

Towards Understanding Nursing within Multidisciplinary Mental Health Teams  
That Serve Vulnerable Youth

by

Suzanne Slater  
BSN., University of British Columbia, 1975

A Thesis Submitted in Partial Fulfillment  
of the Requirements for the Degree of

MASTER OF NURSING

in the School of Nursing

© Suzanne Slater, 2012  
University of Victoria

All rights reserved. This thesis may not be reproduced in whole or in part, by photocopy  
or other means, without the permission of the author.

## **Supervisory Committee**

Towards Understanding Nursing within Multidisciplinary Mental Health Teams  
That Serve Vulnerable Youth

by

Suzanne Slater  
BSN., University of British Columbia, 1975

### **Supervisory Committee**

Dr. Bernadette Pauly, School of Nursing  
**Supervisor**

Dr. Noreen Frisch, School of Nursing  
**Departmental Member**

Dr. Marjorie MacDonald, School of Nursing  
**Departmental Member**

## Abstract

### **Supervisory Committee**

Dr. Bernadette Pauly, School of Nursing

Supervisor

Dr. Noreen Frisch, School of Nursing

**Departmental Member**

Dr. Marjorie MacDonald, School of Nursing

**Departmental Member**

Registered nurses and registered psychiatric nurses are members of multidisciplinary mental health teams that address the assessment and treatment of vulnerable youth. The phenomenon of interest for this study is nursing's distinct contribution to a multidisciplinary team in this clinical domain. An interpretive description drawing on the perspectives of seven nurses and seven clinicians from the professions of psychiatry, psychology, social work, child and youth care, and registered clinical counselling provides insight into understanding nursing's distinct contribution (NDC) to multidisciplinary mental health teams that serve vulnerable youth (MMHTSVY). Six major themes and multiple subthemes were inductively derived. Four major themes describe nurses' contributions: 'Sameness Paradox', 'Way of Being', 'Nurse Doctor Partnership', and 'Expert'. Two major themes describe and illuminate the contexts that underlie nurses' capacity to actualize their distinct contribution. These are 'Nursing Erosion' and 'Nursing Momentum'. The findings make explicit nursing's contribution to MMHTSVY in ways that are meaningful to the clinical practice (i.e., the teams and the health, healing, and well-being of vulnerable youth, their families, and communities). Although nursing's contributions to MMHTSVY are extolled, nursing positions are being eroded. Findings from this research provide insights for influencing policy development to enhance the contribution of nurses.

## Table of Contents

Supervisory Committee.....	ii
Abstract.....	iii
Table of Contents.....	iv
Acknowledgements.....	vii
Dedication.....	viii
Chapter 1: The Problem.....	1
Background.....	1
Statement of the Problem.....	2
Significance.....	4
Research Purpose.....	5
Research Questions.....	5
Chapter 2: The Literature Review.....	7
Vulnerable Youth and Health.....	7
Multidisciplinary Teams.....	11
Macro Systems and Policy.....	15
Nursing Attributes.....	17
Nursing with Vulnerable Youth.....	19
Gaps.....	23
Chapter 3: Methodology.....	25
Approach, Method, and Assumptions.....	25
Personal Disclosure of Interest.....	28
Population.....	29
Setting.....	31
Ethical considerations.....	32
Third Party Recruitment.....	34
Sample.....	35
Data Collection.....	36
Data Analysis.....	37
Research Rigour.....	42
Chapter 4: Presentation of Findings.....	48
Sameness Paradox.....	48
Appears the same.....	48
Valuing.....	50
Overlap.....	52
Way of Being.....	55

Holistic.....	55
Get-to-it-ness.....	57
Helping others.....	60
Nursing aura.....	62
Nurse Doctor Partnership.....	67
Autonomy.....	67
Efficiency.....	68
Doctor retention.....	70
Expert.....	71
Bio-screener handler.....	71
Medication intervention.....	75
Health and development educator.....	80
Health system connectivity.....	82
Critical or complex mental health expert.....	83
Nursing Erosion.....	88
Not going to get one.....	88
Aren't in the driver's seat.....	92
Confusing nursing credentials.....	93
Constraints on access to training.....	96
Nursing Momentum.....	98
Making nursing visible.....	98
Self-regulation.....	100
Policy engagement and leadership.....	103
Expansion of contribution.....	105
Nursing specialty.....	106
Summary of the Findings.....	109
Chapter 5: Discussion of Findings.....	113
Limitations of the Study.....	113
Illustration of Findings.....	113
Surprises.....	114
Nursing standards.....	114
Terms in lieu of nursing.....	115
Links to Scholarly Literature.....	115
Promoting nurses' contributions.....	115
Nursing's policy contribution.....	119
Multidisciplinary teams.....	123
Implications for Practice.....	125
Implications for Nursing Education.....	130

Implications for Policy.....	133
Implications for Future Research.....	137
Conclusion.....	142
References.....	146
Appendix A: Recruitment Advertisements VIHA, MCFD, poster.....	156
Appendix B: Description of Study.....	159
Appendix C: Consent Form.....	161
Appendix D: Information for Recruitment Contacts.....	165
Appendix E: Budget for Researcher (rvsd 2011-2-8).....	169
Appendix F: Interview Questions.....	170
Appendix G: Honorarium Receipt Form (rvsd 2011-2-8) .....	172
Appendix H: Illustration of Concept Mapping.....	173
Appendix I: Illustration of Findings.....	174

## Acknowledgments

Scholars from the past and present influenced the conception and development of the research proposal. Many individuals -family, friends, colleagues, graduate students, health care providers, and University of Victoria personnel- supported me with their encouragement. Learning events that were sponsored through professors at the University of Victoria School of Nursing and the Centre for Youth and Society nurtured my research capacity. Particular persons with scholastic and/or clinical acumen, facilitated my careful completion of each phase of this research project. Above all, 14 participants answered the research interview questions as they shared their perspectives and experiences. An interpretive description of their transcripts is the essence of this study. My research supervisor, Dr. Bernie Pauly, generously shared her time with me, engaged in discussions, and provided guidance through the whole research process. I am in awe of my supervisor and committee members. I attribute the completion of this research project to all of you. Thank you.

## **Dedication**

This thesis is dedicated to youth who intersect with persons in multidisciplinary mental health teams that serve vulnerable youth.

# Chapter 1

My thesis enriches our understanding of nurses' distinct contribution to multidisciplinary mental health teams that are responsible for the assessment and treatment of vulnerable youth. An interpretive description of 14 clinicians' perspectives from the multidisciplinary professions of nursing, psychiatry, psychology, social work, youth care, and registered clinical counselling provides insight into understanding nursing's distinct contribution (NDC) to multidisciplinary mental health teams that serve vulnerable youth (MMHTSVY). I will explain the formulation, outcome, and meaning of the research project.

The thesis is organized in five chapters. The research problem is described in the first chapter. The second chapter is a presentation of the literature that sets a foundation and justification for the research project. The methodological approach is explained in chapter three. Research findings are presented in chapter four and discussed in chapter five.

In this first chapter, I begin with a description of vulnerable youth who are the centre of nurses' and their teams' service in this work environment. That background information is followed by a statement of the research problem, significance, purpose, and questions.

## **Background**

'Vulnerable youth' is a subset of the broader population of youth. Flaskerud and Winslow (1998) define a vulnerable population as a social group that is predisposed to a reduced quality of life, higher morbidity, and premature mortality caused by health disparities and without adequate access to health enhancing resources. While adolescence is a time of pubertal changes (i.e., hormonal effects) and role changes (i.e., developmental responsibilities and freedoms that are entrenched in social expectations) that all youth experience, adolescence can intensify vulnerabilities that some youth have. These vulnerabilities are related to biological factors (i.e.,

organic damage, physical health neglect, substance use, exposure to detrimental agents, hormone imbalance, neural-molecular and genome disturbances, or syndromes), attachment fractures, cognitive difficulties with resultant educational struggles, trauma effects (i.e., emotional, sexual, and physical abuse), and environmental stress (such as strained psychosocial relationships or criminal influences).

In chapter two, I will expand discussion of this defined population. An understanding of youth and vulnerability is fundamental to understanding and thinking about the clinical and administrative practices of multidisciplinary teams, and the nurses' contribution within these teams. While the focus of the research is on nurses' role and contributions, vulnerable youth are at the heart of this research project. The knowledge that is taken from this research project can be translated to useful applications within MMHTSVY that should ultimately contribute to improvements in the lives of vulnerable youth.

### **Statement of the Problem**

Understandably, a supportive community and professional intervention can make a difference in the mental health, healing, and well being of vulnerable youth. Multidisciplinary mental health teams are one mode of service that assesses and treats the needs and condition or illness of vulnerable youth but what is distinct about nursing's contribution? As members of MMHTSVY, nurses can contribute to making a meaningful difference in the lives of vulnerable youth and their families and communities. However, an explicit understanding of NDC to MMHTSVY has yet to be developed and limited attention has been given to understanding the role of nurses on multidisciplinary teams that serve youth. The elements of a nurse member's practice (e.g., knowledge, resources, approaches, skills, influences, and attributes) that address the broad health risks of vulnerable youth are often unclear. Furthermore, the contexts that can

sustain, promote, constrain, and erode nursing's capacity to enact NDC to MMHTSVY have not been identified. My hope is that the research reported here can increase our understanding of NDC to the health (i.e., from nursing's conceptualization of health where mind and body are indivisible), healing, and well being of vulnerable youth (and their families and communities). At the same time, the research is poised to increase our understanding of the contexts that promote nursing's contribution, where nursing services are provided through MMHTSVY.

Throughout this research project, I have selected the term 'multidisciplinary' rather than 'interdisciplinary' aside from when cited authors or study participants have chosen the latter term. 'Multidisciplinary' signifies that two or more team members of various professional disciplines are working together, without characterizing team dynamics. Additional descriptors are necessary to convey the extent and ways that a multidisciplinary team makes use of several disciplines. For example, there can be varying degrees of interdependence to assess and address clients' issues. Homogenous perspectives across professional disciplines may evolve in a variety of areas. Roles can blur. The team process for decision making can range from inclusion of each discipline's input for consensus to hierarchal control. In contrast, 'interdisciplinary' is a subset of multidisciplinary that signifies a pursuit of integration. The term 'interdisciplinary' tends to reflect the optimal use of team members from a variety of professional disciplines. However, I perceive that team members may not have a common vision or understanding of 'integration' and 'optimal'. Perhaps individual members' ideals for 'interdisciplinary' are fraught with values, expectations, comparisons, and evaluation. Moreover, according to Lattuca (2002) the meaning of 'interdisciplinary' has "little consensus on its exact meaning" (p. 712). For these reasons, I selected the term 'multidisciplinary'. Therefore, study participants were invited to conceptualize their experiences and expectations of NDC to MMHTSVY.

## **Significance**

In this study, the relationship among nursing, professional disciplines in MMHTSVY, policy processes, and the health, healing, and well-being of vulnerable youth, their families, and communities is probed. This qualitative exploration provides new knowledge and insights on NDC to MMHTSVY. These insights include how nurses address vulnerable youths' challenges in accessing and accepting a wide range of health enhancements, and insights on contexts that can preserve or enhance nursing's effectiveness. The study widens an awareness of NDC among team members that can cultivate effective multidisciplinary collaboration which is a key principle (Canadian Collaborative Mental Health Initiative, 2006; Enhancing Interdisciplinary Collaboration in Primary Health Care, 2007; Romanow, 2002) in the transformation of the delivery of health care services. Insights on NDC to MMHTSVY can lead to strategies that can optimize NDC within a team in ways that can benefit vulnerable youth, their families, and communities. Improving multidisciplinary team members' understanding, facilitation, and utilization of NDC is an important aim. Moreover, this scientific inquiry highlights the value of focusing on one particular discipline (i.e., nursing) in order to explore the multidisciplinary contexts that impact a discipline's distinct contribution to vulnerable youth and the team.

This inquiry brings nursing knowledge to the nursing discipline. Nursing scholar Dr. Sally Thorne's (2008) 'interpretive description' is this study's methodology. The four nursing meta-paradigm concepts (i.e., human beings, health, environment, nursing [Fawcett, 2005]) are specified in this study as 'vulnerable youth', 'health', 'MMHTSVY', and 'NDC'. According to Fawcett and Garity (2009) "the actions and processes that nurses use in practice" (p.5) are part of the ongoing nursing inquiry, and the object of a nursing inquiry is to "improve patient outcomes" (Fawcett and Alligood, 2005, p. 231). In this study, our understanding of nurses' actions and

processes in MMHTSVY can facilitate good practice and practice improvement. Altogether the nursing knowledge from this project contributes to the nursing discipline's knowledge base.

### **Research Purpose**

The purpose of this scientific inquiry is to reveal a rich description of NDC to MMHTSVY and to examine the contexts that underlie nurses' capacity to actualize their distinct contribution. The research makes explicit nursing's contribution to MMHTSVY in ways that are meaningful to the nurses' clinical practice, the teams, and the health, healing, and well-being of vulnerable youth, their families, and communities. The research objectives are to:

- Describe nurses' and their team members' expectations and experiences of the nurses' distinct facilitation of the health, healing, and well-being of vulnerable youth, their families, and communities.
- Explore and describe what nurses and their team members perceive are the ways that nurses strengthen their teams and influence policy development.
- Explore and describe the contexts that affect NDC to MMHTSVY.

### **Research Questions**

The key research question is: "what is NDC to MMHTSY and what are the contextual factors that affect nursing's contribution". The corollary is "what is missing when the nursing discipline –that is one of several disciplinary orientations- is absent from MMHTSVY".

Altogether, there are three inter-related questions that underlie the key questions.

1. What are the individual team members' expectations for NDC -and their experiences of NDC- in the care of vulnerable youth, the youths' families, and communities?
2. How do team members perceive that nurses strengthen the team, and contribute to the team's policy development?

3. What are the contextual factors that can sustain, enrich, constrain, and erode NDC?

In the next chapter I will review the literature that provides a foundation for this research study. The rationale for investigating NDC will be further described.

## Chapter 2

In this chapter, I provide an overview of the literature that informs current understanding of nursing in MMHTSVY and I describe gaps in the scholarly literature. In this literature review I examine five subject areas from the scholarly literature. I examined literature that described the characteristics of 'Vulnerable Youth and their Health Needs', 'Multidisciplinary Teams', 'Macro Systems and Policy', 'Nursing Attributes', and 'Nursing with Vulnerable Youth'. 'Gaps' in the scholarly literature are summarized in a conclusion.

### **Vulnerable Youth and Health**

Literature that describes the characteristics of vulnerable youth and their health is essential to understand nursing in MMHTSVY. In this section I expand on the definition of vulnerable youth that was presented in the background section of chapter one.

Vulnerable youth have been described as including economically disadvantaged youth (World Health Organization [WHO], 2007a, 2007b), lesbian/gay/transgendered youth (Benoit, 2007), youth from immigrant families (Prahst, 2007; Yearwood, Crawford, Kelly & Moreno 2007), physically and sexually abused youth (McCreary, 2002; WHO, 2007a, 2007b), intellectually and developmentally disabled youth (Floyd, Costigan, & Curran, 2007), sensation seekers who use substances (Barnes, Murray, Patton, Bentler, & Anderson, 2000), and youth from disintegrating families (Cote, 2007), particularly families affected by parental mental illness or addiction (Clarke, July 2012). Many vulnerable youth are in government care, on the street, or in custody, and they have significant health needs (McCreary, 2001, 2004, 2005, 2006). While all adolescents may engage in health-harming behaviours (Maggs, Almeida, & Galambos, 1995), vulnerable youth are at increased risk of harm (McCreary, 2007a, 2007b). The risks in which vulnerable youth engage begin at an earlier age, surpass experimentation, and expand to

include other risks (Jessor & Jessor, 1977; Lerner & Galambos, 1998). Evidently vulnerable youth have a constellation of risk factors that can manifest at variable intensities.

The relationship among risk factors, health needs, and vulnerable youth is further illustrated. The McCreary Centre Society (a non government organization that is dedicated to improve the health of BC youth through education, projects, and research) uses the behavioural marker of *smoking* as an indicator for identifying vulnerable youth (McCreary, 2006). The 2003 Adolescent Health Survey revealed that “7% of the entire school population in BC [are smokers]” (McCreary, 2006, p. 76), and the probability of being a smoker is associated with marijuana use, binging on alcohol, and sexual intercourse (McCreary, 2006). An extrapolation of the risks that are associated with adolescents who smoke can be correlated with the 75% smoker rate in the 2004 Youth Custody Survey (McCreary, 2005) in order to glimpse the spectrum of vulnerabilities and associated risks among incarcerated youth.

Marijuana use is another marker for identifying vulnerable youth. The McCreary Centre Society’s (2005) 2004 survey on special populations of adolescents found a higher prevalence of marijuana use among street entrenched adolescents and adolescents in custody centers (i.e., 100%), in comparison to (McCreary, 2003) rates among the public school group (i.e., 12%-53%). Marijuana use causes youth significant harm in health and in psychological and social well-being (Barnes, 2007; Barnes, Barnes, & Patton, 2005; Canada, 2002; Everson, 2006; Hall, 2006; Hammersley & Leon, 2006; Leatherdale, Ahmed, & Kaiseman, 2006; McCreary, 2005; Terris, 2006; Wadsworth, Moss, Simpson, & Smith, 2006a, 2006b). The evidence for harm from marijuana is so strong that Canada’s Senate Committee announced in 2002 that “because of its potential effects on the endogenous cannabinoid system and cognitive and psychosocial functions, any use in those under... 16 is at-risk use” (Canada, 2002, p. 166).

A description of the combined health, mental health, and substance use challenges among incarcerated youth are evident in Griel and Loeb's (2009) review of the broad health needs of incarcerated youth in 25 American and four international research studies between 2005 and 2007. The prevalence, severity, and co-morbidities for identified behavioural and psychiatric disorders in the population of incarcerated youth were identified in the context of each research design (Griel & Loeb). In general, incarcerated youth may have anxiety disorders, mood disorders, conduct problems, substance use disorders, attention deficit hyperactivity disorder, pervasive development disorders, adjustment disorders, psychoses, sleep disorders, learning disabilities, and intellectual disability. Griel and Loeb reported that the literature on mental health needs was extensive in comparison to providing content on physical health needs. From the literature on physical health, the evidence described that early mortality and lost life years in this population were related to drug related causes, unintentional injuries, interpersonal violence, suicide, and physical morbidities. Some of the causes for persistent or non-reversible physical morbidity among these vulnerable youth included physical injuries with resultant backache and joint pain; asthma; obesity/eating disorders; poor dental hygiene, smoking/alcohol/drugs causing such major illnesses as heart, lung, and kidney disease, diabetes, and cancer; incomplete immunization status; infections from unprofessional tattoos, sexual assault, and unprotected sex causing HIV/AIDS and hepatitis B&C, and pelvic inflammatory disease among female youth (Griel &Loeb).

The World Health Organization's Department of Mental Health and Substance Abuse for Child and Adolescent Mental Health (2007b) correlates poor mental health with weak adherence to indicated treatment, resistance to targeted health promotion activities, failure to achieve educationally, and an inability to participate in work skills development. Moreover, poor mental

health is associated with "increased participation and instigation of violence, abuse of self and others, and support for a broad range of illegal activities" (WHO, 2007b). Clearly health risks, detrimental social functioning, poor mental health and substance use difficulties are intertwined.

There is hope as vulnerability is explored and understood. Individual and systemic interventions that reduce risks can improve health and mental health. Accessible multimodal interventions can augment vulnerable youths' range and degree of static and dynamic protective factors to allay a significant portion of their vulnerabilities (Costa et al, 2005; Leadbeater, Smith, & Clark, 2008).

Nevertheless, youth who have multiple and complex health needs and risks often have challenges accessing and accepting a wide range of health enhancements. They can be dismissive of their health needs and risks. For example, most of the vulnerable youth in custody experience real and potential health concerns but they contrarily tend to rate their overall health very positively as evidenced in The McCreary Centre Society's (2005) 2004 survey of youth in custody. "Ninety two percent of girls in custody rate their health as 'excellent' or 'good,' ... [and] for boys, 83% in custody rate their health as 'excellent or good' " (p. 15). Consequently, vulnerable youths' potential engagement with health enhancing resources can be obstructed by habitually or unwarily underreporting clinically significant symptoms and risks. This paradoxical pattern of service utilization can be explained, at least in part, by poor mental health and an avoidance of the associated stigma, combined with a tendency for adolescents to assume that health and mental health problems can go away without intervention, and a misjudged reliance on self-help (WHO, 2000). In their research with homeless (i.e., homeless more than one month) young people, McCay et al. (2010) described that youth have "high levels of mental health symptoms [and] exhibited moderately high levels of resilience and self-esteem" (p. 31). Rew (2003) learned from her

interviews with street youth that they stayed alive with few resources and handled their own health. However, reports of self-care while important, do not dim the evidence-based explanation that vulnerable youth under-report risks and unmet bio-psychosocial needs and challenges (Canadian Collaborative Mental Health Initiative, 2006; Denscombe, 2001; McCreary, 2005; WHO, 2000).

In summary, a review of the literature review of vulnerable youth and their health describes their intertwined, multiple risks that signify bio-psychosocial needs. Moreover, there is evidence that this special population is experiencing unmet health needs.

### **Multidisciplinary Teams**

Mental health care for vulnerable youth is often organized and provided by multidisciplinary teams (McColgan & De Jong, 2009). Nurses are members of a diverse group of mental health professionals working together in multidisciplinary teams to address the complex health needs of vulnerable youth. Registered nurses and registered psychiatric nurses are frequently members of such teams. The Canadian Nurses Association (2002) identifies that potential difficulties in team relations are an area for inquiry and resolution because team dynamics can influence the effectiveness of nursing and vice versa. Consequently, in this section I focus on a review of the literature related to potential difficulties and resolution in multidisciplinary teamwork that can be applicable to teamwork in MMHTSVY.

Lankshear's (2003) qualitative research study examined the disparity among various disciplines regarding the purpose of their mental health teams and the assignment of referrals. Team members experienced conflict, manipulation, and isolation. A restructured allocation of acute cases to the nurses caused an inequitable workload, isolation for the nurses, and a threatened nursing identity for nurses who perceived a lack of managerial and collegial support.

The Canadian Health Services Research Foundation's synthesis of literature on multidisciplinary collaboration within the domain of primary health care (Barrett, Curran, and Glynn, 2007) supports collaboration and identifies the need to gather evidence that can build it.

Collaboration and teamwork produce high-quality results, including flexibility, adaptability, resistance to stress, cohesion, retention and morale associated with effective team performance... One of the most critical tasks facing researchers, managers, policy makers and clinicians will be to work together to create, share and use all forms of evidence... toward effective teamwork [and multidisciplinary collaboration]. (p.12)

In a discussion paper, Clark (2006) described the elements that can transform disciplinary boundaries and enhance the cooperative and collaborative outcomes. His premise is

Health care providers have all been socialized to adopt the health care worldview characteristic of their profession. The real challenge.. is for them to be able to see the world through the eyes of other professions, to be able to frame the patient's problem and the potential solutions to it in the terms of understanding of other kinds of health care providers. (p. 578)

With a purpose to improve relationships among the professional disciplines in child and youth teams in the United Kingdom, a British multidisciplinary group of four experienced clinicians shared their understandings of discipline identity issues. Hill-Smith, Taverner, Greensmith, and Parsons (2012), from the professions of psychiatry, psychology, nursing, and family therapy, developed a discipline identity matrix. This matrix illustrates interactions among team members that are purportedly intrinsic to the discipline identities of psychiatry, psychology, nursing, and social work. The model clarifies interactions that either complement or clash with identified contributions or approaches among the four classic disciplines in MMHTSVY.

According to Hill-Smith et al., team tension that arises from disciplinary differences can be quelled by team members endeavoring to understand other disciplines' professional identities and how those professional identities affect team members' contributions.

A rich description of the benefits to collaborative participation from teams understanding members' professional identities is evident in Simpson's (2007) investigation of team members' interactions. Nurses challenged doctors' views and decisions because nurses had established an equitable professional relationship with doctors (Simpson). When disparate disciplinary contributions were identified and valued, trust among different professional disciplines became evident in team members' transformative openness in their participation in case discussions (Simpson). Better planning and solutions emerged from team members' enhanced collaboration, and effective teamwork benefitted clients (Simpson, 2007). Evidently teams benefit from understanding their members' professional discipline identities and valuing their contributions.

Cioffi, Wilkes, Cummings, Warne, and Harrison (2010) described the separate experiences of 21 community nurses and 12 allied health professionals working in fairly new multidisciplinary teams in community health services. These community teams provide care to clients of all ages with chronic conditions in one area of Australia. The definition and function of a multidisciplinary team, working in the team, and roles were examined. Team members from three disciplines (physiotherapy, social work, and occupational therapy) from a possibility of several allied professionals participated in the study. Through a qualitative description of transcripts from four audio-taped focus groups, the authors found that some nurses understood their team members' roles while team members did not understand the nurses' role. Team members relied on nurses, consulted nurses, and recognized the clients' trust in the nurses. Nurses were more likely to refer clients to team members, do the work of team members who

were less accessible, and advocate for their clients regardless of conflict with allied professionals' decisions. The contexts underlying nurses' actions that had posed conflict between nurses and other disciplines were identified in the focus groups, and solutions emerged. A part of improving team performance is by team members achieving a deeper understanding of other disciplines' roles (Cioffi et al. 2010 citing Cashman et al., 2004; Field & West, 1995; van Loon, 2008; Wiles & Robinson, 1994). However, the researchers (Cioffi et al.) did not find that their evidence of a misunderstanding of professional roles was the main cause of team tension among these team members. Rather, the key difficulty was a lack of formal leadership (Cioffi et al.). By introducing a team coordinator role that would rotate among the professional disciplines, a coordinator would integrate new professional relationships, introduce team building interventions, and facilitate conflict resolution. (Cioffi et al.). Consequently, the researchers found that an evaluation of the team environment (against an optimal team environment that has a shared purpose, quality care, innovation, valuing members, participatory decision-making, and identification of needed resources) is at the crux of effective multidisciplinary collaboration (Cioffi et al.). In summary, team members' understanding of professional identities may not be the key component in improving teamwork. An evaluation of the team environment can reveal the contexts that underlie effective and ineffective teamwork (Cioffi et al.).

In these articles, the principles of inclusion and equality seem to be implicit for effective collaboration, and lacking in ineffective multidisciplinary teams. Moreover, we have learned that team members' understanding of other professional disciplines is an important component for valuing members and building effective collaboration. One dimension of research in multidisciplinary collaboration is an approach that focuses on a selected discipline's distinct contribution (Barrett et al., 2007). In my study, I focused on NDC to deliver a thick description

of NDC and the mechanisms that forge nursing's contribution. The premise is that team members who understand NDC can comprehend their nurses' actions, value nursing, and facilitate effective collaboration with nurses for integrated teamwork that can improve the health, healing, and well-being of vulnerable youth, their families, and communities. This is an important aim that is appropriately drawn from the scholarly literature.

### **Macro Systems and Policy**

In this section, I describe how macro systems and policy shape nursing practice and ultimately impact care for vulnerable youth. Policies may facilitate good nursing practice or unwarily dismiss or obstruct nursing. Policy at multiple levels influences the structure of nursing work, and that affects nursing contribution to teams and care of vulnerable youth. Nursing practice in MMHTSVY is impacted by policies of organizations that range from the United Nations', the federal and provincial governments, to an organization's program initiatives and worksites. As well, the regulations, goals, and position statements of the nursing profession, nursing associations, and licensing colleges influence nursing practices. Varcoe and Rodney (2009) state that "nurses must take active roles individually and collectively both in countering the erosion of health care and nursing practice, and in formulating policy" (p.138).

Investment in nursing resources are affected by a country's economy and policies for the distribution of wealth that can be impinged or enhanced by the conditions in our global community. Moreover, the World Health Organization (2003, 2007b) recognizes that the ecological effects of global and local social, monetary, and environmental conditions are reflected in the prevention, assessment, consultation, and treatment services for vulnerable youth and the epidemiological reports of adolescent mental health. Seemingly a decline in the economy could threaten nursing resources at a time when the economic pressures simultaneously can increase the

vulnerabilities for youth. We do not know if policy makers in Canada and BC perceive any correlation between an investment in nursing resources in MMHTSVY and the epidemiological statistics on adolescents' mental health. However, my study is an exploration of nursing within multidisciplinary teams which may contribute to better understandings of nursing's contributions.

Thomas (2001) describes how the characteristics (i.e., organizational decision-making, procedures, and determinations on who participates in policy development and implementation) of an organization's settings can influence the policies that originate from the government, ministries, and services. The organizational structure represents the positioning of where each professional discipline is integrated in decision making, and the corresponding influence that a particular discipline has on the development of an organization (Thomas). Accordingly, Thomas recommends that the principles, interests, assumptions, and processes at a work place need to be investigated as much as the programs and services. For example, in a multimodal constructivist qualitative study using interviews, observation, and document reviews, Simpson (2005) investigated structures, processes, and interactions that impacted the effectiveness of nurses' newly expanded care coordination accountabilities on South England's community multidisciplinary mental health teams for nurses' clients' and care-givers' needs. Policy and organizational matters were examined. The nurses' strength in monitoring clients with severe mental illness and complex needs in evidence-based ways that reduce tertiary care was negatively impacted by competing demands (Simpson). Nursing and tertiary admission rates were compromised by nurses having high case loads that included more clients with less severe illness who required psychosocial interventions, time learning therapies, time engaging in 'on call' responses, mounting paperwork, and stress arising from insurmountable duties and insufficient clarity in expectations and skills (Simpson). In my study, I took an indirect approach to explore the underlying contexts that may

impact NDC. Participants were invited to identify and explain elements that positively and negatively impact the possibilities for NDC to their teams' programs and services.

The nursing profession shapes the pursuits of the nurse by establishing professional ethics (i.e., the Canadian Nurses Association's 2008 Code of Ethics), the scope of nursing practice, professional standards and licensing to practice nursing (i.e., that are mandated by the Health Professions Act and regulated by the Colleges of Registered Nurses and Psychiatric Nurses of British Columbia), and position statements for nurses on practice issues. Moreover, the College of Registered Nurses of British Columbia (2006) has defined a research-based quality practice environment that can maximize the effectiveness of nurses. The information is available to employers as standards and guidelines that can facilitate improvements for effective nursing. However, we do not know if such nursing policies are integrated by MMHTSVY or how these policies may impact MMHTSVY and nurses.

The World Health Organization's Mind Project (2007c) affirms nurses' competency in policy development for mental health that enables positive changes in organizational systems. However, we do not know the nature and degree that MMHTSVY are structured to empower nursing's contribution to policy development, or the multidisciplinary dynamics that can shift an organization's intentionality to facilitate each discipline's contribution. Thus, as part of this project, I felt it was important to investigate the contexts of NDC to MMHTSVY that included the nature of nursing's influence over policy development.

### **Nursing Attributes**

Knowledge of nursing's attributes is fundamental to exploring NDC to MMHTSVY. Nursing's key attribute is that nursing has a compatible and an empowering relationship with the

public who have an explicit voice in shaping the nursing profession. Nurses are one of the most trusted professionals (Imprint, 2006).

The following authors describe their expectations for nursing's distinct attributes in any clinical practice. Bryant-Lukosius, Dicenso, Browne, and Pinelli (2004) describe how "a nursing orientation to practice [is] characterized by coordinated, integrated, holistic, patient-centered care [that is] designed to maximize health, quality of life and functional capacity" (p. 524). Thorne et al. (1998) contrast nursing against other disciplines by the nurses' "attention to both the individual's body and the person's meanings" (p. 1259) and nurses' "social mandate to attend to illness... [including the] effects of environmental factors and poverty on disease incidence, illness experiences, and bodily wellbeing" (p. 1260). Kikuchi and Simmons (1998) state that nurses do not leave the "bodily wellbeing... out of the activities of nurses" (p. 30). Bishop and Scudder (1995) validate nursing as being more than technical skills and interventions. Leininger and McFarland (2002) emphasize nursing's *caring* to the degree that they would like caring to displace the concept of *nursing* in the nursing meta paradigm (i.e., nursing's four concepts are human beings, health, environment, and nursing) because they perceive that caring is a pervasive element in nursing. Bee et al. (2008) reviewed the scholarly literature on users' and their carers' views and expectations of registered mental health nurses in Great Britain. The authors (Bee et al.) identified nursing's relational skill (which is valued as being therapeutic) to "listen, empathize, and understand" (p. 452), recognition of symptoms and addressing these, flexibility to enact a range of roles, and effective interventions were valued.

In the aforementioned research and scholarly papers, nursing attributes were not from literature that focused on registered nurses and registered psychiatric nurses who provide services for adolescents and their families. However, these articles indicate that the discipline of

nursing has qualities that are distinct from the other disciplines, and in my study I explored nursing's disciplinary distinctness in MMHTSVY.

### **Nursing with Vulnerable Youth**

Nurse clinicians, scholars, and researchers have revealed some facets of nursing roles, approaches, and competencies of nurses' provision of care to vulnerable youth. Through these research articles and scholarly papers, a beginning sense of nursing with vulnerable youth is illuminated. In particular, several research articles describe the significance of the nurses' therapeutic relationship with vulnerable youth. Geanellos (2002) provided a substantive description of nursing's use of self in mental health therapy with adolescents. The nurse-client relationship was clearly described as the tool for healing (Bee et al., 2008; Geanellos, 2007). Murray and Wright (2006) investigated youths' perspectives on their experience of nurses' suicide assessments, and the youth described and valued the quality of the nurses' therapeutic relationship. Nursing theories give substance to the therapeutic relationship. For example, Pharris (2002) validated Newman's (1990) 'Health as Expanding Consciousness (HEC) Theory' as a meaningful approach to treat adolescents who murder. When HEC was applied "each revisiting of traumatic childhood events [helped] participants... to shed... their... detached manner and connect with their ability to feel" (Pharris, p. 38). Pharris invited nurse researchers to similarly test HEC in order to transform adolescents and their communities.

Sin and Gamble (2003) described the contribution that nurses make to MMHTSVY through engagement that is even embedded in medication management. In their study (Sin & Gamble), an 18 year old youth diagnosed with schizophrenia had been reluctant to accept interventions from other clinicians. Then a nurse brought a caring, relational approach and

shared expert knowledge of medication side effects and their management with the patient. That approach triggered a therapeutic alliance (Sin & Gamble).

Nursing's holistic approach is also described as being important to nurses' work with vulnerable youth. Eckstein Greene's (2004) exploration of the work of psychiatric mental health nurses with in-patient suicidal adolescents revealed that nursing's holistic perspective "gave nurses the strongest position from which to work with any given patient" (Eckstein Greene, p. 211) in the words of one nurse participant who compared the nurses' approach to their multidisciplinary team members. Another difference between the nurses and their team members was that the nurses increased their clients' coping skills (Eckstein Greene).

The literature describes additional forms of nurses' contributions with vulnerable youth in particular settings. Shelton (2003) described the nurses' practice in youth custody centres from the perspectives of nurses who work in custody settings. Nurses in this setting develop therapeutic relationships, administer and monitor medications, care for asthma and skin infections, attend to symptoms of detoxification, and manage suicide behaviour, aggression, and manipulative behaviours in a noisy, rough, secure environment (Shelton). In their scholarly article, Self and Peters (2005) described rural street nursing where youth were an ample portion of their attention. The 'team' members were professionals and lay people in other organizations. The kinds of nursing knowledge and skills involved "nutrition counselling, social work, mental health counselling, and drug and alcohol intervention [in]... collaboration with other professionals" (p.23). The role also included client advocacy, assertive tracking to address infection prevention or to provide medication, woods outreach for party safety, sexual health educator, and responding to crises. In their paper, Potter, Cashin, Andriotis, and Rosina (2008) described nursing's role in an Australian community's youth drug court program, and the authors also provided an overview of

the research literature on nursing's role in youth court drug programs. Nurses in the Australian program conduct and interpret a comprehensive health risk assessment with young persons and their families, collaborate with their multidisciplinary team to determine eligibility or conditions for participation in the program, individualize care plans, and treat youth and their families from a harm minimization framework. They arrange for substance withdrawal management, monitor the therapeutic and adverse effects of medication, assess mental status and treatment adherence. However, their key role seems to be that of intensively educating youth in health and linking them with health services.

In Great Britain, clinical nurse specialists in MMHTSVY are "children's champions" (McDougall, 2005, p.82). Clinical nurse specialists strengthen this nursing in MMHTSVY by providing practice guidance, stimulating and doing nursing research, integrating new knowledge into care, encouraging nurses' innovations and presentations, contributing to program policy development, developing the organization and health system, and by providing care consultation (McDougall). Furthermore, these nurse leaders address succession planning to maintain an effective nursing presence (McDougall).

The scholarly literature on the relevancy and dimension of health in MMHTSVY was examined. In a Swedish qualitative study, Jormfeldt, Svedberg, Fridlun, and Arvidsson (2007) investigated nurses' concept of health in mental health nursing through the perspectives of 12 diverse mental health nurses. Mental health nurses' meaning of health is a potential resource to empower clients' process, autonomy, and participation (Jormfeldt et al.). Anderson, Vostanis, and Spencer (2004) described the adolescent population's perceptions of "health needs and services, at the time of entering the youth justice system" (p. 151). The evidence from their study (Anderson et al.) underscores how health care providers must proactively address the health and mental

health needs of this population. Rew (2003) identified that vulnerable youths' core strength is their tenacity for self-preservation. Accordingly, nurse clinicians can be mindful of youths' strength in self-preservation and collaborate with youth around their tenacity for self-preservation to fortify their health, healing, and well-being. Through an exploration of NDC to MMHTSVY, my study was poised to collect data on the relationship between nursing and clients' health, nurses' approach to health, the dimension of health promotion and illness prevention that nurses provide to vulnerable youth, and the relevancy of health to MMHTSVY.

