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Mental Health Nurses' attitudes towards mental illness and recovery-oriented practice in acute inpatient psychiatric units: A non-participant observation study

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Abstract

National mental health policies accentuate the importance of having positive attitudes, skills, and knowledge among mental health professionals to facilitate recovery-oriented practices in all areas of mental health care. However, evidence suggests that mental health professionals' negative attitudes towards mental illness are still evident and that recovery-oriented practice in acute inpatient units may be poorly implemented. At the same time, there is also a paucity of research to understand Mental Health Nurses' attitudes towards mental illness and recovery-oriented practice specifically. Therefore, this non-participant observation study aimed to explore Mental Health Nurses' attitudes towards mental illness and recovery-oriented practice in acute inpatient units by observing the interactions between the consumers and nurses. The Mental Illness Clinicians Attitudes Scale-v4 and The Recovery Attitudes Questionnaire inspired the development of a non-participant observation chart for this study and the observations were recorded on the chart. Six observations were conducted in three acute inpatient units. Observations focused on Mental Health Nurses' knowledge about mental illness, communication, dignity, respect, anxiety, fear, punishment, facilitation of real choices for consumers, physical care, cooperation with consumers' families and others and recovery orientation. Interpretive descriptive analysis was used to analyse the data. The results show that Mental Health Nurses generally have positive attitudes towards mental illness and recovery-oriented practice. Some deficits in the physical care of people with mental illness in the acute inpatient units were observed. Therefore, future research could address the adequate preparation of Mental Health Nurses to provide physical care to people with mental illnesses.

KEYWORDS
mental health nurses, mental illness, non-participant observation, recovery, recovery-oriented practices, stigma

INTRODUCTION

Negative attitudes towards mental illness impair recovery of people with mental illness and generate stigma. Despite working within mental health service contexts, evidence shows that mental health professionals are also not free from pessimistic attitudes towards mental illness (Reavley et al., 2014; Stull et al., 2017). Such attitudes of health professionals diminish the provision of recovery-oriented practice in all areas of mental health (Reavley et al., 2014; Sreeram et al., 2021, 2022). As nurses are the frontline workforce of the health care system (Clark et al., 2014; Henderson et al., 2014), it is critical that Mental Health Nurses have positive attitudes towards

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mental illness and demonstrate recovery-oriented practices to support consumers' well-being.

Background

Health status impacts quality of life for human beings. Poor mental health can lead to chronic physical conditions (World Health Organization, 2018). Therefore, mental health is essential to lead a satisfactory life. However, negative attitudes towards mental illness prevent achieving a better-quality life for people with mental illness. According to Global Health Data Exchange, one in every eight people lives with a mental disorder (Institute of Health Metrics and Evaluation, 2022; World Health Organization, 2022). Despite the availability of treatments, many do not want to seek help due to stigma and discrimination (World Health Organization, 2017, 2018). In Australia, 4.0 million Australians (17.5%) reported having a mental or behavioural condition and 15.8% of all Australians (3.6 million people) reported coexisting long-term mental, behavioural and physical health conditions (Australian Institute of Health and Welfare, 2018). Between the period of 2019 to 2020 a total of 275 270 mental health-related hospitalisations occurred in Australia, in which 62.7% of the admission required acute inpatient care (Australian Institute of Health and Welfare, 2022).

Negative and stigmatic attitudes towards mental illness are not only evident among the general population but also present among mental health professionals, including Mental Health Nurses (Sreeram et al., 2022; Stull et al., 2017). Negative attitudes are often presented through frustration, avoidance and discriminatory behaviour towards people with mental illness (Fokuo et al., 2017). In mental health settings, discriminatory behaviours are often expressed with the diagnosis of mental illness. There is global variation in attitudes towards mental illness and recovery due to the effects of socio-cultural factors and mental health literacy of mental health professionals. In Australia, mental health professionals have been found to have increased avoidant behaviour towards people with borderline personality than people diagnosed with depression, bipolar affective disorder or schizophrenia (Mental Health Council Of Australia, 2011; Sreeram et al., 2022).

National mental health policies and legislations in Australia highlight the qualities required of mental health professionals including adequate knowledge, effective skills and positive attitudes to provide recovery-oriented care for consumers (Commonwealth of Australia, 2013).

Mental health recovery could be classified as personal, clinical and organizational recovery (Le Boutillier et al., 2015). Personal recovery is an enabling process that helps consumers to lead a satisfactory life, even with the presence of debilitating symptoms of mental illness, while clinical recovery focuses on symptom reduction of individuals with mental illness. Organizational recovery follows stakeholders' views of facilitating recovery through the organization (Le Boutillier et al., 2015; Sreeram et al., 2021). The recovery model of care principally supports the personal recovery of people with mental illness (Commonwealth of Australia, 2013). Waldemar et al. (2019) and Waldemar et al. (2016) observed that recovery-oriented practice facilitates the personal recovery of people with mental illness. The basis of such practice is focused on collaboration with consumers through communication, supporting them to make decisions, developing hope and integrating consumers' views and choices in their own care to ensure autonomy. The manifestation of recovery-oriented practice can be observed through the interaction between health care providers and consumers. Therefore, one way to understand the incorporation of recovery-oriented practices in mental health is by observing authentic interactions in the clinical context (Waldemar et al., 2019). However, there are few studies focused on recovery-oriented practices in clinical settings (Lim et al., 2019, 2020; McKenna et al., 2014). Although several studies in Australia have focussed specifically on recovery-oriented practices in acute mental health settings to reduce consumer aggression. (Lim et al., 2019, 2020), it has also been acknowledged that the provision of care is not consistently nor completely recovery-oriented in both acute inpatient psychiatric settings and community settings (McKenna et al., 2014, 2016).

Pessimistic attitudes towards mental illness prevent the recovery of people diagnosed with mental illness. Many western countries have integrated recovery-oriented practice into mental health services (Glick et al., 2011; Shepherd et al., 2008). The national recovery-oriented framework in Australia provides guidance and support for recovery-oriented practices in all areas of mental health. The duty of mental health professionals is to support consumers in their recovery journey (Roberts & Boardman, 2014).

