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Publication Details

Kriticos, J. (2023). Caring for Individuals Who Have used Methamphetamine: A Study Exploring the Experiences of West Australian Nurses Working in An Authorised Mental Health Institute [Master of Philosophy (School of Health Science and Physiotherapy)]. The University of Notre Dame Australia. <https://researchonline.nd.edu.au/theses/396>

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CARING FOR INDIVIDUALS WHO HAVE USED METHAMPHETAMINE: A STUDY
EXPLORING THE EXPERIENCES OF WEST AUSTRALIAN NURSES WORKING IN
AN AUTHORIZED MENTAL HEALTH UNIT

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(B. Nursing)

Submitted in fulfilment of requirements for the Master of Philosophy (Health Science)



The University of Notre Dame Australia
School of Health Science and Physiotherapy
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2023

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Acknowledgements

The completion of this thesis would not have been possible without the support provided by my supervisors. Their expertise guided me throughout this process, and I would like to thank them for all the many qualities they brought to this study. In particular, I would like to thank Professor Jim Codde for applying his extensive research experience to my development as a novice researcher, Doctor Greg Gordon for sharing his invaluable industry knowledge and expertise, and Doctor Amanda Timler for her qualitative research expertise, patience, commitment, and kindness. The research team's support is greatly appreciated.

I would also like to thank my family for their support throughout this process; my sister Olivia, for inspiring me to complete the degree, my father Del, for the interest he showed in my work, and my mother Florence, who has always encouraged and supported me.

Lastly, I would like to thank my wife Halszka. Your emotional and intellectual support mean the world to me. We share this achievement, and I couldn't have done this without you.

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Abbreviations and Acronyms

ACEM – Australian College of Emergency Medicine

ACIC – Australian Criminal Intelligence Commission

AIHW – Australian Institute of Health and Welfare

AMHU – Authorised Mental Health Unit

AOD – Alcohol and Other Drugs

AOD-CL – Alcohol and Other Drug Consultation Liaison

APRAH – Australian Health Practitioner Regulation Agency

ATS – Amphetamine Type Stimulant

CBT – Cognitive Behavioral Therapy

CL – Consultation Liaison

DASSA – Drug and Alcohol Services South Australia

ED – Emergency Department

EN – Enrolled nurse

GOWAMHC – Government of Western Australia Mental Health Commission

HREC - Human Research Ethics Committee

ICU – Intensive Care Unit

IPA – Interpretive Phenomenological Analysis

IM - Intramuscular

IV – Intravenous

IWUM – Individual(s) Who Uses(s) MA

JCH – Joondalup Health Campus

MA - Methamphetamine

MDMA – Methylenedioxymethamphetamine

MHAU – Mental Health Assessment Unit

MHOA – Mental Health Observation Area

NMBA – Nursing and Midwifery Board of Australia

NSW – New South Wales

PICU - Psychiatric Intensive Care Unit

PRN - pro re nata

QLD – Queensland

RN – Registered Nurse

SA – South Australia

UNODC – United Nations Office on Drugs and Crime

VIC – Victoria

WA – Western Australia

WADOH – West Australian Department of Health

Definitions

Mental health organisations

Authorized Mental Health Unit (AMHU)– is a specialized psychiatric treatment facility authorized by the Office of the Chief Psychiatrist to provide involuntary treatment - specific to Western Australia (WA; *Mental Health Act 2014*). These units are standalone psychiatric hospitals or mental health units in tertiary hospitals and provide voluntary psychiatric treatment. They provide an average admission of two weeks, but admissions can last several months or even years (Government of Western Australia Mental Health Commission, 2015)

Mental Health Observation Area (MHOA) – are specialized mental health services integrated either within Australian Emergency Departments or as standalone units in tertiary hospitals. They differ from an AMHU as staff focus on assessment and offer short stay admissions (under 72 hours) with intensive intervention for those experiencing mental ill health. MHOA are the first mental health assessment point in WA tertiary hospitals, where staff can refer patients who require further care to psychiatric inpatient services, such as an AMHU (Government of Western Australia Mental Health Commission, 2015; Joondalup Health Campus, 2018; Lyell McEwin Hospital, 2018).

Psychiatric Hospital – a place where individuals who have been diagnosed with a mental illness stay and receive specialised psychiatric treatment (Cambridge Dictionary, 2020).

Nursing Professionals

Enrolled Nurse – is an associate who provides nursing care under the supervision of a registered nurse. The minimum qualification is a Nursing and Midwifery Board Australia approved Diploma of Nursing (Australian Nursing and Midwifery Accreditation Council, 2017).

Registered Nurse – is an individual who has completed a Bachelor of Science (Nursing) or a Bachelor of Nursing and are registered under the Health Practitioner Regulation National Law in Australia. A registered nurse provides direct patient care, health promotion, and delegation of care related tasks to enrolled nurses and allied healthcare workers (Australian Nursing and Midwifery Accreditation Council, 2019).

Alcohol and other Drugs (AOD) Nurse – is a registered nurse specialised in the care and support of individuals experiencing substance abuse (Searby et al., 2022).

Psychostimulants

Amphetamine type stimulants –describes amphetamine like stimulants (aminorex, methcathinone, amphetamine, MA), MA type amphetamine analogues (MDA, MDMA, MDEA, MBDB) and licit stimulants (amfepramone, ephedrine, methylphenidate, fenethylamine, fenfluramine, pemoline, pseudoephedrine, phenmetrazine) (World Health Organization, 1996).

Ice – A local street name used for the crystallized, highly pure, and potent form of MA (Gordon & de Jong, 2018; Usher et al., 2017).

MA – a potent neurostimulator classed as an amphetamine type stimulant and comes in many different forms including powder, base, and crystal (Harada et al., 2018; Parliament of Australia, 2017).

Abstract

Background: Methamphetamine (MA) use in Australia has stabilized over the last 22 years, however changing routes of administration and increased purity of the drug has led to greater rates of physical dependency and higher rates of cardiovascular, neurological, and mental health complications. Challenges managing MA related presentations have been reported in Australian Emergency Departments (ED's), with limited research considering nurses' experience treating individual(s) who use MA (IWUM) and require prolonged mental health care. **Purpose:** The aim of this study was to understand nurses' experiences who care for IWUM in a West Australian hospital's inpatient mental health service. **Methods:** Interpretive phenomenological analysis was the chosen methodology for this study. Purposive sampling and one-on-one interviews were conducted with 10 nurses to explore their experiences providing mental health care for IWUM. **Results:** Three superordinate themes emerged to describe the nurses' experiences of caring for IWUM across different inpatient mental health services. These included; "*Hit by the Storm*" [presentations in Mental Health Observation Area (MHOA/ED)] "*Working in the Rain*" [Authorized Mental Health Unit (AMHU)], and "*After the Storm*" (discharge and community support services). The nurses highlighted the most acute phase of care was the initial presentation to ED, as IWUM often arrived intoxicated by the drug. The risk management strategies used by the nurses interviewed to manage aggressive behaviour in ED were notably Intravenous (IV) sedation, restraint, and security. Most IWUM who recovered quickly and showed signs of compliance were either discharged directly from ED or monitored in MHOA then discharged within 72 hours. A small proportion of IWUM who experienced drug induced psychotic symptoms were admitted to AMHU, where many nurses felt they had less access to medical resources, relied on their colleagues, security, and the Alcohol and Other Drug (AOD) community liaison team for support to safely manage these patients. Training to provide specialized care for IWUM, discharge planning and community follow up were areas viewed as inadequate or needing improvement. The high rate of continued MA use and representations also raised stigma among nurses caring for IWUM. **Conclusion:** Nurses associated the highest levels of acuity with their experiences caring for patients intoxicated by MA in ED/MHOA and reporting a perceived reduction of acuity when working with the small cohort of IWUM who were admitted to the AMHU. Nurses acknowledged overcoming stigmatising behaviours, required specialised MA training and education, and valued the support received from AOD nurses when caring for IWUM.

Chapter 1: Introduction

MA is a potent neuro-stimulator classified as an amphetamine type stimulant (ATS), similar to other illicit drugs such as amphetamine, cocaine and methylenedioxymethamphetamine (MDMA) ((Harada et al., 2018). MA causes the central nervous system to speed up, increasing an individual's heart rate and blood pressure, while also affecting the storage, release, and production of neurotransmitters including noradrenaline, dopamine, and serotonin (Degenhardt et al., 2017). Ingesting MA alters the body's homeostasis, often causing long lasting adverse effects (Redona et al., 2019). In comparison to other drugs such as cocaine, MA metabolises at a slower rate, increasing an individual's risk of developing serious cardiac, neurological, and psychiatric illness's (McKetin, Degenhardt, et al., 2018). The adverse physical and psychological effects associated with taking MA continue to place significant demands on medical services (Isoardi et al., 2019).

In 2022, the United Nations Office on Drugs and Crime [UNODC] (2022) estimated 34 million individuals globally had used an ATS such as prescription stimulants, MA, or amphetamine. South East Asian crime organisations have been able to access MA's precursor chemicals without the regulations imposed in Australia, and have increasingly been able to use these unregulated substances to make MA (UNODC, 2023). This has led to increased accessibility in many locations such as North America, parts of Europe, Southeast Asia, New Zealand, and Australia, resulting in 375 tons of MA being seized by international law enforcement agencies in 2020 (UNODC, 2022). Since 2009, the purity and potency of MA in various forms such as powder, base, and crystalline in Australia has increased, with a subsequent rise in adverse physical and psychological effects (Parliament of Australia, 2017). In Western Australia (WA), the crystalline form of MA (commonly referred to as "ice" due to its translucent and colourless appearance) (Parke, 2021) contains the highest purity (average 70-80%; (Parliament of Australia, 2017) allowing users to vaporize and inhale the drug (McKetin, Degenhardt, et al., 2018). Ice has emerged as the most problematic ATS in Australia due to its high risk of addiction and associated harms (Redona et al., 2019). In some instances, this drug causes catastrophic consequences for the consumer, their families and care providers (Cleary et al., 2017; Gordon et al., 2021; McCutcheon et al., 2019).

Health care services such as Emergency Departments (EDs) and psychiatric hospitals are highly utilized among IWUM (McKetin et al., 2018). In particular, studies conducted within Australian ED's have highlighted the complexities associated with treating adverse

physical (Redona et al., 2019) and psychological effects of MA (Usher et al., 2017), as well as the increase in mortality due to cardiac and neurological complications (Isoardi et al., 2019). The psychiatric symptoms associated with MA such as agitation, paranoia, insomnia, and aggression cause significant communication and behavioural management issues, making it difficult for staff to provide safe and effective care (Usher et al., 2017). Unadkat et al. (2019) found 65.7% of IWUM in ED settings were aggressive to staff and 50% were aggressive to other patients, resulting in a large proportion requiring physical (69%) and mechanical (61.5%) restraints while receiving treatment. Interviews with nine ED staff working in these high priority environments highlighted the complexity in providing care as many felt unsafe (Cleary et al., 2017).

Previous research examining the implications of MA use in Australian hospitals has predominately focused on the impact of the drug in ED (Cleary et al., 2017; Usher et al., 2017). ED is the first port of call for IWUM requiring medical treatment (Jones et al., 2019) with the estimated ED presentations in 2013 reported between 29,700-to -151,800 (McKetin et al., 2018). However, within the ED, medical assessments are brief due to constraints on resources, and patients are often discharged without receiving appropriate treatment of comorbid mental illness (Cleary et al., 2017; Usher et al., 2017). Although patients are typically referred to alcohol and other drug (AOD) consultation liaison (CL) services or specialist AOD staff in ED, they are often discharged before being assessed by an AOD clinician (Gerdtz et al., 2020). AOD CL services can help manage withdrawal and offer relapse prevention interventions (Reeve et al., 2016), however acutely unwell IWUM require further hospital-based mental health care to manage their persistent psychological symptoms such as psychosis, depression, anxiety, and suicidal ideation (Gerdtz et al., 2020; Isoardi et al., 2019). Sibanda et al. (2019) highlighted that mental health trained nurses play a significant role when providing care among patients who have used MA.

In Australia, previous research has linked the mental health complications affiliated with MA use with an increased demand for public inpatient mental health services, known in WA as Authorized Mental Health Units ((West Australian Department of Health [WADOH], 2017, McKenna et al., 2017; McKetin, Degenhardt, et al., 2018; 2018). Admission into these specialized units can occur; (1) when consumers voluntarily seek mental health care, including drug users with comorbid mental illnesses, or (2) patients who have been referred for assessment by a consultant psychiatrist, who may subsequently provide involuntary treatment under the Mental Health Act (*Mental Health Act 2014*, WA). Admission to an

AMHU provides a unique opportunity for IWUM to receive intensive psychiatric interventions provided by staff specialized in mental health care. The average length of admission in this environment is approximately two weeks, resulting in nursing staff having prolonged exposure and experiences providing care to IWUM. However, the experiences of nurses working in this environment have not yet been explored.

1.1- Purpose

Nurses working in AMHUs in WA regularly care for IWUM who suffer co-morbid psychiatric symptoms. Some Australian researchers have recognised the importance of mental health trained nurses and their unique skills when managing patients affected by MA in ED (Cleary et al., 2017; Keltner & Steele, 2019; Kuivalainen et al., 2017). However, understanding how nurse's provide care for a similar patient cohort in an AMHU setting has not yet been explored. Therefore, the aim of this study was to gain an understanding of nurse's perceptions of the care they provide to IWUM in an AMHU. This was achieved using a qualitative approach to allow nurses to describe the care provided through inpatient psychiatric services in a hospital in WA.

1.2- Significance

IWUM who present to a hospital are often discharged without receiving adequate mental health treatment of underlying psychiatric disorders such as depression, anxiety, and post-traumatic stress disorder (Cleary et al., 2017; Stuart et al., 2020). Admission to an AMHU is a rare outcome among IWUM, however this environment represents a unique opportunity to explore the delivery of intensive psychiatric interventions from the perspective of the nurses. Nurses who work in AMHUs spend a significant amount of time observing and supporting patients, placing them in a unique position to provide meaningful and insightful evidence on the psychiatric treatment provided to patients who use the drug.

MA use may be related to self-medicating, which often exasperates symptoms of mental illness (Arunogiri et al., 2020). Therefore, IWUM and suffer a co-morbid psychiatric disorder have a worse prognosis (Sibanda et al., 2019). Providing nurses with an opportunity to share their experiences working with IWUM in this environment will facilitate enhanced

understanding of effective treatment strategies and supports that may improve outcomes for both the nursing staff and the patients they care for.

Qualitative interviews allow nurses to reflect on their practice and come to new realisations they may not have otherwise reached (Pitman et al., 2018). Moreover, interviews can facilitate an emotive response assisting participants to recognise any stigmatising attitudes and beliefs they may hold (Deen et al., 2021). For example, Lovi and Barr (2009) interviewed nurses who cared for patients with substance use disorders and found these nurses felt compelled to advocate for their patients to be treated with dignity and respect, which is consistent with what nurses shared in their interviews.

1.3- Primary Research Question

- *What are the lived experiences of nurses who have recently/regularly provided care for IWUM in an AMHU setting?*

1.4- Sub Research Questions

- *Do nurses who work in an AMHU perceive any helpful or unhelpful strategies or supports when caring for IWUM?*
- *Do nurses who work in an AMHU perceive any unique aspects of the care they provide to IWUM?*

Chapter 2: Literature Review

2.1- Introduction

The following literature review describes MA use and associated harms in the Australian context. Preference has been given to recently published Australian peer reviewed journal articles. However, in some cases, older citations and grey literature are used to explore the social and historical context in which the research questions are situated. Several international sources have been cited, allowing the reader to understand how Australia is situated in the global phenomenon of MA use. All sources have been synthesised to present a summary of previous researcher's findings and identify gaps in the current knowledge that align with the study's research questions.

2.2- MA use in Australia

Beginning in 2006, a high volume of Australian media began reporting on a MA epidemic (Fife-Yeomans et al., 2006) and gave negative attention to MA use as they focused on violent crimes, impact on emergency services and front-line health care workers, and the increasing availability/consumption of the drug (Rawstorne et al., 2020). Despite the media narrative, MA use has steadily decreased and stabilized within Australia since its peak in 2001 (Gordon & de Jong, 2018) and as early as 2015, Australia's academic community began contesting the commonly propagated and sensationalized idea of a MA "epidemic" (Usher et al., 2015). According to Jones et al. (2020), the media's portrayal of MA use has led to increasing stigma towards IWUM among healthcare staff responsible for their care. Consequently, for those suffering with MA addiction, stigma has been identified as a major barrier to accessing treatment (Clifford et al., 2023) even though at a national level, MA related harms are increasing (Degenhardt et al., 2017).

Australia has one of the highest rates of per capita of MA consumption in the world (UNODC, 2022). In 2019, WA had the highest rates of consumption in the country (Australian Criminal Intelligence Commission [ACIC] (2019). Recent waste water analysis suggests South Australia (SA) has now overtaken WA to have higher MA consumption (ACIC, 2022). The National Drug Strategy Household Survey (2019) showed 1.2 million (5.8%) Australians had used MA in their lifetime, with males using the drug more than females. The median age of first use in Australia is 20 years and the median age of a recent user is 32 years old (Australian Institute of Health and Welfare [AIHW] 2020). On average,

50% of users prefer to use MA's most potent form – ice, with 36% of these users experiencing high psychological distress, and 31% of users receiving a diagnosis or treatment for a mental illness (AIHW, 2020). The high variability in consumption patterns among IWUM suggest 32% consume the drug weekly or more and 37% use the drug once or twice per year (AIHW, 2020). Despite the decrease in the number of users (eg. 3.4% in 2001 and 1.3% in 2019; AIHW, 2020b), MA remains a national concern due to the high mortality and morbidity rates (Sibanda et al., 2019), risks to individual users (Evren & Bozkurt, 2018) and high number of regular and dependent users (Degenhardt et al., 2017). Thus, the psychological and physical effects associated with MA use continue to remain a serious issue and a source of many presentations at tertiary hospitals (Degenhardt et al., 2017).

2.3- Psychoactive Effects of MA

The psychoactive effects of MA are influenced by multiple factors such as the size of dose (Evren & Bozkurt, 2018), purity and route of administration (Degenhardt et al., 2017), frequency of use (Jones et al., 2018), and genetic predisposition to psychiatric illness (Gouzoulis-Mayfrank et al., 2017). Furthermore, MA use is distinguished from other drugs by its cyclical nature, with users experiencing extreme highs, but also extreme lows, often for weeks at a time (Gordon et al., 2021). This may be due to MA's uniquely potent action in the reward centres of the brain, which results in both positive and negative reinforcement (May et al., 2020).

MA intoxication is typically characterised by intense euphoria, heightened libido, dilated pupils, enhanced concentration, loss of appetite, and wakefulness lasting up to 12 hours (Redona et al., 2019). Following cessation of the drug, withdrawal symptoms can occur and be highly distressing (Evren & Bozkurt, 2018). The euphoria associated with initial intoxication is often followed by an unpleasant crash including cravings as the drug wears off, leading some users to repeatedly dose over 3-15 days (Jones et al., 2018). These binge episodes can result in the initial euphoria experienced being replaced by troubling signs and symptoms of MA's crash phase such as agitation, paranoia, delusions, thought disorder, and aggression. Some users experience withdrawal symptoms approximately 6-12 hours after the last dose, however the intensity and duration depends on the individual (Evren & Bozkurt, 2018). Subjective symptoms of withdrawal may include low mood, irritability, anxiety, and lethargy. Objective signs of withdrawal may include emotional lability, paranoia, agitation, insomnia/hypersomnia, hyperphagia, psychomotor retardation, and in rare cases, psychosis

(Drug and Alcohol Services South Australia [DASSA] 2017, Arunogiri et al., 2020; 2017; Evren & Bozkurt, 2018).

2.4- Routes of Administration

MA can be ingested, snorted, injected, or “smoked” (vaporised and inhaled; (Gordon & de Jong, 2018). The route of administration affects the speed of onset and the intoxicating effects which IWUM experience. For example, the high purity of ice allows users to smoke the drug and experience an immediate effect, as it circumvents metabolic processes, compared to ingesting or snorting the drug which takes longer to reach the bloodstream (Degenhardt et al., 2016). Consequently, the physical and psychological adverse effects associated with the high purity form (ice) are similar among users who smoke or inject the drug (Degenhardt et al., 2017; Parliament of Australia, 2017). In addition, smoking MA is popular in Australia as it is less stigmatized and more socially acceptable than injecting, but provides users with a similar powerful and euphoric effect (Cleary et al., 2017). Gordon and de Jong (2018) suggested the two key factors responsible for increasing harms relating to MA in Australia were how the drug was being administered and the increased purity.

2.5- Adverse Physiological effects of MA

Physiological complications of MA use are frequent among patients presenting to hospital. MA is associated with a range of acute (eg. aortic dissection, myocardial infarction and sudden cardiac death), and chronic cardiac conditions such as coronary arterial disease, pulmonary arterial hypertension, and cardiomyopathy (Abdullah et al., 2020). Ultimately, these cardiac conditions are known to increase risk of mortality and after acute intoxication, cardiac complications are the second leading cause of death among IWUM (Tobolski et al., 2022). The drug’s action on catecholamines (dopamine and noradrenaline) has shown to be cardiotoxic and cause hypertension, tachycardia, vasospasm, and vasoconstriction (Abdullah et al., 2020). In particular, tachycardia and hypertension are known to increase the heart’s demand for oxygen and can lead to cardiac ischemia (Baliga & Eagle, 2020). Although these outcomes are often a transient effect of intoxication, chronic exposure leads to persistent cardiotoxicity and greater risk of cerebrovascular accident. Darke et al. (2019) found a fivefold increase in ischemic or haemorrhagic stroke among dependent users. In addition, risk

factors for lethal toxicity are increased when large doses of the drug are injected or smoked, or when other intoxicating substances such as opiates or gamma-hydroxybutyrate are used simultaneously (Alqallaf, 2021; Corser et al., 2022; Harnett et al., 2022).

2.6- Adverse Psychiatric Effects

MA has been strongly associated with adverse psychiatric effects. Acute exposure to the drug acts as a potent dopamine receptor agonist. Agonist action at these receptors results in a short-term increase of dopamine release and transmission in the brain, which is associated with increased risk of psychosis (Hume et al., 2020). Between 15% and 40% of IWUM experience a psychotic episode at least once over their lifetime (Arunogiri et al., 2020; Lamyai et al., 2019). Furthermore, the rates of psychosis among IWUM in some inpatient settings has been as high as 60% (Arunogiri et al., 2020). Psychotic symptoms associated with use are more common among individuals who have been diagnosed with a primary psychotic disorder, but users without any history of mental illness can also experience psychotic episodes (Hume et al., 2020; Wearne & Cornish, 2018).

Extended exposure to MA causes “a downregulation of dopamine receptors and transporters in the brain” (Proebstl et al., 2019, p. 1). Chronic impaired dopamine function is associated with poor cognitive function, reduced capacity to make complex decisions, depression, and anxiety, increasing the risk of relapse as IWUM attempt to self-medicate (Everett et al., 2020; Proebstl et al., 2019). Darke et al. (2017) also found 18% of MA related deaths in Australia from 2009-2015 were from suicide. Several factors (notably extent of exposure to the drug) influence the brains capacity to regain homeostasis, and whilst there may be permanent changes, there may also be recovery and return to baseline cognitive function following several months of abstinence (Proebstl et al., 2019).

