

**The Work of Child and Adolescent
Mental Health Nurses:
A conceptual framework**

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Declaration

I declare that the following research is original. All citations and references have been acknowledged. It has not been submitted previously for a degree at any University.

Signed:

Philippa Rasmussen

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List of Related Publications and Presentations

Related publications

Rasmussen, P.E., Henderson, A., & Muir-Cochrane, E.C, 2012. An analysis of the work of Child and Adolescent Mental Health nurses in an inpatient unit in Australia. *Journal of Psychiatric and Mental Health Nursing*, 19(4), 374-377.

Rasmussen, P., Muir-Cochrane, E., & Henderson, A. (2012). Document analysis using an aggregative and iterative process. *International Journal of Evidence-Based Healthcare*, 10: 142-145.

Related presentations at conferences

Rasmussen, P., Muir-Cochrane, E., & Henderson, A. (2011). An analysis of the work of Child and Adolescent Mental Health Nurses on an inpatient unit. Paper presented at the 37th International Conference of the Australian College of Mental Health Nurses, Gold Coast, Queensland, 4-7 October.

Rasmussen, P., Muir-Cochrane, E., & Henderson, A. (2012). A holistic conceptual framework for the work of child and adolescent mental health nurses on an inpatient unit in Australia. Paper presented at Horatio: European Festival of Psychiatric Nursing, Stockholm, Sweden, 20-23 September 2012.

Summary

Background

Recent changes to national nursing legislation in Australia have resulted in the removal of a separate register with regulatory authorities for the specialty of mental health nursing. Aspects of mental health nursing are not easily defined with some characteristics of the work being tacit. Child and Adolescent Mental Health (CAMH) nursing is a specialty area of mental health nursing. Developing a deeper understanding of the contribution that CAMH nurses bring to an inpatient setting through their work was the focus of this research.

Aim

The purpose of the research was to:

- Identify the specific knowledge and skills that CAMH nurses use in an inpatient unit.
- Explore and interpret the role (e.g.. nursing practice, beliefs and attitudes) of mental health nurses working in a CAMH inpatient unit.
- Provide a comprehensive understanding of the role and function of mental health nurses in an acute child and adolescent mental health unit.
- Explore the relationships within the multidisciplinary team.

The expected outcomes were:

- the development of a comprehensive understanding of the role and function of mental health nursing within a child and adolescent mental health inpatient unit, and
- recommendations in relation to the significance of the unique knowledge and skills that the mental health nurse brings to a child and adolescent mental health inpatient unit.

Research Question

The research question was “What is the work of CAMH nurses in an inpatient unit?”

Methodology

The epistemological framework was social constructionism which is concerned with the making of meaning and the social processes involved. The methodology was interpretive enquiry, as it allowed for the interpretation of multiple realities. This resulted in a rich description of the work of CAMH nurses.

Methods

There were three stages of data collection each with a different method; document analysis, focus groups interviews and individual interviews. The participants included current and previously employed nurses from the inpatient unit as well as staff from other disciplines. The documents were analysed using iterative and thematic analysis. The focus group and individual interview data were analysed using an adaptation of the six phase thematic analysis process.

Findings

The findings of the research led to the development of a holistic conceptual framework that explained the work of the CAMH nurse in an inpatient unit. The holistic conceptual framework identified the knowledge and skills that CAMH nurses needed and considered how knowledge development assisted them in moving through the five developmental stages of becoming a specialist CAMH nurse. The findings were supported via elements of role theory and patterns of knowing. The conceptual framework was found by practitioners in this specialty to be reflective of their practice, useful for the education of colleagues and had potential for further research in other settings in which CAMH nurses worked.

Conclusions/implications

How CAMH nursing knowledge and skills are generated and sustained was identified. The five stages of understanding the role and developing an individual perspective of the nature of the work were also supported by the elements of role development and

the patterns of knowing. Implications for practice and further development of the role through education and research were identified. This research led to two publications in refereed journals (Rasmussen, Henderson & Muir-Cochrane 2012; Rasmussen, Muir-Cochrane & Henderson 2012).

Chapter 1: Setting the Scene

1.1 Introduction

To work in the specialty area of mental health nursing in Australia has until recently required a specific mental health nursing qualification. This has been central to ensuring a level of quality care for the client as well as protecting the integrity of the mental health nursing profession. The guarantee for the mental health client that their care would be undertaken by a nurse with a mental health qualification has somewhat diminished in the past two decades. Australia comprises States and Territories each having their own legislation and therefore regulatory frameworks. Each State and Territory nursing regulatory authority had individual legislation and therefore responsibility for the registration of specialty areas in nursing such as mental health nursing. In some nursing jurisdictions this meant that mental health nursing had its own register and therefore prerequisite education preparation to be admitted to that register. In other jurisdictions mental health nursing was not recognised as a separate specialty. Changes to legislation and the regulation of nursing in Australia in July 2010 meant that there was national registration rather than by each jurisdiction. The legislative change also meant that mental health nursing was no longer listed on a separate register by a regulatory authority in Australia. Whilst mental health nursing specialty was still recognised within the nursing profession, the regulatory changes meant that a mental health nursing qualification was no longer required for a registered nurse to be able to work in mental health nursing. In preparation for this legislative change, a review of mental health content in undergraduate curriculum was undertaken (Mental Health Workforce Advisory Committee 2008) and a framework for mental health curriculum was developed. The uptake of the framework was evaluated in 2010 (Mental Health Workforce Advisory Committee 2010) and highlighted the importance of mental health content in pre-registration curriculum.

There are competency standards for mental health nurses in Australia which have been endorsed by the Nursing and Midwifery Board of Australia. Mental health nurses with an appropriate qualification and experience can be credentialed by the Australian College of Mental Health Nurses by a peer reviewed process (Australian College of Mental Health Nurses Inc 2011). However it has never been mandatory

that mental health nurses be credentialed for them to work in this specialty area. In addition, under the *Health Practitioner National Law Act* (2010), registered nurses without a mental health qualification are able to work in mental health clinical practice.

A sub-specialty of mental health nursing is CAMH nursing. Whilst there is a definition of what encompasses mental health nursing as a broader concept, there is no clear definition of the work of the child and adolescent mental health (CAMH) nurse in Australia. A British study (Baldwin 2002; Limerick & Baldwin 2000) investigated the role of CAMH nurses in an outpatient unit, and concluded that nurses were unable to articulate their practice. Further McDougall (2006) highlighted the effect on the future of CAMH nursing if, as a specialty area of nursing, they were unable to identify their particular skill and contribution compared to non-CAMH nurses working in the area.

1.2 Prevalence of mental health issues

According to the World Health Organisation (WHO) (2002) one in four people will develop a mental health problem during their lifetime. In 2002 half of the 10 leading causes of disability in the world were represented by mental health (Altmann 2007). In 2011 nurses made up the highest proportion of health professions in mental health globally (WHO 2011).

The global prevalence of children and adolescents developing a mental health problem is 20% (Altmann 2007; McDougall 2006). Half of all enduring mental health problems begin by the age of 14 and a link is evident between early intervention in childhood and adolescence and the reduction of mental health problems in adulthood (Averill & Clements 2007; McDougall 2006; WHO 2003a). Research to identify the prevalence of mental health problems in children and adolescents in Australia (Sawyer et al. 2000) discovered that 14% of the participants surveyed had mental health problems. (Altmann 2007).

There is a clear link between early intervention of potentially enduring mental health problems in adolescence and the reduction of mental health problems in adulthood (Altmann 2007; McDougall 2006; WHO 2003a). The care of children and adolescents

with mental health problems occurs in both community and inpatient facilities. An inpatient unit is designed to provide acute inpatient care for children and adolescents with mental health problems that cannot be managed in the community. Clients may be admitted to a CAMH unit with issues ranging from behavioural issues, through to personality and mood disorders, and early psychosis episodes (Dogra & Leighton 2009b; Johnson 1995). The inpatient setting can present a challenge for CAMH nurses because it requires different knowledge and skills (Hogan, Rogers & Hemstock 2009) to undertake the role and work than those required in community settings. The skills include how to manage young people who are maturing and still developing while concurrently experiencing mental health problems (Leighton & Dogra 2009).

1.3 Professional practice

Professional practice in mental health nursing encompasses a broad range of knowledge, skills and attitudes (Crowe, Carlyle & Farmar 2008). Due to the mainstreaming of mental health nursing into more generic nursing practice (Happell 2009b) opportunities for mental health nursing practice such as the diversity of roles need to be more clearly identified. The need to identify the scope of practice for mental health nurses (Clinton & Hazelton 2000a, 2000b, 2000c, 2000d) was highlighted in a series of articles that mapped the future for mental health nursing in Australia. This thesis will address the lack of definition of the role of the child and adolescent mental health (CAMH) nurse in an inpatient unit. The researcher is a CAMH nurse but has never worked in an inpatient environment in this field. The researcher undertook the study because of an awareness of the imminent changes to nursing regulation and the lack of a clear definition of what constitutes the role/work of a CAMH nurse.

The work within the role was central to this research. Within our social and professional lives the individual has many roles that they enact. Each of these roles is governed by specific parameters over which the individual may or may not have some influence (Hardy & Conway 1988). Roles encompass all facets of our social and professional life and have an effect on how we play our roles. In this thesis, the term 'work practice' refers to how the CAMH nurses conduct their work and 'role' refers to the various components of their professional practices.

1.4 The research question

The research question presented in this study was “What is the work of CAMH nurses in an inpatient unit?”

The purpose of the study was to:

- To identify the specific knowledge and skills that CAMH nurses use when working in an inpatient unit.
- Explore and interpret the role (e.g. nursing practice, beliefs and attitudes) of mental health nurses working in a CAMH inpatient unit.
- Provide a comprehensive understanding of the role and function of mental health nurses in the acute CAMH unit.
- Explore the relationships within the multidisciplinary team on a CAMH inpatient unit.

The expected outcomes were:

- The development of a comprehensive understanding of the role and function of mental health nursing within a CAMH inpatient unit, and
- recommendations in relation to the significance of the unique knowledge and skills (the work) that the mental health nurse brings to the CAMH inpatient unit.

Given this the research was designed to illuminate many aspects of the role and work of the CAMH nurse in the inpatient unit, a particular interest was how they made meaning of, and interpreted, their roles. The researcher was interested in how the participants considered that they *became* a CAMH inpatient nurse, and how they navigated through the role. Establishment and maintenance of the therapeutic relationship with the young person and their family was also considered important and explored through the research.

1.5 The research framework

The research framework chosen for this study was based on Crotty's (1998) framework for social research that logically linked the areas of epistemology, the theoretical perspective, methodology and methods of the research. The epistemology of the research was social constructionism which is concerned with the making of meaning and the social processes involved. The epistemology was based on the work of Burr (2003).

The theoretical perspective in the research was symbolic interactionism which facilitates the recognition and explanation of society and human interaction. This approach was influenced by the work of Mead (1934) and Blumer (1969). The former identified that human interaction shapes how individuals are and that human behaviour has a social derivation. The latter extended Mead's work by adding the three tenets of symbolic interactionism; the meanings individuals take from interaction; the social interaction with others and; the individual's interpretation of those interactions.

The methodology was interpretive enquiry, which was the appropriate methodology for the study as it allowed for the interpretation of multiple realities to give a rich description of the work of CAMH nurses. The methods utilised were document analysis, focus groups and semi-structured interviews. The document analysis led to the formulation of the questions for the focus groups. The analysis of the focus group data resulted in the formulation of the individual interview questions. These methods allowed for a deep interpretation of the data as each phase informed the next and therefore extricated a deeper level of information.

1.6 Significance of the research

Mental health nursing is not easily defined, with elements of it being tacit (Dziopa & Ahern 2009b; Leishmann 2003, 2004), and not easily understood by non-specialist nurses and other health care professionals. Mental health nursing no longer exists as a separate register in Australia and this has implications not only for the mental health nurses but also for the outcomes for clients (Happell 2004). This means that non-specialist nurses are being employed to provide nursing care for mental health clients

(Happell 2004, 2006). This has led to a decrease in the availability of appropriate mental health services.

This study contributes to the nursing knowledge by providing a clear understanding of the role of the CAMH nurse in an inpatient unit. Further it provides insight into the epistemological facet of CAMH nursing by illuminating the development of nursing knowledge within this complex area. Also, the study presents the ontological facet of *becoming* a CAMH inpatient nurse by identifying and describing the stages of *becoming* a CAMH nurse in this area.

1.7 Organisation of the thesis

The thesis consists of eight chapters. This first chapter sets the scene for the research, identifies the research question and expected outcomes, theoretical framework and significance of the research. Chapter 2 contains the literature review and as such a justification of the gap in the literature to support the research question. The chapter covers the areas relevant to the question such as the prevalence of mental illness, mental health nursing, CAMH nursing, regulation of the profession and the multidisciplinary team. Chapter 3 offers the theoretical framework and discusses the epistemological and ontological underpinning for the study. Additionally the relevance of social constructionism and symbolic interactionism to mental health nursing is discussed. Chapter 4 justifies and details the three methods employed to undertake the research. The study setting is described and ethical considerations presented. Each method; document analysis; focus group interviews; and individual interviews is presented sequentially describing document identification, participant selection, data collection procedures and processes used for data analysis. Research rigour and reflexivity are also addressed.

Chapter 5 presents analysis of the data collected through each of the three research methods. Thematic analysis processes were used to generate emergent themes in each stage of the research. Documents identified in stage one of the methods were analysed using an iterative process by Attride-Stirling (2001) and an aggregative process by the Joanna Briggs Institute Thematic Analysis Program. The results of the document analysis assisted in developing questions for the focus groups in the next stage of the

research. Focus group and individual interview data sets were analysed using the six-stage thematic analysis process identified by Braun and Clarke (2006).

Chapter 6 is concerned with the conceptualisation of the findings from the research. The concepts of the ways of knowing and the stages of *becoming* a CAMH nurse are discussed. This chapter ends with the development of a conceptual holistic framework of the CAMH nurse's knowledge and learning. Chapter 7 provides the discussion of the findings in the context of relevant literature. First the stages of *becoming* a CAMH nurse in an inpatient unit are discussed within the context of role theory (Biddle 1986; Biddle & Thomas 1966; Hardy & Conway 1988) and the development of clinical nursing practice (Benner 1984). Second the knowledge development (Carper 1978; Chinn & Kramer 2004, 2008; Chinn & Kramer 2011) of the CAMH nurse is discussed. Implications for practice, education and research are also discussed. Chapter 8 provides a conclusion to the thesis and identifies recommendations for future practice, education and research. There are appendices that provide further information and these are referred to in the relevant chapters. The reference list contains all the citations from the thesis.

1.8 A note on language

Throughout this thesis the words *client* and *young people* (consumers of CAMH services) are interchanged. This reflects the language of the participants in the study. Both refer to the *young people* that the nurses are working with on the CAMH inpatient unit. The words *family* and *significant care giver* as they are used in this thesis can refer to a range of individuals. Due to the complexity of the *family* situations of some of the *young people* they can still be involved with their *family* and because they are under eighteen years of age and therefore legally minors the *family* is involved in their admission. A *significant care giver* can be a non-parental member of the family, a person over the age of eighteen or a worker from either a government or non-government organisation. Appendix 1 provides a glossary of terms that were used by participants as well as a list of acronyms used in the thesis.

Chapter 2: Literature Review

2.1 Introduction

This chapter presents a comprehensive account of literature pertinent to the research question in this thesis. The review of the literature covered the prevalence of mental health problems; mental health nursing; CAMH nursing; the multidisciplinary team; recognition of CAMH as a distinct area of healthcare; legislation and regulation; and the changing workforce landscape for mental health nursing.

At the commencement of this research in 2008 there were imminent changes to legislation in Australia that would impact on mental health nursing, as this group would no longer have a separate register with regulatory authorities. This came into effect in July 2010. Within mental health nursing, CAMH nursing is a sub specialty. The role of the CAMH nurse is not clearly defined, which creates the risk of it being homogenised into a generic nursing role. Furthermore the role of the mental health nurse in an acute inpatient environment is not clearly defined. This study sought to find a deeper understanding of the work within the role of CAMH nursing, with a focus on CAMH nursing in an acute inpatient setting.

2.2 Parameters of the literature search

A comprehensive and wide-ranging search of the literature was performed. Search terms used for scope of practice were; *mental health practice guidelines, research nursing, practice acts, advanced nursing practice, nursing practice evidence based, nursing practice research based and nursing practice theory based*. Search terms for CAMH nursing were; *child, paediatric, adolescent, youth, mental health, psychiatric and psychology*. Search terms for Competency CAMH were; *clinical competence, legal competence, clinical supervision, credentialing and professional competence*. Search terms for inpatient mental health nursing were *psychiatric training, psychiatric clinics, psychiatric units, psychiatric hospital, mental health programs, psychiatric nursing practice, mental health nursing practice, professional licensing and psychiatric hospital admission*. Search terms for legislation nursing role mental health were; *psychiatric nursing, mental health nursing, scope of practice, advanced nursing*

practice, regulation, legislation, professional practice, advanced nursing practice and professional competence. Search terms for scope of practice mental health nursing were; *psychiatric nursing, mental health nursing, clinical care nursing diagnosis, acute care nurse practitioners, nursing care co-ordination, scope of practice, advanced practice and practice guidelines.*

The following electronic databases were accessed; EBSCO Host including, EJS E-journals, MEDLINE with Full Text, Psychology and Behavioural Sciences collection, CINAHL Plus with full text, Health Business Full Text Elite and Scopus. Grey literature such as procedures, protocols, standards, reports, government and non-government documents and unpublished thesis were also accessed.

In addition, a search was made of all reference lists and bibliographies of retrieved articles and documents to identify further articles relevant to the study. The literature search uncovered relatively few articles relating to specific research studies on the work of CAMH nursing. Literature located encompassed discussion papers on the scope of Mental Health Nursing (MHN) practice, mental health issues and their treatment, reviews of mental health education and services, prevalence studies re mental health issues and their treatment, qualitative studies on the CAMH nurses' role and mental health issues as well as theoretical papers and texts on caring for children and adolescents with mental health issues.

To highlight the work of CAMH nursing the researcher followed a logical sequence in this literature review to provide a context to the practice of these nurses.

2.3 Prevalence of mental health issues

The terms mental illness and mental health disorder are used interchangeably throughout the literature and, will be evident in this chapter. Both terms refer to an absence of mental health. To consider the prevalence of mental health issues one needs to consider the following; what is mental health and what is the burden of mental health for the individual, their family and society.

The World Health Organisation (WHO) states that,

“Mental health is a state of well-being in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for individual well-being and the effective functioning of a community.”

(www.who.int/entity/mediacentre/factsheets/fs220/en/)

A mental health problem or disorder can prevent the individual from fulfilling their potential by impeding their ability to function cognitively and emotionally at an optimum level. The WHO (WHO 2002) Report on mental health states that 25% of people will develop a mental health problem during their lifetime, representing 450 million individuals. Mental health problems represent 50% of the 10 leading causes of disability in the world (WHO 2002). For example, one of the most common mental health disorders is depression, which is the leading cause of disability as measured by Years Lived with Disability (YLDs) and ranked fourth in contributing to the global burden of disease 2000. It is estimated that the ranking will be second by 2020. The organisation Disability Adjusted Life Years (DALYs), measure the amount of years an individual has been prevented from living life to their potential, ranks depression second (WHO 2010). These sobering reports are testament to the increasing prevalence and burden of mental illness on the individual and society.

Mental health disorders and vulnerability are interlinked worldwide, with individuals being marginalised and stigmatised by society (WHO 2010) and under-resourced in terms of treatment and intervention. Patton et al. (2012) undertook a synthesis of internationally comparable data on the health of adolescents which included CAMH. The research focussed on non-communicable diseases such as mental illness and the health information systems that support prevention and early intervention.

2.4 Prevalence of mental health issues in children and adolescents

When considering children and adolescents, the age groups represented can differ. Firstly, from a legal perspective, children would be considered as under the age of 18

years. Adolescence within some jurisdictions is considered as between 13 and 18 years of age (Sawyer et al. 2012). The comprehensive discussion paper by Sawyer et al. (2012) highlights some of the issues faced in adolescent mental health and makes recommendations for governments to focus on this distinct developmental phase. Internationally these age ranges vary, with some countries considering that as soon as a child works although they may be only be 6 years old, they are an adult (Patel et al.). However, W H O defines adolescence as commencing from 12 years and lasting until the age of 25 years (WHO 2003a, 2005, 2011)

In the worldwide context, the physical health and the environments inhabited by young people have improved overall, yet there has been a decline in mental health wealth (McGorry 2011). This inequity in the recognition of the impact and prevalence of mental health issues in young people is reflected in the literature (Yearwood 2010; Yearwood & DeLeon Siantz 2010). The prevalence of children and adolescents developing a mental health problem is 20%, with 4 to 6% of these having a significant mental health problem requiring clinical intervention (Arbuckle & Herrick 2006; Bayer et al. 2009; Dogra & Leighton 2009a; Kessler et al. 2005; McDougall 2006; Patton et al. 2012). Half of all enduring mental health problems begin by the age of 14 and a link is evident between early intervention in childhood and adolescence and the reduction of mental health problems in adulthood (Costello 2003; McDougall 2006; WHO 2003b, 2005). Young people are exposed to a variety of situations through their peer groups and social media where they need to “problem solve” issues (such as more complex interpersonal relationships) without protective factors such as family as they transition to support from close friends, peers and themselves to help them make informed decisions. Birleson and Vance (2008) suggest that young adults develop increased levels of autonomy and experimentation during this phase of their lives. Accompanying this is an increase in risk-taking activities during the adolescent phase of life (Tylee et al. 2007) which can have an effect on the young person’s mental health.

In global rankings, mental health problems feature prominently, with the years lost to disability (YLDs) figuring in the top three burdens of disease for young people 10-24 years of age (Gore et al. 2011), second to unintentional injuries and infectious diseases. In New Zealand for example, the burden of mental health illness in young

adults is similar, with a significant impact on life outcomes in relation to education, employment and health (Gibb, Fergusson & Horwood 2010).

In an Australian national survey to determine the prevalence of mental health problems in children and adolescents, Sawyer et al. (2000), found that 14% of the participants surveyed ($n = 4,500$) had mental health problems. In addition, they suggest that children and adolescents with such problems benefit from receiving help from specialist Child and Adolescent Mental Health Services (CAMHS). One of the main health issues that affect young people in Australia currently is mental health rather than physical health problems (McGorry 2011; McGorry & Goldstone 2011) along with substance abuse, accounting for 50% of the burden of disease within the age group (Australian Institute of Health and Welfare 2011). These data demonstrate that the prevalence of mental health issues in young people increasing, as is the complexity of the issues, with a strong link between mental health illnesses and substance abuse. McGorry & Goldstone (2011) and McGorry (2011) suggest that it can be difficult to separate what is considered normal adolescent behaviour from emerging symptomology of mental illness and that health professionals play a pivotal role in assessing the risk for the young person and the need for clinical support.

2.5 Mental health nursing

Although the terms psychiatric nursing and mental health nursing are used interchangeably throughout the literature and in practice, for this research the term mental health nursing was used as it reflected contemporary nomenclature.

Internationally there are differences in mental health nursing in terms of its recognition as a separate specialty in the nursing profession. Some developing countries have limited mental health nursing training, others have undergraduate training, while most of the developed countries have post graduate qualifications specifically in mental health nursing (WHO 2007). The therapeutic relationship is fundamental to mental health nursing (Hungerford et al. 2012) and is reflected in the literature. This has remained throughout as one of the tenets of mental health nursing during changes in practice and practice settings since the 1950's.

Harriet Bailey published the first mental health nursing text, *Nursing Mental Diseases* in 1920 (Church & Buckwalter 1980) and was considered a pioneer for mental health nursing as her text provided a comprehensive view of mental health care. Bailey was an advocate of experiential learning and emphasised the need to distinguish nursing as separate from medicine and a distinct field. Further, the framework for the development of psychiatric nursing as a distinct field was influenced by Hildegard Peplau's seminal work *Interpersonal Relations Theory* (Peplau 1952). This was followed by further work entitled *The Crux of Psychiatric Nursing*, Peplau (1962). Peplau was often referred to as "the mother of psychiatric nursing" as she was the first nursing theorist to specifically focus on mental health. Peplau's theory was influenced by the work of Eric Fromm and Harry Stack Sullivan whose discipline was psychology. Stack Sullivan's and Fromm's theories focussed on interpersonal psychology, which considered "Human processes/interactions occur through the interrelational network and not in isolation of people and environments." (Happell et al. 2008, p. 33). Peplau's model put the relationship between the nurse and the patient, as well as communication, at the centre of mental health nursing practice (O'Toole & Welt 1989). However mental health nursing does not exclusively follow one theory but rather has a pluralistic approach, adapting nursing theories as well as those from other disciplines such as sociology, psychiatry and psychology on which to base their practice.

More recently the work of Barker (2000), *The Tidal Model*, presented a recovery orientated model developed in collaboration with mental health nurses and clients. The model reflected the worldwide change in public health and mental health policy which was increasingly focussed on recovery.

2.6 Mental health nursing in Australia

Australia's first mental health facility, Castle Hill Asylum, was opened in New South Wales in 1811 (Happell et al. 2008.) but the first mental health nursing training program was not until 1877, with the first register appearing only in 1911 (Green 2012). Though the philosophy was one of human care, the earlier mental health facilities provided more of a custodial care model, due to the large numbers of patients (Happell et al. 2008). Before the 1950's, care was predominantly given by

male attendants. After that, with the advent of new pharmacological interventions, the use of physical restraint was reduced. Mental health nursing was first recognised as a separate field in South Australia (SA) by the Nurses Board of South Australia (NBSA) in 1963.

Mental health services changed in the 1970's and 1980's with a health reform initiative designed to move mental health inpatients from large institutions out into the community. Mental health nursing practice changed in the 1980's in response to deinstitutionalisation and the movement of some services to the community (Warelow & Edward 2007) which meant that there was no longer just a focus on the inpatient setting for mental health nursing. There has been widespread criticism of the decision to move mental health services to the community, claiming that the infrastructure and resources were not adequate (Happell et al. 2008). However, the philosophy underpinning the move was to increase the individual's freedom and autonomy as well as mainstreaming services to reduce stigma. More recently, Hamden et al. (2011) reviewed the impact of deinstitutionalisation of mental health services between 1996 and 2007. Their findings labelled clients with mental health problems as the "new chronic patients" who had multiple admissions to acute facilities. Not only did the practice settings change during these times, there was also a transformation in mental health nursing education. As this was a small, single unit study their findings should not be considered as applicable to a larger population.

During the 1980's and 1990's mental health nursing education changed in Australia with a move from traditional hospital based training which was either preregistration or post registration as a second certificate, to the higher education sector. In most states and territories, this also led to mental health nursing training becoming part of a comprehensive undergraduate degree in nursing rather than a distinct specialty. Consequently, this meant that nurses could no longer choose to exclusively train in the area of mental health as a three year hospital based program. Nurses were required to undertake general nursing training, either through a hospital based program or an undergraduate degree, as a prerequisite to a post graduate mental health nursing program.

In 2006-2007 a review of mental health in pre-registration nursing courses was undertaken by the Mental Health Nurse Education Taskforce (MHNET). This

comprehensive review included consumers and carers as well as health providers and recommended that mental health be a core component in all nursing undergraduate curriculum (Mental Health Nurse Education Taskforce 2008). McCann et al. (2009) critiqued the outcomes of the review and the impact it would have on curriculum development and clinical placements for the tertiary education sector. As a follow-up to the review in 2009 all Australian Schools of Nursing and Midwifery were surveyed to establish the uptake of the recommendations and the Framework for Mental Health in Pre-Registration Nursing (Mental Health Workforce Advisory Committee 2010). The results were variable with differences in the level of commitment to implementing the framework and consequently the level of exposure to mental health nursing of the students. In a discussion paper Moxham et al. (2011) presented a précis of the findings of the follow-up review and the recommendations to increase the uptake of mental health in all nursing and midwifery curriculum.

Specific mental health nursing courses in Australia are only available in post graduate studies such as graduate certificates, graduate diplomas and masters as course work (Happell 2009a). Combined undergraduate nursing degrees are available in Australia where students can exit with a mental health nursing qualification. Nurses can undertake mental health research at either a Masters or PhD level. Advanced mental health practice roles such as mental health nurse practitioner have become more prevalent (Wand et al. 2011a, 2011b) with the advent of change to the healthcare sector resulting in nurses working more independently and having the ability to prescribe medications. In a qualitative study Wand et al. (2011a, 2011b) examined the role of the mental health nurse practitioner (MHNP) in an emergency department. The findings of the study suggest that there is an acceptance amongst health care professionals as well as consumers of the MHNP role. However collegial and consumer understanding is vital to ensure the growth of these advanced practice roles as well as succession planning. Hampel et al. (2010) undertook a review of the literature and suggested that a clear model of succession planning was essential in managing current and future advanced practice mental health nursing workforce planning.

Mental health nursing is a broad area encompassing sub specialties one of those involving work with children and adolescents.

2.7 Child and adolescent mental health nursing

Mental health nursing is a solid and necessary underpinning for CAMH nursing as it affords a broader understanding of this specialty area. Mental health nurses have traditionally been educated in the adult mental health area either through hospital or university training. These mental health nursing programs tend to focus on adult mental health rather than CAMH. However, CAMH nurses additionally practice within the framework of human development and a legislative context pertaining to children and adolescents (Arbuckle & Herrick 2006; Dogra & Leighton 2009a; Geanellos 2002; McDougall 2006; Wille 2006). In the United States of America (USA), CAMH nursing has been a specialty since 1959 (Clunn 1991). The American Nurses Association developed standards of practice for nurses working in the specialty area in 1985 (American Nurses Association 1985). The standards were intended for any nurse, with or without a mental health qualification, who was working with children and adolescents. CAMH nursing was practiced in both acute and community settings (Johnson 1995; Pothier, Norbeck & Laliberte 1985) and the standards were broad enough for use in all settings. The standards were designed to be used in conjunction with other psychiatric and mental health nursing standards. A search of the literature did not result in the identification of specific standards for CAMH nursing in countries other than the United States.

In the United Kingdom (UK), the CAMHS workforce is a multidisciplinary team, 25% of whom are nurses that have been trained in either adult or CAMH (Dogra & Leighton 2009a; McDougall 2006). There is no single definition of the CAMH nurse role and the specific contribution that they make remains undefined (Dogra & Leighton 2009a) but implicitly accepted, according to McDougall (2006), who suggests that the role is more holistic within the context of individual and family systems. In the UK there are no specific standards for CAMH nurses. McDougall, (2006) advocated for “a set of capabilities” (p. 269) for CAMH nurses to compliment any existing broader standards for mental health nursing.

The description of CAMH nursing practice varies from the United States of America (USA) to the UK in the nursing literature. In the USA literature there is more emphasis on diagnosis and medication (Clunn 1991; Johnson 1995) whereas in the UK the emphasis is more on therapeutic interventions and the use of medications in

CAMH and is more controversial (Dogra & Leighton 2009b; McDougall 2006) as it is in Australia.

In Australia, there are CAMH services or child youth mental health services but the services differ across States and Territories. Some States and Territories have separate services for children with an age range up to 12 years, and then services for adolescents or young people generally from 13 years to 18 years, but with some services being provided to people up to 25 years (Groom, Henderson & Masters 2009). The delivery of services varies from acute inpatient settings to outpatient clinics and specific child and adolescent community services to outreach services with community health centres. While nurses working in the specialty of CAMH usually have a background in mental health nursing (Groom, Henderson & Masters 2009), even with the changes to comprehensive undergraduate programs, this is not a prerequisite in all States and Territories in Australia.

In South Australia, the CAMHS incorporates one inpatient unit in a metropolitan paediatric hospital along with CAMHS community services. Both are specialist mental health services catering for young people from the perinatal period to 18 years of age. CAMHS also provides services to rural and remote areas of South Australia, having permanent teams in regional centres. Nurses are an integral part of CAMHS working in acute inpatient, community and country teams. The CAMH nurses work within multidisciplinary teams which include health professionals who practice psychology, psychiatry, social work, occupational therapy and speech therapy. The nurses are either qualified mental health nurses or are undertaking a post graduate mental health nursing qualification. Whilst there are some post graduate mental health nursing programs available in Australia, nurses working in CAMHS may also enter multidisciplinary post graduate courses such as psychotherapy and family therapy to augment their practice. (Groom, Henderson & Masters 2009).

2.8 Child and adolescent mental health nursing and the multidisciplinary team

From a global perspective, Vostanis (2007) considered that the development of multidisciplinary teams in CAMH was a matter of urgency, especially in countries “...with unidisciplinary services, usually psychology and/or psychiatry.” (p. 114).

Further, Vostanis (2007) suggested the addition of nursing positions were possibly a good way to move forward and expand the service. In most of the developed countries the CAMH nursing role occurs within the multidisciplinary team. In their UK qualitative research, Limerick and Baldwin (2000) highlight difficulties the multidisciplinary team has in defining the role of the CAMH nurse. In a South Australian Department of Health report entitled, “Mental Health Nurses’ Reflections on Their Role”, one of the limitations acknowledged was that the viewpoints of non-nursing team members on the role of the mental health nurse were not canvassed (South Australian Department of Health 2006). This concludes that it is imperative to take the multidisciplinary perspective into account when reviewing the mental health nurse’s role within so clearly defined a culture as the CAMHS inpatient unit. As noted above there is no universally accepted definition of the role of a mental health nurse, nor of a CAMH nurse.

2.9 Child and adolescent mental health nursing in an inpatient unit

The practice of CAMH nursing occurs in both community and inpatient settings. It is preferable to provide CAMH nursing care for the young person in the community because it can be less stressful for the young person and their family (Scharer & Jones 2004) but depending on the severity of the mental health issue, inpatient care may be the best option. Inpatient units provide a therapeutic milieu (Gunderson 1978) in which CAMH nurses play a pivotal role (Hogan, Rogers & Hemstock 2009) in establishing and maintaining the therapeutic relationships. In a series of discussion papers Delaney (1992a, 1992b) examined nursing in child psychiatric milieus in an effort to clearly delineate the nurses’ role in maintaining the milieu. The therapeutic relationship between the nurse and the family featured prominently in achieving a therapeutic milieu. Additionally there was a role for the nurse within the family, learning what parents wanted (Scharer 2002) and building that relationship (Scharer 1999; Scharer 2000) was fundamental to the therapeutic relationship with the young person and their family. These aforementioned factors affect the therapeutic milieu by reducing the stress that the young person and their family are undergoing regarding the admission to an inpatient unit. In their discussion paper on establishing a therapeutic milieu with adolescents, Creedy and Crowe (1996) also drew this

conclusion. The literature supports the significance of the milieu in the CAMH nurse role in the inpatient unit, irrespective of whether the inpatient unit is for children or adolescents. Regan, Curtin and Vorderer (2006) investigated the effect of a child and family centred approach in the provision of inpatient care and established that it had a positive impact on the milieu.

A brief length of stay, less than three to six weeks, is not conducive with nurses effectively intervening with the young person's problem area (Delaney 1992b). Further, in a discussion paper Delaney (1997) questioned the use of milieu therapy reporting that it had become "... a catch-all term that indiscriminately serves as a rationale for the supposed therapeutic intent of any and all inpatient nursing activities." (p. 19). The CAMH nurses role is important in establishing a therapeutic milieu, and of including the developmental considerations of children and adolescents (DeSocio, Bowllan & Staschak 1997). The developmental perspective was one of the major challenges for nurses in the CAMH inpatient environment because of the diversity of age range of the young people.

2.10 Recognition of child and adolescent mental health as a distinct area

An immense range of physical, behavioural, cognitive and emotional changes takes place in the child and adolescent phases of human development (Gore et al.. 2011; Sawyer et al. 2012). During adulthood, whilst there are changes as the individual develops, they are not as profound. Given this, there is a need for CAMH to be considered in its own right as an area where there are distinct elements of development that have an influence on outcomes for the individual's physical and mental health. Sawyer et al. (2012) suggest that "...adolescence is central to many emerging global health trends." (p. 1637) and as such "...these agendas are unlikely to be successful without a greater focus on adolescence." (p. 1637). Further, Sawyer et al. (2012) suggest that too much emphasis is placed on individual diseases and not enough on the developmental processes of adolescence and the determinants of health that consider the specific needs of this group.

During childhood some anxiety disorders and behavioural disorders appear whilst in adolescence, anxiety, mood and psychotic disorders can become apparent (De

Girolamo et al. 2012). Given this context, it is imperative that appropriate services are available for this distinct group. There is no worldwide consistency in the availability of CAMH services specifically developed to cater for this demographic (De Girolamo et al. 2012). This reflects a lack of recognition of the specific needs of this group. There is a link between behavioural and emotional issues in childhood and developing psychosis in adolescence Bendall et al. (2011). This supports the argument that there needs to be distinct CAMH services with resources that are able to provide assessment, formulation and ongoing clinical care for this group.

The effectiveness of screening young people for emerging or existing mental health issues does assist in identifying young people at risk and does not cause undue distress Robinson et al. (2011). This validates the concept of providing resources that provide an early intervention framework for young people to identify those who are at risk of developing mental health disorders and that addressing their concerns is beneficial if conducted in a sensitive fashion. Schools are considered an ideal entry point for mental health services for children, even in countries where there was no specialist CAMH service available (Vostanis 2007). Some of the potential limitations of universal screening are identified in a mixed methods study (Essex 2009) which was concerned with screening for childhood mental health problems. Essex (2009) highlighted that there are problems with the accuracy of universal screening and false positives may be created as well as children not attending follow-up appointments.

If mental health disorders in young people go undetected or untreated, this can lead to chronicity and a lifetime of poor functioning and disability (Purcell et al. 2011). Therefore it is clear that CAMH needs to be recognised more widely as a distinct area. This is the case not just nationally in Australia, but globally. Services optimally should be customised to reflect the needs of this group, with their provision by appropriately qualified mental health professionals. There is a lack of policy globally in regards to CAMH needs (Shatkin 2004) which compromises the optimal development of services.

In the global context, the need for service provision by suitably qualified health professionals is an issue that faces the health sector currently, with a shortage of mental health professionals as well as a lack of understanding of the specialty in generic health workers (Patel et al. 2007). In Australia this is no different, with a

shortage of mental health workers there is a trend towards generic workers in mental health settings (Happell 2006) as well as an aging population of service providers, particularly mental health nurses.

2.11 The future of mental health nursing in Australia

A national accreditation board for nurses and midwives, the Australian Health Professionals Regulatory Authority (AHPRA) has impacted directly on mental health nursing in Australia. AHPRA works with 14 National Health Practitioner Boards in implementing the National Registration and Accreditation Scheme. Until 2010, the then Nurses Board of South (NBSA) recognised mental health nursing as a specialist area but it stood alone in this respect as there was no requirement in the other states and territories for individual nurses working in mental health to have a mental health nursing qualification (Happell 2006). With no separate register for mental health nurses, nurses without a mental health qualification were able to work in mental health settings (South Australian Department of Health 2006). Happell (2006). argued that practice in this field should be undertaken only by those with a mental health qualification and that consumers of mental health services have a right to care delivered by an appropriately qualified nurse. She stated that mental health nurses needed to send a clear message about why mental health nursing knowledge was valuable and important.

Non-mental health nurses working in mental health areas are only required to comply with the 2002 National Practice Standards for the Mental Health Workforce, which were designed in consultation with relevant professional groups to benchmark those working in mental health (National Mental Health Strategy 2002). The standards were consumer focussed and provided individuals working in the field (both with and without formal mental health qualifications), with a guide to best practice. Furthermore, these benchmarks aimed to complement existing professional standards such as those from the Australian College of Mental Health Nurses (ACMHN), which were specifically developed for mental health nursing. ACMHN Standards for Practice were developed in consultation with the profession and therefore in line with what encompasses mental health nursing practice. These were also part of the regulatory framework that informs the practice of mental health nurses (Australian

College of Mental Health Nurses Inc 2010). With the resultant loss of a separate register through national registration and therefore an unclear professional identity for mental health nursing in Australia, the standards were pivotal in determining the parameters of practice for nurses in the mental health arena.