The majority of anti-stigma and recovery-oriented studies have been conducted among heterogeneous occupational groups within the mental health profession (Sreeram et al., 2021, 2022). Mental Health Nurses are an important occupational group and constitute the vast majority of health care providers, facilitating round-the-clock services for consumers (Australian Institute of Health and Welfare, 2021; Bureau of Labor Statistics, 2019; Rolewicz & Palmer, 2021). They plan, implement and evaluate the varying treatment modalities for the benefit of consumers individually as well as through a cooperative teamwork with other health care professionals (Jacobs & Mkhize, 2021; Mullen, 2009). Nevertheless, studies show that they are also not free from pessimistic attitudes towards mental illness. For example, Dickens et al. (2016) and Raveneau et al. (2014) found that Mental Health Nurses have negative attitudes towards people with borderline

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personality disorders and eating disorders. Mental Health Nurses provide care in acute inpatient settings, emergency departments, community care unit settings, rehabilitative settings as well as in forensic care units. Mental Health Nurses working in acute inpatient units show more pessimistic attitudes towards mental illness than nurses working in community and rehabilitative facilities (Hsiao et al., 2015; Rabenschlag et al., 2014). Regarding recovery-oriented practices, studies show a lack of awareness about the non-linearity principle of recovery and an indigent recovery-oriented practice observed in both acute inpatient psychiatric units as well as in community care facilities (Cleary et al., 2012; McKenna et al., 2014, 2016). Nurses' negative attitudes towards mental illness and recovery could prevent the provision of quality care for people with mental illness. There is a dearth of studies to understand Mental Health Nurses' attitudes towards mental illness and recovery-oriented practice specifically nurses working in acute inpatient psychiatric units (Hsiao et al., 2015; Rabenschlag et al., 2014; Repique et al., 2016; Waldemar et al., 2019).

In this study, a non-participant observation methodology was used to observe the activities of Mental Health Nurses in acute inpatient psychiatric units as they interacted with consumers, each other and other colleagues.

Ethical considerations, participant recruitment and consent

The research ethics application was grounded by the principles of the Australian Code for the Responsible Conduct of Research (National Health and Medical Research Council, 2018). Ethics approval was obtained from the health service and the university human research ethics committees.

After ethical and site approval were gained, a flyer was displayed in the adult acute inpatient psychiatric units inviting all Mental Health Nurses and consumers to participate in the study. Researchers spoke to potential participants face-to-face and explained the scope and purpose of the study. If they were willing to join the study, written consent was obtained from them. Separate Participant Information-Consent Forms (PICF) were devised for the Mental Health Nurses and consumers who participated in the study.

METHOD

This non-participant observation study was conducted to understand Mental Health Nurses' attitudes towards mental illness and recovery-oriented practices in acute inpatient psychiatric units by observing their interactions with consumers.

Aims

The aims of this study were to:

- Explore Mental Health Nurses' attitudes towards mental illness
- Investigate Mental Health Nurses' recovery-oriented practices in the acute inpatient units.

Design: Non-participant observation

Non-participant observation is a qualitative research method in which the researcher is involved with the research field to understand the context as well as to observe the areas of interest. However, the researcher is not involved directly in the activities of the participants (Liu & Maitlis, 2010; Williams, 2008). Observation can be covert or overt. In this instance, the study involved overt observation. The Hawthorne Effect, selectivity and ethical issues are the main concerns regarding the use of this method (Liu & Maitlis, 2010; Williams, 2008). These issues are addressed in the limitations of the study.

Non-participant observation methodology was used to observe the activities of Mental Health Nurses in these units as they interacted with consumers and others. All participants were aware of the observation. A predeveloped observation record based on the literature, The Mental Illness Clinicians' Attitude Scale-Version 4 [MICA-v4] (Gabbidon et al., 2013) and The Recovery Attitude Questionnaire-7 [RAQ-7] (Borkin et al., 2000) was used to record observations of interactions with consumers related to the attitudes towards mental illness and recovery. The components of the record included knowledge about mental illness, communication, demonstrating dignity, respect, anxiety, fear and punishment; facilitation of real choices for consumers; physical care; cooperation with consumers' families and others and recovery orientation.

Observations were conducted in the morning and afternoon shifts within both Intensive Care Areas as well as in Lower Dependency Units. The Intensive Care Area is a facility where acutely mentally unwell people are admitted. Once recovered from an acute episode of mental illness, consumers are transferred to a Lower Dependency Unit. Six observations were collected from 3 units. The observations were conducted in various places within the units where interactions took place among nurses as well as nurses and consumers and others. These included consumers' bedrooms, courtyards, medication areas, kitchens, nurses' stations, common lounges and consumers' trust office. The trust office is a facility where consumers can keep their property during the time of their admission and nurses assist them to access their property according to consumers' requests. The researcher shadowed the consumers and nurses in the course of their normal activities while observing.

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The observers were not involved in any activities other than observation. However, the researcher answered consumers' questions. Table 1 shows time, physical environment and nurses' interaction among themselves and with consumers.

Researchers

Two observers who were trained in mental health nursing and had extensive experience in acute inpatient settings undertook the observations. They had theoretical and practical knowledge about mental illness and recovery orientation. This insider knowledge helped them to understand the professional languages and routines in these units. The first observer, the research assistant, conducted the observation in Unit 1 because the other observer was familiar with the staff and consumers in Unit 1. However, the second observer, the researcher conducted the observations in Units 2 and 3, which involved staff and consumers unfamiliar to her. This could prevent the research participant bias.

Clinical settings

This study was conducted in a public acute mental health hospital in Victoria, Australia. In Victoria, acute inpatient units are integrated with the general hospital under the Victorian mental health system. This site was chosen purposefully because these Adult Acute Inpatient Psychiatric Units provide mental health assessment, management, treatment and care for people during the acute phase of mental illness.

Three inpatient psychiatric units participated in the study. They all were closed units, in these settings consumers were not permitted to leave without the treating team's permission. Units 1 and 2 had 29 beds and Unit 3 had 25 beds. All three units had an Intensive Care Area to provide care for acutely unwell consumers. The consumers in the Intensive Care Area are admitted under the Victorian Mental Health Act 2014. Consumers who recover from the acute episode of illness were transferred to Lower Dependency Units. However, consumers can also be admitted directly to the Lower Dependency Units depending on their severity of their illness. They can be admitted in the Lower Dependency Units either as a voluntary consumer or involuntary consumers under the Mental Health Act 2014.

