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Investigating the Suitability of the Forensic Mental Health Nursing Clinical Reasoning Cycle for Nurses Working in Generalist Mental Health Settings

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ABSTRACT

The clinical reasoning cycle was designed to guide nursing care and assist with clinical-reasoning and decision-making. While originally developed with an acute health lens, more recently an adapted version has been created for forensic mental health nurses. It is possible that such a framework may also be helpful for mental health nurses working in generalist settings. This study aimed to explore the utility of the original cycle and adapted forensic version with mental health nurses across the state of Victoria, Australia, to determine if the cycle might be suitable to their practice and if any adaptations were necessary. Eighteen nurses participated in focus groups or interviews to explore both versions of the cycle. Following thematic data analysis from phase one, a Nominal Group Technique was used to facilitate exploration of adaptations. Verbal and written responses were collected and participants ($n = 6$) voted on changes. Three main themes were interpreted from phase one: (1) the mysterious disappearance of nursing frameworks, (2) the CRC fits with what we do, says what we do, and demonstrates what we do, and (3) The CRC becomes more relevant without the word "forensic" in the title. In the nominal group, consensus was reached on 4 of 10 suggested changes from phase one, and the mental health nursing-clinical reasoning cycle was developed. There was concern that many nurses did not have a framework to guide decision-making, and the newly adapted cycle was seen as offering a way of demonstrating the contribution of mental health nursing care to safe practice.

1 | INTRODCUTION

Mental health nursing requires sound assessment, planning, intervention and evaluation, to ensure evidence-based practice and provide recovery-oriented person-centred care (Moyo, Jones, and Gray 2022). Mental health nurses also need to be aware of how their personal assumptions, beliefs, and values impact their nursing practice (Younas et al. 2020). Frameworks can be used to guide nursing care and can positively influence collaboration, judgement, clinical reasoning, and reflection (Maguire et al. 2023). For many years, the nursing process has been widely used as a guide to systematic person-centred care (Mahmoud and Bayoumy 2014). While the nursing process has been used globally and across nursing specialities, a systematic review has identified challenges associated with use and implementation (Zamanzadeh et al. 2015). These challenges include problems gaining a concrete understanding of the concept of the nursing process and a lack of knowledge as to how to operationalise the process in practice (Tanner 2006; Zamanzadeh et al. 2015). There are, however, alternative frameworks to

guide practice such as the clinical reasoning cycle (see Levett-Jones 2018), the framework that is the focus of this study.

2 | Background

The clinical reasoning cycle (CRC) is a contemporary systematic framework designed to guide care and includes a strong focus on reflection on care provision and nursing practice (Levett-Jones 2018). The CRC (see Figure 1) comprises eight steps (consider patient's situation, collect cues, process information, identify issues, establish goals, take action, evaluate outcomes, and reflect on process) and uses a variety of strategies to prompt critical-thinking, decision-making, and problem-solving. In practice, once the situation and issues are identified, specific goals are set, nursing interventions are planned and instigated, and outcomes are evaluated. The final phase is a reflection on care provision, and how new learnings can be integrated into future nursing practice (Hunter and Arthur 2016; Levett-Jones et al. 2010; Levett-Jones 2018). The cycle can be used to improve clinical reasoning and judgement, to ultimately enhance patient care, avoid adverse outcomes, and increase nurses' work satisfaction (Levett-Jones 2018).

There has been suggestions that the CRC can be used in a variety of settings; however, it is important to highlight that the cycle was developed from an acute health care perspective, and therefore by nature, is acute health centric. However, the potential for the CRC to be a helpful framework in forensic mental health nursing (see Maguire et al. 2023) led to the development of the forensic mental health clinical reasoning cycle (FMHN-CRC; Maguire et al. 2023). The FMHN-CRC (see Figure 2) differs from the original CRC in a number of ways including language changes to ensure the cycle fits with contemporary FMH practice and is grounded in recovery-oriented, person and family/carer/supporter-centred care (e.g., the word issues has been placed with needs). Additional prompts with the intent of catching potential bias at certain stages during the cyclical process were also added, and the addition of prompts to consider the influence of offending behaviour and certain risks pertinent in a forensic mental health (FMH) setting is required to provide effective and holistic care (Maguire et al. 2023).

While there is now a version of the CRC for nurses working in the FMH setting, there is also the possibility that the CRC may also be suitable for nurses who work in other areas of mental health nursing. In Victoria, like other places globally, there has been significant reform resulting from a Royal Commission into Victoria's Mental Health System; an independent public inquiry held on matters of public importance, only established in rare and exceptional circumstances (see State of Victoria 2020), including a new Mental Health and Wellbeing Act 2022, as suggested by the Royal Commission. The act supports changes to create a diverse, responsive, and compassionate public mental