Baldwin (2002) investigated the function that nurses perform in MMHTSVY. The research design did not attempt to capture the contexts associated with the nurses' contributions. The findings were developed from a descriptive inquiry and content analysis of a purposive sample of eleven team members' (nurses and non-nurses, though no psychiatrist) perceptions of the nurses' function in six MMHTSVY in England. Baldwin suggested that nurses in MMHTSVY do not have a special function. Without a special function there was a suggestion that perhaps nurses were going "*beyond* nursing to become therapists rather than nurses" (p. 523). The generic role that the nurses shared with their team members in assessment and treatment suggested to Baldwin that without a definitive nursing role, that nursing in MMHTSVY could disappear. He perceived that nursing's historical presence in the provision of mental health services did not justify sustaining nursing. On the other hand, Baldwin described that nurses brought caring, outreach, medical knowledge, and their experience in adult psychiatry to MMHTSVY. Although Baldwin found that the utility and expression of nursing's distinction in MMHTSVY were not captured in his study, a list of distinct nurses' traits were established.

[Nursing traits in MMHTSVY include] the advocacy role...; more home visiting than other professionals;...a broad-based view of mental health difficulties[;] ...dealing with

people with extreme mental health difficulties and... an approach which is different to that of social workers, psychologists, or other professionals[;] more emphasis on holism, interpersonal skills, and the use of self[;] ... client-centered practice[;] ...[and] the use of interpersonal relationships to develop therapeutic change. (Baldwin, p. 523-524)

Baldwin encouraged an exploration of NDC to MMHTSVY in other places that would aim to depict a clear functional role for nursing in MMHTSVY. A decade later my study brought insight on nursing's functional role in MMHTSVY. That met the gap which Baldwin identified.

### **Gaps**

I have examined five categories of literature that provide current knowledge and understanding of vulnerable youth, multidisciplinary teams, relevant macro systems and policies, nursing attributes, and nursing with vulnerable youth. The literature extensively described that vulnerable youth have a cluster of risks and special needs. There was evidence that vulnerable youth are often assessed and treated by multidisciplinary teams, and that nurses are members of these multidisciplinary teams.

Nursing's valued traits are described in the literature as well as nurses' roles, approaches, conceptualizations of health, and nursing knowledge that are relevant to nurses' work with vulnerable youth. Research studies and scholarly articles describe how nurses distinctly facilitate the health and mental health of vulnerable youth. The body of literature describes nurses' role in assessments and interventions that are relevant to the care of vulnerable youth who have specific challenges.

Multidisciplinary teams, macro systems, and policy can impact the contributions and potential contributions of nurses. Moreover, there is evidence that when team members have a

deeper understanding of other disciplines' contributions and professional identities, that teamwork and collaboration improve.

However, in these studies we do not have a thick understanding of NDC that delineates the breadth and contexts of NDC in ways that make a meaningful difference to vulnerable youth and strengthen the teams. Relatively little is known of how nurses and their team members perceive that nurses distinctly contribute to their teams. Although vulnerable youth have substantial health and mental health needs, and nurses are present in MMHTSVY, we do not know if nurses in MMHTSVY endeavour to bring health to mental health. We do not know the ways in which multidisciplinary teams, macro systems and policy impact the contributions of nurses in MMHTSVY in BC. A review of the literature brings evidence of a gap in having a deep understanding of nursing in MMHTSVY that can illuminate the functional contributions of nurses to their teams, and the contexts that impede and facilitate the contributions that nurses make.

Through this literature review I have provided a basis for an exploration of NDC to MMHTSVY. In the next chapter I will discuss the methodology for this study.

## Chapter 3

The literature review revealed gaps in detailed descriptions of nursing's distinct contributions (NDC) to multidisciplinary mental health teams that serve vulnerable youth (MMHTSVY) and the context in which NDC can make a meaningful difference to vulnerable youth. This qualitative study aims to close that gap. To investigate NDC and the contextual factors I used an interpretive description underpinned by constructivism. I collected and analyzed the perspectives of 14 study participants whose disciplinary training reflect the span of traditional professional disciplines in MMHTSVY. In this chapter I describe the methodological approach used in this study.

The methodology is presented in ten sections. The first section is an explanation of the approach, method, and assumptions. The second section is a personal disclosure of my interest in the study. The next six sections describe the population, setting, ethical considerations, third party recruitment, sample, and the collection of data. The ninth section is a description of the steps that were applied in the data analysis. The tenth section is an evaluation of rigour.

### **Approach, Method, and Assumptions**

Researchers must select an approach that is consistent with the researcher's underlying philosophy regarding truth and knowledge, and a method that can appropriately address their research questions. I ascribe to Appleton's and King's (2002) understanding of constructivism that knowledge is socially constructed and not static. The structural framework that I selected is an interpretive description, as described by Thorne (2008). Thorne clearly indicates that an interpretive description is a flexible structure in which the researcher must bring their beliefs about knowledge that can guide the researcher's decisions within an interpretive description. I will describe how I understand interpretive description underpinned by constructivism.

Interpretive description is a practice based method that was developed for an applied science like nursing (Thorne (2008)), for a research purpose that "makes sense of something that clinicians ought to understand" (Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004, p.3). Thorne (2008) describes how an interpretive description can guide a researcher to craft a practical purpose for the acquisition and utilization of new knowledge for nursing practice. Munhall (2007) similarly implores nurse researchers that "research narratives of description and interpretation need to have implications for the profession [in nursing practice and/or nursing theory]"(p.202). The suitability of interpretive description for this research project is clear because my research project was a practice-based investigation. The research questions for this study have a practice based aim to enhance team members' understanding, facilitation, and utilization of nursing's distinct contribution -in ways that can address the needs of vulnerable youth, their families, and communities.

Interpretive description can elucidate "something below surface meaning -beyond the self-evident-"(Thorne, 2008, p.175). Munhall (2007) explains that human purpose pre-structures an individual's perceptions and worldview, and consequently persons are often unaware of the deeper meanings of their lived lives. According to Lopez and Willis (2004), persons who are situated in a phenomenon under study gain a richer understanding from the research findings. Therefore, through an interpretive description, this study offers nurses and their team members in MMHTSVY a deeper understanding of nursing's contribution.

In comparison to generic qualitative description which summarizes the collected data with an interpretive view, the interpretation is deeper in interpretive description (Sandelowski, 2000; Sandelowski & Barosso, 2002). Moreover, an interpretive description has been a good fit for a principal investigator like me who is familiar with the phenomenon as a nurse member of

MMHTSVY. As such, I brought an informed perspective to investigate NDC to MMHTSVY. I drew upon my insider knowledge as a member of MMHTSVY to both develop the interview questions and interpret the meaning of the study participants' responses. Following data collection, Thorne (2008) states that

[Interpretive description] uses human experience as its starting point...[and] it is not constrained from considering other dimensions within which that experience may be situated. Thus, it seems necessary and relevant to include within the full interpretation of findings those *explanations* and interpretations that may shed light on what influences are shaping the circumstances and how they may be interacting with one another to mould the manner in which people live and interpret their living. (p.202)

I gleaned from Thorne's view that a researcher extends interpretation to the qualitative data by drawing from a personal awareness of the social, historical, and cultural complexities of the studied phenomenon. The contexts of vulnerable youth, macro systems and policy, multidisciplinary teams, nursing, and nursing with vulnerable youth (i.e., subject areas in the literature review) are pertinent to an interpretation of NDC. Altogether, Thorne's (2008) interpretive description was a suitable way to explore NDC to MMHTSVY and the factors that affect nursing's contribution.

I will now explain how Appleton and King's (2002) definition of constructivism informed the research decisions in two fundamental ways. Firstly, constructivist researchers believe that social reality exists as individuals experience it and assign meaning to it (Appleton & King). Consequently, constructivists collect and describe descriptive contexts from each participant (Appleton & King). Constructivists gather multiple realities and make sense of the aggregate data without losing the participants' associated individual contextual factors (Appleton & King;

Williamson, 2006). In relation to my study, participants' knowledge of NDC will have been socially constructed from formal education in a particular discipline, observations, experiences, literature, and media. Research answers exist in the minds of members in MMHTSVY. While every member's knowledge of NDC is valid, individual voices are not representative of their respective disciplines. Furthermore, the aggregate perspectives within any sample are not representative of MMHTSVY. The other significant constructivist view is that individuals' realities are not static. Rather, individuals' understandings are relative to time, location, and social forces (Appleton & King). A sample of study participants' views are not expected to be static across time so that transcribed audio-taped interviews are not reviewed with study participants for accuracy (Appleton & King). Noe (2007) explains that "it would be outrageous to challenge subjects about whether they were sure that they were speaking their minds when they made reports about how things seem" (p. 204). The underlying constructivist view (Appleton and King, 2002) affirms that participants' perspectives are their truth at a point in time. Consequently, a constructivist exploration does not yield a static representation of NDC to MMHTSVY. According to Creswell (2007), the post modern conclusion for interpretive research is that "interpretations are seen as tentative, inconclusive, and questioning" (p. 154).

I have described how a constructivist interpretive description is a relevant way to answer the research questions in this study. Through this approach, a slice of team members' understandings of nursing within MMHTSVY were gathered and interpreted as insights of NDC to MMHTSVY in B.C. in the summer of 2011.

### **Personal Disclosure of Interest**

Congruent with qualitative research, a researcher's disciplinary bias and personal interest in conducting a research inquiry are disclosed for transparency (Taylor 1998; Thorne 2008).

Through being a nurse member of MMHTSVY for 27 years, I acquired suppositions of NDC to MMHTSVY. I will briefly define my experience, generalize my beliefs, and clarify my interest. I have in-patient and out-patient experience working in MMHTSVY as a baccalaureate-prepared, registered nurse and nursing graduate student with clients, families, multidisciplinary colleagues, administrators, community leaders, nursing association staff, professional nursing groups, youth court agents, school personnel, and health service personnel. I have collaborated with service providers in multiple agencies that work with vulnerable youth and their families. I believe that it is important for nurses to enact their scope of nursing competencies and their nursing philosophy of care to address the broad health needs of vulnerable youth, and this belief is also my aspiration. As a culmination to a master degree of nursing in advanced practice leadership, I chose to investigate NDC to MMHTSVY. A commitment to improve nursing practice and collaborative team work in MMHTSVY had been the spark for this investigation. It is my assumption that the findings from this scientific study can inform clinicians, administrators, and nurse educators in ways that can improve clinical practice.

In this research project I was situated as an informed observer in the collection and analysis of data. Having transparently disclosed that I have inherent suppositions and aspirations, I ensured research rigour with strategies that are described later in this chapter. Moreover, I have a personal investment in presenting a thesis that genuinely offers clinical practice meaning

In the next seven sections I will describe the elements of the research method.

Furthermore, I will describe how the research design was implemented.

## **Population**

Seeking a variety of team members' perspectives is consistent with a phenomenological interpretive description framework (Thorne, 2008). The non-nurse professionals in MMHTSVY

include psychiatrists, registered and unregistered psychologists, registered and unregistered social workers, registered clinical counsellors, mental health workers (who have undergraduate and post graduate professional degrees in various allied fields such as teaching, educational counselling, and child and youth care), and who may self-identify as social workers. The kinds of nurses include registered psychiatric nurses, registered nurses, nurses who have dual registrations, male and female nurses, staff nurses, contracted nurses, nurses with various forms of advanced nursing education and certifications, and nurses who have masters degrees in nursing, health sciences, counselling, psychology, or administration.

I determined optimal characteristics for "study participants" (Thorne, 2008, p. 94). I required team members who could answer the research questions. I was also seeking diversity among the study participants that would reflect the professional disciplines in MMHTSVY. Consequently, two imperatives for an optimal sample were experience in MMHTSVY and diversity in disciplinary background.

To achieve the first objective, I narrowed the eligible population of team members in MMHTSVY to 'experienced' members. The definition of 'experienced' was open to the interpretation of prospective participants. The timing of the research project was optimal to harvest the experiential practice knowledge of experienced nurse members because an overwhelming majority of nurses in MMHTSVY were nearing retirement. I determined that retired members were eligible study participants as long as they had retired within the past year.

The second objective was to have diversity among the participants in the sample. Multiple, individual realities that provide in-depth contextual meaning about the phenomenon of NDC are expected within a phenomenological interpretive description. A diversity of professional disciplines within the sample was deemed most likely to provide diverse

perspectives (the goal in data collection for this study). For clarification, study participants' views are not intended to represent their respective professional disciplines or demographic categories of clinicians or the collective voice of MMHTSVY.

Nurse practitioners were intentionally left out of the sample for particular reasons. Among the nurse clinicians with masters degrees who worked with vulnerable youth, the nurse practitioners were a new entity in the field. However, it was my understanding that the nurse practitioners were in one work site in British Columbia (BC) at the time of recruitment. The rarity of nurse practitioners would have jeopardized their confidentiality of participation.

### **Setting**

Diversity in team members' settings can bring a wide range of meanings of NDC, and that is the object of an interpretive description. A strategy of drawing multidisciplinary clinicians (i.e., nurses and non-nurses) from multiple work sites across BC in small and large urban centres has a potential to net geographical and work site variations in prospective study participants' perspectives. The potential teams in BC (and from which study participants in this project were recruited) are in-patient and out-patient youth services that are situated in programs under the administration of the Ministry for Children and Families' Development (MCFD) and the Regional Health Authorities. The types of programs included office-based, assertive outreach, day programs, residential, and hospital programs. Examples of Vancouver Island Health Authority (VIHA) programs with eligible participants included Ledger House, Anscomb, Victoria General Hospital Paediatric Unit, Integrated Mobile Crisis Response Team, Health Assessment Resource Centre, Adanac, and Mental Health and Addictions Services for Youth. MCFD programs with eligible team members included Child and Youth Mental Health Services, Youth Forensic Psychiatric Services (YFPS), and the Maples Adolescent Treatment Centre.

## **Ethical Considerations**

In this section, I will describe the ethical considerations for this study wherein 14 study participants were individually interviewed by telephone for up to an hour and these interviews were audio-taped. The ethical aspects of the study involved approval for the research process and the associated recruitment materials that described the study, recruitment dates, eligibility and criteria for participant selection, voluntariness of participation in the study, risks and how risks would be managed, parameters for receiving a described honorarium, contact persons (besides me) to whom questions or concerns about the study could be addressed, and the interview questions.

I prepared the following recruitment materials to accompany an ethics application. Recruitment advertisements and a poster were prepared for VIHA and MCFD members of MMHTSVY (Appendix A: Recruitment Advertisements). A description of the study (Appendix B) was an addendum to the recruitment advertisements and the consent form (Appendix C). I described third party recruitment (Appendix D: Information for Research Contacts). I outlined my research budget (Appendix E), interview questions (Appendix F), and the parameters that pertained to the study participants' honoraria (Appendix G: Honorarium Receipt Form).

The research proposal, ethics application, recruitment materials, and interview questions were approved by my research supervisor and committee prior to submission of these to three organizational bodies for ethical approval. Through communication with VIHA staff, I located a VIHA signatory for my study. Approval from MCFD and YFPS was dependent on the Joint Committee, that comprised a sub-committee of the University of Victoria's Human Research Ethics Board (HREB) and VIHA. The Joint Committee requested revisions to the materials prior to granting a Letter of Approval. In the revised ethics application and revised recruitment

materials, I clarified that through third party recruitment I would interview acquaintances but not friends or my team members, how I would manage an excessive number of participants, direct an upset participant to counseling, cause zero impact to the clients, discourage participants from describing names and identifying details in their examples of NDC, indicate that there is no cost to the organization, and lock raw data in a filing cabinet in my home office rather than in a locked briefcase. A copy of the March 16, 2011 Joint Committee's initial Letter of Approval was sent to MCFD to complete an application for research ethics approval that had begun simultaneous to my application to the Joint Committee. I identified the signatory for my research project within MCFD settings. Furthermore, I addressed the particular expectations that were required by MCFD. Meanwhile, I had applied for research ethics approval in 2010 through the Program Evaluation Review Committee of YFPS within MCFD. With minor revisions the research materials met their requirements. All revisions through YFPS, MCFD, and VIHA were included in communications to the Joint Committee. The Joint Committee's final Certificate of Approval for the research project was released on May 2, 2011.

Members of MMHTSVY in in-patient and community settings across BC from two large agencies were recruited. Everyone who expressed an interest to become a study participant and then signed a consent was interviewed (Appendix F: Interview Questions). While most of the participants offered to forgo their honorariums, two participants refused their honorariums. I did not mail honorariums to those two participants. Recruitment was efficiently achieved through third party facilitation which I will explain under the next heading 'Third Party Recruitment'.

Through multiple strategies, confidentiality for the study participants' participation was preserved. I removed clues to any identities when I transcribed the audiotapes. Work site locations, programs, and organizations in the transcripts and artifacts were masked in general

terms or omitted. Codes replaced participants' names in their transcripts. By drawing study participants from a wide distribution of MMHTSVY (in comparison to a singular geographical location or a singular organization), confidentiality of participation was enhanced.

The study participants' expressions of interest, signed consents, transcripts, artifacts, and analyzed data were organized by participant in a binder that I kept with my audit journal in a locked filing cabinet in my home office. The material was constantly used for reference through the writing phase. The materials were available to my research supervisor and committee for auditing purposes until the conclusion of the thesis. I disposed of the raw data by shredding it at the completion of the thesis. The audio tapes were kept for audit purposes through the thesis process and then these were erased as described in the approved proposal. At the completion of the project, a project completion notification was sent to VIHA, MCFD, and YFPS.

### **Third Party Recruitment**

Third party recruitment was enacted due to my affiliation with prospective eligible study participants (Lykkeslet & Gjengedal 2007). Having third party recruiters meant that I did not approach anyone directly and secondly, that individuals who did not wish to be interviewed were made aware that I was the researcher so that they would have a choice to continue to become study participants. I also made it clear in the recruitment materials that nurse and non-nurse team members at my worksite were ineligible to become study participants. I approached persons having administrative or managerial authority in VIHA, MCFD, CYMH, and YFPS for their willingness to facilitate third party recruitment.

Third party recruiters were provided with information (i.e., Appendix D: Information for Recruitment Contacts) regarding the study so that they understood the recruitment process and circulated (e.g. in internal newsletters or as an e-mail attachment to an address list of eligible

team members) the applicable recruitment advertisements for VIHA or MCFD (Appendix A: Recruitment for Study Participants). Advertising for a meaningful variation among the nursing mix and the multidisciplinary mix in MMHTSVY stimulated an inclusive recruitment. In the advertisement, the clinicians in MMHTSVY (including newly retired clinicians) were invited to review the description of the study (Appendix B: Description of Study). Interested prospective participants were then directed in the advertisement to voluntarily and confidentially contact the principal investigator, and I was identified as the principal investigator. Through third party recruitment, nurse and non-nurse clinicians in MMHTSVY who knew me were not approached by me to become study participants. Third party recruiters ethically facilitated the recruitment of study participants.

Following third party recruitment, fifteen eligible volunteers came forward to explore becoming study participants in that they had either faxed their 'expression of interest' c/o my research supervisor Dr. Bernadette Pauly, or they had e-mailed that information to my university e-mail address. Consent forms (Appendix C: Consent Form) were then sent by attachment to respondents' e-mail addresses (when these were provided) or consent forms were mailed according to the preferences that were indicated by the respondents. I received 14 signed consent forms. One consent form was not returned. I re-sent a consent form to that respondent as indicated in the individual's 'expression of interest' form. It is likely that the participant reviewed the consent and decided not to participate. Possibly the date for the completion of data collection was a barrier for that prospective participant.

### **Sample**

The sample is described in a manner that protects the participants' confidentiality. Fourteen people participated in the research study. Five of the participants were male and nine of

the participants were female. The average age of the total group was 47.5 years. The age in years ranged from 27 to 65. The years of experience was between four and 26 years, and a mean of 13 years. The 14 study participants were from 10 teams in six programs. Two of the programs were in-patient and four programs were out-patient. Three participants worked in in-patient settings and 11 participants worked in out-patient settings. The work settings were located in eight different municipalities in British Columbia.

In the sample there were seven nurse participants and seven non nurse participants. The nurse participants included registered psychiatric nurses, registered nurses, and a nurse with dual registration. Five nurses had a bachelor of nursing degree as their highest level of nursing education. Three nurses had a masters degree. The non-nurse participants had a minimum of a masters degree, and their professional disciplines included psychiatry, registered psychology, registered social work, registered clinical counselling, and child and youth care.

### **Data Collection**

Since prospective participants would be from various settings of MMHTSVY throughout BC, I anticipated that doing telephone interviews would increase opportunities for participants to be involved in the study. Telephone interviews were less costly than in-person interviews -and carbon neutral- in that no travel was required. Study participants expressed appreciation for the use of telephone interviews as the format was more convenient (less time consuming) than face to face interviews.

A few days to a week prior to an individual participant's interview, interview questions were provided (mailed or e-mailed) to study participants along with a telephone confirmation of their interview appointment time, date, and phone number at which I would expect to reach them (and details about their opportunity to reschedule). At that communication juncture, participants

were invited to reflect on their personal experiences and knowledge regarding NDC to MMHTSVY, if they wished, and they all chose to do that.

Data collection through fourteen single, individual, audio-taped interviews was conducted over an eight week period, beginning June 2 and ending July 22, 2011. Study participants were guided to elaborate on their meanings as they answered six semi-structured questions during an interview lasting from 30 to 60 minutes. Guided by Thorne (2008) I probed and gathered a diverse scope of study participants' perspectives, including perspectives and explanations that I had not previously considered. Thorne describes "listening, really hearing, on prompting further depth, on expressing your curiosity and genuine interest in the expertise that they are offering" (p.130).

Artifacts can be significant sources of data when these are identified by informants (Thorne, 2008). Atkinson and Delamont (2008) encourage "serious attention to visual data" (p. 288). Thorne et al. (1998) similarly recommend "a range of data sources [that] can add considerable strength to the usual data sources of interviews... for the purposes of generating practice knowledge for nursing" (p. 174). In this context, artifacts are nursing paraphernalia, tools, or documents that participants mention in their interviews as having relevance to understanding NDC. Artifacts in text format were faxed c/o my research supervisor, or sent to me as e-mail attachments. These artifacts are interpreted in chapter four under the last category 'Nursing Momentum', in the sub-theme 'Nursing specialty'.

### **Data Analysis**

In preparing for the data analysis process, I examined the structured plan for data analysis in my research proposal. I had integrated Thorne's (2008), Thorne et al. (2004), and Creswell's (2007) analytic approaches to develop my analytical steps. I had also drawn from my previous

analytical experience that was gained from analyzing three participants' transcripts in a pilot study for a master's level nursing methodology course. In discussing the analytical process with my research supervisor, I made one significant change to the data analysis plan that was outlined in my research proposal. I decided to manually manage my data instead of using a software product due to the cost of the resource and the training time that it would have taken to use the product.

Guided by Thorne (2008), I mindfully "set aside preconceptions [of the phenomenon] so that entirely new conceptualizations... [could] be inductively derived" (p. 152). I did not interview myself in order to avoid crystallizing my suppositions. In my mind, I gave the participants' perspectives a prominence over my own experience of nursing's contributions. Moreover, I did not review the research findings in my pilot study in order to avoid positioning these as preconceptions. To be sure that my suppositions of NDC were pushed aside, I immersed myself in the participants' voices, phrases, and meanings. I reviewed the audiotapes and transcripts so that participants' perspectives were foremost in my mind, and I reflected on their meaning.

On the other hand, while I carefully kept my views of NDC in check, I brought all of my knowledge of MMHTSVY and nursing in these teams to the analytical process. I drew on my experience as a member of MMHTSVY, nursing knowledge, and preliminary review of the literature in order to critically reflect on the participants' perspectives and answer the research questions. Through inductive reasoning, a new conceptualization of NDC emerged that was so much more than a synthesis of the participants' interviews. I will describe the strategic, structured analysis of 14 participants' perspectives that led to the inductively derived findings.

The structured plan for data analysis began as soon as I initiated data collection. During the audio-taped telephone interviews, the perspectives that participants put forward were continuously co-examined with study participants for underlying meanings. I made procedural and reflective field notes following each interview.

I personally transcribed the audiotapes to prolong my immersion in the data and to carefully transcribe relevant communication. Data collection from interviews in an interpretive description is not a complex collection of communication nuances (Thorne, 2008). For example, "ums" and identifiable information from the participants' verbal content were stripped in the making of the transcripts. I developed participant codes for the transcripts so that I could identify the content and professional discipline that pertained to each participant. During the transcription process I also made an electronic list of numbered memos. I adopted Creswell's (2007) definition of memos that is "short phrases, ideas, or key concepts" (p. 151) that occurred to me. I reflected on my memos and the transcripts.

To facilitate an inductive analysis of 14 participants' transcripts, I developed and utilized a manual data analysis process. Manually sorting the data was advantageous in terms of further immersion in the participants' data to know the data well in order to reflect on the similarities and differences between individuals' data and the meaning of the aggregate data.

I re-formatted 14 double-spaced transcripts into tables. The tables were divided into four columns, with a transcript in the first column (half the width of the page). Horizontal lines sectioned a transcript into blocks of content -divided by four columns- where the blocks indicated a change of speaker between the researcher and participant. Data blocks were coded with the particular transcript code, the sequential order, and to identify sub-blocks of content within a block. Guided by Creswell (2007) I converted the transcripts in the first column to units

of text when I underlined all meaningful data segments within the transcripts. Where multiple and unrelated data segments were evident in data blocks, sub-blocks (horizontal lines) were hand-drawn and the sub-blocks were manually coded in relation to their respective data blocks.

When I finished underlining significant data in the first column, I began a different process in the second column. I synthesized the meaning of the underlined data segments that were positioned in the first column, and I wrote these 'meanings' in column two, and in the same data block opposite the referenced data segments. However, I intentionally retained significant words and phrases from column one, when these words and phrases seemed to inform a synthesized meaning.

In the third and narrowest column I matched the content of the first and second columns to applicable research questions that were identified as one (i.e., team members' expectations and experiences of Nursing's Distinct Contribution [NDC]), two (i.e., how and what nurses in this specialty contribute to policy development), or three (i.e., identified contextual factors that sustain, enrich, constrain, and erode NDC). Information that did not match one or more research questions was discarded unless the information seemed to be relevant to the research project. For example, I discarded information that described the physical layout of a participant's worksite that was described as not conducive to feeling like a team. In another example (i.e., a participant's description of nurse members in MMHTSVY who were deficient in therapy skills), I did not initially perceive a match to a research question, but I retained the data because it seemed relevant to the research project. Then I reflected on that discrepancy and matched the data to "What are the contextual factors that can sustain, enrich, constrain, and erode NDC?" Consequently, I had identified a contextual factor that can constrain and erode NDC. Moreover,

I recognized a relationship to data that suggested challenges in the preparatory training for nurses in MMTSVY that emerged in a major category 'Nursing Erosion'.

In the fourth column, guided by Thorne's (2008) Interpretive Description analysis system I assigned a topical index (i.e., a topic and sub-topic index) to certain data segments from column two while dismissing other data segments. These topics were then compared within transcripts and across transcripts in order to reduce the multiple topics to a smaller number of categories or themes. Taylor (1998) defines the right number of final categories or themes as "the limits of reduction [without]... losing some of their specialness in relation to the research" (p. 316). Creswell (2007) recommends combining the categories into five or six themes. Through inductive thinking, the topics in the fourth column were eventually reduced to six major themes. While seemingly simple, this process was not simplistic.

I compiled the information for each of the identified sub-themes in the following manner. I made five copies of the completed data tables, separated the coded sub-blocks of data with scissors, and sorted the coded data into piles of single sub-themes. I reflected on the meaning of the aggregate sub-themes as I held and read each sub-block of data in each categorized pile of paper. I developed a concept map (Appendix H: Illustration of Concept Mapping) to understand the relationships among the themes. Thorne et al.(2004) describe that "visual tools such as concept mapping...[imaginatively bring] loosely related ideas within the data into increasingly coherent relational patterns." (p.4)

To some degree, I gained insights about the recognition of -and prioritization of- key themes through a review of three sets of memos. During or following individual interviews I had recorded memos in my audit journal (i.e., interview memos). During data analysis, my reflective

thoughts were recorded about the aggregate data (i.e., general memos), or about selected data blocks (i.e., coded memos). The memos also provided content for the discussion in Chapter Five.

An interpretive approach (Thorne, 2008) requires a search for patterns and associations that are "filtered within a disciplinary lens"(p.50). I examined aggregate team members' perspectives to illuminate how and what nurses contribute to the broad health needs and challenges of vulnerable youth, and to the inter-professional and policy processes. From single transcript analyses of the contexts underlying elements of NDC to cross transcript analyses, I described and compared study participants' perspectives of NDC. I reflected on the relationships between the sub-themes. I reasoned what sub-themes belonged together and I explored which sub-themes were dominant themes in the aggregate data. I reflected on significant anomalies, similarities, and relationships between data while retaining study participants' perspectives with their contextual influences so that I did not transform individual perspectives into distorted plural views (Appleton & King, 2002). The sequentially coded data blocks ensured that the context of emerging themes were not lost. The themes and the related information were visibly connected and readily accessed. Consequently I could locate quotes in the transcripts for key themes.

### **Research Rigour**

Research rigour in qualitative studies demands credibility, trustworthiness, and transferability (Maggs-Rapport, 2001; Maxwell, 2005; Polit & Beck, 2004). This study is a constructivist, interpretive description of NDC to MMHTSVY, in which the findings are a slice of insights from the perspectives of 14 members of MMHTSVY. Accordingly, the following questions serve as the evaluative criteria that can determine the research rigour of my study. Does the study meet the research standards and methodological requirements (Schwandt, 2000; Schwandt, Lincoln, & Guba, 2007; Thorne, 2008)? Were there administrative processes that

supported believability and facilitated the integrity of the data and the data analysis (Polit & Beck)? Is bias transparently addressed (Thorne; Polit and Beck)? Is transferability articulated, and is it consistent with the research design (Maxwell, 2005)?

In the development and implementation of this study, I worked with my supervisor and committee to ensure adherence to research standards. The proposal was reviewed and approved by my research supervisor and committee. Then the proposal and recruitment materials were submitted to three organizations' research ethics standards for recruitment and involvement with some of their clinicians. Revisions were integrated, and my study passed ethical reviews by the Joint VIHA and University of Victoria's Human Research Ethics Board Committee, the MCFD Research Ethics committee, and the YFPS Program and Evaluation Committee.

The study met methodological standards for a constructivist interpretive description. I explained my adherence to principles and processes that were consistent with the research design.

Bias was transparently addressed. Rigour in qualitative studies in which the researcher is both the investigative and the analytical instrument requires a researcher's transparency so that bias is exposed and managed. Earlier in this chapter, for the purpose of transparency, I discussed my member status as a nurse in MMHTSVY with aspirations to strengthen nursing. Moreover, I clarified that I brought a nursing lens to this investigation. I implemented the following qualitative research strategies to manage subjective bias. Through eliminating members on my team from eligibility as prospective participants and by having third party recruitment, volunteers came forward of their own volition. By these measures, colleagues who knew me were spared the potential conundrum of feeling too awkward to refuse and overcome with social pressure to say yes directly to me. All in all, third party recruitment heightened the consent

process. The consent process invited prospective participants to participate and describe their views freely, and to withdraw themselves and their data from the study if they chose to do so. The voluntariness of participation facilitated participants' freedom of expression. Consequently, pressure or influence on the participants to say what they may have perceived the researcher wanted to hear was minimized (Maxwell, 2005). Interview questions were semi-structured to open the possibilities for the participants' answers, including welcoming a disparate view of there being no distinct nursing contributions. I provided the interview questions to the study participants prior to the research interview so they could begin thinking about their answers to the interview questions. That 'head start' on their answers was another strategy to minimize distortion from participants' potential reactivity to the research interview process. I used mindfulness to not make assumptions and to instead probe the participants for their explanations of what they were meaning.

I implemented a purposeful two step process in relation to the literature review in order to further diminish the possibility for carrying researcher bias from the literature into participants' perspectives of NDC. Prior to data collection, and until I was well into the final phase of writing the findings, I limited the initial review of the literature on Multidisciplinary Teams, Macro Systems and Policy, Nursing Attributes, and Nursing with Vulnerable Youth to a sufficient depth of coverage that would satisfy rationale for the study.

When transparency is articulated, and the research purpose is clear, a researcher can impose a personal and nursing disciplinary influence on the analytic interpretive process for the purpose of explicating a phenomenon under investigation (Thorne, 2008). I brought my nursing experience to develop the interview questions, bringing bias that is hinged to expertise (i.e., nurse member status in MMHTSVY) in order to strengthen the questions that would explore

NDC in MMHTSVY. Participants were able to discuss their perspectives in depth, and because they knew that I was familiar with MMHSVY, I was able to knowledgeably probe for deeper meaning. My experience as a nurse in this area assisted the interpretation. I brought my understanding of nursing, and experience of nursing in MMHTSVY to sort, categorize, connect, expand, collapse, and synthesize the data as I engaged in inductive thinking. Through my clinical experience in MMHTSVY, I was able to understand the participants' content and the contexts of participants' perspectives in ways that made sense of their descriptions. In summary, I managed bias through selecting a methodology that integrates the lens of a researcher's disciplinary expertise and practice experience for a practice based outcome, and through implementing qualitative research standards that build rigour.

Administrative processes that ensured the integrity of the data and the orderly processes for data analysis brought believability to the findings. Here I will specifically emphasize how I collected and analyzed the data to maintain rigour. I implemented a series of actions to accurately collect data. The interviews were audio-taped to ensure accuracy of recording. My supervisor reviewed two of the initial interviews and provided feedback on interviewing techniques. I personally transcribed the audio tapes, to help ensure that the understanding of words and meanings were consistent with what I heard in interviews. During the research process I maintained an audit journal, audio tapes of each interview, transcripts that matched the audio tapes, data analysis tables, a succession of conceptual maps that were tools for inductive thinking and thematic development prior to writing the findings, and copies of the evolving drafts of chapter four. In the analytic phase, I worked closely with my supervisor in the process of developing themes with almost weekly meetings to review and reflect on the process of analysis. I included many quotes in my findings because quotes bring credibility and authenticity

to a qualitative study, particularly in a constructivist interpretive description. Moreover, the themes and sub-themes are derived from the participants' words or the themes are a synthesis of the participants' meanings. Qualitative practices for the integrity of the data were followed with attention to methodological consistency. The close supervision of my research supervisor assured the credibility of raw data and analytical processes for believable findings. Charts, diagrams, descriptions, memos, and an audit journal satisfied the requirements for integrity in data collection and the interpretive processes that are part of data analysis.

Transferability means that a researcher specifies the basis and limits for applying the research findings (Stewart, 1998). Transferability in this project is understood within the limits of a constructive interpretive description. Research findings were developed from 14 experienced clinicians who spanned the diverse group of professional disciplines in in-patient and out-patient MMHTSVY in BC. The reason behind having a variety of clinicians' perspectives that were described and interpreted is to increase our understanding of a phenomenon through seeking maximum variation (Thorne, 2008). However, these 14 thick descriptions are not a representation of NDC. The collected and analyzed data is actually representative of 14 specific study participants' perspectives in the summer of 2011 in BC, from the participants' minds when the participants were interviewed. To be sure, transferability of the findings in this research project is not about representation for generalization. Rather, the research findings for this study are insights. The inductively derived insights are applicable to MMHTSVY. Although insights are informative, insights respect more room for untold diverse accounts, and values each individual's perspective (Appleton & King, 2002). The strength of the transferable insights from my study is the 14 multidisciplinary professionals' thick descriptions of NDC to MMHTSVY.

The relationship of conclusions to reality should be tested (Maxwell, 2005; Thorne, 2008; Thorne et al, 2004). I agree with a need to assess the validity of the research findings, and to do this in a way that is consistent with constructivism. Thorne (2008) explains that findings from an interpretive description can be given to a panel of experts to incorporate their reaction and comments as a form of checking the reliability of research findings. Furthermore, Thorne et al. (2004) describe that an interpretive description should pass plausibility among persons who have expertise in the phenomenon and illuminate for them a new understanding of the phenomenon.

Unfortunately, the inclusion of a presentation of the thesis to an audience of MMHTSVY to gauge audience reaction to this thesis was beyond the scope of this research project due to time constraints on the target completion of this thesis by August 31, 2012. However, in addition to the publication of this thesis, I intend to give a poster presentation, a lecture, and possibly a publication in a peer reviewed journal in order to share the findings with MMHTSVY. I have submitted an abstract to an international annual conference in March 2013. If accepted I will deliver a symposium on my thesis to an audience of mixed disciplines, and some of the people who regularly attend the annual conference work in MMHTSVY.

In the next chapter, the findings are described. Fourteen study participants' voices are heard in six categories that comprise the analyzed data.

## Chapter 4

Chapter Four is a presentation of the research findings of nursing's distinct contribution (NDC) to teams in British Columbia that serve vulnerable youth who have mental health and /or substance use challenges. The understanding of NDC is drawn from the perspectives of multidisciplinary team members. The analysis of the themes is organized into six major categories. The six categories are 'Sameness Paradox', 'Way of Being', 'Nurse Doctor Partnership', 'Expert', 'Nursing Erosion', and 'Nursing Momentum'. In the first four categories, I discuss study participants' expectations for NDC, their experiences of NDC, and their perceptions of how nurses strengthen their teams. In the final two categories, I discuss study participants' perceptions of the broader context in which nurses practice. Taken together these themes answer the three research questions posed at the beginning of this project and contribute new knowledge towards an understanding of nursing practice in multidisciplinary mental health teams that serve vulnerable youth (MMHSVY).

