

**Registered Nurses' Perceptions &
Experiences of Nursing Adolescents in an
Adult Mental Health Unit**

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ABSTRACT

In this study the perceptions and experiences of Registered Nurses (RNs) nursing adolescents in an adult mental health (MH) unit were explored with the aim of identifying any nursing concerns regarding such admissions. The reasons adolescents access adult MH in-patient services were also sought alongside what training and knowledge RNs had in relation to the assessment and management of adolescents with MH problems. Findings led to identification of areas of the nursing care environment that may be improved or developed to enhance quality of care.

A qualitative study using a general inductive approach was undertaken to investigate the world of the participants, rather than having a basis solely in the literature (Field & Morse, 1985). A purposive sample using a criterion strategy was used to recruit participants who were considered representative across the clinical nursing staff (Patton, 2002). Semi-structured interviews using an interview guide were audio recorded, then transcribed as verbatim responses. Nine categories were formed from the raw data, each category was then systematically analysed to find patterns of commonality and difference, from which three major themes emerged. Categories were emotional response; personal beliefs; memorable experiences; role; environment; concerns and changes; physical development; cognitive development; social / emotional development. Emergent themes were Attitudes and experiences; Practice implications; and Knowledge.

What is drawn from this study is that RNs made positive or negative evaluative judgements of adolescents based on their knowledge and expectations of them which were influenced by their experiences, beliefs, and emotional response. Differences in RNs' understanding, and tolerance of adolescents was found to affect reciprocal interactions and responses. Negative memorable experiences and negative emotional response correlated with negative attitudes about adolescents and reluctance to work with them. Negative experiences were linked to the RN's lack of understanding, feeling dis-empowered, and with incidents that clashed with personally held beliefs. Admission to the adult unit was primarily to provide a safe environment in which to effectively manage the increased risks associated with the adolescent's presentation; most commonly self-harm and suicidality. The other major reason was the lack of alternative options outside normal office hours, and beds were not always available when required. RNs lacked education and knowledge relevant to adolescents with mental illness, were not adequately prepared to work effectively with this client group, and the adult MH unit was not adequately resourced to meet the needs of adolescents.

ACKNOWLEDGMENTS

I would like to acknowledge that I would not have journeyed into nursing if it were not for the experiences I have had. Let me explain by telling you a true story. There was once a young man who began to show signs of a mental illness, events prompted his presentation to mental health services, not finding the therapeutic benefits he had hoped for, it was not long before he next came to the attention of the substance misuse team. He was now in receipt of help for what was only part of the problem. Unfortunately problems do not stay compartmentalised, and with his mental health needs (undisguised) not being addressed, circumstances deteriorated rapidly. He next came involuntarily to the attention of the police, the consequence was arrest and removal to a remand hostel awaiting trial for which it was believed he would receive a lengthy sentence, but the end was in sight. His problems merged as one – he now came to everyone’s attention, a lethal combination decided his fate, he was now no-one’s problem other than his family’s – left to bury him – my family – this young man was my brother.

I am of the belief many of us shackle ourselves by doubt and fear of failure instead of believing in the possibilities that lie ahead of us. It is only when we are receptive to the idea of success that we dare to venture into uncharted territory. I consider myself fortunate to have met many people that have been supportive and encouraging of the challenges that I have taken on; the most recent of which has been this study. I have not been alone in this journey, my supervisors Dave Carlyle and Henrietta Trip have been fantastic, they have proven reliable navigators preventing me from feeling lost and have kept me on track, I am extremely grateful for their guidance. My husband Ian also deserves a special mention if not a medal for tolerating me when I have been intolerable, and for proof reading this work past the point it has been reasonable to expect him to do so - thank you, you have been a saviour. Whilst I feel I can breathe a sigh of relief at completion of this study, another thought enters my mind...what next?

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LIST OF ABBREVIATIONS

ADHD	Attention Deficit Hyperactivity Disorder
CAMHS	Child and Adolescent Mental Health Services.
CHDS	Christchurch Health and Development Study
CNM	Clinical Nurse Manager
DHB	District Health Board.
ICN	International Council of Nurses
MDT	Multi Disciplinary Team
MH	Mental Health
MOH	Ministry of Health
NAC	National Advisory Council
NCS-A	National Co-morbidity Survey Replication - Adolescent Supplement
NSW	New South Wales
NZ	New Zealand
OCC	Office of the Childrens Commissioner
ODD	Oppositional Defiant Disorder
OECD	Organisation for the Economic Co-operation and Development
PAR	Participatory Action Research
PDD	Pervasive Developmental Disorder
RN	Registered Nurse
SUD	Substance Use Disorder
UK	United Kingdom
U.S.	United States
WHO	World Health Organisation

CHAPTER 1: INTRODUCTION

The introduction provides the clinical context and rationale of this study, followed by an outline of the aims and objectives of the study. A background to adolescent mental health is given followed by a snapshot of the extent of the problem on a National and International level. Finally, a document outline which describes the scope of the dissertation is given.

1.1 Clinical Context and Rationale for This Study

The Child and Adolescent Mental Health Service (CAMHS) within which I work uses a Choice and Partnership Approach (CAPA) for its service delivery. CAPA is a clinical system that was developed by Child and Adolescent Consultant Psychiatrists Dr Kingsbury and Dr York in Richmond, United Kingdom (UK). CAPA has been implemented in 15 of the 20 DHB CAMHS across NZ, one DHB with adult services uses CAPA, and five are considering how CAPA could work for their adult services (The Werry Centre, 2012).

The aim of the CAPA process is to emphasise that the family have some choice in what they want and that the work is a partnership. Therapeutic engagement is a reciprocal interaction in which both parties have a responsibility for establishing effective rapport. The premise is that service involvement is led by families, guided by the clinician who acts as a facilitator with expertise rather than coming from the traditional position of expert with power, and takes a collaborative stance (Kingsbury & York, 2006). I consider the CAPA process lends itself well as a framework on which to build a therapeutic relationship.

The saying “you don’t know what you don’t know” has never resonated so strongly with me as the time I went to work for a Child and Adolescent Mental Health Service. At that time with over five years experience as a Mental Health Nurse I thought I had a reasonable understanding of people across the life span. When working with adolescents I had wrongly thought there were more similarities than differences with adults and so tended to treat them as young adults. It became abundantly clear within a short period of time that the expectations I had of adolescents were unrealistic, and that there was a gaping hole in my developmental knowledge and understanding of this clientele. Reflection on the nursing education I received led to the realisation that there had been none specific to adolescents, and led me to question how it is then possible I could be considered a facilitator with expertise. I contemplated how widespread this deficit is, and what the impact is on services and RNs working within them. As I pondered the issue of preparation to work with adolescents I thought it necessary to establish what is

standard within nursing education programmes. Whilst valuable, personal experiences are highly subjective and need to be augmented with professional frameworks. Without adequate preparation, staff working in adult services having to manage adolescents may feel that they lack the specific skills to respond to them. The issue has wide implications for RNs working in mental health services, particularly those working in DHBs with no specialist provision at all in their regions.

Before working for CAMHS I worked in adult mental health in-patient units and had several experiences of nursing adolescents, many of which had been fraught with difficulties and could best be described as eventful admissions. Since working in CAMHS, when faced with no alternative, I have been involved in arranging adolescent admissions to the local adult MH in-patient unit. Some admissions have gone smoothly and others have been met with resistance to being admitted to an adult MH in-patient unit, not only by the clients or members of their family, but also by the RNs on duty. I wondered what factors affected this response, and queried the accessibility of age appropriate services.

Having reflected on numerous possible reasons for the issues mentioned I thought it would be good to compare my ideas to those reported in the nursing literature. I was surprised to find that whilst a limited number of studies have been conducted into adolescents' experiences there is a dearth of information relating to nurses' experiences of caring for adolescents in adult MH units. Park, McDermott, Loy and Dean (2011) looked at adolescent admissions to adult psychiatric in-patient units. They too reported there is a paucity of data about caring for adolescents in adult in-patient units. A pilot systematic search found only one relevant qualitative study, strengthening the argument for research to be done in this area.

1.2 Aims and Objectives of the Study

Wanting to make sense not only of my experiences, but also those of my colleagues, I decided to conduct a qualitative study with the aim of exploring RNs' perceptions and their experiences of nursing adolescents in an adult MH unit, and to ascertain attitudes towards caring for this client group, in order to gain an understanding of the nursing care currently in place. The study also sought to identify areas of nursing care which can be improved or developed to enhance quality of care.

Specific questions to be addressed:

- What are RNs experiences of nursing adolescents admitted to the adult MH unit?

- For what reasons do adolescents access MH in-patient services?
- Do they have any concerns, if so what are they?
- What training and knowledge do they have in relation to assessment and management of adolescents with MH problems?

The study aimed to elucidate clinical experience and to reveal meaning through a process of understanding and interpretation of RNs' perceptions of nursing adolescents in an adult MH unit. Adolescents with mental illness indicate the most crucial facilitators or barriers to their own recovery are how people interact with them (Kramer & Gayne (1997), as cited in Farkas, Gayne, Anthony & Chamberlain, 2005), highlighting the importance of optimising the therapeutic relationship to maximise engagement and achieve better MH outcomes for adolescents accessing mental health services. By carrying out research looking at nurses' experiences, mental health services can begin making the necessary adjustments to the care environment, through review, evaluation, and amendment to provide best care. Implications for services are that additional training and support for nurses working in adult inpatient areas could help improve both nurse and client satisfaction and outcome levels, while further research can help identify and guide training requirements. To help inform the study, a review of the relevant literature was undertaken, this is described in the background chapter.

1.3 Mental Health in Adolescence

Mental health is a multidimensional and complex concept, regarded by researchers as dimensions or scales with varying positions. Health and illness can be regarded as two independent dimensions that co-exist at the same time. Mental health is conceptualised as a state of well being in respect to adolescents

“an emphasis is placed on the developmental aspects, for instance, having a positive sense of identity, the ability to manage thoughts, emotions and to build social relationships, as well as the aptitude to learn and acquire an education, ultimately enabling their full active participation in society.” (World Health Assembly, 2013, p.3).

Arnett (1999) recognizes that for some adolescents this can be a time of increased risk, for a number of reasons associated with the change process including: intensity of conflict with parents; emotional volatility; increased negative mood; increased risk taking behaviour; novelty seeking; and sensation and reward seeking. Factors responsible for these changes

appear to be both intrinsic and extrinsic in nature, incorporating biological, social, cognitive and emotional, as well as contextual or environmental changes such as stressful life-events, lack of support from parents, absence of normative peers, high availability of drugs, social norms facilitating drug use, and relaxed laws and regulatory policies (Bates & Labouvie, 1995). Research by Frojd, Marttunen, Pelkonen, Von-der-Pahlen and Kaltiala-Heino, (2006) suggests poverty may have direct effects on adolescent mood states. Adolescents' awareness of parental economic hardship has been associated with reported sense of helplessness, shame and inferiority, influencing satisfaction with their family and environment, thereby affecting the parent-adolescent relationship. They are also more likely to be exposed to violence, as victims, witnesses or perpetrators, than those in higher income environments. This increased exposure to violence is associated with increased depressive symptoms, anxiety and externalising problem behaviours (Dashiff, DiMicco, Myers & Sheppard, 2009).

1.4 International and National Extent of the Problem

The World Health Organisation (WHO) (2005) stated that approximately one-fifth of the world's youth suffer from mild to severe mental health (MH) problems. Mental illness in adolescence has a significant impact on life outcomes in relation to education, employment and health (Gibbs, Fergusson & Horwood, 2010) as well as increased family conflict, breakdown and homelessness (The Royal Australian and New Zealand College of Psychiatrists, 2010). Suicide is reported to account for 9.1% of all fatalities in persons aged 15-19 years worldwide (WHO, 2007). In the United States (U.S.) suicide is the third leading cause of death among adolescents (U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2010), whereas in New Zealand (NZ) suicide is the second leading cause of death after accidents for young people (Child and Youth Mortality Review Committee, 2008). Whilst often the desire to intentionally end one's life is assumed to imply 'madness' suicide is not a mental illness per se; there is no diagnosis within the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IVTR) (American Psychiatric Association, 2000) for being suicidal (Maris, Berman & Silverman, 2000). The Ministry of Health (MOH) reported that there are approximately 5,000 non-fatal suicide attempts in NZ each year for which hospitalisation is needed (MOH, 2006). Such information supports the findings of The Adolescent Health Research Group (2003), that many adolescents worldwide do not seek help from health services when they need to, and are more likely to access mental health services in a crisis. For many, that crisis is not met with age appropriate in-patient or community care (Street, 2000). Although the majority of CAMHS are provided in community settings, at times

the severity and complexity of problems can necessitate hospital admission for diagnosis and / or treatment; where possible, this should be provided by child and adolescent units (New South Wales (NSW)Department of Health, 2004).

According to the MOH, 19,329 clients aged 10-19 years were seen by District Health Board (DHB) mental health services in 2007/2008. They were seen by various teams: in-patient services saw 385, community 4,565, CAMHS saw 11,968, Kuapapa Maori saw 844, 1,343 were seen by Alcohol and Drug Services, and 593 by Forensic Services (MOH, 2010). Given that there are only three specialist in-patient adolescent units in NZ to serve the needs of those requiring acute MH care, it is highly likely nurses working in an adult in-patient unit will have occasion to nurse adolescents.

1.5 Document Outline

Chapter two looks at the prevalence of mental illness in adolescence and the reality of accessing appropriate mental health services. Education for registered nurses (RNs) in New Zealand is described in relation to working in mental health services. Adolescence as a lifestage is also considered and explained in this chapter.

Chapter three details the methodology used to undertake the research, including the design, sampling, recruitment, data collection, ethical considerations, data management and analysis.

Chapter four presents the research findings. Demographic information is reported along with reasons for admissions, followed by an introduction to the synthesised findings of themes and categories. The themes are discussed and illustrated with verbatim quotes allowing the participants' voices to be heard. The three themes that emerged from the data are presented separately under individual headings. Theme one, 'Attitudes and Experiences', refers to the evaluative way RNs thought or felt about nursing adolescents was influenced by their experiences. The second theme, 'Practice Implications', pertains to nursing related responsibilities and consequences of nursing adolescents on an adult mental health unit. The third and final theme developed from the data was 'Developmental Knowledge'.

Chapter five contains a discussion of the key findings in relation to the research questions and the literature reviewed. The limitations are also presented here. Chapter six provides a conclusion to the dissertation and identifies recommendations for future practice, training and development, and research.

CHAPTER 2: BACKGROUND

2.0 Introduction

The chapter begins with an overview of adolescence and its stages. To help understand the extent of the problem, the prevalence of mental illness in adolescents is explained. Issues around accessing appropriate mental health services are then discussed. Registered nurse education shows the extent and focus of mental health content in undergraduate courses, allowing the reader to consider what is reasonable and realistic to expect from RNs working with adolescents in context of the deficits identified. The principles of nursing adolescents highlights the skills required to work effectively with this clientele. The inclusion of adolescent development and the effects of hospitalisation on adolescents creates an understanding of their specific needs, and provides a foundation for considering why specific youth services might be needed.

2.1 Adolescence

Adolescence is defined as the life stage between childhood and adulthood, encompassing the transition from total dependence on parents to relative independence. It is a period of significant change, embracing physical, emotional, intellectual, and social growth (Spear, 2000). Adolescence is a distinct developmental period characterised by significant changes in hormones, brain and physical development, and interpersonal relationships. The developmental tasks of adolescence focus on preparation for adulthood: achieving independence; adjusting to physical maturation; establishing co-operative relationships with peers; preparing for meaningful work; developing a personal set of values and ethics; and developing a sense of one's own identity (Conger & Galambos, 1997).

Over time the typical age range of adolescence has been redefined: the onset of puberty occurs earlier for some than for others, indicating there are individual differences in development; different developmental trajectories have been found for different cognitive and emotional processes (Rosso, Young, Femia & Yurgelun-Todd, 2004). Cultural changes such as enrolment in further education have also kept young people from assuming adult roles into their late twenties. The age range of adolescence varies between cultures and countries, however there is consensus that adolescence begins with the onset of sexual maturity (puberty) and ends with the achievement of adult roles and responsibilities (Dahl, 2004). For the purpose of this research the World Health Organisation's definition of adolescence corresponding to the period between the ages of 10 and 19 years will be used. The adolescent process is generally considered as

proceeding through three phases, early adolescence beginning at about 10 and continuing to around 14, middle adolescence spans between 15 and 17, and late adolescence falls around 18 and goes into the 20's (The Collaborative for Research and Training in Youth Health and Development, 2011).

2.1.1 Early adolescence

Physical and cognitive changes predominate. Early adolescence is often experienced as a stressful and explosive period where adolescents turn away from their parents as they struggle for an autonomous sense of self. During this time involvement with peer groups intensify and conformity and concerns about acceptance peak, there is a tendency towards preoccupation with how their peers see them. The intense desire to belong to a particular group can influence adolescents to go along with activities they would not ordinarily engage in (Santrock, 2001).

2.1.2 Middle adolescence

There is a move from belonging to same sex groups to those that are more gender mixed. The awakening of sexual interest often disrupts previous peer groupings and intimate friendships. The need for conformity typically reduces as tolerance of individual differences in appearance, beliefs and feelings are developed (Feldman, 2010).

2.1.3 Late adolescence

This is a period of identity consolidation, whereby the adolescent begins to perceive themselves as a complete and separate person. This leads to them becoming more selective and discriminating in their relationships, peer groups are often replaced by more intimate dyadic relationships, such as one-on-one friendships and romances that have grown in importance as the adolescent has matured (Micucci, 1998).

2.2 Prevalence of Mental Illness in Adolescence

Adolescence is not only a critical period developmentally in the lifespan but can also be considered a critical life-stage for mental health. The impact of a MH problem or disorder in adolescence can be profound (Kosky & Hardy, 1992). Social, emotional or cognitive changes can disrupt identity formation and affect outcomes in adulthood (Kessler, Foster, Saunders & Stand, 1995). Approximately one-fifth of the world's youth suffer from mild to severe mental health problems (WHO, 2005).

With a population of 4.37 million, New Zealand is a relatively small country (Statistics New

Zealand, 2011). According to the 2006 Census, adolescents, defined as being between the age of 12 - 24 years, form around 19% of NZ's population (Statistics New Zealand, 2008). Whilst most New Zealand adolescents describe themselves as healthy, a substantial proportion are not. The Christchurch Health and Development Study (CHDS) and the Dunedin Multidisciplinary Health and Development Study reported prevalence of mental health disorders ranging from 17.6% at age 11, 22-24% at age 15, to 36.6% at aged 18 (Fergusson, Horwood & Lynskey, 1997). At the time of the CHDS 22% of 16-18 year olds had experienced a major depressive disorder in the past year, 17% had experienced an anxiety disorder, and 4.8% a conduct disorder (Horwood & Fergusson, 1998). National statistics reveal Maori 12-19 year olds have the highest annual prevalence of mental illness at 29.5% (Adolescent Health Research Group, 2004). New Zealand research suggested the greatest vulnerability for developing a MH disorder occurs between the ages of 15 and 18 years (Fergusson, Poulton, Horwood, Milne & Swain-Campbell, 2003).

Depression has been found to be consistently related to suicidal ideation and suicide attempts in adolescence (Kessler & Walter, 1998). Adolescents who have been victimised by their peers have a 2.4 fold greater risk for experiencing suicidal ideation (Turner, Finkelhor, Shattuck & Hamby, 2012). Before puberty, rates of depression are approximately equal between boys and girls but by the age of 18 twice as many girls than boys have a depressive disorder. The same is true of anxiety disorders (Merry & Stasiak, 2011): anxiety disorders are cited as one of the most frequent MH disorders in children and adolescents, seeming to have the earliest age of onset (Beesdo, Knappe, & Pine, 2009). Notably two anxiety disorders increase in prevalence in adolescence, namely social phobia and panic disorder (Weisz & Hawley, 2002).