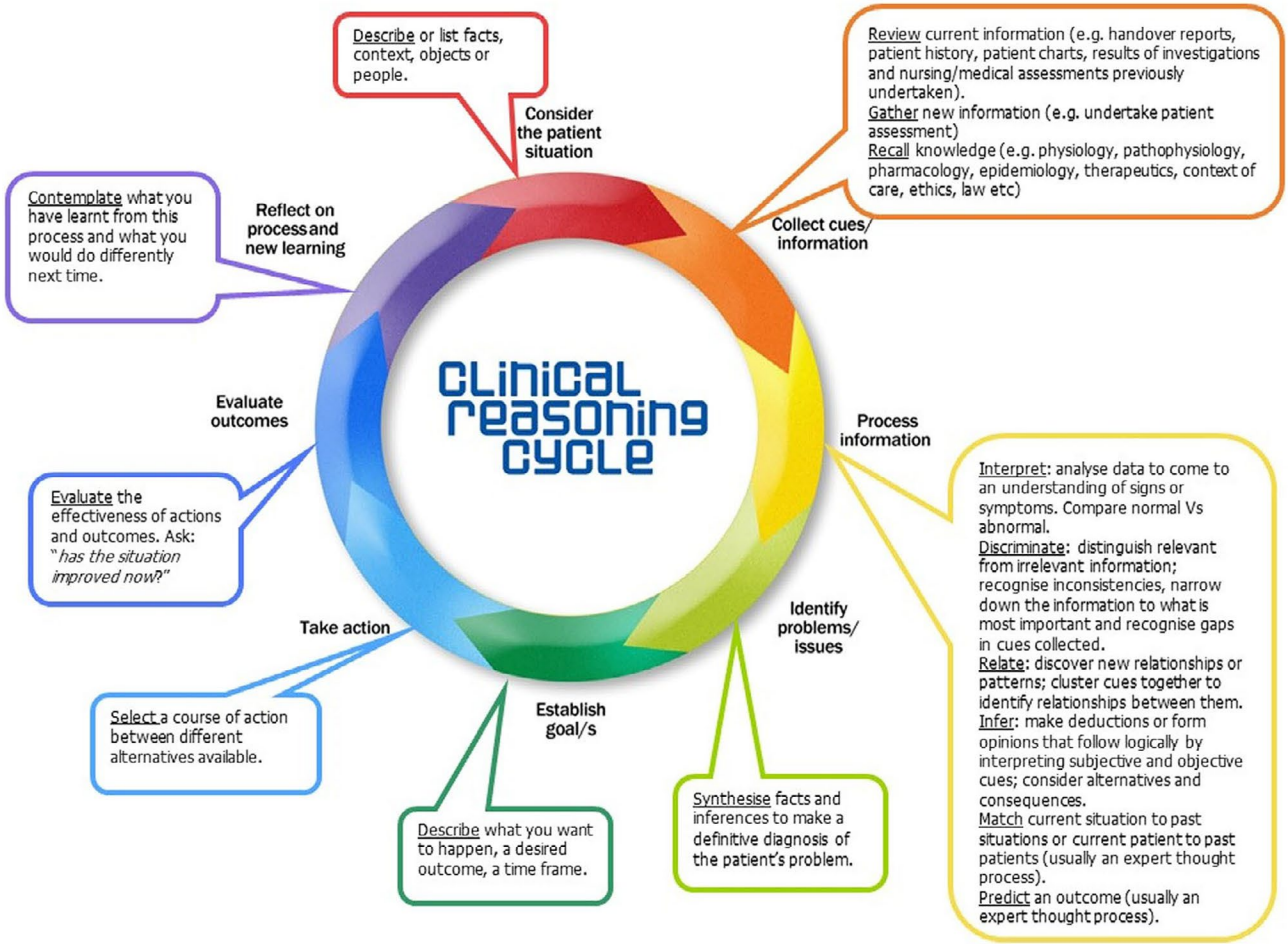

FIGURE 1 | The clinical reasoning cycle (Levett-Jones et al. 2010).