### **Sameness Paradox**

The first major category 'Sameness Paradox' reflects study participants' many and diverse descriptions of nursing's similarity to, yet distinct difference from, other professional disciplines in MMHTSVY. The word 'paradox' is paired with 'sameness' in order to convey the meaning expressed by study participants about the importance of sameness but yet reveal subtle and sometimes hidden elements of nursing's distinct contribution. Within the theme of 'Sameness Paradox', there are three sub-themes including 'appears the same', 'valuing', and 'overlap'.

#### **Appears the same.**

Study participants expressed in many and diverse ways that nurses are similar to other team members and thus their distinct contribution is often diffused or even obscured. Participants

described that, to a large extent, nurses share a similar role and function with their team members. For example, a nurse participant stated

*I sometimes don't think of myself (a nurse) as that much different from everybody else [on the multidisciplinary team]. I have to think hard what the nursing discipline brings (10c1).*

In the following quote, a nurse participant explained that disciplinary differences between nurses and their team members were less remarkable than personal differences among team members.

*I don't see a big difference other than individual differences (3c4).*

A non-nurse participant stated that "*nursing in individual work and family work is just sort of diffused into the mental health practice (7a4).*" In this statement, the participant dually described sameness and an awareness of difference, suggesting that the nurses bring a specific perspective in the provision of individual and family assessment and treatment. In the following quote a non-nurse participant proposed a per cent of sameness between nurses and other team members.

*75% of their (i.e., nurses') practice is very similar (i.e., to the other team members). The other 25% has to do with nuance and the perspective that they bring (12e52).*

Multidisciplinary team members work with the same population, share the mission and value statements of their particular agency, commonly share specific assessment and treatment tools, and are governed by the same policies and procedures. A non-nurse participant described,

*We all have the same role in some sense where we are providing mental health assessment and treatment for youth and their families...We all follow the same basic guidelines for conducting mental health assessment and we all provide the same range of treatment.... Nursing work appears the same as other clinicians (7a18).*

At least on the surface, the roles of team members appear the same. In general, study participants reported that a multidisciplinary assessment and treatment role is the predominant commonality between nursing and the professional disciplines in MMHTSVY.

The sameness (that participants identified and emphasized) between nurses and their team members, is in part explained by their team's purpose. Team members from all professional disciplines in MMHTSVY perform assessment and counselling which is their part of their teams' purpose and a primary area of work. Consequently, competency in assessment and counselling is viewed by team members as being imperative across disciplines without differences.

In the following quote, a nurse participant expressed concern at considering nursing's distinction contribution and the implications for multidisciplinary teams.

*I guess your research study has spawned interest in us looking at the nursing contribution. Because it is so multidisciplinary we really don't, haven't in the past, considered others' backgrounds. So it has been helpful in that respect to be a bit reflective. It would be curious to look at sustaining nursing's distinction because what would the other disciplines feel? It might come back like Quebec as a distinct society in the provinces right! Not looking that favourably at Quebec wanting to be seen as special. And I'm not saying that nursing is special. But it is synonymous with having a distinct contribution (8c19).*

A nurse member's feeling of not wanting to stand out as being different from their team members or 'special' suggests there are social forces within the multidisciplinary work culture that shape the value of sameness within multidisciplinary teams. The study participants consistently perceived that sameness is relevant to understanding NDC. All in all, participants valued nurse members' (indistinct) contribution to tasks that they shared with professional disciplines and across professional disciplines. In the next sub-theme I examine participants' valuing of nursing.

### **Valuing.**

A consistent observation made in the analysis of the data was that the 14 study participants described nursing as bringing something of value to the team that is different from other team members' contributions. This idea of difference and value is juxtaposed against participants' conversations on sameness. While participants emphasized the importance of sameness among team members, ideas of sameness can misleadingly obscure the distinct

contribution and value of nurses on the team. From the perspectives of participants, the overarching emphasis was on sameness among team members at the same time that participants spoke to the distinct contribution of nurses to multidisciplinary teams. This valuing of the distinct or unique contribution of nurses is illustrated in the quotes of five study participants from five different professional disciplines within MMHTSVY, including nursing. For example,

*Most of the teams that I have been on have had nurses...Nurses complete the team (1a2).*

*You sort of have to have nurses on your team to know what you'd be missing. (7a5).*

Two non-nurse participants described that multidisciplinary teams with nurses are complete teams. Moreover, the non-nurse participants described how teams in MMHTSVY that do not have nurse members were lacking something. As a team member, one of the study participants had experienced having and not having nurses and expressed that teams were incomplete or missing something without nurses.

Valuing was also expressed in relation to a variety of attributes that nurses brought to the team. One participant described nurses as bringing a unique flavour to the team.

*This is going to sound a bit whacky, but here's a metaphor. If I've got a pot of stew and I invite six different people, from six different disciplines to add a seasoning to that pot, it would have a certain flavour... So it is like we bring a certain seasoning to the pot, and I think that it is very much valued (9c16).*

In the following quote a non nurse participant identified and valued certain attributes that nurses bring to their teams.

*It seems to me that the best people [in MMHTSVY] have been nurses. And by best I mean most organized, seeing the big picture, seeing the details, fearless, hard working, organizing the team, following protocols (5d1).*

Attributes such as these, that participants ascribed to nurse members of MMHTSVY, are discussed in the next major theme 'Way of Being'. One participant identified the presence of a nurse on the team as a way of reducing the 'blind spot' with clients. This nurse participant stated

*I think that outcomes are best when we have diverse points of view that are applicable; and nursing is certainly applicable and it's diverse. So without it you're going to get more streamlined and you're going to have a larger blind spot around any number of things to do with clients, families, even colleagues. Nursing, having a nursing perspective, certainly helps to reduce our blind spot (14c8).*

A nurse participant seemingly implied that multidisciplinary teams that do not have nurse members can unwarily subject their clients, families, and colleagues to uncertain omissions. As will be discussed later, these blind spots include the health and medical needs of clients that might not be assessed or addressed by other team members.

The perspective of these five participants reflects the overall belief expressed by all 14 study participants that nurses do make a distinct contribution. These excerpts offer a glimpse of the study participants' rich descriptions of NDC to MMHTSVY. However, study participants described that NDC is often diffused within sameness. In the next sub-theme, I examine nursing's overlap of particular aspects of their team members' professions.

### **Overlap.**

Study participants articulated the overlap between nursing and particular professional disciplines. Overlap is the normative occurrence of team members extending and sharing professional boundaries to capably and legally perform aspects of another profession's work in the assessment and treatment of vulnerable youth. Overlap between nursing and other disciplines highlights both sameness and difference in nursing and other team member roles.

The following quote is an illustration of nursing's overlap with team members who are child and youth care counsellors. Alternatively this could be phrased as an illustration of how team members in the profession of child and youth care overlap with nursing.

*It is difficult to differentiate who is the nurse.... The overlap with child and youth care counsellors is so great. Both the child and youth care counsellors and nurses participate in the same role delivering direct care, being there 24 hours a day. The nurses' role in direct care isn't unique because the child and youth care workers have that exact same*

*role. They help get the kids up in the morning, get their health walk, do their hygiene routine. It provides a great opportunity for assessment when you're there and present which the nursing role also provides, but actually that is unique!(3c9)*

In the example, the nurse participant who works in an in-patient facility described how 'direct care' comprises a domain of activities that are shared between nurses and team members who have the professional discipline of child and youth care. While that participant described overlap, the unique but hidden assessment role of nurses was exposed. More will be said about nurses' unique contribution to assessment in the sub-theme 'bio-screener handler' in the fifth major category, 'Expert'.

In the following quotes, two nurse participants identified that nurses' work overlaps with the psychiatrists' role in medication management and the social workers' role in interventions that involve community systems.

*With the medication we still share a lot with the psychiatrists. Some of the social and community oriented work, I often find, that the social workers can meet us on those areas. There is overlap (14c6).*

*In nursing we tend to coordinate and look at services outside our agency, and help front people into those services. So, in other words, there are some similarities of what we do to what the social worker does (10c32).*

More will be said about nursing's relationship with psychiatry in the third major theme 'Nurse Doctor Partnership'. These quotes are some examples of how nurses' work overlaps with, or seemingly mirrors, that of other clinicians including psychiatrists and social workers specifically, as well as other clinicians in relation to assessment and treatment.

Moreover, nurse participants described that in comparison to their team members, the nursing role seems to span coverage of the full spectrum of disciplines. For example, in the quotes below, two nurse participants described that nurses understand other disciplines'

language, have an awareness of which discipline is particularly needed in an assessment or treatment, and cautiously substitute for an absent member from another discipline.

*We take for granted how eclectic we are. Nursing is such a broad spectrum that involves the psychological, involves the physical, involves the spiritual, involves so many aspects. We take for granted that perspective. So often when we are nurses and sitting in a group we can go down so many paths. For other people, their paths seem a little narrow. They don't have so many options. Nurses are pretty flexible, can go a lot of different ways, a jack of all trades kind of, in ability (14c38).*

The nurse participant in the above quote described the unique breadth of nursing's scope in comparison to other professions. Nurses have a breadth of knowledge and skills that is unique among their team members. Nurses have the capacity to overlap aspects of all of their team members' professions which is in fact distinct among team members. In the next quote, a different nurse participant similarly described nursing's breadth of knowledge and skills that allows nurses to overlap their team members' work.

*One of the things that I like about nurses is that we can wear numerous hats. We seem to be flexible. We may not be psychiatrists through and through but we get where they're coming from. We get where social workers are coming from. So we can kind of wear a little bit of their hat if they can't step in or if they aren't there. And I'm not quite sure that they would be able to do quite the same thing. The nurses here seem to be very well versed in the other disciplines. If they had to they could bring in their perspective. Their perspective isn't ignored even if they are absent. If we work with the other disciplines we always seem to be able to understand where they are coming from. Not to the depth that they understand or are educated in but we definitely understand what their sense is... We also know when this is beyond my nursing scope. I know my limit. I know what I can do and this is beyond it (4c2).*

The nurse participant described that nurses have the capacity to substitute for their team members while pointing out that nurses understand there is a limit to the extent that nurses can overlap their team members' knowledge and skills. Although the situations wherein nurses can represent absent team members' perspectives was not explicitly described, these situations would possibly be at team meetings, in corridor conferences, and at integrated case management conferences to resolve clinical challenges.

In the category 'Sameness Paradox', I have discussed 'appears the same', 'valuing', and 'overlap'. From my analysis of the data, both nurse and non-nurse participants described that nurses' work is similar to their team members. Perhaps the explanation of nursing's similarity with the other professional disciplines in MMHTSVY is due to the order of emergence of the professional disciplines. Historically, the existence of the discipline of medicine preceded nursing, then nursing preceded psychology, social work, clinical counselling, and child and youth care. Nursing's scope has always been wide, and the newer disciplines have specialized in areas that have remained within nursing's holistic approach and responsibility. It may be that nursing's intrinsic 'holistic approach' is another way of looking at overlap. Nursing's holistic approach is a sub-theme in the next major category, 'Way of Being'.

### **Way of Being**

Study participants perceived that nurse members' orientation to the world, which is sometimes understood by looking at their work traits, was remarkable and distinctive in comparison to that of their team members. These subtle but distinct differences between nurses and their team members were explained by a study participant as nursing's "*way of being*" (14c4). In this category, I identify and interpret study participants' descriptions of nursing's way of being that provide evidence of NDC. The sub-themes include 'holistic', 'get-to-it-ness', 'helping others', and 'nursing aura'.

#### **Holistic.**

Both nurse and non-nurse participants described that nurses view a person in a holistic way. For example, a non-nurse participant stated that "*nurses... look at a person physically, mentally, spiritually, and emotionally*"(11a52). In the following quotes, two nurse participants gave comprehensive meaning and value to the nurses' characteristic 'holistic' approach.

*We look at people holistically: physically, intellectually, emotionally, socially, spiritually; kind of look at the holistic nature of the individual and that relationship with their environment. Their environment is home, school, and community.... And see the presenting problem as part of the context of the individual, and the individual within the family, the school, the community.... As nurses we see the client holistically, not just their mental health diagnosis. We are able to talk about health, diet, family, and functioning. We bring in a lot of education [i.e. teaching]. We liaise with community supports, schools. We promote the health of our own clients...whatever promotes the well-being of our clients. That's another piece to how nursing makes a difference to the clinical practice (8c34).*

The nurse participant described how a nurse's holistic approach to assessment and treatment is inclusive of every dimension of an individual, including health, (knowing how these factors affect mental health). Moreover, these factors are understood and addressed within an environmental context that is possible through nurses' outreach approach. This participant emphasized that in comparison to their team members, nurses do not restrict their assessment and treatment to the presenting problem. Nurses have a broader understanding of the individual. This is illustrated in the next quote.

*Some people look very much through strictly a medical lens, and we just don't. We sort of take a step back and try to see the contingency of the life, the family, and the community. Our scope isn't quite so narrow.... Quite often they [i.e., other team members] have a specified task that they are looking at, a specific issue.... We are like the puzzle solvers. We can look at... the whole picture... Because of the layers, there is a concern that if the person wasn't a nurse that some of those layers would not be looked at. You'll maybe just get a couple of layers but you don't get that whole big picture. Plus you have to work with the entire family. You have to be aware of family systems and how the whole thing works.... Yeh. That's what I mean by working with these kids is like working with a puzzle. You can't solve them unless you work with the whole thing, because if you miss a piece it's just not going to fit together. That's the thing that I like about nurses because they seem to be able to look at how the bits fit (4c12).*

The participant explicitly described the nurses' approach as being broader than the medical approach. The choice of words like 'layers', 'whole picture', and 'bits' conveys a notion that nursing's holistic approach is multi-layered and multi-faceted. Both nurse participants described how a holistic approach guards against an omission of relevant parts of a client's comprehensive

assessment. These relevant "bits" can –when identified and addressed- improve a client's well-being. The participants described the importance of assessing a client's family, school, and community. An assessment of their clients' relationship with culture, peers, and broad health determinants is implicit in the descriptors 'family', 'school', 'community', and 'environment'. The participants described that nurses assess and address their clients' mental health and social problems in a wider scope than their team members. It seems that nurses' attention to these kinds of health determinants may be key to facilitating improvements that can positively impact health and mental health when the client is ready. For example,

*As nurses we see the whole person and so we naturally want to be sure that all other aspects are okay before we step out of the picture if we are permitted to do that. The client can say "No thank you" (8c29).*

Nursing's 'holistic' way of being was identified as one of four sub-themes in this category.

The next sub-theme is nursing's 'get-to-it-ness'.

### **Get-to-it-ness.**

Study participants described and valued nurses' action oriented nature. "Get-to-it-ness"(14c4) is how a nurse participant described this unique way that nurses work. In the following quotes, six participants (nurses and non-nurses) described that nurses worked mindfully, steadily, prioritized work, and ensured their work was finished.

*My guess if a nurse was not on the team, some of the qualities that would be missing would be a certain 'get-to-it-ness'. That's a hard word to define. But nurses tend to be very practical, especially in the settings where there can be a lot of head work, where people are really contemplating and maybe even philosophizing about how to best help youth and their families. Nurses have a knack of having larger client loads at times, and really marching through it, and maybe a little more succinct in their practice... So they tend to be able to take on a large client load and be pretty efficient in their practice. Given that a lot of us have done time in the Emergency Ward, or a lot of situations where quick, quick, quick you're on it and you have to move on, I think that we are naturally, that we just have that personality –or that way of being- that we can clip along pretty quick. That could look like prioritizing. I think it's just quicker. Let's get to the heart of it. Let's deal with that. We won't worry about the beautiful Cadillac service. Let's make*

*sure that something is being done quickly, and in the most important spot (14c4).*

In the above quote, a nurse participant described that nurses know how to help youth and families, and that nurses are practical and efficient. The participant suggested that nurses' caseloads are sometimes higher than their team members. Nurses need to be knowledgeable in the 'specialized body of knowledge' for their area of practice in order to be efficient and accountable. This is their way of being. In the next example, a different nurse participant inferred that nurses utilize the nursing process to determine the nature of the problem and follow through (ie., assess, hypothesize, plan, act, then evaluate).

*We are trained to solve problems. We are very task oriented, and outcome oriented. I recall that in my training and I think that is just who I am. We have follow through, we don't leave stuff. We don't give up. Finish what you start. It's from working on the wards. What you don't finish off you make sure the next person knows so they can pick it up and carry on. If you're late for work the other people can't go home (9c24).*

The example also reflects nurses enacting the nursing standards for 'continuity of care' (safely and ethically facilitate the continuity of a client's treatment) and 'respect for colleagues in the work setting' to facilitate their capacity to provide client centred care (College of Registered Nurses of British Columbia, May 2012). 'Get-to-it-ness' is seemingly the way to meet nursing standards. In the next three quotes, two non-nurse participants and then one nurse participant described that nurses are action oriented.

*What I've seen with nurses, this is quite a generalization, nurses in comparison to social workers, that nurses are very much focused on action. I would think social workers are much more focused on kind of general process. In acute care the focus is action...They would understand the sense of urgency (12e20).*

*[Nurses] are hard working and they don't stop working. Even if they take a break at work and they go and chat to somebody it is in a way that has a meaning behind it. They have less of a tendency to waste their time.... Nurses are able to visualize or conceptualize what is maybe needed next so that they can anticipate what the system could need. They see what needs being done and do it... [N]ot that anyone is directly coaching them to perform per se, they just seem to be these active forward thinking people... It might be the*

*discipline...because the training would teach a person to use your time wisely, to anticipate what might go sideways, to put safeguards in place (5d13).*

*I don't think you'll very often find a nurse who would drop the ball on something (9c25).*

The action quality that the study participants described or inferred is purposeful. Nurse members are conscious of adverse outcomes, and consequently nurses do everything they can to prevent adverse outcomes.

In the next quote a non-nurse participant described that nurses have more of a structured approach to their work than their team members.

*It occurs to me that nurses seem to have a whole check list that they go through. Social workers, we tend to be, I don't know if we are all over the place, but we tend to go with the flow. Nurses seem to be very structured. I think their contribution to the team is that they pull us back to be a little more structured (11a45).*

The participant also described that the nurses' structured approach influences the team to be more structured. The nurses have a structured approach to provide safe, competent, ethical care.

A prime example of nursing's get-to-it-ness is how participants described nurses' documentation. In the following quote, a non-nurse study participant compared nurses' documentation to their team members', and highlighted the benefits that nurses' consistency and quality of documentation can bring.

*They really understand record keeping. They don't resent it and they do it. And they do it well. They are more focused. This is somewhat of a gross generalization. My observations in the therapy world, is that there are a number of therapists who think paper work is a bother and it interferes with their real work that they're doing with their clients. When you do the audits for quality assurance, nurses would have their paperwork done....[I]f they are keeping really good records, documenting well, likely they are pretty focused in their work with patients....I definitely believe...[the nurses' documentation] could be a support to research [in practice based evidence](12e29).*

Moreover, a nurse participant in the next quote explained how documentation is important.

*I always see the progress notes as a legal document. So if you don't write in what is kind of reflected in the session, then it hasn't necessarily kind of happened. And so for myself I do a mental status on the majority of my clients for each session. And the way that I want*

*to capture what is this client's baseline and how has this kind of changed so that if I do leave this position and someone else is able to pick it up and say "Well I see the changes, how the client initially presented and improvement." And I know for some of my colleagues their charting is very different from... my charting...a lot different (6c14).*

The nurse participant emphasized that documentation is a legal record of treatment with a record of the client's mental health status as a baseline to evaluate progress or change in relation to treatment. The participant also remarked at the difference in documentation between nursing and some of the other professional disciplines. An explanation for the nurses' consistent high quality of documentation is that nurses are accountable to their regulatory nursing association to comply with nursing standards that include documentation. Not all team members are under a similar compunction to meet the documentation standards of a professional regulatory body. Agency standards for team members' documentation tend not to be as high as nursing standards. Nursing's standards for documentation is instrumental in the facilitation of safe, competent, ethical care for vulnerable youth and their families.

Participants who were nurses and non-nurses described the essence of nurses' 'get-to-it-ness'. Study participants described that nurses are practical and succinct, rapidly make informed decisions, and execute these. Nurses conscientiously share relevant information with team members and systems for effective continuity of care. Nurses structure and prioritize their work. Nurses understand the volatility and severity of bad outcomes wherein they initiate work and then work carefully, endlessly, and ensure continuity to achieve good outcomes unmarred by lapses in safety measures.

### **Helping others.**

Study participants described nurses in MMHTSVY as helping and mentoring their team members. Nurses bring their nursing knowledge, standards, and a focus on wellness to their teams. Like their colleagues, nurses contribute to a positive interpersonal practice environment

but in a distinct nursing way. In the following quote, a nurse study participant described mentoring team members in the skill of documentation.

*Usually the psychologists are very detailed, but sometimes I find with some of the newer staff, sometimes you have to role model or teach them some of the things that they should be trying to capture (6c16).*

In that quote the nurse participant inferred that nurses have a higher practice standard for documentation than new team members from some of the other disciplines (not psychology or psychiatry). A nurse would likely use the documentation guidelines in their nursing standards to mentor team members.

Three nurse participants described that nurses use nursing knowledge to teach other team members. A participant described how team members *"actually seek me out to have a discussion...on a clinical realm, as far as what might be beneficial for their client"* (10c7). The participant also said *"over time the staff grow in their knowledge through having a nurse on their team"* (10c12). Another participant described the team's increase in knowledge from having taught co-workers *"I work with other disciplines and I've been on this team for a long time so people... take that up just by saying "what about the medical piece, has that been worked out?"* (6c24).

Nurses contribute to their team's wellness as an expert resource. They assist team members in answering their personal health questions. In the following quotes, two nurse participants described how nurse members provide or explain nursing knowledge to their team members to accommodate members' personal and family health and wellness issues or interests.

*You also get personal questions because you're a nurse. Can I ask your opinion? Or, I'm going for this kind of treatment, what is your understanding of that? While it's not clinical per se, it's interpersonal at the workplace. People will seek it out for their own individual counselling to a point(10c7).*

While team members can train and volunteer as first-aiders, study participants remarked how the nurses are their team's first-aiders. For example, "The nurses cover the first aid piece too" (3c12). Study participants also described that nurses provided consultation or helped to manage team members' clients' health, illness, and medication issues, and examples of these behaviours are found in the major theme 'Expert'.

In the following quotes, a nurse participant and then a non-nurse participant described ways in which nurses mentor members in a motivational way that sets the 'tone of the team'.

*I think nurses in general, not all, but some aren't afraid to get to know other members of the team in a more personal way.... [Nurse] team leaders seem to be quite caring for the work on their teams.... The nurses do have a real impact on the tone of the team. The real get up and go kind of working together kind of thing. Rah Rah. Motivating. In kind of a 'not a top down way', but like 'a personal way'. It is motivational for me. For instance, to do well is coming from within me, not because I'm afraid this nurse manager will come down on me. It's more like something in them is inspiring so I rise to that (5d24).*

*[Nurse members of the team have] a very supportive approach, and a 'working together as a team' (1a5).*

These participants described their experience of how nurses contribute to a positive practice environment. That identified action is another nursing standard (College of Registered Nurses of British Columbia, May 2012).

It seems from the study participants' descriptions of nurses helping and mentoring team members and bringing wellness and a positive tone to their team that nurses have a distinct contribution in fostering a positive practice environment. A good practice environment ensures team members' collaborative support for clients' health and well being.

### **Nursing aura.**

Study participants viewed nurse members as being trustworthy, caring, and approachable. 'Nursing Aura' is a collection of these nursing attributes that study participants ascribed to their nurses in MMHTSVY.

In the following two quotes, participants compare the degree of public trust in nurses to the spectrum of their team members' disciplines.

*Because of past historical reasons, children had been apprehended by social workers. So... we would kind of be treated differently. Definitely nurses were more welcome than social workers (1a33).*

*An author by the name of Scott Miller talks about how different professions are valued in society. Apparently the most highly ranked, highly respected profession among all professions, is nursing. He (i.e., Scott Miller) didn't say why. Therapists are much lower. And doctors are lower too. So if they [nurses] are one of the most trusted professionals, I think that has a certain cachet about it, just saying that you're a nurse (12e15).*

Other non-nurse study participants validated these assumptions. For example, a non nurse participant's belief in nursing's essence of trust is evident in the participant's comments.

*Well I think generally I like nurses and I seek out nurses for consults whereas I might not go to other team members as easily. In my subconscious I believe that nurses are trustworthy. Not that there aren't issues, but I tend to attribute a certain authority or expertise even though I might not be asking them a question directly related to nursing (5d7).*

The non nurse participant described that because nurses are trustworthy, matters that are outside of the scope of nursing are discussed with nurses.

Nurses' aura positively impacted collegial relationships between nurses and other team members. Non-nurse study participants transferred their positive personal experiences and beliefs about nursing to other nurse team members. The following quote illustrates how a study participant's positive nursing experience set up positive expectations and feelings for nurses in MMHTSVY.

*When my brother was dying of cancer he said "What's the difference between an angel and a nurse?". I said "I don't know". He said "You're right. There's no difference". He was on morphine. He was seeing angels and when he came back there were angels. He was treated so well. Everywhere I look, nurses play an important part. We are lucky if we can get one on the youth team (1a32).*

Non-nurse study participants' positive experiences with nurses in their personal lives seems to influence how they perceived nurses in MMHTSVY as having compassion and being approachable and caring.

Participants described in multiple ways how caring was integral to the nurses' practice and part of the nursing aura. For example,

*My colleagues described the nurse on their team as calm and caring...bring[ing] that patience to the clinical practice setting (9c2).*

In the next quote, a nurse study participant described using empathy as a form of relational caring in her engagement with clients.

*I know that in nursing education one of the things that they really stress in the program, especially in the psychiatric nursing program was about 'empathy'. You are always empathizing with the client... Among the other professionals I don't necessarily hear the word a lot, of 'empathy' (6c10).*

A different nurse participant described how nurses' caring extends to the client's family.

*You're exploring whether a mental disorder is coming in a child and you're helping families adjust (10c11).*

In the following quote, a non-nurse participant described how nurses enact community caring and culture care. The participant described nurses' caring approach in aboriginal communities.

*They cooked a big stew and elders, family members, village members would come in, sit around, and talk about any subject that might come up. They had that wealth of knowledge, it was attainable right there, plus handouts and all that other kind of medical stuff that may not otherwise be there. They always participated in the events whether it was a community dinner, a pot latch, or things like that. They participated in community events and became very well known to village members (1a12).*

*This (i.e., building a relationship) was very helpful because you just got to get to know people then you can talk about touchy subjects like STDs and things (1a15).*

The participant described how the nurses' relational approach with the community facilitates a receptivity for health information and healthier outcomes for clients, their families, and the community. Furthermore, the nurses' broad community caring manner is viewed by the study

participant as being different from their team members. The same participant concluded "*They are compassionate*" (1a37). Caring is a significant attribute of the nursing aura.

Another non-nurse study participant commented on their team's nurses' attention to "*keeping the patients' rights in mind.*" Nurses promote discussions of ethical issues and advocate for ethical treatment of clients and a moral community. While all members have professional ethics that ensure a client's rights are respected, nursing has an ethical standard of ensuring their patients' rights, choice, and dignity under all circumstances, levels of consciousness, and cognitive capacity (Canadian Nurses Association, 2008). The nurses' perspective is particularly applicable in their caring protection of vulnerable youth from further debilitating decisions and actions (i.e., 'at risk' to themselves and others) arising from the youth having misinformation, emotion dys-regulation, substance use, or developmental and cognitive challenges. Nurses address clients' needs when the clients do not have capacity (Canadian Nurses Association).

Participants discussed how nurses in MMHTSVY are perhaps more approachable than their team members because they reduce the stigma of mental illness. In the next quote, a non-nurse participant described why a client's interaction with a nurse might be less stigmatizing.

*A nurse on the team brings another kind of perspective that I think youth listen to in terms of their health care. It makes the mental health issues of kids more of a health concern that a youth might respond to. It takes it out of the realm of social workers, or the agents of society wanting to shape their behaviour. I see it as the profession that has less baggage in terms of working with vulnerable youth, and more acceptability ....[I]f the youth won't talk to anybody else, he may talk to the nurse because she is not there as an agent of control, she is just a health care person who you would think is going to be concerned about your health, not about your behaviour (12e18).*

The participant in the above quote described that a client can have their mental health needs met under the guise of seeing a nurse to resolve a health matter. Stigma is associated with having a mental illness, or seeking help for a mental illness. Invariably, the associated stigma is more blatant with persons who participate in assessment and treatment with certain professional

disciplines. In comparison, seeing a nurse does not carry that stigma. Nurses are valued for their health and wellness knowledge, so interaction with a nurse puts the mental health into the realm of health and wellness, not a stigmatizing social or psychiatric issue.

In the following quote, a nurse participant described a nursing approach to diagnosis that illustrates a strategy which can avert stigma when that is possible.

*We try very hard not to use a diagnosis if we don't need to, if we can use a V code. Maybe the youth is going through an adjustment, just a moment in time. We take diagnoses very seriously.... If we are talking major depression we will use a V code initially. We would rather not have a person living a label if we can work without it... We would want them to see themselves as experiencing depression, not being a clinically depressed individual. We don't want them to be defining themselves as depressed because then you can believe that and it is hard to work towards wellness (8c42).*

The nurse participant described how nurses protect the best interest of a youth by carefully weighing the advantages of applying a diagnostic label against the disadvantages of stigmatizing a client with a diagnostic label, when a diagnosis is not crucial. On the one hand, diagnostic labels benefit the multidisciplinary professionals by communicating a synthesis of information about a client's mental illness that signify aetiology, prognosis, risks without treatment, and best treatment practices for specific diagnoses. A diagnostic label can often enable a youth's access to regulated services and financial assistance. However, a person who is labelled may inscribe the diagnosis on his/her identity, thus possibly limiting development of personhood to an illness. Furthermore, some of their peers and adults may stigmatize (and even harass) youth who have diagnoses when their diagnostic labels are revealed.

Study participants described a nursing aura and the kind of attributes that they associate with nursing as a profession. Nursing aura includes bringing trust, caring, compassion, and approachability to the team and to the clients. Study participants perceived that their nurses' aura had a positive effect on clients and families and the nurses' team members.

In the sub-themes 'holistic', 'get-to-it-ness', 'helping others', and 'nursing aura' I have discussed NDC in nursing's way of being. Some of the nurse and non-nurse participants reasoned that the nurses' way of being is engrained into nurses in their basic hospital training. However, there is evidence from the participants' descriptions that nursing standards shape nurses' way of being. Study participants' views on self-regulation and nursing standards are discussed in the seventh category 'Nursing Momentum'. The next major category is 'Nurse Doctor Partnership'.

### **Nurse Doctor Partnership**

The partnership between the nurse and the team's doctor emerged as a prominent theme in the interviews with 14 participants of multidisciplinary teams for youth. Participants from various teams in MMHTSVY described that the pairing of the two disciplines among the team members was unique. Study participants gave evidence of nurses' unique relationship with medical practitioners on their teams. The medical practitioners were usually psychiatrists or paediatricians. The sub-themes within this category 'Nurse Doctor Partnership' are 'autonomy', 'efficiency', and 'doctor retention'.

#### **Autonomy.**

Study participants perceived that nursing was not subsumed in medicine and that nursing's partnership with the doctors occurred autonomously. Moreover, study participants did not describe the nurse as having a formal role of 'gate-keeper' for non-nurse members' access to psychiatric consultation or psychiatric direct care for clients. For example, in the following quote, a non-nurse participant described their team's protocol for accessing a psychiatrist, and the participant explained that other teams had different protocols.

*A referring mental health worker or the nurse, the counsellor, or social worker has to make a referral to the GP for a psychiatrist. It happens a number of different ways. On another team quite usually a psychiatrist meets with the youth ...and does that on their own (5d18).*

Across MMTHSVY there are seemingly a variety of protocols for accessing the team's psychiatrist. Participants on community teams and in-patient teams acknowledged the interdependence between the nurse and doctor, and they perceived team members were unobstructed in their access to the team's psychiatrist.

The partnership looms larger in in-patient settings. In the following quote, a non-nurse participant on an in-patient team described and accepted that communication between team members and their psychiatrist in regards to a client's medical issue is through a nurse.

*They would divert the medical issues to the nurse and the nurse would let [the psychiatrist] know (2b3).*

In the nurse doctor partnership the nurse may play a unique role channelling information in one or both directions between the team and the medical practitioner, or the nurse may be assigned the primary care role for medically involved clients. Seemingly when the unique role of the nurse is to be a conduit between the psychiatrist and the team, the role would involve mediating or translating for the team what the psychiatrist has said or recommended.

### **Efficiency.**

I explored with a non-nurse participant on a community team whether the clinical practice would be enhanced if team members could work more directly with their team's doctor. That study participant indicated a preference for having the nurse as an intermediary between the clinician and the doctors, the reason being efficiency. In the following quote, a non-nurse participant described the efficiency of the nurse doctor partnership.

*I think that we would probably end up consulting more with the psychiatrist if we didn't have a nurse on our team. The paediatrician and the psychiatrist don't always have the time. Having a nurse [on the team], or being able to call one of the nurses on the adolescent in-patient psychiatric unit [is preferable to]... having a psychiatrist without nursing support (11a14).*

The participant described efficiency in saving the psychiatrist's time, the team's time, and efficiency in addressing a client's needs more quickly. Furthermore, the combination of having nurses and psychiatrists was viewed as favourably utilizing and broadening the services of a psychiatrist whom the nurse would call if needed. Another non-nurse participant described that in a nurse doctor partnership, nurses are "*able to interpret decisions or recommendations from the physicians to the parents*" (12e11). It seems that the presence of both professions on a team strengthens the other's contribution.

In the following quote, a non-nurse participant described the interdependence between the nurse and the psychiatrist in order for a team to safely monitor and treat vulnerable youth.

*[The nurses in an in-patient unit] have their finger on the pulse of the milieu, and they can really communicate that back to me, and then I can communicate things to them that they can spread back up [to the team]. Kind of like an hour glass. In my mind, the nurse is the centre part of that hour glass communicating in both directions, an enrichment for the whole team... They're certainly tracking things like blood pressure, weight gain, duplicating the orders, so they really clarify it. Some of our orders include 'may go on outings, may go on passes'. But the nurse considers it is not safe enough. Or they sound psychotic so they can't go out. So the nurses have their extra lens where they are looking at the orders that I am writing down. There is this different level of communication with the nurse that I would have versus one of the other counsellors... We are constantly communicating with nurses about the clients so we're looking at the med issues, we're looking at follow-up, we're looking at prescriptions, we're looking at the medical piece, we're looking at weight gain. I feel like it's really been intertwined that stuff, as a partner for me... There were times we didn't work with nurses and we kind of cobble it together but it doesn't feel as tight as when we have a nurse. So it feels like a really important partnership. And I know they've had training in medicine.... I was amazed that basically they had to learn [much of] what I learned in medical school. I think that the discipline that they went through is such a similar one in some way, that we do different jobs when it comes to the day to day practicalities but truly when someone speaks the language with me and I know that they've had training about certain areas and then we also apply the counselling component so it really feels like there's someone else as a bridge with the whole team... With some issues, you just know. You understand what I'm talking about when I mentioned that aspect, and I don't have to go through it. Some of the other counsellors want to know, so you take the time and you explain some things. But with nurses you don't. It's like a time saver. In some ways it's more efficient because you don't have to slow down and go back and explain how certain things work. So it's kind of more efficient time (2b14).*

The participant described that nurses provide doctors with the information that the doctors require to make informative decisions regarding the team's clients. Furthermore, in a collaborative partnership with the doctors, the nurse can knowledgeably take action to clarify, interpret, monitor, or modify doctor's orders for the well being of the team's clients. In that way, nurses enhance the effectiveness of physicians' intended outcomes for their clients. Moreover, the participant's example of a nurse doctor partnership highlighted the nurses' role in communicating, facilitating, and mediating information between the doctor and the team.

### **Doctor retention.**

Participants in in-patient and out-patient settings described that due to the presence of nurses, the team is a more welcoming environment for doctors. In the following quote, a non-nurse participant described how nurses facilitate a team's psychiatrist's work, and show their appreciation for the psychiatrist's contribution.

*The nurses give the kind of support to the client that the doctors appreciate (e.g., monitoring health status for complications, thorough documentation), and the doctors are happier. [Nurses] understand the systems and pressures in which the doctors work. So they often help to make the experience of doctors within our organization a much more pleasant and welcoming kind of experience for them. I think they're important in terms of retaining their interest and their continuing to work with us. I just have a couple of things here. There are managers who really don't understand the medical role and who have complained about some of the contracts we have with doctors and the salaries they get when they work...[i.e., payments for time worked] for us, and yet most of us who have some exposure to doctors know that they actually get less money when they work for us and we're lucky to have them. And I think that nurses understand that... That's right, paid less and respected less, and the nurses will see that is a problem. And they will help to in some ways restore the doctors' rightful sense of dignity in their profession (12e6).*

In the next quote, a nurse study participant explained that by the nurse understanding and supporting the medical model, the physician had an ally.

*We look at a file from a bio-psychosocial type of lens I think. And I think that is why we probably work very well with a lot of psychiatrists. I know I do anyways personally. I know I work really well just because when I'm sitting in with a psychiatrist I know exactly sort of like the medical model, and I think as nurses that is the training. I think a*

*majority of nurses support the medical model. Other professions may not like the medical model but there is a place [for it] in psychiatry (6c1).*

A different nurse participant described the doctor's reliance on the nurse as the basis for the nurse doctor partnership.