In acute inpatient units, consumers are admitted through the emergency department, the community and the 'Police, Ambulance and Clinical Early Response' [PACER] Unit. Inpatient units facilitate both voluntary and involuntary admissions of consumers between the ages 18–65 years who are diagnosed with varying mental health issues. The units were closed. This suggested that consumers were not allowed to go out of the units without the treating team's permission. There were 10 nursing staff allocated during morning and afternoon shifts. Table 2 shows the structure and facilities of the units. Consumers' length of stay in the hospital may vary from 2 weeks to several months according to the severity of illness.

Nursing teams in these units included Registered Nurses, Enrolled Nurses, Associated Nurse Unit Managers, Nurse team leader, Clinical Nurse Educator, Clinical Nurse Consultant and Nurse Unit Manager. Other health care professionals include psychiatrists, registrars, social workers, occupational therapists and peer support workers.

Participants

Participants included Mental Health Nurses and consumers. Each nurse assigned to a consumer was observed by the researcher. The ability to provide consent for each consumer was determined through Mental Status Examination (MSE). Voluntary consumers could consent themselves; however, for involuntary consumers, a psychiatrist's decision needed to be considered. The researcher consulted the treating team for consumer participation in the observation phase in the research. Whilst no information about the consumers was collected, their involvement in the research related to the times of observation and they were asked to consent to be observed.

TABLE 1 Non-participant observation process.

Unit	Time: AM	Time: PM	Areas where interaction took place
1	10.00–11.00	3.00–4.00	ICA, consumers' bedroom, courtyard, medication area, kitchen, nurses' station, common lounge and consumers' trust office
2	8.30–9.30	3.00–4.00	Consumers' bedroom, courtyard, medication area, kitchen, nurses' station, common lounge and nurse educators' room
3	8.00–900	3.00–4.00	Consumers' bedroom, courtyard, medication area, kitchen, nurses' station, common lounge

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TABLE 2 Structure and facilities of each units.

Unit	Type of unit	Gender	Age group	Admission		LDU Beds	ICA Beds	Average length of stay in the unit	Number of MHN each shift (AM–PM)
				Voluntary	Involuntary				
1	Closed	Male & Female	18–65	Both		21	8	1–2 weeks	10
2	Closed	Male & Female	18–65	Both		21	8	1–2 weeks	10
3	Closed	Male & Female	18–65	Both		20	5	1–2 weeks	7

Empirical data

Observations in unit 1

The observation was conducted for 1 h, between 10.00 AM and 11.00 AM and again between 3.00 PM and 4.00 PM. Five Mental Health Nurses and four consumers participated. The observation was conducted in both the lower dependency unit and the intensive care area (ICA). However, consumers in the ICA were unable to consent because of the high acuity of their mental illness and they did not participate in the study. Therefore, the observations were conducted among the nurses and their general activities in the ICA.

The ICA of Unit 1 was hectic. It was observed that two consumers needed to be contained in seclusions in order to prevent harm towards themselves or others. Some consumers' behaviours were escalating in that they were becoming increasingly agitated and distressed. Consultants were also present in the ICA reviewing consumers during that time. One consumer needed one-to-one nursing special care due to high suicidal ideation. Some consumers needed constant support, reassurance and redirection from staff. Nurses worked hard to reduce the acuity and maintain a calming atmosphere. The nurse-patient ratio in the ICA was 1:2.

Though the ICA was highly acute it was observed that nurses were confident in communicating with consumers. Both consumers and nurses maintained respect and dignity while communicating with each other. We observed respect and dignity by their compassionate provision of nursing care, addressing each other appropriately, respecting personal boundaries, maintaining a safe atmosphere for consumers, promoting and engaging them in social activities as well as maintaining therapeutic communication with the consumers. There was no evidence of fear or anxiety while caring for consumers in the ICA. Nurses actively participated in one-to-one interactions to de-escalate challenging behaviours and prevent emergencies. Nurses could facilitate choices for consumers according to consumers' likes and dislikes. For example, they utilized many sensory modulation techniques such as a massage room, boxing devices, technology (I-pods, television) and mindful colouring activities to prevent the use of unnecessary physical restraints. Nurses utilized these activities based on the choices of consumers. It was also observed that nurses were competent in administering medication judiciously and were knowledgeable about mental health conditions.

The lower dependency unit was also busy, although consumers were quite settled. Four consumers agreed to participate in the observation. It was observed that good teamwork was apparent in this acute inpatient unit. It was observed that nurses maintained excellent communication between medical professionals, social workers and occupational therapists in caring for consumers. Nurses demonstrated their communication skills by actively listening in the handover meeting, giving and taking feedback during teamwork, actively responding to meet the needs of consumers and maintaining professionalism.

Nurses' interactions with consumers demonstrated respect and dignity. They addressed consumers by name. They pleasantly listened to them and could meet their needs by appropriately providing pro re nata [PRN] medication, toiletries and nutritional requirements.

Nurses facilitated consumers' choices by identifying and supporting their strengths and reality orientation, assisting them in making their own decisions. The nurses were active listeners, facilitating recovery goals and assisting with consumers' recovery journeys. They showed active listening by listening to the consumers carefully, without interrupting and judging consumers' conversation and could clarify their questions at the end of the conversation. For example, one nurse explained the need for discharge to a rehabilitation unit before going home. The nurse described the importance of achieving independence in activities of daily living to integrate successfully in the community.

The nurses documented consumers' progress thoroughly in medical progress notes using recovery terms, plans to facilitate recovery and the autonomy in consumers' choice. Discharge planning was also observed. Discharge goals and messages focused on consumers' recovery. The nurses were able to follow the policies and procedures of the Unit. They utilized different mechanisms to maintain the safety of consumers such as engaging with them and observing their whereabouts, their behaviours and interaction with others.

Nevertheless, documentation of consumers' physical needs was less clear. It was observed that very few physical observation charts for vital signs (e.g. pulse, blood pressure) and important clozapine physical observations (e.g. weight, BMI, fasting blood glucose, bowel charts) were recorded.

