief or reflect on what had happened throughout the shift or address what was bothering me, I think it would've made my husband a lot happier. Some nights I'd get home, and I wouldn't want to speak to anyone because I've been drained.
>
> (P11)

Participants (nurses and Consumer Consultants) suggested that unlike lived experience staff, nurses are not encouraged to share their personal experiences and not being able to do this may impact on nurses being able to nurture their personal and professional self.

> If you're a lived experience worker, personal self-awareness elements are expected. It's a heavily encouraged part of what we do. We have the disciplinary freedom to wear that on our sleeves. Historically, clinicians are encouraged to do the exact opposite. All of your personal stuff you box it up and leave it at home. You've got a job to do. You've got to keep that straight clinical face. It encourages that cold divide between the actual self and the professional self
>
> (I2)

4 | Discussion

This study aimed to explore how risk assessment and intervention, such as the DASA + APP, can be best applied, and how nurses could be supported to implement these in practice. While participants in this study were supportive of the DASA + APP, they were more focused on the application of interventions (APP) rather than the DASA. This may be due to the inherent complexity of applying interventions as opposed to the administration of risk assessment, which is a more straightforward clinical task. Nurse participants had difficulty considering how they could be supported in risk assessment and intervention. Rather, they talked about how they supported consumers when applying interventions to prevent and manage aggression. In this regard, they were focused on early intervention and reducing restrictive interventions.

What participants did articulate in this study was the need for nurses to be able to regulate their own emotions before and while engaging consumers to apply interventions such as those contained in the APP, and at times the need for others to assist staff to regulate emotions if they were unable to do this for themselves. The need for debriefing and reflection at the end of a shift was also identified as a supportive activity to assist staff switch from their professional to personal selves. Participants thought that reflecting on the application of the DASA and APP interventions and identifying the strengths during the shift, via debriefing, could be beneficial.

The importance of nurses being aware of their emotions has been highlighted in other research. Delgado et al. (2022) reported a key component for maintaining internal equilibrium was the capacity to deliberately engage in self-regulation, and where mental health nurses were aware of their mental and emotional state and understood how this could affect their behaviour. In this study, while there was acknowledgment that some nurses were able to remain composed and apply APP interventions in a calm manner to prevent or manage aggression, there was concern that some nurses had difficulty managing themselves whilst intervening with consumers at a heightened risk for aggression. There was also concern expressed that some nurses may not be aware when they are struggling to remain composed and that support from colleagues may be necessary to help them regulate or to take leadership in the intervention.

Difficulty with emotion regulation may be a result of the emotional toll experienced by mental health nurses in their everyday work. Mental health clinicians including nurses, practice in a culture of one-way caring, working in what are often challenging circumstances, while not always being aware of the impact of profession-related stressors (Posluns and Gall 2020). This emotional labour ('the effort consumed by suppressing one's own emotions to care for others effectively while also caring for oneself' Edward et al. 2017, 215) can result in role conflict for nurses, when having to manage emotions and ensuring care delivery in line with service goals, which can result in suppression of emotion. This conflict between emotions expressed and suppressed by can lead to role stress, dissatisfaction and burnout (Edward et al. 2017; MacLaren et al. 2016).

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One example used in practice to support nursing colleagues in the identification of emotions and early signs of stress was the use of a weekly personal mental health check-in form (Black Dog Institute 2025). While this was originally developed for use during the COVID pandemic, it was reported as now being used as a tool by some nurses to check in with how they are coping at work. Personal safety plans, or wellbeing plans, have been used in many mental health services, often introduced as part of the Six Core Strategies for use by consumers in collaboration with staff to identify early signs of change, identify symptoms of trauma, encourage emotional self-management and determine what strategies might be helpful for an individual (National Association of State Mental Health Program Directors 2005; Te Pou 2020). Use of such a tool for nurses may prove helpful in terms of taking time to consider triggers and signs of stress to assist with developing an awareness of emotions and making plans to address threats to wellbeing if they arise.

While all staff are expected to contain or express their emotions and adhere to professional standards, lived experience/Consumer Consultant workers roles are differentiated by the use of their own lived expertise and knowledge acquired through personal experiences of diagnosis, mental health service use and personal recovery from their mental health experiences. These experiences are used to assist others and contribute to system change (Roennfeldt and Byrne 2021). As such, expressions of emotions and self-awareness are expected and encouraged. Conversely, there is stigma associated with clinicians disclosing experiences of emotional distress (King et al. 2020), and 'taboo' regarding nurses disclosing their own experiences of mental ill health or emotional distress (Oates et al. 2017). Personal experience can impact nursing care in positive ways such as assisting the development of the therapeutic relationship and enhancing understanding of consumers experiences (Oates et al. 2017). There is evidence to suggest that workplace interventions that provide the chance to express emotions to colleagues, share clinical experiences with colleagues and feel validation and support from colleagues can be a positive experience for clinicians and assist in developing emotional literacy and establish an intention for becoming a more compassionate service for clinicians to work in (Allen et al. 2020).