*I think the fact that we have some understanding of physiology, we have some understanding of pharmacology, that we seem to have -and this is what the psychologists have told me- sort of eyes and ears for physicians (9c4).*

I have discussed the distinct nursing contribution to MMHTSVY in the nurse doctor partnership.

The nurse doctor partnership is another example of nursing's unique role on the team. Nurses facilitate the clients' access to high level specialized, individualized medical care. In the next major category 'Expert' I will discuss the ways in which study participants identified nursing's expertise in the medical systems of which doctors are a part.

## **Expert**

Nurses in MMHTSVY are valued for their applied nursing knowledge that explicitly distinguishes nurses from their team members. The fourth major category, 'Expert', encapsulates the study participants' descriptions of nursing's expert knowledge in five sub-themes which include 'bio-screener handler', 'medication intervention', 'health and development educator', 'health system connectivity', and 'critical or complex mental health expert'. The first sub-theme that will be discussed is nurses' expertise as a 'bio-screener handler'.

### **Bio-screener handler.**

Terms such as "*the nursing piece*", "*the medical piece*", the "*biological piece*", "*physical dimension*", and "*all aspects of health*" were some of the ways that study participants described nursing knowledge. For example,

*The nursing piece is so important, very important, because it [can address] one of the main things that are affecting these kids, their health (1a24).*

*The nurses have the unique perspective of having the medical background (7a2).*

*The nurses are always aware of how physical health can impact mental health (3c12).*

This kind of knowledge is applicable to the nurse members' 'bio-screener handler' role on the team. Participants identified their nurses' capacity to screen persons' functioning and perceive emerging or existing acute and chronic health problems. The nurses' screening skill is founded on their nursing knowledge. Nursing knowledge involves understanding of human biology, hormones, physiology, metabolism, disease, infection, genetic syndromes, alcohol and substance use, pharmacology, range of motion, reflexes, disability ability, organic brain injury, emotional stress and mental illness, sleep, exercise, nutrition, hydration, bio-psychosocial development, health determinants, health promotion, and illness prevention. A non-nurse participant expressed that "*without having nurses the medical side and biological side gets diminished*" (12e57). The joint theme 'bio-screener handler' captures participants' depiction of nurses' inseparable knowledge and action. Study participants recognized that nurse members independently or collaboratively pick up and handle matters of a biological concern.

In the following quotes, nurse study participants described how the nurses' bio-screener handler knowledge is critical for a thorough mental health assessment and effective treatment.

*I just think the fact that we have a good solid basic training and understanding of medical disorders and the combination of psychiatric and medical understanding and integrating that (9c15).*

*If the person didn't have the medical training then you're missing that too... you're forgetting that a lot of these kids are coming in with sleep issues and nutrition issues, and medication issues, and substance use issues (4c10).*

The participants described how nurse members are mindful of health issues. Screening for, and addressing, health issues (such as sleep difficulties, nutrition challenges, medication, substance use, and illness) is essential because health issues can both distort mental health assessment and

impact mental health intervention. Nurses understand mental health as being part of health, and that the relationship between health and mental health cannot be underestimated.

In the following quote, a nurse participant on an in-patient team described the importance of having an integrated knowledge in health and mental health when working with vulnerable youth.

*All of the nurses have the responsibility of being in charge when they work in the evenings and on the weekends. If there were medical emergencies then the nurse would have to coordinate that, delegate that. They have to be able to provide in the moment crisis management and delegation of staff. The nurses also have to have that medical piece because sometimes those emergencies are medical in nature, whether these are an adverse reaction or a suicide attempt (3c29).*

This study participant described how the integrated psychiatric and medical knowledge is particularly invaluable for the responsible person to assess, understand, and coordinate the full dimension of a crisis.

A non-nurse participant's description of nurses illustrates the bio-screener handler role.

*It has certainly always been a good fit to have a nurse working with youth who have eating disorders. They will pay attention to biological markers and indicators, do weigh-ins, check on nutrition, [and chart] that (12e42).*

Using eating disorders as an example that illustrates nurses' monitoring knowledge, nurses have expertise in knowing what to monitor and how to monitor a client who has an eating disorder. Through effective monitoring, nurses intervene with appropriate actions that either prevent tertiary care or mitigate the severity of potential outcomes. The nurses have the knowledge and skills to accomplish effective monitoring.

In the following quotes, two non-nurse participants described their dependency on the bio-screener-handler characteristic of their nurses. “*And it does seem that the nurses will pick up the medical piece*” (2b3). A non-nurse participant described being “*dependent on the nurses to*

*enlighten the team or address a client's medical needs when they become aware of a medical issue" (1a6).*

In contrast to an assumption that the bio-screener handler domain of the team's practice is an exclusive role for nurses and doctors, a non-nurse participant described this as the team's responsibility. The participant expressed a wish

*that the team's nurse could take care of asking clients about their medications, making sure that their health is good, blood pressure, nutrition, metabolism because of the effects of medication, and we would not have to take care of that part as clinicians (11a48).*

According to the participant, team members from other professional disciplines evidently monitor client's health and medications. The participant described a preference to change the team's practice and delegate that role to nurses. Effective monitoring is associated with clients' compliance with interventions that can lead to better outcomes and protection from risks.

Study participants described that although nurses had their own case loads, nurses provided consultation and helped to manage team members' clients' health, illness, and medication issues. In the following quotes, two nurse participants described their consultation role on the team in relation to nursing's expertise as a bio-screener handler.

*I've had people consult with me about a client having diabetes.... I've helped other colleagues with clients who have had a medical illness. And I've helped them work with clients in a crisis (8c13).*

*Folks will come across a malady—from a brain injury to a heart defect-, medication, body/physical health issues and approach me for my knowledge. Because I'm a nurse they will consult with me (14c27).*

*We forget that there are a lot of people who have never administered a needle, never administered a medication, never had to think about the variety of things around anatomy that we have, all of that stuff.... It's important to them. Some things have never crossed their mind.... Coworkers find some of that realm uncomfortable and out of the zone of their knowledge for sure. And we are comfortable with the information and knowledgeable (14c36).*

These nurse participants described that team members consult nurses for their expertise in this area of applied bio-screener handler knowledge. Although the doctors on the team also have this domain of knowledge, participants described that team members frequently approach the nurses for consultation.

Nurses in MMTSVY provide an extensive role in unsolicited consultation to team members in the realm of bio-screener handler expertise. A non-nurse participant says that nurses *“in the [multidisciplinary] team meetings and in the case discussions verbally add their perspectives... For example, “Have you thought if the person has a thyroid condition? Have you thought of the particular interaction between this medication and the other medication? That sort of thing.”* (7a4) The 'helping others' sub-theme of the nurse's strength in providing consultation in this area is a component of the second category 'Nursing's Way of Being' that has been discussed earlier.

### **Medication intervention.**

Study participants described how and when the nurse is valued in relation to the nurse's broad knowledge of medications. For those study participants who were doctors, nurses, psychologists, or had experienced a nurse's involvement in a medication crisis, there was evidence that team members fully appreciated the nurses' contribution to the team through having an applied knowledge in medication and pharmacotherapy.

In the following quote a nurse participant described when pharmacotherapy is particularly vital to a client's treatment plan.

*For some clients there is definitely a chemical imbalance and so things like psychosis the talk therapy won't necessarily help until you get the client stable; so that they will be able to do the talk therapy in treatment, on the road to recovery (6c2).*

The participant indicated that pharmacotherapy is sometimes the unsurpassable treatment, and when medication is prescribed, then nurses are required for medical monitoring which is described by a non-nurse participant in the next quote.

*[Nurses are] able to do some of that medical monitoring with some of our clients particularly those that are in early psychosis and require medical monitoring because of some of the antipsychotic medications that they are on (13d3).*

The next quote illustrates a non-nurse participant's experience of nursing's contribution to the team through nurses' experiential pharmacological knowledge.

*I know there was one time when there was a young person who had a rash on his body. And the nurse knowing the medications and saying "I've seen this before". Even though the rash was not listed as a side effect of the medication on-line or in a book there was an allergic reaction and she was able to see that and stop the medication and consult with the doctor. They have that physical biological training that is not part of social workers' training unless the social workers learn this from their multidisciplinary team (11a25).*

It seems that the non-nurse participant gained insight on the nurse's applied medication knowledge when a rare situation brought out the nurse's expertise. Then the nurse's distinct contribution was visible and appreciated. The nurse was there –a member of the team-, accessible and approachable for consultation. The participant experienced that a nurse had the knowledge to pick up the unusual, acute, critical medication concern. Furthermore, the participant recognized that the team's nurse had the knowledge and skills to resolve the issue.

In the following quote, a study participant described how a non-nurse team member had assisted with medication in the absence of a nurse team member, and how the role was consequently limited to tracking prescriptions for renewal.

*And they were trying to get someone who wasn't educated around medicine but eventuated kind of tracking prescriptions and calling me when something was running out, but it really wasn't someone who was trained around medicine and I think that was not great. We did really well considering but it would have been good to have had a nurse there as well... If there was any medication issue or questions or anything that had to do with weight issues or blood pressure or nitty-gritty medical stuff there wasn't*

*anybody there to kind of help to reassure people. It just helps everybody stay calm. It's okay. Somebody is looking at this piece (2b2).*

In an excerpt from a research interview, a nurse study participant provided a rich example of helping a team member manage a client's medication issue.

*Participant: A distraught angry parent called, and a colleague wanted me to talk to that parent who was asking questions about her son's medication. "I don't know what to say, can you talk to her?". I said "certainly, I can help you. I'll talk to the parent." The parent said that she hadn't wanted her son on the medication. I talked to her and told her that we were here to help. She described her son's medication and his symptoms. I listened. She was upset. She hadn't been able to get a hold of her son's physician. I told her to cut the medication in half, and I told her that I would consult with a physician to make sure that was okay. I followed through with our physician who said "Bang on, everything's good." When I talked to the social worker afterwards, the social worker said "Well I just wouldn't know to do that. I don't know anything about that stuff." And I said that's okay, I was here, and I understand these things. And I explained to the social worker that you don't want to get caught up in the emotional part of this mom. You can help her to understand the situation, and allow her to be the mom, and empathize with her "You're doing the right thing, if this was my son and he was put on a new medication and then responding in that manner I would be concerned too. You absolutely did the right thing in calling this office. We're going to address this immediately." The mom was satisfied and the youth settled down. What has occurred to me, is that was an approach, a role, that only I could have taken care of, and it worked out (9c11).*

*Researcher: And it still held together the youth's and parent's willingness to continue with the medication and the relationship with the clinic.*

*Participant: You never know what would have happened if they had gone to the emergency department. Perhaps if I had not intervened, that mom would have dragged her son to the emergency department because he was so out of it. And then an emergency physician may have taken the youth off the medication altogether. I think in that scenario a nurse was crucial to intervene and settle down a crisis situation in the mom's eyes and preserve the integrity of the treatment plan. Things have worked out fine since that event was handled in that way (9c13).*

In this example, the nurse described how utilization of tertiary care was reduced through having a nurse on the team. Moreover, the outcome was likely more favourable for the young person and his family. The nurse's intervention was instrumental in the youth's and his family's uninterrupted therapeutic alliance with the team.

Continuity of medications back and forth from tertiary treatment centres or residential programs and custody centers is an important piece of nursing's work that is recognized by a non-nurse participant in the following quote.

*[When youth were] coming back to the community and they were on medications, the nurses would go and educate the family members about the importance of taking the medication at the same time, and the right amount, and supervising the medication regime (1a10).*

Study participants described that nurses on in-patient teams do more medication administration than nurses on out-patient teams who seldom or never administer medication. In the following quote, a non-nurse study participant pointed out that the option for a team to directly provide medication administration requires a nurse, so the infrastructure is not dismantled.

*In the past with some of our cases where a client required an injection for medication the nurse had all the necessary equipment and [we have] that (13d15).*

A different non-nurse participant described that pharmacotherapy is managed externally from the team when there isn't a nurse or a doctor on the team.

*Nurses administer medications, and of course if you don't have a nurse on the team, the nurse can't administer the medications. Physicians have to administer the medications, so we send the clients to their GP (12e37).*

When there isn't a nurse on a team to administer the medications, and there isn't a team psychiatrist, then neither medication administration nor medication intervention and monitoring are provided through the team.

In contrast to the visibility of medication administration, it seems that other forms of medication intervention such as medication monitoring are invisible nursing contributions. A non-nurse participant on a community team flatly described "*There isn't an expectation that the nurses would be taking blood pressure or temperature*"(7a18). Another non-nurse participant

described that “*Nurses know medications a little better than I do. I mean they have to look them up the same way as I do*” (5d4). The action of checking the compendium of medications to increase understanding of the medication(s) that a client is prescribed is an overt part of the activities that are associated with having a client on medication that all team members can do. The participants' comments in the above examples provide insight that nurses' medication monitoring is largely an invisible task (i.e., to prevent complications through reviewing applicable contraindications against a thorough nursing assessment of an individual client's profile; to facilitate medication compliance with caring encouragement for the purpose and identify/address/reduce/eliminate side effects or encourage tolerance for side effects; to safely guard against adverse reactions by collecting, recording, and reporting information that the psychiatrist and/or doctor require to effectively provide pharmacotherapy [take/record/report vital signs with appropriately maintained equipment]; to recognize and address adverse effects; to communicate the prescribed dosage, consultation for missed doses and modifying the form and timing; and to ensure there is compliance with the recommended lab tests).

Generally participants described that, in comparison to nurses and doctors, other team members have limited knowledge in pharmacotherapy. For example,

*The training nurses have in pharmacology and all of the psychotropic medications, and often in conversations in teams, primarily social workers and counselling psychologists, the people really have limited knowledge in that area so having a nurse on the team helps to interpret and bring some knowledge base when people are often mystified, whereas going on partial information is dangerous* (12e2).

The participant described that because nurses have a depth of pharmacological knowledge, that other team members should consult nurses for medication management to keep clients safe.

Team members are often unaware that when nurses have minimal to no involvement in medication administration, nurses have a role in medication intervention. Medication

intervention includes a variety of knowledge and tasks. Nurses follow nursing standards for administering medication or teaching care givers how to administer and store medication. Nurses are familiar with the psychotropic medications that are typically prescribed by teams' doctors or clients' physicians to clients in MMHTSVY. Nurses ensure there is medical follow-up for clients on medications, that the clients obtain and take the medications as prescribed, and that the clients continue on the medications when they move from one place to another. Nurses respond with immediacy for concerns of medication safety to evaluate the situation and act upon the evidence with appropriate action. Nurses communicate with the clients, their care-givers, their selected pharmacy, laboratory, prescriber, and the client's family doctor. Monitoring medication can be as important as prescribing or administering medication, and without the assertive outreach of a nurse, the medication monitoring may not be as safe. When a psychiatrist prescribes oral medication that youth and their care-givers administer, or a psychiatrist provides consultation to the youth's community physician who prescribes the medication, or the nurse learns from the youth or caregivers that another physician has prescribed medication for the youth, the nurse monitors the youth to a greater or lesser extent.

In the sub-theme 'medication intervention, study participants described that nurses are vital to a team's capacity to include pharmacotherapy among a range of treatment modalities. In contrast to the visibility of medication administration that is more prevalent in in-patient settings of MMHTSVY, nurses' pharmacological work is largely invisible. However, nurses are active in the provision of medication intervention and contribute to safe pharmacotherapy.

#### **Health and development educator.**

Study participants described that nurses have expertise in teaching (preparing content and presenting) individuals and groups in topics related to health and development. Study

participants particularly appreciated their nurses' educator role with youth in the topic of sexual health. For example, a non-nurse participant described a nurse teaching safe sex to a group.

*[The nurse] talked to the youth about safe sex, very open and approachable, making sure they had condoms and that they knew everything that they needed to know to protect themselves on the streets. She did it in such a wonderful way that she connected and therefore the message got passed... One guy "I don't wear condoms". Why?" "My penis is too big" "Oh yeah?". And she picked up a safe, contraceptive, whatever it's called and put her whole arm right into it. "Is your penis bigger than my arm?" He laughed and she made her point. In other words, you know, you can wear a condom and protect yourself and the girls...So what I've seen is that nurses who can connect with youth do fantastic work (1a19).*

In the next quote, a nurse participant described that nurses engage groups in health promotion and illness prevention.

*The nurses run groups on whatever topics might be pertinent for the clientele at that time, sexual health, drug addiction, that kind of stuff. The nurse has a unique knowledge base that they can bring to the multidisciplinary team (3c1).*

Study participants described that the nurses' broad health knowledge, knowledge in facilitating normative development, and teaching skills are valued.

Participants described how nurses engage with community systems in their broad role as health educators and change agents. For example, a nurse participant stated

*I bring a sense of going into the community, so outreach work, and starting usually with the client or a small group of clients, finding common issues, and advocating for that at more of a community level, and putting together a community type of intervention. I learned that at nursing school (14c1).*

This participant described nurses' capacity to assess communities for healthy living (i.e., broad definition of health) and collaboratively work with the community to address bio-psychosocial risks (i.e., risks that impact youth) with a tangible intervention, and implement positive changes.

The health and development educator role is unique, and this contribution is a smaller contribution to some teams than others. Through this role, nurses positively impact the needs of - and influences on- their clients.

### **Health system connectivity.**

Nurses are distinguished in MMHTSVY for their health system connectivity. Nurses initiate, optimize, and promote shared care, facilitate continuity of care, and carefully transfer care. In the following quotes, participants described and valued nurses' health system connectivity.

*We have influenced transfer of care issues, continuity of care issues, encouraging that our clients have proper medical coverage and service (9c37).*

*A lot of us [nurses] have done some work in the hospital setting. We get the system. We know the hospital setting. We kind of know how the different disciplines work and how they contribute to the client's needs (6c27).*

Participants described nurses expertise in navigating the community health system and hospitals through knowing the domain of health care resources. Non nurse participants similarly said:

*Typically our nurses have been very closely liaising with our hospital staff, with our in-patient psych unit, with emergency professionals, with our adolescent crisis response program. So our nurses have been plugged to the hospital system, and know that system well, and have close relationships with staff there and are able to liaison with other professionals in the community about these really high risk youth. So they sort of have a real expertise around some of the medical language, medications, about all that type of stuff. And that is what I see as the added benefit of having nurses working here (13d1). Nurses know the hospital system, and they liaise with other professionals.... I don't have the expertise that our nurses do (13d17).*

*Nurses really understand doctors and acute care quite well, and the demands there, so they can interface with the hospital, determine what the needs are, with the doctors, and bring these needs back to the team. When we have people more from other disciplines like social work or counselling psych they really don't understand the pressures within acute care. The nurses sort of interpret back into the hospital system how the social services network performs, and also to help the social services network understand what the kids needed when they were hospitalized and coming out of hospitals. (12e19). Some therapists... are very comfortable communicating with the GP, but most aren't. As a rule, nurses are very comfortable with it and ensure that they are communicating with the other medical people. That is a real clear advantage of having nurses on the team (12e41).*

Nurses engage in liaison activities that build rapport with professionals in agencies with whom the team shares care (potentially, rarely, or frequently). Nurses communicate with clients'

doctors, these doctors' nurses, and health service providers who are external to the team to exchange information in one or both directions in compliance with nursing's standards and ethics. The information exchange is specific and deliberate. Nurses are knowledgeable informed health care providers who ensure that they have a relevant understanding of a client's presenting problem and associated challenges, health status, affiliation to service providers, and past/present/planned interventions. Sharing such knowledge assists other health care providers to aptly assess and appropriately address their clients' changing needs in a collaborative way that benefits the clients, their care givers, and the efficiency of the health care system. All in all, nurses communicate with health care professionals in order to collaboratively and ethically share care across agency boundaries, manage continuity of care, effectively transfer care, or access additional health services for their clients and their clients' families.

#### **Critical or complex mental health expert.**

There was a dominant theme of nursing's critical or complex mental health expertise. Participants described that nurses in MMHTSVY generally have expertise in working with adolescents who have suicidal or psychotic episodes and dual diagnoses (i.e., two Axis 1 that are described in the Diagnostic and Statistical Manual) of mental health disorders. Moreover, nurses have expertise working with youth whose mental health challenges are compounded by having a medical disorder or a developmental delay. Nursing's critical or complex mental health expertise seems to be at the apex of NDC. Elements of NDC that have already been identified and discussed in this chapter are evident in the descriptions and discussions within this sub-theme.

In the next two quotes, nurse participants described how the nurses on their team are selected to provide crisis intervention counselling with clients and the clients' families because they perceive that nurses are the most suitable team members to provide this type of work.

*[Nurses provide] solution focused problem solving like crisis intervention because... people are in a state of crisis when they are referred to us.... [W]here their strengths are, where they count the most... nurses are going to do a decent job (10c45).*

*For people waiting on the wait list, struggling, you are helping them cope, building their skill level until they can be picked up and assessed more thoroughly. The other disciplines don't seem to like that kind of work [i.e., triaging clients on the wait list, providing crisis intervention, linking clients with resources, teaching coping strategies, building resiliency]. It tends to fit better with the nursing group. They cope with it better (4c41).*

Nurses' expertise in mental status assessment and bio-psychosocial assessment is taken to a higher level in that they knowledgeably identify, prioritize, and handle urgent and emergency needs of youth who have critical and complex mental health needs. Handling such needs involves prompt collaboration, referral, and teaching coping resources while monitoring risk. A nurse participant articulated that "*triaging 'what's urgent', 'what's not urgent', is not the same as people saying 'this is urgent'*" (10c37). In the following quotes, two other nurse participants described that nurses have assessment skills that are critical to working with youth who have critical or complex mental health challenges.

*One of the things that we really worked on, was more of the mental status... You could have a conversation for two minutes and basically you would be able to do your mental status right then and there, on just what they kind of said to you and how they kind of presented. I think psychiatric nurses, and nurses in general, have that...[assessment piece]down, because it is really kind of in their training (6c22).*

*If someone becomes psychotic, ...not being able to pick up side-effects, adverse effects, efficacy, in a way that helps the psychiatrist's treatment would lead to something worse quickly (3c12).*

I specifically confirmed (in the research interviews) with the two nurse participants above, that when a client is worsening, nurses are likely to recognize the cluster of symptoms and the seriousness of the situation, and have an understanding of where that could go without intervention.

Study participants described nurses' expertise at facilitating the certification of involuntary patients under the Mental Health Act. A participant described that in their program the psychiatrist delegated that authority to the nurses, "*[N]urses are the delegates to the Mental Health Act*" (3c30). A nurse participant in the following quote described how the nurses' assessment of the severity of a client's mental health status benefits both the young person and the health care system.

*[Nurses] are well trained with safety; you could miss something or you could be unnecessarily cautious and the discharge time would be very different (4c27).*

Nurses evaluate the severity of a youth's challenges and requirements for system supports, in order to determine when a youth can progress to levels of monitoring and interventions that correspond with their assessment recommendations. Nurses' assessments can include evidence for voluntary or involuntary in-patient supports or evidence and recommendations for a client's readiness for discharge to their own, family's, and community physician's responsibility. Nurses use resources effectively to keep clients safe and safely discharged. In other words, appropriate resource utilization is better for clients and cost effective for the system.

According to the study participants on both in-patient and community out-patient teams, nurses in MMHTSVY have expertise in assessment and treatment of clients who have critical or complex mental health issues, as well as serious health issues. In the following quote, a nurse participant described integrating knowledge of normative social-emotional development and the physiological challenges posed by diabetes to help a team member treat an adolescent who has self-destructive behaviour related to diabetes denial.

*I've had people consult with me about a client having diabetes, not understanding the normal development of the youngster before looking at the illness model or their mental health status. Normally teens are testing the limits and feeling invulnerable. But when you have a teen who has diabetes, you don't want them in denial of their illness, eating*

*Friday night with all their friends at McDonalds. It's quite dodgy. It's a difficult line helping the youth navigate being a normal teen but medically stable (8c15).*

Nurses in MMHTSVY bring their integrated understanding of adolescent development, physical health, and mental health to safely guide clients who have complex challenges through their adjustment to adolescent social development. In the following quote, a non-nurse participant indicated nurse members are valued for their capacity to respond to the team's responsibility for complex clients who have physical or medical issues (estimating "10% to 20% "of the agency's clients).

*The nurses have the unique perspective of having the medical background, so that is particularly helpful when we have youth who have complex mental health issues that are intertwined with some sort of physical or mental problem.... I wouldn't say most cases though are complex in terms of physical issues or medical issues. But probably a good ten to twenty per cent of the cases there is something going on that is physical or medical involved. And so it's of value to have that expert knowledge (7a3).*

Study participants described that due to nurses' greater expertise and/or comfort in working with clients who have these characteristics, nurses are deliberately matched with these clients. Their view is illustrated in the following quotes by nurse and non-nurse participants.

*There is a tendency to pass individuals who have medical complications onto nurses. The nurses tend to deal with the more chronically mentally ill (like schizophrenia and bipolar) as well as people who have medical disorders like diabetes and that type of thing (10c24).*

*If it's a referral that we have for a youth who does have some combination of mental health difficulty and a medical difficulty or some complex combination of medications we'll often... specifically choose the nurse as a match for certain cases that have that complexity (7a4).*

It would seem that a recognition of nursing's expertise, has in some situations, shaped the team's allocation of case assignments. In the following quotes, a nurse then a non-nurse participant described nurses' expertise and suitability for working with vulnerable youth who have more of the complex challenges and severe mental illness. For example, a nurse participant compared

nurses' expertise to their team members' capacity to work with clients who have critical needs and high risk symptoms.

*I have noticed that with the young people who have been hired in the other disciplines, quite a few psychologists, they are not comfortable with major mental illness, major DSM diagnoses. They are not comfortable working in crises, crisis theory. They don't have that expertise that a nurse comes to the table with. A bit more academically oriented, and they haven't had the experience of working in a hospital like a nurse has had.... [Team members] certainly consult a lot about crisis theory and clients in crisis [with nurses because] they are not comfortable handling major mental illness themselves. They haven't had the experience. Their knowledge about psychosis, psychotic breaks, working with borderline personalities is less developed (8c10).*

It would seem that a recognition for nursing's expertise and readiness to work with clients who have critical needs and high risk symptoms includes recognition for nurses' system knowledge that was discussed in the theme 'Health system connectivity'.

*I've worked on a number of multidisciplinary teams, and coming from a non-nursing background I've experienced having nurses and not having nurses on the team. I've experienced the gap, a bit of a gaping hole in terms of our service, particularly in serving our psychosis clients when we didn't have a nurse. That has been a huge learning curve for me. I've had to step up and learn a little more about the hospital system, and liaising with other professionals, and being more involved in our more high risk psychiatric clients. And I still don't have the expertise that our nurses have. That sort of changed a little bit of my angle, my perception of their importance and the value that they add to the team (13d18).*

A nurse participant perceived that non-nurse team members are experientially disadvantaged in providing assessment and treatment of critically ill clients by not having had related training in an in-patient psychiatric setting.

*Because of our training a lot of us have actually worked at Riverview or done our clinical practicum at Riverview. We have also done them in the hospital. And so in a way for psychiatric nurses... I think that we get to see that recovery. We get to see them basically when they're at acute and... training and helping the client to recover. I don't think that a lot of those different disciplines in my team have actually even ever had that experience (6c29).*

The experience of being with hospitalized clients in their acute and recovery phase of mental illness is a part of NDC that many of the nurses bring to their community teams. The nurses'

experiential learning hones their skills at recognizing emerging psychiatric symptoms and their fastidiousness to prevent morbidity and mortality.

Study participants' perspectives on nurses' expertise in critical and complex mental health illustrate nurses' skill in crisis intervention and overlap with other aspects of NDC presented in the previous three categories. Next I present the fifth major theme 'Nursing Erosion'.

### **Nursing Erosion**

The public is well aware of the nursing shortage and that the population of nurses is aging (Johnson, Billingsley, Costa, 2006). Agencies have predicted shortages of nurses as a large cohort of nurses move into retirement. Yet, within that context, participants identified particular elements that exacerbate the nursing shortage in MMHTSVY. Nursing's erosion summarizes participants' descriptions about the precarious nature of nursing's continuous membership in MMHTSVY. The themes in this major category are 'not going to get one', 'aren't in the driver's seat', 'confusing nursing credentials', and 'constraints on access to training'. The study participants' key concerns, explanations, or beliefs for the impending reduction in the number of nurses in MMHTSVY are described in this category.

#### **Not going to get one.**

The theme 'not going to get one' is the study participants' evidence, feelings, and explanations regarding the reduction of nurses in MMHTSVY. Participants reflected on the teams' declining numbers of nurses. Causal factors were revealed as being more than a scarcity.

A non-nurse participant reasoned that an incomplete multidisciplinary team (i.e., not having a nurse member) is an outcome of scarcity and other factors.

*I think a lot of it has to do with whether nurses are available, how large the community is, therefore how large the team is. If you have a small community with only three full time positions you're not going to have the number of positions to go around to make the team fully multidisciplinary. And then there are some areas where there may have been a*

*nursing position, they tried for a year to fill the position with a nurse but couldn't so they shifted that position to make it a clinical social worker position for example. By design, economics, or purpose (7a7).*

Study participants described that filling vacant nursing positions with nurses who have advanced education and or experience is improbable. A non nurse participant had this to say.

*We do not have a nurse on our team and we're not going to get one. There seems to be a limited pool to draw from in terms of nurses who are trained and experienced in working with vulnerable youth.... [The current skilled nursing work force in MMHTSVY is due to] the early nineties and the downsizing of Riverview. There were quite a few nurses that came into the community... The adult and youth services were integrated, some nurses would drift over to work with youth... A number of nurses that I have known have had counselling training as well as nursing training. Some nurses in this field have double degrees (12e33).*

The participant explained that MMHTSVY's past acquisition of nurses with counselling experience primarily came from downsizing Riverview (i.e., de-institutionalization), and these nurses further developed their specialization with vulnerable youth. That historical process for nursing recruitment and nursing development filled many nursing positions. Registered nurses with baccalaureate degrees and master degrees had also entered MMHTSVY. Consequently, the characteristics of current practising nurses have shaped expectations for hiring nurses who have superior nursing qualifications. Nurses who have advanced degrees, nursing experience with vulnerable youth, and counselling expertise that includes particular therapies are wanted to fill the vacant community nursing positions in MMHTSVY. The general nursing shortage may contribute to some of the challenges, but the issues are more complex than that. The scarcity of nurses in MMHTSVY is in part a recognition that the circumstances that precipitated the last large influx of nurses into MMHTSVY were unique. Nonetheless, teams want elite nurses who can bring a defined set of contributions that include higher education and experience.

Nurse participants reported that they see fewer nurses in the community teams and expressed concern for the loss of nurses. According to a nurse participant,

*There seems to be fewer nurses that I encounter in the community teams [in MMHTSVY] ...and there are a whole whack of generic clinicians and social workers (9c27).*

The nurse participant perceived that a generic paradigm is diminishing nursing. Low numbers of nurses in community MMHTSVY and a generic paradigm impose challenges on nurses in MMHTSVY struggling to sustain their nursing identity. In the next quote, a nurse participant on a community team described how generic training is a dominant focus for their team. *"I have been to so many in-services that are specific to the job that I am working in now. I am learning in that way so it is not so much nursing discipline stuff"* (10c50). Another nurse participant described that meetings are generic, and there are no nursing specific meetings, so there is no room to explore nursing issues. *"We are not talking about the science and art of nursing... so there is no conversation really that is specific to nursing in our team meetings"* (8c17). It would seem that when training is explicitly generic that nursing professional development is unsupported. A nurse participant explained that *"defining the role of the nurse on the team has been a slow progress that has been constrained by the corporate hierarchy"* (9c27). The participant described nursing's disempowerment within community MMHTSVY.

In the following quote, the participant contrasted in-patient to out-patient settings to explain that nurses prefer to stay in the in-patient setting where the practice environment supports nurses' interests.

*The status of nurses in the community is behind the status of nurses in the hospitals that are nurse-driven in caring for vulnerable youth (9c41).*

It would seem that an explanation for the decline of nurses on out-patient teams is that, in comparison to a previous time, there isn't a continuous mobilization of nurses from in-patient teams to out-patient teams in the community.

Although nurse participants described that nursing's stronger identity on in-patient teams is attractive, in the next quote an in-patient nurse participant described recruitment issues there.

*We are hearing of nurse shortages and there are other units where they are replacing nurses with a different type of nurse, and in our team there is a thought to put in a therapist or a counsellor. And I'm saying you have to make sure that you have a nurse so that you do not lose what you have. What you have is working so well. The feedback is good. The vulnerable kids are getting all the help they want. They are not coming back to the hospital. Their length of stays are good. Everyone is leaving happy (4c16).*

The participant expressed bewilderment at the displacement of nurses for clinicians who have other professional disciplines in MMHTSVY. If the recruitment of qualified nurses for in-patient teams is becoming a challenge, the forecast for nursing in MMHTSVY seems grim.

Study participants expressed a belief that executive decision-makers in community MMHTSVY are uncommitted to sustaining the multidisciplinary model. Nurse and non-nurse participants expressed reluctant acceptance, helplessness, grief, and dismay at the reduction of nursing positions in MMHTSVY. In the following quote, a non-nurse participant indicated exasperation in reflecting that recruitment for nurses in outpatient services is "just left" (7a6).

*[For community teams] recruitment is an issue... that is just left. I don't think it's really on the radar.... The current situation is contrary to the vision that ideally each team should have a nurse..., a psychologist, a social worker, a psychiatrist, that sort of thing. It's a pretty longstanding service philosophy to have multidisciplinary teams (7a6).*

A nurse participant observed that vacant positions "are not posted specifically anymore. If I were to leave my nursing position, my position may not be posted as a nurse... which is kind of sad" (8c7). Study participants described that nursing retention in MMHTSVY is threatened due to filling vacant nurses' positions with non-nurses, and by designing teams without nurses. For example,

*We have seen nursing positions come and go and be replaced by non-nursing backgrounds (8c19).*

In the following quote a non-nurse participant perceived that the recruitment enigma is due to the decision-makers' misjudgement of the value that nurses and doctors bring to MMHTSVY.

*At the field level there is recognition for the particular contribution of the nurse whereas it might be seen as more generic at the higher level. There is not a lot of appreciation and drive to ensure that we do have nurses. And we have that same problem with doctors that we have with nurses. (12e30)*

Another participant perceived there is a recruitment decision to replace nurses with less costly team members like social workers to reduce expenditures in salaries and contracts. For example,

*Finances are a barrier [to sustaining nurses in this field]. It's the government to a certain degree. I don't know how much this factors in. Economics are tight. People who come into this field with a Masters degree in social work, let's just take social work as an example, they do not have the same salary as nurses. Nurse are a higher paid entity...They are looking at the strength of our team and they are looking at salaries. A social worker is a .8 of a psychologist's salary, for instance. And the cap level is based on salaries, not on positions like before. That is just happening now. So if a social worker leaves and you hire a psychologist, the psychologist can only work .8 of their position. When there is a job vacancy and you hire a different position that is higher paying, you may not get a full time equivalent back. That is how they are looking at it. They are totalling salaries. They are not looking at positions, whereas that was not an indicator previously. So staffing a multidisciplinary team becomes that much more difficult (10c21).*

The participant perceived that, at a higher level within the organization, there is seemingly a lack of value for nursing.

A nurse participant reflected on the extinguished role of a school nurse and wondered if nursing in MMHTSVY will have a similar outcome.

*It used to be that schools had a school nurse attached to them. That hasn't happened for a number of years (10c11).*

The participant suggested that school nurses' preventative health and mental health teaching, health screening, and counselling with individual students and their families were invisible work that was seemingly cut by decision makers who did not fully comprehend nursing's contribution.

**Aren't in the driver's seat.**

Nurses' influence on policy is thwarted in some community MMHTSVY. In the following quotes, two nurse participants and two non-nurse participants described feeling powerless about influencing policy that could potentially impact the retention of nursing at their respective work sites.

*Nurses are pretty much removed from policy... because the [quantity of] leadership goes to social work folk, and the language.. is pretty much all social work (8c23).*

In the first quote, the nurse participant believed that the social workers' policy perspectives carried more weight in the administrative system than the nurses' perspectives.

*Policy is made at that level, never our level. We contribute to policy makers when we are given certain directives and we are asked for input. However in my experience they listen very little to our input. They go through the motions but you see little evidence that they have factored some of those comments in (10c46).*

*All team members are asked for input but I don't know whether the executive is responsive to what our team and individual team members have to say (11a51).*

*Our team doesn't really contribute to policy... Once in a while we might have some recommendations. We certainly aren't in the driver's seat of anything policy wise. The nurses wouldn't, but neither would anyone else (7a13).*

The nurse and non-nurse participants described that nurses and non-nurses had equivalent lack of influence on policy formation in MMHTSVY. For these participants, it seems that their degree of collaboration in administrative structures and processes in their programs is insufficient to facilitate the effective involvement of nurses and their team members in solutions for relevant issues. Furthermore, these participants reported not being informed of the rationale for decisions. Study participants identified nursing's erosion and disempowerment from influencing policy.

### **Confusing nursing credentials.**

Understandably, mystifying credentials and competencies are a conundrum when agencies and team members make decisions about nurses. Study participants, particularly non-nurse study participants, described that they are mystified by the variety of nursing educational

programs, nursing licenses, credentials, and competencies that nurses in MMHTSVY have. For example,

*I'm just not aware of the training tracks for nurses in this field (12e33).*

*I haven't asked or explored it but I'd be curious to know what kind of graduate programs, training programs there are for nurses who want to work in this area of mental health (7a22).*

In the following quote, a nurse study participant experienced team members not understanding their nurses' competencies.