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There was no evidence of fear, frustration or anxiety among the nurses caring for the people with mental illness in the lower dependency area of the unit. Due to COVID-19, no visitors were permitted. Therefore, it was not possible to observe the nurse's interactions with consumers' families.

To conclude, Mental Health Nurses were knowledgeable and had positive attitudes in caring for consumers. The nurses were focused on recovery-oriented practices in the unit. They demonstrated recovery-oriented practice by maintaining dignity and respect, non-judgmental communication, facilitating choices, no coercion and ensuring autonomy of consumers. However, there were some insufficiencies in determining and maintaining consumers' physical needs. Table 3 shows examples of interpretation of collected data from Unit 1.

Observations unit 2

The observation in this unit was conducted for 1 h in the morning between 8:30 AM and 9:30 AM and 1 h between 3:00 PM and 4:00 PM in the afternoon. Four staff and six consumers participated in the morning and afternoon sessions. The observation was conducted only in the Lower Dependency Unit (LDU). The Intensive Care Area of the unit was highly volatile and acute. Therefore, the researcher could not conduct observations in the Intensive Care Area of unit 2.

It was observed that the unit was busy with routine daily practice. Observations were conducted while nurses were talking to consumers. They were competent in conducting a mental status examination. Nurses were generally confident, and the researcher did not observe any evidence of fear and anxiety among them. Senior nursing staff were more self-assured in meeting the needs of the consumers. For example, during medication administration senior staff followed the medication administration policies and administered medication without any fear or frustration on their face. However, some level of anxiety was observed among the junior staff before talking to consumers. They maintained consumers' dignity and respect while interacting with them.

Nurses attempted to facilitate consumers' recovery by talking and listening to them. They requested consumers to write down their needs and expectations to facilitate their recovery in the acute inpatient unit. These messages were then forwarded to the unit manager by the nurses. There was no evidence of force or coercion while talking to consumers and staff respected their rights.

The Unit followed *the primary care nursing model*, in which nursing care of a consumer is coordinated by a single nurse. The nurse allocated to a consumer facilitates and coordinates their physical, mental, social and spiritual well-being care. Five patients were allocated to each nurse. This workload, therefore, limited the interaction between staff. Nurses were highly focused on meeting the needs of consumers. Consumers were always in contact with their nurses to meet their needs such as for medication, food, toiletries and information about treatment aspects. Each consumer had different needs. It was observed that nurses were able to care and support each other as well as consumers. While one nurse was giving one-to-one care (special) to a consumer who was acutely unwell, another nurse asked the special nurse about the current mental state of that consumer and offered help in terms of providing PRN medication and organizing a break for the special nurse. Staff maintained dignity and respect while communicating with each other. Their communication was focused on the consumer's mental states and judicial administration of medication. They showed empathy in the caring process.

Nurses in Unit 2 undertook and recorded appropriate physical observations and engaged with consumers to maintain their safety throughout their stay in the unit. All charts were up-to-date and fully documented. The medication chart showed that there was no unnecessary usage of PRN medications.

The shift changeover occurred between 3:00 PM and 4:00 PM. The nurse in charge of the unit allocated consumers for the afternoon staff. The staff discussed their allocated consumers in the nursing station briefly and immediately they dispersed themselves to their respective consumer. In the nurse educator room, nurse educators discussed a risk report and the need for improvement of patient safety while administering medication. It was observed that though unit 2 was highly acute, staff continually attempted to maintain consumers' safety. Because of COVID-19, visitors were not permitted in the Unit. Therefore, the researcher could not observe nurses' interaction with consumers' families.

To conclude, Mental Health Nurses working in Unit 2 were able to care for consumers with respect and dignity while working in a busy environment. The recovery model is integrated into the Unit with the depiction of hope, recovery messages of confidence, strength and improved self-esteem as well as peer involvement to support consumers in the unit. This evidence suggested that nurses have positive attitudes towards recovery-oriented practice. There was no evidence of negative attitudes towards mental health consumers and nurses attempted to facilitate consumers' recovery using unit facilities and policies. This was a closed unit. Consumers were not allowed to go out without permission. However, the unit incorporated many activities such as cooking, informative sessions and sensory modulation for consumers' mindfulness and well-being. Staff were very aware of the importance of meeting the physical needs of consumers. Table 4 shows examples of interpretation of collected data from Unit 2.

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TABLE 3 Examples of interpretation of the collected data from Unit 1.

Unit	Environment	Interaction	Action	Description	Evaluation
1	Nurses' station	Nurse and multidisciplinary team	Doctor: who is your patient? We are going to see the consumer at 11 AM. How is he? Nurse: He is improving in his mental status and much more settled in the unit.	It was observed that there was a good interaction between nurses and other health care team member pertaining to the care or consumers.	Good communication among multidisciplinary team.
	Nurses' station door side	Nurse and consumer	Consumer: Knocked the nurses' station. Contact Nurse: Went beside him pleasantly, asked calling her name! How can I help you mate? Consumer: I need some toiletries! Contact Nurse: Asked him to accompany her to the storeroom and handed over the toiletries to the consumer. Consumer: Thank you "calling nurse's name" Nurse: You are welcome, call me whenever you need help.	It was observed that nurse was keen to meet her consumer's needs and she was friendly and showed empathy, respect and caring attitudes.	Good communication between nurse and consumer. Showed respect, dignity, caring, empathy and positive attitudes towards mental illness.
	Lounge	Nurse and consumer	Consumer: I have been admitted here for months. They are planning to transfer me to AMHRU. Contact Nurse: Conducted mental status while communication to him and explained "Doctor informed me about it, AMHRU is a rehabilitation unit, it is designed to promote recovery of people with mental illness. There you will have more freedom and it's not a locked ward. It will help you with your recovery". Consumer: "thanks"	It was observed that nurse was a good listener and knowledgeable about mental illness and recovery. There was no evidence of fear or frustration. Nurse tried to facilitate the real choices within her scope of practice.	Good communication between nurse and consumer. Showed respect, dignity, caring and empathy, facilitation of real choices and positive recovery attitudes. There was no fear, frustration or anxiety showed empathy and caring attitudes as well as knowledgeable about mental illness.
	Intensive Care Area Nurses' station	Between Nurses	Nurse 1: We will give some PRN for consumer. He is floridly responding and highly distressed. Nurse 2: ok, 1 min let me finish this recording of the visual observation. Nurse 1: Waited patiently. Nurse 2: Joint to double-check medication for the consumer.	It was observed that nurse dispensed the medication together following hospital medication policy. Contact nurse pleasantly spoke with the consumer and administered the medication.	Nurses were knowledgeable about mental illness. There was no fear, anxiety and showed respect as well as facilitated real choices for the consumers. Followed hospital policies. There was no force or coercion while administering medication. Observed good communication between nurses and consumers.
	Nurses' station	Consumer's physical observation chart and bowel chart.	Not recorded the physical observation and bowel chart for the consumer on clozapine consented for the study.	It was observed that there was some lack in maintaining physical observation of people with mental illness.	Lack of knowledge in maintaining the physical care of people with mental illness.

