The Impacts for the Registered Nurses of the New Entry to Specialty Practice Mental Health and Addiction Nursing Programme, of the Programme, on their Personal and Professional Development

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ABSTRACT

A qualified and competent nursing workforce is critical to the health and wellbeing of any society. New Entry to Specialty Practice Mental Health and Addiction Nursing (NESP) programmes were developed in New Zealand to assist nurses’ transition to mental health nursing practice. These programmes have been well embedded in mental health nursing for over twenty years and are reported to have been highly effective in the preparation of a skilled and competent mental health nursing workforce.

Mental health nursing has always struggled to attract sufficient numbers of nurses to this field, therefore to date review has primarily focussed on fiscal and retention measurement, with little exploration of the mental health nurses’ experiences following completion of the entry to specialty practice programme.

The purpose of this small study, involving thirteen participants, was to develop a greater understanding of the nurses’ experiences three to six years after the programme, in terms of exploring the impact on their personal and professional development. Personal development activities being those that improve awareness and identity, develop talent and potential, facilitate employability, enhance quality of life and contribute to the realisation of dreams and aspirations. Professional development focuses on skills and knowledge attained for both personal and career advancement.

Taking a qualitative descriptive approach, data was gathered from in-depth semi structured interviews, which were then thematically analysed. This study illuminated the impact of the NESP programme on the nurses’ personal and professional development, reflected in the key themes of well set up, thinking differently, interconnectedness and reciprocation.

The impact of the programme for the nurses was that they were well prepared for a career in the specialist field of mental health nursing. The programme afforded them opportunities, experiences and connections that enabled them to competently deliver evidence-based, contemporary and collaborative person-centred care. The nurses were able to advance in their careers. Reciprocation, as the final theme reflected the participants’ engagement with the next generation of nurses through activities that sought to support, nurture and inspire them.
ACKNOWLEDGMENTS

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Thank you to my thesis supervisors Bev Burrell and Marie Crowe, for your wisdom and guidance, scholarly expertise, understanding and patience. I am truly grateful.

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# Glossary of Māori Terms

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<tr>
<td>Hui</td>
<td>A meeting or gathering</td>
</tr>
<tr>
<td>Manaakitanga</td>
<td>Affording others hospitality, encompasses generosity and kindness and responsibility to look after people. Nurturing and fostering relationships.</td>
</tr>
<tr>
<td>Manaaki</td>
<td>To care for, to show respect</td>
</tr>
<tr>
<td>Mihi Whakatau</td>
<td>Official welcome speech - speech acknowledging those present at a gathering.</td>
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<tr>
<td>Tangata Whaiora</td>
<td>People with experience of mental illness, who are seeking wellness, or recovery of self.</td>
</tr>
<tr>
<td>Tikanga</td>
<td>Protocols, practices, customs</td>
</tr>
<tr>
<td>Whakapapa</td>
<td>Ancestral links, genealogy, lineage</td>
</tr>
<tr>
<td>Whanaungatanga</td>
<td>Relationship, kinship, sense of connection</td>
</tr>
<tr>
<td>Whakawhanaungatanga</td>
<td>The process of making whakapapa, or genealogical links</td>
</tr>
<tr>
<td>Whānau</td>
<td>Birth; Family Group. Whānau is derived from the word meaning to ‘give birth’. Can include friends who may not have any kinship ties to other members but share a common aspiration, purpose and or activity.</td>
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CHAPTER 1: INTRODUCTION TO THE STUDY

This chapter explains the researcher context and the purpose of the study. Mental health nursing is defined, and the socio-political context of mental health nursing is explored to situate the establishment of the New Entry to Specialty Practice Mental Health and Addiction programmes in New Zealand. The programme rationale and components are discussed. Personal and professional development are defined and discussed within nursing and mental health nursing. The chapter concludes with an outline of the thesis structure.

Nurses in New Zealand who work in the field of mental health are operating in a system that views mental health nursing as:

a specialised branch of nursing practice that builds on the competencies expected of all nurses who practice in Aotearoa, New Zealand. It is a specialised expression of nursing which focuses on collaborative partnerships and meeting the needs of people with mental health issues, family/whānau and communities. It is an interpersonal process that embodies the concepts of caring and therapeutic relationship within a cultural context. Mental health nursing is holistic and considers the needs and strengths of the individual, family, group and community (Te Ao Māramatanga, 2012, p. 4).

As a mark of respect to the indigenous people of this land and in support of the Te Ao Māramatanga / New Zealand College of Mental Health Nurses (NZCMHN) the terms people with mental health issues or tangata whaiora, meaning people seeking wellness, will be used rather than patient or consumer. This term is inclusive of those people with addiction. A glossary of Māori terms is provided at the beginning of this work to guide the reader when Māori language is used.

1.1 Researcher Context Related to the Formulation of the Research Question

I had been passionate about working with nurses new to the field of mental health, long before being appointed to oversee the New Graduate Preceptorship Programme, a component of the New Graduate Programme, established in Canterbury in late 1996. The brilliant experiences, and tough times from the late 1980s, shaped and motivated me to facilitate positive learning experiences for new nurses, fuelling my passion to provide the best nursing care possible for people with mental health issues.
During the early years of clinical practice, I worked in a range of settings within the acute and rehabilitation areas of the then Sunnyside Hospital. In 1989 I embarked on the quintessential kiwi big OE, an ambitious climbing expedition to Nepal. Work and travel through the United Kingdom provided me with a new view of the world and greater appreciation of many things I took for granted in New Zealand. After 18 months away climbing, travelling and working I returned to work as a registered nurse in the newly established forensic service. This was a time of huge change and great opportunity within the mental health service in Canterbury.

By the late 1990s I was employed in the Training Resource Unit with a focus to co-facilitate the orientation programme for a large cohort of new nurses entering the inpatient areas. I also delivered training in cardio pulmonary resuscitation and calming and restraint. These experiences helped equip me to work well alongside the team providing the New Graduate Programme, now known as the New Entry to Specialty Practice Mental Health and Addiction Nursing Programme (NESP), which began in January of 1997. Twenty years later, I remain active within the programme, in a significantly evolved role, yet with the same focus of facilitating the development of nurses newly registered or new to the specialty of mental health nursing.

I have always been curious about people, and none more so than the many nurses who have undertaken this intensive and focussed clinical and academic programme. Over the years I have contemplated what happens after the programme? What do the nurses do because of the experiences? Who is important in their professional world and what is the nature of the support afforded them in our complex and everchanging system? How are they advancing, are they moving into leadership and senior nursing roles? Are they still engaged in research? Are they engaged in supervision and other professional development activities? How has the programme shaped their identity as a nurse, as a mental health nurse? In my role as NESP Nurse Coordinator I am in contact with the nurses who have completed the programmes. They tell me it is important for nursing. I know it is important, but how do you measure this value, and why is it important now?

In the fiscally constrained health care environment, and when considering increasing talk of a more generalist approach to nursing I am mindful of the pressure to provide and articulate evidence that mental health nursing is a valued specialist branch, is
beneficial to the population of New Zealand, and receives the resources it needs. It is imperative to continue in the development of a specialist workforce that is well prepared and effective for the complex health environment we operate in, and most importantly is suitably positioned to deliver the best care possible for tangata whaiora, and whānau in New Zealand.

My contemplations about the nurses who have completed the programmes have fuelled this research. It is important to continue to monitor recruitment and retention, however, it is also timely to consider what the nurses say is important in their professional and personal development. It is not what you have got, but what you do with it. What happens after the programme? For the purposes of this project the research question is:

*What are the impacts for the registered nurses, of the NESP programme, on their personal and professional development?*

1.2 Purpose of the Study

This thesis explores the experiences of nurses, either recently graduated, or new to the field of mental health, who have undertaken the New Entry to Specialty Practice Mental Health and Addiction Nursing (NESP) Programme delivered within the Canterbury region of New Zealand between the years of 2010 and 2013. The study set out to assess and gain an understanding of how the NESP programmes impacted on the personal and professional development of the nurses who undertook them. Personal development, in this context, considered general notions that the nurses’ growth related to activities that improved their awareness and identity, developed talent and potential, facilitated employability, enhanced quality of life and contributed to the realisation of their dreams and aspirations. Professional development, albeit inextricably linked, focussed on the development of their skills and knowledge which then contributed to personal and career advancement.

In New Zealand, there are very few studies that provide an in-depth evaluation of the impact of NESP programmes for the nurses, after the first year of practice (Stuart, 2014). There are no peer reviewed and published studies that specifically link the NESP programmes with ongoing personal and professional development.
1.3 Socio-political Context of Mental Health Nursing Workforce Development

A suitably qualified and competent nursing workforce is critical to the health and well-being of any society (Haggerty, McEldowney, Wilson, & Holloway, 2009; Mental Health Commission, 1998; National Nursing Organisations, 2014). The government of New Zealand is charged with providing this workforce to adequately meet the current and projected health needs of this country. This has been a significant challenge, with some initiatives having a detrimental effect on both the population of this country and the nursing profession. New Zealand experienced major health reforms in the 1980s and 1990s which severely restricted the funding available to develop the nursing workforce, ultimately resulting in a national shortage of nurses, a very disenfranchised workforce and inadequate health care (Gage & Hornblow, 2007; Mental Health Commission, 2007).

Deinstitutionalisation through the 1980s resulted in downsizing of inpatient numbers in the large psychiatric hospitals. Many of these people with mental health issues were released into the community, often with inadequate supports and oversight (Brunton, 2005). Because of significant media attention a commission of inquiry, headed by Judge Ken Mason, was established. This exposed many serious incidents involving tangata whaiora, including high rates of suicide and assault, sub-standard care, and inadequate involvement of family, in both inpatient and community facilities (Mental Health Commission, 2007). It was apparent that poor mental health service provision and inadequate workforce development had impacted this most vulnerable group of the New Zealand population (Ministry of Health, 1994).

A contributing factor to the serious incidents and concerns raised was that the move from an institutional based service delivery to a community based setting was inadequately planned and poorly resourced (Mental Health Commission, 2007). The Mason Report in 1996, lead to several substantial improvements in the mental health sector (Ministry of Health, 1996). The first was the establishment of the Mental Health Commission, which had a key objective to ‘act as a catalyst to improve performance and lift the priority given to mental health in New Zealand’; is also was to develop a national anti-stigma initiative; and establish an ongoing funding stream for sector improvements (Mental Health Commission, 2007, p. 3). The Mental Health Commission was set up in 1996 and set about ring fencing money for mental health
service development, with funds specifically for post entry clinical training, to provide
the much-needed mental health workforce development (Finlayson, O'Brien, McKenna, Hamer, & Thom, 2005).

Through the 1970s and 1980s significant developments were unfurling in the education
sector, namely the move away from the hospital-based apprenticeship training model. In the mental health sector, psychiatric and psychopaedic nurse training and registration was slowly phased out. By the late 1980s there were no single scope registered nurse training programmes in New Zealand, all nurses undertook a generalist comprehensive nurse education programme, and received the title Registered Nurse (Prebble, 2001). This was an uncomfortable relationship, as comprehensive nurses were poorly prepared for the realities of working in psychiatric hospitals due to their predominantly theory-based education and limited clinical hours compared to their psychiatric trained nurse colleagues (Adlam, Dotchin, & Hayward, 2009; Prebble, 2001). Comprehensive nurses struggled to assimilate into the workplace, reporting that they were poorly orientated and inadequately supported (Adlam et al., 2009). This change from training to education of registered nurses, on top of the health reforms, further compounded the effect of psychiatric nurses feeling marginalised in nursing (Prebble, 2001, 2012). Prebble contends that a mental health nurse conference held in 1988 provided the platform for mental health nursing to reclaim its identity (Prebble, 2012). From this gathering of likeminded nurses, the New Zealand branch of the Australian and New Zealand College of Mental Health Nurses was established in 1994. Being part of a college enabled a collective professional identity to be forged and access to information and international developments in this field (Prebble, 2012). The New Zealand branch of the college published Standards of Practice for Mental Health Nursing in New Zealand, and served as the scaffolding for the new graduate programme of 1995 (Cook, 1998).

The early 1990s was a period of considerable workforce activity as reflected by the Ministry of Health’s 1994 document outlining the strategic directions for mental health services and, in 1997, the national mental health plan for more and better services (Ministry of Health, 1994, 1997). These two plans were instrumental in guiding the development of the mental health workforce as it moved from an institution-based setting to care primarily delivered in the community. Responsibility for the funding of
post-registration education for all health professionals within New Zealand, shifted to the Ministry of Health. The Clinical Training Agency (CTA) was established in 1993 and acted on behalf of the ministry. Its objectives were to ensure money for training was used for the purpose that it was intended, and to set priorities for training in line with governmental policies and strategic directions within the health sector (Finlayson et al., 2005). This post entry clinical training (PECT) was available for health professionals post registration and engaging in training programmes with clinical components of 30% or more. These funds for mental health were often referred to as ‘Mason money’, perhaps reflecting the significance of the work undertaken by Ken Mason and his colleagues to bring about vital change in the sector (Finlayson et al., 2005; Mental Health Commission, 2007).

With this drought in funding breaking, and access to ‘Mason money’ mental health nursing leaders responded quickly. A pilot of an intern programme for new graduate nurses entering mental health nursing practice was undertaken in 1994, in Wellington (Cook, 1998). This was reported as being successful, and in 1995 the first New Graduate Mental Health Nursing programme was launched, as a joint venture by Capital Coast Health Limited and Whitireia Community Polytechnic; the first organisations to access CTA funding for new graduate nursing education (Cook, 1998; Haggerty, 2000). This forty-week programme provided nurses with theory classes, clinical rotations in inpatient and community settings, clinical supervision for role development, and preceptorship. The qualification conferred upon completion was a Certificate of Entry to Psychiatric Mental Health Nursing Practice, at the degree level, that is, level 700 on the national qualifications framework (Haggerty, 2000).

Canterbury followed suit in 1997 with the ‘New Graduate Mental Health Nurse Programme’, providing a similar programme except for the theoretical component, which was a level 800, post graduate paper. This programme was a joint venture between the University of Otago and Healthlink South’s Mental Health Division (now known as the Canterbury District Health Board and Specialist Mental Health Service). Other regions recognised the value of the programmes and tendered for contracts for their mental health services.

By 1998, the ‘Blueprint for Mental Service in New Zealand’ was released by the Mental Health Commission to guide the further development of services in mental
health care. It provided a clear indication of the size of the services needed to meet the needs of the population and described the thinking informing the changes that were needed to improve care (Mental Health Commission, 1998). At this point the concept of ‘recovery’ was introduced, with the clear expectation that all mental health professionals operate under the assumption that tangata whaiora have strengths and natural resources. This change in the philosophy of care now compelled mental health nurses to work in ways that were more empowering for consumers, challenging of discrimination and that instilled hope (Wilson, 2006). The key message was that nurses needed to foster a recovery approach, which was seen to be occurring “when people can live well in the presence or absence of their mental illness” (Mental Health Commission, 1998, p. 1).

By 2006 the Expert Reference Group to Deputy Director-General of Mental Health released a report, Mental Health Nursing and its Future: A Discussion Framework (Wilson, 2006). This report outlined a strategic framework to guide the mental health nursing profession forward, building capacity and capability within the specialty, by strengthening leadership and practice. The report highlighted the issues with a shortage of nurses worldwide and made several specific recommendations in relation to clinical career pathways, professional supervision, education, research, recruitment and retention. Notably, this report observed that measures to develop the workforce in the past had been poorly executed, in that there were no timelines, specific actions and accountabilities. Progress has been made on the implementation of many of these strategies, however significant aspects still require work. Stuart, in a recent independent best practice review of the NESP programme cautioned that a delay in addressing these issues would impact on the service users of New Zealand (Stuart, 2014).

Over the last 20 years the NESP programmes have continued to evolve in response to legislation and policy change and as well as developments within the sector. Te Pou o Te Whakaaro Nui (Te Pou), the national centre of evidence-based workforce development for mental health addiction and disability sectors, has worked for Health Workforce New Zealand (HWNZ) to lead the development of this workforce and manage the Skills Matter post graduate training contracts for programmes funded by HWNZ.
1.4 New Entry to Specialty Practice Mental Health & Addiction Nursing Programmes (NESP) in New Zealand

The intent of NESP programmes were to provide a robust system of support and preparation for the nurses, newly graduated or experienced in other fields of nursing, to seamlessly transition into the specialist field of mental health (Haggerty, 2000; Te Pou o Te Whakaaro Nui, 2016). This preparation was viewed as important to support nurses develop the knowledge and skills to deliver best practice for working with people with mental health issues, and whānau, within an increasingly complex health care environment. For this reason, NESP programmes were purposely both clinical and academic in their focus, and jointly delivered by an academic and a clinical provider. The intention was to provide nurses with the opportunity to apply clinical skills, specialist knowledge and critical enquiry to their developing practice (Te Pou o Te Whakaaro Nui, 2016). All programme providers met Te Pou’s Skills Matter specifications for a post-registration nursing programme in mental health and addiction (Te Pou o Te Whakaaro Nui, 2016).

Key components of NESP programmes are as follows:

1. Academic study at a post graduate level
2. Clinical Preceptorship
3. Clinical Supervision
4. Rotations in inpatient and community areas
5. Achievement of a Professional Development and Recognition portfolio at competent level

Academic support was provided by the university with the nurses undertaking two papers delivered over a forty-week period (two semesters) resulting in a post graduate certificate. Upon completion nurses had a portable and relevant qualification that was on a pathway toward a Masters’ level qualification. Preceptorship supported clinical learning and practice development in inpatient and community clinical workplaces and was facilitated by trained preceptors who encouraged critical reflection on clinical practice. A minimum of twenty hours professional supervision was expected to be achieved by all participants, either as individuals or in groups. Clinical experiences were required in inpatient and community areas reflective of the emphasis on
community-based care. All programmes are underpinned by Nursing Council of New Zealand Competencies for Registered Nurses and NZCMHN standards of practice for mental health nursing in Aotearoa New Zealand.

Reflected in the standards are the values, attitudes and seven Real Skills identified in Let’s get real (Ministry of Health, 2008) which underpin the provision of effective mental health and addiction services in New Zealand. Standard five of the NZCMHN framework (Appendix 6) is particularly relevant to this research question with a focus on the mental health nurses being committed to their own professional development and to the development of the profession of mental health nursing (Te Ao Māramatanga, 2012). These standards outline the knowledge, skills and attitudes expected of a mental health nurse, and reflect the increasing emphasis on community-based care and the concepts of recovery and wellbeing, working in partnership with consumers, meeting physical health needs and health promotion (Cassie, 2013; Te Pou o Te Whakaaro Nui, 2016). It is expected that new graduate nurses, with the support of a preceptor, will meet these standards by the end of the programme, in addition to meeting the competent level of a Professional Development and Recognition Programme (Te Pou o Te Whakaaro Nui, 2016).

The Health Practitioner’s Competence Assurance Act (Ministry of Health, 2003) requires nursing to evidence competency. As the regulatory body overseeing nursing practice the New Zealand Nursing Council require all nurses to provide a professional portfolio that shows they are practising competently. This requirement is supported by the national nursing contracts, Multi-Employer Collective Agreement (MECA) and was instrumental in the introduction of Professional Development and Recognition Programmes throughout New Zealand. From 2006 nurses on NETP and NESP programmes were required to complete a portfolio evidencing practice at a competent level.

Building on the critical social theory underpinnings of the undergraduate nursing education programmes, and utilising the NZCMHN standards, the Real Skills framework and Nursing Council Competencies, the NESP programme has the goal to bridge the gap between the broad comprehensive nursing preparation to the clinical workplace. NESP programmes focus on the development of greater understanding of, and application of the unique specialty of psychiatric/mental health and addiction
nursing, to deliver contemporary and best practice nursing for the people of New Zealand.

### 1.5 Theoretical Underpinnings of Canterbury’s NESP Programme

From inception, the Canterbury programme design was unpinned by a critical theory approach to learning and clinical practice. This approach is concerned with “identifying and exposing those aspects of the existing social order which are unjust and oppressive and which contribute to constructions of mental health and illness” (University of Otago, 1997, p. 2). Christensen’s Partnership Model (1990) was drawn upon to focus on the concept of therapeutic relationship and working in partnership with people with mental health issues, and their families. Key to the model was learning through critical reflection on practice, based on scholarly enquiry and reflection. This was fostered by a problem based learning approach in both the academic and clinical components of the programme (Crowe, 1994).

In Canterbury, the formal teaching component of the programme was delivered by the University of Otago, in block study days. The intended aim of the theoretical papers being to,

encourage students to develop the skills for life-long learning and self-directed professional development through the development of analytic and clinical reasoning skills that can be applied to a wide range of complex clinical situations in mental health and addictions (Department of Psychological Medicine, 2017).

The assumption was nurses would develop their critical thinking skills. A critical thinker, according to the American Philosophical Association, is one who is,

… habitually inquisitive, well-informed, trustful of reason, open-minded, flexible, fair-minded in evaluation, honest in facing personal biases, prudent in making judgments, willing to reconsider, clear about issues, orderly in complex matters, diligent in seeking relevant information, reasonable in the selection of criteria, focused in inquiry, and persistent in seeking results which are as precise as the subject and the circumstances of the inquiry permit (Facione, 1990, as cited in Facione & Facione, 1996, p.130).
1.6 Personal and Professional Development

Personal and professional development are often interlinked. A useful definition to signal the point of difference is the notion of self-development. Glen contends that,

personal development in our culture involves self-development and self-development is a process by which individuals accept responsibility for changing the personal core of attitudes and motivations manifested in their performance. This process involves the development of powers of self-determination (e.g. reflective self-monitoring and self-control) (Glen, 1998, p. 97).

In contrast, Jasper, in exploring professional development in nursing, asserts that professional development involves advancing as professional practitioners, and the assumption is made that this activity occurs throughout the nurses working life (Jasper, Koubel, Rolfe, & Elliott, 2006). Being professional is associated with the possession of certain qualities, such as those of being competent, efficient, altruistic, and having integrity (Lakeman, 2000). Personnel working in the mental health and addiction sector are expected to be engaged in personal and professional activities. These include accessing evidence based training and education; recognising that learning and development are lifelong; having an aspirational personal and professional development plan; being personally responsible for meeting one’s own goals but seeking out organisational support to meet them; and lastly integrates supervision and reflective practice into routine practice (Cuthbert & Basset, 2008).