In response to the anticipated change in the profile of mental health nursing through national registration, the ACMHN Inc. developed a Credential for Practice Program (CPP) which was launched in 2004. The CPP was designed to provide an opportunity for nurses to have their qualifications in mental health professionally recognised. To highlight the need for a mental health nursing qualification the ACMHN (Australian College of Mental Health Nurses Inc 2011) CPP specifies the following,

“...the applicant to provide evidence that specialist mental health nursing or psychiatric nursing qualifications have been obtained. This is essential to gain a level of nursing expertise in the field of mental health and illness beyond that which is available within a comprehensive entry to practice registered nurse course.” (p7).

The number of credentialed mental health nurses has increased every year since the inception of the CPP with many nurses still undertaking post graduate qualifications in mental health nursing. However, overall, the scope of mental health practice and what mental health nurses do remains unclear, not only within the profession, but also to the wider nursing and multidisciplinary health community.

In order to highlight the value and importance of mental health nurse practice Clinton and Hazelton (2000c) discussed the need to identify and expand the scope of practice for mental health nurses. The lack of clear definition of the role could be attributed to the dynamic and responsive nature of mental health nursing (Elsom 2006) which is responding to the ever changing climate of health reform and consumer need. Elsom et.al., (2007) stated that there were many mental health nurses who were working in expanded practice roles but there was little recognition of this, either by the profession, or through legislation.

Issues contributing to the demise of mental health nursing as a specialty in Australia have been highlighted in the literature such as lack of exposure to mental health settings through education and placement (Clinton and Hazelton 2000d). Universities

argued that the undergraduate program did not allow enough time to accommodate exposure to experience and training in mental health service provision (Clinton & Hazelton 2002). A review of mental health nursing in NSW found problems with regard to "...the questionable adequacy of the undergraduate comprehensive nursing curricula to advantage nurses who intend a mental health career..." (White & Roche 2006, p. 217). Not only were there issues in relation to the adequacy of the curriculum but problems with recruitment and retention of mental health nurses also became evident. Cleary and Happell (2005) described the difficulties in recruitment and retention as being "...highly complex and multifaceted." (p. 110), identifying problems such as the limited exposure of undergraduate student nurses to mental health specialty placements. However this is not a problem unique to Australia. The problem of recruitment and retention of mental health nurses is global (Holmes 2006). In addition, Transition to Practice Programs for new graduates generally have a focus on acute general nursing rather than mental health nursing. A project funded in South Australia by the Department of Health Nursing Office, which reviewed the mental health nursing role within mental health workplace settings, found that nurses agreed the role could be ambiguous and needed to be more clearly defined (South Australian Department of Health 2006).

With the title of mental health nurse no longer protected by the *Health Practitioner Regulation National Law Act 2009* any nurse will be able to work in the area of mental health and be assumed to be appropriately qualified. Presumably this will also apply if the setting is a CAMH facility. An additional risk is that positions within mental health could become generic posts and potentially lost to nursing if mental health nurses are not able to define their role. Hurley and Lakeman (2011) suggested that the loss of identity and inability to clearly define their role is a worldwide phenomenon for mental health nurses. Barker and Buchanan-Barker (2011) suggest that although individuals believe that they know what mental health or psychiatric nursing is they have difficulty defining it. Contributing to this is a lack of experience in working in the mental health area during nurses' education. It has been argued that this is where their identity as mental health nurses is formed (Hurley & Lakeman 2011) through the interpersonal relationship with clients (Peplau 1952) and exposure to their perspective. With the changing workforce landscape the mental health nursing

profession must take a lead in shaping their future. This also applies to the specific role of the CAMH nurse.

A UK qualitative study (Limerick & Baldwin 2000) examined the roles of CAMH nurses and warned that unless nurses were able to clearly articulate and identify the specific contribution they made to CAMH service delivery, there was a danger of the role being filled by generic workers. The report further suggests that nurses applying for generic positions were not always successful because "... in some areas there was a tendency for nurses to struggle to validate skills, experience and actual qualifications." (p. 44), and that "... CAMHS nurses needed to be able to define the qualities that they bring by virtue of their nursing background and training, and how it is important to the team" (p. 44). A further study was designed to explore both the perceptions of nurses and other health professionals of the CAMH nursing role as even CAMH nurses were unclear specifically what nursing contribution they made to the multidisciplinary team (Baldwin 2002). Baldwin's conclusion paints a bleak picture for CAMH nursing as a specialty if the role cannot be defined and further research was suggested to define the role of the CAMH nurse and develop a specific nursing philosophy for CAMH that would emphasise the strengths and develop a better understanding of the contribution that nurses bring to the CAMH setting. Dogra and Leighton (2009a), McDougall (2006) and Johnson (1995) also state that the lack of a clear definition of CAMH nursing is an issue that may affect the future of this specialty area.

In South Australia the then NBSA developed a decision making tool to assist nurses and midwives to define their scope of practice (Nurses Board of South Australia 2006). This tool was later replaced by the Australian Nursing and Midwifery Accreditation Council's scope of practice document (Australian Nursing and Midwifery Council 2007). There are no specific standards for CAMH nurses in Australia, as this specialty is covered by the ACMHN (Australian College of Mental Health Nurses Inc 2010) standards. Although these standards provide a broad framework for the practice of mental health nursing, there are no specific considerations, as highlighted in this literature review that are pertinent to CAMH nursing.

2.12 What do child and adolescent mental health nurses know? Uncovering their ways of knowing and the tacit knowledge associated with their role.

Although it was not clearly articulated in the literature, the tacit knowledge that belongs to CAMH nursing is the key to a better understanding of their role. The patterns of knowing that encompass the nursing role was first described by Carper (1978) who identified four patterns of knowing; aesthetic, empiric, personal and moral. These patterns laid the foundation for nurses to embrace a deeper understanding of their role, taking into consideration the internal perspectives of the individual nurse as well as the external perspectives of the role. Chinn and Kramer (2004, 2008; 2011) expanded Carper's work by including a fifth pattern of knowing; emancipatory knowing.

Baldwin's (2002) exploratory research found that CAMH nurses were unclear about what nursing contribution they made to the multidisciplinary team. The research was designed to explore the perceptions of both nurses and other health professionals in relation to the nursing role. In the findings, Baldwin (2002) stated that most participants were unsure why nurses were historically included in the team yet it was acknowledged that CAMH nurses had a higher level of training than the other professionals. Whilst all participants found it easy to define the role of non-nurses, they found it difficult to define the role of CAMH nurse. The CAMH nurse's view of themselves as nurses indicated they believed that they did not have a lot in common with other nurses. Dogra and Leighton (2009a) also stated that the role of the CAMH nurse is not easily defined partially due to its inception in the child guidance movement and because mental health nursing was not directly involved with children and adolescents until the 1970's. A gap in the literature in relation to tacit and explicit knowledge that CAMH nurses had about their role was evident. Therefore, in this time of potential demise of the specialty, there is a need for further research in this area to provide some clarity.

2.13 Summary

This chapter has provided a background from which to consider the importance of the definition of the role and understanding the work of CAMH nursing. It is

unmistakably evidenced by the literature, both nationally and internationally, that the prevalence of mental health issues has a significant impact on the population. Disorders of CAMH are no different, with a significant prevalence nationally and globally, as well as a clear need for separate service provision in line with the unique needs of this group. In addition, there is a need for a multidisciplinary approach to the delivery of these services, with nursing as a vital part of this in both inpatient and outpatient practice.

The changing regulatory climate in relation to mental health nursing has the potential to further dilute the significance of this speciality. There is a risk of the meaning of mental health nursing becoming more vague and harder to define if nurses with no specific mental health qualification are employed in the mental health field. Credentialing of mental health nurses in Australia provides some validation of the scope of the specialty, but it is not mandatory. Therefore, it is prudent that mental health nurses are able to clearly articulate the distinctiveness of their role. Additionally it is essential that CAMH nurses define and express exactly what child and adolescent nursing is in order to protect the role from becoming generic.

Against this background, it is necessary to further explore and define the work of CAMH nurses. This thesis therefore uses an interpretative framework for this exploration. The scope of defining this role across all settings would be onerous. Therefore, as a contribution to this need, the researcher has focussed specifically on CAMH nursing in an inpatient unit. This is a recognised limitation of the study as there may be a difference in the work of CAMH nurses on other child and adolescent mental units nationally.

The next chapter will identify the theoretical underpinnings and justify the methodology used in the research.

Chapter 3: Theoretical Framework

3.1 Introduction

As evidenced by the literature review in the previous chapter, there is no clearly defined role definition for mental health nurses working in a CAMH inpatient unit. This study seeks to address this deficit and therefore identify the specific knowledge and skills that such nurses demonstrate. This chapter explores the theoretical underpinnings of the methodology of this study and its relevance to mental health nursing. Further, the study will explore the work of CAMH nurses in an acute inpatient setting with the participation of the CAMH nurses and their multidisciplinary colleagues. The specific focus is to be an interpretation of their work through their eyes and their experiences, along with those of the multidisciplinary team.

Constructionism, specifically social constructionism, is the epistemological stance adopted in this study. It is embodied in the theoretical perspective of symbolic interactionism (Crotty 1998). Epistemology is concerned with how individuals know what they know and in the case of social constructionism, the making of meaning and the social processes involved. The theoretical perspective provides a context for the process and grounds the logic and criteria for the study (Crotty 1998). In the case of this study, symbolic interactionism facilitates the recognition and illumination of society and human interaction. The methodology is the strategy or process which links the methods to the outcomes (Crotty 1998). Interpretive enquiry is the methodology of this study because it allows the interpretation of data from multiple realities which will result in a rich description of the work of CAMH nurses. These interpretations are in the context of social constructionism and symbolic interactionism as they are concerned with the making of meaning and understanding it within the human context. The methods are the procedures used to collect and analyse the data (Crotty 1998). Methods for this study; document analysis; focus groups and semi-structured interviews are compatible with interpretive enquiry as they allow for

a broad interpretation. Data was analysed for themes that reflect participant's understanding and meanings of the work of the nurses in the inpatient setting.

The research framework of the study follows the work of Crotty (1998) which sets out the logical pathway from social constructionism (epistemology) to symbolic interactionism (theoretical perspective) to interpretive enquiry (methodology), concluding with the methods of document analysis, focus groups and individual interviews for data collection.

The following framework was adapted from Crotty (1998, pp. 4-5)

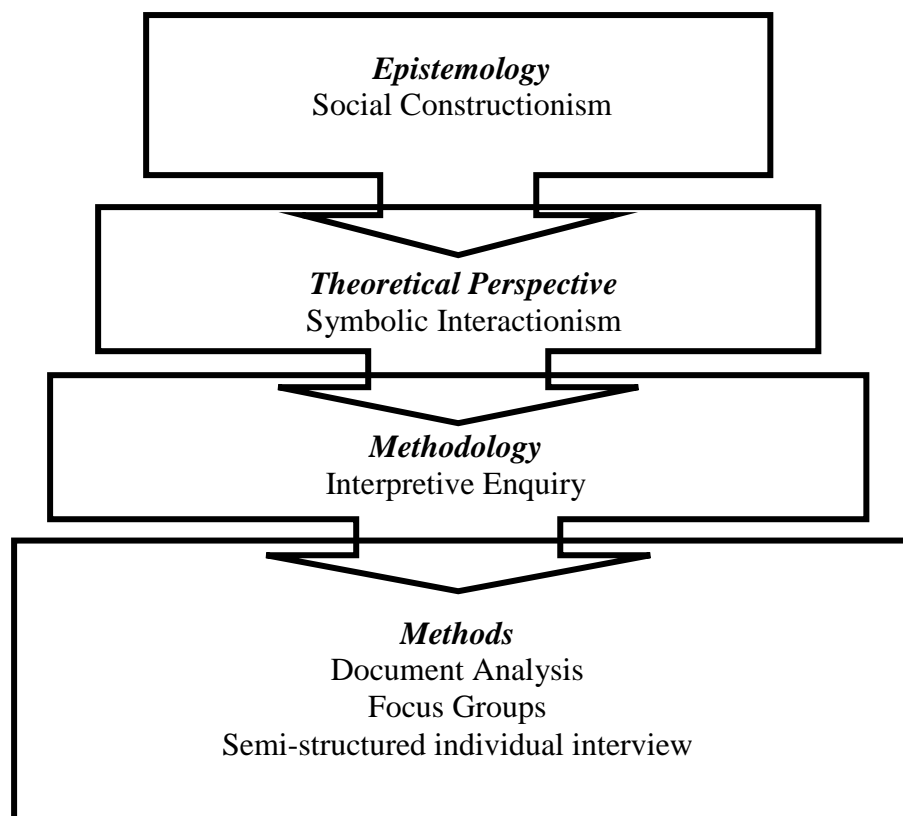


Figure 1 Framework (adapted from Crotty 1998, pp.4-5)

The theoretical underpinnings and the relevance of the methodology are now discussed.

3.2 Epistemology

Social constructionism, the chosen theoretical framework for this study lies within the interpretive paradigm. The underlying assumption about reality (ontology) of this paradigm is that acting units or human beings produce and reproduce the social world

(de Laine 1997). Further, reality is derived as a result of social interaction and there are multiple interpretations within the social construction of realities (Hibberd 2005). The interpretation of meaning is pivotal to this paradigm (Sarantakos 1995). The role of the researcher working in this paradigm is not just to observe phenomena but also to interpret them (de Laine 1997). Social constructionism seeks to illuminate how human beings make sense of the world in which they live, through the processes of description and language (Gergen 1985).

Constructionism holds the view that all knowledge and meaningful reality is constructed through the relationship between the individual and the environment within a social context (Crotty 1998). That is, meaning is not discovered but rather constructed by humans as they engage in the world they are interpreting. Reality does not exist separately from social meanings which individuals have to account.

3.3 Social constructionism

Social constructionism has its foundations in anthropology, sociology, psychology and philosophy (Burr 2003; Cromby 2004; Danziger 1997; Edley 2001; Gergen 1985; Harre 2002). Berger and Luckmann (1966) argue that the objective world was constructed: "...despite the objectivity that marks the social world in human experience, it does not thereby acquire an ontological status apart from the human activity that produced it" (p. 78). In other words, the structure of reality is not objective but rather socially constructed by humans. The emergence of social constructionism in psychology came from Ken Gergen's (1985) paper 'The Social Constructionist Movement in Social Psychology', in which he stated that all knowledge is historically and culturally specific and that social, economic and political realms need to be incorporated to properly understand psychological and social evolution (Gergen 1985). Moreover, Gergen moved away from the generalist description of people and society, arguing that one enduring feature of society is that it is always changing. His paper was developed to introduce traditional psychology to social constructionism as a replacement for positivism (Hibberd 2005). A positivist theory endorses that people are born into a society that is already constructed for them whereas social constructionist theory considers that society is constructed through interaction.

3.4 Assumptions of social constructionism

Social constructionism has at its foundation some of the following assumptions (Burr 2003; Gergen 1985);

3.4.1 A critical stance towards taken for granted knowledge

Social constructionism is critical of the idea that observation of the world generates an unbiased account of events. This is juxtaposed to the positivist stance where empirical evidence is taken for granted as an accurate representation of events. Positivists believe that we are born into a world where meaning exists independent of our consciousness and experience and there is truth and meaning residing in objects (Crotty 1998). Traditional psychology has held a positivist position and therefore has considered social psychology to be radical in its belief in relation to taken for granted knowledge.

3.4.2 Historical, cultural and time specificity

Social constructionism does not generalise historical and cultural specificity and endorses the making of meaning as historically and culturally specific and dependant on the social and economic provisions existing at that time. So the underlying assumption of social constructionism is not just historically and culturally specific, but also time specific. Given this, social constructionism is a snapshot of history, culture and time reflecting a shared meaning of a phenomenon.

3.4.3 Knowledge is sustained by social process

Human knowledge of the world and common ways of understanding it are constructed through social processes. These social processes are the daily interactions between groups of people which also sustain the constructed knowledge (Hosking 2004). This knowledge can be constructed in both formal and informal ways. For example, this can be achieved formally through the social process of learning experienced by participants from an educational course. Informally it can be achieved through observing and learning from a colleague.

3.4.5 Knowledge and social action go together

Agreed knowledge generated from these assumptions can bring about different social constructions. This will depend on the individuals involved and their agreed knowledge and selected social action. An example cited by Burr (2003) is found in

the Temperance movement and its view that individuals with an alcohol dependency should be incarcerated, whereas contemporary knowledge views alcohol dependence as an illness which therefore requires medical and psychological intervention, not punishment. The same can be said for societies' changing views on mental health. Social constructionism differs from traditional psychology in its position on the following areas: anti-essentialism, language and knowledge, conversations and relativism, reality and truth (Burr 2003).

3.5 Anti-essentialism

Essentialism purports the view that human beings have a central, intrinsic nature which can be revealed (Burr 2003). Social constructionism is anti-essentialist as it rejects the idea that one's personality is generated from within and from biological factors but rather subscribes to the idea that personality is developed through the social process. Anti-essentialism challenges realism stating that there is no such thing as an objective fact but rather that there is an individual or agreed upon group perspective of the world. Our ways of understanding originate from people from the past and present. Within our cultures we are born into a conceptual framework and categories that have already been generated for us (Danziger 1997). The development of these social processes that pertain to CAMH nursing practice are anti-essentialist as they involve agreed upon knowledge. The agreed upon perspectives of the world are communicated to other human beings through language and knowledge.

3.6 Language and knowledge

Language provides us with a framework of meaning for the categories and concepts we use to make sense of our world. Social constructionists view language as a form of social activity with interactions being centre stage. Language facilitates individuals in constructing their world (Denzin 2001; Gergen 1999). Whether an individual in a particular group is a novice or is experienced affects both how language is learned and how it is interpreted (Denzin 2001). Language can be "performative" and therefore has practical consequences which constitute an act of (performance) some kind, for example "I detain you" rather than just a passive vehicle for conversation (Burr 2003) is more directive and means invoking legislation and therefore has an active

consequence. Social constructionism focuses on the social practices of people and their interactions with each other. Knowledge is considered to be something that people develop together rather than something people either have or not. The focus of the social inquiry of constructionism is the process by which people generate knowledge through their interactions with each other (Wainwright 1997).

Within the theoretical perspective of social constructionism exists micro and macro social constructionism. Micro social constructionism concerns itself with the construction of accounts of personal identities within interpersonal interactions whereas macro social constructionism concerns itself with the constructive force of culturally available discourses and the power relations embedded within these. To this end macro social constructionism takes a more critical stance focusing on power relations. Micro social constructionism is aligned with discursive psychology and is concerned with everyday dialogue between people in interaction.

Animals communicate with each other through fixed communication whereas language is unique to human beings. Language is seen as the foundation of social constructionism because it is constantly changing and is diverse in its meaning. The basis for our thoughts are provided by language and therefore language and thoughts are inseparable, this develops more as people mature because children are less capable of thinking “voicelessly” (Liebrucks 2001). Language provides us with a method of separating our experience and giving it meaning and human beings become a product of the language. In looking for explanations of the social world the linguistic space in which individuals move with other people rather than inside the individual should be considered. Language creates and constructs our understanding of each other and ourselves (Burr 2003).

A principal assumption at the core of social constructionism is the potency of language and therefore the analysis of language and other symbolic forms are the foundation for social constructionist research methods. Language encompasses a set of symbols, metaphors, images, stories, representations that produce a particular set of events. Human beings see the world in a certain way and they express their knowledge of the world through language. Our communications change depending on the context, so in relation to the work of the CAMH nurse, these would be constantly changing because of the client group and the inpatient environment.

Geertz (1973) refers to a system of significant symbols which is society and meaningful symbols, this represents society as an indispensable guide to human behaviour (Crotty 1998). Society is best seen as the source rather than the result of human thought and behaviour. It is a set of control mechanisms (plan, rules, and instructions) for the governing of behaviour (Geertz 1973). Such a stance raises these questions. What agreed upon symbols are used in the work of CAMH nurses to socially construct their way of life? How is conversation employed in the social construction of their work?

3.7 Conversations matter

Central to social constructionism are the processes by which people make sense of how their world is construed. It is within this context how we make clear our reasons for our actions. Conversation is a fundamental tenet of social constructionism. Careful questioning, how questions are asked, why and by whom are all part of the formative process of social constructionism (Hosking 2004). Social constructionism is concerned with how people make sense of their world through conversation. During the last few decades the thinking in regard to social constructionism has progressed towards a messages and meanings focus, which has put more of an emphasis on collective construction rather than individualism (Burr 2004). This has afforded people the opportunity to work through multiple interpretations in relation to dialogues.

Communication is fundamental to mental health nursing and conversation is a vehicle for that communication. This raises questions such as, how does conversation impact on the work of CAMH nurses? How do nurses tailor the conversation to fit the developmental stage of the client? How do they use conversation as a tool in assessment and therapeutic processes?

3.8 Relativism, reality and the truth

Social constructionists reject the positivist stance that the external world exists without us thinking of it and perceiving it. They believe that there is no ultimate truth but rather there are multiple realities (Burr 2003; Denzin & Lincoln 2005; Nightingale

& Cromby 2002). Everyday reality is socially conditioned and we construct knowledge within it (Stam 2002).

3.9 Agency and structure

Is society created by individuals or does it already exist and the individual fits into it? If indeed society is predetermined then there are issues for social constructionism in relation to agency, i.e. the individual's ability to exercise choice. Conversely, if the individual determines society, then agency is conserved but this does not explain the homogeneity of aspects of society such as rituals and fashion. The dichotomy of society and individual can in itself be seen as a construction, an artefact of intellectual analysis (Burr 2003). An alternative allegory was suggested by Giddens (1991) who, in his theory of structuralism, viewed the individual and society as two sides of the same coin.

Do individuals really have a choice or are they given no chance to participate in a dialogue? Drewery (2005) discusses "position calls", which she states can be exclusionary. Agency in positioning is what Drewery is referring to when considering dialogue that individuals have where there may not be room for agency on the part of the respondent. This is an example of where an interaction is not socially constructed because there may not be opportunity for an agreed upon meaning.

3.10 The social construction of reality

Berger and Luckmann (1966) established three characteristic cyclical processes by which human beings construct their social world; externalisation, objectification and internalisation. Berger and Luckmann (1966) talk of the meanings of aggression which may be attached to a knife. In human society there is language which is utilised to externalise an individual's interpretation. So a knife may be seen as a symbol of aggression. The objectification of the knife may not have a link to the present situation. Internalisation is the final part of the cycle in which the symbolism of aggression associated with the knife become part of the ideas and ways of a culture. In describing this process the authors identified the interaction between the individual and society whilst considering both the role of agency and the constraints of society. (Berger & Luckmann 1966).

3.11 Self

There is an absence of the self in social constructionism which goes against the beliefs of mainstream psychology. Burr (2003) argues that it has become an effect of language which is spread across discourses and interactions. Burr (2003) cited constructionists Holloway (1984) and Walkerdine (1987) stating that to facilitate the self they have incorporated a psychoanalytical component to their work however, this leads the way open for essentialism. Further, Burr (2003) maintains the absence of self can be incorporated in social constructionism through positioning which is "...the practice of locating oneself or others as particular kinds of people through one's talk," (p.204). This allows individuals to incorporate the self in discourses and interactions.

Whilst there are different varieties and opinions in relation to the meaning of social constructionism, this study was guided by Burr's (2003) interpretation. Burr considered that a social constructionist perspective must include the following beliefs: a critical stance towards taken for granted knowledge; historical and cultural specificity; knowledge is sustained by social processes and knowledge and social action go together (Burr 2003). Burr's work is very much influenced by the 1985 work of Gergen, from whom Burr derived the components of a social constructionist perspective (Gergen 1985). In essence social constructionism is about the meanings and interpretations of phenomena which are shaped and maintained by members of a group or society which gives them an historical, relational and cultural context.

Berlin, describes seven themes of social constructionism based on the work of Giambattista Vico, a 17th century Italian philosopher who criticised the enlightenment perspective and developed the idea of a socially constructed viewpoint of the world (Berlin 2000). The seven themes are as follows: the nature of human beings is not static; one does not have to create something to understand it; an individual's knowledge of the external world differs in principle from their understanding of their internal world; the activities of a society have a ubiquitous configuration; the creations of humans are forms of expressiveness to communicate with other individuals; different symbols and languages are relevant to particular times and places; and reconstructive imagination which is concerned with understanding other cultures (Berlin 2000). Some of these viewpoints have links to symbolic interactionism. The themes elucidate that the world is constructed by

individuals and their interactions and conversations, particularly through the use of symbols and language (Hosking 2004).

3.12 Theoretical perspective – symbolic interactionism

The theoretical perspective provides a context for the process of research and grounds the logic and criteria for the study. The theoretical perspective chosen for this study was symbolic interactionism. Whilst social constructionism provides meaning and context for the study, symbolic interactionism positions it in the natural world, in this case an CAMH inpatient unit. To facilitate the understanding of people their world of objects must be known (Blumer 1969). Therefore for the purposes of this study the natural world of these nurses and the objects that are relevant to their work, must be identified.

3.13 Defining symbolic interactionism

Symbolic interactionism is a major theoretical and sociological influence of social constructionism. In their book *The Social Construction of Reality* Berger and Luckmann (1966) draw from a symbolic interactionism stance that humans construct reality through their own and others identities and from social interaction (Berger & Luckmann 1966). At the core of symbolic interactionism is the concept that identities are constructed through day to day exchanges with each other in social interactions.

Symbolic interaction can be defined as a philosophical viewpoint which encompasses a unified group of assumptions, concepts and propositions from which the world and human behaviour can be understood (de Laine 1997). This stance relates well to any individual having to interpret the meanings of an environment. Society is the end result of interaction and human beings interpret their environments and interactions to make meaning of their world. The emphasis for symbolic interactionism is on the ability to place oneself so one can understand the perspective of others (Crotty 1998). “Taking the role” of the other is important when navigating a new environment when attempting to align ones behaviours to promote social interaction (Crotty 1998). This concept fits well with this study as the researcher was concerned with eliciting the interpretation and perspective of the participants in the field identified. Not only was

this study drawn out the perspective from the nurses but also the perspective from the non-nursing participants, which will add to the richness and the rigour of the data.

Although the term symbolic interactionism was first identified by Herbert Blumer, through a 1937 article *Man and Society*, it was a culmination of the work of some of his predecessors. Amongst them are Herbert Mead (1932), Georg Simmel (1950), Max Weber (1920) and John Dewey (1932). Symbolic interactionism is about society, its symbols and rituals; interaction between the individual and the self as well as the individual and others; and the interpretation of those events.

3.14 Mead's view of symbolic interactionism

Central to Mead's view of symbolic interactionism was the concept of the self. He did not consider the self to be an inactive vessel but rather an active organism (Wallace 1999). This was the first time that the self was seen as having an internal dialogue and not just an external interaction with others. This was opposed to the functionalist's stance, such as that of Parsons (1937) who considered human beings to be passive agents. Mead spoke of two phases of the self; me and I. The former refers to the self which are an organised group of perspectives that the individual has gained from others in relation to themselves. The latter however is more disorganised, creative and free (Mead 1934). With regard to the CAMH nurses in an inpatient unit, how does the interaction with the self and others facilitate the I and the me? Has the self interaction led to any changes in practice for these nurses?

3.15 The tenets underpinning symbolic interactionism

According to Blumer (1969) symbolic interactionism is underpinned by three premises; First, that human beings act towards things based on the meaning they make of things. The second is that such meaning is the product of the social interaction that an individual has with another, and thirdly that an interpretive process is employed by the individual to make sense of these interactions. Blumer (1969) argues that this first premise is often taken for granted or ignored by the social sciences and psychology and seen simply "...as a neutral link intervening between the initiating factors and the behaviour they are alleged to have produced." (p. 3). It is here that the social constructionist perspective can enhance symbolic interactionism.

3.16 The link between the tenets of symbolic interactionism and social constructionism

The first tenet of social constructionism is a critical stance towards taken for granted knowledge which challenges the individual to consider the perspective of the other when making meaning. This stance enriches the first tenet of symbolic interactionism, action being based on meaning, which Blumer (1969) suggested was often overlooked.

The second tenet of symbolic interactionism, (meaning being the product of interaction) relates well to the third tenet of social constructionism, knowledge is sustained by the social process. Both of these tenets are concerned with meaning, knowledge, communication and the social process. The interpretive process the individual utilises to make sense of these interactions (the third tenet of symbolic interactionism), links well with the second tenet of social constructionism, historical, cultural and time specificity. These tenets are both connected to language, knowledge and communication and acknowledge the context of the interaction. The fourth tenet of social constructionism (knowledge and social action go together) can also be related to symbolic interactionism because both take in hand the concept of agreed upon knowledge which can lead to social action.

3.17 The significance of meaning

Meaning is central to both symbolic interactionism and social constructionism. Blumer (1969) suggests that contrary to the tenets of symbolic interactionism, the position of symbolic interactionism is "...the meanings that things have for human beings is central to their own right" (p. 3). So to disregard the meanings and instead focus on the elements that produce the behaviour is to completely ignore the significance of meaning in the shaping of behaviour. Symbolic interactionism rejects two of the traditional ways of looking at the origin of meaning. One of these ways is to say that the object already has meaning and all that is required of the individual is to recognise the meaning in the object. The second is that the individual interprets the meaning of the object through psychological organisation of their own memories, thoughts, motives and experiences. The symbolic interactional stance "...sees meaning as social products, as creations that are formed in and through the defining

activities of people as they interact” (Blumer 1969, p. 5). A process of self interaction is necessary to see that meanings play their part. First the actor (individual) must engage with themselves to indicate to themselves the object to which they are acting, this is an internalised social process in which the actor is interacting with themselves. Next the “...actor selects, checks, suspends, regroupes, and transforms the meanings...” (Blumer 1969, p. 5) in the context of the situation with a view to choosing an action.

The focus of this study was on the meaning making and associated processes for the nurse participants and how it informs their practice as well as what meaning the multidisciplinary participants make of the work within the role of the CAMH nurse.

3.18 Social interaction

The term social interaction takes as fact that group life (society) consists of the interactions between individuals. Social interaction places primary importance in the formation of human behaviour and the formation of the meanings that underlie behaviour. According to Blumer (1969) the actions of others must be continuous in the decision-making process of the individual; therefore it is the interaction either internalised or externalised with the other individuals that is the first and most important determinant of the behaviour of the individual.

Blumer (1969) described symbolic interactionism as being grounded in “root images” (p. 6). These images consisted of the following matters; human society or human group life, social interaction, nature of objects, human being as an acting organism, nature of human action and interlinkage of action. Human groups or societies are described as human beings engaging in action. Action may be taken by an individual, collectively, on behalf of others, or as the representative for an individual or group of others. However, action remains the property of the individual and is carried out in light of the current situational context in which the individual carries out the action. This is similar to the social constructionist position on historical, cultural and time specificity.

3.19 Reality

Like social constructionists, symbolic interactionists also regard reality as a social construct; a product of the individual and their shared understanding of the environment through the process of interaction with others.

3.20 Agency

Both social constructionism and symbolic interactionism highlight the role of agency, or choice, in the individual's communications in relation to meanings (Brown 1995). People's interactions when developing meanings and interpretations also include how and where they play out their social roles (Brown 1995).

Blumer suggested that it is the complex ongoing of activity that establishes and portrays structure or organisation.

“A cardinal principle of symbolic interactionism is that any empirically oriented scheme of human society, however derived, must respect the fact that in the first and last instances human society consists of people engaging in action. To be empirically valid the scheme must be consistent with the nature of the social action of human beings.” (Blumer 1969, p. 7)

Crotty (1998), stated that it is not surprising that symbolic interactionism is the theoretical underpinning for interpretive methodology given that they both focus on the putting of oneself in the place of another.

3.21 Methodology – interpretive enquiry

A qualitative methodology is compatible with the theoretical stance of symbolic interactionism and this was chosen for the research. Interpretation is at the core of the social constructionist and symbolic interactionist perspective.

The basic tenets of qualitative research are a belief in multiple realities; a commitment to identifying an approach to understanding the phenomenon studied; a commitment to the participants viewpoint; preserving the natural environment and limiting disruption to the phenomena; acknowledging the researcher's participation in the

phenomena; reporting the data in a rich literary style which includes the participants commentaries (Fossey et al. 2002; Streubert & Carpenter 2011; Streubert Speziale & Carpenter 2007). Qualitative research methods are widely used within mental health practice because of the nature of that practice (Fossey et al. 2002).

3.22 Methods of data collection

There are a variety of ways to collect data in qualitative research, including document analysis, focus group and individual interviews. Semi-structured interviews are the preferred technique in qualitative research, allowing the researcher to ask some open-ended questions to illicit further in depth information in relation to the phenomenon (de Laine 1997). These interviews are either audio taped, or notes are taken to collect the data for later analysis. Given that the researcher endeavoured to see the phenomenon from the participant's viewpoint, focus group discussion and semi-structured individual interviews were utilised (Crotty 1998).

3.23 Relevance of social constructionism, symbolic interactionism and interpretive enquiry to the study

Mental health nursing is not easily defined (Leishmann 2003, 2004), and elements of it are tacit and of limited visibility to those looking at the practice from the outside. The defining parameters of nursing are steeped in history and therefore, although contemporary in their time, do not fit into the multidisciplinary and multi-professional world in which it now resides. There is an opportunity to enable mental health nurses to articulate their identity within this complex health and social system. There is a synergy between social constructionism and mental health nursing which will facilitate a more relevant definition of the identity of their practice (Leishmann 2003, 2004). Social constructionism allows individuals to understand and make meaning of the complex phenomenon that is mental health nursing. This research seeks a rich and comprehensive understanding of how CAMH nurses working in an inpatient environment generate the agreed upon knowledge for their practice and the social processes that are engaged to develop and facilitate those social constructions. In developing and facilitating those constructs, the nurses data must be interpreted through a position of anti-essentialism, language and knowledge, conversations and relativism, reality and truth.

*So how do the CAMH nurses construct their social reality in relation to their work?
What are the processes for agreeing upon the meanings associated with their role?*

In relation to this study, what is the taken for granted knowledge of CAMH nurses in the inpatient environment? How does their work within the acute environment challenge / affect their taken for granted knowledge?

Given the fluidity and fluctuation of the nature of their work involving young people with acute episodes of mental health issues, how do these nurses keep work historically and culturally specific whilst still in the moment?

There are external and internal factors that influence their practice which may be relevant historically (we've always done it this way) and culturally (this is how we do it here) but not necessarily with the current situation.

In mental health nursing there is certain knowledge which needs to be sustained by the students to gain admission to the profession. Knowledge will also be sustained informally by the nurses through the social process of being a member of the profession.

What are the social processes utilised by CAMH nurses to sustain the knowledge pertinent to their practice? How do they identify these processes? What are the formal and informal processes? How do they agree on what these processes should be?

How do CAMH nurses agree on the knowledge that is generated through their practice? What processes are employed to agree on the social action which may result from such knowledge? How do these nurses relate those changes to other members of the multidisciplinary team?

In relation to mental health nurses in the CAMH acute inpatient setting, they need to interpret and make sense of their environment. How do they do this? What knowledge and skills in mental health nursing assist them in this? What meaning do mental health nurses make of CAMH practice? How does their previous experience help them interpret and negotiate their interactions within the world of CAMH? What is

their cultural reality? How do they identify the overt and tacit symbols which are part of the role?

3.24 Summary

This chapter has explained the theoretical underpinnings for this study and discussed its appropriateness and how it fits within the interpretive paradigm. The social constructionist framework and symbolic interactionist stance is compatible with research into mental health nursing because of its reflective and collaborative nature.

An interpretive methodology utilising a three stage design of document analysis, focus groups and semi-structured individual interview is an appropriate approach for defining the role of and understanding the work of CAMH nurses in an inpatient unit as it allows a rich description of the studied phenomenon. The next chapter describes the study design, study setting, participants, their selection, methods of data collection and data analysis.

Chapter 4: Methods

4.1 Introduction

As discussed in the previous chapter, the methodology for this research was interpretive; social constructionism provided the epistemology and symbolic interactionism the theoretical perspective. The interpretive methodology provided the lenses by which to focus the methods. In the context of social constructionism and symbolic interactionism these lenses were language; communication; knowledge; relativism; agency and structure.

This chapter describes the study design, comprising a three-stage sequential process in which the methods of document analysis, focus groups and individual interviews were used. Each stage will be presented sequentially throughout the chapter beginning with the study setting and ethical considerations within study. The three methods chosen in this research design were conducive to the interpretive methodology which sought to elicit a rich and detailed description of the work of CAMH nurses from their perspective and that of their work colleagues. Each stage of data collection and analysis in the interpretive enquiry informed the next.

4.2 Study setting

The setting for the study was a CAMH service inpatient unit in a public hospital in South Australia. The ward was a twelve bed open unit which provided a 24 hour a day specialist support for children and adolescents with mental health problems. The facility is an open unit but as it is the only CAMH inpatient unit in the state, they did at times have young people as patients who were detained under the *Mental Health Act* 2009. The inpatient unit provided a therapeutic environment in which young people from 3 to 18 years of age could focus on their issues with a view to improving their mental health. The young people in the mental health unit were admitted for behavioural and mental health issues which needed assessment and intervention in an inpatient environment. The mental health issues were complex with specialised care and support for children and adolescents with severe mental health problems. These problems were early psychosis, severe mental disorder (including depression) often

with a suicidal component and complex and coexisting disorders requiring multiple assessments and specialised care.

Although the researcher was a mental health nurse who had worked in the CAMH arena she had never been employed in an inpatient unit. The researcher needed to spend time in the unit to familiarise herself with the environment in which these nurses worked in order to understand their role within the unit and to locate sources of data for the first stage of the study.

The participants were registered nurses across four levels. In South Australia, at the time of the research, the nursing career structure had five levels (Nursing Office 2006). The majority of nurses were classified as level one which was the entry point to nursing with nine yearly increments. Some nurses in these positions had many years of clinical experience and stayed at this level due to lack of opportunity for promotion to level two. The level two nursing positions were associate leadership and experienced clinical positions. The level three nurses were experienced nurse consultants in education, management or clinical areas. The level four nurses were Directors of a Nursing Division within a healthcare facility. The multidisciplinary team on the inpatient unit who participated in the research were made up of consultant psychiatrists and a psychologist. The After Hours Mental Health Nurses were all level three nurses who were experienced nurse consultants. These nurses worked in collaboration with the inpatient unit and in the Emergency Department of the Women's and Children's Hospital when children and adolescents presented with mental health issues.

4.3 Ethical considerations

The researcher followed the principles of the National Health and Medical Research Council National (NHMRC) Statement on Ethical Conduct in Human Research 2007. The NHMRC principles ensure that the study is conducted with integrity and an ethos that will pervade all of those involved in the research (National Health and Medical Research Council 2007). These principles include justice, beneficence and respect.

Ethical approval was granted from the following organisations: Children, Youth and Women's Health Service Human Research Ethics Committee; and the Flinders

University Human Research Ethics Committee. Approval and Divisional certification was granted by the Division of Mental Health, Children, Youth and Women's Health Service in June 2008 (Appendices 2 &3).

The researcher did not undertake participant observation as there were ethical issues involved in relation to the vulnerable patient population in a mental health inpatient area. Initially, the researcher had sought ethics approval for a study which included participant observation of the nurses. The feedback from the Ethics committee required that in order for approval to be granted the researcher would have needed to acquire consent from all young people in the unit and their families or carers. The process was cumbersome and prohibitive therefore the researcher changed the methodology. Some of the legislation underpinning the ethics of this study were the Nurses Act 1999 (Nurses Board of South Australia 1999) and the Child Protection Act 1993 (South Australian Government 1993). The participants were voluntary and able to freely consent or refuse participation in the study (Cozby 2007). They were given an information sheet about the study and given the opportunity to discuss the study with the researcher before signing a consent form. The participants were informed that they could withdraw from the study at any stage, whether it was before or after the data was collected, without penalty.