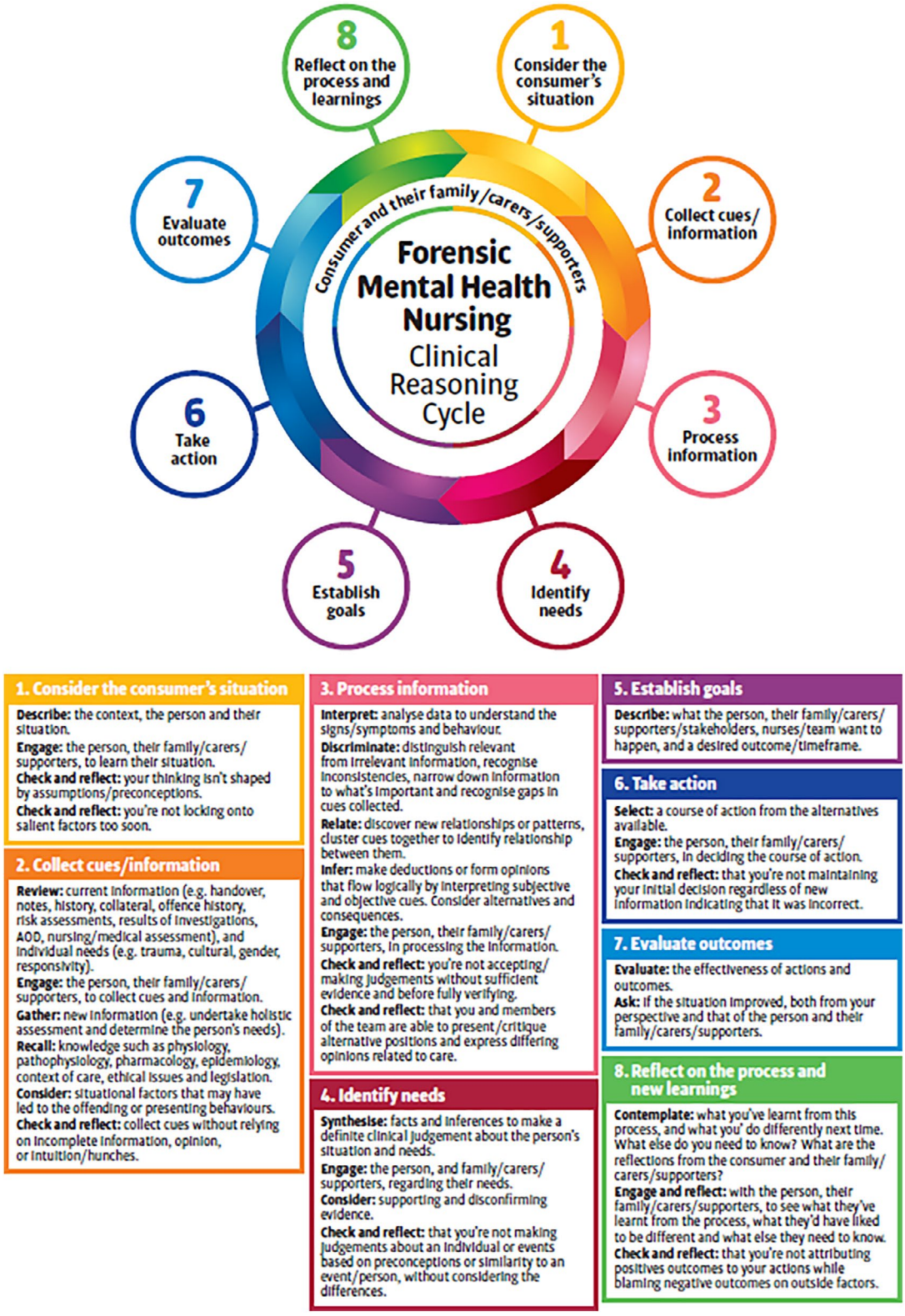

FIGURE 2 | The forensic mental health nursing clinical reasoning cycle (Maguire et al. 2023).

health and wellbeing system (Mental Health and Wellbeing Act 2022). There has also been the instigation of a mental health improvement program designed to work towards the elimination of restrictive practices (such as restraint and seclusion), prevent gender-based violence within mental health inpatient settings, support Victorian healthcare services to adopt the Zero Suicide Framework, and reduce compulsory treatment (Safercare Victoria 2024).

Given all of the reform work and required change to practice, now more than ever this may prove to be an important time for nurses to have a suitable framework to guide clinical reasoning,

clinical judgement, and decision-making. Against this background, this study aimed to explore the clinical reasoning cycle and the forensic mental health-clinical reasoning cycle with mental health nurses working across the state of Victoria to determine if either the CRC, the FMHN-CRC, or an adaption version of either model might provide a suitable framework for use in mental health practice.

3 | Method

Two phases were used to explore the CRC and FMHN-CRC frameworks with mental health nurses across the state of Victoria (see Figure 3). First, a series of focus groups and one-to-one interviews (TM moderated all interviews, and the focus groups were with assistance from TF and MO) were conducted with nurses to explore their thoughts on the two frameworks. This was followed by a nominal group technique with those who had participated in the first phase of the study to determine adaptations and considerations for implementation (see Figure 3).

The NGT is a structured method to enable the development of ideas and contribution from all group members which are then explored, discussed, and voted on as a group (Mullen et al. 2021). In this study, following data analysis from phase one, suggestions for adaptations from the focus groups and interviews were compiled and then presented at the NGT. The phases of the NGT were as follows: (1) the silent generation of ideas where members of the NGT were asked to write their responses to questions in the chat function on Teams; (2) round robin, where participants share the ideas, they had submitted to the chat; (3) clarification of the ideas as a group; and (4) voting privately and assessing the group views. The NGT was facilitated by TM, and TF who are both researchers with extensive qualitative experience. Prior to the NGT, participants were sent a document outlining the suggested changes which they were asked to read. Prior to the commencement of the NGT, participants were given a short refresh on the CRC and adaptations. The adaptations were derived from the data analysis from phase one.