2.7- MA Treatment Efficacy

Considerable efforts for a viable pharmacological treatment for MA addiction have failed to identify adequate pharmacotherapies (Gordon & de Jong, 2018), resulting in high rates of relapse one year post residential rehabilitation ranging from 61% (Brecht & Herbeck, 2014) to 77% (McKetin, Kothe, et al., 2018). Several studies assert that cravings and withdrawals can be partially ameliorated by several drug therapies (Ahmadi et al., 2019; Lim

et al., 2020). Medications such as benzodiazepines and antipsychotics have shown some limited benefits managing signs and symptoms of withdrawal (DASSA, 2017), with three systematic reviews suggesting drug-based approaches do not have a persuasive or consistent effect on rates of abstinence for individuals suffering from MA use disorder (Acheson et al., 2023; Chan et al., 2019; Stuart et al., 2020). According to the systematic review conducted by Chan et al. (2019), antipsychotics have not been effective to help IWUM maintain abstinence. Clozapine has, however, been shown to significantly reduce rates of relapse in IWUM with a comorbid diagnosis of schizophrenia (Rafizadeh et al., 2023).

Studies examining non-pharmacological interventions such as Mindfulness-Based Therapy Programs (Maneesang et al., 2022) and contingency management (López et al., 2021) have shown some (although limited) benefit. Tatari et al. (2021) found that rates of abstinence were reduced among IWUM and lack effect stress coping strategies, recommending that AOD support services target effective coping strategies as a priority during supportive interventions. Although cognitive behavioral therapy (CBT) is often cited as a first line treatment option for substance abuse disorders, a review of the literature found that there is insufficient evidence to demonstrate that CBT interventions have a persuasive or consistent effect on rates of abstinence among IWUM (Harada et al., 2018).

2.8- Prevalence of MA Related ED Presentations

The impact of MA in Australian hospitals has led to focusing on service implications in EDs. Jones et al. (2018) conducted a systematic review and found that globally, MA related ED presentations had increased, accounting for 2.3% of all ED presentations. However, a literature review conducted by Redona et al. (2022) identified significant challenges estimating the true impact of MA in Australian ED's. Currently, local studies focus on prevalence in one or two states, limited numbers of hospital sites, and at times only assess the prevalence of ED presentations related to a single ATS. Additionally, ATS cause a wide range of physical and psychological complications, meaning some MA related presentations may be misreported. Polysubstance use further complicates the data, as many presentations are the result of ATS combined with alcohol or other illicit substances. Therefore, estimates rates of ATS related ED presentations in Australia range from 0.1-3.3% (Redona et al., 2022).

A report released by the West Australian Department of Health ([WADOH], 2018), detailed MA related presentations in four Perth tertiary hospitals from July-December 2017, finding that MA contributed to 1.3% of ED presentations. In WA, 40% of IWUM arrive at the ED via ambulance transport or private transport, 19% by police transport and 1% through airborne emergency service transport (WADOH, 2018). Patients in WA stay an average of 4.2 hours in EDs, as some recover quickly, while others are admitted for further assessment (Gerdtz et al., 2020; Isoardi et al., 2019). Unfortunately, 15% leave against medical advice or avoid being seen, which may reflect the small average reported length of stay. The three most common symptoms identified by triage presentations in WA were suicidal ideation (18%), drug use (17%), and inappropriate behaviour (17%; (WADOH, 2018). The most common diagnoses given to MA affected patients were amphetamine toxicity (15%), psychotic episode (11%), and drug induced mental disorder (11%; (WADOH, 2018). Thirteen percent of patients were admitted to ED for observation and assessment, and 17% of patients admitted to a ward or transferred to another hospital (WADOH, 2018). The top three reasons identified for admission were psychotic episode (15%), amphetamine poisoning (14%), and drug induced mental disorder (11%; (WADOH, 2018). Within WA metropolitan tertiary hospitals, 20% of initial MA related presentations return to ED within a six month period (WADOH, 2018).

More recently, WA has reported a significant decrease in MA related ED presentations from 5.9% of all presentations in 2018 to 3.3% in 2019, however prevalence remained higher than the national average of 2.8% (Australian College for Emergency Medicine, 2019). Although evidence from a single metropolitan tertiary hospital indicates that MA related presentation began increasing in 2020 (Marais et al., 2020), more recent statistics are not available.

2.9- Unique challenges caused by MA use in ED

MA affected patients who are treated in ED often experience paranoia, aggression, insomnia, agitation, suicidal ideation, and psychosis (Isoardi et al., 2019). Jones et al. (2018) found MA users were more likely to be agitated, homicidal, and aggressive compared to other drug related presentations in ED and were more likely to present with acute psychiatric symptoms requiring involuntary treatment. Police officers and paramedics who are often involved in transporting IWUM to Australian EDs, as well as the clinical staff responsible for

their care on arrival, have raised many concerns that MA use increases the risk of being assaulted at work (Isoardi et al., 2019; Jones et al., 2022). Additionally, safely managing patients presenting with acute MA intoxication often requires intensive resourcing such as restraints and Intravenous (IV) sedation (Humphreys et al., 2023). Further demand on personnel resources is evidenced by staff regularly requiring additional assistance from key personnel such as police, doctors, nurses, paramedics, and security guards (Cleary et al., 2017). For example, Humphreys et al. (2023) reported that 70% of MA intoxicated patients presenting to a QLD ED required parenteral sedation due to acute behavioural disturbance. Sibanda et al. (2019) suggest Australian ED clinicians find it difficult to manage the psychological pathology caused by MA use. ED nurses may lack the time and training to fully treat the complex psychiatric symptoms associated with the drug. Furthermore, they may not feel confident identifying appropriate interventions for different stages of intoxication and withdrawal (Jones et al., 2018).

Two qualitative studies have highlighted staff's experiences caring for IWUM within ED. Participants of both studies identified their safety as the main concern when treating these patients (Cleary et al., 2017; Usher et al., 2017). Usher et al. (2017) interviewed nine Australian ED clinicians including a social worker, a psychotherapist, paramedics, and nurses. Participants reported that in addition to personal safety, the safety of everyone in the environment was compromised by delayed access to security personnel, which slowed their ability to respond to escalating behaviours. Cleary et al. (2017) interviewed nine ED staff (eg. nurses, paramedics, a social worker, and a psychotherapist) and found empathy was the key aspect that contributed to improved outcomes and successful de-escalation of volatile situations caused by aggressive patients. Conversely, in some cases, ED staff also displayed unhelpful, stigmatizing attitudes while providing care which was associated with patients being discharged without receiving adequate treatment for their underlying psychiatric disorders (Cleary et al., 2017). Some ED clinicians also reported the mental health team declined referrals if patients were intoxicated or had not been medically cleared, which delayed access to necessary inpatient mental health services. Other clinicians reported that their workplace hospital had a psychiatric emergency unit attached to ED, which benefited patients by expediting referral to specialized mental health services (Cleary et al., 2017). Overall, advanced communication skills and targeted training were key areas for service improvements (Usher et al., 2017) as many valued communication, training, and security (Cleary et al., 2017).

Humphreys et al. (2023) conducted a retrospective study examining 287 ED presentations involving acute MA intoxication over four months in 2020 and found 71% of patients presented with symptoms of psychosis. However, Humphreys et al. (2023) highlights the transient nature and often quick resolution of MA induced psychotic symptoms, as 98% of these presentations were managed in ED without admission, typically in the short stay unit with an average length of stay of 15 hours. Approximately 83% of patients who presented with psychotic features experienced a complete resolution of symptoms prior to discharge, with Humphreys et al. (2023) suggesting that most patients will recover from MA induced psychosis within 24 hours. However, individuals with an underlying primary psychotic disorder such as schizophrenia were more likely to experience persistent psychotic symptoms requiring inpatient treatment, with 4% of the 205 patients who presented with psychotic symptoms being admitted for inpatient mental health care.

2.10- Australian Psychiatric Hospitals

MA use has resulted in significant service implications for Australia's psychiatric hospitals. In 2013, MA use accounted for approximately 28,400 and 80,900 additional psychiatric hospital admissions in Australia (Mcketin et al., 2018). Jones et al. (2018) found a 4%-to-58% range in psychiatric admission following MA related ED presentations, with many users requiring involuntary treatment under local legislation. Involuntary treatment was associated with increased severity of psychotic symptoms, suicide risk, lack of insight, and impaired capacity to make reasonable decisions (Canova Mosele et al., 2018). Some IWUM were admitted to an AHMU due to experiencing paranoia and psychosis, amplifying the risk of aggressive behaviours (Unadkat et al., 2019). McKenna et al. (2017) found inpatients at a public mental health service who had recently used MA were three times more likely to require restraint and seclusion compared to other patient cohorts.

Nurses working in psychiatric hospitals routinely manage self-directed harm, aggression, and violent behaviours. These nurses use unique risk management, communication, and de-escalation skills (Boyd, 2018; Kuivalainen et al., 2017) to help mitigate the risk of suicide, manage aggression, and reduce incidence of violence (Keltner & Steele, 2019). In addition, their knowledge of psychiatric diagnoses and psychotropic medications, involuntary treatment legislation, physical and chemical restraint, chemical dependence, and self-care help to mitigate challenging situations (Boyd, 2018). These skills

are met by their responsibilities of planning, implementing, and assessing intensive psychiatric interventions (Keltner & Steele, 2019; Nursing and Midwifery Board, 2013). Therefore, these nurses are uniquely qualified to comment on inpatient mental health care provided for IWUM.

Nurses who work in an AMHU are well equipped to understand the potentiating relationship between MA use and mental illness. The nurses' knowledge and skills help IWUM to develop alternative coping strategies (Sibanda et al., 2019). Some qualitative evidence has highlighted the importance of treating comorbid mental illness within an ED setting and shone a light on MA related ED presentations in Australia (Cleary et al., 2017; Usher et al., 2017). McKenna et al. (2017) also suggested that the challenges faced by clinicians in ED may be similar in psychiatric hospitals. Despite the significant issues affiliated with providing hospital-based care for those who have used MA, nurses experiences providing care for MA users in an AMHU in WA have yet to be explored.

2.11- Reflection

Completing a literature review caused me to challenge the preconceived notions I had about MA use in Australia. Like most of the broader public, I was under the impression that there was a "meth epidemic" in Australia. I was surprised to find that that the number of IWUM in Australia had actually decreased and stabilized. In retrospect, my experience working in an AMHU and being regularly exposed to patients who suffered adverse effects from MA biased my perspective on these issues. As I became aware of my own bias I allowed the literature to guide a newfound understanding of MA's impact in Australia.

There were times throughout the literature review process that I lost clarity on the purpose of my research project. However, during my exploration of the available literature as background to my study, I became confident that interest in exploring the experience of nurses caring for IWUM in an AMHU was largely unique and justified, particularly in the Australian context.

Chapter 3: Methodology and Methods

3.1- Research Design

Interpretive Phenomenological Analysis (IPA) utilises a phenomenological approach where researchers try to understand human experience. Descriptive phenomenology, originally developed by Edmond Husserl (1931), was designed to study the structure of experience by reflecting on conscious perceptions to describe an individual's personal view (Moustakas, 1994). Husserl (1931) recommended researchers "*Bracket*" their own preconceived ideas pertaining to the experience shared by others (Reiners, 2012). Interpretive phenomenology, developed later by Martin Heidegger (1962), builds on the reflective processes of descriptive phenomenology but diverges from Husserl's epistemology by recognizing the interpretation of experience as a fundamental ontological property of reality (Pietkiewicz & Smith, 2014; Smith et al., 2009). Therefore, interpretive phenomenology emphasises the dynamics of double hermeneutics, where the researcher shares their experience as they endeavour to make sense of others' (Smith & Shinebourne, 2012). Heidegger (1962) viewed the researcher as embedded in the inquiry and asserted that disregarding one's previous experience with a phenomenon was not possible. Therefore, IPA includes both the participants' and researcher's experiences, thoughts, feelings, and emotions (Pietkiewicz & Smith, 2014).

This pilot study adhered to Heidegger's (1962) interpretive phenomenology by recognizing the researcher's previous experience working as a nurse in acute mental health care environments as a factor which contributed to the interpretation of results. Therefore, bracketing was not attempted when analysing the results. This design was chosen for its ability to apply double hermeneutics, moving past description and interpreting the meaning of the participant's personal experiences (Smith et al., 2009; Smith & Shinebourne, 2012). Smith et al. (2009) seminal work in IPA (Alase, 2017) guided this study in terms of the individual participant's subjective reality of consciousness (Burrell & Morgan, 1979).

3.2- Setting

The setting for this study was the inpatient mental health services at Joondalup Health Campus (JHC) in Perth, WA. JHC is owned and operated by Ramsay Health Care. The site consists of 722 beds, treating both public and private patients under a public-private

partnership established in 1996 (North Metropolitan Health Service, 2021). JHC offers a range of specialist services, including a 47 bed AMHU. This unit consists of a 37-bed open ward and a 10-bed secure ward (Ramsay Health Care, 2023). The AMHU is physically attached to the main hospital and admits patients who are voluntarily seeking treatment. Additionally, the AMHU is authorized to provide involuntary psychiatric treatment in accordance with state legislation (Government of Western Australia Chief Psychiatrist, 2015). Hospital policy indicates that all patients who are admitted to the AMHU need to be triaged through ED and medically cleared prior to being accepted for psychiatric admission.

Many tertiary hospitals in WA have opened specialized MHOA, which are embedded within their ED's or act as standalone units (Fiona Stanley Hospital, 2020; Government of Western Australia, 2019; Joondalup Health Campus, 2018; Royal Perth Hospital, 2021; Sir Charles Gardner Hospital, 2020). The focus of these units is on mental health assessment, acting as a gateway between the community and psychiatric hospital admissions. MHOA services are designed to provide brief but intense supportive intervention and assessment, followed by discharge or admission to inpatient services with the capacity for longer admissions (such as an AMHU) within 72 hours (Government of Western Australia Mental Health Commission [GOWAMHC] 2015; Lyell McEwin Hospital, 2018).

In 2018, JHC opened their MHOA unit, which consists of 10 beds and acts as an extension to the main ED and Emergency Assessment Unit. Patients presenting to JHC who need mental health assessment are typically triaged through the ED into MHOA. Initial assessment includes a preliminary physical assessment by an ED Doctor, with complex physical symptoms assessed and managed by ED medical staff. If patients do not have significant physical complications and their presentation is predominantly driven by psychiatric symptoms and/or social issues, some are admitted into MHOA for a detailed mental health assessment.

Care of patients in MHOA is managed by nurses, allied health clinicians, and doctors who are part of the hospital's mental health service. Staff in MHOA work in conjunction with medical staff employed by the hospital's ED and the AOD CL team to provide assessment and acute care interventions. The protocols in MHOA suggest either discharge patients from MHOA with appropriate referrals to community services within 72 hours or admit patients to the appropriate hospital inpatient service.

Notably, AOD CL play an important role in the management of IWUM who present to the hospital. This team is led by an AOD clinical nurse specialist, and several clinical nurses who provide specialized AOD assessment and referral to community and residential AOD services. Furthermore, AOD CL assessments often guide inpatient management strategies and identify appropriate interventions.

It is important to note that the MHOA unit at JHC is not authorized to provide involuntary psychiatric treatment. In practice, however, patients are often detained in MHOA while they await examination by a psychiatrist. MHOA provides a preliminary psychiatric assessment, which is typically conducted by a psychiatric registrar under the supervision of a consultant psychiatrist. This initial assessment results in a decision to admit or discharge. In some instances, IWUM are help seeking and are admitted to the AMHU for voluntary treatment., however if it is suspected that a patient meets the criteria for involuntary treatment, medical staff refer them for examination by a consultant psychiatrist in the AMHU under form 1A and they are detained in MHOA on form 3A (*Mental Health Act 2014, WA*). In some circumstances, a lack of beds in the AMHU means that acutely unwell patients are detained and cared for in MHOA until a bed becomes available for admission.

3.3- Sampling methods

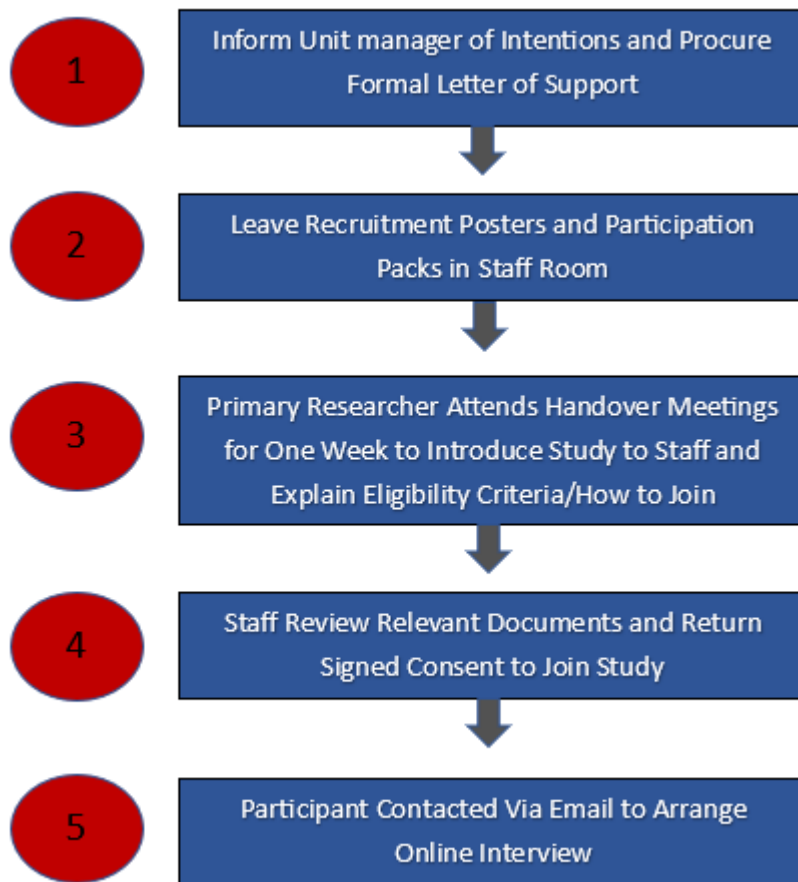
The primary researcher used their professional knowledge and experience working in the AMHU to guide the sampling process. Purposive sampling was used to identify nurses working in mental health with relevant shared experiences and a high potential for insightful contributions (Ames et al., 2019; Smith & Shinebourne, 2012). Homogeneity among participants helped to facilitate detailed learning about subject matter relevant to the central concept of the inquiry (nursing care while treating IWUM; (Suri, 2011). The number of participants remained flexible until data saturation was reached, the detail was enough for the study to be replicated, and no new information was being obtained (Fusch & Ness, 2015). Data saturation was guided by audit trails, reflection, and the interviews being transcribed directly after the interviews (all transcriptions were completed 3-weeks after the interviews). In accordance with IPA, (Smith et al., 2009) the number of participants did not exceed 25 to allow for an in-depth exploration of participants experiences (Alase, 2017).

The primary researcher works in the AMHU where the study was conducted, which allowed for ease in recruitment and organizational support. Information regarding the study

was provided to the unit manager prior to recruitment, who was able to provide a formal letter indicating his support of this study (Appendix A). A recruitment poster (Appendix B) outlining the details of the study was posted in the staff room at the AMHU and the primary researcher attended handover meetings for a period of 1-week to describe the study and facilitate recruitment. Nurses who were interested to take part were given “participation packs” containing a screening questionnaire (Appendix C), participant information sheet (Appendix D), and consent form (Appendix E). The researcher reviewed the “participation packs” and the eligible participants were contacted to be interviewed (Figure 1). The primary researcher’s role working in the AMHU where the study was conducted had the potential to result in coercion and/or dependant relationships. However, the primary researcher was not working in a leadership capacity and all participation was based on the formal consent of the participants, who agreed to be interviewed after reviewing detailed information about the study and were aware they could withdraw from the study at any time without experiencing any negative consequences.

Figure 1

Recruitment Process Utilized in the Study



3.4- Inclusion Criteria

Participants were included if they met all of the following criteria;

- Registered or enrolled nurses with a minimum of 1-year experience working in an AHMU
- Nurses who currently work in an AMHU in WA and consider themselves to have recently/regularly provided care for IWUM
- Nurses who work at least three days per week or 0.6 full time equivalent
- Nurses who meet all the above criteria were assessed as eligible to participate in the study

3.5- Exclusion Criteria

- Registered or enrolled nurses who work outside of mental health in a general/medical capacity

3.6- Ethical considerations

The University of Notre Dame Australia's Human Research Ethics Committee (Appendix F, HREC; approval reference 2021-79F) and JHCs' HREC and governance provided ethical approval for this study (Appendix G, Approval reference 2202W). Informed consent was obtained from each participant prior to their one-on-one interview. Participants were de-identified, preventing their data from being removed after the interview was complete and retaining confidentiality from hospital management to protect their employment. All participants were contacted by the primary researcher the day after their interview to make sure they did not experience any psychological distress from the interview. Electronic copies of the data have been stored on a secure, password protected server and will be retained for a period of seven years (State Records Office of Western Australia, 2013). The participants were provided with a summary of the results three months after the interviews were completed.

3.7- Participants

A total of 10 nurses were interviewed and had extensive clinical experience working in mental health (Table 2). A total of five Registered Nurses, four Clinical nurses, and one Enrolled nurse took part in an interview. Fifty percent of the participants had more than 10 years' experience, 40% had 5-10 years, and 10% had 3-5 years working in acute psychiatry. The nurses' ages ranged from 20 to 69 years. All participants were not currently nursing outside of mental health in a general/medical capacity and confirmed that they had recently and regularly provided care to IWUM.

Table 1*Participant demographics*

Participant pseudonym	Role	Experience Working in Mental Health (yrs)	Employed at JHC in Mental Health (yrs)	Shifts per week	Age Bracket
Mabel	CN	5-10 yrs	1-3 yrs	4	30-39
Kristina	RN	3-5 yrs	1-3 yrs	4	20-29
Rachel	EN	5-10 yrs	5-10 yrs	4	50-59
Steve	CN	> 10 yrs	5-10 yrs	5 or more	30-39
Geoff	CN	5-10 yrs	1-3 yrs	5 or more	40-49
Brenda	CN	> 10 yrs	> 10 yrs	4	40-49
Ashley	RN	> 10 yrs	3-5 yrs	5 or more	60-69
Isaac	RN	> 10 yrs	> 10 yrs	5 or more	50-59
Suzy	RN	5-10 yrs	5-10 yrs	4	20-29
Anna	RN	3-5 yrs	3-5 yrs	3	20-29

Note: CN = clinical nurse, RN = registered nurse, EN = enrolled nurse, yrs = years

3.8- Data collection

One-to-one semi-structured interviews were used as it aligns with IPA methodology (Smith et al. (2009)). An interview schedule was developed by the research team and consisted of 13 questions (Appendix H), designed to elicit thoughts and feelings that nurse's experienced when caring for patients who use MA. The questions were guided by the available literature, the expertise of the supervisory team, and piloted with one nurse prior to the main interviews commencing. These questions assisted in guiding the areas of discussion and to diverge in pursuit of emerging ideas (Chadwick et al., 2008). Questions were written to elicit responses that were detailed, spontaneous, and vivid (Kallio et al., 2016). As recommended by Turner (2010) and Whiting (2008), questions were designed as single faceted, clearly worded, participant orientated, open ended, and not leading. Questions were used only as a guide, with the interviews remaining flexible, allowing participants to direct the conversation to areas they felt were important parts of their experience.