4.4 Stage One – Document Analysis

Stage One entailed the researcher analysing documents relevant to the practice of CAMH nursing in areas that reflected professional, legal and organisational parameters. This was an initial data collection method that was necessary to identify the broad context of the work and role of the CAMH nursing. Note taking and journal writing was an essential component as it provided the opportunity for the researcher to reflect on the process of analysis and the consequent interpretation of the documents.

4.4.1 Aim/purpose

The purpose of the document analysis was to identify the common domains of the role of the CAMH nurse within relevant documentation of professional, legal, and organisational contexts.

4.4.2 Advantages of document analysis

The advantages of using document analysis was that it allowed the researcher to provide a broader context to the research by studying the existing documents relevant to the topic. Document analysis provided the researcher with an opportunity to understand and elucidate the meaning of pertinent documents (Ritchie 2003). Document analysis was also useful when a public or outside view as well as a private or inside view of a topic was required (Ritchie 2003) such as documents associated with the role. Through examination of the documents a picture of the context was revealed (Rebar et al. 2011) and therefore added to the richness of the data.

4.4.3 Limitations of document analysis

The disadvantage of using document analysis was inherent in the documents themselves. There was a risk of being unaware of the records bias (Polit & Beck 2010) as the data for the documents was not collected by the researcher herself. In addition, the researcher needed to be mindful of whether the documents represented the entire set (Polit & Beck 2010) or a partial account. The disadvantages needed to be noted, but were beyond the scope of the researcher's role as the researcher was reliant on the CAMH nurses identifying which documents were relevant to their practice. However rigour was enhanced by the researcher personally going through the documents which were available in the unit. This enabled the researcher to identify any documents which the CAMH nurses had not. Through this process there were no documents identified by the researcher that the CAMH nurses had not identified.

4.4.4 Finding the documents

To determine which documents were relevant, the researcher collaborated with mental health nurses in an inpatient unit. In discussion and consultation with the nurses the documents were identified and located. The documents that were reviewed consisted of standards, procedures and policies that were mandatory to the role of a nurse in a CAMH inpatient unit. The scope of the documents spanned four fields. Three of the fields were documents that were developed at an organisational, divisional or unit specific level. The fourth field was those documents developed by professional and regulatory bodies concerned with mental health nursing.

The documents which were relevant were competencies (professional and organisational), job and person specifications and other documents that related specifically to the practice of the nurses. Some of the domains which were relevant were knowledge; skills; attitudes; experience and supervision. The rationale for selecting the job and person specifications was that they prescribed the framework in which the nurses worked. Every nurse employed in the unit was required to work according to a job and person specification.

4.5 Data Analysis

The researcher chose thematic analysis as most appropriate for this study as it allowed the researcher to compare and contrast the emergent themes throughout the process (Talseth & Gilje 2007). This was a congruent analysis method with focus group and individual interviews and due to the large volume of data produced was therefore an appropriate analytical approach for the study.

4.5.1 Thematic Analysis

Analysis is the process by which data is broken down into fundamental units or themes (Freshwater & Avis 2004) and thematic analysis is one form of this process (Guest & McLellan 2003). Thematic analysis is frequently chosen as the method for the qualitative research paradigm however it is also a tool that spans qualitative methods rather than a method in its own right (Boyatzis 1998). Thematic analysis can be either dependant or independent of a theoretical or epistemological stance and it is this adaptability that is beneficial for qualitative research (Braun & Clarke 2006). Both the essentialist and constructionist parameters are able to accommodate thematic analysis (Braun & Clarke 2006) and therefore it was congruent with the study and compatible with the constructionist paradigm.

There is no one prescribed way in which to undertake thematic analysis (Attride-Stirling 2001; Tuckett 2005) so this further enhances the flexibility for the researcher. In addition, there is no prescribed size for a pattern or theme in thematic analysis which once again allows the researcher the flexibility to include a range of themes in the questions that may be less frequent than others. Clearly identifying the process of data analysis allows the reader to evaluate the research in terms of appropriateness and rigour because it provides a clear map that leads to the outcome and an audit trail.

(Roberts & Taylor 1998). In addition, Braun and Clarke (2006) suggest that thematic analysis is situated between essentialist and constructionist epistemology as a contextual method because it not only considers the individual making of meaning and understanding of experience but also, is able to position it in the social context.

Themes can be identified by either inductive or theoretical analysis (Braun & Clarke 2006; Burr 2003). The theoretical approach is utilised when the researcher already has established the research questions whereas inductive analysis is a “ground up” approach which helps to direct the research question (Jacobson 2003). There are also two levels of analysis inherent in thematic analysis and they produce either semantic or latent themes. The semantic themes are the explicit or surface themes that are discovered through either exactly what has been said or in a written document (Boyatzis 1998). Latent themes identify the underlying assumptions and ideas that form the semantic themes (Braun & Clarke 2006).

In this study thematic analysis through its flexibility allowed the researcher to adapt to the depth of information required. The analysis of the data from the documents was of less depth as the purpose was to reveal themes that would inform the questions for the next stage of the study. Thematic analysis utilised in a social constructionist epistemology considered the themes that were identified as socially created for a particular group, in the case of this research CAMH nurses, so it explored “...the ways in which events, realities, meanings, experience...” (Braun & Clarke 2006, p. 83) affected the participants. The researcher in this stage of the study was seeking to develop research questions so therefore the inductive process was the most appropriate.

Thematic analysis of the documents was undertaken at a semantic or explicit level. For the purposes of this study the researcher examined the surface meanings of the documents with a view to identifying themes. These themes provided the parameters for developing the questions that were used for stage two of the study. The questions needed to be broad enough to capture a rich description from the participants but specific enough to reflect the semantic themes from the documents.

4.5.2 The Joanna Briggs Institute Thematic Analysis Program

The data analysis was facilitated by the Joanna Briggs Institute Thematic Analysis Program (TAP) (Joanna Briggs Institute 2008). The program enabled the researcher to proceed through a three step approach in the analysis of data. The three steps were extraction of illustrations, aggregation to categories and synthesis of categories into themes. These processes generated a Thematic Analysis Program (TAP) chart which demonstrated the connection between the illustrations, categories and themes.

The TAP illustrations included the titles and content of the documents which were identified by the researcher in collaboration with the nurses in the CAMH inpatient unit. Each illustration was assigned to a category using an iterative process (Attride-Stirling 2001). The TAP themes were created from the descriptors identified in the initial review of the documents. After categorisation of the primary data/documents, the categories were reviewed to determine if they could be further aggregated on the basis of similarity in focus. This process enabled the researcher to develop focussed and relevant questions that were used in stage two of the study.

4.6 Summary of Stage One

This section has described stage one of the study in which document analysis was used to identify the common domains of the work and the role of the CAMH nurse from professional, legal and organisational contexts. Analysis was facilitated by the use of a Thematic Analysis Program (TAP) which subsequently led to the development of pertinent questions for use in stage two of the study. It was felt that these questions provided for a rich and deep examination of the work and role of the CAMH nurses.

4.7 Stage Two – Focus Groups

The previous stage addressed document analysis, the initial stage of the data collection, and analysis of the relevant documents and generation of the questions that would be used in this next stage of the data collection. This study used focus group interviews as the second sequential method of collecting data on the work of CAMH nurses in an inpatient unit.

4.7.1 Purpose of Focus Groups

The purpose of a focus group was to generate data from a group discussion (Barker, Jackson & Stevenson 1999; Krueger & Casey 2009). When intending to utilise focus groups the researcher must consider the research questions and determine whether focus groups are appropriate. This study was concerned with interpretation of the role and work of nurses from their perspective and that of other relevant health professionals working in this same area of health care. Given this, the opportunity for discussion of different interpretations of the role was enhanced by a focus group. However there were some considerations when undertaking focus groups.

4.7.2 Advantages of focus groups

Focus groups have the potential to yield a rich description of the research topic. Focus groups that are moderated appropriately allow the participants to exchange and discuss experiences in relation to the topic and ask each other questions. Focus groups allow the researcher to meet with more than one participant and to seek the interpretation of each participant concurrently as the data are generated. This assists with the breadth and richness of the data. Another advantage is, if there is a difference of opinion between group members in relation to the topic it can be explored contemporaneously and can add to the depth of the data. Collecting multiple interpretations concurrently can save the researcher time in the data collection process.

4.7.3 Limitations of focus groups

Focus groups have their limitations. The researcher needs to be clear about the purpose for utilising this method. In past decades focus groups have become popular for market research (Barker, Jackson & Stevenson 1999; Krueger & Casey 2009). However the researcher needs to be careful not to go into a focus group with preconceived ideas of possible outcomes. This would not be a focus group but rather an opinion poll. Focus groups are not designed to validate a hypothesis. There needs to be a power balance within a focus group to facilitate all participants contributing to the discussion. A skilled moderator needs to be aware of not allowing individual participants to dominate the discussion which will result in data that lacks depth. Another limitation of focus groups is the possibility of group speak where some individuals may subscribe to the consensus rather than offer their own opinion. As

mentioned before the skill of the moderator is vital to the success of the focus group. The moderator needs the skills to facilitate the discussion, focus the group when they go off track and be aware of the possibility of power dynamics within a group.

4.8 Population

Mental health nurses and other non-nurse multi-disciplinary colleagues working in a CAMH inpatient unit were the population of this stage of the study. The participants were representative of each of the following groups who worked in the unit; mental health nurses who had completed their training and were currently working in an inpatient area; registered nurses who were currently undertaking a Graduate Diploma Mental Health Nursing program; non-nurse members of the multidisciplinary team e.g. psychologists, medical staff, etc.; members of the After Hours Emergency Mental Health Nursing team who worked from the unit and mental health nurses who no longer worked in the unit but did so for more than six months since 2003. There were five focus groups planned each with separate membership that represented various staffing groups within the unit. During recruitment the number of focus groups increased to six with potential participants identifying a group of nursing colleagues from community CAMHS who shared clients with the inpatient unit and worked with the inpatient unit CAMH nurses closely. When focus group number four was about to commence participants informed the researcher that due to staff constraints it was necessary to split the group into two focus groups which the participants wished to undertake on that day. This resulted in a total of seven focus groups.

4.8.1 Recruitment

Participants were recruited via invitation to participate in the study. A flier was placed in the tea room of the inpatient unit. Those seeking more information in regards to the study were invited to contact the researcher for further clarification and given a letter of introduction and an information sheet (See Appendices 2 and 3). The researcher also conducted information sessions with staff to discuss the research, and sought an invitation to present information sessions at the Divisional Nurses meeting and the Ward Nurses meeting. In addition, the researcher contacted nursing staff who no longer worked in the inpatient environment via business Email or telephone to inform them of the study. Other members of the multidisciplinary team working in the unit

who were not nursing staff were invited to participate in the study. The researcher was available to conduct information sessions with them at their professional meetings. These sessions were conducted on two occasions.

The recruitment of participants used for this study was purposive sampling which allowed the researcher to select participants whose employment present or past had specific relevance to the research topic. Further, homogenous sampling was undertaken to allow "... a detailed investigation of the processes in a specific context." (Ritchie, Lewis & Elam 2003, p. 79). During recruitment, the conduct of focus groups snowballing or chain sampling approaches were utilised where participants identified other individuals who met the criteria for inclusion (Ritchie, Lewis & Elam 2003). Given that the area of research was specific and not diverse it was not surprising that this manifested and that participants recruited colleagues for the study. This sampling approach led to the identification of an extra focus group.

4.8.2 Participant inclusion criteria

Mental health nurses with a minimum of six months experience in CAMH nursing and Graduate Diploma of Mental Health Nursing students employed in the unit were recruited. In addition, mental health nurses who no longer work in the Child and Adolescents Mental Health inpatient unit but did so for six months or more since 2003, were recruited. Other members from the multidisciplinary team such as psychiatrists, psychologists and social workers were also recruited as this added to the richness of the data by allowing a further etic perspective apart from the researcher. The etic perspective was the outsider's view of the studied phenomenon and was complimentary to the emic perspective which was the insider in this case the nurse's view of the data (Cluett & Bluff 2000). The multidisciplinary team in the inpatient unit worked closely together so they had a broad understanding of the work of the CAMH nurse in the team.

4.8.3 Participant exclusion criteria

Excluded from the criteria were mental health nurses who worked in the CAMH inpatient unit for less than 6 months since 2003 or prior to 2003. Transition to Professional Practice – Registered Nurses, students, and students of other disciplines were also excluded.

4.9 Timing and location of group discussions

The focus groups and interviews were not conducted in the inpatient environment due to the issues of confidentiality. They were conducted at a convenient location for the participants away from their work. Seven focus groups totalling 19 participants were conducted between November 2009 and March 2010. Each focus group discussion lasted approximately 1 hour.

4.10 Questions

Structured questions that were derived from the document analysis in stage one were used as a basis for the interview. These questions reflected areas about qualifications, experience, knowledge, skills and safety and risk management. Rationale for their inclusion is discussed in the analysis of stage one data in the next chapter. The eight questions used were:

- How do you define the work of a CAMH nurse?
- As a beginning practitioner how did you navigate through the role?
- What knowledge and clinical skills in assessment are required to undertake the role of a CAMH nurse in the inpatient unit?
- What knowledge and clinical skills in treatment are required to undertake the role of a CAMH nurse in the inpatient unit?
- How does the CAMH nurse balance and regulate the therapeutic milieu? What comes first the skill or the experience? How do you learn that?
- What factors contribute to becoming a competent CAMH nurse working in the inpatient unit?
- What is the most professionally challenging aspect of the CAMH nurse role?
- What is the most professionally rewarding aspect of the CAMH nurse role?

4.11 Data collection method/procedure

The researcher welcomed each participant to each focus group and explained the purpose of the discussion and encouraged them to contribute their ideas. Consent for their involvement and audio taping of the discussion was sought and received. The confidentiality of discussion within the group was emphasised. The researcher employed note taking and audio taping both during and after each focus group to allow opportunity to debrief, reflect and analyse. The researcher's principal supervisor joined as an observer and note taker on the first focus group which added rigour to the process. After each focus group was completed the digital audio file was transcribed verbatim. Demographic data was collected at the beginning of the focus group as part of the joining activity of the groups with each member stating the length of their experience working in CAMH nursing.

4.12 Facilitation of focus group discussion

The researcher is a mental health nurse with thirty years' experience in conducting interviews and facilitating discussion groups and therefore has a solid understanding of group processes. The groups were conducted by moderating the discussion of the group being mindful of equity in opportunity for all participants to contribute. It was important to promote a comfortable group dynamic to enable rich discussion. The focus group questions provided a basis for the discussion.

4.13 Data analysis

The thematic analysis of the focus groups was undertaken at the latent level. This allowed the data to be analysed and interpreted to elicit the underlying assumptions and meanings that the participants made of the role of CAMH nurses.

The focus group data was analysed using an adaptation of the six phase thematic analysis process as described by Braun and Clarke (2006). The process is as follows: Phase 1: Familiarising yourself with the data; Phase 2: Generating the initial codes; Phase 3: Searching for themes; Phase 4: Reviewing the themes; Phase 5: Refining and naming the themes and Phase 6: Producing the report. The researcher adapted Phase 6 by developing the questions for the third stage of the study rather than producing a report.

4.13.1 Phase 1: Familiarising yourself with the data

Transcripts functioned as the primary data source complemented by researcher field notes. After each focus group had been completed the digital audio file was transcribed verbatim. In the meantime the researcher reviewed the reflective notes which were taken during and after the focus group. When the transcriptions were completed the researcher gave a copy to each participant in the focus group in order for them to verify their contribution. Concurrently the researcher checked the transcript against the digital audio tape for accuracy and to verify the content. During the process of thoroughly sifting through the data repeatedly, the researcher became familiar with the excerpts from the participants. This process was repeated with all of the seven focus groups. The researcher was immersed in the data through reading and re-reading the transcripts.

4.13.2 Phase 2: Generating the initial codes

An inductive process identified themes, categories and codes that emerged from the data. The transcripts from each of the focus groups were examined individually and then assigned initial codes. This was undertaken working through the transcript of one group at a time, question by question looking for the codes initially within the questions and then across the data set of the focus group, (Krueger 1998). Each whole transcript was then revisited to determine whether additional excerpts would be included that may have been overlooked in phase one. Further, this process of generating the initial codes allowed the researcher to arrange the data extracts into clusters which were significant to the research question. Given the social constructionist theoretical framework of this research, the transcript excerpts coding sought to identify sociocultural contexts in the data. Social constructionism is concerned with the making of meaning and experience within a sociocultural context (Burr 2003), so this was the lens through which the excerpts were viewed to identify the initial codes.

4.13.3 Phase 3: Searching for themes

The initial codes generated from Phase 2 were re-examined to look for any candidate (potential) emerging themes. This phase entailed a careful repeated reviewing of the initial codes. This process was undertaken by physically separating the initial codes then allocating them to theme groups that were potentially related.

4.13.4 Phase 4: Reviewing the themes

This phase involved the modification of the candidate themes produced in the preceding phase. The purpose of this phase was to elicit the authenticity of the themes produced. This was achieved by examining them in the context of their transcript to ascertain if there was sufficient data to support them. The process necessitated re-examining each candidate theme to determine if it reflected the meanings of the data included in it. In addition, it aided in identification of extra themes that could be added to more accurately represent the data.

4.13.5 Phase 5: Refining and naming the themes

In this phase the themes were further refined and analysed to identify the core meaning of each theme and its accompanying extracts. The themes were worked through one at a time always within the perspective of the overarching research question. This phase elicited each of the themes that were related to the account of the role of the CAMH nurse in the inpatient unit. Also this phase identified that some of the themes had sub themes.

4.13.6 Phase 6: Developing the questions for the stage three data collection

Individual interview questions were developed based on the thematic analysis of the data from the focus groups. These were used in stage three of the research.

4.14 The reflexive researcher

It is important researchers be aware of their own professional work role in qualitative research processes. This was particularly vital for this researcher as she had worked in the area of CAMH previous to the research being conducted but not in an inpatient unit where most of the participants were employed. The researcher conducted a process of note taking to document any preconceived ideas. This process helped to externalise any thoughts, biases and misconceptions about the research topic that were experienced by the researcher. The researcher also listened carefully to the audio tapes whilst reading the transcribed data. This was useful in determining whether there were any leading questions asked, and therefore provided the opportunity to reflect on the origin of these.

The researcher did not identify any leading questions although there was at times clarification sought by the participants about the meaning of questions. When the researcher was immersed in the interview process it was vital to witness their own thoughts and the effect they may have on analysis and interpretation of the data. This was undertaken post interviews in the aforementioned note taking process.

4.15 Summary of stage two

This section has described stage two of the study in which focus group interviews were used to collect data from CAMH nursing about their work and role. A detailed examination and analysis of the data followed an adaptation of the model by Braun and Clarke (2006) which generated themes to elicit meanings of the role of the CAMH nurse. Further, more specific questions were developed based on these themes for use in stage three of the study.

4.16 Stage Three – Individual Semi-structured Interviews

Stage three involved semi structured interviews with selected participants based on a series of more specific questions that had been generated through the focus group data analysis. The interviews were semi-structured to allow flexibility in relation to the depth of the response and spontaneity from the participants.

4.17 Purpose of individual semi-structured interviews

The purpose of interviews with individual participants was to explore in more depth the themes that emerged during the focus groups. This study was concerned with the interpretation of the role and work of nurses. Individual interviews provided opportunity to gather more in-depth and richer data about this phenomenon. However there were some advantages and limitations when undertaking interviews.

4.17.1 Advantages of individual semi-structured interviews

The advantage of semi-structured interviews was that they were more flexible and therefore allowed the researcher to explore the topic in more detail (Streubert Speziale & Carpenter 2007). The depth and complexity of the data is fundamental to qualitative methodology and open-ended questions allowed the interviewees to

answer questions in more depth (Polit & Beck 2010) which was an advantage of semi-structured interviewing. This type of interview is useful where the researcher has a clear idea of the subject but does not want to limit the discussion (Nagy et al. 2010) which was applicable to the research undertaken.

4.17.2 Limitations of individual semi-structures interviews

There are disadvantages with interviews in that the participants may tell the interviewer what they think they want to hear (Streubert Speziale & Carpenter 2007) rather than what their own thoughts and opinions were on the questions asked. Unless there was a level of rapport and trust established between the interviewer and the interviewee this could be a disadvantage (Streubert & Carpenter 2011) and therefore affect the richness of the data collected. Another disadvantage with interviews was if the interviewer is unable to maintain the balance between flexibility and focus in asking the questions (Nagy et al. 2010) it may affect the quality of the responses.

4.18 Selection and recruitment of the participants for interviews

The participants selected for the individual interviews were members of previously conducted focus groups. At the time of undertaking each focus group the researcher informed the participants that there would be individual interviews conducted with further and more specific questions generated from the focus group data analysis. The researcher informed the participants that they would be asked to nominate one person from their focus group for the interview. In addition, the researcher informed the focus group participants that if there was more than one member of the group that wished to nominate they would also be offered an interview. Members of each focus group were contacted individually and asked if they would nominate someone or themselves for participation in an individual interview. There was only one member from each focus group who nominated for the individual interviews.

The nominee from focus group one had not participated in the focus group interview as they had needed to take unexpected leave on the day. The participant was still keen to be involved in the study and was supported by the other focus group members to do so. Therefore this individual represented their own perspective as did all of the participants in the individual interviews. Focus group two had three participants but a

fourth who was unexpectedly unable to attend on the day of the focus group nominated themselves with the support of the focus group members. There were six individual interviews conducted. These interviews were conducted between August and October 2010.

4.19 Facilitation of interviews

During the interviews the researcher used a technique called probing which elicited information of more depth from the participants. Probing, paraphrasing and open ended questions were common techniques used in counselling.

As with the focus groups a level of expertise was required by the interviewer in order to elicit information from the participant in regards to their interpretation of the role and work of these nurses. The researcher possessed the skill to ask open ended questions which would reveal the information sought. The ability to focus the participant was required by the researcher to encourage them to explore their own interpretations of the topic.

4.20 Data collection method/procedure

These interviews were recorded and transcribed. A copy of the transcription was given to the participant to verify the contents. It was anticipated that participants may be required to attend more than one interview to clarify information and interview content to achieve a rich and thick description. It was thought that these interviews would be of no more than 45 minutes duration. A longer interview could be negotiated with the participant. None of the participants interviewed were required to attend more than one interview. The interviews were conducted away from the participant's workplace at a site that was convenient for the participant.

4.21 Data analysis

The semi-structured interviews were also analysed at the latent level. This facilitated the researcher being able to extract themes that represented the conceptualisations and beliefs of the individual participants. This knowledge enhanced the data analysed from the documents and focus group stages. This analysis was situated within the

social constructionist paradigm and therefore sought to interpret individual meaning within the socio-cultural context.

4.22 The thematic analysis process

As with the focus group analysis the researcher adapted the six phase thematic analysis process as described by Braun and Clarke (2006). The process was as follows: Phase 1: Familiarising yourself with the data; Phase 2: Generating the initial codes; Phase 3: Searching for themes; Phase 4: Reviewing the themes; Phase 5: Refining and naming the themes and Phase 6: Producing the report. For the individual interviews there was no Phase 6 as the findings were culminated into a whole for a conceptualisation of the meaning of the role and work of CAMH nurses.

4.22.1 Phase 1: Familiarising yourself with the data

The data was listened to repeatedly to enable the researcher to become familiar with the participant's words. This process was repeated with all of the six individual interviews. As well as listening to the audio recordings the researcher read and re-read the transcripts to absorb the meanings from the participants.

4.22.2 Phase 2: Generating the initial codes

The participant transcripts were considered individually and then assigned to initial codes. This phase of the analysis, whilst time consuming, was vital as it divulged the initial codes that were produced by the data extracts from the participants. The initial codes were represented by collections of data extracts that had some commonality and were also related to the overall question of the research.

4.22.3 Phase 3: Searching for themes

The initial codes generated from Phase 2 were reconsidered to look for any candidate themes. Reviewing of the initial codes was the beginning focus of this phase. This process entailed separating the initial codes then allocating them to candidate theme groups. The candidate themes generated were based on the initial codes and formed the basis for the next phase of analysis in which the candidate themes were reviewed.

4.22.4 Phase 4: Reviewing the themes

Reviewing the themes led to the modification of the candidate themes produced in Phase 3. The authenticity of the candidate themes produced in the previous phase was

examined in Phase 4. The transcripts were revisited to determine if the candidate themes were supported by the data and whether the candidate theme mirrored the meaning of the data. The researcher also utilised this phase to determine whether there were any extra themes that could be added that more accurately represented the data.

4.22.5 Phase 5: Refining and naming the themes

Phase 5 entailed further refinement and analysis of each theme to ascertain the core meaning. An important aspect of this phase was to ensure that the identified themes related in particular to the research question of this study. Therefore the themes from phase 4 were revisited in detail to scrutinise the data.

4.23 Summary of stage Three

This third and final stage of the study has described the semi-structured individual interviews that were designed to explore a more in-depth interpretation of the role of CAMH nurses. A detailed examination and thematic analysis of the data was conducted following an adaptation of the model by Braun and Clarke (2006) using the six steps for the analysis. Fifteen codes were initially identified and further cultivated and named as the final twelve themes emerged. Chapter 6 considers the commonalities in the themes generated from the focus group analysis and individual interview analysis and their meaning and conceptualisation of the role and work of CAMH nurses.

4.24 Rigour

Rigour is a term used in qualitative research to establish what is termed as reliability and validity in quantitative research (Morse et al. 2002). In qualitative research rigour is encompassed by the term trustworthiness which came from the seminal work of Guba and Lincoln in the 1980's (Morse et al. 2002). Trustworthiness is demonstrated by the following strategies; credibility; transferability; dependability and confirmability (Denzin & Lincoln 2008; Guba & Lincoln 1981; Lincoln & Guba 1985). Building trust and rapport with participants and reflexivity of the researcher are also important. These constructs were addressed in this study through the following strategies.

4.25 Credibility

In qualitative research it is important that the researcher remains committed to the participant's viewpoint which is presented to reflect the true meaning of the participant's interpretation. Rigour is demonstrated in qualitative research by allowing participants to review the transcripts of focus groups and individual interviews to ensure that it is a reliably accurate reflection of content. The raw data from stage two and three of the study was verified after transcription by the participants.

Triangulation was undertaken to ensure rigour in this study. Triangulation is a method in data analysis that enhances rigour by acquiring a broad range of perspectives on the research question from a variety of sources (Polit & Beck 2012; Streubert & Carpenter 2011), in this case mental health nurses and other members of the multidisciplinary team in both group and individual discussions.

4.26 Transferability

Transferability refers to whether the findings of a qualitative study can be replicated in another setting (Lincoln & Guba 1985) or with a different group of individuals. This research provided detail in the descriptive information (Polit & Beck 2012) to enable people other than the researcher to assess this.

4.27 Dependability

Dependability in qualitative research is concerned with consistency and stability of the data over time (Polit & Beck 2012) and whether it could be replicated with a similar group or context. The systematic documentation of the data and materials resulting from a study provide an audit trail with which to measure the trustworthiness of the research (Streubert & Carpenter 2011). Careful description of all aspects of the research including the theoretical approach, setting, participants and methods of data collection and analysis has been undertaken.

4.28 Confirmability

Confirmability is concerned with objectivity (Streubert & Carpenter 2011), that is a lack of dissonance between the participant and the researchers regarding the data's

accuracy and meaning. Clear and comprehensive notes were recorded for all activities within the stages of this research, after documents were selected and analysed, following each focus group. The transcripts from the focus groups and individual interviews were verified by participants to confirm that the content reflected what they had said. The overall findings of the research can also be shared with the participants.

Explicating the researcher's own beliefs is an important part of qualitative research, which must be undertaken in order to separate those beliefs from those of the participants (Roberts & Taylor 1998). This process is something referred to as bracketing and in interpretive research it is achieved through a journal. The researcher may keep a journal of their feelings and thoughts throughout the process which allows them to clearly identify and reflect on their biases. This structured process of reflection is essential to identify and manage the researcher's perspective (Barrett 1996). In this study the researcher did not keep a journal as there were regular opportunities for reflection with the supervisor which allowed the researcher to explicate their own beliefs through the research process.

The participants will sometimes keep a journal to allow them the opportunity to reflect on their thoughts. A key component of the study was the participants as they enabled the researcher to better understand the environment and participant's first-hand experience of the phenomenon.

4.29 Trust and rapport

Trust and rapport between the researcher and participant needs to be established in order to facilitate a meaningful exchange. This is sometimes easier if the researcher is already familiar with the research setting and the potential participants (Borbasi, Jackson & Wilkes 2005; Horsfall et al. 2007). The onus is on the researcher to fit into the routine of the field with a minimum of disruption (Horsfall et al. 2007). In relation to this study the researcher was a mental health nurse and is familiar with the setting where that participants work.

4.30 Reflexivity

Reflexivity is the process by which the researcher reflects on their own attitude in relation to the research process (Burr 2003). The researcher then has the opportunity to consider any influence they may have on the research (Denzin 2001). The researcher may keep a journal of their interpretations to allow them to explore their own values and attitudes in regards to the researched topic. Fundamental to qualitative inquiry is the idea of obtaining an emic or insider as well as etic or outsider perspective which adds to the richness of the data (Denzin & Lincoln 2000). An emic perspective is the interpretation of the research from the perspective of the group being studied, in this case CAMH nurses. The etic perspective represents that of participants outside the group being studied as well as the researcher. The researcher recruited mental health nurses and other members of the multidisciplinary team to the study to ensure rigour through triangulation, review of the data by participants and note taking, as well as audio taping during interviews (Maggs-Rapport 2001). Reflexivity or reflective practice is one of the strengths brought to this interpretive research by the researcher, a mental health nurse (Grigg et al. 2004). In this study, the researcher's interpretation of the data was also included.

4.31 Overall Summary

This chapter has described the three stage qualitative study design and discussed why it fits within the interpretive methodology. The social constructionist framework and symbolic interactionist stance fitted well with child adolescent mental health nursing because of its reflective and collaborative nature.

An interpretive methodology was appropriate for this study as the goal was to understand the role of mental health nurses working in the CAMH inpatient unit and how they interpreted and navigated that environment. Interpretation was a sequential process and was symbolic and relational, interactional, contextual, dialogic and polyphonic (Denzin 2001). With this in mind it was essential that the methods afforded the opportunity for a rich description which reflected the perception, values and attitudes of the participants. The methods of document analysis, focus groups and individual interviews were chosen for this study as they facilitated a rich description of the role of these nurses from their perspective as well as other members of the

multidisciplinary team. In addition, techniques such as reflexivity (Sugiman 2006) and triangulation contributed to the richness of the interpretation and rigour of the research design. Findings of stages one, two and three will be reported in Chapter Five.

Chapter 5: Findings

5.1 Introduction

The previous chapter described the three stage research design which sought to elicit a rich and detailed description of the work of CAMH nurses from their perspective and that of their work colleagues. Findings from Stage One document analysis, Stage Two focus groups and Stage Three individual interviews are presented sequentially. The voices of the participations are represented in italics in stage two and stage three in this chapter.

5.2 Stage One- findings from the document analysis

Stage one encompassed the analysis of documents relevant to CAMH nursing practice. Thematic analysis was used to inductively identify themes within the documents. An iterative process was initially used for the initial review of documents.

5.3 Iterative process – the initial review

The job and person specifications of the nurses working in the CAMH Inpatient Unit were chosen for the initial review. The rationale was that all employees worked within a job and person specification so this provided a framework for their practice. Further, the essential criteria; qualifications, experience, skills and knowledge provided the groupings from the documents that initiated analysis. From the initial review of the job and person specification documents it appeared that knowledge could be divided into professional and clinical practice. Professional knowledge could be interpreted to have a broader context such as legislation and comprehensive understanding of mental health nursing and clinical practice knowledge as being specific to the sub specialty of child and adolescent mental health. In addition, safety or risk management themes became apparent.

The iterative process for the document analysis is represented by the flow chart in Appendix 4. This chart, based on the work by Attride-Stirling (2001) was divided into three themes; basic, organising and global. Basic themes were the fundamental information that the researcher extracted from the text of the documents (Simons,

Lathlean & Squire 2008). Organising themes represented clusters of basic themes that were related. Global themes reflected the allegory of the data. The thematic network began with the basic themes and progressed to organising and global themes which were the core of the thematic network.

The basic themes were then divided into two categories, professional knowledge and clinical practice knowledge. Professional knowledge was defined by the researcher as the parameters which were determined externally within which the nurse needs to work. Clinical practice knowledge was defined as the socially constructed and negotiated parameters that pertained to CAMH nursing practice. For a visual representation of the global, organising, basic themes from the analysis see Appendix 5.

Following the initial review, all the documents were analysed, as primary data, to identify the assigned organising theme and/or basic theme. These data were then entered into an online software program, the Joanna Briggs Institute Thematic Analysis Program, for aggregation and analysis.

If the participants were to interpret and make meaning of their role then these themes would provide a framework to develop the questions for the focus groups and interviews in stage two and three of the study. At this point it was important to distinguish the difference between analysis and interpretation. Analysis as stated in the previous chapter is concerned with the reduction of data to basic units whereas interpretation is in regards to expansion of the data (Freshwater & Avis 2004).

5.4 Aggregative process – ongoing review

An aggregative review process was facilitated by the Joanna Briggs Institute Thematic Analysis Program (TAP) (Joanna Briggs Institute 2008) which included extraction of illustrations, aggregation of categories and synthesis of the categories into themes. These processes generated a TAP chart which demonstrated the connection between the illustrations, categories and themes (Appendix 6).

5.4.1 Illustrations

The TAP categories were developed from the iterative process as explained in Chapter 4. The TAP illustrations were the raw data. They were the titles of the identified documents. Each document was analysed and studied in detail to enable the researcher to become familiar with it and understand the content and context. The following is a list of titles of the documents that were the illustrations;

- Working within the multidisciplinary team
- Shift Coordinator Guidelines
- Professional role of nursing
- Mental Health Nursing Transfer Summary
- Management of Patient Cigarette Smoking - Boylan Ward
- Guidelines for the use of Psychotropic Medication on Boylan Ward (including PRN Medication).
- Guidelines for Monitoring Adverse Effects in Children and Adolescents Prescribed Antipsychotic Medication
- Guidelines for Acute Admissions to Boylan Inpatient Services
- Electroconvulsive Therapy (ECT) for Boylan Ward/ Helen Mayo House
- Discharge of a patient from Boylan Ward / Helen Mayo House.
- Conflict Resolution
- Case Reviews
- Assessment, Admission and Referral of Detained Patients on Boylan Ward
- Assessment and Care
- Absconding Patients - Inpatient Services
- Time Out - Boylan Ward
- Shift Coordinator Guidelines
- Seclusion - Boylan Ward
- Psychiatric Observation Chart
- Prioritisation, time management, flexibility, innovation and creativity

- Observation Charts- detention, psychiatric, acuphase observation chart, neurological, medication, amphetamine withdrawal scale, antipsychotic physical health monitoring chart, withdrawal pathway
- Nursing Assessment Form
- Mental Health Inpatient Unit - Restoration of Therapeutic Milieu
- Mental Health - Suicidal Behaviour Management
- Mental Health - Poor Self Esteem Nursing Management
- Medical Guidelines - Emergency Sedation and Restraint in Children and Adolescents
- Discharge of a patient from Boylan Ward / Helen Mayo House.
- Case Reviews
- Bulimia Nervosa - Management in Boylan Ward
- Assessment of a Patient on Admission to the CAMH Inpatient Unit
- Assessment and Care
- Absconding Thoughts and Behaviour - Prevention and Management - Inpatient.
- Risk Assessment/Awareness
- Post Risk Assessment
- Mental Health Act (2008)
- Children's Protection Act (1993)
- Job and Person Specifications for all levels of nurses working in the inpatient unit
- Transfer of Clients between Division of Mental Health Units
- Standards; Australian College of Mental Health Nurses, Australian Nursing and Midwifery Council, Nurses Board of South Australia
- Personal and Professional Conduct of Staff
- Patient/Client Incident Procedure
- Management of young person in care procedure

- Management of Patient Cigarette Smoking - Boylan Ward
- Guidelines for the use of Psychotropic Medication on Boylan Ward (inc. PRN Medication).
- Guidelines for Monitoring Adverse Effects in Children and Adolescents Prescribed Antipsychotic Medication
- Guidelines for Acute Admissions to Boylan Inpatient Services
- Emergency Mental Health Service - Access
- Emergency Mental Health Mobile Response - Referral of Young People (during business hours).
- Consumer Rights to Privacy & the Release of Confidential Information
- Considerations for Working with Clients from Culturally and Linguistically Diverse (CALD) Backgrounds
- Considerations for Working with Aboriginal Clients
- Consent
- Boylan Closed Ward Guidelines

After this analysis each illustration was assigned to a category.

5.4.2 Categories

The TAP categories were developed from the iterative process used in this research (Attride-Stirling 2001). The categories were previously defined as professional knowledge and clinical knowledge for each of the five descriptors used for the organisational themes in the iterative process. The categories were as follows;

- Clinical Knowledge/Experience
- Professional Knowledge/Experience
- Clinical Knowledge/Knowledge
- Professional Knowledge/Knowledge
- Clinical Knowledge/Qualifications
- Professional Knowledge/Qualifications
- Clinical Knowledge/Safety and Risk Management

- Professional Knowledge/Safety and Risk Management
- Clinical Knowledge/Skills
- Professional Knowledge/Skills

Through this analysis it became clear that some data/documents belonged to more than one category. An example of this was the documents relating to nursing assessment of an inpatient. The categories it related to included; professional knowledge/experience; professional knowledge/skills; clinical knowledge/experience and clinical knowledge/skills.

5.4.3 Themes

The TAP themes were created from the descriptors identified in the initial review of the job and person specifications criteria. The job and person specifications identify minimum essential criteria to fulfil the role. Each of these criteria is listed according to the area of practice to which it relates. These dominant themes were extracted from the Job and Person specifications as part of developing the rationale for the framework. The themes are as follows;

- Experience
- Knowledge
- Qualifications
- Safety and Risk Management
- Skills

After categorisation of the primary data/documents, the categories were reviewed to determine if they could be further aggregated on the basis of similarity in focus. This process enabled the researcher to develop their own questions arising from the thematic analysis. The following are the questions which are linked by to the themes by the legend at the end of the questions;

- How do you define the work of a CAMH nurse? (q,s,e,k & srm)
- As a beginning practitioner how did you navigate through the role? (How did you socially construct it?) (e)

- What knowledge and clinical skills in assessment are required to undertake the role of a CAMH nurse in the inpatient unit? (k,s,srm) (e.g. Case management, risk assessment & caregivers)
- What knowledge and clinical skills in treatment are required to undertake the role of a CAMH nurse in the inpatient unit? (k,s,srm) (e.g. Counselling, groupwork & caregivers)
- How does the CAMH nurse balance and regulate the therapeutic milieu? What comes first the skill or the experience? How do you learn that? (s&e)
- What factors contribute to becoming a competent CAMH nurse working in the inpatient unit? (q,s,e,k & srm)
- What is the most professionally challenging aspect of the CAMH nurse role? (q,s,e,k & srm)
- What is the most professionally rewarding aspect of the CAMH nurse role? (q,s,e,k & srm)

Legend

q	qualification
s	skills
e	experience
k	knowledge
srm	safety and risk management

5.5 Summary of findings of stage one- document analysis

Document analysis findings for stage one of the study has been presented. The content has provided a description of the processes of analysis. Further, it has illuminated the process of the researcher's decision making in relation to the analysis of the documents and the development of the questions for the focus groups. The next section will discuss the findings from the focus group interviews.