3.1 | Setting

This study was conducted online using Microsoft Teams for the focus groups and six interviews, and Zoom meetings were used for the NGT. For the NGT to ensure that participant responses to the questions were anonymous, the direct chat function of Zoom was used, where the participants directly messaged TF to collect all the responses. TF then copied and pasted all responses onto a word document which was then shared with the group to facilitate discussion. Voting was also anonymous using the direct message function.

3.2 | Participants and Recruitment

Purposeful sampling was used to recruit participants in this study. The participants invited to participate included senior mental health nurses from across the state of Victoria (grade 6 and 7 nurses, for example, Directors of Nursing and

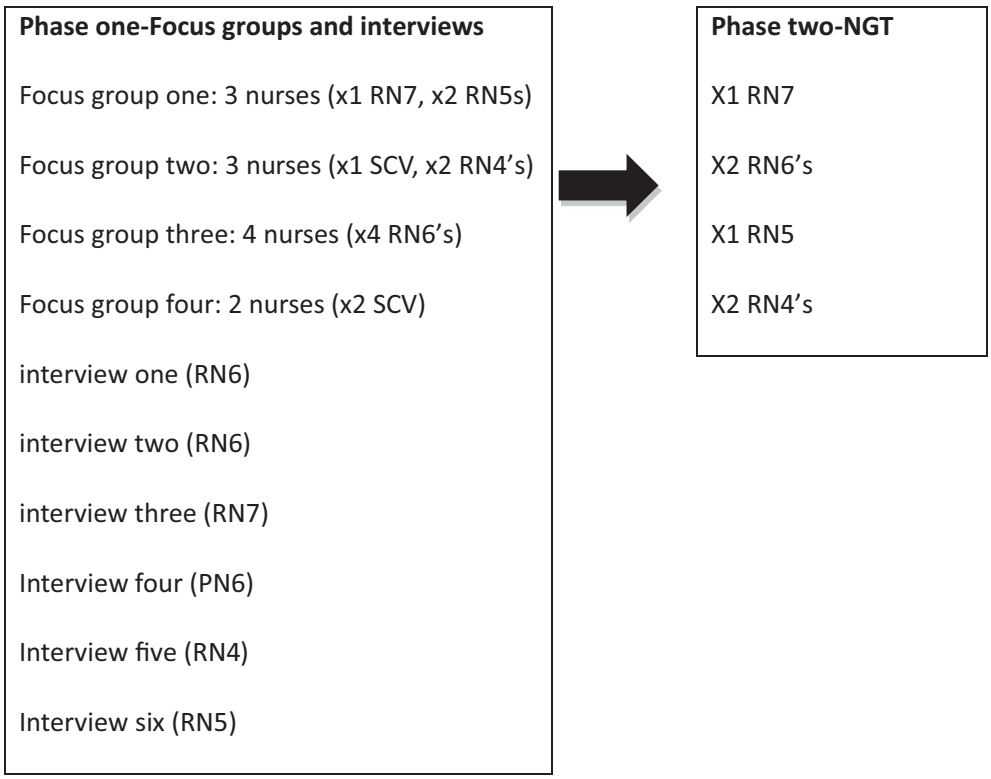

FIGURE 3 | Phases and participants in the study. In Victoria a graduate is a grade 1, second year grade 2. A grade 4 nurse is a clinical nurse educator, A grade 5 nurse is a unit manager or clinical nurse consultant, and grade 6 nurse is a nurse practitioner or senior mental health nurse, and a grade 7 is in the position of director or nursing. RN stands for registered nurse; SCV stands for mental health nurse employed by SCV.

Nurse Practitioners), clinical nurse consultants, and clinical nurse educators (grade 4 and 5 nurses) from across the State of Victoria, and mental health nurses employed by Safercare Victoria. These nurses were recruited on the basis that they have a high level of contemporary knowledge regarding nursing operations and practices and a sound understanding of the translation of theory to practice in contemporary clinical settings across a wide range of public mental health services. An email was sent to the eligible nurses by the person who coordinates the meetings for each of these groups outlining the study. Nurses were asked to indicate their interest to participate by responding to the email. Consent was obtained using electronic consent forms; the participants were able to return the signed consent form via email prior to the focus group/interview. In total, there were 18 participants in phase one from 10 different health care services and in addition representation from Safercare Victoria.

For the second phase of the study, there was an option for participants to tick a box the previous consent form if they were interested in being contacted to participate in the NGT. All participants from phase one selected this option. Participants from phase one were contacted and invited to participate in the NGT.

3.3 | Data Collection

In phase one, a guide was used to prompt the interview questions. The groups and interviews commenced with a brief orientation to the CRC and the FMHN-CRC, and the facilitator inquired if participants were familiar with the CRC, before seeking feedback about the frameworks. The groups and interviews lasted between 50 and 58 min.

For the NGT, ($n=6$) participants were provided with an overview of the CRC and the FMHN-CRC and suggested changes to read prior to the NGT. The NGT was held over 1 h and was audio recorded and transcribed verbatim. All the notes posted in the chat function were also collected for analysis. A group guide was developed to structure the NGT and with consideration to the study objectives. The guide consisted of questions about the suggestions for a modified CRC for mental health nurses. The NGT lasted 60 min.

