

**SCHOOL OF NURSING, MIDWIFERY
AND PARAMEDICINE**

**Exploring the experiences of secondary school nurses
who encounter young people with mental health problems:
A grounded theory study**

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**This thesis is presented for the degree of
Doctor of Philosophy
of
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DECLARATION

To the best of my knowledge and belief, this thesis contains no material previously published by any other person except where due acknowledgment has been made.

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (2007) - updated March 2014. The proposed research study received human research ethics approval from the Child and Adolescent Health Service Human Research Ethics Committee, approval number RGS00056 and from Curtin University Human Research Ethics Committee, approval number HRE2017-0280.

Signed:

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ABSTRACT

Public sector secondary school nurses in Western Australia frequently encounter young people with mental health problems, but little is known about what happens when they do. The work of these professionals is largely invisible in the literature: just one small study has been published, almost 20 years ago. The study described in this thesis used the grounded theory method to undertake a detailed investigation of the experiences of public sector secondary school nurses who encounter young people with mental health problems. The care school nurses provide to this cohort, the unique challenges they face in this endeavour, and the factors that help or hinder their efforts are all considered.

This study presents the substantive theory of *tactical prioritising* to manage the problem of *untenable burden*. Based on interviews with 31 public sector secondary school nurses in metropolitan and rural areas of Western Australia, the study identified a shared pattern of behaviour that explains how participants resolved their main concern. While participants were highly engaged with young people experiencing mental health problems and perceived this to be a very important part of their role, their main concern was one of *untenable burden*. This reflected the complexity, acuity and high levels of stress nurses experienced in their efforts to care for this group, particularly when they could not share the burden with other professionals.

Participants resolved the basic social psychological problem of *untenable burden* by engaging in the basic social psychological process of *tactical prioritising*, which consisted of three stages. In the first stage, participants sought ways to position themselves as a trusted source of health expertise in the school community, a stage conceptualised as *strategic assimilation*. This stage concluded with a good working knowledge of their assigned school and available local resources to which young people experiencing mental health problems could be referred.

Stages one and two were separated by a tipping point, conceptualised as *grappling with unmet needs*. Participants reached the tipping point when they became aware that typical school nurse interventions such as assessment and referral did not always

meet the needs of young people with complex problems. School nurse participants described many young people needing intensive support despite attempts to engage them with more specialist services. In response to this situation, participants entered stage two, *optimising outcomes*. In this stage, participants undertook a broad range of nursing interventions to support young people with unmet needs. Interventions were oriented to supporting young people's developmental trajectory through adolescence, continued school engagement, and support for complex social problems.

Engagement in stage two simultaneously prompted participants to engage in stage three of the core process, *managing self*. In *managing self* participants engaged in activities that built their professional capacity and sought to maintain their own emotional wellbeing in the face of complex clinical demands. In this study *optimising outcomes* and *managing self* spiralled together without end: each of these stages informed and built on the other, culminating in increasingly sophisticated clinical and professional practice. Secondary school nurses who had engaged in stages two and three for a long duration often became highly skilled practitioners with a unique skill set that had significant potential to facilitate better adolescent health trajectories, school completion, and improved life outcomes.

The study identified that a range of factors influenced whether and how quickly nurses progressed to these more advanced levels of practice. The substantive theory of *tactical prioritising* to manage the experience of *untenable burden* indicates that addressing those factors that exacerbate the experience of *untenable burden* and enhance the process of *tactical prioritising* will pay dividends. Not only will this improve the wellbeing of the secondary school nursing workforce, but a greater proportion of this valuable resource can be utilised in *optimising outcomes* for young people experiencing mental health problems.

CONTENTS

ACKNOWLEDGEMENTS	5
ABSTRACT	7
CONTENTS	9
CHAPTER 1 INTRODUCTION AND BACKGROUND TO THE STUDY	19
1.1 Introduction.....	19
1.2 Organisation of the thesis	19
1.3 Study definitions	20
1.4 International history and early development of school nursing.....	21
1.5 Education and health: A reciprocal relationship.....	23
1.6 Model of school nursing practice in Western Australia	25
1.7 Schools in Western Australia.....	27
1.8 School Health Service structure in Western Australia	28
1.9 Memorandum of Understanding between the Western Australian Departments of Health and Education.....	29
1.10 The school setting and young people’s mental health.....	31
1.11 Role of school nurses in young people’s mental health	34
1.12 Prevalence and epidemiology of young people’s mental health problems .	38
1.13 Diagnosis of mental health problems in young people	40
1.14 Common mental health diagnoses in young people	41
1.15 Social and functional recovery in young people’s mental health	43
1.16 The Australian national young people’s mental health reform agenda.....	44
1.17 Aims and purpose of the study.....	46
1.18 Research objectives	47
1.19 Need for the study	47

1.20 Significance of the study	48
1.21 Summary	49
CHAPTER 2 METHODOLOGY	51
2.1 Introduction	51
2.2 Qualitative research	51
2.3 The grounded theory method	52
2.4 Rationale for the use of the grounded theory method in this study	54
2.5 Application of the grounded theory method for this study	56
2.5.1 <i>Data collection</i>	57
2.5.1.1 <i>Sampling strategy</i>	57
2.5.1.2 <i>Inclusion criteria</i>	57
2.5.1.3 <i>Recruitment</i>	58
2.5.1.4 <i>Research interviews</i>	59
2.5.1.5 <i>Field notes</i>	60
2.5.2 <i>Data analysis</i>	61
2.5.2.1 <i>The constant comparative method of analysis</i>	61
2.5.2.2 <i>Bracketing researcher bias</i>	62
2.5.2.3 <i>Theoretical sensitivity</i>	65
2.5.2.4 <i>Data preparation for computer management</i>	66
2.5.2.5 <i>Coding</i>	66
2.5.2.6 <i>Theoretical memos</i>	69
2.5.2.7 <i>Comparison with existing theories</i>	70
2.5.3 <i>Writing the grounded theory</i>	71
2.5.4 <i>Notations used in this thesis</i>	72
2.5.5 <i>Quality, trustworthiness and transferability of the findings</i>	72

2.5.5.1 <i>Fit, relevance, work and modifiability</i>	73
2.5.5.2 <i>Credibility, transferability, dependability and confirmability</i>	74
2.6 Ethical considerations.....	75
2.6.1 <i>Informed consent</i>	76
2.6.2 <i>Withdrawal from the study</i>	76
2.6.3 <i>Privacy, confidentiality and anonymity</i>	76
2.6.4 <i>Minimising risk of harm</i>	77
2.6.5 <i>Data storage, access and disposal</i>	78
2.7 Summary.....	78
 CHAPTER 3 THE BASIC SOCIAL PSYCHOLOGICAL PROBLEM:	
UNTENABLE BURDEN.....	81
3.1 Introduction.....	81
3.2 Overview of the major findings.....	82
3.3 Wicked problems.....	85
3.4 Persistent intensity.....	91
3.4.1 <i>High volume</i>	91
3.4.2 <i>High stakes</i>	95
3.5 Autonomy and isolation.....	99
3.5.1 <i>Working autonomously</i>	100
3.5.2 <i>Every school is different</i>	104
3.5.3 <i>Left holding the baby</i>	106
3.6 A heavy toll.....	109
3.7 Summary.....	112
 CHAPTER 4 CONDITIONS THAT INFLUENCE THE PROBLEM OF	
UNTENABLE BURDEN.....	115
4.1 Introduction.....	115

4.2 Capacity to engage with wicked problems.....	115
4.2.1 <i>A passion for the wellbeing of young people</i>	116
4.2.2 <i>Being okay to sit with the darker stuff</i>	119
4.2.3 <i>Accessibility versus uninterrupted clinical time</i>	124
4.3 Case, clinical and professional support.....	127
4.3.1 <i>School-based case collaboration</i>	128
4.3.2 <i>Nursing support</i>	137
4.3.2.1 <i>Transition-to-role support</i>	138
4.3.2.2 <i>Clinical support</i>	144
4.3.2.3 <i>Management support</i>	146
4.4 Community partnerships	148
4.4.1 <i>Parents</i>	149
4.4.2 <i>External service providers</i>	155
4.4.2.1 <i>Lack of services</i>	156
4.4.2.2 <i>Referral not accepted</i>	157
4.4.2.3 <i>Into the void</i>	159
4.5 Ability to function in the school.....	160
4.5.1 <i>Misperceptions of the school nurse role</i>	161
4.5.2 <i>Professional respect</i>	171
4.6 Summary	178
CHAPTER 5 THE BASIC SOCIAL PSYCHOLOGICAL PROCESS: TACTICAL	
PRIORITISING	179
5.1 Introduction	179
5.2 Stage one: Strategic assimilation.....	181
5.2.1 <i>Being there</i>	183

5.2.2 <i>Knowing where to send them</i>	185
5.3 Tipping point: Grappling with unmet needs	187
5.4 Stage two: Optimising outcomes	188
5.4.1 <i>Opening Pandora's Box</i>	189
5.4.1.1 <i>Finding out what's going on</i>	191
5.4.1.2 <i>Having a chat</i>	192
5.4.1.3 <i>Reading between the lines</i>	194
5.4.1.4 <i>The reluctant Pandora</i>	195
5.4.2 <i>Safety first</i>	197
5.4.3 <i>Life skills 101</i>	200
5.4.4 <i>Student support</i>	204
5.4.5 <i>Family support</i>	208
5.4.6 <i>Advocacy</i>	211
5.5 Stage three: Managing self	215
5.5.1 <i>Sharing the responsibility</i>	215
5.5.2 <i>Learning, learning, learning</i>	219
5.5.3 <i>Seeking personal balance</i>	220
5.5.4 <i>Extreme measures</i>	223
5.5.4.1 <i>Seeking false reassurance</i>	223
5.5.4.2 <i>Breaking the rules</i>	224
5.6 Summary.....	226
CHAPTER 6 CONDITIONS THAT INFLUENCE THE PROCESS OF TACTICAL PRIORITISING	229
6.1 Introduction.....	229
6.2 Capacity to engage with wicked problems	229

6.2.1	<i>A commitment to the social model of health</i>	229
6.2.2	<i>An interest in finding solutions</i>	233
6.3	Collegial relationships.....	235
6.3.1	<i>School-level collegial relationships</i>	235
6.3.2	<i>Nursing collegial relationships</i>	237
6.4	Community partnerships	239
6.4.1	<i>Becoming known</i>	240
6.4.1.1	<i>Being real</i>	240
6.4.1.2	<i>Creating connections</i>	242
6.4.2	<i>Parent partnerships</i>	247
6.4.3	<i>External service providers</i>	248
6.5	Ability to function in the school	251
6.5.1	<i>Misperceptions of the school nurse role</i>	251
6.5.2	<i>Professional respect</i>	256
6.5.3	<i>Duration of assignment to the school</i>	259
6.6	Summary	260
CHAPTER 7 DISCUSSION.....		263
7.1	Introduction	263
7.2	The substantive theory of tactical prioritising to manage the problem of untenable burden.....	263
7.3	Comparison with other school nursing literature	266
7.3.1	<i>Comparison of the study by Simmons (2002): Autonomy in practice: A qualitative study of school nurses' perceptions with the substantive theory of tactical prioritising to manage the problem of untenable burden</i>	267

7.3.2 Comparison of the dissertation by Sendall (2009): Conceptions of school based youth health nursing: A phenomenographic study with the substantive theory of tactical prioritising to manage the problem of untenable burden.....	269
7.3.3 Comparison of the study by Downie et al. (2002): The everyday realities of the multi-dimensional roles of the high school community nurse with the substantive theory of tactical prioritising to manage the problem of untenable burden.....	273
7.3.4 Comparison of the thesis by McCluskey (2015): The formative evaluation of a practice framework for nurses working in secondary schools with the substantive theory of tactical prioritising to manage the problem of untenable burden.....	275
7.4 Comparison with other published theories	277
7.4.1 Comparison of Lazarus and Folkman’s (1984) Theory of stress and coping with the substantive theory of tactical prioritising to manage the problem of untenable burden.....	278
7.4.2 Comparison of Benner’s (1982) Model of skill acquisition with the substantive theory of tactical prioritising to manage the problem of untenable burden.....	280
7.4.3 Comparison of Bandura’s (1977) Theory of self-efficacy with the substantive theory of tactical prioritising to manage the problem of untenable burden.....	281
7.4.4 Comparison of Watson’s (1988a) Theory of human caring with the substantive theory of tactical prioritising to manage the problem of untenable burden.....	282
7.5 Comparison with other concepts.....	284
7.5.1 Comparison of the concept of nurse moral distress with the substantive theory of tactical prioritising to manage the problem of untenable burden	284

7.5.2 Comparison of the concept of personal recovery in mental health with the substantive theory of tactical prioritising to manage the problem of untenable burden	286
7.5.3 Comparison of the commentary by White (2012): Youth suicide as a 'wild' problem - Implications for prevention practice with the substantive theory of tactical prioritising to manage the problem of untenable burden	287
7.6 Summary	289
CHAPTER 8 IMPLICATIONS AND CONCLUSION	291
8.1 Introduction and overview	291
8.2 Significance and implications of the findings	291
8.2.1 Implications for school health services	294
8.2.1.1 Acknowledging and measuring the work.....	294
8.2.1.2 Role preparation	296
8.2.1.3 Clinical support.....	298
8.2.1.4 Ongoing training and education.....	299
8.2.1.5 Professional support	301
8.2.1.6 Support for untenable burden	303
8.2.2 Implications for managers.....	304
8.2.3 Implications for postgraduate nursing education providers	306
8.2.4 Implications for current and aspiring secondary school nurses	307
8.3 Limitations of the study	311
8.4 Recommendations for further research	312
8.5 Concluding statement.....	315
APPENDICES.....	317
APPENDIX A: RECRUITMENT, AUGUST 18, 2017	317

APPENDIX B: RECRUITMENT, OCTOBER 11, 2017	319
APPENDIX C: STUDY INFORMATION SHEET	321
APPENDIX D: PARTICIPANT CONSENT FORM	325
APPENDIX E: DEMOGRAPHIC DATA SHEET	327
APPENDIX F: QUESTION GUIDE	329
APPENDIX G: DEPARTMENT OF HEALTH ETHICS APPROVAL	331
APPENDIX H: CURTIN UNIVERSITY ETHICS APPROVAL.....	335
APPENDIX I: COMMUNITY HEALTH GOVERNANCE APPROVAL	337
APPENDIX J: WACHS GOVERNANCE APPROVAL	339
APPENDIX K: ADVERSE EVENT PROTOCOL	341
APPENDIX L: CURTIN UNIVERSITY DATA MANAGEMENT PLAN ...	343
APPENDIX M: GOOD CLINICAL PRACTICE RESEARCH TRAINING ...	345
REFERENCES	346
ORAL PRESENTATIONS	379

CHAPTER 1

INTRODUCTION AND BACKGROUND TO THE STUDY

1.1 Introduction

Mental health problems in young people are a growing public health concern at the Australian national and global level (Erskine et al., 2015). In the most recent mental health survey in Australia just over 14% of youth aged 12-17 years had experienced a mental disorder in the previous 12 months (Lawrence et al., 2015, p. 26) and 7.5% had seriously considered attempting suicide (Lawrence et al., 2015, p. 12).

The impact of mental health problems in young people can be significant and long lasting. In the immediate term, mental health problems negatively impact wellbeing and increase risk for suicide (Erskine et al., 2015; Lawrence et al., 2015). In the longer term there is significant risk for curtailed school attainment and completion, with potentially significant ramifications for subsequent adult life (Bowman, McKinstry, & McGorry, 2016). While data is scarce, it is estimated that up to 50% of school “drop out” in Australia may be attributable to mental health problems (Bowman et al., 2016). Young people with mental health problems typically want to remain engaged in education (Orygen Youth Health Research Centre, 2014) and identify this as a priority personal concern (Killackey, 2015). North American and British research (Bohnenkamp & Stephan, 2015; Ravenna & Cleaver, 2016) identify the school nurse as having a key role in the support of young people experiencing mental health problems, but there is a paucity of published literature examining the work of these professionals in the Western Australian context.

1.2 Organisation of the thesis

This thesis will explore the experiences of Western Australian secondary school nurses who encounter young people with mental health problems using grounded theory methodology (Glaser & Strauss, 1967). There are eight chapters. Chapter one commences with an outline of the thesis document and study definitions. Important background is then provided which locates the study in the context of three themes: the history and contemporary role of public sector secondary school nurses, school as

a setting for optimising young people's health, and contemporary findings in youth mental health. While presented sequentially, the themes are highly interrelated. Chapter one concludes by addressing the purpose of the study, the research objectives, the need for the study and the significance of the research.

Chapter two provides detailed information about the grounded theory method and its application to the current study. Chapters three to six present the theory of *tactical prioritising* to manage the experience of *untenable burden* and are based on interviews with 31 public sector secondary school nurses. Chapter three outlines the basic social psychological problem of *untenable burden* that participants identified as their main concern and explains how the problem occurs. Chapter four describes the conditions that ease or exacerbate the problem of *untenable burden*. The process participants engaged in to manage the experience of *untenable burden* was conceptualised as *tactical prioritising* and is explained in chapter five. Chapter six explores the conditions that influenced the core process of *tactical prioritising*, aiding or thwarting a resolution of the core problem of *untenable burden*.

In chapter seven the substantive theory of *tactical prioritising* to manage the problem of *untenable burden* is placed in the context of the literature by comparing the theory to existing nursing theories and published literature. The eighth and final chapter discusses the implications of the study findings for key stakeholders and makes recommendations for addressing the study findings. Finally, the study limitations are discussed, recommendations for further research suggested and a concluding statement provided.

1.3 Study definitions

In the literature, the terms 'youth', 'adolescent' and 'young people' are used inconsistently to refer to different age ranges. The Australian National Youth Mental Health Foundation defines 'youth' as 12 to 24 years (McGorry, Tanti, et al., 2007) and the International Association of Youth Mental Health as 12 to 25 years (Coughlan et al., 2013). The United Nations Educational, Scientific and Cultural Organisation (2016a) identifies youth as 15 to 24 years, and the Western Australian Mental Health Plan as young people 16 to 24 years (Mental Health Commission

Western Australia, 2015). The term ‘adolescent’ is similarly varied: in the Lancet Commission on adolescent health and wellbeing, Patton and colleagues define the term ‘adolescent’ as an individual between 10 and 24 years (Patton et al., 2016), while the United Nations Population Fund (2016) defines adolescents as being between 10 and 19 years. In this thesis the terms ‘youth’, ‘adolescent’ and ‘young people’ are used interchangeably to refer to young people attending secondary schools in Western Australia, aged approximately 11 to 18 years.

The research described in this thesis also has a broad definition of the term ‘mental health problems’ and does not necessarily refer to a diagnosed mental illness. Young people who do not have a mental health diagnosis are not necessarily doing well. Mental ill health that presents at sub-threshold levels may still cause high levels of distress and functional impairment (Cross et al., 2014). Many young people experiencing poor mental health will not be in contact with mental health services and will subsequently not have a diagnosis. Given that diagnostic specificity is a relatively late marker of mental ill health, a case has been made in the youth mental health literature for a general diagnosis of poor mental health necessitating care (McGorry & van Os, 2013). This thesis adopts a similar stance: the term ‘mental health problems’ is defined as the school nurses’ assessment that poor mental health is contributing to the young person’s presenting difficulties. The literature underpinning this position is discussed further in subsequent sections of this chapter.

1.4 International history and early development of school nursing

The provision of health services in schools is not a new idea. Health professionals were visiting schools as far back as 1874, originating in many countries as a state-provided public health measure (Madsen, 2008). Although some school health services initially employed only doctors (O’Hara, 1988, pp. 175-176), others were established as nursing services from the outset (Madsen, 2008; Wright, 2011). The unique contribution nurses make to health in schools was extolled in the literature by a school health physician as early as 1910 (Kiefer, 1910), however there are few publicly available documents that describe the history of school nursing. With the exception of a memorable review of a typical working day penned in the form of a letter by an American school nurse in 1939 (Swanson, 1939), historical school nurses

have largely failed to describe their day-to-day activities in the literature. This is disappointing, because school nursing has always been a highly heterogeneous specialty with significant differences in roles and activities (Madsen, 2008). For example, in the early 1900s school nurses in Scotland acted predominately in the role of physician assistant, preparing children for medical 'inspection' (Madsen, 2008). In the same time frame, British school nurses were promoting nutrition and sanitation, conducting individual health assessments and providing parent support (Madsen, 2008).

School nursing is also one of the oldest nursing specialties in Australia, commencing in most states at the beginning of last century and developing over a number of distinct phases (Keleher, 2000; O'Hara, 1988, p. 176). Originating from the mid-1800s as a public health service designed to address environmental health protection, the focus changed to personal health services early in the twentieth century (O'Hara, 1988, p. 174). Despite the long history of school nursing in Australia, community and public health nurses have paid scant attention to documenting their activities in the literature (Keleher, 2003).

In Western Australia the state school health service began in 1906-07 with the appointment of a part-time school medical officer, a position which became full-time in 1918. By 1923 three nurses had joined the service which ostensibly covered the whole state (O'Hara, 1988, p. 176). There were still only five school nurses employed in Western Australian in 1950, while the first fulltime secondary school nurse was not appointed until 1972 (Holman & Coster, 1991). Western Australian school nurses have also been remiss in documenting their activities in the literature. Only one article describing the work of public sector secondary school nurses in Western Australia could be located in the academic literature. A small descriptive study published in 2002, the findings indicated that secondary school nurses undertook complex clinical work encompassing seven key roles: clinical care, counsellor/mediator, advocacy and support, liaison/referral, health promotion/education agent, and professional management/research (Downie, Chapman, Orb, & Juliffe, 2002).

In contemporary times, school nursing around the world remains a highly heterogeneous specialty with significant variations in purpose and model of practice. A comparison of school nurse activities in the United States (Council on School Health, 2016), United Kingdom (Nicholson, 2012), Sweden (Fagerholt, 2009) and Western Australia (Department of Health Western Australia, 2019a) suggests there is only one commonality: the delivery of nursing interventions to children at school. While variation at the international level can be understood as a reflection of different health systems and different health priorities, the heterogeneity is also evident in Australia. There is no standard model of school health nursing practice in Australia and variation exists between states and between the public and private education sectors within states. This theme will be returned to in subsequent chapters.

1.5 Education and health: A reciprocal relationship

In Australia, as in many countries, school is a legal requirement (Australian Government, 2016). Young people between the ages of 4 and 18 years spend a significant amount of time in school, the influence of which is substantial (Aldridge et al., 2016). Representing a ‘captive audience’, young people are more accessible in schools than they are in any other setting. Education itself has clear health benefits (Zimmerman & Woolf, 2014, p. 3) and more education leads to greater benefit, especially at the secondary school level (Viner et al., 2012). This is particularly so for young women where more education delays marriage and childbearing, lowers birth-rate and infant mortality, improves child health and increases household income (Patton et al., 2016).

While the core business of schools is education, health and education have a reciprocal relationship (Zimmerman & Woolf, 2014). Poor health in childhood affects learning and school success (Jackson, 2009) and poor school attainment has implications for future health and wellbeing (Patton et al., 2016). Difficulties with hearing, vision, chronic illness and poor nutrition have all been shown to impact learning (Michael, Merlo, Barsch, Wentzel, & Wechsler, 2015). Young people with poor health are not simply educationally disadvantaged relative to their peers (Jackson, 2009), they are typically also socially disadvantaged (Commission on the

Social Determinants of Health, 2008). Social disadvantage has been identified as both a cause and a consequence of poor health (Marmot, 2015).

Secondary school is a particularly important setting for promoting health, because health habits adopted in adolescence are typically carried into adulthood (Viner et al., 2012). Health behaviours that young people adopt in areas such as nutrition, physical activity, drug and alcohol use and sexual behaviour, influence and shape future health (Hagell & Rigby, 2015). For example, tobacco smoking is typically initiated in secondary school (Scollo & Winstanley, 2019, section 1.6) and early regular alcohol consumption is associated with problematic drug and alcohol use in adult life (Bolland et al., 2016). In addition to this, major physical, emotional, cognitive and social changes occur during the transition to adulthood (Patton et al., 2016) that modify trajectories towards optimal adult health and wellbeing (Viner et al., 2012). Adolescence is therefore widely regarded as a key period for intervening in maladaptive health behaviours (Hagell & Rigby, 2015) and promoting health-optimising behaviours (Patton et al., 2016).

As a setting for promoting health, school has been endorsed at the highest level in the Ottawa Charter for Health Promotion (World Health Organisation, 1986). Cognisant that school is a universal platform for promoting health in school-attending young people, the World Health Organisation developed the Health Promoting Schools Framework which outlines the six essential components for optimising the health promoting potential of schools: healthy school policies, optimal physical environment, positive social environment, capacity building approach to individual health skills, and availability of community links and health services (International Union for Health Promotion and Education, 2009). Schools that seek to be health promoting typically adopt a “whole school” approach, identifying and implementing strategies in each of the six core areas (Langford et al., 2015) often assisted by the school nurse (Banfield, McGorm, & Sargent, 2015). The health promoting schools framework has also been used in the promotion of mental health (Turunen, Sormunen, Jourdan, von Seelen, & Buijs, 2017), but in a relatively recent review British researchers Weare and Nind (2011) concluded that mental health promotion and problem prevention programs in schools across the world are highly

heterogeneous. In Australia programs such as Act-Belong-Commit (Anwar-McHenry et al., 2016) and MindMatters (Australian Government, 2014) have been adopted by some schools. Programs combining universal and targeted components appear more effective than universal programs alone (Weare & Nind, 2011) but getting this balance right can be challenging. For example, the Australian school program SenseAbility is a depression prevention program employing cognitive behavioural therapy (BeyondBlue, 2019). Cognitive behavioural therapy is an evidence-based treatment for depression in young people (Gearing, Schwalbe, Lee, & Hoagwood, 2013). SenseAbility was well-funded with extensive classroom resources and was extensively evaluated over five years, but when employed as a prevention initiative at the universal level the program demonstrated a lack of effect (Sawyer, Harchak, et al., 2010; Sawyer, Pfeiffer, et al., 2010). Findings such as these highlight some of the challenges in this still emerging field.

1.6 Model of school nursing practice in Western Australia

In contemporary times, the Western Australian Department of Health employs community health nurses to provide services to public sector schools. Community health nursing is a complex field of practice which adopts a holistic, socio-ecological perspective of health (McMurray & Clendon, 2011, p. 5) where health is defined as a state of “complete physical, mental and social well-being and not merely the absence of disease or infirmity” (World Health Organisation, 1978). Community health nursing therefore primarily promotes wellness, and has a focus on health promotion, prevention and early intervention (Department of Health Western Australia, 2019a).

Drawing specialist expertise from a diverse range of fields (McMurray & Clendon, 2011, p. 96), community health nurses use a partnership approach to target interventions to the individual, family, groups and whole community (McMurray & Clendon, 2011, p. 5). A key focus for intervention are the *social determinants of health*, the source of disparities in health status between and within populations (Marmot, 2005). Frequently referred to as the “causes of the causes” (Marmot, 2005), the influence of social determinants in health were first described in the seminal work of Marmot in the early 1990s (Marmot, 1993; Marmot et al., 1991).

Marmot investigated the morbidity and mortality of public servants employed in the highly stratified British civil service and found these were correlated with social status (Marmot, 1993; Marmot et al., 1991). This finding has subsequently been replicated in a broad range of studies and confirms that poorer health outcomes are correlated to social disadvantage: the lower a person's position on the social gradient, the worse their health and the shorter their expected lifespan (Marmot, Friel, Bell, Houweling, & Taylor, 2008). As described in *The Solid Facts* (Wilkinson & Marmot, 2003, p. 7), health across the lifespan is strongly influenced by social and economic factors that lie outside the health domain and access to medical care alone is insufficient to improve health.

Social disadvantage has many forms and can include chronically stressful life circumstances, adverse early life experiences, social exclusion, unemployment, poor social support, addiction, and limited availability of food and transport (Wilkinson & Marmot, 2003). As factors that contribute to social disadvantage are socially determined and modifiable with good public policy, a failure to address social disadvantage reflects a lack of social justice (Marmot et al., 2008). In Australia there is limited absolute deprivation, however the social gradient also has important implications for relative deprivation, because at each point on the social gradient those with higher social status experience better health (Wilkinson & Marmot, 2003). These findings present a complex challenge: if the major causes of health inequities are social, then the solutions are also social (Wolff, 2011).

The social determinants of health have a significant impact on the health and development of adolescents (Viner et al., 2012). Social influences at the level of the family, school and peer group can support the transition to a healthy adulthood or hinder it (McMurray & Clendon, 2011, p. 207). Young Australians also identify the influence of social factors on their wellbeing: findings from the Mission Australia 2018 national survey of young people identified that two of the top three personal concerns were coping with stress and school or study problems (Carlisle et al., 2018, p. 4). The third highest personal concern for young people was mental health (Carlisle et al., 2018, p. 4).

Primary health care is a philosophy and framework for practice that addresses the social determinants of health (McMurray & Clendon, 2011). Different from *primary care*, which typically describes the provision of medical interventions, primary health care focusses on the social and environmental factors that predispose to a need for medical interventions (Keleher, 2001). Primary health care involves the fair and equitable provision of essential health care that is evidence-based, socially acceptable, universally accessible, facilitates self-determination, is affordable and encourages community participation (World Health Organisation, 1978). Vulnerable populations are a particular focus in primary health care, as there is clear evidence that these groups have a lower position on the social gradient and experience significantly worse health outcomes (Marmot, 2015). Individuals experiencing mental health problems were identified by the World Health Organisation as one such vulnerable group in 2010 (Chan, 2010).

1.7 Schools in Western Australia

The research described in this thesis was conducted in Western Australia where the system of schooling is broadly divided into the private and the public funded education systems. All children who turn four years of age by June 30 are eligible to commence in kindergarten that year, although schooling is not compulsory until the following year when children enter pre-primary (Department of Education Western Australia, 2019a). The pre-primary year is followed by Years 1 to 6 of primary school. Year 7 is the first year of secondary schooling when most children turn 12 years of age. Education is compulsory up to the 16th birthday, however there is a requirement to be engaged in an approved combination of school, training and employment up to the 18th birthday (Department of Education Western Australia, 2019a).

There are over 100 public sector secondary schools in Western Australia enrolling just over 107,000 students. Approximately 74% of public sector secondary school students attend schools in the Perth metropolitan area, with the remainder spread across the vast regional and remote areas of Western Australia (Department of Education Western Australia, 2018a, pp. 171-172). In addition to employing teaching staff, public sector schools in Western Australia employ a wide range of

administrative and professional support staff. School psychologists support public sector schools to meet student social, emotional, learning and behaviour needs with services provided at the individual, group, whole school and system levels (Department of Education Western Australia, 2019b). The Competency Framework for School Psychologists (Department of Education Western Australia, 2015) outlines the knowledge and skills with which school psychologists should be equipped.

1.8 School Health Service structure in Western Australia

Western Australia and Queensland were the only Australian school health services that were not set up under their respective state education departments (Madsen, 2008). This has important implications for how school health services are planned and delivered in Western Australia. In metropolitan Perth school health services are delivered by the Child and Adolescent Health Service - Community Health (CAHS-CH). In regional and remote areas school health services are provided by the seven regional divisions of the Western Australian Country Health Service (WACHS). Although both health services employ a range of medical, nursing and allied health staff, clinical services in schools are provided almost exclusively by nurses.

As at February 2017, the Child and Adolescent Health Service - Community Health employed approximately 55 full-time equivalent secondary school nurses in the Perth metropolitan region, and the Western Australian Country Health Service approximately 30 full-time equivalent school nurses throughout regional areas of Western Australia. The entry level to practice for registered nurses in Western Australia is level one, and levels two and beyond are promotional positions that reflect more senior roles. All nurses working in public sector secondary schools at the commencement of this study were registered nurses employed at level two. In addition to nursing education at registered nurse level, many school nurses have additional qualifications, although these are not mandatory.

Community health nursing underpins the model of school nursing in Western Australia (Department of Health Western Australia, 2019a) and school health services address three key areas of service delivery: health promotion, early

intervention and specialist health expertise (Department of Health Western Australia, 2019a). Service parameters are further defined in the Memorandum of Understanding between the Western Australian Departments of Health and Education (Government of Western Australia, 2018) which will be considered next.

1.9 Memorandum of Understanding between the Western Australian Departments of Health and Education

In the absence of clear guidelines articulating how the public sector health and education sectors will collaborate to promote student health and wellbeing, the Memorandum of Understanding between the Western Australian Departments of Health and Education (2018) outlines the terms of public sector school health service provision, which includes an agreement to jointly fund the service. While all public sector secondary schools are eligible for school nursing services, student census numbers and school demographic characteristics influence the school's share of school nursing resources. The exact means by which this is determined is not in the public domain.

According to the Memorandum of Understanding secondary school health services are principally focussed on the provision of primary health care and health counselling for young people in the form of "assessment, brief intervention, health information, referral, monitoring and support" (Government of Western Australia, 2018, p. 5). Schools are principally responsible for the care of young people who are sick or injured at school, a distinction that was present even when the service first commenced (Holman & Coster, 1991, pp. 77-78). The Memorandum of Understanding outlines that school nurses are employed by the Department of Health and line-managed by a Department of Health clinical nurse manager located off-site from the school. School nurses are accountable for their practice to the clinical nurse manager, not the school principal. Policy and guidelines for school health service provision are also the responsibility of the Department of Health (Government of Western Australia, 2018).

In addition to the Memorandum of Understanding, at the start of the year the clinical nurse manager and assigned school nurse enter into a school-level agreement with

the school principal to outline the health services that will be provided in the school. These must conform to the parameters described in the Memorandum of Understanding. A core component of the school health service is that students can self-refer, although school staff and parents frequently also refer young people. The service is universal and conditionally confidential. There are no exclusion criteria. Most nurses are based in the school at least some of the time and operate a school-based health centre. Large schools typically have a nurse allocated five days per week, while smaller schools may only have a nurse on-site a proportion of the week. Although nurses work independently, they are also intended to be part of the school's Student Services team.

The model of school nursing outlined in the Memorandum of Understanding contrasts sharply with the school nursing role in Western Australian private schools, where the employing school determines the role and function of the nurse. While published literature is scant, doctoral work undertaken by McCluskey (2015) suggests that only a small proportion of Western Australian private schools employ a registered nurse, but where they do the role is predominantly a medical (or "traditional") role, oriented to the provision of first aid and care of students who are sick.

Although the Memorandum of Understanding is signed off at the highest level by the respective Directors General of the Departments of Health and Education, anecdotal reports suggest a level of dissatisfaction with the agreement at the level of the school, particularly in relation to the lack of school nursing support for student first aid and minor illness. Many public sector secondary schools are large (over 1000 students) with potentially high student first aid and minor illness demands. Perhaps unsurprisingly, education staff are more concerned that immediate student health needs are appropriately managed, and a school nurse who declines to provide these services in order to focus on adolescent health counselling may find it difficult to convince education colleagues that they are providing a genuine health service. According to Madsen (2008), this problem is not new: historical state school nurses also faced difficulties negotiating their way between "schools, parents, doctors, and various government departments." While literature is scarce, generalist community

health nurses in Australia have experienced similar problems. Kemp, Harris, and Comino (2005) examined the changes generalist community health nurses in New South Wales perceived were occurring in their workload between 1995 and 2000. Key among the findings was a perception that the acute care sector was increasingly encroaching on community health nursing by demanding the provision of a greater number of medical nursing interventions.

1.10 The school setting and young people's mental health

Schools are ideally placed to identify mental health problems early and have been proposed as a setting for universal mental health screening (Humphrey & Wigelsworth, 2016). There is some evidence that screening improves identification of mental health problems (de Wilde, van de Looij, Goldschmeding, & Hoogeveen, 2011; Husky, Kaplan, et al., 2011) and several feasibility pilots have been conducted using different approaches (Dowdy et al., 2015; Husky, Sheridan, McGuire, & Olfson, 2011). As explained by Levitt, Saka, Hunter Romanelli, and Hoagwood (2007), a major difficulty with screening tools for use in schools relates to the balance between sensitivity and specificity, a challenge that does not appear to have been resolved in the intervening years.

In the absence of systematic approaches to case finding, non-normative behaviour may suggest potential mental health problems. Teachers often spend the most time with young people at school and there has been considerable interest in how teachers perceive their role with young people experiencing mental health problems (Graham, Phelps, Maddison, & Fitzgerald, 2011; Mazzer & Rickwood, 2015). For example, in a recent qualitative study conducted in Australia teachers expressed the view that caring for young people's mental health was a fundamental part of their role but emphasised that this could only be achieved in collaboration with strong pastoral care networks that supported referral to specialist external service providers (Mazzer & Rickwood, 2015).

Schools are an ideal setting for the identification of mental health problems on the basis of behaviour because the usual structure of school stratifies young people horizontally according to age. Most schools also retain students for a number of

years, permitting both a direct comparison against same-age peers and a longitudinal assessment of an individual young person over time. These factors allow schools to more readily identify young people whose behaviour may warrant further assessment. As behaviour, development, mental health and academic progress are closely intertwined, a problem in any one domain may indicate a need for further assessment (Achenbach & Ruffle, 2000). Educators and other school staff may identify a broad range of student behaviour that could be indicative of mental health problems. Difficulties with concentration and motivation, a failure to pay attention or submit written work at school are likely to attract negative attention from educators. Cases of declining academic performance, social functioning and mood should be evaluated in a timely manner as these may be early indicators of emerging mental health problems (Shanahan et al., 2015). Repeated requests to go home during the school day, generalised somatic complaints and high absenteeism for non-specific illness may all indicate mental health problems and should be investigated further (Crawley et al., 2014).

In addition to the low level behavioural problems already outlined, more challenging at the classroom level are the externalising mental health problems that masquerade as “bad behaviour”. In the absence of a confirmed diagnosis teachers might reasonably expect young people to comply with standard school demands and demonstrate appropriate behaviour. Schools have a duty of care for young people under the age of 18 years, and there is an expectation that young people will comply with reasonable instructions and not leave the classroom without permission. Some students with symptoms of mental health problems (such as panic and agitation) may experience an overwhelming need to leave class, but leaving without permission may result in further negative consequences.

More overt dysregulated emotion and behaviour such as impulsive outbursts and aggression can be especially difficult for teachers to manage and may have significant impacts on other class members. For example, substance abuse problems can result in markedly dysregulated behaviour and are often comorbid with other mental health problems (Brewer, Godley, & Hulvershorn, 2017). In extreme cases, disruptive and difficult behaviour may result in school suspension or expulsion,

known in Western Australia as *exclusion*. In a systematic review, Whear et al. (2013) found that there was a correlation between young people being excluded from school and having an impairing psychological or behavioural impairment.

Where young people have been identified as having a mental health problem they might reasonably expect increased school support, but a systematic review by Kaushik, Kostaki, and Kyriakopoulos (2016) found that young people with mental illness experience a universal and disabling level of stigma from the broader community. While a mental health diagnosis would typically be held in the highest confidence at school, stigma may negatively impact a young person's behaviour or school attendance and might also impact the teacher's expectations of the young person. Further research is required to determine how disclosing mental health problems impacts a young person at school.

In Australia most young people with mental health problems attend school most of the time (Lawrence et al., 2015, p. 8). Barriers to education on the basis of disability (including mental health problems) constitutes discrimination under the Disability Discrimination Act 1992 (Amended) (Federal Government of Australia, 2018). This has not always been so. Records from the 1960s indicate that young people with mental health problems were seen to be a burden (Lambert, 1964, pp. 40-41) and encouraged to leave school (Morse, 1964, p. 7). Over the past 40 years the education of children with physical and intellectual disabilities has been reoriented from the previously segregated model to an inclusive education model (Forlin, 2006). There is strong recognition that education is a fundamental human right (United Nations Educational, Scientific and Cultural Organization, 2016b) and schools have developed significant capacity to meet the individual education needs of young people who require a range of education adjustments.

Teachers have a long history of providing pastoral care in schools (Velasquez, West, Graham, & Osguthorpe, 2013), but many schools have gone further, employing specialist health and counselling professionals to augment support for young people (Sharpe et al., 2016). In Australia more than 40% of young people with mental health problems accessed support at school (Lawrence et al., 2015, p. 6), however the service provider, quality and effectiveness of these interventions is unclear.

Elsewhere, a recent systematic review of mental health services provided by school-based health centres in North America had to be reported in narrative form as the interventions and outcome measures were so diverse (Bains & Diallo, 2015). While there has been a growing focus on collecting universal school health data in North America (Maughan, Johnson, & Bergren, 2018), there is currently no equivalent data collection strategy in Australia.

While there is evidence that young people with mental health problems want to remain engaged in education (Orygen Youth Health Research Centre, 2014), it is estimated that as many as half do not complete secondary school (Bowman et al., 2016). Data is scarce, and it is unclear at what point young people with mental health problems typically disengage from school. As many young people with mental health problems do not seek care (Gulliver, Griffiths, & Christensen, 2010), untreated mental health problems may present an insurmountable barrier to continued school engagement. Absenteeism can become the default pattern simply because daily school attendance has become too hard. This is of considerable concern: in addition to curtailing educational attainment, a sense of “thwarted belonging” at school has been strongly implicated in suicide (Van Orden et al., 2010).

1.11 Role of school nurses in young people’s mental health

In North America, school nurses perceive that they are well-positioned to identify and respond to young people’s mental health problems (Bakker, 2018). School nurses have also been identified as effective case-finders in young people’s mental health in the United Kingdom (Bartlett, 2015) even though they did not always feel confident in this role (Pryjmachuk, Graham, Haddad, & Tylee, 2012).

In contrast, the role of public sector secondary school nurses in adolescent mental health in Western Australia has had little attention. In the only publication addressing the work of this group Downie et al. (2002) reported that nurses were increasingly caring for young people with psychosocial issues such as stress, family conflict, bullying, drug and alcohol problems, and depressed mood. More recently the role has simply been overlooked. For example, in a broad investigation into ways in which state government departments could prevent or reduce suicide in young people the

Western Australian Ombudsman did not consult with, comment on or cite the role of public sector secondary school nurses, presumably because he was unaware that school nurses were active in this domain (Ombudsman Western Australia, 2014). Similarly, an inquiry into the mental health and wellbeing of children and young people undertaken by the Commissioner for Children and Young People in Western Australia (2011) paid scant attention to the work of school nurses but noted the work of school psychologists in multiple sections of the ensuing report.

Policy in relation to the identification of young people's psychosocial concerns was introduced by the Western Australian Department of Health in 2007 (Department of Health Western Australia, 2007). A suite of guidelines for brief intervention in psychosocial problems were endorsed in subsequent years, including stress management, positive coping, conflict resolution and problem solving (Department of Health Western Australia, 2010). Importantly, policy has always emphasised that the role for secondary school nurses with young people experiencing mental health problems complements but does not replace referral for clinical treatment.

Screening for mental health problems is not routinely undertaken in Western Australian schools and public sector secondary school nurses rely on alternative strategies for identifying young people experiencing mental health problems. For example, opportunistic evaluation of young people who present with a decline in mood, functioning or behavioural difficulties. School staff and parents may refer a proportion of young people for evaluation, but self-referral is also common. Reliance on self-referral is problematic because many young people with mental health problems are not good help-seekers (Rickwood, Mazzer, & Telford, 2015). Worryingly, distress and help-seeking also have an inverse relationship; the more distressed a young person becomes the less likely they are to seek help (Deane, Wilson, & Ciarrochi, 2001).

In a review, Smith (2012) identified stigma, a preference for self-reliance and limited mental health literacy as key reasons young people may not seek help. Jorm and colleagues (1997) introduced the term mental health literacy to refer to "knowledge and beliefs about mental disorders which aid their recognition, management or prevention". Help-seeking is a complex process and involves the conversion of

distress into a request for assistance in the context of an interpersonal relationship (Rickwood, Mazzer, & Telford, 2015). Many young people are concerned about confidentiality (Santelli et al., 2019), doubt the capacity of adults to help, and are anxious about being judged, invalidated or misunderstood (Kalafat, 2003). When combined with the normal adolescent developmental task of becoming independent, “individuating” from the family of origin (De Goede, Branje, & Meeus, 2009), many young people have a preference for self-reliance, although they may also seek the assistance of their peers (Smith, 2012). Efforts to improve help-seeking have focussed on stigma and mental health literacy, but stigma continues to be a major problem (Kaushik et al., 2016) and it is not yet clear whether improved mental health literacy promotes help-seeking among young people (Wei, Hayden, Kutcher, Zygmunt, & McGrath, 2013).

According to Department of Health policy, a public sector secondary school nurse who suspects a young person is experiencing a mental health problem should conduct a HEADSS adolescent psychosocial assessment (Department of Health Western Australia, 2019b). The HEADSS assessment was developed by Goldenring and Cohen (1988) and is an acronym for the broad domains of adolescent psychosocial functioning addressed in the assessment, including Home; Education/eating/exercise; Activities and hobbies; Drugs and alcohol; Sexuality/sexual behaviour/gender; and Suicide/depression/mental health. Considered to be the gold standard in assessment of adolescent health issues (Klein, Goldenring, & Adelman, 2014), the HEADSS psychosocial assessment is also used by headspace, the clinical arm of the Australian National Youth Mental Health Foundation (headspace, 2019a) together with validated mental health assessment tools (Rickwood, Mazzer, Telford, et al., 2015). Department of Health policy outlines that the HEADSS assessment is conducted in the form of a conversation with the young person: skilled communication, and a high degree of knowledge and expertise in young people’s health are required for an optimal understanding of the health risks and protective factors the young person is experiencing (Department of Health Western Australia, 2019b).

A broad range of interrelated social and psychosocial issues may be uncovered during an adolescent psychosocial assessment. Adversities in childhood often occur in clusters and when associated with poor family functioning correlate with the highest risk of mental health problems (Kessler et al., 2010). For example, young people who are bullied, who perpetrate bullying or who are victim-perpetrators are more likely to report suicidal ideation or suicide attempt within the past year (Hepburn, Azrael, Molnar, & Miller, 2012) and more likely to attempt suicide in later life (Meltzer, Vostanis, Ford, Bebbington, & Dennis, 2011). Young people with experiences of family and domestic violence are at significantly increased risk of poor psychosocial and mental health outcomes (Briggs-Gowan et al., 2019; Kitzmann, Gaylord, Holt, & Kenny, 2003), as are young people with a history of child sexual abuse (Adams, Mrug, & Knight, 2018). Young people in Western Australia who belong to particular population groups, such as young Aboriginal people experience disproportionately worse mental health (Sabbioni et al., 2018) as do young people who are trans or gender diverse (Strauss et al., 2017). Youth who are refugees (Hirani, Cherian, Mutch, & Payne, 2018), children in the care of the state (Greenson et al., 2011) and young people with chronic illness (Pinquart & Shen, 2011) also represent vulnerable groups, as do those who have a parent with a mental illness (Reupert, Maybery, & Kowalenko, 2012).

The decision-making framework described in the Department of Health adolescent psychosocial assessment policy is not specific to young people with mental health problems but alerts the clinician to consider mood and functioning as indicators of a need for referral (Department of Health Western Australia, 2019b). Young people identified as experiencing mental health problems should be referred for appropriate further assessment and treatment (Department of Health Western Australia, 2019b). Specialist mental health services for young people in Western Australia are limited, particularly outside of metropolitan areas (Commissioner for Children and Young People WA, 2011) and engagement of the young person with a more specialist service may not always be easily accomplished. At the service level potential barriers include waiting lists and poor acceptability or accessibility of the service offered. At the individual level potential barriers include resistance from the young person or their caregiver and premature disengagement from the specialist service

(Commissioner for Children and Young People WA, 2011). Irrespective of referral uptake, engagement in treatment does not preclude a young person from experiencing a mental health crisis at school. While assertive follow-up is recommended, Department of Health policy does not clearly outline the role of secondary school nurses in adolescent mental health beyond the point of initial referral.

1.12 Prevalence and epidemiology of young people's mental health problems

At the global level, mental and substance abuse disorders in young people represent a considerable burden of disease (Erskine et al., 2015). As many as 50% of mental health problems emerge by 14 years of age, but a majority are neither recognised nor treated (World Health Organisation, 2014, p. 4). In Australia, findings from the most recent national survey found that the prevalence of mental health problems in children and young people 4-17 years of age was one in seven (Lawrence et al., 2015, p. 4). This situation has not gone unnoticed by young people themselves: 43% of Australian young people identified mental health as the most important issue facing this generation (Carlisle et al., 2018), double the number that did so in the same survey in 2016 (Bailey et al., 2016). In Australia, the mental health problems with the highest 12 month prevalence in young people 12-17 years were anxiety disorders (7%) followed by major depressive disorder (5%) (Lawrence et al., 2015, p. 26). Gender has important implications for the distribution of mental health problems. For young men 12-17 years the highest 12 month point prevalence was for attention deficit hyperactivity disorder with anxiety disorders in second place, while for young women it was anxiety followed by major depressive disorder (Lawrence et al., 2015, p. 26).

According to Sarah-Jayne Blakemore, professor of cognitive neuroscience at University College London (UK), adolescence is a period of neurodevelopmental promise and risk (Blakemore, 2018). Since the 1980s, epidemiological studies in psychiatry have revealed that mental disorder starts much earlier in life than previously thought, prompting Insel and Fenton (2005) to describe mental illness as the "*chronic diseases of the young*". Adolescents are vulnerable to developing mental disorder, predominantly because puberty, brain development, social

environment and latent genetic risk factors interact to increase risk (Blakemore, 2018; Blakemore, Burnett, & Dahl, 2010). Indeed, adolescence is the peak period for the onset of mental illness (Giedd, Keshavan, & Paus, 2008), and 75% of life time mental disorder has its onset by 24 years of age (Kessler et al., 2007).

Adolescent brain development builds on childhood brain architecture and function, with the onset of puberty triggering an accelerated period of neural redevelopment (Giedd et al., 1999). While the early years are not the focus of this thesis, it is important to note that many mental health problems in young people have their origins in the early years (Center on the Developing Child at Harvard University, 2012; Sonuga-Barke et al., 2017). Adverse childhood events such as poverty, domestic violence, abuse and neglect can derail optimal neurodevelopment through the problem of toxic stress, influencing subsequent brain architecture and function (Center on the Developing Child at Harvard University, 2014). Effects are potentially long-term and have been referred to as *complex developmental trauma*, a term first introduced by Bessel van der Kolk (2005). This type of childhood trauma, occurring repeatedly in the interpersonal context has been found to be a common element in many adults with mental illness (Kezelman & Stavropoulos, 2012). Recent findings suggest that deficits in early neurodevelopment cannot be easily remediated, even when toxic stresses are replaced by more positive social conditions (Sonuga-Barke et al., 2017), however more research is required.

While efforts to optimise social and emotional development is crucial in early childhood, the distinct phase of adolescent neurodevelopment is a second opportunity which should be harnessed for its own merits. During this period complex brain development occurs on an accelerated schedule, with discrete brain regions developing on independent but interacting schedules (Casey, Jones, & Hare, 2008). Essential to maturation, the emotional and cognitive centres undergo significant redevelopment strongly influenced by social and environmental influences (Blakemore, 2018). Commonly this interplay has significant effects on mood, behaviour and cognition (Konrad, Firk, & Uhlhass, 2013). In 1904 adolescence was identified as a period of ‘storm and stress’ in seminal work by Stanley Hall (Stirrups, 2018), and although the degree of this apparent upheaval has subsequently been

questioned (Arnett, 1999; Rutter, Graham, Chadwick, & Yule, 1976), many emerging mental health problems in young people first present as a non-specific decline in mood and functioning (Cross et al., 2014). The onset can be so gradual that many go undetected or are initially misattributed to a phase of adolescent development. Therefore, discriminating longer-term mental health problems from normal development in the phase of emerging illness can be challenging (Patton et al., 2014), with implications for diagnosis and treatment.

1.13 Diagnosis of mental health problems in young people

Mental health problems are diagnosed using the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM5) (American Psychiatric Association, 2013b) or the International Classification of Diseases, 10th edition (ICD-10) (World Health Organisation, 2016). Both systems are largely categorical with clear diagnostic criteria that are more useful in well-established mental disorder of the type typically seen in adults. In the early or emerging phase of illness, young people frequently present with subclinical symptoms that do not meet the diagnostic threshold (McGorry & Nelson, 2016). Sub-threshold symptoms can have a significant impact on mood and functioning, and the absence of a diagnosable disorder does not mean the young person is thriving (Cross et al., 2014).

Whether at the clinical or sub-threshold level, symptoms of mental health problems in young people may also be characteristic of a variety of possible problems. Diagnostic uncertainty is common (McGorry, Purcell, et al., 2007) and comorbidity the norm (McGorry & Nelson, 2016). Adults with mental health problems typically have a relevant history of illness and treatment which guides subsequent clinical care. A first presentation of irritability and persistent low mood in a young person may represent depressive disorder, but may also be suggestive of other mental illnesses such as an emerging eating disorder (Ferreiro, Seoane, & Senra, 2012) or increased risk for a psychotic illness (DeVylder et al., 2014). The phase of undifferentiated mental illness that typically includes a decline in mood and functioning during adolescence is well-recognised and referred to retrospectively as the prodrome or prodromal period (McGorry, Purcell, et al., 2007). Despite concerted efforts, only minimal progress has been made in accurately identifying

young people at serious risk of mental illness prior to the onset of more overt symptoms (Schmidt et al., 2016).

The diagnostic challenges associated with emerging mental illness in young people have prompted calls for a more useful approach than that offered by the categorical system of diagnosis described in DSM5 (American Psychiatric Association, 2013b). For example, McGorry and Nelson (2016) highlighted the common elements evident in early undifferentiated mental illness and advocated for a transdiagnostic approach that addresses immediate need for care in the absence of a clear diagnosis. Such an approach might adopt clinical staging, a dimensional approach where treatment is matched to stage of illness along a continuum (Cross et al., 2014). Clinical staging has been identified as a means of assertively addressing sub-clinical mental health problems, although the evidence for improved outcomes remains uncertain (Cross, Hermens, & Hickie, 2016).

1.14 Common mental health diagnoses in young people

One of the most common mental health problems in Australian young people are anxiety disorders. In young people 12-17 years, the 12 month point prevalence for anxiety disorders was almost 8% in Australian females and just over 6% in males (Lawrence et al., 2015, p. 26). A group of disorders (American Psychiatric Association, 2013a), anxiety can be highly debilitating with significant life impacts. Typically starting in early childhood, untreated anxiety can have a longitudinal course where the clinical presentation changes as the young person grows (Rockhill et al., 2010). Anxiety disorders are frequently comorbid with other anxiety disorders and also with other mental health problems (Kendall et al., 2010).

Anxiety disorders and depressive disorders are the most significant mental health causes of disability affecting young people in Australia and globally (World Health Organisation, 2014, p. 5). In Australia, depressive disorders had a 12 month prevalence of 5% in young people (Lawrence et al., 2015, p. 26). Compared to childhood, rates of depression are markedly higher in adolescence, particularly in young women (Thapar, Collishaw, Pine, & Thapar, 2012). Far from a benign “adolescent moodiness,” depression in adolescence is associated with substantial

morbidity (Davey & McGorry, 2018) and significantly increased suicide risk (Thapar et al., 2012).

While a complete review of mental disorder in young people is beyond the scope of this chapter, it is important to note the broad range of less prevalent mental illnesses that also typically emerge during adolescence. Eating disorders, borderline personality disorder and schizophrenia are briefly highlighted here as examples of heterogeneous disorders that disproportionately affect young people and have potentially devastating impacts on the life of the individual and their family. While less prevalent than anxiety or depression, the prevalence for each of these disorders is in the order of 1%. In a school of 15 hundred students, 15 individuals on average will be affected by each of these disorders, or almost 50 students with an emerging eating disorder, borderline personality disorder or psychotic disorder.

The peak age of onset for eating disorders is approximately 18 years (Volpe et al., 2016). Of the eating disorders, anorexia nervosa has one of the highest rates of mortality of any of the mental illnesses, reflecting both medical complications of starvation and the increased risk for suicide (Keshaviah et al., 2014). The prevalence rates have been variously reported as being between 1% and 4% (Smink, van Hoeken, & Hoek, 2012).

While historically highly contentious, the evidence that borderline personality disorder can be reliably diagnosed in adolescents continues to grow (Kongerslev, Chanen, & Simonsen, 2015), and Kaess, Brunner, and Chanen (2014) estimate that the cumulative prevalence rate of borderline personality disorder is 1.4% by 16 years of age. Borderline personality disorder is marked by high rates of psychological distress, deliberate self-harm and suicidality (American Psychiatric Association, 2013c), having significant negative implications for social and functional outcomes over the life course (Newton-Howes, Clark, & Chanen, 2015).

Schizophrenia is a form of psychotic illness with a heterogeneous clinical presentation and course (Meyer & MacCabe, 2016). It affects slightly less than 1% of the population and typically emerges in late adolescence or young adulthood (Millan et al., 2016). The condition is associated with significant distress, impairment and

high socio-economic burden (Meyer & MacCabe, 2016), all of which contribute to the high rate of suicide (Popovic et al., 2014).

Non-suicidal self-injury and suicidal behaviour are briefly included here as they represent late indicators of high psychological distress and likely mental health problems. Both are common among young people in Australia (Lawrence et al., 2015, p. 103; Robinson, McCutcheon, Browne, & Witt, 2016). While not indicative of a specific mental disorder, non-suicidal self-injury and suicidal behaviour increase the risk of accidental death and death by suicide (Hawton, Saunders, & O'Connor, 2012; Robinson et al., 2016, p. 5). Suicide has become a significant concern in Australia and in 2017 accounted for more than 35% of deaths among young people 15-24 years of age (Australian Bureau of Statistics, 2018). Youth suicide is also a significant problem at the global level. The second leading cause of death among 15-29 year olds (World Health Organisation, 2019), suicide is the leading cause of death among young women 15-19, having overtaken maternal mortality (World Health Organisation, 2014, p. 2).

1.15 Social and functional recovery in young people's mental health

The impact of mental health problems in young people is not limited to psychiatric symptoms. Impacts typically include significant social and functional effects that may be of more personal concern to the individual than the clinical symptoms of illness (Killackey, 2015). Clinical treatment for mental health problems is typically provided by specialist treatment services, however the adult mental health literature has stressed that clinical treatment is only one component of recovery from mental health problems. The Australian National Framework for Recovery makes a specific distinction between personal and clinical recovery: where *clinical recovery* relates to a reduction or resolution of symptoms of mental illness, *personal recovery* is defined as "being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues" (Commonwealth of Australia, 2013, p. 2).

The concept of personal recovery was put forward in the 1970s by people with a lived experience of mental illness as a way to re-establish a sense of personal identity

beyond illness (Commonwealth of Australia, 2013, p. 11). Personal recovery is defined by the individual and has a broad focus, with the social determinants of health explicitly described as key targets for action (Commonwealth of Australia, 2013, p. 15). Although there is little published literature examining personal recovery as it pertains to youth, the Mental Health Coordinating Council of New South Wales in Australia has endorsed the concept and placed a strong emphasis on school as a context for personal recovery (Mental Health Coordinating Council, 2014). School has the potential to be a positive, normative experience for young people, providing structure, a sense of belonging, social contact, and opportunities to meet developmental goals.

Not all young people see the value of school (Graham, Van Bergen, & Sweller, 2015) but school disengagement risks more than the loss of educational opportunities. In Australia, it is estimated that as many as 50% of young people with mental health problems do not finish school (Bowman et al., 2016), providing insight as to why this cohort frequently experience poor educational and employment outcomes (Bowman et al., 2016; Orygen Youth Health Research Centre, 2014). Ranging from sub-optimal grades to a failure to graduate secondary school, poor academic achievement at the level of the individual can limit post-school education and employment opportunities, impacting future earning potential and increasing the risk of long-term disadvantage (Bowman et al., 2016). Relevant not just to the individual, at the community level sub-optimal educational achievement in a substantial cohort of young people has the potential to significantly impact the future mental wealth of the nation (McGorry, 2017).

1.16 The Australian national young people's mental health reform agenda

Traditionally, mental health services for young people have been provided by Child and Adolescent Mental Health Services with a transition to adult mental health services at 16 or 18 years of age (Coughlan et al., 2013). Critics of this system have been vocal that neither model properly meets the specific developmental needs of youth aged 12-24 years, and have advocated strongly for a "new paradigm of care" specifically contextualised to the needs of this cohort (Coughlan et al., 2013).

Although now established as an emerging field, a debate about the legitimacy of this

approach appeared in the literature as recently as 10 years ago (Birleson, 2009; McGorry, 2009).

Strongly promoted in the Australian context, the multidisciplinary youth mental health field has distinguished itself with an ambitious international reform agenda (International Association for Youth Mental Health, 2011). Committed to raising community awareness and spanning the service continuum from mental health promotion to recovery (Mrazek & Haggerty, 1994), youth mental health espouses the provision of accessible youth-friendly care, early intervention, a transdiagnostic approach to emerging illness, clinical staging and tertiary prevention (Coughlan et al., 2013; Hickie et al., 2013).

McGorry, Bates, and Birchwood (2013) summarised the core principles underpinning the youth mental health approach. Of key importance is young people's participation in designing services intended to meet their needs. Incorporating the design and development of stigma-free, youth-friendly mental health services (Association for Child and Adolescent Mental Health Special Interest Group in Youth Mental Health, 2013), young people should also be involved in all aspects of youth mental health research, including project design, implementation and authorship (Orygen Youth Health Research Centre, 2016). Bi-annual conferences developed and promoted by key proponents of the reform agenda have also involved young people as key facilitators and contributors (International Association for Youth Mental Health, 2019).

The youth mental health reform agenda promotes a holistic, preventative, hopeful stance in treatment with shared decision-making and treatment selection appropriate to degree of illness (clinical staging) (McGorry et al., 2013). This stance reflects both a therapeutic partnership approach with young people, and a recognition that many mental health problems respond to appropriate treatment and psychosocial support, especially when offered early in the course of mental ill health. Of note is that "early intervention" does not refer exclusively to preventing the onset or intensification of illness (Chanen, 2012; Killackey, 2015). Social inclusion and support for broader life outcomes are key goals (McGorry et al., 2013), consistent with a focus on personal recovery and tertiary prevention. For example, there is some evidence that early

treatment provided to young people at risk for psychosis reduces transition to psychosis (van der Gaag et al., 2013). Of equal significance is that this cohort are more likely to have improved social and functional outcomes when provided with treatment in an early intervention service, irrespective of whether they experience a first episode of psychosis (Nelson et al., 2016; Tsiachristas, Thomas, Leal, & Lennox, 2016).

At a service delivery level, the reform agenda calls for significantly increased service capacity at peak periods for onset of mental illness as well as smooth, developmentally informed transitions between services (McGorry et al., 2013). These principles are reflected in Australia's headspace service for young people (the National Youth Mental Health Foundation) which was set up in 2006 by the Australian Federal Government to invest in youth mental health reform in a systematic and practical manner (Rickwood, Mazzer, Telford, et al., 2015). Now adopted in other parts of the world (Illback & Bates, 2011), easily accessible locations and youth friendly physical environments, together with branding and peer influence have been credited as critical in encouraging help-seeking (Coughlan et al., 2013). These strategies have also markedly increased access to health services for young people experiencing mental health problems (Hilferty et al., 2015, p. 18). The purpose of this study is therefore timely and well-situated in the context of the Australian national youth mental health reform agenda.