The maintenance of competence is a professional expectation for all nurses in New Zealand and is monitored by the Nursing Council of New Zealand, which is charged by the government to protect the health and safety of the public. Competence is regarded as having the skills and knowledge required to perform a task effectively or work safely in a particular area of practice (Ministerial Taskforce on Nursing, 1998). All nurses are required to annually declare that their competence is current. A component of this evidence includes that of maintaining professional development, albeit, that activities are threaded throughout all the competencies. Professional development is explicitly covered under domain two, Management of Nursing Care, competency 2.9 which details the following indicators expected:
Contributes to the support, direction and teaching of colleagues to enhance professional development. Updates knowledge related to administration of interventions, treatments, medications and best practice guidelines within area of practice. Takes responsibility for one’s own professional development and for sharing knowledge with others (Nursing Council of New Zealand, 2007, p. 22).

Activities regarded as professional development can be in the workplace or in an educational environment and include such learning actions as online learning, in-service education, short courses, seminars/conferences, or degree courses (Jasper et al., 2006). The types of professional development activities undertaken are influenced by the context of the area of practice and for some nurses the scope, which is related to qualification or experience, and may limit the areas they can practise in.

A key component of professional development in nursing is reflective practice, which is described as:

an in-depth consideration of events or situations outside of oneself: solitary, or with critical support. The reflector attempts to work out what happened, what they thought or felt about it, why, who was involved and when, and what these others might have experienced and thought and felt about it. It is looking at whole scenarios from as many angles as possible: people, relationships, situation, place, timing, chronology, causality, connection, and so on, to make situations and people more comprehensible. This involves reviewing or reliving the experience to bring it into focus (Bolton as cited in Jasper et al., 2006, p. 42)

It is contended that professional development is more than a technical process, it involves reflection upon practice to inform decision making which in turn is informed by knowledge and experiences (Jasper et al., 2006). Reflection on practice facilitates the identification of learning needs, which in turn guide development.

Professional supervision is one mechanism to facilitate reflection, and has a long association in mental health nursing, in fact it is regarded as an essential component to facilitate development (Bond & Holland, 1998; McKenna, Thom, Howard, & Williams, 2010).
Clinical supervision is regular, protected time for facilitated, in-depth reflection on clinical practice. It aims to enable the supervisee to achieve, sustain and creatively develop a high quality of practice through the means of focused support and development. The supervisee reflects on the part she plays as an individual in the complexities of the events and the quality of her practice. This reflection is facilitated by one or more experienced colleagues who have expertise in facilitation and the frequent, on-going sessions are led by the supervisee’s agenda (Bond & Holland, 1998, p. 12).

Supervision is a process that continues throughout one’s career, regardless of the role, whether it be clinical, management, education or research (Bond & Holland, 1998). Within mental health nursing supervision is essential to ensuring nurses are supported to critically reflect on their practice and explore new ways of approaching complex situations involving care provision, families and whānau, colleagues and other health care personnel. According to Barker, as cited by Lakeman, supervision is protective, “to protect people in care…and to protect nurses from themselves” (Barker, 2000, p. 91).

In Canterbury, supervision was mandatory for NESP nurses during their programmes, thereafter it was optional. Much of the clinical supervision was delivered by nurses trained in the role theory model approach developed by the late Mike Consedine (Consedine, 2000). This model defines supervision as,

a relationship within which nurses reflect on all aspects of their professional practice with a view to processing their experiences so that blocks are removed, real abilities are developed and spontaneity (creativity) is maintained in the patient relationship (Consedine, 2000, p. 47).

This section has explained the objective of the study and set the scene by providing an overview of the historical context of NESP programmes in New Zealand. Key components of the programme have been defined and outlined. An outline of the organisation of the thesis follows.
1.7 Thesis Structure

Chapter 1 explains the researcher’s position in relation to the research question, provides an historical context of the NESP programme, and describes the current programme and key terms.

Chapter 2 describes the literature review process, explains the search strategy and explores the literature. This is in two parts, firstly the relevant literature related to the first year of practice and mental health nursing. The second part explores early career and relevant literature examining mental health nursing after the first year.

Chapter 3 offers an overview of the research methodology used in the study. It briefly explains qualitative research, its applicability to this study and links it to the mental health nursing context. Qualitative description is described and the analytical framework, thematic analysis, is defined and the steps described. Ethical considerations are explained, including the approval process, consent, confidentiality and anonymity and a discussion on risk to the participants. The specific design considerations and working strategies of the study are explained in detail. This encompasses preparation for the research process, data collection and data analysis. The system of documentation is described.

Chapter 4 is the findings chapter. The sample group is described, and the themes are discussed. The chapter concludes with a diagrammatic representation of the themes.

Chapter 5 is the discussion chapter, the four themes provide the structure for this discussion, which exposes their significance in relation to the research question as situated within contemporary mental health nursing literature. The limitations of the study are described, along with implications and recommendations for practice and ideas for future research on this topic.

Chapter 6 is the conclusion and provides a summary of the study and proposes recommendations. Limitations of the research are noted. The chapter concludes with a discussion of the implications of the study for future research.
CHAPTER 2: LITERATURE REVIEW

The literature review has been undertaken to summarise information relevant to the New Entry to Specialty Practice Mental Health & Addiction Nursing (NESP) programmes in New Zealand. The question under consideration is what is the impact of the programme for the nurses who undertake the programme, in terms of their personal and professional development?

The review is structured to establish the context in which the Canterbury NESP programme is situated, internationally and nationally within nursing, and specifically in mental health nursing. It explores the evaluations and reports of the impact of the programme, drawing upon peer reviewed articles or research and reports from New Zealand and overseas. Given an apparent paucity of literature explicit on the impact of NESP programme much of the material explored is peripheral information, with the intent of building an understanding of the wider research context.

This chapter is divided into sections, firstly the literature search strategies applied and an explanation of the effectiveness of these, then the relevant data surrounding the first year of practice and finally consideration of the period after NESP, the early career period.

2.1 Literature Searches

A review of the literature was undertaken using computerised data bases. CINAHL, Medline, Pub Med, EMBASE, OVID Psych Info, OVID Medline(R), The Joanna Briggs Institute EBP Database, COCHRANE and Web of Science were used to identify journal articles or books containing key search items. The National library resources Kiwi Research Information Service, Index New Zealand and lastly Web of Knowledge were explored when it became apparent that New Zealand literature was scarce. Each concept was explored utilising alternative vocabulary and truncation to ensure all alternatives were considered.

Key search included

- Entry to Specialist/ty Practice
- Graduate nurse program*
• Post graduate study
• Transition to practice
• Skill development
• Advancing nursing practice
• Mental health nursing
• New Zealand
• Psychiatric nursing
• Nursing education
• Professional development
• Personal development
• Masters level education
• Early Career nursing
• Workforce development
• Supervision
• Preceptorship
• Australia
• England
• USA

Non-database sources were employed, this included emails to colleagues who had undertaken research in a similar field. *Nurse Education Today* and *Journal of Continuing Education, Contemporary Nurse: A journal for the Australian Nursing Profession* and the *Whitireia Nursing Journal* were all subsequently searched (where able) for specific authors. Massey Research online was also explored.

The search was complicated in that there was not a lot of clarity in the international literature in relation to levels of qualification, when seeking to include a focus on the post registration and postgraduate study aspects of this research. Many of the articles reviewed were focussed on undergraduate education, and the terminology was at times inconsistent across the spectrum of data available. Notably in Australia the term
transition is most often used, compared to new graduate in New Zealand and the UK, and residency in American literature (Haggerty, Holloway, & Wilson, 2013).

A search using Google Scholar also elicited several articles previously not seen in the other computerised databases.

Useful content and further supporting articles were sourced from several masters theses. The components covered included supervision, preceptorship, advancing nursing practice, clinical leadership, first year of practice, early career nurses, organisational climate and job satisfaction, graduate nurse programme.

Whilst best practice in scholarly research would dictate consideration of recent literature, in the interests of painting a clear picture of the context of this programme literature has been considered relevant covering a timespan from programme inception in the early 1990s to the current day.

Peer reviewed articles focussing on the New Zealand NESP programmes were scarce with one article presenting the findings of the evaluation of the first NESP programme in New Zealand (Cook, 1998). To date the main piece of research exploring NESP is a critical case study exploring the experiences of seven nurses (Haggerty, 2000). Organisational climate and its impact on clinical practice for Nurse Entry to Practice (NETP) and NESP nurses is the most recent literature, yet this is not explicitly focussed on the NESP nursing experience (Were, 2016). However, data pertaining to NETP was prevalent and relevant to this research, albeit not specifically commenting on mental health nursing in New Zealand. A key supportive document was the extensive evaluation of the NETP programmes 2006 – 2009 (Haggerty et al., 2009). The post graduate study aspect of the NESP programme was supported by New Zealand research (Cotterill-Walker, 2012; Haggerty, 2000; McDonald, Willis, Fourie, & Hedgecock, 2009; Spence, 2004a, 2004b) and international studies that explored personal and professional development associated with postgraduate study (Pelletier, Donoghue, & Duffield, 2005; Spencer, 2006; Whyte, Lugton, & Fawcett, 2000).

Given the limited material available, grey literature, personal communications and editorials were also explored.
For the purposes of providing clarity in this review the literature has been divided into two sections.

1. First year of practice and transition
2. Post NESP / Early career

2.2 First Year of Practice

There is plethora of literature evidencing how critical it is for nurses to be well supported in the first year of practise in the transition from student of nursing to registered nurse (Duchscher, 2008; Haggerty et al., 2009; Scott, Huntington, Baker, & Dickinson, 2011a). Theoretical frameworks such as those of Kramer’s (1974) Reality Shock, and more recently, Duchscher’s Transition Shock© clearly articulate the need for a robust and supportive pathway for new nurses as they adjust to the professional practice role, becoming competent and confident practitioners (Duchscher, 2009).

Essential elements for effective new graduate programmes comprise positive environments, with structured orientation and robust systems of support including preceptorship (Haggerty, McEldowney, Wilson, & Holloway, 2010). This is a critical time for the new nurse and when it is inadequately supported has multiple impacts for the nursing profession, employers and crucially, on tangata whaiora care (North et al., 2013). The cost of nurses leaving or becoming burnt out, in terms of workforce and service delivery are well documented (Happell, 2008; North et al., 2013; Were, 2016). Because of these factors programme impact reports have tended to focus on retention and recruitment. This is the case with NESP programme evaluations spanning the twenty-year period they have existed in New Zealand.

The first formal mental health new graduate nursing programme in New Zealand was implemented in 1995, in Wellington. It was forty weeks in duration and funded by Clinical Training Agency (Cook, 1998; Haggerty, 2000). A longitudinal study was undertaken by the Clinical Training Agency (CTA) to evaluate the effect of it, however, this document could not be sourced, only a reference to it by Cook, who reported on the findings, briefly citing personal communication with graduates and the CTA (Cook, 1998). For three years all course participants were followed up via a postal questionnaire sent out by the CTA. The data provided minimal information about the impact of the programme for the nurses personally, other than to say the participants
found it relevant to their role. Two extracts showed the programme contributed to career progression for one nurse, and for being prepared for a challenging work environment for another. Retention rates of the nurses involved in the programme were noted, indicating that rates increased over the three years, that is, increasing from 71% in 1995 to 88.8% by 1997 (Cook, 1998, p. 29). Cook stated she viewed the programme as successful for the nurses involved, the nursing profession and the mental health services.

Following this evaluation, in 1999, Haggerty undertook a critical case study to illuminate the new graduate nurses’ experiences in their first year of practice, with the intent of ascertaining ways in which the programme could better support and enhance the nurses’ transition from student to registered nurse (Haggerty, 2000). This research, undertaken with seven nurses provided an extensive review of a NESP programme capturing the mental health nurses’ perspective. Haggerty, taking a critical social theory approach, and through discussion groups with the nurses, reported that the nurses experienced conflict when they entered an environment dominated by a medical model. This process of enculturation had the effect that they did not feel valued or supported, and they experienced this as oppression. Engaging in supportive critical reflection provided the nurses with the means to take the steps to understand this and respond. Other themes identified the need for better support in preceptorship, particularly in relation to communication of information regarding roles and expectations for nurses, preceptors and clinical workplaces. Recommendations were made in respect of preceptorship selection, training and support. The nurses indicated that greater emphasis on the socio-political context of nursing would facilitate their understanding and socialisation into the nursing role, and that this should be emphasised more in the programme curriculum.

In 2005, the Mental Health Workforce Development Programme Committee initiated a review of all Post Entry Clinical Training (PECT) programmes, including mental health nursing, with the intent articulating the usefulness from this investment, the “training and fiscal value of post entry clinical training” (Finlayson et al., 2005, p. 1). Whilst this review painted a comprehensive picture of the value for money, particularly in terms of recruitment and retention, it did not specifically explore the impact of the mental health nursing programmes in terms of ongoing professional development, nor
outcomes for tangata whaiora. Participants commented about practice upon completion of one intensive year of education and support, not the application of these skills over subsequent years, thus affording a view of the application of the learning, and perhaps impact on health outcomes for people experiencing mental health issues.

The New Zealand programmes have been regularly audited, reviewed and reported on at a government level through the Clinical Training Agency, and from 2008 Health Workforce New Zealand contracted Te Pou o Te Whakaaro Nui (Te Pou), which works to support and develop the mental health, addiction and disability workforces in New Zealand.

In 2010 an extensive report, examining the value and effectiveness of Nurse Entry to Practice Programmes in New Zealand from 2006 – 2009 was released (Haggerty et al., 2009). The research was prepared for the Clinical Training Agency, part of the Ministry of Health and focussed primarily on the first year of practice. This report indicated significant benefit from the programmes for nurses, in terms of confidence and competence; and for the employer in terms of positive impacts on recruitment and retention, from this supported first year of practice. Significantly the NETP programme when situated in the international literature over the previous 10 years, reflected the ‘most successful and effective qualities of new graduate nursing programmes’ (Haggerty et al., 2009). Post graduate study in the NETP programme, in contrast to the NESP programme, was not a mandatory requirement. Whilst not focussed on extensively in this report, the recommendations suggested that inclusion of a level 8 paper focussed on assessment of tangata whaiora and clinical reasoning has merit in enhancing competence, confidence and better patient outcomes (Haggerty et al., 2009). NESP can include nurses new to the specialty but not to nursing, whereas NETP is solely for new graduate nurses.

NESP programmes purposely were not included in the brief for the above-mentioned research, and therefore afforded little mention other than to acknowledge that when the NETP programmes were being established, a Ministry of Health recommendation was that the mental health nursing programme “should be used as a template for nursing as a whole” (Ministerial Taskforce on Nursing, 1998, p. 60). Many of the findings from this research could be extrapolated out to the specialty of mental health nursing, in terms of structures required for effective transition of nurses new to the field.
This important aspect was emphasised in the most recent evaluation of the NESP programme, undertaken in 2014 by Dr Gail Stuart, an American Distinguished University Professor and authority in mental health nursing (Te Pou o Te Whakaaro Nui, 2014). Dr Stuart was commissioned by Te Pou to undertake an independent best practice review of the Skills Matter programme, as part of the organisation’s ongoing quality improvement process. Overall, she spoke positively of the programmes, describing them as “highly effective, efficient and excellent return on investment for New Zealand” (p. 6), providing the only specialised mental health and addictions training for new allied and nursing graduates” (Stuart, 2014). In relation to ongoing professional development she recommended that the Te Pou programmes needed to be linked to ‘career ladders’ to develop a ‘national pipeline’ for mental health and addictions workforce (Stuart, 2014, p. 13). NESP programmes, she contended are a successful strategy for recruitment and retention and meeting the issues with provision of ongoing workforce in this area. A significant recommendation was the need to make more overt the outcomes of Te Pou’s work, by publishing, and widely disseminating structure, process and outcomes of the programme. She noted that just one dissertation study has been undertaken in relation to the NESP programme (Stuart, 2014).

2.2.1 Post graduate study

The inclusion of post graduate education as a component of the post registration programmes was viewed as an essential part of a suite of measures to address the deficits in undergraduate training and prepare the workforce effectively (Haggerty, 2000). This initiative was also in alignment with government and nursing leadership drives to prepare the New Zealand nursing workforce, through the provision of post graduate education, for this altered health care environment (Prebble, 2001; Spence, 2004a; Wilson, 2006).

Post graduate education within these Entry to Specialty Practice Programmes has been a contentious issue with some authors urging caution in using post graduate education as ‘a panacea to any problem facing nursing’ (Lakeman, 2000, p. 91). However, it is recognised by others that post graduate education is important in terms of personal and professional development and patient outcomes (Barnhill, McKillop, & Aspinall, 2012; Cotterill-Walker, 2012; McKillop, Doughty, Atherfold, & Shaw, 2016; Pelletier, Donoghue, & Duffield, 2003; Spence, 2004a; Whyte et al., 2000).
McDonald, Willis, Fourie, and Hedgecock (2009), undertook a cross-sectional survey with forty nurses undertaking a NETP programme. This looked at the value of postgraduate education in the first year of practice. Whilst finding that most nurses felt well prepared and benefited from the experience of postgraduate study in their first year of practice, the research was inconclusive regarding the impact on the nurses in the longer term.

Cotterill-Walker (2012), in reviewing the literature examining postgraduate study and whether engaging in it made a difference to patient care, found that whilst nurses had positive gains in terms of personal and professional development, the data evidencing whether this study made a difference to patient care was not overt within the literature. Her recommendations included that future research be focussed on specific outcomes and the development of measurable and observable criteria. Lakeman (2000), likewise, also urged caution stating “what happens after the postgraduate course is over? Viewing nursing education as a production line in which raw material is placed in one end and a polished finished product, be it advanced or beginning practitioner is produced at the other end is flawed” (Lakeman, 2000, p. 92). For the nurses undertaking these mental health nursing programmes it is imperative to take a more in-depth examination of the factors influencing what happens after the programme.

2.2.2 Clinical preceptorship

Preceptorship in nursing has long been regarded as an essential strategy in supporting nurses new to the field to develop the knowledge, skills and confidence to practice safely and effectively in a professional manner (Haggerty, Holloway, & Wilson, 2012; Haggerty et al., 2013; New Zealand Nurse Educators Preceptorship Subgroup, 2010). Significantly, it has been associated with improved patient outcomes through the increased confidence and competence of the nurse receiving effective preceptorship (Haggerty et al., 2013).

Effective Preceptorship contributes to nursing retention by supporting the nurse through the vulnerable period of role socialisation (Crowe, 1994; Duchscher, 2008). A preceptor assists the new nurse in their transition into a cultural setting by acting as a resource person immediately available within the clinical workplace. Role modelling,
questioning and challenging are all aspects of the role which has a focus on encouraging critical reflection and analysis, thereby providing the best nursing care (Crowe, 1994). Preceptors ideally work alongside the new nurse and supportively challenge practice and encourage reflection.

2.2.3 Inpatient and community experiences

Mental health nursing is delivered in inpatient and community facilities and specialist knowledge and skill is required to work in and across both these areas. It is widely reported that new graduate nurses when employed into community positions without significant support and guidance, struggle (Haggerty, 2000; Haggerty et al., 2012; Ministerial Taskforce on Nursing, 1998). Yet in this field understanding the continuum of care is vital, especially given the focus on working with people as much as possible in their own homes and delivering care in the community rather than institutions. From inception, the programmes have had a clear focus on a range of inpatient and community learning experiences (Cook, 1998). This is at odds with some authors contending that in the first year of practice nurses should be placed in consistent, and where possible, stable workplaces and be gradually exposed to increasingly more complex clinical situations (Adlam et al., 2009; Duchscher, 2009). Adlam et al (2009), in making recommendation for the standardised NETP framework, strongly suggested that rotations be limited to one or two, they noted that several of the new graduates surveyed in the research stated they found rotations disruptive.

2.3 Early Career/Post First Year of Practice

Aside from Haggerty’s research in 2000, there have been few published studies associated with New Zealand NESP programmes (Haggerty, 2000). In 2016 Were’s master’s thesis examined whether organisational climate is conducive to personal and professional development, and the relationship with success in clinical practice for nurses in the first two years of practice (Were, 2016). Participants included NESP and NETP nurses, however it was difficult to extrapolate out the NESP programme impact from within this material. It appears that the inclusion of NESP nurses was accidental, as the survey was unintentionally distributed to a wider audience than intended. This may account for the Were’s statement that the NETP and NESP programmes were relatively new, when NESP programmes have been in existence for over twenty years.
This research did however provide valuable insights into the relationship between job satisfaction and a positive organisational climate. Notable in the recommendations to support a sustainable future nursing workforce, were the importance of nursing relationships, ward leadership and staff organisation (Were, 2016).

One study was located that explored the professional development perceptions and activities of psychiatrists and mental health nurses and was undertaken by members of the Society for Psychotherapy Research, a collaborative group of nurses and psychiatrists in New Zealand (Kazantzis et al., 2010). Using a questionnaire, the participants were asked a series of questions related to use of the use of supervision, training and personal therapy. Eighteen of the forty-four participants were mental health nurses working in public outpatient and independent private practice facilities. The results indicated that supervision and personal therapy were more highly regarded by both groups than didactic training, and that the nurses rated personal therapy as the most influential source of their development. The results were difficult to interpret, and the recommendations indicated the need for more in-depth research in this area exploring past, present and future professional development training.

Spence (2004a) undertook a phenomenological study of 20 nurses who worked in a range of rural and urban settings, but not in the specialty of mental health, exploring the impact of clinically focussed postgraduate education on advancing nursing practice in New Zealand. The findings confirmed her beliefs that post graduate education as part of advancing nursing practice benefits tangata whaiora outcomes and provided valuable insights into the New Zealand context. She identified that nurses who undertook post graduate study questioned practice, were more able to apply research to their practice and developed a wide knowledge base. Engaging in post graduate study enhanced the nurses’ capacity to think more critically, process and integrate information more readily, and consider more perspectives. Increased knowledge facilitated greater confidence which supported the nurses in articulating a sound rationale for practice and meant they could confidently collaborate with other health practitioners. Spence concluded that because of these activities nurses felt more able to support other nurses by role modelling advanced practice (Spence, 2004a).
Internationally several longitudinal studies have been undertaken to explore the value of postgraduate study in advancing practice. These were undertaken by Whyte et al (2000) from 1986 to 1996 in Scotland, Pelletier et al (2005) from 1998 until 2002 in Australia and Spencer (2006) in United Kingdom. Whilst none of these studies included mental health nurses the studies did provide considerable amounts of data, in their respective countries, linking personal and professional growth with post graduate study. Whyte et al, in Scotland, undertook a ten-year study and found that masters level study prepared nurses well for ‘higher level practice’, by enhancing clinical practice, personal growth, core academic skills and provided the nurses with career options (Whyte et al., 2000). Whilst this research is widely cited there is caution in its rigor, with confidence being reduced in the Australian study due to issues with validation. Similarly, the Scottish study had a low response rate of 51% by the end of the ten-year period. Given that the most recent of these studies was undertaken 17 years ago, caution is needed in applying these findings to the New Zealand context.