3.4 | Data Analysis

Data from the focus groups and interviews were analysed using Braun and Clarke's (2019) suggested phases of thematic analysis. Phase one analysis was conducted by TM listening to the audio recordings against the transcripts to ensure accuracy of the transcription. TM and GW then read and reread the transcript several times while also developing notes. Coding then occurred which involved identifying similar statements in the text and assigning codes. Searching for themes was carried out by TM and GW developing thematic maps on a word document. The themes were then discussed by the research team, which resulted in further analysis and refinement. Themes were then finalised and written up in the form of this paper.

The NGT analysis followed a very similar process. TM listened to the NGT audio recordings several times (the group discussion, voting, and final questions in the guide) and checked transcripts for accuracy against the audio-recording, rereading several times while simultaneously generating notes. The notes in the chat function were also pasted onto a word document for analysis. During the NGT, the voting was added, and results reported back to participants. Quotes that reflected the discussions are provided below.

3.5 | Rigour

The Consolidated criteria for REporting Qualitative research (COREQ) checklist has been used to report this study (Tong, Sainsbury, and Craig 2007). To ensure rigour, a methodical and reflexive approach was employed in the study design as well as in data collection and analysis. We sought to engage participants who had the necessary knowledge and clinical experience to consider the research questions. The interviews, focus groups, and NGT were conducted by experienced researchers. All of the notes and transcripts were checked for accuracy. Interpretating data was collaborative with themes being interpreted built on reflections of the team and quotes chosen to illustrate the themes.

3.6 | Ethical Considerations

Approval to conduct this study was given by Swinburne University of Technology (Project ID: 7008). Ethical requirements were adhered to and confidentiality of participants was retained by de-identifying data and assigning participant numbers. The letter P is used for focus groups and interviews, and for the NGT, 'N' was used to code nurses in the NGT.

4 | Findings

From Phase one of the study, three themes were interpreted: (1) the mysterious disappearance of nursing frameworks; (2) the CRC fits with what we do, says what we do, and demonstrates what we do; and (3) The FMHN-CRC becomes more relevant without the word "forensic" in the title, along with suggestions for changes to the FMHN-CRC. In addition, the NGT group reached consensus on four changes. It is interesting to note that most participants had not heard of the CRC or the FMHN-CRC, and the few participants who were familiar, occupied roles working with undergraduates and graduate nurses.

4.1 | Phase One Results

4.1.1 | Theme One: The Mysterious Disappearance of Nursing Frameworks

The first theme presents the observations from many participants about the lack of/and or absence of nursing frameworks to guide mental health nursing practice. Many of the participants acknowledged that having a framework for practice such as the nursing process or the clinical reasoning cycle is important, however noted that nursing frameworks were not being discussed or seen to be

used in practice. One participant stated that in terms of nursing frameworks "ISBAR is probably as deep as it gets" (P16). Nurses who had been trained in the nursing process commented on how it had been ingrained in their practice from undergraduate training; however, they noted that often when providing supervision, the absence of a framework to guide practice was apparent. These nurses were also not aware of other nurses talking about using the nursing process as demonstrated by the following quote.

> The nursing process isn't used. I don't know if treatment plans are based on anything like this...I have a feeling they are developed independently and not attached to any process. I think we're in that stage where we're trying to move away from the medical model and we don't want to let go of some of the medical model stuff, so we end up with this free-floating documentation and processes that aren't actually attached to any frameworks.
>
> (P3)

There was also the identification of potential issues with an absence of a framework.

> If you don't know your own framework for what it is that you're doing as your nursing practice, you become fodder for the institution and you find things that stick to you become the truth. It's not like you can actually create something from the inside out. It's like what hits you and makes an impact is the thing that's going to be carried on through your practice, and it's not all necessarily healthy.

The current state of practice regarding the use of a framework was described by one participant as having "a chasm around it" as well as being "absolutely necessary" and where the FMHN-CRC, was seen as "the missing jigsaw piece." (P16).

4.1.2 | Theme Two: The CRC Fits With What We Do, Says What We Do, and Demonstrates What We Do

Participants felt that the original CRC was missing some important components for mental health nursing including the absence of consumer/carer/supporters' perspectives and support for their personal goals as well as being more task oriented than the work of mental health nurses. However, they considered the FMHN-CRC to address most of these concerns and to be more reflective of recovery-oriented, person-centred practice. There was also a sense that the FMHN-CRC fitted well with the current aims of reform work, organisational values, and that it could be used in mental health nursing supervision, mentoring, and guiding documentation.

> It (FMHN-CRC) is very much in line with current thinking and current reform around carers, family supporters being just such a critical element in the care of a consumer, particularly in a reflective analysis cycle like this, in that a lot of the information and a lot of the dialogue is actually going to be happening with consumers, families, supporters.
>
> (P12)

> It (FMHN-CRC) is about prompting a bit of critical thinking among nurses, especially when clinical supervision or reflective practice kind of things are not done very well among nurses.
>
> (P6)

> It is (FMHN-CRC) to guide people, to nurture them, and to give them something to hang things off of so that they then can get to the experienced clinicians that we are today.
>
> (P7)

Participants also spoke about the FMHN-CRC describing the practice of nursing and that this is something to be promoted to others.