5.6 Stage two – Findings from the focus groups

Seven focus groups were conducted ranging from two to four participants in each group from November 2009 to March 2010. Focus group one originally had four participants but one was on unexpected leave and another was called away on a

clinical matter so only two participated. One participant had twelve years' experience in CAMH the other had six. Focus group two had three participants who had previously worked in the CAMH ward for more than six months in the last three years. One participant had two and a half years of experience in CAMH and the other two had three years experience. Group three had four participants who work in a community team which had an ongoing relationship with the ward. One participant had two years experience in CAMH, two had seven years' experience in CAMH and one had sixteen years experience in CAMH. Group four originally had four participants but due to a variation in working hours the group was divided into two. One participant had twenty years experience in CAMHS the other had four. Group five originally had four participants but due to a variation in working hours the group was divided into two. One participant had six years experience in CAMH the other had three. Group six had three participants who were associated with the ward clinically but in non-nursing roles. One participant had thirteen years experience; one had eight years experience and the other had thirty one years experience. Group seven had three participants who all had management or education roles associated with the ward. One participant had twenty nine years experience; one had twenty four years experience and the other had sixteen years experience. In total there were nineteen participants spread across seven focus groups.

As is evidenced by Table 1, there was a wide range of experience across the participants which reflected a demographic representation of this group of CAMH nurses. The range of participant experience allowed the researcher to capture the interpretations of participants at different levels of their exposure the profession. In turn this provided both a contemporary and historical account of the making of meaning of the work within the role of CAMH nurses in an inpatient unit environment. The researcher divided the years of experience into five year intervals as the data appeared to reflect these natural grouping.

Table 1: Demographic data from focus groups

Focus group	Number of participants	Gender distribution	Years of CAMHN experience	Less than 5	Less than 10	Less than 15	More than 15
One	2	1Male 1Female			1	1	
Two	3	1Male 2Female		3			
Three	4	1Male 3Female		1	2		1
Four	2	2Female		1			1
Five	2	2Female		1	1		
Six	3	2Male 1Female			1	1	1
Seven	3	3Female					3
Total	19	5Male 14Female		6	5	2	6

In reporting excerpts from the data the researcher randomly numbered the participants from one to nineteen to maintain their anonymity rather than report by focus group number.

When conducting the focus groups the researcher was impressed by the level of commitment and enthusiasm displayed by the participants in their willingness to contribute both their time and ideas. The researcher also employed note-taking and audio-taping both during and after the focus groups to debrief, reflect and analyse.

5.7 Thematic analysis

The focus group data was analysed using an adaptation of the six phase thematic analysis process as described by Braun and Clarke (2006) as described in Chapter Four. Each phase of analysis will be described here.

5.7.1 Phase 1: Familiarising yourself with the data

After each focus group had been completed the digital audio file was transcribed verbatim. The researcher checked the transcript of each focus group against the digital audio tape for accuracy and to verify the content. Reflective notes were also reviewed. During this process of thoroughly sifting through the data repeatedly, the researcher became familiar with the excerpts from the participants. This process was repeated with all of the seven focus groups. The researcher was immersed in the data through reading and re-reading the transcripts.

5.7.2 Phase 2: Generating the initial codes

An inductive process identified initial codes within the data from each focus group as described in Chapter Four. Table 2 illustrates initial coding.

Table 2: Focus Group Analysis Phase 2 Initial codes

The nine initial codes generated from Phase 2
Knowledge Transfer is learning to become a CAMH nurse
Theoretical Framework which underpins the nursing knowledge utilised by the CAMH inpatient nurses
Nursing Practice is the operational scope of the role
Team Context in which the CAMH inpatient nurses practice
Contextual perspective in which the CAMH inpatient nurse practices
Risk and Safety, monitoring and maintaining the environment
The Learning Environment in which the CAMH role is positioned
Child and adolescent mental health practice framework
Miscellaneous

5.7.3 Phase 3: Searching for themes

The initial codes generated from Phase 2 were re-examined to look for any candidate (potential) emerging themes. Some data had relationships to more than one potential theme. The initial code Child and Adolescent Practice Framework was renamed Professional Issues as this better encompassed what the participants described in the data. Careful analysis of the initial codes resulted in the initial code ‘miscellaneous’ being excluded. On review it became apparent the data could be coded in other candidate themes. An example of this was “managing family and visitor accommodation” which was included in Nursing Practice and concerned with the operational scope of the role. Also moved from Miscellaneous to Nursing Practice was “administration” which was regarded as an operational facet of a role. There were nine candidate themes generated which are represented in

Table 3 which demonstrates the development of initial codes to candidate themes.

Table 3: Focus Group Analysis Phase 3 Searching for the themes

Phase 2 Initial Codes	Phase 3 Candidate Themes
Knowledge Transfer is learning to become a CAMH nurse	Knowledge Transfer, becoming a CAMH nurse
Theoretical Framework which underpins the nursing knowledge utilised by the CAMH inpatient nurses	Theoretical Framework which underpins the nursing knowledge utilised by the CAMH inpatient nurses
Nursing Practice is the operational scope of the role	Nursing Practice is the operational scope of the role
Team Context in which the CAMH inpatient nurses practice	Team Context in which the CAMH inpatient nurses practice
Contextual perspective in which the CAMH inpatient nurse practices	Contextual Perspective in which the CAMH inpatient nurse practices
Risk and Safety, monitoring and maintaining the environment	Risk and Safety, monitoring and maintaining the environment
The Learning Environment in which the CAMH role is positioned	The Learning Environment in which the role is positioned and CAMH
Child and adolescent mental health practice framework	Professional Issues are the situational perspectives that frame the role
Nursing practice professional framework	Nursing practice professional framework
Miscellaneous	Omitted as the data was coded into other existing themes

The candidate themes generated were based on the initial codes and formed the basis for the next phase of analysis in which the candidate themes were reviewed.

5.7.4 Phase 4: Reviewing the themes

Themes were re-examined in context of each focus group transcript to establish sufficient and meaningful data to support the candidate theme. In addition, it aided in identifying extra themes which more accurately represented the data. Knowledge Transfer, which was about acquiring the knowledge to undertake the role gained the following participant quote “...more active participation in assessment and knowledge transfer to other team members” (participant 10). The Contextual Perspective obtained the following participant quote “...physical environment of the inpatient unit” (participant 7) which was echoed in other data in that candidate theme.

Within the other candidate themes it became apparent that some contained two clear themes. An example is the Team Context in which the CAMH nurse practices where the participants had made reference to the nursing “team” and the multidisciplinary “team”. Whilst both teams were identified as playing a role in CAMH nursing practice they were attributed different roles by the participants. The nursing team was

identified more as providing support in working with clients with an unfamiliar diagnosis and supervision by the participants.

Phase 4 involved rereading the entire data set of transcripts to determine the validity of the candidate themes and whether they accurately represented the data. This research was theoretically framed by a social constructionist view and as such was concerned with the making of meaning and how the CAMH nurses interpret their environment in the context of their role. This was from all participants' viewpoints, nursing and multidisciplinary participants.

Knowledge transfer related to how one became a CAMH nurse in an inpatient unit and the data extracts reflected the participant's views. The theoretical framework which underpinned the knowledge of the CAMH nurse was represented by the participant extracts. Nursing Practice in the operational scope of the role was represented by the data participants' recorded extracts. The team context in which the CAMH nurse practices was divided into two sub themes as previously stated. The contextual perspective in which the CAMH inpatient role practices remained unchanged with the reviewed participant citation considered to be appropriate. Risk and Safety – monitoring and maintaining the environment had representative participant extracts. The learning environment in which the role is positioned contained participant extracts that supported the theme. The CAMH practice framework on review was considered problematic as the participant extracts fitted into the theme of professional issues which are the situational perspectives that frame the role.

The review of the themes and the extracts within the social constructionist perspective of the study added further clarity to the analysis by providing a clear focus on the theoretical parameters.

5.7.5 Phase 5: Refining and naming the themes

In phase 5 the themes were further refined and analysed to identify their core meaning in relation to the research question. Table 4 identifies the themes and related sub themes that were refined and named.

Table 4: Focus Group Analysis Phase 5 Refining and naming the themes

Themes	Sub themes
Knowledge Transfer, becoming a CAMH nurse	learning to become a CAMH nurse
	the support needed to become a CAMH nurse
Theoretical Framework which underpins the nursing knowledge utilised by the CAMH inpatient nurses	developmental framework forms a basis for all assessment and intervention
	conceptual formulations
Nursing Practice is the operational scope of the role	working with families and family systems
	communication skills
	walking therapy and driving therapy every interaction matters
Team Context in which the CAMH inpatient nurses practice	the nursing team
	the multidisciplinary team.
Contextual Perspective in which the CAMH inpatient nurse practices	the wider hospital perspective of the CAMH nursing service
	the community including CAMH community services, schools, family and community services,
	they provide a state-wide and cross borders service
Risk and Safety, monitoring and maintaining the environment	understanding the relationship between patient acuity and environment
	advocacy for the young person
The Learning Environment in which the role is positioned and CAMH	education of students from nursing, medicine and allied health
	psychoeducation of young people and their families
Professional Issues are the situational perspectives that frame the role	nursing practice professional framework including regulation and legislation
	organisational framework

Each theme is now discussed in turn along with supportive data from participants.

5.8 Knowledge transfer – learning to become a CAMH nurse in an inpatient unit

Knowledge Transfer described the process of becoming a CAMH inpatient nurse from the perspective of the participants in the study. It not only described how they became a CAMH nurse but also how they were supported through the process by colleagues. As the participant’s data extracts were once again analysed it became apparent that in the theme of Knowledge Transfer was represented by two sub themes which were learning to become a CAMH nurse and the support needed to become a CAMH nurse.

5.8.1 Learning to become a CAMH nurse

The process of becoming a CAMH nurse was identified through participant's data across all focus groups and described in the data by the participants in the following ways.

The Knowledge Transfer provided a safe environment for the nurse to develop confidence in undertaking the role. The participants talked of how practically they gained experience through "*seeing it and experiencing it*" (participant 14) and further by having a "*range of experiences*" (participant 14) through which there was "*development, discovery and watching*" (participant 10). The process of gradual absorption through continual exposure was described as being practically based in the clinical environment. Participants described the knowledge acquisition as being "*more on the job*" (participants 6&18) which reflected elements of an internship or a traineeship which was appropriate given the skills base required for a complex role.

5.8.2 The support needed to become a CAMH nurse

The participants described the support provided to them as guiding their practice formation through "*back office*" (participants 4, 7, 10,13 &14) and informal conversations which provided "*opportunities for skill development*"(participant 14) and being "*gradually introduced to having a caseload*" (participant 4). These concepts demonstrated an environment conducive to developing knowledge and the nursing role. The participants provided examples of support in the role by "*knowledge transfer amongst the nursing team*" (participant 10) which included the "*sharing of ideas*" (participant 15) and described "*the clinical knowledge pool*" (participant 7) and how "*CAMH nurses all have different skills*" (participant 3). The participants also revealed that although there was "*some formal teaching*" but the role was "*not something that you can learn in a textbook*" (participant 18) and as such requires the clinical support to succeed. These examples of support revealed an informal system that supported the development of the CAMH nurse role in the inpatient unit.

All of the concepts built a picture of how the nurse learned to become and was supported in becoming a CAMH inpatient nurse. Further, the participants described how the information was shared amongst the nurses in the unit through the communication process.

5.9 Theoretical framework which underpins the nursing knowledge used by the CAMH inpatient nurse

The theoretical framework identified by the focus group participants provides a structure for the nursing knowledge utilised by the inpatient nurses. The theoretical framework described by the participants formed two sub themes, the developmental framework and conceptual formations. The participant's data acknowledged the importance of the framework as "*theoretical frameworks assist in conceptualisation formation*" (participant 17) which is "*what a CAMH nurse needs to know*" (participant 17).

5.9.1 Developmental framework: a basis for all assessment and intervention

The theoretical framework described by the participants in the data focused on several theoretical perspectives one of which was "*the developmental context*" which was considered "*a key building block*" and also "*forms a basis for all assessment and intervention*" and that "*often there was no diagnosis so developmental framework is important*". This was particularly pertinent to the CAMH nurse because of the age group of the clients and the participants expressed the significance of this because they needed to have this understanding because they need "*the ability to play within a young person's developmental context to engage with them and establish a rapport*" (participant 4).

5.9.2 Conceptual formations

Conceptual formations referred to what the nurse needed to know to undertake a comprehensive assessment and intervention. Additional to the developmental framework, attachment theory was highlighted as important because of the client group and therefore was prevalent in the data. The neurological and biological context was identified as being important for symptom recognition and management and indeed to eliminate any organic cause. The pharmacological framework highlighted a need for "*knowledge of medications and how it is different to the adult context*" (participant 1) which also included "*pharmacological knowledge and competence*" (participant 15) as well as "*medication potential side effects*" (participant 2). The biopsychosocial paradigm and the holistic approach were also identified by the participants in the data. The data brought to light the importance of understanding "*a*

range of disorders and presentations for assessment” (participant 11) and *“understanding different treatment and therapeutic interventions”* (participant 5).

The participant’s data emphasised the need to understand the underlying theoretical frameworks and the complexity of the client presentations, to undertake assessments and interventions in their role in the inpatient unit.

5.10 Nursing practice in the operational scope of the role

Nursing practice identified the operational scope of the role by describing some of the practical applications of the role as illustrated by the participants. These descriptions formed three sub themes; communication skills; working with families; and walking and driving therapies - every interaction matters.

5.10.1 Communication skills

The participant’s comments illustrated that the nursing practice of the CAMH nurse was centred on communication skills whether it be *“informal conversations with young people and their families”* (participant 7) or being part of the *“communication hub”* (participant 7) which disseminates information to clients and other staff.

5.10.2 Working with families

The participants identified the role of the nurse as working with families and family systems through engagement and developing rapport as well as validating the parents concerns. Further, the participant’s data presented a multifaceted role for the nurses in *“translating what the psychiatrist has said and making it real”* (participant 10) as well as advocacy for clients and families and *“making a difference to people’s lives”* (participant 18). The researcher found that the nursing participants compared their role with that of mental health nurses in the adult sector. They saw the role as different because of the level of involvement of the family. They defined family as being not only parents but sometimes carers or the State agency. In addition, the role was identified by the participants as providing continuity of care, tailoring and adjusting care plans through comprehensive health assessment *“informal and practical treatment”* (participant 15) and discharge planning.

5.10.3 Walking and driving therapy - every interaction matters

The participants acknowledged that they needed to be creative in working with young people in order to undertake a comprehensive assessment and indeed intervention therapy. Some of these creative approaches were described as “*walking therapy and driving therapy the informality of the assessment and therapy processes evolve*” (participant 14). This was when the nurses were able to assess the young person in a less threatening environment than sitting in an office and interviewing them. The development of rapport was essential to the care of the young person so the participants identified the need to endeavour to achieve a level of informality in terms of assessment and therapy to facilitate this. The nurses provided a twenty four hour inpatient service so they were continually observing the young person “*continuous monitoring and evaluation a lot of which is unspoken*” (participant 1). Along the lines of this opportunistic approach to the care of the young person the participants were cognisant that “*every interaction matters*” (participant 17).

5.11 Team context in which the CAMH nurse practices

The team context was the collegial network that provided the environment for CAMH nursing practice in the inpatient unit. In Phase four of this analysis the researcher identified that the team context comprised two sub themes, the nursing team and the multidisciplinary team. However some participants felt they belonged in both sub themes. The data that crossed both team perspectives was concerned with support and collegiality “*being part of a team helps*” (Participant 6).

5.11.1 The nursing team context

It became evident that the nursing team played a significant role in how the CAMH inpatient nurses undertook their work. The participants viewed it as “*a supportive network for nurses*” (participant 3) which enabled them to practice within a strong nursing collaboration.

Part of that collaborative support was described in the following way “*flexibility within the team (nursing) that provides support and an opportunity to work with clients with a diagnosis less familiar to you and team (nursing) support and supervision*”. (participant 4). Here the participants highlighted the support of the team

through allowing the individual nurse to advance their clinical skills through the supervision with new areas of practice (diagnosis), guidance and flexibility.

5.11.2 The multidisciplinary team focus

The participants distinguished that the multidisciplinary team played a pivotal role in the CAMH inpatient unit and was responsible for the overall care planning. This is highlighted in the following data:

“other disciplines seeing a snapshot rather than the bigger picture planning care with the multidisciplinary team at meetings and nurses have an expert role in formulation as part of the multidisciplinary team”. (participant 10)

The team context was identified by the participants as being pivotal to the role providing support and also in assisting to manage anxiety through debriefing. The nursing team was viewed by the participants as providing flexibility and a supportive network that afforded an opportunity for supervision. The participants acknowledged that the multidisciplinary team offered a wider context for the CAMH nurse role to contribute expert opinion in formulation and planning care.

5.12 Contextual perspective in which the CAMH inpatient nurse practices

The contextual perspective in which the nurses practiced considered the wider hospital and CAMH service as well as the community, state and national viewpoint. Three sub themes identified through analysis were: the wider hospital perspective of the CAMH nursing service; the community perspective; the state and national perspective.

5.12.1 The wider hospital perspective of the CAMH nursing service

The role of the nurse in the initial contact with the patient was drawn attention to in the participant data excerpts by their role as *“first contact/front of house”* (participant 9) and their skills in *“front line assessment and triaging”* (participant 1). That underlined the fact that the nurses needed to be familiar with *“the components of the system in CAMH”* (participant 3) in other words that they needed a thorough understanding of not only assessment and triaging in the CAMH perspective but also

where and how to refer. The participant's excerpts also showed "*a public health focus with the normalisation of mental health*" (participant 7) within the general hospital environment in which they practice.

5.12.2 The community perspective of the CAMH nursing service

The community perspective included CAMH community services, schools as well as and government and private child welfare agencies "*the bigger picture perspective being a strength of the CAMH nurses*" (participant 8). Participants established that the relationships with community CAMHS, schools and the community play a role in the contextual perspective in which the CAMH nurse practices. The participant data recognised there was a strong relationship between the inpatient unit and the community and the nursing role "*is to keep children out of hospital*" (participant 6) and to "*start linking them in with a community clinician as early as possible*" (participant 4) which is part of understanding "*what is in your community*" (participant 11) and how they can best help the patient.

5.12.3 State and national perspective of the CAMH nursing service

The unit is the only CAMH inpatient service in the State and therefore provides a State-wide service. As the service is unique in the State they also viewed themselves as "*leaders in their field State-wide and nationally*" (participant 17). The unit also provides a service cross borders providing inpatient care to children and adolescents from rural and remote areas.

This bigger picture perspective was also identified as being the strength of the CAMHS nurse. The data also revealed that the participants believed there was a lack of understanding about the CAMH inpatient nursing role and the function of the ward by the community which has led to "*not being connected to the community*" (participant 15) in some instances.

5.13 Risk and safety – monitoring the environment

The risk and safety theme referred to monitoring and maintaining the environment and how this was achieved through CAMH nursing practice. There were two sub themes identified as understanding the relationship between patient acuity and

environment and advocacy for the young person. The following data indicates the participant's perspective;

5.13.1 Understanding the relationship between patient acuity and environment

Participant's data revealed that there were intricate components related to monitoring and maintaining the environment which include "*understanding the relationship between patient acuity and environment*" (participant 12). The participants described "*assessing and monitoring the behaviours of young people*" (participant 3) which included "*knowing the patient's baseline which is always changing in the acute setting*" (participant 6) and "*noticing interactions between patients' early warning signs*" (participant 7). Participants described a complex level of assessment that the nurse must undertake to ensure a safe environment with minimum risk.

5.13.2 Advocacy for the young person

Another aspect of risk and safety described by the participants was "*advocacy for the young person and other patients*" (participant 1) which may consist of nurses initiating "*a discharge to promote a therapeutic milieu*" (participant 7). The CAMH nurse was identified in the data as having a crucial role in reading the milieu.

The participants expressed a high level of monitoring of the environment to "*balance the conflict and distress with harmony*" (participant 9) which is a skill developed whilst working in the setting. Another facet of this complex situation emphasised was "*understanding the relationship between family dynamics and the environment*" (participant 2). The participant considered monitoring and constantly assessing the dynamic between visitors and the ward as integral to the therapeutic milieu.

5.14 The learning environment in which the role is positioned

The learning environment considers the education perspective of the CAMH inpatient nurse role. The participants indicated that the learning environment could be related to the client and family, students and staff. There were two sub themes; education of students from nursing, medicine and allied health and professional development of the CAMH nurses; and Psychoeducation of young people and their families.

5.14.1 Education of students from nursing, medicine and allied health and professional development of CAMH nurses

The education role in relation to nursing students and students of other disciplines was a facet of the CAMH role that was included “*education role supporting students from a variety of disciplines*” (participant 5); Of course this role was also important in recruitment of future nurses to mental health. The participants also ascertained that the CAMH nursing role was involved with the training, professional development and education of ward staff and other CAMH staff. Mentoring, preceptoring and staff supervision were also recognised by the participants as part of the CAMH nurse role.

5.14.4 Psychoeducation of young people and their families

The CAMH nurses had a key role in psychoeducation for families and young people not only in relation to mental health but also through “*helping parents understand the role of the ward*” (participant 3) and “*modelling and reinforcing positive behaviour*” (participant 15).

5.15 Professional issues

The two themes of CAMH practice framework and professional issues which are the situational perspectives that frame the role were combined in phase four of this analysis to form a new theme entitled professional issues. This theme captured the professional issues that frame the role and was supported by the following participant comments;

5.15.1 Nursing practice professional framework including regulation and legislation

The data exposed the parameters of professional practice from the focus group participant’s perspective. These included “*working in a legislative framework*” (participant 2) with some legislation being different to the “*adult sector such as custody and consent*” (participant 16) as well as the “*moral dilemmas*” (participant 19) which arose.

5.15.2 Organisational framework

The participants also identified that there were organisational philosophies, organisational frameworks, clinical standards and core competencies which framed the practice of the CAMH nurse. Succession planning and “*issues re the future of*

mental health nursing and core competencies” (participant 1) were two other concepts related to the role which were raised in the data excerpts by the participants.

5.16 Phase 6: Developing the questions for the individual interviews

Through the final phase of the thematic analysis individual interview questions were developed. The researcher developed eight interview questions from the themes revealed through the analysis. All eight themes in the analysis were given equal weighting as they all contributed to the participants’ data in relation to the work of the CAMH nurse in the inpatient unit.

Knowledge transfer described the process of becoming a CAMH inpatient nurse from the perspective of the participants in the study. Through analysing the data the following question has been developed;

In learning to become a CAMH inpatient nurse how is that knowledge transferred and how is the role supported?

The theoretical framework identified by the focus group participants provides a structure for the nursing knowledge utilised by the inpatient nurses. Through analysing the data the following question has been developed;

Which theoretical frameworks underpin the nursing knowledge used by the CAMH inpatient nurse?

Nursing practice identifies the operational scope of the role by describing some of the practical applications of the role as illustrated by the participants. Through analysing the data the following question has been developed;

What is the operational scope of the CAMH inpatient nursing role, can you define the practical applications?

The team context was the collegial network that provides the environment for CAMH nursing practice in the inpatient unit. Through analysing the data the following question has been developed;

Tell me about the team context in which the CAMH inpatient nurse practices.

The contextual perspective in which the nurses practiced considered the wider hospital and CAMH service as well as the community, state and national viewpoint. Through analysing the data the following question has been developed;

What is the contextual perspective of the CAMH inpatient nurse practice?

The risk and safety theme was with reference to monitoring and maintaining the environment and how this is achieved through CAMH practice. Through analysing the data the following question has been developed;

How does the CAMH inpatient nurse manage risk and ensure safety in the inpatient unit?

The learning environment considered the education perspective of the CAMH inpatient nurse role. Through analysing the data the following question has been developed;

How is the CAMH nurse positioned in the learning environment in regards to students, clinical practice and self-development?

The two themes of CAMH practice framework and professional issues which were the situational perspectives that frame the role were combined in phase four of this analysis to form a new theme entitled professional issues. Through analysing the data the following question has been developed;

What are the professional issues that relate to CAMH nursing in the inpatient unit?

In summary the following eight questions were developed from the analysis and utilised in the individual interview sessions;

- *In learning to become a CAMH inpatient nurse how is that knowledge transferred and how is the role supported?*
- *Which theoretical frameworks underpin the nursing knowledge used by the CAMH inpatient nurse?*
- *What is the operational scope of the CAMH inpatient nursing role, can you define the practical applications?*

- *Tell me about the team context in which the CAMH inpatient nurse practices.*
- *What is the contextual perspective of the CAMH inpatient nurse practice?*
- *How does the CAMH inpatient nurse manage risk and ensure safety in the inpatient unit?*
- *How is the CAMH nurse positioned in the learning environment in regards to students, clinical practice and self-development?*
- *What are the professional issues that relate to CAMH nursing in the inpatient unit?*

5.17 Summary of findings of stage two- focus groups

This section has presented the findings from the focus groups interviews in this study. Eight themes emerged which were investigated and refined through the analysis. Eight questions were developed for use in the final stage of data collection. The next section presents the findings of the individual semi structured interviews.

5.18 Stage Three – findings of the individual interviews

5.18.1 Introduction

The previous section discussed the findings of the focus groups that generated a more specific set of questions which were used in the final and third stage of the semi-structured individual interviews. This section presents the findings. The emergent themes are discussed using illustrations from the transcripts.

5.19 Individual interviews

There were six individual interviews conducted. Focus groups four and five were originally one group but due to a work variation on the day of interview had to be split into two. From these two groups they nominated one person to be interviewed resulting in six individual interviews from seven focus group interviews. These interviews were conducted between August and October 2010. The participants selected for the individual interviews were members of previously conducted focus groups. Members of each focus group were contacted individually and asked if they

would nominate someone or themselves for participation in an individual interview. There was only one member from each focus group who nominated for the individual interviews. There were six individual interviews conducted with one male and five female participants in total. The years of experience working in CAMH ranged from 4 to 29.

As is evidenced in Table 5, there was a wide range of experience across the participants. The range of participant experience allowed the researcher to capture the interpretations of participants at different levels of their exposure to the profession. In turn this provided both a contemporary and historical account of the making of meaning of the role of CAMH nurses in the inpatient unit environment. The researcher divided the years of experience into five year intervals as the data appeared to reflect these natural groupings and were the intervals used for the focus groups.

Table 5: Individual Interviews Stage 3 Demographic data of the study participants

Individual Interview	Gender	Years of CAMHN experience	Less than 5	Less than 10	Less than 15	More than 15
One	Male					1
Two	Female			1		
Three	Female					1
Four	Female		1			
Five	Female					1
Six	Female				1	
Total	1 Male 5 Female		1	1	1	3

5.20 The thematic analysis

The researcher again adapted the six phase thematic analysis process as Braun and Clarke (2006) and described in Chapter 4. The overall findings from the three-stage study will be combined to conceptualise the meaning of the role and work of CAMH nurses.

5.20.1 Phase 1: Familiarising yourself with the data

The audio-taped interview transcripts were listened to repeatedly to enable the researcher to become familiar with the participant's words. This process was repeated with all of the six individual interviews. As well as listening to the audio recordings

the researcher read and re-read the transcripts to absorb the meanings for the participants.

5.20.2 Phase 2: Generating the initial codes

The participant’s transcripts were considered individually and then assigned to initial codes that were reflective of data extracts and related to the overall question of the research, the work of the CAMH nurse in an inpatient unit.

Table 6: Individual Interviews Phase 2 The Initial codes

Phase 2 Initial Fifteen Codes
People don’t value what we do
Some of our clients aren’t appropriate for the unit
Colleagues propping you up
People don’t know what the ward is for
Maintaining a refuge (Risk and Safety)
Working with the families
The differing ages of the clients
Guiding and teaching
How you learn depends on who you are with
Supervision
Eclectic theoretical framework
Working with other systems
Observing, listening and understanding
Knowing what to do
Miscellaneous

5.20.3 Phase 3: Searching for themes

The initial codes generated from Phase 2 were reviewed and reconsidered to look for any candidate themes. This process entailed separating the initial codes then allocating them to candidate theme groups. This process is illustrated in Table 7.

Table 7: Individual Interviews Phase 3 Searching for the themes

Phase 2 Initial Codes	Phase 3 Candidate Themes
Lack of understanding of the role by people outside the unit	Lack of understanding of the role of mental health outside the unit
Dealing with client groups out of their scope of practice e.g. Disabilities	
Lack of understanding of mental health in the hospital setting	
Colleagues propping you up	Team Support
Maintaining a refuge (Risk and Safety)	Crisis Management
Working with the family	Partnership with the family
The differing ages of the clients	Developmental level of the child / young person
Guiding and teaching	Education role
How you learn is different with different people	Approaches to learning
Supervision	Supervision and reflective practice
Eclectic theoretical framework	Flexible theoretical framework
Working with other systems	Working with other systems both within and outside of CAMH services
Observing, listening and understanding	Assessment skills
Knowing what to do	Intervention
Miscellaneous	How the CAMH nurses define themselves
	Impact of Regulation and Legislation on Practice

The following three initial codes were combined: People don't value what we do (1); some of our clients aren't appropriate for our unit (2) and people don't know what the ward is for (4) and renamed "Lack of understanding of the role of mental health outside the unit" as this better encompassed what the participants described in the data. Four of the initial codes were renamed in the Candidate themes to better reflect the participant's data. The changes were: Maintaining a refuge (Risk and Safety) (5) became Crisis Management; Supervision (10) became Supervision and Reflective Practice; Eclectic theoretical framework (11) became Flexible theoretical framework and Working with other Systems (12) became Working with other systems both within and outside of CAMH services.

Careful analysis of the initial codes resulted in the initial code Miscellaneous (15) being excluded. The data from this initial code created two new candidate themes; How the CAMH nurses define themselves and Impact of regulation and legislation on practice. However there was participant data from the initial code Miscellaneous that

did not fit in the two new candidate themes so they were relocated to the appropriate candidate themes. The Crisis Management theme gained the following participant data, *“It’s difficult for staff to work in our unit, very unwell children, little real stability, on the spot management of ever-changing problems”* (participant 5). The candidate theme Developmental Level of the Child/ Young Person was allocated *“The Department of Health thinks that early intervention is at around 15 (years) when it should be in pregnancy or pre pregnancy”* (participant 3). The participant data *“...limited career path”* (participant 2) was transferred to the candidate theme Education Role. Supervision and Reflective Practice gained *“CAMH inpatient nurses have a lot of interface with trauma with the acuity of the clients they see”* (participant 2). The Flexible Theoretical framework acquired the participant data *“drug and alcohol problems”* (participant 3).

5.20.4 Phase 4: Reviewing the themes

Reviewing the themes generated from initial coding led to the modification of the candidate themes produced in Phase 3. The researcher also utilised this phase to determine whether there were any extra themes that could be added that more accurately represented the data.

The candidate theme How the CAMH nurses define themselves was generated by the following two participant views *“The CAMH inpatient nurses don’t articulate their practice so people don’t understand their role. “* (participant 2) and *“It can be frightening for them to move from an area where another nurse will confirm their practice out into the community where they are expected to be more autonomous”* (participant 2). Both of these data came from the theme Lack of understanding of the role of mental health outside the unit. No additional participant quotes were revealed during the comprehensive re-examination of the transcripts.

Lack of understanding of mental health outside the unit is concerned with the participant’s view of how their role and the unit are perceived by the rest of the hospital and the community. Team support reports on how the overall unit team as well as the sub teams function and relate contained participant views that supported the theme. Crisis management looked at how the environment is managed and maintained by the CAMH nurses and was represented by participant data. Partnership with the family was supported with sufficient participant data. Developmental level of

the child/young person was a theme which was widely represented by participant's data. Education role was contained participant data that supported the theme. Approaches to learning contained a diverse range of participant data. Supervision and reflective practice was represented by the participant data. Flexible theoretical framework was maintained by the participant data. Working with other systems both within and outside of CAMH services as a theme was preserved by the participant data. Assessment skills as a theme were upheld by the participant data. Intervention as a theme was retained with the support of the participant data. How the CAMH nurses define themselves was supported by the participant data as a theme. The Impact of Regulation and Legislation on Practice was kept as a theme with the support of the participant data. There were no themes added or deleted in this phase. Reviewing of the themes and the extracts within the social constructionist perspective of the study added further clarity of the analysis by providing a clear focus on the theoretical parameters.

5.20.5 Phase 5: Refining and naming the themes

A further refinement and analysis of each theme ascertained their core meaning as well as its relationship to the research question. The candidate theme - How the CAMH nurses define themselves was discarded as there was not enough data to support the theme. The outcome of the analysis supported that each of the remaining themes were related to the role of the CAMH inpatient nurse. This process also identified that some of the themes were sub-themes which belonged to an overarching theme. Table 8 represents the refined twelve themes and their related sub-themes.

Table 8: Individual Interviews Phase 5 Refining and naming the themes

Themes	Sub themes
Lack of understanding of the mental role health outside the unit	The role of the mental health nurse
	The role of the mental health unit
Team Support	The Unit Team
	The Nursing Team
Crisis Management	Assessing and Monitoring
	Maintaining
Partnership with the family	Partnership with the family
Developmental level of the child / young person	Developmental level of the child/young person
Education role	Education role
Approaches to Learning	Formal
	Informal “Learning Conversations”
	Case Based Learning
Clinical Supervision and Reflective Practice	Clinical Supervision and Reflective Practice
Flexible Theoretical Framework	Flexible Theoretical Framework
Working with other systems both within and outside of CAMHS	Working with other systems both within and outside of CAMHS
Clinical Skills	Assessment
	Intervention
Impact of regulation and legislation on practice	Impact of regulation and legislation on practice

Each theme and sub-theme is now discussed in turn, along with supportive data from participants.

5.21 Lack of understanding of the mental health role outside the unit

Lack of understanding of the mental health role outside the unit considered the comprehension of the role from an external perspective. Within this theme two sub-themes emerged, the role of the mental health nurse and the role of the unit.

5.21.1 The role of the mental health nurse

The participants revealed that particularly within the hospital community there was a lack of understanding of the mental health nursing role. One participant commented *“The rest of the hospital doesn’t really understand our role. They see us as some kind of onsite gaol. Although Adolescent ward is quite supportive”* (participant 4). Stigma

was identified not only about mental health but also the mental health nursing role as being custodial and dealing with anger and aggression. A participant stated that *“The CAMH inpatient nurses don’t articulate their practice so people don’t understand their role.”* (participant 2) so there was a view that the inpatient nurses needed to seize the opportunity to demystify their non-mental health nursing colleagues. The CAMH nurses described undertaking this through communication with the non-mental health units in the hospital. Opportunities were seized whenever they shared clients or the CAMH nurses were sent to work in the non-mental health units for a shift when the CAMH unit was overstaffed. Non-mental health staff were not sent to the CAMH unit when there was a staffing shortfall as a mental health qualification was required therefore there was no opportunity for exposure to the role of the mental health nurse in that context.

5.21.2 The role of the mental health unit

The participant’s experience had been that the general wards tried to have young people with behavioural problems such as aggression, transferred to the mental health inpatient unit. One participant commented *“The general wards try to pathologise children with behavioural problems and have them transferred to the unit”* (participant 2). The unit being in an acute general hospital meant that the focus was not on mental health but rather physical health so the focus of the staff in the main is not mental health. The nurses in the ward tried to counter this through opportunistic teaching and *“spreading the mental health word”* (participant 1). The unit also encouraged nurses from the general wards to spend some time in the unit as reflected by one participant who stated *“Nurses from the general wards are reluctant to come to the ward to relieve. They don’t understand about mental health.”* (participant 3). However, the participants indicated that the mental health nurses relieved, helped out, on the general wards as well as providing assistance with the general patients, *“The nurses are quite isolated and are often called upon by the general wards when there is an aggressive incident with children and adults”* (participant 2).

5.22 Team support

The concept of Team support was highlighted by all of the interview participants. This theme encompassed identifying the role of the team. During analysis it became apparent that there were two-sub-themes, The Unit Team and the Nursing Team.

5.22.1 The unit team

The Unit Team comprised the inpatient unit staff as well as other health professionals from within the organisation who work with the unit. The participants described a sense of collegiality and reverence amongst the team which was reflected in the way it functioned. One participant stated “*There is a great deal of support, trust and respect, it’s almost like family*” (participant 1).

Communication was depicted as playing an important role in the successful functioning of the team, “*Communication isn’t a problem everyone is given the opportunity to express their opinions and they are listened to*” (participant 5). The Unit Team was perceived by the participants as being medically driven that there was a medical model in terms of how the unit was run with the medical staff having a strong influence on decisions made. Despite this the participants identified that everyone across disciplines in the ward contributed to the team and how it was run. The aforementioned concepts were contradictory in a sense but individual nurses influenced processes through contribution in meetings, clinical decision making which resulted in influencing how the unit was run.

5.22.2 The nursing team

The Nursing team featured strongly in the participant’s data. The nurses clearly saw themselves as a separate team even though they were also members of the unit team. The participants described the Nursing team as being “*...the backbone of the ward*” (participant 1) because “*...they are there 24/7*” (participant 2). In addition, the shift work allowed them to work with a variety of nursing staff which they saw as a positive. “*Shift work means that whoever is in the (nursing) team changes every day*” (participant 2).

The participants described the nursing team as supportive particularly in a crisis when they “rally” and this was when they took leadership in the unit. “*The nursing team mainly makes decisions when there is a crisis*” (participant 2). Given the acuity of the

unit there are many such opportunities for the nurses to take a leadership role. Even when there was no crisis the nursing team was cohesive providing decision-making support for each other and influencing the operational elements of the ward such as admissions and discharges of the young people.

5.23 Crisis management

Crisis management was identified by all of the participants as a significant proportion of the work of the nurses in the unit. The acuity of the clients and developmental stage (mainly adolescents) played a role in the development of crisis situations. Safety for young people and the staff was a paramount consideration in crisis management. When the participants described the crisis situations and how they managed them it became apparent that there were two sub-themes, assessing and monitoring; and maintaining.

5.23.1 Assessing and monitoring

Participants talked about the risk management policies for the unit which they used as a framework to guide their practice. In talking about risk and also safety they specifically considered observation to be a pivotal facet of assessing a potential crisis situation. This was reflected by one participant who commented on “*Watching for changes in behaviour, interactions with other young people and yourself*” (participant 1). The participants spoke of learning to read the milieu which is something that comes with experience gained through watching other staff and seeing how they react and what cues they are picking up on.

In addition, to the crisis management in the ward there were also young people who put themselves at risk by leaving the ward. One participant spoke of “*Vulnerable clients who are not detained going into the city they might be from the country (and not know their way around)*” (participant 4). So part of the role was to assess the risk for this group of young people. Planned discharges occurred if the assessment of the ward by the nurses was that there was a risk to younger clients because of the behaviour of older clients. A participant commented that, “*The nurses will discharge younger children if they have older irritated, aggressive and agitated clients*” (participant 2). With such a varied age group there was a risk of younger children leaving as well because of it being an open unit which was highlighted by one

participant, *“The developmental context, it’s an open unit so you don’t want a young child leaving, you need to keep them safe”* (participant 2). From the participants commentary it became obvious there was a further layer to the care role that nurses have working with adults, encompassing a developmental context which framed all care.

Social networking is important during adolescent development so there may be a large number of visitors to the ward. This needs to be monitored as it can affect the unit milieu. So the nurses were constantly assessing and monitoring the situation trying to build a picture of what was happening in the ward. There were two other factors identified by the participants which increased the chance of a crisis including having more than one psychotic young person in the unit at any given time. The other was being short staffed which took into account not only the staff patient ratio but also whether the staff were experienced in the area of CAMH or not. Assessing and monitoring these occurrences meant that the nurses had to think strategically about how to best manage the unit to provide optimum outcomes regarding the safety of young people, visitors and the staff. Interventions such a timeout, medication and discharging young people were initiated by the nurses as part of crisis management.