Finding published and peer reviewed research has been a challenge. Whilst research has been undertaken into the effects of the programme it was often captured in unpublished thesis. Ford was cited in several of the government documents for her research evaluating the NESP programme in the Auckland region, around the period 2004-2005, however this research was not able to be accessed (Wilson, 2006). From these accounts, it was apparent this was an evaluation undertaken shortly after programme completion and supported previous findings that undergraduate education was inadequately equipping nurses with knowledge and skills for mental health nursing; 78% of the nurses felt the programme prepared them well and that the nurses valued the theory and clinical mix; clinical rotations fostered increased understanding of the nursing role in different settings; and that confidence was enhanced by undertaking supervision (Wilson, 2006).

It is evident that there are few New Zealand studies that focus on NESP programmes, and that research associated with NESP programmes has tended to focus on surveying participants during or upon conclusion of the first year of practice. Notwithstanding the favourable reviews from most stakeholders, as outlined in the government reports, there is very little in the way of published and peer reviewed research in New Zealand which links the effects of these specific mental health nursing programmes with
personal and professional development for the nurses. Research in this area would benefit nursing workforce understandings and perhaps contribute to improved health outcomes for tangata whaora and whānau.
CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

The methodology chapter provides a justification of the philosophical stance underpinning and informing the research, with a detailed account of how the study objective has been met through the research process, outlining why the approach was undertaken and how it was done. The research design provides the framework for the study and shows how all the major parts of the research work together to address the research objective: to describe the perceptions and experiences of a sample of thirteen registered nurses who had undertaken the NESP programme. The intention being to illuminate the impact of the programme on the nurses’ personal and professional development three to six years after programme completion.

In contemplating undertaking any research, there are several aspects that require careful and in-depth consideration. What approach should be taken and why? What are the theoretical underpinnings and the assumptions supporting the approach? What methods are best suited to this approach? Careful thought is required to understand that how the research is undertaken determines the information received and the possible ways it could be interpreted (Dew, 2007; Fontana & Frey, 2005).

3.1.1 Epistemology

Methodology refers to “the principles or assumptions underlying particular research approaches” (Dew, 2007, p. 433). Crotty describes this as “the strategy, plan of action, process or design, lying behind the choice and use of particular methods and linking the choice and use of methods to the desired outcomes” (Crotty, 1998, p. 3). Methodology is the second of, what Crotty contends are, four foundational components in any research process. These are the method, methodology, theoretical perspective and epistemology (Crotty, 1998). In exploring the methodology appropriate to the research, one needs to be mindful that the theoretical perspective is the philosophical position which informs the methodology and therefore provides a context for the process. Furthermore, the ontology or understanding of what the world is, and the epistemology or the way in which we know that world or our theory of knowledge, are
embedded in this theoretical perspective and therefore the methodology (Crotty, 1998; Guba & Lincoln, 2000).

### 3.1.2 Theoretical perspectives: qualitative methodology

Research is commonly divided into two distinctive branches, quantitative and qualitative with much debate about the superiority of one approach over the other (Creswell, 2009; Cutcliffe & Goward, 2000; Polit & Beck, 2014; Thorne, 1991). Creswell (2009) contends there is a third branch in that of mixed methods approach, although caution is urged when utilising a variety of methods that the researcher remains true to the philosophical underpinnings of the approaches taken. Nursing research has dominated in qualitative approaches attaining what is known as ‘methodological orthodoxy’, that is, it has become regarded as the most well-suited approach for research undertaken by nursing (Thorne, 1991; White, 2003). These authors both contend that nursing research has traditionally valued a qualitative approach over that of quantitative, however one approach is not superior to the other; White cites the use of survey as a valuable tool in nursing research (White, 2003). Similarly, research by the medical profession has a well-known affiliation with quantitative methods, in contrast, a strong tradition exists in theology, philosophy and sociology for a qualitative realm (Thorne, 1991). The different perspectives are underpinned by contrasting worldviews which is why it is important to explore why one approach has a better application for the research question than another.

Simplistically put quantitative research often has a numerical association and claims to objectively measure or report on the frequency or prevalence of a phenomena or the relationship between variables. It is an approach with an epistemology of objectivism, that seeks to predict, describe and explain, drawing upon data that has been measured and analysed (Polit & Beck, 2014). The lens that the data is seen through in this approach is one which holds that the world can be explained in terms of universal laws that apply regardless of time and place (Cutcliffe & Goward, 2000). Quantitative research has historically been perceived as the superior science based on empirical information (Cutcliffe & Goward, 2000).

Qualitative research in contrast, is associated with understanding the meaning individuals or groups ascribe to an experience, which is in the subjective realm and
based in a naturalistic epistemology that sees the social world as fluid and ever changing (Cutcliffe & Goward, 2000). These studies have been regarded as ‘soft science, unscientific or exploratory’ (Denzin & Lincoln, 2000, p. 7). This perspective however has been changing, particularly in nursing. Cutcliffe and Goward contend that qualitative approaches are well suited to mental health nursing due to three key themes, ‘purposeful use of self; creation of an interpersonal relationship, and the ability to accept and embrace ambiguity and uncertainty’ (Cutcliffe & Goward, 2000, p. 594-596). Nurses are drawn to this line of research due to the similarities in approach with mental health nursing practice sharing a naturalistic or constructivist worldview that seeks to understand the world of those they are working with (Cutcliffe & Goward, 2000).

Research in the qualitative realm deals with subjective experiences. The intent is not to objectively measure or report on the frequency or prevalence of a phenomena or the relationship between variables. The focus is on the social world not that of the world of nature, where phenomena can be treated as objects, and natural laws generated (Dew, 2007). According to Morse, in arguing for qualitative research to be recognised as important, ‘subjective, is explored subjectively’ (Morse, p. 151). This type of research does more than illuminate, explain or provide understanding; it provides substance and rationale, which is said to be central to the development of healthy hospitals and populations (Morse, 2004). Participants articulate their own perceptions through their opinions, beliefs and values in response to providing care. Their understandings of reality can change over time and in different social settings (Dew, 2007). The approach taken to research has implications for the data collected and what can be done with it.

One of these implications is related to partiality, or bias of our world view. Quantitative and qualitative research attend to partiality in different ways. Quantitative approaches set out to address confounding issues and focus on producing results that can be generalised to the population (Dew, 2007). Implicit in this approach is the assumption that a full and comprehensive view of the world is possible. In contrast, most qualitative approaches assume the view of the world is at best a partial representation (Dew, 2007).
Another aspect related to world view is whether the approach is deductive or inductive. A quantitative approach works deductively by drawing on prior understandings to put forward a hypothesis which is tested. If the test holds the theory is accepted, if not the theory is modified or rejected. In contrast, qualitative research puts aside prior theories and builds up an understanding of the world from the data and which leads to the development of a theory or argument (Dew, 2007). When there is little understood about a specific topic it is fitting to take an inductive approach, as generating a theory from limited prior understandings could be a significant challenge.

Given that the objective of the research was to explore the impacts, for the nurses in the NESP programme, qualitative descriptive inquiry was considered a methodological approach in keeping with this. This next section explores the research method and data analysis framework which are in accordance with exploring the responses of individuals and capturing the meanings they ascribe to experiences.

3.1.3 Qualitative descriptive methodology in nursing research

A qualitative descriptive method, as described by Sandelowski is the research approach adopted for this study (Sandelowski, 2000). It has been in existence for many years and whilst associated with Sandelowski is not her method, she states that in qualitative description ‘…there is no bounded entity constituting a pure method’ (2010, p. 78). The approach is known for its eclectic approach with opportunity for variation within the method at the points of sampling, data collection, or analysis. It has been extensively critiqued and is viewed as a credible and functional approach to research seeking to provide a comprehensive summary of events using ordinary everyday terms for those events (Lambert & Lambert, 2012; Neergaard, Olesen, Andersen, & Søndergaard, 2009).

In contrast to the well-known qualitative approaches of phenomenology, grounded theory, ethnographic and narrative studies, which are purposely orientated to theoretical views or particular phenomenon, qualitative description provides a straightforward narrative of events using ‘everyday’ terms. The foundation of this approach is in naturalistic enquiry, which seeks to study phenomena in their natural state, in as much as is possible in the research process with the researcher, through judicious
technique usage, ‘…allowing the target phenomenon to present itself as it would if it were not under study’ (Sandelowski, 2000, p. 337).

Qualitative description is viewed as suitable ‘to obtaining straight and largely unadorned (i.e. minimally theorized or otherwise transformed or spun) answers to questions of special relevance to practitioners and policy makers’ (Sandelowski, 2000, p. 337). Significantly, the approach is not without theory nor without interpretation. In fact Sandelowski emphasizes that this approach ‘…requires moving somewhere: that researchers make something of their data’ (Sandelowski, 2010, p. 79). The goal of the researcher is to strive for an accurate rendition of the events or meaning for those involved in the research, what Sandelowski names as ‘descriptive validity’ (Sandelowski, 2000, p. 336). One of the strengths of this approach, particularly when undertaking in-depth interviews, is that the researcher strives to transfer as much control as is possible to the participant who has chosen to give of their time and share their experiences. This approach recognises that the participant is the expert regarding their life and what is important to them, and, as van den Hoonaard contends, there is no right way or a wrong way to respond to the questions (van den Hoonaard, 2005).

The objective of the research was to explore the impacts for the nurses, in terms of describing how their experiences have been shaped by the NESP programme. Qualitative descriptive inquiry, a methodological approach in keeping with exploring the responses of individuals and capturing the meanings they ascribe to experiences, is an approach that facilitates this expression.

Key to a qualitative approach is the role of the researcher. In this interpretative research experience the researcher has an intensive period of time with the participant, because of this the influence of the researcher cannot be removed from this approach, and it is inevitable that the researcher will hold preconceptions (Creswell, 2009; Sandelowski, 2010). In contrast to quantitative research, the role of the researcher in relationship to the researched is acknowledged and seen as integral in creating knowledge. The researcher, rather than being positioned as a detached observer is an active participant and part of the process. A researcher’s bias, beliefs and interests are acknowledged and presented to enable their impact on the research to be acknowledged. Reflexivity is the term used to describe this role, whereby the researcher consistently reflects on how they affected the research and how the research affected them (Polit & Beck,
Fontana and Fey (2005) contend that through being attuned to others, the researcher comes to know themselves. Reflexivity occurs throughout the entire process of the research and is important for ensuring the research is transparent and authentic. Therefore, it is important that the researcher understands their own preconceptions, in order that they don’t impose these and therefore cloud the understanding of the world of the researcher (Fontana & Frey, 2005).

3.1.4 Researchers preconceptions

Prior to undertaking the study, the researcher identified several well ingrained ideas held about the nurses who undertake NESP programmes.

1. The NESP programme is effective in preparing nurses for the specialty of mental health
2. Nurses will continue in professional development after the NESP year
3. The nurses will have effective role models in their nursing worlds
4. Nurses will continue to be critical in their nursing approach and challenge practice
5. Nurses will take up leadership and advanced practice roles in nursing

3.2 Thematic Analysis Method

Qualitative descriptive methods are not wedded to specific approaches regarding sampling, data collection or data analysis. Given this seeming lack of structure, yet high degree of flexibility it is important to establish scaffolding to keep the research on track. Braun and Clarke’s (2006) step by step guide of the phases of thematic analysis was used for this study as a tool to guide the analysis of the data. The purpose of such a guide is to ensure a robust process is deployed, that is in keeping with the methodological approach, and ensures qualitative information is captured and organised and interpreted rigorously, in a systematic and congruent manner (Braun & Clarke, 2006, p. 96).

Thematic analysis, according to Sandelowski (2010), is an effective approach in qualitative descriptive studies. This method is prevalent and has been successful in answering research questions of a qualitative nature in nursing. O’Brien (1999) through a qualitative thematic approach explored what mental health nurses perceive
to be expertise in nursing in relation to how they practice in New Zealand. Fourie (2005) similarly used a qualitative descriptive method to compare perceptions of nursing roles with actual practice in acute mental health units in New Zealand. Richardson and Gage (2010) taking an exploratory descriptive approach, looked at opportunities and constraints encountered by practice nurses when engaging in post registration education. Cleary et al, (2012) in Australia, applied a qualitative interpretive approach to their research which examined mental health nurses’ perceptions of good work in an acute setting.

Thematic analysis ‘is a method for identifying, analysing and reporting patterns (themes) in data’ (Braun & Clarke, 2006, p. 79). This process guides the researcher to recognise, illuminate and capture something important about the data, in relation to the research question, that is prevalent in each data item and across the whole of the research data (Braun & Clarke, 2006). The raw data is examined closely, and similar ideas are clustered together to form broad categories, which are then further reduced to dominant and sub themes.

In alignment with a qualitative methodology, the data is identified taking an inductive approach to analysis, in that the themes are driven from the data. With this approach data is collected via focus group or interviews with the clear intention of the data itself driving the creation of themes; bearing in mind that the interview questions asked of the participants may not relate to the themes identified (Braun & Clarke, 2006). In contrast, a deductive approach would have the researcher approaching the data with a set coding framework as they sought to explore a specific theoretical perspective. This is further expanded upon in the data collection and analysis sections further along in this chapter. Before any research can be undertaken ethical approval must be granted.

3.3 Rigor in Qualitative Research

As noted earlier in this chapter, the role of the researcher in relationship to the researched is acknowledged and seen as integral in creating knowledge that is an accurate rendition of the experience for the participants. Taking a reflexive approach as a researcher is important to the role of the researcher in relationship to the researched is acknowledged and seen as integral in creating knowledge ensuring rigor in this process. Sandelowski argues that ‘rigor is less about adherence to the letter of rules and
procedures than it is about fidelity to the spirit of the qualitative work’ (Sandelowski, 1993, p. 2). Accordingly, she further contends that for research to be regarded as trustworthy it requires a visibility of the practice of interpretation, which in turn is auditable (Sandelowski, 1993). Lincoln and Guba (1985) assert that in evaluating rigor, or merit of the research four objectives need to be met. These are credibility, transferability, dependability and confirmability; referred to within the literature as trustworthiness (Sandelowski, 1993).

Trustworthiness in this research has been attended in the following ways.

1. Credibility – this is evidenced in the narrative around data collection strategies of the formal consent process, participants check transcripts for accuracy, recording verbatim participant experiences. This methodology section and the subsequent participant quotes in the next chapter support the thematic interpretations and fit within the context of the literature, thus allowing the reader to draw their own conclusions as to the credibility (Hancock, Ockleford, & Windridge, 2009).

2. Transferability – detailed descriptions of the context allow the reader to determine whether the work could be transferred to another setting. The fit within the literature serves to give the work validity.

3. Dependability – is evidenced in the provision of a clear audit trail, with detail in the thinking informing the decision making and processes undertaken. This serves to allow the reader to understand and follow the logic used. Interviews, review of audio tapes and transcripts were all undertaken by the researcher. Transcription was completed by a transcriber and checked entirely by the researcher for accuracy. Interviews were all guided by the semi structured interview questions. The consent process was explained including amendments.

4. Confirmability - reflexive practice by the researcher has ensured influence on the data has been minimised, as explored in this chapter under researcher preconceptions, rapport and critique of this in the data collection section.
3.4 Ethical Considerations

To undertake research with human participants it is of paramount importance to ensure that no harm will be done to participants or the community that the research is undertaken in. Gaining ethical approval has purpose in protection for the clients and the community that the research resides within, and for the researcher from undue criticism from the community. Nursing research is underpinned by ethical principles of beneficence, doing good and non-maleficence, to do no harm (Lakeman, 2009). Davidson and Tolich (1999) suggest that the code of ethics can be condensed into five key principles for application to research activity, namely, that it will do no harm; participation is voluntary; confidentiality and anonymity of participants is preserved; it will not be deceitful, and lastly, that data will be analysed and reported in a faithful manner.

This next section describes the ethics process and the ethical principles that underpin this nursing study.

Ethical approval was granted from the University of Otago Human Ethics Committee (Health) H15/054, as health research principally for the purposes of an educational qualification and involving healthy participants not recruited as patients. In addition, a Canterbury District Health Board, Specialist Mental Health Service, Research Locality Assessment was undertaken providing approval to undertake research involving staff.

3.4.1 Research involving Māori

Consultation with Māori was undertaken, as per the University of Otago guidelines, to ensure that the research incorporated the principles of the Treaty of Waitangi, was sensitive to the needs of Māori and considered and protected their cultural interests. The research was not specifically a Māori piece of research, however in the interests of a having a presence reflective of the Canterbury population (estimated to be 8%) it was anticipated that some participants would identify as Māori, per the Ministry of Health 2013 consensus question regarding ethnicity. Māori nurses, as with all the nurses in the sample, were free to participate, or opt out at any time.

The overarching principles of Te Tiriti o Waitangi were applied to the study, namely that the researcher participant relationship was based on a partnership, whereby the
contributions of both were equally valued. All nurses who met the inclusion criteria were invited to participate and were provided with sufficient information to do this in an informed way. Through the process of informed consent, the nurses had their privacy, rights and their own beliefs protected.

The Specialist Mental Health Service, Te Korowai Atawhai were presented information about the research, and feedback was sought from cultural advisors to ensure due process was followed.

3.4.2 Informed consent, confidentiality and anonymity

Informed consent was obtained only after there was confidence that the participant had received a copy of the research information and consent forms and indicated that they understood the purpose of the research and any inherent risks associated with it. Included in this information was how the data was to be stored, confidentiality maintained and what the information would be utilised for (Appendix 1). Consent was verbal and written (Appendix 2). To preserve participant identity and maintain confidentiality of the data all transcripts were anonymised, and data masked by using pseudonyms. Nurses were also not able to be identified by sex, ethnicity or geographical location, instead broad terms were used, for example them rather than he or she, and New Zealand or overseas for geographical locations; where it was relevant to mention location.

3.4.3 Relationship and potential risk to participants

All research has potential for conflict of interest, in this situation arising from the researcher’s role and status, as the Nurse Coordinator of the NESP programme. Recognition of the power component of the research work is imperative given the potential for impact on the data collection. In qualitative research, it is impossible to remove the researcher’s influence on the process with many points of potential disparity where age, ethnicity, religion, culture, gender, and social status differ between the researcher and the participants of the research. Recognition of the power component is a key responsibility of the researcher operating in a social system in a certain time. The researcher abides by the ethical principles whilst being cognisant of the unique cultural aspects of that system, for example in New Zealand, the Treaty of Waitangi (Snook, 1999). Researcher experience, understandings and capabilities all
influence the responses that come about from the participant narrative, and therefore the data collected (Dew, 2007).

All participants had contact with the researcher in her role as Programme Coordinator. This prior relationship on the one hand could be seen to facilitate trust and rapport, leading to greater richness in the data collected. On the other hand, participants could feel intimidated by the researcher’s status as Programme Coordinator and feel obligated to participate and perhaps less likely to freely express their ideas. It is inevitable that the researcher-researched relationship is one-sided (Webb, 1993). Van de Hoonoard (2005) contends, having status as a ‘friendly stranger’ can sometimes be useful in research, it allows people to be open and forthcoming about both negative and positive experiences. However, with the establishment of rapport and trust also comes the risk that participants could disclose information they later regret, this is something the researcher needs to be mindful of (Graham, 1984; Reinharz, 1992). Other authors contend that moral dilemmas may be raised because of the relationship and empathy that may arise, and the way questioning is undertaken (Finch, 1984). Paradoxes will exist regardless of researcher/researchee communication and negotiation around, for example, transcript content (Webb, 1993). Ultimately it is the researcher, with a different status and education than that of the researchee, that has the final say on how the results are shaped. In determining measures to attend to these tensions the question in the researcher’s mind must remain, ‘whose interests are being served’ through the process of, and outcome of the research endeavour (Hall & Stevens, 1991).

Attention was paid to mitigating the effect of this potential for power imbalance in the researcher/researchee relationship by purposely recruiting from a pool of nurses of whom the researcher had limited contact and no educational or line management oversight, that is, since the programmes run from 2010 – 2013. A detailed explanation of the measures undertaken to attend to this risk, as well as an independent peer review of the proposal were undertaken as part of the process of submitting for ethical approval.

With respect to the researcher’s prior role in employment and authority during the period of the programme, the following measures were undertaken to further mitigate the influence.
Participants were invited via a generic email using email distribution lists, to support a more neutral approach, rather than a personal one. The existing prior relationship with participants had the potential to make it difficult for the participants to decline to participate or conversely be a deterrent to participate, therefore an opt-in recruitment strategy was adopted, and participants ranged from three to six years post programme completion, and therefore had little contact with the researcher. Close monitoring and regular review with the academic supervisors were undertaken to ensure participants consented freely and to ensure practice was in keeping with ethical requirements.

Within the interview emphasis was placed on attempting to equalise the relationship by focussing on the research role and interests of the project with the participant rather than the researcher’s status as Programme Coordinator. Van den Hoonaard (2005), in her account of undertaking research with older women, found it useful to mitigate the risk of participants being intimidated by her status as a doctor and university staff member by focussing on the connections she had with the participants (The Third Age Centre), keeping her business card very simple and not referring to herself as a doctor or emphasising her role with the University.

3.5 Research Method and Procedure

This research set out to answer the question - what is the impact of the New Entry to Specialty Practice Mental Health and Addiction nursing programme on the nurses’ personal and professional development?

‘Particular problems demand particular solutions’ in saying this Davidson and Tolich (1999, p.21) reiterated a key message that research should always be tailor made. There is no one recipe to fit every piece of research, as it is all unique to the context it sits within, the question, the participants, the theory involved and the resources of the researcher.

3.5.1 Research setting

This research was undertaken within the Specialist Mental Health Service of a large South Island District Health Board (DHB) in New Zealand. However, participants were not all current employees of this DHB. To be included in this research the participants needed to have undertaken their NESP programme under this Te Pou
contract between 2010 and 2013 but did not need to be current employees. At the time of interview only eight of the thirteen participants were employees of the contract DHB. Two participants were working overseas and three were employed by other health providers.

3.5.2 Recruitment and sampling

All registered nurses who completed the programme provided by the Specialist Mental Health Service, of the Canterbury District Health Board located in Christchurch, New Zealand, within the years 2010 – 2013, were invited to participate in this study. The rationale behind this specific timeframe was to ensure that the nurses had adequate time to establish themselves in workplaces and the nursing role following completion of their NESP programme. Therefore, the registered nurse experience in the field of mental health ranged from three to six years.