1.17 Aims and purpose of the study

The aim of the current study was to develop a substantive theory which has explanatory power for the behaviour of the group of interest. The purpose of the study was to explore the experiences of secondary school nurses who encounter young people with mental health problems. Findings will assist in the development of strategies to support the school nursing workforce and to enhance the capacity of this workforce to care for young people experiencing mental health problems. Stakeholders such as the Western Australian Department of Health and postgraduate nursing education providers are likely to benefit from the findings which may also inform mental health policy, service planning, and funding bodies such as the Western Australian Mental Health Commission.

1.18 Research objectives

The objectives of the research are to:

1. To explore the experiences of school nurses who encounter young people with mental health problems.
2. To identify the barriers and facilitators school nurses experience in their work with young people experiencing mental health problems.
3. To develop a substantive theory that explains how school nurses respond to young people experiencing mental health problems and places it in the context of the relevant theoretical literature.

1.19 Need for the study

Little is known about the work of Western Australian public sector secondary school nurses with young people experiencing mental health problems. The high prevalence of mental health problems in school-attending young people (Lawrence et al., 2015) and the momentum behind the youth mental health reform agenda (International Association for Youth Mental Health, 2011) present an ideal opportunity for all health professionals working with this cohort to be optimally engaged in the provision of effective, visible, measurable services that enhance the life outcomes of young people experiencing mental health problems.

The youth mental health reform agenda strongly endorses an approach to early intervention that focusses on functional and social recovery (Killackey, 2015). Public sector secondary school nurses in Western Australia provide a bridge between health and education, have a focus on early intervention, and support young people and their families to address the social determinants of health. Positive life outcomes for young people experiencing mental health problems are much more likely to be realised if all possible sources of expertise and assistance are working in partnership across a collaborative, integrated continuum of care. A clearer understanding of the work of public sector school nurses, the activities undertaken, and the barriers and facilitators nurses encounter will assist in determining how the Western Australian state secondary school nurse might be better supported to meet the needs of young

people experiencing mental health problems. This has potential benefits for nurses, young people, health service development, and partnerships with education and mental health treatment services.

1.20 Significance of the study

The significance of the study will be to develop a substantive theory that explains the work of Western Australian public sector secondary school nurses with young people experiencing mental health problems. Findings will make visible the work of school nurses with this cohort, will increase stakeholder understanding of school nurse activities with this group and will inform school health service planning, policy direction and workforce development in the public sector. The findings will also be of benefit to school nurses. School nurses work autonomously and are isolated from health colleagues and the broader health service. A shared understanding of common concerns and social-psychological means of addressing these concerns has the potential to reduce nurse isolation and permit discussion of issues that nurses may not otherwise raise.

Findings might also be expected to lead to more optimal health interventions for young people experiencing mental health problems and subsequently better outcomes. Initial assessment and referral are described in Community Health policy, but beyond this point the activities of the Western Australia state secondary school nurse with this cohort has not been outlined. Early intervention is cost-effective (Access Economics, 2009), and greater clarity about effective health support for young people with mental health problems at the school nurse level may increase the likelihood that students complete their education.

Lastly, a substantive theory of the work of school nurses with young people experiencing mental health problems may also assist in placing the work of public sector secondary school nurses in the broader context of the youth mental health reform agenda. It is especially important to document the often hidden work and contributions that nurses make to the mental health care system. Given the prevalence of young Australians experiencing mental health problems (Lawrence et al., 2015) and the potential for the school nurse workforce to optimise the health,

wellbeing and functional outcomes of this cohort, it is critical to understand the capacity of this workforce and harness the expertise school nurses possess.

1.21 Summary

This chapter commenced with an introduction to the history and early development of school nursing. The relationship between health and education was examined and the model of school nursing in Western Australia explained. The chapter then provided an overview of the school system in Western Australia, the structure of school health services, and the Memorandum of Understanding between the departments of Health and Education that guides school health service delivery.

Following this, the chapter reviewed the role of school nurses in young peoples' mental health. The prevalence and epidemiology of young people's mental health problems was investigated, common mental health diagnoses in adolescence discussed and the limitations of diagnosis for emerging mental health problems considered. The chapter examined social and functional recovery from mental health problems and the implications of the youth mental health service reform agenda in Australia. The purpose of the study, research objectives, need for and significance of the study concluded the chapter. Chapter two provides detailed information about the grounded theory method (Glaser & Strauss, 1967) and application of the grounded theory method to the study described in this thesis.

CHAPTER 2

METHODOLOGY

2.1 Introduction

This chapter provides a detailed review of the methods used to investigate the experiences of Western Australian public sector secondary school nurses who encounter young people with mental health problems. The chapter begins with a brief overview of qualitative research, followed by a description of the original method of grounded theory developed by Glaser and Strauss (1967). The procedural steps in grounded theory are outlined and the rationale for the choice of methodology explained. Subsequent to this the implementation of the research method is reviewed. The chapter concludes with a discussion of the processes undertaken to ensure the trustworthiness and transferability of the findings and ethical considerations.

2.2 Qualitative research

Research methodologies are broadly divided into quantitative and qualitative approaches; combining the two is referred to as a *mixed methods approach* (Graff, 2014). Quantitative research uses numeric data to conduct statistical analysis (Burns & Grove, 2009). In contrast, qualitative studies use narrative data and non-statistical methods of analysis (Graff, 2014; Ingham-Broomfield, 2015).

Qualitative research is frequently used in the behavioural and social sciences where human reality is viewed as subjective and multi-faceted (Ingham-Broomfield, 2015). As a qualitative approach facilitates a thorough understanding of a social situation (Nieswiadomy, 2014), it is particularly suited to the investigation of human experiences and is often used as a first line of enquiry (Ingham-Broomfield, 2015). Common data sources in qualitative research include interviews, field observation, journal entries and diary collections (Kolb, 2012).

There are a number of qualitative research designs with distinctive and overlapping features, including phenomenology, ethnography, case studies, historical studies, action research and grounded theory (Ingham-Broomfield, 2015; Nieswiadomy,

2014). The choice of qualitative methodology is highly dependent on the nature of the research problem to be examined.

2.3 The grounded theory method

The grounded theory method is a qualitative research approach used in a wide variety of disciplines including psychology, education and nursing (Holloway, 2008; McCann & Clark, 2003a; Nieswiadomy, 2014). Grounded theory is based on the premise that the group under investigation experiences a shared social psychological problem, even if this is not explicitly articulated (McCann & Clark, 2003a). Also referred to as the basic social psychological problem or shared common concern, the problem is a recurrent social pattern that can be uncovered by using the grounded theory method (Glaser & Strauss, 1967, pp. 2-3).

Originally developed by sociologists Barney Glaser and Anselm Strauss while conducting research in the 1960s with dying patients in hospitals (Glaser & Strauss, 1967, p. ix), the word 'grounded' refers to the grounding of a new theory in empirical data. A theory generated this way has "grab," fits the data, is relevant and works in the real world (Glaser, 1978, p. 4). It has high explanatory power in the substantive area (Holloway, 2008). As the emphasis is on identifying social patterns and presenting an integrated set of hypotheses in the form of a theory, grounded theory does not seek to present verifiable facts or a full description of the substantive area (Glaser, 2001, p. 45). This emphasis on developing theory from empirical data remains a distinct feature of grounded theory among qualitative research approaches (Kolb, 2012).

Glaser and Strauss (1967, p. 10) noted that prior to the development of grounded theory many sociological research approaches emphasised testing and verification of 'grand theories' which had been developed using a logical, inductive process. In grounded theory this approach was rejected because it was viewed as pre-conceptualising the problem, with the potential risk that data would be "forced" into a preferred theory (Glaser, 1998, p. 67). Instead, Glaser and Strauss explained how new, contextualised theories could be developed from empirical data using an orderly approach with clear steps (Dey, 1999, p. 12; Willig, 2013). This was a radical

departure from previous sociological research approaches. It also explains why existing literature is reviewed only after the grounded theory has been written up. In this thesis, a detailed analysis of existing literature with relevance for the newly developed theory is provided in chapter seven.

Grounded theory is distinguished by several core processes, including the concurrent collection and analysis of data referred to as the *constant comparative method of analysis*, theoretical sampling, and theoretical sensitivity (Glaser & Strauss, 1967; Holloway, 2008; Willig, 2013). In order to understand the shared social psychological problem and the process participants engage in to resolve the problem, the researcher explores how the group of interest negotiates social situations and influence social processes (Willig, 2013). Although the steps outlined for undertaking grounded theory are highly structured with clearly articulated procedures, the stages are not strictly sequential. The methodology is flexible and non-linear (Glaser & Holton, 2004), with the researcher moving back and forth between the different steps as the research unfolds.

Like many research methods, grounded theory has evolved since it was first developed (Walker & Myrick, 2006). Subsequent to the publication of their original work in 1967, co-founders Glaser and Strauss had a methodological disagreement and went on to develop the method independently. McCann and Clark (2003b, p. 21) reflect that this methodological divergence may have been present from the beginning and assert that the articulation of these differences represents a maturing of the method, not an indication of the method's demise. The grounded theory method subsequently evolved into three main approaches (Willig, 2013). The research described in this thesis uses the original method of grounded theory, as first described by Glaser and Strauss (1967) and subsequently by Glaser (1978; Glaser, 1992; 2002a). The second form of grounded theory was elaborated from the original by cofounder Strauss together with Juliet Corbin (Strauss & Corbin, 1994). The third and most recent form of grounded theory is the constructivist approach developed by Kathy Charmaz (2008), a former pupil of Glaser.

These divergences have important implications for the novice researcher who selects the grounded theory approach. On first assessment, the three main approaches

present as very similar, further complicated by highly similar terminology. Walker and Myrick (2006) assert that the differences are in the execution of the processes, while Willig (2013) identifies three main variances: the role of induction in each approach, the concept of discovery versus construction of the grounded theory, and the relative importance of social and psychological processes versus individual experiences.

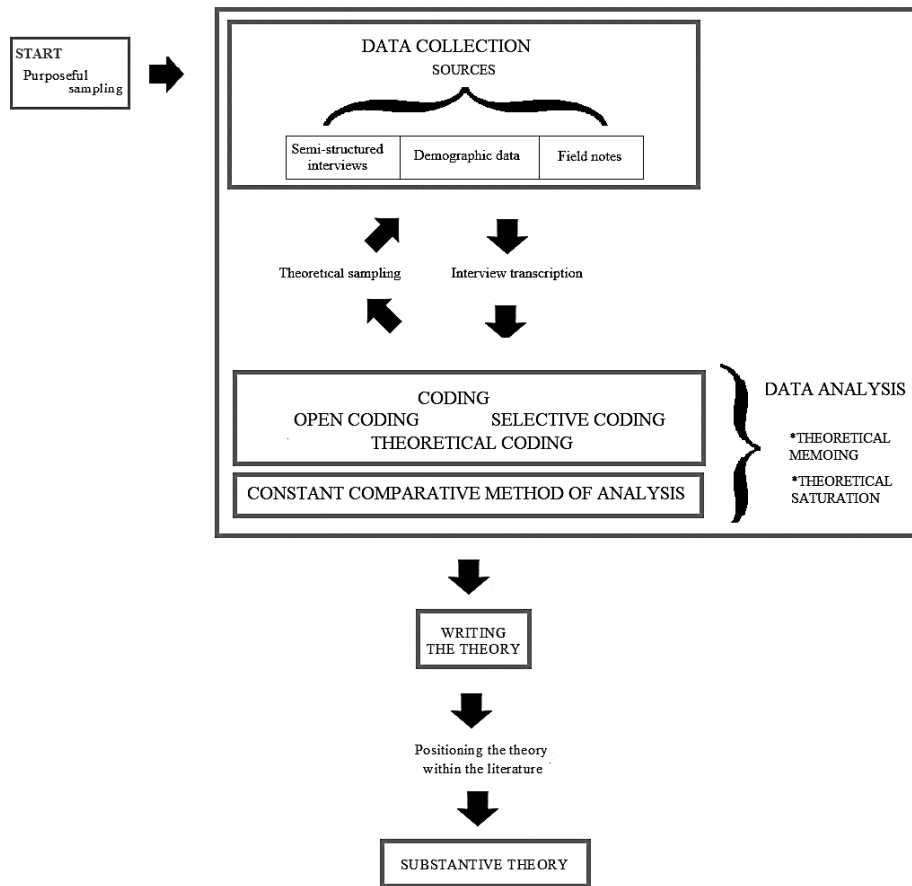
In the current study the researcher had the benefit of supervisors with extensive experience of grounded theory, and this mitigated the risk of the researcher diverging from the original method due to a lack of experience with the process. To develop an understanding of the divergences the researcher read widely on grounded theory, seeking guidance from her supervisors to understand differences in approach while avoiding deviation from the original method in her research (Glaser & Strauss, 1967). A visual representation of the process of conducting grounded theory is shown in figure one.

2.4 Rationale for the use of the grounded theory method in this study

In the current study, the researcher identified three main reasons for the choice of grounded theory as an appropriate methodology: 1) the lack of previous literature in the field; 2) the focus on identifying social and psychological factors relevant to the practice of secondary school nursing in Western Australia and 3) the relevance of a grounded theory to addressing the real-world concerns of this group.

As previously identified, there is little published literature about the work of Western Australian public sector secondary school nurses and the field has been minimally explored. Having previously practiced as a public sector secondary school nurse, the researcher was sensitive to the unique and complex nature of the role and sought to avoid the opportunistic use of theories with questionable fit and function. As Glaser and Strauss (1967) perceived that grounded theory was especially useful in these circumstances, grounded theory was identified as a suitable methodology for conducting the proposed research.

Figure 1



The second rationale for the use of this method was the emphasis grounded theory places on social and psychological factors. Nursing is strongly oriented to social interactions (McCann & Clark, 2003a; Nieswiadomy, 2014). The role of public sector secondary school nurses in Western Australia has a particularly strong emphasis on social interactions due to the role's focus on the social model of health. Public sector secondary school nurses in Western Australia do not typically undertake clinical activities such as giving injections, administering medication or attending to wounds. The role is oriented to health promotion, early intervention and support for optimal development, functions where interpersonal and social skills are vitally important to effective clinical practice. Secondary school nurses negotiate social interactions not only in their clinical role with adolescent clients, but also in their professional role, managing the social dynamics of their assigned school and the school Student Services teams in which they are embedded. The researcher was cognisant that professional relationships at the level of the school had the potential to

be both highly complex and crucially important to undertaking the secondary school nurse role to a high level. A critical first step to understanding this minimally investigated field was therefore to select a research methodology that emphasised social and psychological processes.

Real world applicability was the third rationale for the use of grounded theory in this program of doctoral research. Glaser emphasised this aspect of grounded theory, affirming that the goal of the method is to: “generate a conceptual theory that accounts for a pattern of behavior which is relevant and problematic for those involved” (Glaser, 1978, p. 93). In addition to identifying a ‘relevant and problematic’ shared common concern, the process in which participants engage to overcome the problem facilitates “predictions, explanations, interpretations and applications” (Glaser & Strauss, 1967, p. 1) that are meaningful to the group of interest. This has clear potential to guide the professional practice of Western Australian public sector secondary school nurses in the future.

A challenge the researcher predicted was the potential for highly diverse data. Public sector secondary school nurses in Western Australia practice autonomously and are geographically dispersed. Nurses have few opportunities to compare or benchmark their practice against colleagues, and the researcher was aware at the outset that school nursing practice was likely to be diverse. Moreover, public sector secondary schools are not uniform settings, nor are clinical nurse managers present in the workplace to influence practice. For this reason the researcher sought a methodology that would cope with inherent variation. According to Nieswiadomy (2014), grounded theory presumes that fundamental patterns can be discovered in all aspects of social life and can accommodate great diversity in the data. Grounded theory was therefore deemed as an appropriate methodology choice for this study.

2.5 Application of the grounded theory method for this study

This study adhered to the original method of grounded theory described by Glaser and Strauss (1967) and subsequently by Glaser (1978; Glaser, 1992; 2002a). More recent iterations of grounded theory, such as Charmaz’s constructivist grounded

theory (Charmaz, 2000) were reviewed to consider differences in approach but avoided as sources of guidance.

2.5.1 Data collection

Consistent with the original method of grounded theory (Glaser & Strauss, 1967) data analysis and data collection were undertaken concurrently in this study but are presented here in sequence for clarity. This section provides further information about data collection, including the sampling strategy, inclusion criteria, recruitment processes, research interviews and field notes. Data for this research was primarily collected in the form of semi-structured open-ended interviews, a common data collection method in grounded theory (Cheer, MacLaren, & Tsey, 2016; Glaser & Holton, 2004). Interviews were supplemented with demographic data such as age, gender and duration of practice as a secondary school nurse.

2.5.1.1 Sampling strategy

The first five interviews conducted for this study used purposeful sampling, a non-random sampling technique that seeks out participants who have experience with the phenomenon of interest (Cresswell & Plano Clark, 2011). The researcher analysed this interview data to identify emerging concepts and subsequent participants were selected on the basis of their ability to further develop these ideas, a sampling strategy known as *theoretical sampling* (Holton, 2010). Theoretical sampling is a core aspect of the original method of grounded theory, and led to the interviewing of participants who had been working in their assigned school for a long duration, those with experience in multiple schools and those who had only recently commenced working as a secondary school nurse. Consistent with recommendations made by Glaser (1978, p. 47), other theoretical sampling strategies included changing the interview questions and locating alternative data collection points such as interviewing rural and regionally located nurses.

2.5.1.2 Inclusion criteria

The study sample comprised of registered nurses with experience working as public sector secondary school nurses in Western Australia. Prior to recruitment the

researcher identified five inclusion criteria that determined eligibility to participate in the research interviews. Respondents were screened by the researcher to ensure included participants met the following criteria:

1. Employed by the Western Australian Department of Health (Child and Adolescent Health Service - Community Health or the Western Australia Country Health Service) either currently or recently.
2. Employed as a community health nurse (registered nurse level 2) or senior registered nurse (SRN) level 3 in the community health context.
3. Have current or recent knowledge and experience related to the provision of direct clinical services to individual adolescent clients in the school health context.
4. Express an interest in participating.
5. Provide written consent to participate.

2.5.1.3 Recruitment

Public sector secondary school nurses in the metropolitan area of Perth were invited to participate in the study via an email distributed by the health service nursing director on August 2, 2017 and an entry in the subsequent health service newsletter on August 18, 2017 (see Appendix A). Twenty-one metropolitan participants were recruited through these invitations to participate.

Regional public sector secondary school nurses were invited to participate via an entry in the regional health services email newsletter on October 11, 2017 (see Appendix B). This did not yield any responses. The director of the regional health services subsequently distributed the Study Information Sheet and Participant Consent Form (Appendices C and D) to regional nurse managers for further distribution to secondary school nurses. This prompted 10 public sector regional secondary school nurses to respond, all of whom were included as study participants.

2.5.1.4 Research interviews

On receipt of a request to participate, the researcher telephoned the potential participant to confirm interest and eligibility. The researcher also took this opportunity to assess the potential participant's capacity to articulate experiences in a reflective manner, as this can affect the credibility of the data (Palinkas et al., 2015). To assess this, the researcher asked respondents to briefly explain what had prompted their interest in participating. A mutually convenient time and mode for conducting the interview was arranged with suitable participants. In this study all the participants who expressed an interest in participating were suitable candidates and were included in the sample.

A total of 31 semi-structured open-ended interviews were conducted with 31 participants over four months, commencing on August 7, 2017 and concluding on December 6, 2017. The interviews ranged in length from 19 minutes to 64 minutes, with an average duration of 33 minutes. Twenty-one interviews were conducted in person in the Perth metropolitan area and 10 were conducted by telephone or videoconference with regional participants. Telehealth services are common in Western Australia (Rimal, Huang Fu, & Gillett, 2017; Sharp, 2018) and previous research has established that participants in a grounded theory study can be highly satisfied with telephone interviews (Ward, Gott, & Hoare, 2015).

Each interview was commenced with a verbal orientation to the research. This created an opportunity for the researcher to develop rapport, review the purpose of the research, ascertain that the consent form had been completed and respond to participant questions. As outlined in the *Study Information Sheet* (Appendix C), participants were reminded that the study definition for the term *mental health problems* related to any student presentation where the nurse perceived the young person was presenting with poor mental health, irrespective of the presence or absence of a mental health diagnosis. Participant demographic data was then collected (see Appendix E), followed by the question "Why did you choose school nursing?" as per the *Study Question Guide* (see Appendix F). As the interview progressed the questions became more focussed on specific aspects that the researcher desired to learn more about, consistent with theoretical sampling (Butler,

Copnell, & Hall, 2018; Glaser, 1978, p. 47). The interview was underpinned by a non-judgemental approach and genuine curiosity about participants' experiences. Interviews were digitally audio-recorded with participant consent and transcribed verbatim immediately afterwards.

The researcher was highly cognisant that "much grounded theory interviewing is very passive listening" (Glaser, 2002b), and was particularly alert to limiting her own interjections in the interview. A subsequent review of the interview transcripts confirmed that the researcher's verbal input was restricted to only those prompts required to support the flow of the interview. At the conclusion of the interview participants were thanked for their participation. Where participants had disclosed issues such as intervening with young people who were suicidal or had experienced abuse, these experiences were acknowledged as difficult and distressing.

2.5.1.5 Field notes

Field notes were recorded in the hours immediately after each interview. The purpose of field notes was to document contextual information, reflect on the main concern of the participant and "capture the essence" (Holton, 2010) of how the participant resolved these concerns. As explained by Glaser (1998, pp. 109-110), digitally audio-recorded interviews capture only words, field notes also capture context and meaning. Two examples are provided below:

August 8, 2017. I realised that when [the participant] came in [for the interview] they'd had a difficult day. I wouldn't say they were tearful but they were very late and looked very weary. I asked if they were okay. [The participant] explained it had simply been an 'ordinary' highly stressful day. In the interview they kept saying they were coping, but all I could think [of] was that line from [Shakespeare's] Hamlet, "the lady doth protest too much, methinks".

August 30, 2017. After the interview [the participant] reported they had recently been away for a break. They'd come back home at short notice due to an unexpected death in the family. Shortly after returning to work they

were referred a Year 7 boy who had put a rope around his neck that morning after the family left for work. He'd been sitting at home with the rope around his neck thinking about hanging himself. He'd decided not to go ahead with it and came to school instead. The participant knew they were emotionally depleted and would have asked a colleague to manage the case but there was no one else available. Subsequent to managing the case the participant reported heightened fearfulness that a young person would die by suicide at school.... [the participant] had the hooks removed from the back of toilet doors as they were worried about ligature points... [the participant] said that these intensely stressful experiences were a significant motivator for their participation in the research interview.

2.5.2 Data analysis

Data analysis was conducted concurrently with data collection using the *constant comparative method of analysis*, a core characteristic of the grounded theory method (Glaser & Strauss, 1967, p. 39). This section commences with an explanation of the constant comparative method of analysis and then examines strategies for managing researcher bias and developing the researcher's *theoretical sensitivity*, another core component of grounded theory (Glaser & Strauss, 1967, p. 46). The section concludes with an examination of the coding processes employed.

2.5.2.1 The constant comparative method of analysis

In grounded theory the method of *constant comparative analysis* is a continuous and iterative task (Holton, 2010) which becomes increasingly theoretical as it progresses (Glaser & Strauss, 1967, pp. 105-106). Glaser and Strauss (1967) described four central stages in the constant comparative method of analysis: "1) *comparing incidents applicable to each category*, 2) *integrating categories and their properties*, 3) *delimiting the theory* and 4) *writing the theory*" (Glaser & Strauss, 1967, p. 105). As instructed by Glaser, the researcher applied the method of constant comparative analysis to all data collected for this study, including the interview transcripts, participant demographic information, field notes, reflective journal and diagrams (Glaser, 1998, p. 8).

The first stage of the constant comparative method of analysis, *comparing incidents applicable to each category*, was undertaken simultaneously with the initial coding of interview transcripts. In this first step the researcher compared incident to incident and sorted incidents into categories with similar properties. Glaser and Strauss (1967, p. 106) emphasised that this facilitates the researcher's awareness of "the full range of types of continua of the category, its dimensions, the conditions under which it is pronounced or minimised, its relation to other categories, and its other properties".

In the second stage of the constant comparative method of analysis the categories and their properties are integrated in as many different ways as possible (Glaser & Strauss, 1967, p. 109). Gaps in category development are identified, and further data is collected to close the gaps. It is through this process of assimilation and refinement of categories that a central or core category starts to emerge (Glaser, 1992). The core category reflects participants' shared common concern and has links to subcategories that explain a pattern of behaviour noted in the study (Glaser, 1978).

In the third stage of the constant comparative method of analysis the core category becomes the focus. This is referred to as *delimiting* (Glaser & Strauss, 1967, pp. 109-110). Coding and categorising continue, but only in relation to those codes and categories with a significant relationship to the core category. Further constant comparative analysis refines the number of categories into higher level concepts (Glaser & Strauss, 1967, p. 109), generating an emerging theory where the core category is central.

The fourth and final stage of the constant comparative method of analysis is *writing the theory* (Glaser & Strauss, 1967, p. 113). During this process the newly developed theory is compared with existing theories already articulated in the literature. This confirms the theory and locates it in the context of the literature.

2.5.2.2 Bracketing researcher bias

Bias is 'any influence that may alter the outcomes of a research study' (Borbasi & Jackson, 2012, p. 271). The preconceptions the researcher brings to the research can contribute to bias, and it therefore critical that the researcher identifies their

expectations and assumptions in a process referred to as 'bracketing' (Borbasi & Jackson, 2012, p. 271). Glaser was not unduly worried about the potential for bias, perceiving that the constant comparative method of analysis would expose and counter these assumptions if the method was properly followed (Glaser, 1998, pp. 72-73).

Although Glaser recommended against extensive reading in the substantive area prior to undertaking grounded theory research (Glaser, 1978, pp. 31-32), he was also of the view that the researcher should select an area of interest (Glaser, 1998, p. 48). As a former public sector secondary school nurse, the researcher was highly motivated to conduct research in this field, especially as she was aware that research investigating the work of this cohort was limited to one journal article (Downie et al., 2002) published almost 20 years previously. The lack of published literature therefore precluded against extensive reading in the substantive area. While university requirements for doctoral candidacy required review of this article, the major literature review for this thesis was undertaken after the substantive theory was developed, consistent with the original method of grounded theory (Glaser & Strauss, 1967). The lack of published literature did help verify the need for, purpose and significance of the study.

A separate consideration was the researcher's current employment in the field, and the potential influence this might have on participants. The researcher holds a clinical nurse specialist role in the Child and Adolescent Health Service - Community Health. This role predominantly provides strategic level support at the organisational level and has no functions in employee recruitment, management or clinical audit, all of which is undertaken by the relevant manager. While the researcher does not have any employment authority over potential participants, the possibility that participants might make assumptions about the researcher's previous knowledge in the field and not articulate their concerns in a comprehensive manner was identified as a risk. To mitigate this risk the researcher emphasised several points at the beginning of each participant interview:

1. Participants were specifically instructed not to assume the researcher had any knowledge of the field. Participants were advised to fully elaborate on their concerns so that these could be transcribed and form part of the research data.
2. Participants were advised that the researcher might ask questions about topics the participant perceived the researcher would have previous knowledge of, but that this should not be a barrier to a fully elaborated response.
3. The researcher specifically indicated to participants that she would remain neutral throughout the interview in order not to influence the direction or content of the interview.

Participants indicated an understanding of these aspects of the research process, confirming that they were cognisant of the distinction between the researcher's employment and research roles.

To further mitigate the risk of bias in relation to the researcher's long history of employment in the field, the researcher engaged with her university supervisors to bracket her assumptions and expectations prior to engaging participants in an interview. The following were identified:

- Public sector secondary school nursing practice in Western Australia would be highly diverse.
- Some secondary school nurses would provide a high level of support to young people experiencing mental health problems.
- Many secondary school nurses would provide a safe space for a distressed young person to retreat to, non-judgemental support for the expression of painful thoughts and feelings, access to preferred self-soothing activities and adult support in the containment of distress.
- Routine supportive health monitoring for young people with mental health problems might include support for reducing harmful drug and alcohol use, stress management, nutrition advice, medication adherence surveillance, liaison with external specialist services and routine suicide risk monitoring.

- Secondary school nurses would identify that being a Western Australia Department of Health employee working in a Department of Education setting could be both a barrier and a facilitator in the care of young people with mental health problems at school.
- Less experienced secondary school nurses might not feel confident caring for young people with mental health.
- A lack of available services might be a barrier to effective referral in some areas.
- Some young people (or their caregiver) would decline, resist or neglect a referral for mental health problems with school-level implications for secondary school nurses.
- Where schools had an expectation that nurses would attend to first aid and illness, nurses would have curtailed opportunities for providing appropriate support and follow up to young people experiencing mental health problems.

2.5.2.3 Theoretical sensitivity

Theoretical sensitivity is a personal characteristic of the researcher and means that the researcher has the cognitive ability to identify important concepts in the data (Holloway, 2008). An essential quality for generating grounded theory, theoretical sensitivity makes it possible to visualise and organise abstract connections in empirical data (Glaser & Holton, 2004), facilitating the transition from a purely descriptive level of enquiry to the conceptual and theoretical level (Willig, 2013). Glaser asserted that some natural theoretical sensitivity is critical even for the novice grounded theorist (Glaser, 2001, p. 16), however theoretical sensitivity is not static, it is developed (Glaser, 1978, p. 3; Glaser & Strauss, 1967, p. 46).

As recommended by Glaser (1978, pp. 19-32), the researcher's theoretical sensitivity was developed by engaging in self-reflection, journaling and reading of substantive grounded theories in unrelated fields. The researcher also engaged in regular reviews of the emerging categories and related theoretical connections with her university

supervisors. The review meetings were digitally audio recorded to provide the researcher with enhanced opportunities for considering theoretical relationships. The research notes generated as part of this process were subsequently analysed using the constant comparative method of analysis.

2.5.2.4 Data preparation for computer management

Each interview for this research was digitally audio-recorded on an Olympus Digital Voice Recorder DS-50 in Windows Media Audio (WMA) format. Transcribed interviews were imported into NVIVO-11 (QSR International, 2016), a qualitative analytical software program. Use of this software facilitated the coding of interviews and category development, but was not used to generate the emerging theory. This is consistent with findings from other studies which show that qualitative analytical software is useful in grounded theory for data storage and category development, but has significant limitations in the generation of theory (Soliman & Kan, 2004).

2.5.2.5 Coding

In grounded theory there are several coding steps: open coding, theoretical coding and selective coding. Open and selective coding are both forms of substantive coding (Holton, 2010), which is oriented to delineating categories and their properties (Walker & Myrick, 2006). Theoretical coding identifies conceptual links between categories (Holloway, 2008) and articulates how the substantive codes relate to each other (Glaser & Holton, 2004). Each will be discussed in turn.

Open coding is the first step and commences shortly after the initial interviews are conducted and transcribed (Holloway, 2008). The data is analysed line-by-line (Willig, 2013), and a descriptive label applied to sections of the text. In grounded theory this process is called “fracturing” the data (Holton, 2010) or “running the data open” (Glaser & Holton, 2004). The goal is to code the data in as many ways as possible, and this often results in a very large number of codes. Coding labels are not predetermined and often use participants’ exact words, referred to as an *in vivo code* (Glaser, 1978, p. 70). In the current study codes were initially applied to typewritten transcripts as shown in figure two, before adopting the use of NVIVO-11 qualitative

analysis software (QSR International, 2016). Continued open coding produced in excess of 600 open codes.

During open coding the researcher also identifies the category to which the data belongs (Glaser, 1992). Similar data is grouped in a category based on common elements (Glaser, 1978, p. 56). The constant comparative method of analysis is employed to explore similarities and differences in the data and comparisons are made “incident to incident, incident to codes, codes to codes, codes to categories, and categories to categories” (Birks & Mills, 2015, p. 11). Coded data that is identified as lying outside existing categories results in the formation of new categories. Some existing categories may also be subsumed or collapsed, and smaller units of meaning will be grouped within each category (Willig, 2013). It is through the iterative process of constant comparative analysis that categories become increasingly refined. Gaps in category development are remediated by further data collection and coding, aided by theoretical sampling. As explained by Glaser, “after sufficient coding and analysis the core emerges: it just has to, as it is on all the participants’ minds one way or another” (Glaser, 1992).

Figure 2

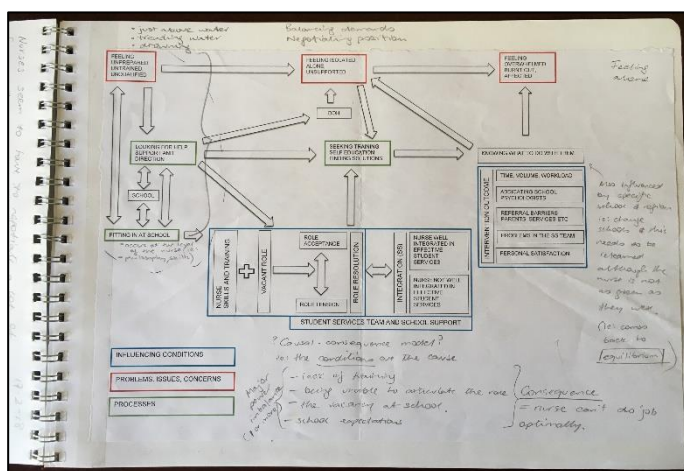
Timespan	Identifier	Content	
00:02:48	AM	So tell me why did you choose school nursing?	
00:02:53	Participant	I always liked that “community health thing” so when I did my training when I first trained I actually did community health down in ██████████ and I worked with a father who had two Aboriginal kids and these kids had not been to school, they had not been immunised, they hadn’t been anything and I walked away from that with him looking at job prospects, kids in school, the kids in uniform, the kids de-nitted, the kids having started their immunisation program... that I’d really achieved something and I quite liked it. I quite liked working there, developing that relationship and working with that person for their goals and to make sure that they got what they needed.	Community health Changing lives Sense of achievement, meaning Relationship with client

The second form of coding is *theoretical coding*. Theoretical coding articulates how the substantive codes relate to each other at the conceptual level (Glaser, 1998, p. 163), weaving “the fractured story back together again” (Glaser, 1978, p. 72). The

intent of theoretical coding is to generate a theory, an integrated set of conceptual hypotheses that explain as much variation in participants' behaviour with as few concepts and categories as possible, principles known as *parsimony and scope* (Glaser & Strauss, 1967, p. 111). The ultimate goal of theoretical coding is to integrate all the categories under the core category, generating a theory that is both explanatory (Glaser, 1998, p. 165) and abstract of the data which informed its development (Glaser & Holton, 2004). At this point the process of theoretical coding is complete (Glaser, 1992).

The researcher was aided in the task of theoretical coding by referring to Glaser's (1978, pp. 74-78) 'theoretical coding families'. Comprising 18 families of theoretical codes, Glaser's guidance assisted the researcher to make theoretical connections between substantive codes and categories, facilitating integration of the theory. Visual and conceptual maps as shown in figure three were developed, to aid in establishing theoretical and hierarchical relationships between substantive categories.

Figure 3



Continued constant comparative analysis permitted the identification of the core category, which is both the main concern of participants (Glaser, 1978, p. 73) and the main variable which "integrates the theoretical findings" (Glaser, 1998, p. 115). It is recognisable to the researcher because it is central to participant concerns, occurs frequently in the data and accounts for variation in participants' behaviour (Glaser,

2001, p. 49). Once the researcher is confident that a core category has emerged, selective coding can commence (Glaser & Holton, 2004).

Selective coding is the second form of substantive coding (Glaser, 1978, p. 61) and is characterised by the researcher's focus on only those codes that have a significant relationship to the core category (Glaser & Holton, 2004). Aided by theoretical sampling (Holloway, 2008), selective coding continues until the core variable, its properties and connections to other categories are sufficiently integrated by the data. When constant comparative analysis identifies no new properties or dimensions of a category, categories are conceptually complete (Holton, 2010). This reduces data to "themes, essences, descriptions, and theories" (Walker & Myrick, 2006) culminating in *theoretical saturation*. Borbasi and Jackson (2012, p. 257) define saturation as the "the point at which sampling and data collection are stopped ... because the information being collected is redundant and repetitive". According to Holloway (2008) saturation is "a particular point in category development," however Willig (2013) disagrees, citing theoretical saturation as a goal, not a precise reality.

In the current study, no new concepts emerged after 31 semi-structured interviews. At this point the categories associated with the core category had been identified, and their properties and dimensions established. For the purposes of study trustworthiness and credibility, theoretical saturation was also confirmed by the researcher's university supervisors' review of data and developed categories.

2.5.2.6 Theoretical memos

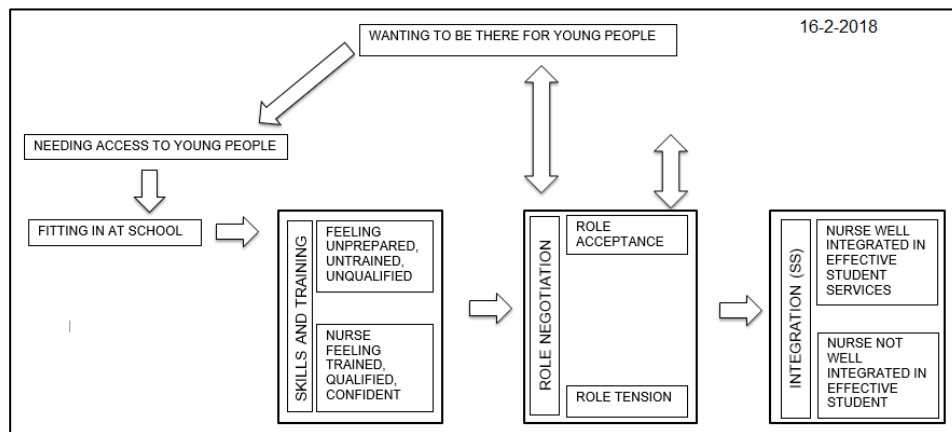
Memos capture theoretical notes about the relationships between categories of data at the conceptual level (Buckley & Waring, 2013). Theoretical memoing is a core task in the grounded theory method, and is undertaken concurrently with coding to document the researcher's developing theoretical ideas (Holton, 2010). Glaser emphasised that ideas about theoretical links in the data should be noted as soon as possible: "the *prime rule* is to *stop and memo* – no matter what [it] interrupts" (Glaser, 1978, p. 83). Consistent with this emphasis, the researcher used several different methods to record contemporaneous theoretical memos for subsequent collection into one *memo fund* (Glaser, 1978, p. 83). Some memos were digitally

audio-recorded into the researcher’s smart phone for later transcription, some were hand-written in a notebook, and others took the form of diagrams and flowcharts. Previously recorded field notes, memos and journal entries were also reviewed to elaborate on conceptual and theoretical ideas (Walker & Myrick, 2006). Examples of theoretical memos are shown below:

Memo, January 26, 2018: *Being there* seems to be one of the categories or sub-categories in the process because it helps resolve the main concern. Nurses want to *be there* for the young person because it seems to be one of the few ways they can have a sense of effectiveness when *wicked problems* can’t be ‘fixed’.

Memo, February 16, 2018 [See figure four]: How does wanting to *be there* for young people relate to other emerging categories such as *fitting in at school* and *integrating at school*?

Figure 4



2.5.2.7 Comparison with existing theories

The penultimate stage of data analysis involves using the constant comparative method of analysis to review the newly developed theory against relevant theories already existing in the literature. This is conducted late in the analysis to minimise pre-conceptualisation of the findings (Glaser, 1978, pp. 50-51). Glaser asserted that existing literature should be woven into the new theory as simply ‘more data’

(Glaser, 1998, p. 67). In this study, formal theories, published research and other doctoral dissertations were reviewed for relevance to the newly developed grounded theory after the theory was first written up. The findings of the literature review are presented in chapter seven.

2.5.3 Writing the grounded theory

The theory generated in the current study was drafted and redrafted over the course of a year, a typical duration of endeavour in grounded theory (Glaser, 1998, p. 14). Importantly, the time available for this task was not limited, permitting a high degree of personal pacing (Glaser, 1978, p. 19). This ensured that the theory was emergent and not imposed, an essential feature of the original method of grounded theory (Holton, 2010).

In writing the grounded theory the researcher presents the conceptual and theoretical elements of the newly developed theory, illustrated by direct quotes from participants. The written manuscript must have due regard for carrying forward conceptual elements so that the reader can understand the links between concepts in the grounded theory (Glaser, 1978, p. 134). The initial write-up commenced in February 2018 by ‘funneling down’ (Glaser, 1998, p. 194) to delimit the main concern, labelled *untenable burden*. Further coding, constant comparative analysis and writing of theoretical memos facilitated the identification of the process participants engaged in to manage the main concern. Subsequently, the conditions which influenced the main concern and the core process were also identified. As emphasised by Glaser (1998, pp. 202-203), extensive reworking and editing of the manuscript were essential in order to produce a “set of integrated conceptual hypotheses systematically generated to produce an inductive theory about a substantive area” (Glaser & Holton, 2004). When the reworking and editing neared a conclusion, the researcher used the constant comparative method of analysis to compare the emerging theory with existing theories, placing it in the context of the literature.

2.5.4 Notations used in this thesis

It is common in Western Australia to refer to secondary school as ‘high school’. Many participants used the term ‘high school’ in their interviews, but for the international reader these have been replaced with the term ‘secondary school’. The following notations are used in this thesis to articulate the substantive theory:

- Participants are identified by a randomly allocated number between one and 31, for example “P11”.
- Conceptual terms with specific relevance for the substantive theory are in italics.
- Where the researcher added information to participant quotes, this was enclosed in square brackets [].

2.5.5 Quality, trustworthiness and transferability of the findings

A number of strategies were employed to ensure the trustworthiness of the data and the transferability of the findings. A grounded theory should be systematically generated, conceptually abstract, have explanatory power for the behaviours noted in the data, be able to accommodate new concepts as they arise and have relevance beyond the substantive area under investigation (Glaser & Strauss, 1967, p. 36). Evaluating the quality of a grounded theory study might therefore be best achieved by using the criteria emphasised by grounded theory’s founders, however other authors disagree, citing the potential for evaluation becoming circular and self-confirming (Elliott & Lazenbatt, 2005). For this reason the researcher evaluated the quality, trustworthiness and transferability of the findings against two sets of criteria.

The first set of criteria were those emphasised by Glaser and Strauss who identified *fit*, *work*, *relevance* and *modifiability* as essential criteria for a quality grounded theory (Glaser, 1978, pp. 4-5). The second set of criteria were those of Lincoln and Guba (1985) comprising *credibility*, *transferability*, *dependability* and *confirmability*. The criteria proposed by Lincoln and Guba (1985) were selected because it is a common framework for evaluating qualitative research and has previously been used

to evaluate grounded theory (Elliott & Lazenbatt, 2005). Each set of criteria will be considered in turn.

2.5.5.1 Fit, relevance, work and modifiability

In their seminal work, Glaser and Strauss emphasised that a quality grounded theory must have *fit*, *relevance* and *work* (Glaser, 1978, pp. 4-5). Glaser later expanded this list to include a fourth criteria, *modifiability* (Glaser, 1978, pp. 4-5). As these criteria are applied after the theory is generated, the most salient factor in a credible grounded theory is close adherence to the method described by Glaser and Strauss (1967). To achieve this, the researcher had the benefit of university research supervisors with extensive experience of grounded theory who provided mentoring consistent with Glaser's recommendations (Glaser, 1998, p. 5). The researcher also read widely on grounded theory, particularly the seminal text by Glaser and Strauss (1967) and subsequent original texts by Glaser (1965, 1978, 1992, 1994, 1998, 2001, 2002a, 2002b) and Glaser and Holton (2004). Outside of the original sources, guidance from other authors was limited to those articles and books that were consistent with the original method of grounded theory.

In addition to the measures described above, the emerging theory was constantly evaluated during sequential write-ups for fit, relevance, work and modifiability as described by Glaser (1978, pp. 4-5). According to Glaser *fit* is synonymous with validity and questions whether "the concept represent(s) the pattern of data it purports to denote" (Glaser, 1998, p. 236). *Fit* is a function of close adherence to grounded theory methodology, where concepts are generated from data and not 'forced' or 'received' (Glaser, 1998, p. 236). *Relevance* flows from *fit*, as concepts that fit will be highly relevant to participants, in the form of a shared common concern and core process for continually resolving the main concern (Glaser, 1998, p. 236). According to Glaser (1998, p. 237) it is only in the context of fit and relevance that the core category can be integrated and the substantive theory *work*. That is, a substantive theory that *works* has meaning to participants and feels familiar (Glaser, 1998, p. 237). The fourth criteria, *modifiability* is an inherent function of the method of constant comparative analysis and theoretical sampling. The substantive

theory reported in this thesis was refined and reworked as new concepts were identified, attesting to modifiability.

Future research may seek to test the fit, relevance, workability and modifiability of the substantive theory presented in this thesis. The researcher will also seek opportunities to share the findings of this study at future meetings with public sector secondary school nurses to confirm if study findings resonate with participants. ‘Checking’ of results or validation processes with participants are not requirements of grounded theory (Cheer et al., 2016) but present future opportunities to expand on the work initiated in this thesis.

2.5.5.2 Credibility, transferability, dependability and confirmability

According to the criteria proposed by Lincoln and Guba (1985), key elements of excellence in qualitative research include *credibility, transferability, dependability* and *confirmability*. In the current study, clear evidence that the original method of grounded theory was adhered to is essential to meet the criteria of *credibility*.

Credibility is further enhanced when there is evidence for the application of core processes such as concurrent data collection and analysis, application of the method of constant comparative analysis, theoretical memoing and theoretical sampling.

Other strategies to enhance credibility of the current study included the prolonged engagement in the field, checking of interview transcripts against digital audio recordings for errors, joint-coding of interviews with university supervisors for feedback purposes, researcher confirmation that participant quotes were used in their proper context and regular discussions with the researcher’s university supervisors about the emerging findings. Credibility was also enhanced by the achievement of data saturation. Glaser and Strauss defined saturation as meaning that “no additional data are being found whereby the sociologist can develop properties of the category” (Glaser & Strauss, 1967, p. 61). Confirmation that data saturation had been achieved was confirmed by the researcher’s university supervisors.

A grounded theory has inherent *transferability* owing to its design. Being conceptual in nature, grounded theory transcends specific experiences and is abstract of people,

place and time (Artinian, Giske, & Cone, 2009, p. 12). *Dependability* is the degree to which there is enough information to replicate a qualitative study (Bitsch, 2005); it is highly reliant on a clear audit trail, detailed research processes, and transparency in relation to methodological decisions. In the current study several factors contributed to the study's dependability: close adherence to the original method of grounded theory, research supervisors with specialist expertise in grounded theory, and regular supervision meetings with the researcher's university supervisors. *Confirmability* is "the degree to which the findings of the research study could be confirmed by other researchers" (Korstjens & Moser, 2018). As with dependability the essential requirement for meeting confirmability is to use clearly articulated processes with a detailed audit trail to explain methodological decisions. Close adherence to the original method of grounded theory, audio-recorded discussions with the researcher's university supervisors in relation to methodological decisions and extensive memoing contribute significantly to this study having a high degree of confirmability.

2.6 Ethical considerations

Prior to conducting field work, the researcher addressed the ethical implications of the study and considered how participants would be protected. The researcher obtained ethics approval for the proposed research from the Child and Adolescent Health Service Human Research Ethics Committee in Perth, Western Australia, as shown in Appendix G with approval number RGS 00056. Reciprocal ethics approval was granted by Curtin University Human Ethics Committee, as shown in Appendix H. The Child and Adolescent Health Service - Community Health and the Western Australia Country Health Service provided governance approval for the conduct of the research in their respective health services, as shown in Appendix I and J. The remainder of this section examines processes for gaining participant consent, provision for withdrawal from the study, considerations in relation to participant privacy, confidentiality and anonymity, minimising the risk of harm to participants, and data storage, access and disposal.

2.6.1 Informed consent

The Study Information Sheet (Appendix C) and Participant Consent Form (Appendix D) were provided to potential participants in electronic form prior to recruitment. The Study Information Sheet provided written information about the nature and purpose of the study, and emphasised the private and confidential nature of participation. The Participant Consent Form specifically sought permission to audio-record the interview. Each participant was provided with a paper copy of the Study Information Sheet at interview and the information was verbally reiterated by the researcher to ensure voluntary participation.

2.6.2 Withdrawal from the study

The Study Information Sheet also explained participants' right to withdraw their consent at any time prior to, during, or after the interview, without reason or penalty. No participants withdrew their consent to participate at any stage of the study.

2.6.3 Privacy, confidentiality and anonymity

Throughout the research the privacy of participants was maintained by conducting interviews in a private setting of the participant's choosing. The majority of interviews were conducted in a private room at the participant's community health work base where confidentiality could be assured. Three interviews were conducted in an alternative location at the request of the participant: two in a public outdoor setting and one in a public indoor location. In these circumstances confidentiality was maintained by undertaking the interviews away from the presence of others and pausing the interview when there was a passer-by or other circumstance where there was a risk the participant could be overheard. The 10 rural and regional participants provided telephone contact details for their work base or a personal mobile phone number and took responsibility for arranging to be in a preferred and private location at the time of interview.

The majority of interviews were transcribed verbatim immediately after the interview, with the exception of identifying features such as names and locations. All transcription activities were undertaken by the researcher assuring participant

confidentiality. Each audio file was allocated a 12 digit reference number in the form of the date and time the interview was conducted. For example, the interview conducted on February 20, 2017 at 1130 was denoted in the date/time format as 200220171130. The researcher held a separate, password protected digital diary indicating the name of the person who was interviewed at that time and date. This information was stored separately from other data associated with the research.

The 12 digit reference number was replaced with a participant identity number between 1 and 31 (eg: 'P6') when the findings were written up and the sample size known. Participant identifiers were randomly allocated and do not indicate the order of interview, further protecting participant confidentiality.

2.6.4 Minimising risk of harm

The researcher considered the possibility that some participants may become distressed as a consequence of recounting difficult experiences. An *Adverse Event Protocol* (see Appendix K) was outlined for this purpose in the research protocol. As an experienced mental health nurse the researcher has well-developed skills in responding to emotional distress and was equipped to implement strategies such as being vigilant about the potential for distress, provision of immediate therapeutic support and assistance with arranging ongoing care if required (Kavanaugh & Ayres, 1998).

The majority of participants did not require specific debriefing. Five participants required up to 30 minutes of non-specific debriefing with the researcher immediately after the interview, and one participant required further support as per the Adverse Event Protocol. This participant became sufficiently distressed that the researcher offered to terminate the interview to which the participant agreed. During subsequent phone calls for the purposes of support and monitoring this participant was reminded of the option to withdraw consent to use the interview data. The participant declined to do so, citing emotional distress in the context of professional stressors as a partial motivation for their participation. The additional support provided to this participant involved three further phone calls over the subsequent 10 days and was concluded when it was ascertained that the participant had accessed adequate ongoing support.

As outlined in the Adverse Event Protocol a de-identified report was submitted to the Child and Adolescent Health Service Human Research Ethics Committee and the Curtin University Human Research Ethics Committee, who advised the researcher that no further follow-up was required.

2.6.5 Data storage, access and disposal

Research data management includes the “planning, creating, storing, organising, accessing, sharing, describing, publishing and curating of data” (Curtin University, 2018). In preparation for undertaking this study the researcher developed a *Data Management Plan* (Appendix L), in fulfilment of Curtin University’s Research Data and Primary Materials Policy (Curtin University, 2014). The Data Management Plan was also reviewed in the process of gaining ethics and governance approvals from the Child and Adolescent Health Service and Western Australian Country Health Service where this research was conducted.

Immediately after each interview the audio-recorded digital file was transferred to the secure research drive at Curtin University and a backup copy made to an encrypted drive on a password protected computer and locked in the researcher’s home office. The original digital file was then deleted from the digital voice recorder, consistent with the Data Management Plan (Appendix L). As per Curtin University’s Research Data and Primary Materials Policy (Curtin University, 2014), all records will be securely held for a period of seven years and subsequently destroyed in line with Western Australian standards at that time.

2.7 Summary

This chapter provided an overview of the original method of grounded theory as developed by Glaser and Strauss (1967) and subsequently by Glaser (1978; 1992; 1994, 1998, 2001, 2002a, 2002b; 2004). The rationale for this choice of methodology in relation to investigating the experiences of secondary school nurses who encounter young people with mental health problems was explained. Application of the grounded theory method for the current study was discussed, including sampling and recruitment, processes related to concurrent data collection and analysis, coding

procedures and ethical considerations. Strategies employed to ensure the trustworthiness, quality and transferability of the findings were presented next, with the aid of two frameworks: that of Glaser and Strauss (1967), and of Lincoln and Guba (1985). The chapter concluded with a brief outline of the major findings and an introduction to the *substantive theory of tactical prioritising to manage the problem of untenable burden*. Chapters three to six provide a detailed explanation of the newly developed substantive theory, with participants quotes to provide a rich description.

CHAPTER 3

THE BASIC SOCIAL PSYCHOLOGICAL PROBLEM: UNTENABLE BURDEN

The reader should note that some participant experiences described in the next four chapters have the potential to be unsettling or distressing and include reflections on child abuse, deliberate self-harm and suicide risk.

3.1 Introduction

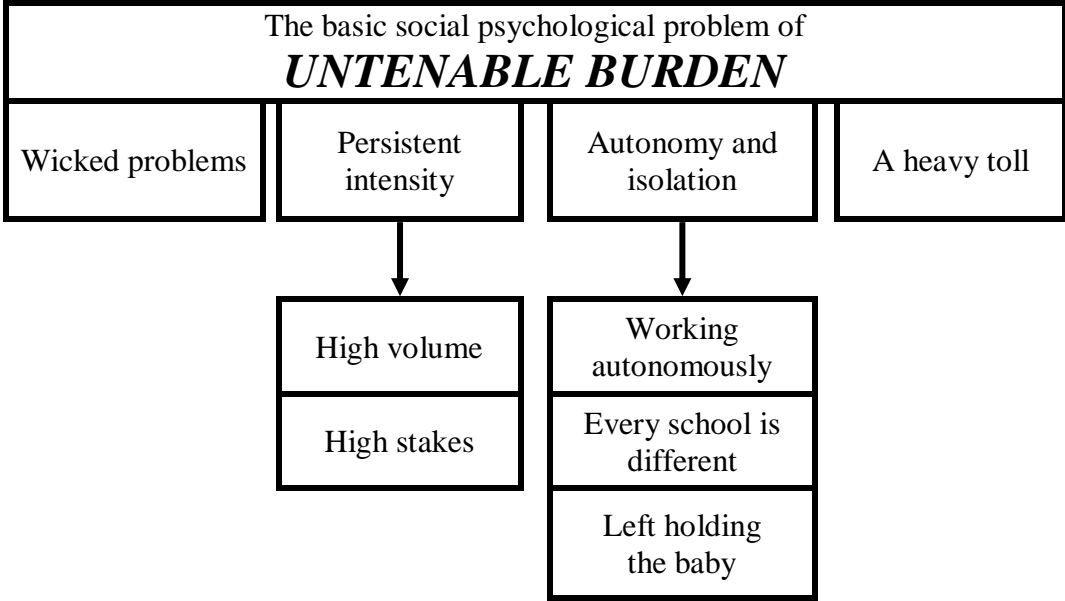
This chapter presents the basic social psychological problem that public sector secondary school nurse participants faced in their work with young people experiencing mental health problems. The grounded theory method was used to identify the basic social psychological problem by seeking the main issue, problem or concern for study participants. Also known as the ‘core category’ or ‘shared common concern’, the basic social psychological problem has links to subcategories that explain a pattern of behaviour noted in the study (Glaser, 1978). According to Glaser (1998, p. 115) the basic social psychological problem "revolves around the main concern for participants whose behaviour continually resolves their concern. It is what is going on! It emerges as the overriding pattern".

In this study, the main problem which participants sought to manage was the experience of *untenable burden*. The Australian Macquarie Dictionary defines the word *untenable* as a position that is “incapable of being defended” (untenable, n.d.). The same dictionary defines a *burden* as “that which is borne with difficulty” (burden, n.d.). There were four categories in the core problem of *untenable burden*: 1) *wicked problems*, 2) *persistent intensity*, 3) *autonomy and isolation* and 4) *a heavy toll*. The four categories are illustrated in figure five.

Participants were motivated to engage with young people experiencing mental health problems and perceived that supporting this cohort was an important part of their role, but they experienced *untenable burden* in consequence of high clinical complexity and intensity which they negotiated with limited support. This frequently resulted in nurses experiencing distress. Although participants encountered the basic

social psychological problem of *untenable burden* in varying degrees and intensity, it was faced by the majority of participants in this study. The shared common concern was articulated in words and in expressed emotions, manifesting itself in myriad ways from feeling ambushed by the complexity and autonomy of the work when first starting in the role, to worry when appropriate specialist care for young people could not be sourced, to strong fears that a student would die by suicide.

Figure 5



This chapter provides a detailed account of the basic social psychological problem of *untenable burden*. To orientate the reader, a brief overview of the substantive theory is first provided in the next section.

3.2 Overview of the major findings

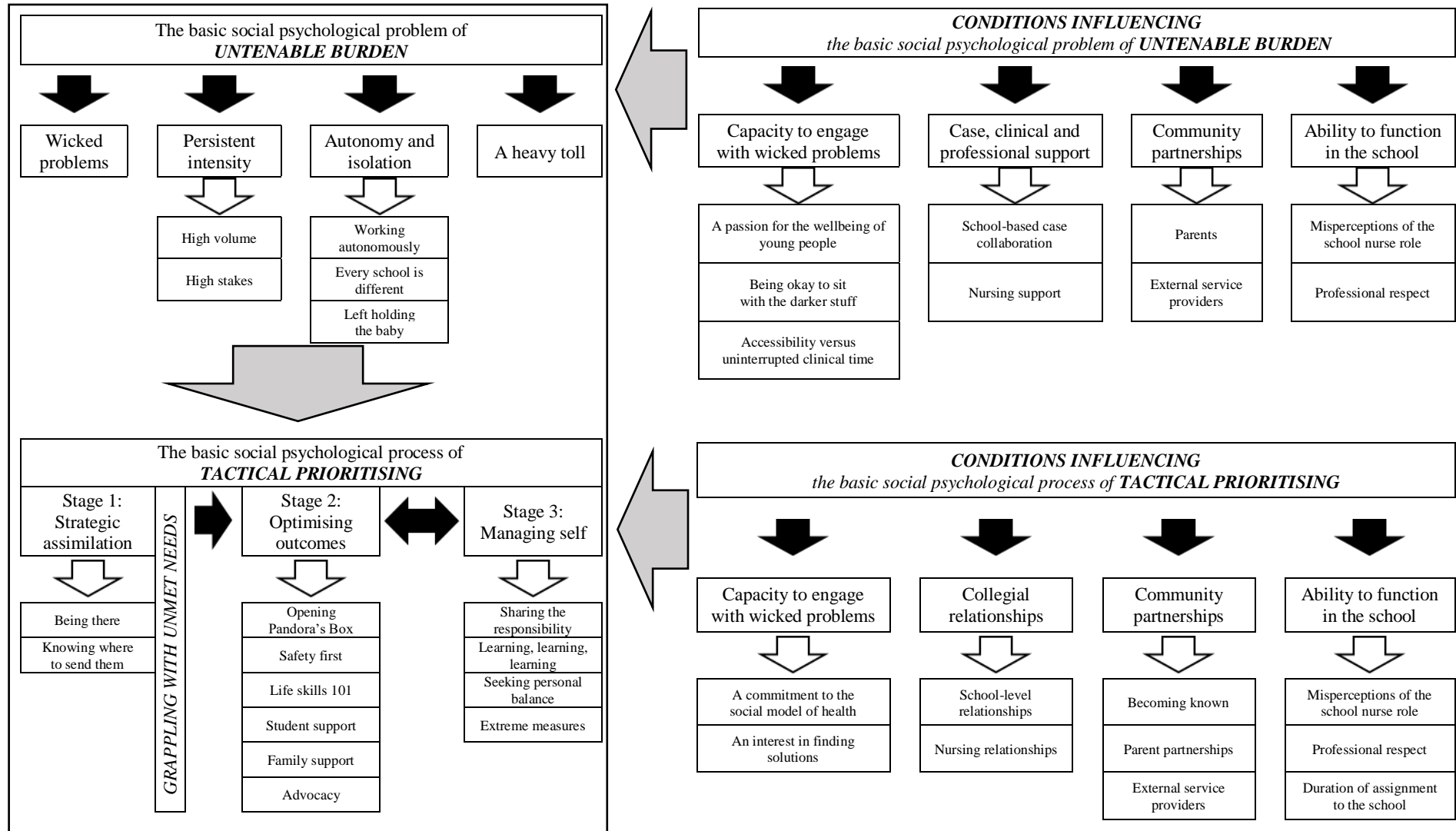
The *substantive theory of tactical prioritising to manage the problem of untenable burden* is presented in this thesis and shown in figure six. The theory provides a framework for understanding the experiences of Western Australian secondary school nurses who encounter young people with mental health problems, and the process they engage in to manage the shared common concern of *untenable burden*.

The basic social psychological process of *tactical prioritising* conceptualises how school nurse participants managed the clinical, professional and personal factors that contributed to the problem of *untenable burden*. There were three stages in the core process of *tactical prioritising*: *strategic assimilation*, *optimising outcomes* and *managing self*, each of which had a different focus. The stages were not always strictly sequential. Participants engaged in *tactical prioritising* by selecting the stage that best assisted management of *untenable burden* at that point in time.

In stage one participants engaged in *strategic assimilation* at the level of the school. *Persistent intensity* and *a heavy toll* were negligible at this point, but *strategic assimilation* facilitated clinical effectiveness and promoted the participant's sense of belonging. This in turn diminished participant's feelings of *isolation*. Stages one and two were separated by a tipping point labelled *grappling with unmet needs*. When participants had achieved a level of *strategic assimilation* and became known in their assigned school, their experiences of *untenable burden* escalated as the *persistent intensity* and complexity of young people's *wicked problems* became increasingly evident. Routine methods for managing these problems, such as referring the young person to another service provider did not always resolve the difficulties, leaving the participant *grappling with unmet needs*. In stage two participants responded to *grappling with unmet needs* by developing a toolbox of strategies and techniques for working with young people, with the aim of *optimising outcomes* and getting young people through their difficulties. *Optimising outcomes* meant supporting young people to cope with the *wicked problems* in their lives. This in turn enhanced participants' feelings of effectiveness as an *autonomous* practitioner. Stages two and three were concurrent. In stage three participants engaged in *managing self by* undertaking activities that promoted and maintained their wellbeing in the face of *wicked problems*, *persistent intensity*, *autonomy and isolation* and *a heavy toll*. Very experienced clinicians could engage in seamless *tactical prioritising* such that all three stages were undertaken in a near simultaneous manner. Although the substantive area is Western Australian nurses working in public sector secondary schools, the ideas presented in this thesis are potentially generalisable to other areas where individuals are trying to survive an *untenable burden* by *tactical prioritising*.

Figure 6

THE SUBSTANTIVE THEORY OF TACTICAL PRIORITISING TO MANAGE THE PROBLEM OF UNTENABLE BURDEN



The remainder of this chapter provides a detailed outline of the categories in the basic social psychological problem of *untenable burden*. Direct quotes are provided to give a thick description of participant experiences.