> What I think it does is it puts words to things that were previously described as intuition or just knowing. So, it actually allows us to describe better the process that we're going through to reach our decision versus what we've previously relied on, which is nurse's intuition.
>
> (P3)

> We need to be showing off the hard work we really do as nurses; we're always the underdog and then somebody else comes in and calls it something else.
>
> (P7)

4.1.3 | Theme Three: The FMHN-CRC Becomes More Relevant Without the Word "Forensic" in the Title

This final theme is about having the word forensic in the FMHN-CRC. All participants in this study were of the opinion that the FMHN-CRC would be suitable for public mental health and well-being settings, that it did not seem overly forensic mental health focused and acknowledged they do come across many patients who have had either experience in the forensic mental health system or had forensic mental health needs.

> We often have patients on our ward who require forensic input or who have required transfer to a forensic facility at some point.
>
> (P11)

> Risk and offending is everywhere, unfortunately. You might think offending, okay, that doesn't apply to the person I'm thinking about, I'll just park that, but having an offending prompt gives the nurse the permission also without upsetting anyone. It's just a fact.
>
> (P13)

However, participants considered that some people would see the word "forensic" in the title, and this may result in some nurses to automatically think that the CRC was not for them despite the fact that many nurses encounter patients with forensic histories/forensic mental health needs. In order to make the CRC more relevant for generalist mental health settings, it was suggested by the participants that the word "forensic" be removed.

> It is (FMHN-CRC) very relevant and really good, but I think just seeing that forensic is in there they might think oh no, this is for a different group of people.
>
> (P17)

> I think if I was looking it up and I saw the word forensic, I would not necessarily translate it or think it was translatable to daily practice.
>
> (P9)

> I mean if you just took that word out (forensic), you would not know it was, what you're doing is mental health nursing. The setting is a forensic one, but at the core of it, it's your therapeutic alliance with the consumer and how to support them in their growth and development of their own goals.
>
> (P4)

4.2 | Phase One Suggestions for Adaptions

After data analysis in this phase one, suggestions for adaptations from the focus groups were complied (see Table 1).

4.3 | Phase Two Results

4.3.1 | Results From NGT Voting

Results from the NGT are displayed in Table 2.

Participants reached consensus on four of the ten suggestions for additions/adaptations: the inclusion of consumer perspectives, prompts to consider legislation, presenting behaviour to be stated prior to offending behaviour, not changing the wording of current presentation, adding strengths as well as needs and deleting the word "forensic." Where consensus was not reached (including peer workforce, prompts for governance, checking with others, and adding therapeutic alliance to the centre of the cycle), participants were able to articulate their rationale and were in agreement that these factors might form part of an introduction manual to the cycle in terms of providing background and consideration to these factors in practice, but they did not all agree that they should be included as part of the cycle.

The rationale for not including the peer workforce and checking in with other disciplines was based on the cycle being about the "nurse's clinical reasoning" (N2), as opposed to other disciplines, and "acknowledging that we need to be working with the person and their family's carers and supporters and other disciplines" (N3). Rather, it was proposed that the clinical reasoning needed to be the nurses' clinical reasoning and part of nursing identify (N8) as well as nurses taking "responsibility for our own clinical decisions and not being reliant upon the acceptance of other disciplines." (N5).

Adding clinical governance prompts also did not reach consensus. The following quote reflects a view as to why it should not be included.

> Governance is particularly around being risk averse, and clinicians trying to avoid risk rather than use their own critical thinking and create a care plan that is reflecting the practice that they would like to take, rather than what they think will avoid the risk mitigation. I would encourage never having that in there, that's a systems issue, not a clinical issue.
>
> (N7)

Others in the NGT agreed with this statement and felt governance could be mentioned in the manual, and however, should not be included in the model.

TABLE 1 | Suggestions for adaptations obtained from focus groups and interviews.

Peer workforce to be included in the adapted CRC
Consumers' perspectives and treatment preferences be included in the adapted CRC
Prompts to think about legislation be included in the adapted CRC
Prompts to consider governance be included in the adapted CRC
Prompts to checking in with others, for example, other disciplines, colleagues be included in the adapted CRC
Put presenting behaviour before offending behaviour
Change to current presentation to—how the person currently is feeling, is there evidence of acute distress from the person
Therapeutic alliance/relationship in the centre of the circle
Add identify needs and *strengths*
Delete the word forensic so it becomes the mental health nursing clinical reasoning cycle

TABLE 2 | Results from NGT voting.