Interviews were conducted using the zoom online platform. Prior to the interview, participants were asked to protect the confidentiality of the patients (IWUM) being discussed

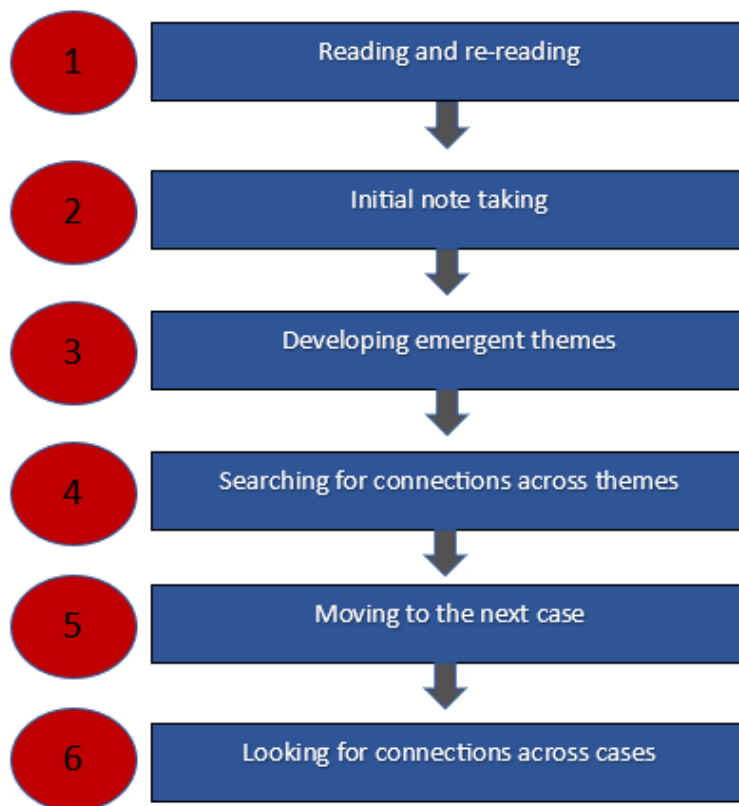
by refraining from using their names or any other identifiable details. Each interview lasted for approximately one hour, were audio-recorded using an electronic recording device and transcribed by the primary researcher. The primary researcher kept an audit trail to record any non-verbal cues and a reflective journal to record any personal thoughts or feelings that could contribute to hermeneutic dynamics (Smith et al., 2009). These methods allowed for data triangulation.

3.9- Data Analysis

The primary researcher transcribed the data using Descript transcription software. Electronic copies of the transcripts were exported into Microsoft Word and a second member of the research team audited the transcripts for accuracy. The primary researcher followed (Smith & Nizza, 2022) six data analysis steps (Figure 2): reading and re-reading, initial note taking, developing emergent themes, searching for connections across themes, moving to the next case, and looking for connections across cases.

Figure 2

Six Steps of Interpretive Phenomenological Data Analysis



Note. Adapted from (Smith & Nizza, 2022).

The transcripts were read and then re-read by the primary researcher, who made linguistic, descriptive, and contextual preliminary notes. The contextual components of the preliminary notations were used to apply double hermeneutics to understand participant's experiences, drawing upon the primary researcher's experiential and professional knowledge to make interpretive comments. Next, the preliminary notes were used to identify emergent themes and decrease the quantity of the data in the notes and transcripts. At this stage, themes were assessed for relevance and accurate representation of participant's experiences, with subpar themes being discarded. A second researcher assisted in this process, ensuring the most relevant data were retained in the emerging themes. Once the emergent themes were finalized for each participant, they were printed and spread out on a large table to get an overview of the emergent themes (Smith et al., 2009). This overview allowed the researcher to compare and cluster similar themes across all cases. A table was created to compile similar

themes that were grouped to form superordinate themes. Themes were named by the research team and adjusted as enhanced understanding of the data occurred. Once all transcripts were completed these documents were entered into the QRS NVivo software (version 12) for data management and storage. Conceptual illustrations and diagrams were used to illustrate the participants shared experiences. Smith et al. (2009) IPA data analysis process was followed by moving from the descriptive to the interpretive and from the idiographic to the shared (Cassidy et al., 2010). The primary researcher created metaphors and figures to illustrate meaning behind each theme.

3.10- Trustworthiness

Table 2 illustrates seven quality improvement strategies employed by the research team as recommended by Polit and Beck (2017). Trustworthiness standards (Guba & Lincoln, 1994; Whitemore et al., 2001) guided this study. For example, credibility was established through member checking between the researchers and participants, ensuring congruency of the results with expert opinions and the participants contributions. Identified themes were supported by thick descriptions and verbatim quotes (Sundler et al., 2019). Differences of opinion were debated by the research team to reach a singular conclusion. Detailed background of the participants including their current workplace, age, gender, and work history established transferability (Elo et al., 2014). As recommended by Smith et al. (2009) an internal audit was used to file all data, from initial data collection to final report.

Table 2*Table of quality enhancement strategies utilized during the study*

Strategy	Criteria: Guba and Lincoln			Shared Criteria		Criteria: Whittemore et al. (Primary)		
	Throughout the inquiry	Depend-ability	Confirm-ability	Transfer-ability	Credibility	Authenticity	Criticality	Integrity
Reflexivity/reflective journaling					✓	✓		
Careful documentation, audit trail	✓	✓					✓	✓
Data Generation								
Comprehensive field notes			✓		✓			✓
Theoretically driven sampling					✓			
Audio recording and verbatim transcription					✓	✓		
Triangulation (data, method)	✓				✓			
Saturation of Data			✓		✓			
Member Checking	✓				✓		✓	
Data Coding/Analysis								
Transcription rigour					✓		✓	
Triangulation (investigator, theory, analysis)		✓			✓		✓	
Search for confirming evidence								
Search for disconfirming evidence/negative case analysis		✓	✓		✓		✓	
Peer review/debriefing		✓			✓		✓	
Inquiry audit	✓	✓					✓	✓
Presentation of Findings								
Documentation of quality enhancing efforts			✓		✓			
Thick, vivid description			✓		✓	✓		
Impactful. evocative writing						✓		
Disclosure of researcher credentials/background					✓			
Documentation of reflexivity					✓			✓

Note. Adapted from (Guba & Lincoln, 1994; Whittemore et al., 2001) cited in (Polit & Beck, 2017, p. 562).

3.11- Reflection

Reflecting on phenomenological methods of inquiry allowed me (primary researcher) to enhance my understanding of how human experience can be formally investigated and described. Ultimately, this led to a marked sense of responsibility to manage the participants contributions with respect. I wanted the results of the study to be a true reflection of what the participants felt compelled to discuss. This led to a considerable issue when I piloted the semi-structured interview questions.

I had originally designed the questions (and study) to explore nurses experiences working in the AMHU. I felt that this was where there was a gap in the current literature and subsequently conceptualized the study focusing on patients who were admitted to the AMHU. This focus on the AMHU did not include nurses' experiences working with IWUM in MHOA. On reflection, my lack of experience working in MHOA may have biased the original focus of the study.

As I piloted the questions, I quickly realised that nurses felt compelled to discuss their experiences managing MA related presentations in MHOA. Although two participants self-selected to only work in the AMHU, they still felt compelled to make comments about the services provided in MHOA and how this impacted on treatment provided in the AMHU. I realised that not including nurses' thoughts, feelings, and experiences in/about MHOA would compromise the study's trustworthiness. This prompted me to include MHOA as part of the phenomenon being examined. Immediately after making this decision, I felt confident that the study would provide a more holistic view of nurse's experiences and also provide an overview of the typical treatment pathway for IWUM in Joondalup Hospital's inpatient psychiatric services.

Chapter 4: Findings

The three key themes identified by the primary researcher are presented in Figure 3. The first theme, *“Hit by the Storm”* focuses on the nurses’ experiences managing initial MA related presentations in ED/MHOA. The storm analogy represents the high acuity associated with initial presentations in ED/MHOA. The second theme *“Working in the Rain”* represents the nurses’ experiences working with IWUM who are admitted to the AMHU. The rain represents a reduction in acuity, although significant challenges in care remain. The umbrella signifies the supports and strategies reported by these nurses in the AMHU. Finally, *“After the Storm”* explores the nurses experiences working with IWUM at the end of a treatment episode including discharge planning and community follow up. The sunshine appearing above the cloud represents positive patient outcomes and the nurses’ positive emotions. The cloud suggests a perceived lack of community treatment available, and the negative emotions experienced by nursing staff. The black arrows illustrate how IWUM progress through the different services, with the blue arrow showing how many IWUM are discharged from ED without being admitted to the AMHU. The orange arrow represents the high rate of IWUM who continue using MA and represent to the service. The nurses interviewed articulated their unique perspective on the care of IWUM as they had a range of experiences across the inpatient mental health services. This allowed for deeper explorations of MA related issues in each environment to give a more holistic understanding of treatment pathways for IWUM who present to JHC.

Figure 3

Conceptual frame work of nurse's experience working with individuals who use MA

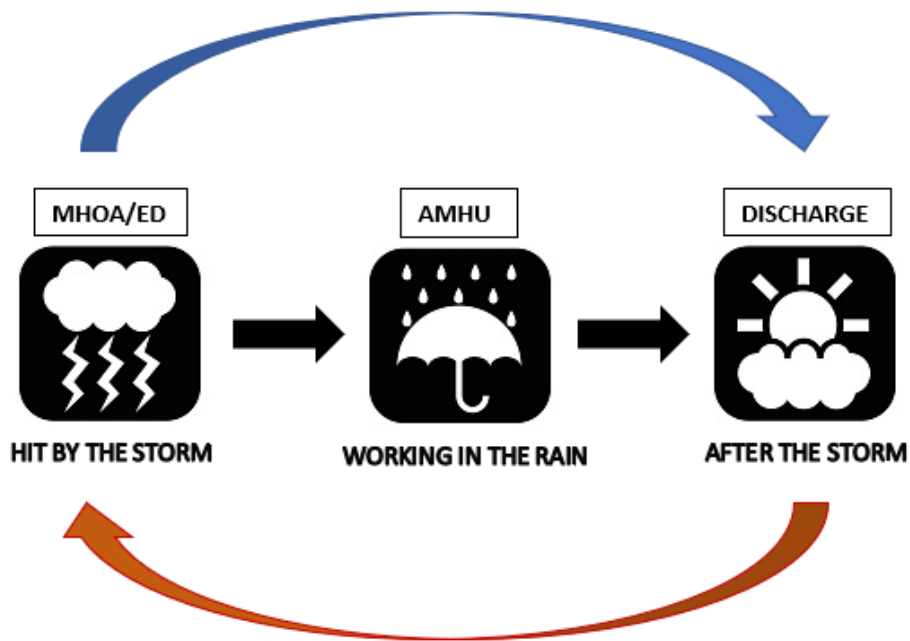


Table 3 provides an overview of the participants contribution to each theme during their one-on-one interview. All participants contributed to every theme, with the exceptions of Isaac and Brenda. These two participants did not work in MHOA so did not contribute to 'Hit by the Storm' and 'Building a Storm Shelter' respectively.

Table 3*Superordinate themes and subordinate themes for the MA pilot study*

Participant pseudonym	Hit by the Storm		Working in the Rain		After the Storm		
	Expecting Stormy Weather	Building a Storm Shelter	Persisting rain with Clearing Skies	Access to Umbrellas	The Clouds Remain	Eroded by the Rain	Finding Rays of Light
Mable	✓	✓	✓	✓	✓	✓	✓
Kristina	✓	✓	✓	✓	✓	✓	✓
Rachel	✓	✓	✓	✓	✓	✓	✓
Steve	✓	✓	✓	✓	✓	✓	✓
Geoff	✓	✓	✓	✓	✓	✓	✓
Brenda	✓		✓	✓	✓	✓	✓
Ashley	✓	✓	✓	✓	✓	✓	✓
Isaac		✓	✓	✓	✓	✓	✓
Suzy	✓	✓	✓	✓	✓	✓	✓
Anna	✓	✓	✓	✓	✓	✓	✓

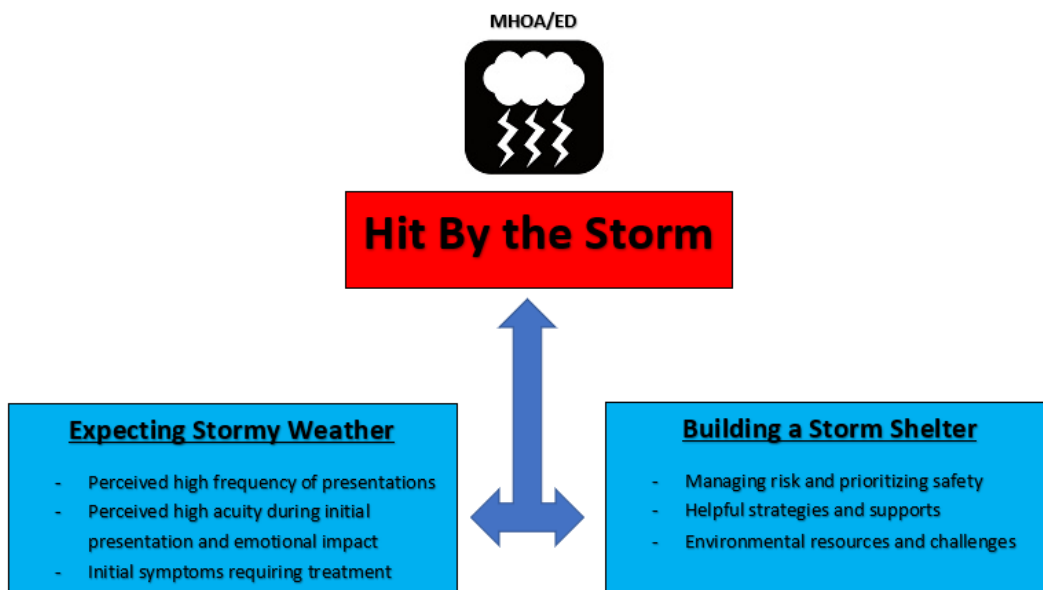
Note - ✓ = participant's quotes contributed to generation of theme

4.1- Hit by the Storm

The metaphor of *'Hit by the Storm'* describes nurses experiences of working in ED/MHOA and managing IWUM's initial presentations (Figure 4). The *'Storm'* represents nurses' perceptions of care as intense, disruptive, confronting, and frightening. A subtheme includes; *"Expecting Stormy Weather"* which describes the nurse's exposure to high acuity among IWUM when they first present to the hospital in ED/MHOA. The second subtheme *"Building a Storm Shelter"* presents the nurses thoughts regarding managing the risk of verbal/physical aggression and how they perceived themselves prioritising safety in challenging environmental circumstances.

Figure 4

Conceptual model illustrating the first superordinate theme and two subthemes – 'Expecting Storm Weather' and 'Building a Storm Shelter'.



4.1.1- Expecting Stormy Weather

All nurses reported that caring for IWUM was most challenging when patients first present to the ED/MHOA. Many experienced a confronting level of acuity with the initial presentation, which was attributed to high levels of MA intoxication. These patients were commonly escorted to hospital by police, ambulance, or family members. Nurses perceived IWUM as often lacking the insight to understand that they required treatment. Nurses reported that lack of insight was typically compounded by the highly stimulating effects of MA, which led to nurses discussing their experiences dealing with agitated, intrusive, entitled, and disruptive behaviours. Psychosis and associated paranoia were also described as significantly challenging symptoms, which nurses felt often culminated in aggressive behaviour, compromising the safety of everyone present; staff, the patients presenting for treatment, visitors, and other patients in the surrounding environment. Working within this challenging environment raised uncomfortable feelings for the nurses who described feeling confronted, frustrated, and at times scared. Nurses attempted to process their uncomfortable thoughts by empathising with patients. Two nurses commented about how unpredictable and volatile some IWUM could be;

Working in the ED section means that anything can happen at any given moment. They're usually so unpredictable. There's that unsettledness with them. Initially when they present there's that safety question. Am I safe managing this patient? It starts often in an aggressive way. A lot of the time where a patient has been either brought in by police or brought in by the ambulance because they're high and they've been aggressive and violent in some way, or they have harmed themselves or wanting to harm others in some way (Rachel).

While another nurse commented on their aggressive behaviours;

A lot of patients are coming through, they're kicking, they're screaming. They are incredibly agitated, they're scared. It can be full on, and it can be scary at times. There's a couple of scary incidents where [patients] are so agitated... it is scary. They just want to lash out because they're fearing for their life and they're desperate to get out of there. You couldn't say with absolute certainty that you're going to be safe on every shift (Steve).

During the interviews, nurses felt their daily exposure to IWUM who had recently used the drug included significant challenges. Three nurses reported that the high frequency and recency of exposure (two-to-three presentations per shift) to MA related presentations was increasing as one shared;

Each patient is drug screened on arrival. So that gives us an understanding of what they've been up to. I don't think I've come across a day where there hasn't been at least somebody coming in, who's been using meth according to their Urine Drug Screen (UDS) (Steve).

Nurses discussed the wide range of psychological and behavioural issues commonly observed during initial presentations. For example, psychotic symptoms, aggression, intrusive and elevated behaviour, lack of insight, and ambivalence regarding treatment made caring for these patients particularly challenging. A nurse reflected on his experience caring for IWUM during their initial presentation. He said;

I think when they first present in MHOA we're seeing them at the peak of the high. Their brought in by police and ambos or family. We're seeing their ambivalence to any treatments, because I don't think that they've got the insight to realise how their presenting. So, it's not a case of reasoning with them... [it] is the main presentation. The aggression and psychosis. Paranoia, noncompliance (Geoff).

Nurses often reflected on their experiences working in this high acuity environment and shared their thoughts on why these patients present in a threatening manner. Many felt drug induced psychosis made these patients severely unwell and impacted their ability to respond effectively and resulted in some confronting experiences. A nurse shared how attempting to understand these patients' behaviour impacted her emotionally;

In ED, you get all the aggression, you're copping the brunt of it. And when they're intoxicated they're nasty people. I mean, you know, that's not really them, it's the drugs. I guess it's just hard when it's day in, day out and the risk of aggression is so high and assault and that sort of thing. At times it can be quite frightening because you don't know what they're going to do, what they're capable of. The more you have to deal with people like that, the difficult behaviours are more..., it can cause burnout and exhaustion and you, need to make sure you're looking after yourself and you don't take that home with you (Suzy).

Some of the nurses tried to personally connect with the patients knowing 'that's not a bad person' (Steve) and showed their desire to empathize with IWUM. Other nurses reflected on the co-morbid psychiatric illnesses many IWUM suffered. A nurse shared;

The patients that are presenting have other diagnoses and they use meth. So, we've got patients who are obviously bipolar or schizophrenic that are using meth as well (Rachel).

In one instance, a nurse acknowledged that IWUM were not always problematic to manage in MHOA. He explained stereotypes such as being psychotic and aggressive were not always true. He said;

Some Meth users that come through the door... they're not a problem whatsoever. Well, there is quite a few that you wouldn't... have down as a typical meth induced presentation. There might be a lot of social situations that have led to the initial presentation and it's only when you delve a bit deeper that you can establish that somebody has been using meth, as opposed to screaming, fighting, arguing, coming through the door high as a kite, that aggressive kind of patient that we probably have generalized a little bit throughout this conversation (Steve).

4.1.2- Building A Storm Shelter

Nurses experiencing these high acuity episodes of care often used different treatment strategies and supports/resources to manage risk and prioritize safety. These strategies and supports included relying on colleagues, teamwork, support from security, and sedation.

Nurses used these to effectively maintain safety by mitigating verbally and physically aggressive behaviours. One participant said; *'the goal is to contain them as safely as possible'* (Geoff). Many of the nurses positively perceived high levels of staff support in this acute environment. A nurse valued the staffing resources available to her as she said;

A lot of the time, because the patients, they're so aggressive and unpredictable, you need a team of nurses, if not doctors, to contain the situation, especially with security guards. All my shifts, no matter how serious the situation may be, there's always people there to help you and to support you (Suzy).

One participant acknowledged how nurses' level of experience played an important role in risk management. He provided an example when he said;

For the most part, you can predict where you're going to encounter problems. If you've got a bit of experience and a bit of bounce about you, then you're generally prepared for it. Even if it's just a kind of giving someone a heads up, I'm going to go in with this patient. I'm a bit wary. They may be kind of escalating. And just so people are aware of potential consequences and get as geared up for it as possible, I suppose (Steve).

Nurses felt there was a deficit in medical resources including medical staff and equipment in MHOA compared to the ED. The lack of resources such as single rooms or seclusion rooms, bright lights, and glass used to separate rooms often exacerbated environmental challenges in MHOA. Furthermore, nurses were concerned that MHOA did not contain a locked nursing station or a safe place accessible for nurses to retreat when dealing with threatening, aggressive behaviour. These issues were so concerning for one nurse, he refused to work in MHOA and self-selected to only work in the AMHU. He felt unable to support these patients in this highly clinical environment and was concerned for his safety;

I choose not to work [in MHOA] at all. It's not a well-designed unit to do any therapeutic mental health there. It's too light, too bright and quite frankly, a bit dangerous because, you're going to get people who start smashing glass and I can foresee that somebody is going to get seriously hurt there (Isaac).

All nurses felt environmental factors made it difficult to safely manage MA intoxicated and aggressive patients in MHOA. Nurses preferred aggressive patients be sedated in the ED safe/resus room, which contained equipment to safely restrain a patient using four-point restraints and IV medications. Some nurses worked in an *"advanced triage role"* allowing experienced mental health nurses to use their risk assessment skills and advise on the *"safety"* of admitting a patient to MHOA, or if they needed ongoing medical management and sedation in ED. A nurse shared her experience in the advanced triage nursing role;

So basically..., we try not to let them come through to MHOA. We assess them and if they're coming off meth, and we think they're going to arc up and be super agitated, we try and get ED to keep them in the safe room where they give IV drugs to sedate them. When it comes to our ED triage nurses, they do their best, but they're not as comprehensively trained as we are. So, we... do that second assessment to see who is [a] higher risk and who needs to come through and be treated (Kristina).

The nurses spoke of the importance of IV sedation as an effective risk management strategy to improve the outcomes of care for both staff and patients. A nurse shared his experiences of using IV sedation when working with patients who were intoxicated with MA;

If they are to be sedated they'll be sedated for... maybe six to 12 hours. Then they'll bring them around from sedation. If there's still aggression and paranoia, then they'll look at sedating them and intubating them again. So, the timescale varies on each person... so once the sedation's off, if their compliant and willing to be assessed, then we will look at bringing them into the MHOA unit where the [Psychiatry Registrar] will carry out an assessment on them. Then we'll determine what's the best course of action, either admission or follow up themselves. And again, if they're willing to sort of comply as well (Geoff).