Suicidal behaviour in young people has become a complex problem around the world (Anderson, Standen, Nazir & Noon, 2000). Suicide is a major cause of death in males and females aged 15-24 years in New Zealand, with approximately 129 deaths per year (Coggan, Patterson & Fill, 1997). New Zealand is reported to have the highest youth suicide rate in the Organisation for Economic Co-operation and Development (OECD) countries (The Werry Centre, 2013). Even more concerning are reports that suicide attempts are approximately 20 times more frequent than every completed suicide (WHO, 2007). Non-lethal suicidal behaviour is also of concern in adolescence, an estimated 15.9% of high school students in the United States have reported some type of deliberate self-harm by methods including cutting, scratching and self-hitting (Fortune & Hawton, 2005). An international study incorporating seven countries and over 30,000 interviews found self-harm was reported in one in four teenagers aged 15-16 years

during the previous year (Madge et al., 2008). Higher rates of 40-80% have been reported in adolescents receiving mental health treatment (Klonsky & Muehlenkamp, 2007).

Disruptive behaviour disorders are described in the DSM-IV under three broad categories: Attention Deficit Hyperactivity Disorder (ADHD); Oppositional Defiant Disorder (ODD); and Conduct Disorder. Prevalence rates of ODD have been reported between 5-10% of non-clinical samples (Fonagy, Target, Cottrell, Phillips & Kurtz, 2000). Prevalence rates of children and adolescents with conduct disorder between 1.5% and 3.4% were found by Horwood and Fergusson (1998). Significant difference in gender rates have been found in diagnosis of conduct disorder, with 75% being reported in males (Fergusson, Boden, & Hayne, 2011). ADHD is usually diagnosed in the age range of 5-13 years, and it is generally agreed that 2.5% of the school age population are affected by ADHD, a condition characterised by hyperactivity, inattention, and impulsivity. Symptoms of ADHD continue through adolescence and into adulthood for many (The Werry Centre, 2013).

Adolescence is also a time when substance use disorders (SUD) begin to emerge. High rates of co-existing problems have been reported among New Zealand young people (The Werry Centre, 2013). In the CHDS among youth aged 16-18, 22% were diagnosed with a mood disorder, of whom 37.6% had a co-morbid SUD. Likewise 17.1% had an anxiety disorder, 39.4% with a co-morbid SUD, and of the 4.8% diagnosed with conduct disorder 89.8% had a co-morbid SUD (Horwood & Fergusson, 1998). Results from the National Co-morbidity Survey Replication - Adolescent Supplement (NCS-A) found lifetime prevalence rates: 58% adolescents met criteria for one class of disorder; approximately 24% met criteria for two classes; 11% for three; and 7% for 4-5 classes (Merikangas et al., 2010).

2.3 Accessing Appropriate Mental Health Services

Whilst CAMHS in New Zealand are funded to meet the needs of 3% of the population in a six month period (Mental Health Commission, 1998), access rates for those under the age of 20 years were 1.28% at the beginning of 2008 (The Werry Centre, 2009). Also of note are the findings that despite high mental health need, Maori youth appear less likely than non-Maori to make contact with mental health services (Adolescent Health Research Group, 2004). However, Maori are not in isolation, ethnic minority populations worldwide have been identified as having particularly high unmet mental health needs (Garland et al., 2005; Yeh, McCabe, Hough, Dupuis, & Hazen, 2003). More than seven out of ten American adolescents who have mental health problems receive no assistance, and this is even higher among adolescents from

ethnic minority groups (US Public Health Service, 2000). It is apparent that despite a high prevalence of mental health problems many adolescents worldwide do not seek help from health services when they need to (Adolescent Health Research Group, 2003). One frequent effect of not seeking timely help or early intervention is the worsening of problems until crisis point is reached and admission is necessary. Martin and Oades (2000) purport the preference for community based management has led to admissions happening at a later stage in illness when patients present with severe clinical symptoms and increasingly disturbed and problematic behaviours (as cited in Cleary, 2003, p.140). Key reasons for admission to adult MH units were identified in a literature review by Bowers (2005) as the acute risks of dangerousness to self or to others and the need for intensive observation, diagnosis, and medical treatment or stabilisation within a secure and controlled environment. Adolescents with mental health problems should, where possible, be treated within their community context. When this is not possible for safety or therapeutic reasons in-patient admission may be necessary. Where possible this should be provided by child and adolescent units (NSW Department of Health, 2004).

The reality is that adolescents are often unable to access specialist support so are generally treated in adult psychiatric or paediatric wards (MOH, 1998). This is not a problem unique to NZ. Adolescent psychiatric admissions in England and Wales reflect similar patterns, with over a third being admitted to adult or paediatric wards (Worrall et al., 2004). A two year in-depth qualitative study focused on a sample of in-patient units drawn across England and Wales completed by Young Minds in 2003 found that 16% of their sample of young people had been placed in a paediatric ward, of whom 25% had found the provision inappropriate to their needs. Another 20% had been admitted to adult psychiatric wards, 13% of whom reportedly found the experience frightening (Street & Svanberg, 2003). An earlier Australasian report returned similar findings, stating that reasons for necessitating the use of adult psychiatric in-patient or paediatric beds included geographical location delaying prompt admission to child and adolescent psychiatric units, and a lack of specialist beds (O’Herlihy et al., 2001).

According to Burdekin (1993) such admissions have attracted criticism and are widely considered inappropriate. Concerns regarding the poor level of care received by young people on adult psychiatric wards have been acknowledged, a report by the Office of the Children’s Commissioner for England (OCC), cites a lack of safety, security and therapeutic care, and disorganised discharge arrangements (OCC, 2007). Although it has been argued mainstreaming psychiatric services within the general health system will improve access to services, reduce stigma and discrimination, and improve the quality of services (Singh, 1992; Whiteford, 1993),

the care of adolescents with mental health problems in general settings has not been fully evaluated (Ramritu, Courtney, Stanley & Finlayson, 2002). Farrelly (1994) acknowledged the adolescents' need for individuality and independence during hospitalisation differs to the close supervision and protective approach needed for younger children. Geanellos (1999) concluded mental health services orientated to children fail to meet the needs of adolescents, while adult-focused services provided in generalist settings tended to neglect the specific developmental needs of young people. Mahoney (1997) purported that skills learned in adult mental health and / or paediatric nursing are not always transferable or sufficient for working with adolescents.

2.4 Registered Nurse Education

In both NZ and Australia the requirement to become a RN is to complete an education programme consisting of a three year undergraduate Bachelor of Nursing degree. Upon completion of the degree, nursing graduates are permitted to work as entry level RNs in a broad range of practice settings, including mental health. It is assumed these RNs will be equipped to work in any area of health. However, a review of undergraduate training in child and adolescent mental health conducted by The Werry Centre acknowledged in the undergraduate degree there is only one competency for mental health specifying two weeks mental health theory and 160 hours clinical experience. In the seven undergraduate programmes reviewed, Peters (2003) found the focus was on adult mental health, and the average time devoted to adolescent mental health was between 1-3 hours, with one or two programmes providing a little more. The focus of comprehensive training for nursing is fundamentally different to mental health nursing ; it is argued that mental health nursing has been minimalised and marginalised within comprehensive programmes (Prebble, 2001).

There was a deficit in the up-to-date available literature, therefore much of the literature used is acknowledged as being dated. Outdated terms such as “comprehensive” and “training” are included to reflect the terminology contained in the literature referred to.

A number of reports have contributed to public recognition that comprehensive programmes were failing to meet the needs of the mental health speciality (Ministry of Health, 1996; Mental Health Commission, 1999; National Mental Health Workforce Development Co-ordinating Committee, 1999). Such findings led to the recommendation that “...all newly graduated registered comprehensive nurses wanting to enter mental health nursing will participate in certificate of mental health (new graduate) nursing programmes.” (National Mental Health Workforce Development Co-ordinating Committee, 1999, p.74). Following these recommendations in

many parts of NZ, there is now a pre-requisite to have completed a new graduate programme to secure employment in mental health services (Prebble, 2001).

The UK is one of the few countries that has retained a separate specialist undergraduate preparation for MH nursing, but there is increasing pressure to reduce undergraduate specialisation in favour of postgraduate specialisation (Hurley & Ramsay, 2008). Perhaps because similar problems were acknowledged in the earlier report “Addressing Acute Concerns” (Department of Health, 1999) which suggested current educational and training provision is not addressing the needs of mental health nurses working in acute inpatient settings, and is failing to equip them with the skills, knowledge and attitudes required to work effectively. This is of concern considering mental health nurses are the largest professional group delivering mental health care in the UK’s National Health Service (Sainsbury Centre for Mental Health, 1997). It is argued a strong foundation in MH nursing is required if nurses are to be able to provide quality care to patients with MH issues (Waite, 2006).

2.4.1 Principles of nursing adolescents

According to Kramer and Gayne (1997) (as cited in Farkas, Gayne, Anthony & Chamberlin, 2005) people with mental illness indicate the most crucial facilitators or barriers to their own recovery are how people interact with them. Youths’ perception of devaluation and rejection by others on account of their problems may reinforce the idea of having a serious illness or condition, leading to self-labelling and self-stigma, lowering self-esteem and self-efficacy. Negative self-efficacy is linked with general unhappiness and past worries, and increases the possibility of health-risk behaviours, whereas a positive self-esteem is linked with a greater sense of self-efficacy, and is considered a strength (Link & Phelan, 2006). Strengths can often be seen in terms of protective factors that increase resilience in the face of stressors. Generally the interplay of risk and protective factors determines whether the person overcomes the stressors they face (DeShazer, 1988). Rutter (2006) purported that development occurs through bi-directional interactions between the individual and the environment. Using selective patterns of attention, action, and responses with people, objects and symbols in their environment, the adolescent is viewed as being actively involved in their development. The implication is that nurses have a duty to promote health by enhancing protective factors and intervening to reduce health risk behaviours. The key intervention strategy to achieve this is the therapeutic relationship the nurse enacts with the client. Hildegard Peplau is credited with being the first to conceptualise that nursing relationships could be therapeutic, recognising it to be a two-way

relationship that is participated in and contributed to by the nurse and patient (Peplau, 1988).

Sometimes issues arise in the two-way relationship, namely transference and countertransference; it is important to be able to recognise when either takes place. Transference is defined as a client regarding and treating the counsellor or nurse as a significant other, such as mother, father, or other family member. It takes place most often with authority figures, especially when these figures are considered superior as opposed to equals (Fischer, 1991). Adolescents can evoke various feelings in those working with them, these feelings can include pity, sympathy, hostility, disgust and resentment; and are generally referred to as countertransference, or treating the adolescent as one would a significant other (Hanna, Hanna & Keys, 1999). Other feelings of countertransference cited by Church (1994) are irritation, anger, wanting to control, frustration, helplessness, and feeling defeated. Countertransference can lead clinicians to be tempted to want to parent or nurture adolescents as they would their own children, which if happened would not only be unprofessional but could adversely affect the therapeutic relationship (Hanna, Hanna & Keys, 1999). RNs need to develop their ability to recognise and effectively manage these feelings and may need to seek supervision at times. Supervision can help develop reflective practice which can be defined as the process of making sense of events, situations and actions that occur in the workplace (Oelofsen, 2012).

Despite acknowledgement of how difficult adolescents are to engage in treatment (Church, 1994) there is a lack of training in counselling approaches with adolescents (Rubenstein & Zager, 1995). Elliot and Watson (2000) found that adolescents have difficulty raising personal or sensitive issues with health professionals due to their fear of loss of privacy and perception that they are not interested in them holistically. By demonstrating respect and a genuine desire to seek to understand adolescents, it is possible to move the relationship from being condition centred to child centred, where promotion of self-efficacy and self-esteem is possible (Beresford & Sloper, 2003). Studies show that young people work best with professionals who convey respect for them (Ahmad et al., 2003). Additionally, it has been suggested the empathic relationship is a pivotal point determining success or failure when working with defiant and difficult adolescents (Bernstein, 1996; Mordock, 1991). It is proposed that the absence of an empathic and trusting relationship seems to be a threat to adolescents' integrity, or an adult attempt at manipulation (Hanna, Hanna & Keys, 1999). The therapeutic relationship is widely considered crucial to achieving positive outcomes, Yalom (1980) succinctly stated "It is the relationship that heals." (p.401). This is supported by Kadzin (1994) who acknowledged there is some evidence that the therapeutic relationship itself will produce some change in adolescents

(as cited in Bergin & Garfield, 1994, pp.543-594).

The therapeutic relationship is a fundamental element of mental health care (McGuire, McCabe & Priebe, 2001) and has been associated with therapeutic outcomes across a range of clinical settings and patient populations (McCabe & Priebe, 2004). Reynolds (2000) suggests the aims and purpose of the therapeutic relationship remains the same regardless of the context: seeking understanding of the perceptions and needs of the client through supportive interpersonal communication; empowering the client to learn or cope more effectively with their environment; and the reduction or resolution of their problems. The main constructs of a therapeutic relationship are conveying understanding and empathy, accepting individuality, providing support, being there and / or being available, being genuine, promoting equality, demonstrating respect, maintaining clear boundaries and having self-awareness. Additional qualities include active listening, trust and responding to clients' concerns (Registered Nurses Association Ontario, 2002).

Given that optimal growth and development occurs within nurturing relationships it is proposed that engagement must occur with the adolescent in the context of their parents or caregivers (Karoly, Kilburn & Cannon, 2005; Zeanah, 2000, as cited in The Werry Centre, 2008, p.15). Overwhelmingly researchers conclude strong families assist young people develop resilience, help overcome life challenges or crises, and develop enhanced health and well-being outcomes (Denham, 2003). The development towards autonomy during adolescence can be challenging for adults in their lives who need to provide them with both structure and freedom. Church (1994) stated that teenagers are able to explore their autonomy safely when they have secure relationships with their parents, and defines autonomy as "...adolescents' conviction that they have the freedom and capability to articulate and act on their own goals while remaining in relation to their parents" (p.102).

The same however applies to the client-therapist therapeutic relationship, particularly in regards to the goals and tasks of treatment. Given their developmental focus on autonomy and independence adolescents may be "sensitive to having other's goals imposed on them" (DiGuiseppe, Linscott & Jilton, 1996, p.88), especially when often they are admitted for concerns adults have about them, rather than by their own choice or request. Church (1994) proposed better working relationships are formed when therapists meet teenagers need of freedom through presenting themselves as partners opposed to authorities.

Normal parameters of development need to be understood in order to be able to discern

anomalies (Critchley, 1992), suggesting it is only when clinical observations are placed into a developmental theory that it is possible to correctly interpret patient behaviour and identify their health needs (Critchley, 1992). Erickson's psychosocial model (1963) provides a useful framework for understanding the challenges facing adolescents with mental health problems in achieving typical tasks, as potential exists for it to be life-altering because of the interference with or delay of psychosocial development (Leavey, Georing, McFarlane, Bradley & Cochrane, 2000). Erickson describes the adolescent task as identity versus role confusion, the premise of which is that successful conflict resolution and outcomes in earlier stages lead to positive achievement of identity. The search for identity is made easier if a sense of trust and strong sense of industry has been developed by the individual. If the adolescent cannot make deliberate decisions and choices, especially about vocation, sexual orientation, and life in general, role confusion becomes a threat (Erickson, 1963).

2.5 Physical Development in Adolescence

The first outward sign of puberty is the rapid gain in height and weight known as the growth spurt. The growth spurt usually begins about age 10-12 in girls, and 12-14 in boys, and is complete around age 17-19 years in girls, and 20 in boys (Hofmann & Greydanus, 1997). Because estrogens trigger and then restrain growth hormone secretion more readily than androgens, girls are taller and heavier than boys during early adolescence; this advantage is short lived, as at age 14 the typical boy's growth spurt starts whereas the girl's has almost finished (Bogin, 2001). Large sex differences in body proportions also appear caused by the action of sex hormones on the skeleton. Boys shoulders broaden relative to the hips, whereas girls hips broaden relative to the shoulders and waist (Rogol, Roemmich, & Clark, 2002). For most adolescents sexual maturation involves achieving fertility and the physical changes that support fertility. For girls these changes involve breast budding which may begin around age 10 or earlier, and menstruation which typically begins around 12-13 years of age. For boys, the onset of puberty involves enlargement of the testes around 11 or 12, and first ejaculation typically occurs between 12-14. The development of secondary sexual changes, such as body hair, and (for boys) voice changes, occur later in puberty (Rogol et al., 2002).

The age of onset and progression of puberty can be affected by numerous factors including genetic and biological influences, stressful life events, socioeconomic status, nutrition and diet, amount of body fat, and the presence of chronic illness (Kipke, 1999). Early and late physically maturing adolescents appear to be at increased risk for a number of problems. Early maturing

girls have been found to be a high risk for depression, substance abuse, disruptive behaviours, and eating disorders (Graber, Lewinsohn, Seeley, & Brooks-Gunn, 1997), whereas early maturing boys are more likely to be involved in high risk behaviours such as sexual activity, smoking or delinquency (Harrell, Bangdiwala, Deng, Webb & Bradley, 1998). It appears late maturation places boys at greater risk of depression, conflict with parents, and alcohol problems (Graber et al., 1997). The smaller stature of later maturing boys has also been associated with an increased likelihood for being bullied (Pollack & Shuster, 2000). Weight gain associated with puberty results in many adolescents experiencing dissatisfaction with their changing bodies. Some adolescents become overly preoccupied with their physical appearance, and in an effort to achieve or maintain a thin body, begin to diet. A minority of these adolescents will eventually develop an eating disorder such as anorexia nervosa or bulimia (Archibald, Graber & Brooks-Gunn, 1999).

2.5.1 Brain development

A number of specific changes happen in the brain during the adolescent years. These include a continuation of pruning of unused synapses but at a slower rate than during middle childhood. In contrast myelination of neural fibers greatly accelerates contributing to a slight increase in brain volume and to the gradual refinement of diverse cognitive skills, including attention, planning, the capacity to integrate information, and self-regulation (Giedd et al., 1999; Sowell, Trauner, Gamst & Jernigan, 2002). As lateralisation of the cerebral cortex progresses the brain functions more efficiently, consequently the energy consumed during cognitive processing declines to adult-typical levels. Additionally, sensitivity of neurons to certain chemical messages changes. During puberty, neurons become more responsive to excitory neurotransmitters, resulting in adolescents reacting more strongly to stressful events and experiencing pleasurable stimuli more intensively (Spear, 2003). These changes are believed to play a prominent role in the drive for novel experiences and drug-taking during this period, particularly among highly stressed teenagers, who engage in reward seeking behaviour influenced by feelings and social influences, opposed to simply considering risks and consequences (Steinberg, 2004). The restructuring of neurotransmitter activity may also be involved in adolescents increased susceptibility to certain disorders, such as depression and eating disturbances (Dahl & Lewin, 2002).

2.5.2 Sleep

The circadian timing of sleep changes with the onset of puberty; sleep onset is delayed, especially in mid-late puberty around the age 14-16 years (Taylor, Jenni, Acebo & Carskadon, 2005).

Consequently sleep declines from an average 10 hours in middle childhood to 7.5-8 hours in adolescence. Studies show that despite cultural differences adolescents worldwide sleep less than the recommended 9-10 hours (Carskadon, 1990; Liu, Liu, Owens & Kaplan, 2005). It has been suggested a number of psychosocial factors correlate with this finding, including the waning influence of parents on bedtimes, ready access to TVs, computers and phones, more time spent in leisure and job related activities, and the desire for greater self-determination (Carskadon, 1990; Carskadon et al., 2002). Because insufficient sleep impairs the regulation of attention, emotion and behaviour, sleep deprived adolescents are more likely to achieve poorly in school, to suffer depressed mood, and to engage in high-risk behaviours including drinking and reckless driving (Dahl & Lewin, 2002). However, studies also indicate children and adolescents are able to compensate for brief periods of sleep restriction, and impairments only emerge after prolonged sleep restriction or total sleep deprivation (Randazzo, Muehlbach, Schwitzer & Walsh, 1998).