Inclusion criteria was that the nurses:

- have completed the Canterbury NESP programme between 2010 – 2013 (inclusive of the West Coast DHB nurses)
- be Registered Nurses currently in practice (not necessarily in mental health nursing settings)
- have at least one year of nursing experience following completion of the programme
- were available for a face to face interview

Sampling is the decision making that surrounds who will participate in the study. Qualitative studies select participants because of their experience of the phenomenon (the NESP programme) and their willingness to talk about the impact of these experiences. This research was purposive for the programme in terms of selection of participants with as much diversity as possible, capturing a wide range of perspectives, in keeping with a qualitative approach, which is effective when small numbers are studied in depth (Denzin & Lincoln, 2000). Nurses were selected based on those that met the criteria and were available for interview within the timeframe available. The ideal was to have a sample with an equal spread of nurses across the four-year band of the programme participants and of the nurse population in terms of gender, age and ethnicity. Purposeful sampling was achieved by accepting the offers that reflected the diversity sought (age, gender, ethnicity and year of participation) in the replies from
the people in these groups, until a suitable number of participants was reached, on a first-in-first-served basis.

Uniquely to NESP programmes, not all nurses are newly graduated registered nurses when they enter this specialty practice. In keeping with the desire to have a broad range of perspectives, the research was inclusive of experienced nurses new to the field of mental health who had undertaken the NESP programme. Two men opted into the study, serendipitously reflecting the proportion of the Canterbury population of men in mental health nursing, which is 13.6% (Nursing Council of New Zealand, 2016).

Consultation with Māori indicated that to be representative of the Māori population in this region would require 8% of the total number recruited, which in this case was 1.04, being 8% of thirteen (personal communication Karen Keelan, Kaitohutohu Rangahau Māori / Māori research Advisor 23/7/15). Whilst representativeness was not necessary for this research, two of the participants who opted into the research identified as Māori.

Information about the research was distributed in a flyer via email using the database of email contacts held by the Programme Coordinator. Those who responded were supplied with an information sheet (Appendix 1) and consent sheet (Appendix 2). Participants were provided with the opportunity to ask questions throughout this process before choosing to opt-in. Several participants had a telephone conversation with the researcher and four booked an appointment time and met to discuss the study. At this point a system of documentation organisation, both electronic and paper, was established to keep track of communication with potential participants and to ensure a robust system was in place in preparation for interview recordings and transcripts, enabling expedient access and close monitoring, and importantly, ensuring the material remained private and protected the confidentiality of those involved.

3.6 Data Collection

Data was collected via means of an in-depth semi structured interview, conducted by the researcher. Each interview was audio taped and transcribed, by a professional transcriber, recommended by the University of Otago (Appendix 5). Participant consent also included an agreement that the interview was audio taped and transcribed by the researcher or an approved transcriber. Each tape was carefully listened to and
checked against the transcription for accuracy, then sent to the participant to check for accuracy, this also gave them the opportunity to remove any material that they may have had second thoughts about including. One participant requested a change in a word to more accurately reflect the meaning intended.

Employees of the DHB’s negotiated approval from their line managers for release time, the researcher provided flexible times and interviewees chose a time to suit them. As it transpired the average interview time was forty-six minutes; the shortest interview was twenty minutes and the longest sixty-eight minutes. The Skype interviews were more challenging in terms of engagement than those that were face to face, and the telephone interview was the shortest and most challenging in terms of maintaining rapport and engagement.

3.6.1 Interviewing guide

A pilot interview was undertaken as a means of testing the interview guide and for the novice researcher to gain confidence, in preparation for the interviews. The participant was a nurse who had undertaken the NESP programme, and a colleague of the researcher who was not within the target population being recruited. The data was not utilised for the research. Confidentiality of this information and an explanation of the purpose of the pilot was discussed prior to the interview with verbal consent obtained to record the conversation and share any implications from this exercise with the researcher’s supervisors. The interview took place in a negotiated private space and was fifty-five minutes in duration, in keeping with the proposal.

The researcher has a background in delivering Clinical Supervision and was conscious that this could unintentionally lead to reflective responses with participants, more in keeping with counselling than interviewing (Morse & Field, 1995). This was identified in the pilot interview and reframed by turning the reflection into a question. Additionally, a closed question inadvertently asked in the pilot, resulted in an affirmative response. A salient reminder that closed questions are not useful for understanding the experience of the participant and tend to disrupt the natural flow of the interview.

An interview guide is useful, however, it is important to be cautious in developing guides that are too detailed, as this may detract from the participant’s account of their
experience (Opie, 1999). The interview guide was checked by supervisors and further refined down to eight key open questions (Appendix 3). All interviews were undertaken using this structure, which provided a consistent and systematic framework for the interview process using semi-structured and open-ended questions that explored the who, what and when through the thoughts, feelings and experiences of interviewees (Sandelowski, 2000).

### 3.6.2 The interviews

Interviews were predominantly undertaken in training rooms on a local hospital facility, at a time negotiated with the participants. Three were Skype interviews (for those participants not living in the Canterbury region). Two of these were undertaken from the participant’s home and the third was in a private workplace with telemedicine facilities. One interview was not face-to-face and necessitated a telephone interview when the Skype connection failed twice. Participants were asked their preference for interview venues and one candidate requested to undertake the interview in their home. It is important for all parties that the venue is supportive of a private uninterrupted interview, for this reason clinical workplaces were not selected as they are both prone to interruption and are not always private.

A stance was taken whereby the researcher explained that their interest was to learn of the nurse’s experience of undertaking the NESP programme in terms how this experience contributed to personal and professional development, drawing upon key programme components (post graduate study, supervision, clinical rotations and preceptorship) as a broad framework to keep the focus on the programme. There were no further guiding questions other than curiosity and the use of naive enquiry when the researcher was not clear of what was being said. Non-verbal and verbal cues supported an approach that conveyed openness, respect, genuine interest and warmth of engagement. It is important to pay attention to these details as they promote interviewee confidence and facilitate a more effective enquiry. All interviewees were asked the same lead-in questions, although the order may have varied.

In the interests of putting participants at ease and facilitating rapport, interviews can have a flavour of a social occasion (van den Hoonard, 2005). All participants were offered refreshment for the face to face interviews undertaken on the hospital campus.
Whilst no remuneration was afforded to participants, having kai or sharing food is regarded as a culturally respectful gesture to reciprocate appreciation for time and generosity in the sharing wisdom (Edwards, McManua, & McCreanor, 2005). This was especially important for the one interview undertaken in the nurse interviewee’s home. On this occasion food was provided as a form of koha and as part of the cultural ritual of sharing food which also is a symbolic of acknowledgment respecting tikanga (Edwards et al., 2005). All participants were thanked for their time at end of the interview and a commitment given to provide a follow up email with the transcript to check for accuracy. In addition, permission was sought to make contact again if any clarification was required in transcripts and to share the findings when the project was completed.

Throughout this process the researcher maintained a journal which served to highlight areas of interest, noting thoughts and feelings that were evoked in the process and later using this material to reflect upon ideas and areas of difficulty with the research supervisors. Data analysis was undertaken as soon as the data was collected.

### 3.6.3 Confidentiality and safety of data

To mitigate risk that participants could be identified from the data, names were replaced with pseudonyms thus masking identity. Participants opted in, and data was masked in a pool of participants spanning several years, reducing the likelihood of being identified. Interviews were conducted in confidential spaces acceptable to participants and away from the work place. Recordings of interviews and written transcripts were de-identified and held securely and not made available to anyone other than the researcher and supervisor. A copy of the transcript of the interview was made available to the participant upon request.

The data was kept in storage until deemed suitable to dispose of, in the approved manner, as per the University of Otago guidelines on ethics in health research. If practice issues had emerged, close attention would have been given to reporting and monitoring this through academic supervision.
3.7 Data Analysis

Data analysis, not in an in-depth form, merely noting the presence of ideas and commonality across the interviews, was undertaken from point of collection and continued throughout the sampling process until all thirteen interviews were completed. As noted earlier, the sample was purposive with the intent having as much diversity as possible.

The audio-recorded data from transcriptions allowed the researcher to become thoroughly immersed in the participants’ responses. Braun and Clarke’s (2006) inductive thematic approach was used to guide the analysis of the transcripts. Detailed readings of the transcripts were made to highlight manifest content, that is, the narratives were interpreted as given, without assumptions or philosophical meanings being placed on the text. Participant responses were considered line by line and coded using meaningful words or phrases. Then all similar codes were grouped together into potential themes and subthemes. Once initial themes had been established they were reviewed to see if there was congruence in the coded extracts across the entire data set, and a thematic ‘map’ was created. According to (Sandelowski, 1986) qualitative descriptive studies are “unavoidably interpretive” and a level of latent (interpretive) analysis ensured that the final themes accurately captured the most significant sub-themes and codes.

In acknowledgment that interpretations are shaped by the researcher’s personal biases, values and ideas, a reflective journal was kept throughout the analytic process to record amendments and new interpretations of the data collected. These ideas were reflected upon and shared within research supervision sessions, which provided guidance to develop a deeper understanding of analysis and the emerging themes.

As noted in summary above, following collection of the data, Braun and Clarke’s (2006) six inductive steps were utilised as a pragmatic framework to analyse the data. Below is a more detailed account of this process.

Step 1: Familiarising yourself with the data

Interviews were transcribed verbatim and key extracts related to impact identified in each interview transcript. The actions of interviewing, listening to the audio tapes,
reading, re-reading and correcting the transcriptions facilitated an in-depth exposure to the data. The process of checking the audiotape against the transcription for accuracy brought about a greater awareness and in-depth closeness with the information provided.

**Step 2: Generating initial codes**

Key passages indicating impact were highlighted and a couple of words written in the margin to capture the meaning of this. Segments of text were extracted from each interview and loaded into a word document as a table with columns for context, code, category. Each interviewee was quickly identified using colour, and each segment of text had a letter denoting the participant and the line number of the transcript to ensure ease of follow up. All thirteen interviews were coded in this manner. 119 codes were generated in this manner. The codes were then examined for duplication, and using a word document, codes were clumped together by means of the cutting and pasting computer function.

At this point the extracts of data were written up on sticky post-it notes and attached to large sheets of white paper. In the process of writing up each extract it became clear some extracts were not related to the impact of the programme on personal and professional development and were discarded. Codes with similar shared ideas were clumped together and key words written alongside to name what was present. The next step was to place the like codes together and to name categories capturing the key ideas. This process was undertaken using large sheets of paper with data extracts organized into codes and categories. This was time consuming, with some rich learning in terms of appreciating the need to put enough of the surrounding data to capture the context of the comment. This was important in ensuring the data was not misrepresented. This required some re-reading and listening of the tapes to maintain accuracy and authenticity. Those extracts that were contradictory, or outliers to the dominant ideas were highlighted and included within the theme if deemed relevant to the research question.

**Step 3: Searching for themes**

Categories were written on blue post-it notes with the key data extracts pasted below in the summarized form of a code. These sheets were then able to be moved about and
the categories with similar codes clumped together under tentative themes. As a means of staying true to the data, wording from the extracts was used to describe the theme where possible, for example, ‘advocacy is part of everyday practice’ and ‘well set up’ were statements from the extracts. At this point the process was reviewed by means of a critical discussion with my supervisor to identify, clarify and confirm plausible themes. The large posters were reviewed, and the data extracts captured in a written table without the extracts themselves, however a reference letter indicating the participant and the line number was attached to each code. These were named as categories, the system allowed for the codes to be checked back to the data extract source in case the context was not clear.

**Step 4: Reviewing themes**

Systematically all the themes were checked to ensure that they were an accurate reflection of the coded data. At this point a map of themes was emerging, showing themes that were linked and fitted together to illustrate the story from the data. Starting with the categories, these were checked with my supervisors and two participants to ensure the story truly reflected information in the data.

**Step 5: Defining and naming themes**

This process of analysis supported the exploration and generation of clear definitions and the naming of each theme. Because of this some themes were renamed, others joined together to form broader theme. The challenge in telling the participants’ stories through thematic analysis is that it is simply not possible to capture every aspect of each participant’s story, what is sought is a rendition reflecting the essence of the whole. A key determinant in this process is that the data comes together in a cohesive manner, that there are clear distinctions between the themes, whilst reflecting that there are commonalities and connections across the themes. The table below names the themes and categories discussed in this chapter.
Table 1: Themes and Categories

<table>
<thead>
<tr>
<th>Themes</th>
<th>Categories</th>
</tr>
</thead>
</table>
| 1. Well set up (solid foundation) | • Learning is ongoing  
|                               | • Having options  
|                               | • Finding my niche  
|                               | • On a career pathway  
| 2. Thinking differently       | • Being reflective  
|                               | • Begin critical  
|                               | • Staying fresh  
| 3. Interconnectedness         | • Supportive networks and connections  
|                               | • Advocacy is part of everyday practice  
| 4. Reciprocation (Manaaki)    | • Supporting and developing others  
|                               | • Inspiring others  

Step 6: Producing the report

Drawing upon the data through participant extracts, the thematic analysis, in the form of a report explains the story within the data. These extracts are embedded in an analytic narrative illustrating the argument relating to the research question. This is the thesis, capturing the experiences of the participants. This step is detailed in the next chapter, Findings, which follows.

3.8 Summary

In this chapter I have explored the theoretical and philosophical assumptions that underpin this research project. A qualitative descriptive methodology supported the aim of this study, to assess and understand the impact of the NESP programme on the nurses’ personal and professional development. Justification for the method and methodology underpinning and informing the study has been described in detail, inclusive of sampling, data collection and thematic analysis method, ethical considerations and lastly, factors allowing the reader to determine the trustworthiness. Researcher reflexivity has been detailed and continues in the subsequent chapters to ensure the research stays true to the data and thus is an authentic account of the participants. The next chapter explores findings, the participant’s stories.
CHAPTER 4: FINDINGS

This chapter uncovers the participants’ stories, obtained by means of semi-structured interviews with the researcher. The chapter begins by detailing the socio-demographics of the sample group. Following this the four themes are presented, with quotes from the transcripts used to illustrate key messages.

Whilst the findings are described here in a seemingly clear-cut and linear fashion, the ideas are interrelated and at times do not sit exclusively in just one theme or one category. The intention in describing this in a linear fashion is a pragmatic one to best represent the nurses’ narrative in an authentic, contained and logical manner. What follows is a logical attempt to re-present the complicated story of the data. Pseudonyms have been used for all the participants.

4.1 The Sample

Thirteen candidates opted in to this study, were interviewed and choose to remain involved in the research throughout the process. In keeping with the intention of having as much diversity and yet be as representative of the region’s population of nurses, as noted in the methodology chapter, two of the nurses who opted in were male and two identified as Māori. The four bands of years from 2010 - 2013, consisted of at least two nurses each, and one band comprised of five nurses; at the time of interview the years of experience post completion of a NESP programme ranged from three to six. Just over half the nurses worked in inpatient facilities and the rest in community workplaces. Further study at the post graduate had been undertaken by over half the group, with two nurses obtaining masters. At the time of interview, nine participants indicated they were pursuing further study at the post graduate level.
Table 2: Key characteristics of the thirteen participants

<table>
<thead>
<tr>
<th>Age bands</th>
<th>25 – 35 years (5)</th>
<th>36 – 45 years (5)</th>
<th>46 - &gt;50 years (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PDRP* Level</td>
<td>Competent (7)</td>
<td>Proficient (6)</td>
<td>Expert (0)</td>
</tr>
<tr>
<td>Highest current Qualification</td>
<td>PG Cert (6)</td>
<td>PG Dip (5)</td>
<td>Masters (2)</td>
</tr>
<tr>
<td>Aspirational qualification</td>
<td>Post graduate Diploma (2)</td>
<td>Masters (10)</td>
<td>Doctorate (1)</td>
</tr>
<tr>
<td>Aspirational roles</td>
<td>Nurse Practitioner (4); Registered Nurse Prescribing (1); Nurse Consultant (1); Nurse manager (1); Nurse Educator (1); Research role (1).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*PDRP is the Professional Development and Recognition Programme, a national programme that has three levels for Registered Nurses.

4.2 Theme 1: Well Set Up

This theme was named as to reflect the general notions of being firmly established and well prepared. The participants when asked to reflect upon their experiences of the programme, and its impact on their personal and professional development, described it as providing “a solid foundation” (Sophia) and “a good base of interlinks” (Emma) “good grounding” (Olivia, Emma), “set me up to be able to go out and do the job” (Riley). One nurse framed the programme as “the cement between the bricks” further saying that “I am convinced my practice would not be a solid as it is” (Mia). The notion of being prepared, on the one hand for being put in challenging situations and on the other to take up opportunities were also aspects of this theme.

The nurses all reflected that the programme prepared them well for working in the specialist field of mental health and addiction nursing:

…it take[s] you from having quite a little understanding and experience as an undergrad in nursing, not doing that much in mental health...and ... it really helps solidify some of that stuff and gets you on the path to learn all the things that you actually need to know to do your job effectively (Sophia).

The key idea linking this data together was the notion that the nurses were facilitated in establishing themselves in the mental health nursing field, through the development of knowledge and skills. However, the learning did not cease after the programme and this was identified as a key impact, in that learning and upskilling is ongoing process. Through these experiences, they described gaining ability and confidence which
enabled them to have options in finding their niche and being able to follow career pathways that interested them.

In talking about the impact of the programme on their personal and professional development the nurses all spoke of key people that had influenced them on their developmental pathways, both during the programme and in an enduring way within their current support networks. The well set up theme assumes these relationships are significant, however in the interests of flow and relevance in this thesis the discussion of the impact of these relationships is explored within the theme of interconnectedness, which follows shortly.

Whilst all 13 nurses described experiences that indicated the programme over-all was important in their ongoing development, there were aspects of it that impacted in unforeseen ways, not always positively, some with longstanding consequences. These aspects of the nurse’s narrative will be revealed in the categories as they are explored. From the 39 codes generated in the Well Set Up theme, four key categories were identified, notably these are interlinked with each other, and are impacted upon with the other themes. The four categories of learning is ongoing, having options / agency, finding my niche and on a career pathway are explored below.

I. Learning is ongoing

The determination of this category came from codes which included the notions of wanting to keep learning, and that learning is ongoing:

“you don’t just get your skills all done and dusted, and off you go…you have to continually up-skill all the time” (Emma).

This was supported by Riley, who said, “once the programme had finished my learning really began”. Participants talked of the impact of the programme on their learning, Sam said “I think it accelerated my learning. It gave me a really good grounding”. Learning was framed up as including research activities such as reading articles, checking for evidence to inform practice and engaging in further post graduate study. Included in this category but present in others is the notion of learning from experiences and learning about oneself. Learning from others was cited by all participants as an important component in their development as nurses, and as people.
This was significant enough to warrant a whole theme devoted to this aspect, that of *interconnectedness*, therefore the relational aspect of learning is not covered in depth within this section.

The concept of learning was not just applied to formal study, it included roles, relationships, and working with different people. Riley spoke of learning to adapt to different people, as in staff; “the new grad programme gave a few tough old dragons that I had to work with…learning just to adapt… that is just how that person is”.

Kara described the learnings from working in teams as in,

> you’re not always going to have a whole team of people that are calm … There will always be some that are and some that aren’t …. recognizing … if they’re the black and white ones, can’t think outside the box. You learn how to work with them, and that’s still about self-managing I think your own emotions around it as well”.

Being able to adapt quickly was a common thread for many of the nurses, Emma said “you just had to adapt to all these different places, all these placements that you got really fast at learning how to adapt”. This process of adapting and learning to engage with new teams and new people experiencing mental health issues meant that, “you had to be at your professional best, because you were always coming somewhere new” (Isabella). Isabella explained the impact of this learning as,

> …you kind of had the most challenging year to begin with and then you got to have the knowledge and the skills to have that professional front that you can kind of just work out the following years as well. I guess kind of throwing us into the deep-end a bit for the first year really helped the following years because everything seemed to get easier.

People have differing motivations for learning. Over half the participants had engaged in further study following their NESP year. Many spoke of the programme fueling this motivation; Morgan said it “provided the momentum to keep studying”. Others spoke of their internal drive to learn. Ava said “I loved the learning. I was hungry for knowledge, I got that, and I came out with greater knowledge and understanding of mental health than I’d ever had before. Which is what I’d wanted”. Emma said, “it’s developed an interest in doing more and more papers, I may be addicted to them I’m not sure. It definitely made me realise the importance of continuing to educate and develop skills”.
For Kara, it was about knowing it was achievable, “there’s always more that you can learn, knowing that you can do ...things…and have the ability to manage it all”. Taylor echoed this sentiment saying programme was “a real challenge but it was good because I think it showed me actually I could do it if I wanted”.

Learning experiences outside of post graduate study, or engagement with others had greater value for several of the nurses. Tracy said, “It was all about what the conditions were, the DSM and everything like that, but there was very little practical in terms of okay, so they have anxiety what can we do about that...”. Because of this Tracy said she “purposefully put off studying both for personal reasons and for feeling like I wanted to gain more practical experience before I went in and filled my head with lots of theory”. Others also said they found training helpful, Logan said “…the Hearing Voices workshop was brilliant. I think that’s helped inform my therapy quite a lot… in terms of dealing with people who potentially might be psychotic or experiencing some psychosis. It means that I’m more confident in terms of linking in with the local services.”.

Morgan spoke of training to be a supervisor as a significant enhancement to her clinical practice,

> Oh, the training is incredible! Like the training that you get as a supervisor is out of this world. Like it’s so invaluable and but it also informs your practice. It’s enhanced my practice. It’s enhanced my facilitation which is important because I do heaps of facilitation. So, it’s enhanced my practice in so many ways ... that amazing relationship with very skilled people, it’s good.

That structured and supportive learning programmes contribute to improved care was a key message across all the nursing narrative, regardless of where the participants perceived the best learning experiences came from. Kara captured this sentiment when she said,

> I think rather than just, sort of, on-the-fly learning, you know, when you just turn up and you work, and you’ve had no experience before, you can see that just wouldn’t make sense now. Because, it’s like, this way you’re getting structured experience and structured education around nursing, mental health nursing...and that makes for overall, better patient care, it makes for better patient safety.
A key impact for all the nurses was that the programme provided them with learning experiences that supported them to develop the knowledge and skills they needed to work as mental health nurses. Being able to adapt and manage in a changing environment whilst studying, and knowing they could, contributed to self-confidence and provided the motivation to continue in their professional development.