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TABLE 4 Examples of interpretation of the collected data from Unit 2.

Unit	Environment	Interaction	Action	Description	Evaluation
2	Courtyard Medication room	Nurse and researcher Senior Nurse and consumer Senior Nurse and Junior Nurse	Before the conversion with consumer Young Nurse: going to meet her allocated consumer. Researcher: walked with the nurse Nurse: I haven' seen him before, probably came yesterday. I was off for few days. Researcher: observed her face and nurse action and listened to her carefully. After the conversation with consumer Young nurse: Spoken about the consumer pleasantly and confidently Researcher: observed her face and nurse action and listened to her carefully. While administering medication senior nurse dispensed medication following the rights before administering. Senior Nurse: dispensed medication from the shelf and checked with another Registered Nurse. Senior nurse: "Hello" "what's your name and date of birth" Consumer: Answered her question. Senior Nurse: "These are your morning medication, olanzapine and diazepam, they will help you to reduce agitation and anxiety as well as with your thought". Senior Nurse: Provide water and observed the consumer was swallowing medicine. Junior nurse: Where is this medication kept? Senior Nurse: showed place and smiled. Junior Nurse: Is it half of the medication? Senior Nurse: Yes	It was observed that nurse was anxious in appearance, bit pressured in speech, before talking to her consumer. However, it was also observed that after a while she won the confidence to talk to the consumer. Senior nurse was observed to be confident and knowledgeable about medication administration. Junior nurse was less confident about administering medication while he was able to clarify his doubts with senior nurse.	An element of anxiety was observed on the face of the young nurse before conversing with unfamiliar consumer. Both nurses followed medication administration standard. There were good communications between staffs and consumers. Nurses were caring and supportive of each other.
	Lounge	Nurse and consumer	Senior Nurse: Confidently approached allocated consumer. Politely called him by his name asked to do a set of physical observations. Consumer: Was watching his laptop. Told, her "will do it bit later as I am working on my laptop". Senior Nurse: after five minutes Consumer: Yes After 5 minutes Senior Nurse: Are you ready? Consumer: Looked at her showed his arm Senior nurse: spoke to him while doing vital signs. After taking the observation nurse explained the reading to him and said, "Thank you" and returned to the nurses' station and documented the observation in that consumers record.	It was observed that senior staff was confident, patient, and respectful for the consumer. She was aware about the importance of documentation of physical observation and vital sign.	Good communication showed empathy respect, no force or coercion, knowledgeable about physical and mental health of the consumer.

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TABLE 4 (Continued)

Unit	Environment	Interaction	Action	Description	Evaluation
	Courtyard	Nurse and consumer	Contact nurse: spoke to her consumer regarding how to facilitate recovery in acute in-patient unit. Consumer: explained in detail what are her expectation while her stay in acute inpatient unit. Contact Nurse: Listened to her carefully and handed over a form to write about consumer's view on how to facilitate recovery in acute inpatient unit. Consumer: wrote her view and handed over to nurse. Contact nurse: Received the form and said, "thank you and I will submit to my manager".	It was observed that nurse and the consumer had good rapport. Respectful and friendly with each other. Showed facilitation of real choices for the consumer and her recovery.	Positive attitudes towards consumer's recovery.
	Courtyard	Nurse and consumer	Contact Nurse: Hi! Addressed consumer by her name. Consumer: Hello…. Contact nurse: conducted a mental status examination while talking to her. Consumer: Answered pleasantly Contact Nurse: asked "you need to do lithium level today" Consumer: No dear "I had done that yesterday and no more blood test". Contact Nurse: showed. "Pathology slip" Consumer: "no… no I had done". Contact Nurse: no worries I will check again. Contact nurse went back to nurse's station and checked online. It was found that blood was done as consumer reported. Contact nurse: Returned to consumer and said sorry and informed that the blood test was done and said probably they had used another path slip. They smiled each other.	It was observed that nurse was knowledgeable about lithium therapy. However, accepted her mistake. Evidence of good rapport among them.	Good communication skill, maintained respect, dignity, no force or coercion, facilitated real choices and knowledgeable about physical and mental health of the consumer.
	Courtyard	Nurse and consumer	Contact nurse: spoke to allocated consumer Consumer: "When am I Going to CCU". Contact Nurse: Explained "You will be discharged to CCU by the end of this week. CCU is not like inpatient unit. You will be responsible for your activities. This will help you become more independent. You have improved a lot, but do not forget your medication, especially clozapine, like here they also will do your levels. You will be fine there".	It was observed that staff facilitating recovery through CCU given adequate explanation and observed supportive and caring.	Positive recovery attitudes towards the consumer. No evidence of stigmatic attitudes.

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Observations in unit 3

Observations were conducted for 1 h between 8:00 AM and 9:00 AM and between 3:00 PM and 4:00 PM. Staff were cooperative to participate in the study. However, only four consumers were interested in participation.

It was observed that the unit was busy with their routine daily practice. Observations were conducted while the staff administered medications. In the medication room, it was observed that nurses were knowledgeable and confident in administering the medications following hospital policies. At the same time, junior staff were able to assuage their doubts after clarifying with more senior staff. They maintained respect and dignity while communicating with each other.

Staff had good interactions with consumers and communicated with them with respect and in a friendly manner. They respected consumers' rights and there was no evidence of force or coercion while administering the medications. They provided consumer-focused care. The nurses were assertive when consumers did not follow hospital policy and regulations while maintaining respect for them. There was no evidence of anxiety and fear while interacting with consumers.