3.3 Wicked problems

The first category in the basic social psychological problem of *untenable burden* was conceptualised as *wicked problems*. The term “wicked problems” was first used by Rittel and Webber (1973) to describe problems that have multiple causes, are not easily solvable and do not have a specific right answer. Rittel and Webber (1973) asserted that every wicked problem is unique and may be a symptom of another problem, making wicked problems difficult to describe. To add to the complexity, attempted solutions to wicked problems may lead to unforeseen outcomes that may not be reversible. As outlined in this section, the category *wicked problems* conceptualises the complex circumstances with which young people frequently presented to participants.

By definition, *wicked problems* were not limited to what happened at school. Many participants described clinical cases that went well beyond the school walls, affected multiple systems in the young person’s life, were frequently ongoing and difficult to resolve:

I had this girl self-harming. Year 12 I think she might have been, and her family issues weren’t [being dealt with]. The father had left her to go to [location], left her in his house, with the older brother who [used] drugs. He didn’t provide money for her... She came in one day with [self-harm] cuts and [I] did all the appropriate things... we tried to link her up with Centrelink [government financial support], [and the] Department for Child Protection and Family Support because she was an older [student]. She just wanted to finish Year 12 but she didn’t have any [home] support. (P2)

Participants embraced the broad context and reported that caring for young people experiencing *wicked problems* aligned with community health nursing and the employer expectations of the role. For this reason, having an ecological understanding of the young person’s life was very important: “it’s not a child in

isolation. It's a child within a peer group, within a family, within the community and the school" (P31).

The extent of *wicked problems* not uncommonly took participants by surprise when they first commenced working as a secondary school nurse: "I wasn't prepared for the scope of their problems" (P23); "I was not prepared to handle the amount of mental health... and [the seriousness of] mental health conditions that are coming through my door" (P11); "there's a lot more mental health than I expected" (P3); "I didn't realize there would be that much [mental health]" (P26).

Wicked problems ranged from highly stressful but transient life circumstances to complex ongoing difficulties: "things like parents in prison, or parents dying or parents with mental health issues, things like that" (P5). The breadth of clinical concerns precipitated by *wicked problems* was significant:

[Presenting issues] can range from anxiety, suicidal [ideation], self-injury, bereavement, relationship breakdown, peer conflict, family issues at home, drug and alcohol dependant parents, exam stress, sexual health issues... just anything and everything that walks through the door, a really wide range.
(P30)

Clinical cases frequently precipitated extensive interagency contact:

I do a lot of referrals to Child and Adolescent Mental Health Services [for] kids with self-harming, suicide ideation, anxiety [and] depression. [I'm] starting to see some more eating disorders now as well. [There are] disclosures of abuse - physical, sexual, emotional. [I'm] doing a lot of reporting to [the Department for] *Child Protection and Family Support*. (P31)

In some schools, the proportion of young people experiencing *wicked problems* was particularly high: "about 50-70% of students at the school [are] impacted by either poverty or [dysfunctional] family dynamics or substance use. It's huge. It is huge" (P31). Several participants who had been employed as secondary school nurses for a long duration commented that the acuity and complexity of *wicked problems* had increased in recent years: "the nature of issues that young people are presenting with

has gradually become [more complex] ... Over the last [few] years I've noticed that there's more and more social [and] mental health issues" (P28). Another participant explained:

Starting off [as a secondary school nurse many years ago], it was, I wouldn't say rare, but... very infrequent that I got the assessments that I get now. The students that I get now... the degree where they're socially, emotionally, mentally [impacted]... The issues I would say, have increased [in acuity and complexity]. (P2)

To gain insight into young people's *wicked problems* participants reported undertaking a structured adolescent psychosocial assessment. It was typically through this assessment that *wicked problems* were uncovered. Consistent with the term *wicked problems*, the psychosocial assessment often indicated a range of inter-related concerns: "most of these kids it's not just one thing. It's a majority of different things that are pulling them down" (P17); "it's often not just one thing, it's often a huge lot of things together" (P29).

For many young people, complex difficulties at home precipitated mental health problems: "a lot of the kids' mental illness is situational, it's family-based that they're coping with" (P10); "a lot of it [impacts] their mental health because there's so much stuff happening in the homes" (P20); "the parents have got drug issues or [are] alcoholic, [there are] abuse or relationship issues. [Young people's] problems seem to stem from that" (P1). Significant reports of family and domestic violence were not uncommon:

Dad hit the [son] and he flew into the shower glass. It didn't smash, but... the sisters have come to school absolutely shaken because they thought [the father] was going to kill him, that he was going to get cut, because [the father] kept on punching him. (P31)

A commonly cited factor in young people's mental health problems were parents who were unable to provide sufficient effective parenting to their young person:

They might have parents who are so incapacitated and so overwhelmed with everything that they're not given any guidance, and this is where I find a lot of students with mental health issues... They don't have good parenting. (P21)

I've [had] him seen at [the] Child and Adolescent Mental Health Service. They've all said "[there's] nothing wrong with him." [The mother's] got another child that he babysits. There's little parental involvement with that [child]... it's a parenting issue really. (P18)

Looking at the kids and the way that they've been brought up at home. The parenting, the drug and alcohol use, the trauma, the abuse, the neglect. I see that that's gone on for a long time, a lot of years. Parents have gone through the same as well [had a similar upbringing]. (P7)

One participant illustrated how a young person could appear to be provided for but was actually lacking in essential parental input:

Mum was a lawyer, dad was [a] doctor or surgeon. They were never home. He had the credit card to do whatever he wanted, order in whatever he wanted, so he ordered in his weekly dose of cocaine as well. (P6)

Not unexpectedly, family breakdown was a common source of grief for young people because it typically resulted in having less access to the non-resident parent. For some young people, a single parents' efforts to put food on the table led to ramifications that were more significant:

Her mother is fly-in-fly-out [flying to a remote area of Western Australia for employment] ... away for four weeks and home for one. From the time I met her when she was only 14, she was living at home by herself, with the aunt-neighbour down the street who helped, but she actually had the house to herself. She had no one else in the house, four weeks out of five. (P3)

Although family breakdown did not always reflect family dysfunction, the consequences of a fractious family breakdown could have particularly significant effects on the mental health of young people:

One student we have has been going through a Family Court case for some time. She has panic episodes at school and out of school. She is seeing someone externally [for treatment], but we still have her on our books [for support at school]. (P22)

At the extreme end, some young people found themselves homeless in the context of family breakdown:

She's Year 10, so she's 15. She lived with her mother and [her] parents are [separated]. She lived with her mum and they fell out [became estranged, prompting the girl to leave her mother's home]. Dad doesn't want her, he told the teachers he doesn't want her... She's a wreck. I've seen her, she looks absolutely terrible... [with] self-harm wounds up both her arms. (P29)

Some young people were attempting to cope with the permanent absence of a parent, and presentations for grief and bereavement were common:

He's Year 10. Very sadly last year his dad died very suddenly. Within a very short period of time his grandfather, who also lived with him died... He didn't want to talk about it, he just wanted to go along as normal... But it seems he hasn't been coping. We weren't aware until he just stopped coming to school. (P19)

Other young people were bereaved as a result of parent suicide:

We have a little Year 8 boy [who] has a really difficult family life. His mother has killed herself. He has [attention deficit hyperactivity disorder], he lives in a difficult family situation with his dad. He's grossly overweight, he gets picked on, he picks on people, he fights, he's in trouble at school. (P29)

Some participants expressed feeling quite surprised at the home lives some young people reported: "I'm blown away by the number of children that are living in circumstances that are really quite detrimental to their wellbeing" (P31); "I did [find it] quite surprising to realise what some young people have [to deal with], what they're home lives look like... that they can function and get on with life to some degree" (P24).

Children in the care of the state (the Department for Child Protection and Family Support) were frequently known to participants because an interagency Memorandum of Understanding required all children in state care to have an annual health assessment which was conducted by participants: “we get a lot of students under the care of the Department for Child Protection and Family Support, [in] foster care or living with other families” (P16). Although participants reported that many children in the care of the Department for Child Protection and Family Support were living in stable and supportive homes, this was not always so. One participant described a young woman she worked with who had experienced multiple out-of-home placements as a child, became a mother while still an adolescent and had her own child removed in a scenario that threatened to repeat her life story:

I've come across a couple of teenagers who have babies now. One was really poignant in that the girl had had 34 foster homes. [Then she] had had her own baby, and within two days of taking that baby home, [the] baby is in foster care. (P7)

Knowledge about the home circumstances of a young person typically led participants to view the young person's behaviour through a different lens:

It frustrates me [that] they get those labels of being a ratbag and rebellious kid. You're privy to know what goes on at home, [and] you feel like saying to people “you know what? If you lived in that life you'd be behaving the same way.” (P24)

Home lives were not the only source of stress for young people. Academic demands were also a cause of young people's problems: “our students are very high achievers and put a lot of pressure on themselves to achieve. They compare themselves to others, which is never good. We also have parents put a lot of pressure on students” (P19). Similar concerns could arise at the other end of the continuum:

We have students in Year 10, with a reading level of about Year 3. A good proportion of those students can't read the *West Australian* [newspaper]. Around 40% of our Year 10 students [15-16 year olds], of which we have around 300... are not at the reading level of an 11 year old child. (P22)

As demonstrated by the quotes above, there were multiple complex contributors and consequences of young people's *wicked problems*, and these young people often required intensive and ongoing support.

3.4 Persistent intensity

Persistent intensity was the second category in the basic social psychological problem of *untenable burden* as participants reported that young people experiencing *wicked problems* were frequent visitors to the school health centre and often presented with complex and risky clinical scenarios. There were two aspects to the category of *persistent intensity*: 1) *high volume* and 2) *high stakes*.

3.4.1 High volume

Almost all the participants interviewed for this research reported that they had daily contact with young people experiencing mental health problems, reflecting both individual frequent presenters and the scale of young people seeking help: "the majority of my work is around mental health, social health, neglect, abuse, poverty" (P28); "my day to day contact [with young people attending] health clinics is mostly social and emotional health" (P29); "pretty much everything I do now is mental health" (P17). Although untreated mental health problems were a common reason why young people persistently presented to participants, young people who were receiving treatment were often also persistent presenters. Participants who had limited experience as a secondary school nurse sometimes found this vexing, but more experienced participants were very aware that young people receiving treatment were not precluded from experiencing symptoms of mental ill health at school.

It was evident early in the study that many participants were faced with student problems of significant complexity, but this was not necessarily how young people first presented. Initial presentations were often for a discrete issue which was usually trivial and frequently fell outside the role description. Minor illness and injury were frequent motives for presentation despite the role description specifying that

participants were employed to address the social determinants of health and managing minor illness and injury remained the responsibility of the school:

Our job description is not to see the kids that have got small illnesses and ailments. However, if you're not nice to them when they come in [with a minor ailment] ... they're not going to come back when they've got a real problem if they think you're unapproachable. So that's a really difficult balance. (P29)

Although responses to this conundrum varied, all nurse participants had opportunities for young people to drop-in for any reason including for minor illness and injury ("open clinics"). Many nurse participants perceived that providing support for minor illness and injury facilitated an opportunity to investigate further:

I've stopped fighting it [minor illness and injury] because many of the children I've seen with "not feeling well," headache, tummy-ache, they're all presenting with mental health issues. I see first aid as a step-in, rather than a step out of my role. (P31)

Like the quoted participant, many participants reported that assessment beyond the presenting issue typically revealed a more complicated picture, as described in *wicked problems*.

Another common reason for presentation to the school health centre was for emotional distress. At the most recognisable level this included tearfulness: "they're knocking on the door crying" (P26); "They self-present to my door and come out with something, or they're crying..." (P29); "sometimes they come in and they're just tearful and they'll disclose all sorts of things" (P16). At other times young people presented to participants for assistance with anger or panic: "a lot of students... if they're feeling a bit overwhelmed or panicky or anxious or not safe, they will automatically come to my room" (P4). Another participant described de-escalating a young person's intense feelings:

[I said] "Okay, let's do some deep breathing. What specifically set you off?
... Has your counsellor given you anything to work on in between

[appointments]? ... [Let's] spend 10 or 15 minutes sitting down and thinking about that and trying to refocus your attention onto that, rather than what's just happened'. (P6)

Some young people clearly felt there was nowhere else to go:

I had a child once kick the door [to the health centre] off the hinges... because they wanted to come and see me. They were quite stressed. They tried to get in and it was locked so they kicked the door off the hinges.... I was behind another door... I could hear [the noise] because I was on the phone... I didn't know what was happening... They kicked the [health centre] door in and then knocked quietly on [my office door] At first it was quite alarming, but later on I thought... at least I'm seen as someone who can help them when they're desperate. (P27)

When young people presented with intensely distressing emotions, some participants could describe how they might get a better sense of what was happening in the young person's emotional landscape:

Validating, "yes, I understand you have those sorts of feelings, that you have these thoughts. Tell me more about it. When does it happen? How does it occur? How do you deal with it? What are your strengths? Do you do anything to distract yourself? Do you have support people?" (P11)

Further probing typically led to a comprehensive adolescent psychosocial assessment which could be very time-consuming: "that can take me a good hour to do" (P2); "sometimes I can spend two or three hours with one student" (P8). Participants reflected that there were multiple reasons why these assessments were time-consuming:

If they're very basic, [a psychosocial assessment] will take at least an hour...a child with multiple issues could be three hours... [or conducted] over a period of two or three days or a week, because there is so much to discuss, and so much ... to refer or support with. (P17)

It's not just the face-to-face contact because it takes such a long time to write up your contacts. To write up [a psychosocial assessment] well is very time consuming. Then [writing] the summary, the action plan, and any referrals that you need to do. (P30)

Although referral to more specialist mental health services was identified as a core component of school nurse practice, participants identified numerous barriers to this which are detailed in chapter four. For this reason, untreated mental ill health was a significant contributor to *high volume*: “you're stuck because they haven't got any help so they're going to be a repeat appearance over and over until such time as they do get looked after” (P23). Participants often felt reassured when a young person was receiving specialist mental health treatment, but *high volume* often continued. Many participants spoke at some length about the general sequela of mental ill health that schools had to manage on a daily basis, including risk for suicide, distress and crises. To use the words of one participant: “mental health and those sorts of issues are much more ongoing and much more non-specific [than physical health issues]” (P5).

Responding to distress and crises were not the only contributors to *high volume*. Participants also described undertaking a broad variety of clinical work with young people experiencing mental health problems that ranged from prevention to optimising general development. For example, one participant described a situation where a young adolescent had inadvisably shared with a peer that she had a history of child sexual abuse. Being alert to the potential ramifications for the adolescent should such a disclosure become known among a larger group of students, the participant took assertive action to: “protect [the student] from being vulnerable to what kids will do with this information [having been sexually abused]” (P31). Many participants also reported pre-emptively and assertively monitoring young people with known mental health and wellbeing concerns:

I could probably name 10 or 11 students at the moment that I would check in on nearly every week. Especially Monday. Monday is difficult because things may have happened on the weekend. Tuesday is difficult for the ones that also use cannabis, because they tend to fall in a heap on Tuesday mornings [due to symptoms of cannabis withdrawal after weekend use]. (P29)

It was common for participants to intervene with young people who presented with distress, but not all such situations were for low level concerns. The next section examines how *persistent intensity* could involve high clinical risk.

3.4.2 *High stakes*

Participants reported that they often responded to young people at known risk of self-harm or suicide who presented with feelings of wanting to hurt themselves: “the kids will come to you and say ‘I don’t feel safe’, which [means] ‘I don’t feel safe that I’m not going to harm myself’” (P29); “she came to me one afternoon [and said] ‘I feel terrible, I feel unsafe, I feel like I’m going to go and harm myself. I don’t feel that I can keep myself safe’” (P18). This aspect of *persistent intensity* was conceptualised as *high stakes*.

In the Cambridge English Dictionary, the term *high stakes* is defined as “the potential for serious risk of loss if there is no success in an endeavour” (high stakes, n.d.). The term *high stakes* reflected participant awareness that a failure to intervene effectively could result in significant consequences for the young person, including school disengagement and suicide. In *high stakes* clinical scenarios participants needed to be able to respond effectively to volatile crisis situations:

It all became too much for him and he decided that this particular day he’d had enough... he had written a [suicide] note and it was found. He was going to run out in front of a bus in front of the school and kill himself. So the school psychologist was called, she then called me, he then did a runner [tried to run away], and we literally held on to each of his arms. We had 10 minutes before the end of the day. [The] school bell was going and we were right out the front of the school. Student Services were trying to get hold of dad to say we need you to come and collect your son and take him to a doctor or Emergency Department. I used every single skill and tactic that I could, to try, rather than dragging him back physically into Student Services, to preserve his dignity but also to protect the other children as well. Because he was really distressed, he was crying, he was sobbing, he was dribbling, he was just – yeah. (P21)

Typically these situations occurred in the context of a school-based *Risk Management Plan* which identified the participant as a safe individual when the student was feeling distressed with thoughts of self-harm or suicide. Although the number of students on a Risk Management Plan varied, in many schools a significant number of students were monitored for this purpose: “we’ve got about 45 [students on Risk Management Plans]” (P29); “we’ve got 15 students on a Risk Management Plan, purely for suicidal disclosure” (P31). Students on Risk Management Plans were subject to much closer monitoring than other students:

We need to be aware of where they are at all times. It’s down to the teacher to mark their roles... [If the] student’s not here... the teacher will inform myself, the school psychologist and administration staff, whoever they get hold of, [to] say ‘this student is not where they’re meant to be’. Then one of us would follow that up and find out where they are. Obviously it’s a big school, you can’t go searching because you could be walking around one half of the school, they could be walking around the other half. So you check the usual [places]. [For example] I know this girl sometimes goes to the toilet or the arts [studio]. If within five or 10 minutes you can’t ascertain where they are, it’s a [phone] call to [the] parents, saying ‘your child isn’t in class. Please can you call their mobile?’ That normally ascertains where they are. (P29)

Some participants worked in schools that had been disproportionately impacted by suicide: “in my initial three years at the school we had two students suicide, an ex-student suicide [and] four parents suicide. It was very pointy-end [acute]” (P18). According to Department of Education (2018b) policy, school staff have primary responsibility for locating students at known risk of suicide or self-harm who are unaccounted for. As employees of the Department of Health many nurse participants reported that they undertook this role in partnership with school staff, because they perceived that they were best-placed to respond in case an assertive medical response was required: “we’ve had attempted suicides at the school, during school time. We’ve had self-harming at the school, during school time” (P17). Another participant reflected on the impact such events had on other students if they inadvertently discovered the situation instead of a staff member: “I’ve had a few major self-harms

at school which have [caused] a few ongoing issues with other students who have either found them or brought them in [for care] to Student Services” (P4).

Not surprisingly, suicide risk intervention was a commonly reported task, and often necessitated the participant keeping the young person under direct observation until a parent came to collect them: “there are situations where you have to sit with someone until you have a parent [come to collect them] because I don’t think they’re safe. That’s a really common one” (P29). One participant was interviewed in a park and explained that they had been in the same park with a suicidal student only the week before:

A friend came to tell me she was really worried about [the student] because of a text message she’d received [from her]. [The student’s] mum’s got GPS [global positioning system] tracking [for her daughter], so she’d worked out [the girl] was here. I came down to find her and just sat with her... [I was] glad to find her [lying] in the foetal position. [I] just sat with her, [together] with her friend. She didn’t want to talk. She said she hadn’t harmed herself, she said she hadn’t taken anything [overdosed]. (P19)

Managing young people at risk for suicide who were angry was not uncommon and could present a significant challenge in an uncontained space such as a school:

When they’re angry and you can’t rationalise with them, you can’t get them into a position where they’re safe. They’re not listening to anything you say, so they’re a ‘difficult student’. They’d be a ‘difficult patient’ in hospital because they would be ranting and raving and throwing things. [They would be] trying to escape [from the hospital] just as much as they are at school. (P23)

[She said] “Yes, I have a plan [for suicide].” [I said] “How [are] you going to do it?” [She said] “I’m going to throw myself in front of the train.” I [said] “oh, okay... you live in [suburb with train station], you catch the train home every day. Why [are] you going to throw yourself in front of the train? Because your dad’s a train driver and you want to get back at him”. ... [I] said “don’t let her leave [alone]” ... She trashed [destroyed] my office. When

she realised that I'd cottoned on to what was happening [realised] she was...very angry. (P6)

While managing crises that occurred at school was a common task for many participants, experienced participants also recognised that young people often required support for events that occurred outside of school. As with crises that were precipitated at school, these situations were unanticipated, necessitated putting other priorities to one side, and typically took up a great deal of time:

I had a student nurse a few weeks ago. Monday morning I wanted to do her induction. By quarter to nine [in the morning] I had two girls in the health centre and we went right into it on Monday morning, the full [crisis intervention]. I couldn't turn them away because it was a crisis, things had happened over the weekend... [For] that student nurse induction happened later on in the day and even the next day. I think she was amazed by how the kids come down and [say] "I need to tell you something" and then it comes out. (P7)

A key source of stress was the unpredictability and fluctuating nature of mental health risks presented by young people participants provided care to:

With teenagers, the risk assessments are at that very moment. Five minutes later those risk assessments could be out the door [irrelevant] and totally different because they might have a break-up with a partner or best friend argument. My biggest concern is that they escalate to the point where they self-harm or they're thinking about killing themselves. (P17)

Young people who concealed their suicidality or the degree of their suicidality were also a source of stress: "my main concern is that they might lie to me... because they may be hiding how bad [suicidal] they are, [when they deny suicidality] yet they've got a plan [to suicide]" (P6). Some participants were concerned that despite being vigilant, the distress of students in their school community might go undetected: "the sort of young boys that slip under the radar [go unnoticed], and then suddenly they write a suicide note in the middle of the night. They always worry me a bit" (P28).

Many participants sought to keep the young person safe from harm in and out of school, but the majority of participants were highly aware that circumstances beyond their control could easily impact this: “safety for them [is my main concern] ... [but] I can only deal with the situation that’s in front of me. If the kid decides to go home with bad thoughts and decide to do something [such as self-harm or suicide], that’s difficult” (P11). The combination of *wicked problems* and *persistent intensity* defined the clinical workload. The work was further complicated by the level of *autonomy and isolation* participants had in the role.

3.5 Autonomy and isolation

The third category in the shared common problem of *untenable burden* was the experience of *autonomy and isolation*. This category conceptualised the dual aspects of a role that is uniquely autonomous and simultaneously highly isolated. In addition to being faced with *wicked problems* and *persistent intensity*, participants had to function as autonomous health professionals in a non-health setting where they were isolated from nursing support. So significant was this aspect of the role that some participants referred to it solely in the context of isolation: “traditionally [secondary school] nurses have been isolated. It’s a very isolated job” (P25); “the majority of secondary school nurses work in isolation. I really worry [about] the impact on their mental health” (P21). The *autonomy and isolation* were aspects of the role for which participants often felt the least prepared:

[It would have been easier] starting at a school ... where you can go back to [the community health base] and just have that office banter... just discussing a student that you're not too sure about. [It’s difficult] trying to chase someone down by phone just to have a bit of chit-chat. If I had had experience in a team setting to start with and then moved out into a more isolated job that might have been helpful because I would know what everyone else does. (P9)

For some participants the autonomous nature of the secondary school nurse role was a potential source of fear even before they had encountered *wicked problems* and *persistent intensity*:

[In the hospital] nurses work in teams, we've always got support. You've always got your manager. If you haven't got your manager you've got the after-hours [manager]. If you're the manager, you've got somebody else always there. You've got your team to liaise with. But you're so, so isolated [and] on your own [as a school nurse]. (P1)

With time and experience feelings of *autonomy* could outweigh feelings of *isolation*: "I feel quite protected by the [Department of Health]. I don't have to do what the [school] principal tells me" (P29). For other participants, trying to assert professional *autonomy* could exacerbate *isolation*: "I can't have it both ways. I can't say 'I'm [a] Health Department [employee], therefore you are not my boss... But I'm also one of you'. I can't have it both ways" (P15). Even the most positive participants often articulated themes of *autonomy and isolation* in dichotomous terms: "we've got a really good principal and we've got good staff. Our [school] is a lot better than a lot of the other schools, but it's still Health and Education" (P17). There were three aspects in the category of *autonomy and isolation*: 1) *working autonomously*, 2) *every school is different* and 3) *left holding the baby*.

3.5.1 Working autonomously

The experience of *working autonomously* in the early days of their career as a secondary school nurse could be overwhelming for participants. The majority of participants spent the entirety of the working day at their assigned school where they were isolated from the broader health system and nurse colleagues. Being a Department of Health employee in a Department of Education setting could feel like being a stranger in a foreign land: "you are a guest, hypothetically, within the school" (P11). Many participants had undertaken workplace orientation to prepare them for anticipated clinical scenarios, but this was not necessarily enough to prepare them for managing difficult situations independently for the first time:

I had knowledge of Gatekeeper [suicide prevention training], I had knowledge of the policies and procedures... I had other members of the staff at school there... but when they're busy, you're it [*working autonomously*]. (P11)

Although the majority of participants were highly skilled registered nurses with significant nursing experience prior to becoming a secondary school nurse, previous nursing experience did not always mitigate fears related to *working autonomously* in a new speciality area. A participant who had more than 30 years of previous experience as a registered nurse when she started secondary school nursing stated: “I was left in there [the school health centre]. I had the [outgoing] nurse with me for a week [to orientate me] and then she was gone. I [thought] [whispers] ‘oh my god’ [I was terrified]” (P1). In this study, the average duration of participants’ nursing experience prior to becoming a secondary school nurse was 17 years, but the level of isolation was often a new experience: “I just think I’m completely under-prepared for it” (P13); “[I felt] very unprepared [to start with]” (P24); “I wasn’t prepared” (P23).

The first days of *working autonomously* in a school often stood out. Two participants used a metaphor of water and drowning to describe their early experiences. From one who had only recently commenced the role: “I feel like I’m constantly just above water, trying to pedal and trying to do the best that I can” (P13). Another reflected on the first few years: “I was drowning when I first came in [to the role]. Now I feel I’m treading water” (P1). Being isolated from other nurses was a particular problem for participants because it was not uncommon for them to be confronted with complex issues very early in their school nurse career:

[In the first week of my employment] I had a boy who came in telling me... he was a boy but he was the size of a man, which was the other thing that was... a bit scary... [He was] telling me that he was suicidal ... That was truly terrifying. (P19)

Many participants reported feeling uncertain or fearful when *working autonomously* meant managing new and unfamiliar clinical situations:

A teacher had referred to me... [a girl with a] possible eating disorder... It’s broaching that subject. How do you say to a girl “have you got an eating disorder?” You know that they’re not going to tell you straight away that they have, if they have. You feel a bit ridiculous asking, because it’s not going to

be a proper answer. Okay, so they say “no.” Well, what do I do then? Do I [say] “okay, great, you know we’re here if you need us”? (P3)

I had one student come in to me and it was completely... for me it was quite overwhelming. [The] student had had several [suicide] attempts over the past couple of months, had suicide ideation, [and] a lot of self-harm [issues the student had not previously disclosed to anyone else]. (P11)

As participants became more aware of their *autonomy and isolation* this could prompt some alarm: “we have to be ready for it, we can't just be [haphazard] about it. This is really serious.” (P1).

Notably, participants recalled feelings of fear even when they commenced the role many years apart. Fourteen years separated the commencement date of these two participants: “I will never forget my first day, it was terrifying” (P19); “[it was] a baptism by fire for me... it was quite overwhelming” (P11). For some participants the initial fears were intense enough that they wanted to hide. At the time of interview, this participant had been a registered nurse for almost 20 years:

At the beginning it was more of a ‘oh god, please don’t come through my door’ feeling.... ‘please don’t come to me’. If I just sit here with my head down nobody will notice I’m here. [I] did that a few times. (P12)

Not feeling prepared could also occur when contacting families:

We’re cold-calling families [making unsolicited phone contact], and we don’t know what [we’ll get]. You’re either going to get somebody who responds and listens, or one that never returns your call. Or you ring up and suddenly I’m getting the history of this sexual abuse which was really, really terrible to hear.... But I didn’t know how to stop her without shutting her down. (P31)

It was not uncommon for fears related to *working autonomously* to manifest as clinical uncertainty: “Should I have said this? Should I have done that? Should I have reported it to...? I do that, a lot” (P12); “I’ve just done my best, I think.... mostly it’s just... hoping I’m not saying the wrong thing” (P13). The variation and unpredictability of the clinical workload meant that participants often had no prior experience of a clinical scenario which was especially difficult when *working autonomously*:

At the beginning I’ve definitely had a few come through and I thought ‘I don’t think I know what to say to you. You’ve come to me with this problem and I don’t know what advice to give you’. (P3)

A significant number of participants used strikingly similar terms to describe this: “you never know what’s going to walk in the door” (P23); “you just don’t know what’s coming through the door” (P7); “I don’t know what’s going to come through my door” (P11); “just anything and everything walks through the door” (P30). Participants adapted to this unpredictability over time: “now I definitely [feel comfortable], but when I look back at my first experience[s], when I look back at the first year, some of the students that I dealt with, I found it really [difficult]” (P24).

While participants adapted to *working autonomously* the feeling of being isolated and alone persisted: “you sometimes feel very isolated... you’re working on your own” (P20); “I do feel very professionally isolated” (P15); “I feel very alone” (P28); “I was really lonely being the only nurse in the school” (P21). The quoted participants had been employed as a secondary school nurses for up to 13 years, indicating that the sense of isolation did not necessarily lessen over time.

Participants with considerable experience *working autonomously* as a secondary school nurse were not immune to feeling clinically uncertain but had developed a tolerance for it: “I don’t know that I’m getting it right. I feel like I am, and I’ve got eight years’ [secondary school nursing] experience... I feel like I’m getting it right, but nobody is telling me that I’m getting it right and I’m not sure” (P8); “I’ve walked away from some of the [professional development] courses I’ve done, [thinking] ‘I think I’m doing the right thing’” (P6). A participant who had worked as a secondary

school for many years stated: “when you’ve been doing it for [as long as I have] it doesn’t stress me too much. I think if you were a new school health nurse it would be very, very, very stressful” (P17).

3.5.2 Every school is different

In addition to the specific challenges inherent in *working autonomously*, the school settings that participants described were far from homogenous. All the participants in this study worked in public sector secondary schools, and over 70% of participants had worked in more than one school. Some were working in more than one school concurrently because only large schools were allocated a nurse five days per week. Many participants commented that *every school is different*: “the schools that you work in are all very different” (P22); “every school is different” (P30); “[my role is very] much different at the other secondary school [I work in]” (P9); “each role is different, each school is different. My role is different to [former school], it was different at [another former school] because the clientele and their circumstances are different” (P6).

The differences were not entirely surprising given the enormity of the State of Western Australia where this research was undertaken (2.65 million square kilometres). Participants commented on geographic location: “schools and areas are so vastly different, they work differently” (P22); “[the] metropolitan and [country services] are worlds apart” (P27). Other participants commented on socioeconomic factors: “[I] did [a very low socioeconomic status secondary school], [and a moderately low socioeconomic status secondary school], which were very, very different to where I am now [a high socioeconomic status secondary school]” (P20).

Some schools had a unique structure or function: “this school is quite a unique school” (P11); “the school I’m in, there is no other school like it in the State [of Western Australia]. You can’t compare it to [any other school] because there’s nobody else like us” (P22). In some communities there were different campuses for young people in different year groups: “they’re different age groups and that changes it again... we’re not dealing with the same [age] clients” (P22). Participants described working in Education Support settings co-located with mainstream

secondary schools, government boarding schools, specialist colleges (for dance, drama, high academic achievers and agriculture) and Intensive English Centres catering to the needs of young people arriving in Australia as humanitarian refugees.

Participants anticipated and acknowledged variation as a legitimate aspect of contemporary secondary school nurse practice: “each school has different aspects... you can’t be... prescriptive [and say] ‘this is what I do, this is me’ and if that doesn’t fit into your school I’ll just sit in my office” (P10). A reflection on the impact of school socioeconomic factors illustrates the potential for impact on the secondary school nurse role:

[My school is in a] low socioeconomic [area] so the basic health and the chronic health issues are [high]. You’ve got children coming to school malnourished, with chronic constipation and overflow, with gastroenteritis, with colds, with ear infections, with skin infections and mental health issues. (P21)

This description contrasted with reflections from higher socioeconomic areas. From a middle income area: “most parents around here are pretty good. We don’t have a large group of vulnerable students or anything like that. Most parents at our school are contactable and proactive” (P9). From a high socioeconomic area: “[parents] can be challenging... I think that may be our demographic. We have predominantly professional parents” (P19). Another participant worked in two schools that were a study in contrasts:

In one [school] you have the affluent families who are very busy and [too] pre-occupied with their lives to notice things that are going on [with their adolescent children]. They think everything’s fine [when they’re not]. In the low socioeconomic [school], you have the parents who are there all the time [in the home], but aren’t engaged. They probably [have] more issues themselves. Not in terms of work, but their own personal issues. (P1)

In practice, variation in the characteristics of the school community led to variation in the role: “secondary school nursing works so differently in different schools. What I have been exposed to and the role that I’m doing at the moment [are] very different”

(P13); “the role for every school nurse is different because there’s different personalities, there’s different principals, there’s different clientele” (P6); “the role for secondary school nurses varies a huge amount between different schools, and that depends on the nurse themselves, and the school that they're working in” (P3).

While participants adjusted to *working autonomously* and adapted their role to accommodate *every school is different*, there was a specific set of circumstances that continued to present challenges in relation to *autonomy and isolation*. This occurred when specialist mental health care for young people could not be sourced and participants were *left holding the baby*.

3.5.3 *Left holding the baby*

The term *left holding the baby* is defined by the Collins English Dictionary as “being put in a situation where you’re responsible for something, often in an unfair way because other people fail or refuse to take responsibility for it” (*left holding the baby*, n.d.). A feeling of having been *left holding the baby* could occur whenever participants perceived they were unable to appropriately involve other service providers in the care of young people to the necessary degree: “if they’re not going to follow-up [with referrals] then they’re on my plate, you know” (P15); “you can guarantee with those ones that don’t follow my request [for a referral to be actioned], they come back to me” (P23). The effect was that: “I have these kids who are not getting any support except from me” (P3). Of particular concern for participants was the co-occurrence of *high stakes* and *left holding the baby*:

She wasn’t getting support from her parents, they were not getting her to [mental health] services. She was just repeatedly self-harming, she was suicidal. I felt as if I didn’t know what to do with her, so it was quite scary. I also felt, ethically, like I needed to keep her on my radar, constantly. (P3)

I was fairly unhappy at this point with the situation [the student’s untreated suicidality] ... I did a lot of exploration to see who had done what, what the outcome was, etc. It’s been a lengthy process and one I've been fairly

disappointed with because I feel that too many agencies let this boy go.... I think he's a very high risk little boy. (P28)

The referral of young people experiencing mental health problems to other services was described by participants as a key function, but this was not always easily accomplished:

It's those children who come to you, and then you refer them but that process just doesn't work for them. There are lots of reasons that doesn't work, but it continues to not work with some children, and then they fall between the cracks. They keep bouncing back to you, so you do see them [again]. You might see them more than once a week, and you're [thinking] 'wow, I'm not really sure what to do with you next.' (P3)

Although participants sought to work collaboratively with school staff, parents, and other service providers, the willingness, capacity and availability of these key partners was a key influencing condition which is detailed in chapter four. Commonly, participants were *left holding the baby* because there were multiple barriers to young people receiving specialist assessment and support, both within and external to the school: "there are school psychologists at the school, although I find that they're not as accessible, so the kids are bouncing back to us" (P26).

Another participant reported:

The parent wouldn't take her [to the Child and Adolescent Mental Health Services appointment]. [The parent] said "she's just doing it for attention." I don't work for Child and Adolescent Mental Health Services, so I don't know. I rang the case worker and said... "Dad's a fly-in-fly-out [worker]. Mum doesn't drive. We think mum might have a mental health issue as well, just from things we picked up. You sent a report saying she didn't turn up for her assessment." (P31)

A sense of having been *left holding the baby* could be particularly strong when a student had a high utilisation of school nursing services, because the participant often had frequent, ongoing contact with the student and was sensitive to fluctuations in presentation and risk: "in schools you see the students for a longer period of time.

You can observe and... you can see their interaction... Rather than them going to a particular psychiatrist's office for a half hour appointment and... [the young person denying there's a problem]" (P19).

Thwarted referrals and untreated mental health problems were significant contributors to participant perceptions that they had been *left holding the baby*, but in some circumstances this could also occur when a young person was receiving specialist mental health care. One participant recounted how they had phoned a student's mental health service provider because they perceived an exacerbation in suicide risk:

I rang the Child and Adolescent Mental Health Services and said "what do you want me to do in this situation? The child has told me she's got strong [suicide] ideation, she's got past history, significant past history [of suicide attempts], she's self-harmed, and she's telling me that she doesn't feel safe... I'm a bit worried about this." He said "if she's got a timeline [to die by suicide], if she's been on the internet trying to find ways to [suicide], [then contact us]." [I thought] How am I supposed to know whether or not [she's been doing this]? ... Do I feel really safe in myself about that one? No. (P18)

When barriers to having young people cared for by specialist mental health services proved insurmountable, the feeling of having been *left holding the baby* was inescapable:

She's thinking [about], she's planning [suicide]... Bless her disclosure because she was being very honest, but now she's very cagey [secretive]. She went to Princess Margaret Hospital for Children. Of course she was referred to Child and Adolescent Mental Health Services: she was a no-show [didn't attend the appointment]. (P31)

Back in May he wrote a suicide note. He's a 12 year old Aboriginal boy. From what I can gather... [he] lives with mum and a couple of other siblings, [and an] older sister who is known to me as well. I think life at home is pretty tough. I think mum is fairly unavailable... about a week after he wrote this suicide note mum disappeared to Bali [Indonesia] and a Department for Child

Protection and Family Support report was put in by our [school] psychologist because she felt that was concerning... [The boy] attended Child and Adolescent Mental Health Services with his Year 10 sister. [He] attended on a couple of occasions, but mum wouldn't engage so they discharged him. They discharged him into the care of the school psychologist... who equally discharged him because she couldn't get mum to sign consent [for her to see him]. So this little boy was then just flying in the ether really [no-one's professional responsibility]. (P28)

It was not unexpected that the frequently chronic nature of the clinical and professional stresses many participants experienced had a significant impact on their emotional wellbeing. This is detailed in the next section and was conceptualised as *a heavy toll*.

3.6 A heavy toll

A heavy toll was the fourth category in the shared common problem of *untenable burden* and was articulated in words and in expressed emotions. More than one participant became tearful during the interview. One interview was terminated due to participant distress, but the participant was emphatic that their data be included, citing their distress as a motivating factor for participating. Some participants identified *a heavy toll* directly: "I've been dealing with some really heavy, heavy cases. It's taking a toll on me" (P15); "The only thing that would make me consider not doing the job anymore is [that] it takes a toll" (P24). Throughout participant interviews the word "heavy" arose over and over again: "it does weigh heavy on me because I want that child to be safe" (P11).

I've had teachers ringing up [and] saying to me 'I can't believe this kid's just told me this, can I bring them down to you?' Then [the teacher has] needed support as much as the child has. Sometimes it's a heavy load to carry. (P31)

I felt burnt-out after a while. I was sometimes doing more than one [suicide risk assessment] a day, which is a really heavy load to talk about that sort of issue. Then [I have to] talk to the parents, follow the whole thing through, write the whole thing up. It's quite heavy. (P3)

A heavy toll was also articulated by other participants using different words: “we’ve got students who’ve attempted suicide, they’re behaviour... it’s really very distressing” (P22); “it’s horrible when you have to make that phone call and actually have that conversation [with the parent about the young person’s suicide risk]” (P20); “I’m dreading... again I’m feeling the emotions come [participant tearful]. I’m absolutely dreading there being a suicide, and I feel like it’s coming” (P7).

It was clear that a *heavy toll* was more than work stress. It reflected the vulnerability of young people and the uncontrolled nature of the stresses participants experienced. A participant who had been employed in another high stress nursing position offered the following:

What I’m exposed to at the secondary school is as traumatic, if not more so [than my previous employment in the hospital], because we’re dealing with... children who are... in very difficult situations. In a hospital environment it’s quite controlled, quite contained. (P31)

At times, *a heavy toll* was so burdensome that participants felt they could not continue. A participant recently returned to secondary school nursing after an extended period of leave explained what led to the request for leave:

[I was caring for] a 12 year old Chinese boy... I said “I need to contact your parent.” [He said] “Oh, they’re in China.” [I said] “Who’s at home?” “The dog” “So you’re home alone?” “No, I have the dog.” “No, an adult, a person?” “No, the dog” “So you’re alone?” “No, not alone.” I got to the point where I [needed] a break from the role for a little while. (P6)

A participant who was undertaking alternative employment at the time of interview specifically named vicarious trauma as contributing to *a heavy toll*:

I’ve [been in alternative employment] for six weeks [and] I haven’t asked anybody if they’re going to take their own life. That’s massive [highly significant to me]. I feel my emotion, the vicarious trauma is quite high in me at the moment.... It affects what I watch on the television. I can’t watch any

violence, violence towards women, children, that kind of stuff, because I deal with so much mental health [in my school nursing role] every day.” (P7)

An especially painful source of *a heavy toll* was the tension between the relationship-building and reporting aspects of the secondary school nurse role. These twin duties were often incompatible and sometimes severed the relationship that had facilitated the reporting. One participant described *a heavy toll* in relation to a group of young Aboriginal women who had made a disclosure to the participant that had to be reported to the Department for Child Protection and Family Support:

I feel very torn between being an advocate for these children and supporting them and building relationships which is a hard thing to do. They feel betrayed by you because you’ve reported to the authorities. There’s an investigation [by the Department for Child Protection and Family Support] and then they get in trouble [with their families] and stop seeing you. (P31)

Although participants did not report feeling that their duty of care extended beyond the school setting, it was evident that participants often felt a strong obligation to intervene assertively in an attempt to prevent harm both in and out of school. This commitment had the potential to precipitate *a heavy toll* when they felt impotent in the face of the perceived failures of other service providers. One participant recounted a case where a 15 year old student with significant mental health problems had recently become homeless:

The chaplain and the [deputy] principal went to meet this girl in [suburb], and they’d asked myself and the psychologist’s advice. We both said, “get her to a hospital” ... They managed to get the girl to the hospital, and she was discharged. She did see a social worker, she did get a Child and Adolescent Mental Health Services referral, but I felt somebody needed to take care of this 15 year old child that had been saying to men “I’ll have sex for money.” Covered in self harm, both arms, and I sometimes feel a bit let-down. (P29)

A similar sentiment was echoed by a participant who had identified that a young adolescent was being groomed by an adult external to the school for the purposes of future sexual gain. Becoming tearful, the participant reported:

There'd been a disclosure of grooming, which had been reported [to the Department for Child Protection and Family Support]. [The] worker said to me "well, grooming is not illegal in Western Australia." [Participant indicates outrage] 'So it's okay then? Alright.' Do you know what I mean? So, I'm thinking, 'who has protected this child? Nobody'. (P31)

The *heavy toll* participants experienced was not limited to circumstances where the young person was enrolled at the school. Reflecting on a case where a young person with mental health problems was sent interstate against his will, the participant reported:

The family uprooted [the student] and sent him back to the [origin] of his problems in Queensland [4000 kilometres from Perth]. He ended up in [the psychiatric] hospital for two weeks... I was really worried about his wellbeing. I thought he was going to [die by suicide]. (P6)

Similarly, although participants were often reassured when a young person was receiving specialist care, this did not prevent the experience of a *heavy toll*: "I do feel concerned for students sometimes... five suicide attempts recently... known to [the] Child and Adolescent Mental Health Service. They've got all that support, [but] still they're doing these sort of things [attempting suicide]" (P11).

3.7 Summary

This chapter identified that participants shared the basic social psychological problem of *untenable burden*. Analysis of the data identified four categories that contributed to participants' experience of *untenable burden*, including the complexity of the difficulties young people faced, the intense workload, the risk of devastating outcomes such as suicide, the autonomous nature of clinical practice and the emotional burden of the work. These were conceptualised as 1) *wicked problems*, 2) *persistent intensity*, 3) *autonomy and isolation*, and 4) *a heavy toll*.

Wicked problems conceptualised participant reports that young people presented with difficulties that were complex, multidimensional, not easy to resolve and frequently resistant to intervention. Distress and other symptoms of mental health problems

were a common reason for visits to the school health centre, and the majority of participants had contact with young people experiencing mental health problems on a daily basis. While participants endeavoured to refer young people with significant mental health problems to specialist services for treatment, this did not always result in fewer visits to the school nurse. Participants spoke at length about young people with whom they had frequent or ongoing contact, sometimes over years. The second category in the shared common problem of *untenable burden* was therefore conceptualised as *persistent intensity*.

The third category in the basic social psychological problem of *untenable burden* was *autonomy and isolation*. Faced with daily exposure to complex problems and young people in difficulty, participants reported that the high level of *autonomy and isolation* contributed to high levels of personal and professional stress that impacted on their wellbeing and their capacity to sustain the role's demands. The high level of work-related stress participants experienced in their role was conceptualised as *a heavy toll*, the fourth and final category in the basic social psychological problem of *untenable burden*. Chapter four of this thesis will examine the conditions that influenced the basic social psychological problem of *untenable burden*.

CHAPTER 4

CONDITIONS THAT INFLUENCE THE PROBLEM OF UNTENABLE BURDEN

4.1 Introduction

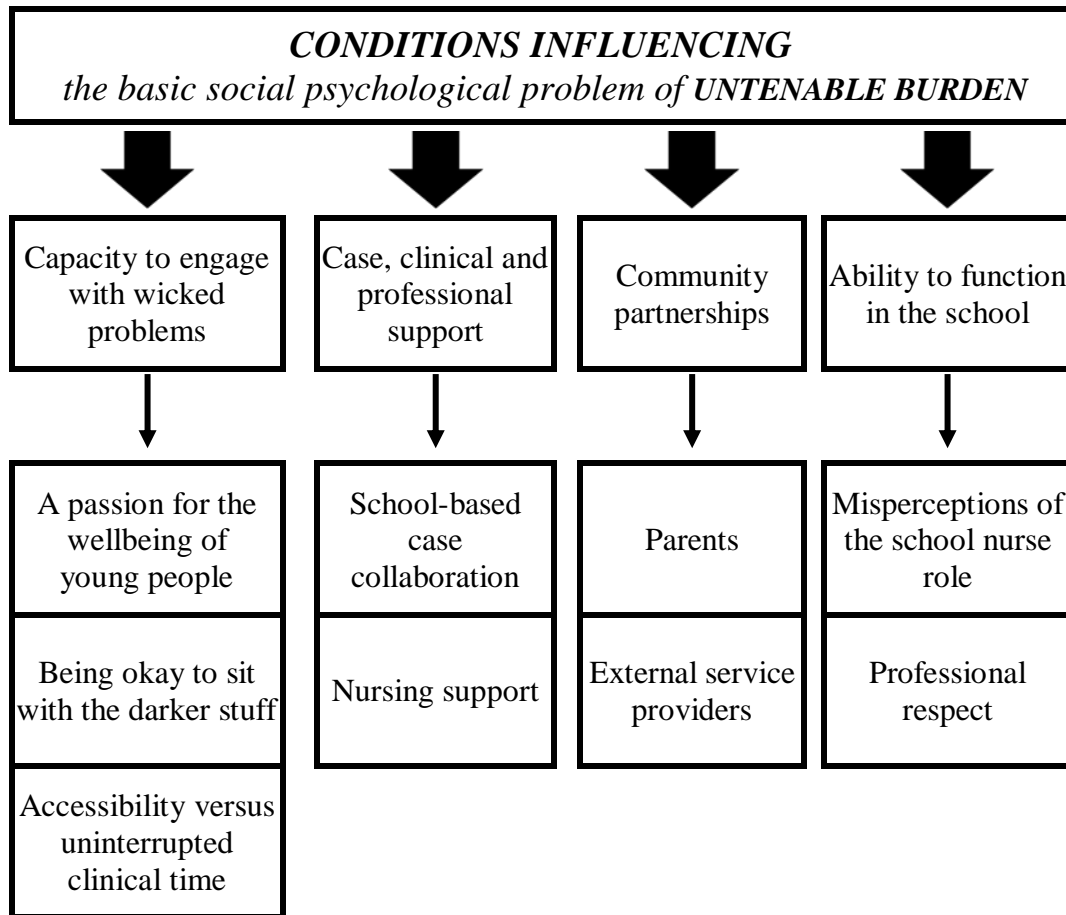
When the basic social psychological problem of *untenable burden* had emerged from the data, the researcher sought to understand under what conditions the problem was exacerbated or relieved. Some participants perceived that the experience of *untenable burden* was simply an occupational hazard: “I know that my role is safe-guarding and I have to report [certain disclosures]. [That] sometimes [has] quite a detrimental mental health impact on me” (P31); “having a lot of students with mental health [problems] can affect you and your mental health. You’ve got to make sure you as a practitioner have got good mental health yourself” (P20). Notwithstanding the inherently stressful nature of the role, data analysis identified four conditions that influenced the shared common problem of *untenable burden*. These were 1) the *capacity to engage with wicked problems*, 2) *case, clinical and professional support*, 3) *community partnerships* and 4) *ability to function in the school*. This chapter describes in detail these four conditions, shown in figure seven.

4.2 Capacity to engage with wicked problems

The first condition influencing the problem of *untenable burden* was a *capacity to engage with wicked problems*. Unexpectedly, participants who had greater *capacity to engage with wicked problems* were more likely to experience *untenable burden*, principally because this capacity acted as a catalyst for disclosure: “if you’re totally honest, not shocked and take things in your stride when you’re talking to [young people], they open up a lot more, especially with mental health” (P17). In addition to enhanced capacity for eliciting young people’s difficulties, a well-developed *capacity to engage with wicked problems* marked the participant as a safe and effective adult to seek out. This exposed participants to a greater degree of *high volume* and *high stakes*, further intensifying the experience of *untenable burden*. Three components of *capacity to engage with wicked problems* were identified: 1) *a passion for the wellbeing of young people*, 2) *being okay to sit with the darker stuff*,

and 3) *accessibility versus uninterrupted clinical time*. These will be addressed in turn.

Figure 7



4.2.1 *A passion for the wellbeing of young people*

This section explains how *a passion for the wellbeing of young people* exacerbated the shared problem of *untenable burden*. It was evident very early in the study that *a passion for the wellbeing of young people* motivated many participants in their work: “the majority of nurses working in the secondary schools do so because they have chosen to and they are passionate about it” (P21). Not unexpectedly, this high level of investment also had the potential to simultaneously exacerbate the problem of *untenable burden*: “you see them on a regular basis, and you know you're doing your bit by being a face for them and being a support for them while they're at school, but [you ask yourself] ... am I doing enough?” (P22).

Notably, most participants in this study described a strong affinity for youth. They valued young people, often using emotive language to convey this: “I absolutely love working with young people” (P16); “my passion is secondary school and young people... my heart is with young people and teenagers” (P7); “I like working with teenagers because they're interesting and you never know what's around the corner. They keep you on your toes” (P3); “I like teenagers. I used to love them in the hospital. I found them fun and interesting, and I seemed to have a bit of a connection with them” (P1); “I like working with adolescents...I actually feel that I can make a difference, and I like that feeling that I can make a difference” (P6).

In an organisation that also provided opportunities for nursing staff to engage in infant health nursing and primary school nursing many participants disclosed a strong preference for working with adolescents over other age groups: “I'd always been more interested in the adolescent side of it rather than the primary school [aged children]” (P5); “I haven't got my [infant health] certificate and it doesn't appeal to me. I'm not a 'baby person'. I like children and adolescents” (P12).

Two participants reported that they had only recently commenced the role and had not specifically sought out working as a secondary school nurse. This was of interest because it was not unusual for secondary school nurses to report that they had stumbled into the field, only to find that they became deeply invested. Again, participants used emotive language to convey this, frequently using the word “love”: “I [worked in] primary schools first and found that really boring. [I've been working] in secondary schools since, and I love it” (P17); “After my experience [nursing] in a secondary school, I ended up falling in love with secondary school [nursing]” (P24); “I started [working in a secondary school] and I realised that I'm quite passionate about it. I've accidentally fallen in love with it” (P27).

For other participants *a passion for the wellbeing of young people* was initiated when the participant's own children became teenagers: “I have an adolescent [child], and starting to go into that world of adolescents, wanting to understand it better, to support her journey through it” (P31); “My [child] is also in secondary school now so it's been nice for me to be working in a similar environment and see how schools work because [it's] obviously 30 years later for me. Schools have changed quite a

bit” (P5); “I think my head just started getting into teenagers because my kids were becoming teenagers” (P4).

Many participants indicated a strong sense of social justice in their advocacy and belief in young people, particularly when those young people had few other resources: “[it’s about] catching those kids that just don’t have anyone to help them” (P27); “I felt like I was pretty much the last stop on the road... I feel like [young people are] the forgotten people really” (P24); “I’m very passionate in regards to ensuring that young people are able to find a service and get their needs met. I’ve always been quite passionate [about] adolescent health” (P30). This strong sense of commitment and social justice could significantly exacerbate the experience of *untenable burden* when young people presented with *wicked problems* that were not easily resolved.

Some participants referred to *a passion for the wellbeing of young people* more obliquely: “seeing what a gift these children are to the world, and what a privilege I feel it is to work with them” (P31); “I was really excited about getting into the school nursing role” (P8). Empathy for the problems adolescents faced was common: “personally I like young people. I feel that they have a lot of challenges, and I like working with youth. I was really ecstatic when I got the school nurse job and I’m still enjoying it” (P8); “it’s such an awkward age and a lot of people don’t know how to be around them... I just felt that I connected” (P24). Sometimes this empathy stemmed from reflections on participants’ own experiences of adolescence: “[I] think back to when I was teenager, occasionally, because it’s not a very nice time” (P6). This prompted participants to want to support young people who were experiencing a challenging adolescence: “[I was] really overwhelmed at what some of these [young] people go through, the lack of understanding of the adults in their lives, how much things compound the conditions they’re experiencing” (P24).

Participants with *a passion for the wellbeing of young people* often had a strong developmental focus and wanted to see young people grow into fine young adults: “I wanted to see the kids grow and graduate. I wanted to follow a year [group] through [from the beginning of secondary school to the end of secondary school, Years 7 to 12]. I managed to do that with two year groups... and I love it” (P10). This focus was

also expressed in the goals school nurse participants had for young people: “As a broader society we all want people to ... enjoy life and to get the best out of their life. Ultimately, I guess that’s what we’re trying to do... as much as we can make this passage through [adolescence] comfortable for them and enjoyable, to bring out the best in them” (P5). When young people were experiencing significant mental health problems the problem of *untenable burden* was exacerbated because this goal was thwarted.

Notably, participants with *a passion for the wellbeing of young people* actively developed and protected their professional reputation as effective caregivers of young people. Participants were highly aware that there was a significant public relations aspect to their role: “you only need one student to have a bad experience [with the school nurse], and they would tell all the other students not to go and see that nurse” (P8). Another participant explained:

I had one girl last year who thought she was pregnant. [The] pregnancy test came back negative, so then we went through [related sexual health interventions]. She brought a friend along about two weeks later who thought she had a sexually transmitted infection. [The first girl said] “I brought my friend in. I told her that you really helped me” and that was it... that friend, it was like ‘okay [I can trust the nurse]’. (P6)

While *a passion for the wellbeing of young people* often motivated participants in their work, to engage with *wicked problems* participants also required the capacity to enquire about the messy reality of young people’s lives. This was conceptualised as *being okay to sit with the darker stuff* and is considered in the next section.

4.2.2 *Being okay to sit with the darker stuff*

The second component in *capacity to engage with wicked problems* was, as one participant put it “being okay to sit with the darker stuff” (P14). *Being okay to sit with the darker stuff* exacerbated the experience of *untenable burden* because participants with this capacity often attracted young people experiencing *wicked problems*: “if you have an openness about you for mental health and you don’t fear it, then [young people] will talk to you” (P3). While participants were motivated to

engage with this group, increasing numbers of young people seeking support for *wicked problems* translated into an increase in *persistent intensity* and exacerbated participant's experiences of *untenable burden*.

Participants in this study recognised that *being okay to sit with the darker stuff* was a choice: "some [school nurses] don't necessarily want to see kids the way I want to see kids and have that involvement [with them]" (P6). Other participants perceived that *being okay to sit with the darker stuff* was an essential part of the school nurse role:

For a nurse to be able to work in a secondary school, that's a really important part of employing someone to do that job... you need to come to the role with a certain level of comfort and willingness to work in that area. Maybe not to be an expert, but to actually want to work in that area, to see that as an important part of your role. (P3)

Participants reflected that colleagues who were not *okay to sit with the darker stuff* might not experience the same level of disclosure about *wicked problems* or the same level of *untenable burden* as a result: "a few [school nurses] don't seem approachable [about difficult issues]. Are they actually going to get [young] people presenting to them with something personal, [when] they don't understand [it] themselves?" (P6). The terms *comfortable* and *uncomfortable* came up several times: "some [school nurses] are really willing to deal with students and their mental health issues. They feel reasonably comfortable, at least talking [to the young person] ... other [school nurses] feel very uncomfortable" (P25); "the nurse previous to me... she steered clear of mental health altogether. My understanding... is that she was very uncomfortable with it herself" (P3).

Not unexpectedly, previous experience contributed to *being okay to sit with the darker stuff* because it increased the level of comfort participants had in eliciting information about difficult issues:

Having been [professionally exposed to] sexual assault, incest, death in car accidents, poisonings and suicide... has opened me up to be much more able to go deeper. [Being able to ask] those questions around self-harm and

blended family issues that maybe some other people don't feel so comfortable about. (P14)

In addition to being able to elicit sensitive information, participants who were *okay to sit with the darker stuff* were confident that they could manage emotionally demanding situations. They recognised non-verbal signals of emotional distress and were able to invite disclosure of emotional problems, even as they acknowledged that it exacerbated their experience of *untenable burden*:

[The] mum's body language just said it all. So I took her into my room, made her a cup of tea, sat down and said 'okay, what's going on?' and she just sat and cried for about 20 minutes... Her daughter doesn't feel any better after counselling. [She says it's a] 'waste of time'. Her daughter's so, so negative. The counsellor has recommended that they go back to the [doctor], because the counsellor thinks that she might need to be medicated. This girl is only a Year 9 girl, and mum is so [against] the girl being medicated. So that was hard. (P20)

Confidence managing emotionally demanding situations also translated into agile clinical responses. As one participant put it: "you've got to think on your feet" (P11). Many participants only referred to this agility in passing. One participant described supporting a distressed adolescent girl to disclose to her mother that she'd recently been sexually assaulted. Almost as an addendum the participant added:

[After the meeting] mum disclosed that she had been [sexually] assaulted when she was a similar age. She'd had a baby... [which] she'd been forced to... give up for adoption. The mum broke down. I wasn't envisaging any of this happening... A lot of the issues at home between the daughter and the mum was that the mum was very depressed about these things that had happened to her when she was younger, and she felt that she couldn't talk about it to anybody.... [I was] then able to get help for the mum as well. (P8)

One participant acknowledged that it was difficult to train for all eventualities and described an agile response in the midst of a crisis:

No training can prepare you for [some things] I said to [the suicidal student I was physically restraining with the school psychologist], “you know how I had to run after you?” and he said “yes.” I said “you know I’ve had kids, right?” and he said “yes.” I said “you know that ladies that’ve had children shouldn’t really run [referring to pelvic floor dysfunction]?” [I said] “I’m busting, busting [to go to] the toilet, so you’ve got two seconds mate. You can either walk with us into Student Services and I’ll go and do a wee on the toilet, or I’m going to go right here in my pants to keep holding on to you. Your time starts now. One...” I hadn’t even [counted] to two and he [said] “let’s go!” ... The school psychologist said to me afterwards “that was brilliant, how did you know to do that?” and I said “I didn’t. That was just – I’d exhausted every avenue.” (P21)

Being okay to sit with the darker stuff also meant having the emotional energy to engage with young people who might be perceived as “difficult” or “challenging”: “I’ve been called the bitch from hell because I put things in place for somebody and they didn’t like it” (P6). One highly experienced participant recalled a student who was under significant stress and lacked the skills to appropriately articulate her needs:

[A young Aboriginal girl] had come in just as the bell had gone [for the end of] lunch time. She said she wanted some paracetamol for a headache. I said “no, you have to have your three glasses of water, come back in an hour if it’s still there” ... She stood up and told me “[expletives], you’re not listening to me” ... [She] got up, smashed my door shut... I took a few deep breaths, found out where she was supposed to be, [and] of course she wasn’t there. (P21)

Reflecting on the situation, the participant acknowledged:

I hadn’t read the signs [that there was another reason for her visit]. [I could have] said “What else is going on for you at the moment? Life’s really busy

isn't it? What's happening? What can I do for you?" If I'd approached it that way there wouldn't have been this outburst. (P21)

The capacity to engage with challenging young people could significantly exacerbate the experience of *untenable burden*, because these participants were not afraid to reflect on *the darker stuff*. Participants who had a capacity for *being okay to sit with the darker stuff* typically described applying a social lens to the difficulties some young people experienced regulating their emotions. Reflecting on young people who were violent at school, one participant explained:

You need to take a holistic view of it... They could have mental health conditions, they could have stresses in their lives that they're not disclosing. Maybe [they feel] they have to conform [like] everyone else. Bottling things up builds that tension to a point where they explode. Maybe not understanding, not [having been taught] how to be tolerant of other people... I see a lot of students who use drugs and alcohol which can be a contributor [too]. (P11)

Previous experience in mental health could also enhance understanding:

My mental health training at Graylands [Psychiatric Hospital in Perth] as part of my [Western Australian School of Nursing] training opened my eyes to a lot of mental health issues... I'll always remember, because it obviously had a huge impact [on me], the girl who was my case study [for a nurse education activity]. [She] had been used [sexually abused] by her father.... [She] was pimped out to her father's mates and cigarettes put out on her butt [buttocks]. No wonder she was in Graylands with a huge amount of issues related to that kind of stuff. (P14)

As with the participant quoted above, *being okay to sit with the darker stuff* meant recognising that some variables were not amenable to intervention: "we can't change their parents [and] we can't change their history, so it's about finding how they are

going to cope with life and go from there” (P5). This often translated into being able to tolerate a certain level of clinical uncertainty:

She is still struggling, this [young person] ... If she was one that turned [out] to [die by suicide], I wouldn't be surprised. She is impetuous, and she is contemplative [of suicide] ... [The parents and mental health services] all know about it but I'm not sure what more I could do to prevent that situation [or] outcome. (P18)

By contrast, a participant in the same circumstances who had not yet developed the same capacity to tolerate clinical uncertainty stated: “Gatekeeper [suicide prevention training], [is] very grey... it's not black and white... there's no form saying: list protective behaviours, list this, ask these questions” (P26).