Nurses viewed IV sedation as the most effective pharmacological treatment for acutely unwell IWUM, but also described how alternative oral and intramuscular (IM) options were useful in this environment. One nurse commented on the differences between these types of medication as she said;

A lot of the time we use olanzapine mixed with benzodiazepines [benzos], lorazepam, diazepam, clonazepam. Sometimes depending on the patient, if they're significantly difficult to manage, we go for Haloperidol. They're probably the most common ones that we do use. If they get through to MHOA and their withdrawals make them agitated on arrival or not following direction, we [use] IM injection ten and two (10mg haloperidol 2mg lorazepam) (Suzy).

All nurses benefited from security assistance when managing acutely unwell and aggressive IWUM in MHOA. They viewed security as “*an integral part of that environment*” (Steve) and felt assured “*they would be there really quick*” (Anna), when managing aggressive patients who posed an imminent risk to the safety of others. Two nurses found support from security was favourable compared to previous hospitals they had practiced in. A nurse commented on the role of security in ED/MHOA, and shared;

We do have security on hand, which is good compared to other places I've worked. You've always got a good amount of security on hand. They're the first people to get involved in ED, because it's not authorized. So, we will use security more than nursing staff... that's the safest option (Geoff).

In many circumstances, discharging patients from MHOA into the community was perceived as an appropriate intervention, as nurses observed the effects of MA wearing off quickly, leaving patients wanting to go home. These nurses acknowledged only a minority of patients experienced acute psychiatric symptoms following the effects of the drug. They felt persisting psychotic symptoms occurred more commonly among patients with an underlying psychotic illness, such as schizophrenia or bipolar affective disorder. These circumstances often predicted referral for psychiatric assessment under local involuntary treatment legislation. A male nurse shared how a patient would progress through the service;

With the meth induced psychosis, they have a quick resolution. So ideally there's a dramatic improvement within 24, 48 hours of them arriving. Sometimes there's ongoing psychotic illnesses, a more enduring illness, such as schizophrenia, which would potentially be triggered by meth use. [If] psychosis

remain[s], they... then have a much longer or extended stay within the mental health unit. A lot of time within the locked ward to get back to baseline where they're not psychotic (Steve).

Many questioned the patients' motivation to stop using the drug. The nurses viewed MHOA as a crisis management service that stabilized patients to recover from the adverse effects of MA in an environment monitored by health professionals. These nurses only perceived the benefits of admitting patients into AMHU who had persisting psychotic symptoms or posed a risk to themselves/others. Some nurses viewed themselves as responsible for the allocation of public resources and were hesitant to endorse admissions if the patient did not want to stop using the drug. A nurse commented on how she evaluated using these resources;

Usually, the meth users just want to withdraw and well, they just want us to discharge them as soon as possible, so they can go back out again and use. You'd hope that after a while the nurses get the idea and [have a] management plan moving forward. This is their presentation. They've gone out and had like a meth kind of like week or weekend or whatever, we will get them stable again and then discharge them. Normally... it's the MHOA and then get them out. But again, it depends. If they're psychotic and need actual medicating or treatment, and they're not wanting to like comply, then you need to bring them up to the PICU, which [is] the avenue that they go up more so..., if they go like from the MHOA somewhere, it's more likely going to be the PICU (Anna).

The AOD team was highly valued, as these specialist clinicians provided intervention and community treatment referrals for IWUM. They also completed detailed assessments to gain a better understanding of the patients' drug/alcohol history and motivation to change. One nurse spoke highly of the AOD services as she discussed the quality of the assessments they provided;

The drug and alcohol services... get honest feedback from the patient in terms of their drug or alcohol use. An honest indication of... quantities, how often they use, whether it's for recreational purposes or whether it's for... numbing pain... They get to assess whether the patient is ready to stop because some patients are pretty honest (Mabel).

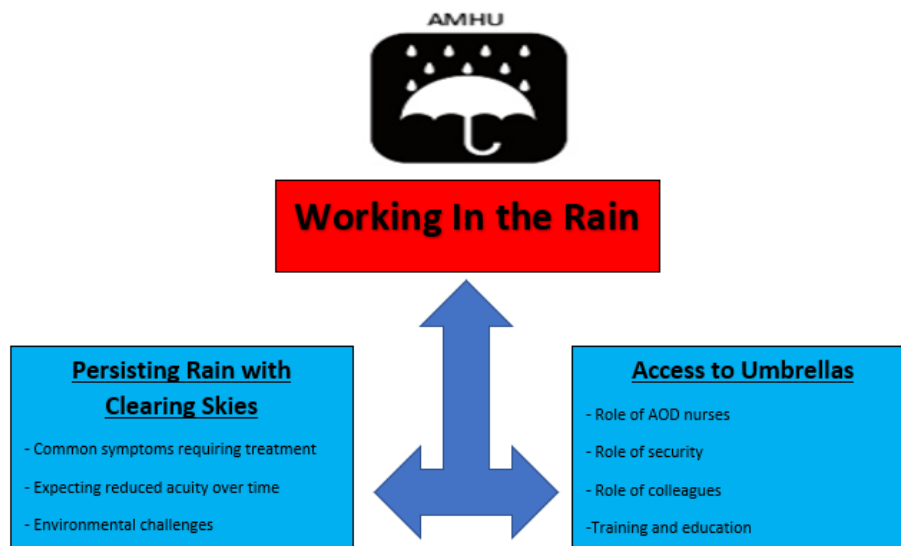
4.2- Working in the Rain

This theme – “*Working in the Rain*” explores the nurses' experiences caring for IWUM in the AMHU. This metaphor is used to describe a shift that occurs over time; from managing acute presentations in MHOA to providing prolonged mental health care in the AMHU, similar to an intense storm resolving and then followed by extended periods of rain. As illustrated in Figure 5, this theme comprises of two subthemes. The first – “*Persisting Rain with Clearing Skies*” describes a perceived reduction in acuity compared to the ‘*Storm*’ nurses experienced in ED/MHOA. Nurses acknowledged IWUM benefited from treatment in ED/MHOA, however, some required prolonged treatment to address unresolved psychiatric symptoms. The second subtheme “*Access to Umbrellas*” represents the supports used when managing challenging presentations in the AMHU which included support from colleagues,

security, and the AOD team. Nurses in the AMHU had access to seclusion rooms and were responsible for leading restraints. Several preferred nursing staff to manage the physical aspects of restraint. If security became involved, it was under the direction of a nurse. MA related training and education was viewed as inadequate by the nurses who worked in the AMHU. Many felt they lacked the necessary skills to provide specialised care to IWUM. Nurses perceived the Psychiatric Intensive Care Unit (PICU) as the most appropriate environment to provide involuntary treatment to patients without insight, although some IWUM were able to request voluntary treatment on the open ward. Nurses who worked in PICU felt they had more time to observe and support their patients, making it easier to establish rapport and therapeutic alliances. All nurses agreed that they often worked with IWUM who used MA after discharge and represented to the service under similar circumstances.

Figure 5

Conceptual model illustrating the second superordinate theme ‘Working in the Rain’ and two subthemes – ‘Persisting Rain with Clearing Skies’ and ‘Access to Umbrellas’.



4.2.1- Persisting Rain with Clearing Skies

Nurses acknowledge that most individuals who use MA and present to the ED quickly recovered and were not admitted to MHOA or examined by the mental health team. However, the nurses perceived a reduction in acuity compared to ED/MHOA to the small

cohort of patients who were admitted to the AMHU. These nurses felt that they were less likely to be exposed to aggressive behaviour in the AMHU, although IWUM were perceived as more likely to be aggressive than other patient cohorts. Nurses felt time spent in MHOA allowed the stimulating effects of the drug to subside, improving patient insight and adherence as a nurse shared;

In the MHOA they're either coming off their high, or they're on a high. So just depending on how they're coming through at that point. When they do go to the ward [AMHU], they are more stable. Of course naturally anything can happen, but, at the end of the day they've got a little bit more insight at that stage of the game rather than what they do when they first present. So, there's a bit more insight. Um, they're a little bit more compliant in terms of being more accepting of treatment on an average (Rachel).

Aggression was less prevalent in this environment, but nurses acknowledged that some IWUM continued to show verbal and/or physical aggressive behaviours.

The risk is less, but the risk is still there. You know, it's not as acute as in MHOA, but it depends on the individual as well. That risk is definitely still there because they're often still quite threatening and hostile (Suzy).

Many observed persisting signs of psychosis such as paranoia and delusions as the most common reasons IWUM were admitted to the AMHU for involuntary treatment. IWUM often felt threatened by staff or other patients, which sometimes resulted in “aggression that comes with the paranoia” (Brenda). Nurses perceived themselves as capable of conducting high quality assessments to identify symptoms. These nurses also identified the importance of timing the assessment and gathering information when it was safe to do so as an important aspect of their role. A nurse shared how he remained safe when conducting an assessment;

You've got to be strong in your Mental State Examination (MSE) and nonverbal cues. If there's paranoia or auditory hallucinations or anything like this, just talk openly with the person, if they're willing to talk openly to you and have a good awareness of your own safety and where the door, where the exits are because it's dangerous if people are under the influence of these substances and experiencing different things. A strong awareness of how they're behaving and your own thoughts about it. If you don't feel safe, don't do it. If you don't feel safe, interview them in an open area... or just stop the interview straight away, or let the person know – anytime that you feel that you want to stop, let's just stop. Don't feel that you need to continue. So, it gives them an out. People often escalate if they don't feel that there's an out. It comes with a bit of experience. The system wants information, but if you [are] getting the information and it's not the right time, just don't do it (Isaac).

All nurses found it difficult to “sort out what's illness behaviour and what's the drug behaviour” (Ashley). Several reflected on how patients with severe mental illnesses attempted to self-medicate their psychiatric symptoms with intoxicants such as MA. A nurse summarized these challenges as he said;

It's the old saying – what came first, the drug use or the illness? What are we treating as the main priority here? You're either treating any related mental illness or the detox. It's figuring out what you're treating (Geoff).

A marked differences in presentations was noted amongst these patients once the effects of MA wore off. In the AHMU, users were often observed ‘coming down’ (Rachel) and transferring to the crash/withdrawal phases resulting in low mood, isolation, irritability, and suicidal ideation. This raised feelings of compassion, and nurses ‘wanting to be there’ (Rachel) for their patients. A nurse described managing patient’s depressive symptoms following the MA high;

In most cases, when they come onto the mental health unit, they’re kind of like recovering. So, there’ll be very flat and all they want to do is sleep or that quite irritable. They’re just quite brittle (Mabel).

A nurse reflected on his experience working with IWUM at different stages, which he referred to as the ‘cycle’ (Isaac). He highlighted the importance of maintaining flexible treatment to meet IWUM’s needs;

It depends on what stage of usage they are at. If they’ve freshly used, then you’re going to get more erratic behaviour, more aggressive type stuff. Once they are on the comedown they might be irritable. We’re going to see a very different presentation from that person, when the drug is out of their system, we’re going to see a different kind of person then. So sometimes with the same person, you can get four different presentations. So, you have to adjust, even though it’s the same person they present differently. So, there is a cycle to that (Isaac).

Several nurses described the AMHU (particularly PICU) as a “low stimulus” (Brenda, Steve) and “intentionally boring” (Isaac) highly controlled and restrictive environment. At times, the challenges in this environment were offset by the large amount of time nursing staff were able to spend with their patients. Nurses felt they could get to know their patients and used this time to establish therapeutic relationships. A nurse explained the difference between treating patients in MHOA compared to AMHU;

The MHOA is fast paced and there’s such a high turnover of patients. There could be 20 patients coming through the doors on a MHOA shift. You’d be admitting, you’d be discharging sometimes within hours, sometimes within days, if they’re not going to be admitted to a mental health unit. Whereas [AMHU], particularly the authorized section where detained patients could potentially be there for.. about two weeks... [or] an awful lot longer. It’s slower in pace, [and] much lower stimulus. The [AMHU] comes with its own issues, when people are there for too long, but you do have substantial amounts of time to deal with patients. For example, if somebody is on the...PICU in the mental health unit, each nurse would have two or three patients. That’s divided amongst eight hours and those patients would very rarely change throughout your shift. You’ve got a couple of hours to spend with each patient... an awful lot of time to get to know patients quite well (Steve).

Nurses felt environmental constraints prevented psychological symptoms from escalating even though the IWUM often struggled with these restrictions. A nurse shared “they don’t see the need for those rules, and they don’t like abiding by them. So that creates challenging situations” (Ashley). Many nurses empathised that restrictions were difficult for IWUM to accept. For example, stopping patients from smoking was viewed as countertherapeutic by many nurses “having that to relieve any sort of anxiety always went a long way and we can’t

even offer that as a relief (Benda). Nicotine replacement therapy was available for patients, however nurses acknowledged that it was “not the same” (Isaac), and that smoking was a coping mechanism to manage boredom and distressing feelings. Without access to smoking, nurses assisted in “*distraction techniques and finding their own coping mechanisms*” (Kristina). A nurse highlighted PICU lacked the resources to allow patients to self-regulate their emotions and lacked therapy programs that would help patients address their addiction as she said;

We don't have areas where they can go to calm down. There are no quiet rooms. The only place they can escape is their own bedroom. We have very limited resources because our units were not designed to cater for people with addictions and withdrawing. [In] the open ward, they don't get many groups to promote recovery (Ashley).

Many nurses used honesty with their patients to manage restrictions and lack of environmental resources during their visit to the AMHU. One nurse found this helped him establish rapport with his patients;

I build a better rapport with them, so they know how I'm going to come across with them. How I'm straight up with them. I'm not going to give them any bullshit. Tell them how it is. I will tell them what we're going to do while they're here, what my expectations are with them and I suppose the honest approach with them is what they would rather have with you (Geoff).

Advocacy was a rewarding component of these nurses' role as it helped establish rapport, however the nurses often struggled to balance advocating for their patients' rights with risk management. For example, many were concerned that patients who were granted leave may use MA while in the community or bring the drug back into the AMHU. One nurse shared how this occurred on one of her shifts;

We had a patient who was struggling with meth addiction, and she went out on leave, used meth and also used some Lyrica. I think she snorted some Lyrica, came back and was unresponsive. We ended up calling a Medical Emergency Team (MET) call. We're trying to get an ECG done and, doing all that, we discovered she had snuck in some meth, some crystal meth as well. It was just in her underwear. It's those experiences whereby you know, it's expected (Mabel).

4.2.2- Access to Umbrellas

‘Access to Umbrellas’ represents the supports and strategies that nurses used the AMHU. Many of these strategies and supports were similar to those described in MHOA. The key differences included the role of nurses, the AOD team, and security as care transitioned from crisis management to prolonged mental health care. For example, in the AMHU, nurses did not have access to IV medications and relied on seclusion rooms and IM medications to manage aggressive behaviour. These nurses were responsible for (and physically involved) in physically restraining patients, although security did assist nursing

staff when required. This increased levels of trust and reliance among colleagues when managing verbal or physical aggression in the AMHU. A culture of “*team cohesion and a value for patient and staff safety*” (Mabel) was shared as many relied on their colleagues for additional assistance if IWUM presented as paranoid. A nurse described how her colleagues assisted in her protection from unfounded accusations;

If the patient has delusions against a certain gender or a certain ethnic group then you'll find that you have issues when you have the wrong help, according to the patient. So sometimes you have to try and find someone else, whether they prefer to communicate with females rather than males, then you'll have to get a female nurse. If they have delusions about that particular nurse and you didn't know that, then that would be a bad idea. If they're paranoid then I would have to ask another colleague to come with me, as a two-nurse approach, [as] they may have unfounded delusions or make some accusations (Mabel).

Effective interventions used by these nurses focused on managing psychosis, aggression, and MA withdrawal. Many highlighted the importance of sedating medication when treating IWUM in the AMHU, but acknowledged IV administration was not an option in this environment. A nurse said;

In the authorized unit, we don't have access to IV drugs. So, if somebody was disruptive to the extent that they would have to be sedated, we give them medications that could take 20, 30 minutes to kick in. Even then it's not as drastic as the IV medications. So that would mean potentially holding someone down whilst the medications kick in, which is obviously a lot more stressful for the patients, for the staff, for everyone involved (Steve).

In the AMHU, oral and IM medications played an important role in reducing psychiatric symptoms and aggressive or disruptive behaviour. In some cases, these medications allowed IWUM to sleep off undesirable effects of the drug. Nurses reported that some patients arrived in the AMHU with these sedating medications already prescribed in MHOA. A nurse appreciated this as she could administer effective psychotropic medication without “*having to get things charted, get forms sorted and things like that (Brenda).*” Other nurses offered pro re nata (PRN) medication to manage the signs and symptoms of withdrawal and prevent escalating behaviours. Some nurses were concerned about “*medication seeking behaviour*” (Kristina) and felt sedating medications may reinforce addictive patterns of coping with distress. Some acknowledged that not all IWUM were adherent with oral medications and required restraint and involuntary administration of IM medication. A nurse shared her thoughts on PRN medication;

They're prickly. They're irritable, you need to have that understanding. They'll need some medication to assist with that. If you don't manage that withdrawal symptom period or meet their needs, then that's when they become aggressive and agitated. So, it's about trying to manage and prevent all that happening. When they ask for PRN use it wisely. Don't withhold it. It depends whether you're in a punitive mode or you're in a helpful mode. Sometimes you sit and think, am I giving them too much? Am I giving it just because they're demanding it? What are the benefits for this person and for their

illness at the time when you say yes. Sometimes it's a matter of, we're just going to have to restrain people and give them IMI (Ashley).

Medication was not just viewed by the nurses as a crisis management tool, but also viewed as a key component of recovery for many IWUM. Many recognised their patients lacked the insight to understand they needed medication and took it upon themselves to educate IWUM about the medications they were being prescribed. A nurse shared how medications played in important role in an IWUM's recovery in the AMHU;

It was really just finding medications that helped him. So anti-psychotic medications and it took a long time to get him well. But yeah, a lot of input on the locked ward and a lot of playing around with medications until he started to respond to them and there was slow improvement over a long period of time (Suzy).

All nurses valued their colleague's experience, however felt a shortage of experienced nurses compromised staff and patient safety. Newly qualified graduate nurses completing their programs in the AMHU limited the team's capacity to respond to dangerous situations, a nurse shared;

We've got a lot of grads and they're not experienced, and you wouldn't want to be putting them in a situation where there's a lot of aggression and increased risk of assault, because they don't have the experience to manage that kind of behaviour (Suzy).

In the AMHU, nurses had to plan ahead if they wanted to have 24/7 security care in place for aggressive patients. A nurse described "putting a guard in place" (Anna), as a risk mitigation strategy. However, in the event of an emergency, security was less accessible and could not respond as quickly as they could in the ED/MHOA. Several nurses harboured concerns regarding a lack of training and empathy among security staff. Some felt security had a countertherapeutic effect on patients and escalated their behaviour, particularly if they were paranoid. A nurse spoke about the lack of training and empathy she observed among some security guards;

On the unit, you have to pre-book or ask for guards. It's got to be agreed upon. If you're needing a guard really quick up on the locked side, or even on the open, it's going to be a while just because of the location and it's a bit of a distance to get there. I guess the way that they handle their patients is however they are taught and that can escalate some of the patients. It can be distressing for them and escalate their behaviours more and make it more difficult for nursing staff to be able to deescalate them again. I guess that's because a lot of the security staff may not understand mental health issues. (Anna).

All nurses spoke positively of the AOD team when assessing their support in the AMHU. Many described them as “*really good to lean on*”, “*excellent*”, “*very useful*”, “*very easy to contact*”, “*invaluable*” “*a very strong asset for the unit*” and “*very knowledgeable*” (Geoff, Ashley, Isaac, Kristina, Rachel, Steve & Suzy) as the AOD team were able to follow up with patients originally assessed in MHOA, or initiate contact with patients who had made progress in the AMHU. AOD nurses often provided IWUM with supportive counselling, input into specialized care planning, and referrals for community and residential treatment. As one nurse said

“once they’re up on the unit they’ll keep following up with them, checking in with them and pushing for outside help and follow-ups” (Geoff).

Only one nurse felt he was unable to access assistance from the AOD team as he shared;

They are understaffed or under resourced, because we have people that we’d like them to see, but they’re so busy in ED/MHOA, the general hospital, that they may not have the time to come to us. From my perspective, if they don’t have the time to see us, they’re not much use (Isaac).

The nurses looked to the AOD team for training and education on MA. One nurse shared how the AOD Clinical Nurse Specialist’s competency and capacity provided superb training; “*the education sessions that he puts on for the rest of the team are just fantastic*” (Steve). Two nurses attended a drug and alcohol “*study day*” (Suzy, Brenda), however one acknowledged the training “*... wasn’t targeted to just treating people who use meth. It was a full comprehensive drug and alcohol day*” (Suzy). All nurses agreed the AOD team were well situated to provide formal MA training, they felt most of their learning opportunities were informal and looked to the AOD team for advice. A nurse said;

There’s a gap. I have not received any MA training. I’ve actually had to enrol in a course on health and substance misuse (Mabel).

One nurse sought education from a psychiatric registrar to better understand what medications were helpful to treat MA induced psychotic symptoms. Other nurses looked to experienced colleagues to improve their MA knowledge. A nurse described the value of learning from her peers’, she said;

My learning is from other people that I watched how they deliver their care to different patients. So, somebody that’s delivering care to somebody that might be really aggressive or coming down from meth or whatever. It’s purely by watching my colleagues and going, wow, they’ve managed their patients really well. I need to take that on and use that in the future. Otherwise, just asking colleagues. I know that there’s always going to be more experienced, more experienced people than me on the ward that have dealt with those kinds of patients. (Anna).

Training and education were viewed as empowering, as this improved confidence working with IWUM. However, many felt inadequately trained and poorly supported. A nurse highlighted the lack of MA training and policies;

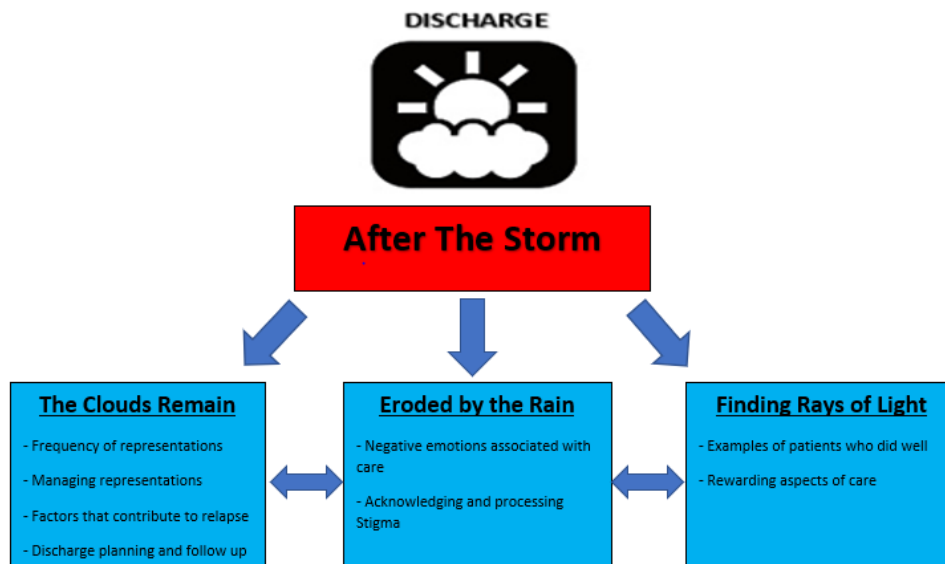
I don't have a problem managing meth patients or patients who are long-term meth users, but I would like the competence to have more knowledge within myself. I think that we almost need to have some specialist skills in this area and build up our knowledge base. I don't like flying by the seat of our pants like we do. I'd like to have firm policies in place and training that we can really use for backup and managing meth patients. I mean... someone who's having a manic phase... I prefer to nurse [them] because I know a little bit more about what to expect and I've got better training, whereas a patient on meth, I haven't. So the confidence level at times, my beliefs, and my ability to provide the patient with what they actually need is stronger on one side than the other (Rachel).