Nurse participants suggested some type of debrief or safety huddle as a support that could assist them in their use of the DASA + APP. Safety huddles are short interdisciplinary meetings (10–15 min) that focus on consumer safety and facilitate team communication (Shaikh 2020). There is evidence to suggest that huddles can enhance team communication, personal resilience, mental health awareness and coping skills among clinicians working in high-stress settings (Ho et al. 2024; Paleri et al. 2021; Stapley et al. 2018). Given that huddles are designed to be brief and may have positive benefits, the introduction of safety huddles at the end of the shift may encourage reflection around the use of the DASA + APP in practice and allow the chance to decompress before leaving the unit.

The use of clinical supervision and reflective practice is mirrored in mental health nursing standards of practice, as part of the provision of evidence-based innovative nursing care and professional development (Australian College of Mental Health Nurses 2010). Due to the high levels of stress and trauma among mental health nurses, clinical supervision and reflective practice have been identified as important activities to assist nurses to process personal stress, reduce burnout, sustain and improve the quality of their care and facilitate personal awareness and coping (Howard and Eddy-Imishue 2020). Clinical supervision and reflective practice could also facilitate discussion and review of the application of the DASA + APP when working through clinical scenarios to assist in understanding how to best intervene to prevent and manage aggression and reduce the use of restrictive practices.

4.1 | Limitations

Focus group recruitment was impacted by sick leave and rostering. The recruitment of Consumer Consultants was impacted by there being few Consumer Consultants and this group being busy. We would have liked to have had more than two nurses in the fourth focus group; however, several participants were unwell that day and could not attend. We would have also liked to recruit more Consumer Consultants as their insights are critical to collaborative ways of working to prevent aggression. A limitation of this study is the difficulty the participants had in not being able to articulate how they could be supported to conduct risk assessment. While they were able to discuss how they could be supported to intervene, there were little to no suggestions about how risk assessment activities could be supported.

5 | Conclusion

Strategies for nurses to prevent and manage aggression and reduce the use of restrictive interventions in mental health units are necessary to ensure a safe workplace for staff and a therapeutic environment conducive to recovery for consumers. The use of validated risk assessment instruments coupled with structured intervention can assist in preventing aggression and restrictive interventions. While the assessment of risk may be considered a relatively straightforward task, risk assessment should not be considered 'straightforward'. While the assessment of risk for imminent violence may be aided by a structured risk assessment procedure such as the DASA, responding to people who present with a heightened risk for violence requires the application of multiple complex clinical skills. A structured aggression prevention framework like the APP can organise these skills, but applying them carefully and effectively is challenging, particularly when staff are feeling threatened and patients are in a state where they are upset and irritable. This may prove difficult in a setting that may be unsupportive of acknowledgement of distress or inability to cope. Wellness plans might also be helpful for nurses to identify early signs of work-related stress and enact strategies to assist. Consideration also needs to be given to how nurses can take time to decompress before leaving their shift, where the adoption of strategies such as end of shift safety huddles may allow time to reflect on the shift, support communication and assist in the development of personal awareness. These strategies may help nurses move out of a professional stance and into their personal selves.

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6 | Relevance for Clinical Practice

Nurses must provide care for others and in doing so they may not always acknowledge their own self-care needs. Just as you are encouraged to place an oxygen mask over your face when on an aeroplane before helping others, mental health nurses need to prioritise their own self-care to ensure they can care for others. Nurturing one's own professional self involves keeping up to date with evidence-based practice and engaging in clinical supervision and other forms of reflection such as safety huddles. The DASA + APP can support nursing practice by structuring nursing intervention following risk assessment. However, nurses need to be aware of their own emotions to ensure the interventions are applied effectively. Furthermore, it is critical that nurses reflect on the use of the DASA + APP while also working with consumers and involving them in assessment and intervention. Future research should examine their important role in the implementation and use of DASA + APP in inpatient mental health settings.

Author Contributions

All authors listed meet the authorship criteria of the International Committee of Medical Journal Editors, and all authors are in agreement with the manuscript. T.M., B.M., and M.D. were involved with study concept and design. T.M., M.D., T.F. and B.M. collected data. T.M., B.M., T.F. and M.D. were involved in data analysis and write up.

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Conflicts of Interest

Michael Daffern is a co-author of the Dynamic Appraisal of Situational Aggression (DASA). The DASA manual is sold by the Centre for Forensic Behavioural Science. Profit from these sales are used to support research. There are no other disclosures or conflicts of interest to declare.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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