2.6 Cognitive Development in Adolescence

According to Piaget (1973), around age 11 young people enter the formal operational stage in which they develop the capacity for abstract, scientific thinking. Problem-solving abilities develop through hypothetic-deductive reasoning, that is, the ability to analyse hypothetical situations through internal reflection in terms of cause and effect, and draw logical conclusions. Propositional thought is also developed; the ability to imaginatively evaluate the logic of propositions without referring to concrete things and events as objects of thought (Inhelder & Piaget, 1955 /1958). The development of formal operations leads to dramatic revisions in how adolescents see themselves, others and the world in general. This advanced thinking allows the adolescent to envisage and compare different future events and outcomes, and to establish their own objectives and goals (Keating, 1990).

The use of formal operations is demonstrated through the ability to modify and adjust one's behaviour, where choices are made depending on the evaluation of multiple variables and the alternatives (Taylor & Muller, 1995). Research findings suggest only 35% of adolescents have attained the cognitive skills of formal operations by the age of 16-17 years (Hales, Yudofsky & Talbott, 1999). Geldard and Geldard (1999) proposed that cognitive development may be impaired or facilitated by the successes and failures, and the confidence gained through role experimentation, when trying new skills in a variety of situations.

Adolescents exhibit intellectual egocentrism, where the personal self begins to dominate, and

they begin to think about themselves more; Piaget believed this stage is accompanied by the inability to distinguish the abstract perspectives of self and others (Inhelder & Piaget, 1955 /1958). Adolescents develop a belief they are the focus of everyone else's attention and concern (Elkind & Bowen, 1979). The belief that everyone is monitoring their performance leads to them becoming extremely self-conscious and sensitive to public criticism. Additionally they develop an inflated opinion of their own importance, of being special and unique, and having experiences no-one else could possibly understand (Elkind, 1994). Others argue these views of self do not, as Piaget suggests, result from egocentrism, instead are an outgrowth of gains in perspective taking, which cause teenagers to become more concerned with what others think (Vartanian & Powlshita, 1996). Bell and Bromnick (2003) asked adolescents why they worry about the opinions of others and found they do so because others' evaluations have real consequences for self-esteem, peer acceptance, and social support.

Adolescents' cognitive development, in part, lays the groundwork for moral reasoning, honesty and pro-social behaviours such as helping, volunteering, or caring for others (Eisenberg, Carlo, Murphy & Van Court, 1995). They develop a sense of values and ethical behaviour. Thompson and Fox (1994) found that in some models of the development of affect regulation, an explicit emphasis is placed on cognitive systems exerting control over emotions and emotion-related behaviour. Steinberg acknowledged "Many aspects of affect regulation involve the ability to inhibit, delay or modify an emotion or its expression in accordance with some rules, goals or strategies, or to avoid learned negative consequences" (Steinberg, 2005, p.72), recognising the opposite can also be true: This suggests that, "emotion has an important impact on basic cognitive processes, including decision-making and behavioural choice" (Steinberg, 2005, p.72). He hypothesised "...that age differences in social and emotional factors, such as susceptibility to peer influence or impulse control, lead to age differences in actual decision-making" (Steinberg, 2005, p.71). This is further supported by findings reported by Gardner and Steinberg (2005) that adolescents' risk-taking is more influenced than that of adults by the presence of peers. Risk-taking is a way of experimenting with the limits of one's power and influence, and with the limits set by parents and other figures of authority. Adolescence is a period of questioning the expectations others have of them, and ways of doing things, and of developing the capacity for effective arguments. It is by this process of proposing, justifying, criticising and defending a variety of solutions that adolescents move to a higher level of understanding (Moshman, 1999).

2.7 Emotional Development in Adolescence

Emotional development in adolescence involves establishing a coherent sense of identity in the context of relating to others and learning to cope with stress and manage emotions (Santrock, 2001). Establishing a sense of identity has traditionally been thought of as the central task of adolescence (Erikson, 1968). Identity formation was believed to start at puberty and to have completed by the end of the teenage years. Beliefs have since changed, and it is now widely accepted that identity formation neither begins nor ends during adolescence. Although the seeds of identity formation are planted early it appears the bulk of the identity work occurs late in adolescence, and perhaps not even until young adulthood. It is acknowledged though that adolescence is the first time an individual is able to define who they are, to reason why they are unique, and also consider the possibilities of what and who they would like to become (Markus & Nurius, 1986).

According to Erikson (1968) young people experience an identity crisis, a temporary period of confusion and distress as they experiment with the alternatives before settling on values, beliefs, roles and goals, and eventually arriving at a mature identity. Whilst current theorists agree with Erikson that questioning of values, plans and priorities is necessary for a mature identity, they no longer refer to this process as a crisis (Grotevant, 1998). It is accepted that for some, identity development may be traumatic and disturbing but for many it is not. They propose the typical experience is better described as exploration followed by commitment, and in the process forge an organised self-structure (Arnett, 2000; Moshman, 1999). Identity formation is a lifelong, dynamic process. Identity may be reformulated as personality develops and context changes (Kunnen & Bosma, 2003). There are two concepts to identity: self-concept, the set of beliefs one has about oneself; and self-esteem, which involves evaluating how one feels about one's self-concept.

High self-esteem has been linked with authoritative parenting and an experience of encouragement and success at school (Carlson, Uppal, & Prosser, 2000). In contrast, a critical parenting style where attention is rarely called to positive aspects of behaviour is associated with adolescents having highly unstable, and generally low self-esteem (Kernis, 2002). Low self-esteem develops if there is discrepancy between a person's perception of themselves and how they think they should be (Harter, 1990). Jaffe (1998) reports researchers have identified low self-esteem is characterised in adolescents by feeling depressed; lacking energy; disliking one's appearance and rejecting compliments; feeling inadequate most of the time; having unrealistic

expectations of oneself; doubting the future; being excessively shy and rarely expressing one's own point of view; conforming to what others want and assuming a submissive stance in most situations.

Adolescents must acquire and master emotional intelligence, the skills to emotionally manage stress, and be sensitive and effective in relating to others. This involves developing self-awareness, and most importantly relationship skills; the ability to make and be able to keep friends and get along with others (Goleman, 1994). Without these skills adolescents are at greater risk for a number of problems including rejection. Rejected adolescents are often aggressive, irritable, withdrawn, anxious, and socially awkward (Pope & Bierman, 1999). The skills necessary for emotional development incorporate: recognising and managing emotions, and thereby identifying options to resolve problems; developing empathy; learning to resolve conflict constructively; and developing a co-operative spirit (Goleman, 1994).

2.8 Social Development in Adolescence

Relationships serve as a context for the development of emotional reactivity because of the conflict that arises within them. Conflict facilitates adolescent identity and autonomy through expression and tolerance of disagreement. Emotional reactivity has long-term implications for future adjustment for mental and physical health, and close relationships. Emotional reactivity has been associated with both intrapersonal, for example internalising behaviour (Harold, Shelton, Goeke-Morey, & Cummings, 2004) and interpersonal development, for example relationship behaviour (Bartle-Haring & Sabatelli, 1997). Close friendships are central to socio-emotional development during adolescence (Burhmester, 1990). Social development of adolescents occurs in the contexts of peers, family, school, work, and community. In adolescence inadequate or poor quality social relationships can lead to loneliness. Loneliness has been found to be a life-time risk factor for cognitive impairment and a broad range of MH disorders including depression, anxiety, personality disorders and psychosis (Heinrich & Gullone, 2006).

2.8.1 Peer relationships

Burhmester (1996) acknowledged that the establishment of friendships during adolescence is a core activity for personal development (as cited in Ojanen, Stratman, Card & Little, 2012, p.553). Bukowski, Hoza and Boivim (1993) (as cited in Ojanen et al., 2012, p.557) propose friendships are where adolescents practice and develop social skills, they are considered developmentally critical, and socially normative. "Friendships are vital to later romantic relationships because

friends and romantic partners can experience intimacy and reciprocity in ways that are not possible in hierarchical relationships such as those with parents” (Sullivan, 1953. Cited in Cook, Buehler, & Blair, 2013, p.342).

Adolescent friends tend to be alike, and become more similar over time in their identity status, educational aspirations, political beliefs, and willingness to try drugs and engage in law-breaking acts (Berndt & Murphy, 2002). During adolescence, peer groups provide sources of popularity and status, and a desire to be part of the prominent peer system is often seen in early adolescence and may influence and lead to a modification in beliefs and behaviours, albeit temporarily (Santrock, 2001). Peers are individuals around the same age or maturity level.

“One of the most important functions of the peer group is to provide a source of information about the world outside the family. From the peer group, adolescents receive feedback about their abilities. Adolescents learn whether what they do is better than, as good as, or worse than what other adolescents do. Learning this at home is difficult because siblings are usually older, or younger, and sibling rivalry can cloud the accuracy of comparison.” (Santrock, 2010, p.313).

Peers do not influence one another through coercion but through admiration and respect for their opinions (Susman et al., 1994). Notably, both sexes are attracted to aggressive boys as friends, a contributing factor to increased antisocial behaviour (Bukowski, Sippola & Newcomb, 2000). Research suggests peer contact may only predict problem behaviour among adolescents with a history of externalising problems (Pettit, Bates, Dodge & Meece, 1999). Successful peer relations are linked to the ability to regulate emotion (Eisenberg, Fabes & Spinrad, 2006), for instance emotionally positive adolescents have found to be more popular, in contrast, moody and emotionally negative adolescents experience greater peer rejection (Saarni, Campos, Camras, & Witherington, 2006). Positive peer relations during adolescence have been linked to positive psychosocial adjustment.

In early adolescence the desire for intimacy grows, the need for which is satisfied through active pursuit of friendship (Buhrmester, 1990). Relationships with friends differ from those with the peer group, those with friends are closer and more involved, friends engage in mutual companionship, support and intimacy (Santrock, 2010). Deci and Ryan (2000) suggested the inherent desires for, and the enjoyment of friendships, are intrinsically motivated. The need for relatedness (Veronneau, Koestner & Abela, 2005) and need satisfaction (Demir & Ozdemir, 2010) are positively related to well-being and friendship quality. Emotional adjustment and

friendship quality have also been found to be positively related to peer acceptance (Newcomb, Bukowski, & Pattee, 1993). However, friendships may also be motivated by extrinsic factors such as perceived pressure from parents or teachers, or concern about social acceptance (Rankin, Lane, Gibbons & Gerrard, 2004). Friendships established and maintained for extrinsic reasons are related to poor personal and social adjustment (Deci & Ryan, 2000). A correlation has been found between low friendship quality and emotional difficulties, with behavioural difficulties such as aggression (Fanti, Brookmeyer, Henrich & Kuperminc, 2009), suggesting extrinsic friendship motivation may be negatively related to social adjustment in the broader peer group (Ojanen et al., 2012).

There is some evidence for sex differences in friendships; among girls friendship intimacy is fostered by conversation, whereas boys gain it through shared activities (McNelles & Connolly, 1999). Exchanges among girls contain more self-disclosures and mutually supportive statements, which may explain the finding that emotional closeness is more common between girls than boys (Markovits, Benenson & Dolenszky, 2001). Research has also found that girls manifest more emotional difficulties as a result of experiencing conflict within family and peer relationships than do boys (Davies & Lindsay, 2004; Rudolph, 2002).

2.8.2 Family

A number of researchers have found a moderate correlation with secure attachment to parents and adolescents' positive peer relations (Allen & Antonishak, 2008). However other factors such as being physically unattractive, maturing late, and experiencing cultural and socioeconomic-status discrepancies have been cited as reasons a significant minority of adolescents from strong, supportive families struggle in peer relations (Santrock, 2010).

Parents and peers differ in their spheres of greatest influence, whilst peers are more influential in short-term, day-to-day matters such as dress, music and choice of friends, parents influence more important issues such as basic life values and educational plans (Steinberg, 2001). In well-functioning families adolescents remain attached to their parents and seek their guidance, but in a context of greater freedom. During adolescence parent-teen conflict tends to increase, mild conflict facilitates adolescent identity and autonomy by helping family members learn to express and tolerate disagreement. Parents often give greater meaning to conflict-laden interactions and experience them as more distressing than the adolescent who may see it as part of asserting their individuality, viewing the interaction as far less significant (Steinberg, 2001). Conflict is considered an important part in the process of maintaining a connection

with parents while becoming independent from them (Steinberg, 2001). Parental monitoring and supervision contributes to a strong sense of attachment and closeness to family, and is associated with better emotional development, better school performance, and less engagement in high-risk activities such as drug use (Smetana, 2008).

Adolescents increasingly seek autonomy, independence and a sense of control over their lives. One study found increasing autonomy led adolescents to perceive their parents more as persons in their own right and less in the idealised terms they previously held about them (Steinberg & Silverberg, 1986). The increase in adolescent autonomy changes the relationship and power balance within it, dynamics shift from parents holding most of the power and influence over the relationship at the beginning of adolescence, to a more egalitarian relationship where power and influence are shared by the end of adolescence.

2.9 Effects of Hospitalisation on Adolescents

The impact of hospitalisation on adolescents has been described as traumatising (Cohen, 1994), and stressful due to separation from family and friends, the loss of autonomy, and the restrictive environment. The effects of higher level stress have been found to relate to poorer hospital adjustment and contribute to the risk of disruptive behaviours while hospitalised (Causey, Mckay, Rosenthal, & Darnell, 1998). Other environmental factors such as staff behaviour or ward milieu that could be considered punitive, coercive or isolative are known to increase the risk of aggressive behaviour and exacerbate on-going conflict (Natta, Holmbeck, Kipst, Pines & Schulman, 1990; Morrison, 1990). Limit setting or verbal directions from staff have also been linked with assaults against staff within an adolescent psychiatric in-patient unit (Ryan, Hart, Messick, Aaron & Burnette, 2004). However, aggression may reflect impaired developmental capacity to regulate behaviours, linked with impulsivity and poor affect regulation (Sugden, Kile & Hendren, 2006). The challenge to staff is to understand which behaviours are age-typical responses of stress and which represent psychopathology and / or altered development. Accounts given by young adults who had experienced hospitalisation during middle adolescence led to Hauser concluding that “experiencing a serious psychiatric disorder leading to hospitalisation regardless of how time-limited, can markedly change the experience of self, often leading to lowered self-regard and lowered personal competence.” (Hauser, 2006, p.549).

In common with adults, young people often know what helps them and what does not; the difference is their views are not always sought by those making decisions about their lives (Aubrey & Dahl, 2006). The concern is that such negative experiences may result in adolescents

developing an aversion to engaging with mental health services, leading to poorer MH outcomes for this clientele (Hoagwood, Jensen, Petti & Burns, 1996). The National Advisory Council's [NAC] Young People's Reference Group referred to "the pain of not being understood" by those supposed to be helping them, and how this made them walk away from therapy rather than stay (NAC, 2011, pp.8-9). This highlights the importance of optimising the therapeutic relationship to maximise engagement and achieve better MH outcomes for adolescents accessing mental health services.

2.10 Chapter Summary

Mental illness is a significant problem for adolescents. About 20% of the demographic will present with symptoms. Adolescents are rarely able to access appropriate mental health services due to limited service availability. Nurses working in adult mental health services are inadequately prepared to recognise and meet the needs of this client group.

Adolescence is a period of great change, a transitional phase between childhood dependency and adult independence, encompassing important physical, cognitive, emotional and social development. Separation from family, loss of autonomy and the restricted environment associated with hospitalisation has been described as traumatising for adolescents.

The methodology used to undertake the research, including the design, sampling, recruitment, data collection, ethical considerations, data management and analysis is detailed in the chapter that follows.

CHAPTER 3: METHODOLOGY

3.0 Introduction

This chapter describes the methodology used in this study, including the design, participants, recruitment, data collection, ethical considerations, data management and analysis.

The purpose of this study was to explore the perceptions, attitudes and experiences of RNs working with adolescents in an adult mental health unit to gain an understanding of the nursing care currently in place. It was considered that this goal fitted best with the interpretive research paradigm, which states that people construct individual meanings as they navigate and interpret their world(s), being influenced by their own personal frames of reference and contextual point of view (Crotty, 1998). It acknowledges humans are incapable of total objectivity because they are situated in a reality constructed by subjective experiences, therefore subjectivity is valued. Qualitative research is by its nature a subjective process (Gulliver, Griffiths, & Christensen, 2010, p.119). The research is value-bound by the nature of the questions asked, values held by the researcher, and the way findings are generated and interpreted (Ajjawi & Higgs, 2007).

A qualitative study using a general inductive approach was undertaken which allowed the researcher to directly investigate the world of the participants, rather than having a basis in the literature (Field & Morse, 1985). This methodology is rooted in sociology, and is associated with symbolic interactionism (Blumer, 1969) a social-psychological framework which posits that human beings interact and act on things in their lives based on meanings derived from social interactions. This methodology fits well with the interpretive paradigm, as meanings and actions are modified through an interpretive process. It was chosen because it is person-centred and focuses on the experience, behaviour and perspectives of the participants, with the goal of understanding action and interaction within the context in which people function and share their social world with others (Gerrish & Lacey, 2010). It aims to describe data within a social setting whilst trying to conceptualise the underlying social process (Pandit, 1996). The researcher commenced the study with a mind open to the possibilities of the data and the perspectives of the participants (Strauss & Corbin, 1998).

Qualitative research relies on inductive reasoning which starts with no assumptions or theories, categories and themes come from the data through investigator interpretation, leading to the generation of new ideas; it is considered a theory building process (Halloway, 1997). In contrast, quantitative research, a formal systematic approach incorporating numerical data

to obtain information about the world (Burns & Grove, 2009) predominantly uses deductive inquiry. It is considered a hypothesis testing process, as it commences with a theory, and uses the data to confirm or refute it (Halloway, 1997). Quantitative research would not be suitable to gain the information required for this study.

Hence, a qualitative approach was appropriate for the aim of this study which was to explore RNs' perceptions and their experiences of nursing adolescents in an adult MH unit, and to identify any nursing concerns regarding such admissions. It also looked for: the reasons adolescents access adult MH in-patient services; what training and knowledge RNs had in relation to the assessment and management of adolescents with MH problems; and to identify areas of the nursing care environment that may be improved or developed to enhance quality of care.

3.1 Participants

The guiding principle in the selection of the sample was that all participants must have experienced the phenomenon and be willing and able to articulate what it was like to have lived that experience, and for the views to be useful to explore the phenomenon in-depth. For these reasons a purposive sample using a criterion strategy was used to select those that would be representative across the clinical nursing staff (Patton, 2002).

The inclusion criteria for this study was: RN aged 21 years or older, employed for a minimum of 32 hours per week in an adult mental health unit, with a minimum of 12 months work experience as an RN in an adult mental health unit. In addition participants were to have had experience of caring for adolescents admitted to adult mental health units.

Enrolled nurses (ENs) were excluded due to differences in accountability and the level of clinical responsibilities expected of them. ENs practice under the direction and delegation of a RN and must not assume overall responsibility for nursing assessment or care-planning (New Zealand Nurses Organisation, 2010). Additionally ENs undergo different training, they are educated to diploma at level 5 of The New Zealand Qualifications Authority (Nursing Council of New Zealand, 2010) opposed to RNs who train at degree level.

The desire to fully investigate the chosen topic and provide information-rich data means smaller numbers are involved than in probability sampling (Grbich, 1999). Conducting in-person interviews and analysis of data produced from open-ended questions can be time-consuming (Johnson & Turner, 2003). Due to these considerations the study aimed to recruit a small sample of 6 – 8 participants who met the inclusion criteria. It was anticipated this sample size

would provide for the possibility of saturation to be achieved, that is, to reach a point in data collection and analysis where no new ideas are arising (Ajjawi & Higgs, 2007).

3.2 Recruitment

The researcher approached a District Health Board (DHB), who gave permission for recruitment from the adult mental health unit of their organisation. Letters of invitation to participate in the study (information sheet, appendix 1; consent form, appendix 2) were distributed by the Clinical Nurse Manager (CNM) to the RNs meeting inclusion criteria (numbered 12). Prospective participants were asked to contact the researcher if interested, or had any questions relating to the research. A week later the CNM followed the letters up with an email. Six RNs volunteered to participate, and returned their consent forms. Mutually acceptable times for the interviews were arranged over a period of 10 days.