4.3- After the Storm

“*After the Storm*” encompasses the end of a treatment episode (Figure 6). The sun emerging from the clouds describes those patients who benefited from treatment, and the positive experiences nurses associated with care. The cloud partially covering the sun illustrates the high rate of relapse, perceived lack of community follow-up treatment, nurses’ negative emotions, and personal stigma towards IWUM. A subtheme - “*The Clouds Remain*” discusses the high rates of continued MA use and representation to the service. Nurses perceived discharge planning and community follow up as crucially important, but often inadequate. Some nurses developed stigmatizing views of IWUM, particularly towards patients who continued to use MA after treatment and represented to the service. The second subtheme “*Eroded by the Rain*” demonstrates how nurses made attempts to recognise their own stigma. Nurses articulated ways they managed this, preventing negative views or beliefs from impacting their care. Not all episodes of care were viewed negatively, as the final subtheme demonstrates “*Finding Rays of Light*”. Nurses felt their role was rewarding when observing the benefits of mental health care and were able to provide examples of patients who recovered.

Figure 6

Conceptual model illustrating the third superordinate theme ‘After the Storm’ and three subthemes – ‘The Clouds Remain’, ‘Eroded by the Rain’, and ‘Finding Rays of Light’.



4.3.1- The Clouds Remain

‘The Clouds Remain’ illustrates how frequently patients relapsed and represented to the service and how they are more likely to be treated in MHOA compared to the AMHU. Several nurses felt this was due to patients being discharged quickly after the effects of MA had subsided. One nurse said *“last week there was one in the morning, I saw him in the morning, we discharged him by noon, and he was back before I finished my shift high on meth”* (Ashley). A nurse commented on the cycle of continued MA use. She said;

Unfortunately, it tends to be a little bit of a vicious cycle. They may come in under the effect of MA and then they come onto the unit. We get them to baseline and then they go out, use again and often they do come back in (Kristina).

Nurses linked continued MA use and re-presentation to Australia’s social security benefits enabling patients to continue to use rather than prioritising their basic needs. Other nurses highlighted peer groups post discharge, and spending time with friends or family who used the drug increased the likelihood of relapse, as *“nine times out of ten, if they're living with somebody that's doing it, they're probably going to jump back on the bandwagon”* (Anna). Family support during and after treatment episodes was an important topic shared by the

nurses. Several felt IWUM often suffered from fractured relationships with their families, which limited the support they were able to receive in the community as many “*pushed either the family away, or they're not as supportive, or that might be the reason they're actually on it because they don't have those family supports*” (Brenda). The family structure was another predictor of relapse as a nurse commented on the importance of helping patients reconnect with their families;

The families say we don't want them back and then trying to re-establish that link. Sometimes we're lucky enough they can go back to their families if we can keep them in long enough to show that, this is what they're like when they're not on drugs, they have potential (Ashley).

Discharge planning was an important part of treatment episodes. One nurse shared to “*be mindful of your discharge plan, as soon as they get to the ward*” (Anna). Several voiced frustrations in the lack of engagement in discharge plans once IWUM left the hospital. They highlighted that the responsibility to engage with community treatment ultimately rested with patient, and “*if they're not wanting to be involved, you can't force them to follow up in the community with a stranger at some clinic*” (Anna). Many nurses used informal conversations to help reiterate the importance of discharge plans with patients. A nurse shared her thoughts on how patients needed to be involved in this process;

I would like to see patients included in the weekly reviews with their doctors and their multidisciplinary team, I would like them to be given a discharge book that they write in about what they feel they need for discharge. I need more inclusion (Ashely).

Many of the nurses perceived there was a lack of community support and difficulty with availability in residential rehab programs which delayed discharge. A nurse described her experience working with IWUM who sought residential rehab. She said;

I've found that for rehab, some of the wait times are a week to about three weeks wait. So just depending on the rehab facility that the patient has to go to, you will find that the rehab facilities that are non-profit and voluntary [are] the ones who often have short wait times, however, the patients [who] discharge prematurely because they don't like the conditions, because they are not allowed to take medication. You'll find that the ones that actually do give the medication, they're the ones that have longer wait times. (Mabel).

Many nurses felt the hospital met its role as a crisis management service but was lacking when follow up support in the community was required. Despite this, most nurses were unaware of what community services were available. A nurse shared;

I don't really know what happens out there in the community. I don't really know if they've got the community mental health, community caseworker, for example, if they've got a mental health diagnosis, as well as being a meth user, whether they're getting that support, help giving up using meth or whether it's just concentrated on their mental health diagnosis. Do they do both? You know, I don't really know” (Rachel).

Many nurses viewed lapses and relapses as learning opportunities and a chance to reflect on their past care. One nurse said “*you have to see what it is that they need extra of*” (Brenda).

A nurse supported the notion of learning from repeated presentations as he said;

In a way it's helped because I know how to treat them because we've treated them before. I know what we can do. You can have an input with the treatment team. If they're under a different treatment team, you can tell them what we've done before, what works, what doesn't. So, it's helpful that you know what you're up against in a way. It's not like you're coming against something new or don't know what the patients are going to present with” (Geoff).

Several nurses perceived continued MA use as a part of the dependence and used this to avoid negative judgements and fostered empathy as a nurse shared;

I'm a big believer of accepting what is, and I know it means they're not ready to change. Eventually, one day they will consider changing. It took many attempts. It's like cigarettes. When giving up cigarettes, smoking many attempts, and eventually one day the Penny will drop, and they will want to change (Ashley).

Not all nurses were able to accept IWUM continuing to use MA without judgment. A nurse explicitly reported that repeated exposure to IWUM negatively impacted the level of care she would provide. She said;

It probably causes more negative opinions from myself towards them. Sometimes you think what's the point? They're just going to be back again next week. You shouldn't let that change how you treat them, but it probably does. You give them less time, less of that therapeutic interaction (Suzy).

Many acknowledged that repeated exposure contributed to negative future perceptions of providing care. IWUM who were “*not willing to help themselves*” (Kristina) or “*going to be in and out, back again*” (Suzy), were sometimes regarded as wasted resources. Several nurses observed their colleagues not wanting to invest too much effort in patients who frequently presented, and therefore, commonly lacking empathy which negatively affected their level of care. A nurse commented on his experience and said;

There is a lot of judgment and I'd say stigma between staff. You do see a lot of staff say ‘wow, they're just a meth head’. To them, they see them as a waste. It's a waste of a bed, it's a waste of time trying to treat them. They're not here to be treated, that they don't want to be treated. So they'll do like the bare minimum they can with the patients. I suppose it is with repeat presentations, with the same person. I think a lot of people... deal with them differently initially. But once they've seen them in and out they're thinking well, they're not willing to help themselves, so why am I willing to help them? (Geoff)

4.3.2- Eroded by the Rain

The widespread stigma perceived by nurses towards IWUM is summarised by ‘*Eroded by the Rain*’. All nurses acknowledged that caring for IWUM was confronting, emotionally intense and ‘*Eroded*’ what was typically an impartial approach to nursing care. Repeated exposure to intense episodes of care resulted in nurses developing a growing sense

of resentment and compassion fatigue towards IWUM. At times, many harboured their own frustrations, negative thoughts, and views about IWUM. However, all valued impartial care as a nurse shared “... you’ve got to treat everybody the same” (Anna). These nurses tried to prevent stigma from negatively impacting the care they provided to IWUM and articulated some of the strategies they used to prevent stigma. For example, avoiding labels and accepting people’s choices without judgement were viewed as beneficial. One nurse ignored the diagnosis and focused on symptoms;

Everyone uses drugs in some shape or form, whether that's coffee, tea, chocolate, alcohol. It's just a matter of choice and the consequences of the use of it. It's not our normal, but it's their normal. So sometimes we've got to accept when we make judgements about what's best for the person, we've got to know what they consider their norm is, and not try to force them into our norm. I just see [the] use of meth, is a way of life for some people. And we've just got to accept that. That's what it is for them. It fulfills a role in their life, whether it's to help them feel good or to be in a social circle. I've just learned to accept it. You don't want to label them because people saying they've been using meth sort of gives a negative a label already. Saying they've got mental illness, that's a negative label. I'm very anti labels, even though there's diagnosis. And I say the patient may have schizophrenia, but to me, you're Joe Bloo with symptoms ofAnd you're dealing with your symptoms, not with the labels. It's so easy to be stigmatized by those labels. Sometimes you have to take a step back or take a breath and say, this is what I have to deal with. Let's do it respectfully (Ashley).

A nurse felt the lack of training regarding aggressive behaviours among IWUM contributed towards stigma among her colleagues. She thought education was one way of addressing this;

The level of aggression at the time that the nurse either fears for themselves, or they don't understand why they need to be that aggressive. So, it could be a lack of knowledge really as to, you know, we are meant to be nonjudgmental as nurses. And it's just educating, maybe those people that have those thoughts really (Brenda).

Empathy was a powerful tool to help nurses provide care without judgement as they wanted to understand IWUM’s perspectives. Many asked themselves the same question – why do they choose to use the drug? These nurses did not view MA use as a recreational activity. Rather, they felt these patients were attempting to self-medicate, dampen past trauma, or alleviate withdrawal symptoms. A nurse explained his empathy towards IWUM;

Most people that end up in a mental health institution don't use the substance for entertainment purposes. They use it to nullify maybe what they're going through or have experienced. A lot of nurses probably don't think about the reasons why a person might be using these substances. If you walk in their shoes, well maybe using substances is the only way to get through this life now. Our own attitudes towards people who use substances have a massive impact on how that person might feel (Isaac).

Some nurses identified unique aspects of their experiences as they viewed MA as powerful and dangerous substance, more harmful than other illicit drugs. Several described “higher levels of aggression” (Brenda) and a “culture of entitlement” (Steve). A nurse shared her perception of the entitlement she observed among IWUM;

The patients have become more selfish. It's more about them and not more about how they're making other people feel or how the environment is affected by their behaviour. So it's more like we have to

conform to their behaviour. If they're angry we have to adjust to their anger that's behind their meth use" (Mabel).

Not all nurses felt caring for IWUM was unique compared to other patient cohorts, as entitlement was “*representative of the general population*” (Isaac). Many described similar psychosis, irritability, and aggressive behaviours among other psychiatric patients. One nurse felt her specialised MA training prevented her from developing stigma;

I did the MA training to be one of those dual diagnosis people. I found that good... And because of that, I understand a bit better and I'm a bit more open. So, I don't see drug use as a barrier or a reason for people not to have good treatment. It may have stopped me being biased (Ashley).

4.3.3- Finding Rays of Light

‘*Rays of Light*’ refers to nurses’ experiences when IWUM benefited from treatment and were able to improve the quality of their lives. They felt rewarded by these positive outcomes. This resulted in their desire to “*see them recover, to improve their functioning, to get better, to have some quality of life*” (Ashley). Many described wanting to “*make a difference*” (Brenda) and felt fulfilled in their role when intervention was successful. They highlighted the pleasure they felt when the patient stabilised and were able to “*make a significant change in their health and in their life*” (Suzy) and “*help them on that bit of their journey*” (Geoff). Several shared positive examples. For example, a nurse said;

Initially he was coming in and out of ED, heavily intoxicated on meth, very highly aggressive. You could not go near him at all without risk of assault and so [we] give him medications to sedate him, discharged him home from ED, and it was continuously happening until the point where he was finally admitted to the ward. He had quite a lengthy admission, ended up having schizophrenia, after years and years of meth use. He had a very lengthy, I'd say a few months' admission to the ward, [and] managed to get him as well as we could get him. Genuinely a very nice guy once he was well and not using drugs. Like you wouldn't even think it's the same person you met in ED. We made a hell of a difference with his life. Got him set up with drug and alcohol services, supported accommodation, we haven't seen him since he's been discharged (Suzy).

4.4- Summary

The nurses perceived a higher level of acuity when working with IWUM in the ED/MHOA compared to the AMHU. MA intoxicated patients in ED/MHOA were best managed by experienced nurses with support from colleagues, sedating medications, and security to mitigate high levels of psychosis, paranoia, aggressive behaviour, poor compliance, and lack of insight. Most IWUM were discharged from ED/MHOA without receiving additional mental health care in the AMHU, but a small portion of IWUM admitted to the AMHU for voluntary or involuntary psychiatric treatment. The severity of most patients’ symptoms often reduced as intoxication resolved, which often led to a greater risk of

developing depressive symptoms as part of ceasing use of the drug. Discharge planning was perceived as poorly organised and lacked patient inclusion. A lack of community treatment was perceived by these nurses, as many were unaware of the available services. Formal MA related training was not perceived as accessible for nurses, which prompted some to seek external training and education. At times, nurses felt under skilled and inadequate to care for IWUM. Strategies such as providing a low stimulus environment, building rapport, understanding reasons behind drug use, recognising and managing withdrawal symptoms, and treating without judgment were strategies used to provide effective treatment. All nurses felt rewarded when patients recovered, regardless of the high rates of continued MA use and representation. Nurses agreed that caring for IWUM was a complex issue, as nurse said;

I feel that there's still more that needs to be explored in terms of how we manage these patients. I find that sometimes their presentation can actually cause a lot of problems if they're not managed well. It's how we manage them that can try and prevent escalation (Mabel).

4.5- Reflection

As I started writing this results chapter, I felt overwhelmed by the volume of data I had to interpret. I struggled with how to present the data in a logical and engaging format. Eventually, I realised that illustrations would be a helpful tool in organizing the nurses' contributions. Initially, I started writing using Figure 1. When I finished writing up the first superordinate theme, it was disjointed and had to be reorganised. One of my supervisors suggested I break down each theme with illustrations. I found this to be largely beneficial and ended up using illustrations to introduce each theme and outline what would be presented in the sub themes. This helped me organise the data into a more engaging and logical format.

As I wrote the results chapter I began to learn more about the interpretive process. I often reflected on how my own experience in the role contributed to the meaning that I attached to the participants comments. In some cases, this would be as simple as my own industry knowledge of psychiatric "lingo" that came up in the interviews. I was able to understand this without any effort but had to acknowledge that this may not be easy for some readers. In other instances, I was able to recognise how my own experience working with IWUM raised both negative and positive emotions. I realised that for myself, these emotions were often an involuntary reaction to stressful and confronting circumstances. I concluded that it was possible to temporarily feel negative or positive emotions that do not reflect my core values. This realization prompted me to carefully review how nurses discussed their emotions and try to consider how congruent their emotions were with their values as nurses.

Chapter 5: Discussion

The lived experience of nurses caring for IWUM across different inpatient psychiatric services has been summarised as ‘*Hit by the Storm*’ (experiences in ED/MHOA) “*Working in the Rain*” (AMHU), and “*After the Storm*” (discharge, community support, representations). For example, ‘*Hit by the Storm*’ encompassed the nurses’ experiences of high intoxication rates among IWUM when presenting to the ED, which led to these nurses managing significant behavioural and safety concerns. A small percentage of IWUM were admitted to the AMHU for voluntary or involuntary psychiatric treatment, with these nurses ‘*Working in the Rain*’, perceiving less acuity and intoxication. In the AMHU, nurses felt that IWUM transitioned to withdrawal, which led to treating MA-induced psychotic symptoms (e.g. paranoia), heightened irritability, and aggression compared to other patient cohorts. Nurses in the AMHU were responsible for leading restraints and questioned whether security’s involvement was beneficial in this environment. IV sedation was not available in the AMHU, leaving nursing staff to rely on IM/oral medications and seclusion rooms when managing overt aggression. At the end of the treatment episode (‘*After the Storm*’) the nurses described high rates of continued MA use and representation to the service and managing their self-stigma. The AOD CL team were sought after for MA training as many nurses felt they lacked specialised skills to meet the needs of IWUM. Although nurses were not always aware of the available community services, inpatient addiction groups, discharge planning, and community follow-up were identified as areas for improvement.

5.1- MA Cycle – Phases and Treatment

All nurses shared the greatest challenges treating IWUM in the ED/MHOA were the daily exposure, high acuity, and intoxication when providing MA-related care (Eg. *Expecting Stormy Weather*, subordinate theme to *Hit by the Storm*). Frequent exposure to MA intoxication was viewed as the main distinguishing factor between IWUM and other patient cohorts, which is consistent with Jones et al. (2018), who found MA was involved in 2.3% of all ED presentations globally. Redona et al. (2022) highlighted the overall national prevalence of MA presentations in the ED was related to local hospitals not always accounting for polysubstance use. However, many studies suggest that the number of IWUM presenting to EDs across Australia has increased (HealthStats New South Wales, 2019; Jones et al., 2019; Marais et al., 2020; Queensland Health, 2017), which is associated with the

greater purity of MA (particularly in crystallised form) and changing routes of administration (Gordon & de Jong, 2018; McKetin, Degenhardt, et al., 2018).

The euphoric intoxicating effect of MA is followed by an initial crash phase lasting hours to days, with acute withdrawal peaking in the first 7-days and lasting up to 4-weeks (Acheson et al., 2022). The extinction phase of withdrawal can occur for a 12-month period, and often includes chronic depression (Acheson et al., 2023). Nurses in this study observed patients progressing through intoxication and crash phases of the cycle in ED/MHOA, and the crash and subsequent withdrawal phases in the AMHU. Gordon et al. (2021) described how the cyclical nature of MA including the severe highs and lows impact upon family members of IWUM. Similarly, nurses in the current study observed the harms associated with using the drug as patients progressed through the different phases of intoxication, withdrawal, abstinence, and continued use of the drug. Additionally, nurses reported high rates of continued MA use, similar to McKetin, Kothe, et al. (2018), who found 77% of IWUM relapsed one year post residential treatment.

According to Kaviyani et al. (2023) a return to drug use can be conceptualized two ways; (1) relapse, which is a complete and prolonged return to former harmful levels of drug use, and (2) lapse, which is a brief and transient period of drug use. Notably, nurses in the current study made no distinction between lapse and relapse, often using the term “relapse” to describe a brief episode of drug use or continued use without a significant period of abstinence. The high rates of continued MA use observed by the nurses in this study meant they saw the same patients progressing through the “*cycle*” of MA use and receiving treatment over multiple periods of time (Eg *After the Storm* subordinate theme to *The Clouds Remain*). The nurses provided examples of patients who required multiple MA related admissions but were eventually able to maintain a healthy lifestyle in the community without being readmitted. These nurses described a profound sense of reward when IWUM benefited from the care they provided, as described by ‘*After the Storm*’ subordinate theme to ‘*Finding Rays of Light*’. Similarly, Adams et al. (2021) conducted a systematic review and thematic synthesis of factors impacting the retention of mental health nurses and identified a sense of reward as a key motivator for nurses to continue their role in mental health.

Nurses in this study acknowledged the perceived stigma towards IWUM as described by ‘*Eroded by the Rain*’ (subordinate theme to ‘*After the Storm*’). Many nurses in this study recognised their own negative attitudes and beliefs surrounding MA use, enabling them to articulate ways they prevented this from impacting their care. For example, they empathised

trying to understand why IWUM used the drug. This meant that these nurses recognised the risks for continued substance use such as social disenfranchisement, peer groups, past trauma, comorbid mental illness, and family dynamics (Kaviyani et al., 2023; Lowe et al., 2019; Zarse et al., 2019). Kaviyani et al. (2023) interviewed 10 IWUM and found these risk factors contributed to relapse, and the positive and negative emotional states associated with extended drug use. Stigma was more commonly associated with patients who continued to use MA and represented to the service, as many described compassion fatigue when patients re-presented shortly after discharging (Eg. *The Clouds Remain*). The level of stigma attached to MA exceeds that of alcohol or other drugs, as it is viewed as a more potent, addictive, and dangerous drug (Forchuk et al., 2023). Additionally, stigma is a known barrier that prevents IWUM from accessing treatment (Deen et al., 2021). Education and training are effective strategies to minimize stigma associated with various mental illnesses (İnan et al., 2019)

5.2- Aggression

As illustrated by *'Hit by the Storm'* subordinate theme to *'Expecting Stormy Weather'*, nurses working with IWUM in ED/MHOA reported challenging symptoms including suicidal ideation and agitation, as well as signs of intoxication/withdrawal such as paranoia, psychosis, aggression, insomnia, and intrusive behavior, which were often amplified by poor insight and treatment adherence. In particular, nurses in this study perceived aggression as a significant factor affecting their care. The perception of these problematic symptoms and behavioral concerns has been previously reported by Cleary et al. (2017) and Usher et al. (2017) highlighting the increased risks of MA induced psychosis and aggression in ED. Nurses in this study reported a reduction in acuity when working in the AHMU, although aggression was still commonly perceived among IWUM (Eg. *Working in the Rain*; subordinate theme to *Persisting Rain with Clearing Skies*).

Many nurses in this study highlighted organizational constraints that affected all patient cohorts, such as staffing issues, lack of quiet rooms, boredom, and limited structured activities in this environment. Psychotic illness, in particular paranoia was another factor that contributed to the increase risk of aggressive behavior. Jenkin et al. (2022) interviewed 20 nurses working on acute psychiatric wards and found factors of aggression; psychotic symptoms, lack of quiet spaces, staffing issues, and boredom impacted their level of care.

Furthermore, nurses in this study felt smoking bans increased the risk of aggressive behaviour, reflecting a retrospective review of health records by Hasnaoui and Ramachandran (2021), which found forced smoking cessation increased verbal conflict and physical aggression. Symptoms such as emotional lability, agitation, and irritability that are associated with the crash and withdrawal phase of MA often increased the risk of aggression in the AMHU (DASSA, 2017). Similarly, McKenna et al. (2017) found psychiatric inpatients were three times more likely to require restraint and seclusion if they had recently used MA compared to other patient cohorts. Whiting et al. (2021) found MA withdrawal was associated with violence in health care settings.

5.3- Withdrawal symptoms and management

Nurses working in the AHMU perceived less aggressive behaviors among IWUM as the stimulating effects of MA had already partially or fully resolved. As described by ‘*Working in the Rain*’; subordinate theme to ‘*Persisting Rain with Clearing Skies*’ nurses in this study recognised insomnia/hypersomnia, changes to appetite, persisting paranoia and agitation, irritability, and anxiety as symptoms of withdrawal. The crash and acute phases of MA withdrawal vary between 6-12 hours to 2-4 weeks after the last dose respectively (Acheson et al., 2022; Acheson et al., 2023). In a broader sense, nurses in this study supported IWUM as they transitioned to depressive symptoms when the stimulating effects of MA wore off. Similarly, Sibanda et al. (2019), reported depression as the most common psychiatric symptom among IWUM. Suicidal thoughts and actions were associated with severe depression, as according to Darke et al. (2017), suicide is the third leading cause of death among IWUM. Nurses in this study acknowledged mental health was a priority and discussed ways of mitigating the risk of self-directed harm.