*Within the Ministry I don't think that there is a lot of education to what the nurses can actually offer. I know that when I came on this team there wasn't really a lot of awareness what the nurses' competencies were and how that could relate to the job. I don't know if there was a lot of public education around what education nurses have (6c37).*

The variety of nurses in MMHTSVY is indeed complicated. There are multiple academic qualifications among the nurses in MMHTSVY. There are standardized entry to practice licensing qualifications for registered nurses and registered psychiatric nurses, but there isn't uniformity in entry to practice competencies between the two licensing bodies. The College of Registered Nurses in British Columbia has a baccalaureate degree for entry to practice while the College of Registered Psychiatric Nurses maintained the diploma training program for entry to practice. Nurses can challenge both licensing exams, and if they pass both tests, and pay both annual licensing fees, they can be dually registered as registered nurses and registered psychiatric nurses but a majority refuse their eligible dual title due to costs. Both of the nursing regulatory bodies have higher levels of nurses within their respective licensing bodies. Registered nurses have an option to attain national certification in mental health nursing. Although there is no official restriction on the use the title 'advanced practice nurse', the title 'advanced practice registered nurse' usually requires a masters degree in nursing. Nurses with less education also

hold this title in the name of a nursing position at a workplace. In comparison to registered nurses, the designation 'advanced practice registered psychiatric nurse' requires a baccalaureate degree in psychiatric nursing rather than a masters degree. Registered nurses can advance their achievement further to include a PhD in nursing. Advanced practice nursing roles for registered nurses include 'clinical nurse specialist' and 'nurse practitioner'. Nurses often have non-nursing degrees in addition to their nursing qualifications. Surprisingly, nursing job descriptions in MMHTSVY are often similar yet academic qualifications and titles vary. In MMHTSVY, expertise from experience has been a taken for granted equalizer to post basic higher education. These differences among nurses are heightened by influences of particular practicum experiences and the infinite possibilities for clinical experiences.

A nurse participant perceived that new nursing graduates from schools of nursing have less mental health training than previous graduates.

*Specific mental health training, there isn't a lot of it in the [registered nurses' school of nursing basic training] program, especially with the new grads that we are seeing (3c5).*

Other study participants similarly described a lack of uniform proficiency in new nurse members' counselling skills. A non-nurse participant remarked that a newly hired nurse did not do therapy.

*We had a nurse who had no therapy background... She was open to learn and open to grow.... We look at filling in that [therapy] gap with other workers because that is typically sort of a piece that the nurses don't bring so much (13d6).*

Study participants seemingly derived conclusions about nurses' competencies from their personal experience working with nurses on their teams. Participants evaluated a nurse's counselling competency relative to their team members' counselling competency and their personal experience of other nurses' counselling competency. While some participants described having nurse team members who had greater expertise in counselling than team members, other participants expressed disappointment in working with nurses who were less competent than

their team members. In the next quote, a nurse participant explained nurses' variation in counselling abilities.

*You have to be aware that individual nurses' underlying training in therapy differs according to the era of a nurse's training and the philosophical influences of a particular school of nursing that the nurse graduates from. Our training meets the nursing standards but your training is weighted according to the school that you go to. And then it depends on what the nurses' clinical specialties are. And hospital training in mental health is a very different venue than community mental health. The practice settings vary so widely. Nursing and nurse training continue to evolve (10c16).*

The participant suggested that through multiple factors, most notably the curriculum of schools of nursing and individual student nurses' practicum placements that graduating student nurses' competencies in therapy are inconsistent.

#### **Constraints on access to training.**

Student nurses who are working towards a career in MMHTSVY are constrained in their access to field practice in MMHTSVY. A nurse participant described the dilemma.

*It is difficult for student nurses to get access to a placement like this. Nurses are in a specialty program in their undergraduate degree. At a minimum the student nurses probably have to be in their fourth year to work here. And their nursing preceptors are required to have the same degree that the student nurse is working towards, or higher. And not all of the teams have nurses (10c18).*

The nurse participant described that student nurses who are preparing for baccalaureate degrees in nursing have additional individualized training and experience in their fourth year with a nurse preceptor in a selected nursing specialty. In light of the practicum protocol for a student nurse in a baccalaureate program who has an interest in developing expertise in mental health nursing with vulnerable youth, the student nurse would require a field placement in MMHTSVY in their fourth year. However, there are relatively few eligible worksites in MMHTSVY that can provide an appropriate practicum for prospective student nurses who wish to prepare for a career in MMHTSVY. First of all, there are administrative constraints. Work sites have a certain capacity

for numbers of students, professional disciplines, entrance competencies, and clinical restrictions. As well, there is an insufficient number of volunteer nursing field practicum supervisors (i.e., nurse preceptors) at work sites in MMHTSVY who are eligible to guide the nursing education of advanced practice registered psychiatric nurses, registered nurses, and advanced practice registered nurses. Students generally choose (or are required to choose) a nurse preceptor who has more formal training than they have. Student psychiatric nurses prefer to have registered psychiatric nurse preceptors, and student nurses who will become registered nurses prefer registered nurse preceptors (although under the nursing standards, mismatched preceptors can be delegated by a higher level nurse) who have the same regulatory body as the students. On the whole, there are few potential nurse preceptors for student nurses in nursing degree and advanced nursing degree programs, and that is contributing to the nursing shortage in MMHTSVY.

Nursing is falling behind the other disciplines in sustaining nursing in MMHTSVY, particularly in the community, due to the shortage of eligible preceptors. The current preceptor dilemma is seemingly a key determining factor that is a barrier to graduating degree and advanced degree nurses in both registered nursing and registered psychiatric nursing. Nurses who have experience and degrees and advanced degrees can contribute to nursing's identity and practice improvements through nursing knowledge translation and nursing research in MMHTSVY but the trend suggests that the eligible field practicum placements for degree students will continue to shrivel. Consequently, the continuation of nursing in MMHTSVY, particularly in community teams, is in jeopardy. Other professional disciplines (except perhaps psychiatry) prepare a sufficient quantity of graduates to meet the need for multidisciplinary teams in this specialty practice.

In this fifth category, 'Nursing Erosion' there are insights that nursing in MMHTSVY is eroding. By design or by default, the staffing of nurses in MMHTSVY seems to be in jeopardy. When nurses are not on the team, then the clients, their families, communities, and the team will lose nursing's distinct contributions that were identified in the previous four major categories in this chapter. However, participants also described a number of elements that spur nursing's momentum. The final category of the analyzed data is 'Nursing Momentum'.

### **Nursing Momentum**

Both erosion and momentum for nursing are at play in MMHTSVY. In this theme, participants' views on momentum in MMHTSVY are described. The five sub-themes within 'Nursing Momentum' include 'making nursing visible', 'self-regulation', 'policy engagement and leadership', 'utilization expansion', and 'nursing specialty'.

#### **Making nursing visible.**

Affirmation of nurses for their distinct contribution to the team is a source for, and a product of, nursing's momentum. Nurse and non-nurse participants remarked that the process of team members identifying nursing strengths seems to make nursing visible. A nurse participant remarked that "she *appreciated hearing from a team leader 'Your knowledge and what you have contributed to the team is very valuable'*"(6c48). A different nurse participant explained that "*the process of accreditation was a significant impetus for articulating nursing's knowledge and work, procedures on risk management, ...articulating what our practice is*"(3c22). In recognition of the value of bringing in nursing's distinct perspective, a nursing participant described being "*asked to specifically sit on a... multidisciplinary type of panel*"(6c54). A nurse participant's self-described daily mantra in the next quote is an inspiration for nurses making nursing visible.

*Nurses have never been really good at clarifying themselves as experts. Nurses have learned to take direction really well. Nurses take orders really well. But for nurses to*

*claim ourselves as experts and stand firm in that declaration of expertise –and all the possibilities that go with that- is really important. So I've taken it upon myself every day when I go to work to act like a seasoned professional, that I know what I'm doing. That if I don't have the answer to something that I'm going to make sure that I help find the answer to it. I model a value of ongoing learning. I interact with others on the team in an assertive and respectful way. Ultimately I stand behind the nursing lens that I look through. I will accept no disrespect for my nursing lens. I stand behind the term 'expert' in what I do. With that comes possibilities and on-going learning (9c45).*

In the following quote, a nurse participant described how a degree program in psychiatric nursing, certain media attention for psychiatric nursing, and the participant's personal demonstration of psychiatric nursing competencies to team members has advanced psychiatric nurses' visibility in MMHTSVY.

*When I started there wasn't a great type of program specifically for a psychiatric nurse. I think that you could go for a degree in health sciences, and that kind of limited [the advancement of psychiatric nursing]until [the College of Registered Psychiatric Nurses] actually kind of came up with a degree program [in psychiatric nursing]... I think probably educating people has made it better. I think there has been more media exposure about psychiatric nurses. I certainly think that also exposure to a psychiatric nurse -being me- that they (i.e., team members) know about my education and what I can possibly bring to the team (6c36-39).*

In the next quote, another nurse participant described how and why nursing is becoming visible.

*We know intrinsically [what nurses do, such as the numerous elements that nurses assess] but to be able to describe it and break it up for other people so that they know that these are all the things that we are looking at. So we are changing our paperwork so that people who come upon us and wonder what we're doing when we're spending hours with the case or family will go "Oh". Our scope is quite comprehensive, and our work has to be reflected in the paperwork (4c25).*

Making nursing visible seems to make nursing worth preserving. According to several participants, this research project has made nursing's strengths and challenges (that participants described to the researcher and in their team discussions) visible to nurses and their teams. For example,

*I would say that your research proposal and research questions have caused me to be more protective of nursing positions and to honor nursing a bit more. Your questions have helped me to appreciate nursing more for what they do. The circulation of the*

*recruitment materials for your research project stimulated thoughtful reflection here among our team (8c43).*

*Your research raises the profile of the expertise that nurses bring to their teams, and I appreciate you for doing that (9c47).*

Affirmation for each facet of nursing's distinct contribution to MMHTSVY makes nursing visible and that seems to strengthen nurses' pride and nursing's identity.

### **Self-regulation.**

Some of the nurse participants described how their clinical practice is developed through adhering to nursing standards of practice, drawing practice guidance from nursing conceptual frameworks, and participating in nurses' community of practice. Nurse participants described that nursing standards of practice empower them to overcome barriers in order to provide good care.

For example,

*As nurses, our standards of practice are absolutely crucial. And standing by those standards of practice in the face of constraints or barriers to meet the needs of a client, I will stand behind my standards of practice, and be confident in doing that.... I have had in the past reproach from supervisors and managers to not take care of that. And I say "Look, this is a person that we are intervening with here, I don't really care that it's not our mandate, it's a service matter, it's an issue of humanity, and helping this person, and I am going to make sure that this person gets connected to where they need to, whether it's our service mandate or not. This is a person who needs help." I have a nursing hat on and |I am going to make sure that this is followed through (9c34).*

The participant identified that the nurses' standards of practice are the authority behind the nurse's practice decisions. Nurses have authority over their clinical practice because they are licensed professionals. They have legitimacy in their actions through nursing standards. The next quote illustrates a nurse participant enacting nursing's standards without actually naming these.

*[We] tend to stand back and look at things, and recognize that things aren't going quite right, and we are willing to own up to things that could be working better, that yes there have been a few pieces where we have said this needs to be safer, this needs to be working better for families, we need to change what we are doing, and have things run a different way (4c21).*

The participant implied adherence to the nursing standard for the provision of responsible, accountable service in the public interest wherein the nurses were identifying safety and ethical concerns and reflecting on how to resolve these to improve client care and nursing practice.

Nursing is a self-regulated profession. Although nurses appreciate administrative structures such as administrative supervision and quality assurance audits that facilitate nurses' work, these are secondary instruments in relation to the primacy of self-regulation. Self-regulation for maintenance of nursing registration and licensing is a formal requirement that is monitored by the individual nurses, their nurse-peers, and the nurses' respective colleges. Nursing standards by the College of Registered Nurses of British Columbia (May, 2012ab), College of Registered Psychiatric Nurses of British Columbia (May, 2012), Canadian Nurses' Association's Code of Ethics (2008), and Registered Psychiatric Nurses of Canada (2010), as well as position papers by these nursing associations, establish individual, collegial, and public expectations for nurses in BC. Not all team members in MMHTSVY are licensed professionals, and not all licensed professionals have self-regulated licensing bodies or a set of standards that are as rigorous as nursing standards. All registered nurses, nurse practitioners, and psychiatric nurses are bound to integrate nursing standards in their practice. Moreover, in the second major category of these findings, 'Way of Being', nurse and non-nurse participants directly or indirectly described nurses enacting nursing standards.

Participants described how nurses achieve their continuing competency standard. Nurse participants attributed improvements in their clinical practice to their participation in training with team members as well as specific training and discussions with nurses (within their respective agencies or for nurses across MMHTSVY). Nurse and non-nurse study participants reported that nurses have particularly developed their nursing practice through their participation

in nursing communities of practice. The following quotes by two non-nurse participants and then a nurse participant illustrate that nurses meet as a group to productively discuss practice issues.

*When they [i.e., nurses] meet together they're making sure they are staying up to date on things they need to know (2b7).*

*The nurses have a practice group and they meet regularly so that they can work on their role and maintain their identity (12e36).*

*[Nurses] have regular nursing practice meetings where we talk about the role of the nurse and difficulties that [we] have, and orientation and information exchange between the nurses, and we can talk about nursing specific issues... such as a need for a...nursing update on a certain skill area (3c15).*

The same participant also valued "*breakout sessions for the nurses at in-service training conferences*" (3c19). According to this participant, "*as well as nurses meeting at the...leadership level to talk about specific nursing issues*" (3c22). Nurse and non-nurse participants described that nurses' meetings facilitated the nurses' attainment of their nursing standards and their nursing identity. Consequently, nurses' meetings develop nursing's specialized knowledge and processes in MMHTSVY, and nurses' continuing competency benefits the team.

A study participant clarified that nurses' clinical meetings are different than meetings with inclusion of team members from other professions in MMHTSVY. In the following quote, a nurse participant described how the language, meaning, and assumptions are not necessarily the same across disciplines, whereas in nursing "*there is this sort of unspoken understanding that when we get these kids and these families, because we have this nursing background, that we always understand what the other is thinking*" (4c1).

I have described how nursing standards of practice and nurses' practice meetings tend to guide and improve nurses' work and I will explore this more in Chapter 5. Consequently, nurses' actions to provide good care are not limited by their agencies' established practices or financial deterrents when nurses perceive that care and care-services can be improved.

### **Policy engagement and leadership.**

Nursing's inclusion in policy development builds nursing's momentum according to the aggregate data which suggests that nurses are change agents who aspire to influence policy. A non-nurse participant described that *“nurses should definitely be at the table for policy work. People who make the policy should get the information from front line nurses to help direct policy”* (1a28). Study participants from in-patient settings described that historically and currently, policy development in in-patient services has been inclusive of nurses or led by nurses. A nurse participant from an in-patient setting described

*Education and communication helps to sustain the nurses' role here (3c16). We really don't have any barriers (3c21). I do a lot of policy work...a lot of work on accreditation,...procedure development,...and specific nursing issues (3c22).*

Evidently the nurses' inclusion in policy development supports their clinical practice. The participant suggested that barriers to enacting good nursing practice are either nonexistent or irrelevant when nursing issues are aptly addressed.

By contrast, some nurse participants in out-patient settings shared feelings of futility in relation to exclusion from policy formation (i.e., discussed in the previous major category 'nursing erosion') Other community nurse participants described satisfactory inclusion in policy development. The significant focus of interest is a deeper understanding of what is going on when nurses in in-patient or out-patient teams perceive their voice is invited and heard in policy development. Where nurses successfully engage in policy development, multidisciplinary cooperation and facilitation seems to be evident at the next level of management. In the following quote, an out-patient nurse participant described that a big leap for nursing has been nursing's launch into policy formation that paralleled nurses' advanced leadership positions.

*Now, more than ever, nurses have emerged into positions whereby they can influence policy. Nurses have been very patient, nurses have persevered, nurses have remained*

*connected, nurses have communities of practice, nurses have elevated the profile of nurses in the eyes of management. We are being asked for input about nursing matters and we were denied that in the past. Nurses are being recognized. They have demonstrated competency and leadership. Nurses are not only vocal on their teams, they have moved up to executive positions. The executive is –and should be- a multidisciplinary team in its own right. Nurses are starting to infiltrate the executive a little bit more. As nurses become more senior into management into executives I think nurses have an ability to influence policy in that multidisciplinary setting. Historically we have influenced transfer of care issues, continuity of care issues, encouraging that our clients have proper medical coverage and service, medically we've been involved in getting satisfactory equipment to work with. I think that we have contributed to policy work in the immediate sense, but I still think that we have started to generate some momentum (9c36).*

Although nurse participants such as the participant in the above quote, and non-nurse participants, perceived that “*policy teams are typically multidisciplinary*” (7a12), some participants perceived that 'multidisciplinary' was not a sufficient element for effective policy formation without having a 'presence' of executive nursing leadership. For example, a non-nurse participant described

*Nursing in MMHTSVY is sustained by having a nurse consultant with a Masters Degree who provides some of that consultation to our nurses and to the rest of the team. I believe that nurse has been helpful in developing the nursing program. That nurse is a real leader (13d14).*

The participant observed that nurses' influence on policy is heightened through having formal nursing leadership (i.e., nurse consultant or clinical nurse specialist) in the multidisciplinary teams. In other words, nursing leadership positively impacts the team, invites field nurses' perspectives, and altogether sustains nursing. It seems that nurse leaders who have a presence with the multidisciplinary teams facilitate policy development.

A non-nurse participant reported “*there are nurses with advanced degrees or dual degrees who have leadership roles at all levels of leadership including the provincial office*” (12e34). These layers of nursing leadership presumably enhance nursing's voice in policy and reflect advanced nursing scholarship with attention to facilitating the translation of nursing

research in nursing practice. Study participants described two other influences that they expect from having nursing leadership at the executive level. A non-nurse participant described “*Nurses are in roles and venues in the executive and committee work in the organization that offer a kind of perspective that keeps the balance to ensure the medical model remains in mental health*” (12e51). A nurse participant described

*Nursing’s capacity for coordination and leadership with the scope to look after vulnerable kids and leave no gaps is being recognized and utilized (4c11).*

Formal advanced education and discipline specific research seem to elevate a professional discipline's status for influence and leadership in a clinical domain, and this is true for nursing in MMHTSVY. In other words, the presence of a nurse leader on the teams enhances nursing's influence in policy. It seems that nurses' contribution to policies is conducive to nursing's momentum.

### **Expansion of contribution.**

Study participants offered their ideas on expanding the utilization of nurses' strengths in ways that would enhance MMHTSVY. Two non-nurse participants and one nurse participant described that nurses would enhance MMHTSVY by delivering parent education meetings.

*Enlighten or educate other people and family members of medications and illness (1a8).*

*Evening meetings to speak to parents about medications... [because] nurses have more approachability and time [than doctors] for the types of real questions that parents have (12e44).*

*We've talked...about parenting groups,... doing parenting meetings that are more nursing focused. But I've heard mixed feedback from parents about that. You don't want to overwhelm parents with their time (3c20). We are just looking at it from the parents' and families' perspective, what they feel would be helpful;..and where we want to put our energy and resources (3c21).*

Although enthused about the idea of a prospective parent education service, the participant was uncertain whether the team would allocate nursing resources to provide parent education

meetings, and whether the service would be positively received by parents. The participant would likely survey parents to determine if they want the service and if they would attend.

In the following quote, a non-nurse participant described a possibility for expanding the nursing contribution that would procedurally invite input from each discipline, including nursing, in the assessment procedure for complex cases.

*Having the nurse for part of that assessment from the medical and physiological perspective will be important.... Definitely we are talking about prior assessments, family histories, current functioning, early developmental stuff. Of course medications... We are still in the planning stage (11a42).*

A non-nurse participant suggested the merit of developing a pilot project that would introduce the position of a nurse practitioner to the team.

*I know that in the Victoria area there is a nurse practitioner team. They have the unique ability to do some assessment and some prescription writing for clients. I know there is potentially a new ability for nurses to go more into the GP and psychiatric territory. So I could see that as a possibility for our team. I don't know that it has been talked over. But I can see that being a role or a possibility where a nurse practitioner that is certified and has a narrow ability to monitor medications and such... My first reaction is that it could be augmenting the psychiatrist's role, think of sort of an assistant to the psychiatry role. Or you could say augmenting the nursing role, because it's allowing the nurses to do more things (7a11).*

These possibilities for a wider utilization of nursing's strengths give nursing momentum.

Moreover, an expansion of ways that can utilize NDC suggests possibilities for changes that can improve the health and well being of the clients, their families, and communities.

### **Nursing specialty.**

Nurse participants described that nursing in MMHTSVY is gradually becoming recognized as a nursing specialty within mental health nursing. In the following quote, a nurse participant described how nurse's work in MMHTSVY is a nursing specialty.

*It's a very specialized field and we have that comfort in our knowledge. There's therapy, medications, and family work, and so professionals from other disciplines consult with us because they know that they can rely on our expertise (4c28).*

The participants' descriptions of NDC in this research project provide new insight on competencies that are distinct from their team members and valued for this nursing specialty within a multidisciplinary team. Although nurse participants were not asked to provide a list of competencies for the nursing specialty, nurse participants emphasized that bio-psycho-social nursing is required. For example, the following quote describes a certain suitability among nurses for appropriately filling the nursing niche on the team.

*But not because you are a nurse that you would specifically be trained for this. This work is a good fit for a person who has a medical background and the mental health piece..(6c27).*

Nursing scholarship is the foundation for this nursing specialty. A nurse participant described that *"Nursing's science based practice is respected. Theory development and research helps us achieve, helps us understand and predict"* (8c2). Overall, participants described that nursing research (reviewing scholastic nursing literature, initiating nursing research projects, and participating in research projects) positively impacts nursing, nursing assessment, nursing interventions, and MMHTSVY.

Participants described how the utilization of communication technologies facilitates the development of this nursing specialty in that accessible nursing peers, nurse consultants, reliable knowledge, and networks improve practice. Electronic information facilitates knowledge translation through implementation of relevant research findings. Information about a client is more accessible and more easily updated. Similarly, orientation documents, policies, and procedures are on line. Podcasts are useful for training without the cost and time for travel. Audio and visual live meetings expand the reach for consultation and inter-nurse connections that can individually and collectively improve nursing practice. Moreover, *"basically everything is on line"* (3c23).

Study participants also described 'Nursing Artifacts' that signify this nursing specialty. I categorized the artefacts into six groups. These are 1) practice guides, 2) policies and procedures, 3) tools and check lists, 4) the nurse is the tool, 5) equipment, and 6) multidisciplinary artefacts.

Some of the nurse participants identified that in addition to nurses' standards of practice, nursing theories and non-nurse theories guide nursing practice in MMHTSVY. Four nursing theories that were specifically identified by nurse participants included Neuman's System Model, Dr. Gweneth Doane's Relational Nursing Theory, Florence Nightengale's Theory, and Orlando's Nursing Theory (Current Nursing, May 2012).

Participants identified that the organization's policies and procedures, and activities surrounding the development, implementation, and monitoring of the policies and procedures, were particularly important to their nurses for safety and emergency issues. The policies and procedures were accessible in the form of "*big binders*" at the work-sites and on-line.

Participants remarked on their nurses' utilization of tools and check-lists that the nurses accessed in scholarly nursing literature, from each other, from trustworthy web sites on-line, and that the nurses created themselves. Participants described how nurses use tools or check lists to conduct mini mental status exams, medication inquiries, and assessments. Some of the nurse participants provided copies of clinical tools that had been developed by nurses in their program.

According to a nurse participant, "*the very, very best tool that we as nurses have is ourselves*" (9c42). A different nurse participant similarly identified the nursing tool is "*just who I am and how I emit my training and knowledge*" (10c49).

Nurses' equipment and supplies, that were specifically identified by nurse or non-nurse participants, altogether included a weight scale, assorted blood pressure equipment, thermometer, swabs, cleaning agents (i.e. antiseptics and disinfectants), first aid supplies, condoms, and

paraphernalia for nurses administering medications (i.e., needles, syringes, medication cupboard, refrigerator, and medication). References to nurses administering injections, oral, and topical medications in out-patient MMHTSVY were described as being less frequent than historically. Nevertheless, they described that the equipment and supplies were available or accessible for when they would be required. In the description of nursing artefacts, participants also mentioned nurses' utilization of multidisciplinary artefacts. These included the Diagnostic and Statistical Manual, assessment tools that all members use, and "*therapeutic tools...[that] have been pulled from multiple disciplines to develop best practice*"(10c49).

### **Summary of Findings**

The findings are summarized for exemplification of nursing's unique and valued contributions and to explicitly answer the three research questions posed at the beginning of this project. The analyzed perspectives of seven nurses and seven clinicians from the professions of psychiatry, psychology, social work, youth care, and registered clinical counselling provide insights on how multidisciplinary team members in MMHTSVY understand NDC. The analyzed data has been arranged in six categories that paint a rich picture of 14 study participants' perceptions of NDC to MMHTSVY and the underlying contexts that shape NDC. In this summary, I emphasize the sub-themes in the first four categories that describe nursing's contributions. Next I share insights from these four themes that particularly indicate how nurses make a difference to their clients', families', and communities' broad health needs. Finally, I highlight the sub-themes from the last two categories that are factors which impact NDC.

Study participants' descriptions of their expectations and experiences of nurses' care of vulnerable youth, their families and communities, have been presented and discussed in the first four major themes in this chapter, 'Sameness Paradox', 'Way of Being', 'Nurse Doctor

Partnership', and 'Expert'. Sub-themes in these four categories directly answer the first research question "*What are the individual team members' expectations for NDC -and their experiences of NDC- in the care of vulnerable youth, the youths' families, and communities?*" and half of the second question, "*How do team members perceive that nurses strengthen the team?*"

Although nursing's shared interdisciplinary role of assessment and treatment is important, nursing brings something different that a participant described was a 'gaping hole' when nurses are not on the team. Nurses can partially substitute for other team members to address clients' issues. This adaptable characteristic of nurses brings accessibility and flexibility to teams that serve vulnerable youth. Nurses bring their nursing standards to their teams and these are recognized as nursing's 'way of being'. Nurses strengthen their teams and address their clients' needs through nursing's unique 'holistic' approach, 'get-to-it-ness', 'helping others', and bringing their 'nursing aura' of trust, caring, compassion, and approachability that clients may feel when they attend MMHTSVY. The 'nurse doctor partnership' is a distinct pairing among disciplines. The partnership develops autonomously, and facilitates doctors' 'efficiency' and their 'retention' with these teams. Among their team members, nurses in MMHTSVY have expertise in the areas of 'bio-screener handler', 'medication intervention', 'health and development educator', 'health system connectivity', and 'critical or complex mental health'.

Thick descriptions of NDC revealed that nurses contribute to meeting the broad health needs of vulnerable youth, their families, and communities. Insights suggest that nurses have an integrated knowledge of health and mental health, and from their holistic approach they assess and treat whole clients, their families, and communities within the broad scope of their nursing discipline. That expansive approach identifies more than the presenting problem for attention and places presenting concerns into a broader context. Consequently, nurses can identify, address, or

reduce a broad range of risks and harm that impinge on clients, families, and communities. Through the use of a relational approach, nurses increase their clients' acceptance of help and accessibility to a wide range of health enhancements. Another characteristic is that nurses are knowledgeable and active in facilitating connections in the healthcare system. They precipitate communication exchanges among health care providers to coordinate their clients' care, and thereby effect cost savings across administrative boundaries (i.e., maximize the benefits of health specialists' planned interventions, and reduce admissions and length of stay in tertiary care facilities). All in all, nurses bring their expertise to MMHTSVY in ways that address the safety and broad health challenges of vulnerable youth, their families, and communities, with the potential to increase the efficiency and reduce costs to the health care system.

The remaining research questions focused investigation on the contexts surrounding NDC. "How do team members perceive that nurses contribute to the team's policy development? What are the contextual factors that can sustain, enrich, constrain, and erode NDC?" Factors have been identified and discussed in the two final categories, 'Nursing Erosion' and 'Nursing Momentum'.

Participants have illuminated multiple factors that negatively impact nursing's participation in MMHTSVY. 'Not going to get one' is the essence of the perceived shortage of qualified nurse applicants in this specialized field of practice. Most importantly, nurses 'Aren't in the driver's seat' when nurses are in teams and programs where they feel they cannot influence policy formation. Another negative impact is the 'Confusing nursing credentials'. For non-nurses in particular, there seems to be confusion surrounding the academic qualifications, licensing titles, and the plethora of job titles in relation to understanding nursing competencies. Consequently, individuals' assumptions about nursing competencies that arise from working with

one or very few nurses can be distorted. Furthermore, 'Constraints on access to training' are depleting the numbers of nurses who have the capacity to fill vacant nursing positions. There is a shortage of qualified nurse preceptors in MMHTSVY. The qualifications for hiring nurses in MMHTSVY seem to rest on experience or training or a requirement for both. Moreover, it seems that NDC to MMHTSVY has not been identified in a meaningful way, and the decision makers have seemingly not understood the dimension of having nurses on the teams. There seems to be an option to fill vacant nursing positions with lower paid clinicians from other disciplines. Simultaneously, there seems to be a promotion of a generic paradigm for team members that both threatens the inclusion of nurses on the team and diminishes the nurse members' nursing identity. The combined effects are detrimental to motivating nurses to choose a career in MMHTSVY. The sub-themes of the fifth category 'Nursing Erosion' capture the challenges to sustain nursing in MMHTSVY.

Furthermore, the contexts in which participants perceived NDC can flourish emerged as five sub-themes. These sub-themes include 'Making nursing visible', 'Self-regulation', 'Policy engagement and leadership', 'Expansion of contribution', and an awareness that nursing in MMHTSVY is a 'Nursing specialty'. Moreover, nursing in MMHTSVY is positively impacted by collaborative learning with members from other disciplines in MMHTSVY, nursing communities of practice, nurses' academic development, inclusion of nurse practitioners among the variety of nurses in MMHTSVY, and an increasing body of special nursing knowledge in psychiatric mental health nursing with vulnerable youth.

## Chapter 5

In this chapter, I will interpret further the findings that were presented in the previous chapter. The meaning and relevance of this research study is discussed in relation to limitations, illustration of findings, surprises, location in the literature, and implications. The implications are discussed in terms of nursing practice, nursing education, policy, and future research. I will conclude with an overview of the research project. To begin, the limitations of the findings will be reaffirmed.

### **Limitations of the Study**

The study yields insights rather than conclusions about understanding nursing's distinct contributions (NDC) to multidisciplinary mental health teams that serve vulnerable youth (MMHTSVY). The findings are applicable to the participants who were interviewed, and to the period of time at which they were interviewed (i.e., June and July 2011). The findings are not representative of the disciplines of members who participated. Consistent with standards for qualitative research, these findings provide insights on NDC. These insights can be meaningful to MMHTSVY, researchers, policy makers, administrators, and nursing educators.

### **Illustration of Findings**

For ease of discussing NDC, I have created a diagram of the major themes of NDC and a list of the sub-themes under the major themes (Appendix I: Illustration of Findings). The four major themes in the oval are nurses' contributions to MMHTSVY, and the two outer hovering themes are the contexts that sustain and enhance nursing above (i.e., Nursing Momentum) or constrain and erode nursing below (i.e., Nursing Erosion). The shapes of the four major themes in the centre are all different in form and color, because these are not equivalent concepts.

Although in this diagram I have placed 'Expert' in the centre, these contributions float in the oval.

These four distinct areas of contribution are always present, but they not equally weighted. These contributions can dynamically change in size and significance in relation to the needs of the team. In the classic description of nursing as an art and a science, the art is the 'Way of Being' and the science is the 'Expert'. The 'Nurse Doctor Partnership' is a clarified reality. 'Sameness' is the indicator of successful multidisciplinary integration. Teams can examine the full meanings for these six major themes and their sub-themes that are found in Chapter Four. In this chapter, I will discuss how nursing standards were a significant element in NDC. Then I will discuss how discipline neutral health knowledge was often represented as medical knowledge.

### **Surprises**

Particular details in the research findings have surprised me. I will first discuss how nursing standards were a significant element in NDC. Then I will discuss my surprise at how discipline neutral health knowledge was often represented as medical knowledge.

#### **Nursing standards.**

Some of the nurse participants overtly described that nursing standards guided their practice. Moreover, I inductively discovered that nurse participants' thoughts and actions regarding clinical practice were nursing enactments of nursing standards, and that non nurse participants' accounts of nurses' *'way of being'* were equivalent descriptions of nursing standards. I found these descriptions of nurses' performance were unmistakably evidence of nurses enacting nursing standards. Moreover, it seemed that the nursing standards were more than a practice guide for nurses. The profound insight is that nurses' identities, the lived lives or at least the working lives of nurses, are their standards. This is the nurses' way of being. For nurses, this is ordinary, but to their team members, their nurses' intensive way of being is extraordinary. Perhaps the sheer responsibility and accountability to apply nursing standards (College of

Registered Nurses of British Columbia, May 2012b; College of Registered Psychiatric Nurses of British Columbia, May 2012) in their practice is inscribed on nurses' identities as their 'way of being'. The theme 'Way of Being' is a major category of NDC to MMHTSVY.

### **Terms in lieu of nursing.**

Study participants utilized the terms 'medical knowledge', and 'medical piece' more often than discipline neutral terms like biological knowledge, health knowledge, physical health, or the nursing discipline term that is nursing knowledge. Team members perceive that nurses are proficient in medical knowledge, without having an awareness that the domain of knowledge is possibly nursing knowledge. Are the historically embedded semantics perpetuating nursing's invisibility?

### **Links to Scholarly Literature**

I will discuss how research findings from this study relate to other scholarly literature in three areas including promoting nurses' contributions, nursing's policy contribution, and multidisciplinary teams.

#### **Promoting nurses' contributions.**

Five years earlier than my study, Mantie (2007) investigated how registered psychiatric nurses (RPNs) can enhance community multidisciplinary teams in Child and Youth Mental Health Services (CYMH) in northern BC, the factors that impact RPNs, as well as the benefits and barriers for RPNs and their team members in relation to working in northern BC. Data was collected from a survey of 23 provincial CYMH leaders across BC, a survey of 29 northern CYMH clinicians, and two audio-taped meetings of a focus group of seven RPNs.

There are four key differences between these two studies. I explored nursing's contributions that were distinct from their team members'. Furthermore, I did not exclude RNs'

contributions. In my study, prospective participants were drawn from in-patient and out-patient teams in MMHTSVY in BC. I explored the perspectives of multiple disciplines qualitatively, including RPNs' and RNs', thus providing additional understandings of nursing's role on multidisciplinary teams.

A key finding is that RPNs' contributions which Mantie (2007) identified are present within my findings. For example, in Mantie's study, participants in three groups foremost valued RPNs for their closer working relationships with the hospital staff, psychiatrists, and community physicians through having a greater linkage with, and understanding of, the medical system's services and resources. These collaborative linkages facilitate liaison outreach, shared care, and case management (Mantie). This contribution in Mantie's study reflects RPNs' and RNs' contribution to 'Health system connectivity' in my study. All in all, Mantie describes that RPNs bring their biological psychiatric knowledge to assist families by demystifying the medical and medication concerns they may have, administer medication to mentally ill clients, and screen for side effects. In general, RPNs are valued for their contribution to assessment, diagnosis, crisis management, case management, generic treatment, and technical skills (Mantie).

A second key finding is that participants in Mantie's (2007) study described challenges that are seemingly particular to RPNs. Forty five per cent of the survey participants who were northern members of multidisciplinary teams acknowledged that they did not know what RPNs did or their training (Mantie). Individual survey participants among the clinician and leadership groups expressed that RPNs were overly dependent on psychiatrists, and diploma RPNs earn more money than team members with a baccalaureate degree or higher in another professional discipline (Mantie). The comment that RPNs depend on psychiatrists, may relate to the origin and purpose of RPNs in Western Canada that had been to assist psychiatrists (Davis, 2011).

Team members in Mantie's study viewed a proficiency in therapy, group, and family counselling as more relevant to the team's work than RPNs' contributions without those skills. The recruitment and retention threat to diploma trained RPNs, in comparison to the higher education of their nursing colleagues and team members, is not merely a Canadian phenomenon (Koekkek, Van Meijel, Schene, & Hutschemaekers, 2009). Participants in Mantie's study described the difficulties surrounding recruitment of RPNs were exacerbated by northern geography.

The seven RPN participants in Mantie's (2007) study suggested solutions for some of the unique challenges that impact RPNs. They recommended enhancing their contributions by RPNs proactively identifying and demonstrating their value, increasing their professional development, increasing practicum opportunities for psychiatric nursing students, establishing communities of practice, opening all job postings in CYMHS to all disciplines, and bringing nurse practitioners onto the teams (Mantie). The RPNs described that their nursing association has the onus of improving the visibility and legitimacy of psychiatric nursing. Mantie included in her discussion that the profession of RPN is distinct from RN and requires an autonomous scholastic foundation to advance RPNs' professional development in RPN above the new baccalaureate level.

Through their case study, Burriss, Breland-Noble, Webster, and Soto (2011) recommended greater utilization of the competencies of registered American psychiatric mental health nurses (PMHN) for better identification of youths' and families' needs and prompt treatment of diverse youth in the justice system. Identified competencies of PMHN include emergency assessment and stabilization, facilitation of a more comprehensive review of psychosocial, neurological, and familial concerns that complement the psychologists' services, and provision of counselling that strengthens family bonds, corrects youth's thinking errors, and resolves trauma with cultural competence (Burriss et al.). My study similarly suggests that nurses

in MMHTSVY are experts in caring for vulnerable youth who have severe and complex challenges such as suicidal youth, and that nurses increase client safety with their bio-screener handler expertise, identification of broad health risks, holistic assessments, inclusion of the family in treatment, and bridging health system connections. Similar to their team members, nurses provide generic therapeutic treatment but integrate nursing standards in their practice.