Despite possessing sophisticated clinical skills, participants who were able to tolerate clinical uncertainty accepted the limits of their influence: “there's going to be times when I'm going to stuff up [make mistakes], but you can't always get all the information. You can only deal with what that person gives you” (P6). Participants with a tolerance for uncertainty also accepted the scale of the problems they faced: “[Initially] I felt very overwhelmed with [the *wicked problems*] and so often wanted to fix the world. [I] pretty soon realised that that was not feasible” (P28). Accepting that one had done ‘all that could be done’ was a common thread: “everything had been done that we could [do]” (P16); “I've got to tell myself ... I've done as much as I can do” (P23); “sometimes you just have to take that step back and say “I've done as much as I can” (P2).

These perspectives were often hard-won, requiring significant self-reflection on the part of the practitioner. *Being okay to sit with the darker stuff* also required something that was often in short supply: *uninterrupted clinical time*.

4.2.3 Accessibility versus uninterrupted clinical time

Many participants struggled to find a balance between being highly *accessible* to young people and having *uninterrupted clinical time* for responding to young people's *wicked problems*: “our diaries just keep filling up and filling up, plus there's

the kids coming in, knocking on the door crying” (P26). Both *accessibility* and *uninterrupted clinical time* had implications for the problem of *untenable burden*. *Accessibility* meant: “I never have to turn a child away, whereas I feel other people have to turn them away for things” (P27). Conversely, *uninterrupted clinical time* made it possible to investigate presenting concerns more thoroughly, and helped uncover the nature of young people’s *wicked problems*: “time is what you need with adolescents and mental health, to establish relationships for them to tell you more about what’s going on” (P14).

Although many participants reported that they had *autonomy* and control of their time working in the school, this was not the case for all. Some participants did not have a great deal of *autonomy* or control of their time because the school demanded a highly accessible nurse, often for the purposes of responding to minor first aid and injury: “I was seeing a minimum of 20 students per day, up to 30 students per day... easily 15 of those would have been first aid issues. Anybody that was sick was sent to me” (P21). A lack of control and *autonomy* over time had significant implications for the scheduling of *uninterrupted clinical time*, an influencing condition that is discussed further in *ability to function in the school*.

Where participants had *autonomy* over their time they were divided as to the most optimal level of *accessibility versus uninterrupted clinical time*. Time was a finite resource so as *accessibility* increased, *uninterrupted clinical time* decreased. Some participants did not like to limit their *accessibility*, because they perceived that presenting for help often required courage: “when they need something, when they get that courage up to go and tell somebody, they want that person to be there” (P6). The same participant described observing how a young person could struggle with the help-seeking process, highlighting the importance of *accessibility*:

He walked up to my office, he turned around and walked away. He walked up, he turned around and walked away. He walked up and he threw open the door and said “I need to talk to you, I have a really embarrassing problem.” I could see his decision-making. Am I, aren’t I [going to go and see the nurse]? (P6)

Participants who articulated a preference for prioritising *accessibility* over *uninterrupted clinical time* reflected that young people tended only to present in crisis: “it’s all fighting fires really, the kids who come through crying” (P26). For this reason, many participants perceived that any reason was essentially a good reason for young people to seek out the school nurse: “if you're feeling sad or you’ve got worries or you’ve got problems at home, anything, you can always come and run it by me in the first place” (P28); “we’ll accept anyone wherever [they’re] at. Come in and talk” (P27); “we always just have that open door policy. ‘Come on in’ is what we try and do” (P22).

The disadvantage of prioritising *accessibility* over *uninterrupted clinical time* was that participants with a high degree of *accessibility* often found it difficult to manage their time: “you just can’t [manage your time easily], because these poor students are standing there distressed” (P26). Another participant explained:

We put forward [that] the health centre is a really safe place to come to and you will get kids [who have] nowhere else to go. They want to talk to you, and they want to tell you that Mrs So-and-So’s said this to me, and I told her to eff-off [offensive phrase], and now I’m a scared rabbit and I don’t know where to go. I’m [like a deer] in the headlights, I’ve come to you. (P7)

By contrast, participants who sought to prioritise periods of *uninterrupted clinical time* perceived that this was essential to addressing *wicked problems*, because this was necessary to elicit a highly detailed understanding of the young person’s life:

[In] that first session... we discussed home... that his biological mum left him when he was three. [We talked about] the difficulties and fights at home with his dad... then we got on the subject of education... the behavioural issues and the suspensions... [Outside of school he was] getting involved with adult-orientated activities with fake identification. Trashing places, [he was] very lucky he’d not been caught by the police doing any of these things. He was the eldest Muslim boy in the family, so cultural issues as well and exploring those. We looked at sexual activity, which he was very open with.

He was dealing with a lot of different issues, and very at-risk of going down a really dark path in regards to his outcomes for the future. (P30)

Regardless of the way participants balanced *uninterrupted clinical time* against *accessibility*, it was evident that time was in short supply. Participants frequently articulated that demand outstripped nurse availability: “you could have three students asking to see you in one morning. You know they’ve all got difficulties and you haven’t got time, because you’ve got other things to do” (P29); “the huge amount of kids that need to be seen. Whether they’re referrals or they’re knocking on the door crying, when our books are full” (P26); “everybody now is spread very thin” (P24); “[The school health service is] so stretched now, it’s more a consultancy role ... [there’s no] time to actually ... do anything” (P14).

A lack of time aggravated the problem of *untenable burden*, because participants felt unable to provide adequate clinical services to those who needed it: “time [is the barrier]. Sometimes, you’re very busy. You can’t [do what you want to do]” (P29); “now that [a nearby secondary school] is down a nurse, we’re pulled from our school to go there as well. Now we still have the same volume of work at [current school], but less hours, so it’s very stressful” (P26).

This section concludes the first condition that influenced the experience of *untenable burden*, conceptualised as the *capacity to engage with wicked problems*. While this influencing condition strongly influenced participants’ willingness and ability to elicit the difficulties young people experienced, *case, clinical and professional support* determined the degree to which participants felt supported in their clinical interventions with *wicked problems*. This influencing condition is considered next.

4.3 Case, clinical and professional support

The second condition influencing the basic social psychological problem of *untenable burden* was the level of *case, clinical and professional support* participants had. A lack of *case, clinical and professional support* exacerbated *untenable burden* by aggravating participants’ feelings of *isolation*. In contrast, high levels of *case, clinical and professional support* eased the experience of *untenable burden* by diminishing participants’ sense of *isolation*. Two components of *case,*

clinical and professional support were identified: 1) *school-based case collaboration* and 2) *nursing support*.

4.3.1 School-based case collaboration

The first component in *case, clinical and professional support* was *school-based case collaboration*, where participants emphasised the importance of the school Student Services team: “[In] Student Services at the moment we've got a really good team. We do collaborate a lot bearing in mind confidentiality all the time” (P23). For participants, being part of the Student Services team was seen to be critical:

It's extremely important for the nurse [to be part of the Student Services team] because we are part of a whole team that deals with [the student]. You can't be a part [of the team] if you have no information, and if you're left in the dark. (P10)

The majority of participants reported a sense of belonging to the Student Services team, but the teams varied in size and composition: “[at] our school we have quite a strong Student Services team which is made up of two counsellors who are school chaplains, two psychologists, a Student Services manager and myself” (P8). Other teams also included year level coordinators:

There's two Student Services managers. We have year co-ordinators, one for each year level. [We have] a school chaplain, a male chaplain three days a week and a female chaplain two days a week, [and we have] the school psychologist and myself. (P22)

In very large schools the Student Services team was often overseen by a deputy principal who coordinated student pastoral care, and in smaller schools this role was undertaken by a manager or coordinator who sometimes did the role part-time while also teaching classes. Occasionally schools did not have a Student Services team, or the team was very small. This could be difficult for participants, because it limited opportunities for *school-based case collaboration*: “when I came in [to the school] I was very much a lone practitioner. I didn't feel like there was another soul in the

school that cared about [student] wellbeing” (P27); “when I first went to the school, I was just there on my own and isolated from everybody else” (P7).

How the Student Services team worked had a significant impact on participants: “they had an extremely effective Student Services [team]. I’ve never worked with such an effective Student Services [team]. [In no] time my workload was full, and I was utilised fully” (P21). Another participant explained:

[Our Student Services team] wants to do the best for the students, and Student Services is the hub of the school. [The Student Services team are] very respected. [The school community] appreciate the specialities that we've got, and it's utilised in such a fantastic way We've got a great triage system from a coordinator who decides who's the best person to manage [a case]. Everything's carefully documented, [and we have] weekly meetings. [The team are] very, very on top of what's happening. (P16)

As illustrated by the two previous quotes, optimal *school-based case collaboration* meant a sharing of responsibility, diminishing the experience of *untenable burden*. In contrast, when *school-based case collaboration* was ineffective or inadequate, the problem of *untenable burden* increased because participants felt more isolated:

Student Services doesn't function very well. In fact I think we've had five Student Services managers in the eight years I've been there, and deputy managers [have changed] as well. The *Aboriginal and Islander Education Officer* role has changed, [and] chaplaincy's been taken away and never replaced... I don't have a lot of confidence in [Student Services]. (P7)

Frequent changes to the Student Services team could also impact *school-based case collaboration*: “the positions at school that monitor and manage all those things are like a yo-yo [constantly changing]. There's somebody else in that position every week, different [staff members]. [It creates] a lot of holes in the system” (P18); “in my nine years at [current school], I'm on my seventh school psychologist” (P22). Other participants also reported that changes in the team had significant impacts:

We used to have a good system when it was the school psychologist, the chaplain and I, and we all got on well, we were all on the same page. When something works well it works really well, but when you don't have a school psychologist that's got the same qualities, or you don't have the same relationship [due to staff changes], then all of those programs break down and you're just left [with] little silos. (P14)

As with the participant quoted above, being 'on the same page' with the school-based Student Services team was essential for effective *school-based case collaboration*, but it did not always occur: "I was going to the Student Services meetings every week and hearing about the cases that they had... they weren't handling them [well] because they were taking the punitive approach. I could tell it wasn't going to work" (P15). Another participant disclosed:

I see the school trying to move a lot of students [with mental health problems] on... [The rate of] suspension is really high. We don't really seem to be solution based. They just seem to suspend the kids. Then they come back in [to school], and have a re-entry interview... and then they're suspended again. They just seem to go around in this vicious circle. (P7)

At the individual level the Student Services colleague that participants identified most frequently as being critical to *school-based case collaboration* was the school psychologist: "I have worked with some very good psychologists who very much worked as a team. I almost shared offices with one psychologist at one point, and very much knew our roles and very much worked together" (P28); "I work quite closely with the school psychologist. We have a lot of clients in common" (P22); "we tend to work collaboratively" (P31); "I've got a really good working relationship with the school psychologist" (P7); "[I] work very closely with the school psychologist" (P24). As with the Student Services team, discussing professional concerns with a trusted colleague diminished participants' experiences of *untenable burden*:

If [the school psychologist has] something that's really concerning her or I [do], we'll go through that with each other...It might be that you just want

another set of eyes, [from someone who has the] type of experience that you trust. (P3)

Participants also perceived opportunities for inter-professional learning: “I can discuss issues with [the school psychologists]. They can give me a [different] perspective” (P11); “[I’ve been] working with different school psychologists, some of whom are amazing. I’ve learned a lot from some of them” (P19). Participants were also sought out by school psychologists for their nursing expertise: “[the psychologist] feels overwhelmed with cases... I do try to support her, and sometimes she’ll run through her list with me and say ‘what do you think I should do with this, what do you think I should do with that?’”(P28); “being a nurse, you have a vast knowledge [about] a lot of things, from medical to mental health... [the school psychologist has] come to me... saying ‘I’ve had this issue ...how would you deal with it?’” (P11).

Participants identified that a key element of *school-based case collaboration* with the school psychologist was appropriate information-sharing:

[The school psychologist is] very good at sharing information. She will share with me what's happening, and vice versa if I think the safety of the child is at risk. Sharing the information, sharing that knowledge, sharing what's happening for [the student] so that we know so we're on the same page. (P19)

Other participants reported that both they and the school psychologist at their school worked part time, and appropriate information sharing was essential in the delivery of safe clinical care: “we all share [information] so that if I was case-managing a student and I was absent then there are key people in the school who are aware of what’s happening [and] it can be picked up straight away” (P15); “obviously you have to share information because when... students present, you need to be able to support that student” (P20); “I always discuss [serious issues] with one of the psychologists because I'm only there three days a week. If I drop dead somebody else needs to know [about the student’s problems]” (P18).

Despite the importance participants placed on appropriate information-sharing, participants reported that it did not always occur: “[the school psychologist] doesn’t

share relevant information about students, even at Students at Educational Risk [meetings]” (P2). Some participants reported that they were unaware of students who were seeing the school psychologist with implications for their clinical work:

There are certain things that, on a need-to-know basis, should be shared, and they don't get shared. I'm finding [out] regularly about kids who have mental health issues that we had no idea about. We might be seeing them in clinics and we don't know anything about this. The ones that we have to know about are the ones on the Risk Management Plans... if they're done through the school psychologist we'll quite often find out about them by mistake or the next time we have a meeting and they bring out the list. (P17)

Another participant explained:

All I would have liked to know [from the school psychologist] is that she's seeing a student. [I] have had a student knock on my door not travelling very well and had a list full of mental health issues, and I didn't know one thing about her. (P2)

Participants perceived that certain kinds of information should always be shared because a lack of appropriate information-sharing could have consequences:

One time when I first started at the school a student walked into Student Services. There was no-one around. He came and saw me. Sat down, had a conversation with me. I worked him through the difficulties at that time and escorted him back to class. Later to find out that the student has a history of aggression and violence. That he has two education support [staff] members that are supposed to be [with] him [who] were nowhere to be found. The school were searching up and down for this student. I walked this student back to class with no issues, [but] to hear afterwards that this kid has [a] risk management plan [for] excessive violence, excessive aggression did make me feel a bit concerned... had I had that knowledge, I could [have] better adapted in that situation to work through [the problems]. (P11)

There were also other difficulties participants faced in *school-based case collaboration* with the school psychologist which exacerbated the problem of

untenable burden. The chief concern related to barriers in referring young people to the school psychologist: “[school psychology is] available, but only if it’s very formally completed as a referral.” (P30).

The most significant barrier to *school-based case collaboration* with the school psychologist was the requirement that the school psychologist have parent consent to see a young person: “I got an email back from the school psychologist saying that she would only see her if she got consent from the mum” (P15); “the psychologist only sees [students] if the parents agree, or they’ve given permission” (P2); “[the school psychologists] have to get consent from a parent to talk to the child” (P26); “[the school psychologist] is happy to accept referrals from me, with a signature from a parent.” (P30); “[the school psychologist said] ‘we won’t work with them until we’ve done evidence-gathering and met with parents and got consent.... Our current school psychologist says she won’t accept the mature minor consent” (P27).

Not unexpectedly, where consent was a barrier to *school-based case collaboration* with the school psychologist, *persistent intensity* escalated: “the resources outside of me are very limited, so these kids will come back to you” (P3). In the absence of a crisis, consent first had to be negotiated with the young person to discuss concerns with the school psychologist. If the young person consented and the school psychologist subsequently agreed to accept a proposed referral, the participant then had to negotiate with the young person to discuss the referral with their parent and have a consent-for-referral form signed by the parent. Some participants were able to gain consent from the student to speak to the school psychologist about the presenting issues but could not gain consent from the student to speak to the parent about making a referral: “I did speak to the school psychologist about [the student], but [the student] wouldn’t engage with [the psychologist] because the school psychologist has to get [parent] permission to talk to her. [The student] wouldn’t give permission” (P3). Some young people did not want their parents’ involvement: “she didn’t want to go to the school psychologist if it meant she had to have [parental] consent” (P15); “I definitely do get kids who don’t want [to get] parent permission [to see the psychologist] and they come to me” (P3). Even where parents were not opposed to referral, gaining parent consent for school psychology services was not an

easy process: “for me to refer to [the school psychologist], usually I need a parent meeting. I need parents to sign that they're happy for the young person to go and see the school psychologist.” (P30); “trying to get the parents into the school for that meeting is a huge barrier.” (P27). When participants were unable to appropriately involve other professionals in the care of a young person, the participant was *left holding the baby*.

At times, participants perceived that school staff such as teachers also found the process of referral to the school psychologist difficult to negotiate: “[the school psychologist] doesn’t really see the pointy-end ones [acute cases] because the staff now see it as a barrier that they’ve got to ring home and [get written consent]” (P30). Where school staff perceived that nurse participants’ were an easier point of access than the school psychologist, this exacerbated *persistent intensity*: “some of the staff say ‘can you just see this one because it’s too much hard work trying to get into the school psychologist’” (P30).

A further barrier for some participants was that a proportion of school psychologists would only accept referrals if the mental health problem related to or impacted on school: “[the school psychologist] said ‘I’ll only see her if its school-based anxiety, best send her to the [doctor]’” (P15). Another participant explained:

Usually we get them into the school psychologist, but they only take on kids that it’s impacting on their school work. If it’s something to do with the weekend or long-term, or a romance break-up or something, then [the school psychologists] don’t want to pick them up because they're running a full case-load as it is. (P23)

Another participant commented:

[The school psychologist] won’t take on complex cases or acute students, so then you think ‘what’s the point [of referring to the school psychologist]?’ This poor child - student - is bouncing to the first psychologist and then they’re getting referred on. I hope they don’t get disheartened with that. (P26)

In urgent or emergency circumstances such as suicide risk the requirements for referral to the school psychologist were more variable. Some participants reported that in a crisis the school psychologist could see the young person without parent permission: “my understanding of it is that... if it’s a crisis, then [the school psychologist] can deal with a situation without parent permission, but if it’s not a crisis and she’s seeking to do counselling with the student then she needs parent permission to go ahead” (P3). Other participants reported that in urgent circumstances the school psychologist could conduct a risk assessment with verbal parental consent, but similar issues with parent engagement could make this impractical: “you get a lot of parents that don’t answer the phone” (P5). Another participant explained:

The school psychologist will see [the student] if the parents have said “yes, I’m happy for the school psychologist to see them for a [suicide] risk assessment.” Obviously that’s very different from the way I operate. [My perspective is], if they need a risk assessment, I’m not going to have them sitting around waiting until we can get hold of somebody at home, until someone answers the phone. I’ll just be doing [the suicide risk assessment] in the best interests of the young person. (P30)

Some participants reported that the school psychologist could not see a young person without parental consent under any circumstances: “[the school psychologist] won’t see a student in crisis, and they’ll say ‘we can’t get consent because that student was too upset’” (P26); “it’s quite clear that she’ll not see a child in distress or deal with that until there’s been an appropriate written referral with evidence attached and steps taken before they got there” (P27). Participants less commonly reported that they were *left holding the baby* because the school psychologist was at the beginning of their career:

[The school psychologist] is new to psychology. She’s just finalised her [qualifications]. She was provisional before, I don’t know whether she’s had a lot to do with those sorts of issues [suicidality].... she’s a nice young girl, I don’t want to say inexperienced [but] you know... naïve to life? I don’t know. I don’t know, I just can’t [find the right words]. (P2)

Our school psychologist has been primary school based. It's only her third year out [post registration]. [It's] her first year in a secondary school with this age group, so she's been on a very steep learning curve. (P22)

I have a school psychologist at the moment who does not relate very well to young people [embarrassed laugh], so [it's] very difficult... She's a little bit unwilling to take [students]. I know she's not that busy. (P28)

At the extreme end some participants reported that the school psychologist did not see individual young people at all: "I'll quite often try to refer students to [the school psychologist] and she won't see them... [She] will do case management, policy... group [and] family stuff, but very rarely does individual one-on-one-kid stuff" (P17). At other times strategies employed by the school psychologist did not contribute to *school-based case collaboration*, leaving the participant *holding the baby*: "[the school psychologist's] strategy for students who have mental health problems is to tell them all to go to the [doctor], [but the student] was not going to go" (P15). Other participants reported confusion about the role of school psychologist:

We get told that school psychologists are not supposed to be seeing individual kids anymore... we also get told 'that's rubbish' from other school psychologists. Then we get told it's on an individual basis, whether that's how [the school psychologist wants to do the] job or not. As far as I'm concerned school psychologists are supposed to be doing the mental health stuff. Obviously they can't do it all, but the higher end stuff, and that's not necessarily happening. (P17)

Participants who were experienced clinicians assessed the skills of the psychologist in their school and took this into account when deciding whether to refer a young person to them: "I'm fairly mindful of the way that this school psychologist works, and the sort of children that she might engage with or who would see her once and bolt [run away]" (P28). Other participants also adjusted their clinical decision-making in relation to the school psychologist's skill set:

[The] two visiting private psychologists that come in [to the school] are fantastic with young people, so I always want to refer to them. In the first

instance I'll try to give the school psychologists the first right of refusal, although they are limited within their role from my understanding. (P26)

When participants could not access *school-based case collaboration* with the school psychologist they often identified themselves as the key source of support for young people with mental health problems at school: “[I do the mental health] work in the school. The [school] psychologist is working on the behaviour plans, the learning plans, assessing and testing kids for attention deficit hyperactivity disorder or the autism [spectrum]” (P7); “I feel like I'm really overseeing the majority of the students with mental health issues in the school, and calling the direction of where we go with them as well” (P28). These circumstances exacerbated the problem of *untenable burden* because it aggravated *persistent intensity* and increased the sense of *isolation*: “hugely, [it impacts] hugely [on my workload], because I'm stuck at the moment with a school psychologist that doesn't relate well to anybody particularly... [it's] really frustrating” (P28). Another participant explained:

I feel like I'm carrying the lion's share [the largest proportion of student mental health problems] ... when I ask [the school psychologist to collaborate], they will advise, but they won't necessarily step forward and say “that sounds quite complex” or “maybe I should see that person. That sounds like somebody I should be seeing.” (P7)

Many participants relied almost exclusively on *school-based case collaboration* for their *case, clinical and professional support*, but as the only nurse in the school participants also highly valued *nursing support*. This component is discussed next.

4.3.2 Nursing support

Nursing support was the second component in *case, clinical and professional support*. A lack of *nursing support* exacerbated the experience of *untenable burden*: “I actually do feel a bit lost, being within the school without that [nursing] support” (P11). *Nursing support* could take different forms, and participants identified four aspects of *nursing support*: *transition-to-role support*, *clinical support*, *management support* and *collegial support*. Some participants described having clinical nurse managers who fulfilled all of these roles, but for other participants these roles were

undertaken by different individuals. For example, some participants had non-nurse managers who provided *management support*, while they received *clinical support* from geographically remote specialist nurses and *collegial support* from local nurses. Nursing *collegial support* is discussed in chapter six in relation to the process for managing the problem of *untenable burden*. *Transition-to-role support*, *clinical support* and *management support* directly influenced the experience of *untenable burden* and are addressed next.

4.3.2.1 Transition-to-role support

The first aspect of *nursing support* was *transition-to-role support*. Participants reported that *transition-to-role support* was critical because the secondary school nurse role was uniquely autonomous and required independent functioning from the commencement of employment. Despite this, many participants reported a lack of knowledge about the role prior to their commencement, highlighting the need for *transition-to-role support*: “I first started at [name of school] and at the time [I] knew nothing about it” (P21); “I had no idea [what a school nurse does]” (P9). There was a perception that the level of *nursing support* provided did not match the degree of specialised skills that participants subsequently perceived they needed: “it’s that presumption that ‘you’re a trained nurse, so you should have these skills.’ Which you may have, but some may not. I’ve had to learn a lot along the way” (P30). It was evident that experienced secondary school nurses recognised how stressful this might be for nurses new to the role: “there’s a new nurse in our team... She hasn’t worked as a secondary school nurse before and I feel that that must be such a challenge to her” (P3).

Although participants reported feeling comparatively unprepared, many had significant experience in other nursing specialities prior to becoming a secondary school nurse. Demographic data collected revealed that the oldest participant was 63 years of age, and the youngest was 30 years of age. The participant with the longest nursing career had been registered for 41 years, and the most recent graduate had been registered for four years. The average age of school nurse participants at time of interview was 48.5 years, and the average duration of practice as a nurse in any

setting was 25 years. By any measure, the majority of participants were highly experienced professionals, but this was not protective.

Given the variation in previous nursing experience, it was not unusual that participants reported significant disparity in the level of knowledge and skills they had on commencement into the role. Some participants acknowledged this: “everybody’s starting from a different base. Maybe the assumption that everybody starts off from zero [as a secondary school nurse] ... would be helpful” (P25). Many participants reported that on commencement they anticipated being provided with *transition-to-role support* in the form of role preparation and training:

When I [said] I was going into secondary school, so many people said to me ‘it’s all about mental health’. Practically every nurse [said], ‘it’s full of mental health, full of mental health’. [I thought] ‘How am I going to deal with that? That’s going to be a bit tricky.’ But I just thought ‘I’ll get support, training and everything else. It should be good’. (P1)

While participants may have anticipated being provided with role preparation and training as a component of *transition-to-role support*, many reported that this was minimal: “when I started working for the [employer] in school health I think there was very little preparation for what secondary school nursing was about” (P31); “I don’t think there’s enough preparation beforehand to give you an idea of what you’re going to deal with, and how to deal with it” (P1); “being a new practitioner [in secondary school health], I’ve found that that hasn’t been recognised” (P13). One participant recounted being orientated to the work setting, but not to the clinical role:

When I went into the school originally, there was a nurse that handed over to me. Just mainly about the layout of the school, the working of the school, when recess was, when lunch was, that kind of stuff. Where the Student Services team were, a list of [telephone] numbers, but not about the actual [clinical work]. What you’re going to get in [the health centre], what you’re going to deal with [clinically]. There was no preparation for that. (P1)

Other participants did not even have the benefit of this level of *transition-to-role support*: “when I started my job as a school nurse the other school nurse had already

left two terms before. I basically started the job with nobody there to mentor me” (P8). Another nurse participant recounted: “I actually stepped into a job where the [previous] nurse had [died]... My first day as a school nurse was at her funeral... I’d not even had a handover from her or knew how she worked. It was really the strangest way I’ve ever started a job” (See footnote¹). On average, these nurses had been in their respective roles as a secondary school nurse for five years.

As a result of limited *transition-to-role support* some participants reported that they had relatively little knowledge about the role even as they arrived at their assigned school to commence employment: “I knew that the job would have some social [and] psychological elements to working with teenagers, and some mental health, but I didn’t really know what I was getting myself into” (P3); “a lot of the stress ... [for me, was] not really having the skills to know how to handle it” (P24); “I really had no idea what I was in for... I was hit with the floodgates, and not having enough preparation on how to deal with it” (P15). Other participants had made false assumptions: “when I started reading [school health] policies I realised that my job was different to ... what I thought it would be” (P23). The assumptions participants disclosed were very varied: “I thought [being a] school nurse was... doing first aid... being that advanced medical knowledge person” (P11); “I thought I’d be doing a little bit of first aid. Before I’d even had my [recruitment] interview I’d heard a little bit about ‘there’ll be mental health’, so I was expecting some mental health. That’s about all I knew” (P3); “I thought I might be checking for head lice, dealing with fights and doing a bit of triage. I might get to go into classrooms and help the teachers do some health lessons. That was my understanding [of the role]” (P21).

Transition-to-role support was particularly important because a significant number of participants undertook the role of secondary school nurse simply because the opportunity arose: “the nurse who was in the secondary school was leaving and our manager said, ‘do you think you’d like to try [secondary school nursing]?’” (P31); “a friend that I’d previously worked with in [another specialty of nursing] was working

¹ As these circumstances are potentially identifying, the participant number has been omitted to preserve their confidentiality elsewhere in this thesis.

in school [health] and she said, ‘would you like to try this out?’” (P26). Other participants indicated that it was the result of chance circumstances: “I fell into school nursing” (P22). Some initial anxiety was common: “I was pretty intimidated about working in a secondary school setting” (P9); “a position came up in a secondary school. I knew I was slightly interested but scared about doing it because I didn’t have any background training” (P26); “the lack of [background] knowledge for me has been my major [worry]. That was my main concern going into it” (P12). Although uncommon, one participant reported that a colleague had been assigned to work in a secondary school even though they did not feel confident in that role:

I found out recently that there is a nurse that’s been forced into [working in a] secondary school. She’s only [worked in] primary schools [because she doesn’t want to work in a secondary school]. Her manager has said she has to [work in] secondary schools... that concerns me because her mental health is now under more stress than it should be. I don’t [think anyone is] mentoring her... I think we have a responsibility as professionals [to ask] ‘do you feel competent going into that school?’ (P21)

By contrast, a participant who had trained specifically as a school health nurse overseas commented:

I was really shocked when I came [to Australia]. I could have come as a generally new nurse, [with] not much experience in a secondary school, and... they would still have placed me in a secondary school if I wanted it. (P30)

The most common means by which participants prepared for the role was at the level of the workplace, in the school setting: “I wasn’t too sure what the role entailed and I’ve been learning on the job” (P9). An experienced participant recalled:

It’s training on the job basically. When you’ve been doing [secondary school nursing] for [as] long [as I have], it doesn’t stress me out too much. I think [this is] because it’s happened over a period of time for me, and I’ve learnt on the job.... I think if you were a new school health nurse it would be very, very, very stressful. (P17)

Training “on the job” was far from ideal. Participants explained that there were practical problems getting clinical support and advice from more experienced colleagues when they were working in isolation and the young person was in the room with them: “it’s a bit hard when you’ve got the student in the room with you” (P19); “in a situation [with the student] you don’t have time to [say] ‘hold on a second, I’m going to pull out this policy and read up’ or ‘I’m going to grab this person [to help]’” (P11). Another participant explained:

It’s more, what do you do in certain situations? When you’ve got a teenager [in your office] and [you think] ‘I don’t know what advice to give you’. You can’t really get on the phone with [the student there] and say ‘I’ve got so-and-so with me right now, what shall I tell them?’ (P12)

Training “on the job” also led to significant variation in the way the role was undertaken: “when I sit with a room full of school nurses, we’ll all have a different idea of what we do” (P27). Some participants attributed the variation to the length of time a school nurse had been employed and where: “I think [that nurses in different schools are doing different things], especially if they’ve [been] there for years. I think they’ve just got into [a] habit” (P1). Other participants felt this reflected geographical variation: “you talk to other school nurses and they’re able to do things that we’re told is not core business in our region so we can’t do them” (P22); “when I network with other school nurses in different districts, my [region] is a lot different to [other regions]” (P27). Another participant commented:

You have a combination of nurses [in the service. Some] have worked here for years and have seen the changes over the years. Some have changed with it, some haven’t. Then you have nurses coming from overseas, different places, who also have different ideas and different experiences of secondary school nursing. (P30)

Although there were a variety of documents intended to guide school health practice, participants did not find these particularly helpful: “the expectation from the school and [the guidelines] you have, it just doesn’t really give you a clear indication of what your job really entails” (P13). More direction was desired:

I know that there are some [guidelines] out there, but.... it might have put my mind at ease if there was [a] document that said ‘this is who you are. This is what you're going to do, and this is how you're going to do it’. I might feel a little bit more at ease. (P27)

Another participant reported: “[it’s] a hard job to do because it’s not prescriptive. You can’t write a relievers file and [say] this is what you do” (P10). As a result of this variation, some participants perceived that the role was vague: “the role of the secondary school nurse is so ambiguous” (P13); “there’s no real clear ‘this is what a school nurse is’” (P27). A participant who had only recently commenced the role stated: “I find the role as a school nurse quite confusing, [and I am] a school nurse. I can't imagine what staff and students think” (P9).

Some participants reported that *transition-to-role support* in the form of orientation and induction programs had improved significantly in recent years: “I think now in fairness, the induction is a lot better. We didn’t have any induction, so any induction would be better [than none]” (P19). Even so, some participants who received a few days of formalised clinical education for the role reported that this did not necessarily include any adolescent mental health: “I don’t think there is enough training [available] for us as nursing professionals, for what we’re dealing with” (P1); “[the employer] did give me some training but certainly none of it covered adolescent mental health” (P22); “with [clinical orientation], [the employer] should be putting something on in regards to mental health [training]” (P30). With the benefit of hindsight, the majority of participants perceived that training and professional development were essential to prepare them for the clinical workload:

[You need] education before you get into the role. So better preparing nurses [before they] go in. I've been very lucky and did all those courses, but it wasn't until four, five, six months [after I was employed] that I've been able to do them. I've had that period beforehand where I've had nothing to draw on. (P12)

Participants who had only recently commenced employment as a secondary school nurse were more positive about *transition-to-role support* in the form of training and professional development: “[the employer] do have a lot of opportunities for

training... that's one of their strengths, they provide a lot of opportunities for upskilling" (P31). Another participant reflecting on recent changes explained:

We've got lots of training for our nurses now, Gatekeeper [suicide prevention training], [and] [psychosocial assessment] training ... We've got all those resources in place. If people are new to the role we've got the Clinical Education team who can go out and [support the nurse]. There's mentoring in place, [a] Learning and Development [team]. There's all [these resources] in place. (P21)

While *transition-to-role support* could ease the initial experience of *untenable burden* by preparing participants for the clinical workload, the complexity of *wicked problems* combined with the *autonomy and isolation* highlighted a need for ongoing *clinical support*.

4.3.2.2 Clinical support

The second aspect of level of *nursing support* was *clinical support*. Participants who experienced a lack of *clinical support* frequently reported an escalating experience of *untenable burden*: "I am coping but [feel] that I am burning out quite badly" (P11). A highly experienced participant explained:

When I started at the school [I thought] 'I am so fascinated and interested in mental health'. Twelve months on I was thinking 'I don't want to see another person come through my door [with a] mental health problem, because I don't feel [clinically supported]. I feel really worn out by it. (P3)

Clinical support was particularly important because the legal and ethical commitment to maintaining young people's confidentiality could intensify feelings of isolation, in turn exacerbating *untenable burden*: "It's made more difficult because [students] disclose things that I can't tell the [school] staff about... I can't betray their confidence [if it's not] a harmful thing. I have to keep the secrets that they tell me" (P15).

It was evident that the majority of participants felt that *clinical support* was lacking: "I love the job that I do, but I don't feel clinically supported" (P7). Participants

perceived that formal arrangements for the provision of *clinical support* were not especially effective, and it could be difficult to get *clinical support* when it was most needed: “I know people say ‘but your manager’s on the end of the phone’. I’ve rung managers and they’re not available. They’re at meetings or they’re at this or that” (P1); “I ring my manager when there’s issues [to resolve], and my manager is very supportive, but she can’t be everywhere all the time” (P31); “there’s not always people available to talk to. There is on paper, but then when you ring that person, they’re busy doing something themselves” (P3). Participants also found it impractical to use established systems for *clinical support* in the midst of a crisis: “I can contact many other members of the Health Department within my [geographical] region, but unfortunately when a kid with a mental health condition comes in you don’t have time. [It’s a] crisis situation” (P11). For many participants, the lack of effective *clinical support* prompted them to develop other arrangements: “one of the school nurses is very experienced. She was like a role model and someone that I could turn to for support and direction” (P24). Informal measures were common: “I’ve made connections at trainings, and [other nurses] would say ‘give me a call’...so [*clinical support*] was informally done... you definitely had to build you own [*clinical support network*]” (P31).

In addition to needing *clinical support* with urgent high priority issues, participants also desired more *clinical support* to better meet the needs of young people. Without adequate *clinical support* for developing new skills participants felt that they could not take advantage of the opportunities they had to intervene: “there is an opportunity for me to do so much with teenagers around their mental health but I don’t feel as if I have enough tools to do the job as well as I would like to” (P3). *Clinical support* therefore included specialist support to develop new skills: “[if] they self-identify that they’ve got anxiety, but they’re not interested in going elsewhere [to receive specialist care], [then] I haven’t really been trained how to help that person” (P15).

While the lack of *case support* could aggravate the experience of *untenable burden* in the context of clinical complexity, the experience of *untenable burden* was further exacerbated if *management support* for operational issues was also inadequate.

4.3.2.3 Management support

Management support was the third aspect of *nursing support*. Participants did not only want *management support* when things went wrong: “it would be great to have [managers] communicating a bit more with the leaders at the school... And not because ‘oh, there’s a problem’, actually just as a positive thing and a sort of pre-emptive thing” (P8). Managers who came to the participants’ school were particularly valued:

She was such a supportive manager who... would come over [to the school to] meet with me [and] the principal twice a year. Just [to] give you that moral support and say “[name of nurse] is doing a wonderful job. Is there anything else we can help you with or do? Or do you think there are any needs?” (P22)

Most valued of all were nurse managers who had experience of secondary school nursing themselves, but these were in the minority: “[the manager] had a lot of experience in school health herself, so I had that back-up ... lots of nurse managers have had minimal, if any experience in secondary schools and are not there to support their school nurses” (P21).

For participants who did not have *management support* its absence was noted: “I’ve worked at the school for six years. My manager has been over once to the school that I work at. The head of community health has never been to my school since I’ve been there” (P8). Many participants who reported they had inadequate *management support* perceived that this was due to managers not understanding the demands of the role. For example, some participants in rural and regional areas were not line-managed by a nurse: “when you have management that don’t come from a nursing background it’s very difficult for them, but I still think they need to try and have an understanding of where that role is at” (P22). Other participants reported frequent changes in management that affected *management support*: “we’ve had managers come and go, many times... Some have understood the challenges and rewards of working in secondary school, and some of them haven’t” (P25). Some participants felt that secondary school nursing was a low priority for the employer: “secondary school [health] has always been on the back-burner” (P16); “we’re sort of in the

shadows somehow” (P8). A lack of understanding about the secondary school nurse role at the management level was a common complaint:

My line managers have no understanding of my role because unless they've worked in that role they don't understand it. I don't feel... we get the support we need because management don't understand the role. (P22)

I don't think [the managers] understand our role in secondary school... it seems at times, they do not look at the [school health] service beyond school entry [health assessments]. That is what [they perceive] school health is about... I think our role has been very poorly understood by the people that we work for. (P25)

A perceived lack of *management support* was particularly problematic for participants because of the isolation inherent in the role. As lone Department of Health practitioners in the school participants often perceived that they were at a disadvantage when negotiating with school leadership and appreciated the support a manager could provide: “having that backup, rather than just yourself walk in [to] the principal... [when] you don't have the backup of your [manager] behind you” (P22).

Some participants did not feel able to approach their line manager for *management support*: “I haven't felt very supported at all... from my manager's point of view that I'm just [there to fill the] seat. I'm to sit there, shut up and do the job” (P13). Other participants could not rely on their manager for assertive *management support*: “I have spoken to my manager, in regard to this. She is aware and is concerned that I'm having these issues [but] ... I'm not quite sure what to do” (P11); “I've gone to my manager about job-sharing load and I haven't had a lot of support” (P13).

Management support meant different things to different participants highlighting the need for managers to respond at the individual level. Some participants reported that the *management support* offered did not meet their needs: “I feel [that] sometimes when there's an issue [at the school] I'm given the [Employee Assistance Program] leaflet... but I don't necessarily want to go for counselling” (P7). Another participant explained:

[I said] “I don’t really feel like I’m getting [management] support.” All I got was an email saying “set up a meeting and I’ll come on over,” and I really don’t think that’s it. I think there’s more to it than that. (P22)

A lack of *management support* could have significant ramifications for the organisation: “we are losing staff. I can think of at least five nurses that I have mentored into the [secondary school nurse] role who have not had support from their nurse manager, who have then left the organisation” (P21). While participants were well-motivated to establish a collaborative relationship with their assigned school, when there were intractable difficulties many participants valued *management support* that was active and assertive: “[the manager] said ‘I’m not going to let my nurse be treated like that’ (P15); “my [manager said] ‘stay away [from the school] for the rest of the term. When the principal is back, we’ll ring him and have a discussion’” (P27); “[my manager] said ‘so much bullying going on in the school. I’m pulling you out’” (P18).

While *case, clinical and professional* support was essential to participant’s clinical and operational activities, partnerships with parents and external service providers in the community were essential for assuring that young people received required specialist care. *Community partnerships* was the third influencing condition in the basic social psychological problem of *untenable burden*.

4.4 Community partnerships

In contrast to *case, clinical and professional support* which related to clinical and operational support for participants, *community partnerships* related to the support participants could source for the young person in their care. Many participants reported that the problem of *untenable burden* was directly diminished by *community partnerships* with parents, primary health care professionals and community agencies because professional care of the young person experiencing mental health problems was shared. Conversely, when *community partnerships* were unreliable or absent, the basic social psychological problem of *untenable burden* was exacerbated: “it’s hugely impacting [being almost entirely responsible for young people with mental health problems]. I feel very alone” (P28). Two components of *community*

partnerships were identified: 1) *parents* and 2) *the availability and capacity of external service providers*.

4.4.1 Parents

The first component in *community partnerships* was *parents*. When young people experienced problems that impacted them at school, a meeting was commonly sought with the young person's *parents*:

Depending on what the nature of the issue is, and who's been having most to do with the student or the parent, [we] will meet. We usually have more staff that would like to be [at the meeting] than that don't want to be there. We've got quite committed staff. Sometimes it's more a case of culling how many of us [attend] so it's not so intimidating for the student and the parents. Usually we'll meet with the parents first, or with the parents and child, and then meet with parents on their own. (P19)

When young people experienced significant mental health problems, referral for appropriate treatment was a high priority for participants, who typically referred the young person either to the school psychologist or to a community agency. Both of these options usually required parent consent, but parents did not always support or action a referral: "[there are] multiple reasons [parents don't action referrals]. They haven't got enough time, usually they're at work, there are other kids in the family, they change their mind when they walk out the door. They can come up with lots and lots of excuses" (P23). Another participant explained: "it's all very well and good saying 'just go to [mental health service]'. If they don't go... you can't make them go" (P15).

Sometimes it was difficult even to engage the parent in a conversation about the young person's wellbeing: "sometimes you can't get in touch with parents" (P1). Consent to refer the young person could be challenging: "[getting] parent consent [for referral] when the parent is so [disengaged] from the school [is difficult]" (P27). When parents were difficult to engage the likelihood that the participant would be *left holding the baby* increased: "unfortunately mum's one of these mother's that's really hard to contact. [She] won't return messages or phone calls. So, because we

haven't been able to get explicit consent this student hasn't been able to access the school psychologist" (P9). When combined with *high stakes*, the experience of *untenable burden* could be overwhelming: "trying to get [the student] to Child and Adolescent Mental Health Services... While you're trying to get that child into some safe place, they're in your office and you're it with them [responsible for them]" (P1).

The experience of *untenable burden* could also be exacerbated when parents declined referral for their child:

If [the parents] don't want to sign the referral I can't refer [the student]. If [the parents] don't want to take the next step... if they're not agreeing to a referral to the school psychologist, then these kids are there with no care, with no cover or follow-up. (P23)

Stigma was a common reason why parents were reluctant to take their young person for more specialist assessment and care:

A lot of time the resistance isn't with the young person, it's actually with the parents who don't want to give their child a label. They don't want a mental health diagnosis, because they see it as being detrimental and their kid's going to be labelled and put in a box. (P25)

Another common reason why parents did not consent to or support referral was that they interpreted the young person's presentation as typical adolescent behaviour or 'looking for attention':

One of the most frustrating things is parents. Trying to get parents on-board... they don't feel that the problem is such a big deal. They often underplay it and think 'oh, they're just being a normal teenager and looking for attention'. That's a famous response you get from parents. (P24)

At other times, parents denied that their child was experiencing problems. This sometimes caused participants to question their clinical judgement:

We will contact the parents and relevant people in school to share that information [regarding risk for self-harm or suicide] to keep them safe. But

quite often we'll have the parents say "oh no, that's a load of rubbish. There's nothing wrong with her, she's just being a bitch." (P17)

It's disappointing that [the parents] didn't see it the way [I did]. Then I sometimes question myself... did I misinterpret that? Did I overreact? ... [The] school gets frustrated because these kids are not in class. (P23)

Other participants were exasperated when parents reported resolving complex problems such as deliberate self-harm by having a brief conversation with the young person:

[The parent said] "It's all sorted out, I've talked to them." Sometimes you get from the parents, "I've talked to them. I've talked to them." So they've settled it in-house, instead of going and telling the whole family gamut of why this child may be self-harming. (P2)

Some parents agreed to referral but were slow to action this, or changed their mind about seeking treatment after agreeing with the participant to action a referral: "you talk to a parent and [agree] it's the [doctor] assessment and then the mental health care plan. But then three weeks later they still haven't managed to get around to it" (P4); "you'll find that maybe the [barrier] is the parents. [The parent] can't get them to the appointments, won't take them to the appointments, they're not doing anything" (P2); "you can make the referrals and then you get the parents who won't take them to the appointments" (P31); "I find it's their parents that don't want to take that next step. I can send kids home with a parent, saying 'I would really like you to take him to the hospital. I think that's what we need to do'. [It's] that serious, and they don't go" (P23).

Under these circumstances participants were often *left holding the baby*: "the kid that a parent walks out the door and changes their mind [about following up a referral], they're the kids that keep coming back" (P23); "[the] parent will come back and say 'no, they don't need a psychologist'. So then the student keeps coming back [to the school nurse]" (P26). Participants were very cognisant that it was the parent's right to decline referral: "[it's] the parent's prerogative... the next step is the parent's responsibility, and they chose not to go [to the hospital]" (P23); "at the end of the

day I am a community nurse, I'm not a parent to that child" (P2). Even though participants recognised the parent's right to decide, this outcome had the potential to impact the problem of *untenable burden* because participants were also conscious that young people who did not receive early and effective treatment were more likely to experience ongoing problems:

With both of those students [where the parent declined to action the referral] one was drug-related and the other was a type one diabetic and was self-harming through cutting herself and self-harming through manipulating her insulin. Both of those, we had the hospital already prepared. Child and Adolescent Mental Health Services wanted to section [detain under the Mental Health Act] the boy with the drugs because he was just suicidal. The girl, if she could have gone to Princess Margaret Hospital for Children, I think her recovery time would have been really good, because it would have been handled, it would have been addressed, but hers is still ongoing. (P23)

As with the examples above, it was not just young people with mild difficulties where parents failed to follow up as expected. One participant commented that parents could become desensitised to chronic issues, even in the context of five recent suicide attempts: "It is concerning for the safety of that child. Over time I've noticed that the parents become a bit more apathetic to [the mental health problems], so they don't understand. I've had engagements with the student's parents, who don't see it as a big issue" (P11).

Participants understood that some parents presented with difficulties that contributed to barriers to care for the child: "[the parent's] got mental health issues, so engaging with mental health support for their child is too confronting" (P31). Other participants recognised that some families found it intrusive for a mental health service to enquire about family life:

You send them to the [doctor], you can make the Child and Adolescent Mental Health Services referral, you can make the [community agency referral], you can... do all that... but sometimes it's not followed through by the parent. [The parent perceives that service providers will] invade the

house, so that's an invasion of their personal space. They don't want people to be judgemental. They don't get their back up, but they put barriers up. (P2)

Where there were clear indications that a young person was in urgent need of mental health care and parents were unable or unwilling to access treatment for the young person, some participants felt they had no alternative but to file a report with child protection services for medical neglect, although this was typically perceived to be a last resort:

The parents... [don't want] to believe that their kid has an issue, and therefore [are] not following up with referrals. [This is happening] to the point where we have had to refer to the Department for Child Protection and Family Support for neglect [of] medical concerns. (P17)

We're at the point that today is the appointment, so we'll see if they attend. If they don't attend I'm going to put a Department for Child Protection and Family Support report in. I spent a lot of time working on that [case], a lot of liaison with other agencies.... I don't use the Department for Child Protection and Family Support threat because that doesn't get you anywhere. (P28)

In addition to participants perceiving the parent's unwillingness to seek treatment for their child as personally stressful, participants reflected that under these circumstances schools subsequently became default mental health services: "you just keep chipping away [when the family or child won't engage in an external service]. So much falls on the school to keep these kids supported... basically the school becomes that service. You're constantly trying to keep these kids afloat" (P24).

Participants were slow to give up on young people who they perceived were disengaging from school and recognised that school was often protective for vulnerable youth: "a lot of these kids, the safest place is school for them" (P17). Promoting school engagement was a routine element of their work with young people, but when a student was no longer attending most participants felt that they were unable to continue offering meaningful support beyond some initial phone calls:

He just can't, poor kid, he just can't do it [come to school]. I keep saying, even if he'll just come in, we can look at his timetable and we'll pick a class. He'll come [to school] for half an hour, we'll just... one class, he doesn't have to do any work, just to try and gradually... but I guess until we get him to cross that threshold and actually get into school, we can't work with him. (P19)

This stance reflected participant views that they were based solely in the school. Participants who had worked in the school health service in the United Kingdom (where home visiting is undertaken) commented that there was little support for home-visiting in the Western Australian school health model. Home-visits were only rarely offered by participants: "I made contact with mum... I went and did a home visit on that one, which you never do really in secondary schools" (P18).

Participants were well aware of the *high stakes* when young people did not have parent support for engagement with a mental health service. One participant described how a young person disengaged from school after efforts to facilitate mental health treatment had failed, with tragic results for the young person and their family:

Unfortunately we recently did have a completed suicide at our school... [The death occurred] at home on a weekend. He hadn't been engaged at school... so we'd not seen the student for a few months but we'd worked previously with him. We'd done all the assessments; everything had been done that we could. We'd referred him, we'd involved parents, we'd referred to services, but the family had not, at that point engaged in anything. I don't know what happened once he'd not been at school, but we've got some severely... very, very high risk [for suicide] students [as a result of] that as well. (P16)

There were also occasions when parents or primary caregivers had enrolled a child in a new school during the year and had not disclosed a recent history of mental health problems. One participant recalled:

[The student] came to us with nothing on the books. When I rang grandma, [the student] had made a very serious attempt [to end her life]. She'd

contemplated [suicide]... waited for [her] mother to go to sleep, then taken 100 mg of ... I can't remember what it was. Took about 25 of them [tablets], [and] ended up in the Intensive Care Unit. (P18)

Failure to provide participants with this information exacerbated *untenable burden* because it meant that the duty of care participants owed the young person was impacted by a lack of essential information:

Parents don't always disclose [student mental health problems] when they're coming [to a new school in the middle of the school year]. I always make a point of ringing up the parent to find out information, why they've come. Initially they're hesitant to disclose. (P18)

Many participants expended a great deal of effort to engage *parents* in accessing care for a young person experiencing mental health problems, but this was not always enough. Some participants reported that the main barrier was the availability and capacity of *external service providers*.

4.4.2 External service providers

The second component in *community partnerships* was *external service providers*. When young people were unable to appropriately access specialist mental health services or disengaged prematurely, *untenable burden* was markedly exacerbated because the participant was *left holding the baby*. This research was undertaken in the State of Western Australia which has an area of 2.65 million square kilometres. The state has one major metropolis (the capital city of Perth), and a number of mainly coastal small cities and towns with the vast majority of the state only sparsely inhabited. Despite the variation, both regional and metropolitan participants described difficulties with the availability and capacity of *external service providers*. These ranged from a deficiency of services, to delays in assessment and feeling that concerns were not taken seriously. There were three aspects to the availability and capacity of *external service providers*: 1) *a lack of services*, 2) *referral not accepted* and 3) *into the void*.

4.4.2.1 *Lack of services*

Consistent with findings from the Commissioner for Children and Young People WA (2011), the majority of participants reported a *lack of services* in their communities: “I think our challenge here is referral processes. Obviously, we’re a bit more regional, there’s nothing just down the road” (P4); “there’s been a big decline in the community health [services] and the agencies that [are] supportive of it” (P14). Understandably, a *lack of services* was reported to result in longer waitlists for available services: “all the services have been reduced. The waiting times are longer, and in the meantime that student is trying to [keep] things together” (P25); “[the] waiting list even for [the local mental health service is] 6-8 weeks” (P20). Participants described the impact that waiting lists had on young people and their families: “[the] time between the referral and when they’re [seen], for kids who are really struggling with their mental health and [their] families. It’s a very tricky time” (P25). Delays in having a student assessed were a common source of frustration:

[There] has been at times an eight day delay to even get a triage appointment.... then it’s been another seven or five or eight days to have the appointment. Then it’s still got to go to their [intake meeting]. That becomes really challenging. (P4)

Hampered by a *lack of services*, participants described having to make persistent efforts to source mental health care for a young person. This participant had been persisting for two years:

She’s now 16, she’s in Year 11 and I have got her into the Youth Community Access and Treatment Team [a tertiary level service] but that’s taken a lot of time and [her] continually coming back to me and telling me all of this stuff about all of her behaviours. (P3)

Persistence was key, because some families would only consider engagement with an external service provider after a lengthy period of therapeutic engagement with the participant:

I struggled very hard to work with the family. The dad’s a single parent, [with] two children. By the time I got on the scene [there had been] years of

behavioural issues and dysfunction and poverty and drug use. I finally got a foot in the door with this family, with dad. I did a lot of work around developing a non-judgemental relationship to try to get him some support so that he could be a better support to his kids. [But] just trying to get services for that family has been very, very difficult. (P24)

For young people living outside the major metropolitan centres, time and transport issues compounded the *lack of services*: “our kids can’t get into [the local agency] very much, because it’s [in a large regional town some distance away] and it’s for mild to moderate [mental health concerns]. You’ve got all the transport issues [trying to get there]” (P14).

The *lack of services* was evident not only in the non-government sector. Government agencies that participants relied on to take action were often also not able to offer intervention: “I haven’t done a Department for Child Protection and Family Support referral. I did one on the younger brother, but nothing was done” (P2); “[The Department for Child Protection and Family Support] don’t follow up teenagers. They’re too busy with [younger children], and they’ll tell you that” (P17); “you make a referral to Department for Child Protection and Family Support and no action is [taken]” (P31).

When agencies had long waiting lists as a result of the *lack of services*, the referrals they accepted could be more carefully curated. Despite persisting in their efforts to source specialist services for young people and their families, it was not uncommon for participants to report that referrals were declined.

4.4.2.2 Referral not accepted

The second aspect of availability and capacity of *external service providers* was *referral not accepted*. For some participants, the narrow intake criteria of *external service providers* proved to be a significant barrier: “their criteria for taking the student is often quite narrow.... I understand they’ve got their criteria and their guidelines, but it’s pretty hard to make an assessment over a triage phone call. [It’s] really frustrating” (P24). For other participants *referral not accepted* manifested as difficulty even speaking with a referral agency. A participant who was attempting to

engage a young person with a Department of Health tertiary service in a crisis was unable to speak personally with someone who could take the referral:

Even getting through to triage sometimes... I haven't been put through to triage when I've wanted to send a child [in] who was suicidal.... There was one day I couldn't get past the receptionist on the phone. I said "I work for your organisation," and she would not put me through to triage. (P31)

Participants perceived that ineffective efforts by *external service providers* to engage a young person in treatment were also an oblique *referral not accepted*: "they'll say 'we tried to get in contact with the kid and they never answered their phone'. I say 'well did you ring after school time? Because they're not allowed to answer their phone in school time'" (P2).

Some participants articulated a paradoxical version of *referral not accepted* where the external service provider perceived that a young person was too high risk for them to manage and handed the case back to the lone participant:

[I referred] a couple of students to them, [but the agency] said they didn't meet the criteria because they were too high risk. They make that judgement on one triage phone-call when you've been working with that student for six months. [It's] very frustrating. (P24)

Another participant described a version of *referral not accepted* when a mental health crisis intervention service was replaced with a telephone helpline:

[The] Child and Adolescent Mental Health Services Acute Response Team and Acute Community Intervention Team have disappeared [been decommissioned]. We're now back to the telephone referral service which is a very, very brief: "ring these people," "I've rung those people," "well, ring them again." (P25)

Some participants described cases of *referral not accepted* because the case was not proven. In a case of alleged sexual abuse: "when I asked the Department for Child Protection and Family Support why this child had not been referred, the response was 'well the case was not substantiated'" (P31). As described by one participant:

[The student] was identified as [having been] sexually abused in [regional town]. I said “have you... seen your doctor and had any tests?” [She said] “no.” [I said] “have you had any counselling for it?” [She said] “no.” [She’s] 14, 15 [years old]. [I thought] ‘that’s ridiculous, apart from sexually transmitted infections, what about this huge issue [of sexual assault]?’ I rang the Department for Child Protection and Family Support. It was before a holiday. [They] didn’t come back to me, didn’t come back to me, didn’t come back to me. Eventually I rang three times in one day and said “sorry, I’m not getting off the phone until I speak to a case manager.” (P18)

Persistence and tenacity were common responses to *referral not accepted*, but in some cases participants did not receive any feedback about the referral at all. The third aspect of availability and capacity of *external service providers* was when referrals went *into the void*.

4.4.2.3 Into the void

Some participants reported that their referrals to *external service providers* went unacknowledged and they did not know if services had been offered or provided to the young person. It was as though the referral had disappeared *into the void*: “there’s no feedback from [the service] either. We refer people there, [but] it’s a one-way trip” (P15); “we don’t always know if they attend [external appointments] or not” (P22); “you don’t always get feedback and find out how students are going because the [mental health] system just rolls on” (P5).

Other participants described the young person disappearing *into the void* when the referral was actioned:

You’re doing all that groundwork and then when it goes for referral to a service ... I feel it’s hard to be able to actually hand that over... [I wonder if] the service is going to take [the student] on and make sure that the student receives the best support. (P24)

This was very frustrating for participants: “you’ve given your student that support but then you don’t always have the rewards or the satisfaction of knowing how they

are coping” (P5). When young people disappeared *into the void*, participants described remaining interested in the young person’s welfare and hopeful that their needs were being met, although misgivings were common:

[The student] was feeling overwhelmingly anxious about things and sad. She didn’t know why she was feeling sad and it was getting worse. She went to her [doctor]. Her [doctor] prescribed her anti-depressants, but no referral to a psychologist.... then on the flip side I had another student in the same week that had suicidal thoughts, really flat, low mood, couldn’t get out of bed, went to [another doctor]. He gave her a referral to psychology, but no other medicinal support. (P26)

When participants were particularly concerned about a young person, assertive enquiry with the external service provider was a common response: “I spoke to the Child and Adolescent Mental Health Services worker and said that I really would like to know if the family attend” (P28). Assertive enquiry was not always possible, such as in the case of mandated reporting when the flow of information was typically one-way. This version of *into the void* was often perceived to be highly stressful: “I actually find the inter-agency relationship quite fraught for me. I feel very anxious every time I have to do a report, because I’ve not had positive experiences from case workers” (P31).

The foregoing section explained that when *community partnerships* were unreliable or absent the experience of *untenable burden* was exacerbated because participants were unable to source appropriate specialist support for young people. These very stressful experiences could be further exacerbated if the participant was also managing challenges in relation to their *ability to function in the school*. It was not uncommon for participants to report that their assigned school did not understand the purpose and intent of their role. This final condition influencing the experience of *untenable burden* is considered next.

4.5 Ability to function in the school

The *ability to function in the school* was the fourth condition influencing the problem of *untenable burden*. The majority of participants reported that the *ability to function*

in the school directly mitigated or exacerbated the degree of stress participants experienced in their role. The problem of this additional stressor therefore had the potential to exacerbate their experiences of *untenable burden*. An experienced nurse who had been a school nurse visitor overseas but was new to Western Australia confided: “I hadn’t experienced building a relationship with school staff... all the bureaucracy and policies for the Department of Education and how I had to work within those as well as within the community health policies” (P8). Another participant explained: “it can be difficult because there’s sometimes that clash of policies and procedures, having an understanding of what they can do, and their understanding of what I can do” (P11). Two components of the *ability to function in the school* were identified: 1) *misperceptions of the school nurse role* and 2) *professional respect*.

4.5.1 Misperceptions of the school nurse role

Variation in the school nurse role was accepted and anticipated by participants, but some school demands for health service delivery fell outside the parameters of the role as defined by the Department of Health. These were conceptualised as *misperceptions of the school nurse role*.

Participants often reported that the school nurse role was not well-understood by Department of Education staff: “a lot of the Education Department staff don’t really know what our role is, and to be honest, they’ve got their own roles to do. They’re not that interested, as long as you [do] what they want you to do.” (P3); “the school doesn’t see my job as what the [Department of Health] policy says” (P23); “[the school] don’t know what school health nurses do” (P15). Another participant explained:

Some [school staff] understand the role and some don’t understand the role. Some are interested in finding out your capabilities and others want to put you in a little box. ‘That’s what you do and you’re not coming out of that box’. (P25)

Even within the relatively close confines of the Student Services team, some participants felt that the school nurse role was not well-understood: “our psychologist

and our chaplain are great, but I sometimes feel that they don't really understand what our role is" (P20); "there are a few people who do really respect my role and understand what I do, but there's just not enough of them. I do feel very isolated personally and professionally" (P15).

A recurring theme in *misperceptions of the school nurse role* was a mistaken expectation that the school nurse would attend to minor illness and injury. Despite both Department of Health and Department of Education policy stipulating that schools were responsible for managing minor illness and injury, many participants described undertaking this as an additional workload. By way of explanation, some participants perceived that school staff simply had outdated perceptions of the role: "I just wish the schools could get away from this old-fashioned idea of the school nurse doing the first aid and sending sick kids home" (P7); "some of these teachers have been doing this job for 20 years...they're just behind the times" (P8). In reality, a review of local historical literature highlighted that the role in Western Australia was never intended to have a focus on minor illness and injury, but that "even senior headmasters" had these *misperceptions of the school nurse role* when the first dedicated secondary school nurse was appointed in 1972 (Holman & Coster, 1991, pp. 77-78).

The situation does not appear to have improved in the intervening years: "[the school] think that we should be doing the first aid. That's what they want us to do" (P15); "I get a lot of students coming to me with basic first aid issues, and it's the school's expectation that I address this" (P11); "the school really wants to treat you as a nurse that comes in and deals with first aid" (P13); "I found the biggest challenge when I got to the school was that the school staff very much believed that the school nurse should be a first aid role" (P8); "that's still predominantly what I'm seen as, the first aider" (P9).

Some participants were very exasperated with *misperceptions of the school nurse role* in relation to minor injury and illness: "they saw me [solely for when] the kids were sick, health care plans and stuff like that.... So that was very frustrating." (P21). Others were more pragmatic:

[Schools] all have that idea in their head [that school nurses should be doing first aid]. They will all say that if you would take it away from them they'd happily give it up. That is always there, that will never go away. (P10)

As outlined in the historical report by Holman and Coster (1991) *misperceptions of the school nurse role* were typically independent of the individual nurse and pre-existed the nurse being assigned to the school. *Misperceptions of the school nurse role* were often strongly related to what previous school nurses did: “the previous school nurse had been there for 20 years. [First aid] was what she did, and that was what I was expected to do... I was just expected to carry on from what went before.” (P7). Other participants had similar experiences:

When I went into my current school, [the previous nurse] had been there a very long time. Over 20 years, and that person worked in the first aid room. [The same thing] happened to me in a previous school as well. [I was told] “This is where the nurse has always been. The nurse will never be anywhere else. This is where the nurse lives.” (P25)

As participants did not often have influence over their school assignment, this aspect of the role was sometimes referred to as chance: “I know some [nurses] have problems with the actual school. How they're treated or what they're expected to do, but I have been very lucky” (P12). Participants often became aware of *misperceptions of the school nurse role* in the first days and weeks of their allocation to that school:

When I first arrived [at the school], I [thought]... What am I supposed to be doing? Am I supposed to be doing the role as it's advertised? Because that's what I'm good at and that's what I'm experienced in. Or am I supposed to be doing first aid and they're expecting an Emergency Department nurse? Which I'm not. (P30)

Although attendance to minor injury and illness could facilitate the discovery of *wicked problems*, it also diminished the time available to address *wicked problems*. Many participants reported that they perceived requests to attend to minor injury and illness as an additional workload: “it's got to the stage where I'm taking [the first

aider] role on top of my [school] nurse role and it is affecting [my wellbeing]” (P11); “[the principal is] very good, but she did not want to spend the money on a first aid officer. I said ‘I wouldn’t be happy to continue [both roles]. I cannot maintain this workload’” (P21).