II. Having options (personal agency)

This category is named as having options and describes the views associated with the participants having a sense of control on how and where they choose to work as a nurse; within this is the notion of having capacity to act independently and to take up opportunities because of undertaking the NESP programme. Whilst the category is named as having options, the concept is much broader than this. Drawing upon psychology the additional label of agency is included with the intent to more accurately define and reflect of the ideas behind this category.

Confidence was a frequently used word in the narratives, and a personal attribute the nurses ascribed to having an influence on their development. This was in relation to the ability to respond to situations, and to be in control of themselves. Phrases such as, being able to “handle situations”, “knowing what you were doing” and “learning how to be in charge of what you were doing” were prevalent. Confidence was spoken of about challenging practice, as Riley explained “to be able to say, actually this is best practice, this is the reason why I do it, and have the confidence to stand up to somebody and say, ‘well, no sorry’ I’m not going to do that…”.

Sam described the satisfaction achieved by being able to facilitate autonomy in others, “being able to guide people without compelling them or diminishing their autonomy or their control, putting power back into their hands, giving them options and choices instead of, ‘if you do this, this will happen’ and, ‘you should do this’.

Having choice in the way they practiced was important for Ava, who said “I got to see a lot that helped me better understand my values as a nurse in general. Not specifically to mental health just in general…so it helped me kind of solidify what I thought nursing was about and how I wanted to practise”. Knowing what was important for practice was something Mia spoke of as well, this was in relation to choosing not to take up a senior position because of the inadequate support for the role.
Positive impacts on lifestyle were important for two nurses. Isabella felt having knowledge and skills from the programme enabled a lifestyle that supported being able to travel and study when it suited. For Taylor having the ability to go into new jobs and take senior roles provided a financial benefit that “stood me in good stead majorly and it’s given me the ability to … financially speaking here, get really a lot of benefit out of it and knowledge on how to get that benefit as well”.

Having a range of experiences in different workplaces and specialty areas, acknowledged as being hard at the time, had a resultant effect in that the nurses were not scared to move on to new areas. Emma explained that “it gives you a really good grounding and confidence to go and take on different roles because I could imagine you could get quite set in your ways and too scared to move”.

Having opportunities and experiences others did not have was a key message (Sophia, Kara, Ava). Emma said,

> Going on the programme gives you the confidence to go into different roles quite readily because you have to adapt so quickly to so many changes in a year of being in different places and picking up different [computer] systems and working with different teams and how they operate.

Whilst Isabella spoke of this preparation as being helpful in that “it prepared me for being put in unfamiliar, uncomfortable situations...which helped the following years as everything seemed to get easier”. Mia also described how her early experiences helped in later years.

> ...you make decisions on the spur of the moment you make the best ones you can and the outcome of one of those was I had to write an incident report for the [government official] ...those sorts of things I felt more able to handle because we were put in uncomfortable positions and challenged, and our workplace positions, when we were doing our new-grad thing.

Confidence grew with each move for Kara who said, “for someone like me, especially being more introverted, it’s like you just get settled and get to know stuff and then you’re moved again but that got easier each time as well…so I think it helps develop confidence”.

Having options also enabled some of the nurses to branch out into other roles and take on additional responsibility or unique projects. Knowing they could do things was
spoken of by several nurses in slightly different ways. For Olivia, a new role involved “dealing with the doctors a lot more as well [as] putting people under the Act…. It was a bit more full on but I knew I could do it …I think doing the NESP programme made me be able to do it”. Whilst Riley likened additional roles to having different hats; one of these was working for the local polytechnic, “I never thought I would be able to do this sort of stuff, so my confidence has definitely grown a lot more. I suppose I’ve got lots of different hats that I wear at the moment”.

Study specific to the specialist service enabled greater responsibility within the workplace for Isabella, whereas for others it was about taking on challenging projects (Logan, Morgan). Taylor developed a sexual health curriculum, almost entirely using visual media for a population with very poor reading ability. For her, this experience was helped by having done the programme which “lay down some of those foundations to give myself the ability to do that follow-up research and to … look something up if I don’t know”. Taylor said, “the role was extremely interesting, and I got to learn, I had to learn how to teach”.

This notion of being able to have choice is informed by a developing confidence because of experience, knowledge and having opportunity. It is threaded across the categories in the well set up theme, reflecting the connected nature of learning is ongoing, having options and the finding my niche, which follows.

III. Finding my niche

The programme exposed the nurses to a range of clinical workplaces in inpatient and community settings. This experience was described by Emma as useful in that “because you’ve got such a broad view you could understand where your interests lie…which has probably helped me in where I have ended up”. She explained this further by saying, “I really liked the high acuity of working in acute inpatients and then when I went to the community I realised that that was maybe a little bit too slow for me. Not slow, I shouldn’t say that, but it wasn’t the best fit for me”.

In contrast, Logan, identified a preference for a community workplace, saying it was “because I was with the [regional service] I think that’s probably created or helped me identify what I like to work with. Not so much from an inpatient ward but more so working with families, young people and communities so I think that’s probably helped
shape where I’ve been feeling comfortable in terms of going or found a niche if you will”.

Several of the nurses said that their experiences strengthened a passion for clinical work. Emma said, “I like being clinical and, so I don’t want to take on a role which is involving paper work or management”. Sam similarly had no desire to be a manager because “there’s too much of meetings and being tugged to and from by administration stuff and management stuff”. The experience of working in a clinical area where “we have a lot of chiefs but not enough Indians” has led Tracy to reconsider a formal manager role, confirming instead a desire to work in education and quality. A formal leadership role was not something that appealed to Logan either, who said it “is not something that I’m drawn to, if anything, I think I’d rather be the guy out the back sort of doing the slog than the one up the front”.

A consistent message from the nurses was that the NESP programme was instrumental in helping them find a good fit in a workplace, a niche. Kara reflected this view in saying,

I think if you just possibly worked in one place without the programme you’re restricting what you can learn because of the exposure. And it would be the same exposure over and over again rather than changing, and by having to work in certain areas I think increases that knowledge and experience you get and it gives you a different range of experience, so you can kind of try and figure out where it might be that you want to be rather than just applying for a job and staying there even if it’s something that you don’t feel you fit there completely.

The programme provided the nurses with options and opportunities to work in different areas of mental health, with different teams, thus expanding their knowledge and skills whilst developing new learnings of themselves and the others. This exposure enabled them to determine which facet of nursing they preferred and provided them with several pathways to choose from.

IV. On a career pathway

The perception that the programme put them on a career pathway was prevalent within all participants. Over half the nurses had gone on to obtain further postgraduate qualifications; five of the thirteen nurses held formal leadership roles and six of the nurses had continued to progress through the Professional Development and
Recognition Programme to the Proficient level. Notably none had reached the expert level, despite the passage of six years since programme completion for nearly half of the group.

Engaging in further study was regarded by most of the participants as important for practice development, and as a key component of career progression. Emma said, “doing the papers has probably put me on a bit of a pathway of continuing my nursing education ...and developing practice”. Ava said, “my post-graduate study that I’ve done has really helped shape the way that I practice”. Kara noted,

people are doing more study, afterwards ... and that’s like what I did as well. Rather than ... just go into a job and just start working it... Having the knowledge, and the development of your skills, that you can get by doing more study....you’re more aware of that by being through the programme.

Being well set up for professional progression, in terms of the value of the post graduate papers, was described by Emma as “on the right trajectory because you already got two papers under your belt rather than the daunting task of starting from scratch”. The added implication here was that it was a significant step up in career progression, Ava affirmed this in saying, “I think it’s helped get me into mental health areas… it’s a good thing to have that qualification to say that you’ve been through a NESP programme… it’s very reputable and I think it has been a leg up into the job”. Riley and Isabella reflected that if you want to progress in your career then you must do study.

Post graduate study is not the only component of career progression. NESP nurses’ experiences in their first year of practice gave them a taste of therapeutic skills such as those of motivational interviewing and cognitive behavioral therapy. The expectation was that the nurses would engage in the development of skill in various talking therapies as part of their ongoing professional development. The nurses were not asked directly about the talking therapy skills they had developed in the years after completing the programme.

Accessing skills training when they wanted it or needed it for their roles was not a straight forward process for some nurses. Morgan spoke of the frustration of working in an inpatient area with the expectation “to deliver therapy by the psychiatrists and the multidisciplinary team”, but “feeling bereft of skill”. Training described as “really
brief little in-services from people with not much more experience than myself” was provided. Support for further training was hard to access, as Morgan recounted, “if you applied for it, it was rare that you would get it… and …that people were sort of hand-picked for things”. This led Morgan to question the nursing practice, and her ability to remain in that workplace, “it was really difficult to actually see therapeutic skill …I was thinking while they [tangata whaiora] are here what do you actually do with them aside from monitoring and giving medications?”. Engagement in further post graduate study provided a way forward for her. She described this as having a “strong practical assessment” focus, and that included talking therapies.

In contrast, Emma, who was employed into a community workplace within two years of completing NESP, was supported when she requested training in cognitive behavioral therapy. She was clear this was of her own volition, “before it was mandatory”. Of the thirteen nurses, Sam faced numerous challenges in her quest to gain support for ongoing study at the postgraduate level. She explained, “I’ve been trying to get acceptance approval to complete my diploma for four years. Can’t spare you, bodies on the ward, that kind of thing, nights it’s not a good time”. Changing workplaces enabled Sam the option to pursue study again. Eight of the nurses have or intend to engage in further post graduate study.

Being told you can’t do something, for some people, can be a strong motivation to do the opposite. A conversation between Isabella and her manager provided the impetus for her to consider challenging the status quo regarding a Nurse Practitioner pathway, “… when I first told my manager that I wanted to go down the nursing[sic] practitioner pathway [they said] ‘but you can’t do that in mental health’. I …was like, well now I’m going to prove you wrong, you can do it in mental health!”.

Several of the nurses had worked overseas, or in different regions within New Zealand; they spoke of being well prepared and having a new appreciation of their preparation for working in mental health. They spoke of the programme enabling them to take up either unique or specialist roles. Sophia said “having gone overseas and seeing … what the other places do in terms of their new graduate programme, it [NESP] is very good. It’s very structured, it’s very supportive. I really do think it sets you up quite well for moving forward in mental health career”. Mia said, “critiquing the DSM even when you have to look at what they say is a mental illness versus someone that’s in
front of you, was really good…the training I got …is what’s got me where I am here in [country]”. Olivia spoke of her experience of being offered a clinical nurse specialist role,

*I just felt like I knew what I was doing, and I could help people, I could answer questions. It just came like so naturally ... being over in [country] in remote as well just gave me that confidence boost. And I mean I got offered a CNS position for three months while the person was away but to be considered just coming out of new grad I thought well... obviously, it looks like I know what I’m doing.*

Taylor attributed several unique job opportunities to having undertaken the NESP programme, particularly the post graduate study and experience in specialist teams, “they employed me because of my work that I’d done at the [inpatient] unit… the mental health background and my papers basically. That was what got me the job”.

Career progression and personal development are not just about post graduate study and the appointment into formal leadership roles. Ava spoke of the conflict experienced in determining which pathway to follow having completed a post graduate diploma.

“I know that the way that I see health isn’t mainstream, but I know that I haven’t just plucked that out of the air. Its wisdom based, you know you’re seeing it, you’re in it all the time and unless we can really get some numbers behind it and put it out there there’s just going to be no recognition, it’s just going to be the same old thing. But I don’t like research, so I just don’t know... so [I am] looking at a different pathway. I feel that I’m already being a leader in what I do. I don’t need a title. I don’t need to be doing a leadership paper.

In this exploration of the well set up theme the participants reflected that the programme has provided them with a solid foundation for their development through the provision of clinical and academic learning experiences that have been supported by critical reflection. The result of this was having options or agency and a range of pathways in career development. Threaded throughout the narrative is the view that they were compelled to see things differently.
4.3 Theme 2: Thinking Differently

This theme arose from the nurses talking about the impact of the programme on their personal and professional development in terms of viewing things in a different way. The words seeing and looking, appeared frequently in the transcripts, however, seeing and looking or variations of these did not always imply literally looking and seeing. When taken in the context of what was being said the words conveyed the notions of developing understanding through observation and reflection, comparing and contrasting, reviewing, checking things out with others, trying things out, seeking guidance from people or gathering information from other resources.

Knowledge and skills were acquired, and practice developed by means of postgraduate study, and ongoing reflective processes within the clinical and academic systems. A common phrase to describe this experience was seeing the ‘bigger picture’. It was also conceptualized as taking a more holistic approach to nursing care, with the emphasis on working therapeutically with people within the health system. This section reflects the nurses’ experiences that contributed to their development through reflecting upon and taking a critical approach to practice as a means of enhancing their knowledge and developing more skill.

Mental health nursing involves working with whole systems, inclusive of the health care team, tangata whaiora, families and significant others. Whilst this section focuses on the nurses’ processes of developing practice there are significant relational and at times interpersonal components that support this, for the purposes of containment these aspects are explored in a more in-depth manner under the theme of interconnectedness.

The theme of thinking differently is explored through the following three categories, which had 34 codes, being reflective, being critical, and staying fresh.

I. Being Reflective

Nurses learn from their experiences and develop practice through reflecting on events that impact on them. This component of thinking differently explores the nurses’ experiences of being reflective, as an impact of the NESP programme. Reflection is a personal process that can be facilitated by another. Critically reflecting on practice enables nurses to develop new understandings and apply these in practice. In the
context of the NESP programme reflection was facilitated through the provision of individual and group supervision, preceptorship, and through the academic programme with its problem-based learning approach and critical social theory underpinnings. People and relationships are pivotal in mental health nursing development, this is explored under the theme of *interconnectedness*.

Eleven of the thirteen nurses spoke of an active engagement in individual supervision. Clinical supervision, as described in chapter one, is uninterrupted time during which the nurse is supported to engage in an in-depth reflection on clinical practice. In this region, much of the clinical supervision is delivered by nurses trained in the role theory model approach developed by the late Mike Consedine. Individual supervision is a key component of the NESP programme, most of the nurses interviewed spoke of seeing it as a valued and valuable support for their personal and professional development, “supervision keeps me on track” (Morgan); “helps me work things out for me” (Mia). Tracy said, “you pick apart situations and look at them in a much more rational manner than you might have at the time” and you learn “how to handle awkward situations professionally”.

Supervision serves as a vehicle for personal development. Sam explained,

> the programme challenged me to confront things that I was afraid of, didn’t know and didn’t understand, and that still ongoing... I’m still learning ...It helped me to rethink and reassess myself to be far more patient with my expectations of myself than I usually am. I tend to expect it to be perfect or I’m leaving... I tend to expect to achieve perfection, and it helped me recognise that I expect far less of everybody else than I do from myself and that I’m a lot harder on myself than I am on other people.

In a similar vein Tracy spoke of supervision as being “essential to dealing with all that emotional load”. She explained that,

> it gives you a space to vent but in a positive way and re-look at situations that have either been confusing, troubling or even positive, but re-look at what worked and didn’t work. Re-look at your role and reconfirm your own ethics and reconfirm your own value as a nurse to yourself, as well. Sometimes we get in these situations where we feel I didn’t do enough or I should have done more, or I should have helped this person better. Especially in the case of suicides. But supervision is quite a good way to re-look at your nursing and go, okay this person didn’t have the happy ending that we wanted for them but that doesn’t diminish the fact that I go and help people every day.
Learning new ways to approach situations was important for Mia who said that it was through supervision she,

* grew a thousand-fold ... instead of getting defensive and freaking out like I was all the way at the beginning. Getting angry with other people. I worked out how could I better do stuff...instead of me feeling like I’m just the savior of all... I felt so offended by stuff that other people did because I didn’t think it reached my standards but through the supervision I was able to reflect back and maybe not take offence so much, look at a different point of view and work out how I could approach it differently and that sort of thing.*

Others spoke of the value being in being able to develop new understandings of the wider system issues. Ada spoke of this in terms of:

> *It is not just the families and young people that you’re working with it’s also dynamics, colleagues, system structures in place and frustrations of not being able to access the equipment for example...there are frustrations in the job, but it really helps to have someone ... a neutral person, that you can actually just go and have a chat with.*

Supervision has a protective function in terms of managing risk. Ada said it was helpful in staying connected, “especially if things go pear shaped it’s important to have those people that you have to link into”. This was a sentiment echoed by Morgan, who described working in an isolated work situation with a complex client load, “It’s very isolated sort of work and there’s an enormous amount of risk and my supervision was just gold at that time”. For Isabella, the protection was about having a safe space to work things out, she said it provided

> *a safe place to work things out, there is a bit of a bullying culture in nursing. Whether it’s horizontal or hierarchical there is a culture there. Supervision protects you from that. You need that safe place away from that service that you can actually go and take your issues.*

Not all nurses appreciated the individual clinical supervision received during NESP. For Riley, “it was a big let-down…I haven’t had it since…it impacted on me quite badly”. Logan attended to “tick off my hours” and observed, “it really depends on that relationship you have with your supervisor”. Morgan said, “I thought it was something to do with me, rather than it not being a good fit”. Having a good connection is important in supervision. Olivia had an experience in another country where she learnt supervision is not universally the same. She spoke of a session where she realised, “you’re not really listening to what I’m saying, you’re just kind of telling me… this is
how we do it over here and it wasn’t supervision as I knew it… I don’t think they understood where I was coming from… that was hard”.

Group supervision is unique to the NESP programme in this region. Most of the nurses talked of the value of this experience, from varying perspectives. Ava found it supported a better appreciation of the wider service.

Not many people have group supervision so having in the NESP programme group supervision is the first time I’ve ever done group supervision… I found that really valuable... I got to hear about other people’s experiences without having to go and work in those areas... I got a better understanding of how the wider mental health services and I would never had been able to get that ... in a confidential environment where people were sharing freely.

Sharing experiences in a safe environment was important for confidence, “other new-grads were facing similar problems … it didn’t make us feel like we were the odd ones out for feeling a bit out of our depth sometimes” (Tracy). New learnings in this forum also supported personal growth. Ada explains,

It was a good time to sort of link in with colleagues and find out how they’re going ... I found it really helpful in terms of the training aspects of things as well. You do, going into a new environment, feel a wee bit out of sorts in terms of knowledge and I think the programme sort of gave you that boost that made you feel just more confident. Being in a new environment but also being comfortable a bit more in who you are yourself.

Just as with individual supervision, not everyone interviewed experienced group supervision as helpful. Two nurses spoke of not feeling they had opportunity to talk as the group was dominated by some participants. They both indicated more structure in the facilitation would have been helpful in resolving this. A distrust that the information would remain confidential within the group was another factor; as was the group size. One nurse spoke of participating in activities, despite feeling very uncomfortable and not being clear of the purpose. Despite their experiences group supervision as a concept was supported by both these nurses. Sophia said “I can see there is a benefit of group supervision for maybe like a ward environment. I could see how it would be quite beneficial … where you know people quite reasonably well and you work alongside them daily… you have an idea of who you can and can’t trust”.

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Becoming trained as a supervisor enabled Morgan to develop a better understanding of the skill involved and exposed a need that was best met by engaging a mentor.

*A while ago I started to feel a bit blah about my supervision and thought it’s kind of translated into a bit more of just a relationship. We talk, and we do this, and we do that, but then I did the supervision training myself, and I could more clearly see the skill my supervisor actually had and thought what I actually need was a mentor as well.*

Reflecting upon this situation helped Morgan to see the real issue and identify the strategy to rectify it, thus enabling a much-valued supervision relationship to be preserved, and her ongoing development needs to be met.

The section has explored the nurses’ experiences of reflection largely through the processes of supervision, which involved in-depth examination of the factors involved, and processing of the information with the intention of negotiating a pathway around or through the barriers. Central to reflection is thinking about situations, this next section further explores another component of thinking differently, that of thinking critically.

**II. Being Critical**

In this category, with fifteen codes, the nurses spoke of *seeing the big picture, looking deeper, having a critical perspective, backing it up with evidence.* Predominantly the narratives relate to engagement with post graduate study and activities associated with this and how these experiences contributed to the nurses’ development.

Scholarly endeavors such as knowing how to go about sourcing reliable and relevant information quickly, were attributes Riley and Taylor said they developed considerably because of the NESP programme. Talking of critiquing, Riley said,

*...you can tear it apart quite quickly and go is this relevant to what I’m looking for or what’s best practice, what’s actually been studied and researched... I think that helps your practice develop and it also changes the way that you look at things ...with your skills that you use when you’re nursing.*

For Taylor, it was about her engagement with the process. She said, “I found the whole research process a lot more interesting and so therefore I became a lot better at finding information”. Writing and critiquing were other aspects of being scholarly that the
nurses spoke of. Riley said he enjoyed being able to “write about whatever you want and back it up with evidence”. Likewise, Taylor developed a new-found appreciation of writing, declaring, “I actually really enjoy writing now!” Sophia discovered a penchant for reading articles,

I’m a bit of a reader. I’m a bit of an article reader so I like to do that and I probably … wouldn’t have been an article reader if I’d not found them interesting in the first place or ever gone out of my way to access those in the first place except for the purposes of the course.

Undertaking research for her job exposed Taylor to some issues with finding adequate and reputable resources and highlights the critical approach she took to the problems encountered.

I didn’t have any access to all the proper databases … I was like this is not good, because it needs to be evidence based you can’t just like tell them whatever…luckily, I’d… made friends with some people from family planning and another one from the university, that kind of gave me a little bit of extra information that probably I should have had to pay for access to.

Engaging in research activities, especially participating in research being undertaken by other nurses was something the participants all agreed was important for improving care, and this they attributed to the NESP programme. Tracy said,

I’ll generally put my hand up to help in any research in terms of if there’s any study, you know those emails you get from NZNO about so and so is doing a research. I will generally put my hand up to participate in that because I think it is important, especially this qualitative stuff more than the facts and figures because that’s a lot of what our job is about is human experience and it’s our experience as well as our clients.

Thinking about how doing the programme impacted on care of tangata whaiaora was spoken of by all the nurses. Emma said, “looking back now, it developed us to think about what it is we do, and why we do it”. Morgan’s difficulty in seeing therapeutic skill, within her workplace, in her NESP year fueled a determination to expand her skills and deliver care that was more than “monitoring and giving out medications”. Sam said she found that developing new understandings about seclusion made her realise that “seclusion in itself could be punitive, and it could be quite an objectionable process, but by him seeking seclusion, it was a safe place, and that in itself was therapeutic”. Sam described this person moving from being comforted having people
holding him, so he wouldn’t damage himself, to him using a weighted blanket and learning how to have more self-control.