Question	Yes (%)	Yes (*n*)	No (%)	No (*n*)
Should peer workforce be included in the adapted CRC?	50	3	50	3
Should consumers perspectives and treatment preferences be included in the adapted CRC?	83.3	5	1.6	1
Should prompts to think about legislation be included in the adapted CRC?	100	6	0	0
Should prompts to consider Governance be included be included in the adapted CRC?	33.3	2	66.7	4
Should presenting behaviour before offending behaviour?	100	6	0	0
Should prompts to checking in with others e.g. other disciplines, colleagues be included in the identifying needs section?	66.7	4	33.3	2
Should we change to current presentation to- how the person currently is feeling, is there evidence of acute distress from the person?	17	1	83	5
Should the therapeutic alliance/relationship in the centre of the circle?	66.7	4	33.3	2
Should we add identify needs and Strengths?	83	5	1.6	1
Should we delete the word forensic-so it is the Mental Health Nursing Clinical Reasoning Cycle?	100	6	0	0

Finally, there was also discussion as to whether the therapeutic relationship should be included in the cycle, whether reflections about the inclusion of this were similar to including checking with others, in that the centre of the cycle should be focused solely on nurses' clinical reasoning.

5 | Discussion

The aim of this study was to seek feedback on the FMHN-CRC to see whether an adapted version might be suitable for mental health nurses working in generalist mental health settings. Senior mental health nurses from across Victoria participated in focus groups and one-to-one interviews to explore the CRC and the FMHN-CRC to see if there might be an interest in such a framework for generalist mental health settings. There was support for a version of the CRC with some adaptations to ensure suitability (see Figure 4 for the final version).

One of the reasons for support of such a model was the reported absence of contextually relevant nursing frameworks to guide mental health nursing practice. The use of guidelines/frameworks in nursing practice to inform clinical decision-making has demonstrated improvement in care processes and health outcomes (Matthew-Maich et al. 2013; Thomas et al. 2009). In practice, nurses need to recall their ways of knowing and how they make sound decisions. To achieve this, nurses engage in self-reflection to advance their professional decision-making processes further (Johansen and O'Brien 2016). Just as nurses working in acute medical and surgical settings are required to make many decisions to meet patient and family/carer/support needs which are often complex in nature (Nibbelink and Brewer 2018), so do nurses working in mental health care settings. Lack of frameworks to guide practice has also been reported in other studies. A study by Coombs, Crookes, and Curtis (2013) exploring mental health nursing assessment found that mental health nursing assessment practice was invisible in nature, resulting in variation between what was being assessed, which then determines the types of interventions being offered. Participants in this study acknowledged that there is a current practice-gap and were supportive of a framework to guide care and decision-making. An adapted version of the FMHN-CRC was considered to offer guidance for nursing practice from the novice to expert.

Nurses' ownership of their practice requires professional identity, professional competence, and the recognition that their practice is influential in the healthcare system (Akhlaghi et al. 2023). There is however evidence that suggests that the work of mental health nurses is often not well understood by other disciplines, patients, and at times, nurses themselves (Rungapadiachy, Madill, and Gough 2006; Terry 2020). The work of mental health nurses has also at times been regarded as invisible and lacking role clarity. Lack of understanding about professional identity can impact recruitment and nurses' confidence in communicating their valuable contribution to care (Terry 2020). One of the advantages of the CRC, as identified by participants, was that it supports the identification of mental health nursing practice and offers a way of showcasing the work of the nurse. This was also reflected in the desire to ensure that the CRC remains focused on the work that is nursing care and that decision-making is owned and made by the nurse, rather than deferring to others. While all the nurses in this study agreed that working with and the inclusion of essential others (e.g., the patient, other disciplines, the lived experience and peer workforce, families/carers and supporters) in the work they do is vital, when considering the clinical decision-making component, nurses in this study wanted to own this and make sure that it is the focus of the framework.

The theme referring to the cycle becoming more relevant without the word forensic in it was important in terms of the participants wanting to make sure that mental health nurses knew the cycle was for them and out of concern that if the word forensic remained in the title it may result in nurses dismissing the cycle. There is possibly still an element of stigma attached to the word forensic, and there remain negative attitudes held by some

1. Consider the consumer's situation

Describe the context, the person and their situation.
Engage the person, their family/carers/ supporters, to learn their situation.
Check and reflect your thinking isn't shaped by assumptions/preconceptions.
Check and reflect you're not locking onto salient factors too soon.

2. Collect cues/information

Review current information (e.g. handover, notes, history, collateral, offence history, risk assessments, results of investigations, AOD, nursing/medical assessment), and individual needs (e.g. trauma, cultural, gender, responsivity).
Engage the person, their family/carers/ supporters, to collect cues and information and seek to understand their perspectives and treatment preferences.
Gather new information (e.g. undertake holistic assessment and determine the person's needs).
Recall knowledge such as physiology, pathophysiology, pharmacology, epidemiology, context of care, ethical issues and legislation.
Consider any relevant legislation. Consider situational factors that may have led to the presenting behaviour or offending.
Check and reflect cues without relying on incomplete information, opinion, or intuition/ hunches.