For participants wanting to engage with young people’s *wicked problems*, the inability to do so due to *misperceptions of the school nurse role* could be highly stressful: “I went in knowing my role, understanding my role but thinking ‘oh my god, what have I done [in accepting this employment]?’” (P4). Participants with advanced skill sets reported that their skills were under-utilised: “it’s such a terrible waste of money if I’m doing first aid and I’m not doing what I could be doing” (P15). This experience could significantly exacerbate the experience of *untenable burden*: “I hated doing all the first aid stuff. It wasn’t very good self-worth. It didn’t really help my self-esteem” (P7). Other participants also reported that their specialist skills were squandered: “I have close [school nurse] colleagues that have not been able to function to their fullest ability” (P21); “the school... underuse us. They don’t use the expertise that we’ve got, or they leave it too late when there’s interventions that could have happened earlier on.” (P2); “anyone can put a bandaid on, but these are the [specialist] things I can do” (P27); “I’ve had 20 years of professional development in domestic violence training and child sexual abuse training and delivering sex education and Family Partnerships training and all of that. I felt, you know, anybody can do first aid” (P15).

Although participants were at pains to emphasise that they were entirely prepared to respond to an emergency, many participants expressed frustration because school staff requested support with minor injury and illness for which a registered nurse was not typically required: “it can be very wearing if every teacher, all they want from you is ‘can you have a look at this kid’s rash?’ [and] ‘this kid says they feel sick. What are you going to do about it?’” (P21). Another participant explained: “I constantly get Student Services calling me to consult on issues they have. ‘[A] kid’s got an itchy eye, can you come down to have a look just to make sure there’s nothing in it?’ [and] ‘This kid’s fallen over, can you have a look?’” (P13).

It was common for participants to feel frustrated because they perceived that this was not a good use of their time or skills: “I don’t believe you have to be a nurse to look after somebody who is unwell at school because they’re not seriously ill. They’ve normally got a [minor] illness” (P29); “it’s constantly about managing their expectations and empowering them to make first aid decisions with their first aider. [I have to emphasise to them] that I don’t really need to be there” (P13). Another participant explained:

It was extremely frustrating because we were very much seen as just first aiders and matrons to do the sickness and the bandaids and that kind of role which I found really frustrating actually.... [I thought] ‘we don’t train for all these years, we don’t have all these skills and experience and knowledge to do this [first aid]’. (P16)

Participants attributed demands for attendance to minor injury and illness as school staff lacking confidence that they could manage minor concerns:

I find that [the school] panic about everything. Our [Student Services] runs on adrenalin and panic, that’s just how they operate... a kid comes down with a rash on their legs, and they [say] “this kid’s going to go into anaphylaxis”. (P13)

Reorientating *misperceptions of the school nurse role* towards the legitimate role required significant time and energy which impacted the time available to address the *wicked problems*. Moreover, school communities did not always respond positively when participants sought to challenge *misperceptions of the school nurse role* because it defied public perceptions of what it means to be a nurse:

They think [as] a nurse, you cover everything.... you go somewhere and you meet someone and you say you’re a nurse, [and] they’ll tell you about their stage of cancer and you’re supposed to know everything about it... I think that’s what teachers [perceive]. It’s just a public perception. I think a lot of people would think that [nurses cover everything]. (P2)

Not acquiescing to school demands could leave the participant exposed to hostility, feelings of mistrust or simply increased isolation within the school community. One participant explained:

[The principal and I] clashed a lot when [I] first started [less than three years ago]. I said I wasn't going to do first aid and the principal got very angry and started thumping his table.... [He said] "We're never going to get a first aider and if you're not going to do [first aid], we don't need you." (P15)

Conflict drained participants' energy and impacted school level relationships:

I've been in lots of trouble with the school with these changes [not attending to minor injury and illness] ... I've been going in as a change-maker [and] it's obviously ruffled feathers along the way... There was a lot of friction that was caused by trying to [address *misperceptions of the school nurse role*]. [It was] very difficult at times, to the point that I [was] thinking 'I don't think I can stay [employed] here'. (P30)

In addition to prompting participants to question whether they desired to stay in the role, these experiences could leave participants feeling very isolated, particularly from similarly qualified professionals at their school: "I've made some friendships amongst the Teachers' Aides... and also the reception staff. So I'm not completely alone" (P15). Hostility was not uncommon: "sometimes I feel the [tense] atmosphere in certain areas of the school. That's fine, I can live with that to a point. I know I'm onto a good cause" (P30); "I did get an email once about 'maybe she should change her [professional title], and not be the nurse'" (P2).

Not unexpectedly, participants often expressed fear about initiating change: "I still feel a bit frightened to take that next step forward because [of the potential for conflict]." (P7). Another participant explained: "You are there alone. You have your off-site manager pick and choose what you can do, but you also want to work conductively [with the school], otherwise it's a very lonely life" (P10).

Misperceptions of the school nurse role could therefore be so powerful that participants could see no alternative but to comply:

If I keep telling them “no, no, [I] can’t do that, [I] can’t do that [because it’s not part of my role],” unfortunately I’ll end up like the past nurses at the school. Burnt out, worn out and not trusted within the school by students and staff. (P11)

Capitulating to *misperceptions of the school nurse role* was not a benign experience. A disenchanted participant recalled: “I was being governed by what the school wanted me to do, even though the Department of Health were telling me that [was not] my role” (P7). One participant used the word *bulldoze*: “the school’s voice, [their] wants and needs literally bulldoze [the nurse]” (P21). Another participant used the word *bullying* to describe domineering *misperceptions of the school nurse role*: “there’s been a lot of workplace bullying and expectations from the school” (P25). Other participants also spoke about school expectations:

The school does have an expectation that you will pick up every kid that they need you to see, that you’ll be there for first aid emergencies, that you can attend all the Students at Educational Risk meetings, [and] that you’ll be there on the staff wellbeing committee. I feel as though you do get pulled in a million directions all the time. (P13)

Once established as a cultural and functional aspect of the school, it could be very difficult to reorientate *misperceptions of the school nurse role* towards the legitimate role, even when there was a change of nurse: “unfortunately it’s the perspective of the school, but also now the perspective of students [that my role is to manage minor injury and illness]. It’s become the precedent.” (P11).

Not unexpectedly, *misperceptions of the school nurse role* to attend to minor illness and injury also had significant implications for participants’ autonomy and control of their time. Participants recounted that *misperceptions of the school nurse role* for attendance to minor injury and illness typically came with a further expectation that they would be highly available and responsive. The very reactive nature of the first responder role was often not conducive to longer consultations with young people about sensitive issues because it commonly resulted in frequent interruptions and time pressure: “there’s lots of interruptions, it’s not a quiet workplace” (P7). Other

participants also reported that capitulating to *misperceptions of the school nurse role* contributed to problems with managing their time:

If you're constantly interrupted with phone calls saying "I've got this situation. Can you come and help?" or "can I send this one down to you?" it's just very difficult to manage your time. You don't know what you're going to get from one day to the next and you've still got a list of jobs to do. (P30)

It's really challenging, because the phone's ringing, the door's still tapping and knocking even though it's closed. You know that you're not going home on time, and then you've got the [employer] saying "you need to manage your time better, you need to go home, you need to have a lunch break." (P26)

While *misperceptions of the school nurse role* prompted expectations that participants would attend to minor illness and injury, the same *misperceptions* could preclude some schools from referring young people experiencing mental health problems to participants, perceiving that this was not part of the school nurse role. One participant who had spent years reorientating the service to the legitimate role stated:

I [explained that] we work in a different way to hospital nurses... [The role is] primarily about early intervention, health promotion, helping the school with young people [who have] complex health needs. I explain that we don't just work with physical health; we work with social health, mental health [and] spiritual health. (P28)

Many other participants reported that *misperceptions of the school nurse role* significantly impacted their ability to provide holistic nursing care: "that's the line at the moment, verbatim from a Student Services team member. 'The psychologist and the chaplain are there for the social and emotional wellbeing of the students, the nurse is there for the physical stuff'" (P25). Another participant faced similar difficulties:

You give the teachers lots of education about your role, [and] what you can do. It's on my door, what I can do, and I promote my role, [but] they still see mental health as psychologist, psychologist, psychologist, or possibly the chaplain. That can be very frustrating. (P20)

At its most casual, *misperceptions of the school nurse role* resulted in schools simply overlooking the mental health aspect of the school nurse role:

[I'm not expected to do] the first aid, no, but more the physical health as opposed to the mental health. The physical [health], the sexual [health], the drug and alcohol [interventions]. But the mental health, that is [perceived by the school to be] what the psychologist does. (P20)

I think we need to put more about supporting mental health [in the School Level Agreement]. Being involved [with the] team, going to Students at Educational Risk meetings. [We need to put] all of that in [the School Level Agreement] so that the school realises that that is part of our role. (P10)

Misperceptions of the school nurse role impacted whether the school would refer young people experiencing mental health problems for evaluation by participants. One participant who had been working in the same school for a number of years was particularly exasperated. Interviewed in the month of November, the participant stated: "I complained [to Student Services] that I'm not getting any [mental health referrals] ... then I may get one. I've had two this year, which is ridiculous" (P18). Another participant disclosed:

The school I work in didn't really refer many students [with mental health problems] on and would try to handle a lot of things [themselves]. That included a lot of child protection issues that weren't necessarily reported on [to the Department for Child Protection and Family Support]." (P30)

As a consequence of *misperceptions of the school nurse role*, participants often reported that they did not receive information of a mental health nature that they perceived to be very important to their role. This could lead to missed opportunities for early intervention: "you don't know about anything because they haven't shared

the information. Then you get the tail-end of it, when you could have done some intervention earlier on” (P2).

At the other end of the continuum, a common concern related to *misperception of the school nurse role* was the failure to share school-based *Risk Management Plans* that indicated a young person was at risk of self-harm or suicide:

There’s supposed to be [a process to advise nurses when student mental health *Risk Management Plans* are implemented at school]. We keep bringing it up in discussion, we keep talking about it at [school] meetings and saying “we need to be included”. But it’s still a battle. It’s getting better, but it’s still a battle. As nurses we don’t necessarily get included [in student mental health information]. (P17)

The barriers to information sharing could also extend to circumstances where there was a risk of contagion and distressed young people were likely to seek assistance:

We had a girl [with] a long mental health history and she suicided... I was at the [secondary school] on that day, but the principal didn’t let me know. [The principal] didn’t let me know that there was a meeting in the morning [to coordinate a community response to the suicide], yet they called the [other local secondary school], called the chaplain in on her day off, but still never gave me the information.... [The situation] got a bit nasty and quite big.... it was much easier for me to be removed out of the school to [defuse the situation]. (P14)

As with the participant above, at its most overt *misperception of the school nurse role* could result in some participants being actively excluded from intervening with young people with mental health problems. This could come from unexpected quarters, such as the school psychologist: “the [school] psychologist had been around for a long time and she was quite proactive in squeezing out the [school] nurse from dealing with the mental health” (P18). A *misperception of the school nurse role* could also result in gatekeeping by schools, which restricted the participant from attending to the mental health needs of young people: “[the school] explicitly said to me that they don’t want me to deal with any mental health issues” (P9); “[I was

prevented] from seeing any of the mental health kids and [I said] ‘this is ridiculous, look at the training I've done’” (P18). The same participant continued:

[The school psychologist] wrote a letter saying to [school] management that I could see mental health students for 15 minute each. I could do a [psychosocial] assessment on them, make a determination of their need, refer them where I needed to. In 15 minutes and that was it, max[imum]. (P18)

Some nurse participants felt supported by the principal as providers of holistic care but needed support of a different kind during periods when the *persistent intensity* was especially onerous. During a crisis period that followed several student deaths by suicide in one school, a nurse participant recalled:

I was very clear with the principal at the time that I needed more support [with the volume of suicide risk assessments]. I know that the school psychologist felt like that as well... I was very clear with the principal that when we'd been to Gatekeeper [suicide prevention training] there were a lot of Student Services staff [present], and there was absolutely no reason why [our Student Services staff] could not [attend training too]. Her response was ‘well look, I'd like them to do it too, but I'm not going to make them do it’, or ‘I can't make them do it’. I felt a bit stuck at that point. I thought ‘well okay then, but I just can't keep doing this.’” (P3)

Misperceptions of the school nurse role reflected cultural and functional factors at the level of the school that were reflective of the school's expectations of the school nurse role. In contrast, *professional respect* occurred at the level of the individual nurse.

4.5.2 Professional respect

The second component in *ability to function in the school* was *professional respect*. Participants reported that *professional respect* meant being seen as a professional in their own right who was personally and professionally valued by the school. *Professional respect* occurred at the level of the individual and could therefore vary by school staff member: “currently I have a principal that is really on-side

[supportive]. A deputy principal that very much understands the [school health] service, and a Student Services manager who doesn't and is not interested. So you can have lots of different layers" (P25). Nurse participants commonly described *professional respect* as feeling supported: "[the school is] very supportive" (P12); "[both schools I work in] are very, very supportive" (P1).

Participants who enjoyed a high level of *professional respect* were aware of nurse colleagues who were not as fortunate: "[the school staff] have been great. I think I have been one of the lucky ones, from talking to other colleagues about their secondary school experiences" (P12); "I don't think many other school nurses are included the way I am" (P16). When participants experienced a deficit in *professional respect* they were more likely to articulate this directly: "I don't think we as school nurses have professional respect anymore" (P14); "there is sometimes from different [school staff] a lack of [professional] respect" (P17). Some participants felt that they were not seen as professionals in their own right: "the Education Department probably thinks we're an extra body so we can pick up the slack for whatever incident arises" (P2).

Although the school principal was not ordinarily a direct work colleague, participants were in no doubt that a principal who demonstrated *professional respect* for the school nurse could have a significant positive impact on their working lives: "whether [you have] a supportive principal... goes a very long way towards making your life a lot more comfortable" (P12). Many participants perceived strong *professional respect* when the principal publicly valued their contribution to the school community: "[to] have [the principal] acknowledge 'you're worth your weight in gold'. That's all we need" (P21). A small number of nurse participants reported that their secondary school employed them directly for one or more days per week to supplement the allocation of school nurse hours that the Department of Health provided. One participant in this situation who was returning to work after being away clearly indicated the feeling of being personally valued that this engendered:

I walked into the meeting this morning and [the principal said] ... "We're so excited to have [name of nurse] back working Mondays to Thursdays...

Everybody, welcome her back from her holidays.” I just wanted the ground to open up and swallow me, but yes, he’s extremely happy with the role. Which is why he pushed [the school budget] to get me another day a week [of paid employment]. [I] don’t know how he did it but he did. (P6)

Whether the principal demonstrated *professional respect* was largely dependent on whether there was congruence between the principal and participant as to the school nurse role: “the principal’s been really good and really supportive. He really understands the importance of [the school nurse role]” (P27). Another participant noted:

The principal doesn’t see my role as first aid. I feel very supported in that. At the moment the principal is very much wanting me to get into the classrooms, doing proactive work. [He] knows my main role is safeguarding [and] working with children from that mental health perspective. (P31)

The presence or absence of *professional respect* influenced whether nurse participants could engage with *wicked problems* and be valued for their professional role: “[two] very alpha-male ex-physical education teachers [were the] principal and Student Services [manager]... [They] did not want me to do my role... that was very frustrating” (P21). An overt lack of *professional respect* could also occur when participants sought to challenge *misperceptions of the school nurse role*:

I had some quite negative responses from some of the older [school] staff. When I put the flyer out saying ‘these are the workshops I can do’, some of the teachers had just written on the bottom ‘we don’t need you to do this. What we need is you to do first aid.’ And that was just stuck back in my pigeon hole. So very negative, and very fixed in their views of what a school nurse should be. (P8)

A casual lack of *professional respect* was more subtle but still common:

The principal said “don’t think you’re going to be running that [program in our school]. There’s plenty of resources external [to the school] for [the students]. They come to school to learn.” So of course you couldn’t run some

of those programs or support those kids or the community because it was not valued by the principal. (P14)

A lack of *professional respect* could also be inferred, by failing to make it possible for the participant to undertake the professional role:

I was in an isolated room... with the chaplain... and the Student Services manager who was never really there because she was dealing with everything else. The psychologist would come in once or twice a week. The kids would [arrive at the health centre] as soon as the bell went for class and sit there and say "I'm sick, I'm sick." There was no [school] admin support or anything. (P4)

A participant who struggled to achieve an appropriate location from which to provide clinical services reported:

[School staff said] 'You can sit in the sick bay... with the bed, because we'll need students to go in there'. Then we had to have lots of discussions about confidentiality and availability, and suitable premises. So then my office was moved... out of Student Services, into a different building. (P25)

One participant described a lack of *professional respect* that manifested as gatekeeping. A highly skilled nurse, the school limited young people's access to the participant and compromised the ability of the participant to undertake the role:

At the moment the school have not yet agreed for me to have an open drop-in [clinic] in senior school [Years 10, 11 and 12] ... [The school nursing service is] not promoted as much as it can be within the school [because]... I have to ask permission...and [what the school agrees to is] very limited... I have to ask permission to put up a couple of posters [advertising the school health service]. I've made suggestions to put posters in the toilets, that's where a lot of the students tend to go if they're quite upset and distressed. But as yet, five months on [I'm] still waiting for an answer. I have to be very careful and mindful in the school not just to go ahead and do it, even though you think 'it's only a poster. It's a very basic poster', because there will be difficulties if I [do]. (P30)

Although the Memorandum of Understanding between the Departments of Health and Education was intended to outline service delivery at the school level, a lack of *professional respect* could render the Memorandum of Understanding of limited value:

[The principal asked] “Are you one of these nurses that hide behind the Memorandum of Understanding [between the Departments of Health and Education]?” [I thought to myself] ‘if I don’t follow the Memorandum of Understanding then what am I following? I’m then going to follow what you want me to do’... I’ve had a previous principal say to me “they should just rip that Memorandum of Understanding up, it’s not worth the paper it’s written on.” (P7)

A lack of *professional respect* could also interfere with participants’ obligations as a health professional:

[I rang the parent and said] “I need you to monitor this student [tonight because they’ve sustained a head injury at school today]” and the school had not contacted the parents in regards to [what led to the head injury]. Then I’m stuck in the position where the parent is having a go at me, [saying] “what’s going on? Tell me what’s happening,” and me saying to them, “that’s for the school to advise you. I’m going from [the healthcare] perspective. [Please] contact the school [for information about what happened] because they are doing the investigation.” Only for school staff to [say] “why did you contact the parents?” And I’m following my policies and procedures. (P11)

Similarly, another participant stated:

If I had a student come to me... with a child protection concern... then I referred that on to child protection. That’s what I’m used to doing. That caused friction, because [the school said] “we know they’re just a drama queen.” I’ve had to explain, “look, it’s my duty.” (P30)

A lack of *professional respect* also took the form of questioning participants about their legitimacy as a nurse: “we still get questions like ‘are you a real nurse?’ and things like that” (P17). Another participant stated:

We have admin at the front of the office saying “we don’t have a nurse anymore” [because I don’t provide first aid]. I’ve had people say “are you really a nurse?” I’ve had lots of different versions of “do we have to call you a nurse?” (P30)

A variation of this questioning of professional legitimacy could stretch to the very top of the school hierarchy: “[the] principal is a very intimidating looking woman, and she said ‘well, you know, if [the nurse] is not going to do first aid you need to change the name because they’re not nurses’” (P15). Some participants reported that their school found it difficult to conceive of a role for the school nurse that did not revolve around minor first aid and illness:

We would go to the schools and they would say “well, what are you here for [if you’re not doing first aid]?” They didn’t [understand] that the positions we have aren’t for putting bandaids on and doing papercuts. We [are there as] consultants for health issues and promoting health. (P2)

Questions about professional legitimacy when the participant was undertaking the role as outlined by the Department of Health left participants feeling devalued and exacerbated the experience of *untenable burden*: “I still get the feeling everybody thinks I do nothing all day because I’m not doing the first aid” (P15); Another participant who also declined to attend to minor first aid and illness used very similar terms: “[school] staff [were] thinking I was there doing nothing” (P2). A lack of *professional respect* also had the potential to exacerbate feelings of isolation. A participant who did not provide minor first aid became aware that their secondary school mistakenly thought they were leaving after many years of service:

I thought ‘wow. You think I’m leaving and you haven’t given me a card, a box of chocolates, a bunch of flowers, a thank you, a goodbye?’ And it really made me question, what do you think I do here [at the secondary school]? (P7)

Participants identified that *professional respect* from less senior staff also had the potential to affect *ability to function in the school*:

[Admin] staff would say “oh, [name of previous nurse] didn’t do this” and I'd say “oh, really? Let me show you my paperwork.” I brought the [psychosocial] assessment [form] out to the school officers who are very important people on the front desk. Some of them have been there a long time and they know exactly how the school operates... It took a full year before they respected that [I could conduct a psychosocial assessment]. Now, if I come out to them and say that I need to talk to a student, they know that I need to have a long talk to a student. They will keep the other students away from me unless it’s an absolute emergency. Which is really wonderful. (P3)

A change of staff in a school frequently had implications for the problem of *untenable burden* because previously won battles were resurrected: “I think I've brought in some changes, but again, you change staff, you change principals and you backtrack again” (P7); “every time there’s new staff again, I get calls ‘can you come and check if this kid’s got nits?’ or ‘come and do first aid’” (P8). A school principal in any given school who understood the role was no guarantee that subsequent principals in the same school would demonstrate equal *professional respect* for the school nurse, even if they were in a care-taking role:

When [the principal] went on long service leave the deputy principal was acting [as principal] for him. [The acting principal] said “I don’t think what you're doing is valuable, and I don’t want this at the moment.” (P27)

Where schools undertook the management of minor injury and illness it was typically undertaken voluntarily by a school staff member. If that staff member moved to other work it was not uncommon for problems to re-emerge. This typically reflected a lack of *professional respect* because a formal mechanism to allocate the responsibility for management of minor illness and injury to a school staff member was absent:

[The admin lady] was really happy to deal with [the first aid]. Then they swapped her... to another role. We got someone new and she said “my duty of care has nothing to do with students. I’m going to send them all to you.” (P21)

4.6 Summary

This chapter presented the conditions that influenced the basic social psychological problem of *untenable burden*: 1) *capacity to engage with wicked problems*, 2) *case, clinical and professional support*, 3) *community partnerships* and 4) *ability to function in the school*.

Capacity to engage with wicked problems was identified as the first influencing condition and included participants' motivation for working with young people experiencing mental health problems, their level of comfort with *wicked problems*, and the uninterrupted clinical time available to address *wicked problems*. *Case, clinical and professional support* was identified as the second influencing condition and described the support that participants had in the form of *school-based case collaboration* and *nursing support*. Both of these were perceived to be critical to counter the effects of *autonomy and isolation*. The third condition influencing the core problem of *untenable burden* was *community partnerships*. This condition described the barriers to sourcing more specialist support for young people experiencing mental health problems and focussed on the role of parents and external service providers. The fourth and final condition was the *ability to function in the school*. Some participants identified that their assigned school had strong *misperceptions of the school nurse role* which affected their ability to undertake their legitimate role and could result in conflict or an additional workload. Other participants reported that there was a lack of *professional respect* for their nursing skills and perceived that they were not seen as a professional in their own right.

These four influencing conditions had repercussions for the clinical and professional practice of participants which mitigated or exacerbated the experience of *untenable burden*. The next chapter introduces the basic social psychological process participants engaged in to manage the problem of untenable burden. This was conceptualised as *tactical prioritising*.

CHAPTER 5

THE BASIC SOCIAL PSYCHOLOGICAL PROCESS: TACTICAL PRIORITISING

5.1 Introduction

This chapter presents the basic social psychological process of *tactical prioritising*. In contrast to the basic social psychological problem which describes the issue or concern that most occupies the attention of participants, the basic social psychological process explains “how that concern or problem is managed, processed, or resolved” (Holton & Walsh, 2017, p. 88). The basic social psychological process has two or more stages and “gives the feeling of process, change, and movement over time” (Glaser, 1978, p. 97). In this study, data analysis revealed that participants undertook the three-stage core process of *tactical prioritising* in order to gain mastery over the basic social psychological problem of *untenable burden*.

As explained in chapter three, participants were motivated to engage with young people experiencing mental health problems and perceived this to be an important part of their role. The experience of *untenable burden* was prompted by the complexity and intensity of the clinical caseload they negotiated as an autonomous clinician. After the shared common problem of *untenable burden* was identified, a further analysis of the data revealed that participants were continually engaged in one of three stages to manage the problem of *untenable burden*. This core process was conceptualised as *tactical prioritising*. The first stage related to participant’s relationship with their assigned school, the second to their efforts to help young people experiencing mental ill-health and the third to activities they undertook to maintain their own wellbeing. The three stages in the basic social psychological process of *tactical prioritising* were conceptualised respectively as: 1) *strategic assimilation*, 2) *optimising outcomes*, and 3) *managing self*.

The stages were not necessarily sequential, with participants continuously *prioritising* the stage that best managed the problem of *untenable burden* at that point in time. Importantly, this selection was not random, it was *tactical*. The Collins Dictionary defines the word *tactical* as “an action or plan which is intended to help

someone achieve what they want in a particular situation” (tactical, n.d.). According to the same dictionary, if you “prioritise the tasks that you have to do, you decide which are the most important and do them first” (prioritising, n.d.).

As explained in chapter four, the majority of participants in this study were motivated in their work by a *passion for the wellbeing of young people*. In theory, participants desired to be consistently engaged in the second stage of the process, *optimising outcomes*. In reality, influencing conditions sometimes forced participants to prioritise *strategic assimilation* or *managing self* above *optimising outcomes*. Participants who were new to their assigned school or at the beginning of their career in secondary school nursing career often moved through the stages in a largely sequential manner. Participants with more experience and those who had worked in their assigned school for a long duration were often so highly skilled at *tactical prioritising* that they were agile in managing all three components of the core process in a near simultaneous manner. The remainder of this section provides a brief introduction to each of the three stages.

Strategic assimilation was prioritised when participants first started work as a secondary school nurse or when they first started working in a secondary school they had not been previously assigned to. This stage described the efforts participants engaged in to strategically position themselves to be most effective in their assigned school. Approximately 20% of participants were in this stage at the time of interview, and *untenable burden* was minimal in this stage. Although the focus of this stage was on the participant’s efforts to establish their role and place within the school community, participants in this stage also sought to become knowledgeable about the broader community surrounding their assigned school. A key element of this was to identify community resources to which they could refer young people for more specialist intervention. Initial assessment and referral of mental health problems were common activities in stage one.

Stages one and two were separated by a natural tipping point, entitled *grappling with unmet needs*. As participants approached the tipping point their experience of *untenable burden* climbed steeply, generated by a growing awareness that young people had needs that were not met by referral to a specialist service. When

participants considered how they might meet these *unmet needs* they commenced stage two, *optimising outcomes*.

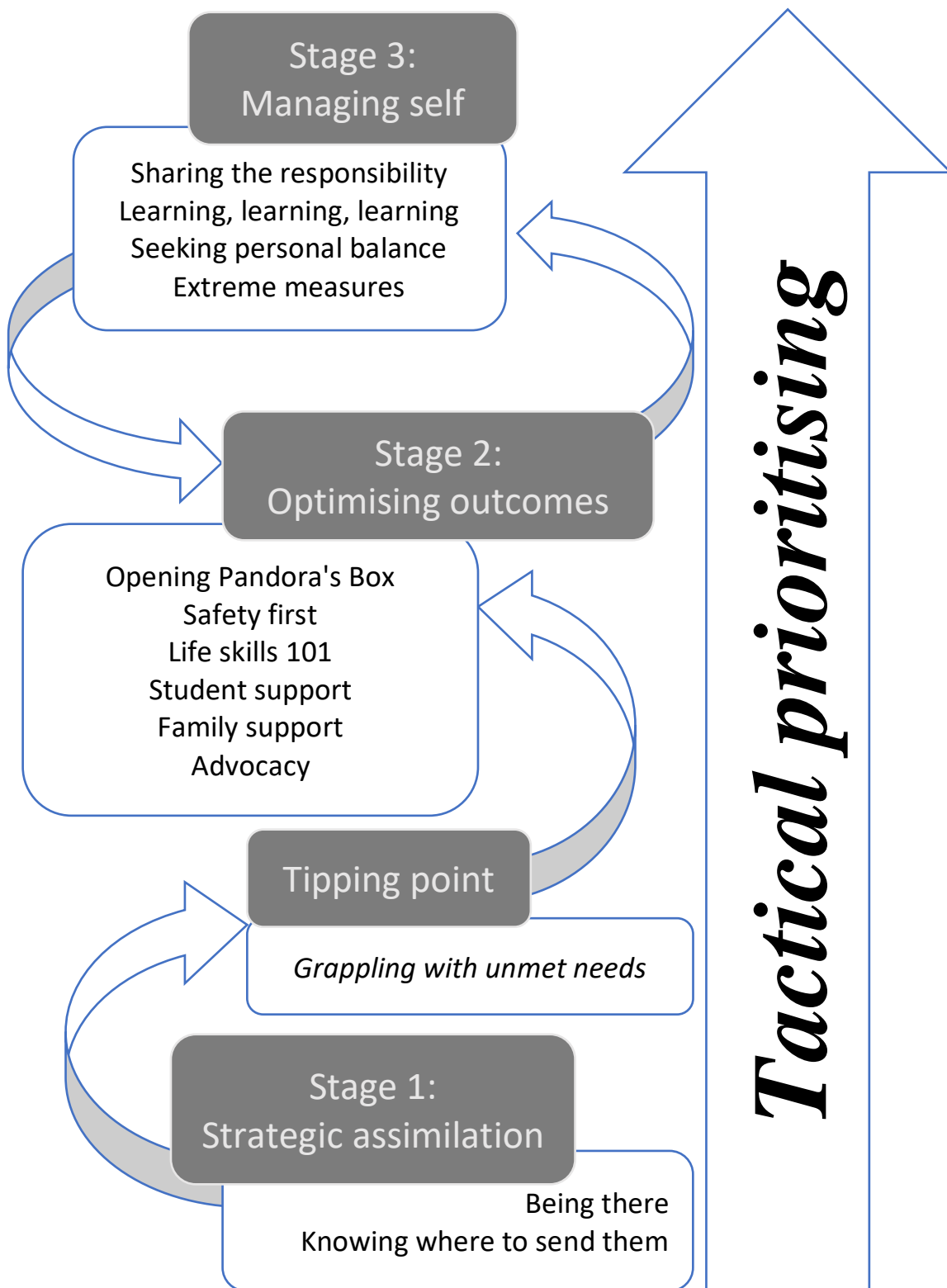
Participants initially engaged in stage two to give them a sense of agency in the context of *untenable burden*, but it commonly resulted in intensified experiences of *grappling with unmet needs* and escalated *persistent intensity*. This prompted participants to engage in stage three, *managing self*. Some activities that participants engaged in for *managing self*, increased participants' *capacity to engage with wicked problems*. This facilitated *optimising outcomes* at a more sophisticated level, but also contributed to further increases in *persistent intensity*. This resulted in an exacerbation of *untenable burden* and a new need for *managing self*. Stages two and three continued to spiral and build on each other as participants engaged in *tactical prioritising* over the longer term. Not unexpectedly, there was a high degree of variation between participants who had been engaged in stages two and three for an extended duration, and those who had only recently reached the tipping point and were *grappling with unmet needs* for the first time.

The *basic social psychological process of tactical prioritising* is shown in figure eight. The three stages and the tipping point will subsequently be discussed in more detail with participant quotes to illustrate the findings.

5.2 Stage one: Strategic assimilation

The first stage in the basic social psychological process of *tactical prioritising* was *strategic assimilation*. The Cambridge English Dictionary defines *assimilation* as “the process of becoming a part, or making someone a part, of a group, country, society, etc.” (assimilation, n.d.). The same dictionary defines the word *strategic* as “helping to achieve a plan” (strategic, n.d.). *Strategic assimilation* at school meant intentionally becoming part of the school community by demonstrating good will in meeting the school community's needs and fitting into the established order: “I haven't even [worked] a full year yet [at this school] ... [I'm] just learning what the school needs” (P9). Participants perceived that this was of strategic importance because “if you don't get on with the staff in the school, that's not going to help the kids, the staff or anyone else” (P10). For this reason, all participants commenced in

Figure 8



the stage of *strategic assimilation* when they started working as a secondary school nurse or commenced working in a school they had not previously been assigned to. *Strategic assimilation* occurred in the context of two concurrent aspects, one related to school-based relationships and the other to knowledge of local resources. These were conceptualised respectively as: 1) *being there* and 2) *knowing where to send them*.

5.2.1 *Being there*

Being there was about having a physical presence at the school but also about being seen to be warm, welcoming and ready to help. Many participants directly articulated the importance of *being there*: “I think school nurses need to be there” (P6); “you just have to be there” (P2). Participants engaged in *being there* by building relationships: “the whole job is about relationship-building, whether with the teachers, the admin staff or the students” (P24). Many participants perceived that building relationships was an essential first step: “when I first started at the school the teachers didn’t know me, and they’re quite protective of their students, of course, and I understood that” (P15). Mutual goodwill and cooperation were critically important: “you’ve got to work with the staff. You want them to respect you and vice versa” (P3); “you want a working relationship with the school” (P11).

Without exception, participants had a strong focus on *being there* for young people: “first and foremost I’m there for the students” (P23); “just believing in, you’re there for the students” (P30). Other participants articulated *being there* in related terms: “[I said] ‘I’m here.... come and see me, you know where I am’” (P2); “I do want it to be known that I am here if the kids need me” (P9). *Being there* was perceived to be necessary if participants were to find out which young people needed help. A participant who had limited physical capacity for *being there* due to operational issues explained:

I don’t have the time that’s required to be there. I would get a lot more [young people presenting] if I was [at the secondary school] more; I would see more [young people], I would do more...what you don’t know, you don’t know. (P14)

Being there was a broad construct: “my aim is to be there for the kids, no matter what they want” (P10); “I can't turn my back on a crying child. No matter what it is, if they're really upset... a child that's sad, whatever's going on for them, or even angry, I can't walk away from it” (P27). Another participant explained:

[When] I'm talking to the kids I usually say ‘I'm here to help you with anything you need help with, and if it's not something that's my job or falls in with what I can do for you, I'll help you find the right person’. (P28)

Consistent with *being there*, many participants spoke about positioning themselves as being easily accessible to both school staff and students: “I am the port of call for any discussions in regards to... anything [health related]” (P11); “I do seem to be that first port-of-call, ‘just touch base with [name of nurse]’” (P5); “you can be one of their first points of contact” (P23); “school staff very much use me as their first port of call for support for students” (P4).

Being trusted by students was perceived to be essential to being approached for help: “it's about being that sort of person they feel comfortable [with] and trust. Having that open personality and not judging” (P24); “[the student] says she comes to me because she... trusts me” (P11); “she wouldn't have come to me if she didn't [feel] that she could trust me” (P6). Some participants perceived that simply being a nurse engendered trust: “I think they trust me because I'm a nurse” (P8). Another participant reflected: “they feel we've got that caring aspect, we listen, we validate, we understand and we work through, and [the student] feels that helps” (P11).

Being there was only the first step in *strategic assimilation*. As another participant explained, having local knowledge and *knowing where to send them* was the next step:

[They need] to have someone they can trust. A health professional, someone that they can access fairly easily. Someone who will help them to know what to do, to negotiate the health system, [someone who has] knowledge of evidence-based intervention, and [can] help them to know where they need to go and what they need to do. (P28)

5.2.2 *Knowing where to send them*

Knowing where to send them meant having local knowledge of referral agencies and other resources in the broader community. This knowledge marked a participant as belonging to the community and was a sign of *strategic assimilation*. The purpose of *knowing where to send them* was to be able to link young people to local sources of information or help: “you need to know what you can do and where you can send them” (P23); “I’ll talk to them about... all the organisations that young people can access” (P20); “we’ve got a good knowledge of services that are out there, so we’re able to network for our students” (P8).

Signposting was the first step: “[I] work through different information on where to go for extra support like headspace [youth mental health service]” (P24); “we might talk about [the] people they can go to” (P5). Some participants sat with a young person at the computer to help them navigate the wide variety of resources available online: “I’ve often sat with students [at the computer] ... we’ve logged on together, and [I’ve] shown them... self-help apps [applications] about meditation, mindfulness, Smiling Minds, online headspace, ReachOut” (P20).

When participants perceived that signposting was insufficient, a further process of clinical assessment occurred: “can we resolve what’s going on for them within that session or do we need extra sessions to get to know them a bit more?” (P26); “is it something that we can support within our own role, or is it something that needs referring on?” (P30). Another participant described this process in more detail:

I would encourage a follow-up [visit], to see how [the situation] develops...
The next point would be thinking of some different referral options and discussing that with them and educating them around that. If they agree, following that process, [referring] them through to formal support or to [another service] depending on what the issue is. (P24)

Participants were highly cognisant that early intervention was critical: “the earlier ...these young people can get help around mental health, the better the outcomes. The research definitely shows that” (P24); “if we don’t do that early intervention in

adolescence, we end up with a bunch of kids that are lost” (P10). Participants closely monitored young people who hovered between signposting and referral:

It depends on what it is and it depends if you’re seeing any progress. If [the student] comes back the week after and says “thanks very much, everything we talked about has really helped, I’m doing fine now,” then great. But if they’re coming back three weeks later and saying “I feel worse, I’ve got this, [and] I’ve got that.” Okay, what I’m doing obviously isn’t what you need, we need to refer you on to someone else. (P6)

Risk of deliberate self-harm or suicide precluded unconditional confidentiality: “[I] always try to encourage [students] to talk to one of their parents about what’s going on for them, but also maintain their privacy unless they’re at risk” (P24); “I try to be... clear about... what my duty of care is, what I can keep private and what I can’t” (P21).

When young people were not doing well, referral to other service providers was a priority task: “you’re not going to sit on them and keep them to yourself... I want them to see somebody else, I want them to take the next step” (P23); “when you see these kids you can’t encapsulate them into your health centre and [say] ‘okay, you can only see me’” (P10). Being able to recognise when a young person required referral was therefore an essential skill: “the biggest thing is recognising when we should [refer] it. If I’m not sure... I’ll [refer on]” (P6); “We’re actually quite good at understanding where our limits are and when we need to refer on” (P22). Another participant explained:

You can either come up with a solution quite quickly, or it’s not going to be a solution and you need to refer them on. You can still catch up with that person, but you’re not actively engaging in any specific [health] counselling. (P6)

The involvement of parents in referral decisions was always a key consideration, but some identified risks influenced the involvement of parents in referral decisions: “obviously we occasionally get students where the problem is that the family are

violent, and I wouldn't advocate anything that puts [the student] at risk" (P8).

Another participant explained:

[In some families] there's that cycle of dysfunction and trauma... often in those situations [the young person has] been told not to talk about home life [to people outside the family], so it's always that [balance between] trying to keep student confidentiality... but [also] trying to also ensure that they're getting the support that they need. (P24)

Having engaged in the process of *being there* and *knowing where to send them*, participants become aware that this was not always sufficient. As explained in *left holding the baby* some young people did not or could not access sources of help to which they had been referred. Other young people experienced mental health crises at school even though they were appropriately engaged with other services. These circumstances contributed to *persistent intensity* and were not alleviated by signposting and referral, prompting participants to contemplate *grappling with unmet needs*.

5.3 Tipping point: Grappling with unmet needs

The tipping point between stages one and two was entitled *grappling with unmet needs* and was precipitated when participants became aware that young people had needs that were not being met despite *knowing where to send them*: “[students] bounce back to you and you're sometimes sitting there thinking ‘okay, I've referred you, you're not getting there” (P3). At this point the experience of *untenable burden* escalated: “it's [what to do with] the kids that come and see you again and again?” (P15). This could occur even in the context of effective referral:

Some of them are engaged with other services but you can't send them away. You can't say ‘no, I'm sorry... you have been accepted by Child and Adolescent Mental Health Services. I'm no longer available to you’. They still want you to [help]. (P13)

A minority of participants had only recently commenced their secondary school nursing career and had not yet engaged in *grappling with unmet needs*:

She'd seen psychologists outside [school] and she'd seen Child and Adolescent Mental Health Services and I'm thinking 'she can't be with me. She's already getting all those services. This is like backtracking, coming to the school nurse in that situation'. (P1)

Another participant still felt very conflicted, but was tentatively engaging in *grappling with unmet needs* and commencing the process of *optimising outcomes*:

Sometimes those students, even though they've been referred on, still want to come back. I find [this] difficult [because]... I don't want to give them new information... but I think it's also beneficial for them if they want to come back and seek our services. (P26)

Successful negotiation of the tipping point marked the transition into stage two of the core process, *optimising outcome*. Participants who had commenced *optimising outcomes* identified that young people needed: "someone who's going to help them" (P6). Experienced participants recognised that stage two activities related to: "trying to meet a need that can't be met anywhere else" (P21). Importantly, *optimising outcomes* complemented but did not take the place of appropriate referral. While *optimising outcomes* was intended to assist the young person with their *unmet needs*, engaging in *optimising outcomes* also provided participants with a sense of agency, purpose and professional satisfaction.

5.4 Stage two: Optimising outcomes

In the second stage of *tactical prioritising* the process of assessment and referral described in *knowing where to send them* were no longer the end point for intervention. Assessment and referral continued as before, but participants identified that young people often needed more support than referral alone and considered how they could provide this: "you sit there and think 'where am I going to start?'" (P30).

In *optimising outcomes* participants focussed on the young person's developmental trajectory and supported young people as they navigated their lives: "monitoring and

keeping in touch, being that lighthouse person, just checking in” (P22). Another participant explained:

It’s that regular seeing them. With a self-harm client you’d be saying “right, okay, yes, we’ll set you up with some counselling, you’ll see the psychologist.” [I’d be] dealing with [the] family if they want support, but still seeing [the student] from a [holistic] point of view... So [asking] “how are you sleeping? How [have] your thoughts been? Are you eating breakfast before you come [to school]?” (P20)

Optimising outcomes was highly reliant on interventions provided by the participant and reflected a sophisticated clinical role. Pondering a job-share arrangement where a non-participant secondary school nurse had not progressed to this stage, the participant reflected: “if somebody could have worked with the other nurse and identified that she wasn’t fulfilling the full role, [that might have] given her the confidence to start intervening with young people” (P21).

There were six components in *optimising outcomes*: 1) *opening Pandora’s Box*, 2) *safety first*, 3) *life skills 101*, 4) *student support*, 5) *family support*, and 6) *advocacy*.

5.4.1 Opening Pandora’s Box

According to the Collins English Dictionary, ‘opening Pandora’s Box’ means an action that causes problems to appear that were “not known about before” (opening Pandora’s Box, n.d.). Participants with well-developed skills for *opening Pandora’s Box* had a sophisticated capacity to uncover *wicked problems* and integrate complex findings into a comprehensive picture:

Then you open up the whole Pandora’s Box... [He’s] got disordered eating with anxiety, this young man with his panic attacks. He’s been medicated [with] diazepam. He will not engage, there’s stuff going on with his family [and] they don’t have a good parent-child bonding. That’s why [he’s not living at home]. (P14)

A participant with a highly developed capacity for *opening Pandora's Box* confided:

They do open up. They do tell you everything, once you've built up that rapport with them. They'll actually tell you about the hydroponic [cannabis] set-up in the garage. They'll tell you absolutely everything. (P17)

Some participants described incidental cases of *opening Pandora's Box*:

A kid came in who [was] self-harming. [They] had been self-harming on and off since primary school, then stopped and something had triggered [it again] ... Obviously there was an ongoing history there, it wasn't like she was [just] upset that day. It was the start of further problems [and] there was potential for things to deteriorate in her mental health. She had been sort of okay, and then it came out that all this other stuff was there. (P1)

Other participants set aside time to plan for *opening Pandora's Box*:

I'd probably do as much detective background work as I could do [before seeing the young person]. Looking at the [school health] notes, have they been seen? What sorts of things did I see them for? Is there anything in the Student Services [record]? Is there anything going on at home? Are there family changes? With their academic [grades], have they always been a solid "C" [grade] and now they're an "E" [grade]? What's their attendance? [Any] behaviour issues? I gather all those clues first. (P21)

Participants with well-developed skills for *opening Pandora's Box* were confident about their ability to manage the consequences:

Within an hour, an hour and a half, they've let it all out on the table and I've got a plan in place. They've been cutting for weeks and no-one knows and they've been able to hide it from everyone. Sometimes I'm very surprised at what you find out in a really short amount of time. (P4)

There were four aspects in *opening Pandora's Box*: 1) *finding out what's going on*, 2) *having a chat*, 2) *reading between the lines* and 3) *the reluctant Pandora*.

5.4.1.1 Finding out what's going on

Finding out what's going on was articulated in various ways by the majority of participants: “[I] find out what’s going on in all areas of the child’s life” (P17); “when someone first presents with a problem, you're the one that’s doing that assessment and working out what’s going on for that person” (P24). Other participants used related terms: “[I’m] a bit like a detective. I’m going to ask lots of questions and gather all the clues” (P21); “I do a lot of that ‘first assessment’ of a young person” (P28).

Finding out what's going on was a clinical activity, and a common reason for referral to the participant by school staff: “they see the value of my role in doing the [psychosocial] assessment, and being able to find out what’s actually going on with the student” (P8); “[when school staff] are not sure what’s going on for this child, they’ll ask me to see them” (P18); “the teachers really know now how I work and what I work with. Immediately they get a sniff of something that’s not right mentally or otherwise with a child they’ll send it to me” (P28); “if the teacher’s concerned about the young person they’ll send them my way and ask me to chat with them” (P9).

The most common means by which participants reported *finding out what's going on* was to conduct a psychosocial assessment: “[I] always make sure that I follow the [psychosocial] assessment [framework] because it’s a fantastic tool. [It’s] so good to use with young people.” (P20); “[I use] the [psychosocial assessment framework] in trying to get some background information, to try and see what their life situation is for them, what that looks like” (P26). A psychosocial assessment could also be beneficial for the young person: “it’s allowing them to see the whole picture of themselves” (P10).

A key component of *finding out what's going on* was to explain confidentiality:

It’s really important that they feel safe and that they know that the information is going to be kept confidential. Once they realise that that’s the case, then you’ll find that they're reasonably willing to come and have a chat, the majority of them. (P24)

Most participants made young people aware early in the consultation that disclosures of suicide and self-harm risk, as well as significant risks of harm from others could not be kept confidential: “first of all [I] explain the limits of confidentiality to the student before I do anything with them” (P19); “at the beginning, I explain the limits of confidentiality” [P20]; “I’ll explain my role and [the limits of] confidentiality agreement. Then we [start] talking” (P26). Some participants were more hesitant about addressing this early as they perceived it could be a barrier: “[I] always [explain] the [limits of] confidentiality statement if I think they’re going to start heading that way, but I [also] don’t like to put them off. So [initially] I just get them to talk” (P16).

In circumstances where the young person had self-referred with a specific problem, participants acknowledged that young people first needed help with the concern that prompted their visit:

It could be down the track [later], [I’ll say] “okay, let’s do [a psychosocial assessment] so we can get a whole picture” ... Not straight away when they have one situational crisis at that moment. Whatever it is, and [however small] we feel it is, to them that’s their biggest problem... and we need to deal with that. (P10)

Participants used clinical judgement to consider whether to conduct an in-depth psychosocial assessment at the first meeting or subsequently: “certain areas of the [psychosocial assessment] they are very reluctant to discuss at first presentation. Often I will just skip through that and say, ‘when I follow you up maybe we can address [that] later on’” (P20). As participants became more adept at *opening Pandora’s Box*, they became less overtly clinical in their approach. They still engaged in *finding out what’s going on*, but in a more relational manner. This second aspect of *opening Pandora’s Box* was conceptualised as *having a chat*.

5.4.1.2 Having a chat

Having a chat was less clinical and more relational than *finding out what’s going on* but had essentially the same purpose. It described an informal, holistic approach

where participants conducted a non-specific but sensitively inquisitive probe into a young person's life:

That gives you a really holistic [picture] of what's happening. I'll always do that in a really informal way because they'll come in and we'll talk about one particular incident and until you get the whole picture... I'll always say that to them: "it's hard for me to really know what's going on, and if I could just ask a few questions about home and friends and family and that kind of thing? It gives me a better idea of how I can help you." That's how I tend to get the holistic picture. (P16)

The core feature of *having a chat* was building a relationship with the young person: "making a relationship with that young person and exploring every possible avenue" (P21); "developing that relationship and working with that person for their goals and to make sure that they got what they needed" (P6). This could take time: "it might be that they'll not tell me anything on the first appointment... then they'll come back, and we'll build up a relationship that way" (P16).

A seemingly innocent phrase such as *having a chat* belied the very real issues that *having a chat* could uncover: "I just had a chat with him, just exploring all aspects of why he might be feeling unwell. He relayed to me that he still wanted to die and thought about dying all the time" (P28); "they would [chat to me] about whatever was going on. You know, 'dad's gone back inside again [to jail]', 'mum's pissed off, she's [left the family].' [They would] talk about life" (P25). Another participant recounted:

[A school staff] member said "there's a girl in the toilets, could you please go and see if she's alright, because she won't answer." [The girl] came out and had a chat with me. She was very behind in her school work. She was also saying [that] she feels very low, that she couldn't do this anymore, [that] she wanted to lose herself... she had suicidal ideation. (P29)

Having a chat often lead to the disclosure of *wicked problems*: "it soon emerged that it was a good thing that I'd done the assessment because her father had [died by] suicide three years earlier" (P15). Another participant recounted:

[She disclosed] ... social [and] mental health [problems]. She was cutting...she'd been sexually assaulted. [It] just started off as this little thing and as she got more comfortable... it was like I pulled the plug and it just all came out. (P6)

Some participants noted that being a nurse was an advantage and encouraged disclosure: "Often the students will really open up to me. I think they trust me because I'm a nurse. They'll come and tell me that something is going on at home or there's domestic violence" (P8). Other participants emphasised that *having a chat* was compatible with silence or reticence: "they'll either talk or they'll not. I'll just try and get them to relax, 'let's go somewhere quiet and comfortable'... we'll just have a chat" (P16). It was at these times that participants particularly engaged in *reading between the lines*.

5.4.1.3 Reading between the lines

Reading between the lines was the third aspect of *opening Pandora's Box*. According to the Cambridge English Dictionary, *reading between the lines* means "to find meanings that are intended but that are not directly expressed in something said or written" (reading between the lines, n.d.). *Having a chat* and *reading between the lines* were mutually compatible and emphasised the young person's autonomy in deciding to tell or not tell: "[I said] 'you only have to tell me what you want to'" (P2). Participants identified that listening was a key aspect of *reading between the lines*: "I guess it's really listening more, is there something else happening?" (P22). Skilled participants could further the relationship this way: "[I said] 'it's totally up to you [whether to tell], but my instinct is that you're really struggling with something at the moment'" (P21). Experienced participants could support a young person even in the absence of specific knowledge about their problems:

I'm sure she only tells me some things. I say "I'm reading between the lines here. There are issues at your house that you probably aren't allowed to tell me." She smiles at me, because she knows [that] I know what's going on. (P2)

Other participants commented on the importance of non-verbal communication in *reading between the lines*:

The pace that they're walking, the angle of their head, their shoulders, are they with other people or on their own, what they're wearing, how they're wearing it, how they're expressing themselves. Have they got textas [marker pens] of hate shit and dickhead [vulgar slang] written all over their arms? Have they grown their hair to hide their face? Is their hair greasy? The first thing would be [to notice] their appearance and body language. (P21)

Previous experience often prompted participants to *read between the lines* even when the young person or family were not specifically known to them:

I was going to the Student Services meetings every week and hearing all the talk about the cases that they had... when these kids were absent ... [the school] were taking the punitive approach, blaming the parent and getting the parents in to sign an agreement to bring their kids to school. All the time I'm thinking 'no, that's not going to work. If the parents are struggling, you know they're not going to be able to meet their kids' needs and it's a bigger problem than bad parents'. (P15)

As participants developed their skills for *reading between the lines*, they became aware that there was a cohort of vulnerable young people who were more difficult to engage. Experienced participants were not afraid of *the reluctant Pandora*.

5.4.1.4 The reluctant Pandora

The reluctant Pandora conceptualised young people who were difficult to engage, hostile to health interventions or reluctant to pursue health recommendations. Participants who had highly developed skills for *opening Pandora's Box* could often engage *the reluctant Pandora* when others had failed:

Last year I worked with a Year 9 male. Initially referred to me [for] behavioural issues, lots of suspensions from school, and everyone had tried to engage with him... [The school staff] were saying, "no, everyone's tried everything with him, it's really hard work, and we're really struggling." [I

said] “if you like I can offer him a contact and introduce myself.” So we went ahead with that. He was very open. Very open. (P30)

Participants were emphatic that young people had a right to decline health services: “if they grunt, [say] ‘no’ or tell me in no [uncertain terms] that they do not want to work with me, you have to be the professional [and respect that]” (P21); “I don’t make them come. I offer that to them. If they don’t want to come and see me that’s fine, but they know where I am” (P10). Even so, participants realised that *the reluctant Pandora* was often a vulnerable young person that they did not want to give up on. Some participants were well-skilled at creating connections to engage *the reluctant Pandora*:

I’ll casually touch base with [the student] again, but normally the second time I’ll make it more informal. I’ll find out what class they’re in. I’ll go into the class and pretend I need to talk to the teacher about something and as I come past I’ll say hello to a few of the other [students I know]. Then I’ll just make contact [with *the reluctant Pandora*] and [say] “Alright? Hi, how [are] you going?” And just do it [engage] really gently. (P21)

Highly skilled participants who could engage *the reluctant Pandora*, reported that this sometimes came as a surprise to the young person: “after the first session [the young man] got up and said ‘I’ve not spoken to anybody like that for, I can’t remember [how long]. I can’t believe I told you all that stuff’” (P30).

Sometimes *the reluctant Pandora* was happy to engage with the participant but not ready to follow health recommendations: “she’s not ready to [action the referral] and I acknowledged that. I said to her ‘I know you’re not ready’” (P2); “[I make] sure they have an appropriate referral [to action] ... provided they’re ready to do so, and at their level.” (P11). At other times *the reluctant Pandora* was hostile and needed encouragement to engage on their own terms:

I say “there’s no way you can offend me. You can tell me to f*ck off or go away. I’ll still keep being here if and when you want to come back and ask me ‘what were those choices again?’ or ‘that was crap, can we try something else?’” (P21)

Sometimes the problems resolved with time or there were other barriers:

Sometimes the kid just doesn't want to engage, whether it's been just a transient thing that's happened to them at school and it's resolved, or they've gone home and talked to the mother and [she's] said 'well you're not going to [a referral agency], there's nothing wrong with you.' (P2)

Participants who were adept at *opening Pandora's Box* were poised and ready to respond to the issues young people raised, but their immediate priority was always the same: *safety first*.

5.4.2 Safety first

Almost all the participants engaged in stages two and three articulated *safety first* directly: "I always make sure that they're going to be safe, that's the priority" (P16); "I have to make sure that they're safe" (P2); "my main concern [is] making sure that the child is safe" (P28); "that's all you can do. We make sure that they're safe at school" (P17). *Safety first* related to many different things: offering a place of safety at school, being a safe adult to discuss problems with and supporting young people to develop a safety plan for crisis management.

The most immediate element in *safety first* was offering young people a place of safety at school: "I want to be a safe place for them to come" (P31); "the secondary school nurse [is] a place for kids at school to go to that's a safe place" (P13); "[they] know they've got a safe spot to come to at school" (P4); "[they need to] have a place of safety that they could go to (P25); "it's about... giving them somewhere safe to go to" (P27).

Offering safety was about offering respite from a hectic world. One participant explained how their Student Services centre looked and felt on a regular day:

Student [Services] is not a quiet relaxing place to go. We're a school of nearly 2000 kids. Student [Services] is manic. You can feel it as soon as you get in there, the stress and tension and panic levels of everyone are just off the chart. I walk in there having a very calm, peaceful day, and immediately I

am overwhelmed and I think ‘oh my god, what’s happened?’ But nothing would have happened, it’s just the way that they operate. (P13)

Participants explained that the purpose of offering safety was to offer young people a place of calm: “I offer a place of respite for the kids. I’ve got a room called a chill-out room and they can come there, and they can do whatever” (P28); “[the school nurse is] a safe place for you if you’ve got anxiety, [or] you’re having a bad day” (P2).

Some participants had paid close attention to the physical environment to achieve this: “I deliberately decorated my office, I ‘de-clinicalised’ my office. So I’ve created a physical space that is inviting and relaxing” (P31). Participants explained that a brief period away from school stresses could be beneficial: “[if] you want to just chill, we can sign you out [of class], because sometimes that’s all you need” (P2).

Other participants explained:

If it’s getting too much, use your time-away card, and come back to Student Services. It doesn’t have to be talking, it can just be [until you’re] okay. We have colouring in books. We have games, Rubik’s Cubes, things like that. They can help as well. (P29)

[It’s about having a] go-to person when they may just need some time out. Sometimes they may feel overwhelmed in class, the teacher doesn’t understand, and they need to go somewhere safe for a period of time until they’ve got themselves back together. (P6)

Some participants used this time to help young people to develop a mental health first aid kit:

We talked about putting together a first aid kit for mental health for her on the days that the gloomy clouds just landed. We talked about some of the things that were making her happy, some of the things she had to look forward to, and some of the things she could use like creative imagery. A special place, a special memory... and talking about all of the compliments that she’d received and the awards, and maybe put those in a box, a warm fuzzy box. (P15)

Many participants recognised that school could be the safest place for some young people: “she knows that the school cares, knows we’re [keeping] in contact [with] where she’s at and be with her along the way. That just seems quite beneficial” (P22); “we might be doing something to keep them coming to school because that might be the only safe place. Hopefully then they can access the support they need” (P21).

Unsurprisingly, *safety first* was particularly important for young people experiencing a crisis:

Often [students] self-present... [when] they’re in a crisis. So it’s really dealing with that crisis. It’s dealing with [it], listening to what they have [problems with], ascertaining whether it’s something that needs urgent intervention. Working out your confidentiality issues with the student, and how we can help them within the school context. (P29)

For some young people the crisis was more serious. It was not uncommon for young people to seek support when they experienced an exacerbation of suicide risk:

This Year 9 girl told me that she was feeling suicidal... [and she was] looking at the equipment in the [workshop] and how she could hurt herself with the equipment ... I did get her to [the hospital]. If you’re thinking that, it’s not just a “life’s shit, I wish I wasn’t here” kind of [thing]... She’s thinking, she’s planning [suicide]. (P31)

Another participant explained:

I let them know... ‘thank you very much for coming. This is the best thing to do, you’ve come to me and we can help you with that. Is it something you want to talk about? Has something happened?’ I assess the level of risk they’re at. (P29)

Although young people often initiated support in the context of an exacerbation of suicide risk, participants also reported undertaking suicide prevention activities proactively: “it’s constantly checking in with them, supporting them, giving them the

emergency numbers, making sure that they're safe. Asking them “are you [safe]?” And if they're not, okay, this needs to go to [the] Emergency Department” (P19).

Although *safety first* was common in the health centre it also arose in the wider school community. It usually occurred in the context of a young person at known risk of deliberate self-harm or suicide being unexpectedly absent from class and involved more members of the school community:

The process is that a member of Student Services, it's usually the co-ordinator will go to the classroom and just double-check that the teacher's not mixed up that student with somebody else, and then will try and back-track and try and find out where that student could potentially be, phone that student and phone the parents. Say ‘look, your child's not at school, is there a reason why?’ ‘Yes, oh sorry, I forget to inform [the school] that they're sick’ or ‘yes, I saw my child get out of the car and walk into school so I don't know where they could possibly be.’ We've had a few scares where we've had to go around and look in toilets. (P20)

After addressing *safety first*, participants turned their attention to supporting young people to navigate their lives and develop essential skills to manage life's complexities. The third component in *optimising outcomes* was *life skills 101*.

5.4.3 Life skills 101

Life skills 101 was the third component of *optimising outcomes* and related to supporting the young person's growth and development on their way to adulthood. The addition of the number *101* behind the term ‘life skills’ was used by one participant to explain the developmental nature of this component:

Sometimes it's very much life-skills 101 that we're doing with these kids... [they're] growing and learning [about themselves] ... working out who [they are] and trying to work out [how] they want to be seen by other people. It's really just supporting them through that growth. (P10)

Participants reported that young people often needed support for managing common experiences in adolescence: “it can be a teacher that's giving them grief, it can be

just not getting on with parents, or friendship [issues]” (P10); “it’s them becoming independent, and learning those skills that throughout adolescence and adulthood, there’s always somebody there for some support” (P30). This could be particularly necessary when those events all occurred at once:

It’s often a lot of things together. [For example], not only has she fallen out with her mum and her English teacher’s on her back, [but] everybody’s seen [unflattering] pictures of you [on social media] at the weekend. It’s often lots of small problems. (P29)

Other participants reported similar views:

I would say that 90% of the students that I come into contact with, once I’ve built that rapport, at the very least, they are struggling to deal with everyday stress, from pressures of academia and curriculum at school as well as dealing with issues at home. (P21)

Life skills 101 was about intervening with young people to negotiate these challenges: “helping them to manage their situation. So empowering students to be part of a solution and getting them to manage that solution” (P22); “it’s trying to work out how we can help, how I can help them. Giving them strategies, how to deal with situations that come up” (P29).

Managing feelings was a key target for intervention: “working the student through how they’re feeling, validating their feelings” (P11). Participants perceived that many young people found it difficult to talk about their feelings: “the boys do not want to discuss their mental health, how they’re feeling, I found. [Some] do not like to give you eye contact, so they can sometimes be quite tricky” (P20). Stigma was perceived to be a contributing factor: “there is that stigma that students believe that if they disclose [their feelings, others will perceive] they’re crazy, they’ve got a problem. [They’re afraid] they’re going to be judged’ (P11). Participants explained strategies for overcoming this reticence:

I found [it helpful] to not sit down in an office environment with them. To say ‘come on, let’s make a drink’, or ‘let’s go have a walk around the oval’.