Nurses in this study used antipsychotics and benzodiazepines to manage agitation due to withdrawal. Similarly, Tucker et al. (2020) conducted focus groups with nurses who identified pharmacological interventions as beneficial when managing generalised agitation and arousal. Guidelines in WA suggest benzodiazepines and antipsychotics help manage agitation and arousal, even though this recommendation does not specifically target MA withdrawal (WADOH, 2021). Evidence presented by DASSA (2017) suggests that diazepam and olanzapine are beneficial when supporting patients who have recently used MA in an inpatient setting. Acheson et al. (2022) conducted a pilot study with 10 MA dependant

inpatients at a detox facility and found lisdexamphetamine showed promising results in mitigating withdrawal symptoms. However a more recent meta-analysis of pharmacological treatments for MA withdrawal concluded no medications have been proven to alleviate withdrawal symptoms (Acheson et al., 2023). A synthesis of the literature suggests that broad variation in MA use and presenting symptoms requires symptomatic management, and pharmacological management may need adjustment throughout the intoxication, crash, and withdrawal phases (Acheson et al., 2023; Chan et al., 2019; Stuart et al., 2020). Further research is required to identify suitable pharmaceutical agents that can effectively manage withdrawal and promote abstinence.

In this study, several nurses were concerned about medication seeking behaviour. Drug seeking behaviour is common among patients who have a history of using alcohol or other drugs (Hogarth, 2020). According to King et al. (2020), changing levels of oxytocin and dopamine reinforces continued use, which may drive medication seeking behaviours among patients with a history of substance misuse.

5.4- Safety

Nurses working in ED/MHOA often felt confronted and scared when caring for intoxicated IWUM due to the increased risk of being assaulted at work. This safety concern of verbal/physical assaults at work has been reflected previously (Cleary et al., 2017; Usher et al., 2017). Richards et al. (2018) found 70% of ED nurses had been assaulted by an IWUM at work. As described in *'Building a Storm Shelter'* subordinate theme to *'Expecting Stormy Weather'* nurses concerns about personal safety prompted them to consider available resources and highly valued experienced colleagues for support and advice when managing their safety. Sibanda et al. (2019) asserts that nurses who specialize in mental health possess unique knowledge and skills that qualify them to work with IWUM in ED. Although nurses in the study often feared for their safety, no reports of physical assaults were disclosed during the interviews. This suggests that the experience and training among nurses who were employed by a mental health service may have mitigated the risk of assault. Okundolor et al. (2021) found that targeted training completely eliminated assaults on staff in a psychiatric ED. In terms of experience, a recent systematic review of the prevalence of aggression and associated risk factors in psychiatric settings by Weltens et al. (2021) showed contradictory results, as no conclusive evidence of mental health nursing experience preventing assault was

identified. Nurses in this study felt the presence of security mitigated their safety concerns when working in MHOA/ED. This differs from Usher et al. (2017), who found nurses experienced delays when accessing security personnel in the ED. Partridge and Affleck (2017) explored rates of violence, perceptions of safety, and attitudes towards security in four public QLD ED's and found clinical ED staff valued prompt responses from security even though these EDs did not have permanent security staff.

As described in '*Access to Umbrellas*' subordinate theme to '*Persisting Rain with Clearing Skies*', security staff's availability and role differed in the AMHU, as nurses were responsible for initiating and leading restraints. These nurses reported poor response times from security to assist nursing staff and security having to be booked in advance, which some nurses felt was concerning. Other nurses in the study reported that the presence of security guards could exasperate any developing agitation, thereby increasing the risk of aggressive behavior. This was perceived as a greater concern if patients were paranoid and being treated involuntarily. Partridge and Affleck (2017) surveyed ED staff and found uniformed security escalated problematic behavior, although this finding was generalised to all patient populations. Several nurses reported that excessive use of force and lack of empathy from security guards damaged therapeutic relationships and increased the risk of aggressive behavior towards nursing staff. Johnston and Kilty (2016) interviewed eight security guards employed at psychiatric hospitals and found they refused responsibility for any harm done to patients during restraints and blamed the clinicians who had ordered the intervention. There was inconsistency among nursing staff regarding the role of security in the AMHU. Wand et al. (2020) interviewed 26 security staff working in three NSW public ED's and found that security perceived a lack of clarity regarding their role and scope of practice. Nurses and security working in AMHUs would benefit from increased clarity surrounding security's role, scope of practice, which may need to be further defined in this environment.

5.5- Sedation Reducing Risks

Nurses highlighted administration of sedating medications as the most important aggression management strategy in both the ED/MHOA and the AMHU (Eg *Building a Storm Shelter*, subordinate theme to *Expecting Stormy Weather* and *Access to Umbrellas*, subordinate theme to *Persisting Rain with Clearing Skies*). In ED oral, IM, and IV sedatives were used to manage the most disruptive stages of intoxication. If patients were deemed to be

highly aggressive, they were not managed in MHOA. Rather, they would be restrained and given IV sedation in a safe room attached to the main ED. Other studies have also reported that ED clinicians relied on administration of sedating medications to manage the challenging behaviors and risks associated with MA intoxication (Humphreys et al., 2023; Sibanda et al., 2019). However, there is limited literature examining risk management when caring for IWUM in a psychiatric hospital. This study highlights the importance of sedating medications in the AMHU. Nurses in this study described a lower baseline of acuity but recognised the need to treat escalating behaviors early and offer oral sedating medications. These nurses acknowledged that non-adherence and risk of patients harming themselves or others required restraint, seclusion, and involuntary administration of IM sedating medications, but accepted the hospital policy which excluded IV access in the AMHU. This meant some patients were restrained for up to 30 minutes while IM medications took effect, which was distressing for both staff and the patient.

5.6- Clinical Assessments

Clinical assessments were completed quickly within the ED/MHOA due to time constraints, which was not experienced in the AMHU. Cleary et al. (2017) found mental health assessment were delayed when IWUM presented to the ED, but was improved when specialized mental health assessment units were added to the ED. As described in *'Building a Storm Shelter'*; subordinate theme to *'Expecting Storm Weather'* no delays were identified in MHOA as specialized mental health nurses, doctors, and allied health clinicians were able to complete assessments and brief interventions for patients who presented with psychopathology. Nurses felt intoxication was a common barrier when completing a mental health assessment in ED/MHOA. In these circumstances, patients would undergo preliminary risk assessments by an advanced triage nurse, with the comprehensive mental health assessment being delayed until the stimulating effects of the drug subsided. There were fewer barriers to comprehensive assessment in the AMHU as intoxication had resolved and nurses had adequate time to observe and assess their patients. This was related to MHOA's guidelines of providing brief interventions then admitting or discharging within 72 hours, whereas clinicians working in specialized mental health units are responsible for continued assessment, often over a period of weeks or months (Foster et al., 2021).

Nurses in the study perceived themselves as capable of conducting high quality mental health assessments. While all of the nurses in this study considered the impact of trauma, several clinicians primarily focused on risk management and identification of problematic symptoms. This reflects a recent study conducted by Wand et al. (2020), who found that although Australian contemporary mental health practice places a high value on the principles of the recovery model, in practice mental health assessments often do not reflect this. This may indicate that mental health nurses could benefit from assessment training, particularly with a view towards inclusive questioning and collaborative care planning, allowing patients to better identify their own goals, skills, coping strategies, and strengths.

Nurses highlighted the value of AOD CL nursing assessment in both ED/MHOA and the AMHU (Eg *Building a Storm Shelter*, subordinate theme to *Expecting Stormy Weather* and *Access to Umbrellas*, subordinate theme to *Persisting Rain with Clearing Skies*). AOD CL were viewed as highly skilled as they offered thorough assessment, care planning, and referral to community resources. This AOD team often improves evidenced based approaches as Reeve et al. (2016), found AOD CL improved patient outcomes and reduced financial burden to public health. Similarly, Gerdtz et al. (2020) identified specialized AOD clinicians as valued resources in an ED setting.

5.7- Need for Training and Education

Within Australia, specialized AOD nurses have been identified as skilled clinicians to provide MA specific training to other health care professionals (Ward et al., 2021). As described in '*Access to Umbrellas*'; subordinate theme to '*Persisting Rain with Clearing Skies*' nurses felt they received informal MA training and advice from AOD nurses. Many nurses perceived formal MA training as inaccessible, despite formal training being offered at the hospital, with only one nurse receiving specialized training in the United Kingdom. Mlambo et al. (2021) acknowledged the importance of continued education, training, and professional development in all areas of nursing. Sibanda et al. (2019), asserted that mental health nurses are specialized staff members that were well equipped to manage the challenging psychological symptoms among IWUM. However, the nurses in this study wanted more specific MA training to manage these complex presentations. This relates to Lakeman and Molloy (2018) who reported the lack of leadership, specialized undergraduate

training, and mandatory credentialing has led to the term ‘mental health nurse’ losing significant meaning in Australia.

5.8- Strengths and Limitations

As this study was undertaken with a small number of nurses who worked at a single AMHU in WA, it may not be possible to generalise the findings to a wider population, despite the participants identifying some important differences in the care provided within an AMHU compared to the ED/MHOA. However, the small sample size is congruent with IPA methodology because it allows for in-depth analysis of lengthy interview transcripts (Pietkiewicz & Smith, 2014). The interviews were conducted using the online zoom platform. This did not affect the quality of the interviews, however some non-verbal cues in body language may not have been collected as video recordings only displayed the participant’s face. This limitation was overcome by the interviewer keeping a reflective journal and applying the primary researcher’s psychiatric experience (double hermeneutics) to analyse participants contributions (Smith et al., 2009).

The study was designed to explore the experiences of nursing staff working the AHMU, however, nurses who were interviewed were compelled to discuss their knowledge and experiences surrounding the care of IWUM in the ED/MHOA. The nurses who worked in MHOA may have conceptualized their experience working with IWUM differently compared to those who work in the AMHU. To help avoid this, the interviewer allowed nurses to discuss their experiences in MHOA, but also asked for real-world examples specific to the AMHU. The interviewer has experience working in this hospital environment and was able to account for these experiences when analysing the transcripts (double hermeneutics). The researcher’s own experience working in the AMHU had potential to bias results, however the IPA methodology allowed for this to be monitored throughout the data analysis and was acknowledged when adding descriptive, linguistic, and conceptual comments to interview transcripts. Ultimately, IPA allows the researcher’s lived experience to contribute to the emerging themes identified in the study (Smith & Nizza, 2022). The data collection period occurred during the coronavirus pandemic time (April 2022), however the interview questions were not related to this time period and all measures were taken to keep the participants safe (E.g. online interviews). The research team does not believe the data

collection was impacted by this period as none of the participants commented about the coronavirus and their level of care during their interviews.

The AOD CL staff were not interviewed as this was outside the scope of this study. Therefore, interviews with the AOD CL team to gather a holistic understanding could result in improved understanding surrounding the care of IWUM and receive hospital-based treatment. In addition, the patient's (or their families) perspectives were also not captured as they were not interviewed in this study. Again, this is something that future research could examine to compare and contrast the perspectives of staff and patients.

5.9- Reflection

Writing the discussion chapter forced me to consider what the implications of this study are. I had to ask myself, what does all of this mean? This process resulted in several drafts and multiple conversations with supervisors. When I finished writing the chapter, I was confident that the key findings were an accurate representation of the nurses' thoughts, feelings, and experiences shared during the interviews. It is, however, important to note that the nurses who participated in this study work in acute care environments. This means they are exposed to some of the worst outcomes associated with MA use, which is what they were compelled to discuss in the interviews. Many IWUM do not present to health care services in the circumstances discussed in this study. Among those that do present to hospital, physical complications are a common reason for presentation that the nurses in this study did not discuss. In terms of the implications for inpatient mental health services, key findings from the themes identified in the study could guide recommendations for future research, improved policies, and practices.

5.10- Conclusion

This study explored the experiences of nurses who provided care for IWUM in an ED/MHOA and AMHU. In the ED/MHOA, intoxication was the most challenging phase of care, due to the risk of disruptive and aggressive behavior. In this setting, teamwork, security, and sedation were identified as the key risk management strategies. Nurses felt the care they provided for IWUM were often confronting, and at times were concerned for their own safety. Although all nurses agreed the most acute aspects of care were related to intoxication

and managed in ED/MHOA, it was reported that MA withdrawal, including depressive behaviour and persisting psychotic symptoms were common concerns in the AMHU. Repeated exposure to acute episodes of care led to feelings of compassion fatigue and resentment in most nurses. Stigma was the only factor that separated IWUM from other patients in the AMHU and nurses recognised this as an important issue that required mentoring and support to enable them to undertake the care of IWUM. The AOD CL was highly valued and recognised as a source of knowledge, making them an ideally skilled group that could provide targeted training for nursing staff working in this environment. The experiences of the nurses who were interviewed in this study can be used to guide future research and recommendations.

Chapter 6: Recommendations

The focus of this study was to understand nurses experience providing care for IWUM patients in an ED/MHOA and AMHU. Several recommendations are discussed below that target 1) clinical practice, 2) training and education, 3) professional development.

6.1- Recommendations for Clinical Practice

Two recommendations for clinal practice include;

6.1.1- Recommendation One: Clearly defining security's role and scope of practice in AMHUs

Nurses in this study highlighted their collaboration with security employees when managing disruptive and aggressive behaviour. Therefore, the security's role and scope of practice in the AMHU could be further defined in this environment, allowing nurses to better understand what circumstances warrant security staff's involvement, and the specifics of their role when managing psychiatric emergencies. Wand et al. (2020) found clarity in security's role improved communication from clinical staff and the legal implications of their interventions with mental health patients in NSW EDs.

6.1.2- Recommendation Two: Provide quite spaces in AMHUs (specifically PICUs) to help deescalate agitated patients.

Quite spaces would help nurses separate agitated patients from their peers and reduce the amount of aggression other patients may be exposed to during their admission to the AMHU. Providing a low stimulus environment would allow nurses to de-escalate volatile situations, and focus on effective communication without distraction (Price et al., 2018).

6.2- Recommendations for Training and Education

A key finding from this study was related to education and training.

6.2.1- Recommendation One: Improve access and awareness of established AOD seminars

Nurses in this study perceived a lack of formal MA related training. This is not consistent with the availability of training at JHC, which is ran by the AOD CL team. Methods to address this perceived lack of available training could include annual AOD training, training during clinical updates, and training upon orientation. Additionally, information on external established AOD training seminars delivered in the Perth metropolitan area could be provided to staff. For example, WA's Mental Health Commission has an established AOD annual training calendar, which runs face to face training seminar and also offers free online training for nurses (GOWAMHC) (n.d.). Further awareness of already established MA training modules could help minimize stigma associated with various mental illnesses (İnan et al., 2019).

6.2.2- Recommendation Two: Additional education for mental health nursing staff regarding medical complications associated with MA use

Nurses in this study were unaware of the medical complications that can occur as a result of MA use. Greater access to training on medication complications could teach nursing staff how to recognise the signs and symptoms of serious adverse outcomes and outline the appropriate escalation pathways. The AOD CL team have materials available and AOD nurses are qualified to deliver MA related training (Ward et al., 2021).

6.2.3- Recommendation Three: Adapt training modules to include the management of problematic MA behaviours and awareness of recovery principles

Nurses in this study reported a lack of formal training regarding the management of MA related aggression and disruptive behaviour. Managers in AMHUs could leverage upon pre-existing annual aggression management training to include a module outlining behavioural management and communications strategies that consider the effects of MA use. Okundolor et al. (2021) demonstrated targeted training reduced the risk of assaults on staff. Annual training modules could also target updated assessment strategies that incorporate the principles of the recovery model. Wand et al. (2020) found that within Australia, mental health assessment does not always adequately promote recovery.

6.3- Recommendations for Future Research

Recommendations for future research include:

1. Conduct interviews with other participants such as staff working in other settings (eg. AOD CL team) and IWUM to understand their experiences receiving treatment in the AMHU.
2. Evaluate the effectiveness of specialized nursing education for IWUM. For example, design pre- and post-surveys to understand confidence and knowledge.
3. Design a large-scale cross-sectional survey to capture perspectives across Australia to generalize the results.
4. Deliver a clinical trial to understand the efficacy of different medications such as antipsychotics and benzodiazepines when managing MA withdrawal.

References

- Abdullah, C. S., Aishwarya, R., Alam, S., Morshed, M., Remex, N. S., Nitu, S., Kolluru, G. K., Traylor, J., Miriyala, S., & Panchatcharam, M. (2020). Methamphetamine induces cardiomyopathy by Sigmar1 inhibition-dependent impairment of mitochondrial dynamics and function. *Communications biology*, 3(1), 682.
- Acheson, L. S., Ezard, N., Lintzeris, N., Dunlop, A., Brett, J., Rodgers, C., Gill, A., Christmass, M., McKetin, R., & Farrell, M. (2022). Lisdexamfetamine for the treatment of acute methamphetamine withdrawal: A pilot feasibility and safety trial. *Drug and Alcohol Dependence*, 241, 109692.
- Acheson, L. S., Williams, B. H., Farrell, M., McKetin, R., Ezard, N., & Siefried, K. J. (2023). Pharmacological treatment for methamphetamine withdrawal: A systematic review and meta-analysis of randomised controlled trials. *Drug and Alcohol Review*, 42(1), 7-19.
- Adams, R., Ryan, T., & Wood, E. (2021). Understanding the factors that affect retention within the mental health nursing workforce: A systematic review and thematic synthesis. *International Journal of Mental Health Nursing*, 30(6), 1476-1497.
- Ahmadi, J., Sahraian, A., & Biuseh, M. (2019). A randomized clinical trial on the effects of bupropion and buprenorphine on the reduction of methamphetamine craving. *Trials*, 20(1), 468-467. <https://doi.org/10.1186/s13063-019-3554-6>
- Alase, A. (2017). The Interpretative Phenomenological Analysis (IPA): A Guide to a Good Qualitative Research Approach. *International Journal of Education and Literacy Studies*, 5(2), 9-19. <https://doi.org/10.7575/aiac.ijels.v.5n.2p.9>
- Alqallaf, M. (2021). Toxicological Aspect of Fatal Methamphetamine. *Chemical & Pharmaceutical Research*, 3(1), 1-5.
- Ames, H., Glenton, C., & Lewin, S. (2019). Purposive sampling in a qualitative evidence synthesis: A worked example from a synthesis on parental perceptions of vaccination communication. *BMC Medical Research Methodology*, 19(1), 26-29. <https://doi.org/10.1186/s12874-019-0665-4>
- Arunogiri, S., McKetin, R., Verdejo-Garcia, A., & Lubman, D. I. (2020). The methamphetamine-associated psychosis spectrum: a clinically focused review. *International Journal of Mental Health and Addiction*, 18(1), 54-65.
- Australian College for Emergency Medicine. (2019). *Alcohol and methamphetamine harm in emergency departments*. https://acem.org.au/getmedia/f7bec2c4-6573-471f-8cf4-f9a0bc466506/Alcohol-Snapshot-Report_R6
- Australian Criminal Intelligence Commission. (2019). *National wastewater drug monitoring program - Report 7*. https://www.acic.gov.au/sites/default/files/2019/06/nwdmp7_140619.pdf?v=1560498324
- Australian Criminal Intelligence Commission. (2022). *National wastewater drug monitoring program - Report 18*. https://www.acic.gov.au/sites/default/files/2023-03/NWDMP%20Report%2018_1.PDF
- Australian Institute of Health and Welfare. (2020). *National drug strategy household survey 2019*. <https://www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey-2019>
- Australian Nursing and Midwifery Accreditation Council. (2017). *Enrolled nurse accreditation standards* https://www.anmac.org.au/sites/default/files/documents/ANMAC_EN_Standards_web.pdf

- Baliga, R. R., & Eagle, K. A. (2020). *Practical cardiology evaluation and treatment of common cardiovascular disorders* (3rd ed.). Springer International Publishing. <https://doi.org/10.1007/978-3-030-28328-5>
- Boyd, M. (2018). *Psychiatric nursing: Contemporary practice* (6th ed.). Wolters Kluwer.
- Brecht, M.-L., & Herbeck, D. (2014). Time to relapse following treatment for methamphetamine use: A long-term perspective on patterns and predictors. *Drug and Alcohol Dependence*, *139*, 18-25. <https://doi.org/10.1016/j.drugalcdep.2014.02.702>
- Burrell, G., & Morgan, G. (1979). *Sociological paradigms and organizational analysis*. Heinemann.
- Canova Mosele, P. H., Chervenski Figueira, G., Antônio Bertuol Filho, A., Ferreira de Lima, J. A. R., & Calegari, V. C. (2018). Involuntary psychiatric hospitalization and its relationship to psychopathology and aggression. *Psychiatry Research*, *265*, 13-18. <https://doi.org/10.1016/j.psychres.2018.04.031>
- Cassidy, E., Reynolds, F., Naylor, S., & De Souza, L. (2010). Using interpretative phenomenological analysis to inform physiotherapy practice: An introduction with reference to the lived experience of cerebellar ataxia. *Physiotherapy Theory and Practice*, *27*(4), 263-277. <https://doi.org/10.3109/09593985.2010.488278>
- Chadwick, B., Gill, P., Stewart, K., & Treasure, E. (2008). Methods of data collection in qualitative research: Interviews and focus groups. *British Dental Journal*, *204*(6), 291-295. <https://doi.org/10.1038/bdj.2008.192>
- Chan, B., Freeman, M., Kondo, K., Ayers, C., Montgomery, J., Paynter, R., & Kansagara, D. (2019). Pharmacotherapy for methamphetamine/amphetamine use disorder—A systematic review and meta-analysis. *Addiction*, *114*(12), 2122-2136. <https://doi.org/10.1111/add.14755>
- Cleary, M., Jackson, D., Woods, C., Kornhaber, R., Sayers, J., & Usher, K. (2017). Experiences of health professionals caring for people presenting to the emergency department after taking crystal methamphetamine ("ice"). *Issues in Mental Health Nursing: Special Issue on Addiction and Mental Health Across the Lifespan*, *38*(1), 33-41. <https://doi.org/10.1080/01612840.2016.1251516>
- Clifford, B., Van Gordon, K., Magee, F., Malone, V., Siefried, K. J., Graham, D., & Ezard, N. (2023). "There's a big tag on my head": exploring barriers to treatment seeking with women who use methamphetamine in Sydney, Australia. *BMC health services research*, *23*(1), 1-9.
- Corser, J., Palis, H., Fleury, M., Lamb, J., Lock, K., McDougall, J., Mehta, A., Newman, C., Spence, H., & Buxton, J. A. (2022). Identifying behaviours for survival and wellness among people who use methamphetamine with opioids in British Columbia: a qualitative study. *Harm reduction journal*, *19*(1), 1-12.
- Darke, S., Duflou, J., Kaye, S., Farrell, M., & Lappin, J. (2019). Psychostimulant use and fatal stroke in young adults. *Journal of forensic sciences*, *64*(5), 1421-1426.
- Darke, S., Kaye, S., & Duflou, J. (2017). Rates, characteristics and circumstances of methamphetamine-related death in Australia: a national 7-year study. *Addiction (Abingdon, England)*, *112*(12), 2191-2201. <https://doi.org/10.1111/add.13897>
- Deen, H., Kershaw, S., Newton, N., Stapinski, L., Birrell, L., Debenham, J., Champion, K. E., Kay-Lambkin, F., Teesson, M., & Chapman, C. (2021). Stigma, discrimination and crystal methamphetamine ('ice'):