3. Process information

Analyse data to understand the signs/ symptoms and behaviour.
Distinguish relevant from irrelevant information, recognise inconsistencies, narrow down information to what's important and recognise gaps in cues collected.
Discover new relationships or patterns, cluster cues together to identify relationships between them.
Infer and make deductions or form opinions that flow logically by interpreting subjective and objective cues. Consider alternatives and consequences.
Engage the person, their family/carers/ supporters, in processing the information.
Check and reflect you're not accepting/making judgements without sufficient evidence and before fully verifying.
Check and reflect that you and members of the team are able to present/critique alternative positions and express differing opinions related to care.

4. Identify needs and Strengths

Synthesise facts and inferences to make a definite clinical judgement about the person's situation and needs.
Engage the person, their family/carers/ supporters, regarding their needs.
Consider supporting and disconfirming evidence.
Check and reflect that you're not making judgements about an individual or events based on preconceptions or similarity to an event/person, without considering the differences.

5. Establish goals

Describe what the person, their family/carers/ supporters/stakeholders, nurses/team want to happen, and a desired outcome/timeframe.

6. Take action

Select a course of action from the alternatives available.
Engage the person, their family/carers/ supporters, in deciding the course of action.
Check and reflect that you're not maintaining your initial decision regardless of new information indicating that it was incorrect.

7. Evaluate outcomes

Evaluate the effectiveness of actions and outcomes.
Ask if the situation improved, both from your perspective and that of the person and their family/carers/supporters.

8. Reflect on the process and new learnings

Contemplate what you've learnt from this process, and what you'd do differently next time. What else do you need to know? What are the reflections from the consumer and their family/carers/supporters?
Engage and reflect with the person, their family/carers/supporters, to see what they've learnt from the process, what they'd have liked to be different and what else they need to know.
Check and reflect that you're not attributing positives outcomes to your actions while blaming negative outcomes on outside factors.

FIGURE 4 | Mental health nursing-clinical reasoning cycle.

healthcare professionals towards individuals with a mental illness and/or offending background (Vorstenbosch, Masoliver-Gallach, and Escuder-Romeva 2022).

Interestingly, there were only a few changes made from the FMHN-CRC; however, the nurses in this study did consider the FMHN-CRC to be more relevant to their practice as compared to the CRC, which was seen to be needing more of a recovery-oriented and person-centred focus essential to mental health nursing practice. This may also reflect the contemporary shift in FMH practice away from authoritarian custodial practice and towards recovery-oriented approaches to enhance consumer recovery (Marshall and Adams 2018; Maguire et al. 2023). It is also possible that nurses who have learnt about the CRC in their

undergraduate training and then move into mental health nursing may have not considered the CRC relevant due to it being acute health care focused. The adapted versions of the CRC; the FMHN-CRC, and the MHN-CRC may therefore signal to FMH and MH nurses that there are models specific to their speciality practice.

While it could be argued there is very little difference between the FMH and MH nursing versions of the clinical reasoning cycle, it was considered important for MHN to have their own version of the CRC. It is also important that FMH nursing is recognised as a subspecialty of mental health nursing, and frameworks such as the CRC assist in articulating the work of FMHN that is "more" than just mental health nursing in a forensic context and assist in identifying the nursing contribution to assessment and treatment of forensic patients (Martin et al. 2012, 2013; Maguire et al. 2023). Second, having offending behaviour before presenting behaviour is important because this is the work that distinguished FMH nursing from other areas of mental health nursing, and it is the offending behaviour that brings patients into the FMH service (Askola et al. 2017; Maguire et al. 2023). It is essential that FMH nurses purposefully work with their patients to address offending behaviour as well as their other needs, so making this first and foremost in the FMH-CRC is intentional and a necessary component.

5.1 | Strengths and Limitations

This study was conducted with mental health nurses from one state in Victoria, which may limit generalisability to other settings. While we were able to recruit 18 participants for the focus groups and interviews, we only had six people attend the NGT as some who had committed to attend were not able to attend on the day due to unforeseen clinical issues they had to attend to. A clear strength of the study was the participation from experienced mental health nurses who had a sound knowledge of contemporary evidence-based mental health nursing practice.

6 | Conclusions

This study explored the suitability CRC and the FMHN-CRC with senior nurses and then an adapted version was agreed upon by a group of nurses in a NGT called the mental health nursing-clinical reasoning cycle. A key issue identified in this study was the absence of a framework to aid nurses clinical-reasoning and clinical decision-making. Having such a framework was seen as important to guide and nurture nursing practice. The MHN-CRC was seen to offer a way of articulating the work and showcasing the mental health nursing contribution to care. Implementation and evaluation will be important to determine suitability and application in practice.

7 | Relevance for Clinical Practice

Given the reform agenda, the complex environment, and clinical challenges that mental health nurses work with on a daily basis, having a framework to guide clinical practice is essential. The MHN-CRC offers a systematic framework to enhance practice, and a similar process to the development of the MHN-CRC may also be warranted for other speciality areas of mental health nursing such as children and adolescents and older adult. Further research is needed to further describe implementation, impact, and efficacy of the MHN-CRC to improve patient care.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

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

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