In terms of recovery, a nurse discussed the management plan for a consumer including the expectations regarding his recovery during transfer to the Community Care Unit (CCU), the importance of medication and clozapine titration. The consumer listened to the nurse carefully and verbalized his concern about going to the CCU. The nurse explained in detail about the role of the CCU to support the consumer's recovery. This communication helped the consumer to develop a positive self-esteem and a sign of hope on the face of the consumer was noted.

This Unit also followed the *primary nursing care model*. Therefore, interactions between the staff at the nurses' station were limited. However, there was some consumer-focused discussion between the nurse in charge and other staff. It was observed that a large poster focusing on hope is presented in the unit facilitating the recovery of consumers.

With regard to observing the physical care of consumers, one nurse explained the procedure before undertaking a blood test. However, it was observed that staff did not generally focus on the physical symptoms/concern of consumers. For example, one consumer complained of vomiting, staff were unable to address the physical needs of that person. In another instance, the nurse failed to document the bowel chart of a consumer who was taking clozapine. Clozapine bowel chart is a highly important observation tool. Clozapine is an anti-psychotic medication that could cause constipation, bowel obstruction, peritonitis and death. Therefore, appropriate documentation of the bowel chart is necessary. The unit maintained different forms to maintain consumers' safety such as fall risk assessment, substance withdrawal forms, sexual safety forms, substance use assessment form, neurological observation form, consumer engagement observation form. The treating team updated risk associated with each consumer regularly and the nurses facilitates the engagement observations according to the Crisis Risk Assessment and Management (CRAAM) plan. CRAAM can be low, medium and high. Consumers with low and medium observations are admitted in the LDU and high CRAAM consumers are admitted in the ICA of each unit.

In the afternoon, while observing, there was a code red which is a fire emergency. Nurses were aware of the fire emergency procedure. The nurse in charge was able to coordinate the code red procedure, with managerial staff involvement. Staff were able to maintain the safety and security of consumers with appropriate explanations and support. However, the researcher could not conduct observations in the intensive care area as it was too acute. Because of COVID-19, visitors were not permitted in the Unit. Therefore, the researcher could not observe nurses' interactions with consumers' families.

To conclude, Mental Health Nurses working in Unit 3 were able to care for consumers with respect and dignity while working in the busy environment. The recovery model is integrated into the Unit with the depiction of hope, recovery messages with confidence and improved self-esteem as well as peer involvement to support consumers in the unit. There was no evidence of negative attitudes towards mental health consumers and nurses attempted to facilitate consumers' recovery using inpatient unit facilities and policies. This was a closed unit. Consumers were not allowed to go out without permission. However, the unit incorporated many activities such as cooking, informative sessions and sensory modulation for consumers' mindful well-being. However, there were some deficiencies in the physical care of consumers. Table 5 shows examples of interpretation of collected data from Unit 3.

Data analysis

The recorded observations were analysed using interpretive descriptive analysis. This approach enables the researcher to understand clinical phenomena related to the aim of the research (Thorne et al., 2004). It is mainly used in small-scale qualitative investigations focusing on clinical practices, in which the researcher explores the subjective perceptions and interprets the description related to research questions (Thorne et al., 2004). Development of coherent, auditable, credible interpretive descriptions requires intellectual processes (Thorne et al., 2004). In this study, the nonparticipant data were recorded using a predeveloped observation record and interpreted and transcribed following interpretive descriptive analysis [See Appendices S1 and S2]. The observations in the

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TABLE 5 Examples of interpretation of the collected data from Unit 3.

Unit	Environment	Interaction	Action	Description	Evaluation
3	Medication room	Interaction between nurses	Senior nurse: Observed confidence while administering the medication. Junior nurse: "which olanzapine will be given tablet or wafer" and checked the medication Senior nurse: he prefers "olanzapine wafer" Junior nurse: Dispensed olanzapine wafer and the medication to consumer's room.	It was observed that there was good rapport and respect among nurse and able to share practical knowledge.	Knowledgeable and respectful with each other.
	Courtyard	Nurse and consumer	Nurse: How are you? identified consumer by her name. Spoke to her about her medication. Consumer: reported "I have vomited" and showed vomitus in the courtyard Nurse: Observed and handed over the medication and returned to medication room and concentrating on administering other medication.	It was observed that nurse did not give importance to the physical symptoms of the consumer and did not maintain a vital signs of the consumer and did not report to nurse in charge or doctor.	Lack of knowledge about the physical care of people with mental illness.
	Nurses' station	The researcher observed the physical observation and bowel chart of the consumer	Contact Nurse: showed physical observation chart to the researcher. Researcher: Looked at the charts	It was observed that clozapine bowel chart was not recorded in the bowel chart of the consumer consented to participate in the study.	Lack of knowledge about the importance of physical observation of consumers with mental illness.
	Nurses' station	Between nurses	Coordinating cod red Nurse in charge: allocated code red duties Explained to staff and wore uniform for fire emergency. Nurses: Dispersed and evacuated the consumers from the areas to a safety zone. Nurses: Stayed in the safety zone with consumers till obtaining a green signal from the emergency response team.	It was observed that nurse in charge coordinated the code red procedure. Maintained safety of all consumers and staff.	Knowledgeable about the local procedures. Good communication and maintained dignity respect and safety.

three units were converted into professional narratives. These narratives were reviewed by three reviewers individually. They used their extensive insider knowledge to understand the components needed to be assessed in clinical settings. Thereafter they discussed the findings and developed descriptions of the results.

SUMMARY OF THE RESULTS

An industrious atmosphere was observed in all units. The intensive care area and lower dependency units were the physical settings for the observation. Observations mainly focused on knowledge, communication between nurses and consumers, provision of care and facilitation of recovery-oriented practices.