5.23.2 Maintaining

Another facet of crisis management was maintaining the milieu. Nurses endeavoured to keep the environment safe physically and emotionally. The participants described a holistic approach to risk and safety trying a variety of interventions, one participant stated, *“Trying to keep things as normal as possible”* (participant 2). A young person may need to be separated from the rest of the clients, *“We manage risk by using seclusion if medication and distraction doesn’t work”* (participant 3). The nurses’ goal with intervention was to keep the young person in the unit however this was not always possible, one participant quote was, *“The unit isn’t set up for aggression but because we don’t have an HDU (High Dependency Unit) we are reluctant to transfer them to the adult services”* (participant 3).

The participant’s views indicated they believed that although the unit was not designed to manage aggressive behaviour, as nurses they practiced in the developmental context which allowed them to manage the young person in the unit rather than transfer then to an adult facility. They stated that this developmentally

framed practice was more beneficial for the young person so the outcome was more positive. From the data analysed the ability to manage a crisis situation within a developmental context has emerged as a valuable and sound skill of the participants who work in the unit. The CAMH nurses maintained the milieu by carefully selecting the intervention based on their clinical knowledge and skills. The more experienced CAMH nurse was more adept at using counselling as an intervention guiding the young person through the feelings they were experiencing and helping them to contextualise these. The less experienced CAMH nurse would seek the support and guidance of the more experienced nurse in dealing with these scenarios.

5.24 Partnership with the family

The partnership with the family was identified by the participants as one of the main frameworks for the role of the CAMH inpatient nurse. The family not only supports the young person but they also provide a framework for the assessment and ongoing intervention.

The role with the family takes the form of “*Family assessments and family meetings*” (participant 1), and this was described as ongoing, beginning at admission, continuing throughout the young person’s stay and sometimes after discharge. The purpose of these assessments was identified by the participants as initially being able to develop a picture of how the family works. The following participant perspective elaborates, “*You need to connect with the family and understand how they are functioning to understand how the child is functioning*” (participant 6). So, firstly to be able to connect, the nurse needs to establish a relationship with the family which is an ongoing process as one participant stated “*Building a therapeutic relationship with young people and their families*” (participant 1). The connection and ongoing relationship with the family is pivotal to the assessment and intervention for the young person as highlighted by the participants point of view, “*Being there for the family so they can in turn be there for the children*” (participant 6). Being there encompasses not only assessment and ongoing work advice but also ongoing advice and consultancy.

Part of building the picture of the family also involved developing an understanding of what other systems encircle them. This was described by the following participant

view that, *“Family, living environment, school, sexuality and peers are factors”* (participant 1). The partnership with the family through the ongoing relationship allows the nurse access to valuable insight into the young person’s life from many different angles including educational and social functioning. Pivotal to engaging with the family was the family work undertaken. Through the family work the nurses developed a partnership with the family which also included the development of the care plan for the young person. Building a rapport and clear communication with the family was a way in which the nurses strengthened the partnership. This facilitated the family being part of the decision-making and therefore the development of the care plan. Working with the family to assist them in understanding what was happening for the young person was an important facet of the CAMH nurses role. Through the family’s counselling with the CAMH nurses they were better able to support the young person.

Whilst the participants revealed a comprehensive picture of the family and partnerships, the following participant view was salient, *“Siblings are often forgotten”* (participant 1). To understand this view it is important to provide a context. Families were often discouraged from bringing in siblings because of the stressors in the ward environment therefore the sibling may only see the young person when they went home on leave or if the sibling was brought in, the visit would occur off the ward for example, in the cafeteria. Therefore there wasn’t an opportunity for siblings to have their concerns or stress addressed in relation to the welfare of their brother or sister. In terms of practice this issue provided the opportunity for nurses to advocate for siblings being included. This would facilitate siblings being supported by the nurses through a difficult time not just for themselves but also their families.

5.25 Developmental level of the child / young person

The unit is designed to provide a service for young people aged 18 years and under. The age range needs to be taken into consideration in nursing practice. A participant’s perspective on this context was as follows, *“The developmental stage which is huge, their brain is still growing, they are still putting down the neurons and the tracks and developing their personalities. There are so many more filters than there are when you are working with adults”* (participant 6). Having an understanding of child and

adolescent developmental stages was considered by the participants to be crucial in working with young people. The application of that developmental framework was regarded as vital in the practice of the nurses in the unit. An example of this from one participant was *“Working with a 6 year old compared with a 10 year old is vastly different. A 6 year old will still believe that there is a monster under the bed and a 10 year old has just learned that Father Christmas isn’t real anymore”* (participant 4). The nurses undertook comprehensive assessments of the young person to establish their developmental stage as age may not always be a guide due to other variables such as trauma and illness. These comprehensive assessments not only included interviewing the young person and their family separately and together but also observations. These observations by the CAMH nurses of the young person’s behaviour and their interactions with other young people, their families, visitors and staff added insight into their developmental level. As the CAMH nurses became more experienced their observational skills developed further.

Another important developmental perspective revealed was considering the usual activities of the young person. One participant stated that *“Being in a strange environment with other people doesn’t mean that you stop being a 5 year old or a 17 year old kid”* (participant 6). This comment not only highlights the importance of age specific activities but also that there may be some anxiety or stress related to being separated from the young person’s usual environment and supports. The participants identified that part of the work with young people involved play and undertaking homework. These activities varied depending on the age of the young person. In addition, to this the participants advocate for the young person.

5.26 Education role

An education role featured strongly in the data and was identified by the participants as being diverse. An education role emerged as being concerned with young people and their families, students as well as for the inpatient nurses. First the participants identified a clear role for the inpatient nurse in educating young people and their families. This role encompassed psychoeducation, advocacy and an interpretation role in regards to explaining mental health concepts. The participants discussed how families were often overwhelmed because usually they had no or little contact with a

mental health inpatient service prior to the young person's admission. Therefore the education role of the nurse was pivotal to the family's familiarisation to the environment and mental health services. In addition, to the young person's need to understand what is happening to them, the nurses' role is "*Educating young people on coping strategies*" (participant 1). The participants described how the young person's symptoms and the environment could be very stressful for them and therefore they needed extra support to identify coping strategies. The CAMH nurses worked with the young person to identify any strategies that could help alleviate stress, such as relaxation therapy and lessening the environmental stimulation. The nurses were able to teach the young person strategies such as relaxation if they weren't familiar with them. As discussed earlier in the chapter the environment can be volatile and therefore add to the young person's distress. Helping the young person understand the symptoms of their illness or their medication was an element of the CAMH nurses work which assisted the young person in developing the skills of coping.

The participants depicted the inpatient unit as having a diverse range of students constantly. One participant stated that, "*We have a lot of students across disciplines*" (participant 1). There was also a nurse educator in the unit who supported the nursing students however, the main support and teaching came from the nurses working clinically alongside the students. One participant did this by "*Always trying to think of the experience of this for the other person and helping people to make sense of their experience and dovetail that into what they are learning*" (participant 6). The participants identified that they were trying to provide the student with the best possible clinical experience within their current theoretical learning. The following excerpt illustrated how they worked with students, "*We work with the nursing students, go through their (client's) notes with them and ask them to talk to and spend time with the kids to learn to develop a picture of them*" (participant 4). The support of the student in their clinical experience is modified over the time of their placement as they become more confident, "*You are observing the students and their interactions with the patients. You gradually watch them from a distance*" (participant 4). The participants also acknowledged that the nurses were good at supporting their students not just educationally but also emotionally, "*As well as education we support the students emotionally especially those who haven't been exposed to what some of the kids have been, it can be very distressing*" (participant 3). The participants also

stated that the students are involved in activities such as family meetings, ward rounds and case review meetings.

The final facet of the education role identified was the education of the nurses themselves. To work in the unit it is mandatory that they have a mental health qualification. As some of the qualified mental health nurses recruited to the unit had not worked in CAMH before the unit was developing a three month program to assist these staff in developing competencies. This program was not developed at the time of the data collection. There was no CAMH nursing curriculum leading to a qualification available in Australia. Therefore much of the education took place in the unit and therefore was dependant on the knowledge and skills of the more experienced nursing staff. The participants stated that the unit staff also had access to professional development activities to enhance their learning.

5.26.1 Approaches to learning

The participants identified that there were approaches to learning that were central to becoming a CAMH inpatient nurse. The approaches to learning fitted into three sub-themes: formal “learning conversations, informal “learning conversations”; and case based learning. These three approaches to learning provided the nurses with different opportunities to increase their knowledge. As the three approaches were different they accommodated the unique learning styles of the individual nurses.

5.26.2 Formal - qualifications

As previously stated the nurses who worked in the inpatient unit either had a formal qualification in mental health nursing or they were a student of a Graduate Diploma in Mental Health Nursing who was employed in the unit. The participants recognised that the formal learning took place in various forums as demonstrated by this participant comment

“Knowledge base is shared with other staff through case presentation and handovers which in itself becomes a learning environment. Knowledge base is acquired through two different pathways; through their studies and observation and mentoring” (participant 5).

The integration of theory and practice was highlighted by the participants as important e.g. *“Absorbing and immersing yourself in the workplace learning”* (participant 3). In

addition, the participants acknowledged that in regard to learning, nurses needed to be self-motivated to embrace learning as demonstrated in the following participant commentary, “A lot is up to the individual clinician in terms of reading and getting your head around the different theories” (participant 4).

5.26.3 Informal “learning conversations”

The participants remarked that a lot of the knowledge is transferred informally through observations of other staff as one participant stated, “It’s intuitive but you also learn the skills from watching other nurses with patients” (participant 4). The participants identified “learning conversations” that happen in the ward and provide new and less experienced staff with support to increase their confidence in the nursing role. The informal approach took the form of buddying, observing, practicing and watching. But beneath this there was also trust of the more experienced nurses and their guidance. An example of this was in the following participant comment “Sometimes you get thrown in the deep end but other nurses can see you are ready before you do” (participant 1). So establishing that collegiality with the other nurses is important to allow the individual nurse to acquire the clinical skills necessary to undertake the role. Another aspect of trust and respect was provided in the following participant statement, “Making mistakes, being taught by other people who have been there before” (participant 6). This highlighted the trust, respect and safety evident in the professional relationship of the nurses in the inpatient unit. Taking risks and trying new things, practicing were all integral to learning to become a competent and confident nurse.

5.27 Case based learning

The participants talked about the way in which the nursing staff learn and develop in the clinical role. They described a system of case based learning which encouraged critical thinking and problem solving. As experienced staff worked alongside less experienced staff they had the opportunity to gain skills in clinical work through case based scenarios or actual cases they were managing on the day. After assessing a young person, a clinical case discussion would be held between a less experienced nurse and a more experienced nurse. The less experienced nurse would be asked to provide a clinical formulation of the case. The less experienced nurse would work

through the case being asked questions by the more experienced nurse about how they were formulating the case and asked to justify their decisions. The more experienced CAMH nurse would guide and add new information as required. The case based learning allowed CAMH nurses to develop skills in critical thinking and reflective judgment through discussing real-life scenarios. One participant called it a “*Staggered approach to learning*” (participant 1) that “*helped identify the gaps*” (participant 1). The staggered approach to learning meant that the nurse could practice skills and develop confidence in clinical scenarios with support from more experienced staff. A description of the operational component of this process was described by a participant in the following way. “*Questions go each way the new staff have questions but so do the experienced staff of the new ones*” (participant 2). So it is a staggered circular approach to enhance learning and provide a scaffold for developing clinicians. The approach is team based and also provides mentoring for new and ongoing nurses. The case based learning process usually takes place in the “back room” in the nurses’ station where there is the opportunity to discuss cases with other staff as well as learning from hearing about their cases.

5.28 Clinical supervision and reflective practice

The clinical work in the inpatient unit was identified by one participant in the following way, “*Child and adolescent mental health inpatient nurses have a lot of interface with trauma with the acuity of the clients they see*” (participant 2). Given the acuity and intensity of the client interactions as described by the participants in the data, supervision and reflective practice are important aspects of the nursing role. One participant described it in the following way “*the clinical supervision side of things, that’s the main clinical support*” (participant 6). The support mechanism of clinical supervision was identified as being both formal and informal. Formally there was a system where nurses entered into a supervision contract with a nominated person which was typically another more experienced nurse. The formal supervision sessions ordinarily had a frequency of 4 to 8 weeks. Informally, supervision could be opportunistic as explained by the following participant “*Supervision is not necessarily in a formal way it can be about asking questions like what are you doing, what is the benefit*” (participant 6). These interactions could also be seen as reflective practice conversations which assist in self-development. The other important aspect of clinical

supervision that emerged from the data analysis was self-care being able to identify and process their own feelings and reactions to the clinical scenario and client. This aspect was highlighted in the following participant observation, “*Clinical supervision is important, looking at yourself and working out what your triggers are and why you are responding in the way you do, so finding out about yourself as well*” (participant 4). The nurses identifying and understanding their feelings and interactions was the beginning of the clinical supervision and reflective practice process but they also needed to know how to cope with their reactions. Coping was about the nurses managing their own stress and understanding the anxiety that clients and families could induce in them. The nurses had the opportunity to undertake formal training in clinical supervision which was offered external to the unit and supported by the unit. Many of the participants had undertaken the training and incorporated the principles into their work in the unit with colleagues as well as new staff and students.

5.29 Flexible theoretical framework

There was a flexible theoretical framework that informed the participant’s work as CAMH nurses. This framework was identified by the participants as being eclectic, that is, being influenced by many theoretical frameworks which were adapted to individual cases. Some participants drew from Cognitive Behavioural Therapy as this had been a facet of the mental health nursing training they had undertaken and adapted that to the clinical area. Family work rather than family therapy was undertaken. The participants did not have any formal family therapy training but adapted some of the principles to their family interventions. This flexible theoretical framework was informed by the educational and clinical expertise of the individual nurse depending on what they had studied. The following participant comment highlights this “*Eclectic approach that is driven by the therapist or clinician*” (participant 4). Overall the participants did not identify a particular theory but two theories that were prevalent across all participant data were child development theory and systems theory. The developmental theories were considered essential as identified by the following participant remark, “*Child development theory this is particularly important because of the broad age group*” (participant 3). The focus on child development and age range of the clients was highlighted across several different themes in the study including, crisis management; partnership with the

family; developmental level of the child/young person; and clinical skills. The theory formed a basis for the clinical work undertaken by the nurses. The systems theory considered the family as well as the social and educational aspects of the young person's life; they were seen as part of a system. The family and young person were placed in the centre of care in systems theory and became partners in the health care episode involved in their care plan for the young person. The following participant observation drew attention to that, "*Kids are part of the bigger picture. You know it's the whole person it's not just the problem being brought to us*" (participant 6). The philosophy of the CAMH inpatient team both nursing and multidisciplinary was one of partnership in care. A reason for the broad range of theoretical frameworks used in the unit was a lack of consistency in education/training before the nurses were employed by the ward. Some nursing staff had entered the ward with a mental health nursing qualification but their training and experience was diverse. Some had worked mainly in adult mental health services prior to employment in the unit whereas others had worked with children and adolescents. There was also a range of formal training and/or experiences in other theories such as attachment theory, family therapy, cognitive behavioural therapy, recovery framework, narrative therapy, behaviour modification, art and music therapy, psychotherapy and humanistic frameworks. This demonstrated the depth of the theoretical knowledge pool of the nurses in the unit. Such diversity presented an opportunity for a flexible theoretical approach framed by child development and systems theories.

5.30 Working with other systems both within and outside of CAMHS

Working with other systems both within and outside of CAMHS formed a major aspect of the inpatient nurses role. On analysis it became obvious that the work of the nurses centred on advice, consultancy, advocacy and co-working. Within CAMHS the nurses provided "*Good communication between the community and inpatient teams*" (participant 1). This role was vital for the case management plan for the client, connecting in with the community CAMHS teams and setting up structures that enabled the client's ongoing care when they were discharged. One participant stated that "*Sometimes if the patient is a long term one the nurses will attend the initial appointments in the community with the client to ensure a smooth transition*"

(participant 5). In addition, the nurses provided advice and consultancy to community and to other wards in the hospital in relation to the mental health acuity of a young person, assessment, intervention and appropriateness of an admission to the inpatient unit. This included “*Working within the hospital with medical teams*” (participant 1).

Outside of CAMHS and the hospital the nurses worked in a collaborative and collegial way with multiple agencies across education, health, welfare and legal sectors. The analysis identified a strong advocacy role that the nurses undertook for their clients and their families with community agencies. One system that played a major part in the young person’s life was school. Children and adolescents spend almost as many hours a day at school as adults did in their work place. School not only provided an educational platform for the clients it also provided a social one. Therefore it was important that the nurses advocated for their clients by working in unison with the school. One participant commented “*Schools and the wider community often don’t have a good understanding of mental health*” (participant 1). This insight into the clinical experience of the nurses demonstrated the complex layers that needed to be considered when working with children and young people. Co-working and consultancy with schools, FamiliesSA and Non- Government agencies were used as a strategy to overcome such barriers.

5.31 Clinical skills

The participants acknowledged that clinical skills were a fundamental part of the nurses’ role in the inpatient unit. During the analysis it became clear that there were two sub-themes within the theme: assessment skills; and intervention skills. Although they initially appeared to go hand in hand and be part of the same continuum there were some distinct differences.

5.31.1 Assessment

Biopsychosocial assessment was emphasised by the participants as being the most appropriate framework for the nurses working with young people. Assessment by the nurses was described by one participant in the following way, “*The core to the work is observation of mental state, safety, developmental history and neurovegetative aspects. CAMH nurses tend to use genograms*” (participant 4). Participants identified an assessment framework which covered the biopsychosocial sphere. Some of these

assessments were undertaken by nursing staff alone while others were undertaken as part of a multidisciplinary interview process. The aim of the staff according to the participants was to minimise the duplication of assessment of the young person as this may be stressful.

Observation was identified as a significant component of assessment by the participants as encompassed in the following participant comment, *“Assessment of the patient’s through the nurses observational skills so they judge the person’s mental state altering and implement appropriate strategies straight away”* (participant 5). Contextualising the observations were a contributing factor to the assessment. To observe behaviours/reactions of the young person in relation to their peers and their social skills in the unit environment was pivotal, not just to the mental state assessment but also to the developmental assessment.

Physical assessment featured in the participant’s data as a core component to assessment, *“They need to be up to date in monitoring and assessing physical health, functional assessment as well as understanding medication and its effects and side effects”* (participant 2). The participants highlighted the importance of the nurses in the unit being competent in physical assessment as well as mental health assessment. The nurses’ commitment to this is reflected in their use of the biopsychosocial framework for assessment. In addition, the young people aged under 12 who were admitted for behavioural assessments also undergo medical tests to eliminate and organic cause so the nurses needed to be familiar with the normal ranges of the diagnostics and pathology assessments being undertaken. Although these test could not be ordered by the nurse they included recommending them in their case formulations for these clients.

5.31.2 Intervention

Constant interventions tailored by the ongoing assessment were identified as part of the clinical assessment role. The components of a successful intervention were underlined by the following participant remark as *“developing a strong therapeutic relationship and having the ability to anticipate and intervene prior to anything happening”* (participant 4). A successful intervention was considered by the nurses as one where the client was engaged and there was a beneficial outcome for the young person’s health. This may not have been immediate but as part of a care plan so

change would happen over a period of time. The participants described an innate ability to assess the environment by being vigilant yet creating a space for the young person as part of the intervention. This innate skill was developed as the nurse became more experienced and through observing other more experienced CAMH nurses in the practice setting. “*Driving therapy*” (participant 4) the informal conversations that occurred whilst the nurses were driving the young person to an appointment or a day program were identified as opportunities for intervention. Some of the interventions were less formal such as “*The nurses care for these kids they do teach, they do parent, they do comfort or nurture or discipline*” (participant 6). An *in loco parentis* situation was evident as the nurses took on some of the day to day obligations of the young people, even though they may still have been residing with their parents normally, they were the charges of the staff whilst in the unit. The nurses’ role was also identified as providing support around any interventions which included helping to reduce the intensity of the symptomology for the young person.

5.32 Impact of regulation and legislation on practice

As previously discussed in Chapter 2, the regulation of mental health nursing in Australia had recently changed at the time of undertaking the individual interviews. Mental health nursing is no longer listed on a separate register with the regulatory authority, although it is still acknowledged within the profession as a specialty area.. All of the nursing participants raised their concern about what they saw as their role being devalued and misunderstood. They expressed a feeling of losing their professional identity and worth. One participant contributed the following view that, “*The national board has just taken away our separate registration so that leaves mental health vulnerable to staff that may not have the necessary experience and qualifications. Mental health is complex*” (participant 3). All of the nursing staff in the ward either had or were working towards a qualification in mental health nursing and there were no plans to change that.

Legislation was also recognised as underpinning the role of the CAMH nurse. The legislation identified by the participants was attributed to two areas - mental health in general and legislation specifically for young people aged less than 18 years. The legislation pertaining to mental health in general was in the area of occupational

health and safety, confidentiality, consent and the *SA Mental Health Act 2009*. Particularly for young people there was legislation in regards to the Family Court and child protection. The participants expressed that Family Court orders posed particular difficulties for the nurses in the ward as they needed to enforce them often against the family's will. Family Court matters were an example how CAMH nurses needed to be have a good working understanding of the legislation pertinent to their practice. This was not only so the nurses understood the legislation but so they had a role in explaining the legislation to the young people and their families. The same example applied for the *SA Mental Health Act 2009* where it was part of the nurses' role to interpret the impact of the regulation of the Act for the young person and their families. When a young person was detained under the *Mental Health Act* it was the nurse's role to support "*The young person and family get upset, they don't know about detention, we need to explain and support them*" (participant 5). Other participants identified the role that nurse's had in educating and supporting the young person and their family through the process of detention.

5.33 Summary of findings of stage three- individual interviews

This section has described the findings from the individual interviews in the study. Initially fifteen codes were identified. These codes were further cultivated and refined to a final twelve themes.

5.34 Overall chapter summary

This chapter has presented the three stages of analysis concerned with the research. The sequential nature of the data analysis through stages has been identified. The relationship between each stage has been made explicit to clarify the use of the three stages of data analysis. The next chapter considers the commonalities in all the themes generated from the focus group analysis and individual interviews analysis and their meaning and conceptualisation of the role and work of CAMH nurses.

Chapter 6: Conceptualisation of the Findings

6.1 Introduction

In the previous chapter the document analysis, focus group and individual interview data were analysed and discussed. The analysis of the focus group and individual interview data derived two sets of themes that reflected the participants' views on the role of the CAMH nurse in an inpatient unit. The two sets of data had some commonality as well as some differences.

In this chapter through an inductive process the themes will be positioned within the CAMH nursing context to elicit the meaning of their work/role (Burr 2003; Streubert & Carpenter 2011; Streubert Speziale & Carpenter 2007). All themes generated through the analysis of focus groups and individual interviews have been reviewed and conceptualised as components of the work of CAMH nurses that is the bigger meaning of the data. A culmination of the findings led to the development of a conceptual holistic framework. As in Chapter 5 the narrative of the participants is presented in italics throughout this chapter.

6.2 The role

The process of identifying and understanding the aspects of the role is pivotal to the individual's successful transition through each stage of the role development. These stages can also be aligned to Benner's (1984) guide to excellence in clinical practice from novice to expert.

The data collected by the three research methods explicitly identified some of the processes both tacit and overt that contributed to the participant's ways of knowing. Ways of knowing were about practice and understanding practice and how the nurse applied it to the clinical situation in their role. This was also about moving through stages of understanding mental health nursing and applying it clinically. These stages are outlined in Figure 2. The framework was devised through the identification of themes from the focus group and individual interview data analysis. The data sets

were re-examined again as a whole to allow the researcher to elicit the themes that were prevalent. Through the analysis, a pattern of the stages of knowing about the role of the CAMH nurse and its clinical application emerged. These stages are now further explained.

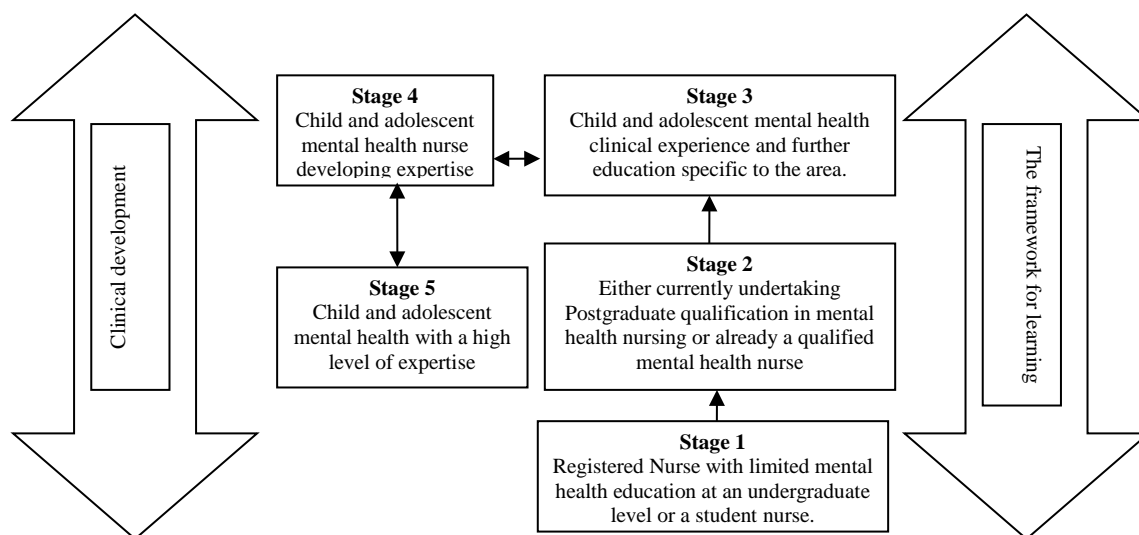


Figure 2 Ways of knowing / learning about CAMH nursing

6.2.1 Stage 1 - The introduction to CAMH nursing

Stage one was concerned with entry level into nursing. Some nurses had student placements in CAMH inpatient units and community teams. From the participants' view there was a minimal amount of theory and practice undertaken by nurses during the undergraduate nursing programs. Theory and practice usually focused on adult mental health nursing. The limitations of both the time given to theory and the exposure to the clinical setting provided a cursory understanding of this complex area.

6.2.3 Stage 2 - Feeling confused

The second stage was where most nurses entered the area of CAMH. The nurses were either undertaking a postgraduate qualification in mental health nursing or they were already qualified mental health nurses. Participants reported that the postgraduate programs available had an adult focus rather than a child and adolescent one so they did not feel prepared for working in the area. In addition nurses who were already qualified mental health nurses also stated that they felt out of their depth when moving to the specialty.

6.2.4 Stages 3, 4 & 5 - Looking, learning, understanding and becoming

The final three stages in Figure 2 were about developing an understanding and applying the parameters of CAMH nursing as they pertained to the clinical scenario. Participants described a process of moving between stages of knowledge and competence that were related to the clinical experience and the integration of knowledge. Even at the final stage of high level expertise the nurses needed to update their knowledge when working with a young person whose clinical scenario was not within their scope of expertise. The clinical development of each nurse was individual depending on the clinical experiences so even the most experienced nurses would encounter clinical scenarios outside of their expertise.

6.3 Ways of knowing

The concept of ways of knowing in nursing was identified in the seminal work by Carper (1978). This opus provides an insight into the foundations of knowledge development in nursing. The paper identifies four fundamental patterns by which nurses develop nursing knowledge: empirical knowing; aesthetic knowing; personal knowing; and moral knowing (Carper 1978). To further expand empirical knowing is an objective perspective which is concerned with the scientific facts that nurses need to know. Aesthetic knowing is about understanding and interpreting subjective elements. Personal knowing is in relation to one's own beliefs and values. Moral knowing is centred on ethical obligations i.e. what is right and just. Several nursing scholars have supported Carper's (1978) model of knowing in nursing and expanded it over time (Averill & Clements 2007; Chinn & Kramer 2004; Chinn & Kramer 2011; Henderson 1995; Sandelowski 1994; Wainwright 2000). The latter work by Chinn and Kramer (2011) add a fifth pattern, emancipatory knowing which is concerned with the broader social meaning of praxis. Knowing is defined as the understanding of self and the world whereas knowledge is about communication of knowing to others (Averill & Clements 2007).

6.4 Ways of knowing and learning

The stages of learning to become a CAMH nurse are identified in Figure 2. This concept was at the core of the study. Parallel to these stages were two distinct areas,

clinical development and the framework for learning which were represented by the scaffold that supported the stages of learning to become a CAMH nurse. These two concepts, clinical development and the framework for learning will now be discussed in turn.

6.5 Clinical development

Clinical development encompasses both the practice and theoretical aspects of the role of the nurse. It is concerned with the clinical field of the role. These fields include the clinical skills, risk and safety (assessing, monitoring and maintaining), theoretical framework for practice, clinical supervision and reflective practice and becoming a CAMHS nurse (knowledge transfer). The clinical development scaffold outlining the clinical fields is illustrated in Figure 3.

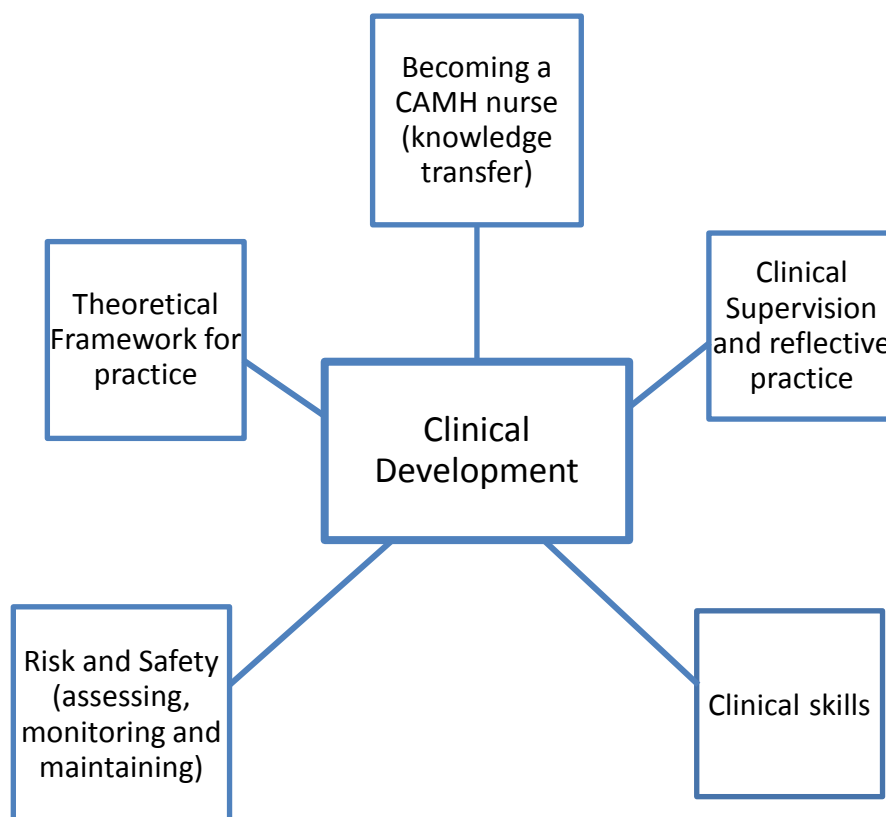


Figure 3 The Clinical Development of the inpatient CAMH nursing role

6.5.1 Becoming a CAMH nurse (Knowledge Transfer)

Knowledge Transfer was the broad term which participants described as the path for becoming a CAMH nurse. The term covered the practical processes that aided the nurses in understanding their role. Sharing the knowledge and developing confidence

in regards to the role and what it encompassed was perceived to be crucial to understanding the role. Continual exposure and confirmation was the process by which the nurses navigated what they described as the work within their complex role. There was a process of gradual exposure through case allocation and informal as well as more formalised case discussions which incorporated case based learning. The process of applying the formal knowledge to the clinical scenario was the key to understanding the role and therefore developing confidence. There was a clinical *knowledge pool* that was shared and provided a safety net through which the nurses explored their emergent understanding of the role. All nurses contributed to the *knowledge pool* as they gained experience in the area. Observation was a significant part of this as they watched and experienced what the role entailed. This process allowed the nurses to develop and understand at their own pace adding experiences and information as it was learned.

6.5.2 Clinical supervision and reflective practice

Clinical development was provided through the support and guidance of clinical supervision and reflective practice. This was one aspect of the *knowledge enhancement* that the participants reported. There was a fluid learning environment in which the nurses negotiated their clinical development needs. This allowed for a *flexible* approach to clinical development within the supervision/mentoring relationship which supported individual learning needs. The nurses predominantly used the term mentor rather than supervisor as they considered the term to be a more collegial. Trust and respect were important components of the relationship as the participants reported that the nurse was sometimes *taken out of their comfort zone* in terms of clinical assessment and intervention. Examples given by the participants were when nurses were exposed to clinical situations such as interventions where they were taking a lead role while the mentor was in the background. The nurses who were learning the role were not always as confident of their clinical abilities as their mentors. Hence the trust and respect within the supervision relationship was paramount. In the group discussions there was a view that by observing the interactions and practices of new nurses to the CAMH area the supervisors could see the nurses develop their practice and ascertain when they were ready for the *next step* before the nurse could themselves.

As well as the designated mentors there was an informal network of clinical development support which was an integral part of the inpatient unit. The informal network evolved through more experienced nurses *being aware* of the clinical development support that they required when they first came to the inpatient unit. The participants indicated that on each nursing shift the membership to the network would change due to varying the rosters. This contributed to the nurses establishing mentoring relationships with more than one nurse. The advantage of this was that it allowed the nurses to achieve their clinical development through the clinical experience of CAMH nurses with a broad range of expertise. There was a culture of every nurse working in the inpatient unit being involved in mentoring. In interviews the participants indicated that *relatively inexperienced* nurses would still contribute to the mentoring of new staff and students on placement. The focus group participants believed that this opportunity added to the *confidence* of the nurses and therefore to their clinical development. These inexperienced nurses were guided through the process mentoring by the more experienced nurses.

Mentoring provided a forum which allowed the nurses to reflect on their own feelings and reactions to their clinical development. Clinical environment was acute and intense which made this retrospective analysis an important component for their clinical development. Participants regarded the two layered system of both *informal and formal mentoring* as providing a constant support which enabled timely reflection on clinical scenarios. Trust and respect within these networks made it safe for the nurses to explore their feelings and reactions to their clients.

6.5.3 Clinical skills

The admission of a young person to a mental health inpatient facility was often the *family's first encounter with such a system involving their child*. Participants reported that understanding what was happening and what the admission meant could be a difficult time for the young person and the family. Nurses acted as *a conduit in bridging the experience* to help support the family in an intricate transition. The family was negotiating a new system and developing an understanding of the roles of the health care professionals. Participants considered that the nurses were in the best position to interpret the meaning of the assessments undertaken by the other health professionals for the family after the sessions were completed as they are more readily

available. Establishing rapport and a relationship not only with the young person but also with the family was described by the participants as the platform for clinical assessment and intervention. Participants felt that by understanding how the family was functioning provided a valuable insight for the nurses in terms of clinical work with the young person. Siblings were also an important part of understanding how the family worked, not just the young person and the parents. These clinical skills were gained through participating in assessments and interventions with the young person and their families or significant adult. Nurses were gradually exposed through looking, learning and understanding the interactions. These interactions helped participants elucidate the role of the CAMH nurse in the process as well as illustrate the *therapeutic boundaries* that were so important in this complex environment. The age of some of the nurses put them on the periphery of the peer groups of some of the young people and their visitors. Participants perceived that it was crucial that nurses were cognisant of this when interacting with the young person in establishing and maintaining therapeutic boundaries. Conversely some of the older nurses who were parents themselves felt that they needed to be aware of the therapeutic boundaries in relation to two areas; how the child was being parented and how they would parent the child themselves. Once again the participants' viewed this as potentially problematic if the boundaries weren't clear. The underpinning of the CAMH nurses role was in *supporting the family to support the young person* so if either of the aforementioned therapeutic boundary issues transpired, that would compromise establishing a rapport and relationship and therefore inhibit assessment and intervention. According to participants, potential and identified therapeutic boundary issues were discussed in supervision and mentoring sessions as well as informally in the *back office* conversations.

The participants regarded family assessments and family meetings as well as individual interviews with the young person *as the processes by which the CAMH nurses learned the clinical assessment skills*. The nurses were gradually introduced to having their own case load therefore initially they were "*sitting in*" with another nurse or member of the multidisciplinary team during an assessment. Learning the clinical assessment skills was *a combination of looking, listening and reflecting*. Discussions indicated that the nurses' experiential learning was supported by the more

experienced clinician and their own reflections. This process allowed them *to integrate the information needed to develop their clinical skills.*

Some of the more informal assessment and intervention were described by participants as *driving therapy and walking therapy.* These occasions occurred when the nurse was transporting a young person to another facility or when they were going for a walk together for some exercise. For the CAMH nurse working in this complex area, *'every interaction matters'* so every opportunity to connect with the young person was important. This was a skill that was gained through exposure and practice as the nurse moved through the stages of the ways of knowing/learning about CAMH nursing (Figure 3).

Part of the engagement and rapport building with the young person meant that the nurses had to have an understanding of age specific activities and play as well as homework activities. The participants described the nurses' role as being in *loco parentis.* There was a view by the participants that *the young person doesn't stop being a child or adolescent because they are in hospital.*

The other system identified by the nurses that surrounded the young person was school and therefore *an assessment of educational and social functioning at school* was important. Participants indicated that whilst the educational assessment was undertaken by the teachers the social functioning assessment was undertaken at the hospital school by the nurses through liaison with the teachers and observation of the young person's interactions. Nursing practice was the operational scope of the role.

6.5.4 Risk and safety (assessing, monitoring and maintaining)

Due to the acuity and the broad age range of the young people in the unit risk and safety were identified by the participants as paramount considerations for the nurses. The relationship between patient acuity and the environment was something that the nurses reported as important in order to develop a comprehensive understanding of crisis management. Careful assessment, monitoring and maintaining of the environment was fundamental to the clinical development of the CAMH nurse. The nurses described a process of immersing themselves in the milieu in order to learn the skills of assessing, monitoring and maintaining. This involved a process of initially looking but not seeing what was happening in the unit when they first undertook their

clinical experience. This was something the nurses commented on, that new staff had some difficulty understanding because they felt as though they were doing nothing except *hanging out with the young people*. The more experienced nurses reported that they used this as an opportunity for skill development and intuitive growth for their newer staff. Less experienced nurses found it harder to predict the trajectory of the milieu when the changes were subtle. It was felt that the ability to understand and interpret the environment came with exposure and experience. The nurses were gradually guided through a process of watching for changes in behaviour and being aware of the interactions that young people were having with each other and with staff. As their confidence grew they were able to more independently manage the milieu and gain confidence in and defend their decisions. Another variable apart from age range that needed to be considered was the social networking and the large volume of visitors that the young people often received. Social networks are an important facet of the social development of children, particularly adolescents. The nurses saw the need to balance the developmental need for socialising with the care needs of all of the young people in the unit. Participants identified that this was a clinical skill that developed as the nurse moved through the stages of becoming a CAMH nurse (Figure 2).

Avoid a crisis situation at times meant discharging young people to maintain the milieu. This was an important advocacy role for the other young people. If there was a young person who was non-compliant and disruptive it would affect the progress of a younger child or a more settled adolescent.

6.5.5 Theoretical framework for practice

The CAMH nurses had no set theoretical framework for practice. The nurses did however describe the developmental context as a key building block. Often there was no diagnosis for the young person which meant that the developmental context was pivotal and served to eliminate any age appropriate cause. As there was a huge age range of young people, from 6 to 17 years, the nurses needed to have a comprehensive knowledge of the developmental context to augment their practice. The depth of the theoretical knowledge pool demonstrated by the nurses as a collective was shared by participants as the nurse progressed through the stages (Figure 2) of becoming a CAMH nurse. The nurses individually added to this pool of knowledge as they gained

clinical experience. Highlighted across several areas in the study was a flexible theoretical approach framed by child development and systems theories.