Current attitudes in Australia. *The International Journal of Drug Policy*, 87.
<https://doi.org/10.1016/j.drugpo.2020.102982>

- Degenhardt, L., Larney, S., Chan, G., Dobbins, T., Weier, M., Roxburgh, A., Hall, W. D., & McKetin, R. (2016). Estimating the number of regular and dependent methamphetamine users in Australia, 2002–2014. *Medical Journal of Australia*, 204(4), 153-153. <https://doi.org/10.5694/mja15.00671>
- Degenhardt, L., Sara, G., McKetin, R., Roxburgh, A., Dobbins, T., Farrell, M., Burns, L., & Hall, W. D. (2017). Crystalline methamphetamine use and methamphetamine-related harms in Australia. *Drug and Alcohol Review*, 36(2), 160-170. <https://doi.org/10.1111/dar.12426>
- Drug and Alcohol Services South Australia. (2017). *Management of patients presenting with acute methamphetamine-related problems: Evidence summary*. <https://www.sahealth.sa.gov.au/wps/wcm/connect/915c4c60-a766-414c-8606-94d1702d052f/Management+of+meth+presentations+-+evidence+summary+2017+final.pdf>
- Elo, S., Kääriäinen, M., Kanste, O., Pölkki, T., Utriainen, K., & Kyngäs, H. (2014). Qualitative Content Analysis: A Focus on Trustworthiness. *SAGE Open*, 4(1), 215-263. <https://doi.org/10.1177/2158244014522633>
- Everett, N. A., Baracz, S. J., & Cornish, J. L. (2020). The effect of chronic oxytocin treatment during abstinence from methamphetamine self-administration on incubation of craving, reinstatement, and anxiety. *Neuropsychopharmacology (New York, N.Y.)*, 45(4), 597-605. <https://doi.org/10.1038/s41386-019-0566-6>
- Evren, C., & Bozkurt, M. (2018). Update on methamphetamine: an old problem that we have recently encountered. *The Journal of Psychiatry and Neurological Sciences*, 31(1), 1.
- Fife-Yeomans, J., Watson, R., & Masters, C. (2006). A new deadly ice age—how our city is losing the battle against a chilling drug epidemic. *The Daily Telegraph*, 7, 31.
- Fiona Stanley Hospital. (2020). *Mental Health Service*. <https://www.fsh.health.wa.gov.au/Our-services/Service-Directory/Mental-Health>
- Forchuk, C., Serrato, J., & Scott, L. (2023). Identifying barriers and facilitators for implementing harm reduction strategies for methamphetamine use into hospital settings. *Frontiers in Health Services*, 3, 1113891-1113891.
- Foster, K., Marks, P., O'Brien, A. J., & Raeburn, T. (2021). *Mental health in nursing: Theory and practice for clinical settings* (5th ed.). Elsevier Australia.
- Fusch, P. I., & Ness, L. R. (2015). Are we there yet? Data saturation in qualitative research. *The qualitative report*, 20(9), 1408.
- Gerdtz, M., Yap, C. Y. L., Daniel, C., Knott, J. C., Kelly, P., Innes, A., & Braitberg, G. (2020). Amphetamine-type stimulant use among patients admitted to the emergency department behavioural assessment unit: Screening and referral outcomes. *International Journal of Mental Health Nursing*, 29(5), 796-807. <https://doi.org/10.1111/inm.12710>
- Gordon, D. G., & de Jong, G. (2018). Gaps in the ice: Methamphetamine in Australia; its history, treatment, and ramifications for users and their families. *International Journal of Mental Health Nursing*, 27(6), 1861-1868. <https://doi.org/10.1111/inm.12480>

- Gordon, D. G., Russel, K., & Coventry, T. (2021). Methamphetamine in the family: Looking below the iceberg. *Australian Nursing and Midwifery Journal*, 27(4).
- Gouzoulis-Mayfrank, E., Härtel-Petri, R., Hamdorf, W., Havemann-Reinecke, U., Mühlig, S., & Wodarz, N. (2017). Methamphetamine-Related Disorders. *Deutsches Ärzteblatt International*, 114(26), 455-461. <https://doi.org/10.3238/arztebl.2017.0455>
- Government of Western Australia. (2019). *New mental health emergency centre opened at rph*. <https://www.mediastatements.wa.gov.au/Pages/McGowan/2019/10/New-Mental-Health-Emergency-Centre-opened-at-RPH.aspx>
- Government of Western Australia Chief Psychiatrist. (2015). Clinician's practice guide to the mental health act 2014. https://www.chiefpsychiatrist.wa.gov.au/wp-content/uploads/2015/11/CPG_Edition-3_25112015.pdf
- Government of Western Australia Mental Health Commission. (2015). *Western Australian mental health, alcohol and other drug services plan 2015-2025*. <https://www.mhc.wa.gov.au/media/1834/0581-mental-health-planprintv16acc-updated20170316.pdf>
- Government of Western Australia Mental Health Commission. (n.d.). *Training for professionals*. <https://www.mhc.wa.gov.au/media/1834/0581-mental-health-planprintv16acc-updated20170316.pdf>
- Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. *Handbook of qualitative research*, 2(163-194), 105.
- Harada, T., Tsutomi, H., Mori, R., Wilson, D. B., & Mori, R. (2018). Cognitive-behavioural treatment for amphetamine-type stimulants (ATS)-use disorders. *Cochrane Database of Systematic Reviews*, 2018(12), CD011315. <https://doi.org/10.1002/14651858.CD011315.pub2>
- Harnett, J. T., Dargan, P. I., Dines, A. M., Archer, J. R., Greene, S. L., Hunter, L. J., & Wood, D. M. (2022). Increasing emergency department attendances in central London with methamphetamine toxicity and associated harms. *Emergency medicine journal*, 39(6), 463-466.
- Hasnaoui, S., & Ramachandran, V. (2021). Evaluating appropriate use of nicotine replacement therapy on acute adult psychiatric units and adverse events related to smoking bans on wards. *BJPsych Open*, 7(S1), S325-S325.
- HealthStats New South Wales. (2019). *Methamphetamine-related emergency department presentations*. <http://www.healthstats.nsw.gov.au/>
- Hogarth, L. (2020). Addiction is driven by excessive goal-directed drug choice under negative affect: translational critique of habit and compulsion theory. *Neuropsychopharmacology*, 45(5), 720-735.
- Hume, C., Massey, S., & van den Buuse, M. (2020). The effect of chronic methamphetamine treatment on schizophrenia endophenotypes in heterozygous reelin mice: Implications for schizophrenia. *Biomolecules (Basel, Switzerland)*, 10(6), 940. <https://doi.org/10.3390/biom10060940>
- Humphreys, M., Martin, C., Theodoros, T., Andronis, D., & Isoardi, K. (2023). Psychosis in acute methamphetamine intoxication is usually self-limiting and can be managed in the emergency department: A retrospective series. *Emergency Medicine Australasia*. <https://doi.org/10.1111/1742-6723.14287>

- İnan, F. Ş., Günüşen, N., Duman, Z. Ç., & Ertem, M. Y. (2019). The impact of mental health nursing module, clinical practice and an anti-stigma program on nursing students' attitudes toward mental illness: a quasi-experimental study. *Journal of Professional Nursing*, 35(3), 201-208.
- Isoardi, K. Z., Ayles, S. F., Harris, K., Finch, C. J., & Page, C. B. (2019). Methamphetamine presentations to an emergency department: Management and complications. *Emergency Medicine Australasia*, 31(4), 593-599. <https://doi.org/10.1111/1742-6723.13219>
- Jenkin, G., Quigg, S., Paap, H., Cooney, E., Peterson, D., & Every-Palmer, S. (2022). Places of safety? Fear and violence in acute mental health facilities: A large qualitative study of staff and service user perspectives. *PLoS one*, 17(5), 1-22.
- Johnston, M. S., & Kilty, J. M. (2016). "It's for their own good": Techniques of neutralization and security guard violence against psychiatric patients. *Punishment & society*, 18(2), 177-197. <https://doi.org/10.1177/1462474516635884>
- Jones, R., Jackson, D., Woods, C., & Usher, K. (2022). Complexity, safety and challenges: Emergency responders' experience of people affected by methamphetamines. *Nursing & Health Sciences*, 24(3), 535-544.
- Jones, R., Usher, K., & Woods, C. (2019). Crystal methamphetamine's impact on frontline emergency services in Victoria, Australia. *Australasian Emergency Care*, 22(4), 201-205.
- Jones, R., Woods, C., & Usher, K. (2018). Rates and features of methamphetamine-related presentations to emergency departments: An integrative literature review. *Journal of Clinical Nursing*, 27(13-14), 2569-2582. <https://doi.org/10.1111/jocn.14493>
- Jones, R., Woods, C., & Usher, K. (2020). The impact of media sensationalism and crisis framing on stigma and negative attitudes towards methamphetamine users. *International Journal of Mental Health Nursing*, 29(3), 319-321. <https://doi.org/10.1111/inm.12708>
- Joondalup Health Campus. (2018). *Mental health observation area opening a benefit to local community*. <https://www.joondaluphealthcampus.com.au/For-Media/News/Mental-Health-Observation-Area-opening-a-benefit-to-local-community>
- Kallio, H., Pietilä, A.-M., Johnson, M., & Kangasniemi, M. (2016). Systematic methodological review: Developing a framework for a qualitative semi-structured interview guide. *Journal of Advanced Nursing*, 72(12), 2954-2965. <https://doi.org/10.1111/jan.13031>
- Kaviyani, F., Khorrami, M., Heydari, H., & Namvar, M. (2023). Understanding the laps and relapse process: in-depth interviews with individual who use methamphetamine. *Substance abuse treatment, prevention, and policy*, 18(1), 1-7.
- Keltner, N. L., & Steele, D. (2019). *Psychiatric nursing* (Eighth ed.). Elsevier Health Sciences.
- King, C. E., Gano, A., & Becker, H. C. (2020). The role of oxytocin in alcohol and drug abuse. *Brain research*, 1736, 146761.
- Kuivalainen, S., Vehviläinen-Julkunen, K., Louheranta, O., Putkonen, A., Repo-Tiihonen, E., & Tiihonen, J. (2017). De-escalation techniques used, and reasons for seclusion and restraint, in a forensic psychiatric hospital. *International Journal of Mental Health Nursing*, 26(5), 513-524. <https://doi.org/10.1111/inm.12389>

- Lakeman, R., & Molloy, L. (2018). Rise of the zombie institution, the failure of mental health nursing leadership, and mental health nursing as a zombie category. *International Journal of Mental Health Nursing*, 27(3), 1009-1014.
- Lamyai, W., Pono, K., Indrakamhaeng, D., Saengsin, A., Songhong, N., Khuwuthyakorn, P., Sribanditmongkol, P., Junkuy, A., & Srisurapanont, M. (2019). Risks of psychosis in methamphetamine users: Cross-sectional study in Thailand. *BMJ open*, 9(10), e032711.
- Lim, A. C., Grodin, E. N., Green, R., Venegas, A., Meredith, L. R., Courtney, K. E., Moallem, N. R., Sayegh, P., London, E. D., & Ray, L. A. (2020). Executive function moderates naltrexone effects on methamphetamine-induced craving and subjective responses. *The American Journal of Drug and Alcohol Abuse*, 1-12. <https://doi.org/10.1080/00952990.2020.1741002>
- López, G., Orchowski, L. M., Reddy, M. K., Nargiso, J., & Johnson, J. E. (2021). A review of research-supported group treatments for drug use disorders. *Substance abuse treatment, prevention and policy*, 16(1), 1-51. <https://doi.org/10.1186/s13011-021-00371-0>
- Lovi, R., & Barr, J. (2009). Stigma reported by nurses related to those experiencing drug and alcohol dependency: A phenomenological giorgi study. *Contemporary Nurse*, 33(2), 166-178. <https://doi.org/10.5172/conu.2009.33.2.166>
- Lowe, D. J., Sasiadek, J. D., Coles, A. S., & George, T. P. (2019). Cannabis and mental illness: a review. *European archives of psychiatry and clinical neuroscience*, 269(1), 107-120.
- Lyell McEwin Hospital. (2018). *Mental health assessment unit model of care*. <http://www.cpsu.asn.au/upload/2018-Info-Updates/Mental%20Health%20Unit%20MoC.pdf>
- Maneesang, W., Hengpraprom, S., & Kalayasiri, R. (2022). Effectiveness of Mindfulness – Based Therapy and Counseling programs (MBTC) on relapses to methamphetamine dependence at a substance dependency treatment center. *Psychiatry Research*, 317, 114886. <https://doi.org/10.1016/j.psychres.2022.114886>
- Marais, C., Soderstrom, J., & Fatovich, D. (2020). Comparison of illicit drug-related presentations to the emergency department: Pre-COVID versus COVID. *Emergency Medicine Australasia*, 32(5), 901-901. <https://doi.org/10.1111/1742-6723.13597>
- May, A. C., Aupperle, R. L., & Stewart, J. L. (2020). Dark Times: The Role of Negative Reinforcement in Methamphetamine Addiction. *Frontiers in Psychiatry*, 11, 114-114. <https://doi.org/10.3389/fpsy.2020.00114>
- McCutcheon, D., Raghavan, M., Soderstrom, J., Oosthuizen, F., Douglas, B., MacDonald, E., & Fatovich, D. (2019). An early warning system for emerging drugs of concern in the Emergency Department: Protocol for the Western Australian illicit substance evaluation (wise) study. *Emergency Medicine Australasia*, 31(3), 411-416. <https://doi.org/10.1111/1742-6723.13185>
- McKenna, B., McEvedy, S., Kelly, K., Long, B., Anderson, J., Dalzell, E., Maguire, T., Tacey, M., & Furness, T. (2017). Association of methamphetamine use and restrictive interventions in an acute adult inpatient mental health unit: A retrospective cohort study. *International Journal of Mental Health Nursing*, 26(1), 49-55. <https://doi.org/10.1111/inm.12283>
- McKetin, R., Degenhardt, L., Shanahan, M., Baker, A. L., Lee, N. K., & Lubman, D. I. (2018). Health service utilisation attributable to methamphetamine use in Australia: Patterns, predictors and national impact. *Drug and Alcohol Review*, 37(2), 196-204. <https://doi.org/10.1111/dar.12518>

- McKetin, R., Kothe, A., Baker, A. L., Lee, N. K., Ross, J., & Lubman, D. I. (2018). Predicting abstinence from methamphetamine use after residential rehabilitation: Findings from the methamphetamine treatment evaluation study. *Drug and Alcohol Review*, 37(1), 70-78. <https://doi.org/10.1111/dar.12528>
- Moustakas, C. E. (1994). *Phenomenological research methods*. Sage.
- North Metropolitan Health Service. (2021). Joondalup health campus. <https://www.nmhs.health.wa.gov.au/Hospitals-and-Services/Hospitals/Joondalup>
- Nursing and Midwifery Board. (2013). *National competency standards for the registered nurse*. <https://www.nursingmidwiferyboard.gov.au/>
- Okundolor, S. I., Ahenkorah, F., Sarff, L., Carson, N., Olmedo, A., Canamar, C., & Mallett, S. (2021). Zero staff assaults in the psychiatric emergency room: Impact of a multifaceted performance improvement project. *Journal of the American Psychiatric Nurses Association*, 27(1), 64-71. <https://doi.org/10.1177/1078390319900243>
- Parke, E. (2021). *Crystal meth is resurgent and 'ravaging' regional Australia. Where it's coming from is a mystery*. <https://www.abc.net.au/news/2021-05-16/regional-meth-market-booming-despite-covid-impact-addicts/100098682>
- Parliament of Australia. (2017). *Overview of crystal methamphetamine and its use in Australia*. https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Law_Enforcement/Crystalmethamphetamine45/First%20report/c02
- Partridge, B., & Affleck, J. (2017). Verbal abuse and physical assault in the emergency department: Rates of violence, perceptions of safety, and attitudes towards security. *Australasian emergency nursing journal*, 20(3), 139-145. <https://doi.org/10.1016/j.aenj.2017.05.001>
- Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological journal*, 20(1), 7-14.
- Pitman, A. L., Stevenson, F., Osborn, D. P., & King, M. B. (2018). The stigma associated with bereavement by suicide and other sudden deaths: A qualitative interview study. *Social Science & Medicine*, 198, 121-129.
- Polit, D. F., & Beck, C. T. (2017). *Nursing research: Generating and assessing evidence for nursing practice* (10th ed.). Wolters Kluwer.
- Price, O., Baker, J., Bee, P., & Lovell, K. (2018). The support-control continuum: An investigation of staff perspectives on factors influencing the success or failure of de-escalation techniques for the management of violence and aggression in mental health settings. *International Journal of Nursing Studies*, 77, 197-206.
- Proebstl, L., Krause, D., Kamp, F., Hager, L., Manz, K., Schacht-Jablonowsky, M., Straif, M., Rietschlager, M., Neumann, S., Schreiber, A., Soyka, M., & Koller, G. (2019). Methamphetamine withdrawal and the restoration of cognitive functions – a study over a course of 6 months abstinence. *Psychiatry Research*, 281, 112599-112599. <https://doi.org/10.1016/j.psychres.2019.112599>
- Queensland Health. (2017). *Methamphetamine Paper*. https://www.health.qld.gov.au/_data/assets/pdf_file/0021/641316/methpaper.pdf

- Rafizadeh, R., Frankow, L., Mahmood, H., Poonia, S., Mathew, N., Danilewitz, M., Bousman, C. A., Honer, W. G., & Schütz, C. G. (2023). Association of clozapine treatment and rate of methamphetamine or amphetamine relapses and abstinence among individuals with concurrent schizophrenia spectrum and amphetamine use disorder: A retrospective cohort study. *Journal of Psychopharmacology*, 02698811231191781.
- Ramsay Health Care. (2023). *Joondalup health campus*. <https://www.joondaluphealthcampus.com.au/>
- Rawstorne, P., O'Connor, R., Cohn, A., Fredrickson, A., Jayasinha, R., Hayen, A., Lancaster, K., & Nathan, S. (2020). Australian news media reporting of methamphetamine: an analysis of print media 2014–2016. *Australian and New Zealand journal of public health*, 44(6), 468-475. <https://doi.org/10.1111/1753-6405.13030>
- Redona, P., Jackson, D., Woods, C., & Usher, K. (2019, Aug). Increasing use of stimulants in Australia: Cause for health services concern. *International Journal of Mental Health Nursing*, 28(4), 795-797. <https://doi.org/10.1111/inm.12636>
- Redona, P. T., Woods, C., Jackson, D., & Usher, K. (2022). Rates and patterns of Australian emergency department presentations of people who use stimulants: A systematic literature review. *Curēus (Palo Alto, CA)*, 14(10), e30429-e30429. <https://doi.org/10.7759/cureus.30429>
- Reeve, R., Arora, S., Butler, K., Viney, R., Burns, L., Goodall, S., & van Gool, K. (2016). Evaluating the impact of hospital based drug and alcohol consultation liaison services. *Journal of Substance Abuse Treatment*, 68, 36-45. <https://doi.org/10.1016/j.jsat.2016.05.008>
- Reiners, G. M. (2012). Understanding the differences between Husserl's (descriptive) and Heidegger's (interpretive) phenomenological research. *Journal of Nursing & Care*, 1(5), 1-3.
- Richards, J. R., Hawkins, J. A., Acevedo, E. W., & Laurin, E. G. (2018). The care of patients using methamphetamine in the Emergency Department: Perception of nurses, residents, and faculty. *Substance Abuse*, 40(1), 95-101. <https://doi.org/10.1080/08897077.2018.1449170>
- Royal Perth Hospital. (2021). *Mental Health Services*. <https://rph.health.wa.gov.au/Our-services/Mental-Health>
- Searby, A., Burr, D., & McGrath, I. (2022). The demographic profile of alcohol and other drug (AOD) nurses in Australia: Experienced, highly qualified... and endangered? *Collegian*, 29(1), 22-30.
- Sibanda, N. C., Kornhaber, R., Hunt, G. E., Morley, K., & Cleary, M. (2019). Prevalence and risk factors of Emergency Department presentations with methamphetamine intoxication or dependence: A systematic review and meta-analysis. *Issues in Mental Health Nursing*, 40(7), 567-578. <https://doi.org/10.1080/01612840.2018.1553003>
- Sir Charles Gardner Hospital. (2020). *Mental Health Observation Area (MHOA)*. <https://www.scgh.health.wa.gov.au/Our-Services/Service-directory/MHOA>
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory method and research*. Sage. [https://bookshelf.vitalsource.com/#/books/9781446243251/cfi/6/10\[vnd.vst.idref=contents\]!](https://bookshelf.vitalsource.com/#/books/9781446243251/cfi/6/10[vnd.vst.idref=contents]!)
- Smith, J. A., & Nizza, I. E. (2022). *Essentials of Interpretive Phenomenological Analysis*. American Psychological Association.