It was observed that Mental Health Nurses were competent in providing care for people with mental illness. Generally, there was no fear, frustration or anxiety while caring for consumers. However, younger nurses appeared to experience an element of anxiety while talking to consumers. Nurses demonstrated recovery-oriented practice by maintaining dignity, respect and there was no evidence of coercion while giving care. Interactions between nurses and consumers were positive and focused on consumers' well-being. Nurses showed positive regard to personal recovery of people with mental illness. The Units were acutely hectic; with special nursing care, seclusion in intensive care areas and various paperwork and documentation to maintain the safety of consumers while caring for their physical and mental health. There was minimal interaction between nurses during the

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periods of observation. Nurses were able to facilitate the recovery of consumers and identify their actual choices. The family and carers of consumers were not permitted to visit during the periods of observation due to COVID-19-related restrictions in the acute inpatient psychiatric units. Therefore, nurses' interaction with the consumers' families could not be explored.

Importantly, it was observed that there was some deficiency in managing the physical needs of consumers and evidence of poor documentation of the physical observations of consumers. Overall, Mental Health Nurses observed in these three units demonstrated positive attitudes towards people with mental illness and recovery-oriented practices. However, they must develop more constructive practises towards the physical health care needs of consumers.

DISCUSSION

This non-participant observation was conducted to identify Mental Health Nurses' attitudes towards mental illness and recovery-oriented practices in acute inpatient psychiatric units. Attitudes towards mental illness were observed based on the dimension of the MICA questionnaire, including Mental Health Nurses' knowledge about mental illness, views towards mental illness, care of people with mental illness and ability to distinguish between physical and mental needs of the consumer. The results of the study show that Mental Health Nurses have positive attitudes towards mental illness. A survey conducted by Gras et al. (2015) regarding health care professionals' attitudes towards mental illness concluded similarly. A comparative study conducted by Happell et al. (2018) among European nursing students and Australian nursing students shows that Australian nursing students had more positive attitudes towards mental illness. Positive views and knowledge towards mental illness might be influenced by effective mental health education, nursing experience and sociocultural aspects of the Australian population. A previous study conducted on literacy and attitudes towards mental illness showed that Western populations have greater mental health literacy than Asian and African populations and that determined less stigmatic attitudes towards mental illness among the Western populations (Altweck et al., 2015).

Nevertheless, the results of this study showed that there was some deficiency in the provision of physical care to people with mental illness, although the perceptions towards physical care of people with mental illness were positive. Deficiency in meeting physical needs of consumers and poor documentation could show lack of knowledge regarding the care of consumers on clozapine or that physical care was not deemed important. Previous studies conducted on Mental Health Nurses' attitudes, knowledge and experiences regarding physical care of people with mental illness showed that there was a significant difference in Mental Health Nurses' perception towards the physical care of people with mental illness and its actual implementation (Dickens et al., 2019; Howard & Gamble, 2011). The identified deficiency in the provision of physical care in the acute inpatient unit might be associated with Mental Health Nurses' attitudes towards physical care, lack of knowledge, experience and poor teamwork to look after people with co-morbid physical health problems with their mental illness or it might be associated with diagnostic overshadowing. Diagnostic overshadowing occurs when health care professionals overlook co-morbid physical symptoms of a consumer as an attribute of their mental illness. Earlier studies related to the barriers regarding physical health care in mental health settings supported the above findings (Dickens et al., 2019; Happell et al., 2012). Co-morbid occurrence of physical ill health is quite common among people with mental illness. This leads to premature morbidity of the people diagnosed with mental illness (Australian Institute of Health and Welfare, 2020; Teesson et al., 2009). Nurses are trained to provide holistic care of people with mental illness. Therefore, it is crucial to address the physical health care needs of consumers with mental illness. Shefer et al. (2014) reported that diagnostic overshadowing can be ameliorated through effective interpersonal relationships and communication within the multidisciplinary team. Furthermore, ongoing and continuous training programs will be effective in developing skills, attitudes and knowledge to provide holistic care for the people with mental illness (Happell et al., 2013).

The observational results also show that young nurses were more anxious to provide care for consumers. A study conducted on factors influencing Mental Health Nurses' attitudes towards mental illness showed that years of mental health nursing experience contributed towards positive attitudes towards mental illness (Hsiao et al., 2015). This study's findings were in line with the current observational results.

Another aim of this non-participant observation study was to investigate Mental Health Nurses' attitudes towards recovery-oriented practice. Theoretically, recovery-oriented practice is focused to achieve personal recovery of people with mental illness. The focal point of such practices is interpersonal communication, ensuring choices and consumer participation with the treating team (Davidson et al., 2016; Waldemar et al., 2016). Recovery-oriented practices are integrated in all areas of mental health. However, there is paucity of research to understand demonstration of recovery-oriented practice in acute inpatient units (Waldemar et al., 2016, 2019). To our knowledge, this is the first non-participant observational study conducted in Australia to understand how Mental Health Nurses implement recovery-oriented practice in acute inpatient psychiatric units. The principles of recovery-oriented practices

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and dimensions of RAQ-7 questionnaire were used to guide the observational approach (Borkin et al., 2000; Davidson et al., 2016).

Mental Health Nurses maintained a recovery-oriented practice in the acute inpatient psychiatric units and maintained good interpersonal relationships through professional communication between staff and between staff and consumers. They showed dignity and respect while providing care for consumers. Previous research on the nurse–patient relationship in the acute inpatient environment is in line with the current findings (Cleary et al., 2012; Tauber-Gilmore et al., 2018). They could facilitate recovery within the limitations of acute inpatient psychiatric units. This is in consistent with the previous findings on recovery-oriented practices in acute inpatient units (Lim et al., 2019, 2020). Previous studies focusing on recovery-oriented practices in acute inpatient units also revealed that mental health professionals could facilitate recovery-oriented practices in inpatient settings, through equal collaboration between consumers and health care providers as well as focusing on consumers' personal preferences (Lim et al., 2019, 2020; Waldemar et al., 2019).

Previous research comparing mental health professionals' recovery attitudes found that Mental Health Nurses generally have more positive recovery attitudes than psychiatrists and psychologists (Luigi et al., 2020). Mental Health Nurses' positive attitudes towards mental illness likely contributed towards recovery-oriented practices in these acute inpatient units, with positive attitudes having been found to enhance the recovery of people with mental illness (Slade et al., 2014).