Engaging in post graduate study, and taking a more critical approach enabled the nurses to take a more in-depth consideration of the perspective of the person experiencing mental health issues:

...we were doing things like people’s narratives, clinical case studies with particular attention to how it affected people, it made me look a bit deeper for my clients and not just look on the surface and it made me even more aware of how our perspective, our diagnosis, our everything doesn’t actually matter, it’s the person’s experience that does. If we don’t work with that we’re not going to get anywhere because we can tell them a million and one things, give them a million and one drugs it doesn’t matter if it doesn’t fit into their life and their world view (Tracy).

Having a bigger picture understanding of the system of care, through inpatient and community experiences, was viewed by many as significant to developing nursing practice, in than it enabled the nurses to understand the pressures.

...seeing different aspects of the service I think that helps develop your practice because you’ve got a more bigger picture, view of the distinction of between community and inpatient...you can understand nuances or idiosyncrasies or pressures that exist in different pockets, so you can just hold that in a different way in your mind (Morgan).

Understanding the pressures within the system through working in different areas enabled the nurses to challenge stereotypes and misperceptions that impacted on care delivery. Mia spoke of her observations and thoughts around the tension between inpatient and community nurses and how this impacted on her.

... it gave me an idea of what went on in the community and how much work the community nurses do to keep these men and women out of hospital. So when I was then in [acute ward] when we think oh we’ve got a soft admission, I was able to go, well maybe we haven’t because these nurses actually don’t want them in hospital...in the community they’ve worked as hard as they can to keep them out so instead of being a dismissive admission nurse in [ward] I was able to go well actually there’s probably been a lot of work go in in the background here so let’s just take this person and stop moaning about it and carry on...The rotation gave me a better appreciation for where other staff were at because a lot of the staff I worked with who hadn’t had that training, who’d been nurses for 20 years would just roll their eyes at some admissions.
Some clinical workplaces were challenging for tangata whaiora as well as the nurses. Sophia gained new insights into workplace culture when she worked in another country, in a ward she described as “very clicky, burnt out, just a really miserable environment”. She spoke of this and her attempts assist staff to take a more critical approach to care.

... you’d sit there and do what you could do and then you’d know you would end up being pulled into ...being asked to assist in things like restraints for people who were ...quite elevated and ... a little bit rambunctious and a bit naughty, but their response was to do full restraint, take to seclusion through the whole building and then inject and seclude... you could only effectively work in your wing and try and keep the people that you were responsible for ... just try and provide little bits of like, 'have you thought about why they’re doing this?’.

Having a bigger picture perspective was not always welcomed by some teams that the nurses worked in. Several commented on the frustration of teams that focused on their service or specialty alone and had a narrow, or as Morgan described, a “silod” view of health.

*I think probably the most influential element of the NESP programme moving across in a safe and held way, moving across many different parts of the service and therefore having a much bigger picture, view. So, therefore, not feeling siloed ...and then at times kind of finding it frustrating that no-one else wants to play that way. And other people don’t get it like so that’s sort of like a dichotomy really, you’ve been given this amazing opportunity to see the service in that way and yet the service resists responding in that way. It says it wants you not to work in that way, but everything reinforces people staying that way.*

In this category of being critical the nurses spoke of seeing things in different ways and being exposed to a range of experiences and challenges and their development. Building on the previous category, reflection was an integral part of this process and enabled new understandings to be gained. This next category explores the activities that support them in being critical and reflective.

III. Staying Fresh

This is the final category of the thinking differently theme and captures the participants’ views of how the programme has influenced them to continue in their development through a range of activities. Just nine codes were identified, and the concepts are interwoven amongst the previously described themes. Here the nurses explain what
they do and what influences them to remain contemporary and enlivened in their nursing practice, learnings from experiences and managing themselves, staying fresh as opposed to becoming complacent.

Post graduate study was one of the activities many the nurses indicated was important in ongoing development. Engaging in study as part of the NESP programme, fostered this according to Kara, who said,

*I think by going through the programme what I’ve noticed is... that more and more people are doing more study, afterwards ... and that’s like what I did as well. Rather than just sort of, again, just go to a job and just start working it... the knowledge and the development of your skills, that you can get, by doing more study.*

For Isabella, it was about keeping her from becoming complacent in her work:

*I guess it’s kept me interested in study, so I have kept developing. I think it’s also prevented the job getting stale too quickly because you don’t just become complacent and kind of learn the bare minimum of the role. You learn why you are doing what you are doing in the role.*

Whereas further study exposed Emma to inspirational people at the “top of their field” which made her think about things in a different way. She explains:

*Doing lots of papers you get to meet a lot of different people and have a lot of different talkers, people come and give presentations and stuff so there’s been ... people who have been quite inspirational or have sort of made me think about things in a different way or question why we do something a certain way or.*

Working overseas gave Taylor an appreciation of the structure and experiences afforded her in the first year of practice in mental health nursing. She found that the new graduate nurses she worked alongside did not have “study days where you get to talk to someone who’s got years of experience and know what they are talking about”. Having access to skilled and knowledgeable role models cannot be taken for granted.

As noted earlier, not everyone found it easy to access training or study. Nurses working in rural and remote areas said they found it very challenging accessing relevant courses. Tracy described this as requiring her to be “self-promoting’ where she needed to be active in,
...seeking out the good opportunities to train. To go to conferences, to connect with other nurses, does require a lot of travel and a lot of organising which is what I mean about the self-promoting bit. If you want to go to a national mental health nurses’ conference … you have to organise that and apply for funding and things like that. We’re very limited in opportunities that are locally based like there’s been things I’ve attended … but they’re few and far between.

A key component of staying fresh is engaging in reflective practice, as detailed extensively in being reflective. Supervision was spoken of as a key mechanism in the nurses’ professional and personal lives that enabled them to keep on track, and work things out. For Sam, supervision enabled her to come to a new understanding of her own health, by understanding “that there is a balance between learning myself and learning the role and how the role affects me”. Through supervision training Morgan said she was exposed to people that “demonstrate values that I really like, and they refresh me to be a better person … I love their curiosity and their very elegant minds… it’s sort of like a light or a topping up or whatever you want to call it. It keeps me on track.

The ability to maintain curiosity and spontaneity are important components in personal development. Morgan spoke of being inspired by a colleague, “she’s kind of an activist in a way…she gets projects off the ground that I sort of like…I see it as being work I aspire to and hopefully will grow into”. For her having access to the DHB design and innovation team meant she had “opportunity to get our ideas out there, which I have managed to do for something and it’s exciting to me”.

Having access to education, training and resources should not be taken for granted. Sam spoke of the challenges experienced in accessing support for ongoing study, and Morgan in accessing talking therapy training. What helped them pursue their goals was a passion for their work. Morgan described her role as one,

where I’ve got the kind of freedom, support and I can just give everything I’ve got. Like I think about this stuff all the time. Early hours of the morning, during the weekend, I love it. So anywhere where I can do that, and do good, I want to be…and I love young people so that is good. And I love the people who work with young people … I don’t really mind as long as it makes sense and it’s not bound up in ridiculous rules or people’s egos.

Professional and personal development do not happen in isolation, all the nurses spoke of people who contributed to the experience of being well set up and that influenced
them to think differently. This next theme explores these relationships and the networks that have been instrumental in the participants' growth and development as mental health nurses.

4.4 Theme 3: Interconnectedness

Hūtia te rito o te harakeke, kei hea te kōmako e kō? Kī mai ki a au, 'He aha te mea nui i te ao?' Māku e kī atu, 'He tāngata, he tāngata, he tāngata'.

If the heart of the flax is pulled out, where will the kōmako sing? If you ask me what is most important in this world, I will reply, 'People, people, people'.

(Traditional Māori proverb)

Mental health nursing is all about people and relationships. Nurses have multiple relationships and connections; with tangata whaiora and their whānau, fellow nurses, the nursing profession, the health care team, the wider health system, the community and the nation. This theme explores the interconnected nature of these relationships and networks that the nurses indicate play a key part in their personal and professional development.

This theme comprises of two categories and nineteen codes. The categories are names as supportive networks and connections and advocacy is part of everyday practice, reflecting the dominant discourse of the thirteen nurse participants.

I. Supportive networks and connections

This category discusses people who were important for the participants, and how they made an impact on their development. As noted earlier, key connections were facilitated by having rotations through inpatient and community areas during the programme, thereby exposing the nurses to a wide range of people, from all disciplines within the health care system. Nurses spoke of the impacts from having these rotations, notably the majority said that although it was hard at the time, having to move into new areas and meet new people, it was useful to develop the skills necessary in adapting to change and being flexible. It also gave them the opportunity to experience different teams. This was largely a positive experience. Isabella said, “where it was a good team you felt supported and you felt encouraged and nurtured”, and there were other teams “where you actually felt isolated even though you had a lot of nurses
around you”. Several of the nurses spoke of workplace situations where their needs were not well met. Morgan said,

“you can have a programme but then you’ve got to have the people who are involved. The flavour, the feel of the NESP programme, is one that I felt like I could flourish. I felt really encouraged so perhaps when I’ve met environments of where you can’t flourish more or grow or whatever it’s kind of a bit of a shock. … but you have to re-adjust and then work out your own stuff.

Interpersonal relationships in the workplace can be very complex, and at times constraining, especially with authority figures. Mia found it challenging being in workplace culture where the medical staff were so dominant that the nurses were “seen and not heard”. Sam was unsupported in her request for study assistance, despite repeated approaches to senior leaders, over several years. Morgan reflected the notion that you need to be careful in your workplace, that “people like you when you’re making them look good and then, above that there’s nowhere else you can go, unless you’re favoured. Unless you’re safe and you’re not going to say the wrong thing to the wrong people or you’re nicely tamed and you’re going to play nicely with managers… if you’re a bit random, and they’re not quite sure where you sit …there’s no place for you to go”.

Being supported by people with shared values was important and provided a sense of stability for many of the nurses. Isabella spoke of the attributes of nurses who provided this for her:

...they’ve always come across as non-judgmental, level headed, practical, logical and all kind of values, all personality traits that I like, and I find securing, and the fact that they don’t panic in a crisis... and they are flexible. Things like that. Really good personality traits that I find quite settling.

Having a sense of collegialism because of their shared experiences on the NESP programme was frequently voiced of by all the nurses. Sophia spoke of the lasting friendships, she said “when you walk around, and you see people and you see what they’re doing and it’s quite nice to know that that’s reasonably supportive”. The relationships “carried on into a professional capacity” for Taylor and Logan. The impact for Morgan was having service wide connections:

those relationships transcended the course and went on to either have kind of ongoing fondness where you don’t see each other all the time but when you do
it’s kind of like a bond that you still have, and you can reflect back... it encouraged me to have service wide relationships in a way that I might not have had if I hadn’t had that.

Being connected with people in the mental health service was something the nurses all spoke of as being a valuable outcome of having undertaken the NESP programme. Taking part in a mihi whakatau, and having her family welcomed to the mental health service was a significant connection for Morgan. She explains,

that first impression aside from the warmth and discussion...how easy it was to connect with something that was very important ... to me at that time, didn’t hardly know anybody, was that first day at [Māori mental health service] was majorly important to me, in the fact that you could take your family and that was huge. I connected with [name] and didn’t know that he knew my Dad’s brother and made a good whakapapa connection and that was really lovely, us connecting... it felt like a great way to start an introduction to a new service.

Having a strong network of connections facilitated greater collaboration. Engaging in supervision, as discussed under being reflective was also present in this category as it enabled the nurses to remain professionally connected. Being able to network with others assisted the nurses in advocating for tangata whaiora, whānau, nursing and for some nurses, their families.

II. Advocacy is part of everyday practice

A critical approach in nursing care compels nurses to ask themselves, whose needs are being met? Unsurprisingly the participants all spoke of advocacy in one form or another. Sam said, “I’ve always felt strongly about advocacy for clients, but that’s become a major focus of what I do rather than an occasional thing that you did when something was so outrageous you had to object”. Logan said, “before doing NESP I would never have really advocated ... as much as what I do now. And it’s in my everyday practice. It’s in everything”.

Establishing good relationships and utilizing their network of connections enabled the nurses to foster greater advocacy for the tangata whaiora under their care. The NESP programme was attributed to providing the nurses with a good platform of knowledge and skills and the development of confidence to work with and on behalf of others less able. Logan spoke of her role within her workplace:
If I wasn’t there now then all people who have mental health either a confirmed diagnosis or even are just struggling with themselves in everyday life, I doubt that anyone would be supporting them if I wasn’t there. So that’s hugely changed and because I have that understanding I want to advocate for them, work with them and then also raise that with the wider team. And on top of that I have the skills and confidence to make those assessments and have those consults when nobody else in the organisation would.

At the heart of mental health nursing role is working with people in ways that best meet their needs. Sophia talked of the programme reinforcing her focus on “patients who fly under the radar… the people who are low key, keep to themselves”. She spoke of the importance of considering the person’s perspective, “if I was in somewhere like this … I’d probably be quite aggressive and agitated”. For her it is important to be “working with people as well as you can to … make sure that they get the best care they can. Thinking about them as a person not …oh this person might do this today and what are we going to do about that?”.

Several of the participants worked in settings outside of traditional mental health facilities. They said this provided them with unique opportunities, and challenges. Mia spoke of her frustration in advocating for good care when there was inequality within the treating team:

I went to [region], nurses were very much seen and not heard, so that was a little difficult for me. Particularly when I had a woman who … kept taking her clothes off … disinhibited…the psychiatrist would meet with them and I’d find out later… he wouldn’t actually take any information from the nurse … I suggested that they Acuphase her, you know I’m not talking about just knocking her off her feet I’m talking about her dignity, her well-being … I walked into the nursing station and in big red writing over her notes was not for Acuphase… Two days later they Acuphased her and she came right really quickly.

As noted earlier for Sam facilitating autonomy in others is a central part of her role now. She explains it as,

being able to guide people without compelling them or diminishing their autonomy or their control, putting power back into their hands, giving them options and choices instead of if you do this, this will happen, and you should do this. I can offer you this or this, which one would suit you better?... our most important role is it answers the need for a person to be seen and heard. That’s satisfying.
Three of the participants spoke of the programme providing them with a greater capacity to advocate for their family and friends as well as those under their care. This they attributed to knowledge, relationships and experiences. Logan said,

*I wasn’t invited to that assessment even though I knew what that assessment entailed ... I had to say well do you want me there? And they were like oh if you want to come... Because I had a placement at that organisation I knew what was involved in that assessment... had I not done the NESP programme I wouldn’t have known.*

The participants have talked of experiences and different ways of thinking and the impact this has had on their practice and development. Working in partnership with tangata whaiora and whānau, and in collaborative ways with colleagues and the wider health care system is important in their work and identity as mental health nurses. Perhaps as a testament to the value they placed on their experiences the nurses all talked of ways they support nurses, and nursing. The final theme of *Reciprocation* explores this idea.

### 4.5 Theme 4: Reciprocation

All participants spoke in some way of the desire to reciprocate or replicate the support and opportunities afforded them because of undertaking the NESP programme. The commonly used words or phrases to describe this concept were to *give back, nurture our new people, pay it forward* and variations of these. Within this theme and connected is the notion of *inspiring others*. The term that seemed to resonate most across the narratives and capture the spirit of the nurses’ accounts was that of manaaki, a word from Māori meaning ‘to support, take care of, give hospitality to, protect and look out for, show respect, generosity and care for others’ (Hurawai & Baker, 2016).

A gauge of the value of an experience could be to afford others the same opportunities. The nurses all spoke of how significant the NESP programme was in their development as mental health nurses. Morgan captures the sentiment:

*its ... important after having that experience myself ... I value new people that come through there and I want to offer that manaaki that sort of reciprocity back to them... like the experience I had, the kindnesses that were shown to me and contrasting it over the not so pleasant situations as well. It’s really important that we nurture our new people, our NESP. It’s kind of good back boning.*
The nurses’ experiences and the influence of key people during their NESP year and subsequent years informs this theme, which has significant overlap with the previously described interconnectedness, however the point of difference here is that it explores what the nurses’ do and why, and the influence on their own development. From thirteen codes, two categories were established, Supporting and developing others and Inspiring others.

I. Supporting and developing others

The nurses’ talked of how well placed they were to facilitate positive experiences for the nurses new to the mental health field and the students because, as Isabella explained, “you know what they are going through so you’re able to support them a lot more”. It is notable that several of the nurses held senior nurse roles, therefore it would have been a professional expectation that they engage in this activity.

Putting themselves forward to be a preceptor or to support preceptorship or other models of working with students, was seen an opportunity to give back to nursing. Riley’s motivation to take on a preceptor role came from having a “mixed bag” of preceptorship as a NESP nurse;

*I think I took that away and made it a positive for others... that’s directly from I think from having positive experiences ... It makes a big difference to how you treat others...Being genuine with somebody is a big thing and I’ll do that with clients as well. There have been so many different people right the way through.*

Activities such as giving feedback on essays, supporting preceptorship by ensuring rosters were aligned and making themselves available to meet with the nurses were activities spoken of that supported new nurses and students. Taylor described the nurses in her early career years as all having,

*a slightly different way about them ... so experienced and always willing to share their knowledge... I think that’s so important as a nurse or any health professional to be always willing to share that knowledge and to remember that actually knowledge shouldn’t be sacred.*

Working alongside nursing students and new nurses was also viewed by some as an important opportunity to challenge some of the myths around mental health nursing. Logan recalled,
Something that’s been good working with students, whether they’ve been my own or I’ve preceptored them, that is conversations that I have all the time, because they go, ‘NESP oh but then I’ll lose my physical skills’... I’m able to go, well actually what am I doing right now? You know, it’s not, whether you choose ...you have to see that mental health nursing assessment skills, everything that you do is still nursing.

Sharing knowledge, seeking out learning opportunities and providing support in a nonjudgmental way for others were things the nurses spoke of as being important in their practice. Taylor recalled how her colleagues made her feel:

I’ve always remembered it and I always think ... you’ve got to always remember the people you work with instead of it’s not necessarily a job it’s made up with the people more so... they were so laid back outwardly but knew exactly what they were doing at all times...and always willing to teach other people like never made me feel like I was stupid or asking a stupid question ... looking back I know that what they were doing a lot of the time ...was really for me, but because they were just doing it, I thought it was a set of obs kind of thing, you kind of thought oh it’s such a dumb question why am I asking this but they never made me feel that that was the case...so I always try really hard to... replicate that and if we’ve got junior staff or whatever it’s always a stressful environment and keeping it in mind so that if someone’s asking you a question it’s because they want to know not because they are being stupid.

Most of the participants described having a leadership role within their workplaces. Of note was that they appeared to value more informal roles, rather than those identified by a title. The nurses all described the many ways they contribute to the development of other nurses and the wider team, and the satisfaction in having an ability to positively influence the workplace and workforce. Isabella spoke of the factors underpinning a drive to establish a more cohesive team in her workplace.

I saw a need for leadership, to build up a team again. It seems to be a lot more people aren’t on the same side as much as what they used to be, and you need everyone to go and approach things together, rather than as individuals ... I noticed the strength of, and kind of irritation at times, of having a whole group of people where you could bounce ideas and discuss things with...the underlying value of that all ...you need to have that cohesion because it’s kind of security and that was definitely something that I learnt from the NESP programme ... places where you had that environment, you felt a lot more secure and safe, and you actually enjoyed your job a lot more.

II. Inspiring others
This was not a category spoken of in an overt way by the participants, it was reflected in the actions and sentiments, yet prevalent enough to be worthy of its own category. The participants talked of being available to talk to new nurses, by proof reading essays and having informal discussions in their workplaces about research and innovation, yet only one person directly stated they inspired others:

I inspire other people to go and study...I know there were five or six people on my unit that were too scared to go and study and I’ve said to them ‘well it’s not actually that bad’...so you can actually be confident and help them (Riley).

Ten of the thirteen nurses actively worked with nursing students and five were in preceptorship roles with new graduate nurses. Coaching and facilitating learning provided opportunity for the fostering of interest in and development of mental health nursing. Kara reflected this:

I quite like, again working with the students, doing the [clinical lecturer role] separate from the new-graduate stuff but working with the students, I quite like doing that teaching and creating those environments and getting, making sure they’ve got exposure to everything involved in nursing and promoting mental health nursing as well.

Similarly, Riley spoke of his enthusiasm and how he encouraged others.

It’s a little bit like I suppose having people be autonomous and giving them that confidence to be autonomous in what they’re doing and the confidence to be able to say I am doing something really good and this is where I’m going with it. I suppose because I’ve always been really enthusiastic, so I think that enthusiasm spills over onto others and I suppose it’s a bit like riding a wave on a surf board isn’t it and you get a whole lot of people jumping on the board with you.

For others, the ability to inspire others came from being able to share projects and develop ideas. All the nurses talked of quality projects they are involved in as part of ongoing practice. Morgan talked of an initiative that had a positive impact on the wider community she works within.

I’m just so thrilled that that exists that we can actually have the opportunity to get our ideas out there... I got the team involved with everyone contributing to it... I managed to get connected with the medical imaging... and they turn it into the most amazingly beautiful thing you’ve ever seen. All interactive pdf. It was so beautiful and now that sits on our website as a link and people and schools go in and all the schools and services, all the other service providers say it is just amazing, they love it.
From these accounts, and others not able to be captured by word limitations, it is apparent nurses sufficiently valued the experiences they were afforded in the NESP programme, that they reciprocate this in the ways they work with others and the activities they undertake to contribute to improved care for people experiencing mental health issues. Being able to influence the nursing workforce is a key mechanism for reciprocation.

As a means of capturing the interrelatedness of the themes explored in this chapter the following diagram and brief explanation of the symbolism associated with it is put forward (figure 1).

**Figure 1.** What is the impact of the NESP programme on the nurses’ personal and professional development? Themes and their relationship to each other.

This stacked Venn diagram is a diagrammatic representation of the themes from the nurses’ narratives. The circles all sit within each other to reflect the relationships and connected nature of the themes identified in this research project. **Well set up**, represents the foundational year and development of knowledge, skills and attitudes. The green colour is symbolic newness and growth. **Thinking differently**, represents critical thinking and reflection. The yellow colour is symbolic of enlightenment and
developing confidence. *Interconnectedness* represents networks and connections. The orange colour is symbolic of warmth and socialization. *Reciprocation* represents supporting and nurturing. The blue is symbolic of respect and trust.