The complexity of client presentations in the unit meant that the nurses adopted an eclectic approach which was driven by the individual nurse. A biopsychosocial framework was adapted to ensure a comprehensive assessment was undertaken which would lead to the appropriate intervention being in place. For the younger age group (under 12) a behavioural assessment framework was utilised which required advanced observational skills from the nurse. To undertake the behavioural assessment the nurses worked in conjunction with a nurse therapist in the unit as they learned and practiced the observational skills. The nurses also required a sound knowledge of medications and how they are different in the CAMH context to the adult context.

The presentations ranged from referrals for behavioural problems, usually for the younger clients, to early psychosis or suicidal ideation with the older clients. The behavioural referrals for the younger clients commonly occurred in the context of familial circumstances, such as separation and divorce, domestic violence or the illness or death of a parent. Presenting symptoms included unresolved grief or post-traumatic stress reactions such as depression and anxiety. Other referrals were of children with learning difficulties. The older clients could also have the aforementioned referral problems but they also had early psychosis; drug and alcohol issues and eating disorders. With some clients, across all age groups, there were also co-existing physical conditions, either acute or chronic, such as respiratory and metabolic syndromes. Participants indicated that all of the conceptual formations that the CAMH nurse makes in order to assess and plan appropriate interventions are within a flexible theoretical framework with the many complex variables of the young person taken into account.

6.6 The framework for learning

The framework for learning set the environmental context for the role. Environmental context was not just about the physical environment but also the contextual factors within which the CAMH nurse practiced. These fields included the contextual perspective of the role, the team, legislation and regulation and the learning

environment. The ways of learning were embedded in a contextual scaffold which informed practice. This structure is illustrated in Figure 4 and each field is explained.

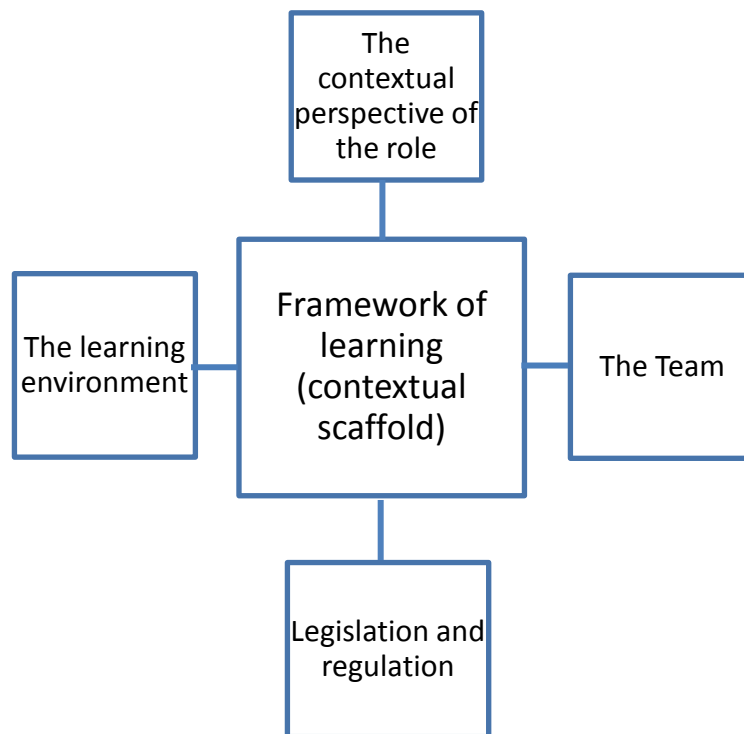


Figure 4 The Framework for learning to be a CAMH nurse in an inpatient unit

6.6.1 The contextual perspective of the role

The CAMH nurses working in the inpatient unit needed to collaborate with a range of other stakeholders. Participants reported that these collaborations were with the wider community; health, education and welfare in government and non-government sectors as well as other units and departments within the hospital. The unit is a specialist facility situated within a paediatric hospital. The CAMH nurses believed that there was a lack of understanding in the hospital community of the role of the mental health nurse and indeed the unit. It was indicated during discussions that the nurses invested time in *clarifying their role* and that of the unit when the situation arose. This position opened the opportunity for the nurses to further *develop their own understanding of the role* whilst engaging with their colleagues who were from the paediatric areas. This process had the primary gain of allowing the nurses to *explore and validate their*

own knowledge and confidence as they moved through the ways of knowing and learning about CAMH nursing (Figure 4). These collaborations took the form of *advice, consultancy, advocacy and co-working*. Discussions with participants indicated that the secondary gain of this process was *a clearer understanding of the role* of both the CAMH nurse and the unit by their *colleagues in the wider hospital*.

The next contextual layer was within the wider CAMHS, mainly with the community teams but also with the After Hours Emergency Mental Health Nurse (AHEMHN) team. Participants felt that the nurses *worked closely with these teams once again often sharing clients in common*.

The next layer was the education, health, welfare and legal sectors that were frequently the *collaborative partners in case management*. These layers bare testament to the complexity of the client group that these nurses were involved with. At the least complex layer these nurses were involved with only the education system but commonly, the health, legal and welfare sectors were involved. The participants regarded *case managing and co-ordinating of the agencies involved with the young person* as an important facet of the CAMH nurses role. This not only supported the young person and their family but also created a more *comprehensive understanding from all agencies regarding the complexity of involvement of services*. This description of the level of support given by the CAMH nurses to their clients provided the identification of the contextual complexity of their work.

In contextualising their role participants reported that the nurses needed to navigate government and non- government systems of which they initially had little or no experience to support the clients and their families. As the nurses moved through the stages of the ways of knowing and learning about CAMH nursing they developed a deeper knowledge and understanding which translated into more confidence in regards to their role but also the *ability to advocate for their role and the young person*.

Participants affirmed that the unit also provided a state-wide and national service to young people and their families. The national service included New South Wales, Victoria and the Northern Territory. Some regional towns from these other jurisdictions were closer to the South Australian border than their own capital cities so

they chose to access the alternative service. This meant that the nurses needed to *develop an understanding of that particular state or territories services* in order to support their clients.

6.6.2 The team

The teams identified by the participants were the multidisciplinary (unit) and the nursing teams which provided a structure for learning in the inpatient unit. The structure offered the guidance and support that the nurses were seeking. From the most experienced to the newest nurse the *guidance and support was tailored* to ensure a robust learning framework. The process of the tailoring was twofold. Firstly the multidisciplinary team added a broader contextual scaffold where there was the opportunity to learn about CAMH through the perspectives of clinicians from a different professional background to nursing. This was also reciprocal as the non-nursing members of the team learned about the scenario from a nursing perspective. The multidisciplinary team provided both formal support such as case conferences, allocation of meetings, staff meetings and informal support such as back up for the nursing staff if there were issues in the ward. The nursing team was more of a *permanent fixture with the nurses providing 24 hour care* in the unit. This allowed the nursing team to provide *continual support to the nurses* in regards to their clinical development and learning. As with the multidisciplinary team there *was formal support through meetings and case review* but the informal support provided a *safety net* for the nurses as they developed their skills. The informal support from the nursing team constituted opportunistic learning which included the *back office* conversations that helped guide the nurses.

6.6.3 Legislation and regulation

Knowledge and understanding of the legislation and regulations pertinent to the role was essential. The young people in the unit were under 18 years of age and therefore there was specific legislation such as the *Children's Protection Act (1993)* which was relevant to their care. The nurses' role as a mandated notifier under the Act meant that they had a vital advocacy role for the young people. As a professional group the *nurses spent more time with the young people than the other health professionals involved* in their care. This meant that nurses had more exposure to the young people and therefore a higher chance of assessing if there were any child protection issues.

The *Mental Health Act* (1993) and *Mental Health Act* (2009) were important legislative documents that the nurses needed to have a good understanding of. Some of the young people admitted to the unit were detained under the relevant *Mental Health Act*. The nurses had a key role in supporting the young person and their family through the process. The nurses developed skills in this key role of clarification of what the Act meant for the young person and the families and what their rights were. The nurses developed this skill as they worked through the stages outlined in Figure 4. There were two parts identified to this skill one was the *understanding of the parameters of the Act* and the second was its *application to the clinical setting*. The second part of this is also linked back to clinical development, discussed earlier, as nurses developed the skills to support the young person and family *to understand the clinical implications of the legislation*. In order to undertake this, nurses needed to understand the impact of detainment on all young people in the milieu and their families. A thorough understanding of the legislation was needed to ensure that the young person and their family understood. The Act needed to be applied to the unit in accordance with the prescribed regulations.

In addition to the aforementioned legislation there were also family court matters which needed to be understood and taken into consideration when providing care for some of the young people in the unit. These orders were sometimes in the form of *court ordered restricted access or restraining orders* that the nurses needed to *enforce and monitor*. These clinical situations added a legislative layer to what was already a complex role.

Regulation of mental health nursing in Australia changed in July 2010 when the profession went to national registration. The impact of this for mental health nursing was that there was no longer a separate register as there had been in some States and nurses with no mental health qualification were working in the specialty. CAMH nurses believed that whether they entered the specialty of CAMH with a mental health nursing qualification or whether they undertook the mental health qualification whilst working in the unit, *it was essential for their practice*. The nurses considered that learning to become a CAMH nurse began as they were undertaking a qualification in mental health nursing as this provided them *with a platform for learning*. The CAMH nurses were concerned about what this meant for the future of their role.

6.6.4 The learning environment

The CAMH inpatient unit provided a learning environment for the nurses, young people and their families as well as students from medical and allied health professions. The learning environment for nurses provided a chance to *find the way through developing the skills* to become a CAMH nurse. The culture of learning and support was continuous with each nurse being involved in *not just learning but teaching* other staff.

The nurses had a strong sense of commitment to ensuring that the undergraduate nurses on placement in the unit received educational support in *navigating the clinical environment*. The nurses based this on their own *experiences of learning to become a CAMH nurse* and what had helped them to understand their environment.

The other role of the CAMH nurse in the learning environment was *psychoeducation for the young person and their family*. The nurses had the highest exposure of any of the health professionals to the young people by virtue of the shifts they worked. This placed them in an ideal position to engage the young person in psychoeducation in regards to their current issues. Being admitted to an inpatient unit was a *frightening experience for young people* as they try to not only make sense of their mental health but also understand a new environment. Nurses identified that part of their role was to assist the young person to work through their *fear and apprehension by appropriate information* and a logical framework. This was achieved through *building rapport and education* for the young person about their mental health issues, their medication (if need be) and *coping strategies to manage their symptoms* or the side effects of medication. Medication could have a significant effect on young people and the nurses had a role in counselling about specific symptoms such as weight gain which could have a profound significance on adolescent development regarding body image. The families also needed the psychoeducational support as they would often be distressed about the admission and the mental health of the young person. The nurses developed the skill of supporting the young person and family through incremental stages of exposure as described in Figure 2.

6.7 A conceptual framework for the work of child and adolescent mental health nurses

The ways of knowing and learning to become a CAMH nurse on an inpatient unit are an integration of the five stages of learning through the clinical environment within the scaffold of clinical development and a framework for learning. The conceptual holistic framework of CAMH nurses knowledge and learning is illustrated in Figure 5 and represents the work components of their role.

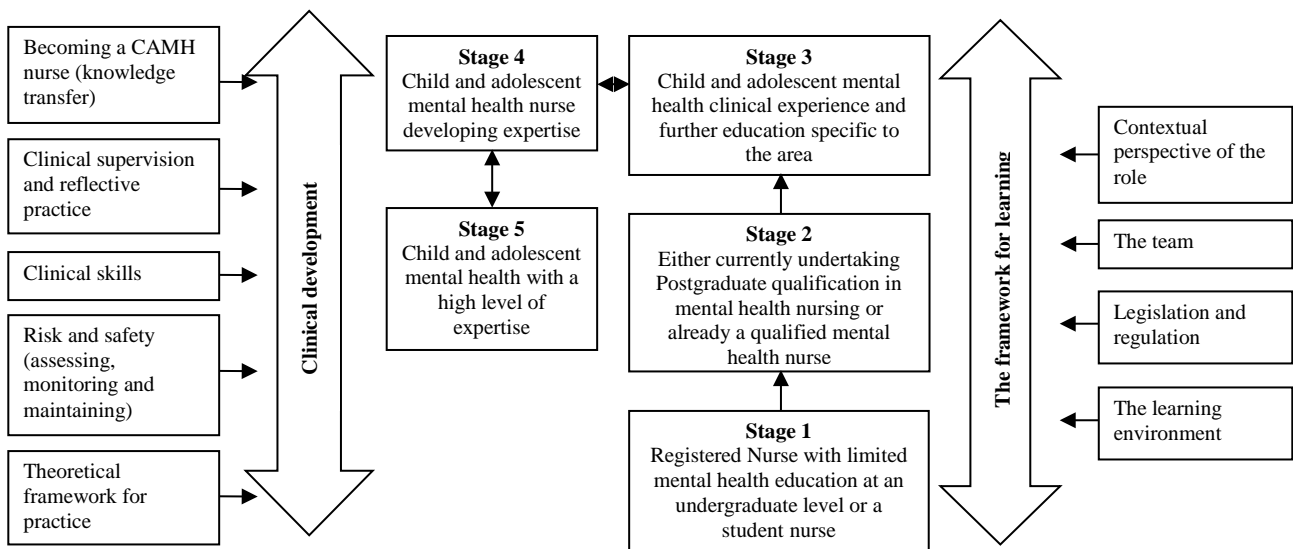


Figure 5 A conceptual holistic framework of CAMH nurses knowledge and learning

6.8 Summary

In this chapter the theoretical meaning of the focus group and individual interview data analysis has been discussed within the context of learning to become a CAMH nurse. The ways of knowing which were represented by a five stage process were identified and discussed. In addition the scaffold that supports those stages, clinical development and the framework for learning, were identified and discussed. A framework that was supported by the findings was conceptualised. The framework illustrated the stages of the ways of knowing and learning about CAMH nursing and the parallel supportive processes of clinical development and the learning framework. In the next chapter the findings of the research and the conceptual framework will be discussed in the context of relevant literature.

Chapter 7 Discussion

7.1 Introduction

The previous chapter conceptualised the findings from the focus group and individual interview analysis. This led to the construction of a conceptual framework that provided a theoretical understanding of the work of the CAMH nurse. Five stages of becoming a CAMH nurse were identified as well as the supporting scaffolds of clinical development and a framework of learning. The concepts of ways of knowing were used to attribute the components of the role within the framework. This chapter will provide theoretical discussion on the nature of the framework in the context of relevant literature concerning the patterns of the ways of knowing, knowledge development and role development for the CAMH nurse. The applicability of this framework for practice, education and research will be discussed along with the strengths and limitations of the study.

7.2 The work of child and adolescent mental health nurses

Mental health nursing has not been clearly defined and therefore it is difficult to precisely articulate the practice of mental health nursing (Leishmann 2003, 2004). One aspect of the mental health nursing role that is clear is the client population. Mental health nursing is the field that incorporates the mental health and mental illness of predominantly the adult population, that is people over 18 years of age, although some jurisdictions include people that are 16 years and older. CAMH nursing is a subspecialty of mental health nursing and its client group is generally aged up to 18 years although in some jurisdictions the client's include up to 25 years of age. As such, CAMH nursing requires a different set of knowledge and skills from that of adult mental health nurses (Hogan et al 2009).

The findings from the research have contributed to a new understanding of the work within the role of the CAMH nurse in an inpatient unit. A holistic conceptual framework illuminates the parameters of the role and provides some clarity in relation to development of the role and the nursing knowledge and skills needed to undertake

the role, a need identified by Dogra & Leighton (2009a). Further, the framework provides a guide to a flexible incremental process that reflects the development of the CAMH nurse through clinical practice.

The five stages of learning to become a CAMH nurse identify previously unknown points in the process. These stages can be clearly linked to the development of clinical skills through the application of knowledge to practice. This is at the heart of learning and understanding the role. These stages are also flexible in that they allow for the development of clinical skills from the least to the most experienced CAMH nurse. They accommodate the ever changing clinical environment that is CAMH and therefore provide a clear structure that guides the individual nurse as well as their supervisor in understanding the development of professional practice.

Supporting these stages are the clinical development and the framework for learning scaffolding. These scaffolds are the components of the role that identifies the work of the CAMH nurse. As much as the five stages identify the process of learning to become a CAMH nurse the scaffolding identifies the fields of nursing knowledge that provide a context to the role. The themes within this scaffolding are similar to those identified by McDougall, Gale and Nixon (2006) who suggested ten essential capabilities for CAMH nurses.

These capabilities are:

“Working in partnership, respecting diversity, practicing ethically, challenging inequality, promoting recovery, identifying people’s needs and strengths, providing child and family-centred services, making a difference, promoting safety and positive risk taking and personal development and learning”.
(McDougall 2006, p. 269)

These ten areas were all identified by the participants in the research and form the scaffolds that support the five stages of becoming a CAMH nurse. The fields of knowledge and the five stages of learning to become a CAMH nurse help to distinguish what their practice is and in turn gives it meaning. This clarity has implications for practice in CAMH nursing.

The aforementioned conceptual framework provided a basis for what encompassed CAMH nursing from a strategic and an operational perspective. The strategic perspective gave a plan of an intention that focussed on the parameters and considerations that make up this area of nursing practice whilst the operational perspective was about the stages of becoming a CAMH nurse and how the individual interpreted that through the social processes of the environment. The operational perspective was also concerned with the factors that scaffolded the stages of becoming a CAMH nurse. These philosophical perspectives for both the strategic and operational perspectives provided an opportunity for participant reflection on and insight into their understanding of the practice of a CAMH nurse and learning from experience to influence future development of practice.

7.3 Becoming a child and adolescent mental health nurse – a developmental approach from *unknowing* to *understanding the known*

Becoming a CAMH nurse is a developmental process in which the individual cultivates the clinical skills and the contextual understanding of the specialty. The CAMH nurse needs continual professional development to be able to expand their role translating clinical activities into nursing practice (Dogra & Leighton 2009a). The role itself is a combination of prescribed parameters and individual interpretation. Dogra & Leighton (2009a) suggest that CAMH nurses provide a range of clinical interventions to the young person and their family. The developmental stages within becoming a CAMH nurse are both uniform and unique. The uniformity refers to the identified stages that all of the CAMH nurses encounter as they negotiate the role. The uniqueness is about the individual and how they interpret the taken for granted uniformity and make meaning of it. Dogra and Leighton (2009a) highlighted the need for CAMH nurses to “...focus on both art and science – i.e. evidence based health care and interpersonal relationships.” (p. 3) by way of safeguarding the uniqueness of their practice. Ways of knowing (Carper 1978; Chinn & Kramer 2004, 2008; 2011) are now used to explain the five stages of the developmental approach and the supporting scaffold.

7.3.1 Unknowing

From the first stage or introduction to CAMH nursing there exists *unknowing* which is about the individual not knowing what they don't know. This professional naivety in relation to understanding the specialty is the entry point to becoming a CAMH nurse. There is a lack of depth of understanding of the meaning of the work within the role and the individual's place within it. The rapid learning curve involved in processing the new clinical environment means that a full understanding of the parameters of the role and indeed the individual's position and function within it, cannot be fully known by the individual nurse. The term *unknowing* does not suggest that the student or registered nurse has no knowledge but rather a lack of knowing within the context of CAMH nursing. The researcher considered that there was a great opportunity at this stage of becoming a CAMH nurse for the individual to begin to articulate the role parameters of the specialty.

7.3.2 A cursory understanding of the known

The second stage of *feeling confused* highlights the beginning of the process of a *cursory understanding of the known* of the role and an increased depth of understanding of how the individual sees themselves situated within the CAMH nursing role and what that means. This marks a beginning of an understanding of what it means to be a CAMH nurse. At this stage the nurse is beginning to develop the skill of critically analysing both the role and how they fit into it. A plethora of knowledge and experiences needed to be processed and understood. A sense of innovative autonomy is felt when integrating what is known and understood into practice and the role juxtaposed with the sense of the great *unknown*. This is a time to begin to cement the individual's identity as a CAMH nurse yet still negotiate the cognitive, emotional and cultural components of the role. These internal and external factors influence the individual's development and ability to articulate the role.

7.3.3 Becoming known

The last three stages of becoming a CAMH nurse described as *looking, learning, understanding and becoming*, are a period when knowledge and skills are *becoming known* and consolidated and an individual identity within the external and internal factors are identified. The confidence to integrate external information in the context of knowledge and skills pertinent to CAMH is emergent in the first of these last three

stages. The parameters of the role are much more evident to the individual nurse which contributes to their self-assurance in understanding the meaning of the role. Although there is still a noticeable theme of reliance on more experienced nurses this stage heralds a new era of exploring what it means to the individual to be a CAMH nurse. Individuals begin to shape their practice within the understanding and meaning they make of this.

7.3.4 The known facilitates

From this stage the CAMH nurse moves on to a more autonomous stage of self-reliance where *the known facilitates* the integration and interpretation of new information, skills and knowledge within their own established meaning of what the role encompasses. The individual meaning they have made of the role is tested and reorientated as they gain further experience and knowledge to augment their practice. The external parameters of the role remain the same as they are more perpetual in their structure and the individual has less influence on changing these. This is in contrast to the internal or individual meaning of the role over which the nurse has much more control.

7.3.5 Understanding the known

The final stage is one of autonomy of practice and *understanding the known* and how it relates to the parameters of the role of the CAMH nurse both within the role and individually. This stage symbolises a high level of expertise and fine tuning of what is known as well as integrating new knowledge and assigning it to previously identified knowledge. This stage is concerned with seamless interpretation and reinterpretation of knowledge into practice. As with the other stages of becoming a CAMH nurse this stage works within the identified external parameters of the role but there is a clearer understanding of the individual's identity within the role. By this stage the individual nurse has developed a comprehensive and distinctive understanding of being a CAMH nurse. In addition they have the insight into what the role encompasses from both an internal and external perspective to identify and delineate the parameters of all of the stages. This level of clarity about the role and what it means is crucial in assisting other less experienced nurses negotiate the trajectory of understanding moving from *unknowing* to *understanding the known*. The CAMH nurse can now see the horizon and put it into context within the foreground.

7.3.6 Moving between the final three stages

Even though the final three stages of becoming a CAMH nurse are identified as being reflective of understanding the role and with a high level of clinical knowledge and skills, the nurse may move between these stages. This situation transpires as new clinical challenges appear and therefore further knowledge and skills are developed. Within these experiences the nurse reassesses what they know and integrates new understandings into their clinical repertoire. The internal or individual meaning of the role is then re-interpreted and adjusted in line with the new understandings. The nurses at stage five who *understand the known* are the least likely of the nurses in the three final stages to move. Their comprehensive understanding of internal and external perspectives of the role was representative of their broad depth of clinical skills and knowledge in CAMH which was developed through experience. The more experienced the CAMH nurse, the less likely they will encounter an unfamiliar clinical scenario but it could potentially happen.

Understandably, the fluctuation is more likely to happen with stage four or stage three nurses as they have less to draw on in their experiential toolkit. The stage four nurses may have moved to a more autonomous stage of self-reliance where they are clearer about the role and what it means to be a CAMH nurse. However, experience of new encounters will still test their understanding of the role. The emergent confidence of the stage three nurses is precarious and easily influenced by external and internal factors. These factors can usurp the nurse as they are developing their own interpretation of the guise of their role and practice.

The fluctuation between the stages can occur in either direction, that is, a nurse at stage three can demonstrate a level of understanding that is reflective of a stage four nurse - not in all areas but in line with a particular clinical scenario. This is the result of a stage three nurse moving from developing confidence to self-reliance by integrating new information and a deeper understanding of an aspect of the meaning of the role. Conversely a stage four nurse may be less self-reliant when encountering an unfamiliar clinical scenario and therefore move to a stage three position in regards to them developing self-confidence and new understandings about the meaning of the role. Stage four nurses also can move to a stage five position in circumstances where

they have a high level of expertise in a particular area and where they have developed a comprehensive level of understanding and meaning.

7.3.7 The individual nurse developing an understanding of what it means to be a CAMH nurse

Moving through all of the five stages is concerned with developing and understanding what it means to be a CAMH nurse. In addition, it is a fluctuating incremental pathway which begins in stages one and two as linear but as the individual explores the new understandings and the meaning of the role, it becomes a more non-linear pattern in stages three, four and five, as the nurse can move between the last three stages depending on particular circumstances.

The timeliness of how any nurse moves through the stages of becoming a CAMH nurse is the idiosyncratic experience. There is no characteristic pathway that the individual needs to undertake in an ordered fashion to reach a meaningful understanding of the role. Rather, there is a self-directed pathway based on both external and internal factors some of which cannot be known and therefore forecasted and those that are given. Those that cannot be forecasted are the specific clinical scenarios and therefore knowledge and experience that the individual nurse will encounter and begin to shape their practice as a CAMH nurse. Even though the scope of the clinical skills and knowledge can be predicted based on the range of clients that have been in the unit and the admission criteria, one cannot anticipate the experience of the individual nurse. These external factors will influence the scope of the individual development of clinical skills and knowledge and how they develop and understand the role and make meaning of what the role is. The internal factors which are about the nurse understanding their individual identity as a CAMH nurse, will also be influenced by the scope of the clinical skills and knowledge pool they are exposed to. These idiosyncratic experiences are what assist in defining the meaning that the individual makes about being a CAMH nurse. These experiences therefore must have an influence on the nurse's ability to move through the stages of becoming a CAMH nurse. The given internal and external factors on the self-directed pathway are the predictable factors such as some of the admission criteria for the unit and the age range of the clients within the scope of practice of the CAMH nurse.

7.4 Role development of the child and adolescent mental health nurse

The individual has many roles that they enact within their social and professional lives. Each of these roles is governed by specific parameters that the individual may or may not have some influence over (Hardy & Conway 1988). Roles encompass all facets of our social and professional life and have an effect on how they are played. Parallel to movement through the stages of becoming a CAMH nurse is the scaffolding surrounding the role which supports their development. The framework for learning and clinical development that were identified as overall concepts, form the scaffold.

Clinical development involves practical and theoretical aspects of the role. The components within this part of the scaffold are knowledge transfer, clinical skills, risk and safety, clinical supervision and reflective practice and a theoretical framework for practice. The components of the scaffold can assist in the recognition of what the role of the CAMH nurse incorporates.

The framework of learning contributed to the scaffold of the CAMH inpatient nurses role. This identified the context in which the role operated and included a range of stakeholders, the team, legislation and regulation pertinent to the role and the learning environment. This aspect of the scaffold places the role within the broader landscape. The scaffold that supports the ways of learning and knowing for the CAMH nurse was constructed through the meaning that the participants of the study made of the role of an inpatient unit nurse. These findings can be articulated into the fundamental patterns or the ways of knowing within the discipline of nursing. The scaffold supports the ways of learning and knowing for the CAMH nurse and was a constructed meaning from the study participants. The concepts can also be discussed using role development and the fundamental patterns of knowing within the discipline of nursing.

Role development has many influences and there is no one theory underpinning role theory (Biddle 1986). However, there are three influences in its development: symbolic interactionism; dramaturgical perspective; and social structuralism (Hardy & Conway 1988) pertinent to the study. As stated in the methodology chapter symbolic interactionism is a theory which has its roots in sociology (Blumer 1969;

Mead 1934) and is concerned with the making of meaning and how the individual interprets their environment in relation to other individuals within their social group and processes. A symbolic interactionist framework was appropriate in this study when considering the individual's interpretation of their professional roles (Brookes et al. 2007). The dramaturgical perspective originated from the work of Moreno in the 1950's, influenced by Mead's idea of role play being central to our performance and the types of behaviours within role were influenced by the expectations of that role (Hardy & Conway 1988).

Social structuralism was also influenced by the work of Mead which focuses mainly on the role that the individual plays within their social and professional contexts. A role-set defined by Merton (1957) states it is the "... complement of role-relationships in which persons are involved by virtue of occupying a particular social status." (p. 110). The role-set concept is applicable to the role of the CAMH nurse who needs to enact several roles such as being a mentor to other staff but also being mentored themselves to gain experience and develop in their role.

A beginning CAMH nurse, for example - a stage one or two, may have a limited life experience which would affect their ability to understand others' perspectives. The more experienced nurses become in the inpatient unit, the broader range of life involvement is drawn upon from the professional toolkit. To shape a role identity an individual needs to develop a good self-perception as well as the context of the perspective of others (Hardy & Conway 1988). As modern society becomes more complex and individuals know less about others' perspectives, Hardy and Conway (1988) question how much impact the perspectives of others have on the individual.

7.5 The patterns of the ways of knowing

The work of Carper (1978) briefly described in the previous chapter provides context and theoretical meaning for this conceptual framework. There are four fundamental patterns of ways of knowing that are factors to Carper's (1978) theoretical framework: empirical knowing; aesthetic knowing; personal knowing; and moral (or ethical) knowing. These four patterns of knowing contribute to the generation of nursing knowledge. They are not exclusive and elements of all four contribute to nurses' ways of knowing and how they make sense of their practice. Carper (1992) posits that "The

practice of nursing requires not only “knowing that” but also “knowing how” and “knowing why” in regard to meaning, value, intentions, and goals.” (p. 79). This highlights the complexity of nursing knowledge and practice and therefore the multilayered perspective in which it needs to be contemplated.

A fifth pattern of knowing was identified much later by Chinn and Kramer (2008) which was emancipatory knowing: the praxis of nursing. This pattern was described as reflection and a critical analysis of all of the other patterns and the integration of that knowledge in the context of social justice, equality and advocacy. In addition this fifth pattern is also concerned with bringing about change through seeing the potential for altering the circumstances of individuals’ lives and outcomes. An outcome that is relevant to the treatment of mental health issues in children and adolescents. These patterns of knowing are inextricably linked to development of knowledge for the CAMH nurse as they assist nurses to understand their work within the role.

7.6 Knowing and knowledge development in child and adolescent mental health nursing

Knowing “...is constructed through experience, shaped by reflection and manifested by meaning.” (Bonis 2009 p. 1337). Distinctive to an individual is knowing and their interpretation of empirical information and how they make meaning of it and process it. So, within the discipline of nursing each nurse will have their own way of understanding and therefore knowing a clinical situation. This leads to knowledge development. The nurse brings a range of personal and professional experiences to any situation related to their work. This is the structure from which they will determine how they will navigate making meaning and sense of both subjective and objective information.

Nursing is a science based discipline but nursing knowledge cannot be considered within only empirical parameters. Kikuchi (1992) argues that there are questions about nursing that cannot be answered empirically but rather from a philosophical stance for example “... “What is the nature of nursing?”...” (p. 26). These kinds of philosophical questions illuminate the tacit aspect of nursing knowledge particularly in relation to practice. Unless one takes a philosophical stance these questions are simply too hard or impossible to answer in a way that reflects their epistemological

and ontological roots. The concept of a scientific basis for nursing knowledge and therefore the view of evidence and evidence based practice have had an empiric focus rather than considering the contribution of other forms of knowledge (Paley et al. 2007) such as professional craft knowledge (Rycroft-Malone et al. 2004).

The findings from this research are supported by Benner's idea of tacit learning and the expert nurse. The final three stages of role development; looking, learning, understanding and becoming are underpinned by the application of tacit knowledge to the clinical scenario. The nurses were able to demonstrate a perceptual process of understanding a clinical situation through intuition rather than the earlier stages where they relied more heavily on external input from their colleagues and more experienced nurses. Benner (1984) described the notion of tacit learning as being the domain of the expert nurse who no longer has to rely on an analytic principle to understand a clinical situation but rather has "...an intuitive grasp of the situation." (p. 32).

Tacit knowledge is integrated with scientific knowledge by the use of intuition (Polanyi 1966) which allows us to find solutions and satisfactory outcomes. Polanyi (1966) describes tacit knowing as "...starting from the fact that *we can know more than we can tell.*" (p. 4). Tacit knowledge is based on hunches and feelings that cannot be easily articulated and form the pre logical phase of knowing. This occurs as we try to comprehend a situation (Billay et al. 2007; Polanyi 1966). The pre logical phase involves two systems, one which is related to feelings through a perceptual process and the other which concerns intuition and imagination (Billay et al. 2007). Tacit knowledge is part of the fundamental ways of knowing pattern, aesthetic knowledge (Carper 1978). In addition to this Polanyi's work focused on personal knowledge which challenged the positive scientific theories of knowledge and added the dimension of the reliance on personal judgment (Allen 1990). This is also about the individual style of the nurses when developing therapeutic relationships. Dziopa and Ahern (2009a) suggest that there are three different ways in which mental health nurses develop quality therapeutic relationships - either equal partner, senior partner or protective partner. Further, Dziopa and Ahern (2009a) suggest that

"In child and adolescent mental health nursing, the Senior Partner nurse may be effective with younger children but might experience difficulties

with adolescents who are very sensitive to power and privacy issues; adolescents may respond better to an Equal Partner nurse.”(p. 21).

CAMH nurses have a broad range of clinical skills and some have a preference for working with the less than 12 year old group while others prefer the adolescent group depending on their individual style. The concept of knowing as unknowing was identified by Munhall (1993) as the phase in which the nurse must remove all filters to their “...own structures of understanding.”(p. 126) in order to facilitate openness to the other’s perspective. CAMH nursing combined the patterns of knowing and knowledge development to assist in evolving a richer understanding of their role.

7.7 Integrating the five patterns of knowing and knowledge development in the role of the CAMH nurse

The findings in relation to the role of the CAMH nurse were supported by the five patterns of knowing (Chinn & Kramer 2004; 2011). Each pattern was intimately linked with the others and that formed an integrated approach to knowing and knowledge development in CAMH nursing. In the reality of everyday clinical practice the young person and their family are central to the role of the CAMH nurse in an inpatient unit. But the comprehensive nursing care provided is strengthened by the patterns of knowing. Each clinical encounter is considered strategically through the questions that guide the authentication process for each pattern of knowing. As the CAMH nurse becomes more experienced and confident they seamlessly undertake the clinical role as they critically analyse and formulate a care plan while integrating all of the facets of knowing in nursing. With experience, some of the components of their practice become more tacit. Therefore, the patterns of knowing are not consciously considered individually but are incorporated into the complex practice of the CAMH nurse in an inpatient unit.

7.7.1 Governance and advocacy

Understanding the bigger picture is not just concerned with what is presented in an obvious way, but also the emancipatory knowing and knowledge which is more covert. This knowing and knowledge is about injustice and equality and being able to see and understand it within the context of the discipline of nursing. The CAMH nurse is challenged in this way not only because of the nature of nursing but also

because of the client group represented within their specialty. Advocating for change and seeking equity is a facet of the clinical development of the CAMH nurse. Emancipatory knowledge is being able to see what hegemonic structures are presented, critically thinking about them and looking at how they can be different to promote a more just and equitable outcome (Chinn & Kramer 2011). In the context of the CAMH nurse this can be seen as a thread weaving through their clinical development. Even though the individual CAMH nurse may not be able to change systems (Dogra & Davies 2009) there is a responsibility regarding governance and advocacy.

The knowledge transfer of learning to become a CAMH nurse and the support needed represents an opportunity to critically question and challenge the *way that things are* and have some input into improving outcomes not just for the nurses but also for the clients and their families. The challenges of working with vulnerable young people and their families are complex (Elliott & Votsanis 2009) often with multiagency involvement (Hogan, Dogra & Kitchen 2009). The CAMH nurse has to be able to critically analyse the clinical situation to achieve the best outcome for their client (the young person) which may mean advocating for them by assisting the family to understand the young person's perspective. This may include helping the family understand the emotional communication and regulation (Elliott & Votsanis 2009) of the young person and the significance of resultant behaviour.

Working through and gaining an understanding of and confidence in what the role entailed, allowed the CAMH nurses the chance to be able to play an instrumental role in implementing change in the inpatient environment. As the nurses became more confident in their abilities they were able to take a leadership role in this. Mental health nurses had an important role in providing clinical leadership in an inpatient unit (Cleary et al. 2012) especially when they were more experienced and able to support a less experienced nurse. In addition, they were able to contribute to the pool of knowledge that reflected and guided their role. They were then able to initiate and influence change to the nursing praxis of CAMH nursing. The role has a developmental focus on learning and supporting through a culture of critically analysing and debating the parameters of their practice.

The creative processes of emancipatory knowledge development are critiquing (finding out what is wrong) and imagining (realising the potential if changes occur) (Chinn & Kramer 2011). By critically assessing and analysing the situation from multiple perspectives (such as from the young person, family and education provider), the CAMH nurse was able to engineer a more beneficial outcome for the young person and their family. Through the process of critically assessing and analysing Dogra and Baldwin (2009) suggest that the CAMH nurse needs to utilise interpersonal skills and the therapeutic use of self to undertake a comprehensive assessment. The CAMH nurses in this study indicated that, supervision and reflection intensified the decision making processes. Buus (2008), in a study of clinical knowledge development in psychiatric nurses, found that nurses were influenced by their clinical environments. Buus (2008) suggests that “The nurses everyday communication has a direct effect on clinical decision-making processes and thereby influences the quality of care and treatment of the patients” (p. 191). The rhetoric of the CAMH nurses is paramount in negotiating clinical knowledge and therefore pivotal to the outcome for the client. The inpatient environment is complex for mental health nurses with competing demands (Cleary 2004). The ability to negotiate this domain and advocate for the client was how CAMH nurses contributed to emancipatory knowing and problem solving.

Role clarity through emancipatory knowing enabled the CAMH nurses to free other staff from the restrictions based on a misunderstanding of the CAMH nurses and the unit’s role in the overall care of the young person. Working with non-mental health nurses who are caring for adolescents with mental health issues (Foster 2009) is an opportunity to educate these nurses about mental health

7.7.2 Values and attitudes

Values and attitudes that develop over an individual’s lifetime form the basis for their ethical knowing and knowledge. These influences were reported strongly and provided a template for the CAMH nurse to navigate their ethical and moral stance on issues and dilemmas which faced them in their personal and professional lives. Nurses within their practice developed ethical knowledge through encountering ethical dilemmas (Chinn & Kramer 2011) which result in “... critical questions such as, “Is this right? and Is this responsible?”(p.88). Reflecting upon and considering these

questions with colleagues in the context of nursing practice develops ethical knowledge. CAMH nursing faces contradictions and ethical challenges through some of the statutory requirements (Leighton 2009b) associated with the care of an individual under 18 years of age. Ethical knowledge encompasses both ethics and morality. Chinn and Kramer (2011) use these terms interchangeably as they considered them to be enmeshed with ethics having an epistemological origin and morality having an ontological stance. The skills of ethical decision making and interpreting legislation are gained through the CAMH nurse practicing ethically and fulfilling their professional obligations (McDougall, Gale & Nixon 2006) and therefore increasing their confidence.

Ethics can be divided into four perspectives: teleology, what is right produces good; deontology, the greater good; relativism, culturally correct; and virtue ethics, which is concerned with the individual (Chinn & Kramer 2011). An ethical decision could be made from a deontological perspective when considering the *Children's Protection Act* (1993) where there are external factors such as codes or legislation which govern the decision even if there is a consequence for the nurse/client (family) relationship. The CAMH nurses became more self-assured in these ethical decisions as they gained experience in the role and found their level of professional understanding. The CAMH nurse had an important role in enabling young people and their families to make choices based on the families' values (Herrick et al. 2006) not the nurses' (Leighton 2009b).

The aforementioned perspectives of teleology and deontology are the two perspectives that is, "Is it right?" and "Is it responsible?" from which ethical knowledge development is made in the discipline of nursing (Chinn & Kramer 2011). More flexibility is afforded with relativism and virtue ethics. Relativism can be applied when considering the culture of a team and within CAMH nursing there is the nursing team and the multidisciplinary team to be considered. Virtue ethics is concerned with the individual's character and how that affects ethical decision making. There are however implications when considering virtue ethics in a profession dominated by one gender, female (Chinn & Kramer 2011). These issues are steeped in the history of nursing being a discipline for females of virtuous

character (Chinn & Kramer 2011; Dossey 1999) and therefore there needs to be a careful consideration of how the word virtuous is defined.