Evidence of positive recovery-oriented practice might be associated with the presence of the young nursing generation who have completed mental health training with the emphasis of recovery-oriented practices. The relationship between years of experience and recovery attitudes of Mental Health Nurses has established that the younger nursing generation has more positive attitudes towards recovery (Cleary & Dowling, 2009). Previous study on recovery knowledge and attitudes of Mental Health Nurses showed that nurses were not completely oriented to facilitate recovery-oriented practice in acute inpatient units (McKenna et al., 2014). Australian nurses' positive attitudes towards recovery and recovery-oriented practices might reflect the steady integration of recovery-oriented practices in mental health since 2013 as well as the provision of mental health nursing training focused on the recovery model of care (Commonwealth of Australia, 2013; Foster et al., 2019). The nonlinearity principle of recovery, the importance of consumer involvement and communication are now commonly incorporated into training approaches (Happell et al., 2019; Jørgensen et al., 2022).

In this study, nurses could not completely support the autonomy of consumers due to closed unit policies and the predominance of the biomedical model in the acute inpatient units. Previous studies conducted about recovery-oriented practice in inpatient settings showed that organizational policies and the biomedical model interfere with recovery-oriented practices even when health care professionals have a positive attitude towards recovery and recovery-oriented practices (Sreeram et al., 2021; Zuaboni et al., 2017).

The observation also showed that nurses were working industriously to meet the needs of all allocated consumers and to complete other administrative work of the units. The workload of nurses was observed to be significantly high. This might lead to staff burnout and absenteeism in acute inpatient units. A systematic review conducted on prevalence and determinants of Mental Health Nurses' burnout showed that workload and role conflict had significant effects on staff turnover and burnout in the mental health settings (O'Connor et al., 2018). Insufficient staffing affects the provision of quality care (Baker et al., 2019; Boden et al., 2019).

Though Mental Health Nurses have positive attitudes towards recovery and recovery-oriented practice organizational support, work culture and appropriate guidelines are key determining factors to the continuance or maintenance of such practices (Cleary et al., 2013; Jackson-Blott et al., 2019; Le Boutillier et al., 2015; Lim et al., 2020; Waldemar et al., 2019).

Strengths and limitations

To our knowledge, this was the first non-participant observation study to understand Mental Health Nurses' attitudes towards mental illness and recovery-oriented practice in acute inpatient psychiatric units. The observation was focused specifically on Mental Health Nurses' attitudes towards mental illness and recovery-oriented practices, which helped the researchers to explore Mental Health Nurses' behavioural outputs regarding those dimensions of care in a real setting. Observations were conducted for a short duration. Therefore, they did not affect Mental Health Nurses' daily routines and practices in the acute inpatient units.

Non-participant observation was an effective method to understand Mental Health Nurses' practices. However, there are limitations associated with this study. The observations were conducted for a limited period. Therefore, selectivity and reactivity could be a major issue of the study (Liu & Maitlis, 2010). For, example in this study the researchers could not conduct the observations in two Intensive Care Units, and COVID-19-related restrictions, nurses' interactions with families also could not be elicited. As it was a short observation, the participants were highly conscious about their surroundings, and this could have changed their regular practice. Only three units agreed to participate in the study. Therefore, generalization of the results could not be possible, comparing these results with findings from other organizations.

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Another limitation of this study is the Hawthorn effect. As it was an overt observation, participants knew about the research process. Therefore, it could have affected their behaviours positively. To limit this bias of the study, a research assistant conducted the observations in the unit where the researcher was known to the participants. Another limitation of the study could be the objectivity of the observer (Liu & Maitlis, 2010). However, to reduce the objectivity of the observation, the researcher and research assistant conferred following the observations to compare their conclusion and reach agreement.

Implications for practice

These findings revealed that Mental Health Nurses generally have positive attitudes towards mental illness. The results could help the nurses to develop job satisfaction and to continue the provision of quality care for consumers. Mental Health Nurses could maintain positive interpersonal relationships with consumers using principles of mental health nursing such as empathy, provision of a supportive environment, maintaining dignity and respect and effective communication. However, there was some deficiency in the provision of physical care of people with mental illness. Education and training could address inadequate areas of care. Future research could focus on the effective preparation of Mental Health Nurses to provide physical care of people with mental illness. Acute inpatient units are a busy environment. Mental Health Nurses worked tirelessly across high- and low-intensity areas. The findings of this study also recommend a review of nurse–patient ratios, to enhance quality care in these demanding acute inpatient units. Mental Health Nurses were able to win the confidence of consumers through education and communication. These positive findings may prevent staff burnout and could motivate the younger nursing generation to choose mental health nursing as their future career.

In this study, Mental Health Nurses were able to implement recovery-oriented practices within the limitations of acute inpatient settings. There was no coercion or forceful administration of medication and nurses could facilitate consumers' choices and perspectives while providing care for them. However, the challenges identified during observations prevent them to facilitate recovery-oriented practices effectively in acute inpatient units. Therefore, constant support from management, appropriate policies and guidelines and recovery-oriented work culture are necessary to maintain recovery-oriented practices in acute inpatient units.

CONCLUSION

Overall, the study results are promising. The observational study identified that Mental Health Nurses have positive attitudes towards mental illness and recovery-oriented practices in acute inpatient settings. However, the physical care of people with mental illness was less satisfactory. Future research should be focused to improve Mental Health Nurses attitudes and understanding towards the physical care of people with mental illness. Education and training would be an effective weapon to enhance awareness, competence and confidence among the nurses. Nevertheless, Mental Health Nurses could facilitate recovery-oriented practice in a busy working environment like acute inpatient psychiatric units. The difficulties identified in the units however could impede such practices in the longer term. Therefore, future research should be focused on the concept of recovery-oriented practices in inpatient settings as well as developing effective strategies to rectify the challenges associated with the processes of implementing recovery-oriented practices in the acute inpatient units.

AUTHOR CONTRIBUTIONS

All authors were involved in planning and implementing this study. AS was responsible for coordination, data generation, analysing the data and drafting the manuscript. WMC and LT provided guidance on the data generation, data analysis, interpretation of the data and drafting of the manuscript. All Authors confirm that they meet the authorship criteria and agree with the content of the manuscript. AS was supported by an Australian Government Research Training Program (RTP) Fee-Offset Scholarship through Federation University Australia.

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CONFLICT OF INTEREST STATEMENT

The authors report no conflict of interest.

DATA AVAILABILITY STATEMENT

Research data are not shared owing to confidentiality offered to participants.

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