### 4.6 Summary

This chapter has described the themes within the nurses' perceptions of the impact of the NESP programme on their personal and professional development. The exploration of narratives through the four themes evidences the importance of the NESP programme as a conduit to this development. The programme was described as providing a solid foundation to support ongoing development by laying down and equipping the nurses with the knowledge, skills, and attitudes to continue on a professional pathway. Being able to think critically, and engage in reflection, supported the nurses to understand and find ways of working through the challenges. Being exposed to a range of people enabled supportive networks and key connections to be made, which facilitated access to information and resources for themselves, but also enabled the nurses to provide this for others. Reciprocation as the final theme, shows how the nurses support and inspire others to develop just as they were. In conclusion, the programme enabled the nurses to be well set up for a career in mental health nursing, as Mia said, “NESP … was the cement between the bricks”.

The discussion chapter follows. Information previously presented in the literature review is discussed in the light of these findings and the significance explored in the relation to the research question. The strengths and limitations of the study are described, along with implications and recommendations for practice and ideas for future research on this topic.
CHAPTER 5: DISCUSSION

In this chapter the four themes of well set up, thinking differently, interconnectedness and reciprocation, identified in the previous chapter, are explored. They provide the structure for this discussion, which exposes their significance in relation to the research question as situated within contemporary mental health nursing literature. The limitations of the study are described, along with implications and recommendations for practice and ideas for future research on this topic.

The purpose of this research was to assess and gain an understanding of the impact of the NESP programme on the mental health nurse participants’ personal and professional development. The previous chapter concluded with the notion that the programme be conceived as providing ‘the cement between the bricks’ for the nurses undertaking it. The cement represents the integration of programme components of masters’ level education, supported clinical experiences and professional supervision. Underpinned by an ideology of critical social theory, the programme challenged nurses to consider whose interests were being served by their actions and those of others. By taking a critical lens to mental health practice and reflecting on their actions the nurses were compelled to consider the visible, and the hidden oppressive culture and power structures enacted in everyday practice. Situating this within the context of New Zealand’s unique culture, particularly in relation to the Treaty of Waitangi, and the principles unique to this country, stimulated the nurses to consider the broader context of mental health care provision within New Zealand. This in turn fostered the development of specialist knowledge, skill and an attitude for working therapeutically with people living with mental health issues.

The cement metaphor acknowledges that the nurses entered the programme with knowledge, skills and experiences from undergraduate programmes, or other nursing experiences and that the programme provided a mechanism for these separate entities, the bricks, to become anchored, or held together, resulting in a solid foundation to continue building practice from. The first foundational theme, and associated categories, are discussed considering the literature and significance for mental health nursing.
5.1 Theme 1: Well Set Up

The nurses spoke of their experiences of the programme and how it influenced the way they practice, reflected in the development of their knowledge, skills and attitudes. The theme *well set up* reflects the narrative of a solid foundation and being well prepared to provide contemporary, person centred and recovery focused care for people with mental health issues. A well-prepared and responsive workforce is associated with positive health outcomes for those experiencing mental health issues (Ministry of Health, 2017). Increasingly consumers of healthcare services are involved in determining their health care, as are the families of those experiencing health issues (Gaskin, O'Brien, & Hardy, 2003; Rydon, 2005). It is important that health professionals working with this complex and vulnerable group of the population do not further contribute to the distress through ignorance or ineptitude, by practising in stigmatising or discriminatory ways. The health reforms of this country are testament to the dire consequences of inattention to adequate workforce preparation, with resultant poor health outcomes for many of the New Zealand population with mental health issues, and distress for their family and whānau (Gage & Hornblow, 2007; Ministry of Health, 1996). Given these factors it is imperative that nurses are also self-motivated in honing the craft of mental health nursing, by keeping abreast of change and employing a philosophy of care that is underpinned by best practice and reliable and reputable evidence; this is a responsibility expected of every health professional.

As noted in Chapter One (section 1.5), this NESP programme has as one of its key assessment components the evidencing of clinical learning outcomes (Appendix 7), presented as a portfolio and serving as a platform to demonstrate the synthesis of all that is mental health nursing. New Zealand specialty mental health programmes are underpinned by standards from the profession, the governing body and national centre for mental health research, information and workforce development (Te Pou o Te Whakaaro Nui, 2016). This programme’s learning outcomes provided the scaffolding for the nurses to evidence integration of knowledge, skill development and critical reflection through clinical practice, undertaken in a scholarly manner and informed by contemporary evidence based practice and literature reflective of this (Crowe, 1998a; Te Pou o Te Whakaaro Nui, 2016).
Nursing is a significant, therapeutic, interpersonal process. It functions cooperatively with other human processes that make health possible for individuals in communities. In specific situations in which a professional health team offers health service, nurses participate in the organisation of conditions that facilitate natural ongoing tendencies in human organisms. Nursing is an educative instrument, a maturing force, that aims to promote forward movement of personality in the direction of creative, constructive, productive, personal and community living. Peplau (1988, p. 16).

As Peplau (1988) contends, interpersonal relationships are at the heart of nursing. What stands mental health nursing apart from nursing in general is the centrality of the therapeutic nursing encounter fostered through the interpersonal nurse-patient relationship within the context of the wider multidisciplinary team. Mental health nursing in New Zealand is delivered in a context that acknowledges and values the indigenous peoples of this land and therefore all healthcare provision is underpinned by the Treaty of Waitangi, with emphasis on cultural safety (Te Ao Māramatanga, 2012). That mental health nursing is holistic and considers the needs and strengths of the individual, family, group and community is significant, as the qualities people with mental health issues value most in nurses are those of having a positive attitude towards them and practicing in a therapeutic way (Rydon, 2005). As noted in Chapter One, the shift of care provision from institutions has placed more responsibility for care with family and whānau in the community. Nurses, as part of the healthcare team need to support the person in the context of their life, within and outside of the institution, this requires not only the right attitude but ongoing knowledge and skill acquisition.

That learning does not end with completion of a NESP programme was a clear message from this group. It is the author’s belief that the NESP programme instilled in the nurses the value of seeing mental health nursing as a specialist field that requires a lifelong learning mindset. Having such an orientation to learning is essential for working in a profession that is constantly changing; nurses must be prepared to face the challenges of working in a constantly developing healthcare environment (Gustafsson & Fagerberg, 2004; Jasper et al., 2006).

Knowing and having the understanding and recognition that you don’t get your skills all done and dusted and off you go (Emma), that being a nurse, and especially being a nurse in mental health requires that you keep your tools as sharp and pristine as you can. The mental health nurse has a kete (basket) of knowledge, which is constantly
being examined and replenished. Skills are built upon, challenged and grown. Skills in communication through learning multiple ways of being with people and facilitating them to connect with themselves and others. Honing the craft of talking therapy and working with distress, trauma, discomfort and conflict. Working with people who are damaged and hurting, whilst staying intact as a health professional. Knowledge and skill development are inextricably linked with attitude, as reflected in the college of mental health nursing standards for this country (Te Ao Māramatanga, 2012). Keeping up to date with best practice and having an evidence-based practice mentality are attributes of being a health professional that are not only desirable, but expected to be maintained by all nurses (Jasper et al., 2006; Nursing Council of New Zealand, 2007).

From psychology and education, agency was evident when the nurses talked of having a thirst to learn, not because they had to, but because the wanted to; I loved the learning. I was hungry for knowledge. I got that (Ava). The nurses spoke of their learning and development and having a voice in this, having a desire to improve and develop not through fear of getting things wrong or getting into trouble, but from a position of honest desire to be the best they can be, as Isabella said, being your professional best (6). Bandura (2001) states being agentic is to intentionally undertake activities; to exercise control over one’s self development, thereby adapting and flexing in response to changing circumstances and times. This is an important attribute in the healthcare environment constantly under pressure. Having control over one’s learning, being self-motivated and developing skills than enabled greater autonomy were important for the nurses in this study when envisaging possibilities, options, and making informed choices about where to work and how to practice. The nurses attributed the programme to fostering confidence to work with change, be flexible and adapt to different workplaces and teams. They recognised the areas they could flourish in and the ones that could not. This is in keeping with the findings by the Ministerial Taskforce on Nursing (1998) report indicating nurses face constraints to advancing in practice. Likewise, Spence (2004b), identified that nurses undertaking post graduate study required ‘cognitive capacity, confidence, clinical credibility, and courage’ to face the oppression in some workplaces (2004b, p.22). Several of the nurses in this research faced challenges in accessing and being supported with professional development activities, namely postgraduate study and skills-based therapy training. Others spoke of seemingly punitive and institution-centric practises that contributed to client distress.
and poor therapeutic alliance. In these cases, the nurses spoke of how they spoke up and challenged practice where they could, others changed workplaces and selected more supportive work cultures that aligned with their care philosophy which enabled them to continue their development, to flourish, thus exercising agency in their nursing careers.

The nurses said that the programme provided a solid platform to their launch careers and develop professionally, this is in keeping with the reported effect of the first NESP programme (Cook, 1998). The post graduate qualification was viewed by the nurses in this study as advantageous in clinical preparation, but also in the career sense, for advancement in nursing. That the study was fully funded and supportive was clearly important for these nurses and contributed to them remaining in this field. This is significant as not all countries provide this level of commitment nor incentive for nurses to advance in their practice (Cooley, 2008; Hickman, Mannix, & Neville, 2014; Holmes, 2006). This is concerning, as it is clear from the literature, and from the nurses in this study, that experience on its own is insufficient to advance in nursing (Barnhill et al., 2012; Cotterill-Walker, 2012; Crowe & O'Malley, 2006; Hickman et al., 2014; Lakeman, 2000; Spence, 2004a).

Structured learning in a variety of clinical areas, as attested by the participants, enabled the identification of a niche area to work in or aspire to work in; this was influenced strongly by experiences and the presence or absence of a supportive clinical learning environment or workplace culture. Workplace leadership and team cohesion are key to the development of proficient nurses, job satisfaction and retention (Were, 2016), and most importantly, good mental health care (Hazelton, Rossiter, Sinclair, & Morrall, 2011). From a recruitment and retention perspective, Generation Y nurses who have choice, or flexibility in workplaces, are said to have greater engagement with the clinical area and learn more (Cubit & Ryan, 2011). The study findings reflected research that suggests that the current generation of nurses are more mobile and will seek out opportunities and workplaces that support career development (Scott, Huntington, Baker, & Dickinson, 2011b). The author contends that clinical rotations provide opportunity for a semblance of choice for the nurses, through structuring this experience for them.
The merit of clinical rotations, as noted earlier, is somewhat contentious within first year of practice programmes. Some authors argue that the first year of practice be limited to no more than two workplaces, ideally just one, and where possible be a consistent and stable environment (Adlam et al., 2009; Duchscher, 2009). Yet others have identified that a broad clinical experience is associated with nurses having greater opportunity to identify areas of specialty preference, and this contributes to their career development (Cleary, Horsfall, Muthulakshmi, Happell, & Hunt, 2013). Haggerty (2000) undertook one of the few New Zealand studies that explored the impact of NESP programmes for the nurses. It is notable that although this study was reported on 17 years ago, the findings resonate with those of this group of nurses, in that rotations afforded participants an opportunity to see how organisations connected with one another, and highlighted how things should function but don’t in some workplaces, and that remaining in one area can stifle professional growth (Haggerty, 2000). The author asserts that clinical rotations serve a useful function in expanding the horizons and exposing the nurses to a range of experiences, including varying approaches, to health care provision. This notion is supported by several authors who identified that diversity in clinical practice expanded clinical practice capacity and expertise (Cleary, Horsfall, Mannix, O'Hara-Aarons, & Jackson, 2011; Cleary et al., 2013; Te Pou o Te Whakaaro Nui, 2015).

Being well set up for working in mental health nursing enabled the nurses to be positioned to develop the higher level of competence required to work in an increasingly complex health care environment, and thus deliver contemporary evidence informed care to people experiencing mental health issues. It also provided the nurses with a sound platform to grow their practice from. The vehicle for this was developing skill in critical reflection, regarded as an essential component in developing advanced mental health (Crowe & O'Malley, 2006; Lakeman, 2000).

5.2 Theme 2: Thinking differently

Thinking differently was identified as a prevalent refrain in the narratives of this study, with the nurses describing the NESP programme as enabling them to look at and see things in a different way, which is a common finding in other studies, particularly those looking at the impact of post graduate study (Pelletier et al., 2003; Spence, 2004a; Watkins, 2011). This was fostered through developing the cognitive skill of thinking
more critically, in conjunction with reflection on practice, components of the NESP programme and outcomes evidenced by Te Pou’s survey data (Te Pou o Te Whakaaro Nui, 2015) and within the findings from an independent review of the NESP programmes undertaken for Te Pou (Stuart, 2014). This finding is consistent with other research, broadly in the nursing realm rather than that specific to mental health, exploring the impact of post graduate education on practice (Spence, 2004a; Watkins, 2011). Described as a less visible aspect of knowledge and skill development, Spence (2004a) identified that by engaging in post graduate study the nurses were able to develop greater ‘breadth, depth and structure in their thinking’ (p.51). Likewise, Watkins (2011), attributed engagement with post graduate study to developing critical thinking, in that it was more objective, structured, systematic and focussed.

The nurses in this research described big picture thinking, a component of critical thinking, as being fostered across all programme components; clinical practice, academic work and in interpersonal interactions with supervisors, preceptors and colleagues; which was also in alignment with other research in this field (Cotterill-Walker, 2012; Haggerty, 2000; Spence, 2004b). The nurses particularly valued the post graduate study days, one aspect was having protected time away from busy workplaces to connect with others and develop an appreciation of the pressures within and across the health system. Notably, some nurses said they missed this supportive environment in the years after the programme, unless they engaged in further post graduate study. Post graduate study enabled them to remain engaged in the research culture, drawing inspiration from contact with experts in the field. Having access to skilled facilitators, being inspired by interventions that contributed to improved health outcomes and better quality of life for the people they worked alongside, were all perceived as important in their ongoing development. Engaging in further study contributed to the development of their aspirational practice goals. That the nurses found their clinical workplaces less able to meet their needs for professional development is not novel in nursing, several authors declare that providing ongoing support after a course of study is essential for practice development (Lakeman, 2000; Scott et al., 2011b; Spence, 2004a). The nurses in this research felt they could have been better supported in their early career development within their workplaces, a finding consistent within the literature that indicates supportive workplace culture is significant for ongoing
personal and professional development (Cotterill-Walker, 2012; Spence, 2004b; Were, 2016).

Were (2016), whilst unintentionally capturing NESP in the exploration of organisational climate and its association with success in clinical practice, suggested that collegial work environments where contributions were valued, impacts on early career nurse success. Enhancing the nursing leadership structure, by better supporting Charge Nurse Managers to build strong positive teams, was suggested as a strategy to enhance early career development. This approach, said to facilitate the development of positive healthy climates, would in turn attract talent, and impact favourably on workforce retention (Ennis, Happell, & Reid-Searl, 2015). The nurses in this study spoke of quality improvement projects that provided them with a framework to not only raise issues, and flag areas in need of improvement, but also fostered their autonomy in making recommendations, and making a difference to the well-being of others. Workplaces, especially inpatient areas, are not always able to support practice innovation, commonly because of patient acuity, skill mix and workforce shortages (Cubit & Ryan, 2011; Phillips, 2005). In this research it was apparent that the nurses who went on to work predominantly in the community perceived they had more autonomy and opportunity to apply their new-found skills.

An unsurprising find from this study was that the nurses said the skills developed through the scholarly endeavours of postgraduate study enabled a more confident engagement with research and other activities, such as taking on complex projects and developing new roles. Having opportunity to engage in innovative and creative activities fostered practice development which is said to contribute to improved outcomes for people with mental health issues (Wilson, 2006). Whilst education is important to advancing health care, and contributes to increased ability, reflection facilitates application in practice (Lakeman, 2000). Assignments encompassing the therapeutic relationship, clinical formulation and writing a patient narrative were viewed by the participants as the most challenging, yet richest learning experiences. These all required the nurses to reflect upon and critique their practice.

The skills of critical reflection cultivated in the NESP programme were enhanced in this sample through their ongoing engagement with clinical supervision. The supervision process enabled expansion of the skills learnt through taking a problem-
based learning orientation to complex clinical situations explored in study blocks and facilitated in clinical practice by preceptorship. This served to position the person experiencing mental health issues at the centre of care and foster in the nurses an ability to articulate a methodical and sound rationale for their practice (Crowe, 1998b; Crowe & O'Malley, 2006). Supervision was viewed, by this cohort, as a mechanism that enabled personal growth through the safe challenging of fears, learning ways of dealing with the emotional burden of work, and managing risk. For some nurses it proved inspirational and lead to them engage in supervision training and the delivery of supervision to others. As commented on in chapter one, clinical supervision, as a key component of all NESP programmes, serves to support the nurses engage in a critical reflection upon practice, particularly in relation to exploring functional ways of working through conflictual situations that arise in care delivery. Haggerty (2000) reported that the participants in her research conceived of supervision as an important mechanism to sustain and maintain themselves in an environment she described as oppressive. Critical reflection skills are necessary to survive in the healthcare environment (Hummelvoll & Severinsson, 2001; Lakeman, 2000), and to develop the necessary skills to work in therapeutic ways with people experiencing mental health issues (Consedine, 2000). Winstanley & White (2003) also propose that supervision contributes to staff morale and work satisfaction and retention, this was the case in this study. Conversely poor quality supervision has been associated with increasing job dissatisfaction (Hyrkäs, 2005). Effective clinical supervision was regarded by this group as having significant impact on personal and professional development. The author argues that the supervisor-supervisee connection is a key component of this. The notion of interconnectedness is explored as the third theme from the nurses’ narratives.

5.3 Themes 3: Interconnectedness

Supportive networks and connections are important for sustaining nurses in the workforce and fostering contemporary person-centred care. The nurses in this study said having a network of connections was important for their practice development. For them a key mechanism for this was the range of clinical workplaces they experienced as part of their NESP programme. Whilst moving workplaces was unsettling at the time, it was perceived later as positively contributing to their
development by preparing them for change. Through being compelled to change and adapt to new environments participants stated that this exposed them to differing ways to practice. To see variation in the way other nurses interacted led to greater options for the way in which they could practice.

The importance of connectedness and relationships has been highlighted by Jackson (2008) as having an impact on the individual’s wellbeing, contentment and ability to respond to adversity. Participants talked of how they felt they could flourish when they felt supported and valued in the workplace. Flourishing for participants meant they could practice in a way that they felt was authentic, and placed the person in the centre of care. Jackson, Firtko, and Edenborough (2007), in exploring factors that contribute to nurses surviving or thriving in complex work environments, linked this to the concept of resiliency, described as the ability to adapt positively in the face of adversity. Of the five strategies suggested for building resiliency, a central strategy was developing professional relationships and networks that are nurturing (Jackson et al., 2007). Participants in this study identified that there were workplaces where they could grow and others where they floundered.

The flip side to interconnectedness of course is disconnection. Disconnection can occur in the workplace when nurses do not feel valued and listened to. In such workplaces the outcome was that participants felt other nurses did not seem to have time for them. Participants described feeling isolated and marginalised leading to a sense of not belonging within that environment. Marginalisation has been identified as a key factor in difficulties of recruitment and retention (Duchscher & Cowin, 2004). A critical difference was the presence or absence of a supportive team. The nurses who floundered said they felt isolated, even though they were surrounded by people. Those that flourished said they felt nurtured and encouraged in their development.

In some teams there are dominant people or professions. Several of the nurses spoke of workplaces dominated by medical staff, they perceived as not seeking to work collaboratively with nurses, by imposing a biomedical model of care which they felt did not serve well the needs of those with mental health issues. Tension can arise in the clinical workplace when one dominant discourse overrides and constrains other possible psychotherapeutic approaches (Carlyle, Crowe, & Deering, 2012).
Participants stated that they found collegiality in ongoing postgraduate study. Here they found the opportunity to discuss contemporary mental health nursing approaches, critically examine practices and divined inspiration for working with people. This is supported by Crowe in her paper examining advanced mental health nursing practice (Crowe, 1998a). The study groups provided an opportunity for participants to feel connected with others and to find a commonality of purpose in their clinical work.

An unexpected finding in this study was the significance the participants still placed on the coming together as a group at the beginning of the programme through the process of hui and formal welcome facilitated by the Māori mental health service. In New Zealand this is a culturally congruent way of engagement, particularly in this field of healthcare (Brannelly, Boulton, & te Hiini, 2013). Given that the Treaty of Waitangi principles are foundational to healthcare delivery in New Zealand; observing and threading Māori protocol throughout practice is a clear way of establishing meaningful and respectful engagement with all peoples of the land, and especially Māori who are overrepresented in mental health services (Lacey, Huria, Beckert, Gilles, & Pitama, 2011). The result of this introduction to the mental health service was to foster connectedness within the new group and across the healthcare teams, setting up the nurses for wider collaborative relationships across the service and sector. One impact of these relationships was that the nurses perceived they were able to have greater influence to advocate for those they were working with.

The ability to advocate effectively is underpinned by a genuine engagement, characterised by really understanding the experience of the person. MacDonald states “…it is the emotional connection and sense of knowing the patient that seems to motivate advocacy actions” (2006, p.124). The nurses in this research were clear the NESP programme facilitated engagement with advocacy roles. They attributed this to the clinically focussed patient narrative and therapeutic relationship assignments, that compelled them to articulate a person-centred orientation to practice. That advocacy was described as ‘part of everyday practice’ would suggest that this is incorporated into routine nursing practice. However, the ability to effectively enact advocacy is influenced significantly by negative workplace culture, especially relationships with other members of the healthcare team (MacDonald, 2007).
The nurses spoke of engagement with advocacy activities in their personal lives, for friends and family members, that was made possible because of their acquired knowledge and experience fostered during their time on the NESP programme. That the NESP programme fostered the importance of the human connection was evident in the narratives of current practice.

...being able to guide people without compelling them or diminishing their autonomy or their control, putting power back into their hands, giving them options and choices instead of if you do this, this will happen, and you should do this. I can offer you this or this, which one would suit you better?... our most important role is it answers the need for a person to be seen and heard. That’s satisfying (Sam).

5.4 Theme 4: Reciprocation

Reciprocation is the final theme identified from the mental health nurses who in this study. Determining the significance of the theme has posed the author with considerable challenge, as the concept that was emerging did not seem to fit neatly into any of the apparent literature associated with typical early career nurses. Psychology frames reciprocation as a situation where one person receives a benefit from another and chooses to give an equivalent benefit in return (Nugent, 2013). Effective peer mentoring relationships are said to be characterised by learning, shared caring, and reciprocity (Glass & Walter, 2000). Hoare, Mills, and Francis (2013), in their research with practice nurses and new graduates, identified that reciprocation, defined as the conveying of shared knowledge exchange, occurred between the nurses once a respectful relationship was established. What the nurses were saying seemed to be different to this.