3.3 Data Collection

Interviews were considered the most appropriate method for data collection as they provide opportunity to understand both the experiences (Seidman, 2006) and perspectives of other people (Patton, 2002). “Phenomena that have already occurred have their explanations in the past” (Parahoo, 2006, p.192). However, retrospective studies are often described as having a “foot in the present” (Parahoo, 2006, p.192). It is this factor that differentiates them from historical studies which seek to understand phenomena as embedded in a particular period. The distinguishing feature of a retrospective study is they “...aim to describe a current phenomenon by examining factors that are associated with it or give rise to it” (Parahoo, 2006, p.192). It was hoped that the retrospective data collected in this study which incorporated reflection on practice could be used to gather information about behaviours the participants planned to engage with into the future (Polit & Beck, 2008). It was also hoped that being a member of the same profession as the participants would facilitate trust and confidence in the researcher-participant relationship, allowing rapport to be established, and providing access to their thoughts. It can be argued the presence of the researcher enhances validity of responses, as not only can clarification be given, but it can also be sought from participants (Parahoo, 2006).

Semi-structured interviews have the advantage of providing greater breadth or richness of data without being tied down to specific answers, as may be the case when asking closed questions or using structured interviews (Morse & Field, 1995). The semi-structured interviews followed an interview guide (appendix 3), listing questions and follow-up probes to be covered with each

participant, with the aim of ensuring all the information required was obtained whilst providing freedom for participants to tell their stories in their own words in as much detail as they decide (Polit & Beck, 2008). The interview guide was moderated by supervisors, modified, then pilot tested in one interview. The results were reviewed, and subsequent alterations made to two questions before interviewing the other participants. Semi-structured interviews lasting approximately one hour were conducted with eligible RNs who had consented to participate. Prior to the commencement of interviews participants were reminded of their right to withdraw from the study, or to stop the recording at any time.

Interviews were carried out in a quiet room within the unit away from clinical areas to minimise chance of interruption, and to promote a safe atmosphere in which experience and feelings could be shared, and anonymity maintained. With participants' permission interviews were audio recorded, then transcribed as verbatim responses. All interviews were coded and no names used to prevent personal identification. Data tapes were labelled with an identification number (to maintain anonymity) and collection date, and were securely stored in a locked cabinet. All data was stored in password protected folders with restricted access. All data is being retained in accordance with Otago University regulations.

Transcripts were reviewed for accuracy against the recordings before copies were sent to the participants for checking, and modifications were made as necessary. This process enabled the researcher to gain an overall view of the raw data, in terms of the approach used it is known as preparation of raw data files (data cleaning) (Thomas, 2006).

3.4 Ethical Considerations

Ethical issues need to be identified and addressed prior to entering into any research process in order to protect all participants from potential harm (Hesse-Bieber & Leavy, 2006). Approval was obtained from the University of Otago Human Ethics Committee before any stage of the research was undertaken. This process included a consultation with the Maori Research Consultation Committee, and, on their recommendation consultation was also sought with a senior Maori Cultural Advisor employed by the DHB concerned, based on the adult mental health unit where the study was conducted.

Though participants were employed by the same DHB for whom the researcher worked this potential conflict of interest was not considered problematic as the researcher was not employed in a position of higher authority. The researcher worked for a different service within mental

health services, and there was no perceived sense of power imbalance or pressure to participate, however the potential impact of recruitment through a third party (CNM) was acknowledged and reviewed through the process of consent. Emphasis was placed on participation being voluntary, and a decision not to volunteer would be respected without penalty or negative consequence (Parahoo, 2006).

Distress can be caused to participants in all types of research, however qualitative studies are associated with greater opportunities for sharing 'confidences' than quantitative studies (Parahoo, 2006, p.113). Therefore the researcher was sensitive and attentive for possible signs of discomfort or distress and sought to act in accordance with participants' wishes.

Despite difficulties identifying risk to participants in qualitative studies Richards and Schwartz (2002) listed four potential risks: anxiety and distress; exploitation; misrepresentation; and identification of the participant in published papers (as cited in Parahoo, 2006, p.113). To reduce such risks the four rights of subjects considering participation in research as identified by the International Council of Nurses (ICN) were incorporated into all stages of the research process: the right not to be harmed; of full disclosure; of self-determination; and of privacy, anonymity and confidentiality (ICN, 2003). These rights are based on the principles of beneficence, non-maleficence, fidelity, justice, veracity, and confidentiality (ICN, 2003) on which the study was based.

In order to uphold the aforementioned principles, informed consent was obtained, participants were given ample time (2 weeks) to review the consent form, and to ask questions before signing it. Consent forms were also signed by the researcher and a copy retained by each party. Prior to the commencement of the interview participants were reminded of their right to withdraw from the study, or to stop the recording at any time. Thus in this study consent was viewed as the on-going, transactional process of process consent, allowing participants to play a collaborative role regarding on-going participation (Polit & Beck, 2008).

3.5 Data Management and Analysis

The research incorporated the specific principles developed by Lincoln and Guba (1985) to examine the trustworthiness and quality of the research: credibility; dependability; confirmability; and transferability. Credibility evaluates quality and refers to truth in data (Polit & Beck, 2008). The researcher, alongside supervisors, triangulated ideas and coded interpretations to help identify and counterbalance any bias. Reflexivity was used to help guard against personal

bias in making judgements and decisions. “Reflexivity is the process of reflecting critically on the self, and of analysing and making note of personal values that could affect data collection and interpretation” (Polit & Beck, 2008, p.202). Credibility was also enhanced by returning transcripts to the participants, providing opportunity to check for accuracy before authorising usage in the study. Dependability refers to the consistency and stability of the data (Polit & Beck, 2008). “Confirmability depends on participants or other ‘experts’ ‘agreeing’ with the researcher’s interpretation” (Parahoo, 2006, p.410). This was achieved by using thick description, and where possible using participants’ words to allow them to speak for themselves. Transferability refers to the extent to which findings can be transferred to other settings (Polit & Beck, 2008). The researcher describes the context sufficiently so that readers can assess the applicability of the research findings to their own contexts (Ajjawi & Higgs, 2007).

According to Miles and Huberman (1994) the goal of qualitative analysis is to reduce large amounts of textual data to meaningful concepts while identifying themes and categories in the data. Data reduction refers to “the process of selecting, focusing, simplifying, abstracting and transforming that data” (p.10). Polit and Hungler (1999) purport data analysis will be ongoing in conjunction with data collection because as interviews are conducted, gathered data is synthesised, interpreted and communicated to give meaning to it. This alternating process of data collection and analysis is acknowledged as being a cyclical or repetitive process known as interim analysis (Johnson & Christensen, 2004).

Inductive thematic analysis was used to analyse the research data. An inductive approach concentrates on identifying themes that are linked to the data themselves (Braun & Clarke, 2006). Thomas’s (2006) general inductive approach was utilised to sort and organise the collected data “...to allow research findings to emerge from the frequent, dominant, or significant themes inherent in raw data, without the constraints imposed by structured methodologies” (p.238). The underlying assumptions of the general inductive approach are that both the research objectives and multiple readings and interpretations determine data analysis (Thomas, 2003). Therefore categories are formed from the raw data. Upper level categories or themes are based on the research aims, and lower level categories emerge from close readings of the text. The ultimate goal is to derive between three to eight categories that concisely present the themes of the raw data (Thomas, 2006).

Following cleaning of the data and after multiple readings, with research aims in mind, sections of text were highlighted, then summarised on a separate sheet with reference to transcript location

(participant identification number and transcript page). Summaries from each participant were then reviewed and placed into categories created from the meaning of the text or actual phrases used (Thomas, 2003). Cross-comparisons were made of the individual collections of categories from which common categories were formed for all the transcripts. This resulted in the identification of 12 low level categories. These were considered preliminary findings. Supervisors checked the extent of overlap by creating a second set of categories from raw text which were then compared with the first set. This process of independent parallel coding was used to indicate whether further analysis was needed to produce a more robust set of categories (Thomas, 2006).

Categories were reduced further through a process of continual review. Categories numbered nine and were: emotional response, personal beliefs and memorable experiences. Role, environment, concerns and changes. Physical development, cognitive development, social and / or emotional development.

Each category was then systematically analysed to find patterns of commonality and difference, from which three major themes emerged, namely: attitudes and experiences, practice implications, and knowledge.

Chapter Summary

A qualitative study utilising an inductive thematic approach was conducted. A purposive criterion sample of six participants was recruited with whom semi-structured interviews were completed. The collected qualitative data were systematically analysed using a general inductive analysis approach. Following a process of continual review, three core themes encompassing nine categories emerged from the collected data.

In the next chapter the synthesised research findings are introduced, and each theme is presented under its own heading, along with its associated categories.

CHAPTER 4: RESULTS

4.0 Introduction

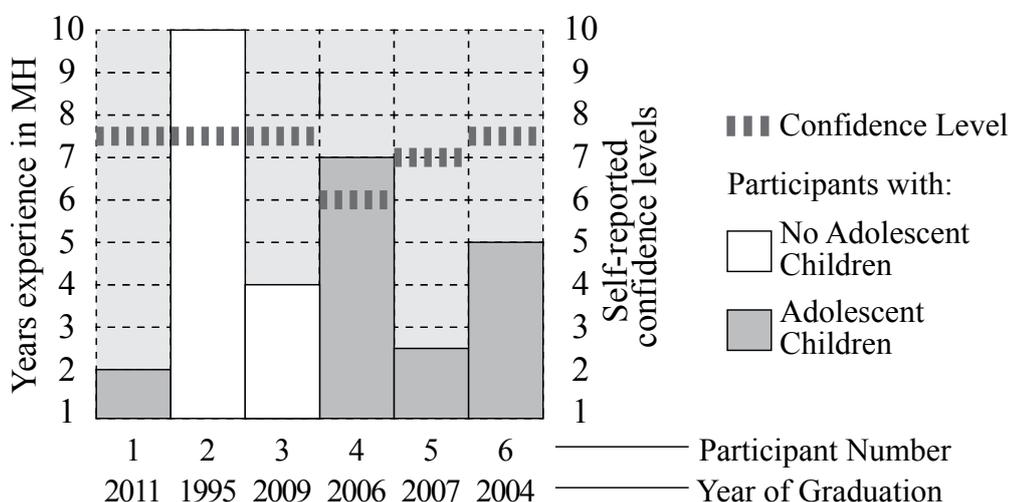
In this chapter the research findings are presented. Demographic information is reported along with reasons for admission, followed by the the three core themes that emerged from the data using Thomas’s (2006) general inductive approach. These three themes were: attitudes and experience, practice implications, and developmental knowledge. Contained within these three themes were a total of nine categories. The inter-related themes and categories reflect the RNs perceptions, attitudes and experiences of nursing adolescents in an adult unit. Each theme is presented under its own heading, along with its associated categories.

4.1 Demographic Data

The participants varied in their length of experience since graduating as a RN; this ranged from two to eighteen years. Four nurses had worked in areas outside of mental health over the course of their career, hence the mental health experience ranged from two to ten years for the participating nurses.

Four of the six participants had no direct experience of working with CAMHS; participants one and three had done a three month placement at CAMHS as part of their postgraduate mental health training. In addition participant three had done a recent six month secondment to CAMHS. Four participants had their own teenage children, participant two had young children, and participant three had no children. All six participants were female. Participants self-rated their confidence on a scale of one to ten with ten being the most confident. The range of responses was from six to seven and a half. Given the small sample size ethnicity was not recorded so as to maintain anonymity of participants.

Figure 1: *Demographic Data*



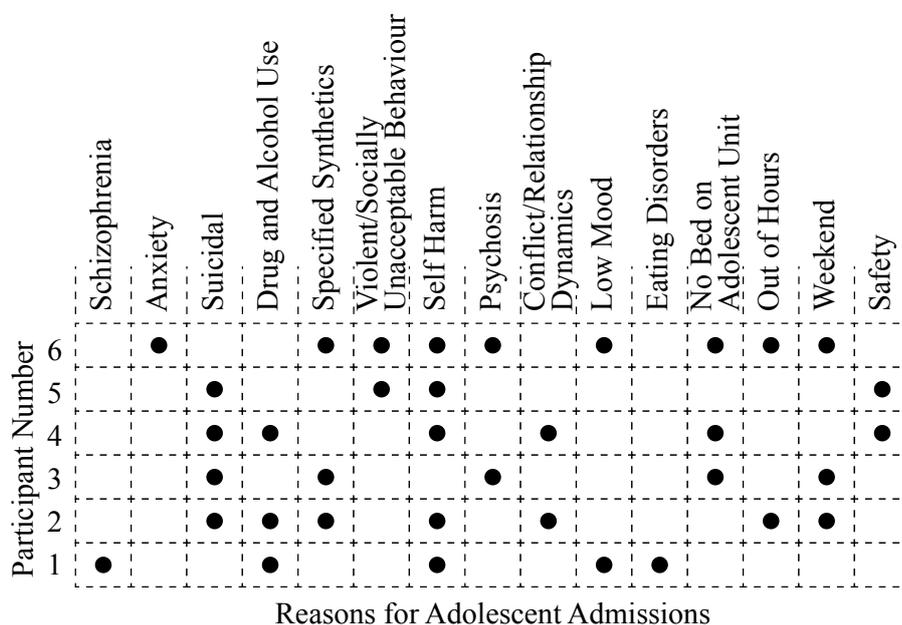
4.1.1 Level of training

All six participants were degree-trained RNs. Only one participant had not completed any post graduate study relating to mental health, whereas five of the six had completed a one year postgraduate mental health certificate. Though two participants included their CAMHS placement as part of their postgraduate training no participants had done any post graduate study specific to child and adolescent mental health. One had attended a workshop which was targeted at adolescent mental health (early intervention), another was aimed at younger children, but all other workshops mentioned were adult focused.

4.2 Adolescent Admissions

Participants' impressions regarding the reasons why adolescents access adult mental health in-patient services were recorded (figure 2). Each participant reflected on the presentations of adolescents they had nursed and gave a general overview of their experiences, a variety of reasons were identified: Two participants acknowledged co-morbid synthetic cannabis use and psychosis, similarly one participant identified drug and alcohol use with schizophrenia. No other co-morbid presentations were mentioned. The conflict and / or relationship dynamics and socially unacceptable behaviours were interpreted as being due to diagnoses of Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), Conduct Disorder, and Pervasive Developmental Disorders (PDD). The researcher believed the reasons given reflected participants' limited knowledge of mental health disorders prevalent in children and adolescents.

Figure 2: *Primary Reasons Given by Participants for Adolescent Admissions*



4.3 The Synthesised Findings of Themes and Categories

Nine categories were formed from the data, and three overarching themes captured the RNs' perceptions, experiences, and their concerns of nursing adolescents in an adult mental health unit. The themes and categories are discussed below. Verbatim quotes from the interviews are used to illustrate ideas and experiences (Sandelowski, 1994).

The relationships and influences of the categories differed across the three themes. In all cases, the themes were derived from the three categories, but in the case of themes one and two, categories were more connected, some or all being influenced by others.

Figure 3: *Outline of Themes and Associated Categories*

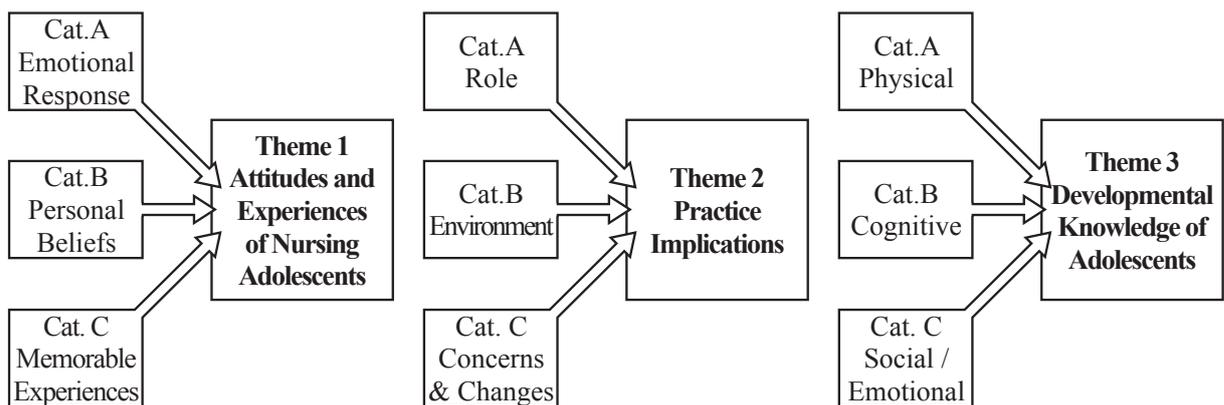
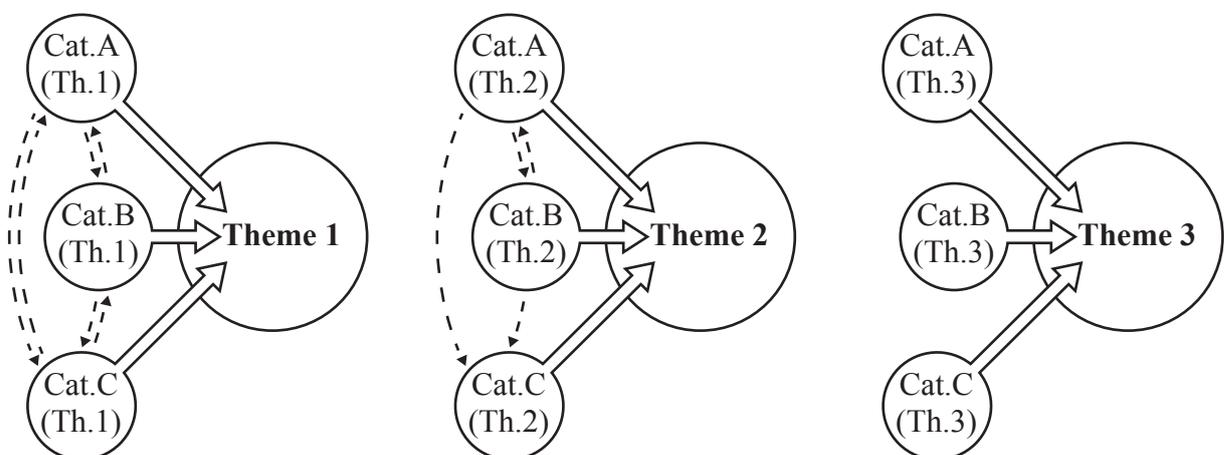


Figure 4: *Relationships of Categories and Their Influences on the Themes*



4.4 Theme 1: Attitudes and Experiences

The categories that make up theme one are shown in Table 1 and are supported by verbatim quotes.

Table 1: *Theme 1*

Theme	Category	Example
1- Attitudes and Experiences of Nursing Adolescents: The evaluative way RNs thought or felt about nursing adolescents influenced by their ‘on the job’ experiences.	Cat.A Emotional Response: The RN’s spontaneous instinctive feeling about nursing adolescents on the unit.	“I feel quite excited because I quite like working with youth.” (Participant 1).
		“...I used to have huge anxieties around it...” (Participant 5).
	Cat.B Personal Beliefs: RN’s individually firmly held opinions about adolescents.	“I think...if they have had a positive experience...then it is more likely to be better for them and sometimes a shorter admission as well...” (Participant 1).
		“...because they’re young they’re more vulnerable...” (Participant 4).
	Cat.C Memorable Experiences: Easily remembered unforgettable incidents or feelings associated with nursing adolescents.	“...she ended up being restrained and somebody ripped the necklace off her and broke the chain...just such a traumatic experience and there was no need for it...things like that I don’t like.” (Participant 3).
		“...had youth send texts to friends saying goodbye...” (Participant 1).

Participant attitudes consisted of cognitive, affective and conative components. Attitudes were found to possess evaluative properties from positive to negative, and affected the RNs’ disposition in how they reacted to the prospect of adolescents on the unit. Attitudes were either learned or acquired through direct experience or indirectly through contact with others who held attitudes about adolescents. On the unit work colleagues were primary forces of influence on participant opinions, attitudes, and behaviours. However, acknowledgement is given to other potential influential forces, such as social groups and significant others. Attitudes towards adolescents were found to relate to the RN’s belief about them which included knowledge, thoughts and feelings about adolescents. Thus feelings or emotions evoked in participants about nursing adolescents influenced attitudes and experiences. Participants were

found to display either positive, negative or neutral attitudes which were underpinned by their experience and were reflected through the three categories in this theme: emotional response; personal beliefs; memorable experiences.