‘Let’s go somewhere where you feel comfortable, where you feel safe, where you feel you can talk to me’. I’ve found that works really well with the boys.
(P20)

Other participants talked about actively intervening with young people to manage their distress: “having one person they can come [to] and offload on and know it’s confidential, know it’s a safe place. That’s really a support for them” (P24); “for kids who are having a difficult time with anxiety, coming down to my office and being able to sit, de-escalate and [do] whatever they want to do. Whether they want to use their phones for meditation, or ...colour” (P13); “they can come and do whatever [helps]. Discuss with [me], self-regulate. They can talk to me or not, it’s up to them” (P28). Crucially, the goal was to encourage young people to reengage in class: “I can make them a drink. They have time to get themselves back on par and try and get to class” (P28); “[to] ‘listen to [their] music for half an hour, 15 minutes, get [themselves] together and go back into the school system” (P2); Another participant explained:

The ideal is that we re-engage her back into school and for her [to] know that she’s got a safe spot. Even if it is getting to school and sitting in Student Services but knowing there’s someone around if she needs [it]. (P4)

Many participants provided direct support for learning new skills related to managing feelings: “with a student that had anxiety, [I’ve] sat with her and done mindfulness together. We’ve actually sat and done it many, many times together” (P20). Other participants explained:

My practice now is very much on resourcing self-regulation. It’s the breathing exercises, anything from breathe in the colours of the rainbow to... breathe in for four, breathe out for six. It’s the moving, it’s the tapping of the body, trying to get them to breathe back in. (P14)

We’ll get them in for an appointment. We’ll talk about early warning signs and what their early warning signs are, and get them to think about that and get them to learn how to pick up on that. So we talk about, if you can pick up on your early warning signs you can lower the anxiety before it gets too bad

and doing that with the breathing techniques – as in counted breathing – obviously taking their mind off the anxiety by counting the breathing but also slowing down the breathing and getting more oxygen in and to the brain and everything like that. But if they've gone beyond that point, where they can't do the deep slow counted breaths, and they're panicking, then we teach them the re-breathing techniques. (P17)

When young people had specific problems, participants perceived that talking a young person through the problem could be highly therapeutic for them: “working them through [the problems] and getting that whole snapshot of their situation. It helps them from what I can see, because they're able to get it out, instead of bottling it up [and] keeping it to themselves” (P11); “the longer that they don't talk to anyone about it and let things bottle up the harder it is to, because the longer it takes to get on top of things as well” (P24). *Life skills 101* was also about building problem-solving skills that would equip a young person for adulthood: “my role is either to be able to work out some solutions, just with that person, whether it be some advice around relationships skills or communication skills, and then maybe encourage them to walk away with that and try [it]” (P24). Participants described being focussed on strengths rather than deficits: “[we identify] what their strengths are... and work on those strengths but also try and work on what's missing for them” (P26).

Supporting the development of communication skills was a common *Life skills 101* intervention: “I do find a lot of communication issues and if we can help facilitate opening up those communication streams that really helps” (P8). Not unexpectedly, participants provided significant support for building young people's communication with their parents. Participants encouraged young people to talk to their parents: “[I said] ‘you need to tell your mum about how you're feeling... you need to have this discussion with [her] tonight, because I'm going to ring mum and we're going to come up with a plan for you tomorrow’” (P6). Another participant described: “giving them some understanding of how to relate to their parents. [Asking] ‘how would you sit and talk with mum?’ Giving them some strategies of how to do that” (P10).

Conflict with parents was a common scenario: “say there's conflict with their parents over something, [we] talk about how they've been handling it, how they could

possibly handle it differently [and] different tips on what to try” (P24); “[I say] make sure that you set an appropriate time. [Ask] ‘mum, I have something serious I’d like to talk to you about, can we make a time when the other kids are in bed to sit down and discuss this?’” (P6). Sometimes young people required direct support for talking with their parents about difficult issues:

Quite often when I have a student that is in distress, or something’s happening, we say “do you want to get mum in?” because they say they can’t talk to mum about this issue. Sometimes we say “shall we get mum in and I’ll help you talk to mum about it?” Often that’s a good outcome, because it opens up some communication. (P8)

Other relationships that young people typically had to negotiate were often also a target for intervention: “[Supporting students] to deal with teachers that they don’t get on with. [Explaining] we all have some people that we don’t get on with in life, but we all have to deal with them... How can you change your ways, because they’re not going to change theirs?” (P10). Peers could also be a source of concern. One participant explained supporting a young person returning to school after a mental health inpatient stay: “[we did] some role play on ‘what are you going to do when that question is asked of you?’ [What’s an alternative response to] ‘why haven’t you been to school?’ [when] you’ve been in a mental health unit?” (P29).

In addition to *life skills 101*, many young people required social support and a confidant who was trustworthy. Conceptualised as *student support*, participants identified this as: “a supportive role, that ‘go-to’ person” (P20).

5.4.4 Student support

Student support was the fourth component of *optimising outcomes*, and meant being: “someone that they can go to that they feel safe [with], they feel comfortable [with], they can talk to, that respects their confidentiality” (P20). Another participant characterised it as: “someone to sit and offload to really. Some of it is just social-emotional support” (P4).

As previously described, young people who presented with *wicked problems* often first presented with non-specific concerns: “some of them are just sad little individuals, and that’s how they present. They’re sad, and they don’t know really what’s wrong” (P23). *Student support* was whatever the young person identified they needed and would accept: “I will offer whatever support that student will allow me to offer” (P21). Consent was a critical component: “my concern would be how we look after this child at school, with the child’s consent?” (P28). Other participants reported that allowing the student to lead this process was critical: “you need to sit back and wait and let the young person tell you how they’re going to work with you. My idea of support is really to be adolescent led” (P21); “I was going with her goals, because there’s no point me telling her where I think she should go” (P15).

Consistent with *being there*, *student support* was often impromptu and student-initiated: “you’ve got your day-to-day kids that you see weekly, daily, that come in. They just need that support to be able to get through [difficulties]” (P10); “it may just be a drop-in” (P4). One participant described a young person who sought frequent *student support* in the midst of an ugly custody battle between her parents: “[the student] comes down [to see us]. She’ll drop in [and say] ‘hi, I’m here, this is what’s happening and I’m good’, or just coming in and having a talk [when things are not good]” (P22). Another participant provided *student support* for a young man with a terminal diagnosis and his friends:

We have a young lad with Duchenne’s disease, a motor neurone disease, and he’s really deteriorating. He knows he’s not going to get better and he’s going to die. So that’s impacting on [his friends] as well. He’s not far off needing commodes and slings and urinal bottles. At the moment he’s insisting [on] using his electric wheelchair in the main toilets but he’s fallen over a few times. He’s been embarrassed and he’s soiled himself. His friends have then had to come [to me] for help. He’s still a 12 year old boy going through puberty with aspirations and dreams but also facing the fact that he probably, if he’s lucky, will have [only] next year at school.” (P21)

When participants identified that a young person had need of more intensive *student support* they often engaged in more regular, nurse-initiated *student support*: “[it]

may be weekly appointments initially, [then] it may become fortnightly” (P4); “[I] support her by catching up with her regularly and seeing how she is” (P22); “[I] support them in whatever way they need. That might be once a week, once a month, it might be every recess” (P21). It was also typically time-limited: “[I] support them through what they’re going through until they get to the stage where they’re feeling comfortable, that they’re okay, that the crisis is [over]” (P10). Another participant explained:

I normally follow them up a couple of weeks later, see how they’re going. Usually they’re travelling a lot better. I don’t necessarily refer them unless there’s other issues. If they’re coping well and they’re getting better, then I think that a referral at that point would be probably superfluous really. (P17)

Participants were aware that *student support* should not interfere with the development of self-reliance: “we can offer that support to get them through... but I’m also aware not to create a dependence” (P5). Another participant explained:

Accessibility is a [very positive] thing, but equally it can be a very negative thing. Sometimes young people want to come and see you and have a chat with you every day, and that’s not in their interest to do that. So I’m very careful with that. (P28)

Student support did not necessarily take a lot of time. Some participants provided *student support* in the form of a brief check-in: “I’ll say ‘just a quick one, I need to touch base with you and [then] I’ll send you back to class’, or I’ll walk and talk [when] I get them from the class” (P2). *Student support* was particularly important when there were barriers to young people receiving more specialist care: “sometimes I do see them weekly because they won’t go and get help, for whatever reason” (P2). Other participants reported planned *student support* for young people who were receiving care from a tertiary mental health service, an element of which was often unobtrusive monitoring of mental state:

I had a 10 minute catch up with [the student] once a week just to make sure she wasn’t escalating in her risk... It was just [conversation] “how’s school

going today? Did you do your homework? Have you done any more beautiful poems?” In fact the poems were all about death and dying. (P6)

Other participants also reported that they continued to provide *student support* to young people who were receiving external care:

My case load... at present [includes] managing students who initially presented with self-harm, who [were] referred to outside agencies, or seeing a counsellor...I see them in the school setting as well. They're getting the external support, but obviously still need that support in the school environment. (P20)

Duty of care was a consideration when planning *student support* for the young person receiving external mental health treatment:

Absolutely [we're monitoring them], because they're coming to our school, so we still have a duty of care as well, even though they're [seeing someone] externally... we always have a system of following up, we don't just leave them to external care. (P22)

Some participants reported that when young people were under the care of *external service providers*, they sought to provide *student support* that consolidated the work of these other professionals:

The kids will often say “that's what my counsellor said.” So it's that back-up. As health professionals [we should] be working together. That's where I see that my role is, supporting whatever the counsellor's saying. If [the student says] “the counsellor said that differently,” [I'd ask] “okay, how do you think they were meaning that?” and try and work it [out with them]. (P10).

The same participant continued:

Sometimes they sit in those psychology [appointments], but later on they just want to talk about it. So, supporting them and getting them to work out how they can implement [what they learned] and trying to set some [goals] with them. “Let's try this, this week. You do this for a week, and then we'll see how you're going and we can evaluate that and [check], did that work?” It's

getting them to look at their life to see what they can change. Some of [the circumstances] you can't change. So you have to look at: what can I do? How can I support them? (P10)

Student support was also about keeping the young person in mind and could occur when the young person was not present:

I may follow up with a phone call, just a random 'how's it going? I've done the referral to [an external agency], has that been supportive? Are you managing to engage with them?' So just to try and facilitate that support [and] follow up on referrals. (P4)

Although often students were the main recipients of nursing care, they were not the only members of the school community that participants supported. Parents were often also a key recipient of nursing interventions.

5.4.5 Family support

The fifth component of *optimising outcomes* was *family support*: "[it's] supporting not only the young person, but supporting the family" (P20); "it's a community nurse [role], [it's] not just your client in the school" (P21). Another participant explained:

It's holistic and it includes the family... I think 'if I don't support mum and get her help, how would she help her child? And how could the child improve if they see mum in that way?' I know from experience that you can't work with the [young person] on their own, there has to be family involvement... It's because I need the support from the family to help [the young person]. (P16)

Participants identified a broad range of social factors that had the potential to respond to *family support*:

A lot of it stems from the economic crisis that some families are in. [This area] is quite poor socio-economically. We have a lot of families with drug and alcohol use, [some] may be unemployed. A lot of single parents. A lot of immigrants so we've got a lot of the diverse culture as well. I just find that the parents have poor knowledge [of] or access to services. Sometimes they

don't even understand what we can offer. There might be domestic violence, or issues in the relationship. They're struggling at home. (P16)

Other participants also described the struggles of parents and how these impacted on young people:

I was talking to a mum this morning. She wakes at 2am, and Uber drives until 8am. Sometimes she's late [getting home] and she drops her daughter to school. Her daughter is late to school every day. I was asked to get involved as part of the attendance [process]: is there a medical issue? She's had multiple eye sties as well, she's had nine lots in this year. I was talking to the mum saying "it could be stress, before a growth spurt or maybe she's worried that you're working [too much]. You've just said that you're working your butt off" so that's going to impact on the daughter. The daughter's aware that money is tight. Probably 90% of the students I come into contact with would have at the least stress, but [some] would have mental health issues. (P21)

Many participants were very aware that *family support* could mitigate these struggles:

Simple things like community support through [a social service agency]. All [the agency is] doing is going once a week, helping mum shop and helping mum clean. Little things like that relieve some pressure from families. (P16)

Arranging this type of *family support* had positive consequences for young people:

[Students] that are helping out a lot at home, they see the frustrations and the anguish that [their] parents are going through... We've seen improvements... students engage at school more because they don't feel as stressed leaving parents at home. Their engagement's improved at school. They're attendance has improved. We've seen some changes, some positive changes. (P16)

Another participant described in detail how providing *family support* enabled a young man to stay at school:

We had a student last year who was a 14 year old, Year 9 boy, who was disengaging [from school] but was the carer of mum who had some major

mental health issues. Hospitalisation for psychosis as well as some physical limitations to her health. [I was] involved in lots of case conferences where mum's come in or the student's come in. The year coordinator, the deputy principal, myself provided support on the phone for mum. Making sure even things like allied health services, [that] she is aware of those and what's in place and what she can access. (P4)

Some parents resisted engagement at the clinical level, but experienced participants had the skills to provide *family support* in a less obtrusive manner:

You get the kid in and [she said] 'oh, I couldn't do it because mum wouldn't [take me to the doctor]'. I know with this student, it's the mother who's the [barrier to accessing care]. I do speak to the mother. I make an effort to go up [to her] when I see her at the school, and say "how are things going?" And she thanks me for being so supportive of her daughter. I say "are you going to the [doctor]?" and she says "we've got an appointment for next week" [but this doesn't happen] ... she's a complex case. (P2)

Parenting support was a particular focus of *family support*. Many participants expressed empathy for parents of adolescents and perceived that parenting adolescents could be a difficult job: "[there's] no real rule book" (P22). When parents were struggling, participants often provided emotional support: "I've had a few mums who will come in in tears. You then have to do quite a lot of counselling with the parent, because if they're mental health is not good, how can they support their child?" (P20). Initial emotional support often led to sourcing more specialist support for parents: "often it's [a case of] 'well, we've sorted your child out, now let's focus and sort you out, and get you the support [you need]'" (P20).

Participants often spoke about supporting parents with skills: "we need to give parents the sort of skills [they need for raising adolescents]. I think they're floundering just as much as the young person is nine times out of 10" (P22). Other participants sought to build parents up: "empowering the parents and carers is really important. I do a lot of work with them" (P21).

Parenting was not the only concern with which participants supported parents. Parents of young people with mental health problems were often struggling to find solutions to assist their child:

One of the mums came in the other day and I could see [on her] face that she needed to talk to me. She'd brought her daughter in, they'd been for [a mental health] appointment. Mum's body language said it all. I took her into my room, made her a cup of tea, sat down and said 'okay, what's going on?' And she just sat and cried for about 20 minutes. (P20)

The intersection of dysregulated behaviour in the context of mental illness with the demands of parenting could collide with serious repercussions:

[The student] identified that she had suicidal ideation. Mum came to school and took her to the hospital for an assessment. That weekend [the student] did something wrong, in her parent's eyes. She went to a party and drank [alcohol] or something, I can't quite remember. Mum gave her a big telling off and she then did attempt suicide [and] was admitted to hospital for a few days. Mum was absolutely traumatised. [She was] in floods of tears on the phone, all the time [saying] "I don't know what to do." (P29)

A particular focus of *family support* was therefore parents who were struggling to care for young people at risk of suicide:

The pressure on the parents is intense. The fear that some of them have. We've got 15 year olds sleeping in between mum and dad because they're terrified [the young person will suicide]. I always make sure [to tell] the parents 'if you're frightened at two o'clock in the morning, this is who you call. Call an ambulance, call the police if you have to. (P29)

The sixth and final component in stage two, *optimising outcomes* was *advocacy*.

5.4.6 Advocacy

Advocacy was a core element of participants' work: "we advocate for [the] students we see" (P8); "[I] see myself as an advocate for the child" (P29); "being that advocate was the biggest part [of the job]" (P10). *Advocacy* could relate to helping

young people negotiate the health system: “[students need] someone to be an advocate... a trusted person with the knowledge base to help a young person and their family [when they] are experiencing health issues” (P28). *Advocacy* could also be specific to wellbeing needs at school: “[A chill card to] get out of class without having to talk [when] they couldn’t talk because they have acute anxiety” (P25); “a graduated timetable because they can’t cope” (P10). The goal of *advocacy* was: “working towards reducing that students [health] risks and enabling them to stay in education” (P22).

When advocating for young people, participants were very mindful about gaining the young person’s consent first:

I always ask the child’s consent to liaise with certain key people in the Education Department. If it’s a Year 10 child I’d say ‘I won’t do this without your consent, but it would be really helpful if I can talk to [your year coordinator] or principal’. (P28)

When young people gave consent, participants discussed with the young person what could be shared. Participants often advised that only a broad outline be shared: “even if you just write ‘this student is going through some difficult personal issues’. [Teachers] don’t need to know too much” (P29). Another participant explained:

I would say to [the student], ‘I won’t tell them everything you’ve said to me but I would say ‘this person’s experiencing some mental health issues, we’ve got that in hand, we’re making some referrals, but they just need you to be aware [of it] at school.’” (P28)

Some participants described negotiating with teachers when young people were having trouble balancing the demands in their lives:

I had a young person... who was very stressed. She’s not the most academic [student], [and] there’s a lot of pressure on her to perform. She does dance [and had] 12 routines to learn... I got permission from the deputy [principal] to allow her to use her study periods, and the dance teachers’ [permission] to use the dance studio to learn her routines. Tick, problem solved. So,

engaging, going around and making sure that I've ticked everybody's boxes and that I'm not doing something that's treading on someone's toes... how's her anxiety? Smile on her face today, 'thank you so much, I feel so much better'. (P6)

Other participants also perceived that these interventions could help reduce academic stress: "[A teacher] might be really hammering them for an assignment, and they just can't concentrate to get it done" (P28).

Many participants reported advocating for young people for whom school could be particularly difficult: "I often spend time negotiating with teachers... some of the children have got difficult family backgrounds, [or] mental health issues. Anxiety, attention deficit hyperactivity disorder, things like that. School can be very [difficult] for them" (P29). Some participants perceived that they had insight into specific difficulties that teachers might not be aware of:

I've had girls with body image issues who are really struggling with physical education. We can adjust things like that. I can liaise with [the teachers] to say 'what can we do here to change this for the young person?' (P28)

Other participants focussed on interpersonal factors: "[I said] 'please be gentle in your dealings with [the student], just be a bit kinder'. Sometimes people can be a bit abrupt' (P29); "with the teachers, explaining that 'no, that's not the way to deal with this child'" (P10).

Participants were very aware that teachers experienced significant problems educating the young person when *wicked problems* interfered with school attendance and behaviour: "the less they're at school the harder it becomes to be at school because they get so far behind. [Poor academic progress brings] real challenges. Because of that you've got challenges in teaching, [and] you've got challenges in behaviour" (P22). Teachers could be placed in difficult schools early in their career: "[teachers] might be young, middle class people, a couple of years out of university" (P21). This lack of exposure to *wicked problems* together with irritation about a young person's behaviour could lead to interactions that did not show much insight:

The frustration is that some teachers don't understand how difficult a child's life is. We had a little Year 8 boy came that has got a really difficult family life. His mother has killed herself. He has attention deficit hyperactivity disorder, he lives in a difficult family situation with his dad. He's grossly overweight, he gets picked on, he picks on people, he fights, he's in trouble at school. We had immunisations on Friday. I was really pleased that he was going to get his Year 8 vaccinations because he was late [to school]. I was making a bit of a fuss of him... Then one of the teachers said "can you give him something else?" and I said "I'm sorry?" She said "isn't there another needle you can give him, like sterilisation?" She thought she was being funny. I just said "no, don't be ridiculous" and walked off. (P29)

When participants perceived that teachers were behaving in a manner that concerned them, they addressed it, even when it was difficult:

Sometimes I've had to be quite brave. I had one [situation] very recently, a very nice teacher, but he was mocking the student. He was looking at me and laughing and expecting me to join in and I refused. Afterwards, I said to him "look, I respect you greatly but I will not be part of a conversation mocking children. It's not the type of person I am." I had a big red face, you know, when you've got confrontation. So I see that as a very big part of my role, being an advocate for the child. (P29)

Supporting teachers to understand the realities of some young people's lives was therefore a priority:

If you can explain to [teachers] 'you know, there's a lot of stuff going on for little Johnny at the moment. He doesn't always know where he's going to sleep at night. He's not always safe. He might not rock up to school until period two [and] he's going to turn up unprepared. He's not going to have his homework, he's not going to have full school uniform on. He might put his head down on the desk and sleep. But you know what? He obviously feels safe to come to your class'. (P21)

These communications were often well received. The same participant continued:

Sometimes that's all teachers need [to say] "oh my god, so little Johnny will always come to my class and he'll go to cooking class because he knows he gets to eat there but he doesn't go to any of the other [classes]. He wanders around or goes to see the school nurse." (P21)

Another participant confirmed:

Sometimes a teacher will get back [to me] and say 'thank you so much for that. I just realised something was wrong with this kid. I'll back off. Let them know that they can come and talk to me any time and I'll try and help them get through the work'. (P28)

The tasks associated with stage two of the core process of *tactical prioritising* took up a great deal of participants' energy and time in the workplace. Participants engaged in this stage because they were motivated by *a passion for the wellbeing of young people* and gained a sense of agency and satisfaction by *optimising outcomes*. In the longer term this work was not sustainable unless participants also engaged in the third stage of the core process, *managing self*.

5.5 Stage three: Managing self

While *strategic assimilation* related to building relationships in their assigned school community and *optimising outcomes* related to supporting young people with *unmet needs*, *managing self* conceptualised how participants sought to maintain their own personal and professional wellbeing. Participants reported gaining relief from *untenable burden* by engaging in such diverse strategies as cultivating collegial support and developing additional skills. There were four components in *managing self*: 1) *sharing the responsibility*, 2) *learning, learning, learning*, 3) *seeking personal balance* and occasionally 4) *extreme measures*.

5.5.1 Sharing the responsibility

The first and most critical aspect of *managing self* was *sharing the responsibility*. *Sharing the responsibility* typically occurred at school and assisted participants in *managing self* because it distributed the professional demands and provided emotional support for distress associated with the problem of *untenable burden*.

Sharing the responsibility reduced feelings of isolation that came with being the only nurse in the school and increased participants' confidence that the care and management of the young person at school had been informed by more than their own perspective.

The most common means by which participants reported *sharing the responsibility* was with the Student Services team: "we have a Student Services team [and] we have a meeting to catch up on all the students that are needing extra support. We share information there and decide which student needs whose help" (P9). The majority of participants reported that Student Services meetings were held regularly: "every two weeks we have [a] meeting at Student Services and we go through all of the kids that we're worried about for whatever reason" (P15); "we regularly meet [for] Student Services meetings, every fortnight" (P4); "we would meet regularly every week for every age group" (P21). In larger schools attendance at Student Services meetings could take up a considerable amount of time: "at Student Services meetings we meet every week. We do a week of lower school students which are Year 7, 8 and 9, and then the following week we do [the Year] 10s, 11s and 12s" (P19).

Importantly, Student Services meetings were pastoral in nature, and often only obliquely academic: "we discuss students at risk, be it for whatever reason. If they're not academically performing, if there's stuff happening at home, or there's anxiety, [or] depression" (P19). Several participants referred to Student Services meetings as a 'triage meeting': "there is a regular triage meeting that we have each week, going through those students who are currently [at educational risk]" (P22); "we meet up every week and we have a sort of triage meeting... we triage basically red, amber or green" (P8). Other participants described similar systems: "we meet every week [and] grade [students at educational risk] on a scale of one to three. We talk about the student, [and] as a team we will decide what level they should be" (P20). The number of students on the Students at Educational Risk list could be quite high:

At any one time we've got between 90 and 120 students on our triage list. That's students that are having support either from us or from agencies that are coming in. They're students that are deemed as very high risk for one reason and another. (P8)

Participants emphasised that *sharing the responsibility* was a two-way arrangement, where the participant not only elicited support from the Student Services team, but also provided support back to the team: “[I’ll] say ‘that’s something I feel confident managing and I will take that [case]’” (P20): “we discuss who the best person [is] to case manage that student. I have quite a few that I manage” (P19). Although one team member might case manage, the process of supporting the student was often interdisciplinary and outcomes based: “the three of us work [together], as in ‘what’s the [desired] outcome?’ It’s not just on paper that you’ve done something, but what are you going to do [next]? How are you going to follow that up?” (P2). Another participant provided more detail as to the division of duties:

We do work very collaboratively, but we still case manage individual students. We’ll always notify each other if we’ve had a disclosure and we’ve done a referral. The school psychologist does the [school] risk management plans. That’s her role. So any student that goes on one, she’ll meet with the parents and draw up the risk management plan. (P31)

Participants were very aware of what could be provided at the school level and what required more intensive external intervention: “We have a tiered level of where we feel the student is at and what we can manage” (P22). Other participants reported that their school had access to visiting therapy services that came into the school:

We have a lot of organisations that come into our school, such as headspace, [and] Helping Minds. They come in and do counselling with the students as well. Part of the triage service is that we do referrals to these organisations that support our students and then each week we review how those students are going, whether they’ve turned up for the counselling, and how they are. Whoever’s referred them to us gets a feedback letter to say we’ve seen this student and they’ve been referred. (P8)

Many participants also reported *sharing the responsibility* by liaising with professionals external to the school setting:

If it’s a more severe case, if it’s a disclosure or I feel they need a lot more care and input I’ll do case-management. I’ll support [the student] but do a lot

of liaison. So it's communicating with the psychologist in school, but primarily I get in touch with the family and try to do family and external agency support. (P16)

Importantly, young people who were receiving external care were not dismissed from the Students at Educational Risk list but were also case managed at the school level:

When we refer them out we still keep tabs on them, monitor them as to where they're at... we keep them on our triage books, on our list, and touch base every week... they never drop off altogether. They can be put back on [for more intensive support] at any stage should something else arise. (P22)

Of particular concern were young people who were identified as at risk for suicide. When a young person returned to school after a suicide attempt, *sharing the responsibility* included a range of wrap-around supports:

When it was time for the girl to come back to school [post discharge from hospital after a suicide attempt] I arranged a case conference with the principal, and the mum and the school psychologist. That [includes] health-care planning for school, [and] risk management planning because if the child has had suicidal ideation or [a suicide] attempt, we need to keep a good track on them at school. The Education Department need to do a risk management plan. [The student was referred] to Child and Adolescent Mental Health Services. With the support of myself, the psychologist, the external support of Child and Adolescent Mental Health Services and the mum [we managed her care at school] ... [Now] she's coming to school, she's getting the support [she needs]. That's quite a typical thing I do, that would be quite a normal thing. (P29)

Participants reported that *sharing the responsibility* positively impacted the basic social psychological problem of *untenable burden*, but they often articulated wanting to be able to provide more in the way of intervention. Those participants who had engaged in the basic social psychological process of *tactical prioritising* for a long duration had often also engaged in extensive *learning, learning, learning*.

5.5.2 *Learning, learning, learning*

Learning, learning, learning was the second component in *managing self*. Many participants were prompted to engage in *learning, learning, learning* to diminish the experience of *untenable burden*: “kids you know are not living in the best of circumstances, but you feel quite powerless... [you ask yourself] ... am I doing enough?” (P22). Other participants were motivated to engage in *learning, learning, learning* when they were *grappling with unmet needs*: “I’ve actually had to pull my finger out [take action] and look for ways to help these kids, because they’re just not getting seen” (P15).

Initially, participants looked mainly to their school nurse colleagues for the purposes of learning, especially early in their secondary school nursing career: “I might have rung one of the other secondary school nurses and said ‘what do I do? Where do I go?’” (P19); “it was really just learning from colleagues” (P24). Other participants were doing this currently:

I’ve looked for help, but the [person] I work with is not wanting a mentor kind of a role, so I looked to other[s]. I found one [nurse], she’s been great. I ring her all the time and I ask her what I should do. She’s been really happy to mentor me. (P13)

Once participants were well-established as secondary school nurses they reported pursuing both self-directed learning and short courses: “I try every bit of training that I can apply for” (P23); “self-education, reading up on whatever [the] problem is” (P9); “[I’ve done] short courses on self-harming, eating disorders, all of that sort of stuff. They’ve helped. Some of them have been very good” (P19); “we did one hour workshops... we had case studies and it felt really real and I really got something out of that that I could take back to [work]” (P3). Other participants used their *learning, learning, learning* to assure themselves that they were still providing young people with the best care: “I walked away from [the course thinking] ‘that was good. I feel like I’m still doing the right thing by my clients’” (P6).

Once participants were engaged in learning they typically engaged in learning over long periods:

I've been in school health for well over 20 years and I still feel I'm learning something new every day, so it's still very stimulating. I'm always learning something new and learning things I didn't know I didn't know. (P15)

A minority of participants had undertaken substantially greater learning: "my mental health qualification has prepared me immensely... what I've got is the background understanding. I really understand the [fundamentals] of mental [illness] and how it impacts: the stigma, the community, society. It's just the bigger picture" (P16); "I did do a specialist practitioner degree ... that was a year [long] course" (P30). It was clear that this too could relieve the problem of *untenable burden*: "I ended up [doing postgraduate studies] because I used to get so frustrated that I would be referring people into external agencies and realising [they] were giving them less than what I [potentially] could" (P14). Other participants were thinking about pursuing postgraduate studies: "within the role it'd be fantastic to have a postgraduate [qualification] in mental health" (P26).

Over time, participants grew a repertoire of sophisticated skills that assisted both in *managing self* and *optimising outcomes*. Although this tool box assisted participants to intervene with *wicked problems*, it paradoxically also increased *persistent intensity*, *a heavy toll* and subsequently the experience of *untenable burden*. The more skilled a participant became at managing young people with complex issues, the more likely they were to report that young people sought them out with increasingly complex issues. For many participants *sharing the responsibility* and *learning, learning, learning* were not enough. Many participants reported that they actively engaged in *seeking personal balance*.

5.5.3 Seeking personal balance

Seeking personal balance was the third aspect of *managing self* and related to active personal coping strategies for overcoming the experience of *untenable burden*. Approaches participants employed in *seeking personal balance* ranged from exercise

and finding meaning in the work to taking time off and seeking temporary alternative employment.

Some participants specifically mentioned *balance*: “I handle my own mental health quite well, I think. [I] try and balance it all out” (P22). Some participants identified activities that aided personal coping: “I like exercising” (P6); “I normally karaoke. That’s my de-stressing” (P21). Other participants reported *seeking personal balance* by delineating between work and other aspects of their lives: “I need to know where [the] boundary lies. I cannot overstep that boundary. I have to cut [my feelings] off there and not take it home with me” (P11). Some participants arranged rosters that gave them scheduled days off: “I get every other [Monday] off. But that [Monday], although I get [things] done at home, I feel like I can't do without it. I need it, to have a break from [the *untenable burden*]” (P7).

Many participants reported valuing the rewards, however infrequent: “you have to hang onto the rewards... because you don’t get a lot of them sometimes” (P25). Other participants described with pride the positive regard young people had for them:

When I’ve helped one student out and they’ve known that they could trust me they will then bring their friends back. That word of mouth gets around and you get more and more kids coming to you. (P17)

Some participants reflected on clinical cases where intervention had led to positive outcomes: “it is a job where you can get compassion fatigue, but then it [is] outweighed when you see the good things that happen, and you see the successes” (P2). ‘Success’ could be hard won, involving many years of intervention:

I know a couple of my [students] that I’ve [supported long-term have survived] what they’ve gone through [in] secondary school... One of my girls was a regular [inpatient] at the [adolescent psychiatric inpatient unit during] Year 9. We got her to Year 12. When you see that... as a school, it’s not just me, but as a school we got her through that. (P10)

Other participants could recall circumstances when young people or their families expressed appreciation: “the student will come up and say ‘thank you’ or the parents come up and say ‘thank you very much.’ (P2). Sometimes appreciation was expressed long after assistance was provided: “[The] student said to me ‘you really helped me to get my life together, because of our sessions’. That sort of feedback is really what keeps you going” (P25); “I’ve had one girl come back and say ‘you’ve helped me get there’. She’s going to be a teacher. She said ‘I never thought I’d do that’” (P10). Another participant recalled:

[The young person] was very thankful for the fact that I didn’t let her kill herself, but at that time there were books going everywhere, there were two people at one stage holding her down because she was just out of control. She went on and got help and... [came] out the other side. (P6)

Understandably, the urgency and need for *seeking personal balance* became more pronounced as the *untenable burden* increased: “I felt really worn out by [the *untenable burden*]. [I] did a little bit of counselling myself, which was helpful” (P3). Others sought to reduce their exposure to *wicked problems* and *persistent intensity*:

[I said] ‘I can’t keep doing this at this rate’. I did take a little bit of time off work, I think I had five working days off and [with] a couple of weekends, had a good stretch of time off. (P3)

It was notable that sometimes this was the only means by which participants felt able to convey the degree of *untenable burden* they faced. The same participant continued: “in a way [that] made the principal realise that it really was a burden for me” (P3). Another participant expressed having to take similar action: “I was not very happy, so I said ‘this had gone on too long, I’m sick of this rubbish’ [and] I walked out of the school. I left the school for [10 days]” (P18).

At the more extreme end, some participants chose to take unpaid leave: “[it was] in my application for [the leave] that I’ve just had [from] work. I felt that I really needed a mental break from dealing with [the *untenable burden*]” (P6). Other participants took a temporary secondment to another position: “the *untenable burden* was] one of the reasons I came into this [alternative] job. I didn’t expect it to be less

stressful, but I'm sick of asking people on a daily basis if they're going to kill themselves" (P7). Another participant made a similar move: "I needed to do self-care and recharge my batteries, so I took up [other work]" (P21).

Although most participants in this study routinely engaged in *managing self* by *sharing the responsibility, learning, learning, learning* and *seeking personal balance*, a small number of participants had to undertake occasional *extreme measures*.

5.5.4 Extreme measures

Extreme measures was the fourth component in *managing self*. This component of *managing self* occurred when a *heavy toll* became so burdensome that participants could see no other options but *extreme measures* to alleviate their distress. *Extreme measures* occurred infrequently, but as one participant explained: "[I did it so] I could sleep at night" (P3). There were two aspects in *extreme measures*: 1) *seeking false reassurance* and 2) *breaking the rules*.

5.5.4.1 Seeking false reassurance

Some participants were so impacted by a *heavy toll* that they engaged in *seeking false reassurance* by becoming more proactive clinically for the purposes of *managing self*:

Do I feel really safe in myself about that one? No. So I make sure that I make weekly [contact with] grandmother, to make sure that grandmother is not taking [the student's suicidality] as 'a phase'. [That's] what grandmother is thinking 'oh, she'll grow out of it'. [The] grandfather was [saying to the student] "get over it, hurry up." (P18)

Other participants became increasingly risk averse:

Even if [the student was] just sad and didn't have self-harm, didn't have [suicide] ideations I would say to the parents "I'm just letting you know. You think it's just that they had a fight with the boyfriend but... they've been in tears, they're upset... if you feel any great concerns you need to take them straight to accident and emergency." (P2)

Another participant had become hypervigilant:

There had been a suicide in a secondary school only a short while ago where a young person hung themselves on the back of a school toilet door during the school day, [so I was thinking about having] all the hooks removed off the backs of the school toilet doors. (P30)

Hypervigilance also manifested as increased attention to risk assessment and risk management:

Sometimes we're getting kids risk-assessed that probably didn't need to be, because [school staff] are jumping to a conclusion very quickly. We're getting [students] put on risk management plans when they probably didn't need to be and that creates its own problems as well, because you've got to follow these kids around everywhere. And go looking for them if they go missing and all sorts of things. [P17]

Participants also reported that *seeking false reassurance* could extend to keeping young people on risk management plans indefinitely:

The ones that are on the risk management plans... We don't actually take them off the risk management plans until we have spoken to the parents, and the parents are happy for them to be removed from the risk management plan. And then [the parents] actually have to come in and sign [for the student to be taken off] it. But to be honest, none of them have actually come off the risk management plans. They're continually on them. [P20]

At times, participants perceived that student risks were so high that vigilance at school was not enough. Although uncommon, some participants also reported *extreme measures by breaking the rules*.

5.5.4.2 Breaking the rules

The second aspect of *extreme measures* was *breaking the rules*. Although very infrequent, this was commonly a response when circumstances conspired against participants: "I had arranged for the chaplain to take her... unfortunately the chaplain

was very unwell that day” (P2); “there weren’t any other good [options] for the girl. I didn’t want her parents to take her, when she was highly suicidal, because I didn’t think she’d get there [due to family dysfunction]” (P3).

Participants engaged in *breaking the rules* by going against Department of Health policy. Participants were clearly familiar with policy: “I know that [the employer has] rules, regulations, and guidelines” (P29); “there are policies and procedures to follow, and they’re there to support us, to assist us” (P10). Despite generally positive perceptions of Department of Health policy, sometimes a situation was so urgent it could not wait: “a colleague [and I] ended up taking her to hospital, which is really against the policy” (P3); “there are times that something needs to be intervened [with] and something needs to be intervened [with] now” (P6). Other participants with specialist skills responded by working outside the ratified parameters of the role: “I do work outside [the role, but I’m using] my mental health qualifications. I just don’t tell anyone what I do. If I’m going to go down that path, I code it as a short counselling session” (P14).

Sometimes participants who wanted to take action that did not align with policy approached their line manager to discuss the circumstances and negotiate an outcome: “I had to ring my manager to find out [whether I could], just this one time [take her to the appointment]. [I said] ‘I know it’s against our policies, but can I take her in my car?’ ...because there was no one else [who could do so]” (P2). Another participant described first taking action and advised their line manager after the fact, risking censure: “My manager gave me a little [telling off] for what I did. Underneath somewhere she didn’t get too cross with me, because she also knew my position. She knew that my hands were tied” (P3). In the latter cases where participants had discussed *breaking the rules* with their line manager, they inferred that their respective managers were complicit. The participant who approached their manager for permission to break the rules reported: “I got permission [to take the student to the appointment]. [My manager said] ‘It’s only this one time, you know you can’t do it’” (P2). The participant who reported *breaking the rules* to their line manager after the fact reflected: “our line managers know that we have those situations, and they can be fairly understanding as long as they say and do the right

things themselves. It's all a little bit of a game so that we can get the right care for the student" (P3). In these types of circumstances, some participants were ambivalent about whether this was genuinely *breaking the rules*, as illustrated by this participant's use of the words 'maybe, possibly': "if I'm going to stick my neck out [take a professional risk] and try to help somebody to have a better life, I want to do that even if it's *maybe, possibly* going a bit beyond my role" (P6).

Participants who disclosed *breaking the rules* were emphatic that this had been the right decision. The following quote illustrates how the participant engaged in *breaking the rules* and experienced relief from *untenable burden*:

To me it's absolutely worth it [even] if I'm going to get told off... It was the only way. Ethically [and] for myself, [the only way to] get something to happen [for the student] was to go against the policy.... [The student] ended up in [the adolescent inpatient psychiatric inpatient] unit. (P3)

The other participant agreed: "to be quite honest... I probably would have done it [*breaking the rules*] if I couldn't have got hold of my manager, because this kid had been struggling for... I don't know how long" (P2).

5.6 Summary

This chapter presented the basic social psychological process of *tactical prioritising* that secondary school nurses engaged in to manage the problem of *untenable burden*. In the first stage participants engaged in *strategic assimilation*. In this stage they sought to become a familiar and trusted individual at their assigned school, a category conceptualised as *being there*. Participants also described their efforts to become knowledgeable about the resources within and external to the school so that young people experiencing mental health problems could be appropriately referred for more specialist support. This was conceptualised as *knowing where to send them*. Despite efforts to engage young people with other service providers, participants reported that these efforts were not always effective or sufficient, leaving them *grappling with unmet needs*. This was a tipping point for participants.

In the face of *unmet needs*, the majority of participants gave further consideration to the means by which they could help young people and entered stage two of the basic social psychological process, *optimising outcomes*. In this stage participants developed sophisticated skills for eliciting young people's *wicked problems* and addressing these with a range of supportive interventions. The purpose of this was to provide support for the young person at school and optimise the young person's immediate and longer-term life outcomes. For participants, stage two simultaneously prompted stage three of the core process of *tactical prioritising*.

Stage three was conceptualised as *managing self*. In this stage participants sought to preserve and enhance their ability to engage in stage two. To facilitate *optimising outcomes* they undertook *learning, learning, learning*, engaged in *seeking personal balance*, adopted strategies for *sharing the responsibility* in difficult clinical situations and occasionally took *extreme measures* such as *breaking the rules*. Stages two and three of the core process spiralled together without end, and participants who had been engaged in these stages for a long duration had a unique and highly sophisticated suite of clinical skills. The next chapter will examine the conditions which influenced the basic social psychological process of *tactical prioritising*.

CHAPTER 6

CONDITIONS THAT INFLUENCE THE PROCESS OF TACTICAL PRIORITISING

6.1 Introduction

In the previous chapters, the basic social psychological problem of *untenable burden* was identified as the shared common concern experienced by the majority of secondary school nurse participants who encountered young people with mental health problems. In chapter five, further data analysis identified that participants engaged in the *basic social psychological process of tactical prioritising* to manage the problem of *untenable burden*. This chapter describes the four conditions that influenced the core process of *tactical prioritising*: 1) *capacity to engage with wicked problems*, 2) *collegial relationships* 3) *community partnerships*, and 4) *ability to function in the school*. The influencing conditions together with their components are shown in figure nine. Subsequent sections describe the influencing conditions in detail, with participants quotes to give a rich description of the concepts.

6.2 Capacity to engage with wicked problems

The first condition influencing the core process of *tactical prioritising* was the *capacity to engage with wicked problems*. This condition influenced the basic social psychological process of *tactical prioritising* by providing the circumstances for moving from the tipping point *grappling with unmet needs* to stage two, *optimising outcomes*. There were two components in *capacity to engage with wicked problems*: 1) *a commitment to the social model of health* and 2) *an interest in finding solutions*.

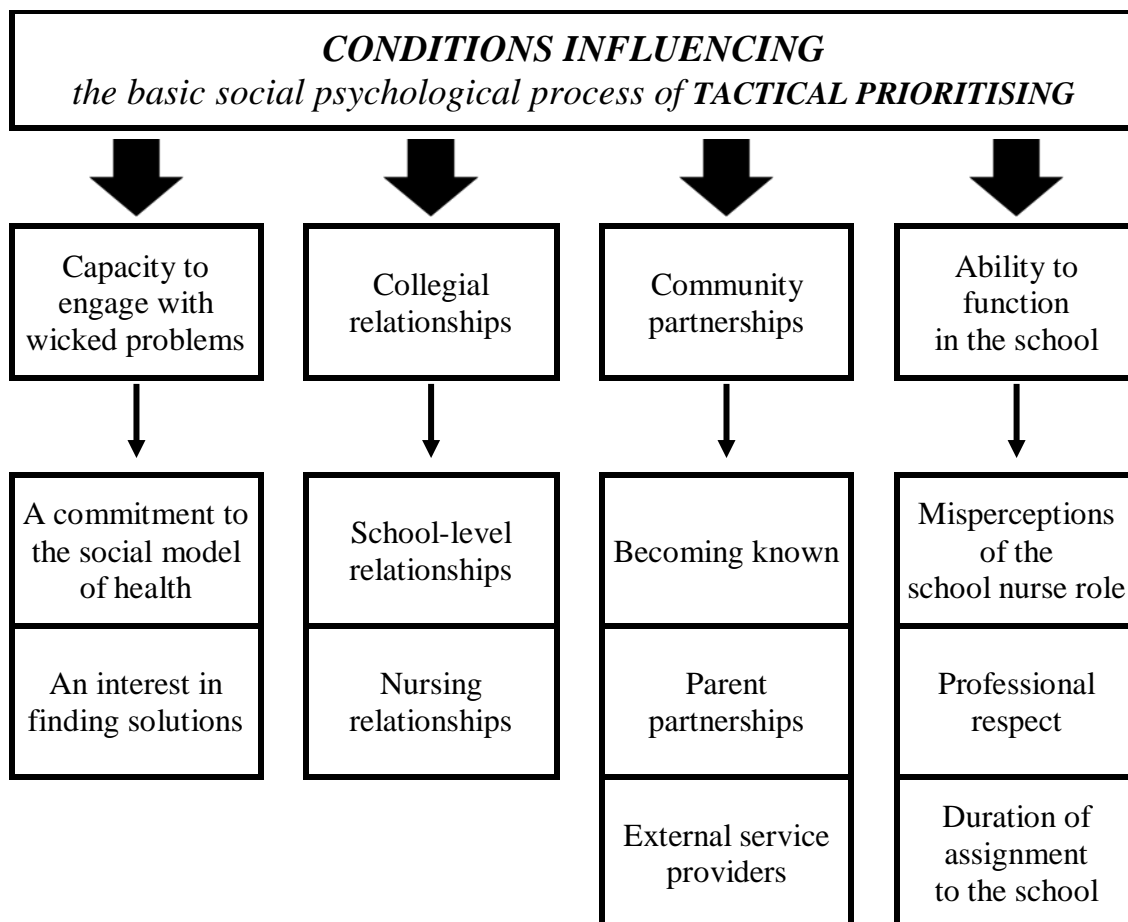
6.2.1 A commitment to the social model of health

As described in chapter one, secondary school nursing in Western Australia is underpinned by *primary health care* and oriented to addressing the social determinants of health. Often referred to as the *social model of health* this model focusses on the social and environmental factors that influence health at the individual and population level (Spencer, 2018). In adolescence, proximal social and environmental determinants such as substance misuse, sexual risk-taking, family and

intimate partner violence, contact with the criminal justice system and mental ill-health influence exposure and vulnerability to health-compromising conditions in the short and long term. These factors are potentially modifiable and form a focus for prevention in the social model of health (Viner et al., 2012). A participant with a *commitment to the social model of health* explained:

[I said] “I’m a community health nurse... It’s a public health role and its primary health [care]... it’s not first aid, it’s preventing teenage pregnancies and preventing anxiety or depression or mental illness or relationship catastrophes. [It’s] preventing bad outcomes in education... some of those cases are probably social health and mental health cases, just give them to me... that’s probably the best use of me, here at the school. Those kids who are chewing up all your time with behavioural issues or trying to avoid classes... send them to me.” (P15)

Figure 9



As illustrated by the previous quote, participants who had *a commitment to the social model of health* had an interest in and were at ease with social complexity. They were not afraid of discovering that a young person was impacted by *wicked problems* and were able to approach and address challenging social circumstances:

I worked with a father who had two Aboriginal kids. These kids had not been to school, they had not been immunised... I walked away from that [case] with him looking at job prospects, [the] kids in school, the kids in uniform, the kids de-[loused], the kids having started their immunisation program. (P6)

A commitment to the social model of health often manifested as an interest in working in settings that were not traditionally perceived to be health settings: “I’ve worked in a lot of different areas, teenage pregnancy, home visiting, in schools, in referral schools², in secure units with correctional services” (See footnote³). Participants who had *a commitment to the social model of health* viewed client behaviour through a social lens. One participant described a young woman who exploded without warning: “[the student] got up, smashed my door shut to the point that people down the corridor came [running]. [They] said “are you okay?”” (P21). Despite having no idea why the student had responded this way the same participant continued:

I took a few deep breaths, found out where she was supposed to be, [and] of course she wasn’t there. [I] wandered around the school until I found her and said, “I’m sorry.” I was really wary because I thought she was going to hit me. She was [really cross]. I’d always had a really good rapport with her, so this just came completely out of the blue. I said “I’m going back to my office. If you want to see me, please come in and I will lock the door, turn the phones off and give you my full attention.” Sure enough, five minutes later

² In the United Kingdom, referral schools cater for children and young people who have been excluded from mainstream schools, often for highly dysregulated behaviour.

³ As these circumstances are potentially identifying, the participant number has been omitted to preserve their confidentiality elsewhere in this thesis.

she came back in. [I found out] she was in foster care. There were eight siblings and the youngest had just been put in jail for murder... There was lots of stress and lots of money issues [at home] ... She'd got her period. She had period pain, but she also needed [menstrual] pads and she didn't know how to ask me. (P21)

Participants also used a social lens to reflect on why parents might be difficult to engage: "a lot of parents don't have a relationship with school. They might have had negative [school] experiences in the past, they don't want to engage, they don't want to come into [the school] building" (P16). Another participant shared: "I know she is a good mum [even though she hasn't actioned the referral], but I feel [that] if the mum dealt with the issues [in the home], things might be easier [for the student]. [The mother's] a complex case." (P2). Participants with *a commitment to the social model of health* had a level of tolerance for these challenges:

It is not a reflection on you if that person doesn't take up that referral at that time. It just means it's not the right time for them. As professionals I think we forget that. We almost feel like our client should be so grateful that we've been able to work out what the best thing would be. (P21)

Unsurprisingly, key capacities in *a commitment to the social model of health* were patience and persistence: "you have to have a passion for it, you really do, for following it through. You know, case by case. Finding the time to do it. You ring home, you follow up with home. You ring home again" (P2). The same participant continued: "for two years I've been trying to work with the mother" (P2). During this time participants were often *left holding the baby*. This participant did so for three years:

[The student] was not getting to any [mental health] services. I felt that she had [mental health] issues, and those issues have continued to get worse. I would say her depression has become deeper, she's got risky behaviour happening around [sex and] just general risky behaviour. [There were] very concerning behaviours and stories that she'd tell me. I [just] couldn't get her to access services. (P3)

A commitment to the social model of health also meant being able to tolerate uncertainty: “it’s such a grey area. There’s no black and white in any of these situations. There are so many factors that come into each different case that it is a bit tricky” (P24); “some of the strategies I come up with... [I know they] may or may not work” (P16). Another participant disclosed:

It’s a difficult case because in the presence of his mum, I think [he] is afraid to tell the truth [about the degree of his suicidality]. I quite accept that he’ll be discharged again from Child and Adolescent Mental Health Services and they’ll say “[it] seems like he’s travelling fine,” [but] I think he’s a very high risk little boy. (P28)

Some participants perceived that working in a social model of health might not appeal to all nurses: “it might not be for [everyone]. [Some] wouldn’t want to be involved and I guess that’s [their] choice. Personally, I find it challenging [and] rewarding. I feel like I connect well with [these families]” (P19). Participants who had *a commitment to the social model of health* typically also had *an interest in finding solutions*.

6.2.2 *An interest in finding solutions*

The second component in a *capacity to engage with wicked problems* was *an interest in finding solutions*: “[Students had] a big range of different issues, and [there were] some very, very complex young people ... with multiple issues. You sit there and think ‘where am I going to start?’” (P30). Participant personality characteristics often revealed an inclination for *an interest in finding solutions*: “I realised it was a very unique and needy community, but I just jumped right in and swam’ (P21); “I have the sort of personality that likes to try something new... I’m up for something different. I’m not the sort of person who feels I have to know everything about a job” (P3). A capacity for tolerating uncertainty was a strength:

If I look back at myself as a nurse over 20 odd years or more, I’ve always been the sort of person that [has] never been too proud to ask. I’d rather ask the question than go ahead and do something and it be the wrong choice. I’ve

always felt reasonably comfortable in doing that. I guess my strength as a nurse [is doing that] and that's really helped. (P24)

Participants perceived that *an interest in finding solutions* was a largely solitary undertaking which could not rely on well-trodden paths or discrete clinical pathways: "a lot of it is just finding your own way to be honest" (P24); "a lot of [school nurses] are not too sure. Where can we refer to? How do we refer? What's the pathway? You have to find that out for yourself." (P25). Others participants perceived that it was the circumstances of their work that made a solitary approach to *an interest in finding solutions* practical: "by the time you make a phone call or by the time you type out the email asking a question that just seems so simple, [you think] 'I'll just try and find out for myself'" (P9).

It was also common for participants with *an interest in finding solutions* to describe seeking new skills from others: "obviously I have to have consent [of] the student, but I do discuss with the school psychologist their perspective on how they deal with [some] things" (P11); "I've been talking to the school psychologist at my school, asking her what she recommends" (P13). Other participants had developed extended networks that demonstrated *an interest in finding solutions*: "I email the Child and Adolescent Mental Health Services worker and I ask [them] what they would like me to do to support [the student]" (P13); "[I] have a really good relationship with the mental health nurse that works at Child and Adolescent Mental Health Services. One of the local [doctors] focusses on youth mental health. [It's about] learning from colleagues" (P24). Other participants also reported making assertive efforts to liaise with other services in the local community: "I will always keep checking what resources are out there" (P21). Participants evaluated the experiences they had with external agencies and adjusted their practice accordingly:

[I'm] constantly [finding new solutions], but having been in the area you know where to look and you know who not to go to... [for example] there's no point in ringing [that agency], I haven't had a good experience with them. I've sent a couple of students that way, and haven't had good feedback so I won't try that agency. (P19)

The same level of initiative that prompted participants to demonstrate *an interest in finding solutions* often also facilitated the assertive development of supportive *collegial relationships*.

6.3 Collegial relationships

The second condition influencing the core process of *tactical prioritising* was *collegial relationships*. *Collegial relationships* influenced the core process of *tactical prioritising* by supporting participants engaged in *managing self*. It differed from *case, clinical and professional support* as described in chapter four because the focus was on the participant's emotional wellbeing. When *collegial relationships* were absent or ineffective, participants had fewer resources to support *managing self* and the experience of *untenable burden* escalated:

I just think [we need] for somebody to ask “are you okay? Do you want to tell me what you've been dealing with?” I'm sitting here [in the research interview] and I feel quite emotional now. If you touch on one of those nerves, I know that I would cry, the tears would come. (P7)

There were two components of *collegial relationships*: 1) *school-level collegial relationships* and 2) *nursing collegial relationships*.

6.3.1 School-level collegial relationships

School-level collegial relationships influenced the basic social psychological process of *tactical prioritising* by increasing or limiting the opportunities for *sharing the responsibility* in stage three of the core process: “[relationships with school colleagues are] very important. For my wellbeing and looking after me, and recognising who I am and what I'm doing and [for] my self-esteem” (P7). Other participants went further: “I'm very grateful that I am supported by the school staff. That's my saving grace, because if I didn't have that, I don't know how well I would be able to do the role over a period of time” (P31).

Participants identified that an optimally functioning Student Services team and strong *school-level collegial relationships* were key factors that influenced the core process of *tactical prioritising* because an effective Student Services team supported

participants, diminished their sense of isolation and gave them a sense of professional value: “we all work as a team” (P25); “the team at [current school] has been absolutely incredible. [I’m] very lucky and I do think it’s a little bit unique compared to other schools that I know of” (P16); “We just need to know that we’re appreciated and part of the team” (P21); “the [school] team there is so good that I can just ask them for assistance” (P12). When the Student Services team worked well, *collegial relationships* were strong and communication effective: “[the Student Services team] also catch up regularly in between [formal meetings], or if one of us feels as though [we should]” (P22); “we’re always talking, as well as formally in the Students at Educational Risk meetings” (P19); “we communicate rather well and I think that helps” (P23).

An important consequence of strong *collegial relationships* was the opportunity to debrief with school-based colleagues who knew the young person at the centre of the case. Although participants described maintaining appropriate confidentiality, often the young person’s problems were already known by other members of the Student Services team: “if it’s during the day I can debrief [with] the school [staff]” (P2); “I debrief mainly within my school, not at the [Department of] Health level” (P22); “the chaplain I’ve got a really good relationship with. She was a good support for me because she was confidential, and I could off-load to her” (P7); “we debrief with each other all the time, but I know from other colleagues they don’t have those relationships with other Student Services members, chaplains, [and] school psychologists” (P31).

Participants especially valued *collegial relationships* with the school psychologist because it could be an informal mechanism for *sharing the responsibility*: “I have a very close working relationship with our school psychologist. We bounce things off each other” (P3); “I work very well with the psychologist. We’ll share information; we’ll bounce ideas off each other” (P20).

When *school-level collegial relationships* were absent or ineffective, the opportunities for *sharing the responsibility* diminished. Sometimes this occurred because other Student Services team members defined their role quite specifically:

The psychologist has defined their role [as educational testing and assessment], [so] who do you come to? You come to [name of nurse]. I've been there eight years [and the students] know that I'm [able to help] and they know that I'm safe. (P7)

[The school psychologist's] office and my office are next door [to each other] ... If a child comes in and is distressed... If the child comes in crying, she'll say "that's not my job." Whereas I see that as every adult's job that's employed within the school: to see what assistance they can provide. (P27)

Not unexpectedly, sub-optimal *school-level collegiate relationships* could lead to a lack of trust, further impacting the potential for *sharing the responsibility*: "I'm not sure that [the Student Services team] have got my best interests at heart... I haven't got that trust in them...I'm not sure [of them]" (P7). Rarely, participants' relationship with the school psychologist did not lend itself to *sharing the responsibility* at all: "I know [a colleague] who's had conflict with the school psychologist and a bullying kind of relationship" (P31).

Although it was clear that *school-level collegial relationships* were typically the first place participants sought support for *sharing the responsibility*, *school-level* colleagues were almost always education professionals. Many participants also specifically sought out *collegial relationships* with nursing colleagues.

6.3.2 Nursing collegial relationships

Nursing collegial relationships was the second component in *collegial relationships*. Many participants reported that they missed working with nurse colleagues and often did not have easy access to *nursing collegial relationships*: "I asked my manager could I have a break from secondary schools [and] work in [another setting], the main reason being [that] I wanted to work side-by-side with other nurses" (P21). Although a proportion of participants job-shared their position with another school nurse, participants were generally the only nurse in the school at any given time. For this reason, participants typically looked for *nursing collegial relationships* outside of the school setting. Participants perceived that *nursing collegial relationships* were essential for *managing self* in the context of the third stage of the core process of

tactical prioritising: “peer support, support for you as a community nurse in the secondary school... you need that support either from your [clinical nurse manager] or another community health nurse in the secondary school” (P20); “I get one or two [cases] a term [that I really need to debrief about]... enough that it’s always in the back of your mind” (P22).

For the majority of participants, their chief source of *nursing collegial relationships* were their nurse manager and school nurse colleagues: “the manager’s very good with [us] calling and saying ‘I’m struggling’ or ‘I need help.’” (P20); “[my nursing] colleagues support me on days where I’ve felt like, yes, [I] just had a very difficult day” (P30). There was an implicit perception that nurse colleagues understood the challenges participants faced, but time was a barrier to accessing *nursing collegial relationships*: “I don’t feel I have the time really to liaise with my [nursing] colleagues as much as [I’d like to]” (P15); “there’s not always time for [school nurses] to offload and share how we’re feeling” (P20); “if you had a lot more time to debrief and discuss things when they arise but everybody else is swamped [too]... Nobody’s got the odd hour to have a bit of a chat about different things” (P24).

Occasionally participants reported setting time aside specifically for *collegial nursing relationships* in the form of peer support: “I’m very good with peer support.... [with] some of the nurses [in the region]” (P20). Many participants arranged *nursing collegial support* on an informal basis:

If I’d had a bad day at the secondary school or a [very busy] day I would ring the manager up and the [other school nurses] would stay behind [at the base] and we’d just have a [coffee] and a joke and a laugh. (P21)

Other participants perceived that opportunities for peer support were limited and nurse meetings were not by themselves helpful:

[We need] more formalised peer support. We do have secondary school nurses meetings, but they’re a bit ad-hoc...they get caught up in policies... sometimes I want to say “will you shut up about the policies, and can we talk about how we’re going?” I still think there’s not enough focus on peer support. (P31)

Some participants worked in areas where there were no other school nurses and these participants often devised alternative arrangements for accessing *nursing collegial relationships*:

The only nurse here I do debrief with is the sexual health nurse that I refer to. I debrief with her, she's the main one that has that listening ear. She's not a line manager of any sort, she's just another nurse that I identify with because she works with young people as well... she's probably my closest ally in that respect. (P22)

Although many participants identified school nurse colleagues as a good source of support, participants also reflected that most school nurses were experiencing similarly demanding workloads: "sometimes nurses don't want to listen to what other [school nurses] are dealing with because I think we've all got pretty heavy case-loads and we're all dealing with a lot of [student] mental health [problems]" (P7).

While *collegial relationships* offered participants support for *managing self* in the form of emotional support, the third influencing condition occurred via both the first and third stages of the core process of *tactical prioritising*. *Community partnerships* were essential to stage one *strategic assimilation* because partnerships facilitated a sense of belonging with and to the community. Effective *community partnerships* were also essential because partnerships enhanced opportunities for *sharing the responsibility* and subsequently facilitated stage three of the core process, *managing self*.

6.4 Community partnerships

The third condition influencing the process of *tactical prioritising* was *community partnerships*. This condition improved participant's sense of belonging and value to the community, enhancing *strategic assimilation*, facilitating *optimising outcomes* and subsequently supporting the participant in the task of *managing self*. Conversely, ineffective *community partnerships* added to participants' difficulties *managing self*, in turn exacerbating *untenable burden*. There were three components in *community partnerships*: 1) *becoming known* 2) *parent partnerships* and 3) *external service providers*.

6.4.1 *Becoming known*

Becoming known was specific to furthering the participant's sense of belonging and value to the community and enhanced *strategic assimilation*. Participants proactively developed *becoming known* by cultivating non-clinical relationships with young people and other members of the school community: "it's important for us to be out-and-about at recess and lunch, going into the classrooms" (P21). Participants perceived that *becoming known* was essential for the purposes of positioning themselves as a non-threatening source of help that young people could feel confident to access:

I've just been delivering sexual health [classes] and one of the girls... [later] disclosed something to me... I've done two classes of hers. I feel that if you're a stranger... [young] people aren't going to come and do that [disclose personal issues]. (P6)

Becoming known was further divided into two aspects: 1) *being real*, and 2) *creating connections*.

6.4.1.1 *Being real*

Being real enhanced stage one *strategic assimilation* and was perceived by participants as essential to their work as a school nurse. It related to being seen as a real person, not simply 'the nurse'. *Being real* prompted participants to engage with students outside the school health centre: "I try to be very involved with the school. I get to know students in any way I can" (P28). Some participants pursued this goal in the classroom:

At the moment I'm going into every classroom doing Protective Behaviours [a child safety program]. I'm also doing something funny with it so I can show a bit of my personality and [show] that I'm approachable. (P21)

Other participants took up opportunities for *being real* by attending school functions: "I go to the discos. If there's anything on at the school, I'll go... so I'm visible" (P31). Other participants also emphasised visibility: "they know that I'm about and

they know that I'm [a] safe [person to talk to]" (P7). Similarly, another participant talked about *presence*:

I try to make my presence fairly well known around the place. I put things in newsletters. I audit all the incoming student [health] forms at the beginning of the year. [I] tell them who I am, what I do [and] what I don't do. (P28)

Participants perceived that not *being real* was likely to be evident to the young person and being authentic was essential to working effectively with adolescents: "you can't bullshit them: they will see straight through it" (P21). Being honest was part of *being real*: "they know they'll get the truth, and they'll get honesty, [even if it's] 'well, that was a silly thing to do' or whatever" (P10). For this reason, participants recognised that how they came across to young people was important: "I try to be [unique], approachable 'me', but I also try to be professional and authentic" (P21). Being seen to be approachable was so important that some participants worried about this: "if I start looking too much older maybe I won't [look] so approachable" (P6).

Being real was not just about appearing in non-clinical contexts but also about using authentic communication: "I try to be authentic with my language... but also remain professional and clear about what my role is" (P21); "[I] chat their lingo [language] and they feel comfortable to talk with me. Hence why they start disclosing [their problems]" (P11). Other participants also commented that *being real* could facilitate help-seeking: "it's so important to be able to get into the classroom. Some of the kids that I've seen [at the health centre] have come to talk about all sorts of things [after meeting me in the classroom]" (P25).

Being real sought to position participants as a real person, enhancing *strategic assimilation*. In contrast, the second aspect was about participant's efforts to get to know young people as real individuals and was conceptualised as *creating connections*. The majority of participants had *a passion for the wellbeing of young people* which genuinely motivated *creating connections* and supported *optimising outcomes*, but this aspect also had the effect of furthering *strategic assimilation*.