The participants’ stories indicated the audience of this reciprocation were other nurses, most often new nurses, and unlike the psychology perspective noted above, the giving back was not necessarily to another person, or indeed the person who provided the benefit, but to nursing. Reciprocation has been constructed by the author as a professional imperative to nurture the next generation of nurses through sharing perspectives, and guiding others. That all new nurses are required to undertake this programme suggests that the participants are supporting others during their NESP programmes and thereafter in their early careers. A critical mass of likeminded people can make a significant difference to the organisational climate, professional practice
and patient care (Glass & Walter, 2000). A recovery-oriented care and leadership study, in mental health nursing, proposed that leadership styles that were transformational and distributed, were most conducive to sustained workplace learning by way of their linear structure and the constructive collaborations enacted through the peer support, coaching and mentoring activities of the nurses (Cleary, Escott, Lees, Molloy, Sayers (2017).

It is notable that the nurses in this sample said they were not enamoured with roles in management, however they were very comfortable being viewed as informal leaders in their workplaces. As Ava said, *I feel that I’m already being a leader in what I do. I don’t need a title.* The demographics of this sample reflect that none of the nurses had taken up Charge Nurse Manager roles, and just one nurse had an aspirational goal to be a nurse manager, yet many spoke of an informal leadership style characterised by a desire to support others, having what Jackson (2008) terms as a ‘service-oriented’ approach to leadership.

Servant leadership is altruistic by nature and can bring about change at personal and service levels, this style of leadership has been associated with a strong and lively research culture (Jackson, 2008). The findings indicate that most of the nurses actively sought to remain engaged in research activities, namely, further postgraduate study. This was an environment that they perceived as supportive and valuing of their contributions, which served to foster passion, innovation and confidence which they then brought back to their workplaces and shared with their teams and the new graduate nurses they worked alongside. The author contends this was an attempt to create a learning environment that was encouraging, nurturing and promoted collaborative teamwork, all characteristics of servant leadership (Jackson, 2008). Jackson states that “authenticity, trust and humility are also features of servant leadership and servant leaders recognise that distant, arrogant and intimidatory leader behaviours only serve to silence, cower and suppress the creative energy of constituents” (2008, p.28). As reflected in the narratives of this study, those nurses who experienced unsupportive clinical learning environments were active in seeking more supportive workplaces that fostered learning.

The author argues that this study supports the notion that critical thinking, clinical experience in a range of settings, having a person-centred orientation to care and a
strong value for collaboration, positions NESP nurses well to continue their own personal and professional development, whilst fostering this in other nurses and the people experiencing mental health issues within New Zealand’s healthcare setting. Perhaps this is in line with the notion of nursing as trephotaxis, which Barker (2009) contends is when, ‘nurses provide the conditions necessary for the person to experience growth, development and change, and to learn something of significance from their own experience’. Postgraduate study has a known association with preparation for higher level practice (Pelletier et al., 2005; Spencer, 2006; Whyte et al., 2000). This coupled with the findings of this research suggesting a proclivity to support others develop, and a possible servant leadership style position NESP nurses to be effective leaders in the provision of high standards of care for people with mental health and addiction issues in New Zealand.

5.5 Summary

The author proposes that NESP programmes have prepared a critical mass of nurses well equipped with the attributes needed to advance the specialty of mental health nursing, and most importantly provide person-centred care. The challenge is how the workplace and organisational culture will continue to nurture and grow the specialty in the face of nursing shortages, and economic imperatives for efficiencies, including pressure on Te Pou to dilute the programme content or align it with the non-specialty Nursing Entry to Practice Programmes (Stuart, 2014). Calls for a more generalist nursing workforce are prevalent throughout the world (Butterworth & Shaw, 2017). The contribution mental health nursing makes to the health and wellbeing of New Zealand is largely invisible. Given the above-mentioned pressures it is now imperative that mental health nursing articulate and share the valuable contribution having such a specialist workforce has for the people of this land experiencing mental health issues.

The findings of this research are in alignment with position statements from Directors of Mental Health Nursing, and Te Ao Māramatanga (New Zealand College of Mental Health Nurses), and reports from Te Pou, that New Entry to Specialty Practice Mental Health and Addiction programmes have equipped the nurses to acquire specialist knowledge and develop the skill set required to be effective in delivering care that is contemporary, person-centred, recovery focussed and attends to the diverse cultural
needs of the population (National Directors of Mental Health Nursing; Stuart, 2014; Te Ao Māramatanga, 2015; Te Pou o Te Whakaaro Nui, 2014).

5.6 Limitations

1. This qualitative project of thirteen participants from varying fields of nursing could be perceived as a limiting factor, it is not possible to generalize the findings with this specific research method.

2. An opt in process of recruitment was adopted which meant those who participated were committed and motivated people who may have had positive experiences. The risk is that this may have biased the results. Conversely, participants may have engaged in the research as they saw this as an opportunity to provide constructive critique.

3. Although every effort was made to stand aside from the data and view it in an impartial manner, the researcher’s relationship with the study participants may have influenced the research because of contact with the participants as a mental health nurse and as programme coordinator.

4. The data was collected at a certain point in time within a particular context. NESP programmes whilst having the same specifications cannot uniformly deliver the same experience for each nurse each year. The size of the group, events in the workplace and in their personal lives, such as shortages of staff and natural disasters will influence the nurses’ experiences and shape their development. Likewise, nurses have differing worldviews and this group whilst having the NESP programme in common, did not all undertake it at the same time. Some moved to other organisations, regions and countries. The data was collected from a very diverse pool.
CHAPTER 6: CONCLUSION

This study has explored the experiences of thirteen mental health nurses, who completed New Entry to Specialty Practice Mental Health and Addiction Nursing (NESP) Programmes delivered within the Canterbury region of New Zealand between the years of 2010 and 2013.

The intention was to assess and gain an understanding of how the NESP programmes impacted on the personal and professional development of the nurses who undertook them.

The impact of the programme for the nurses was that they were well prepared for a career in the specialist field of mental health nursing. The programme afforded them opportunities, experiences and connections that enabled them to competently deliver evidence-based, contemporary and collaborative person-centred care. The participants have advanced in their careers, and now actively support the next generation of nurses.

Recommendations:

1. That further research be undertaken to gather evidence on the impact of the programme in terms of outcomes for people with mental health issues, their families and the wider community.

2. As NESP programmes are effective, this investment by the government needs to continue, with Te Pou managing the contracts and monitoring the workforce development.

3. That postgraduate study continues to be integral to the programme.

4. That funded positions on NESP programmes should be increased so that all new mental health nurses have access to a robust and supportive first year of practice.

5. New graduate nurses need to be exposed to a wide range of clinical experiences in areas that interest them, fostering increased understanding and creating opportunities for collaboration and connections across the services and sector.
6. That development of this workforce continues after the first year of practice with more robust and structured clinical support and access to further postgraduate education.

7. Research should be undertaken looking at the long-term effect of the programme both for the nurses undertaking them, with emphasis on leadership development, collaborative learning cultures, and the recipients of care.

8. NESP nurses need to be encouraged and supported to share their research with the wider mental health community.
REFERENCES:


APPENDIX ONE

Participant Information Sheet
APPENDIX 1: Participant Information Sheet

**Participant Information Sheet**

<table>
<thead>
<tr>
<th>Study title:</th>
<th>The impacts, for the registered nurses of the New Entry to Specialist Practice Mental Health &amp; Addiction Nursing Programme, of the programme, on their personal and professional development</th>
</tr>
</thead>
</table>
| **Principal investigator:** | Name: Gail Houston  
Department: Centre for Post Graduate Nursing Studies  
Position: Master of Health Sciences Student |
| **Contact phone number:** | 03 3377 969 ext. 33717  
027 2298241 |

**Introduction**

Thank you for showing an interest in this project. Please read this information sheet carefully. Take time to consider and, if you wish, talk with relatives or friends, before deciding whether or not to participate.

If you decide to participate we thank you. If you decide not to take part, there will be no disadvantage to you and we thank you for considering our request.

**What is the aim of this research project?**

I am conducting this research as part of the requirements for a Masters in Health Science (Nursing) through the Centre for Post Graduate Nursing Studies, University of Otago, Christchurch.

New Entry to Specialist Practice Mental Health & Addiction Nursing programmes (NESP) have been running in New Zealand now for twenty years. To date review has primarily focussed on fiscal and retention measurement with little exploration of the mental health nurses’ experiences following completion. What appears to be lacking is research that provides in-depth understanding of the human experience and how this impacts on contemporary practices leading to improved patient care.

The purpose of this study is to develop a greater understanding of the nurses’ experiences after the programme, in terms of exploring their personal (activities that improve awareness and identity, develops talent and potential, facilitates employability, enhances quality of life and contributes to the realisation of dreams and aspirations) and profession development (skills and knowledge attained for both personal and career advancement). Through in-depth semi structured interviews and thematic analysis this study proposes to illuminate the impact of the Canterbury NESP programme.

**Who is funding this project?**

This research is not funded.

**Who are we seeking to participate in the project?**

If you have undertaken the New Entry to Specialist Practice Mental Health & Addiction Nursing Programme here in Canterbury between 2010 and 2013 you are eligible to
participate in this project. The rationale behind this is to ensure that the nurses have adequate time to establish themselves in a new workplace and the nursing role.

By purposely recruiting from the pool of nurses of whom I have had little recent clinical contact, from the programmes run from 2010 – 2013, I am hoping to ameliorate any potential power imbalance or undue influence issues.

Sampling for this research is purposive, every endeavour will be made to include participants’ representative of the nurse population in terms of gender, age and ethnicity. The intention is to capture a wide range of perspectives.

Inclusion criteria for selection are:
- Must have completed the Canterbury NESP programme between 2010 - 2013
- Registered Nurses currently in practice
- Nurses have at least one year of nursing experience following completion of the programme
- Nurses are available for a face to face interview

Sample size is anticipated to be from eight to sixteen people from a possible pool of 96.

If you participate, what will you be asked to do?
Your involvement will consist of attending an interview of around 1-hour duration whereby a series of broad questions will be posed in relation to your personal and professional development following undertaking the CDHB NESP programme.

Interviews will be undertaken in a training room on the Hillmorton Hospital site, a convenient place nominated by the participant, or via Skype (for those participants not living in the Canterbury region). It is important for all parties that the venue is supportive of a private uninterrupted interview. For this reason, clinical workplaces have not been selected as they are both prone to interruption and not always private.

This interview will be audio taped and these recordings will be transcribed by a professional Dictaphone typist. A copy of the transcription will be provided to you in order to check for accuracy. You may request to have the tape stopped at any time during this interview.

Is there any risk of discomfort or harm from participation?
There are no risks and no direct benefits to you for taking part in this research. However, the results will assist in future development of the programme and in turn those new graduate nurses entering the programme in the future.

What data or information will be collected, and how will they be used?
Recordings of interviews and written transcripts would be held in secure locked filing cabinets and not be made available to anyone other than the researcher and the supervisor(s). This data would be held in storage until such time as is deemed suitable to dispose of, in the approved manner, as per the guidelines on Ethics in Health Research (Health Research Council, 2005).

A copy of the transcript of the interview will be made available to the participant to check for accuracy. From the information you give, a thesis will be prepared. Later that material could be used in conference presentations and in journal articles. A copy of this thesis will be available on line and in the Hillmorton Hospital Library, Specialist Mental Health Service & Centre for Postgraduate Nursing Studies, University of Otago, Christchurch.
What about anonymity and confidentiality?

Reporting of the completed research will strive throughout to preserve confidentiality and anonymity, by the use of codes, numbers, pseudonyms and secure data management systems. All information shared with me will remain strictly confidential. Your name will not be used and there will be no information that could identify you in any written or verbal research reports. The typist will sign a confidentiality agreement.

If you agree to participate, can you withdraw later?

Participation is voluntary. You may withdraw from participation in the project at any time and without any disadvantage to yourself.

Any questions?

If you have any questions now or in the future, please feel free to contact:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Department</th>
<th>Contact phone number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gail Houston</td>
<td>Master of Health Science student</td>
<td>Centre for Post Graduate Nursing Studies</td>
<td>03 3377 969 ext. 33717 or 027 2298241</td>
</tr>
<tr>
<td>Beverley Burrell</td>
<td>Senior Lecturer</td>
<td>Centre for Post Graduate Nursing Studies</td>
<td>03 364 3860</td>
</tr>
<tr>
<td>Marie Crowe</td>
<td>Professor</td>
<td>Centre for Post Graduate Nursing Studies</td>
<td>03 364 3850</td>
</tr>
</tbody>
</table>

This study has been approved by the University of Otago Human Ethics Committee (Health) reference number H15/054. If you have any concerns about the ethical conduct of the research, you may contact the Committee through the Human Ethics Committee Administrator (phone +64 3 479 8256 or email gary.witte@otago.ac.nz). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.
APPENDIX TWO

Interview Consent Form
APPENDIX 2: Interview Consent Form

The impacts, for the registered nurses of the New Entry to Specialist Practice Mental Health & Addiction Nursing Programme, of the programme, on their personal and professional development

Principal Investigator: Gail Houston, gail.houston@cdhb.health.nz / ph. 027 2298241

CONSENT FORM FOR PARTICIPANTS

Following signature and return to the research team this form will be stored in a secure place for ten years.

Name of participant: ………………………………………

1. I have read the Information Sheet concerning this study and understand the aims of this research project.
2. I have had sufficient time to talk with other people of my choice about participating in the study.
3. I confirm that I meet the criteria for participation which are explained in the Information Sheet.
4. All my questions about the project have been answered to my satisfaction, and I understand that I am free to request further information at any stage.
5. I know that my participation in the project is entirely voluntary, and that I am free to withdraw from the project at any time without disadvantage.
6. I know that as a participant I will be asked to discuss my experiences in relation to the research question. This conversation will be recorded and transcribed.
7. I know that the interview will explore the impact of the NESP programme on my ongoing personal and professional development and that if the line of questioning develops in such a way that I feel hesitant or uncomfortable I may decline to answer any particular question(s), and /or may withdraw from the project without disadvantage of any kind.
8. I understand the nature and size of the risks of discomfort or harm which are explained in the Information Sheet.
9. I know that when the project is completed all personal identifying information will be removed from the paper records and electronic files which represent the data from the project, and that these will be placed in secure storage and kept for at least ten years.
10. I understand that the results of the project may be published and be available in the University of Otago Library, but that either (i) I agree that any personal identifying information will remain confidential between myself and the researchers during the study, and will not appear in any spoken or written report of the study [ ]
11. I know that there is no remuneration offered for this study, and that no commercial use will be made of the data.

Signature of participant: ……………………………………… Date: …………. 
APPENDIX THREE

Guideline for Semi Structured Interview Questions
APPENDIX 3: Guideline for Semi Structured Interview Questions

The impacts for the registered nurses of the New Entry to Specialist Practice Mental Health and Addiction Nursing Programme, of the programme, on their personal and professional development.

1. Tell me about your experience of the programme.

2. How has your nursing practice developed as a result of undertaking the NESP programme?

3. How have you further developed the knowledge and skills acquired through the programme?

4. Tell me about your experience with supervision since completing the programme.

5. Tell me about the people who influence or are important to you. (If not connected at all explore why this might be). (link back to programme for connections) Leaders? Nurses?

6. What opportunities have you taken to write, present, or be involved with projects or research? What was that experience like for you? (sub Q)

7. How has the NESP programme influenced you with regard to taking up a leadership position?
   Formal/informal

8. Where do you see yourself in nursing in the future?
APPENDIX FOUR

Demographic Questions for Participants
APPENDIX 4: Demographic Questions for Participants

1. **What age bracket are you in now?**

<table>
<thead>
<tr>
<th>Age Bracket</th>
<th>20 – 25</th>
<th>36 - 40</th>
<th>41 - 45</th>
<th>Over 50</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. **Gender identity**

3. **With which country of origin or ethnic group or groups do you most closely identify?** (Tick all that apply)

<table>
<thead>
<tr>
<th>Country or Ethnic Group</th>
<th>□</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Zealander</td>
<td></td>
</tr>
<tr>
<td>New Zealand Māori</td>
<td></td>
</tr>
<tr>
<td>New Zealand European</td>
<td></td>
</tr>
<tr>
<td>Samoan</td>
<td></td>
</tr>
<tr>
<td>Cook Island Māori</td>
<td></td>
</tr>
<tr>
<td>Tongan</td>
<td></td>
</tr>
<tr>
<td>Niuean</td>
<td></td>
</tr>
<tr>
<td>Tokelauan</td>
<td></td>
</tr>
<tr>
<td>Fijian</td>
<td></td>
</tr>
<tr>
<td>Fijian Indian</td>
<td></td>
</tr>
<tr>
<td>Other Pacific</td>
<td></td>
</tr>
<tr>
<td>South East Asian</td>
<td></td>
</tr>
<tr>
<td>Chinese</td>
<td></td>
</tr>
<tr>
<td>Indian</td>
<td></td>
</tr>
<tr>
<td>Other Asian</td>
<td></td>
</tr>
<tr>
<td>African</td>
<td></td>
</tr>
<tr>
<td>Other Asian</td>
<td></td>
</tr>
<tr>
<td>Other – please specify</td>
<td></td>
</tr>
</tbody>
</table>

4. **Highest Qualification now**
- Postgraduate certificate
- Postgraduate diploma
- Masters’ Degree
- Doctorate

5. **Year qualification obtained**

6. **Years nursing prior to postgraduate qualification**

7. **Years nursing since completing postgraduate qualification**

8. **Are you still studying at postgraduate level?**

9. **What qualification are you aspiring to?**

10. **Current workplace**

11. **Current level on PDRP**

12. **What is your current role**

13. **Do you have a speciality role, extra responsibilities or areas of practice?** (Preceptorship, DEU, tutor, teaching, research role)
APPENDIX FIVE

Transcriber Confidentiality Agreement
APPENDIX 5: Transcriber Confidentiality Agreement

Transcriber Confidentiality Agreement

Project Title: The impacts, for the registered nurses of the New Entry to Specialty Practice Mental Health & Addiction Nursing Programme, of the programme, on their personal and professional development.

Principal Investigator: Beverley Burrell, Senior Lecturer, University of Otago, Christchurch.

Contact Person: Gall Houston (Researcher)

Address: Training Unit, Hillmorton Hospital, Specialist Mental Health Services, Canterbury District Health Board, Christchurch.

Phone Number: 027 2298241 Email: Gall.Houston@cdhb.health.nz

I, Brigitte Caldwell, agree to transcribe ad verbatim research data from audiotapes from the above named research project. I agree to maintain complete confidentiality in regard to anything I may hear or read in connection with this research.

All tapes, digital files, and paper copy of this information will be password protected and kept in a secure place while in my possession for the purposes of transcription. All the aforementioned material will be returned to the Researcher on completion of each transcription and any information on the computer hard drive will be erased.

I understand this confidentiality agreement is binding both now and in the future.

Signed ___________________________ (Transcriber)

Date 17/07/16

Signed ___________________________ (Researcher)

Date 17/07/16
APPENDIX SIX

Standards of Practice for Mental Health Nursing in Aotearoa
New Zealand Te Ao Māramatanga New Zealand College of
Mental Health Nurses Inc. 2012
APPENDIX 6: Standards of Practice for Mental Health Nursing in Aotearoa New Zealand Te Ao Māramatanga New Zealand College of Mental Health Nurses Inc. 2012

Standard Five
The Mental Health Nurse is committed to their own professional development and to the development of the profession of Mental Health Nursing.

Rationale: Professional development enables the Mental Health Nurse to maintain competence, ensures that nursing practice remains relevant to the needs of people with mental health issues and ensures the profession maintains the highest professional standards.

Practice outcomes
Standard Five is being met when:
1. The Mental Health Nurse’s practice is informed by current evidence, philosophy of care and standards of practice.
2. The Mental Health Nurse works in partnership with people with mental health issues and families/whānau as part of their professional development.
3. The Mental Health Nurse is actively engaged in professional development activities.

Attributes
(a) Knowledge
The Mental Health Nurse demonstrates an understanding of:
1. Standards of practice for mental health nursing.
2. Professional development frameworks and pathways.
4. The Nursing Council of New Zealand competencies for registered nurses.
5. Models of professional supervision, reflective practice and peer review.

(b) Skills
The Mental Health Nurse:
1. Articulates their individual philosophy of practice
2. Evaluates their own professional practice and offers feedback to colleagues
3. Engages in professional development opportunities and supports others to do the same
4. Engages in professional supervision and reflective practice
5. Evaluates the evidence base for professional practice
6. Meets the Nursing Council of New Zealand competencies for registered nurses
7. Develops a personal plan of professional development

(c) Attitudes
The Mental Health Nurse:
1. Values professional development as a Mental Health Nurse.
2. Values the place of professional supervision in professional development.
3. Recognises the role of research and evidence in informing professional practice.
4. Recognises the role of professional organisations in practice development.
5. Respects the role of the individual and family/whānau in articulating acceptable professional standards.
6. Values the advancement of Mental Health Nursing knowledge and practice.

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APPENDIX SEVEN

NESP Clinical Learning Outcomes
APPENDIX 7: NESP Clinical Learning Outcomes

- Demonstrates effective therapeutic communication skills and interpersonal techniques.
- Acquires knowledge and understanding of the cultural beliefs of the consumer/tangata whaiora and incorporates this into collaborative treatment planning and interventions.
- Incorporates the four principles of the Treaty of Waitangi into clinical practice.
- Applies the principle of working in partnership appropriately within mental health services and other settings, pertaining to service, consumer/tangata whaiora, family/whānau and support systems.
- Ensures legal requirements are met within scope of practice.
- Demonstrates sound clinical judgment and ethical decision-making within scope of practice.
- Demonstrates ability to undertake and document comprehensive client-centred assessments.
- Demonstrates ability to assess and take action in relation to the physical health/wellbeing of the consumer/tangata whaiora.
- Demonstrates a collaborative approach to treatment planning within and across settings.
- Incorporates health promotion and education into practice, including early intervention and relapse prevention.
- Demonstrates ability to manage therapeutic risk in partnership with consumers/tangata whaiora and family/whānau.
- Demonstrates the application of therapeutic frameworks that best fit the needs of the consumer/tangata whaiora.
- Demonstrates the ability to support family/whānau as partners in care.
- Applies knowledge of psycho-pharmacological interventions and is aware of the limitations.
- Utilises research findings from a variety of sources to contribute to the development of evidence-based practice.
- Demonstrates critical awareness of own competence and self-responsibility and actively participates in professional development.
- Integrates principles of quality improvement into all aspects of nursing practice.