4.4.1 Emotional response

Affective systems influence behaviour through the intensity of feelings and experiences that evoke strong feelings. Emotion has an impact on cognitive processes including decision-making, especially in relation to what to do and how to behave in a particular situation (Steinberg, 2005). Participants' spontaneous instinctive feelings (their emotional response) about nursing adolescents on the unit differed and the subjective feelings experienced shaped the RN's attitudes towards adolescents. Findings indicated those who displayed positive emotional responses reported liking working with adolescents; conversely those who displayed negative emotional responses held negative thoughts and attitudes about adolescents.

Positive statements were made by three participants in regards to their first thoughts on hearing of an adolescent admission such as "I really like kids, so I feel like I can really relate to them..." (Participant 3). It was also found that participants who had their own adolescent children expressed more positivity towards adolescents, one of whom, whilst enjoying working with them, acknowledged this was not always the case, thereby identifying that feelings changed over time and that experience was a factor.

"...it used to be dread, but not so much anymore...fear of the unknown, I guess, working with adolescents...I enjoy working with adolescents...it comes naturally given I have an adolescent myself and they can't do much I haven't seen."
(Participant 6).

Findings indicated experiences that are unfamiliar are more likely to elicit a negative emotional response. The fear of the unknown was reflected by a participant noted to have the least experience in mental health "...it's the unknown for me and so of course it'll be quite scary." (Participant, 5).

Four participants recognised not all RNs shared their enjoyment of this age group and acknowledged that staff openly made their feelings known. All six participants implied there was an unspoken team awareness about the fact preferences differed between staff. "We do have some nurses here that actually like, you know, young ones because everyone has their own special group, age group that they actually like dealing with" (Participant 4). In practical

terms this meant there was a small group of staff informally recognised as those who liked to work with adolescents so, wherever possible, were allocated to working with them or would willingly volunteer.

RNs drew on their own personal experience to provide a framework for practice. The emotional response of three participants was affected by their experience of being a mother. They had an automatic reaction of what it must be like to go through such an experience, to walk in the shoes of the adolescents' families. The emotion elicited was empathy. Although these three participants empathised with the parents, they each personalised it. "My first thoughts would probably be, being a mother now, would be oh my goodness, poor parents..." (Participant 2).

There was a tangible connection between empathy and sadness:

"You don't want to see a young one here, it's sad to um think that you've got this young woman with all these issues going on that actually need to be here, and that's part of some of our reaction too, I think as well." (Participant 4).

4.4.2 Personal beliefs

Personal beliefs are assumed truths that are individually held. Beliefs require information and are a product of the mental process of gaining, assessing and judging data acquired through direct observation, or by acceptance of information or adoption of beliefs from sources considered trustworthy and knowledgeable (Immigration Advisors Authority, 2012). Hence beliefs result from inferences drawn on what is known, or others share from their experience. The personal beliefs reported related to opinions regarding adolescent admissions, confidence levels, and provision of care. It was difficult to separate participant beliefs and perceptions from experiences, suggesting they were correlated and that the beliefs held influenced how events were perceived, thereby affecting experiences and subsequent responses. Conversely it could be argued the experiences shaped beliefs and attitudes. The beliefs expressed were based on wanting the best possible outcome for the adolescent and that the unit was not adequately resourced to provide the best care.

Participants all held their own views about adolescents being nursed on an adult unit and, regardless of whether or not they liked adolescents, believed the unit was not the best place for them to be nursed. The belief that there were limited options to adolescents requiring admission was shared by all six participants, "I think it's a bit unfair that they have to come here, but...there's nowhere else...it's unfair on the adolescent and their family..." (Participant

2). Only two participants held the personal belief adolescents should not be admitted to adult in-patient units, although one seemed more accepting “In an ideal world I’d like to see no adolescent come through the adult inpatient unit. It is what it is and it has to be that way and I can see that...” (Participant 6). This nurse made the link between length of experience and perception of difficulty “How’s it been? Better as the time has gone on, and easier as the time has gone on” (Participant 6). This point demonstrated not everyone’s beliefs remain fixed, showing some beliefs are fluid, and change over time.

Despite feeling the unit was not the best place for adolescents four of the participants felt supported “I feel safe working within the team, and having the plan, and I feel supported...” (Participant 5). This finding related to support amongst the team working on the unit, however, it did not extend to perceptions of support by other service providers such as CAMHS, as evidenced in concerns raised.

Anecdotally, it was thought that those with less experience in the area of adolescent mental health may experience increased anxiety, lower confidence and therefore a reluctance to work with this population. However, this was found not to be true of those participating in the study as reluctance was found instead to be correlated with whether or not RNs liked this age group and beliefs about whether they thought they should be in an adult service. Surprisingly confidence levels did not vary much despite the difference in years of experience. Reasons given for the identified level of confidence included being interested in child and adolescent mental health; experience of dealing with this population; length of time working in mental health; and feeling supported within the team. Although on face value confidence was not strongly associated with experience it is more accurate to say confidence was not influenced by length of experience. It did not follow that participants with the most years experience had more direct experience of nursing adolescents. It was found those liking adolescents worked more with them, some of whom had the fewest years experience. How participants measured experience and the differences in beliefs regarding what constitutes a lot of experience was not determined.

Though feeling confident at least one participant believed she had limited knowledge “I don’t know all the different mental illnesses for children...I probably don’t have a thorough understanding of their mental health needs...” (Participant 3). Rather than shying away from working with this clientele she believed more exposure would help increase her understanding, she proactively sought opportunities to work with them where she could. This was shaped by the fact she also enjoyed working with them. The opposite was found to be true by those who

were not as keen working with them, some of whom identified finding it difficult working with those unfamiliar to them. “I think oh my God to be quite honest. Only because I’m not used to working with adolescents...I think more hard work...dealing with adolescents’ families I find can be difficult for me...I don’t know what to expect really” (Participant 4). Rather than seeking to resolve this, due to the belief it was hard work, this participant preferred not to nurse them where possible.

One of the participants that identified enjoying working with adolescents held the belief that the experience the adolescent had during their admission could impact on their future decisions regarding accessing mental health services. Recognising positive experiences were more likely linked to seeking early intervention and negative experiences more likely to result in avoidance of services until crisis admission was necessary. She also believed that it shows if you like them when you’re working with them, and gave this as a reason she puts up her hand to work with this age group in the hope it would be a more positive experience for all concerned.

“I think the experience they have with us also impacts on how they see the whole mental health services, ...if they have a crappy experience with us...see us a bit, like someone they don’t want to go near again, so...it might get to that stage again where they need an admission...and kind of avoid it until unfortunately it gets to that crisis point once again”. (Participant 1).

In addition to acknowledging that not everyone likes working with adolescents another belief emerged relating to differences in the RNs’ understanding and tolerance of adolescents. Three of the RNs recognised the need to understand the difference between normal and abnormal adolescent behaviour so as not to pathologise normal developmental behaviour because they occur in tandem with emotional disturbance. Furthermore they believed a lack of understanding could lead to escalation of behaviour, and result in interventions that may be unnecessary if the adolescent’s developmental stage had been recognised, and a different approach had been taken.

“...there’s a little difference of opinion sometimes with how best to work with them... you start to think they should understand...sometimes I think it’s just low tolerance, for normal child behaviour...like pushing boundaries...challenging staff, that kind of stuff, when really there are probably other ways of managing the situation...” (Participant 3).

This example demonstrated a deeper understanding of adolescent behaviour, acknowledging the nurse and adolescent relationship may be challenging, that the adolescent often questions perceived authority as a way of seeking autonomy, and the RN is likely to be coming from a different perspective.

4.4.3 Memorable experiences

Participants responded to strong situational or environmental forces and, after engaging with adolescents, formed attitudes about the experience. Easily remembered or unforgettable incidents or feelings associated with nursing adolescents were categorised as memorable experiences. There was evidence in this study that some RNs used reflective practice to good effect, enabling them to put events into context and to learn from their experiences. Those that did were found to possess positive attitudes.

Two participants recalled positive experiences, one of whom did not refer to specific incidents, simply stating “I think they’ve been quite good overall you know short-term ... it’s been a good experience. I haven’t really had anything terrible.” (Participant 5). She did however acknowledge it can vary depending on the presentation “It can be challenging sometimes when they’re not accepting of anything positive about themselves.” (Participant 5). The other positive experience reported by participant one had two different aspects; one relating to her own positive experiences and enjoyment from the role she plays; and the other relating to the positive outcome for the client.

Findings predominantly indicated experiences remain memorable when they are negative in nature. One such experience arose as a result of not being involved in the care-planning multi-disciplinary team (MDT) process. It was memorable because it did not fit with the belief she held about what should happen, which she outlined:

“when it comes to MDTs that we actually need to be involved, that we’re not just the gatekeepers, that we should be fully informed from when they come in to when they go...that was really horrible that experience...It caused a bit of conflict.”
(Participant 4).

It was made memorable because of the strength of feeling and conflict experienced which led to successfully resolving the matter by raising awareness of the issue, discussing it and reaching agreement regarding protocol for future MDT meetings. This example indicated that staff feeling disempowered or empowered is likely to be memorable.

Four participants specified incidents involving restraint, seclusion or negative behaviours exhibited by adolescents, consistent with it not being a pleasant or enjoyable experience, thus making it memorable. One participant recalled her first experience of nursing an adolescent, made memorable by the lack of sense she made of it. She also described an unusual experience involving a seventeen year old boy who was from out of area, problems arose because of this. There was a sense of frustration at the length of his admission, and perception of him being abandoned by the district he came from. She held the belief that he was “dumped” in the area by Child Youth and Family Services (CYFS) who had arranged for him to stay with relatives he had not had contact with for years. CYFS then pulled out of his care due to his age.

“He ended up here for a month...he was often secluded because he was very changeable, and unpredictable...I didn’t like that...it was quite heart-breaking to see someone go through that really.” (Participant 3).

Another incident involving restraint proved memorable to participant six.

“... the person was actually friends with my daughter, so I walked in and got a massive, massive shock...the fact the person was needing restraint...I was uncomfortable, but I also was very aware of the embarrassment that could cause for him...but, it did make me so much more aware of exactly what’s going on and made me question why...that’s happening...” (Participant 6).

Whilst it was unpleasant it was also a learning experience, resulting in reflection about the event, the reasons for it, actions taken and effects on the client. The main reason it was memorable however, was the personal connection with her family.

4.5 Theme 2: Practice Implications

The second theme to emerge from the data related to the nursing responsibilities and consequences arising from adolescent admissions to the unit. All participants acknowledged that having adolescent clients in the unit affected all aspects of their work, particularly in regards to their role and the environment in which they nursed them. These experiences in turn fed into the participants’ attitudes and beliefs, and were found to result in the formation of concerns. Most of the concerns identified correlated with the environment and perceived inability to provide appropriate care suited to the needs of adolescents. Based on their concerns, participants made several suggestions for change. The theme was termed practice implications and is comprised of three categories: role; environment; concerns and changes. Findings indicated adolescents

require access to appropriate care in an environment supportive to their age and developmental needs.

Table 2: *Theme 2*

Theme	Category	Example
<p>2- Practice Implications: Nursing related responsibilities / consequences.</p>	<p>Cat.A Role: The functions assumed by the RNs when nursing adolescents.</p>	<p>"...getting alongside them, advocating for them...maybe stop further admissions with us...give them coping strategies..." (Participant 1).</p>
		<p>"...try to engage with the family as much as you can when they're here." (Participant 4).</p>
	<p>Cat.B Environment: The surroundings and conditions in which RNs nurse adolescents.</p>	<p>"...we've got separate areas now too that you can nurse people in...it's an area where they can be away from everyone as well...like an apartment..." (Participant 3).</p>
		<p>"...a staff member is with an adolescent client at all times..." (Participant 2).</p>
	<p>Cat.C Concerns and changes: Things the RNs identified as troubling or worrying relating to nursing adolescents. Also specific things they would like to be made different.</p>	<p>"My main concerns would be the isolation and that we're not really equipped." (Participant 1).</p>
		<p>"...having something that we can use to entertain which is also going to increase the rapport..." (Participant 6).</p>

4.5.1 Role

Participants all held personal beliefs about their role as a RN. They outlined the duties of the job they assumed in their role as RN responsible for the care and treatment of adolescents. These functions were influenced by their perceptions of what was required and appropriate relative to their situation, nursing adolescents in an adult unit. The findings regarding the RNs' perceptions of their role nursing adolescents, to some extent, reflected their attitudes towards them. Some descriptions were considered very clinical and matter of fact "My role is just their nurse for that shift." (Participant 2). One participant referred to the organisational systems in place and their responsibility to be aware of and to work within them

“...read policies and procedures and things like that for the unit...if a young person comes into this unit they are on constants, so a staff member would need to know what constants is and what it entails...what areas adolescents can be in...or where they shouldn't be.” (Participant 5).

Participant five summarised further that she considered their role as the adolescent's RN as being an “Advocate, listener, educator, you know anything that needs to be talked over, discussed, understood...” She then elaborated what the role meant to her and her perceptions of what it required

“Honesty, and open-communication...I think giving information...making sure they understand the information and what it entails...Honesty I think is what young people appreciate, even if they may not like the answer, and they definitely don't want to be tricked into anything...just information, and listening, reassurance, yeah.” (Participant 5).

Four participants recognised the importance of maintaining boundaries particularly in relation to the emotional affect adolescents can evoke in individuals. Though not specified it was interpreted to refer to the potential for countertransference: “...really watch your boundaries... it could be quite easy to overstep the boundaries...get caught up in their life...have an effect on you emotionally and or as a person, as a professional...” (Participant 2).

Whilst many placed emphasis on the caring aspect of their role all participants considered maintaining safety an important part of their role and it featured in each interview. All emphasised that in order to create a safe environment adolescents had to be nursed separately from the adult clients. They each recognised that the creation of a stable, safe and secure milieu serves to contain out of control feelings and behaviours, fosters trust and enables the beginnings of work towards recovery. Participants acknowledged having an appreciation of the position the adolescent finds themselves in allows them to feel understood, affirmed and experience acceptance, which in time allows them to come to terms with themselves, to be themselves, to relax and feel safe on the unit. These factors also aid the development of a therapeutic relationship.

Four participants acknowledged their role as facilitating change, increasing self-awareness, and assisting development of appropriate strategies to meet their individual needs in order to promote the adolescent's own role in their recovery and well-being “...giving them some insight on how their behaviour affects other people...maybe they might realise that something needs

to change...” (Participant 3). The participants indicated they adopted a strengths-based or brief solution-focused approach, recognising it shifts the focus to a positive and encouraging one, leading to better outcomes. “...trying to do the groundwork for coping strategies, for how are you going to manage this...” (Participant 6).

All participants identified the need to develop a rapport, to build a therapeutic relationship in order to work in partnership with adolescents and their families “Trying to get a rapport so you can do some finding out of what’s going on for the person, and how they’re feeling.” (Participant 6). Perceptions of the skills and qualities in the development of a therapeutic relationship included showing a genuine interest, being open, honest, friendly, tactful, encouraging them by making them feel listened to, talking to them, getting alongside them, and gaining their trust. Essentially, by relating to the adolescent as a person the RN enabled them to feel understood, conveying understanding instils clients with a sense of importance (Shattell, McAllister, Hogan & Thomas, 2006). More than one participant recognised this process entails putting the adolescent at ease “Someone that they can relate to...you want to make them feel safe and comfortable...you don’t want them stressed...they come in quite scared.” (Participant 4). Another emphasised the need to go at their pace, not rushing, or pressuring them and warned against focusing on problems too soon, showing an understanding that forming a therapeutic relationship requires being available and accessible in order to enable the client to open up and disclose their story, and for the nurse to understand the meaning behind the story. All participants acknowledged it takes time to do this and placed importance on making time to spend with the adolescents.

Other ways of rapport building were identified: “I don’t use big words, I talk to them...using words that they understand...get a bit of a smile out of them maybe...be a bit more light-hearted, or just sort of relate to them a bit better.” (Participant 4). The importance of language, the need for sensitivity and diplomacy was supported by participant one along with other important basics of forming a relationship

“...how you talk to them, the words you use. Your conversation topics...it’s really important with young people if you say you’re going to do something that you do it... Your tone, so they don’t feel like you’re talking down at them. Getting alongside them, so sitting, you know where you place yourself while you’re engaging with them...I think it’s important that they see that we’re trying to do what we can to make it good for them...I think it’s just picking your moments. Judging their mood.”
(Participant 1).

All participants recognised and acknowledged the importance and need for adolescents to have appropriate support which can take many forms. They mentioned sometimes conflict can arise, particularly if the support person is not family and family disapprove of their involvement, or may perceive they are part of the problem rather than part of the solution. Participants identified family dynamics may be an issue, and were aware that negative early experiences of relationships can lead to potential transference arising through associated feelings of mistrust, fear, and unpredictability, making it likely that trust and boundaries will be tested. One participant highlighted the need to find out about family relationships "...important to know kind of how that family works...[as] some of them have really volatile family relationships..." (Participant 1). However, overall family was identified as the main source of support, "Family's a great thing, and it's not until you're in a situation you realise how great...it's hard to say what it is, but if mum's there it makes a big difference. It does help." (Participant 5).

All participants saw working in partnership with families and caregivers or those responsible for the adolescent as an important part of their role; identifying the need to find out what they wanted and involving them in all aspects of care and treatment during admission, "Talk to the family more around that and what they would like." (Participant 4). Specific to cultural support all participants referred to informing families of the cultural services available, and asking how they could meet their cultural needs. This incorporated acting in consultation and taking on a collaborative role "By accessing the cultural advisors and having their input...By asking them how I can meet their cultural needs really. Trying to be appropriate and respectful." (Participant 3). Another participant identified the environment was an important aspect of meeting their cultural needs "I would make sure that there's, the area there for, like day services for the family to meet their cultural needs. We've also got lots of different areas about the unit that you can actually use." (Participant 4).

4.5.2 Environment

There were strict guidelines regarding the surroundings, conditions and environment in which the participants nursed adolescents, which impacted upon and influenced nursing practice, attitudes and behaviour. There were many practice implications associated with the environment which featured heavily in all interviews, most of which were negative in nature. Findings indicated consensus amongst participants that the environment was only suited to meet the needs of adolescents on a short-term basis (2-3 days).

All participants acknowledged the restrictive nature of the environment in which they nurse

adolescents; most rationalised the necessity for this in their identification of risks categorised separately as concerns. Descriptions given of the environment were similar in nature, "...they have this small space that they're allowed to be in, so it's very restricting" (Participant 6). Another said "...need to keep them away from adults on the unit or keep them in their own place. That they don't have leave out to the communal areas." (Participant 4). Explanation for the restrictions was offered by one participant, "...the policy for our DHB is that they must be kept separate [within the unit] for their safety...and their privacy, so we're not exposing them to anything that the adults might be doing...where they might learn behaviour as well." (Participant 1). Restrictions applied even when adolescents were visited by friends, the nurse was required to be present unless a responsible adult accompanied them. One participant recognised the effect curtailment of freedom had on some adolescents, acknowledging it is not without consequence.

"I think it's just about being in an area and not having that freedom to go and see your friends, or go to the shops, or get a video...so it's containment...and a bit of cabin fever sets in pretty quickly." (Participant 5).

The age of the adolescent factored into decisions relating to the environment in which they were nursed; some made it clear there was a policy of separation for under 18s, whereas if they were over 18 they were classified as an adult admission. "...if they're not on constants then they're classed as more of an adult...and they're voluntary...then they've basically got free reign of all of the areas really." (Participant 4). However, participants acknowledged that at age 18 they still considered them young and vulnerable and would keep a close eye on them. One expressed how in her view "I think...they need protecting a bit more because they're vulnerable being a young person, and being in an adult unit...keeping them safe and reassured until they were taken to the right place, to the right unit." (Participant 5).