6.4.1.2 *Creating connections*

The second aspect of *becoming known* was *creating connections*. Participants identified that *creating connections* facilitated the identification of young people's needs furthering the potential for *optimising outcomes*: "relationships [are] really important. Other people are quite happy to skid in and do something and leave again... I get the opportunity to meet their needs better because I have a relationship, or I know them" (P6). As a result of *creating connections* participants reported knowing the student as a person and knowing their individual circumstances: "I'll often know what's going on with those children" (P28).

Creating connections was intended to facilitate the development of pastoral⁴ relationships with young people: "I do Breakfast Club once a week and that's a really powerful way to connect with the kids, because that sense of community over food is important" (P31). Demonstrating caring and interest in young people as individuals facilitated *creating connections*: "talking to them by name [while] out and about in the school yard, I think it does make a difference to them. Someone gives a bit of a hoot [shows concern or interest], someone cares" (P22). A genuine interest and curiosity about common adolescent pastimes was considered helpful in *creating connections*: "you need to have a bit of an understanding of Instagram, Snapchat, Facebook and how the group messaging works... because they often speak in that way" (P29). Another participant explained that a genuine interest and curiosity meant a level of comfort with not having all the answers:

I'm really comfortable with [not knowing everything]. [When] working with young people you need to be very clear and honest... because that's refreshing for them. For a lot of adolescents, they are working for teachers that know the answer to everything. These teachers know all about your

⁴ Pastoral care is defined as: "the commitment of our staff to the wellbeing of each student. Effective pastoral care is achieved through promoting positive school environments that support the physical, social, intellectual and emotional development of every student" (Department of Education Western Australia, 2019c).

future and what you need to do and what you shouldn't be doing, and at home there might be [the] pressure of parents who are like that. (P21)

Creating connections was not just about verbal communication. A participant who engaged with adolescent refugees who spoke limited English commented:

There are some mental health issues in relation to [their refugee experiences] but there's [also] a language barrier. When they have learned a bit more English, I'm quite often the person they come back to. It might be a year later and [they] say "when I was in [the refugee] camp" or ... [for example], "my dad hits me a lot. He says it is discipline, I think he's going overboard." I've already made that connection when I did that screening so they see me as someone they can talk to. (P6)

Levering the distinction between being a nurse and being a member of the school teaching staff aided in *creating connections*: "I have really good rapport with students when they come in and discuss things with me, because I don't [have an] authoritative [school discipline] perspective... I'm easy [going]" (P11). Other participants reported that *creating connections* encouraged young people to spend time with positive adult role models: "[at lunchtime] I do have kids come who just hang out [spend time with me]" (P31). Another participant recounted how *creating connections* permitted minority young people to seek out a safe adult:

He would choose to hang out with me every recess and every lunch, all throughout Year 8 and 9. There were times when I'd say "I can't see you today [student name], I've got someone else in here." "Okay, no worries" [he'd say] but he'd stand out there and eat his sandwich... He made a connection with me... my gut instinct, right from the [beginning] was that he was [same-sex attracted] and I thought... 'that's why you don't feel safe out there'. Come Year 10, SafeSchools [LGBTIQ school anti-discrimination program] had come in and I had posters up. He'd asked tentative questions but I don't think at that stage he realised that he was same-sex attracted. He would watch me with other students who were openly same-sex attracted and he would ask me [questions] about it. (P21)

Although *creating connections* was not specifically about clinical work, participants perceived that it was highly valuable in clinical work and facilitated *optimising outcomes*. Some participants perceived that *creating connections* was an essential precursor to effective clinical practice: “as a nurse... before you can start doing anything, if you haven’t made that connection, you’re not going to get anywhere” (P21). Not unexpectedly, trust was central to *creating connections*:

[These girls had] seen me in a less formal role where [I] was doing workshops on sexual health, contraception, stuff like that. They felt they could come and talk to me about things because they knew I could be trusted. (P8)

Many participants reported that *creating connections* positioned them for future clinical work: “[my] being seen to be approachable [by co-facilitating lessons in the classroom] is what’s got them in the [health centre] door in the first place” (P25); “once you’ve got that connection, that’s quite powerful” (P24). Importantly, *creating connections* was about having unconditional positive regard for young people who resisted engagement at the clinical level: “even those students that don’t want to engage. [For example], we’ve got some students with substance issues. Just being out and about and around, saying ‘hi’. They know who we are, we know who they are” (P22). Previously established connections could also act as a safety net: “My goal would be to further build on the relationship with that student [so that they] know they’ve got a safe spot to come to at school, that they’ve got some connection with someone at school” (P4).

For young people who were difficult to engage or had ruptured the helping relationship, *re-creating connections* could be necessary. One participant described *re-creating connections* with a young person who had lost their temper:

I [said] to her “it’s not good to use that [offensive] language on school grounds, and don’t slam that door – I’m too old to have that shock. I could have had a heart attack! That scared the bejesus out of me” ... [The girl] thought that was hilarious. (P21)

When young people were distressed but not known to participants, *creating connections* was an especially important first step: “some of [the young people presenting] will be new [to us]. We probably don’t have [a] relationship, so it’s a case of just sitting down initially... I might make them a drink... I’ll say ‘is there anything that you want to talk about?’” (P16). *Creating connections* also occurred when young people were referred for assessment: “[I] engage with them [and] just talk about general stuff before [I] get to what... somebody [has] referred them to you with” (P20). Other participants explained:

It’s quite hard when someone gets sent to see you because some of these students don’t know [why] they’re coming to see me. [It’s] sort of this random ‘why am I in the nurse’s office?’ Having a gentle way to explain that you’re just touching base, that general conversation, ‘getting to know you’” [helps create a connection]. (P4)

Sometimes I’ll play games with [students], because we can communicate over Connect Four [a two player strategy game]. Sometimes I’ll get them to show me things, because I’m not that good with the mobile phone and [other technology]. [It means] I’m interacting with them. (P2)

Other participants emphasised that *creating connections* facilitated the disclosure of issues that might otherwise have remained hidden, opening the door to *optimising outcomes*:

One student came [to the health centre] and identified themselves as suicidal. [They] had identified me as a person they could talk to because I had been in their classroom talking about sexual health. They’d seen me as being approachable because of that. (P25)

Peer referral was commonly also facilitated by previously established connections: “a lot of students know who I am, or their friends will say ‘go and see [name of nurse]’” (P28); “[students] will come to me and [say] ‘what do I do about this [problem my friend has]? This is what my friend is saying’” (P29).

Participants perceived that knowing the young person gave them clinical insights they may not otherwise have had: “that’s where knowing that person probably saved her, because we had to call the police... [I knew] it was her plan [to suicide]” (P6). The efforts that had previously gone into *creating connections* could also be valuable in other emergencies:

[We had a] crisis... a drug-induced psychosis. ... We just brought him straight up to the hospital... But he was one of my kids I’d seen regularly. So I was the one who could calm him, I was the one who could deal with him. (P10)

Another participant also relied on knowing the young person when making an assessment of risk:

She has previously had a couple of significant suicide attempts last year. [Subsequently] she has seemingly had a period [of] going really well. Unbeknownst to all of us, her parents, school, [and] friends, she decided to take herself off her medication for the exam period because she was finding it difficult to concentrate on the medication. I think [she] worked out the hard way that that wasn’t a good idea... [When I found her] I asked her if she had [taken an overdose or harmed herself]. From what I could see she hadn’t cut herself, [and] she didn’t appear to be affected by anything [under the influence of a drug]. When I asked her if she had [overdosed] she said she hadn’t, and she’s always been honest with me in the past, so I believed her. (P19)

The capacity for *creating connections* was perceived to be so essential that some participants worried that factors beyond their control might interfere with *creating connections*:

I’m very connected with young people but maybe [as I get older] I might lose it. [Young people might say] “oh god, you’re going to see that old lady” or whatever. I’m hoping that’s not going to happen, but I do wonder whether or not there is a window where you are still capable of performing the role really well to engage with young people. (P6)

While *creating connections* related specifically to the development of relationships with young people, participants also developed *community partnerships* with parents.

6.4.2 Parent partnerships

Parent partnerships was the second component in *community partnerships* and hindered or facilitated the core process of *tactical prioritising* because parents were a key partner in *sharing the responsibility*: “obviously there’s parent involvement if there’s anything significant” (P6); “I often have case conferences, every week, meeting with the parents and the teachers who support children with health conditions” (P29). Another participant explained the process of partnering with parents:

I will ask the parent to come in. [I’ll] sit down with the parent and the young person and explain [to] the parent what our concerns are. [I] explain what we can do in Student Services to support the student... [If] it’s a bit bigger than what can be managed in school, [I explain] we’d be doing a disservice to that student if we didn’t refer them on to the appropriate agencies and support staff. (P20)

Parent responses had significant influence over the basic social psychological process of *tactical prioritising*, because participants recognised that when parents could not be engaged as partners in the care of young people, the participant had increased responsibility for *optimising outcomes*. As previously explained, engaging parents could be difficult:

One particular Year 9 student I’ve been case managing and working [on] with Child and Adolescent Mental Health Services, but the parents shut it down ... that happens so much, where we have parents who won’t engage with services. (P31)

When *parent partnerships* were ineffective, participants struggled with *optimising outcomes*, exacerbating the experience of *untenable burden*:

I worked with a young man for quite some time. He didn’t have a very supportive home life... and you could see his mental state was deteriorating.

We put some things in place but it was undermined at home. He wasn't supported and [I thought] this is going to turn pear-shaped fairly quickly. (P6)

Although participants were tolerant of social complexities that presented barriers to parents engaging with clinical recommendations, sometimes *parent partnerships* were so ineffective that participants were blocked from intervening:

Her father then declined to give me permission to see her or counsel her or organise anything [to support the student's wellbeing]. [I had to make] that known to the mandatory reporting people [the Department for Child Protection and Family Support]. (P18)

Although *parent partnerships* were critically important to participants for *sharing the responsibility* and *optimising outcomes*, when young people presented with serious or significant problems participants worked hard to ensure that *external service providers* were also involved as partners.

6.4.3 External service providers

The third component of *community partnerships* was *external service providers*. *External service providers* influenced the process of *tactical prioritising* by facilitating or hindering *sharing the responsibility*. Participants identified *external service providers* as being both individuals and agencies. At the individual level, some participants had reservations about the input young people were receiving: "I don't have confidence in a referral to the 50 year old [doctor] that doesn't have an understanding of young people. It's so hit and miss" (P26); "we do have a youth worker that comes into school, but that's a bit hit and miss" (P7). Crucially, participants evaluated the care young people reported they were receiving:

Some of the [things] the student says the private psychologist said, you think 'oh gosh, I don't know if that's the best way?' It's hard to say because obviously you're getting it from the student and they might have misinterpreted what the psychologist was saying to them. (P20)

At the agency level, some participants described highly effective *community partnerships* with *external service providers*: "[the local agencies] are very good. If a

student doesn't attend two times, they will contact us and let us know they've stopped attending their appointments" (P22). Effective relationships with *external service providers* were often bi-directional:

[We're trying to] keep her in school. She's engaged with Child and Adolescent Mental Health Services. I had concerns about her self-harm one day... so I rang Child and Adolescent Mental Health Services [and] got her back into Child and Adolescent Mental Health Services [for an appointment]. (P18).

Other participants described school in-reach services where *external service providers* attended the school to provide care to young people, facilitating *community partnerships*: "the in-school service that is provided is a really good option for some of the families" (P4). Some participants who did not have an in-reach service identified that this would be helpful: "if we had in-house [mental health services], it would make it so much easier for the students that want to [attend], and for the parents" (P2). Participants described the process they undertook to determine how *sharing the responsibility* could best be accomplished in the context of *community partnerships*:

I try to assess 'do I think this family can get to an external service? Do I feel that the family are likely to take them [to the appointments]?' If they're not, then I'll try and have a look at in-school support. Either services that are able to come into the school, so we've not got transport fees, we've not got transport issues, or parents remembering their appointments. I'll try and see what services can come in as well as considering the school psychologist. I'll have a conversation with [the school psychologist] saying 'do you think this is something that would come into your arena?' and if he says "yes," [I say] "we'll try and get parental consent and a signed form for that to happen." (P30)

It was particularly helpful if *external service providers* who provided school in-reach were also tolerant and understanding of social factors that were barriers to providing care for vulnerable young people:

Just by the nature of the kids that are needing the counselling, often it's kids that have trauma or they have issues with their family with drugs and alcohol. Often those kids are low attenders at school. So it can be difficult for the organisations because they come in and those kids have maybe 20% attendance. So we have to say "I'm really sorry but Johnny's not here today." But then they're quite understanding of that, they're quite sympathetic and they come back and say "that's fine, we'll see them next week." I think we've got good communication within our team and we've got a good rapport with most of the agencies that support our students. (P8)

Other participants reported less optimal relationships with *external service providers* which clearly impacted *sharing the responsibility* and negatively affected *community partnerships*:

It's frustrating that you look back on cases and you think '[we] referred these kids to Child and Adolescent Mental Health Services but Child and Adolescent Mental Health Services said "no, they don't meet our criteria"'. Then you look at [the student] two [or] three years down the track and they're cactus [severely functionally impacted], and you think 'if only they can take them on when they're referred'. (P19)

We [members of the school Student Services team] have collectively done eight reports to [the Department for Child Protection and Family Support] on this family, for disclosure of physical abuse and emotional abuse, threatening the pets "your cat will be dead when you get home," that kind of stuff. The father is abusing alcohol, and then abusing his children. And the last time I put a report in the case worker [rang] me, which is rare. [They rang] me to say they'd sent a pamphlet, an information sheet to the family for a family therapy kind of thing. And I'm thinking '[that] is not what this family needs.'(P31)

While *external service providers* were crucially important when young people were experiencing significant or serious problems, there was one partnership participants perceived had an even more pervasive influence on the day to day process of *tactical*

prioritising. The fourth condition that influenced the process of *tactical prioritising* was the *ability to function in the school*.

6.5 Ability to function in the school

The *ability to function in the school* influenced the core process of *tactical prioritising* via *strategic assimilation*, *optimising outcomes* and *sharing the responsibility*. *Optimising outcomes* could only occur if circumstances at the level of the school facilitated this, while *sharing the responsibility* was enhanced if participants had effective *school-level collegial relationships*. Notably, both *optimising outcomes* and *school-level collegial relationships* were highly dependent on how the participant and their role was perceived within the school, affecting their *ability to function in the school*. There were three components in the *ability to function in the school*: 1) *misperceptions of the school nurse role*, 2) *professional respect* and 3) *duration of assignment to the school*.

6.5.1 Misperceptions of the school nurse role

As described in chapter four, many schools had *misperceptions of the school nurse role*. This condition influenced not only the problem of *untenable burden* but also the core process of *tactical prioritising* because when schools had *misperceptions of the school nurse role* the employer had an expectation that participants would address this: “I often get told when I do [the School Level Agreement] with my school that I have to deal with [the conflict]” (P22). Another participant explained:

Maybe on the level of the Memorandum of Understanding there’s good communication, but I think when it goes [to the] principal, deputy principal, Student Services manager, it’s up to the nurse. It’s been up to the nurse to educate on the changes that Health and Education [have implemented]. (P7)

In cases of conflict this was akin to pitting the biblical David against Goliath. Many participants found this extremely frustrating: “we have a Memorandum of Understanding between [the] Department of Health and Department of Education and it’s very clearly set out there what our role and what the expectations are” (P21). Even so, *misperceptions of the school nurse role* could be evident at the highest

levels in the school: “[A] colleague’s at a school [where] her role wasn’t supported at all by the principal” (P31).

In these circumstances the potential for conflict was high, and had serious ramifications for participants in the form of *strategic assimilation*, *school-level collegial relationships* and *sharing the responsibility*. In the absence of effective sources of support, difficulties associated with *managing self* were also likely to be exacerbated. Although participants reported that the employer had an expectation that they would address *misperceptions of the school nurse role*, there were often significant consequences for participants who attempted to do so, particularly in terms of how they were personally accepted in the school. Resistance from the school was common:

The school were quite resistant, because they were quite happy to have a nurse that did all [the first aid] because it saves them a lot of time and a lot of work to do all of the first aid. So they were very happy with the service... before I [arrived at the school]. It was quite difficult to change. (P30)

Conflict was keenly felt: “I had some quite negative responses...it was disappointing, because I was trying my best to build bridges. I tried not to take it personally” (P8). In practice, most participants prioritised *strategic assimilation* at school and sought to keep conflict to a minimum: “[I was] trying, as best as possible, to work with the school that didn’t cause too much friction” (P30). Another participant described a decision not to respond to an inflammatory email:

[The email] said ‘well, why doesn’t she change her name then? Why be a nurse and not do nursing duties [first aid]?’ I thought I could answer it and [explain, but] I thought ‘no’ and I just ignored it, because I didn’t want to flare up anything. (P2)

Participants reported that preserving *being there* while addressing *misperceptions of the school nurse role* was a finely balanced activity:

[The school] would send kids in [to me saying] “he’s got a headache, you need to give him [pain relief].” I’d walk the child back to class, and I’d be

really nice to the child because it's not the child's fault. [I'd] get them a drink of water, do all those things, but walk them back [to class] and [address it with the teacher]. (P27)

Some participants capitulated because the potential for conflict to negatively impact *school-level collegial relationships* was overwhelming:

I know it's not my role as a registered nurse to be doing first aid... however to build that rapport with the students and staff, [to] be trusted in the school, I have to [yield]. Unfortunately, that [means] going against [Department of Health] policies. (P11)

A participant who had recently commenced at a new school was less conflicted but also capitulated: “[I first] implement [first aid processes] ... [I'm] getting that part set up so they feel like you're doing what a nurse should do” (P10).

The majority of participants persisted with attempts to undertake their actual role. Some participants used a relational approach: “it's been quite a lot of learning who I could talk to, who would be interested in what my role was, who could support me. There was a lot of work like that to build up what my role was actually meant to be” (P3). Other participants were more forceful: “I felt very certain of what my core business was - primary health [care], prevention and health promotion. I was very assertive and able to stick up for myself in that regard” (P15). The same participant provided insight into how demanding this could be, even for an experienced school nurse: “I would have given up much earlier if I had been a new practitioner and been uncertain of what I was supposed to be doing” (P15). Another highly experienced participant disclosed: “there's definitely been times ... where I [was] thinking ‘it's just too difficult’. But, [I] persevered and got back on track” (P30).

The risk of conflict prompted participants who were confronted with *misperceptions of the school nurse role* to reorientate the role more slowly to preserve *strategic assimilation* at school. It was not uncommon for participants to refer to this in years: “it took probably two years” (P27); “it takes time, but I've only been there 18 months” (P1); “I actually convinced the staff that my role is much more valuable [than first aid]... but it took me about a year” (P15); “getting the school to think of

our role as [it should be] rather than first aid took a couple of years” (P4). Some participants referred to the change process as a journey that had to be very carefully negotiated: “we’re just on an ongoing process with the school, an ongoing journey... gradually and slowly, and treading on egg-shells as we go” (P30). The journey could require great dexterity: “you’re almost juggling. You’ve got to be a politician, you’ve got to be a statesman... it’s definitely a tightrope at times.... the job itself is a challenging one [in] that you have to have negotiation skills” (P25). The juggling act was not only relational, it was also mental: “you’ve got to keep it all in your head, who’s up to where, and who understands, and who understands a little bit and who’s really not on-board, and is not interested in getting on-board” (P25).

One participant disclosed that reorientating *misperceptions of the school nurse role* could only preserve *strategic assimilation* at school if the participant undertook this task personally: “my manager would say ‘I will come in and I will tell them’. I said ‘well, you do that and I’m off-side’. So [I] said ‘let me deal with it’” (P2). Even where participants undertook this task carefully, it was still common for participants to experience resistance: “when I did things a little bit differently, I did get questioned, why I was doing that. I just carried on” (P7). Persistence was a key requirement: “I can be quite determined about just keeping on going, finding the right people [to help me]” (P3). Some participants were still on this journey some considerable years after they had first commenced at their assigned school: “some of those teachers I’ve never been able to win over, but I’d say most of the people now at school do understand my role a lot better. I’ve been there for five years” (P8). Some participants had employed school-based strategies in order to be able to undertake the role they were employed to do. This generated much less resistance, but it was galling to have to seek permission: “we were very lucky that it went through [local school] policy, so it spared us up to do other things which were more important. The counselling, the support, the referrals and that kind of thing” (P16).

As described in chapter four, the common sticking point was management of minor first aid and injury, but participants engaged in addressing *misperceptions of the school nurse role* were at pains to emphasise that they were entirely prepared to attend actual emergencies: “we have always said ‘we’ll be there for an emergency’”

(P17); “I really like being included in emergencies, especially when that’s appropriate” (P13); “I still do major first aid and I’m okay with that” (P3); “I deal with [emergencies] if I’m on-site” (P2); “I handle all the emergencies” (P23). When the skills of a registered nurse improved clinical outcomes, participants often expressed a high interest in being involved with emergency situations: “I totally believe my role is the larger first aid issues. If it’s really a very concerning issue I’m more than happy to [attend] ... [for example] I will manage a really severe asthma attack better than [school staff]” (P3); “it’s really important for me to be there [in an emergency] because teachers have no medical experience at all. I think it’s important to have someone there who can say ‘no, I really think you need to ring the ambulance’” (P13).

Not all participants were confronted by *misperceptions of the school nurse role*. Importantly, a significant proportion of participants reported that their assigned schools had well-developed, effective processes in place for the management of minor first aid and illness: “at this school I wouldn’t see much [first aid] at all because they already have processes [in place]” (P10); “[the school] literally do keep the first aid off my table” (P12); “the first aid is taken over by the school” (P17); “we have an administrator who is also a first aider at the front desk” (P30). Other participants referred to this in terms of *autonomy*: “[the school] know exactly what I should and shouldn’t be doing. I’ve been able very much to direct what comes in [clinically]” (P12).

A key element of not having to negotiate *misperceptions of the school nurse role* was the designation of a school first aider who was accessible, available, and worked in collaboration with the nurse: “the two first aid officers that have been there this year have been awesome. They will filter people through to me” (P18); “I’ve got one first aid person that’s very good and refers them on to me: ‘I’ve seen this kid every week, the same problem, can you see them?’” (P6).

For those participants confronted by *misperceptions of the school nurse role* a strong leader at the level of the school was considered essential if these problems were to be overcome: “the [manager] of Student Services... is very lovely at our school, and very respectful, but not very strong as a leader. If he was, he could make sure those

issues weren't as bad as [they are]" (P17). One of the most important members of the school community for addressing *misperceptions of the school nurse role* was the school principal: "when we bring it down to the local level, as a secondary school nurse you really have to build a good rapport with your principal" (P21). Support from the principal to overcome *misperceptions of the school nurse role* was highly valued by participants: "[the principal] ... read the riot act about everyone's position within the school. [He said] this is our School Level Agreement, and this is what's decided between the Health Department and the Education Department. I felt good... because I knew that there was that support" (P27).

Participants who were not confronted with *misperceptions of the school nurse role* could engage fully in stage two of the *basic social psychological process of tactical prioritising*, but some participants did have to pay attention to maintaining this: "year to year you have to remind them that you're not there [for first aid]. It's getting less that it's happening, but it does still happen. If there's a new nurse in a school they try and go back to the old-fashioned ways" (P2); "whenever a new nurse starts up they will try to flick us all the first aid, and it's happening again because we've got two new nurses who started at the end of last term" (P17). Another participant related:

It's a constant battle over [first aid], even now. The teachers that have been there a while, they'll still try and send them for first aid. I think they've slowly understood. I do staff presentations to them about things that I can do within the school [but it's not enough]. (P27)

Addressing *misperceptions of the school nurse role* affected *strategic assimilation* and diminished the likelihood of effective *school-level collegial support*. In contrast, *professional respect* encouraged *school-level collegiate relationships* and facilitated *optimising outcomes* and *sharing the responsibility*.

6.5.2 Professional respect

The second component in *ability to function in the school* was *professional respect*. Participants reported that *professional respect* significantly facilitated *optimising outcomes*, because it meant they were recognised as skilled professionals who could make a unique contribution to the team: "I feel confident to speak up and say what I

think... [The Student Services team] are certainly prepared to listen... Working as a team is seeing results so it's just continued in that way" (P16). Another participant stated:

Teachers often opportunistically catch you in the staffroom or around the school, and raise their concerns about students. [They] notice a drop in grades, a change in behaviour, and will raise concerns that way, directly to me or through other channels. (P20)

Importantly, participants who reported a high degree of *professional respect* had *autonomy* and control of their time. This made it possible to engage in *optimising outcomes*: "most of it is appointments, based on referrals, Student Services meetings, parent concerns [and] student concerns. [At] appointments we'll do... [a] full psychosocial assessment.... then we can put in place supports and referrals if necessary" (P17). An appointment system gave sufficient time for *opening Pandora's Box*: "[It] could be half an hour, an hour, depending [on the circumstances]. Initially I'll keep an hour [available]." (P2); "our first session probably lasted just over an hour. My consultations with young people tend not to be short ones. They do tend to be quite long, unless they're already known to me and it's a quick pop-in" (P30); "in my initial interview I would [assess] whether there is a concern about someone's coping ...if they're a referral or it looks like a mental health issue then I would consider [a psychosocial] assessment" (P5). Many participants scheduled follow-up appointments:

[I make] an appointment. Particularly the ones I case manage, after the consultation, [I say] 'let's make an appointment for next week'. [We] look at their timetable and try and rotate through the timetable so [I'm] not getting them out [of] the same lesson every time. (P20)

Participants who offered appointments commonly also held *open clinics* at recess and lunchtime, and sometimes before and after school. During open clinics young people could attend for any reason, including first aid or illness: "I have an open clinic where they can come for first aid at recess and lunch, but otherwise they go to Student Services" (P2); "[we] have open clinics at recess and lunch time, where they can come and see the nurse [for any reason]" (P17); "we run open clinics, so the

children can come in and talk about any aspect of their health, physical, social or emotional.” (P29); “[I hold open clinics] at their recess and their lunch [times] and students know that they can access [me] before and after school” (P20): “we do drop-in at recess and lunch, so we get a lot of young people coming down. It can be for anything and everything” (P16). Open clinics were not considered suitable for *optimising outcomes*, but represented an opportunity for *being there*:

When we have open clinics, we’ll have 20 minutes for recess and lunch, and you might have eight people there, waiting to be seen in 20 minutes. Quite often recess finishes and you’ve still got four waiting to be seen. There’s no way you can spend the time [to do an in-depth assessment], and you’ve got no confidentiality. You’ve got to leave the door open when you’ve got an open clinic because you need to see who’s coming in that might need to be prioritised, and how many are waiting. So there’s no confidentiality to discuss [*wicked problems*], and there’s certainly no time. (P17)

Open clinics were an opportunity for young people experiencing complex mental and social health problems to first request support for a non-threatening minor complaint. Participants were highly aware that this occurred and when young people presented in open clinics for a series of non-specific complaints, participants often followed up with an appointment: “at the open clinics, quite often we’ll get these kids that just keep coming back and back, and you can start identifying little red flags popping up” (P17). Not infrequently, young people presenting to open clinics clearly needed more time and attention than could be provided in an open clinic, prompting participants to prioritise additional time that day for *opening Pandora’s Box*:

Sometimes they come in and they're just tearful and they'll disclose all sorts of things. What I've found lately is huge increases in family situations. So family breakdown, single parents, parents on drugs, alcohol. Other children are young carers, [or] sometimes volatile home situations. (P16)

I had somebody say I need to see you urgently... teenagers think that everything is urgent... [but if they] think they're pregnant [they're] just going to go over and [over it] ... I can save that child a huge amount of anxiety and

stress by [assessing as soon as possible] “actually, you can’t possibly be pregnant” ... or “yes, there is a chance you could be pregnant” (P6)

While *professional respect* significantly facilitated *optimising outcomes*, participants explained that they did not want to work in isolation. They wanted to be part of the Student Services team and be valued for the unique contributions they could make to the team. This required not only *professional respect* but also a well-defined place in the Student Services team, which typically developed over time. The third aspect of *ability to function in the school* was *duration of assignment to the school*.

6.5.3 Duration of assignment to the school

Participants reported that a long *duration of assignment to the school* facilitated *strategic assimilation* and aided the development of *school-level collegial relationships*. This in turn supported participants in the task of *managing self*: “out of all the schools I’ve been in... it’s probably the best Student Services team. I think a lot of it is because I’ve been there so long, I’ve become really close with the team” (P16). For some participants a long *duration of assignment to the school* facilitated *professional respect*:

Because I’ve been at the school so long... [Student Services staff] will often come up [to me] and say “have you seen this student before?” ... [It’s] just sharing that generalised [information], have I seen the student before, are there any concerns that were sent across [if] they moved school, were there other things that were flagged [as being of concern]? (P22)

Not unexpectedly, a long *duration of assignment to the school* facilitated *becoming known*: “because I’ve been at the school for such a long time, people know me” (P17). One participant reported *being known* across multiple generations:

I had been in the job for 16 years. I had all the primary schools around the area [that] used to feed into [the secondary school]. When you know kids from [kindergarten onwards] – and I’m on my third generation now – the kids know that you know [their family’s problems] that’s why I got them at [the secondary school] ... talking about drugs, domestic violence, families

breaking up. [*Being known* meant] there were already many barriers that were broken down. (P14)

As with the participant above, the ongoing *community connections* participants built over the course of a long *duration of assignment to the school* facilitated the work of *optimising outcomes*. It was also a source of pride and emphasised the *professional respect* some schools had for the work of participants:

I'm quite well-known in the [school] community now. I've done a lot of networking. I think [that] out there in the community a lot of people would say to others "get in touch with [name of nurse]. She might be able to help you with this." (P28)

6.6 Summary

In this chapter the conditions influencing the basic social psychological process of *tactical prioritising* were considered. Four conditions were identified: 1) the *capacity to engage with wicked problems*, 2) *collegial relationships*, 3) *community partnerships* and 4) the *ability to function in the school*. Participants described two components in the *capacity to engage with wicked problems*: a *commitment to the social model of health* and an *interest in finding solutions*. The presence of these components prompted participants to move from *grappling with unmet needs* to considering how they might engage in stage two of the core process, *optimising outcomes*.

The second condition, *collegial relationships* occurred at the level of the school and between nurses. Participants perceived that *nursing collegial relationships* were essential for *managing self* but as they were often the only nurse in the school, they typically sought *nursing collegial relationships* outside their assigned school. These *collegial relationships* were often not as accessible as *school-level collegial relationships*. Participants described how *school-level collegial relationships* influenced the basic social psychological process of *tactical prioritising* by increasing or limiting their opportunities for *sharing the responsibility* for complex cases and subsequently for *managing self*. Similarly, the third condition, *community partnerships* also influenced the core process through *sharing the responsibility*.

Participants described how *becoming known* in the school facilitated their sense of value and belonging to the school through *being real* and *creating connections*, which in turn facilitated *managing self*. Participants who had a sense of working in partnership with parents and external service providers were able to *share the responsibility* for difficult clinical cases further facilitating stage three of the core process, *managing self*.

The fourth and final condition was *ability to function in the school* in the role outlined by the employer. This condition influenced the core process of *tactical prioritising* by facilitating *optimising outcomes* and *sharing the responsibility*. *Optimising outcomes* could only occur when there was *professional respect* that enabled participants to have *autonomy* and control of their time. *Sharing the responsibility* could only occur where participants had effective *school-level collegial relationships*, and these in turn were highly dependent on how the participant was perceived at school. Participants who encountered *misperceptions of the school nurse role* faced trying to reorientate their role while also seeking to preserve *school-level collegial relationships*, with significant implications for their movement through the core process of *tactical prioritising*.

This chapter concludes the presentation of the substantive theory of *tactical prioritising* to manage the experience of *untenable burden*. The next chapter will consider how the newly developed theory fits with existing nursing theories and other relevant literature.

CHAPTER 7

DISCUSSION

7.1 Introduction

The penultimate chapter of this thesis presents the *substantive theory of tactical prioritising to manage the problem of untenable burden* and places it in the context of the relevant literature. Consistent with the original method of grounded theory (Glaser & Strauss, 1967), the published literature was considered after the substantive theory was developed. A review of the literature failed to identify an identical theory to the one presented in this thesis, nor were any substantive theories identified that related to the experiences of secondary school nurses who encounter young people with mental health problems. The review did identify a number of theories and concepts which align with the components and aspects of the substantive theory presented in this thesis and these are explored here.

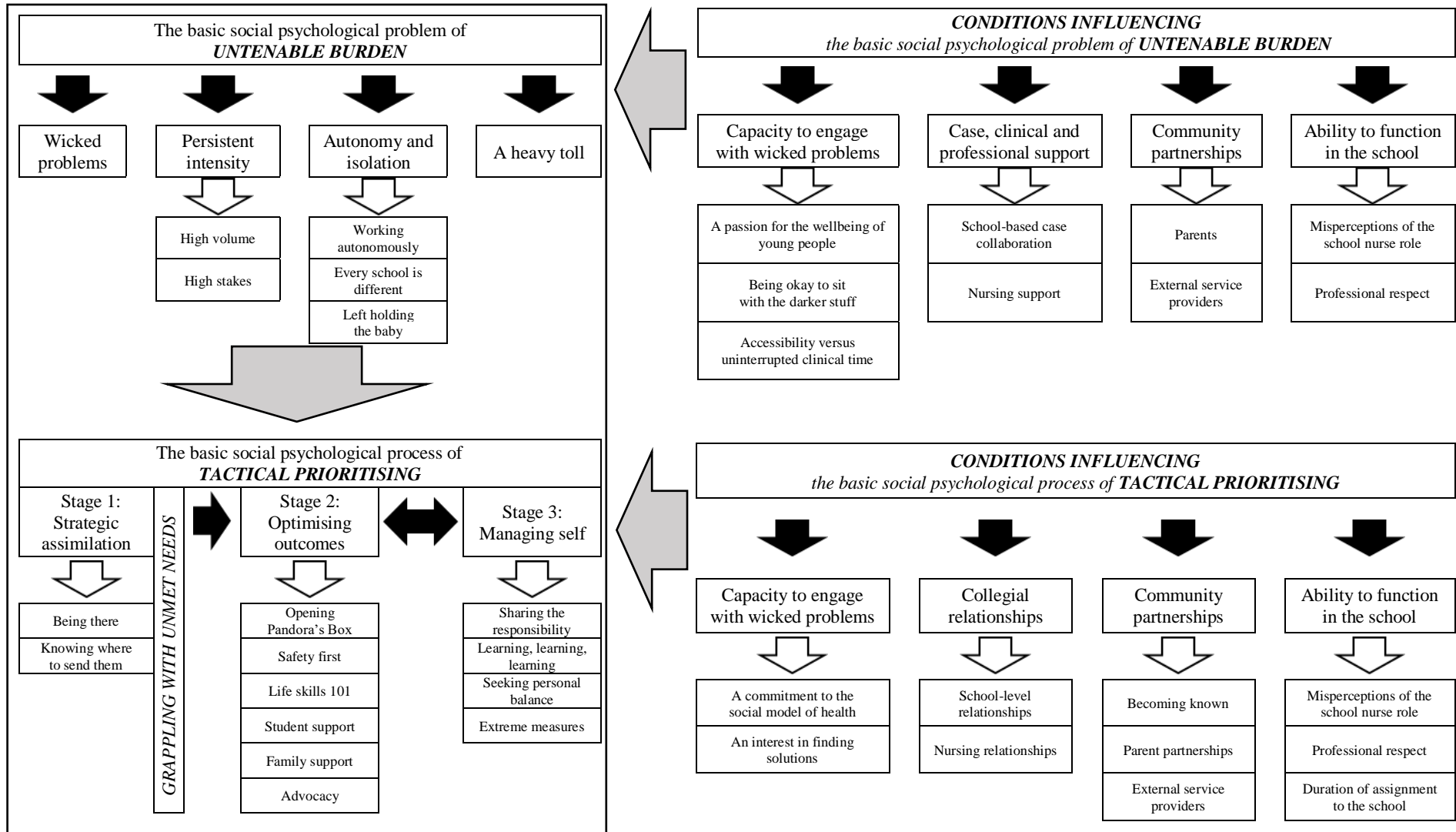
This chapter is presented in three sections. After a brief review of the *substantive theory of tactical prioritising to manage the problem of untenable burden*, the first section examines a selection of international, national and Western Australian school nursing literature and compares these studies to the newly developed substantive theory. The second section reviews a range of existing theories that have relevance for the *substantive theory of tactical prioritising to manage the problem of untenable burden*, such as the *theory of stress and coping* (Lazarus & Folkman, 1984) and Bandura's *theory of self-efficacy* (1977). In the third section the *theory of tactical prioritising to manage the problem of untenable burden* is compared to related concepts such as *personal recovery* in mental health.

7.2 The substantive theory of tactical prioritising to manage the problem of untenable burden.

It is a basic tenet of grounded theory that participants share a common concern in relation to the phenomenon under investigation (Glaser & Strauss, 1967). In the current study, the shared common concern was the problem of *untenable burden*,

Figure 10

THE SUBSTANTIVE THEORY OF TACTICAL PRIORITISING TO MANAGE THE PROBLEM OF UNTENABLE BURDEN



which participants addressed by engaging in the basic social psychological process of *tactical prioritising*. There were four categories in the shared common concern of *untenable burden: wicked problems, persistent intensity, autonomy and isolation and a heavy toll*. Four conditions were identified as influencing the problem of *untenable burden*. These were 1) *capacity to engage with wicked problems*, 2) *case, clinical and professional support*, 3) *community partnerships* and 4) *ability to function in the school*.

The basic social psychological process of *tactical prioritising* was a three-stage process, comprising 1) *strategic assimilation*, 2) *optimising outcomes* and 3) *managing self*. *Strategic assimilation* and *optimising outcomes* were separated by a tipping point, conceptualised as *grappling with unmet needs*. Intense experiences of *untenable burden* together with *grappling with unmet needs* motivated participants to navigate complex social networks in the workplace and pursue solutions that provided relief from *untenable burden*. When participants had passed the tipping point, they engaged in the second and third stages of *tactical prioritising* which were concurrent and without end.

Tactical prioritising allowed participants to negotiate the complex, multidimensional demands within their workload. Progress through the stages of the basic social psychological process facilitated development of a sophisticated capacity to provide support to young people experiencing mental health problems. Although engagement in the process of *tactical prioritising* allowed participants to manage the *untenable burden*, some strategies in which participants engaged had potentially significant implications for themselves, the health service, the schools in which they worked and the young people they provided care to.

Movement through the basic social psychological process of *tactical prioritising* was influenced by a range of personal and relational factors, including: 1) *capacity to engage with wicked problems*, 2) *collegial relationships*, 3) *community partnerships* and 4) *ability to function in the school*. At the time of interview not all participants were engaged in the final two stages. For some participants influencing conditions precluded moving beyond stage one. In this study six participants were engaged in

stage one, *strategic assimilation* while the remaining 25 participants were engaged in stages two and three, *optimising outcomes* and *managing self*. For some participants engaged in stages two and three the influencing conditions they experienced precluded finding relief from *untenable burden*. One participant was overwhelmed by *untenable burden*. This participant was a highly experienced nurse who had employed all four components of stage three, *managing self* however these strategies had not been sufficient. To aid the reader an overview of the *substantive theory of tactical prioritising to manage the problem of untenable burden* is shown in the next section. In the remainder of the chapter the *substantive theory of tactical prioritising to manage the problem of untenable burden* will be compared with other relevant literature.

7.3 Comparison with other school nursing literature

The purpose of this section is to compare the newly developed *theory of tactical prioritising to manage the problem of untenable burden* with other published research findings in school nursing. The international literature in school nursing is relatively abundant, but an identical study to that described in this thesis was not identified in the literature. The literature predominantly examines the work of school nurses in the British and North American contexts, and it is evident that mental health has been a target for school nurse intervention for some time:

I had previously visited the homes of each of the three pupils scheduled [for a psychiatric appointment], had conferred with the mothers and written up the detailed and intimate histories required by the mental hygiene⁵ department. I had received the assurance of each mother that she would come with her child at the exact hour to the clinic. (Swanson, 1939, p. 958)

This section commences with the review of an international study with relevance for the newly developed theory. Following this, the chapter focusses on school nursing literature in the Australian state of Queensland where the model of school nursing

⁵ The mental hygiene movement had a focus on early intervention, prevention, and promotion of mental health in childhood (Gesell, 1930).

has similarities with that described in this thesis. The chapter then considers the very limited published school nursing literature in Western Australia.

7.3.1 Comparison of the study by Simmons (2002): *Autonomy in practice: A qualitative study of school nurses' perceptions with the substantive theory of tactical prioritising to manage the problem of untenable burden*

Simmons (2002) used the original method of grounded theory (Glaser & Strauss, 1967) to investigate the concept of *autonomy* among school nurses in the United States. The study findings have relevance for *autonomy and isolation*, the third category in the shared common concern of *untenable burden*. Using semi-structured interviews, Simmons (2002) interviewed six novice and six experienced school nurses and identified five categories: *essence of autonomy*, *comfort with autonomy*, *nature of school nursing*, *role acquisition* and *preparation for practice*. Of most relevance to the current study were the two categories of *comfort with autonomy* and *the nature of school nursing* (Simmons, 2002).

In *comfort with autonomy*, Simmons (2002) noted that being the only nurse in the school setting was perceived to be a difficult task for novice nurses who consistently expressed themes related to two issues: *isolation* and *uncertainty*. In the theme *isolation*, nurses who had been a full time school nurse for two years or less described being lonely, and felt a lack of support in “an unfamiliar environment,” while quotations from two novice nurses described their initial experiences of *autonomy* as “frightening and overwhelming” and “scary” (Simmons, 2002). These perceptions were also strongly expressed by less experienced participants in the current study, so much so that the category of *autonomy and isolation* was included in the basic social psychological problem of *untenable burden*. In the related theme of *uncertainty*, Simmons (2002) noted that novice nurses reported feelings of self-doubt and anxiety about clinical decisions, which were also identified in the current study. In contrast, nurses with more than two years of full-time experience as a school nurse showed evidence of having adapted to the autonomy of the role and exhibited comfort with the independence of their practice. Experienced school nurse

participants especially valued this aspect of the school nursing role (Simmons, 2002), findings that were also identified in the current study.

In *the nature of school nursing* (Simmons, 2002), the theme *connection* emerged among both the experienced and less experienced nurses. Both groups perceived *connection* as a highly valued aspect of the role. This concept was reflected in the current study as *being there*, a component in the process of *tactical prioritising*. Simmons (2002) identified that nurses related *connection* to caring and perceived this to be essential if they were to facilitate change in young people, concepts that were explored in the current study under *optimising outcomes*, also a component in the process of *tactical prioritising*.

Simmons (2002) noted that the most frequently mentioned frustration among both experienced and less experienced school nurses was *time constraints*, which was related to a larger theme of *powerlessness*. Less experienced school nurses reported more frustration than their experienced counterparts who had developed strategies to manage *time constraints* (Simmons, 2002). In the current study participants who came under pressure to be highly accessible expressed the most frustration about time, discussed in the subcategory *accessibility versus uninterrupted clinical time*.

Simmons (2002) further described *powerlessness* as related to the theme of *role confusion*. Both experienced and less experienced nurses reported that school staff had low-level expectations of school nurses and did not understand the scope of school nursing practice (Simmons, 2002). Less experienced nurses conveyed dismay that school staff perceived their role as “[taking] care of the skinned knees, putting on bandaids, that kind of thing” (Simmons, 2002). More experienced nurses were very aware of this misperception but expressed greater frustration about the constant need to educate others about their role (Simmons, 2002). These themes were replicated in the current study as *ability to function in the school*. Most strongly expressed by participants who were highly skilled, these participants expressed frustration at the need to constantly educate school staff about their actual role and their frustration at the perceived underutilisation of their skills. Although Simmons’ (2002) theme of *powerlessness* was not named in the current study, there was evidence of these feelings in *ability to function in the school*.

The work of Simmons (2002) was conducted 17 years prior to the current study and substantially before the current model of school nurse practice in North America was introduced (Maughan, Bobo, Butler, Schantz, & Schoessler, 2015). As previously noted, the North American model of school nursing has always tended towards blending the medical model of school nursing (first aid, illness management) with the primary health care model which is endorsed in Western Australia. Despite the apparent differences in the context of the two studies, the significant number of participants in the current study who expressed frustration with their *ability to function in the school* may provide insight as to why there are strong parallels in the findings between the two studies.

The next section examines the findings from a study of school nursing conducted in the Australian state of Queensland.

7.3.2 Comparison of the dissertation by Sendall (2009): Conceptions of school based youth health nursing: A phenomenographic study with the substantive theory of tactical prioritising to manage the problem of untenable burden.

In her doctoral dissertation Sendall (2009) explored the meaning of the experience of school nursing in Queensland, Australia by conducting a phenomenographical analysis of 16 in-depth interviews with public sector secondary school nurses. Two published papers (Sendall, Fleming, & Lidstone, 2011; Sendall, Fleming, Lidstone, & Domocol, 2014) stemming from this dissertation are also cited in this section.

The Queensland school nursing service is premised on a primary health care model of school health, similar to that underpinning the Western Australian school nursing service. Sendall was unable to come to an agreement with Queensland Health about how the study should be undertaken (2009, pp. 104-105) prompting her to focus exclusively on secondary school nurses who had resigned. Despite this limitation, the Queensland study is extensively populated with participant quotes reflecting similar sentiments to those expressed by participants in the current study. The sentiments expressed by the participants in the Sendall's research (2009) warrant closer

inspection because some nurses in the current study had absented themselves from their school nurse role by taking leave or seeking temporary alternative positions.

Sendall et al. (2011) identified eight ‘conceptions’ of which four reflected aspects of the basic social psychological problem in the current study. These were *out there by yourself*, *no real back-up*, *confronted by many barriers*, and *hectic and full-on*. *Out there by yourself* was the foremost experience described by Queensland participants and related to the feeling of being isolated from the support necessary to facilitate clinical practice. Participants described struggles with the location of the school health centre within the school, experienced a sense of separateness from teachers, perceived a lack of line management support and had limited access to professional development (Sendall et al., 2011), struggles that participants also identified in the current study. *No real back-up* (Sendall et al., 2011) related to a lack of management support for assuring professional boundaries at the level of the school, limited support from referral agencies as potential partners, poor support for the nurse in the school community, and challenges associated with straddling two Government departments. Almost without exception, these issues were also identified in the current study.

Confronted by many barriers (Sendall et al., 2011) related to the complexity of the workload and difficulties generating solutions to young people’s problems, concepts that are closely aligned to *wicked problems* in the current study. *Hectic and full-on* (Sendall et al., 2011) related to the workload, the inadequacy of clinical referral pathways, conflict with school leadership, having to provide services to more than one school and specific demands related to schools in low socio-economic areas. Sendall’s participants commented on the heavy responsibilities inherent in the role, with one participant referring to this as *life consuming* (2009, p. 212). Of particular note was an example of being ‘left’ to manage the student when there was nowhere to refer to (2009, p. 237), which was conceptualised in the current study as *left holding the baby*. Queensland participants noted a need for debriefing and support for complex clinical situations and nurse distress in this context (2009, pp. 234-235), concepts which were closely related to *a heavy toll* in the current study.

The remaining four conceptions were titled *working together*, *belonging to school*, *treated the same* and *worthwhile* (Sendall, 2009). These conceptions more closely reflected aspects of the basic social psychological process in the current study. *Working together* (Sendall, 2009) related to the collaborative approach in the Student Services team, which provided support, belonging at the team level, and more optimal outcomes for young people. *Belonging to school* (Sendall, 2009) was a larger sense of acceptance within the school community and was characterised by being known among students, participating in the life of the school, and being part of the school community. *Treated the same* (Sendall, 2009) meant feeling respected, recognised and valued for their unique contribution. *Worthwhile* (Sendall, 2009) related to the sense of reward that prompted participants to persevere in the face of the problems described. The small number of positive experiences reflected satisfaction with having made a difference in the lives of young people and occurred in the context of effective student consultations (Sendall et al., 2014). According to Sendall (2009, p. 335) reward in relation to student consultations was so significant it was the reason participants had persisted in the job, a theme closely aligned with the category *a passion for the wellbeing of young people* in the current study.

Notably, Sendall's participants had all resigned as secondary school nurses and were therefore not a comparable sample to that in the current study. It remains relevant however that the dominant experience described by Queensland school nurses was negative because participants reported having to battle to generate respect and survive in the school setting (Sendall et al., 2014). Sendall et al. (2014) identified six themes related to reason for resignation of which two are directly relevant to the current study. These were 1) *the politics: navigating the organisational divide*, and 2) *absolutely exhausted: maintaining physical and emotional strength*.

The politics: navigating the organisational divide (Sendall et al., 2014) related to participant reports that schools did not adhere to the operational framework between the Departments of Health and Education (Sendall, 2009, pp. 277-278) which left them feeling disrespected and undervalued by schools. In the current study this was reflected in the influencing condition *ability to function in the school*. *Absolutely*

exhausted: maintaining physical and emotional strength (Sendall et al., 2014) related to the Queensland nurses finding the role significantly more complex than expected. They reported feeling unprepared for the complexity of the demands, described issues with workload and experienced impacts to their wellbeing (Sendall, 2009, pp. 233-238). These themes were also reflected in the current study.

Two other reasons for resignation identified by Sendall (2009) were reflected more obliquely in the current study. The first, *definitely geographical: managing the tyranny of time and distance* related to a lack of clinical support and the significant distance to resources, described in the current study as *autonomy and isolation and case, clinical and professional support*. The second theme *unconditional positive regard: surviving without team cohesion* (Sendall et al., 2014) related to lack of nursing peer support and management support. Nurses in the current study predominantly reported positive relationships with nursing peers but did not always feel well-supported by their community health manager.

Sendall (2009) concluded that the Queensland participants had resigned from secondary school work because they no longer wanted to navigate the divide between the Departments of Health and Education, found it difficult to maintain their emotional and physical wellbeing in the face of the demands and found the lack of support and access to resources to be problematic. These concerns were also identified in the current study among practicing secondary school nurses. Although these studies were conducted 10 years apart and in different Australian states, the findings from the work of Sendall (2009) have a high degree of similarity with the current study, strengthening the credibility of the current study.

In the next section findings from the only study of public sector school nursing in Western Australian are considered.

7.3.3 Comparison of the study by Downie et al. (2002): The everyday realities of the multi-dimensional roles of the high school community nurse with the substantive theory of tactical prioritising to manage the problem of untenable burden

A review of the literature identified only one study that specifically investigated the work of public sector secondary school nurses in the Western Australian context. The purpose of this study was to identify the dimensions of the public sector secondary school nurse role. Conducted 17 years ago, Downie and colleagues (2002) arranged for nine school nurses from eight Perth metropolitan secondary schools to complete a diary of their clinical work over two working days. Participants provided demographic data and responded to two open-ended questions identifying their main professional issues and concerns. Interpretation of the data was conducted using interpretative analysis and verified through a focus group with the participants. Findings from the study highlighted the complex and demanding role of public sector secondary school nurses and identified seven dimensions of the role: *provider of clinical care, counsellor/mediator, advocacy and support, liaison/referral, health promotion/education and resource agent, and management and research.*

As a *provider of clinical care* (Downie et al., 2002) secondary school nurses responded to a broad range of ailments including psychosocial issues such as “stress, bullying, trauma, drug and alcohol problems, family conflicts, pregnancy concerns, depression, [and] sexual abuse.” These types of problems were conceptualised in the current study as *wicked problems*. In the dimension *counsellor/mediator* (Downie et al., 2002) secondary school nurses provided adolescent health counselling by demonstrating interest in the young person’s problems, listening, and providing support for young people’s wellbeing. This dimension was closely related to *opening Pandora’s Box* and *being okay to sit with the darker stuff* in the current study.

The role of *advocate and support* (Downie et al., 2002) was intertwined with other roles but involved providing support and assistance which was characterised as “being there” (Downie et al., 2002). This concept was replicated in the current study under the same title. The dimension of *liaison/referral* (Downie et al., 2002) was

conceptualised in the current study as *knowing where to send them*. This reflected the requirement that secondary school nurses have contact with and liaise with other health professionals internal and external to the school for the purposes of meeting student health needs. The sixth dimension, *health promotion/education and resource agent* (Downie et al., 2002) related to activities where the secondary school nurse was a resource for the school community, including how health promotion programs could be accessed and utilised. Although this dimension was not reflected specifically in the current study, it was evident in *optimising outcomes* that participants considered a broad range of strategies that might be useful to the young person. The last dimension, *management and research* (Downie et al., 2002) was not specifically conceptualised in the current study but was alluded to in other categories. According to Downie et al. (2002) this dimension was related to professional accountability, and included documentation, management of time, and conflict resolution.

Although the study by Downie et al. (2002) was a relatively small study that significantly predates the current study, the findings have relevance for *the theory of tactical prioritising to manage the problem of untenable burden*. In the current study participants reported that the acuity and complexity of psychosocial issues had increased over time, and this was described at some length in the category *wicked problems*. The work of Downie et al. (2002) therefore lends credibility to the current study, providing evidence that the management of psychosocial issues by public sector secondary school nurses in Western Australia was already noted in the literature in 2002.

The next section reviews findings from a study of school nursing conducted in private schools in Western Australia.

7.3.4 Comparison of the thesis by McCluskey (2015): The formative evaluation of a practice framework for nurses working in secondary schools with the substantive theory of tactical prioritising to manage the problem of untenable burden

In her thesis McCluskey (2015) undertook a mixed methods study focussing on secondary school nurses in the private education sector in Western Australia. The purpose of the study was to facilitate the formative evaluation of a practice framework to support secondary school nurses in mental health promotion with individual students. Of note is that McCluskey's research focussed on the needs of the school community. A published article stemming from the thesis (McCluskey, Kendall, & Burns, 2018) is also cited in this section.

McCluskey conducted a self-report survey of students and parents investigating perceptions of the school nurse role (2015, p. 105). Findings identified that students, parents and teachers often did not understand the role of the school nurse in mental health (McCluskey, 2015, pp. 233-234), findings which were replicated in the current study and described in *ability to function in the school*. In contrast to the current study however, McCluskey (2015) conducted her research with three schools in the private education sector. In her thesis McCluskey describes a medical model of secondary school nursing which has a focus on first aid and illness management. This is not an unexpected finding given that nurses in McCluskey's study were employed by their respective schools. In the current study there was also evidence that schools desired nurses to fulfil a first aid function. This was described as *misperceptions of the school nurse role*, reflecting the different model of school nursing practiced in the public sector.

To facilitate the development of a mental health promotion practice framework to guide secondary school nurse practice in mental health, McCluskey (2015) conducted interviews and focus groups with students, parents, teachers, school nurses and allied health professionals. Of this sample, six participants were registered nurses and two were enrolled nurses. In Western Australia enrolled nurses undertake 12-18 months of vocational training and work under the supervision of a registered nurse

(Department of Health Western Australia, 2019c). The entry level to practice for registered nurses is level one, with levels two and above indicating a more senior role. This contrasts with the current study, where all participants were registered nurses employed in the promotional position of registered nurse level two. This difference has implications for the level of practice described in the two studies.

At the foundational level there are significant parallels between the work of McCluskey and the current study. McCluskey's research identified the need for school nurses to be suitably resourced to undertake mental health work, specifically with respect to *time*, *professional development*, a *clinic* where confidentiality could be assured, and clinical and supervision *support* (McCluskey, Kendall, & Burns, 2018). In the current study, nurses who came under pressure from their schools to be providers of first aid also spoke about challenges with *time* due to needing to be highly responsive and available for this purpose.

With respect to the need for *professional development* (McCluskey, 2015) nurses in the current study engaged in *learning, learning, learning* indicating that continuing professional development was also an identified resource for this group. McCluskey identified the need for a suitable *clinic*, a medical term for the school health centre. A significant number of nurses in the current study also had concerns about the suitability and location of the school health centre. This was described at some length in *professional respect*. McCluskey's nurse participants desired substantially more *support*, which was reflected in the current study as *case, clinical and professional support*.

Beyond *resources for the school nurse* McCluskey's practice framework had a focus on the provision of *information and support* to facilitate *mental health literacy, therapeutic communication* and *assessment* to aid *triage* of problems into *general health care* and/or *mental health care*, subsequently resulting in *collaboration and referral* (McCluskey, 2015). This is where the two studies diverge. *Triage* is a medical term 'where the nurse will consider the priority of the presenting illness or injury and manage this accordingly' (McCluskey, 2015, p. 54). *Triage* leads to an interpretation of the young person's health problems as mental and/or physical in origin. This is at odds with the current study which identified that young people's

wicked problems affected multiple systems in their lives beyond their physical and/or mental health. Further, McCluskey identified *collaboration and referral* as the endpoint of the practice framework (McCluskey, 2015, p. 240). This is consistent with the medical model of school nursing but at variance with the findings from the current study. The equivalent of McCluskey's *collaboration and referral* in the current study was *knowing where to send them*. Notably, *knowing where to send them* arose very early in the core process of *tactical prioritising* and was followed by the tipping point *grappling with unmet needs*. This point often reflected circumstances where *collaboration and referral* (McCluskey, 2015) were ineffective or insufficient, exacerbating participants' experiences of *untenable burden*. Experienced participants in the current study moved beyond *grappling with unmet needs* and engaged in *optimising outcomes*, a concept that was not explored in McCluskey's research.

The next section considers the *substantive theory of tactical prioritising to manage the problem of untenable burden* in relation to other published theories.

7.4 Comparison with other published theories

This section compares the newly developed substantive theory with other relevant published theories. Although an identical theory was not identified, several existing theories reflect important features of the *substantive theory of tactical prioritising to manage the problem of untenable burden*. The section begins with a review of the *theory of stress and coping* by Lazarus and Folkman (1984) as this most closely mimics the core process of coping in the *theory of tactical prioritising*. This is followed by a consideration of how human beings develop mastery over complexity in the form of Benner's *model of skill acquisition* (1982) and Bandura's *theory of self-efficacy* (1977). Finally, the section concludes with a review of Watson's *theory of human caring* (1988a).

7.4.1 Comparison of Lazarus and Folkman's (1984) Theory of stress and coping with the substantive theory of tactical prioritising to manage the problem of untenable burden

Lazarus and Folkman's (1984) *theory of stress and coping* provides a structure for understanding how people respond to and cope with a wide variety of stressful circumstances. Lazarus and Folkman (1984) described the process of coping as serving two purposes. The first function was referred to as problem-focused coping and related to managing or changing the problem (Lazarus & Folkman, 1984, p. 152). Examples of problem-focused coping include strategies for diminishing environmental stressors and learning new skills (Lazarus & Folkman, 1984, p. 152). This is highly relevant to the *substantive theory of tactical prioritising to manage the problem of untenable burden*, as stage two of the core process *optimising outcomes* was highly oriented to problem-focussed coping. The second function of coping in the *theory of stress and coping* was referred to as emotional-focused coping and related to regulating the emotional response to the problem (Lazarus & Folkman, 1984, p. 153). Stage three of the core process *managing self* was largely emotion-focussed. Even *learning, learning, learning* clearly provided participants with emotional relief. One of the examples of emotional-focussed coping provided by Lazarus and Folkman (1984, p. 150) was avoidance, clearly demonstrated in the component *seeking personal balance* where participants took time away from work, or sought temporary secondments elsewhere. Consistent with the *theory of tactical prioritising to manage the problem of untenable burden*, Lazarus and Folkman (1984, p. 153) emphasise that problem-focussed coping and emotional-focussed coping have bi-directional influences during experiences of stress and can facilitate or obstruct the other.

Lazarus and Folkman (1984, p. 141) emphasised that coping is a 'constantly changing cognitive and behavioural effort to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person'. This is also consistent with the *theory of tactical prioritising to manage the problem of untenable burden* where participants made constant tactical decisions to seek relief from *untenable burden*.

Lazarus and Folkman (1984) asserted that the way a person copes is influenced by their available resources. Examples include *health and energy*, *commitment*, *problem-solving skills* and *social support*. These were also identified as facilitating participants' ability to cope with the problem of *untenable burden*. According to Lazarus and Folkman (1984, p. 159) 'it is easier to cope when one is feeling well than when one is not'. This is relevant to the current study, where participants asserted that coping with *untenable burden* was considerably more challenging when they were also confronted by problems related to their *ability to function in the school*. When participants expended *health and energy* addressing *misperceptions of the school nurse role*, the available *health and energy* for coping with *untenable burden* was diminished, impacting their ability to cope.

A second resource for coping described by Lazarus and Folkman (1984) was *commitment*, defined as that which has meaning for the individual. A *passion for the wellbeing of young people* was a key *commitment* identified in the *theory of tactical prioritising to manage the problem of untenable burden*. Lazarus and Folkman (1984, p. 56) assert that *commitment* underlies the choices people make to maintain valued ideals or achieve desired goals. In the current study, participants had *commitment* for the wellbeing of young people. As a consequence of *commitment*, they were able to engage in *optimising outcomes*. Lazarus and Folkman (1984) also emphasised *problem-solving skills* as a resource for coping. Defined as "the ability to search for information and analyse a situation" (Lazarus & Folkman, 1984, p. 162), participants in the current study had *an interest in finding solutions* and engaged in *learning, learning, learning* to facilitate problem solving. This further facilitated coping with *untenable burden*. A further resource for coping described by Lazarus and Folkman (1984) was *social support*. Defined as providing "vital resources which the individual can and must draw upon to survive and flourish," Lazarus and Folkman emphasised the importance of *social support* and social relationships in sustaining individuals (1984, p. 243). In the current study, participants predominantly sought social support from their school-based colleagues because this facilitated *sharing the responsibility*.

The *substantive theory of tactical prioritising to manage the problem of untenable burden* shares a number of similar elements with Lazarus and Folkman's (1984) *theory of stress and coping*. Participants in the current study experienced *untenable burden* as a consequence of stress and their responses throughout the core process of *tactical prioritising* aligned with responses identified by Lazarus and Folkman (1984). Several aspects of the *substantive theory of tactical prioritising to manage the problem of untenable burden* are therefore confirmed on comparison with Lazarus and Folkman (1984). The newly developed theory and findings from the current study explain how public sector secondary school nurses in Western Australia respond to the stressors that give rise to the problem of *untenable burden* and provide insight into the strategies that secondary school nurses use to cope while engaged in *tactical prioritising* to manage the problem of *untenable burden*.

The next section considers the role of skill acquisition as a coping strategy.

7.4.2 Comparison of Benner's (1982) Model of skill acquisition with the substantive theory of tactical prioritising to manage the problem of untenable burden

A significant feature of the *substantive theory of tactical prioritising to manage the problem of untenable burden* was participants' use of learning as a coping strategy, specifically the acquisition of skills that facilitated *optimising outcomes*. A model of skill acquisition described by Dreyfus and Dreyfus (1980) asserted that instruction and experience are critical to skill acquisition. Comprising five sequential stages, the *model of mental activities involved in direct skill acquisition* outlined by Dreyfus and Dreyfus (1980) identified the stages of *novice, competence, proficiency, expertise* and *mastery*. Benner (1982) adapted this model to nursing, providing a new explanation for the development of clinical competence and renaming the sequential stages *novice, advanced beginner, competent, proficient* and *expert* (Benner, 1982).

Dreyfus and Dreyfus' (1980) *model of skill acquisition* and Benner's (1982) *from novice to expert* are relevant for the spiralling that occurred in stages two and three of the theory of *tactical prioritising*. The stage three aspect *learning, learning, learning* assisted participants to engage in *managing self*, but also developed participants'

capacity for *optimising outcomes*. The increased *capacity to engage with wicked problems* frequently contributed to further *high utilisation* of the participant as a resource for young people. This in turn led to a further intensification of *untenable burden*, precipitating a new need for *managing self*. Over time, the ongoing effects of this spiralling propelled participants to very high levels of clinical expertise, commensurate with ‘expert’ status in Benner’s (1982) *from novice to expert*.