Chinn and Kramer (2011) identified a process by which the individual can clarify values and explore alternatives to answer the aforementioned ethical questions, “Is it right?” and “Is it responsible?”. Clarifying values is an objective process by which the individual seeks to place the emotional or subjective elements of ethical decision-making within a rational framework. These decisions can be made through a variety of methods including critical analysis of decisions made by either the individual or in collaboration with colleagues. This process enables the individual to examine personal beliefs which may influence decision-making (Chinn & Kramer 2011). Part of this process is then to explore alternatives to actual or intended. The formal expressions of these processes become the codes and standards by which the nursing profession is underpinned.

7.7.3 The self (the subjective component)

Through learning to become a CAMH nurse the individual gained an emergent understanding of the role allowing them to critically analyse and reflect upon where they fitted not only professionally but also personally. In terms of CAMH, a nurse’s professional practice was much more apparent to the other nurses and the young people than their personal knowing and personal knowledge development. This remained private unless they chose to share it with others. Professional practice was evidenced by the participant’s accounts of how other CAMH nurses could see them advance in their practice before they could see it themselves. The critical questions posed by Chinn and Kramer (2011), “Do I know what I do?” and “Do I do what I know?” would be hard to answer if the CAMH nurse did not have some sense of self and understanding of their personal knowing. What about the less experienced CAMH nurse who is providing nursing care to a young person who potentially could be in the same social group as them by virtue of age alone? How did the less experienced CAMH nurse provide nursing care while establishing a rapport and therapeutic relationship with that young person whilst being mindful of their own personal knowing? Should that be a problem, perhaps not? If the nurse has had a dissimilar life experience to the young person will that influence their care? The participants did not consider this a problem but rather something to be mindful of in terms of their nursing

practice. If the nurse was not conscious of the effect of their own values and attitudes have in shaping their personal knowing, this could change the care they provided to a young person.

Potentially being within the same social group and sharing the same interests in areas such as music and fashion, could blur the therapeutic boundary. The CAMH nurses became clearer about those boundaries as they gained experience and skill in the area (Elliott & Votsanis 2009). Supervision and reflection on clinical practice allowed the CAMH nurse the opportunity to explore some of the reasons underpinning their personal knowing. As the less experienced nurse attempted to adjust to nursing practice and all that it encompassed they became more aware of personal knowing through empathy (Newton & McKenna 2009). There was a recognition that more dimensions were evident about the young person than they first realised. This period in the CAMH nurse's clinical development could be confronting and difficult to comprehend as the theory and practice of nursing teaches the individual to have a clear line between the professional and personal (Leighton 2009a).

Individuals bring personal knowledge to their professional lives and nursing is no different. A nurse's personal experiences form a component of the overall pattern of knowing in nursing. Personal knowledge is based on the experiences, memories and thoughts of the individual (Bonis 2009) and as such are idiosyncratic to the individual as a reflection of the self. The relationship of the self to others through personal knowing is an intrinsic feature of nursing practice. Understanding the self and who they are is the process of personal knowing (Chinn & Kramer 2011).

The essence of CAMH nursing is about communication, developing a rapport and trust with the young person through the therapeutic relationship. This was the bedrock of the clinical practice. Hogan, Rogers & Hemstock (2009) suggested that CAMH nurses in an inpatient unit need to have a strong awareness of the nurse/adolescent relationship. Recognising and understanding the link between the self and others is a skill that is developed over time. Education programs for professionals tend to focus more on knowledge and skills at the expense of what is needed to *become* a professional (Dall'Alba 2009). Developing, understanding and trusting the role of intuition in their practice should be encouraged (Pretz & Folse 2011) and intuition is a

result of the combined effect of knowledge experience and expertise (McCutcheon & Pincombe 2001).

CAMH nurses are exposed to working with a range of service areas both within the health care facility and within the community. In addition they worked in collaboration with an array of health care, education and welfare professionals as well as the young person and their family. This provides a chance for the CAMH nurses to have a variety of professional relationships (Hogan, Rogers & Hemstock 2009) and therefore have a better understanding of their Self. Through working with professionals from outside the unit area the CAMH nurses need to be clear about what their role entails and as they establish a professional rapport they expose more of their Self to the others. The end product of the authentication process of personal knowing is the therapeutic use of Self (Chinn & Kramer 2011). This is a skill that required a knowing of the genuine Self and reflection.

Personal knowing can be conceptualised as being experiential, spiritual, a discovery of the self and others and as unknowing (Chinn & Kramer 2011). The notion of the nurse just knowing or understanding a connection between themselves and the patient was Carper's (1978) conceptualisation of personal knowing. Chinn and Kramer (2011) describe this as "...in-the-moment knowing of another..." (p. 113) where there is a clinical moment that the nurse and patient connect on a level of deeper understanding and the nurse can witness the patient's sense of self.

Spirituality has been linked with personal knowing (Pesut 2008) but this can be seen as either religious or secular (McSherry & Cash 2004) as it is a combination of values and attitudes that influence the individual's life (Chinn & Kramer 2011). Integrating cultural issues, which included spirituality, was a facet of the CAMH nursing assessment identified in this study. Respect for a young person and family's cultural perspective assists CAMH nurses to work within their professional expectations (Dogra & Baldwin 2009).

Personal knowing as the discovery of self and others (Moch 1990) involves experiential knowing, interpersonal knowing and intuitive knowing. Experiential knowing is concerned with an awareness of the experience through utilising one's senses; seeing, hearing and feeling so it takes in the environment or the context of the

experience. Interpersonal knowing is about the interaction and exposing of the self to the other individual. Intuitive knowing is regarding what is not consciously thought through but just known. The nurses demonstrated this through the stages of becoming a CAMH nurse because they integrated the three aspects of personal knowing into their practice. Whether it was during assessment with a young person or assessing the milieu they relied on their experiential, interpersonal and intuitive knowledge for clinical formulations. Gunderson (1978) considered the five variables in milieu management to be containment, structure, support, involvement and validation - each essential for a positive outcome. Skilful observations and management (Hogan, Rogers & Hemstock 2009) of the milieu is a significant role in the work of the CAMH nurse in an inpatient unit.

7.7.4 Interpreting and understanding the clinical environment

From the analysis of data it was evident that CAMH nursing was about recognising the commonality and the uniqueness of the human experience in regards to individual experiences of a health care episode. The development of aesthetic knowing included the interpretation and understanding of the clinical environment and its meaning and what it encompassed in terms of CAMH nursing practice. Aesthetic knowing understands the deeper and the underlying factors for that meaning and locating solutions that are not yet seen (Chinn & Kramer 2011). The participants also described the skill of interpretation and understanding of the clinical environment as a product of confidence and trust. First the CAMH nurse having the confidence to question what they were witnessing and second the trust in themselves to interpret the meaning and then act upon it. Trust was also to do with the other nurse, to trust their own observations and to then share their own interpretation and conceptual formulations of a clinical scenario with their colleagues. In the development of their clinical skills in assessment and intervention the participants identified the importance of interpreting and understanding the clinical environment through developing *the ability to anticipate and intervene* yet creating a space for the young person. Delaney (1992a, 1992b, 1997) suggested that nurses were responsible for initiating and maintaining the CAMH milieu environment. In contemporary nursing the skill of understanding and interpreting the client's perspective has not been emphasised (Austgard 2006). The questions that are meaningful to aesthetic knowing include "...“What does this mean?” and “How is it significant?”.” (Chinn & Kramer

2011, p. 127). Through education and clinical experience nurses develop aesthetic knowing. This is a combination of understanding nursing and the health continuum and through that process the ability to elicit abstract meaning.

The ability to interpret and understand abstract meaning is inextricably linked with the nurse/client relationship and the nurse's ability to establish and build rapport and comprehensively understand the resultant interaction. Through the therapeutic relationship with the client the unfolding story provides inherent details that the nurse can analyse to further understand the uniqueness of the individual (Leight 2002). It was evident in the study that as CAMH nurses became more experienced they became more proficient in interpreting and identifying aesthetic meanings earlier in a clinical encounter and establishing a meaningful connection with the client. Chinn and Kramer (2004, 2008; 2011) define the creative processes of aesthetic knowing as being envisioning and rehearsing. These creative processes were not necessarily shared with others, as the initial experience of reflection on clinical activities to ascertain a deeper understanding and determining how they would approach the same scenario again, were individual. Further, Chinn and Kramer (2004, 2008; 2011) suggest engaging a connoisseur-critic to provide feedback on the nurse's interpretation of their performance in the clinical scenario. This does not imply that the nurse needs to "perform" the clinical scenario again but rather through narrative, take the connoisseur-critic through the scenario identifying the perceived changes and accepting the expert feedback. The CAMH nurses reported that they engaged in these processes through formal supervision and mentoring as well as the informal "back office" discussions with peers.

Clinical supervision is good practice and can be an opportunity to discuss a broad range of issues related to CAMH nursing practice (Dogra & Davies 2009) and provide education and guidance. The participants described the complexity of the clients i.e. mental health problem; physical health co-morbidities such as metabolic and respiratory issues; developmental stage of the young person; family situation and multiple agency involvement - as adding to the intricacy of interpreting the clinical encounter. These complexities resulted in clinical challenges where the CAMH nurse needed to have a comprehensive understanding of both mental and physical health within a developmental framework, a family work perspective and a systems

approach to undertake multi-agency work. To enable a positive outcome for the young person, their family and the nurse, supervision and mentorship were a necessary component of their work.

7.7.5 Conceptualising and structuring human behaviour

All specialty areas in nursing have words or symbols that are particular to their area however, overarching that, there are words and symbols that are pertinent to all areas. Creating a conceptual meaning for empiric knowing in nursing in the context of practice is an important element. The individual CAMH nurse's perception plays a role in the interpretation of the information and the development of the concept. Conceptualising and structuring human behaviour is an essential component of the practice of CAMH nursing as it is fundamental to clinical formulation. Nursing assessment in CAMH nursing needs to encapsulate a clear developmental and behavioural component to conceptualise a clinical formulation (Dogra & Baldwin 2009). Nursing as a science based discipline is seen as empirically based, framed with evidence based practice where hypotheses need to be formulated and then tested to either prove or disprove. This is only one part of empiric knowledge; human behaviour needs to be considered at the core of nursing practice, as the client cannot be wholly considered empirically. Therefore empiric knowledge must encompass both objective and subjective information.

The parameters of the role of CAMH nurses were not easily defined apart from the age range of the young people (Baldwin 2002; Dogra & Leighton 2009b; Johnson 1995; McDougall 2006). The scope of the nursing role and the knowledge required was identified by the research however empiric knowing and its application to clinical practice is a complex dimension. The clinical development of the CAMH nurse was dependent on the integration of both empiric and abstract concepts combined with the other patterns of knowing. To consider the clinical skills required to comprehensively assess a young person and their family and to develop a clinical formulation includes interventions and post discharge planning. The clinical scenario required a comprehensive understanding of all of the elements needed to undertake such complex work which was core to the role of the CAMH nurse. The theoretical framework for practice provided some of the empiric concepts required but even within that area the individual nurse needed to choose which framework was

appropriate. A biopsychosocial assessment elicited a comprehensive picture of the young person (Dogra & Baldwin 2009) and their family but within this empiric concept there were abstract elements that also needed to be addressed.

Through the process of the assessment the CAMH nurse employed deductive reasoning that considered the broader picture such as the family, friendship groups and school that support the young person, before specifically focusing on the presenting issue. Once the whole picture was contemplated then the CAMH nurse could structure and conceptualise their theory in relation to the young person's issue and develop a care plan. The case formulation and conceptualisation of the assessment (Dogra & Baldwin 2009) is the basis of the family work (Frake 2009) of the CAMH nurse. For the less experienced CAMH nurse this would have been undertaken in conjunction with a supervisor or mentor. This reflective practice guided and supported the CAMH nurse identifying and understanding both the empiric and abstract elements of the empiric pattern of knowing.

To understand empiric knowing the following critical questions need to be answered; "...“What is it?” and “How does it work?”..." (Chinn & Kramer 2011, p. 153). As these questions are investigated the creative process of conceptualising and structuring assists in developing a deeper understanding of the clinical scenario (Chinn & Kramer 2011). Empiric theories can be represented through a confirmed hypothesis, a conceptual system, a grouping of knowledge or a general frame of reference (Chinn & Kramer 2011) and as such can be expressed as a creative conceptual framework. For the purposes of empiric knowing Chinn and Kramer (2011) define a concept in the following way "...a complex mental formulation of experience." (p. 158) and they can be either empiric or abstract. Chinn and Kramer (2011) represent this on a continuum moving from relatively empiric to relatively abstract with the concept of a person's height representing the former and a person's self-esteem representing the latter.

In summary, the five patterns of knowing and knowledge development in the role of the CAMH nurse have been integrated to provide theoretical meaning and understanding of their work. This next section focuses on the implications of this research.

7.8 Implications for CAMH nursing practice

The implications for practice are significant with the articulation of the parameters of the CAMH inpatient nursing role being identified. In an interview (Spray 1999) Hildegard Peplau discussed the development of the role of psychiatric nursing throughout her career and emphasised the importance of the nurse/patient relationship, empirical knowledge and holistic care. Peplau warned of the demise of psychiatric nursing;

“If nurses don’t develop that piece (sic), at the point when the linkages between neuroscience and psychosocial begin coming out at a rapid rate, nursing is going to disappear as a field because it will have nothing to do.” (Spray 1999, p. 31)

As mental health nursing has derived professional knowledge from other disciplines, the role is not easily articulated (Hurley, 2009a) therefore it is imperative for the future of mental health nursing that this is undertaken (Crawford, Brown & Majomi 2008; Hurley & Ramsay 2008). The findings from this research have assisted in articulating the work within the role of the CAMH inpatient nurse and therefore added to the body of nursing knowledge.

Ascertaining the stages of development of the CAMH nursing role as well as the fields of knowledge has implications for practice. The stages of development of the role assist in understanding how practice develops and what the differences are in the various stages of development. Browne, Cashin and Graham (2012) in considering the role of mental health nurses in working with children stated that “...mental health nurses seem to be ideally suited to an emerging role, that of supporting children with behavioural disorders/mental illnesses.”(p. 129)

This research has identified how the CAMH nurses in the inpatient unit make meaning of their roles and the social processes involved in developing their practice. The exploration and interpretation of the nursing practices, beliefs and attitudes of the CAMHN nurses both from an etic and emic perspective has provided a broad understanding of their role. This has allowed for exploration of the taken for granted knowledge about the practice of the CAMH nurse in an inpatient environment.

As discussed in an earlier chapter, the researcher validated the participants' views by providing them with a copy of their transcripts. In addition, the researcher invited the participants to attend a feedback forum discussed the findings and introduced the conceptual holistic framework of CAMH nurses knowledge and learning. The forum was not audio recorded but rather notes of the discussion were taken by the researcher and incorporated into this thesis. Participants' reported that the findings articulated the role well and that the concept of understanding the role in stages was helpful and reflected the complexity and the incremental learning that was required to advance in the role. The participants suggested that the conceptual framework would be useful to help the community CAMH nurses understand the role of their inpatient colleagues.

Nurses from CAMH Services were invited to attend a forum to discuss the findings and the conceptual framework after the participants in the research. There was a broad representation of CAMH nurses at the forum from the metropolitan community, country services, inpatient unit, forensic services, psychological medicine, adolescent services and perinatal mental health unit. The feedback was positive with the nurses commenting that the findings and the framework clearly articulated the role. Their feedback indicated that the framework may be applicable to community CAMH for mapping practice. The nurses suggested that this would be useful for articulating their practice, identifying their scope of practice and for developing competencies specific to the area of CAMH nursing.

With regards to making meaning of their work within their role the participants in the study provided a narrative which described the layers of practice that helped identify the meaning. The complexities of the mental health nurses' role within these layers were also identified by Hurley, (2009b) when researching the mental health nurse identity. In the study of the CAMH inpatient nurses the meaning of the role had an individual focus as well as an overall significance. For example each of the five stages of becoming a CAMH nurse was ascribed role responsibilities which differentiated them from other stages. The first two stages were more concerned with making sense of the fundamentals of clinical practice and therefore less about a deeper understanding of the meaning of the role and more about how the role interacts with the more advanced stages, the multidisciplinary team and the wider CAMH services. During the first two stages the CAMH nurse had more of an individual focus of the

meaning of the role as some of the information they were learning was new. More emphasis was therefore placed on learning about the role. In the last three stages of becoming a CAMH nurse there was a higher level of clinical skill and knowledge that underpinned the meaning of the CAMH nursing role. This was demonstrated by a deep understanding of both the individual focus of the role as well as a clear understanding of the interaction with other stages of the role, the multidisciplinary team and the wider CAMH services.

The social processes of supporting CAMH nursing practices at all five stages was clear from the participant's responses. These social processes included a culture which guided and cultivated the CAMH nurse through the stages of the role. The social processes were inferred prior to their explication through the research and were both formal and informal. In a formal sense there were expectations of individual nurses in line with their job and person specifications (role description or position statement) and their level of clinical experience which linked them to their supervisor or mentor. However, the informal social processes which guide the making of meaning were more tacit and were at times initiated by either the individual nurse or another member of the nursing team. This provided a two way mechanism for communication and feedback to support the less experienced CAMH nurse in making meaning of the role. In addition these social processes were beneficial to the more experienced CAMH nurse as they were better able to understand their role and that of their colleagues and how the role develops.

The practice, beliefs and attitudes of the CAMH nurses and the taken for granted knowledge can be explained using the Conceptual Holistic Framework of CAMH Nurses Knowledge and Learning. The framework provides a structure for the stages of becoming a CAMH nurse as well as the scaffolding that supports the knowledge and learning. The scaffolding of clinical development and the framework for learning are actualised through the ways of knowing. Given that there are several patterns of knowing with each given equal weighting, then it is conducive with nature of the nursing profession that it can be empiric and intuitive at the same time. Nursing has a very idiosyncratic approach to considering ways of knowing (Paley et al. 2007) which reflects the craft of the practice. This allows for a broader acceptance of what evidence based practice is in regards to the ways of knowing (Rycroft-Malone et al.

2004) and encourages nurses to consider and employ alternatives such as intuitive and aesthetic ways of knowing. The link between clinical development, the framework for learning and the ways of knowing were apparent in the rhetoric of the participants of the research.

The participants demonstrated that they developed knowledge and understood their practice through the ways of knowing. Interestingly, the patterns of knowledge development that the participants found the most difficult to articulate were the development of aesthetic and personal knowledge. Sometimes what the nurse knows is difficult to make evident (Luntley 2011) and therefore remains known only to the individual. Further Luntley (2011) argues that propositional knowledge, that is know-how, contributes to some of the "... raw behavioural skills that figure in explaining performance..." (p. 22) and therefore challenges some of the ways of knowing suggested by (Benner 1984). This requires a proliferation of different types of knowledge.

As the CAMH nurses navigate the stages of becoming a CAMH nurse, there is a progression of aesthetic nursing which is concerned with the art of nursing and therefore encompasses propositional knowledge. That is the common sense and know-how which the participant's had difficulty articulating. As these skills are refined they become more intuitive through experience of the clinical area in conjunction with propositional knowledge. Carper (1978) acknowledged the equivalence of theoretical and clinical knowledge along with Benner (1984) who also recognised the difference between propositional and non- propositional knowledge. Whilst for the nursing professional there is an emphasis on theoretical knowledge, the role of the CAMH nurse was strongly reliant on clinical knowledge. The distinction between "... 'knowing that and knowing how' ." (Paley et al. 2007, p. 693) became paramount in understanding the role of the CAMH nurse and how they integrated the stages of becoming a CAMH nurse, the clinical development and the framework for learning scaffolding.

The participants demonstrated through their discussions the process of integrating existing and new knowledge and clinical skills within their role. This integration of knowledge, practicality and common sense and ordinary self of a CAMH inpatient nurse supports key findings by Barker (2006) and Hurley (2009a) when considering

the identity of psychiatric and mental health nurses. In a feedback session with participants from the study they considered reflection on practice and ongoing support through good clinical supervision both formal and informal as being crucial for the individual's development in the role. They reported that the findings from this research legitimised their work culture through distinguishing components of their role.

Although outside the scope of this research study, an invitation was received from the Tasmanian CAMHS nurses to attend a forum to discuss the findings from the research and the resultant conceptual framework. The forum included CAMH nurses from state-wide services from both inpatient and community locations. Although the CAMH services are different in Tasmania to the service involved in the research the nurses at the forum identified the findings and the framework to be applicable to their nursing practice. Feedback from the nurses suggested the themes in the findings reflected their roles and they were supportive of the five stages of the conceptual framework with different entry points to becoming a CAMH nurse depending on the individual's prior experience. The nurses also thought that the supportive scaffolding, i.e. clinical development and the framework for learning was representative of their practice. The clinical development scaffold also illustrated what they needed to support them through the stages of becoming a CAMH nurse. In addition, they considered that the framework for learning was important to understanding the context of the role. The nurses deemed the holistic conceptual framework as something that they could use to identify their scope of practice.

CAMH nurses work in a variety of settings which include health facilities in the community and the clients are provided with group as well as individual services by the nurses. The elements of the role may appear similar to different practice settings is different as the client group is constant. It is possible that the framework be transferable to CAMH community nurses and provide them with a structure in which to articulate their role. Mental health nurses not working in CAMH may also be able to utilise the framework by adapting it to the parameters of their practice.

The framework adds new knowledge to the area of CAMH nursing as it articulates the elements of the role, identifies the contextual development and the clinical skills development of the role and provides an understanding of the stages of becoming a

CAMH nurse. These elements in the framework distinguish what belongs to nursing in CAMH practice and provides a professional identity for the CAMH nurse that separates them from the other health professionals in the area.

The implications for CAMH nursing practice are significant as the findings from this research provide clarity in relation to not only the parameters of the nurses' practice but also to the understanding of how the CAMH nurses develop their practice. In addition that way these nurses are educated in the area of practice is important for this specialty.

7.9 Implications for CAMH nursing education

In identifying the parameters of CAMH nursing practice the holistic conceptual framework can contribute in the approach to education for this specialty area. It has the potential to inform the development of education programs at the tertiary level in both undergraduate nursing programs and postgraduate mental health nursing programs. In addition the framework will inform CAMH Services of the specific education and support the nurses need to develop their practice.

In the undergraduate nursing programs a greater understanding of CAMH nursing practice will benefit students on placement so they can recognise CAMH nursing practice and therefore facilitate a more meaningful introduction to this specialty area. This level of understanding and meaning may add to the experience of the nursing student and also to that of the client with whom they are working. It would provide a perspective for the nursing student to better understand the client through understanding the broader context of being able to define the specialty area of practice. This could demystify the role somewhat and facilitate a level of engagement with the client based on understanding.

At a postgraduate level of mental health nursing education the framework would enhance the skills and knowledge that are being learned and practiced. The framework would provide a deeper understanding of the context of the CAMH nurse and how they inform and develop their practice and perhaps highlight the similarities and the differences across the areas of mental health nursing practice. The conceptual framework has a place in assisting the students to define the broader context of mental health nursing by identifying the elements of CAMH nursing. Further, this will be

helpful for the graduates of mental nursing programs if they seek work in the CAMH area as they will have a more comprehensive understanding of the parameters of CAMH nursing practice. As well as preparing them for the specialty area, this will alleviate any confusion about the role of CAMH nursing.

Through the articulation of the framework there is a clearer understanding of the resources that are needed for a nurse to develop practice and become a CAMH nurse. The framework provides a chance for CAMH services to develop education programs to support the CAMH nurses to develop their practice in line with the identified parameters of the role. This will also aid in recruitment and retention of nurses by identifying what the nursing roles are within CAMH rather than the generic components of the role which can be undertaken by a variety of allied health professionals.

As highlighted by the findings CAMH nurses do not undertake any specific education to prepare them for this specialist area of practice within mental health nursing. Hurley (2009) refers to the mental health nurse as a generic specialist which indeed could be used to describe the role of the CAMH nurse. But the term generic specialism is fraught with danger as it does not exemplify the essence of CAMH nursing practice. Happell (2004, 2006, 2009a) has consistently raised the issue of the education of mental health nurses and the implications of a comprehensive undergraduate program which espouses the ideal of mental health nursing being part of the generic role of nurses rather than a specialist qualification. Some of the participants in the research identified that even with a postgraduate qualification in mental health nursing they did not feel equipped to practice in the area of CAMH. In addition some of the participants stated that they had not received any level of education or experience in CAMH in either their undergraduate nursing programs or in the postgraduate mental health nursing programs. The research has illuminated an area of practice that needs to be included in nursing programs at both undergraduate and postgraduate level. Indeed by way of example some of the theoretical fields of practice of the CAMH nurse such as attachment theory (Bowlby 1977) surely would be an appropriate basis from which to further understand adult mental health nursing.

7.10 Implications for CAMH nursing research

The study has contributed to mental health nursing knowledge and in particular CAMH nursing knowledge. With a clearer understanding of the role of the CAMH nurse in an inpatient unit there is scope for further research encompassing other nursing roles within CAMH.

There is scope to undertake further research to ascertain the applicability of the holistic conceptual framework of CAMH nurses practice to other inpatient settings both nationally and internationally. Other nursing roles within CAMHS, such as community and hospital positions such as consultation liaison could be included in research future research. This would contribute to the strength of the conceptual framework. The feedback from the participants at a forum was that the conceptual framework would also fit the community CAMH nurses role. In addition, they suggested further research to determine the conceptual framework's suitability for community CAMH nursing practice.

The conceptual framework may have some application for the mental health nurse competency standards (ACMHN 2010). Further, research would be beneficial to determine how they would augment the current standards which are focussed on the broader scope of mental health nursing practice. The conceptual framework would provide an opportunity to provide more clarity regarding the competencies for the CAMH specialty.

Feedback from the research participants and the wider CAMH nursing community illustrated there is scope for further research that has emanated from this study.

7.11 Strengths and limitations of the study

The strength of this study is that it gave CAMH nurses in an inpatient unit a voice in regards to their practice. The opportunity to articulate, reflect upon and identify their practice means that the CAMH nurse in an inpatient unit has a clearer understanding not only of their role but also of the context of their practice. This research has contributed a new understanding of CAMH nursing practice and the meaning of the role. Also this research has added to nursing knowledge in relation to CAMH nursing

and also mental health nursing. The elements of the role of CAMH nurses and their role development will contribute to a further understanding of mental health nursing.

Disseminating the findings of the study nationally and internationally has enabled a broad range of feedback from within and outside of the State where the study was conducted and has returned positive and encouraging feedback. Another strength of the study was the credibility of the data to other CAMH nurses practice, education and research.

The limitations of the study are that it was conducted in one inpatient unit and therefore did not consider the community CAMH nurses perspective. In addition the study was conducted in one State and therefore may not be reflective of CAMH inpatient nursing as a whole in other parts of Australia or indeed in the wider global community. The unit where the study was conducted was small and therefore the number of nursing participants was limited. There was only one CAMH inpatient unit in the State where the study was conducted so there was no opportunity to gather a broader view in that State.

An acknowledged limitation of the study was the lack of the voice of the young person in providing a different perspective to understanding the work and role of the CAMH nurse. Unfortunately due to the constraints of ethics approval this was neither possible from an interview or observational context. This perspective would have added richness to the data.

7.12 Summary

The holistic conceptual framework identified the knowledge that CAMH nurses need and considered how the knowledge development assisted them in becoming a CAMH nurse. In this chapter the theoretical meaning of the framework has been discussed through the lens of integrated knowledge development as it relates to the role of the CAMH nurse. The CAMH nurse role is complex and as such needed to be viewed through both the perspective of the role and how knowledge was generated. The generation of knowledge and sustaining it is what identifies a specialty area and all of the components of it. The five stages of understanding the role and developing an individual perspective of the nature of the role were also supported by the elements of

role theory and role development (Biddle 1986; Biddle & Thomas 1966; Hardy & Conway 1988). The process of negotiation and recognition of previous experience was fundamental to an area where there was more than one entry point for working in the unit. Without this flexibility and collaboration with existing staff it would have been more difficult for the experienced nurses new to the area to have some license over developing their own practice. The backdrop of Benner (1984) adds to the identification of the stages of development. The ways of knowing (Chinn & Kramer 2011) were clearly identified through the clinical development and the framework for learning that enveloped and supported the nurses in becoming CAMH nurses in the inpatient unit. Although there were some limitations of the study, strengths were also highlighted.

The next and final chapter revisits the purpose of the research, reflects on the research methodology used and rigour of the research process, and presents the major findings. Recommendations for future practice, education and research in CAMH nursing are identified. A final summary is provided.

Chapter 8 Conclusion and Recommendations

8.1 Introduction

This thesis has sought to provide a clearer understanding of the role of the CAMH nurses specifically in an inpatient setting. The meaning that the CAMH nurse makes of their role as individuals as well as a professional group has not been clearly articulated to date (Baldwin 2002; McDougall 2006). Further, the contexts of the multidisciplinary team of health professionals with whom they work have had a limited contribution to this understanding (Baldwin 2002). The findings of this research have led to the development of a framework that conceptualises the role and work of the CAMH nurse. This has implications for CAMH nursing practice, education and research as discussed in the previous chapter. The strengths and limitations of the study were also addressed.

This chapter will indicate that the original research question and purpose was successfully addressed using a social constructionist theoretical framework and a three stage research design. A reflection on the methodological approach is undertaken as well as an examination of the rigour of the research. The major findings are summarised and recommendations for CAMH nursing practice, education and further research, identified. A final summary concludes the thesis.

8.2 Addressing the research question

The research question that was addressed in this study was “What is the work of CAMH nurses in an inpatient unit?” The purpose of the study was to examine the question by illuminating the following areas:

- Identifying the specific knowledge and skills of CAMH nurses in the inpatient unit.
- Exploring and interpreting the role (e.g. nursing practice, beliefs and attitudes) of mental health nurses working in a CAMH inpatient unit.

- Providing a comprehensive understanding of the role and function of mental health nurses in an acute CAMH unit.
- Exploring the relationships within the multidisciplinary team.

The theoretical framework for this study was social constructionism (Burr 2003) and therefore the lens through which the areas of the research question were considered. The specific knowledge and skills of CAMH nurses in an inpatient unit were identified through the research process and have contributed to the development of a conceptual framework that articulated the work of CAMH nurses. Exploring and interpreting the role of mental health nurses working in the CAMH inpatient unit was achieved through the chosen interpretive methodology. Understanding the social process and their meaning to a particular group assists in foregrounding their social reality (Holstein & Gubrium 2008). The social processes and meanings that are ascribed to the CAMH nurses role were extricated in this research.

The data collection methods employed; document analysis, focus groups and semi-structured interviews allowed the exploration and interpretation of the role of CAMH nurses. Each stage of the data collection and analysis added another layer of depth to the richness of the understanding of the role of CAMH nurses. Using these various methods or triangulation added to the richness and the rigour (Denzin & Lincoln 2008) and as such provided another form of validation in qualitative research. Focus groups provided the opportunity for not only the researcher but also the participants, to consider multiple perspectives (Kamberelis & Dimitriadis 2008). The focus groups in the research provided an opportunity for participants to consider not only their own viewpoint but also that of others in regards to their work and the social processes that enable their practice. For the researcher, the focus groups allowed for a proliferation of multiple meanings of how the participants interpreted their practice. Interviews allow the researcher to create accounts of people's lives (Fontana & Frey 2008) and therefore better understand the role of the CAMH nurse. Engaging with the participants through semi-structured interviews afforded a deeper understanding of their reality and the social processes of CAMH nursing in an inpatient unit.

The comprehensive knowledge which characterised the role of the CAMH nurse contributed a new understanding of this specialty area of mental health nursing. The

research also identified and described the relationship between the CAMH nurse and the multidisciplinary team. Having the perspectives of the health professionals who form part of the multidisciplinary team in which the CAMH role is situated added to the richness of the data. The analysis was enhanced by having the unique view of these professionals who sit outside the nursing profession. This perspective corroborated the understanding the CAMH nurses perception of the collaborative nature of their work

8.3 Reflections on the methodological approach

The methodological approach of social constructionism was appropriate for the study. It provided the CAMH nurses with the opportunity to reflect on the meaning of their work and role. Social constructionism is concerned with the making of meaning and the social processes that facilitate that and this study was designed to develop a better understanding of the CAMH nurse in an inpatient unit. The methods of document analysis, focus group interviews and individual interview, were congruent with the theoretical approach and the purpose of the study. The researcher found the social constructionist lens was simpatico with mental health nursing as they both have an element of making meaning of or assessing information and understanding of, social processes. The methods of data collection were congruent with accessing a deeper understanding of the work and role of CAMH nurses. As a mental health nurse the researcher felt a natural affinity with social constructionism as a methodology.

8.4 Rigour

The research was conducted in a thorough manner to ensure the meaning that the CAMH nurses and their multidisciplinary colleagues made of the role was represented accurately. Integrity through rigour is a fundamental tenet in qualitative research (Polit & Beck 2012) and as such warrants some discussion in regards to the research undertaken.

The trustworthiness of the research is represented by five criteria: credibility; dependability; confirmability; transferability (Lincoln & Guba 1985); as well as authenticity (Guba & Lincoln 2005). The credibility of this research was evidenced by the three stages of data collection which allowed the participants' involvement at

different points of the research process. The participants were involved in identifying the documents for analysis. These standards, procedures, protocols and policies reflected the CAMH nurses' work and later informed the development of the focus group questions.

The research dependability was indicated through the rigorous process of analysing and interpreting the data. There was a clear audit trail in the analysis of the documents defined through the aggregative (Joanna Briggs Institute 2008) and iterative (Attride-Stirling 2001) methods employed in this study. Further, the comprehensive six step thematic analysis process (Braun & Clarke 2006) utilised in the focus group and individual interview analysis, provided an understanding of the researcher's decisions and interpretations concerning the data.

The participants of the focus groups and the individual interviews verified their transcripts before the data was analysed to further add to the confirmability of the research. At the completion of the data analysis the findings were presented back to the participants in a discussion forum. Participants were also given the opportunity to provide feedback regarding the findings on an individual basis if they chose.

Transferability was endorsed by the participants of the study during a forum to discuss the findings. The feedback from the participants was that the findings and the holistic conceptual framework were transferable to other practice settings for CAMH nursing as well as the inpatient unit. A broader group of CAMH nurses from a separate jurisdiction than the study participants considered that the findings and the conceptual framework were transferable to other areas of nursing such as mental health and community health. The feedback from the participants and the wider CAMH nursing community added to the rigour and trustworthiness of the research.

The data analysis and the findings highlighted the authenticity of the research by presenting the participants' experiences in the context of the meanings they made of their work. The findings provided a better understanding of the context and the social processes that support the role of the CAMH nurse in the inpatient unit. The researcher's interpretation of the meaning that CAMH nurses make of their role was supported by the participants in the feedback forum and therefore was reflective of their practice. The research question has been answered in depth in a rigorous and

inclusive process through careful planning and implementation. In depth analysis of the data has resulted in the development of a conceptual framework which identified the parameters (knowledge and skills) of the role and the knowledge development of the CAMH nurse.

8.5 Major findings

This research has contributed to a better understanding of the work within the role of the CAMH nurse in an inpatient unit. The findings have articulated the stages of becoming a CAMH nurse and provided insight into the developmental stages of becoming a CAMH nurse. The stages of becoming a CAMH nurse were supported by the clinical development and the framework for learning scaffolding.

The clinical development scaffold provides insight into the complexity of the clinical role of the CAMH nurse. Underlying theoretical frameworks that the CAMH nurses use to augment their practice were identified through the clinical development scaffold. The framework for learning offered an environmental context for CAMH nursing practice and provided a greater understanding of the factors influencing this.

8.6 Recommendations

The implications for practice, education and research illuminated through the study provide an underpinning for future recommendations for CAMH nursing. This research has produced recommendations for future CAMH nursing practice as well as education and research in this specialty area.

8.6.1 Recommendations for practice

- Use the conceptual framework to identify the practice parameters for CAMH nurses
- Incorporate these findings as an adjunct to the existing ACMHN (2010) practice standards

Findings of the study have identified the practice parameters of the role of CAMH nurses in an inpatient unit. This will assist new and less experienced nurses working in CAMH to be aware of the clinical skills and contextual knowledge needed to undertake the role. Further, it will aid the nurses' understanding of the social

processes and CAMH nursing knowledge. The findings of this research have the potential to be beneficial in recruitment and retention of CAMH nurses by providing clarity regarding the parameters of the role. In addition, this lucidity will provide justification for specific nursing roles within CAMH services, as a distinct specialty rather than the role lacking a defined scope of practice.

Findings from this research will be able to be used in conjunction with the ACMHN standards for practice for mental health nurse. The existing standards, as discussed earlier in this thesis, apply to mental health nurses but are not specific to any of the specialty areas such as CAMH nursing. From the findings there exists an opportunity to further define the practice of mental health nursing by highlighting the breadth of the specialty. Further, this will draw attention to the significance of the role and its place within the multidisciplinary team.

8.6.2 Recommendations for education

- Utilisation of the findings in undergraduate nursing education programs
- Utilisation of the findings in postgraduate mental health nursing education programs

Mental health nursing education focuses on the adult age group rather than the child and adolescent age group. Undergraduate nursing education programs have limited mental health focus and also tend to focus on the adult age range. The findings of this research can be incorporated into undergraduate nursing curriculums to provide an understanding of the parameters of practice and therefore the theoretical and practical applications. This CAMH nursing knowledge will provide a basis for students to benefit more from their placements by being cognisant of the context. Further, the nursing students will be able to integrate the CAMH nursing knowledge into their practice in all areas to benefit consumer outcomes.

There are opportunities to provide clarity regarding mental health nursing, concerning postgraduate nursing curriculum, to promote the connectivity between CAMH nursing and mental health nursing.

8.6.3 Recommendations for research

- Apply the holistic conceptual framework to community CAMH nursing

- Assessment of the holistic conceptual frameworks' applicability to CAMH nursing nationally
- Identification of the holistic conceptual frameworks' applicability to CAMH nursing internationally

Further research needs to be undertaken to trial the holistic conceptual framework for the role of the CAMH nurse in the inpatient unit. Initially this will be undertaken in South Australia to determine the framework's applicability to CAMH nursing community settings. Opportunities for researching the framework's application in other CAMH nursing settings nationally would assist in refining.

An international context would also be valuable to add to the perspective of endorsing the framework, particularly the UK which initially identified the need to define the role.

8.7 Final summary

According to the literature there is no clear definition of the role and work of the CAMH nurse. This research has contributed to mental health nursing knowledge by offering a comprehensive understanding of the CAMH nursing role in an inpatient unit. The outcome of the research was the development of a holistic conceptual framework that reflected the work of CAMH nursing in the acute setting. The participants of the research as well as nurses from the wider CAMH nursing community supported the framework and considered that it reflected their role.

Further research to consider the applicability of the holistic conceptual framework in other CAMH nursing settings is needed. This would be beneficial on both a national and international level to gain a more comprehensive understanding of the specialty area.

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Appendix 1 – Glossary of Terms

AHPRA – Australian Health Practitioners Regulatory Authority

ANMC – Australian Nursing and Midwifery Council

ANMAC – Australian Nursing and Midwifery Accreditation Council

CAMH - Child and Adolescent Mental Health

CAMHS – Child and Adolescent Mental Health Services

MHN – Mental Health Nurse

nbsa – Nurses Board of South Australia

nmba – Nursing and Midwifery Board of South Australia

NMBA - Nursing and Midwifery Board of Australia

ACMHN – Australian College of Mental Health Nurses

ANZCMHN – Australian and New Zealand College of Mental Health Nurses

WHO – World Health Organization

Child – Australian legislation states a person under 18 years of age. Generally in the child and adolescent health sector this is a person 12 years of age or under.

Adolescent – In Australia a person over 12 years of age up to 18 years of age. The World Health Organization definition is up to 25 years of age.

Young person – This is a broad term used in child and adolescent mental health services in Australia for anyone under 25 years of age.

Work Practice – Refers to how the CAMH nurses undertake their day to day responsibilities.

Role – Refers to the components of the work practices.