Four participants referred to differences in where adolescents used to be nursed before the in-patient renovations in 2012. All participants referred to the renovations as a rebuild, therefore this terminology is used hereafter and whilst not ideal, the rebuild was considered by all to be a vast improvement.

"Before the rebuild, if the child was under the age of 18 they had to stay in their bedroom and could only come out if they were going to the bathroom...they spent the whole time in their bedrooms, with the nurse 24/7 and that was really horrible, because their rooms were just a bed and a chair." (Participant, 3).

The same participant went on to identify since the rebuild they have more options of where to nurse the adolescent within the unit. "...we've got separate areas now too that you can nurse people in so they don't have to be with the rest...without it being like a jail...It's an area where they can be away ...It is self-contained flat." (Participant 3). There was general agreement that the self-contained unit was the preferred option, however some acknowledged availability could sometimes be an issue, and were critical of their next option: "...it's always been in use the last two times...so you go to the constant room, which is one right outside the nurses station, so it's loud and it's also attached to the seclusion area...so that troubles me." (Participant 6). She went on to outline her concern;

"my concern for that area that we nurse them in, I think it's really clinical...White walls, no pictures, just you and a chair with the adolescent on the bed and really not a lot to do, which is good if they want to engage, there are some positives to that...but for the ones that absolutely don't trust you...then it's no good at all as you're just sat staring really at each other...If it's awkward for me then how awkward is it for them?"
(Participant 6).

Participants acknowledged the environment in which they are able to nurse adolescents impacts on the opportunities for them to engage in activities. Activities included watching TV, drawing, reading, listening to music or playing games on their cell phones. Options and ways of keeping them occupied meant using what little resources the unit had; this was reliant to some extent on the RNs using their initiative to create opportunities for adolescents to use the facilities available on the unit which include a gym, day services and a sensory room. An important distinction for adolescents though, is to access the unit's facilities they have to not be in use by adult clients. They would be the only person there, along with the nurse (as an observer rather than a participator) unless they were over 18 and not on constant observations, which makes for a solitary experience throughout the admission. Findings also indicated there is an expectation that adolescents will use their cell phones to entertain themselves. It seems there are few shared activities RNs engage in with adolescents. Whilst participants acknowledged therapeutic relationships with adolescents are founded on being together and talking it appears opportunities for strengthening it further through shared activities are being missed, overlooked, or not resourced.

4.5.3 Concerns and changes

Implicit in the participants' role as a RN were the nursing responsibilities they carried. All participants were affected by having adolescents in the unit and identified things relating

to adolescent admissions that troubled or worried them. These matters were categorised as concerns. Participants were asked what changes if any they'd like to make, and as responses corresponded closely with concerns raised, the category was extended to incorporate concerns and changes.

All participants were concerned about staffing the unit during an adolescent's admission as extra staff would be required to provide 1:1 care in accordance with the unit's policy "... we always seem to be running on minimum staff and it makes it really hard." (Participant 3). Another expressed concern about the organisational practicalities, "how we are going to juggle the staff and the adult patients..." (Participant 1). Many were concerned with the potential risks to the adolescent from the adult clients "There could be exploitation of some type, they could be violent, could be given drugs..." (Participant 5). All considered the adult unit an inappropriate environment for adolescents and were concerned about the lack of alternative options when adolescents required admission. One participant expressed concern that admission to the adult unit just delayed the treatment required and prolonged the stay away from home. She was frustrated that the function of the unit was purely that of a safe holding area for adolescents until they could be transferred which she perceived was at odds with the purpose of admission. Only one participant voiced concern over staff managing their own anxieties, "I think the biggest impact is on the adolescent, but it's more so on the staff and managing our own anxieties around and not putting that forward onto the adolescent." (Participant 6).

Three acknowledged a range of limitations of the unit in terms of what they could provide: The lack of therapy was mentioned by three, "We don't...offer them therapy." (Participant 2). The lack of structure was of concern to one, "...being isolated with nothing...isolated with their own thoughts, away from everything, is not ideal..." (Participant 1). Participant one also acknowledged that concerns have arisen over the use of Facebook which has led to the current revision of the policy regarding cell phones on the unit, with consideration to banning them (an outcome has yet to be determined). Several participants acknowledged banning cell phones would leave a huge gap and could lead to further concerns on how to keep them occupied.

Some of the concerns already mentioned linked very much to belief that there are better services to meet adolescents' mental health needs. All participants acknowledged adolescents are admitted to the adult in-patient unit due to issues arising when arranging admission to

the nearest CAMHS in-patient unit. All voiced concern along with frustration and confusion at not being able to access beds over the course of a weekend "...the...unit is set up for youth...sometimes there are beds on a weekend...there's nothing to stop...our staff members transporting a young person..." (Participant 1). In addition to a lack of understanding for the rationale behind Monday to Friday only admissions there was also a lack of understanding about the adolescent unit and information relating to it. One participant made the point quite clearly:

"To know...just what happens down there, cos we get a lot of questions from the kids...What activities and what are you going to do through the day, and even how many beds there are...things like that...It's like you're sending them off to another planet. Yeah lots of times you have to say you'll have to find out when you get there, I'm not sure." (Participant 5).

Recognising it as an issue participant five suggested one possible way of addressing it could be for the in-patient staff to help CAMHS with the transfer of adolescents.

Findings indicated the other major concern the RNs had related to their working relationship with CAMHS and information provided. Half of the participants felt unsupported and five of the six participants wanted more CAMHS involvement and guidance on what to do with adolescents. Some of the concerns stemmed from not knowing the adolescent and anxieties associated with this, "when they first come...we might not know them at all...So sometimes it's like we're nursing blindly." (Participant 4). Another shared the view "...we just know what we see on the day and that's about it really..." (Participant 3). One clearly stipulated wanting a plan "Just some clarification, some plan, time frame, especially when you're trying to co-ordinate a ward when you've got people coming in needing a bed. A plan would be good really." (Participant 2). Though not specified, what she was referring to was a discharge plan, to know when they would be gone.

Four believed that keyworkers know the adolescent better and wanted information to be imparted to the RNs, "coming to actually see them and put notes up about what they can see and any improvements that they might have seen. Just coming over once a day...to actually feel that we're supported too." (Participant 4). The same participant acknowledged entry into and exit from the services should be seamless and proposed that "It should be continuous from there to here and back out again...maybe help with a care-plan...about what would meet their needs more on the unit.. us working together as a team..." Explaining her reason for same,

placing the adolescent at the centre of care provision, “It’d be really good for adolescents that come in, because they know the person they can relate to more is here and then working together can be a lot more powerful as well for them and the family.” (Participant 4).

Having more CAMHS involvement was also viewed by participants as an opportunity to gain more education. All but one identified they would make changes to the training available to them to include inservice training or workshops relevant to working with adolescents with mental illness. All acknowledged a paucity in child and adolescent training available to them, referring to making do with on the job learning. Comments included “...I have just been learning...as I go and seeking guidance from others.” (Participant 1). Participants wanted to increase their knowledge and understanding, “I would like us to be getting inservices. Different situations of how we can do this, what we can do better, or what we should be doing...and best ways of working with adolescents...Scenarios would be good.” (Participant 3).

It was also suggested some form of training may alleviate staff’s anxieties working with this clientele, “...more inservice type education...being able to have some sort of either clinical discussion or education around nursing adolescents may help to reduce some people’s anxiety around it.” (Participant 6). Participant three expanded the need for on-going education and professional development more generally “...every week there should be a workshop on something...anything to do with mental health...but if there was some on adolescents that would be really good.”

In addition all participants wanted changes to be made to the unit on which they worked; they wanted a bigger area, resourced with age appropriate activities, and for the environment to look less clinical.

4.6 Theme 3: Developmental Knowledge

RNs’ knowledge of adolescents fell into three developmental categories: physical; cognitive; and social and / or emotional. There was a blurring of the categories, notably cognitive and social and / or emotional, and understanding was of a basic level. Findings indicated that nurses working across settings need to be well-prepared to understand and work therapeutically with adolescents who have a mental illness. Staff need to have a grasp of key concepts related to how children and adolescents think about the world (cognition), attempt to control behaviour (self-regulate), and deal with their feelings (affect regulation) if they are to reach a common

psychological understanding of their behaviour and be able to respond appropriately to meet their needs.

Table 3: *Theme 3*

Theme	Category	Example
<p>3- Developmental knowledge of adolescents: What RNs knew about the predictable sequence of age related biological (changes in physical being), cognitive, social and emotional changes that occur in adolescence.</p>	<p>Cat.A Physical: Changes RNs identified that occur in the body during adolescence.</p>	<p>"...they're becoming adults, they're going through their periods or whatever, they're growing...their bodies are changing." (Participant 3). "...increased hormone levels..." (Participant 5).</p>
	<p>Cat.B Cognitive: RNs' perceptions of adolescents' thought processes.</p>	<p>"...it's a self-centred place to be at that time of your life, where you are the one and the only, and everything's about you and revolving around you..." (Participant 5). "...trying to have some control over what's happening for them." (Participant 1).</p>
	<p>Cat.C Social / Emotional: RNs' awareness of changes in adolescents' social relationships, the way they view themselves, and in their capacity to function independently.</p>	<p>"...there's all the pressure of school, and life and relationships, and friends and family and all that kind of stuff." (Participant 3). "...with adolescents your social life is your whole being really..." (Participant 2).</p>

4.6.1 Physical

Physical development in adolescence incorporates the obvious physical changes of the body, as well as the less obvious physiological and neurological changes that influence other areas of development. Findings indicated that all participants had a basic level of understanding, evidenced by the minimal findings obtained in this category. Physical changes were mentioned but not expanded upon.

All participants named the fundamental physical changes happening during adolescence: "they're becoming adults...they're growing...their bodies are changing..." (Participant 3) and they "...may be participating in sexual relationships..." (Participant 5). In part, physical changes were seen as pivotal given "They haven't fully developed their brains." (Participant 3).

One participant made the point that you cannot accurately tell a person's age by their physical appearance, acknowledging there are individual differences in physical development. "Unless you're told their age, do you really know...There are some 12 year olds that look like 18 year olds." (Participant 2). Another referred to the changes noted in sleeping habits, "They stay up all night and sleep all day." (Participant 4).

4.6.2 Cognitive

Cognitive development is the construction of thought processes including problem-solving, remembering and decision-making. These thought processes influence how adolescents understand and interact with the world. All RNs in the study were aware of how the adolescent's developing brain affects their thinking, "They think they know everything." (Participant 3). Others elaborated further "They're still learning, they haven't learnt about consequences and that yet...I don't think they think twice before they do something, they just react, they're more impulsive." (Participant 4).

Many of the participants acknowledged adolescents begin to start making more decisions and want to be involved about things that affect their lives, that they begin to think hypothetically, extend their thinking to think about the possibilities rather than limiting their thoughts to what is real. Participants identified that adolescents demonstrate an increased interest in thinking about social relationships, and begin to display the ability to think logically and to reason. "And they're making all the decisions about what they're going to do after school...whether they do study, whether they travel or anything." (Participant 3).

Three participants made the observation that adolescents tend to question everything, no-one verbalised an understanding that adolescents begin to see things as relative opposed to accepting facts as absolute as children do, it was however inferred. "They are more immature, they can play up sometimes, they'll push boundaries, challenge staff. Sometimes they can be selective...if it was an adult you kind of expect them to accept it, whereas the adolescent, you're having to keep on saying." (Participant 3).

All participants identified an increase in rebellion and risk-taking behaviour.

"They go through that risk-taking behavioural stage, where they go out and take drugs and drink...they seem to get into those you know quite risk-taking relationships around sex and stuff...They tend to rebel a lot as well...not listening...just want to go out and have fun." (Participant 4).

Most participants recognised adolescence is a period of introspection and self-consciousness,

describing adolescents as ego-centric. “...they only think about themselves, they’re very self-centred in a way.” (Participant 4).

4.6.3 Social / Emotional

The social / emotional development of adolescents includes the ability to form and sustain relationships; experience, manage and express emotions; explore and engage with the environment. It provides the foundation for how adolescents feel about themselves, how they experience others, and how they interact with others.

All participants referred to the significant role cell phones and other forms of social media play in an adolescent’s life, particularly in relation to the role technology is now playing in socialisation. “...it’s how adolescents socialise and interact and maintain friendships. ” (Participant 6). All of the participants acknowledged the social and emotional pressures of adolescence and recognised it is not always easy for a variety of reasons, including the search for self-identity and the search for a group to identify with, belong to and be accepted within. “It’s a very difficult stage...Just that testing stage where they don’t really know where they fit into society and it’s hard...lots of pressures, school pressures...peer groups...” (Participant 2). Participants described it as a time when they seek to “... find out who they are...” (Participant 1), which involves “fitting in and identities...Finding your, learning your ability to cope really with the outside world.” (Participant 6).

Only one participant made reference to the intensification of feelings experienced during adolescence. “It’s the experiencing sort of distress...that can be, I think intensified, and also self-blame. Some low self-esteem all the rest of it, that’s all intensified...” (Participant 6). Another participant’s social / emotional expectation of adolescents was based on her experiences of adolescents during admission: “...no respect...venting their feelings and frustrations...yelling and abusing staff...” The interpretation she made of this was “it depends if they’re unwell or just being behavioural. Some people are just behavioural. They’re fed up with the rules really...” (Participant 3). Participant five offered a different perspective for adolescents’ emotional responses to being on the unit, “They probably want to get out, they probably want the key, to have a swipe card and go. They want their freedom. They want to be let out.” With regards to the expectations RNs had about adolescent behaviour many agreed they can be manipulative to get what they want, one such description was given by participant two “The one I’ve got in mind would spend all day in her pyjamas, in bed, texting, using a little whining voice when wanting something, expecting everything to be given and brought to her...that’s a typical adolescent.” (Participant 2).

Although the majority of the participants referred to the adolescents' drive for autonomy, part of which was to retaliate against authority and limits set for them, one participant acknowledged the importance of boundaries to help contain them emotionally. "...kids push against boundaries but I think they actually quite like boundaries as well, it makes them feel a lot safer. Because then they know where they're at as well." (Participant 4).

4.7 Chapter Summary

The three themes and nine categories were presented in this chapter. The relationships and influences of the categories differed across the themes, and were depicted in figure 4. Theme one described how participants' emotional responses, beliefs and memorable experiences were found to influence and shape RNs attitudes and experiences of adolescents. Attitudes were either positive, negative or neutral. Theme two related to the practice implications of having adolescents on an adult in-patient unit. Adolescent admissions were found to affect all aspects of RNs' work, particularly in relation to their role and the environment they worked in. Concerns stemmed from participants perceptions that they were ill-equipped to provide appropriate care. Participants considered the environment of an adult in-patient unit was not supportive to the adolescents' age and developmental needs. Theme three reflected the developmental knowledge of adolescents held by the participants which was found to be of a basic level. RNs need to be well-prepared to understand and work therapeutically with adolescents who have a mental illness. Without an adequate understanding of when certain skills develop and in what order they are acquired the expectations RNs have of adolescents may be unrealistic and may not be met, leading to frustration and development or reinforcement of negative attitudes about adolescents. Limited knowledge was also linked to a misinterpretation of the symptoms, behaviours, or responses reportedly shown by the adolescents, which in turn affected the RNs' approach to them. Staff need to have a grasp of key concepts related to how children and adolescents think about the world (cognition), attempt to control behaviour (self-regulate), and deal with their feelings (affect regulation) if they are to reach a common psychological understanding of their behaviour and be able to respond appropriately to meet their needs.

Links between the key findings and the literature reviewed as it relates to the research questions will be presented in the discussion chapter that follows.

CHAPTER 5: DISCUSSION

5.0 Introduction

The key findings are discussed in this chapter in relation to the research aims and objectives: Reasons for adolescent admissions to adult MH in-patient units; Training and knowledge relating to nursing mentally ill adolescents; Attitudes and experiences of nursing adolescents in an adult MH in-patient unit; Concerns relating to nursing adolescents in an adult MH in-patient unit. In considering each of these questions, the findings will be explored in terms of the literature reviewed. Limitations of the research are identified at the end of the chapter.

5.1 Reasons for Adolescent Admission to Adult MH In-patient Units

The key findings, to a large extent, were in-keeping with the literature reviewed, with a few minor differences. Participants in this study gave three primary reasons for admission forming three categories: presenting MH condition or diagnosis; safety; and service reasons. Surprisingly not one participant in this study referred to the primary reason for admission that of crisis intervention and assessment (Park et al., 2011), even though most considered assessment part of their nursing role it seems they did not consider it a reason for admission. According to Harper and Cotton (1991), short-term hospitalisation has four specific aims: time out for parents or guardians or child; accurate diagnosis and connection to needed services; crisis intervention for a problem requiring stabilisation; and altering the family system to permit growth. Similarly Simpson (2009) stated “The primary aim of hospital admission is to assess the person’s condition while also providing the human support, care environment and treatment necessary to re-establish emotional stability.” (p.403).

Accounts given in this study of MH presentations or diagnosis covered those known to be prevalent in adolescence. It was the experience of five of the six participants that self-harm had been the reason for adolescent admissions to their unit, making it the most common reason given in this study. The next most frequently cited reason was suicidality, followed by SUD. Though four participants identified suicidality as the reason for admission, interestingly only two participants cited safety as a reason for admission. Perhaps they assumed the association would be made between the two, given maintaining safety was identified by all participants as one of their primary roles when nursing adolescents. Rosina (2013) acknowledged risk assessment and management is a main concern of nursing management. Although it is commonly accepted there is a clear link between MH problems or disorders and suicide acts, “...the suicidal process

is not, synonymous with mental disorder phenomenology.” (Tanney, 2000, p341). Despite this, it is considered surprising that the connection between suicidality and depression was not voiced, given that depression has been consistently related to suicidal ideation and suicide attempts in adolescence (Kessler & Walter, 1998). Nor was it mentioned that self-harm is most often associated with depression and anxiety disorders, and to a lesser extent eating disorders, and substance abuse (Loveridge, 2013). Indeed the only acknowledgment of presence of co-existing problems featured the problematic use of substances, specifically synthetic cannabis use and psychosis; and drug and alcohol use and schizophrenia. No other co-morbid conditions were identified.

On face value the findings indicated a limited understanding of mental illness in adolescence; alternatively it could be argued participants focused purely on primary reasons rather than reporting the various combinations of co-morbidity the adolescents they had cared for presented with. However the information given by participants did show limitations in knowledge, particularly in regards to the sometimes subtle yet distinct differences in clinical symptoms that distinguish certain disorders in adolescence from those seen in adults. Without such knowledge they cannot be expected to make accurate or meaningful assessments based on their observations. Reasons given for admission could not be confirmed without auditing files, and may actually not be the diagnosis recorded by the Responsible Clinician (usually the treating psychiatrist). The possibility of error may account for differences reported in the literature. Literature suggests young people admitted to adult MH wards are most frequently diagnosed with mood and psychotic disorders: A study conducted in NZ (Park, McDermott, Loy & Dean, 2011) reported 38.2% and 25.7% respectively; this is comparable with a study conducted in the UK indicating over half of the young people admitted to adult MH wards experienced mood disorders, psychosis or eating disorders (O’Herlihy et al., 2001). It is also possible the lower reports of psychosis in this study could be explained by the small number of participants who represent a small proportion of staff working on the unit.