Insights on nurses' contributions from Ward's (2011) synthesis of psychiatric mental health nurses' (PMHN's) strengthens insights on NDC from my study, particularly in reference to in-patient MMHTSVY. According to Ward,

No other discipline has the necessary scope of practice to be able to tackle everything that has to be undertaken with, and on behalf of, those suffering from mental illnesses... [PMHNs] deliver such a broad range of supportive and interventionist activities to such a variety of mental health problems, behaviours, and situations. It is not just the interventions provided, or even the therapeutic relationships that have to be developed using specific models and theoretical approaches, but ...in in-patient settings PMHNs cover 24 hour patient contact to provide... the care coordination, assessment feedback and carer support that separates these staff from others within the core multidisciplinary team.... [PMHNs] remove potential obstacles to care effectiveness, ...manage psychiatric emergencies, ...and provide medical interventions (p. 11-13).

Ward's description of PMHNs' contribution to in-patient settings clarifies the team's reliance on nurses' competencies that are distinct from other team members'.

Nelson, Connor, and Alcorn (2009) describe how the nursing contribution to MMHTSVY includes recognition of symptoms of early psychosis, supportive therapy, needs-

based interventions, assertive outreach, health promotion, and reduction in disability. Insights from my study are parallel to these authors' descriptions of nursing's contributions.

Study participants in my research project expressed interest and enthusiasm for nurses' advanced practice. 'Expansion of contributions' was a key sub-theme in the sixth category 'Nursing Momentum'. Research literature indicates that the inclusion of clinical nurse specialists (CNS) in MMHTSVY enhances clinical practice. Nelson et al. (2009) described that in New Zealand, a non-prescriptive advanced practice nursing leader (i.e., CNS role) in youth health can bring innovative clinical practice leadership and service improvements both internally and externally in ways that help the clients, the community, and systems. Furthermore, Baker (2010) describes that advanced practice nurses in MMHTSVY challenge the practices of team members, develop and review policy, engage in research, and provide expert care of young persons who have mental health issues. Nursing's contribution to MMHTSVY can expand further through advanced practice nurses' training in prescriptive authority (Baker, 2010; Nelson et al., 2009). The Australian nurse practitioner (NP) role in youth mental health describes NPs' capacity to order diagnostic tests, prescribe from a limited approved formulary (especially a low dose atypical antipsychotic), validate youth absences due to sickness, refer clients to specialists, and admit clients to in-patient services. Baker describes that the NP role is an expansion of the existing nursing contribution. Burriss et al. (2011) describe that nurse practitioners are particularly needed to prescribe medication in combination with talk therapies for vulnerable youth in the legal justice system among the services provided by registered PMHN.

#### **Nursing's policy contribution.**

Insight from my study suggests nurses should be involved in policy development, and that when they are there are positive outcomes. Moreover, in recognition of the variety of nurses

in MMHTSVY, consideration must be given to the inclusion of the different types of nurses for nurse involvement in policy development and implementation. An overview of the following scholarly literature is shared because these reports illustrate how nurses are involved in policy development that can impact MMHTSVY.

Shamian and Villeneuve (2010) examined and discussed nursing's influence over Canadian human health resource policy on clinical practice as a tribute to nurse Dr. O'Brien-Pallas' work in the advancement of nursing, nursing education, and nursing research on policy. The authors described that nurses should "interpret and market research...[because nurses'] work and working conditions impact morbidity and mortality directly, and their input should be supported and sought in the development of healthy public policy" (p. 102-103). Dr. O'Brien-Pallas' influence reverberates in the nursing discipline as I can attest through my inclusion of a policy focus in my study. Research questions in my study that pertained to policy included "How do team members perceive that nurses contribute to the team's policy development?" and "What are the contextual factors that can sustain, enrich, constrain, and erode NDC?" I examined the literature on 'Macro Systems and Policy' in Chapter Two, investigated and analyzed participants' perspectives on their nurses' involvement in policy development in Chapter Three, reported the findings in Chapter Four, and in Chapter Five I brought insights from participants' perspectives forward for location in the policy literature and for implications on nursing practice that can promote policy changes. Insight from my study suggests nurses should be involved in policy development and that when they are there are positive outcomes.

As policy practitioners, McCarter, Haber, and Kazemi (2010) collaboratively examined the practice literature in qualitative and quantitative research to evaluate behavioural practice models that best serve vulnerable youth and their families. The authors themselves constituted a

multidisciplinary team representing social work, psychology, and nursing. They recognized the significance of having a holistic, multidisciplinary perspective that frames the needs of vulnerable youth and increases the actionable opportunities for system changes across service sectors. The effectiveness of their multidisciplinary process is illustrated by the researchers' identification of five viable practice models (such as the 'wrap around model'). Moreover, this significant contribution to policy development was accomplished by a multidisciplinary team that included nursing.

Study participants in my research project described a nursing shortage in MMHTSVY. Furthermore, study participants suggested there was difficulty in filling vacant nursing positions with qualified nurses. Yet, study participants described that nurses were not involved in the policy discussions to explore and address the recruitment problem. However, the nursing policy literature has much to offer towards solutions. The introduction of research and international models on health workforce issues challenge insular, static, administrative processes (Koon, Nambiar, & Rao 2012). As an illustration of how research literature can inform recruitment of nurses in MMHTSVY, here are two research articles that offer solutions for the nursing shortage.

Ward (2011) prepared an international consultation report that examined and compared strategies for the provision of sufficient numbers of nurses having the necessary competencies that can meet the mental health needs of their respective nations. Ward's masterful design to address nursing shortages includes nurse-informed retention measures and nursing education options that would preserve nations' effective nursing competencies in mental health settings. The first step requires mapping existing competencies and standards in the nursing specialty (i.e., MMHTSVY) in the actual work force (Ward). The next step requires academic preparation of nurses and training and mentorship under the supervision of exemplary PMHNs to develop their

students' potential (Ward). Where a country has a shortage of PMHNs, Ward recommends a nursing skills mix that would allow generalist nurses to fill some of the PMHN positions.

However, there is an expectation that generalist nurses who work in a mental health setting will be expected to achieve the full complement of competencies that will have been established for a country's PMHNs (Ward). To build their PMHN competencies, generalist nurses who would serve in MMHTSVY would participate in regularly scheduled formal academic preparation in adolescent psychiatric nursing through schools of nursing (Ward). In addition to their ongoing formal education, generalist nurses would receive training from CNSs among the nurses (Ward).

The next article illustrates nurses' policy involvement with macro systems to change nursing education policy toward the objective of increasing the number of nurses who may choose to enter MMHTSVY. Tognazzini, Davis, Kean, Osborne and Wong (2009) produced a position paper for the Canadian Federation of Mental Health Nurses that recommended all nursing generalist curricula train student nurses in core mental health competencies and ensure practice experience with mental illness. The core competencies are assess, plan, implement, and evaluate intervention with persons who have mental health challenges or mental illnesses, clients' families, and communities (Tognazzini et al.). The expectation is that the students will develop these core competencies and thereby gain confidence and comfort in mental health nursing (Tognazzini et al.). Nursing students would then have a better basis on which to choose their nursing specialty which could possibly favor their decision to enter a career in mental health (i.e., like nursing in MMHTSVY).

The scholarly literature illustrates nursing's strong involvement in policy. Moreover a review of the literature on relevant nursing policy brings strategies that can address insights from my study that pertain to nursing erosion. For example, I have shown that the complexity of

recruitment can be informed and understood through the nursing policy literature. There is strong evidence on how the nursing shortage in MMHTSVY can be addressed through nursing's input.

Insight from my study suggests that team members support nurses' involvement in policy. Yet among programs in MMHTSVY, there is variability in the extent that nurses participate in policy. Nurses experience a perfunctory invitation to participate in policy, exclusion, or active involvement in policy development.

### **Multidisciplinary teams.**

Clark (2006) describes that sameness among multidisciplinary team members is evidence of a team's competence in working together. Although Clark's interest is to prepare students to work effectively in multidisciplinary teams, his conceptualization of inter-professional processes is relevant to evaluate processes in multidisciplinary teams such as MMHTSVY. According to Clark, homogeneity among multidisciplinary team members' language, skills, and tools is evidence of "a shared epistemology and a collective ontology focusing on defining the problem in a way that a common approach to solving it becomes possible" (p. 585-586). The sameness or homogeneity is a sign that effective common learning for a shared purpose has been achieved (Clark). In my study, participants valued sameness. According to seven nurse and seven non-nurse participants, nurse-members' provision of assessment and treatment is more or less equal in competence to their team members, and this is evidence of nurses' and their team members' integration of their diverse disciplines for the effective provision of services.

Balanced against sameness, Clark (2006) also emphasized that professionals in an interdisciplinary environment must master their respective disciplines. In my study, participants valued both nurses' sameness and distinction, and participants described that nursing's distinction is threatened by a generic paradigm.

Brown, Crawford, and Darongkamas (2000) evaluated community multidisciplinary teamwork to gauge the vision of the formation of multidisciplinary mental health teams against the reality. They described that ineffective teamwork was isolating members from their professions which caused a deprived sense of professional support and professional identity, evidence of hierarchies, and team members engaging in parallel services instead of integrating strategies that foster other disciplines' involvement in team member's clients' care (Brown et al.). It would seem that some of the nurse participants in my study had experienced under developed teams because their descriptions reflected the signs that Brown et al. had described. Many of these nurse participants' descriptions of disempowerment, parallel work, and professional isolation were phrased as being historical experiences. Moreover there were indications of progressive improvements in moving toward effective team collaboration. For example, a study participant described a possible consideration for systematic team collaboration in the provision of assessment services that may replace their current system of nurses' and their team members' parallel provision of assessment services while having access to multidisciplinary consultation. After evaluation, the progressive change to assessment practices would strategically involve nurses' and their team members' professional discipline expertise for a regular integration of multidisciplinary perspectives. On the other hand, there were signs in my study that ineffective teamwork persists. A nurse participant described one professional discipline's control over their team's and organization's language, allocation of resources, and determination of priorities. Nurse participants from community teams also described that their teams and organizational leaders support generic training instead of, or more than, nursing specific training. Some of the nurse participants described that nursing's concerns were not being heard such the displacement of nurses by non-nurses and nurses not having meaningful involvement in policy development.

The challenges and excellence of multidisciplinary collaboration have been illustrated in the literature. In summary, the literature suggests that team members' collaboration with nurses in MMHTSVY is achievable through having a common centeredness on vulnerable youth, and by having systems, structures, and strategies that can build multidisciplinary collaboration. One of the strategies that build multidisciplinary collaboration is a deeper understanding of a professional discipline's contribution and the contexts that forge their contribution. My study brings a deeper understanding of NDC to MMHTSVY.

### **Implications for Practice**

In order for nurses to bring the identified valued nursing contributions to their teams, nursing in MMHTSVY needs to be sustained. Attention to identifying and strengthening nursing's distinctive contribution is good for clinical practice and for nursing retention.

Professional development in both generic skills and discipline specific skills are needed for good nursing practice in MMHTSVY. In the sections 'Implication for Education' and 'Implications for Potential Projects', I will comment on formal nursing education for nurses' competencies to work in MMTSVY. I will discuss in-service training here.

While nurses in MMHTSVY appreciate training and development with their team members in generic skills through their employers and peers, insights from my study suggest that specific nursing discipline development is also important. Discipline-specific education is needed to meet nurses' nursing interests and to meet team members' expectations for NDC.

In my study, nurse participants described a need for employer sponsored nursing specific professional development. Otherwise, nursing development is constrained when training and team building are explicitly generic. Albeit, registered nurses and registered psychiatric nurses have annual licensing responsibilities to meet their ongoing nursing professional development

requirements. Yet, when the costs (i.e., time and money) for discipline specific development are absorbed by individuals in contrast to employer sponsored generic development, sameness across professional disciplines appears to be favored over distinction. Insight from 'Nursing Momentum' in my study suggests that when nurses' employers facilitate on-going nursing professional development, nurses seem to feel that their nursing distinction is encouraged and valued.

There are multiple strategies for training that can develop nursing's discipline specific interests in MMHTSVY. For example, nurses can be supported to attend professional nursing groups, nursing conferences, relevant nursing seminars in general conferences, presentations or discussion groups that are sponsored by health authorities or agencies in the local health sector, pharmaceutical companies' presentations, and electronic webinars with nursing content. Nurses' participation in nurses' communities of practice and mentorship from experienced nurses in this nursing specialty are additional strategies. A virtual practice group is particularly useful when the critical mass of a professional discipline is low in numbers with a resultant feeling of isolation (Fielding, Rooke, Graham, & Keen, 2008). The employer's introduction of CNSs to the nursing mix can further develop nurses' nursing orientation to a multidisciplinary practice. For example, CNSs build nurses' knowledge development through bringing nursing research articles and scholarly papers that are applicable to MMHTSVY and by initiating nursing research. Employers' facilitation of training strategies for nurses' nursing professional development can strengthen each nurse's nursing identity and build nursing's capacity.

A key finding in my study is that nurses and their team members are responsible for providing assessment and treatment with vulnerable youth. However, nurses seem to accomplish these tasks with a nursing approach, and that approach can be further developed. In particular, nurses can apply nursing theory to augment their therapeutic relationship with clients as a

treatment modality. Study participants described applicable nursing theories in the major category 'Nursing Momentum' in the sub theme 'nursing specialty' in Chapter Four. In the literature on nursing vulnerable youth in Chapter Two, Pharris (2002) identified Newman's (1990) Theory of Health as a nursing approach that she integrates in her therapy with vulnerable youth. These theories can be discussed and illustrated within nursing communities of practice. Nursing theories can be explored (Current Nursing, May 2012) and tested for relevant applications in MMHTSVY. Examples of how nurses apply these theories as practice frameworks, and how these theories shape practice can develop this nursing specialty.

The identified NDC in this study has practice implications for teams. The starting place is for teams to become familiar with the conceptualization of NDC and the contexts of NDC. Nurses' and their team members' responses to NDC can be discussed as a team. I perceive that team members' awareness of NDC can enhance team members' understanding of nursing in ways that can enable team members to effectively utilize nurses' strengths. For example, through a discussion of 'Way of Being', team members' understanding of nursing standards can provide team members with the context for understanding nurses' decisions. Nurse participants described an unwavering adherence to their nursing standards to meet their clients' needs. Insights from the study and the literature (Cioffi et al., 2010) suggest there can be a difference of professional opinions on the best action in certain situations that can cause tension in teams. It seems that nurses' efforts toward enacting good nursing clinical practice (i.e., enacting nursing standards) can be misunderstood by non-nurse team members or non-nurse managers, likely due to professional discipline differences in ethics and standards. Policies that impede a nurse's action can create moral distress for the nurse (Musto, April 2012 poster presentation). Yet, clinical actions by a nurse that are supported by nursing standards but are contrary to their team

members' view(s) can provoke team tension or managerial tension. Consequently, team members who understand nursing standards are less likely to misjudge nurses' decisions and actions, and are more likely to support and facilitate nurses' perspectives. Similarly, the respective codes of ethics and standards for all team members' disciplines are relevant to teams, because having an increased knowledge of another team member's discipline can enhance collaboration.

Nurses and their team members can suggest ways to strengthen NDC and to effectively utilize nurses' strengths. Although team members' attention to acknowledging and utilizing nursing's distinction is theoretically good for improvement of clinical practice, team members may have contrary thoughts and feelings about NDC that first need to be heard. Consequently, a process for looking at NDC and then the utilization of NDC can be determined by consensus among the members of each multidisciplinary team. Afterwards, the nurses can autonomously determine the nurses' training needs and solutions for these with support from their teams and employers for implementation of the nurses' decisions.

When nurses individually and collectively evaluate their capacity to enact NDC, they may find identified aspects of NDC that they need to develop or refresh. For example, insights on the sub-theme medication intervention suggests that team members rely on nursing for explaining aspects of psychotropic medications. Consequently, it would seem that nurses' continuing education in pharmacological knowledge is relevant to serving vulnerable youth.

Study participants suggested that nurses' training in the in-patient setting made a difference to nurses' capacity to assess and treat youths with serious mental illness. Effectiveness in 'health system connectivity' in relation to knowing hospital and residential services for young people who develop serious acute mental illness is another benefit from having experience on the hospital wards. Consequently, brief refresher training that is designed by and for nurses in

MMHTSVY (particularly nurses on out-patient teams) may resolve proficiencies that nurses' and their team members' value in nurses. For example, shadowing exemplary nurses on the hospital wards caring for persons suffering from severe acute and chronic mental illness for one to four shifts, may contribute to nurse members in MMHTSVY gaining a meaningful refresher to enhance their capacity to provide certain nursing contributions.

Nurse members will likely perceive that refreshed knowledge and new knowledge in health promotion, illness prevention, addiction, and disease can augment their comprehensive nursing knowledge that they access within this nursing specialty. For example, my study suggests that nurses in MMHTSVY are knowledgeable in sleep assessment and intervention, nutrition, diabetes, asthma, substance use, brain injuries, neurological disorders, metabolic disorders, syndromes, bio-psychosocial trauma, and pharmacological intervention. Furthermore, nurses may recognize deficits in their own knowledge of best health practices such as when youth describe intricacies in partying and piercings.

I found in my study that nurses tend to bring their knowledge to their team members. Perhaps the nurses' natural inclination to share knowledge with their team members can be more formally structured so that nurses and team members in each of the professional disciplines can be the conduits for disseminating research that is produced by scholars in their respective professional disciplines and is relevant to serving vulnerable youth.

Perhaps NDC can be utilized as a practice tool for nurses. Nurses can adapt the conceptualization of NDC for the practicality and suitability of individual teams. The sub-themes of Sameness Paradox, Nurse-Doctor Partnership, Way of Being, and Expert, that conceptualize the fundamental contributions of NDC, can become a kind of check list that may guide nurses in a methodical way to examine their possibilities for a comprehensive nursing contribution. NDC

can guide nurses in their contribution to the team's assessment and treatment of youth, in their consultation and support to team members, to their team's liaison with relevant care providers, and to their team's service outreach in their community.

In sum, with administrative and team supports, nurses can develop and maintain proficiencies in their valued contributions. Although the focus of this study has been nursing's contributions, a similar focus on each professional discipline's contributions can strengthen multidisciplinary sharing and collaboration. Through team members understanding and facilitating nurses' contributions, and through nurses paying attention to their capacity to enact NDC, clinical practice within MMHTSVY can be improved.

### **Implications for Nursing Education**

A study participant described that just any nurse cannot work in MMHTSVY. Therefore, paying attention to the adequacy of basic training and post-basic training to match the capacity of effective nurse members in MMHTSVY is important.

Preceptorships in MMHTSVY can build nursing students' professional confidence, nursing specialty knowledge, generic competencies in assessment and treatment, and role modelling a nursing perspective within a multidisciplinary team. That kind of preparation can equip student nurses for a career in MMHTSVY. Moreover, according to Cleary, Horsfall, and Happell (2012), student nurses who have good preparation in mental health are more apt to choose mental health for their nursing career. However, the limited supply of eligible preceptors and work sites in MMHTSVY need to be addressed. Eligible nurse preceptors need to have the time and interest to volunteer as nurse preceptors. The willingness of nurse members to be preceptors would in part be dependent upon having allied managerial support that would encourage nurse members to be preceptors. Administrative support for volunteer, rare, eligible,

nursing preceptors can facilitate a readiness to provide practicum opportunities for student nurses who may consider a career in MMHTSVY. Clearly partnerships between schools of nursing and organizations with potential preceptors are integral to developing strong preceptorships.

Schools of Nursing influence students' choices in the type of nursing specialty that students select. There are three main influential factors that can impact student nurses' trajectory towards a career in MMHTSVY. The primary factor is the kinds of mental health nursing competencies that are developed through the curriculum and the practicum opportunities. Cleary et al. (2012) underscore the importance of students' time and relationship with their preceptors and the significance of their preceptors' knowledge and skills. Furthermore, the curriculum is fundamental to a student's preparation for a career in MMHTSVY. In a position paper for the Canadian Federation of Mental Health Nurses, Tognazzini et al. (2009) outlined core competencies for all generalist registered nursing graduates both to integrate mental health in generalist nursing and to encourage more student nurses to pursue careers in mental health. The variety and detail in the information on nursing specialties and practicum opportunities that are introduced to nursing students in their schools of nursing guide the students to choices that enable the students to investigate their interests. A second factor is that student nurses' respective Schools of Nursing can encourage or dissuade students from taking an interest in a nursing specialty (such as nursing in MMHTSVY) in proportion to the enthusiasm, pride, knowledge, and training opportunities that are generated within the school for other nursing specialties. Given the uncertainties of nursing careers in community MMHTSVY, and the additional challenges that beset registered student nurses in baccalaureate and advanced practice nursing programs who may want to pursue practicum training and careers in MMHTSVY, the faculty in their schools of nursing may caution students to critically examine a career in MMHTSVY. The

third factor is the outcome of the practicum experience from the perspectives of both the student and the preceptor. If the preparatory competencies that are attributable to a field practicum placement are deficient in comparison to the applicable hiring requirements, or if the practicum opportunities for targeted competency development are in some way blocked, the student is adversely influenced. From the perspective of a preceptor, a student's inadequacy in specific competencies at the beginning, during, or leaving a preceptorship can impact the preceptor's decision to mentor new applicants from the student's school of nursing. On the other hand, a student's negative experience and stories of other students' negative experiences can impact students' choices. The construction of a student nurse's preparation and encouragement for a career in MMHTSVY is clearly a complex endeavour for schools of nursing to accomplish.

In Canada we do not have a comprehensive description of Canadian graduating institutions' target competencies for graduating student nurses who may choose to work in the mental health field with adolescents. Competencies that student nurses can acquire through specific kinds of practice placements are also needed so that students can choose accordingly in order to prepare for a career in MMHTSVY. In terms of competencies and confidence to practice nursing in MMHTSVY, how does the mental health curriculum for registered nurses across Canada compare to the post-basic baccalaureate curriculum for diploma trained registered psychiatric nurses in the Western provinces? For example, Mellett (2010) outlined competencies for registered psychiatric nurses working in CYMH Services within MMHTSVY, and designed a course for post-basic baccalaureate psychiatric nursing students to achieve these.

In a discussion article, Bonham (2011) perceives that child and adolescent psychiatric nursing is a nursing specialty that demands particular training. Without attention to effective preparatory education, fewer nurses will enter this specialty, and vulnerable youth will not have

nurses' contribution to their care (Bonham). With nurses' specialty education from undergraduate nursing to the doctoral level, nursing research can continue to expand this area of nursing science (Bonham).

### **Implications for Policy**

There is a need for projects that can sustain NDC. An analysis of the data brought into view a spectrum of NDC with some contextual insight on factors that are impacting NDC. This study brought evidence from 14 participants about what is at stake if nursing and NDC are not strengthened, and ways to strengthen nursing in MMHTSVY. Projects can emanate from an objective to strengthen nursing practice by attention to policy.

I will begin by describing a project that can address the nursing shortage. Ward (2011) describes two key steps in addressing a nursing shortage. The first step is to identify the competencies of existing nurses in a country (Ward). Presumably, the first step to address the nursing shortage in a specific nursing sector like MMHTSVY, is to identify the nursing competencies in BC. Nursing competencies and descriptions of restricted titles can be accessed from the licensing colleges (i.e., Colleges of Registered Nurses of BC and Registered Psychiatric Nurses of BC) as well as the competencies for certified registered mental health nurses (i.e., certified by the Canadian Nurses Association). The collection of competencies can be compared, contrasted, synthesized, and matched to nursing titles, thus clarifying nursing resources in BC.

The applicability of these nursing competencies to nursing in MMHTSVY can be determined by exploring the research literature and the recommendations of relevant nursing interest groups, nursing associations, and schools of nursing. In part, the themes and sub themes in my study, that describe nurses' valued contributions in MMHTSVY, suggest the kinds of competencies that are valued for the provision of effective nursing in this nursing specialty.

Through identifying the available nursing competencies as well as the required nursing competencies, the foundation for the pursuit of an optimal nursing skill mix in MMHTSVY in BC can be established.

The next step is to examine the scholarly research and policy literature to design a nursing skill mix that can effectively utilize the variety of existing nursing resources. In this way the best design can be determined for a nursing skill mix that draws on particular nursing competencies that are available in BC for an optimal provision of nursing services in MMHTSVY.

Next, a nurse-led outreach to stakeholders can bring their strategies to collaboratively address the implementation of the proposed nursing skill mix. Moreover, through this process, stakeholders can share their perspectives on how to ensure a critical mass of nurses, ensure nursing identity mentorship, and bring nursing research knowledge into practice for clinical improvements. Stakeholders for this project would include nurses in MMHTSVY (in-patient and out-patient nurses), nurse leaders in the organizations that have MMHTSVY, Schools of Nursing, and the regulatory bodies and unions that represent registered nurses and registered psychiatric nurses. Moreover, the stakeholders would reflect on the relevant scholarly literature, discuss system supports for the proposed nursing skill mix, determine an appropriate design for BC, prepare job descriptions that would reflect levels of nurses' work in MMHTSVY and competencies, and determine measureable outcomes for the nursing discipline in MMHTSVY. That group would identify stakeholders whom I have overlooked in this illustration of a practice project that can comprehensively address the nursing shortage in MMHTSVY.

Insights from the major category 'Nursing Erosion' can spawn an array of policy projects that will involve multiple organizations. For instance, the wide variety of nurses' credentials,

competencies, position titles, regulated titles, and terms that nurses name themselves seem confusing to team members and participants perceived that the confusion contributed to the nursing shortage. Consequently I will describe a practice project that can contribute to the resolution of the nursing shortage in MMHTSVY arising from 'Confusing credentials' of nurses in MMHTSVY. As much as possible, the nurses' differences in competencies, licensing titles, position titles, and credentials of diploma registered psychiatric nurses, baccalaureate registered psychiatric nurses, registered nurses, and post-basic programs can be clarified.

A broader project would be the entire clarification of the meaning of Canadian nursing licenses, job titles or terms, credentials, advance practice, and corresponding competencies. There is a need to relate that information to the kinds of nurses in MMHTSVY including CNS and NP for team members', administrators', recruiters', and policy makers' understanding of nurses' competencies, licensing, post-graduate training, nursing mix, nurses' career paths, and remuneration. In contrast to Canada, the United States' nomenclature psychiatric mental health nurse (PMHN) signifies nurses' board certification through a single governmental board that licenses and certifies all nurses although there is no distinction between a board certified nurse and a nurse who works in a psychiatric setting (personal communication with Dr. Josh Hamilton, RN-C, FNP-C, PMHNP-BC, CNE on May 9, 2012). PMHN is recognized by the International Society for Psychiatric Nursing, the American Psychiatric Nurses Association, the American Nurses Credentialing Center, and in the United States (Hamilton, May 2012). Insights from my study on the topic of 'confusing credentials' suggests that a practice project to compare competencies that belong to a variety of nurses in MMHTSVY and broad dissemination of the results would dispel the confusion.

In order to satisfactorily resolve the recruitment issue, the current policies and processes in organizations and programs for the recruitment of nurses in MMHTSVY need to be explored and clarified. Perhaps with increased understanding, decision makers can consider alternative solutions. Insights from my study suggest there are complex issues that pertain to barriers for hiring nurses in MMHTSVY. For example, while there are diploma psychiatric nurses available for hire, the qualifications of 'inexperienced' diploma psychiatric nurses do not meet the hiring criteria that experienced diploma psychiatric nurses have. New graduates who are registered nurses and registered psychiatric nurses who have baccalaureate degrees will not have as much experience as current nurses in MMHTSVY in which expectations for nurses' competencies seem to be based on the characteristics of the existing nursing work force in MMHTSVY. However, master degree clinical nurse specialists can mentor entry level nurses in the work setting from both regulatory bodies in order to enable the recruitment of a nursing skill mix and thus overcome the nursing shortage in MMHTSVY. Moreover, positions for advanced trained CNSs in MMHTSVY would provide nursing leadership, establish a career path for nurses in MMHTSVY, prepare the way for NPs, facilitate the role of NPs, and bring nursing research, and a high level of nurse mentoring to MMHTSVY.

A demand for entry to practice and advanced practice competencies for nursing positions in this nursing specialty would have implications for educators and schools of nursing. There would be a need for curricula that can prepare a career pathway for registered nurses and registered psychiatric nurses entering MMHTSVY with basic and advanced nursing practice training. Insight from my study suggests that student nurses require practice preparation in both in-patient and out-patient settings for flexible nursing careers within a variety of clinical practice teams and programs.

## **Implications for Future Research**

This research study can prompt quantitative and qualitative studies that can increase our understanding of NDC to MMHTSVY, provide insights that can prepare and evaluate the introduction of advanced practice nurses in MMHTSVY, examine what is going well in teams in which members perceive that nurses contribute to policy formation, explore the distinct contribution of other professional disciplines in MMHTSVY, and explore NDC in all kinds of multidisciplinary practice areas. I will explain these musings.

However, right or wrong, participants in my study shared their perceptions that decision makers have intentionally contributed to a decline in the numbers of nurses in MMHTSVY (and in the ratio of nurses to their team members) in comparison to other professional disciplines. The participants primarily perceived that the decline in nurses was related to nursing resources in MMHTSVY being too costly. Mantie (2007) found a similar view among her study participants. It seems that budget-wise team leaders gain more money in their budget when non nurses from a discipline such as social work displace a nursing position (Mantie). Moreover, a solution to trim or cut nursing from MMHTSVY is seemingly under evaluation in relation to the government's justifiable need to identify any resource wastefulness.

For this reason, the evaluation of nursing costs should be framed in a way that nurses' costs and nurses' cost savings can be investigated. According to insights from my study, nurses are more than generic members of MMHTSVY. Perhaps the present and future cost-savings that nurses in MMHTSVY bring to the wider health sector will elude policy makers without explicit identification of the speculative costs arising from the loss of nurses' presence in MMHTSVY. There would be less attention to many aspects of safety enhancements such as recognizing and promptly addressing medication adverse effects or side effects, safety-conscious anticipatory

planning, symptom recognition, and timely referrals. Team members' ineffective or unsafe decisions may arise from having insufficient information when comprehensive nursing participation is lacking in assessment and treatment. A growing concern would be the health care costs from substance use and other high risk activities that increase the likelihood of infectious diseases and deterioration of the brain, heart, kidney, liver, and mobility which could have been more effectively addressed during adolescence by nurses in MMHTSVY. Consequently, without nurses there would be more tertiary care, morbidity, and mortality among vulnerable youth, and impacts on affected persons' health and well-being from increased traumatic outcomes for vulnerable youth.

Aspects of NDC such as the costs and cost savings that are related to 'Health system connectivity' are beyond a particular program's boundaries and are therefore difficult to measure. There may be costly inefficiencies in continuity of care between health care providers and the team because without explicit authorization by a client to release information, health care providers ethically exchange clients' health information with registered health care providers.

Understandably a cost analysis of NDC will be a difficult task. Although quantifying the effects of NDC within a program and external to a program would be a complex task, costs and cost savings need to be in a form that is meaningful to decision-makers. Altogether, a way to measure the nurses' holistic reach and the systemic benefit of NDC would be useful for nursing and public policy. In sum, insights from my study and the scholarly literature suggest that nurses in MMHTSVY bring creative, assertive, holistic, outreach strategies to engage vulnerable youth in health links, health promotion, and illness prevention (Anderson et al. 2009, Burriss et al. 2011, Nelson et al.2009, Potter et al. 2008, Self & Peters 2005, Shelton 2003). What is the value?

The conceptualization of NDC to MMHTSVY that has been determined from an interpretive description of 14 study participants' perspectives can be used to develop items in a quantitative survey. A survey of members' of MMHTSVY agreement or disagreement for items of NDC could enable generalizations about nursing's contributions if the quantitative survey method will demonstrate rigour through the research design and per cent of participation among team members in MMHTSVY. The results of a survey could give more or less weight to the insights or 'findings' that were generated in the qualitative study 'Towards Understanding Nursing within MMHTSVY'. Although insights can influence change, and qualitative research has validity, in certain circumstances decision makers may prefer to have quantitatively validated representational findings to justify a plan.

The collection of data on NDC in MMHTSVY was not exhaustive. In other words, the same research design can be repeated with other participants to enrich our understanding of NDC, and to further investigate consistency or differences in NDC. Clearly the period in time would be different even if the participants were recruited from the same population. Another location apart from BC can also be identified to investigate consistency or differences in NDC across MMHTSVY but most of all, information from replication studies can increase our understanding of NDC in MMHTSVY.

A pilot study that can introduce Nurse Practitioners (NP) in community MMHTSVY and evaluate the difference that NPs make to a team would be informative. Nurse practitioner positions are currently rare or nonexistent within MMHTSVY in British Columbia. While the nature and value of these positions are described in the research literature, the research findings and cost-benefit analyses have possibly not been shared or promoted with the decision-makers in MMHTSVY. Furthermore, nursing research has developed knowledge on the most effective

strategies to introduce and strengthen the new NP role in practice environments. Bryant-Lukosius et al. (2004) explain that CNSs facilitate the introduction, support, and retention of NPs through their development of a strong nursing orientation to clinical practice. There is a need to begin these preparations within the multidisciplinary teams for the inclusion of NPs in MMHTSVY. Clinical nurse specialists are practice leaders who have complex cases, provide practice consultation, facilitate nurses' development and maintenance of NDC, facilitate field nurses' participation in policy development in MMHTSVY, and bring nursing research to practice and practice concerns to research. Based on research evidence, good preparation for the introduction of NPs through the expertise of CNSs can yield good results (Bryant-Lukosius et al.). A pilot study of the introduction and evaluation of an NP on a team in MMHTSVY is timely, particularly in light of recent government announcements for NP positions.

In part, due to 'confusing credentials' and weak marketing for the CNS role in MMHTSVY, nurses who have a CNS skill set tend to occupy undifferentiated nursing positions on their teams. These advanced practice nurses do not receive formal recognition in their positional title, job description, or differential remuneration. It is my assumption that these nurses bring their advanced nursing skill set to the team, even though they are not differentiated from the nursing mix in MMHTSVY. Consequently, the experience and contribution of informally recognized CNS in MMHTSVY is a worthwhile investigation. For example, the role of informal CNS and formally appointed CNS could be compared or combined in terms of their autonomy or barriers to utilize their skills and how they benefit clients, families, communities, nurses, teams, programs, and organizations. The first step would be to identify existing CNS in MMHTSVY.

In my study there were discrepant findings on nurses' participation in policy formation in MMHTSVY. However, nurse participants who perceived that they were involved in policy development were pleased with their engagement in policy. In comparison, nurse participants who perceived that their views were not considered expressed dissatisfaction that they were not engaged in policy development in a meaningful way. Therefore, practice environments where team members indicate there is policy involvement for nurses and their team members, can be investigated to deepen our understanding of what is going on in certain MMHTSVY where feelings of policy engagement are positive. A research study that can identify organizational and team structures and processes that facilitate members' satisfaction in policy development would be informative to MMHTSVY.

The benefits that each profession can bring to their teams can be identified, strengthened, and fully utilized. A scientific inquiry can focus on a different professional discipline (i.e., not nursing) in order to explore the multidisciplinary effects and contexts that impact a discipline's distinct contribution to vulnerable youth and the team. Just as this study revealed how nursing can uniquely benefit their teams and the clients, there are likely hidden and less well understood contributions from each of the professional disciplines. A researcher from a particular professional discipline could modify the interview questions within a similar research design in order to investigate the distinct contribution of the researcher's profession to MMHTSVY. In that way, the unique contributions from each professional discipline can be identified in order to promote the possibility for an effective utilization and strengthening of each professional discipline in MMHTSVY.

Outside of MMHTSVY, a similar research design could be applied to explore NDC in other areas of clinical practice where nurses work in multidisciplinary teams. The investigative

purpose is applicable when team members or nurses perceive that the nurses' unique and valued discipline contributions are minimal, not readily apparent, or the nurses' decisions are misunderstood. Perhaps a deeper understanding by team members of NDC and the contexts of their nurses' roles is lacking. An exploration of NDC among team members can bring insights.

A study that would investigate vulnerable youths' and their families' views of NDC would greatly enhance nurses' direct understanding of the impact of NDC on their clients. After all, the ultimate purpose of investigating NDC has been to improve the lives of vulnerable youth and their families. By exploring the clients' perspectives, an understanding of NDC will be further enriched. Possibly an integration of the perspectives of vulnerable youths and their families will add a new dimension to NDC. Their views may illuminate new understandings of NDC that can lead to improvements in nursing practice.

## **Conclusion**

I conclude this research project with an overview of the successive research decisions that brought this study from a proposal to completion. I began to write the research proposal for my qualitative study in 2007. As a nurse member of MMHTSVY (two years in an in-patient program and 25 years in an out-patient program), I wanted to contribute to a scholarly understanding of nursing in MMHTSVY. I ruled out an auto-ethnography wherein I would have readily analyzed a solitary personal account of my observations and experiences of nursing in MMHTSVY. Instead, I pursued a qualitative exploration of nurses' distinct contribution to their respective multidisciplinary teams that serve vulnerable youth. Moreover, I had successfully completed a pilot ethnographical descriptive study with a convenience sample of three nurses for credits towards my Master of Nursing Degree. Through that preliminary research experience, I recognized that I wanted to explore factors that shape nurses' actualization of nursing in this

specialized area of nursing practice. Accordingly, the research questions emerged in consultation with my research supervisor. Here is a narrative description of the research questions.