Appendix 2 – Ethics Information Sheet

CHILDREN, YOUTH & WOMEN'S HEALTH SERVICE (CYWHS) HUMAN RESEARCH ETHICS COMMITTEE (HREC)

INFORMATION SHEET

PhD Study – The work of the mental health nurse in a child and adolescent mental health inpatient unit.

Philippa Rasmussen RN. RMHN. BN. MN. Grad Cert CAMHN, Grad Dip Psych Studies
Cert IV (T&A)

**Supervised by Professor Eimear Muir-Cochrane, Flinders University
and Dr Ann Henderson, The University of Adelaide**

The Purpose

You are invited to participate in a research project that explores the work of mental health nurses working in a child and adolescent mental health inpatient unit. The purpose of the research is to develop a rich description of the work of child and adolescent mental health nurses in an inpatient environment. Currently there is very little literature available on the role of nursing in relation to the child and adolescent mental health inpatient unit. However there are legislative and regulatory changes in mental health nursing which will impact on the future roles of nurses in mental health. This research aims to develop a deeper understanding of how mental health nurses identify and navigate their role within the child and adolescent mental health inpatient unit. The information collected can inform curricula and guide decision making in clinical practice and workforce planning.

The Study

The project is being conducted by Ms Philippa Rasmussen who is a lecturer at the University of Adelaide and a PhD student at Flinders University.

If you agree to participate in this study you will be required to be involved in focus groups with other mental health nurses as well as being interviewed on one or more occasions. The time commitment for the focus groups will be no longer than one hour unless negotiated with you. The interview will be at a time and location during your

work time, which is convenient for you. The purpose of the interview is to seek clarification on your thoughts about the work of child and adolescent mental health nurses in an inpatient unit. The interview will be recorded and later transcribed by myself or a professional transcriber. The time commitment for the interview will be no longer than 45 minutes unless negotiated with you. Information you provide about your role and work practices will be kept confidential except where there is a requirement by law or including but not limited to relevant nursing and midwifery legislation, for it to be divulged. If during the course of the interview issues are identified which would benefit from further exploration the researcher can provide you with the contact details of professional staff such as staff counselling.

Your participation in this study is voluntary and you may refuse to answer any questions or to withdraw from the study at any time without penalty. There is no payment for participation in this study. The recording, typed interviews and notes will be stored securely at the Children Youth and Women's Health Service for fifteen years, then destroyed. Only the researcher and the supervisors working on the project will have access to the data. No information that could identify you will be released and all records with personal information will be confidential.

If you have any questions about the project or your involvement, please contact **Philippa Rasmussen**, by phone **8303 3643** or email philippa.rasmussen@adelaide.edu.au.

This project has been approved by the Children Youth and Women's Health Service (CYWHS) Human Research Ethics Committee (HREC). If you have any ethical concerns about the project, or questions about your right as a participant, please contact **Brenda Penny** the Executive Officer of this Committee, Tel:**8161 6521**; Email: brenda.penny@cywhs.sa.gov.au.

Appendix 3 – Consent Form

**CHILDREN, YOUTH & WOMEN'S HEALTH SERVICE (CYWHS)
HUMAN RESEARCH ETHICS COMMITTEE (HREC)**

CONSENT FORM

LAY TITLE **The work of Child and Adolescent Mental Health Nurses on an inpatient unit.**

SCIENTIFIC TITLE **The work of Child and Adolescent Mental Health Nurses on an inpatient unit.**

Researcher: **Philippa Rasmussen (PhD Candidate)**

Supervisors: **Professor Eimear Muir-Cochrane
Dr Ann Henderson**

I,

hereby consent to my involvement in the research project entitled:

The work of Child and Adolescent Mental Health Nurses on an inpatient unit.

- 1 I am over 18 years old.
- 2 I have received information about this research project.
- 3 I understand the purpose of the research project and my involvement in it.
- 4 I understand that I may withdraw from the research project at any stage and this will not affect my status now or in the future.
- 5 I understand that while information gained during the study may be published, I will not be identified and any personal information will remain confidential.
- 6 I understand that as part of the study I will be participating in a focus group. In addition, I may be asked to participate in an individual interview.

- 7 I understand that I will be recorded during the focus group and if I participate in an individual interview and that I can request that the recording be stopped or paused at any stage.
- 8 I understand that the recording will be stored at the University of Adelaide, and will be accessible only to the researcher named above and her supervisors.
- 9 I am aware that I should retain a copy of the Consent Form, when completed, and the Information Sheet.
- 10 I understand that my information will be kept confidential as explained in the information sheet except where there is a requirement by law for it to be divulged.

I understand that there will be no payment to me for taking part in this study

Name of participant

Signed

Date

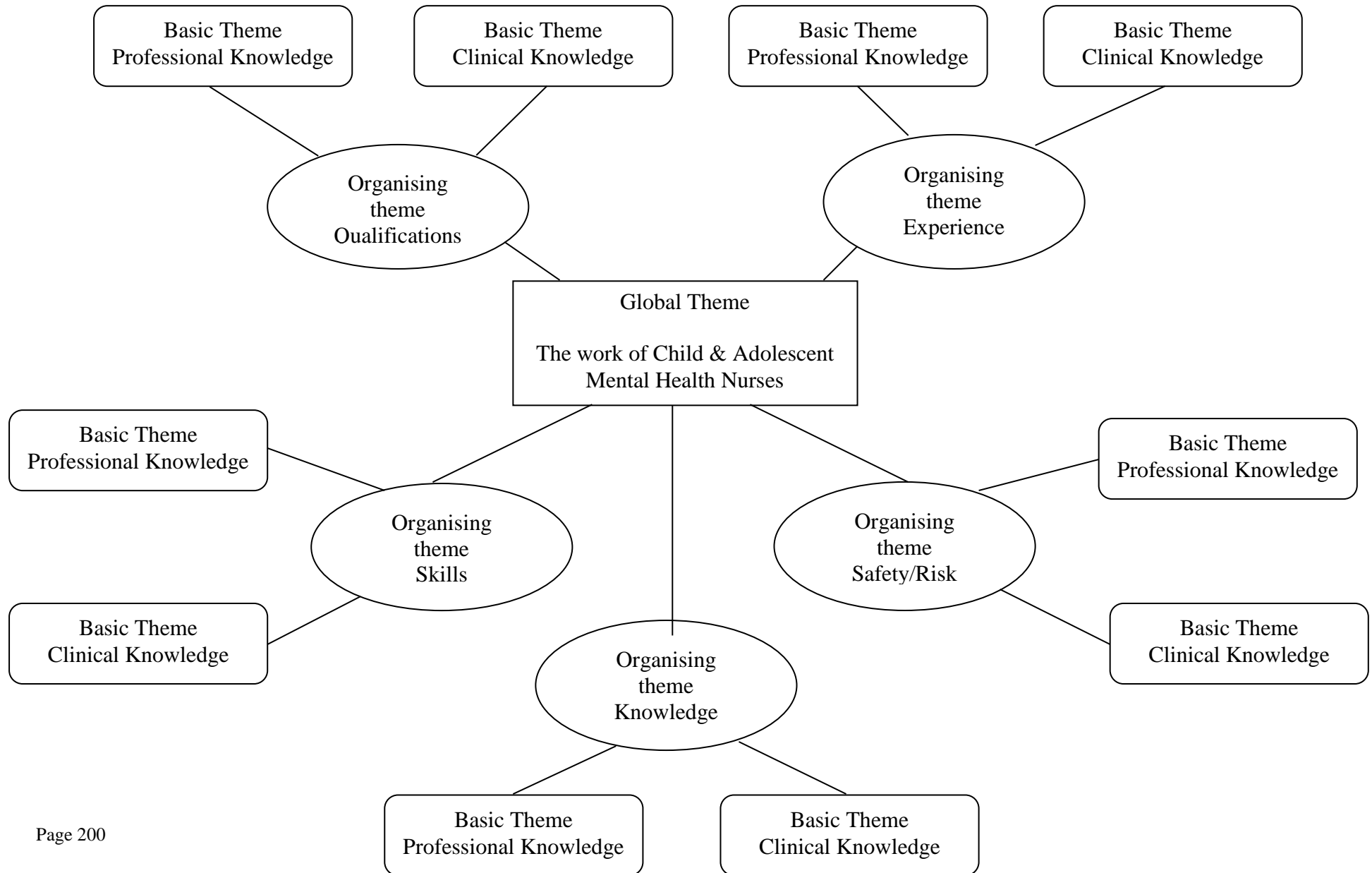
I have provided information about the research to the research participant and believe that he/she understands what is involved.

Researcher's signature

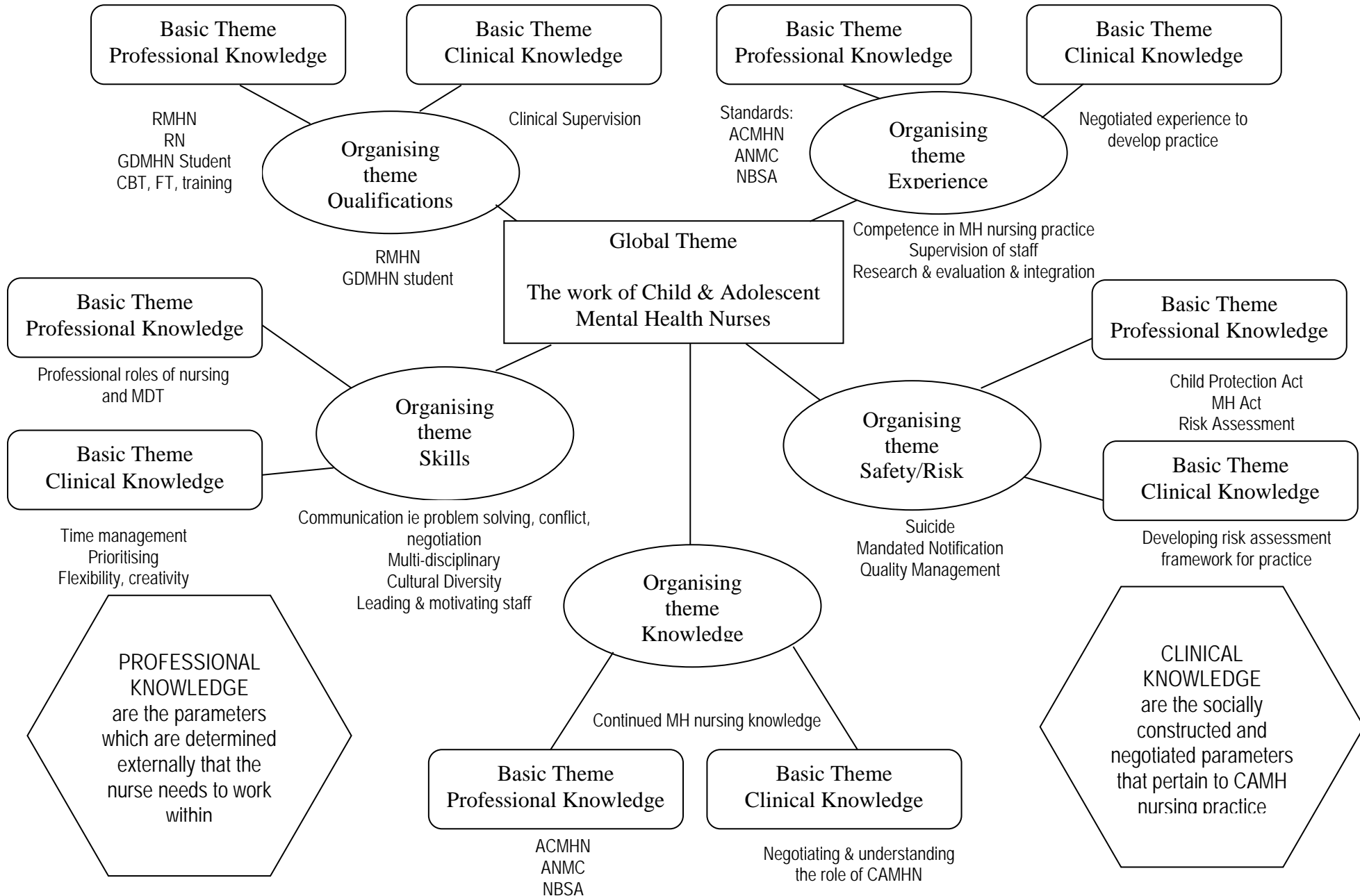
Date

Appendix 4 – Global, Organising and Basic Themes from the Document Analysis pertaining to CAMHN

Appendix 4 and Appendix 5 iterative templates based on the Work of Attridge-Stirling (2001) (Analysis of the Job and Person Specification Criteria)



Appendix 5 – Iterative Template Analysis of the job and person specification criteria



Appendix 6 – Thematic Analysis Program (TAP) Chart

Analysis

This is the TAP-view displaying the Analysis for the Project: "Document Analysis CAMHN"

Theme	Category	Illustration
<p>Experience What role does experience have in being able to synthesise information in assessment? What is the CAMH nurse role with the caregivers? What factors contribute to becoming a competent CAMH nurse working in the inpatient unit?</p>	<p>Clinical Knowledge/Experience</p>	<p>Assessment and Care</p> <p>Bulimia Nervosa - Management in Boylan Ward</p> <p>Medical Guidelines - Emergency Sedation and Restraint in Children and Adolescents</p> <p>Mental Health - Poor Self Esteem Nursing Management</p> <p>Mental Health - Suicidal Behaviour Management</p> <p>Mental Health Inpatient Unit - Restoration of Therapeutic Milieu</p> <p>Mental Health-Care of an Inpatient with Psychosis.</p> <p>Nursing Admission Policy (Unit)</p> <p>Nursing Assessment Policy (Unit)</p> <p>Nursing Observation Levels & Specialling Procedures</p> <p>Observation Charts- detention, psychiatric, acuphase observation chart,neurological, medication,amphetamine withdrawal scale, antipsychotic physical health monitoring chart, withdrawal pathway</p>

Professional Knowledge/Experience	Seclusion - Boylan Ward
	Time Out - Boylan Ward
	Absconding Patients - Inpatient Services
	Assessment and Care
	Assessment, Admission and Referral of Detained Patients on Boylan Ward
	Australian College of Mental Health Nurses standards
	Australian Nursing and Midwifery Council standard
	Guidelines for Acute Admissions to Boylan Inpatient Services
	Guidelines for Monitoring Adverse Effects in Children and Adolescents Prescribed Antipsychotic Medication
	Guidelines for the use of Psychotropic Medication on Boylan Ward (inc. PRN Medication).
	Management of Patient Cigarette Smoking - Boylan Ward
	Mental Health - Care of A Detained Patient Boylan Ward and Helen Mayo House
	Mental Health Nursing Transfer Summary
	Mental Health-Care of an Inpatient with Psychosis.

[Nursing Observation Levels & Specialling Procedures](#)

Theme	Category	Illustration
<p>Knowledge What is the role of the CAMH nurse in the inpatient unit? What factors contribute to becoming a competent CAMH nurse working in the inpatient unit?</p>	<p>Clinical Knowledge/knowledge</p>	<p>Assessment and Care</p> <p>Bulimia Nervosa - Management in Boylan Ward</p> <p>Case Reviews</p> <p>Medical Guidelines - Emergency Sedation and Restraint in Children and Adolescents</p> <p>Mental Health - Suicidal Behaviour Management</p> <p>Negotiating and understanding the role of the CAMH nurse</p> <p>Observation Charts- detention, psychiatric, acuphase observation chart,neurological, medication,amphetamine withdrawal scale, antipsychotic physical health monitoring chart, withdrawal pathway</p> <p>Seclusion - Boylan Ward</p> <p>Time Out - Boylan Ward</p> <p>Transfer of Clients between Division of Mental Health Units</p>
	<p>Professional knowledge/knowledge</p>	<p>Absconding Patients - Inpatient Services</p> <p>Assessment and Care</p>

[Assessment, Admission and Referral of Detained Patients on Boylan Ward](#)

[Boylan Closed Ward Guidelines](#)

[Case Reviews](#)

[Conflict Resolution](#)

[Consent](#)

[Considerations for Working with Aboriginal Clients](#)

[Considerations for Working with Clients from Culturally and Linguistically Diverse \(CALD\) Backgrounds](#)

[Consumer Rights to Privacy & the Release of Confidential Information](#)

[Emergency Mental Health Mobile Response - Referral of Young People \(during business hours\).](#)

[Emergency Mental Health Service - Access](#)

[Guidelines for Acute Admissions to Boylan Inpatient Services](#)

[Guidelines for Monitoring Adverse Effects in Children and Adolescents Prescribed Antipsychotic Medication](#)

[Guidelines for the use of Psychotropic Medication on Boylan Ward \(inc. PRN Medication\).](#)

[Management of Patient Cigarette Smoking -](#)

	Boylan Ward
	Management of young person in care procedure
	Patient/Client Incident Procedure
	Personal and Professional Conduct of Staff
	Standards: ACMHN, ANMC, NBSA
	Transfer of Clients between Division of Mental Health Units

Theme	Category	Illustration
Qualifications What is the role of the CAMH nurse in the inpatient unit? What factors contribute to becoming a competent CAMH nurse working in the inpatient unit? How do you define the work of the CAMH nurse? What is the most rewarding aspect of the CAMH nurse role?	Clinical Knowledge/Qualifications	Other qualifications such as CBT, FT, MT, GW from J&Ps
	Professional Knowledge/qualifications	Children's Protection Act (1993) Mental Health Act (2008)

Theme	Category	Illustration
Safety and Risk Management What factors contribute to becoming a competent CAMH nurse working in the inpatient unit?	Clinical Knowledge/Safety and Risk Management.	Post Risk Assessment
	Professional Knowledge/Safety and Risk Management	Risk Assessment/Awareness

Theme	Category	Illustration
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Skills

How do you maintain a safe environment with a psychotic patient? How do you balance and regulate the therapeutic milieu? What comes first the skill or the experience? How do you learn that? What factors contribute to becoming a competent CAMH nurse?

Clinical Knowledge/skills

[Absconding Thoughts and Behaviour - Prevention and Management - Inpatient.](#)

[Assessment and Care](#)

[Assessment of a Patient on Admission to the Child and Adolescent Mental Health Inpatient Unit](#)

[Bulimia Nervosa - Management in Boylan Ward](#)

[Case Reviews](#)

[Discharge of a patient from Boylan Ward / Helen Mayo House.](#)

[Medical Guidelines - Emergency Sedation and Restraint in Children and Adolescents](#)

[Mental Health - Poor Self Esteem Nursing Management](#)

[Mental Health - Suicidal Behaviour Management](#)

[Mental Health Inpatient Unit - Restoration of Therapeutic Milieu](#)

[Nursing Assessment Form](#)

[Observation Charts- detention, psychiatric, acuphase observation chart, neurological, medication, amphetamine withdrawal scale, antipsychotic physical health monitoring chart, withdrawal pathway](#)

[prioritisation, time management, flexibility,](#)

Professional Knowledge / skills	innovation and creativity
	Psychiatric Observation Chart
	Seclusion - Boylan Ward
	Shift Coordinator Guidelines
	Time Out - Boylan Ward
	Absconding Patients - Inpatient Services
	Assessment and Care
	Assessment, Admission and Referral of Detained Patients on Boylan Ward
	Case Reviews
	Conflict Resolution
	Discharge of a patient from Boylan Ward / Helen Mayo House.
	Electroconvulsive Therapy (ECT) for Boylan Ward/ Helen Mayo House
	Guidelines for Acute Admissions to Boylan Inpatient Services
	Guidelines for Monitoring Adverse Effects in Children and Adolescents Prescribed Antipsychotic Medication
	Guidelines for the use of Psychotropic Medication on Boylan Ward (inc. PRN Medication).
	Management of Patient

Cigarette Smoking - Boylan Ward
Mental Health Nursing Transfer Summary
Professional role of nursing
Shift Coordinator Guidelines
Working within the multidisciplinary team

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Research in brief

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Research in brief

An analysis of the work of Child and Adolescent Mental Health nurses in an inpatient unit in Australia

Introduction

This paper briefly describes the methodology and the initial findings of research carried out as part of a PhD thesis in nursing. The intention of the research was to identify the theoretical and operational parameters of Child and Adolescent Mental Health (CAMH) nursing in an inpatient unit in Australia. This will add to the body of mental health nursing knowledge and identify the characteristics of the role. It is anticipated that these characteristics will contribute to the development of competencies that will complement the existing Australian College of Mental Health Nurses Inc (2010). There is no single definition of the CAMH nurse role and the specific contribution that they make remains undefined but implicitly accepted according to McDougall (2006) who suggests that this role is a holistic one, within the context of individual and family systems.

Background

There is a paucity of literature regarding the CAMH nursing role. Limerick & Baldwin (2000) examined the roles of CAMH nurses and warned that, unless nurses were able to clearly articulate and identify the specific contribution they made, there was a danger of the role being filled by generic workers. A further study was designed to explore the perceptions of both nurses and other health professionals of the CAMH nursing role, as even CAMH nurses were unclear what nursing contribution they made to the multidisciplinary team (Baldwin 2002). Baldwin's conclusion paints a bleak picture for CAMH nursing as a specialty if the role cannot be defined and further research was suggested to define the role of the CAMH nurse and

to develop a specific nursing philosophy for CAMH that would emphasize the strengths and develop a better understanding of the contribution that nurses bring to the CAMH setting. More recently, Bonham (2011) proposed that a science of child and adolescent psychiatric nursing (CAPN) be developed to add to the nursing knowledge and highlight the work of these nurses. Delaney (2011) expressed concern in regards to the diminishing number of nurses' undertaking CAMH practice as a specialty. This was influenced by the emergence of CAMH component in Psychiatric Mental Health Clinical Nurse Specialist education. Further Delaney (2011) stated that the CAPN role was '... vital to all-inclusive to child mental health treatment.' (p. 1). Both Bonham (2011) and Delaney (2011) identified that the specialty is threatened and there was a need to build on knowledge and skills.

Mental health nursing is not easily defined (Leishmann 2003, 2004), with elements of it being tacit and of limited visibility to those looking at the practice from the outside. There is an opportunity to enable mental health nurses to articulate their identity within this complex health and social system. Leishmann (2003, 2004) suggests that there is a synergy between social constructionism and mental health nursing which will facilitate a more relevant definition of the identity of their practice. Social constructionism is concerned with the making of meaning and experience within a socio-cultural context (Burr 2005).

Aim of the research

The aim of this research sought to find a deeper understanding of the role of CAMH nursing in an acute mental health inpatient setting in Australia.

Method

An interpretive methodology within a social constructionism framework was used for this study

(Burr 2005). Document analysis, focus groups and semi-structured interviews were considered appropriate methods for exploring the work of CAMH nurses in an inpatient unit, as this allows for a rich description of the studied phenomenon. First the document analysis was undertaken. The researcher collaborated with mental health nurses on the inpatient unit to determine which documents were relevant. The documents consisted of standards, procedures and policies which were mandatory to the role of a nurse in the CAMH inpatient unit.

The document analysis was conducted utilizing the Joanna Briggs Institute Thematic Analysis Program (TAP) (Joanna Briggs Institute 2008). The program enabled the researcher to proceed through a three-step approach in the analysis of data. The three steps were (1) extraction of **illustrations**; (2) aggregation to **categories**; and (3) synthesis of categories into **themes**. The TAP illustrations are the raw data, in this case the relevant CAMH nursing documents. The TAP categories were developed from the iterative process used in this research (Attride-Stirling 2001). The TAP themes were created from the descriptors identified in the initial review of the Job and Person Specifications criteria. The job and person specifications identify minimum essential criteria to fulfil the role. A TAP chart, which demonstrates the connection between the illustrations, categories and themes, was generated from this process. The researcher's decision making in relation to the analysis of the documents and the development of the questions for the focus groups was informed through this process.

Seven focus group interviews totalling 19 participants were conducted between November 2009 and March 2010.

The participants were of multidisciplinary background, with individuals from nursing, psychology and medicine. The groups were conducted on the campuses of a major paediatric facility in Australia.

The criteria for inclusion was a minimum of 6 months experience working on the CAMH inpatient unit in the previous 3 years or currently working there for a minimum of 6 months. The focus group participants had clinical, education and management roles involved with the inpatient unit.

The researcher adapted the six-phase thematic analysis process as described by (Braun & Clarke 2006). The phases of the process were as follows: (1) Familiarizing yourself with the data; (2) Generating the initial codes; (3) Searching for themes; (4) Reviewing the themes; (5) Refining and naming the

themes; and (6) Developing the questions for the next phase of research, which was semi-structured interviews.

Given the social constructionist theoretical framework of this research, the transcript excerpts coding sought to identify sociocultural contexts in the data. Full ethical approval was gained by the University and paediatric facility (National Health and Medical Research Council 2007).

Findings of the focus group analysis

Themes

Thematic analysis is situated between essentialist and constructionist epistemology as a contextual method because it not only considers the individual making of meaning and understanding of experience but also positions it in the social context (Braun & Clarke 2006). For this study, the analysis also took into account the perspective of the non-nurse participants who were part of the social context. Data were analysed between December 2009 and June 2010. There were eight themes that emerged from the thematic analysis of the focus group data. The following themes and their descriptors concisely present the initial findings from the data.

Knowledge transfer

Knowledge transfer described the process of becoming a CAMH inpatient nurse from the perspective of the participants in the study. It not only described how you become a CAMH nurse but also how colleagues supported less experienced staff clinically through this process. The theme of knowledge transfer is represented by two sub-themes which are learning to become a CAMH nurse and the support needed to become a CAMH nurse.

Theoretical framework

The theoretical framework identified provided a structure for the nursing knowledge utilized by the CAMH nurses and included two sub-themes the developmental framework and conceptual formulations which are concerned with what the nurse needs to know to undertake a comprehensive assessment and intervention.

Nursing practice

The operational scope of the role identified the practical applications of the role, which was centred on communication skills, working with families and walking and driving therapies. The latter was developed because the participants stated they needed to be creative in working with young people to engage them in order to undertake comprehensive assessment and intervention.

Team context

The collegial network that provided the environment for CAMH nursing practice was identified as the team which had nursing and non-nursing members. The team context was identified by the participants as being pivotal to the role providing support and also in assisting to manage anxiety through debriefing. There were two sub-themes identified, the nursing team and the multidisciplinary team.

The contextual perspective

The context in which the nurses practiced considered the wider paediatric hospital setting and CAMH service in the community as well as schools, community health, government and non-government agencies. There were three sub-themes identified: the wider hospital perspective of the CAMH nursing service; the community perspective; the state and national perspective.

Risk and safety

This theme refers to assessing, monitoring and maintaining the environment and how this is achieved through CAMH nursing practice. There were two sub-themes identified understanding the relationship between patient acuity and environment and advocacy for the young person. Developing the skill of understanding patient acuity and the environment was core to the therapeutic milieu and needed to consider other external variables such as the effect of visitors to the unit and phone calls on the young people. To further support the therapeutic milieu the nurses played a role in advocating for the discharge of some patients if their behaviour was detrimental to the milieu and the outcome for other patients.

The learning environment

This theme was connected with the educational perspective of the role and can be related to the client and family, students and staff. Two sub-themes were identified: education of multidisciplinary students and psychoeducation of young people and their families. The multidisciplinary students and staff were from the following disciplines nursing, medicine and psychology. There was a focal point of learning that was inclusive and innovative which the nurses played a central role in. A key responsibility for nurses was psychoeducation to help the young person and family understand their mental health issues and the trajectory of the intervention and outcome.

Professional issues

These were identified as professional standards, legislation and core competencies that framed the role. There was specific legislation identified that related to young people. In addition there were issues concerned with the regulation of nursing with the move to national registration and the loss of the individual mental health nurse register. The participants also acknowledged that there were organizational philosophies and frameworks, clinical standards and core competencies which framed the practice of the CAMH nurse.

These themes will be further examined through a series of semi-structured individual interviews.

Discussion

These data have contributed to the development of the themes which reflect the participants' perspective of the CAMH inpatient role in Australia. The initial findings identified eight themes through analysis of the focus group data. The themes reflect the sociocultural context of the work of the CAMH nurse in the inpatient unit and contribute to identifying how these nurses experience and make meaning of their work. This research built on previous studies (Limerick & Baldwin 2000, Baldwin 2002, McDougall 2006), which identified the need for CAMH nurses to articulate their role.

In this study participants have identified the nursing practice of the CAMH inpatient nurse. The research has enabled nurses from within the environment and those who are no longer in the environment to put into words their interpretation of

the role. Additionally, members of the multidisciplinary team working in the inpatient environment with the nurses were also able to contribute a unique perspective on the role.

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Appendix 8 – International Journal of Evidence Based Healthcare Article

COMMENTARY

Document analysis using an aggregative and iterative process

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Abstract

This paper is a descriptive commentary concerning the use of document analysis in qualitative research concerned with developing an understanding of the role of child and adolescent mental health nursing in an inpatient. The document analysis was undertaken using thematic analysis with both an iterative process (Attride-Stirling) and an aggregative process, the Joanna Briggs Institute Thematic Analysis Program (TAP). After the initial iterative process the data were entered into an online software program, TAP, for aggregation and further analysis. The TAP software consisted of a three-step approach in the analysis of data extraction of illustrations, aggregation to categories and synthesis of categories into themes. A TAP chart was generated displaying the connections between the illustrations, categories and themes. The advantage and limitations of utilising the TAP software compared with Computer Assisted Qualitative Data Analysis Software were discussed. The program afforded direct involvement by the researcher in the cognitive process of the analysis; rather than just the technical process. A limitation of the program would be the volume of the data if the research involved a vast amount of data. The TAP program was a clearly defined three-step software program that was appropriate for the documents analysis for the research. The program would have a wide application for facilitating the thematic analysis of documents, although the program is suitable for smaller amounts of data.

Key words: child and adolescent mental health nursing, document analysis, qualitative methodology, Thematic Analysis Program, thematic analysis.

Introduction

This paper describes the methodologies chosen to analyse documents relating to the role and work of child and adolescent mental health (CAMH) nurses in an inpatient unit in Australia. The Joanna Briggs Institute Thematic Analysis Program (JBI-TAP) which is an aggregative analysis and an iterative analysis based on the work of Attride-Stirling were utilised. The document analysis was undertaken as part of a PhD research project. As there is no single current definition identifying the CAMH nurse role or the explicit contribution they make within the context of individual and family systems, the PhD project seeks to contribute to the development of this definition.

Background

There is a paucity of research regarding the work of CAMH nurses apart from two United Kingdom studies by Limerick

and Baldwin,¹ and Baldwin.² The former explored the role of CAMH nurses and found that the nurses were unable to clearly articulate their roles and which aspects were specifically nursing-related rather than generic.¹ The latter study considered the CAMH nursing role from a both a nursing and other health professional perspective and again there was no clear articulation of what the role consist is.² Baldwin suggested that there is a need to develop a better understanding of the CAMH role and its nursing philosophy.² Both studies were specific to an outpatient setting.

Mental health nursing is not easily defined^{3,4} with aspects of it being implicit and not easily identified by others from different clinical practice areas.

Method

An interpretive methodology within a social constructionism framework was used for this study. Full ethical approval was gained by the University and paediatric facility.⁵ All relevant documents applicable to the role of the CAMH nurse were sourced after consultation with nurses within a CAMH inpatient unit.

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Document analysis

The data in the initial stage of the research were analysed using both the iterative process and the aggregative TAP process and consisted of documents relevant to CAMH nursing practice. This was undertaken in order to inform the development of questions for focus groups and interviews as a later stage of the research. The researcher chose thematic analysis as the most appropriate framework for this study as it allowed the researcher to compare and contrast the emergent themes throughout the process.⁶

Thematic analysis

There were two thematic analysis processes undertaken with the documents relating to the role of the CAMH nurse; the iterative process for document analysis based on the work of Attride-Stirling and the aggregative process using the JBI-TAP. Analysis is the process by which data are broken down into fundamental units or themes⁷ and thematic analysis is one form of this process.⁸ Thematic analysis is frequently chosen as the method for the qualitative paradigm; however, it is a tool that spans a range of qualitative methods.⁹ Thematic analysis can be either dependent or independent of a theoretical or epistemological stance and it is this adaptability that is beneficial for qualitative research.¹⁰ There is no one prescribed way in which to undertake thematic analysis^{11,12} so this further enhances the flexibility for the researcher. Clearly identifying the process of data analysis allows the reader to evaluate the research in terms of appropriateness and rigour because it provides a clear map that leads to the outcome and an audit trail.^{13,14}

Thematic analysis through its flexibility allows the researcher to adapt to the depth of information that the researcher requires. The data from documents required less depth of analysis as the purpose was to reveal themes and surface meanings that would inform the questions for the focus groups. Thematic analysis utilised in a social constructionist epistemology considers the themes that are identified as socially created for a particular group, in the case of this research CAMH nurses, so it explores '... the ways in which events, realities, meanings, experience...' (p. 81) effect the participants.¹⁰

Additionally, Braun and Clarke suggest that thematic analysis is situated between essentialist and constructionist epistemology as a contextual method because it not only considers the individual making of meaning and understanding of experience but also is able to position it in the social context.¹⁰ The documents, which were from organisational, regulatory and professional arenas, provided an additional social context to the research findings.

Iterative and aggregative analysis

Iterative analysis was undertaken through using the Attride-Stirling framework which is divided into three themes, basic, organising and global.¹¹ The thematic network begins with the basic themes and progresses through to organising themes, then global themes which are at the core. The

aggregative analysis consists of three levels of progression resulting in the synthesis of information.

Themes within analysis can be identified by either inductive or theoretical analysis.^{10,15} The theoretical approach is utilised when the researcher already has established the research questions whereas Inductive analysis is a 'ground up' approach which helps to direct the research question.¹⁶

Iterative thematic analysis

The iterative thematic analysis of the documents was undertaken at a semantic¹⁰ or explicit level. For the purposes of this study the researcher examined the surface meanings of the documents with a view to identifying themes. These themes provided the parameters for developing the questions for the focus groups. The questions needed to be broad enough to capture a rich description but specific enough to reflect the semantic themes from the documents. In depth review of all the documents indicated a common overarching concept, that of the job and person specifications for the role. All documents were in some way related to the specifications; therefore the themes were predominately derived from these.

The global theme was the work of CAMH nurses on an inpatient unit as this was at the core of the job and person specification document. Within this context the documents were analysed, as primary data, to identify which organising theme and which basic theme they could be assigned to. Five organising themes were derived from the job and person specifications; qualifications, experience, skills and knowledge and safety or risk management. The iterative process revealed that within the documents knowledge could be separated into two areas, professional knowledge and clinical practice knowledge. Professional knowledge was interpreted as having a broader context such as legislation and a comprehensive understanding of mental health. Clinical practice knowledge was specific to the practice of CAMH nursing. There were two basic themes assigned to each organising theme with a total of ten.

The original data, that is the document titles, were then entered into an online software program, the TAP, for an aggregative analysis.

The JBI-TAP

The data analysis was further facilitated by the JBI-TAP.¹⁷ The program enables researchers to proceed through a three-step approach in the analysis of data. The three steps are extraction of illustrations, aggregation to categories and synthesis of categories into themes. These processes then generate a TAP chart which demonstrates the connection between the illustrations, categories and themes.

Illustrations

The TAP illustrations were the raw data. They were the titles of the documents which were identified by the nurses on the CAMH inpatient unit. Each document was analysed and studied in detail to enable the researcher to become familiar with it and understand the content and context. After this

Table 1 Excerpt from the theme experience

Theme	Category	Illustration
Experience	Clinical knowledge/ experience	Medical guidelines – emergency sedation and restraint in children and adolescents Mental health – suicidal behaviour management Mental health inpatient unit – restoration of therapeutic milieu Mental health care of an inpatient with psychosis Nursing assessment policy (Unit) Observation charts – detention, psychiatric, acuphase observation chart, neurological, medication, amphetamine withdrawal scale, antipsychotic physical health monitoring chart, withdrawal pathway
What role does experience have in being able to synthesise information in assessment? What is the CAMH nurse role with the caregivers? What factors contribute to becoming a competent CAMH nurse working in the inpatient unit?	Professional knowledge/ experience	Australian College of Mental Health Nurses standards Australian Nursing and Midwifery Council standard Mental health nursing transfer summary Management of patient cigarette smoking – Nursing observation levels and specialising procedures

CAMH, child and adolescent mental health.

data extraction each illustration was assigned to a category. The extracted data supported the categories/basic themes that had been developed during the iterative analysis.

Categories

The TAP categories were developed from the iterative process used in this research.¹¹ The categories were previously defined as professional knowledge and clinical knowledge for each of the five descriptors used for the organisational themes in the iterative process. Through this analysis it became clear that some data/documents belonged to more than one category. An example of this is the documents relating to Nursing Assessment of an inpatient. The categories it related to included: professional knowledge/experience, professional knowledge/skills, clinical knowledge/experience and clinical knowledge/skills.

Themes

After categorisation of the primary data/documents, the categories were reviewed to determine if they could be further aggregated on the basis of similarity in focus.

The TAP themes were created from the descriptors identified in the initial review of the job and person specifications. Each of these criteria was listed according to the area of practice to which it was related. Table 1 provides an excerpt of the process.

This process enabled the researcher to develop their own questions arising from the thematic analysis. These questions were later presented to focus groups participants for discussion to further explore the role and work of the CAMH nurse.

Rigour

Conducting both types of analysis on the raw data, that is the documents, contributed to the rigour of the process in the following way. Rigour is a term which is used in qualitative research to establish what is termed reliability and validity in quantitative research.¹⁸ In qualitative research rigour is encompassed by the term trustworthiness which came from the seminal work of Guba and Lincoln in the

1980s.¹⁸ Trustworthiness is demonstrated by the following strategies; credibility; transferability; dependability and confirmability.^{19–21} Rigour was demonstrated in the document analysis by collaborating with nursing staff on the inpatient unit to identify the documents needed for the analysis. Further rigour was also demonstrated through conducting both iterative and aggregative analysis. As mentioned previously, there is no one prescribed way to conduct thematic analysis. Therefore, conducting both types of analysis on the same data and obtaining the same themes, suggests the themes are credible.

Advantages

There were some advantages to using TAP rather than another Computer Assisted Qualitative Data Analysis Software (CAQDAS). An advantage of using TAP was that the researcher remained involved with the analysis through having to enter the information into the groupings of the three-step approach. This allowed the researcher to contribute to the cognitive process of the analysis rather than it being a technical and mechanical process.²² Additionally, this affords the researcher a sense of direct involvement with the data rather than the potential data loss through abstraction that can occur with CAQDAS.²³ The size of the data file for a documents analysis was smaller than that of the focus group or individual interview data so therefore it was conducive with the less complex three step TAP system rather than other CAQDAS such as NVivo or NUD*IST. The TAP system was straightforward to use with the instructions simple and clear. This meant that the user did not have to allocate extra time to navigating a more complex system. As with NVivo and NUD*IST the software program is computer based which makes it easily transportable and the data analysis accessible to the researcher from various locations.

Limitations

Whilst TAP was a useful framework for facilitating analysis in this research there were limitations which became obvious during the process. For complex or voluminous data the

program did not provide adequate support in terms of the time consuming nature of data entry. The use of a CAQDAS such as NVivo would allow for a greater volume of data.²⁴ The document analysis was undertaken at a semantic level and therefore only considered the surface meanings of the documents to ascertain the themes to which they belonged. This level of analysis fitted well with the TAP system as the level of complexity was less than it would be for latent analysis which would have been better suited for other CAQDAS programs such as NVivo or NUD*IST.

Summary

This paper has described the document analysis framework for the research. The content has provided a description of the methods of analysis. The thematic analysis of the documents related to the work of the CAMH nurse working in the inpatient unit has been undertaken through the iterative process based on the work of Attride-Stirling¹¹ and aggregative process of the JBI-TAP.¹⁷ Both of these tools provided a framework which clearly supported the analysis. The advantages and limitations of the TAP system as experienced by the researcher have been identified. Further, the process of researcher's decision making in relation to the analysis of the documents and the development of the questions for the focus groups has been illuminated.

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