Service reasons for admission consisted of no bed being available on the regional adolescent unit, or admissions occurring out of hours or on weekends. This finding is consistent with those of Park et al., (2011) who found two thirds of admissions occurred out of hours following psychiatrist or registrar assessment. They also found a correlation between gender and length of stay, and the reason for admission: boys were found to stay twice as long as girls; reasons for admission were associated with aggression or deterioration in mental status rather than self-harm or suicidality. Whilst the current study did not ascertain gender differences it did find

some admissions became placement issues when families or caregivers decided they could no longer be responsible for the adolescent. This is somewhat congruent with Park et al. (2011) who inferred that some of the admissions associated with aggression could be classified as social admissions when there was nowhere else to place them, as such admissions often result in extended stays due to difficulty finding accommodation following discharge. Similar findings were reported in the two brief sub-studies carried out as part of the national in-patient child and adolescent study (NICAPS). It examined the numbers of young people under the age of 18 admitted with a primary MH problem to adult psychiatric wards, and to paediatric wards in nine Health Authorities over a six month period. Though the numbers of admissions were higher to adult wards (43 as opposed to 11 on paediatric wards), the percentage of admissions deemed “inappropriate” were similar: 60% compared with 56% of paediatric admissions. The two main reasons for not transferring or admitting these patients to a more appropriate setting were the same for adult psychiatric and paediatric wards: the non-availability of an appropriate setting, the appropriate facility was either full or would not accept the patients. Principal or probable diagnosis in the NICAPS included those prevalent in children and adolescents: SUD; schizophrenia or psychotic disorder; mood or affective disorder; acute stress reaction or adjustment disorder; eating disorder; and PDD (O’Herlihy et al., 2001). Overall the reasons given for admissions in this study were congruent with reports in the literature.

5.2 Training and Knowledge Relevant to Nursing Mentally Ill Adolescents

The level to which the participants were trained is believed to be typical of RNs working in adult mental health services across NZ. All six participants acknowledged a lack of child and adolescent training throughout their comprehensive training, even though undergraduate training had been undertaken with three different tertiary institutions, in three different locations within NZ. This finding is consistent with findings of a review of undergraduate training in child and adolescent mental health conducted by Peters (2003) who concluded child and adolescent mental health is scantily covered in the curriculum. This is not surprising given Comprehensive Nursing covers a broad range of knowledge and skills. Peters (2003) suggested The Nursing Council of New Zealand “Strengthened the mental health (and subsequently included child and adolescent mental health) components of the competencies” (p.12). It would appear such suggestions have not been actioned. A more recent study found that it was difficult to secure increases to content in the curriculum without there being specific requirements for inclusion. The same study also acknowledged educators were restricted but argued dedicating extra time to mental health nursing would

potentially increase the students' theoretical knowledge as well as positively influence career preferences and intentions (Lucassen, Doherty & Merry, 2008).

Anecdotally the DHB in which the study took place states it is desirable rather than essential for those working in mental health to have completed a new graduate programme, hence five out of six participants had completed a postgraduate certificate in mental health. However it is important to acknowledge the focus of that training had been on the adult population and there had been little consideration given to child and adolescent mental health. Whilst some of the content was considered by participants to be transferrable to children and adolescents, developmental differences would need to be taken into account.

There are many reports to be found highlighting knowledge and skills deficits arising from gaps in the basic entry to practice preparation for nurses and a lack of on-going clinical opportunities (Ross & Goldner, 2009). One study found "nurses were commonly working directly with young people in inpatient units having received very little or no CAMHS-specific training" (Reeves, 2011, p.5). Jones and Baldwin (2004) found nurses of all backgrounds, including mental health nurses, considered their pre-registration had not adequately prepared them to work with children and young people with mental illness; a finding replicated in this study. One possible reason is that this specific client group falls between two main specialities: children's nursing and mental health nursing (Jones & Baldwin, 2004). They propose as a result nurses working with this client group rarely receive relevant pre-registration training, a finding which was mirrored in this study.

The extent to which participants translated their developmental theoretical knowledge into practice when nursing adolescents appeared variable. This was evident in the accounts the RNs gave of their experiences, some of which showed understanding at a basic level, whereas others demonstrated a failure to make sense of the symptoms, behaviours or responses shown by the adolescents. Participants acknowledged limitations to their knowledge which not only applied to adolescent development but also to the assessment, diagnosis, and management of adolescent mental illness.

"Tucker et al. (2008) recently demonstrated that a three day training workshop for child behaviour management led to significant improvement in psychiatric nurses' knowledge and skills, with improved levels of empathy and a decreased tendency for negative judgements of parents. In addition, there was improved consistency in approach used by individual staff members for the management of behavioural problems in the unit." (Moxham et al., 2010, p.1439).

Most participants in this study were willing to learn and improve their practice, but identified a number of constraints to achieving this, namely cost and funding, lack of training or courses available, and staffing. These findings reflected those of a study conducted by Quality in Evidence who identified barriers to training as cost, staffing arrangements, availability and location of training, and staff resistance (Reeves, 2011).

One of the difficulties associated with providing relevant training is the identification of what is specifically required. In this study nurses varied in what they knew, and gaps in their knowledge differed, indicating there were differences in what individuals needed. In the UK, a study aimed at identifying the post-registration education and training needs of nurses who work with children and young people with MH problems found significant differences in training needs depending on the branch of nursing in which they were trained, most notably between the needs of nurses with a MH qualification and those with other nursing qualifications. Despite this they concluded the most important determinant in their training needs was the nature of their current roles and the knowledge and skills required to conduct those roles effectively and with confidence (Jones & Baldwin, 2004). This applies to findings of this study, which indicated post-registration training was undertaken in the realm of adult psychiatry, appropriate to the context of working in an adult inpatient unit. Never the less, in order to interact effectively with adolescents, staff need to be able to interpret adolescent behaviour more accurately in context of their development, experience, and relationships.

Findings show further consideration needs to be given to how best to address deficits in knowledge of RNs working in adult MH units specific to adolescents with mental illness. In terms of this study its findings are considered an indication that the MOH recommendations to improve knowledge to work effectively with mental health clients (MOH, 1996) are falling short of the intended outcomes, and is failing to consider the needs of those outside of the adult population. The implications of the findings reported suggest unless specific minimum standards are set for the mental health content of both undergraduate and postgraduate nursing programmes, change is unlikely to occur and deficits in knowledge and skills will remain (MOH, 1996; Happell, 2010). This requires an understanding of adolescent development; adolescent psychology; attachment, trauma and loss; transference and counter-transference; and system theory (Reeves, 2011).

5.3 RNs' Attitudes and Experiences of Nursing Adolescents in an Adult MH Unit

Attitudes towards adolescents were found to relate to the RNs' beliefs and experiences which included knowledge, thoughts and feelings about adolescents. Findings indicated differences in the willingness to work with adolescents, as those with negative attitudes acknowledged finding it difficult and preferred not to work with them. Winnicot (as cited in Church, 1994) noted adults' difficulty with adolescents stemmed from their own unresolved adolescent issues. RNs' personal experiences of adolescence were not explored so further comment cannot be made; it may however be worth considering in future research, to increase the understanding of the influence personal past experiences have on those nurses work with.

Findings in this study showed a clear link between negative attitudes and negative emotional response, including fear and apprehension, accounting for the reluctance. Reluctance was found to correlate with not liking this age group and belief that they should not be nursed in an adult in-patient unit. Chan, Chien and Tso (2008) acknowledged the potential for avoidance of interactions with patients and / or their families if nurses did not feel confident in their knowledge of MH issues. In addition those with negative attitudes adopted a more clinical and matter of fact approach to what is required nursing adolescents, along with an absence of warmth.

In contrast, participants with a positive attitude towards adolescents and despite limited knowledge wanted to increase their understanding, and believed one way of doing this was through more exposure or experience of working with adolescents. Those with a positive attitude were found to overtly display enthusiasm and warmth when talking about nursing adolescents. Slevin and Sines (1996) found that nurses who had undertaken more in-depth training and who had more experience of caring for clients with challenging behaviour expressed increased positive attitudes towards them. However, all participants believed the adult in-patient unit was not the best place for adolescents to be nursed, and acknowledged limited options when admission was necessary. Collegial support was reported amongst and within the team, but it was not found to extend to perceptions of support by other service providers, including CAMHS. A participatory action research (PAR) study of nurses looking after mental illness adolescents in a rural paediatric unit also found a perceived lack of collaboration or professional partnership between nurses and CAMHS (Moxham et al., 2010). Heslop, Elsom and Parker (2000) suggested poor communication for the patients diagnosed with mental illness primarily results from ambiguity about the roles and responsibilities of each department.

This study found memorable experiences fell into two categories: positive or negative. Differences in participants' understanding and tolerance of adolescents were found to affect reciprocal interactions and responses. A literature review of stigma, negative attitudes and discrimination towards mental illness within the nursing profession found general nurses' lack of knowledge of MH or psychiatry was itself directly predictive of negative attitudes and stigma towards mental illness (Ross & Goldner, 2009). There was insufficient evidence to support or dispute such a predictive relationship in this study in regards to a lack of knowledge of mental illness in adolescence and negative attitudes towards this clientele. Frequently cited negative experiences included conflict, such as the use of restraint and / or seclusion, as well as negative behaviours reportedly exhibited by adolescents. Negative experiences were associated with incidents judged as being unpleasant or not enjoyable. Frustration commonly accompanied negative experiences, and was linked to participants' lack of understanding, feeling dis-empowered, and with incidents that clashed with personally held beliefs. According to Sideleau (1992) frustration is an unpleasant affect characterised by a build-up of emotional energy when needs, wishes or desires are obstructed by others, one's own abilities, or a given situation. Wilkinson suggested when personal and professional values are compromised it can lead to the experience of moral distress, which encompasses a range of physiological and psychological responses, including feelings of anger, frustration or guilt (Wilkinson, as cited in Musto & Schreiber, 2012, p.138). Moral distress is frequently found to happen after distressing incidents, often involving safety, when no learning takes place. Because no learning takes place such incidents can become repetitive in nature. "Paradoxically, some researchers have noted that the experience of moral distress can have a positive effect on nurses, providing the opportunity for deep-reflection on their values and clarifying what they will - and will not - do" (McCarthy & Deady, 2008; Webster & Baylis, 2000. Cited in Musto & Schreiber, 2012, p.138). There was evidence in this study that some RNs used reflective practice to good effect, enabling them to put events into context and to learn from their experiences, those that did were found to possess positive attitudes. Reflective practice facilitates the development of interpersonal skills and self-awareness by fostering understanding of how one's own approach, personality and personal history contributes to the way a situation arose and got dealt with (Oelofsen, 2012).

Four participants were found to have an awareness of countertransference and acknowledged the importance of maintaining boundaries. It is widely recognised that countertransference may arise as part of the therapeutic process, whereby sadness, loss, desire to rescue, dis-empowerment and hopelessness may be felt (Oaklander, 1978). If unresolved, nurses may

distance themselves or even disengage from clients, making themselves unavailable (Bunner, 2006). It is unclear from the findings whether participants recognised transference as readily.

Regardless of the RNs beliefs whether adolescents should or should not be nursed on the unit it was found that they all wanted to provide supportive conditions to reduce distress. Findings indicated the nurse-client relationship was foundational to the participants' nursing practice. Importance was placed on the process of engagement, developing rapport, and forming a therapeutic relationship. Findings supported those found in the literature, that formation of a therapeutic relationship was based on respect and development of trust, and establishing shared understanding and meaning (O'Brien, 2000; Speedy, 1999). Participants acted as role models, providing opportunity for adolescents to observe different ways of responding more positively or constructively to negative emotions such as frustration or embarrassment. In addition they viewed one-to-one time when doing constant observations as a way of enhancing the adolescent's positive sense of self or identity through helping them improve their interactive skills, gain acceptance and providing support (Cardell & Pitula, 1999).

Participants acknowledged that adolescents are not always in a position of being able to make important decisions without reference to their parents and others in a position of authority. They all recognised the dilemma of enforced admission, and how, when this is the adolescent's experience of involvement with services, it may be perceived as an effort to control them and diminish their autonomy (Hanna & Hunt, 1999). Initial hospitalisation is often the result of an escalating crisis or a pivotal event and is considered a last resort by parents (Scharer & Jones, 2004). Kazdin (1996) identified that troubled adolescents may be less cognitively and socially mature, and less able to understand the rationale or need for treatment. Consequently, they rarely refer themselves to treatment and often show less concern about their problems than do others. Participants demonstrated an awareness of how feelings of powerlessness in the nursing relationship could lead to adolescents feeling patronised, and may result in them wanting to assert themselves by being oppositional, conflicting, or through passivity or withdrawal. They actively attempted to avert this from happening through engaging in collaborative assessment as characterised by adopting a strengths-based approach (Smail, 1993) and / or a brief solution-focused approach (DeShazer, 1988). Participants demonstrated a desire to see things from the adolescent's perspective, helping make their story more coherent, showing respect, and where possible, offering choices to help empower the adolescent. Shih (2004) argued that empowerment helps people with mental illness to develop feelings of mastery and self-efficacy, thereby helping them combat discrimination and avoid internalising stigma.

In this study participants tried to decrease the power differential by actively including the adolescents in their care and keeping them informed, thereby helping them retain a sense of control. Cleary (2003) found nurses "...deemed [it] essential to show empathy and understanding, and to keep patients informed as patients often worry about 'what's going to happen'" (p.141). The unit on which the participants work supports the use of one of the most widely accepted Maori models of health "Te Whare Tapa Wha". The four components of "Te Whare Tapa Wha" : physical; mental/ emotional; spiritual; and family well-being need to be equally strong, stable, integrated and in-balance with each other to be in optimum health (Durie, 1999). The main support system for Maori is family from which a sense of identity and purpose is derived (Kumar, Dean, Smith & Mellsop, 2012). Interdependence rather than independence is viewed as a healthier goal, where whanau is supported to take on the roles of nurturing, disciplining, and supporting individuals in distress (Durie, 1999). The Mental Health Commission (MHC) (2009) in acknowledgment that mainstream healthcare often places emphasis on individuals having and taking responsibility for determining appropriate healthcare provision, recommended the inclusion of families in the care of children and youths with psychiatric illness.

Participants did however acknowledge difficulties of maintaining credibility within partnership when balancing the need for safety and support whilst promoting independence and choice. Participants recognised that the adolescent exists within the context of not only family, but of school, friends, and the local community, and understood that the varying degrees of physical and or emotional dependence on family during adolescence makes it necessary to work in partnership with families and or significant others (Karoly, Kilburn & Cannon, 2005; Zeanah, 2000, as cited in The Werry Centre, 2008). However, participants were also mindful that when considering the family as the foundational support structure for the adolescent, assumptions should not be made with regards to the state of the foundations. Whilst it may be a source of strength and protection and can enhance developmental and health outcomes, the opposite may also be the case.

There was found to be a tension between the roles of partnership and control, concurring with the suggestion that true partnership is not possible if patients are not allowed to choose options that are not in keeping with those recommended by the clinician (Perkins & Repper, 1998), such as when seclusion is deemed necessary. Incidents of seclusion were found to be memorable experiences, negative in nature, where participants took control of the situation. Park et al. (2011) found seclusion occurred in 12.3% of patients, mostly those frequently diagnosed with psychosis. An article by Delaney (2006) cited other studies which indicated the characteristics

of children most likely to be restrained are male, have a previous psychiatric history, a longer length of stay, and a history of suicidal behaviour (Sourander, Ellila, Valimaki & Phia, 2002; Fryer, Beech & Byrne, 2004; Delaney & Fog, 2005. Cited in Delaney, 2006, p.20). Many in the aforementioned group of children have been found to have significant histories of trauma (Finke, 2001; Mohr, Mahon & Noone, 1998. Cited in Greene, Ablon & Martin, 2006, p.610) raising the concern that seclusion or restraint could be a re-traumatising experience. Careful consideration should be given in light that it can be counter-therapeutic and possibly be contraindicated. Findings of this study support existing research which shows that persistent role conflicts around the therapeutic use of self and the controlled environment can cause tension for nurses (Hem & Heggen, 2003).

5.4 Concerns Relating to Nursing Adolescents in the Adult MH In-patient Unit

All participants were concerned they had insufficient knowledge relating to child and adolescent MH to equip them to effectively manage, or provide the best possible age appropriate care to adolescents on the unit, and believed adolescent admissions were inappropriate. All were concerned at not being able to access beds on the regional child and adolescent in-patient unit on weekends, and at the lack of alternative options available. One participant voiced concern that admission to the adult in-patient unit delayed the treatment adolescents require and prolonged their stay away from home, she felt parents were not always presented with the full facts. The importance of information was highlighted in the Where Next? study, in which concerns were raised by 67% of the young people who participated, noting they wanted more information both before and during admission, to alleviate worry over what to expect and provide reassurance (Street & Svanberg, 2003). Such concerns were shared by at least one other RN participating in this study who expressed concern at the lack of information about the regional in-patient unit and lack of opportunity to visit the facility. This extended further to concerns about a perceived lack of support and / or involvement from CAMHS which was voiced by several participants. Other frequently cited concerns related to limitations in what they were able to provide in the unit, specifically in terms of therapy, structure and age appropriate resources or activities. Similarly Moxham et al. (2010) found the lack of facilities or resources impacted on the patient's ability to interact with others or engage in physical activities, and led to nurses' perceptions that patients were bored and felt neglected. The earlier findings of the Where Next? study which included the views of young people, along with some parents as well as staff in their sample group, reported boredom was a common theme, along with a lack of age appropriate resources (Street & Svanberg,

2003). Significant increases in aggressive incidents were found during unstructured time periods on child psychiatric units as compared to structured periods. External structure is needed to help children and adolescents contain their anxiety and regulate their affect (Garrison et al., 1990). Ross and Goldner (2009) reported that a paucity of institutional resources and supports to address clients needs and staff safety factors, were contributing factors to negative staff attitudes.

Findings indicated participants considered adolescents vulnerable due to their age, and were concerned with potential risks to the adolescent from adult clients, including exploitation, violence, and exposure to 'bad habits'. These concerns to some degree were minimised by the unit's policy for admissions under the age of 18 years, requiring they be nursed separately to adult clients and to be nursed on constant observations. The policy, however, gave rise to other concerns relating to the practicalities of staffing the unit, especially in times when they were short-staffed, given extra staff were required to provide constant observations throughout adolescents' admissions. Street and Svanberg (2003) reported staffing deficits lead to more incidents of extreme behaviour and an increased use of restraint in in-patient units. The balance between safety and separation is delicate, and led to other concerns relating to the restrictive nature of the environment adolescents were nursed in. Bandura (1987) and Shapiro and Astin (1998) advocate "...people actually feel better and have better mental health when they can control their surroundings." (as cited in Moxham et al., 2010, p.1440). The restrictions mentioned in this study made it a solitary experience for adolescents, and curtailed their freedom, autonomy and independence, all of which are important concepts in adolescence.

The findings of this study were remarkably similar to the only survey known to have been done on staff experience, knowledge and attitudes regarding the management of adolescent patients in adult MH units which was conducted in Australia by Curran et al. (2010). However, there were a number of key differences in findings pertaining to concerns about adolescent admissions which were not named in this study: lack of peers of a similar age; difficulties with discharge planning; adverse drug reactions in medication naive patients; distress caused to parents and siblings; and the impact on adult patients. Differences in findings may be accounted for by the different research design (survey) and sample group used which included psychiatrists, psychiatry registrars and with clinical staff which incorporated medical, nursing and allied health; compared with semi-structured interviews conducted with RNs.

5.5 Limitations

Whilst it is a strength of the methodology that the experiences unique to RNs in adult MH units

enables in-depth data to be gathered, the same point conversely can be perceived as a limitation as not only are the findings not generalisable to a larger population but neither can they be used for theoretical constructs or for policy decisions. There may have been some bias introduced by the selection process, as some RNs may have been more motivated than others to apply: a few acknowledged having a particular interest in this field of work; a couple of others were against having adolescents on the unit. It is possible participants perceived taking part as a way of influencing future admissions. Participants may also have felt some form of unintentional pressure to participate when the request was made for volunteers for the study, as the CNM had made it known she felt the study would be worthwhile and would appreciate unit staff having a voice. Participants may have wanted to please her for a variety of reasons. A sampling bias was created by those who volunteered. There was a gender bias in the sample, participants were not representative of all staff because the small sample did not contain a male participant.

Findings of the study were limited by the inexperience of the researcher, data collected was very basic, especially in regards to reasons for adolescent admissions to the unit. It is acknowledged that description of past behaviour may be highly subjective, important details may be forgotten, and participants can be selective in how they view the past. How participants reported events may have been affected by how they imagined their replies would reflect on their professional conduct and abilities. It is also possible that the researcher's interpretative framework may have affected the selection and editing of the data even though measures were taken to reduce interpreter bias.