Each profession is valued on the team. In this project, the phenomenon of interest is how nurses, as members of multidisciplinary mental health teams, make a meaningful and distinct difference to the team's dimension of service to vulnerable youth (i.e., youth who have mental health and substance use issues). There is a gap in the scholarly literature that depicts a rich description of nursing's distinct contribution (NDC) to multidisciplinary mental health teams that serve vulnerable youth (MMHTSVY). This research project can help to fill that gap because clinicians in MMHTSVY remain an untapped source for the knowledge of NDC to MMHTSVY. The key question in this study asks "How does nursing make a meaningful and distinct difference to the clinical practice (i.e., to their teams and to the health, healing, and well-being of vulnerable youth, their families, and communities)? Furthermore, what affects the nurses' capacity to actualize their distinct contribution?"

I selected Dr. Sally Thorne's (2008) Interpretive Description methodology because this fit my research questions and my informed observer-investigator status as a nurse member of MMHTSVY (that I disclosed in Chapter Three). Within the structure of an interpretive description, an investigator determines an approach. I chose a constructivist (Appleton and King, 2002) approach in order to obtain a slice of understanding of NDC to MMHTSVY through the analyzed perspectives of 14 participants. I brought my understanding of the phenomenon to develop effective interview questions and to strengthen analytical interpretation of study participants' perspectives of NDC in terms of the meaning and effect of these contributions on clinical practice. The study participants were seven nurses and seven clinicians (in the professions of psychiatry, psychology, social work, youth care, and registered clinical

counselling) from multiple programs across B.C. including in-patient and out-patient settings. These participants were ethically audio-taped for their perspectives during single individual telephone semi-structured interviews that lasted up to an hour. I achieved a constructivist interpretive description of NDC to MMHTSVY from inductive analysis of 14 transcripts.

The dual purpose of the research project has been the identification of NDC to MMHTSVY and the identification of the associated factors that sustain, enhance, obstruct, diminish, or erode NDC. A wide scope of NDC, thick in detail and context, has been achieved. The exact nature of these contributions and the associated contexts have been fully described in Chapter Four.

The ultimate objective of understanding NDC in MMHTSVY has been to improve clinical practice with vulnerable youth, their families, and communities. Rather than directly investigating adolescents' and their families' perspectives of NDC, I investigated nurses' contributions to adolescents' and their families' needs from a sample of nurse and non-nurse team members who shared their ontological knowledge of consumers' responses to nurses' involvement with youth and their families. Analyses of 14 study participants' thick descriptions of NDC generated insights about how nurses contribute to the team based practice to enhance care of vulnerable youth, their families, and communities. In view of the kinds of NDC that have been described in my study, the inclusion of nurse members in MMHTSVY suggests that nurses' expertise in needs recognition, health system connectivity, and broad health enhancements with the youth, their families, and communities are pivotal to address the youths' and their families' needs (especially needs that are not met by other team members), particularly when nurses can contribute to policies that can facilitate nurses' responsiveness.

Reflections on study participants' perceptions of how historical, present, and potential factors have and will impact nursing's participation in MMHTSVY provide insights on this nursing specialty. These insights may surprise those situated in the phenomenon (i.e., MMHTSVY). Moreover, these insights can open discussion on NDC within MMHTSVY. These multidisciplinary discussions may enhance multidisciplinary collaboration on contexts that can preserve or enhance nursing's effectiveness. According to several participants, this research project has made nursing's strengths and challenges (that participants described) more visible. As I have described, a constructivist interpretive description of 14 study participants' perspectives suggests that nurses' contributions are distinct, valued, make a difference within a team, and benefit vulnerable youth, their families, and communities.

## References

- Anderson, L., Vostanis, P., & Spencer, N. (2004). Health needs of young offenders. *Journal of Child Health Care*, 8(2),149-164.
- Appleton, J. V., & King, L. (2002). Journeying from the philosophical contemplation of constructivism to the methodological pragmatics of health service research: Methodological issues in nursing research. *Journal of Advanced Nursing*, 40(6),641-648.
- Atkinson, P., & Delamont, S. (2008). Analytic perspectives. In N. K. Denzin & Y. S. Lincoln (Eds.), *Collecting and Interpreting Qualitative Materials* (3<sup>rd</sup> ed.,9,285-311). Thousand Oaks, CA: Sage.
- Baldwin, L. (2002). The nursing role in out-patient child and adolescent mental health services. *Journal of Clinical Nursing*, 11,520-525.
- Baker, N. (2010). Exploring the mental health nurse practitioner scope of practice in youth early psychosis: An anecdotal account. *Contemporary Nurse*, 34(2),211-220.
- Barnes, G. (2007, October). *Substance use trajectories in youth from biological and adoptive families*. Paper presented at the meeting of the Centre for Youth and Society Conference in Victoria, BC. Transitioning Into Adulthood: Theory, Research, Practice and Policy, Victoria, BC.
- Barnes, G., Barnes, M. D., & Patton, D. (2005). Prevalence and predictors of 'heavy use in vulnerable youth': Marijuana use in a Canadian youth sample. *Substance Use and Misuse*, 40,1849-1863.
- Barnes, G., Murray, R. P., Patton, D., Bentler, P. M., & Anderson, R. E. (2000). *The Addiction Prone Personality*. New York: Plenum.
- Barrett, J., Curran, V., & Glynn, L. (2007). CHSRF Synthesis: Inter-professional Collaboration and Quality Primary Healthcare. *Canadian Health Services Research Foundation*, 1-48.
- Bee, P., Playle, J., Lovell, K., Barnes, P., Gray, R., & Keeley, P. (2008). Service users views and expectations of UK-registered mental health nurses: A systematic review of empirical research. *International Journal of Nursing Studies*, 45,442-457.
- Benoit, C. (2007, October). Psychological and social issues in transitioning into adulthood. Paper presented at the meeting of the Centre for Youth and Society Conference in Victoria, BC. Transitioning Into Adulthood: Theory, Research, Practice and Policy.
- Bishop, A. H., & Scudder, J. R. (1995). Applied science, practice, and intervention technology. In A. Omery, C. E.,Kasper, & G.G. Page (Eds.), *In Search of Nursing Science*, (pp. 263-274). Thousand Oaks: Sage.

- Bonham, B. (2011). Developing the science of child and adolescent psychiatric nursing. *Journal of Child and Adolescent Psychiatric Nursing*, 24,74.
- Brown, B., Crawford P., & Darongkamas, J. (2000). Blurred roles and permeable boundaries: the Experience of multidisciplinary working in community mental health. *Journal of Health and Social Care in the Community*,8(6),425-435.
- Bryant-Lukosius, D., Dicenso, A., Browne, G., & Pinelli, J. (2004). Advanced practice nursing roles: development, implementation, and evaluation. *Journal of Advanced Nursing*, 48(5),519-529.
- Burriss, F. A., Breland-Noble, A. M., Webster, J. L., & Soto, J. A. (2011). Juvenile mental health courts for child and adolescent psychiatric mental health nurses. *Journal of Child and Adolescent Psychiatric Nursing*,24,114-121.
- Canada. (2002). Cannabis: Our position for a Canadian public policy. *Report on the Senate Special Committee on Illegal Drugs, I* (1-2),1-224. Ottawa, On.: Canada. Retrieved November 16, 2007, from <http://www.parl.gc.ca/37/1/parlbus/commbus/senate/Com-ille-e/rep-e/repfinalvol1-e.pdf>
- Canadian Collaborative Mental Health Initiative. (2006). Establishing collaborative initiatives between mental health and primary care services for children and adolescents. *CCMHI planning and implementation toolkit for health care providers and planners*. Mississauga, ON:Author. Retrieved 2012-1-17 from [http://www.ccmhi.ca/en/products/toolkits/documents/EN\\_CompanionToolkitforChildrenandAdolescents.pdf](http://www.ccmhi.ca/en/products/toolkits/documents/EN_CompanionToolkitforChildrenandAdolescents.pdf)
- Canadian Nurses Association. (2002). *Code of Ethics for Registered Nurses*. Ottawa: Author. Retrieved April 20, 2008 [http://cna-aicc.ca/cna/documents/pdf/publications/CodeofEthics2002\\_e.pdf](http://cna-aicc.ca/cna/documents/pdf/publications/CodeofEthics2002_e.pdf)
- Canadian Nurses Association. (2008). *Code of Ethics for Registered Nurses*. Ottawa: Author. [http://www2.cna-aicc.ca/CNA/documents/pdf/publications/Code\\_of\\_Ethics\\_2008\\_e.pdf](http://www2.cna-aicc.ca/CNA/documents/pdf/publications/Code_of_Ethics_2008_e.pdf)
- Cioffi, J., Wilkes, L., Cummings, J., Warne, B., & Harrison, K. (2010). Multidisciplinary teams caring for clients with chronic conditions: Experiences of community nurses and allied health professionals. *Contemporary Nurse*,36(1-2),61-70.
- Clark, P. (2006). What would a theory of interprofessional education look like? Some suggestions for developing a theoretical framework for teamwork training. *Journal of Interprofessional Care*, 20(6), 577-589.
- Clarke, L. A. Children of parents with mental illness: Best practice guide. Retrieved July 21, 2012, from <http://www.parentalmentalillness.org/CYMH%20Best%20Practice%20Guide%20with%20COPMI-%20web%20version.pdf>

- Cleary, M., Horsfall, J., & Happell, B. (2012). Promoting mental health nursing: Employing undergraduate nursing students as assistants in mental health. *International Journal of Mental Health Nursing, 21*,69-74.
- College of Registered Nurses of British Columbia. (2006). Quality practice environments: A tool for nursing students and new registered nurses to use in seeking preceptorships or employment. Retrieved April 20, 2008, from <http://www.crnbc.ca/downloads/418.pdf>
- College of Registered Nurses of British Columbia. Practice Standards. Author. Retrieved May 7, 2012, from <https://www.crnbc.ca/Standards/ProfessionalStandards/Pages/PracticeStandards.aspx>
- College of Registered Nurses of British Columbia. Professional Standards. Author. Retrieved May 7, 2012, from <https://www.crnbc.ca/Standards/Lists/StandardResources/128ProfessionalStandards.pdf>
- College of Registered Psychiatric Nurses of British Columbia. Standards of practice, code of ethics, and competencies. Author. Retrieved May 7, 2012, from <http://www.crpncb.ca/practice-support/competencies-and-standards/>
- Costa, F., Jessor, R., Turbin, M. S., Dong, Q., Zhang H., & Wang C. (2005). The role of social contexts in adolescence: Context protection and context risk in the United States and China. *Applied Developmental Science, 9*(2),67-85.
- Cote, J. (2007, October). Keynote Address: Youth Inclusion/Exclusion in Canada: Estimating Probabilities for At-Risk Transitions to Adulthood. Paper presented at the meeting of the Centre for Youth and Society Conference in Victoria, BC. Transitioning Into Adulthood: Theory, Research, Practice and Policy.
- Creswell, J. W. (2007). *Qualitative Inquiry and Research Design: Choosing Among Five Approaches*, 2nd ed., Chapter 4, 57-62, Sage Pub. Inc.: Thousand Oaks, Ca.
- Current Nursing. A companion to nursing theories and models. Retrieved May 7, 2012, from [http://currentnursing.com/nursing\\_theory/](http://currentnursing.com/nursing_theory/)
- Davis, C. (2011). Literature review of forensic psychiatry as an undergraduate clinical placement. *Project*. Library, School of Nursing, University of Victoria.
- Denscombe, M. (2001). Critical incidents and the perception of health risks: the experiences of young people in relation to their use of alcohol and tobacco. *Health, Risk and Society, 3*(3),293-306.
- Ecstein Greene, P. (2004). The lived experience of psychiatric-mental health nurses who work with suicidal adolescents in in-patient psychiatric settings. *Dissertation*, Degree of Doctor of Philosophy, Texas Woman's University, College of Nursing: Denton, Texas. UMI #3157737 Ann Arbor: MI.

- Enhancing Interdisciplinary Collaboration in Primary Health Care. (2007). Interdisciplinary Primary Health Care: Finding the Answers -A Case Study Report. Retrieved May 19, 2008 from <http://www.eicp.ca/en/toolkit/EICP-Case-Studies-Report-Final-Aug-14.pdf>
- Everson, K. (2006). Drugged driving. *Canadian Medical Association Journal*, 174(1),22.
- Fawcett, J. (2005). *Contemporary nursing knowledge: Analysis and evaluation of nursing models and theories*. 2nd ed. Philadelphia: F. A. Davis.
- Fawcett, J., & Alligood, M. R. (2005). Scholarly dialogue: Influences on advancement of nursing knowledge. *Nursing Science Quarterly*, 18(3),227-232.
- Fawcett, J., & Garity, J. (2009). *Evaluating research for evidence-based nursing practice*. Philadelphia: F. A. Davis.
- Fielding, C., Rooke, D., Graham, I., & Keen, S. (2008). Reflections on a 'virtual' practice development unit: changing practice through identity development. *Journal of Clinical Nursing*, 1312-1318.
- Flaskerud, J., & Winslow, B. (1998). Conceptualizing vulnerable populations health-related research. *Nursing Research*, 47(2), 69-78.
- Floyd, F., Costigan, C., & Curran, P. (2007, October). The transition to adulthood for individuals with intellectual and developmental disabilities. Paper presented at the meeting of the Centre for Youth and Society Conference in Victoria, BC.
- Geanellos, R. (2002). Transformative change of self: The Unique focus of (adolescent) mental health nursing. *International Journal of Mental Health Nursing*,11, 174-185.
- Griel, L.C. & Loeb, S. (2009). Health issues faced by adolescents incarcerated in the juvenile justice system. *Journal of Forensic Nursing*, 5(3), 162-179.
- Hall, W. (2006). Directing the causal anatomy of the link between cannabis and other illicit drugs. *Addiction*, 101(4),470-476.
- Hammersley, R., & Leon, V. (2006). Patterns of cannabis use and positive and negative experiences of use amongst university students. *Addiction Research and Theory*, 14(2),189-205.
- Hill-Smith, A., Taverner, R., Greensmith, H., & Parsons, D. (2012). Staff relationships in multidisciplinary teams. *Mental Health Practice*, 15(8), 14-19.
- Imprint. (2006). Gallop Poll shows nurses most trusted profession in 2005. *Imprint* 53(3),12.
- Jessor, R., & Jessor, S. L. (1977). *Problem Behavior and Psychosocial Development: A Longitudinal Study of Youth*. New York: Academic.

- Johnson, J., Billingsley, M. C., & Costa, L. L. (2006). Xtreme nursing and the nursing shortage, *Nursing Outlook*, 54(5), 294-299.
- Jormfeldt, H., Svedberg, P. Fridlund, B., & Arvidsson, B. (2007). Perceptions of the concept of health among nurses working in mental health services: A phenomenographic study. *International Journal of Mental Health Nursing*, 16,50-56.
- Koekkoek, B., Van Meijel, B., Schene, A., & Hutschemaekers, G. (2009). Community psychiatric nursing in the Netherlands: A survey of a thriving but threatened profession. *Journal of Psychiatric and Mental Health Nursing*, 16,822-828.
- Kikuchi, J., & Simmons, H. (1998). Nursing: a science in jeopardy. In *Nursing Research: Science for Quality Care* (K. King, E. Prodrick, & B. Bauer, Eds.), Toronto: University of Toronto School of Nursing.
- Koon, A. D., Nambiar, D., & Rao, K. (2012). Embedding of research into decision-making processes. Background paper, *Alliance for Health Policy and System Research to Develop Health Systems Research Strategy*, World Health Organization. Retrieved June 5, 2012 from [www.who.int/en/](http://www.who.int/en/)
- Lankshear, A. J. (2003). Coping with conflict and confusing agendas in multidisciplinary community mental health teams. *Journal of Psychiatric and Mental Health Nursing*, 10(4),457-465.
- Lattuca, L. (2002). Learning interdisciplinarity: Sociocultural perspectives on academic work. *The Journal of Higher Education*, 73(6),711-739.
- Leadbeater, B., Smith, A., & Clark, N. (2008, November). Listening to Vulnerable youth Transitioning to Adulthood in British Columbia. Report prepared for the BC Child and Youth Health Research Network.
- Leatherdale, S.T., Ahmed, T., & Kaiseman, M. (2006). Marijuana use by tobacco smokers and nonsmokers: Who is smoking what? *Canadian Medical Association Journal*, 174(10),1399.
- Leininger, M., & McFarland, M. R. (2002). *Transcultural Nursing: Concepts, Theories, Research, and Practice*. (3<sup>rd</sup> ed.), Toronto:McGraw-Hill Medical Publishing Division.
- Lerner, R. M., & Galambos, N. L. (1998). Adolescent development: Challenges and opportunities for research, programs, and policies. *Annual Review of Psychology*, 49,413-446.
- Lopez, K. & Willis, D. (2004). Descriptive versus interpretive phenomenology: Their contributions to nursing knowledge. *Qualitative Health Research*, 14(5),726-735.

- Lykkeslet, E., & Gjengedal, E. (2007). Methodological problems associated with practice-close research. *Qualitative Health Research*, 17(5),699-704.
- Maggs, J. L., Almeida, D. M., & Galambos, N. L. (1995). Risky business: The paradoxical meaning of problem behavior for young adolescents. *Journal of Early Adolescence*, 15(3),344-362.
- Maggs-Rapport, F. (2001). Best research practice: in pursuit of methodological rigour. Methodological Issues in Nursing Research. *Journal of Advanced Nursing*, 35(3),373-383.
- Mantie, C. (2007). Finding the value in registered psychiatric nursing for the enhancement of northern Child Youth Mental Health Services multidisciplinary team. *Thesis*, MA in Leadership and Training, Royal Roads University.
- Maxwell, J. A. (2005). Qualitative Research Design: An Iterative Approach. (2<sup>nd</sup> ed.), *Applied Social Research Methods Series*, 41, Thousand Oaks: Sage.
- Mellet, S. (2010). Children and youth mental health services: Building capacity by educating nurses. *Project*. Library. University of Victoria School of Nursing.
- McCarter, S.A., Haber, M. G., & Kazemi D. (2010). Models to guide system reform for at-risk youth. *Child Youth Care Forum*, 39,465-479.
- McCay, E., Langley, J., Beanlands, H., Cooper, L., Mudachi, N., Harris, A., ...Miner, S. (2010). Mental health challenges and strengths of street-involved youth: The Need for a multi-determined approach. *Clinical Journal of Nursing Research*,42(3),30-49.
- McColgan, M. D., De Jong, A. (2009). Multidisciplinary teams, In E.R. Giardino, Giardino, A.P. & M.A. Lyn (eds.). A practical guide to the evaluation of child and physical abuse and neglect, Chapter 13 (pp. 403-424). Retrieved August 4, 2012 from <http://www.springerlink.com.ezproxy.library.uvic.ca/content/gj11252626717311/fulltext.pdf>
- McCreary Centre Society. (2001). *Time out: A profile of BC youth in custody*. Vancouver, BC: Author.
- McCreary Centre Society. (2002). *Violated boundaries: A health profile of adolescents who have been abused*. Vancouver, BC: Author.
- McCreary Centre Society. (2003). *Healthy youth development: The opportunity of early adolescence*. Vancouver, BC: Author.
- McCreary Centre Society (2004). *Against the odds: A profile of marginalized youth in BC*. Burnaby, BC: Author.

- McCreary Centre Society (2005). *Time out II: A profile of BC youth in custody*. Burnaby, BC: Author.
- McCreary Centre Society. (2006). *Promoting healthy bodies: Physical activity, weight, and tobacco use among BC youth*. Vancouver, BC: Author.
- McCreary Centre Society. (2007a). *Voices from the inside: Next steps with youth in custody*. Vancouver, BC: Author.
- McCreary Centre Society. (2007b). *Against the odds: A profile of marginalized and street-involved youth in BC*. Vancouver, BC: Author.
- McDougall, T. (2005). Child and adolescent mental health services in the UK: Nurse consultants. *Journal of Child and Adolescent Psychiatric Nursing, 18*(2),79-83.
- Mellett, S. (2010). *Children and Youth Mental Health Services: Building capacity by educating nurses*. Project, School of Nursing, University of Victoria.
- Munhall, P. (2007). Nursing research: A qualitative perspective. (4th ed.), Chapter 6, 145-210, Jones & Bartlett Pub.: Toronto.
- Murray, B.L., & Wright, K. (2006). Integration of a suicide risk assessment and intervention approach: The Perspective of youth. *Journal of Psychiatric and Mental Health Nursing, 13*,157-164.
- Nelson, K. M., Connor, M., & Alcorn, G. (2009). Innovative nursing leadership in youth health. *Nursing Praxis in New Zealand, 25*(1),27-37.
- Newman, M. (1990). Newman's theory of health [as expanding consciousness] as praxis. *Nursing Science Quarterly, 3*,37-41.
- Noe, A. (2007). The Critique of pure phenomenology. *Phenomenology and the Cognitive Sciences, 6*(1-2), 231-245.
- Pharris, M. D. (2002). Coming to know ourselves as community through a nursing partnership with adolescents convicted of murder. *Advanced Nursing Science, 24*(3),21-42.
- Polit, D. F., & Beck, C. T. (2004). *Nursing Research: Principles and Methods*. (7<sup>th</sup> ed.), New York: Lippincott Williams and Wilkins.
- Potter, E., Cashin, A., Andriotis, H., & Rosina, R. (2008). Examining the role of nursing in (youth) drug court programs. *Journal of Addictions Nursing, 19*,182-187.
- Prahst, I. (2007, October). Intercultural challenges: Youth experience within South Asian community in transitions. Paper presented at the meeting of the Centre for Youth and

Society Conference in Victoria, BC. Transitioning Into Adulthood: Theory, Research, Practice and Policy.

- Registered Psychiatric Nurses of Canada. (2010). Code of ethics and standards of practice of psychiatric nursing. Author, Retrieved May 7, 2012 from [http://www.crpnb.ca/wp-content/uploads/2011/02/2010\\_Code\\_Standards.pdf](http://www.crpnb.ca/wp-content/uploads/2011/02/2010_Code_Standards.pdf)
- Rew, L. (2003). A theory of taking care of oneself grounded in experiences of homeless youth. *Nursing Research*, 52(4), 234-241.
- Romanow, R. (2002). *Final Report: Building on the Values: The Future of Health in Canada*. Retrieved December 19, 2007 from [http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/HCC\\_Final\\_Report.pdf](http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/HCC_Final_Report.pdf)
- Sandelowski M. (2000). Whatever happened to qualitative description? *Research in Nursing and Health*, 23, 334-340.
- Sandelowski M., & Barroso J. (2002). Finding the findings in qualitative studies. *Journal of Nursing Scholarship*, 34, 213-219.
- Schwandt, T. A. (2000). Three epistemological stances for qualitative inquiry: Interpretivism, hermeneutics, and social constructionism. In N.K. Denzin and Y. S. Lincoln (Eds.), *Handbook of Qualitative Research*, 292-331. Thousand Oaks, CA: Sage Publications.
- Schwandt, T. A., Lincoln, Y. S., & Guba, G. (2007). But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. *New Directions for Evaluation*, 14, 15-25.
- Self, B., & Peters, H. (2005). Community street outreach with no streets. *Canadian Nurse*, 101(1), 21-24.
- Shamian, J., & Villeneuve, M. (2010). Two faces, one agenda: Research and policy. *Mapping the field: Nursing scholarship in health human resources, Festschrift in honour of Dr. Linda O'Brien-Pallas*. S. Nelson & D. Doran (Eds.), 92-104.
- Shelton, D. (2003). The clinical practice of juvenile forensic psychiatric nurses. *Journal of Psychosocial Nursing*, 41(9), 42-53.
- Simpson, A. (2005). Community psychiatric nurses and the care co-ordinator role: Squeezed to provide 'limited nursing'. *Journal of Advanced Nursing*, 52(6), 689-699.
- Simpson, A. (2007). The impact of team processes on psychiatric case management. *Journal of Advanced Nursing*, 60(4), 409-418.
- Sin, J., & Gamble, C. (2003). Managing side-effects to the optimum: Valuing a client's experience. *Journal of Psychiatric and Mental Health Nursing*, 10, 147-153.

- Stewart, A. (1998). The ethnographer's method. *Qualitative Research Methods Series, 46*, Thousand Oaks, CA: Sage.
- Taylor, B. (1998). Qualitative interpretive methodologies. In K. Roberts & B. Taylor (Eds.). *Nursing Research Processes: An Australian Perspective* (pp319-361). South Melbourne, Vic: Nelson.
- Terris, M. (2006). Young people smoking marijuana. *Urology, 67*,100-104.
- Thomas, D. R. (2001). Research strategies. In P. Davis & T. Ashton (Ed.), *Health and Public Policy in New Zealand, 4*,82-102). Toronto: Oxford University Press.
- Thorne, S. (2008). *Interpretive Description*. Walnut Creek Ca.: Left Coast Press.
- Thorne, S., Reimer Kirkham, S., & O'Flynn-Magee, K. (2004). The analytic challenge in interpretive description. *International Journal of Qualitative Methods, 3*(1), Article 1,1-7. Retrieved January 17, 2009 from [http://www.ualberta.ca/~iiqm/backissues/3\\_1/html/thorneetal.html](http://www.ualberta.ca/~iiqm/backissues/3_1/html/thorneetal.html)
- Thorne, S., Canam, C., Dahinten S., Hall, W., Henderson A., & Kirkham, S. R. (1998). Nursing's metaparadigm concepts: Disimpacting the debates. *Journal of Advanced Nursing, 27*, 1257-1268.
- Tognazzini, P., Davis, C., Kean, A.M., Osborne, M., Wong, K. (2009). Core competencies in psychiatric mental health nursing for undergraduate nursing education: Position paper. *Canadian Federation of Mental Health Nurses*, 1- 19.
- Varcoe, C., & Rodney, P. (2009). Constrained agency: the Social structure of nurses' work. In B.S.Bolaria & H.D.Dickinson, (chapter 7), *Health, illness, and healthcare in Canada*. Nelson Education Ltd.
- Wadsworth, E. J. K., Moss, S. C., Simpson, S. A., & Smith, A. P. (2006a). Cannabis use, cognitive performance and mood in a sample of workers. *Journal of Psychopharmacology, 20*(1),14-23.
- Wadsworth, E. J. K., Moss, S. C., Simpson, S. A., & Smith, A. P. (2006b). A community based investigation of the association between cannabis use, injuries, and accidents. *Journal of Psychopharmacology, 20*(1),5-13.
- Ward, M. F. (2011). Educational preparation for nurses working with the mentally ill: The Case of Cyprus. *Horatio: European Psychiatric Nurses, 1*-34.
- Williamson K. (2006). Research in constructivist frameworks using ethnographic techniques. "Research Methods". *Library Trends, 55*(1), 83-103.

- World Health Organization. (2000). Kessler R. Psychiatric epidemiology: Selected recent advances and future directions. *Bulletin of the WHO*, 2000, 78(4).
- World Health Organization. (2003). Caring for children and adolescents with mental disorders: Setting WHO directions, Retrieved April 12, 2008  
[http://www.who.int/mental\\_health/media/en/785.pdf](http://www.who.int/mental_health/media/en/785.pdf)
- World Health Organization. (2007a). Breaking the vicious cycle between mental ill-health and poverty. *Mental Health Core to Development Information Sheet, Sheet 1*, Geneva: World Health Organization. Retrieved April 12, 2008  
[http://www.who.int/mental\\_health/policy/development/en/index.html](http://www.who.int/mental_health/policy/development/en/index.html)
- World Health Organization. (2007b). Child and adolescent mental health. *Child and Adolescent Mental Health Initiatives of the Department of Mental Health and Substance Abuse*, Retrieved November 18, 2007 [http://www.who.int/mental\\_health/prevention/childado/en/](http://www.who.int/mental_health/prevention/childado/en/)
- World Health Organization. (2007c). Nursing matters: Developing nursing resources for mental health. *Mind Project: Mental Improvement for Nations Development*, Geneva: World Health Organization. Retrieved April 12, 2008  
[http://www.who.int/mental\\_health/policy/services/en/index.html](http://www.who.int/mental_health/policy/services/en/index.html)
- Yearwood, E., Crawford, S., Kelly, M., & Moreno, N. (2007). Immigrant youth a risk for disorders of mood: Recognizing complex dynamics. *Archives of Psychiatric Nursing*, 21(3), 162-171.

Appendix A: VIHA Recruitment Advertisement  
**'Towards Understanding Multidisciplinary Nursing with Vulnerable Youth'**

Hello,

The Joint UVIC/VIHA Research Committee has given research ethics approval for this project and related materials. Furthermore, the VIHA signatory for this research project is \_\_\_\_\_. Experienced multidisciplinary clinicians from a variety of disciplines who work as team members with vulnerable youth (i.e., youth who have mental health and substance use issues) are invited to participate in this qualitative research project between May 2 and July 31, 2011. If you are one of these clinicians and you are willing to volunteer for the role of a study participant for **'Towards Understanding Multidisciplinary Nursing with Vulnerable Youth'**, please read on. Are you interested in sharing your experiential knowledge with Principal Investigator Suzanne Slater by participating in a semi-structured audio-taped individual telephone interview for an hour (or less)? The researcher will explore your observations, experiences, perceptions, expectations, and insights about nursing's distinct contribution to the team's clinical practice (i.e., to the team and to the vulnerable youth, their families, and communities). First read the attached 'Description of Study' and then contact Suzanne Slater to volunteer to become a study participant and receive a consent form.

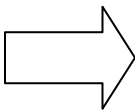
There is a possibility that not all volunteers will be interviewed. An estimate of eight to 15 study participants will be interviewed. If there is a robust recruitment, a planned prioritization criteria for selection will be implemented and I will aim to include a diverse mix of experienced team members among the study participants in order to collect diverse perspectives. Study participants' views will not represent their respective categories of clinicians or the collective voice of MMHTSVY. An examination of the first six interviewed study participants' collective disciplines and relevant demographic characteristics will possibly reveal an omission of clinicians from the remaining variety of disciplines and associated demographic characteristics in Multidisciplinary Mental Health Teams that Serve Vulnerable Youth (MMHTSVY). Prioritization for the selection of study participants will then be given to volunteers who have particular disciplines and associated demographic characteristics that will have been found absent in the study's widening sample of study participants, years of experience in MMHTSVY, the numerical order that volunteers will have contacted the principal investigator and the chronological date that the researcher received their signed consents. Worksites will be notified when the recruitment numbers will have satisfied the data collection objectives for this study. Please provide the following information when you contact Suzanne Slater to express your interest in learning more about becoming a study participant. Date sent \_\_\_\_\_

Name: \_\_\_\_\_ Professional Discipline: \_\_\_\_\_  
Phone # \_\_\_\_\_; e-mail  
Information \_\_\_\_\_

Send to Suzanne Slater by fax c/o her UVIC research supervisor Dr. Bernie Pauly \_\_\_\_\_.

Within three weeks of receiving your expression of interest to examine the role of a study participant, I will contact you at the telephone number and/or e-mail address that you will have provided to discuss the 'next steps' for your participation in the study. Thank you.

\*One attachment: Description of Study



Appendix A: MCFD Recruitment Advertisement

**‘Towards Understanding Multidisciplinary Nursing with Vulnerable Youth’**

Hello,

The Joint UVIC/VIHA Research Committee and MCFD Research Services have given research ethics approval for this project and related materials. Furthermore, the MCFD signatory for this research project is \_\_\_\_\_, Director of Research Evaluation and Accreditation at MCFD. Experienced multidisciplinary clinicians from a variety of disciplines who work as team members with vulnerable youth (i.e., youth who have mental health and substance use issues) are invited to participate in this qualitative research project between May 2 and July 31, 2011. If you are one of these clinicians and you are willing to volunteer for the role of a study participant for **‘Towards Understanding Multidisciplinary Nursing with Vulnerable Youth’**, please read on.

Are you interested in sharing your experiential knowledge with Principal Investigator Suzanne Slater by participating in a semi-structured audio-taped individual telephone interview for an hour (or less)? The researcher will explore your observations, experiences, perceptions, expectations, and insights about nursing’s distinct contribution to the team’s clinical practice (i.e., to the team and to the vulnerable youth, their families, and communities). First read the attached 'Description of Study' and then contact Suzanne Slater to volunteer to become a study participant and receive a consent form.

There is a possibility that not all volunteers will be interviewed. An estimate of eight to 15 study participants will be interviewed. If there is a robust recruitment, a planned prioritization criteria for selection will be implemented and I will aim to include a diverse mix of experienced team members among the study participants in order to collect diverse perspectives. Study participants' views will not represent their respective categories of clinicians or the collective voice of MMHTSVY. An examination of the first six interviewed study participants' collective disciplines and relevant demographic characteristics will possibly reveal an omission of clinicians from the remaining variety of disciplines and associated demographic characteristics in Multidisciplinary Mental Health Teams that Serve Vulnerable Youth (MMHTSVY).

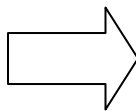
Prioritization for the selection of study participants will then be given to volunteers who have particular disciplines and associated demographic characteristics that will have been found absent in the study's widening sample of study participants, years of experience in MMHTSVY, the numerical order that volunteers will have contacted the principal investigator and the chronological date that the researcher received their signed consents. Worksites will be notified when the recruitment numbers will have satisfied the data collection objectives for this study. Please provide the following information when you contact Suzanne Slater to express your interest in learning more about becoming a study participant. Date sent \_\_\_\_\_

Name: \_\_\_\_\_ Professional Discipline: \_\_\_\_\_


Phone # \_\_\_\_\_; e-mail Information \_\_\_\_\_  
Send to Suzanne Slater by fax c/o her UVIC research supervisor Dr. Bernie Pauly \_\_\_\_\_

Within three weeks of receiving your expression of interest to examine the role of a study participant, I will contact you at the telephone number and/or e-mail address that you will have provided to discuss the ‘next steps’ for your participation in the study. Thank you.

\*One attachment: Description of Study



*Towards Understanding Multidisciplinary Nursing with Vulnerable Youth* (rvd 11-3-1)

<p>What is happening?</p> <p>Participation Entry Ends?</p>	<p>A UVIC graduate student (Suzanne Slater) is interested in hearing clinicians' perspectives of nursing's distinct contribution to their multidisciplinary teams that serve youth who have mental health and/or substance use issues.</p> <p><b>June 30, 2011</b> [or worksites will be notified when recruitment closes sooner]</p>
<p>Eligibility?</p>	<p>In order to participate you must be a clinician (or a newly retired clinician) on a multidisciplinary team whose position provides assessment and/or treatment of vulnerable youth. Multidisciplinary clinicians include psychiatrists, registered and unregistered psychologists, registered and unregistered social workers, mental health workers (who have undergraduate professional degrees in social work or academic credentials in various allied fields such as teaching, educational counselling, and child and youth care), registered psychiatric nurses, registered nurses, nurses who have dual registrations, nurses with various forms of advanced education and certifications, and clinicians who have administrative/hierarchical authority though regularly provide clinical assessment and/or treatment of clients. However, clinicians who currently work at the Victoria office of Youth Forensic Psychiatric Services are ineligible because I will not interview my team members.</p>
<p>Numbers of Participants?</p>	<p>I will interview an estimate of eight to 15 participants. There is a possibility that not all volunteers will be interviewed if the number of volunteers exceeds a reasonable number for the study, and an examination of the interviewed group of study participants reveals an omission of particular discipline demographics. In that situation, a planned prioritization criteria for selection will be implemented.</p>
<p>Your role?</p>	<p>For this project you will be asked to participate for an hour in an audio-taped semi-structured telephone interview on your own time 1:1 with the principal investigator.</p> <div style="text-align: center;">  </div> <div style="border: 1px solid black; border-radius: 50%; padding: 10px; display: inline-block; margin-left: auto; margin-right: auto;"> <p>your observations, experiences, perceptions, expectations, &amp; insights about nursing's distinct contribution to the team's clinical practice</p> </div>
<p>Confidentiality?</p>	<p>The participation process will be confidential.</p>
<p>Compensation?</p>	<p>\$30 following a partial or complete interview will be sent to an address given by recipient, regardless if you withdraw from the study during/after interview</p>
<p>Significance?</p>	<p>Enhancing multidisciplinary team members' understanding, facilitation, and utilization of nursing's distinct contribution is an important aim. Moreover, this scientific inquiry can examine the value of focusing on one particular discipline (i.e., nursing) in order to explore the multidisciplinary effects and contexts that impact a discipline's distinct contribution to vulnerable youth and the team.</p>

For More Information: Please review Appendix A: 'Recruitment Advertisement' and Appendix B: 'Description of Study'

## Appendix B: Description of Study

Thank you for your interest in the qualitative research study called *Towards Understanding Multidisciplinary Nursing with Vulnerable Youth*. The principal investigator is Suzanne Slater, a graduate student in the Masters Degree program at the University of Victoria's School of Nursing. This research project is towards a Master of Nursing Degree in Advanced Practice Leadership. Suzanne Slater's research is supervised by Dr. Bernie Pauly and committee members Dr. Noreen Frisch and Dr. Marjorie MacDonald at the UVIC School of Nursing. The Vancouver Island Health Authority's (VIHA) signatory is \_\_\_\_\_ [file J2009-94] and the Ministry for Children and Families' (MCFD) signatory is \_\_\_\_\_ [file 146-45/RP2009]. Here is a description of the study.