- Smith, J. A., & Shinebourne, P. (2012). *Interpretative Phenomenological Analysis*. American Psychological Association.
- State Records Office of Western Australia. (2013). *Western Australian university sector disposal authority*. https://www.sro.wa.gov.au/sites/default/files/western-australian-university-sector-disposal-authority_-_revised_edition_-_approved_6_dec_2013.pdf
- Stuart, A. M., Baker, A. L., Denham, A. M. J., Lee, N. K., Hall, A., Oldmeadow, C., Dunlop, A., Bowman, J., & McCarter, K. (2020). Psychological treatment for methamphetamine use and associated psychiatric symptom outcomes: A systematic review. *Journal of Substance Abuse Treatment, 109*, 61-79. <https://doi.org/10.1016/j.jsat.2019.09.005>
- Sundler, A. J., Lindberg, E., Nilsson, C., Palmér, L., Akademin för vård, a. o. v., & Högskolan i, B. (2019). Qualitative thematic analysis based on descriptive phenomenology. *Nursing Open, 6*(3), 733-739. <https://doi.org/10.1002/nop2.275>
- Suri, H. (2011). Purposeful sampling in qualitative research synthesis. *Qualitative Research Journal, 11*(2), 63-75. <https://doi.org/10.3316/QRJ1102063>
- Tatari, F., Farnia, V., Salemi, S., Davarinejad, O., Ghaderi, S., Rahami, B., Riazi Doost, M., & Alikhani, M. (2021). Evaluation of stress-coping strategies and their association with relapse rate in people with methamphetamine use disorder: an analytical study. *Journal of substance use, 26*(2), 166-173. <https://doi.org/10.1080/14659891.2020.1800842>
- Tucker, J., Whitehead, L., Palamara, P., Rosman, J. X., & Seaman, K. (2020). Recognition and management of agitation in acute mental health services: a qualitative evaluation of staff perceptions. *BMC nursing, 19*(1), 1-10.
- Turner, D. W., III. (2010). Qualitative interview design: A practical guide for novice investigators. *Qualitative report, 15*(3), 754-760. <http://nsuworks.nova.edu/tqr/vol15/iss3/19>
- Unadkat, A., Subasinghe, S., Harvey, R. J., & Castle, D. J. (2019). Methamphetamine use in patients presenting to Emergency Departments and psychiatric inpatient facilities: What are the service implications? *Australasian Psychiatry, 27*(1), 14-17. <https://doi.org/10.1177/1039856218810155>
- United Nations Office on Drugs and Crime. (2022). *World drug report*. https://www.unodc.org/unodc/en/data-and-analysis/wdr-2022_booklet-4.html
- United Nations Office on Drugs and Crime. (2023). *Synthetic drugs in east and southeast asia*. https://www.unodc.org/roseap/uploads/documents/Publications/2023/Synthetic_Drugs_in_East_and_Southeast_Asia_2023.pdf
- Usher, K., Clough, A., Woods, C., & Robertson, J. (2015). Is there an ice epidemic in Australia. *International Journal of Mental Health Nursing, 24*(4), 283-285. <https://doi.org/10.1111/inm.12155>
- Usher, K., Jackson, D., Woods, C., Sayers, J., Kornhaber, R., & Cleary, M. (2017). Safety, risk, and aggression: Health professionals' experiences of caring for people affected by methamphetamine when presenting for emergency care. *International Journal of Mental Health Nursing, 26*(5), 437-444. <https://doi.org/10.1111/inm.12345>
- Wand, T., Bell, N., Stack, A., Collett, G., Cutten, A., Murphy, M., & White, K. (2020). Multi-site study exploring the experiences of security staff responding to mental health, drug health and behavioural

challenges in the emergency department. *Emergency Medicine Australasia*, 32(5), 793-800.
<https://doi.org/10.1111/1742-6723.13511>

- Ward, B., Lane, R., Quinn, B., & Russell, G. (2021). Qualitative understandings of access to primary care services for consumers who use methamphetamine. *Australian Journal of General Practice*, 50(7), 505-510.
- Wearne, T. A., & Cornish, J. L. (2018). A comparison of methamphetamine-induced psychosis and schizophrenia: a review of positive, negative, and cognitive symptomatology. *Frontiers in Psychiatry*, 9, 491.
- Weltens, I., Bak, M., Verhagen, S., Vandenberk, E., Domen, P., van Amelsvoort, T., & Drukker, M. (2021). Aggression on the psychiatric ward: prevalence and risk factors. A systematic review of the literature. *PLoS one*, 16(10), e0258346.
- West Australian Department of Health. (2018). *Meth-related emergency department attendances*.
<https://ww2.health.wa.gov.au/-/media/Files/Corporate/Reports-and-publications/Meth-report/Meth-Report-July-December-2017.pdf>
- West Australian Department of Health. (2021). *Using agitation and arousal chart (AAC)*.
https://www.health.wa.gov.au/Articles/J_M/Medication-charts
- Whiting, D., Lichtenstein, P., & Fazel, S. (2021). Violence and mental disorders: a structured review of associations by individual diagnoses, risk factors, and risk assessment. *The Lancet Psychiatry*, 8(2), 150-161.
- Whiting, L. S. (2008). Semi-structured interviews: Guidance for novice researchers. *Nursing standard*, 22(23), 35-40. <https://doi.org/10.7748/ns2008.02.22.23.35.c6420>
- Whittemore, R., Chase, S. K., & Mandle, C. L. (2001). Validity in qualitative research. *Qualitative Health Research*, 11(4), 522-537. <https://doi.org/10.1177/104973201129119299>
- World Health Organization. (1996). *Amphetamine type stimulants*.
<https://www.who.int/publications/i/item/amphetamine-type-stimulants-a-report-from-the-who-meeting-on-amphetamines-mdma-and-other-psychostimulants>
- Zarse, E. M., Neff, M. R., Yoder, R., Hulvershorn, L., Chambers, J. E., & Chambers, R. A. (2019). The adverse childhood experiences questionnaire: Two decades of research on childhood trauma as a primary cause of adult mental illness, addiction, and medical diseases. *Cogent Medicine*, 6(1), 1581447.

Appendix A: Formal Letter of Support from Unit Manager



Joondalup Hospital Pty Ltd trading as
Joondalup Health Campus
ABN 61 106 723 183
Cnr Grand Blvd & Shenton Ave
Joondalup WA 6027
PO Box 242 Joondalup WA 6919
Telephone: 08 9400 9400
Facsimile: 08 9400 9054
www.joondaluphealthcampus.com.au

To whom it may concern,

I am writing in support of John Kriticos' proposed research project at Joondalup Mental Health Unit. I understand that he intends to interview nursing staff about their experiences treating methamphetamine users, and I am aware that he intends to recruit participants by handing out participant information sheets, questionnaires, and consent forms during handover meetings. As long as John obtains approval from both the University of Notre Dame and Joondalup Health Campus's Human Research Ethics Committee's, I am happy for him to recruit and interview staff employed at Joondalup Mental Health Unit.

Sincerely,

Craig Creswell,

A handwritten signature in cursive script that reads "C. Creswell".

Unit Manager

Joondalup Mental Health Unit

Appendix B: Recruitment Poster



The University of Notre Dame Australia: School of Health Sciences

Are you a nurse with experience caring for methamphetamine users in the MHU?

Caring for methamphetamine users: A pilot study exploring the experiences of West Australian Nurse working in an Authorized Mental Health Unit (AMHU)

About the study

- Understanding nurses' feelings, thoughts and experiences when caring for methamphetamine users
- Explore this unique nursing issue
- Provide a voice for nurses to build on future research about providing care to methamphetamine users

Who can Participate?

- Registered or Enrolled nurses with at least 1 year experience in acute psychiatry
- Work an average of at least 3 shifts per week in the AMHU
- Regularly provide care for methamphetamine users
- Recently provided care for methamphetamine users

What is Involved?

- You will be asked to participate in a 60-minute interview
- All interviews will be audio recorded
- Your contributions will be kept confidential and anonymous
- Interviews can be conducted online via zoom or face-to-face, depending on your preference

How do I get involved?

- Help yourself to a "participation packs" below this poster. These packs contain a participant information sheet, two consent forms, and a questionnaire.
- Read through the forms and contact John Kriticos by email or telephone (information below)
- If you are happy to participate, complete all forms and place these in John Kriticos' pigeonhole.
- Hold onto the second consent form, as this is for you to keep.
- The research team will contact you to arrange an interview.

For more information on how to participate please contact John Kriticos
John.Kriticos1@my.nd.edu.au
0452612781

Investigators:

Dr Amanda Timler - Amanda.Timler@nd.edu.au
John Kriticos (RN) - John.Kriticos1@my.nd.edu.au
Professor Jim Codde - Jim.Codde@nd.edu.au
Greg Gordon (CNS) - GordonGreg@ramsayhealth.com.au

Appendix C: Screening Questionnaire

Name - _____

Date - _____

Email- _____

Mobile Number - _____

1. Are you a registered or enrolled Nurse?
 registered
 enrolled

2. How long have you worked as a nurse in mental health?
 < 1 year
 1-3 years
 3-5 years
 5-10 years
 > 10 years

3. How long have you worked in Joondalup mental health unit?
 < 1 year
 1-3 years
 3-5 years
 5-10 years
 > 10 years

4. On average, how many shifts per week do you work in Joondalup mental health unit?
 1
 2
 3
 4
 5 or more

5. Are you working outside of mental health in a general or medical capacity?
 yes
 no

6. Have you recently and regularly provided nursing care to patients who have used MA?
 yes
 no

7. Please select the age bracket that describes your age best:
 20-29
 30-39
 40-49
 50-59
 60-69
 70-79

8. Is it okay if the research team contacts you the day after the interview to make sure you are not upset as a result of anything that occurred during the interview?
 yes
 no

9. How would you prefer to be contacted?

telephone call

sms

10. Would you like to be emailed a copy of the study's results when they are published?

yes

no

Appendix D: Participant Information Sheet
Caring for patients who have used MA: A pilot study exploring the experiences of West Australian nurses working in an Authorized Mental Health Unit

Dear Participant,

You are invited to participate in the research project described below.

What is the project about?

This research project will investigate the lived experiences of nurses who work in an Authorized Mental Health Unit and provide care for patients who have used MA. It is important to understand nurse's experiences who work in this challenging environment and how they provide care to MA users. It is hoped that these results will provide valuable insights for clinicians working with people who use the drug. Furthermore, the results from the study may be used to assist in guiding future research about MA.

Who is undertaking the project?

This project is being conducted by John Kriticos and will form the basis for the degree of Master of Philosophy at The University of Notre Dame Australia, under the supervision of Dr Amanda Timler, Professor Jim Codde, and Greg Gordon (Alcohol and other Drug Clinical Nurse Specialist, Industry Supervisor).

What will I be asked to do?

If you consent to take part in this research study, it is important that you understand the purpose of the study and what you will be asked to do. Please make sure that you ask any questions you may have and that all your questions have been answered to your satisfaction before you agree to participate.

You will be asked to complete a short screening questionnaire and then participate in an interview to help us understand your experiences when providing care to MA users in an Authorized Mental Health Unit.

The interview will take place either face-to-face or via zoom online depending on your preference and will last approximately 60 minutes. All interviews will be audio-recorded using an electronic recording device. Approximately one week after the interview you will be given a copy of your interview transcript and asked to review it in order to ensure the transcript reflects your contributions.

Are there any risks associated with participating in this project?

We do not anticipate any risk to you participating in this research project, as you will be asked questions relating to your employment. However, if you find the questions asked bring up difficult feelings, we can arrange for you to see your General Practitioner in order to discuss a mental health care plan. If you experience distressing feelings that cannot wait to be addressed, we will help you contact the Mental Health Emergency Response Line.

What are the benefits of the research project?

Participating in this project may not result in any immediate benefits for participants. However, research has shown that interviews with nursing staff allows participants to reflect on their practice, leading to some nurses making beneficial conclusions that they may not have otherwise reached. It is hoped that the interviews conducted will shine a light on the unique aspects of caring for MA users. Participation will provide nurses with a voice about their experience and may lead to the development of improved future policies and practices.

What if I change my mind?

Participation in this study is completely voluntary. Even if you agree to participate, you are free to withdraw from further participation at any time without giving a reason and with no negative consequences. You are also free to ask for any information which identifies you to be withdrawn from the study.

How will you keep my information private and confidential?

Information gathered about you will be held in strict confidence and will not be released by the researcher to a third party unless required to do so by law.

The audio recording from the interviews and the transcriptions of these recordings will be stored on a university password protected computer. Only the researchers will have access to this information during the project.

Once the study is completed, the data collected from you will be de-identified and stored securely as per university policy for research data management. This will be stored for a five-year period. All participant contributions will be kept anonymous and referred to using a coding system or pseudonyms. The data may be used in future research,

but your information will not be identifiable. The results of the study will be published as a journal article and thesis.

Will I be able to find out the results of the project?

You will be invited to request a copy of the study's published results. Once we have analysed the information from this study, we will email all participants who have requested a copy of our findings. You can expect to receive this summary by the end of 2022 or once the results have been accepted for publication.

Who do I contact if I have questions about the project?

If you have any questions about this project, please feel free to contact John Kriticos at john.kriticos1@my.nd.edu.au. Alternatively, you can contact Dr Amanda Timler at amanda.timler@nd.edu.au.

What if I have a concern or complaint?

The study has been approved by the Human Research Ethics Committee at The University of Notre Dame Australia (approval number 2021-79F). If you have a concern or complaints regarding the ethical conduct of this research project and would like to speak to an independent person, please contact Notre Dame's Research Ethics Officer at (08) 9433 0943 or research.ethics@nd.edu.au. Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

How do I sign up to participate?

If you are happy to participate, please sign both copies of the consent form, keep one for yourself and contact the researchers.

Thank you for your time. This sheet is for you to keep.

Yours sincerely,

John Kriticos (RN), Dr Amanda Timler, Professor Jim Codde, and Greg Gordon (CNS)

If participants have any complaint regarding the manner in which a research project is conducted, it should be directed to the Executive Officer of the Human Research Ethics Committee, Research Office, The University of Notre Dame Australia, PO Box 1225 Fremantle WA 6959, phone (08) 9433 0943, research@nd.edu.au

Appendix E: Consent Form



CONSENT FORM

Caring for patients who have used methamphetamine: A pilot study exploring the experiences of West Australian nurses working in an Authorized Mental Health Unit

- I agree to take part in this research project.
- I have read the Information Sheet provided and been given a full explanation of the purpose of this study, the procedures involved and what is expected of me.
- I understand that I will:
 - Take part in a face-to-face interview
 - Be interviewed for approximately one hour
 - Be audio recorded
 - Be given a copy of the interview transcripts to review approximately one week after the interview
- The researcher has answered all my questions and has explained possible problems that may arise as a result of my participation in this study.
- I understand that I may withdraw from participating in the project at any time without prejudice.
- I understand that all information provided by me is treated as confidential and will not be released by the researcher to a third party unless required to do so by law.
- I agree that any research data gathered for the study may be published provided my name or other identifying information is not disclosed.
- I understand that research data gathered may be used for future research, but my name and other identifying information will be removed.
- I understand I will be asked to provide contact details to the researcher for further follow-up

Please select the interview process you would like to take part in. I would prefer to take part in a:

- Face to face interview
- Online zoom

Name of participant			
Signature of participant		Date	

- I confirm that I have provided the Information Sheet concerning this research project to the above participant, explained what participating involves and have answered all questions asked of me.

Signature of Researcher		Date	
-------------------------	--	------	--

If participants have any complaint regarding the manner in which a research project is conducted, it should be directed to the Executive Officer of the Human Research Ethics Committee, Research Office, The University of Notre Dame Australia, PO Box 1225 Fremantle WA 6959, phone (08) 9433 0943, research@nd.edu.au

Consent Form template (October 2017)

Appendix F: The University of Notre Dame Ethics Approval letter



19 Mouat St (PO Box 1225) Fremantle WA 6959
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11 January 2022

A/Prof Amanda Timler
School of Nursing, Midwifery, Health Sciences & Physiotherapy
The University of Notre Dame Australia
Fremantle Campus

Dear Amanda

Reference Number: 2021-179F

Project Title: "Caring for patients who have used methamphetamine: A pilot study exploring the experiences of West Australian nurses working in an Authorized Mental Health Unit"

Your response to the conditions imposed by a sub-committee of the University of Notre Dame Human Research Ethics Committee (HREC) has been reviewed in accordance with the *National Statement on Ethical Conduct in Human Research* (2007, updated 2018). I am pleased to advise that ethics approval has been granted for this proposed study.

Other researchers identified as working on this project are:

Name	School/Centre	Role
Mr John Kriticos	School of NMHS&P, UNDA	Researcher
Mr Greg Gordon	Joondalup Health Campus	Co-supervisor
Prof Jim Codde	Institute for Health Research, UNDA	Co-supervisor

**All research projects are approved subject to standard conditions of approval.
Please read the attached document for details of these conditions.**

On behalf of the Human Research Ethics Committee, I wish you well with your study.

Yours sincerely

Dr Erica Lewin
Research Ethics Officer
Research Office

cc: Dr Chris Joyce, SRC Chair, School of NMHS&P

Broome Campus 88 Guy St (PO Box 2267) Broome WA 6725
Sydney Campus 140 Broadway (PO Box 944) NSW 2007

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Appendix G: Joondalup Health Campus Ethics Approval Letter



11 February 2022

Mr John Kriticos
Letter via email : kriticosjohn@gmail.com
Cc : amanda.timler@nd.edu.au

Dear Mr Kriticos,

RE: HREC 2202W : Caring for patients who have used methamphetamine: A pilot study exploring the experiences of West Australian nurses working in an Authorized Mental Health Unit

The Ramsay Health Care WA|SA Human Research Ethics Committee (RHC WA|SA HREC) has granted ethical approval to the above project which was reviewed under the low/negligible risk pathway. The sites for which ethical oversight will be provided by the RHC WA|SA HREC include:

Study Site	Site Principal Investigator
Joondalup Health Campus	Mr John Kriticos

The RHC WA|SA HREC provides **ethical approval** for all RHC facilities in WA and SA. **Please note that site-specific approval must be granted before you commence your project at any RHC site.**

Your project approval number is **2202W**, as indicated above; please quote this number in all correspondence to the RHC WA|SA HREC.

The documents approved as part of this submission include:

Document	Version	Date
Participant Information	-	April 2021
Consent Form	-	-
Recruitment Poster	-	-
Screening Questionnaire	-	-
Interview Schedule	-	-
Letter of Support	-	-
Notre Dame HREC Application	-	07/12/2021
Notre Dame HREC Conditional Approval	-	14/12/2021

This HREC is constituted and operates in accordance with the National Statement on Ethical Conduct in Human Research (2007), updated 2018. The Committee's continuing approval is subject to the following conditions being met:

- The Coordinating Principal Investigator will immediately report anything that might warrant review of ethical approval of the project.
- The Coordinating Principal Investigator will notify the RHC WA|SA HREC of any event, including new information from other published or unpublished studies which may have an impact on the continued ethical acceptability of the trial /evolving safety profile of the trial, or which may indicate the need for amendments to the trial protocol/documents and **submit any required**

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amendments in accordance with the instructions provided by the HREC. These instructions can be found on the RHC research website*.

- The Coordinating Principal Investigator will submit any necessary reports related to the safety of research participants in accordance with RHC WA|SA HREC policy and procedures. These instructions can be found on the RHC research website*.
- The Coordinating Principal Investigator will report to the RHC WA|SA HREC annually in the specified format and notify the HREC when the project is completed at all sites.
- The Coordinating Principal Investigator will notify the RHC WA|SA HREC if the project is discontinued at a participating site before the expected completion date, with reasons provided.
- The Coordinating Principal Investigator will notify the RHC WA|SA HREC of any plan to extend the duration of the project past the approval period listed above and will submit any associated required documentation. Instructions for obtaining an extension of approval can be found on the RHC research website*.
- The Coordinating Principal Investigator will notify the RHC WA|SA HREC of his or her inability to continue as Coordinating Principal Investigator including the name of and contact information for a replacement.
- The Coordinating Principal Investigator will notify the RHC WA|SA HREC if the project does not commence within six months of approval.

Your approval is initially for four years from date of approval; after this period, you may be asked to apply for an extension or re-apply. You are also required to notify the Committee promptly of any changes in your contact details.

A copy of this ethical approval letter should be presented when required as official confirmation of the approval of the RHC WA|SA HREC

This letter constitutes ethical approval only. This project cannot proceed at any site until separate research governance authorisation has been obtained from the CEO (or delegate) of the Facility where the research is to be conducted.

Should you have any queries about the RHC WA|SA HREC's consideration of your project please contact the Executive Officer. The RHC WA|SA HREC Terms of Reference, Standard Operating Procedures, membership and standard forms are available from the RHC Research website or from the Executive Officer.

The RHC WA|SA HREC wishes you every success in your research.

Yours sincerely



A/Prof Paul Porter
Chairperson, Ramsay Health Care WA | SA HREC
RHC WA|SA HREC contact details:
Joanna Brisbane, Executive Officer
RamsayHREC.WA-SA@ramsayhealth.com.au
*website: www.ramsayhealth.com.au/Research/Research-Ethics

Appendix H: Interview Schedule

Interview Schedule

These questions will be asked following the provision and explanation of consent and participant information sheet. The semi-structured Interview Questions will not necessarily follow a linear progression. Participants will be allowed to diverge in pursuit of new or emerging ideas.

Title of the research project: MA and Psychiatric Nursing Care

Caring for patients who have used MA: A Pilot study exploring the experiences of nurses who work in a West Australian Authorized Mental Health Unit

Introduction to participants

I am a Master of Philosophy Student at The University of Notre Dame Australia and I am conducting this research to understand what it is like for nurses who work in an Authorized Mental Health Unit and provide care for patients who have used MA.

As I have explained in the PIS document, we are conducting individual zoom interviews with nurses. The interview should take approximately 45 minutes. Are you happy to take part in the interview and be audio recorded today? During the recording, could I please ask that you refrain from using the chat function in zoom.

I would like to take this opportunity to remind you that everything you say during the interview will be confidential. All of your contributions will be de-identified and kept anonymous. Also, please remember you are free to withdraw from the interview at any time without further explanation or negative consequences.

Do you have any questions before we begin?

I am starting the recording now

Thank you for taking the time to be interviewed and showing your interest in this research study. In this interview we will ask you questions about your current role and more specifically your experience of providing care for patients who use MA. I will keep the interview flexible to ensure that you can talk about anything you think is important. There are no right or wrong answers. Everything you can tell me about your experiences will be valuable to me. If any of the questions make you uncomfortable, please let me know – you don't need to answer questions that you aren't comfortable with.

1. Could you please tell me about the reasons you choose to work in mental health?
 - What motivates you to provide psychiatric care?
2. Could you please tell me about your current role when working in Joondalup's Authorized Mental Health Unit?
 - *What does a typical day at work look like for you?*
3. *How often do you work with patients who use MA?*
 - *What symptoms do you normally treat?*
 - *What is that like? (what were you thinking/feeling)*
 - *Are there any specific examples that come to mind?*
4. Is caring for these patients different than caring for other patients or was it the same? Why? *Eg:*
 - Different to patients who use alcohol or other drugs*
 - Different to patients who don't use drugs*
 - Different to treating patients when it is not known whether they have used drugs*
 - In what way is it different or the same?*
5. Could you describe any specific training that you have received to care for patients who use MA?
 - *Any examples of formal training or informal training*
6. Could you tell me about any strategies that you use when providing care to these patients?
 - *What strategies have you found to be helpful?*
 - *What strategies have found to be unhelpful?*

7. Could you describe any incidents where you had to ask for help when providing care to these patients?
 - *What was it like asking for help (what were you thinking. Feeling)?*
 - *Who did you ask?*
 - *Were they able to help?*
 - *Do you feel like resources are available to help with this specific presentation?*
 - *Have you ever felt that asking for help made the situation worse?*

8. Could you describe how often you see the same patients who use MA being re-admitted to the unit?
 - *Where do you see them represent?*
 - *Could you describe why this may be the case? (Eg. because they have relapsed?)*
 - *How does that make you feel?*
 - *Could you describe how you interact with patients who are frequently admitted?*
 - *How do you view them as a patient?*
 - *Do you think other nurses feel the same way as you? (Why/Why not)*

9. Could you describe any changes to the care you provide when patients who use MA present with similar symptoms over time?
 - *Could you provide me with an example of something that you do differently?*
 - *Could you provide me with an example of the way you communicate with MA users?*
 - *Could you describe any changes to the way you feel when providing care to these patients?*
 - *Why do you think these changes have occurred?*

10. Could you tell me about the way you feel after providing care to patients who use MA?
 - *Do you experience any positive or negative emotions?*
 - *What factors have influenced the way you think about this experience?*

11. Could you describe any changes in the behaviours of MA patients you have seen recently?
 - *Eg. Number of presentations, Level of aggression, reasons for presentations*

12. Do you think it's possible for nurses to improve the care they provide to MA users in acute psychiatric environments?
 - How?

13. Is there anything else about your experience when treating these patients that you feel is important to talk about?

Closing Remarks

- Do you have any questions?
- Would you like to add anything to your responses?

Thank you for participating in the interview. Is it okay if I get in touch with you tomorrow, to make sure that you are feeling okay after participating in the interview? If yes, would you prefer a phone call or a text message? Can I just check that I have your correct contact details?