5.6 Chapter Summary

Whilst it would seem that adolescents' needs have been clearly identified in the wider literature there is a mismatch in how this translates into practice. Consistent with findings in the literature, gaps were identified in the RN training curriculum; limited knowledge was evident in participants' understanding and interpretation of the symptoms, behaviours or responses shown by adolescents which in turn affected reciprocal interactions. The researcher does not consider this a poor reflection on the RN, rather it is evidence that the educational, organisational, and environmental systems currently in place do not support the provision of appropriate care to meet the developmental needs of adolescents.

The final chapter provides a conclusion to the dissertation and identifies recommendations for future practice, training and development, and research.

CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

6.0 Introduction

This research explored RNs' perceptions and experiences of nursing adolescents in an adult MH unit, and ascertained attitudes towards caring for this client group to gain an understanding of the nursing care currently in place. It also identified areas of nursing care which can be improved or developed to enhance quality of care. These aims were successfully achieved through the completion of a qualitative study using Thomas's general inductive approach (2006) to sort, organise and analyse data collected from semi-structured interviews. The findings of this study were reported in chapter four. Findings were then discussed in chapter five in relation to the research questions and the literature reviewed. Though the study broadly achieved its aims, many of the questions answered raised additional questions needing to be explored through further research. In this chapter conclusions drawn from the study are presented. The chapter then concludes with recommendations for future practice, training and development, and research.

6.1 Conclusions

The author concludes that mental illness has a major impact on an adolescent's life and heightens the challenges of fulfilling their developmental roles. Mental illness adversely affects the adolescent's ability to engage in activities and relationships with others. By creating a safe and supportive environment the nurse can use the therapeutic relationship to; help the client and their families make sense of their experiences (including reactions to their illness), help to redefine a sense of self enabling them to gain a sense of hope and belonging, reducing discrimination and self-stigma, aiding recovery, and avoiding the despair and social isolation that can arise as a result of stigma associated with mental illness. Clinicians are ideally placed to ask the right questions and address real or anticipated stigma and other negative experiences which could lead to adolescents and their families avoiding recommended services. However, this requires RNs to have a grasp of key concepts related to how children and adolescents think about the world (cognition), attempt to control behaviour (self-regulate), and deal with their feelings (affect regulation) if they are to reach a common psychological understanding of their behaviour and be able to respond appropriately to meet their needs.

Reasons for adolescent admissions in this study were congruent with those reported in the literature. Admission to the adult unit in this study was used primarily to provide a safe environment in which to effectively manage the increased risks associated with the adolescent's presentation, most commonly self-harm and suicidality. The other major reason adolescents accessed the adult unit were for practical reasons, as often assessment occurred out of hours, the regional adolescent unit does not take out-of-area admissions outside Monday-Friday working hours, and beds are not always available when required.

What is drawn from this study is that current CAMHS in-patient provision within NZ is considered insufficient to meet the needs of its child and adolescent population. Adult MH services attempt to provide adequate care, but should be considered a last resort option. The needs of adolescents need to be better understood and provided for. Adolescents aged above 18 years clearly fall between services; they no longer fit the criteria for CAMHS in-patient services, so by default get admitted to adult units, where there is an increased probability they are perceived and treated as adults, and as such are likely to be misunderstood and not to have their needs correctly assessed, identified or met. Adult MH services are not designed or staffed to meet the needs of those outside of the adult population.

Consistent with the literature, this study found the RNs' pre-registration training had not adequately prepared them to work with adolescents with mental illness. The focus of post-registration training in MH was embedded in the realm of adult psychiatry, leaving RNs with limited knowledge of adolescent development and having had little or no training in the assessment, diagnosis and management of adolescent mental illness. Though willing to learn and improve their practice, RNs were constrained by the lack of courses or training available, and by the cost and funding issues for any training they found. Release for training was also cited as being problematic. What can be drawn from the study is that both under-graduate and post-graduate programmes are failing to consider and / or address the mental health needs of those outside of the adult population. In order to be able to interact effectively with adolescents, RNs need to be able to interpret adolescent behaviour more accurately in the context of their development, experience, and relationships. Without developing knowledgeable practitioners in the sub-specialities of mental health (such as adolescence), the outcomes for the users of services are likely to continue to be compromised. Services need to better utilise the expertise they have within the different areas of mental health, and find ways to disseminate specialist knowledge to up-skill staff, grow the interests of, and value their staff.

Attitudes towards adolescents were found to relate to the RN's belief about them, which included knowledge, thoughts and feelings about adolescents. Attitudes were either positive, negative or neutral, and were underpinned by their experiences which were also described as positive, negative or neutral. Differences in participants' understanding and tolerance of adolescents was found to affect reciprocal interactions and responses. In this study it did not follow that RNs with the most years experience had more direct experience of working with adolescents. It was found that those who liked working with adolescents worked more often with them, some of whom had the fewest years experience. Preferences were informally recognised within the team and staff worked together, with those liking adolescents volunteering to work with them in the awareness that a positive experience during admission would likely impact on future decisions regarding accessing MH services.

RNs with negative attitudes acknowledged finding it difficult to work with adolescents, and preferred not to work with them. Findings in this study showed a clear link between negative attitudes and negative emotional response, including fear and apprehension, accounting to some extent for a reluctance to work with adolescents. RNs with negative attitudes to nursing adolescents adopted a more clinical and matter of fact approach when talking about nursing adolescents. This was interpreted as countertransference, the practical implication of which is the intentional or unintentional signalling to adolescents of unavailability. Negative experiences were associated with incidents judged by RNs as being unpleasant or not enjoyable, and often involved conflict. Frustration commonly accompanied negative experiences and was linked to RNs' lack of understanding, feeling dis-empowered, and with incidents that clashed with personally held beliefs.

What can be drawn from this study is that regardless of their belief about adolescents all RNs wanted to provide supportive conditions to reduce adolescents' distress. Importance was placed on the process of engagement, developing rapport, and forming a therapeutic relationship. All RNs demonstrated a solid understanding of the principles required to establish same. Whilst some RNs acknowledged preferring not to work with adolescents this is not considered a negative finding, rather the opposite, it demonstrates an understanding of strengths within the team and allows the best care possible to be provided within the teams resources. RNs providing care to adolescents on adult units should receive regular clinical supervision if they are to be able to put events into context, to look at incidents objectively, and to learn from their experiences. It can also be concluded that no two RNs will experience the exact same emotional response to situations, the responses will be unique to the individual. The way in

which attitudes are formed is complex and warrants further research. It would be useful to explore how life experiences inform RNs' approach to adolescents (and others), particularly in relation to the impact emotion has on cognitive processes including decision-making in regards to what to do and how to behave in a particular situation.

Another conclusion drawn from this study is that adolescents have different needs to those of adults, and that adult units are ill-equipped to provide appropriate care to adolescents in an environment supportive to their age and developmental needs unless resourced to do so. Adolescents require opportunities to be active, occupied, and not to be socially excluded or isolated. The measures the unit in this study took to reduce risks increased isolation, and contradicts the adolescent's growing need for freedom, independence, and self-determination, all of which are important concepts in adolescence. Speciality child and adolescent in-patient services are not easily or readily accessible. When adolescents experience care that is not supportive to their age and developmental needs, such as in an adult MH unit, it may negatively effect their experience of MH services and put them off accessing it in the future.

There is a discrepancy in how adolescents above the age of 18 years are viewed from a service provision perspective; they are classified as adults. Whilst they are acknowledged as being vulnerable, they have full access to the unit's facilities, and are able to interact with the adult clients. Despite the outward physical appearance of an adult, developmentally, adolescents are not yet adults and require a different nursing approach to be taken. This poses a dilemma, older adolescents (those over the age of 18 years) fall between services, and there is currently a void in appropriate service provision to this age range, best described as youth. It can be concluded separate services need to be designed, developed and introduced specifically for youth, and that problems accessing regional child and adolescent units needs to be addressed if adolescents under the age of 18 years are to receive the best care possible.

What can be drawn from this study is that unless adolescent needs are properly provided for, client outcomes can be expected to be less than optimal. Client outcomes in this study were not measured. Given the views expressed within this dissertation, it would be interesting for comparison to be made with adolescents' experiences and perceptions of being nursed on an adult unit, thereby providing a consumer perspective. This would help identify areas of strength and weakness within the service, enabling an action plan to be devised to address deficits identified and to help develop services to fit the need.

6.2 Recommendations

The main recommendation from this study is for changes to be made in the way the adult in-patient mental health unit delivers its service provision to adolescents. Though participants were not directly asked what model of care they used on the unit, it was apparent that they utilised the total patient care delivery model, where one nurse assumes responsibility for the complete care of a group of patients on a 1:1 basis during their shift (Rafferty, 1992). The nurse influences whether the care provided is task-centred, or patient-centred (Kron & Gray, 1987). Success lies in ensuring the skills and knowledge of the RN are matched to the complexity of the patients needs. A limitation of this model is that whilst continuity of care is guaranteed for a given shift, no one person is responsible for co-ordinating the care during a 24 hour period or throughout the patient's hospital stay (Kron & Gray, 1987).

A recommendation from the study is that the unit combine the Choice and Partnership Approach (CAPA) and Primary Nursing. The unit would then be better positioned to harness and develop skills within the nursing team. For instance, it would provide opportunity for those interested in child and adolescent mental health to work as partnership clinicians and to take on the role of primary nurse. The primary nurse would oversee the care delivered to the adolescent and would guide the care to be delivered in their absence through the care-planning process, and through the allocation of a named associate nurse to co-work, ensuring consistency and continuity of care throughout the client's admission. The allocation of associate nurses has the potential to up-skill knowledge of these members of the team who would be working closely, and alongside, an enthusiastic RN knowledgeable in the sub-speciality. The need for regular supervision is emphasised, the Royal College of Nursing (RCN) reported good supervision and support is essential to improve adolescent care practice. Supervision helps clinicians translate theory into practice (RCN, 2003).

Participants in the PAR study by Moxham et al. (2010) suggested rotation through CAMHS. This study makes the recommendation that mental health services take this one step further, and rotate staff working in in-patient services to increase RNs' knowledge of the various sub-speciality areas including, but not limited to CAMHS. Following on from this it is recommended that consideration be given to developing special interest groups, of which CAMHS would be one; the group would be tasked with the development of a child and adolescent MH resource package to be readily available on the adult in-patient unit. Copies of the CAMHS resource would be distributed to other areas within MH where it may be of interest or use. It is believed this process

would strengthen collaborative working across the services and improve communication, whilst also developing knowledgeable practitioners.

The DHB should encourage and support the applications for post-graduate study by RNs actively involved in a special interest group, particularly in the area of the sub-speciality. Despite the preference by RNs in this study for education to be delivered through inservice training caution is recommended against reliance on, or expectation of, any inservice training filling the gaps in basic nursing programmes. Scahill, Laroche and Bondi (1996) found inservice training insufficient for this purpose. There is no escaping the fact that changes need to be made to both under-graduate and post-graduate training, to include a greater coverage of child and adolescent MH into the curriculum if RNs are to be better educationally prepared to work with clientele.

What is evident from this study is that the adult in-patient MH unit is not sufficiently resourced to provide effective care to adolescents, and external structure needs to be provided to help adolescents contain their anxiety and regulate their affect (Garrison et al. 1990). This can be achieved by funding and resourcing age appropriate activities for use on the unit to help keep adolescents occupied during their admission.

There is a gap for development of youth services to meet the needs of late adolescents through to early adulthood hence alternative options to admission also need to be explored and developed. Recommendation is made that changes to the provision of respite for adolescents are made to include the provision of out-of-hours respite that can be accessed by staff doing after-hours assessment. An audit to identify areas of unmet need could be used to help map the direction, and the form, future services should take.

It is clear from the paucity of research available that there is much to be gained from further research into the field of adolescent MH being carried out. Whilst some research has been done exploring adolescents' experiences of MH services the majority of research relates to out-patient services, rather than adult in-patient services. It is considered surprising that the nurses' experiences of providing care to adolescents with mental illness has not been more widely researched, specifically the experiences of nurses working in adult MH in-patient units. This is an area warranting further research, so that findings can be compared, and ideas generated on how best to work with adolescents in the adult in-patient environment. Adolescent consumers who have experienced in-patient admission should be involved in the evaluation and development of service provision, and in the development of a model of care for adolescents, which to my knowledge has not yet been established.

6.3 Concluding Summary

This study found RNs working on an adult MH in-patient unit lacked training relevant to adolescents with mental illness. This was particularly in relation to adolescent developmental stage, presentation of mental illness and classification of mental illness prevalent in adolescence, despite five of the six participants having completed a post-graduate certificate in MH.

Regardless of attitude towards adolescents there was a consensus that an adult MH in-patient unit does not provide an appropriate environment in which to meet adolescents' needs, due to the lack of structure and resources therein. However in the absence of alternative options there are occasions when there is no choice but to accept adolescents requiring in-patient admission.

RNs made positive or negative evaluative judgements of adolescents based on their knowledge and expectations of them which were influenced by their experiences, beliefs, and emotional response, the combination of which affected the RNs' attitude and response to adolescents. Negative memorable experiences and negative emotional response correlated with negative attitudes about adolescents and reluctance to work with them. The pressure of juggling staff to provide constant observations, and to keep adolescents occupied in restricted areas with limited resources also contributed to negative attitudes towards adolescents. Adolescents' experiences of being nursed in the unit were not studied, but would offer a valuable contribution if pertinent improvements are to be made.

The recommendations from this study address three areas where ongoing provision of MH services to adolescents can be improved. Firstly, current provision should be improved by modifying the way that services are delivered to adolescents. Services should be designed to ensure the needs of this client group as identified within the dissertation are provided for, and units accepting adolescents for treatment should be equipped with age appropriate resources. Secondly, training of RNs in the field of adolescent mental illness should be improved. Better identification of the training requirements of RNs working with adolescents is recommended, along with the formation of special interest groups in different areas of sub-speciality, to foster continued improvements in service provision. Finally, to ensure lasting and ongoing improvements, it is recommended that further research into the provision of MH care to adolescents is conducted in order that an adolescent specific nursing model can be built on the latest knowledge and best practice.

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APPENDIX 1: STUDY INFORMATION SHEET

Registered Nurses perceptions and experiences of nursing adolescents in adult mental health units: A qualitative study.

Information Sheet.

Thank you for showing an interest in this project. Please read this information sheet carefully before deciding whether or not to participate. If you decide to participate I thank you. If you decide not to take part there will be no disadvantage to you and I thank you for considering my request.

My name is Jo Hollins and I am studying towards a Master in Health Science (endorsed in mental health) part of which entails undertaking a research project. I am currently employed as a Community Psychiatric Nurse at Child and Adolescent Mental Health Services, Wanganui District Health Board (WDHB). I have been in this position since 2009. Prior to this I worked as a Psychiatric Nurse in the adult MH unit (TeAwhina) of the WDHB, and before emigrating to NZ worked as a Staff Nurse in an acute MH in-patient unit in Aberystwyth (Wales).

The project aims:

- To explore Registered Nurses (RN's) perceptions and their experiences of nursing adolescents in adult MH units, in order to gain an understanding of what these experiences have been like for them, and to identify any nursing concerns regarding such admissions.
- To identify areas of the nursing care environment that may be improved or developed to enhance quality of care.
- It is hoped the outcome of this study will identify support needs or training requirements to improve nurse satisfaction and outcome levels.

I am seeking 6-8 participants to volunteer to take part in the project. Participants will be RN's (comprehensive or psychiatric trained) aged 21 years or above, with a minimum of 12 months work experience as an RN in an adult MH unit. To be eligible RN's must have had some experience of caring for adolescents admitted to adult MH units, and must be employed for a minimum of 32 hours weekly in an adult MH unit.

You will not be eligible to take part in the project if you are an Enrolled Nurse.

Should you agree to take part in this project you will be asked to participate in an individual semi-structured interview comprising a set of open-ended questions. The interview will take place in a quiet room away from clinical areas within the WDHB. It is anticipated the single interview will take between 60-90 minutes to complete. With your permission the interview will be recorded via audio-tape and later transcribed verbatim enabling analysis of transcripts to identify and report themes within data.

The data will be securely stored in such a way that only the researcher, supervisors and transcriber are able to gain access to it. The typist of the transcripts will have signed a confidentiality agreement. Participants will be provided with the transcript from the audiotape for verification or amendment to ensure accuracy. Once the data has been analysed participants will be given a summary of the findings. Data collected will be used for my dissertation and may be used on more than one occasion for research, publication purposes or conference presentations. The results of the project will be available in the University of Otago Library (Dunedin, NZ) and the WDHB Library but every attempt will be made to preserve your anonymity.

All attempts will be made to protect your confidentiality and uphold your rights. All interviews will be coded and no names or identifying details used to prevent personal identification. Similarly data tapes will be labelled with an identification number to maintain anonymity. At the end of the project any personal information will be destroyed immediately except that as required by the Universities research policy, any raw data which the results of the project depend on will be retained in storage for 5 years, after which it will be destroyed.

You have the right to decline to answer any question; request that the audiotape be turned off at any time; request to take a break, or reschedule the interview; and most importantly you have the right to withdraw from the project at any point without penalty or negative consequence (once data analysis has commenced you will be unable to withdraw from the project).

Inclusion in research can be rewarding in that it provides opportunity to reflect on practice and the environment in which you work, it may serve to help identify areas you may wish to develop further, and your experiences may inform future developments to enhance quality of care provision.

APPENDIX 2: STUDY CONSENT FORM

Registered Nurses perceptions and experiences of nursing adolescents in adult mental health units: A qualitative study.

Consent Form.

I have read the information sheet concerning this project, and understand what it is about. All my questions have been answered to my satisfaction, and I know what is expected of me. I understand that I am free to request further information at any stage. If I need to, I can contact Jo Hollins at CAMHS, WDHB anytime during the project.

I know that my participation in the project is entirely voluntary and I may withdraw from the project at any time I wish prior to data analysis without any disadvantage of any kind. If I feel hesitant or uncomfortable I may decline to answer any particular question(s) and / or may withdraw from the project.

Personal identifying information (audiotapes) will be destroyed at the end of the project but any raw data on which the results of the project depend will be retained in secure storage for at least 5 years.

There are minimal risks associated with the project. However, I may be reminded of some challenging or unpleasant experiences that have happened in the past which I may find upsetting. I understand if this happens it may be suggested that I access support through clinical supervision or through the WDHB Employee Assistance Programme.

I realise that the knowledge gained from this project may help improve my own, other nurses, and adolescent client satisfaction and outcome levels in the future.

The results of the project will be published and available in the University of Otago Library (Dunedin, NZ) and the WDHB Library. Every attempt will be made to preserve my anonymity.

I agree to take part in this project.

.....
Signature of participant Date

.....
Signature of researcher Date

APPENDIX 3: STUDY INTERVIEW GUIDE

Warm-up question:

Tell me a little bit about yourself, and your nursing career.

Interview Questions.

1) What are your first thoughts when you hear an adolescent is being admitted to the unit?

- How does it make you feel?

2) On a scale of 0-10 (0 having no confidence, 10 fully confident) how confident are you nursing adolescents?

- How come you're not a ...(lower number than they've chosen)?
- What would it take to move you to 9 or 10/10?

3) For what reasons do adolescents get admitted to adult MH in-patient services?

- Why don't they go somewhere else?

4) What training or preparation have you had relating to adolescents with mental illness?

- What do you know about adolescence as a developmental stage?
- In what ways are they different to adults? (how do you expect them to behave and think?)

5) When mentoring what advice would you give regarding caring for an adolescent?

- How do their needs differ from adults?
- What characteristics do you believe facilitate the development of a therapeutic relationship with an adolescent?

6) Can you tell me about your experiences of nursing adolescents?

- What is your role when looking after adolescents? / tell me what you do.
- How do you identify and meet the cultural needs of Maori adolescents and those of other cultures?
- In your experience what impact do adolescents have on the unit?
- What supports could be put in place to make your experience more positive?

7) What concerns do you have, if any?

8) If you could make changes, what is the one main change you would like to make?

9) Is there anything that I haven't asked about that you think I should know?

- Is there anything you want to add before we finish?