### *Research Problem*

Nursing services that address the needs of vulnerable youth are delivered through multidisciplinary teams. As members in multidisciplinary mental health teams that serve vulnerable youth (MMHTSVY), nurses contribute to making a meaningful difference in the lives of vulnerable youth and their families and communities. However, an explicit understanding of nursing's distinct contribution (NDC) to MMHTSVY has received limited attention. The elements of a nurse's practice (e.g., knowledge, resources, approaches, skills, influences, and attributes) which address the broad health risks of vulnerable youth and strengthen the team have not been identified. Furthermore, the properties of MMHTSVY that promote nursing's capacity to enact NDC have not been identified.

### *Research Purpose*

The purpose of this scientific inquiry is to reveal a rich description of NDC to MMHTSVY that will examine the contexts that underlie nurses' capacity to actualize their distinct contribution. The proposed research will make explicit nursing's contribution to MMHTSVY in ways that are meaningful to the clinical practice (i.e. the teams and the health, healing, and well-being of vulnerable youth, their families, and communities).

### *Research Questions*

The key research question asks "what is NDC to MMHTSY and what are the contextual factors that affect nursing's contribution". The corollary is "what is missing when the nursing discipline –that is one of several disciplinary orientations- is absent from MMHTSVY". Altogether, there are three inter-related questions that underlie the key question. 1. What are the individual team members' expectations for NDC -and their experiences of NDC- in the care of vulnerable youth, the youths' families, and communities? 2. How do team members perceive that nurses strengthen the team, and contribute to the team's policy development? 3. What are the contextual factors in MMHTSVY that can sustain, promote, constrain, and erode NDC? The proposed study participants' six interview questions integrate the inquiry that is expressed in:

### *Research Objectives*

- Describe nurses' and their team members' expectations and experiences of the nurses' distinct facilitation of the health, healing, and well-being of vulnerable youth, their families, and communities.
- Explore and describe what nurses and their team members perceive are the ways that nurses strengthen their teams and influence policy development.
- Explore and describe the contexts that affect NDC to MMHTSVY.

### *Significance*

The proposed research can enhance multidisciplinary understanding to advance clinical practice with vulnerable youth. In particular, the study will contribute to demystifying the nature

of NDC to MMHTSVY to a greater degree than Baldwin's (2002) description of nursing activities and attributes. The study will probe the relationship between nursing, inter-professional and policy processes, and the health, healing, and well-being of vulnerable youth, their families, and communities (where nursing is enacted within a multidisciplinary team) to reveal the dynamics beneath nursing's contribution. A qualitative exploration of NDC to MMHTSVY can reveal how nurses facilitate vulnerable youths' challenges in accessing and accepting a wide range of health enhancements. Insights on contexts that can preserve or enhance nursing's effectiveness can lead to strategies that can optimize NDC within a team and benefit vulnerable youth, their families, and communities. The proposed research project will achieve a slice of understanding of NDC that can be articulated and shared within MMHTSVY to cultivate effective multidisciplinary collaboration which is a key principle (Enhancing Interdisciplinary Collaboration in Primary Health Care, 2007; Romanow, 2002) in the transformation of the delivery of health care services. Enhancing multidisciplinary team members' understanding, facilitation, and utilization of NDC is an important aim. Moreover, this scientific inquiry can examine the value of focusing on one particular discipline (i.e., nursing) in order to explore the multidisciplinary effects and contexts that impact a discipline's distinct contribution to vulnerable youth and the team.

#### *Research Design*

The research design that guides this study is a constructivist framework (Appleton and King 2002) for a qualitative, interpretive description (Thorne 2008). The data collection method will include the estimated eight to 15 study participants' individual one hour (or less) audio-taped semi-structured telephone interviews, representations or descriptions of participants' described nursing artifacts, participants' relevant aggregate demographics, and my administrative notes in reference to the interviews. The researcher's analysis of the information will form a thematic summary of the findings.

#### *Third Party Recruitment*

I will know some of the potential volunteers. Accordingly, to prevent social relationships from influencing individuals' decisions to participate, third party mechanisms are in place to ethically obtain study participants. Furthermore, I will not interview members of my multidisciplinary team. Third party recruitment of volunteers between May 2 and July 31, 2011 will continue until the data collection objectives will have been satisfied.

#### *References*

- Appleton J. V., & King L. (2002). Journeying from the philosophical contemplation of constructivism to the methodological pragmatics of health service research: Methodological issues in nursing research. *Journal of Advanced Nursing*, 40(6), 641-648.
- Baldwin L. (2002). The nursing role in out-patient child and adolescent mental health services, *Journal of Clinical Nursing*, 11,520-525.
- Enhancing Interdisciplinary Collaboration in Primary Health Care. (2007). Interdisciplinary Primary Health Care: Finding the Answers -A Case Study Report. Retrieved May 19, 2008 <http://www.eicp.ca/en/toolkit/EICP-Case-Studies-Report-Final-Aug-14.pdf>
- Romanow R. (2002). *Final Report: Building on the Values: The Future of Health in Canada*. Retrieved December 19, 2007 [http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/HCC\\_Final\\_Report.pdf](http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/HCC_Final_Report.pdf)
- Thorne S. (2008). *Interpretive Description*. Walnut Creek Ca.: Left Coast Press.
- You can reach the principal researcher, Suzanne Slater, by e-mail at \_\_\_\_\_with 'MMHTSVY'in the subject line to discuss any matter pertaining to the study, or you can contact her UVIC research supervisor Dr. Bernie Pauly

You are being invited to participate in a study entitled **Towards Understanding Multidisciplinary Nursing with Vulnerable Youth** that is being conducted by Suzanne Slater. Participation is voluntary and refusal to participate will involve no penalty or loss of benefits to which individuals are otherwise entitled without participating in this study.

Suzanne Slater is a GRADUATE STUDENT in the School of Nursing in the Faculty of Human and Social Development at the University of Victoria (UVIC) and you may contact her if you have further questions by e-mail \_\_\_\_\_ (using the title of the study or *MMHTSVY* for the subject heading), or phone \_\_\_\_\_. Refer to 'Description of Study' for the research purpose, objectives, methodology, and significance.

As a graduate student, I am required to conduct research as part of the requirements for a Master of Nursing degree. It is being conducted under the supervision of Dr. Bernie Pauly You may contact my supervisor at \_\_\_\_\_

This research is funded in part by a Myer Horowitz Award, Centre for Youth and Society, UVIC .

### ***Participants Selection***

You are being asked to participate in this study because you are an experienced clinician who is (or recently was) a member of Multidisciplinary Mental Health Teams that Serve Vulnerable Youth (MMHTSVY) in the Vancouver Island Health Authority (VIHA) or the Ministry of Children and Families Development (MCFD).

An estimate of eight to 15 study participants will be interviewed between March and June 2011. If the number of volunteers exceeds a reasonable number for the study, there is a possibility that not all volunteers will be interviewed. I will continuously interview study participants until the time frame for data collection is reached or until the data collection objectives for the study will have been achieved.

### ***What Is Involved***

Study participants will initially participate in individual five minute guided, telephone discussions with the researcher to prepare for their interviews. At that time study participants will be invited to ask questions and the researcher will review their consent, prompt reflection on the topic, and establish each study participant's selected telephone number for their interview time (during their own time before or after work, or on a day off) and date (between March and June 2011) for one telephone interview that will be up to one hour in length. Each study participant will plan a location for their telephone interview that will facilitate their participation (comfort, reduce the likelihood for interruptions, maintain confidential participation). Where operational requirements will not be affected by a study participant's use of a work phone for an hour, study participants can arrange their interviews at their worksites on their own time.

Interview questions will be mailed or e-mailed up to a week before a scheduled interview. Interviews will be recorded by audio-tape. Representations or descriptors of nursing artifacts (such as objects, nursing spaces, resources, or documents such as job descriptions or organizational charts) that are described in these interviews (i.e., that are meaningful to your description of nursing's distinct contribution to MMHTSVY) will be collected by consent.

### ***Inconvenience***

Participation in this study may cause some inconvenience to you. You will be interviewed on your own time. You may choose to spend additional time identifying nursing

artifacts and making representations of these (e.g., descriptions, copies, photographs, or hand drawn facsimiles).

### ***Risks***

There is a minimal risk of harm associated with participation in this project. As a study participant, you will face no greater risks than that encountered in your everyday work life. Nevertheless, some potential risks to you by participating in this research are emotional and social risks. To prevent or to deal with these risks the following steps will be taken. You can choose to review the set of interview questions before your interview. You can schedule an emotionally safe time and location for your interview in order to optimize your self-care and contribute your valuable views to the project. Should you become distressed during the interview, you can take a break, skip certain questions or return to questions later, stop and reschedule the interview, or withdraw from the study altogether, and may do so without prejudice.

Conversation can trigger unwanted emotions and memories. I will offer to provide affected study participants referral information for counseling assistance (e.g. VIHA and MCFD employee assistance programs) to manage or resolve upset feelings.

I will not be collecting identifiable information about third parties such as patients, clients, and co-workers who have not consented to participate in this research. When study participants share examples to explicate their point and answer an interview question, study participants are advised to use fictitious names and to modify identifying information. Moreover, study participants who may reflect on personal conflicts during the interview will be redirected to examine their interpersonal conflict for possible underlying tension arising from differences between disciplines and to discuss these. Personal conflicts are irrelevant to the study.

### ***Confidentiality***

Although study participants will not have anonymity (because I will interview them), study participants will have confidential participation. In reporting the research, I will mask the identification of the study participants and their particular worksites and artifacts through pseudonyms and modifications of unique information that would potentially identify participants. Moreover, the recruitment of clinicians from multiple MMHTSVY will confound the research audience's potential identification of participants.

Study participants' demographic characteristics will be generalized as categories and described as aggregate data in the thesis.

Study participants' statements can be extracted from the data and recorded in my thesis as quotes by a pseudonym to explicate an evident theme in the analyzed data. Study participants will potentially recognize themselves as the source for a quote.

### ***Data Security***

Access to the information that you will provide for this study is limited to the purpose of this study. My research supervisor, committee, and the principal investigator (i.e., Dr. Bernie Pauly, Dr. Noreen Frisch, Dr. Marjorie MacDonald, and Suzanne Slater) will have access to the data for this study. Faxed information will be securely managed at my research supervisor's office, until I pick it up. I will securely store faxes, forms, all written and electronic information and representations of artifacts in my locked filing cabinet at my home office and on a password protected secure electronic site on my software and home computer.

### ***Disposal of Data***

By September 31, 2011 the thesis will have been completed and consequently all data from this study will be disposed of (paper data shredded and electronic data erased) in order to

remove all sensitive and identifiable information (i.e., expressions of interest, consent forms, honorarium confirmations, field notes, audit journal, audio recordings, transcripts, manual individual and cross data analysis).

### ***Benefits***

There is no intended clinical benefit for individual study participants. However, by sharing your valuable observations, experiences, expectations, perceptions, and insights about nursing's distinct contribution to the team's clinical practice (the team and the adolescents, their families, and their communities) with the principal investigator, your participation in this research will contribute to the state of knowledge about nursing and nurses' contribution to mental health services for youth. Furthermore, the study will possibly reveal multidisciplinary effects and contexts that impact the clinical practice of one particular discipline (i.e., nursing).

### ***Compensation***

An honorarium of 30 dollars for participants in acknowledgement of their inconvenience and time for a full or partial interview will be mailed within three weeks of your interview. You will confirm the address where I can send the sum/cheque and a stamped, addressed envelope for your return of a completed honorarium receipt form. If you agree to participate in this study, the compensation to you must not be coercive. It is unethical to provide undue compensation or inducements to research participants, so decline if you would not participate if the compensation was not offered.

### ***Voluntary Participation***

If you do decide to participate, you may withdraw at any time before, during, or after the interview without any explanation. If you withdraw from the study during the interview or within a few days after the interview, your data will not be used in the study. Moreover, upon confirmation of your honorarium receipt, all identifying information will be removed and disposed of. However, if you delay your decision to withdraw from the study until I will have integrated data from an analyzed transcript of your interview into cross data analysis, your non-identifying data will remain in the study.

### ***Researcher's Relationship with Participants***

I will not be interviewing members of my team, and I do not have supervisory power over any clinicians in MMHTSVY. However, MMHTSVY is a small community and I have worked in MMHTSVY for more than 25 years. To prevent social relationships from influencing individuals' decisions to participate in research, third party mechanisms are in place to ethically obtain study participants. Recruiters within VIHA and MCFD are voluntarily providing parallel roles in the recruitment of study participants for this research project. Having third party recruiters means that I do not approach anyone directly and secondly, that individuals who wish to be interviewed are made aware that I am the researcher so that they have a choice to continue to become study participants.

### ***Dissemination of Results***

This research project will be shared in the following ways. The link for study participants and interested members of MMHTSVY to access the results of the study will be sent to the MMHTSVY recruitment contacts in VIHA and MCFD. An analysis of the findings will be included as part of a thesis that meets the criteria for a Master of Nursing degree that will be retained by the University of Victoria. A presentation or poster presentation (that will include representations of nursing artifacts that are gleaned from this study [See 'initial consent for visually recorded data' below]) will be offered to clinicians in MMHTSVY. An article will be submitted to a peer reviewed journal to promote the understanding of NDC to MMHTSVY. Due to receiving a Myer Horowitz Award from the Centre for Youth and Society towards the honoraria for this research project, information that will describe aspects of the research process, presentation or poster, and highlights of the thesis will appear in the Centre's newsletter and shared at the Centre's events.

**Additional Contacts**

In addition to being able to contact the researcher and research supervisor, you may verify the Joint UVIC/VIHA Research Ethics Sub-Committee's ethical approval of this study (VIHA File #\_\_\_), or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria at 250-472-4545 or ethics@uvic.ca and the VIHA Research Ethics office at 250-370-8620. The VIHA signatory for this research project is \_ The Ministry for Children and Families Development (MCFD) (File # \_\_\_) signatory is \_\_.

**Participant Consent**

Your signature indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researcher.

---

<i>Name of Participant</i>	<i>Signature</i>	<i>Date</i>
----------------------------	------------------	-------------

**Initial Consent for Visually Recorded Data that you may give to the principal investigator**

Consent for Visual Data	Date _____	Initial _____
-------------------------	------------	---------------

...because you may identify nursing artifacts such as objects, photographs of nursing spaces and nursing tools, references for identified resources, documents (printed job descriptions or organizational charts) that you perceive are meaningful to your description of NDC to MMHTSVY. By your consent and assistance, I will collect representations or descriptors of relevant nursing artifacts which you describe.

**Thank you. Keep a copy of this consent form. Send page 3 and 4 of the signed consent form & demographics (below) to Suzanne Slater, Confidential, Towards Understanding Multidisciplinary Nursing by Fax to: c/o Dr. Bernie Pauly or Mail to:** in the stamped envelope. Following the signing and return of your consent to participate in *Towards Understanding Multidisciplinary Nursing with Vulnerable Youth*, you will be contacted within three weeks and informed of the next steps for your participation.

**Demographics**

Circle affiliation VIHA or MCFD; Worksite:

\_\_\_\_\_ City: \_\_\_\_\_

Professional Discipline(s) and Types of Professional Licences:

\_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

Relevant Academic Credentials (Diplomas, Certifications, and Degrees):

Years of Experience in MMHTSVY: \_\_\_ ; Retired \_\_\_; Managerial/hierarchal status if applies\_\_\_;  
 # of Nurses in your MMHTSVY \_\_, Ratio Nurses:Non-Nurses \_\_\_\_:\_\_\_\_; Preferred Phone  
 # \_\_\_\_\_ Preferred E-mail or  
 mail: \_\_\_\_\_

## Appendix D: Information for Recruitment Contacts

Foremost, I appreciate your individual acceptance of my request to facilitate the recruitment of volunteers for the research study 'Towards Understanding Multidisciplinary Nursing with Vulnerable Youth'. Recruiters in VIHA and MCFD will provide independent, parallel roles in the recruitment of study participants. Third party recruitment for eligible clinicians who work for the Vancouver Island Health Authority (VIHA) will be graciously provided by

---

The qualitative research project will involve volunteers who are clinicians at work sites where there are Multidisciplinary Mental Health Teams that Serve Vulnerable Youth (MMHTSVY). An estimate of eight to 15 study participants from among the volunteers will participate in individual interviews. Study participants are invited to answer six semi-structured interview questions that will describe their observations, experiences, perceptions, expectations, and insights about nursing's distinct contribution to the team's clinical practice (i.e., to the team and to the vulnerable youth, their families, and communities). A qualitative analysis of the study participants' views will form a slice of MMHTSVY perspectives towards our understanding of NDC in MMHTSVY. Study participants' views are not intended to represent their respective categories of clinicians or the collective voice of MMHTSVY.

The purpose for the 'Information for Recruitment Contacts' is five-fold. I explain third party recruitment. Then the characteristics of prospective study participants are described. Next, I provide the context for drawing study participants from across British Columbia (BC). The fourth aim is to explain the rationale for a greater recruitment of volunteers than 12 study participants. Finally the recruitment steps are described.

### ***Third Party Recruitment***

Third party mechanisms eliminate the potential for power-over relationships. In particular, third party recruitment is essential to the research design for my study because I may know some of the study participants whom I will interview. MMHTSVY is a small, connected community, and I am a member. Consequently, third party recruitment mechanisms provide an ethical recruitment approach. Having third party recruiters will mean that I do not approach anyone directly and secondly, that individuals who wish to be interviewed will be made aware that I am the researcher so that they have a choice to continue to become study participants. However, members from my team are ineligible study participants, and I will not be interviewing them. Otherwise, the recruitment of potential volunteers is unencumbered. I do not have supervisory power over clinicians in MMHTSVY.

### ***Characteristics of Volunteers***

Eligible volunteers will be experienced, multidisciplinary professionals in MMHTSVY. Access to experienced clinicians from a variety of disciplines and demographics in MMHTSVY will enhance the collection of data that will inform the research questions. Clinicians in MMHTSVY include nurses, psychiatrists, registered and unregistered psychologists, registered and unregistered social workers, and mental health workers (i.e., in this health sector persons are frequently classified as mental health workers or social workers when they have academic credentials in social work, teaching, counselling, and child and youth care). Retired clinicians, who have retired within the past year, and managers who have a clinical role (i.e., direct assessment and treatment) in MMHTSVY are also among the eligible clinicians. The nurses in MMHTSVY are registered psychiatric nurses, registered nurses, nurses who have dual registrations, and nurses with various forms of advanced education and certifications. Among the nurse clinicians with masters degrees in MMHTSVY, there are clinical nurse specialists and nurse

practitioners, but the latter are rare in MMHTSVY in British Columbia (BC) at the present time. Consequently, I will not be interviewing nurse practitioners. The recruitment of a diverse mix of clinicians is optimal for this study because diversity among the participants (i.e., professional disciplines, academic credentials, and worksite locations from among the demographic characteristics of volunteers within the total interview sample) will more likely effect the broadest perspectives. A collection of a variety of perspectives from prospective study participants is consistent with the constructivist interpretive description framework that guides the research design (Appleton & King, 2002; Thorne, 2008).

### ***Across BC***

A wide scope of recruitment across BC -by recruitment contacts in both VIHA and MCFD- is necessary because MMHTSVY is a small community. Drawing study participants from a wide distribution of MMHTSVY will preserve the confidentiality of participation. Participants would otherwise likely be identified if recruitment were limited to a singular geographical location or a singular organization. Furthermore, geographical and worksite differences among the study participants are expected to yield diverse perspectives.

Some of the MMHTSVY worksites within VIHA include Ledger House, Queen Alexandra Centre for Children's Health, Integrated Mobile Crisis Response Team, Mental Health and Addictions Services for Youth, and Adanac House. There are prospective volunteers in MMHTSVY that are located at these worksites and other VIHA worksites. MMHTSVY worksites within MCFD include Child and Youth Mental Health Services, Youth Forensic Psychiatric Services, and the Maples Adolescent Treatment Centre.

### ***Rationale for Numbers***

Eight to 15 study participants will satisfy the minimum requirements to provide a slice of understanding of multidisciplinary nursing in programs in BC that assess and/or treat vulnerable youth (i.e., youth who have characteristics or conditions for vulnerability). The estimate is for eight to 15 study participants from a combination of eligible VIHA and MCFD clinicians. If more than 15 eligible volunteers express their interest in participating in the study within the advertised data collection interval, I will interview a reasonable number of study participants for the research design. The continuation of recruitment and data collection will be guided by two factors. 1) The concurrent analysis on the data that will have been collected from additional study participants will consistently reveal new perspectives. 2) The extra work will not jeopardize the thesis completion limitations.

There are two reasons that a potential recruitment of more than 12 volunteers is desirable. A large number of volunteers will permit a purposive selection of a group of 12 to 15 study participants that will reflect the various kinds of clinicians within MMHTSVY and would likely yield diverse perspectives. (The prioritizing criteria are described in Step 6 under the heading 'Recruitment Steps'.) Moreover, volunteers will not necessarily become study participants (i.e., sign the consent form, participate in an interview, and confirm the inclusion of their data in the study). All in all, the recruitment of a larger number of volunteers than the proposed number of study participants would be optimal.

I am advised by my research supervisor that a shortfall of volunteers is more common than a surplus. If few volunteers express their interest in participating in the study, then none of the volunteers who consent to become study participants will be eliminated.

### ***Recruitment Tools***

Although I have provided recruitment advertisements and a poster (Appendix A) and the Description of the Study (Appendix B) to facilitate recruitment, the details for utilizing these tools

are deferred to the recruiters. Two suggested recruitment methods are 1) circulate the recruitment advertisement and poster to prospective volunteers through an organization's internal newsletter, or 2) send the recruitment advertisement and poster by e-mail to an existing address list of eligible clinicians or to applicable worksite managers to forward to their clinicians. Moreover, I am committed to contribute to the research contacts' respective recruitment plans in a manner that will preserve third party recruitment.

***Recruitment Steps***

Study participants will be recruited through a series of steps:

- 1) When the ethics applications to the Joint UVIC-VIHA Ethics Committee and the MCFD Research Department are approved, recruitment will proceed. I will immediately contact the recruiters from VIHA, and MCFD to launch third party recruitment mechanisms. The anticipated start for recruitment is March.
- 2) Clinicians who accept the expectations for study participants that are outlined in the advertisements and the description of the study will contact the principal investigator Suzanne Slater (\_\_\_\_@uvic.ca with 'MMHTSVY' in the subject line) to express their interest and to share their professional discipline, and their preferred phone number, and e-mail address for discreet contact from the researcher. The date that their expression of interest is received will be recorded. Prospective study participants can respond to the recruitment invitation until June 30, 2011 and interviews can be conducted until July 31, 2011).
- 3) All individuals who respond to recruitment (and notify the researcher of their interest in participating in the study) will be contacted within three weeks at the phone number, address, or e-mail address that they provide. Prospective participants will be asked to identify their demographic factors if they have not already done so, and their research status will be given (i.e., volunteers will be informed that their next step is the consent process, or alternatively, volunteers will be informed by the researcher that recruitment is robust and a selection process [criteria provided] will precede a volunteer's invitation to participate in the next step that is the consent process, or the volunteers will be informed that a reasonable number of volunteers have been interviewed and recruitment has closed).
- 4) The researcher will send each volunteer two copies of the consent form (Appendix C) to examine and sign -one with a stamped addressed envelope to mail to the researcher, and one for the study participant to keep-. Within the consent form there is a section for study participants to consent and initial their understanding of sharing copies or descriptors of relevant nursing artifacts with the researcher.
- 5) As the consents are returned to the researcher, the researcher will record the date that a form is returned, and contact each individual. Study participants will be informed that they will receive a copy of the interview questions (Appendix F) within seven days prior to a scheduled audio-taped telephone interview. The interview time and location will be arranged with each study participant on their own time. Study participants can choose to have their individual telephone interviews at their worksites on their own time (i.e., before work, after work, or on an unscheduled work day) if the operational requirements at their worksites will not be affected by their use of a private workspace and a phone line for up to an hour. Furthermore, study participants are encouraged to select a date, time, and location that will facilitate their optimal participation.
- 6) The first six eligible volunteers who return their signed consent form (Appendix C) will be interviewed without purposive selection. After I will have interviewed the first six study participants I will purposively select study participants. I will aim to have at least one study participant from each discipline in MMHTSVY. Within the study participants who are nurses, I

will aim to have a variation among the nurses' academic credentials and diplomas. Furthermore, I will preferentially select participants from various programs and geographical areas. These are the prioritizing criteria: experience in MMHTSVY; chronological order of the researcher's receipt of volunteers' expression of interest; and in relation to the earliest notifications of interest I will select a sample of study participants who will reflect the variety of professional disciplines in MMHTSVY, demographic mix and a variety of worksite and geographical locations that will more likely produce diverse perspectives among the increasing sample of study participants. However, I will not implement a purposive selection process if there are fewer than 15 volunteers.

7) Prior to commencing data collection, I will again inform the study participants that they can exercise their right to refuse to answer any questions, stop the interview at any time, and withdraw themselves and their data from the study (unless their request to withdraw their data is delayed until their analyzed data is integrated with the aggregate data).

8) I will concurrently analyze data from study participants' interviews while I engage incoming volunteers in their consent process and arrange their appointments for audio-taped telephone interviews. If diverse perspectives will have been steadily and successively collected from study participants, I will continue to interview a reasonable number of study participants in excess of 12 interviews during the data collection time frame for the study. Where the number of volunteers exceeds a reasonable number for the study, I will inform the volunteers that recruitment has closed and thank them for their interest in the study.

9) Recruitment will potentially continue until June 30, 2011, or recruitment will close sooner when an estimate of 12-15 interviews will have been achieved. When recruitment closes, the research contacts will be notified immediately.

10) Where study participants withdraw themselves from the study before the interviews begin, no honoraria will be provided. For their partial or complete interview, honoraria, stamped, addressed envelopes, and honorarium receipt forms (Appendix G) will be mailed to study participants at the address provided to the principal investigator within three weeks of an interview. Honoraria will not be denied to interviewees who choose to withdraw their data from the study. Study participants will mail their signed honorarium receipt forms in the stamped, addressed envelope to the researcher who will be reimbursed (upon validation by her Research Supervisor's witness of the honorarium receipt forms) for up to \$400 of honoraria from the Myer Horowitz Award, Centre for Youth and Society.

11) After the recruiters are informed that the data collection is complete, a notification of completion of data collection with human subjects will be provided to the Joint Committee and the VIHA and MCFD signatories. Attached are the relevant appendixes from the revised Joint UVIC-Ethics Application:

Appendix A: Recruitment Advertisements (VIHA rvsd 2011-2-8; MCFD rvsd 2011-3-1; poster rvsd 2011-3-1)

Appendix B: Description of Study (rvsd 2011-3-1)

Appendix C: Consent Form (rvsd 2011-3-1)

Appendix F: Interview Questions (rvsd 2011-2-8)

## Appendix E: Budget for Researcher (revised 2011-2-8)

*Recruitment Expenses: N/A	
*Travel Expenses to interview study participants: N/A	
*Long Distance Telephone Expenses: N/A	
*Honoraria Estimate for 8 to 15 study participants' inconvenience will be funded through the Myer Horowitz Award, Centre for Youth and Society (Research Centre) at the University of Victoria, but I will pay for honoraria beyond 13 study participants who return their signed honorarium receipts	\$0 - \$60.00
*Miscellaneous expenses that include stationary, audit journal, computer ink, and postage (for participants' consents, interview questions, artifacts, honoraria, and honorarium receipts)	\$25- \$40.00
*Poster Development Printing Costs	0- \$300.00

The Estimate for the Researcher's expense is between 0 and \$400

***Note there are no financial costs to VIHA or to MCFD***

## Appendix F: Interview Questions

**Part One: Research Preparations**

Name \_\_\_\_\_ Pseudonym \_\_\_\_\_

Thank you for volunteering as a study participant in the research project called *Towards Understanding Multidisciplinary Nursing with Vulnerable Youth*. You have read the description of the study and completed the consent form of which you kept a copy. Interview questions will be asked during a one hour (or less) audio-taped telephone interview on \_\_\_\_\_ (Interview Date) at \_\_\_\_\_ (time) at \_\_\_\_\_ (your preferred phone number that the researcher [Suzanne Slater] will call you for your interview). I encourage you to review your rights in the consent form. **Please confirm the one hour telephone interview arrangements with Suzanne Slater (per contact information below).**

Each profession is valued on the team. In this project, the phenomenon of interest is how nurses - as members of multidisciplinary mental health teams- make a meaningful and distinct difference to the team's dimension of service to vulnerable youth (i.e., youth who have mental health and substance use issues). There is a gap in the scholarly literature that depicts a rich description of nursing's distinct contribution (NDC) to multidisciplinary mental health teams that serve vulnerable youth (MMHTSVY). This research project can help to fill that gap because clinicians in MMHTSVY remain an untapped source for the knowledge of NDC to MMHTSVY. The key question in this study asks "*How does nursing make a meaningful and distinct difference to the clinical practice (i.e., to their teams and to the health, healing, and well-being of vulnerable youth, their families, and communities)? Furthermore, what affects the nurses' capacity to actualize their distinct contribution?*" Reflect on your observations, experiences, expectations, perceptions, and insights of NDC to MMHTSVY. You are welcome to read the interview questions (below) in advance of your one hour (or less) telephone interview with Suzanne Slater.

**Part Two: Interview Questions** (These are semi-structured questions. You can answer the questions in a different order, skip questions, come back to questions, end the interview, or withdraw from the study without explanation. Your telephone interview will be audio-taped).

1. What do nurses contribute to the team?
  - Sub-questions:
    - a) How do nurses make a difference to the clinical practice?
    - b) What aspects of a multidisciplinary practice in MMHTSVY are missing when nursing is not included?
    - c) What do nurses pay attention to that is different from the other professionals?
    - d) Would outcomes be different if you didn't have a nurse on your team?
    - e) Share an example in which a nurse has been particularly sought by a team member to contribute certain properties of nursing (e.g., kinds of knowledge, skills, approaches, attributes).
2. How are the nursing contributions that you identified in Q#1 sustained by your team?
3. Are there other contribution(s) that nurses might make that would promote the health of vulnerable youth, their families, and communities? Describe the barriers or facilitators that would possibly constrain or support this/ these other nursing contribution(s).
4. Do nurses contribute to policy work? Describe how nursing influences the policy development for MMHTSVY (i.e., the nurses' work and the work of the clinical practice teams in MMHTSVY).

5. Are there tools, resources, artifacts, documents, or other elements that you perceive are relevant to understanding NDC to MMHTSVY? If yes, what are they?
6. Your discipline and relevant demographic characteristics may affect your perspective and experience of NDC to MMHTSVY. In what way would you say that you have a unique angle on the topic?

Your \$30 honorarium and honorarium receipt form will be mailed to you within three weeks for a partial or complete interview. Please confirm the address where I can mail this to you.

You can reach the principal researcher (Suzanne Slater) at phone \_\_\_ by e-mail \_\_\_\_\_ (with *MMHTSVY* in the subject line) or by mail \_\_\_\_\_ if you want to discuss any matter pertaining to the study, or you can contact her UVIC research supervisor (Bernie Pauly) at \_\_\_\_\_

## Appendix G: Honorarium Receipt Form (rvsd 2011-2-8)

My signature below indicates that I have received \$30.00 for participation in the research project called *Towards Understanding Multidisciplinary Nursing with Vulnerable Youth*

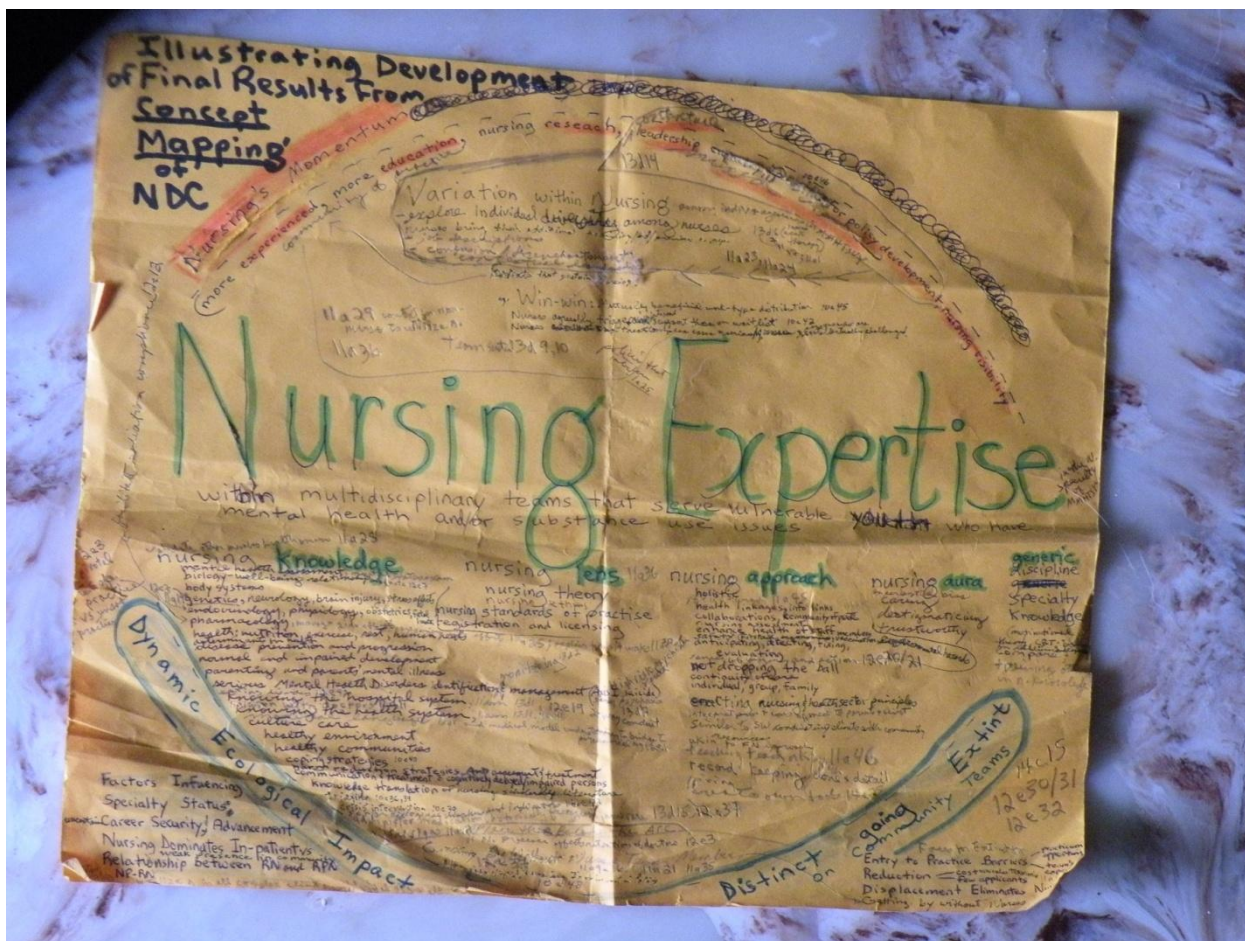
Name (Please Print)	Date of Interview	Date Honorarium Received	Signature

Honoraria for Study Participants who have participated in partial or complete telephone interviews with Suzanne Slater for the research project called *Towards Understanding Multidisciplinary Nursing with Vulnerable Youth* have been financially supported by a Myer Horowitz Award, Centre for Youth and Society. The researcher will be reimbursed by the Centre for Youth and Society upon her research supervisor's validation of study participants' receipts for their \$30 honoraria.

Please return this completed form to Suzanne Slater in the stamped, addressed envelope provided. Thank you.

Appendix H: Illustration of Concept Mapping

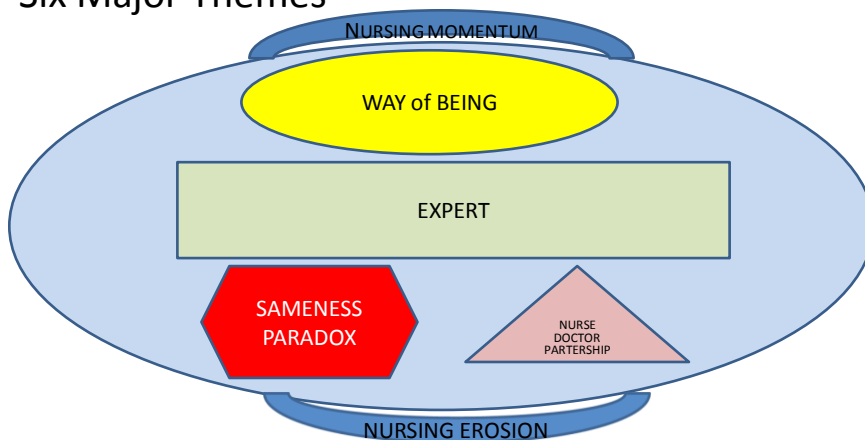
As can be seen, concept mapping is a messy process that aids inductive reasoning. Concept mapping visually facilitates a cohesive examination of the relationships among all of the topics.



## Appendix I: Illustration of Findings

# Nursing's Distinct Contribution to Multidisciplinary MH Teams That Serve Vulnerable Youth

## Six Major Themes



## Major Themes & Sub-themes

- Sameness Paradox
- Appears the same
- Valuing
- Overlap
- Way of Being
- Holistic
- Get-to-it-ness
- Helping others
- Nursing aura
- Nurse Doctor Partnership
- Autonomy
- Efficiency
- Doctor retention
- Expert
- Bio-screener handler
- Medication intervention
- Health and development educator
- Health system connectivity
- Critical or complex mental health expert
- Nursing Erosion
- Not going to get one
- Aren't in the driver's seat
- Confusing nursing credentials
- Constraints on access to training
- Nursing Momentum
- Making nursing visible
- Self-regulation
- Policy engagement and leadership
- Expansion of contribution
- Nursing specialty