7.4.3 Comparison of Bandura’s (1977) Theory of self-efficacy with the substantive theory of tactical prioritising to manage the problem of untenable burden

Social learning theory by Bandura and Walters (1963) proposed that learning and behaviour are cognitive processes occurring in a social context. The *theory of self-efficacy* (Bandura, 1977) was built on *social learning theory* and asserted that human beings are self-organising, self-regulating, pro-active and self-reflective, in contrast to being motivated simply by internal or environmental stimulus. Bandura (1995) defined self-efficacy as ‘*the belief in one’s capabilities to organise and implement a solution to manage situations*’. Bandura’s *theory of self-efficacy* is highly relevant to the current study for its application to the spiralling relationship between *optimising outcomes* and *managing self*. As outlined in previous chapters, both *optimising outcomes* and *managing self* were strategies to ‘*implement a solution to manage situations*’ (Bandura, 1995). In *managing self*, participants utilised a range of intellectual and self-management strategies to promote their own wellbeing, while in *optimising outcomes* participants used a broad set of integrated strategies to manage young people presenting with *wicked problems*.

Bandura asserted that four sources of information contribute to self-efficacy: *personal achievements, vicarious experience, verbal persuasion* and *physiological states* (Bandura, 1977, p. 84). *Personal achievements* are especially important in the context of the current study. Participants who recounted significant *personal achievements* caring for young people experiencing *wicked problems* were much more likely to report greater self-efficacy with this cohort than participants who did not. Although participants who had a longer *duration of assignment to the school* had

had greater opportunities to experience *personal achievement*, *duration of assignment to the school* was not by itself a predictor of a more skilled practitioner. It was evident in the current study that the spiralling of *optimising outcomes* and *managing self* towards more skilled levels of clinical practice could be a steep gradient or gradual incline. This meant that some participants who had been practicing for a great many years were less advanced in their clinical practice than some participants who had been practicing for fewer years.

Notwithstanding this finding, participants who had a long *duration of assignment to the school* were more likely to have a high *perceived self-efficacy* in the context of their assigned school than participants with a shorter *duration of assignment to the school*. Perceived self-efficacy relates to the individual's belief that they can control and manage their performance in challenging circumstances and are confident in their ability to influence and direct their own motivation, behaviour and social environment (Bandura, 1977). The gradient of the *optimising outcomes/managing self* spiral in the current study was also obliquely related to *ability to function in the school*, because *ability to function in the school* largely influenced the barriers and facilitators participants faced as they sought experiences of *personal achievement*.

7.4.4 Comparison of Watson's (1988a) Theory of human caring with the substantive theory of tactical prioritising to manage the problem of untenable burden

Watson's (1979) *theory of human caring* in nursing was a response to the increasing domination of the medical model in nursing and emphasised the importance of nurse-patient interactions in caring-healing (Watson, 1997). Watson explained nursing *caring* as "the moral ideal of nursing whereby the end is protection, enhancement and preservation of human dignity" (Watson, 1988b, p. 29). Initially Watson outlined 10 *carative factors* oriented to the human dimensions of nursing (1979). Over time, Watson's theory evolved to the *caritas process* (Watson, 1988a) which focussed on three major elements: *carative factors*, the *transpersonal relationship*, and the *caring moment* (Watson, 1988a). Watson identifies many influences in her work (Watson, 1997), and draws on a broad variety of disciplines, including science, the humanities, and spiritual dimensions.

Watson's *theory of human caring* provides a framework for understanding how nursing supports human health, quality of life and the human experience. In the current study, *caring* about the broader wellbeing of young people was central to the category *optimising outcomes*. Of note is that *optimising outcomes* was a response to the perceived inadequacy of *knowing where to send them*. *Knowing where to send them* is conceptually consistent with the medical model of school nursing which reflects an illness and injury model of school health.

In the current study, *grappling with unmet needs* prompted nurse participants to critically reflect on the meaning of holistic health and wellbeing for the young person in their care. Consistent with Watson's *theory of human caring* (1979), participants who engaged in *grappling with unmet needs* came to understand that referral alone did not provide the optimal level of respectful and meaningful care young people required. Engagement in *optimising outcomes* followed. This stage required a high level of connectedness with the young person and required nurse participants to engage in a genuine use of the self, consistent with the *transpersonal relationship* of which Watson wrote. Watson explained that the transpersonal relationship requires the authentic and genuine use of the self, a capacity for being reflective and focused not on illness and disease but on holistic caring, healing and wholeness (Watson, 1997). Participants with a *commitment to the social model of health* were particularly likely to demonstrate skills that supported the development of a transpersonal relationship. This was not an unexpected finding given that the model of school nursing endorsed by the Western Australian Department of Health is the social model of health.

Although other authors have discussed Watson's theory in relation to community health nursing (see for example Rafael, 2000), a review of the literature did not identify any articles specifically discussing Watson's theory in relation to school nursing. The current study builds on the work of Watson by demonstrating that key aspects of Watson's (1979) *theory of human caring* are highly relevant to a nursing setting where Watson's theory has not previously been applied.

In the final section of this chapter the *substantive theory of tactical prioritising to manage the problem of untenable burden* is considered in relation to other concepts.

7.5 Comparison with other concepts

The purpose of this section is to compare the newly developed theory with other relevant concepts, beginning with a review of *nurse moral distress*, as described by Mary Corley (2002). This is relevant as it parallels the shared common concern of *untenable burden* in the current study. Following this the concept of *personal recovery* in mental health is compared to *optimising outcomes*. The final comparison examines the work of White (2012), who conceptualised youth suicide as a wicked problem in the style of Rittel and Webber (1973).

7.5.1 Comparison of the concept of nurse moral distress with the substantive theory of tactical prioritising to manage the problem of untenable burden

In clinical practice nurses can encounter a wide variety of ethical and moral dilemmas. Jameton, a philosopher, was the first to describe *moral distress*. He defined it as that which “arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action” (Jameton, 1984, p. 6). More recently, Corley argued that when explicit nursing goals such as protecting clients from harm, providing competent and timely care and maintaining a healing environment are obstructed, nurses experience moral distress (Corley, 2002). The problem of *untenable burden* described in this thesis closely resembles moral distress. It was particularly evident when conditions influencing the problem of *untenable burden* exacerbated difficulties providing young people with adequate or appropriate care and support.

Notably, Jameton explicitly reflected on the role of *institutional constraints* in nurse moral distress (1984). Specifically, he included factors such as time availability, poor supervisory support, the dominance of other decision makers, and organisational policy. These constraints align with the influencing conditions participants in the current study experienced: *parents* who did not support or action a referral, problems

with the *availability and capacity of external service providers* and competing demands, particularly those that were perceived to be additional to the actual workload, such as addressing *misperceptions of the school nurse role*.

While a substantial body of literature has examined the concept of nurse moral distress (Jameton, 2017), it has had relatively little exploration among school nurses (Powell, Engelke, & Swanson, 2018). This despite the evidence that school nurses experienced moral distress as far back as 1939. Swanson (1939, p. 960) was reflecting on a school nurse colleague who was planning to return to hospital work when she wrote: “[she] says it will be a relief to work again with people who know what you're trying to do and who help you do it, instead of working with those who are against you half the time.”

In a Northern American study by Powell and colleagues (2018) as many as 97.3% of the sample of 307 public sector school nurses reported at least some degree of moral distress. The most common precipitants were “students with chronic illness do not receive needed care,” being “unable to provide case management due to workload,” and being “unable to achieve goals for students due to family issues” (Powell et al., 2018). These align with findings in the current study, for example when young people with mental health problems did not receive specialist support. Issues of time and workload were also evident in the current study, with participants often unable to spend time addressing *wicked problems* due to the additional task of negotiating *misperceptions of the school nurse role*. The third precipitant identified by Powell and colleagues (2018), “unable to achieve goals for students due to family issues,” was also reported in the current study.

While the negative impact of moral distress is self-evident, less evident is the potential for positive effects (Mareš, 2016). According to Corley (2002), moral distress can motivate the nurse to act with courage, in turn facilitating professional development. In the current study, the finding that *untenable burden* could precipitate positive effects was demonstrated when participants sought relief from *untenable burden* by engaging in *learning, learning, learning*, in turn facilitating *optimising outcomes*. Nathaniel (2006) also reported participant professional growth

in a grounded theory study with a three-stage process of *moral reckoning*. The first stage, occurring in the *novice period* was conceptualised as the *stage of ease* when internal and external values align (Nathaniel, 2006). Subsequently, a *situational bind* interrupts this stage, prompting *moral distress*. This was followed by the *stage of resolution* which had two foundational choices: *giving up* or *making a stand*. Nathaniel (2006) reported that *making a stand* could be risky for the nurse because it involved going against professional or organisational norms. The third stage was the *stage of reflection*, when nurses learnt to live with the consequences of their moral decision-making and reflected on their values, beliefs and actions. The concept of *making a stand* was also evident in the current study, when nurses resisted *misperceptions of the school nurse role* and occasionally took *extreme measures* such as going against policy. There was evidence in the interviews that participants had reflected on these actions:

To me it's absolutely worth it [even] if I'm going to get told off... It was the only way. Ethically [and] for myself, [the only way to] get something to happen [for the young person] was to go against the policy. (P3)

In the same grounded theory study Nathaniel (2006, p. 429) noted that power imbalances typically exacerbated participants' experience of moral distress, a finding which was also evident in the current study. Participants drew particular attention to the power imbalances they experienced as lone Department of Health employees working in a Department of Education setting and explained that this impacted their *ability to function in the school*, in turn exacerbating the problem of *untenable burden*.

7.5.2 Comparison of the concept of personal recovery in mental health with the substantive theory of tactical prioritising to manage the problem of untenable burden

The Australian national framework for recovery-oriented mental health services distinguishes between *clinical recovery* and *personal recovery* (Commonwealth of Australia, 2013). *Clinical recovery* relates to the cessation or reduction of symptoms of mental illness, while *personal recovery* is defined by the individual with the

mental health problem and relates to living a meaningful life with or without mental illness (Commonwealth of Australia, 2013, pp. 79-80).

There is a paucity of literature describing personal recovery in the context of youth, however it is a reasonable assumption that in the absence of intense suicidal ideation young people experiencing mental health problems, like adults, also desire to live a meaningful life. In common with other young people they are likely to have developmentally typical goals such as meaningful social contact and the desire to progress academic and vocational goals. Indeed, there is evidence that many young people experiencing mental ill-health desire to remain engaged in learning (Orygen Youth Health Research Centre, 2014).

In the current study, participants engaged in *optimising outcomes* as part of the process of *tactical prioritising*. They did so by collaborating with young people to keep them safe, engaged, and moving along their developmental trajectories. These principles are consistent with the principles of personal recovery. Of note is that participants undertook this role as an adjunct to referral for mental health problems, indicating that experienced participants implicitly understood the concept of *living a meaningful life with or without mental illness*, even if they did not explicitly express this as promoting *personal recovery*.

7.5.3 Comparison of the commentary by White (2012): Youth suicide as a 'wild' problem - Implications for prevention practice with the substantive theory of tactical prioritising to manage the problem of untenable burden

White (2012, p. 43) writing in the journal *Suicidology Online* identified that school-based youth suicide prevention literature frequently identifies youth suicide as a 'tame' problem, largely reflective of mental illness. As evidence for this, she notes that language used in school-based suicide prevention material emphasises individual pathology and discourages alternative explanations for youth suicide (White, 2012, p. 46). This leads to an over-reliance on 'pre-determined, standardised, de-contextualised interventions' (White, 2012, p. 42) that are predominantly biomedical in nature.

Informed by a constructionist perspective, White (2012) refutes this interpretation and argues that suicide has been socially constructed in myriad ways throughout human history (White, 2012, p. 44). Citing the work of Rittel and Webber (1973), she proposes that youth suicide might be more helpfully understood as a *wicked* or ‘wild’ problem that reflects ‘high levels of instability, uncertainty, unpredictability and complexity’ (White, 2012, p. 42). White’s work is a commentary specifically about youth suicide, however the findings in the current paper are closely aligned with White’s argument. In addition to conceptualising young people’s mental health problems as *wicked problems*, experienced participants in the current study had a *capacity to engage in wicked problems* which is strongly reminiscent of having a tolerance for the ‘high levels of instability, uncertainty, unpredictability and complexity’ of which White (2012, p. 42) wrote.

White argues that viewing youth suicide as a ‘tame’ problem substantially diminishes the range of possible solutions at the clinician’s disposal (White, 2012, p. 45). In the current study, the few participants who perceived youth mental health problems as a ‘tame’ problem relayed an expectation that referral might be expected to resolve the presenting problem. This is consistent with a medical approach. More experienced participants had already engaged in *grappling with unmet needs* and were keenly aware that young people’s problems were not tame but *wicked*.

White’s commentary goes on to explain that reconceptualising youth suicide as a *wicked problem* permits exploration of alternative strategies in the prevention of youth suicide. In the current study, experienced participants followed organisational policy with respect to referral, but also engaged in *optimising outcomes*. Of note is that *optimising outcomes* was highly relational and not reliant on ‘pre-determined, standardised, de-contextualised interventions’ (White, 2012, p. 42). While there is no evidence that *optimising outcomes* was perceived by participants as a form of suicide prevention, it is clear that the findings from the current study lend support for White’s argument.

7.6 Summary

This chapter commenced with an overview of the newly developed *theory of tactical prioritising to manage the problem of untenable burden*. Subsequently, key theories and existing research were compared with the newly developed substantive theory to place the new theory into the context of the literature. In the first section, the newly developed theory was compared with studies of school nurses conducted in the United States, the Australian state of Queensland and Perth, Western Australia. The second section began with a comparison of the *theory of stress and coping* (Lazarus & Folkman, 1984), as this most closely mimicked the coping elements evident in the *theory of tactical prioritising*. This section concluded with Bandura's *theory of self-efficacy* (1977) which provided insight into the spiralling of *optimising outcomes* and *managing self* which was evident in the core process of *tactical prioritising*. The third section compared *the theory of tactical prioritising to manage the problem of untenable burden* with other concepts relevant to the study such as the concepts of *nurse moral distress* and *personal recovery* in mental health.

Although this chapter identified both theories and research findings that have similarities with the newly developed theory, the newly developed theory is unique. It provides a detailed but comprehensive analysis of the problems that Western Australian public secondary school nurses encountered in their work with young people experiencing mental health problems and outlines how they negotiated the process of *tactical prioritising* to resolve the shared common concern of *untenable burden*. While the findings of the current study identified the problems participants encountered, the findings also highlight the hidden contributions Western Australian public sector secondary school nurses make to the care of young people experiencing mental health problems.

With the exception of the one study reviewed earlier in this chapter by Downie and colleagues (2002), the experiences of Western Australian public sector secondary school nurses have not previously been documented in the literature. This has had unintended consequences for nurses and has exacerbated the shared common problem of *untenable burden*. The *theory of tactical prioritising to manage the*

problem of untenable burden provides a framework for the Departments of Health and Education, policy makers and managers to consider how the energy participants expend in the core process of *tactical prioritising* can be more optimally utilised and how organisational strategies can mitigate the core problem of *untenable burden*.

This is further considered in the next chapter which concludes this thesis.

Chapter eight outlines the clinical, education and research implications of this study and makes recommendations for organisations, policy makers, managers, educators and nurses with responsibility for providing health services to young people attending public sector secondary schools.

CHAPTER 8

IMPLICATIONS AND CONCLUSION

8.1 Introduction and overview

In the final chapter of this thesis the significance and implications of the *substantive theory of tactical prioritising to manage the problem of untenable burden* are considered. Secondary school nursing in Western Australia has had very limited exploration in the literature and this study provides a foundation for understanding the experiences of public sector secondary school nurses who encounter young people with mental health problems. In this chapter the significance of the findings are discussed, implications for key stakeholders are reviewed and recommendations are made for school health services, secondary school nurses and postgraduate nursing education providers. The study limitations and recommendations for future research conclude the chapter.

8.2 Significance and implications of the findings

The significance of this study is the development of a substantive theory that explains how public sector secondary school nurses respond when they encounter young people with mental health problems. Previously unarticulated in the Western Australian context, the theory provides a unique insight into the largely hidden and unacknowledged work public sector secondary school nurses undertake and the challenges they face at the clinical, professional and personal level.

The preceding chapters are evidence that participants who were well-progressed in the core process of *tactical prioritising* had developed a unique skill set and were highly specialist clinicians. These participants possessed sophisticated clinical skills and were agile in a range of unpredictable situations where they drew on well-developed knowledge and expertise in adolescent psychosocial health and development. Participants at this level were highly cognisant of the impact of the social determinants of health on young people and could clearly articulate these in the form of *wicked problems*. Moreover, highly skilled secondary school nurses used a broad range of innovative nurse-led strategies to support and intervene with young

people experiencing mental health problems, conceptualised as *optimising outcomes*. These sophisticated skills have not previously been described in any detail.

In addition to this, participants in the current study also developed a unique skill set for negotiating complex and highly political school systems as an autonomous practitioner. Participants endeavoured to contextualise their role to their assigned school, while still functioning in the role outlined by the employer. At the most optimal and sophisticated level of practice many participants were well embedded in their school teams and had strong professional relationships with other school support staff. A majority reported substantial contributions to the outcomes of young people experiencing mental health problems.

Some participants in this study faced additional challenges in the form of *misperceptions of the school nurse role*. This precipitated an additional workload in the form of first aid and illness management as well as additional pressures to re-orientate the role to that outlined by the employer. These participants reported that this could take years of sustained effort and was easily eroded by changes of school staff. The twin problems of an additional workload and effort expended reorientating the role diminished the time available to assist young people experiencing complex difficulties. This raises serious implications for the equity of service delivery to complex and vulnerable young people in different schools. It also raises pressing questions about the uniformity of secondary school nursing in the public sector. The school nurse role must be more clearly articulated if the Department of Health is to achieve health service goals and the psychosocial needs of young people are to be addressed. It is critical that the influence of individual schools on nurses and the work they undertake is addressed at the organisational level and not delegated to individual school nurses. These challenges for the health service have not previously been explored.

The findings of this study indicate that:

1. Public sector secondary school nurses are highly motivated to support young people experiencing mental health problems, but the complexity and isolation

of their work has significant implications for the emotional wellbeing of nurses.

2. The clinical work public sector secondary school nurses undertake with young people experiencing mental health problems is highly complex but hidden and largely unacknowledged. The contributions nurses make to the lives of school-attending young people experiencing mental health problems has not been measured, but the findings of this study suggest these contributions are broad in scope and sometimes represent the only source of support a young person has access to.
3. Pre-employment role preparation is critically important to prepare secondary school nurses for the clinical problems they are likely to encounter. Once employed, adequate clinical support and role-specific clinical education and training opportunities are required to assist nurses to develop expertise in supporting young people who present with *wicked problems*.
4. The clinical workload of public sector secondary school nurses is complicated by influences at the level of the school, with serious repercussions for the wellbeing of nurses, the effectiveness of nursing time and the level of support provided to young people experiencing complex problems.
5. There are unique professional challenges for secondary school nurses who are based in a work setting where health is not the core business. Increased professional and management support at the health service level is required to support nurses negotiating these challenges and address longstanding misunderstandings about the role of public sector secondary school nurses. This is critical to ensure nurses are able to conduct their core business in schools.

The findings outlined in this thesis have significant implications for a variety of stakeholders including schools, school health service providers, policy makers and managers, youth health services, postgraduate nursing education providers and public

sector secondary school nurses. The remainder of this section examines the implications for some of these stakeholders in detail. Recommendations are informed by the findings from this study and are oriented to addressing factors that contribute to secondary school nurses' experience of *untenable burden* and facilitating the process of *tactical prioritising*.

8.2.1 Implications for school health services

This section addresses implications for public sector school health services. The study findings indicate that school health services can support secondary school nurses in a more meaningful way so that the *untenable burden* associated with their clinical and professional work is addressed and the process of *tactical prioritising* facilitated. The study findings indicate that there are six key areas where school health services should focus their efforts: *acknowledging and measuring the work, role preparation, clinical support, ongoing education and training, professional support* and *support for untenable burden*.

8.2.1.1 Acknowledging and measuring the work

The first implication for school health services relates to acknowledging and measuring the complex clinical work that public sector secondary school nurses undertake. The lack of information in the public domain about the work of public sector secondary school nurses and the dearth of literature in the academic journals conspire to make the role highly invisible. At the local level, the study findings illustrate that many schools have a poor understanding of the scope of modern-day nursing practice, particularly the long-standing inclusion of mental health in a holistic approach to practice. At a broader level, the lack of visibility contributes to the publication of major documents such as the Western Australian Ombudsman's youth suicide prevention report (Ombudsman Western Australia, 2014) that fail to identify the role and contributions that public sector secondary school nurses in Western Australian make to young people's mental health. This diminishes the important role public sector secondary school nurses undertake with this cohort and further impacts the visibility of secondary school nurses to other service providers both locally and internationally.

The current study identified that school nurses were motivated to engage in *learning, learning, learning*, but the lack of visibility impacts access to government funding opportunities that would support nurses in this work. For example, state government funding to support young people's mental health has recently been awarded to senior teachers to upskill in mental health (Department of Education Western Australia, 2019b), but it is not clear if state secondary school nurses were even considered as potential recipients of this funding. There have also been high level demands for greater numbers and better resourcing of school psychologists (Commissioner for Children and Young People WA, 2011; Ombudsman Western Australia, 2014). The findings in this study suggest that funding directed towards psychology in schools may be misdirected when young peoples' *wicked problems* reflect the social determinants of health.

At the clinical level, the lack of visibility diminishes opportunities for effective interagency collaboration with the school nurse workforce. For example, participants reported significant challenges working with *external service providers* such as doctors because these providers were unaware of the existence and purpose of the secondary school nurse role. This has a direct effect on the level of collaborative care young people and their families have access to, and exacerbates feelings of professional *isolation* among individual public sector secondary school nurses.

The lack of visibility has flow-on effects at a national level. For example, the authors of a study of secondary school nurses in the Australian state of Queensland prefaced their study with a review of secondary school nursing in the Australian context, but did not identify that secondary school nursing has a long history in Western Australia (Sendall et al., 2011) Similarly, a discussion paper reviewing mental health supports in Australian schools by state failed to identify the role of public sector secondary school nurses in Western Australia (Orygen Youth Health Research Centre, 2014, p. 22). The current study findings emphasise an urgent need to examine how the work of public sector secondary school nurses is described, acknowledged and measured at the level of the community as well as in the academic domain so that the work becomes visible, valued and adequately resourced. It will also ensure nurses have

access to adequate role orientation and are educationally prepared to provide such care.

In Australia, headspace (the National Youth Mental Health Foundation) was established by the Australian Federal Government in 2006 (Rickwood, Mazzer, Telford, et al., 2015). The number of headspace centres to which young people can go has grown considerably, and now number more than 100 (headspace, 2019b). The budget for headspace is in the hundreds of millions of dollars (headspace, 2019c). While evaluation reports highlight that headspace has improved access to mental health care for young people (Rickwood, Mazzer, Telford, et al., 2015), it is less clear whether the services provided are effective (Jorm, 2018). Many young people attend only once or twice, a disappointing level of engagement (Jorm, 2015). Where headspace have excelled is with their minimum data set which makes it possible to report these outcomes. Future efforts to measure and acknowledge the work of public sector secondary school nurses might reasonably look to this data set for inspiration. The current study demonstrated that public sector secondary school nurses intervene with young people experiencing complex difficulties. Measuring the work may provide evidence that the services they provide are at least as effective as those provided by headspace. While secondary school nurses do not enjoy the level of resourcing available to headspace, it is entirely possible that they represent better value for money.

8.2.1.2 Role preparation

The second implication relates to the professional preparation nurses should have to function in the role of public sector secondary school nurse. The findings in this study illustrate that not all participants understood the role prior to undertaking their employment. These circumstances are not assisted by the absence of a document that outlines the scope of practice of the contemporary secondary school nurse in Western Australia. As outlined in *capacity to engage with wicked problems*, many participants reported that that they initially felt underprepared for the clinical demands they encountered as a public sector secondary school nurse, particularly in relation to addressing young people's social and emotional concerns. Participants reported that a deficit in the *capacity to engage with wicked problems* contributed to feelings of

isolation and exacerbated the experience of *untenable burden*. This finding emphasises a need to examine how nurses are recruited to the role of secondary school nurse and has important implications for describing the scope of nursing practice for contemporary secondary school nurses in Western Australia.

Nurses working as public sector secondary school nurses work independently with limited support. Given the degree of acuity and complexity that many secondary school nurse participants encountered, the findings in this thesis suggest that registered nurses should prepare for the secondary school nurse role by completing specific postgraduate educational requirements. Currently, this is not the case. By way of contrast, Western Australian nurses who provide clinical services to families with children under the age of three years must have child health postgraduate education preparing them for this role, typically requiring a year of part-time study at the tertiary level. Several participants in the current study were from the United Kingdom where role-specific tertiary-level preparation for employment as a public sector secondary school nurse is more rigorous. These participants expressed strong feelings about the lack of post-registration education required for the role in Western Australia:

I was really shocked when I came over here in regards to [the lack of education required for the role]. For me I could have come across [from the United Kingdom] as a generally new nurse [with] not much experience in a secondary school, and more than likely I think they would still have placed me in a secondary school if I wanted it. (See footnote⁶)

Another participant with role-specific postgraduate education from the United Kingdom reflected: “what I've got is the background understanding. I really understand the nitty-gritty of mental health and how it impacts: the stigma, the community, society, it's just the bigger picture” (See footnote⁷).

⁶ & ⁷ As these circumstances are potentially identifying, the participant numbers have been omitted to preserve their confidentiality elsewhere in this thesis.

A failure to ensure that secondary school nurses are adequately prepared for the clinical work they will encounter has implications not only for nurses themselves, but also for the young people to whom they provide care. The findings in this study strongly suggest that secondary school nursing is a specialty area of practice. As explained in the Western Australian Department of Health Youth Health Policy (Department of Health Western Australia, 2018) young people have a right to engage with health care professionals who are well prepared to evaluate their needs and provide an optimal level of care. For this reason, school health services should urgently consider including specialist postgraduate training in young people's psychosocial health and development as an essential criteria for employment as a public sector secondary school nurse.

8.2.1.3 Clinical support

The study findings provided ample evidence that inadequate or ineffective clinical support intensified *untenable burden*, making the provision of effective clinical support a key consideration for school health services. While improved role preparation will equip practitioners with the knowledge and skills to address young people's *wicked problems*, the nature of *wicked problems* means that there is no single solution to the young person's concerns (Rittel & Webber, 1973). Clinical uncertainty is therefore not the exception but the rule. Despite this, participants often reported that clinical support was ad-hoc and could not always be accessed in a timely manner.

In other specialties where there is a high degree of complexity and uncertainty about the most appropriate response it is common for a team of professionals to share clinical decision-making. While there was good evidence in the current study that participants sought to work as part of the school Student Services team, student confidentiality sometimes precluded this and clinical support at the level of the school health service was not consistently available. Some participants were line-managed by non-nurses, but participants who reported to other nurses also indicated that clinical support and direction was of variable usefulness and did not always consider the role-specific difficulties participants faced. As one participant stated: "I brought [my concerns up with] a manager and the response was 'but we refer them

on' and I said... while you're trying to get that child into some safe place, they're in your office and you're 'it' [alone] with them" (P1).

Participants who had been employed for a long duration as a secondary school nurse reported that the degree of complexity they encountered had increased over the term of their employment. This observation is not unique to this study and has been noted in a broad range of Australian nursing settings (Health Workforce Australia, 2013). Many specialty fields of nursing have responded to these developments by reviewing their scope of nursing practice and associated competencies. In public sector secondary school nursing, the absence of a scope of nursing practice is a serious limitation. A failure to outline a minimum scope of nursing practice has implications for the range of competencies front line staff should possess, and facilitates the educational sector using school nursing resources outside of their employment objectives. More concerningly, the flow-on effect is that service delivery is likely to be inequitable. This has implications for the standard of care young people can expect.

The absence of a scope of nursing practice also precludes identifying knowledgeable and experienced clinical staff in a systematic manner. Consistent with the findings in this study, the usefulness of clinical assistance provided to front line staff is therefore likely to be variable. This is highly concerning, because adequate and effective clinical support that is reliable, specialist and timely is highly likely to reduce the feelings of *isolation* participants experienced and subsequently diminish the intensity of *untenable burden*. The study findings support two recommendations to aid clinical support: that public sector secondary school nurses develop a nursing scope of practice and that school health services give due consideration to equipping public sector secondary school nurses with specialist clinical support that is adequate, timely and accessible.

8.2.1.4 Ongoing training and education

The current study highlighted that participants were well motivated to engage in *learning, learning, learning*, because it facilitated *optimising outcomes* and

diminished the experience of *untenable burden*. Despite this, participants reported that ongoing role-specific training and education at the level of the health service was limited. This is a missed opportunity to address the experience of *untenable burden* while facilitating *optimising outcomes* and is relevant not only for school health services but also for postgraduate nursing education providers.

Participants in the current study who undertook the role to an advanced level developed a unique clinical skill set to manage the high degree of complexity in their work. They sourced their own professional development opportunities which they contextualised for their work. Many used educational opportunities as a yardstick for evaluating their clinical responses and growing expertise. It is evident that the identification and appraisal of these learning opportunities requires highly developed critical thinking and analysis skills which may be more developed in practitioners who are already practicing at an advanced level. This ad-hoc approach to professional development at the health service level also permits the evolution of practitioners with vastly differing skills sets which is likely to further confuse schools about the skills and capacities secondary school nurses can be expected to have.

Ongoing education and training is vital to support optimal clinical practice. The uniqueness of the role suggests that ongoing training should be specific to the needs of public sector secondary school nurses and stratified from novice to expert levels to facilitate the process of *tactical prioritising*. To achieve this it is critical that there is improved recognition of the specific learning needs secondary school nurses have and commitment to the provision of ongoing education programs that meet these needs. The provision of ongoing role-specific education will better equip secondary school nurses with the knowledge and skills they need to perform in a unique role and will pay dividends in the form of improved wellbeing for the young people they care for. It is highly recommended that access to regular, ongoing, role-specific education and training for public sector secondary school nurses be implemented at the health service level to facilitate *optimising outcomes* and diminish the experience of *untenable burden*.

8.2.1.5 Professional support

The findings also have important considerations for professional support of secondary school nurses in the workplace. Factors at the level of the school that influenced the experience of *untenable burden* were detailed in this thesis under the heading *ability to function in the school*. The findings indicate that school-level support for the role outlined by the school health service was a key facilitator for nurses working optimally in their schools. Conversely, school-level barriers that negatively impacted *ability to function in the school* could present participants with significant obstacles that were not easily overcome. This significantly exacerbated the experience of *untenable burden*.

While well-developed clinical skills are vital, the experiences of several participants strongly suggest that in the current model of practice where nurses are assigned to a school, clinical skills are not enough. Two participants stood out because they had undertaken role-specific postgraduate education in secondary school health nursing. Both worked in schools which had strong *misperceptions of the school nurse role* that the participants sought to address. Both participants found this so onerous and demoralising that each considered leaving their employment. These findings have significant implications for school nursing resources and young people having access to the highest level of specialist expertise. Where nurses are unable to function in their designated roles, or where nurses expend considerable time and energy attempting to reorientate the role to that outlined by the employer, nurses are distracted from the actual clinical task for which they have been employed. Professional support for secondary school nurses at the level of the health service is therefore a high priority.

Participants in this study reported several inter-related problems when their assigned school had *misperceptions of the school nurse role* which impacted their *ability to function in the school*. In addition to the clinical workload for which they were employed, these participants negotiated the process of *strategic assimilation* with two additional workloads: addressing *misperceptions of the school nurse role*, and attendance to minor injury and illness. These complications affected how the

participant was perceived in the school and significantly exacerbated the experience of *untenable burden*. These problems also impacted the clinical time available to support young people presenting with *wicked problems*. As explained in *accessibility versus uninterrupted clinical time*, while participants highly valued being accessible to young people, effective intervention requires protected clinical time. It is critical that secondary school nurses can find a balance between *accessibility* via drop-in sessions and *uninterrupted clinical time* for private appointments. Where *misperceptions of the school nurse role* preclude this, assertive professional support is required at the level of the manager and school health service.

A major contributor to difficulties with *ability to function in the school* related to a lack of understanding by school staff of the school nurse role. As outlined by Holman and Coster (1991), this challenge is not new. The long-standing nature of the problem and the findings from this study suggest that it is ineffective to expect isolated practitioners in school health settings to overcome the existing school culture and address school *misperceptions of the school nurse role*. School health services must provide sufficient professional support such that nurses have the *ability to function in the school*. Individual nurses should not bear the brunt of this workload in addition to managing the additional workload generated by school misperceptions that the nurse will attend to first aid and injury. A broader, system wide solution to this challenge is required.

In view of the study findings it is highly recommended that school health services work with the public education sector to increase awareness of the role of the secondary school nurse. Where nurses continue to experience challenges at the level of the individual school, assertive professional support should be implemented by the school health service at the management level. Driven by appropriate policy and guidelines to ensure standard and equitable management of identified problems, assertive professional support should ensure that the nurse has the *ability to function in the school* in the designated role. The study findings suggest that an effective level of *professional support* will diminish the experience of *untenable burden* and permit a greater proportion of school nursing resources to be focussed on *optimising outcomes*.

8.2.1.6 Support for untenable burden

Findings from the current study indicate that participants were highly motivated to engage with young people experiencing *wicked problems*, but at times nurses were overwhelmed by the experience of *untenable burden*. This prompted participants to prioritise *strategic assimilation* or *managing self* over *optimising outcomes*. While necessary, nursing resources are finite and the need to focus on *strategic assimilation* or *managing self*, diminishes the resources available to engage in *optimising outcomes*.

Under section 19(1) of the Western Australian Occupational Health, Safety and Welfare Act 1984 (Western Australian Legislation, 1984) the employer has a duty to provide and maintain a working environment that is safe from physical and psychosocial hazards, including workplace stress (Australian Government, 2019). In the current study the experience of *untenable burden* might reasonably be conceptualised as workplace stress, as evidenced by *a heavy toll*, the fourth category in the shared common problem of *untenable burden*.

As explained in previous sections, the study findings suggest that the experience of *untenable burden* can be diminished by closer attention to role preparation, clinical support, ongoing training and education, policy formulation and professional support. These strategies are likely to have flow-on effects for the employer's core business, optimising the health and developmental outcomes of young people. This was described in detail as *optimising outcomes*. While the study findings suggest these approaches will diminish the experience of *untenable burden*, the current study also illustrates that the unique role and function of the secondary school nurse is likely to be unavoidably stressful even under optimal conditions. In addition to supportive strategies that limit the experience of *untenable burden*, school health services should therefore consider strategies that directly address *a heavy toll* to further mitigate the experience of *untenable burden*.

In the current study participants identified the important role that *collegial relationships* played in maintaining their wellbeing but described an ad-hoc approach

to *collegial relationships* and sourced their own forms of collegial support. Participants reported that common structured approaches to collegial support such as peer support networks and access to clinical supervision were desired but not available. This is relevant to school health services because inadequate support for managing stress in an emotionally challenging role can progress to occupational burnout and prompt nurses to seek alternative employment. As explained in *a heavy toll* and *seeking personal balance*, several participants in the current study had experienced such high levels of job-related stress that they took significant periods of leave (sometimes unpaid), had considered resigning or were on secondment to other employment roles at the time of interview. These participants were typically highly experienced secondary school nurses who possessed a sophisticated and unique skill set. The loss of these employees from the workplace even on a temporary basis should prompt school health services to consider the value of formal approaches to *collegial relationships* that support and protect the emotional wellbeing of public sector secondary school nurses in order to further mitigate the impact of *untenable burden*.

8.2.2 Implications for managers

The study findings also have important implications for workforce managers, health planners and policy makers who oversee the work of public sector secondary school nurses. As described in chapter four under *nursing support*, managers are not based in the schools and not all managers are nurses. It may therefore be difficult for managers to have a good understanding of the work secondary school nurses do and the difficulties they face at the level of the school if they do not visit nurses at the school. Findings in this study identified that participants appreciated the efforts of managers to develop a better understanding of their work by visiting them at school. Conversely, some participants reported that managers had not visited them at their assigned schools in many years. Some managers provided professional support that was predominantly reactive and attended the school only when things went wrong. Participants perceived this as a lack of professional support.

Many participants articulated that their direct line manager had little understanding about the professional challenges they encountered, limiting the ability of managers

to provide effective clinical and professional support. As illustrated in this thesis, the work that public sector secondary school nurses undertook was urgent, complex and demanding. Several participants were tearful as they expressed their experiences of *untenable burden* and several participants had taken temporary leave from their work role. The level of clinical complexity in the form of *wicked problems* had predictable emotional impacts for public sector secondary school nurses, but many participants in this study were faced with additional stressors. Early in their careers many participants described being unprepared for the level of autonomy required and needed to adapt to working in a setting where health was not the core business. At exactly the same time, participants also had to achieve a measure of *strategic assimilation* with their schools in order to function in their designated role. When *misperceptions of the school nurse role* impacted participants' *ability to function in the school* many participants undertook additional workloads to the one for which they had been employed, further exacerbating the experience of *untenable burden*. Alternatively, some participants saw no option but to capitulate to *misperceptions of the school nurse role*, which reduced available nursing resources for undertaking the core task of *optimising outcomes*.

These findings have important implications for the level of professional and clinical support managers provide and facilitate at a local level. While participants reported that clinical and professional support was available 'on paper', when they needed additional support this was not always readily accessible. This suggests that there is an over-reliance on managers to provide clinical and professional support, and managers might do more to facilitate alternative forms of nursing support at a local level. Participants in the current study acknowledged and understood the demands on managers, however to overcome a lack of professional and clinical support some participants had no alternative but to create their own peer support networks within and external to their immediate school health service colleagues. Some participants reported more success with this approach than others. Participants gave examples of peer support that was arranged ad-hoc on a particularly difficult day and accessing peer support with nurses working for other organisations. This highlights the

importance of *nursing collegial relationships* and represents a key area where managers can do more.

Many participants in the current study identified that they missed working with other nurses, and even the most competent and skilled participants in this study often referred to the *isolation* they felt as independent practitioners in a non-health setting. Having limited clinical and professional support exacerbated their experiences of *untenable burden*, particularly when they were working in a school that had significant *misperceptions of the school nurse role*. The study findings suggest that a management focus on developing and sustaining a broader range of clinical and professional supports for secondary school nurses at the local level will enhance *nursing collegial relationships* and is likely to diminish the experience of *untenable burden*.

8.2.3 Implications for postgraduate nursing education providers

This section examines implications for postgraduate nursing education providers. The findings in this study indicate that public sector secondary school nursing is a specialist area of practice with unique demands. Participants in the current study were highly motivated and expressed a need for advanced clinical knowledge and expertise to address young people's *wicked problems*. Post-basic education is critical to prepare nurses for optimal clinical practice in a unique practice setting. Particularly essential is appropriate clinical preparation for working with vulnerable young people and strategies for managing independent and autonomous practice in a setting where health is not the core business. In many rural and regional areas school nurses also function as generalist community health nurses which raises additional considerations for assuring adequate clinical preparation for working with school-aged youth. The findings in this study highlight a need to re-examine how nurses are professionally prepared for the role of secondary school nurse.

There are limited postgraduate education opportunities in Western Australia for nurses who wish to undertake studies that provide role-specific professional preparation to become a public sector secondary school nurse. Of the five universities in Perth only one offers postgraduate education with adolescent health

content suitable for public sector secondary school nurses (Curtin University, 2019). Offering a postgraduate certificate comprising one year of part-time study and articulating through to master's level preparation requiring three years of part time study, the course is oriented to child and adolescent health nursing in the community health context. Clinicians who undertake the minimum level of postgraduate studies therefore receive a broad but not specific level of preparation for public sector secondary school nursing, with limited mental health content. These academic requirements are augmented by a clinical rotation in a public sector high school of approximately one week. In light of the current study findings, this duration of pre-employment clinical experience in public sector secondary school nursing is manifestly inadequate.

The leading causes of disability among young people globally are mental health and substance use disorders (Erskine et al., 2015). These *wicked problems* should be a significant focus in a course preparing secondary school nurses for their role, particularly as young people are increasingly experiencing high levels of psychological distress (Bailey et al., 2016; Carlisle et al., 2018). Nurses seeking to specialise in public sector secondary school nursing should have access to considerably greater opportunities to prepare for the demands of the role than are currently available. The study findings emphasise a need to re-examine both the availability and content of postgraduate course offerings that prepare nurses for the role of secondary school nurse.

8.2.4 Implications for current and aspiring secondary school nurses

This section addresses the implications of the findings for current and aspiring secondary school nurses and makes recommendations to support this workforce in their care of young people experiencing *wicked problems*. This study was conducted with secondary school nurses in the public sector, and it is not clear if these recommendations are relevant to secondary school nurses employed by private secondary schools.

This study details the clinical workload that public sector secondary school nurses in Western Australia undertake, and the conditions that influence both the experience of *untenable burden* and the core process of *tactical prioritising*. The study explores the degree of clinical complexity and risk that participants negotiated, often with limited support. Relatively few of the conditions that influenced the experience of *untenable burden* were easily influenced by participants, prompting participants to have a strong focus on *managing self* at the level of the core process of *tactical prioritising*. For this reason, this section has a focus not only on those things that public secondary school nurses can influence directly, but also on those factors for which nurses should advocate as a group.

The single most critical element over which individual public sector secondary school nurses have influence is their own professional preparedness for the demands of the role. Given the lack of literature about the work of secondary school nurses in Western Australia it is not entirely surprising that some participants in the current study felt unprepared for the *wicked problems* and *autonomy and isolation* they encountered, as described in chapter three. The invisibility of the role in the literature precludes aspiring secondary school nurses from comprehensive insight into the likely demands of the role. This may also explain why some nurses in the current study had a limited understanding of the role prior to securing their employment. While participants in this study were generally enthusiastic about secondary school nursing, staff recruitment is resource intensive in time and monetary terms. If nurses are being recruited to a role they have limited insight into the risk is that they will not be retained.

The findings in this study highlight how critical it is that nurses seeking to practice in secondary school nursing have a well-developed understanding of the role and adequate motivation, knowledge and skills with adolescent clients to undertake the work. While many participants in the current study were highly experienced nurses in other specialties, many commented that their previous nursing experiences had not adequately prepared them for working with young people experiencing *wicked problems*, particularly as an autonomous practitioner. On the contrary, findings from the current study suggest that an advanced level of practice is required which can

take some considerable time to develop. For this reason, nurses who desire to practice as secondary school nurses should consider pursuing opportunities to develop clinical skills relevant to young people in the community and postgraduate education that enhances their knowledge and skills for addressing young people's *wicked problems*.

It is important that aspiring public sector secondary school nurses should not be unduly dissuaded from pursuing this goal by the findings in this study. The grounded theory method specifically seeks to identify the participants' shared common concern, permitting a rich description of the challenges participants faced. While not the main purpose of this study, insight into the role rewards are buried more deeply in this thesis. Of the 31 participants interviewed for this study, 15 had been practicing as public sector secondary school nurses for 10 years or more. This indicates that for many participants the rewards outweighed the challenges. Almost without exception participants valued working with young people and found it rewarding to work with this client group. These findings were described in *a passion for the wellbeing of young people*.

The findings in this study should also assist aspiring secondary school nurses to prepare for the challenges they may face in this work and the process of *tactical prioritising* can be used as a map to facilitate progress towards personal resolution of these challenges. *Strategic integration* at the level of the school is a period of transition and will feel unfamiliar irrespective of the duration of service as a public sector secondary school nurse. Once a measure of *strategic integration* has been accomplished many nurses will be confronted by unmet needs. For nurses who are prepared to engage in *grappling with unmet needs* the study provides significant detail about the interventions secondary school nurses undertook with young people that facilitated *optimising outcomes* for vulnerable youth. Equally important are the strategies nurses adopted to manage their own wellbeing. Conceptualised as *managing self*, the study provides significant insight into the strategies nurses can adopt in an emotionally demanding role.

While well-developed clinical skills are vital, the experiences of several participants strongly suggest that this is not enough if the assigned school has strong *misperceptions of the school nurse role*. As illustrated in this thesis, for participants skilled and ready to engage with young people experiencing *wicked problems*, encountering ingrained *misperceptions of the school nurse role* could have significant implications for the wellbeing of secondary school nurses. Given this impact and the extent to which *misperceptions of the school nurse role* were evident in the current findings, secondary school nurses may wish to acquaint themselves with the expectations of a school prior to accepting employment there. This may not always be possible as individual nurses will have a need of employment and the health service has the option of changing the employee's work location within specific parameters. Even so, nurses should discuss the school's expectations with their manager and the school prior to commencing their clinical duties. In the current study, many participants identified that they only became aware that their school had *misperceptions of the school nurse role* in the days or weeks after starting. This limits the opportunity nurses have to enter the school with a well-developed plan for addressing any known issues. Nurses should request that their manager advise them when an assigned school holds *misperceptions of the school nurse role* so that plans can be made jointly for addressing this prior to nurses undertaking clinical duties at the school.

In Western Australia there is no dedicated professional body that advocates specifically for the needs of public sector secondary school nurses. Community health nurses are more broadly represented by Community Health Nurses Western Australia (2019), which is aligned with the parent organisation Maternal, Child and Family Health Nurses Australia (2019). Neither organisation is well-invested in the specific professional needs of nurses caring for adolescent clients in schools. In the absence of a professional organisation to act as advocate, public sector secondary school nurses must find means within their employment to advocate for their needs. This may be difficult, partially because it may have immediate implications for personal employment but also because such advocacy must be conducted internal to the health service. Public sector employees must abide by the Western Australian Department of Health Code of Conduct under which they are not permitted to "use

official information obtained through the course of their employment to provide public comment or communicate in writing, online or via social media without written authorisation from the relevant delegated authority” (Government of Western Australia, 2016). The opportunities for public sector secondary school nurses to advocate for their needs at the group level are therefore limited to those made available within the health service. To add to the conundrum, the model of school nursing described in this thesis is unique to the public sector. School nurses who choose to disengage from the public sector cannot do the same work for a different employer. While there has been an increased focus on staff consultation in the Child and Adolescent Health Service subsequent to concerns about staff morale in 2017 (Government of Western Australia, 2017), it remains unclear if and how progress will be made towards meeting the needs of public sector secondary school nurses.

The lack of forums in which public sector secondary school nurses can advocate for their specific needs is further exacerbated by the lack of academic publications describing the work of public sector secondary school nurses in Western Australia. School nurses themselves have a poor history of recording their activities in this state. As a consequence of the current study a collaborative approach to designing and implementing a program of research investigating the work of public sector secondary school nurses is now being planned. Increased efforts to interest health academics and secondary school nurses in undertaking and publishing research is urgently required if this workforce are to be better supported and valued for their work.

8.3 Limitations of the study

Several limitations of the study were identified. The research described in this thesis was undertaken in Western Australia with public sector secondary school nurses providing school health services in government secondary schools. It is not clear if the findings apply to private sector school nurses or public sector school nurses in other Australian states and territories. This could be interpreted as a limitation of the study. Even so, Western Australia is the largest Australian state and provides school

health services to a significant population of school-attending young people with diverse needs.

The second limitation relates to the selection of participants. Participants in this study responded to an information sheet which specifically identified the topic as young people's mental health. Participants who expressed interest in participating are therefore likely to have an interest in young people's mental health and may not be representative of public sector secondary school nurses generally. Despite this limitation the study sample was of adequate size and highly diverse. Data saturation was achieved.

The newly developed theory also reflects the context and model of school nursing in Western Australia in 2017. This is the third limitation. Subsequent to the interviews for this research a state-wide review of school-aged health services was undertaken. At the time of writing, any proposed changes to the model described in this thesis have not been determined.

8.4 Recommendations for further research

The current study is the first study investigating the experiences of public sector secondary school nurses in the Western Australian context in almost 20 years. The findings identified that public sector secondary school nurses negotiate complex social and psychological demands in their daily work. Given the dearth of material in the published literature, there are myriad opportunities for further exploration in this field.

In relation to the current study, the findings identified several important influencing conditions that affected the experiences of public sector secondary school nurses. The substantive theory of *tactical prioritising* to manage the experience of *untenable burden* should be tested to confirm these findings. Topics that require further exploration include a broader investigation of the factors that facilitate nursing *capacity to engage with wicked problems*, optimal means for schools to include the nurse in *school-based case collaboration*, opportunities to build and evaluate the quality of *community partnerships* and measures for *ability to function in the school*.

Where *role preparation* and *ongoing training and education* is offered, the effectiveness of these opportunities for enhancing *capacity to engage with wicked problems* should be evaluated. Consideration could also be given to assessing how training and education correlate to better outcomes for young people.

Further research focusing on the experiences of secondary school nurses might examine the expectations nurses have when they undertake the role of secondary school nurse, the strategies they use to engage with their assigned school, the factors that assist them to establish collegiate relationships with school staff and the means by which nurses publicise the school health service at the level of the school.

In Western Australia the entry level to practice for registered nurses is level one, with levels two and above indicative of greater clinical seniority. The sample of participants in the current study were all level two registered nurses. Subsequent to this study, level one registered nurses were introduced into public sector secondary schools. Given the study findings, further research is warranted to determine if these nurses report similar or different concerns from those identified in the current study.

Research efforts that facilitate improved referral pathways is also urgently required. This study identified that school nurses experienced significant barriers when attempting to refer young people to other service providers. Research conducted with *external service providers* who are recipients of school nursing referrals might identify barriers and facilitators at this level and inform a more seamless approach to care. Such an endeavour might have the further benefit of raising the profile of school nurses, improving understanding and acknowledgement of the role among *external service providers* and further facilitating referral pathways.

There are also important opportunities for research at the health service level. The findings in the current study highlight the previously invisible work that secondary school nurses undertake with young people experiencing mental health problems. Unpublished service level data captures occasions of service and provides a rudimentary insight into the nature of concerns with which young people present. Consistent with the current study, service level data demonstrates an increasing trend

for young people to present to secondary school nurses with mental health problems. Other than this, the work has not been measured, either in terms of nursing activity or outcomes for young people.

The tracking and measurement of secondary school nursing services is essential. In Australia remuneration for publicly funded health services is largely activity based, and there is growing demand that publicly funded services demonstrate evidence of effectiveness. In the current climate, services that cannot demonstrate efficacy are unlikely to be retained in the long term. This problem is not unique to school nursing in Western Australia. School nursing in other jurisdictions such as the United States have faced similar problems (Bergren, 2011). Measurement is challenging in secondary school nursing (Bergren, 2016), partly because outcomes in prevention are difficult to measure (Kellam & Langevin, 2003) and partly because the value inherent in school nursing does not lend itself to simplistic *key performance indicators* such as the number of young people seen or the general nature of the visit.

In secondary school nursing measures should be possible at the level of the individual as well as at the level of the population. Individual interventions should measure what was provided and the outcome of this service provision. Whatever the agreed format, data needs to be gathered in a consistent manner, should be readily available for analysis, and available to individual secondary school nurses, managers, and the community. Data analysis at the level of the individual should be able to identify trends and patterns of service usage, such as whether a small cohort of young people are high users of school nursing resources or whether a large cohort of young people benefit. At a population level there must also be a focus on linking school nursing data with other data sets such as education. The promise of 'big data' cannot be realised in the absence of measures to evaluate the quality, impact and outcome of secondary school nurse interventions.

Research with young people who are recipients of school nursing services represent another avenue for future research. Research with young people might have a focus on the manner in which young people become aware of the school nursing service, the process young people engage in when deciding to access the school nurse, the barriers young people experience when they seek access to the school nurse, the

expectations young people have when they engage with the school nurse and the services they find most helpful. It is also critical that progress is made towards measuring the outcomes of the care they receive. While research with minors presents unique challenges, these can be overcome (National Health and Medical Research Council, 2018, p. 65). Young adults who were recent recipients of school nursing services may also provide valuable insight into the short-term impacts and outcomes of school nursing interventions.

Finally, the model of school health nursing endorsed by Western Australian public sector school health services has similarities with public sector school health services in the Australian states of Victoria and Queensland. Further research exploring the school health services in other Australian states may be warranted as the potential for a more national approach to young people's health at the level of secondary school nursing services is unclear.

8.5 Concluding statement

In this study the substantive theory of *tactical prioritising* to manage the shared common problem of *untenable burden* emerged using grounded theory methodology. The findings clearly articulate the complex and multi-dimensional experiences of secondary school nurses seeking to optimise the life outcomes of young people experiencing mental health problems in the Western Australian public sector secondary school context.

The objectives of this study were to:

1. To explore the experiences of school nurses who encounter young people with mental health problems.
2. To identify the barriers and facilitators school nurses experience in their work with young people experiencing mental health problems.



3. To develop a substantive theory that explains how school nurses respond to young people experiencing mental health problems and places it in the context of the relevant theoretical literature.

Participant descriptions provided a rich understanding of their experiences. This insight can stimulate appropriate changes to practice and policy as well as seeking to prevent and limit experiences of *untenable burden*.

It is anticipated that this research will provide stakeholders such as secondary school nurses, school health service providers, health policy makers, postgraduate nursing education providers and public sector secondary schools with a better understanding of the needs of secondary school nurses in providing optimal care to young people experiencing mental health problems. Importantly, the findings make visible the work of public sector secondary school nurses, highlight the shared common concern of *untenable burden* and provide a roadmap for navigating the process of *tactical prioritising*.

APPENDICES

APPENDIX A: RECRUITMENT, AUGUST 18, 2017

Government of Western Australia
Child and Adolescent Health Service

A message from Child and Adolescent Community Health

18 August 2017

Inside this issue

School Health Nurses – Young People with Mental Health Problems

School nurse Anita Moyes is undertaking doctoral research to explore the experiences of school health nurses who encounter young people with mental health problems. The support of CACH and WACHS Executive is gratefully acknowledged and permission has been granted for nurses to participate during work hours at a community health base. The research will be supervised by Professor Dianne Wynaden and Dr Shirley McGough from Curtin University.


Anita is interested in speaking to community nurses who meet the following criteria:

- Employed by the Department of Health in Western Australia either currently or recently.
- Employed as a community health nurse (registered nurse level 2) or senior registered nurse (SRN) level 3 in the community health context.
- Have current or recent knowledge and experience related to the provision of direct clinical services to individual adolescent clients in the school health context.
- Express an interest in participating.
- Provide written consent to participate.

An information sheet and consent form are attached. Potential participants can contact Anita on 0450 372 925 or Anita.Moyes@health.wa.gov.au for further information.

[Back to top ↑](#)

APPENDIX B: RECRUITMENT, OCTOBER 11, 2017



Government of Western Australia
WA Country Health Service

Healthy Country Kids Connection

For distribution to all Community Health Nursing and Child Development Teams

Overview
The WACHS Healthy Country Kids Connection aims to keep staff informed of current issues, developments, and changes to policy, procedures and programs. Feedback is welcome from the regions as to how information is shared and in what format.

If you have any questions with the information contained in this update, please email
WACHS.PopulationHealthAreaOffice@health.wa.gov.au

School Health Nurses – Young People with Mental Health Problems

School nurse Anita Moyes is undertaking doctoral research to explore the experiences of school health nurses who encounter young people with mental health problems. The support of WACHS and CACH Executive is gratefully acknowledged and permission has been granted for nurses to participate during work hours at a community health base. The research will be supervised by Professor Dianne Wynaden and Dr Shirley McGough from Curtin University.

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11 October 2017

Contents

Early Years Evidence.....	2
Policies, Procedures & Guidelines...	3
Resources.....	3
Professional Development and Training.....	4/5

APPENDIX C: STUDY INFORMATION SHEET



Government of **Western Australia**
Department of **Health**



Curtin University

INFORMATION SHEET

A grounded theory study: Exploring the experiences of school health nurses who encounter young people with mental health problems.

Investigators: Ms. Anita Moyes, Professor Dianne Wynaden, Dr Shirley McGough

Nature and Purpose of the Study

Many school nurses working for the WA Department of Health have reported that they have significant contact with young adolescent clients experiencing mental health problems, but little is known about the experiences of nurses in these interactions.

What the Study Will Involve

If you agree to participate in this research you will be asked to sign a consent form and participate in a confidential interview with the researcher. At the interview you will be asked personal demographic information such as your date of birth, how long you have been registered as a nurse, and how long you have worked in school health. You will also be asked to discuss your experiences as a school nurse with individual adolescent clients experiencing mental health problems. For the purposes of the interview, “mental health problems” are defined as being any clinical presentation where the nurse perceived that the young person was presenting with poor mental health. The interview may take up to 60 minutes.

Some participants may be requested to participate in a shorter, follow-up interview at a later date to clarify information from the first interview.

Benefits

School nurses who participate in the research will be provided with an electronic version of the final report at its completion. Individual nurses may not receive a direct benefit from their participation, however it is hoped that a more well-developed understanding of the experiences of school nurses who provide care to young people with mental health problems will assist in planning measures that support nurses to manage the challenges they experience with this cohort. Possible benefits might include more appropriate and specific training opportunities, greater clinical support for perceived difficulties and more structured support for nurses to work with young people presenting with mental health problems at school.

Discomforts and Risks

There are no known risks to participating in this study. Should any participant experience distress either during or as a result of participating in the interview, the participant will be provided with assistance to access support through the employee assistance scheme provided by the Department of Health.

Voluntary Participation and Withdrawal from Study

Participation in this study will not in any way interfere with your employment. Your participation is entirely voluntary and completely confidential. There are no repercussions if you decide not to participate, and you may withdraw from the study at any time, for whatever reason.

If you have questions about this research, please contact Ms Anita Moyes on 0450 372 925, Professor Dianne Wynaden on 9266 2203 or Dr Shirley McGough on 9266 9087.

Ethics Approval

This study has been approved by the Child and Adolescent Health Service Human Research Ethics Committee – approval number RGS00056. If you should have any complaints or concerns about the way in which the study is being conducted, you should contact the Chairman of the Child and Adolescent Health Service Human Research Ethics Committee on 9340 8221 or at pmhethics@health.wa.gov.au. This study has also been approved by the Curtin University Human Research Ethics Committee – approval number HRE2017-0280. If needed, verification of approval can be obtained either in writing to the Curtin University Research Ethics Committee, c/- Office of Research and Development, Curtin University, GPO Box U1987, Perth, 6845 or by telephoning 9226 2784 or by emailing hrec@curtin.edu.au.

Privacy, Confidentiality and Disclosure information

At all times your confidentiality and privacy will be maintained and no information that might identify you will be used in any report, presentation or publication resulting from the research. Thank you for taking the time to read this information sheet. If you have any questions, please do not hesitate to contact me or one of the other researchers listed above.

Ms Anita Moyes

Tel: 0450 372 925

[CAHS-CH & WACHS] Master Participant Information Sheet [Version 1.0] [24-10-16]

APPENDIX D: PARTICIPANT CONSENT FORM



Government of **Western Australia**
Department of **Health**



Curtin University

PARTICIPANT CONSENT FORM

A grounded theory study: Exploring the experiences of school health nurses who encounter young people with mental health problems.

Investigators: Ms. Anita Moyes, Professor Dianne Wynaden, Dr Shirley McGough

Participants Name:

Date of Birth:

* I voluntarily agree to take part in *the above study*.

*I have been given a full explanation of the purpose and aims of this study, and what is required from me if I agree to participate.

*I understand that I am entirely free to withdraw from the study at any time and that this withdrawal will not in any way affect my future employment.

*I understand that I will not be referred to by name in any report or publications resulting from this study. In turn, I cannot restrict in any way the use of the results that arise from this study.

*I have been given and read a copy of this Consent Form and Information Sheet.

*I give consent for my interview to be audio-taped for the purposes of transcription, at which time it will be de-identified.

Signature by participant

Signature by researcher

Signed..... Signed.....

Dated..... Dated.....

[CAHS-CH & WACHS] Consent Form [Version 1.0] [24-10-16]

APPENDIX E: DEMOGRAPHIC DATA SHEET



Government of **Western Australia**
Department of **Health**



Curtin University

CONFIDENTIAL DEMOGRAPHIC DATA SHEET

**A grounded theory study: Exploring the experiences of school health nurses
who encounter young people with mental health problems.**

Investigators: Ms. Anita Moyes,
Professor Dianne Wynaden, Dr Shirley McGough

Name: _____ Age: _____

Gender: M / F / Other / Do not wish to provide (*Please circle*)

Year first registered as a nurse: _____

Number of years working as a school nurse: _____

How many secondary schools have you worked in as a school nurse?

How long have you worked as a school nurse in your current allocated
secondary school? _____

Previous FORMAL TRAINING in mental health:

YES NO (*Please circle*)

Details: _____

Previous EXPERIENCE working in mental health:

YES NO (*Please circle*)

How frequently do you have contact with young people you think are experiencing mental health problems?

Daily Weekly Occasionally Never Unsure

Details:

OFFICE USE

Participant provided with Information Sheet: YES NO

Participant provided signed Consent Form: YES NO

APPENDIX F: QUESTION GUIDE



Government of **Western Australia**
Department of **Health**



Curtin University

STUDY QUESTION GUIDE

A grounded theory study: Exploring the experiences of school health nurses who encounter young people with mental health problems.

Investigators: Ms. Anita Moyes, Professor Dianne Wynaden,
Dr Shirley McGough

QUESTION GUIDE

Introductory questions

Collection of demographic data will preface interview – see *Confidential Demographic Data Sheet*

Why did you choose school nursing?

Can you please tell me about your expectations of the role and whether these were/weren't met?

Tell me about your experiences as a secondary school nurse?

Additional Guiding questions

How comfortable are you working with young people with mental health problems?

Do you have previous experience working in mental health? Tell me about these experiences.

What role do school nurses perceive they have with young people experiencing mental health problems?

What do school nurses perceive as the key facilitators and barriers to undertaking this role to a high standard?

How do school nurses support young people with mental health problems?

What are your main concerns when providing care?

How do school nurses promote optimal outcomes for young people with mental health problems?

What types of specialist health expertise do school nurses employ with young people experiencing mental health problems?

Question Guide/ Version2, 2nd March 2017

APPENDIX G: DEPARTMENT OF HEALTH ETHICS APPROVAL



Government of Western Australia
Child and Adolescent Health Service

28 March 2017

Ms Anita Moyes
Child and Adolescent Community Health
233 Adelaide Terrace
PERTH WA 6000

Dear Ms Moyes

PRN: RGS0000000056
Project Title: A grounded theory study: Exploring the experiences of school health nurses who encounter young people with mental health problems
Protocol Number: Version 3.0 (23-3-17)

The ethics application for the project referenced above was reviewed by the Children and Adolescent Health Service Human Research Ethics Committee at its meeting on 16 March 2017. It has been approved and the following documents have been approved for use in this project.

Document	Version	Version Date
RGP00056 DOHWA CACH & WACHS Master Participant Information Sheet	1	24/10/2016
RGP00056 DOHWA Consent Form Master	1	24/10/2016
RGP00056 DOHWA Question Guide	2	02/03/2017
RGP00056 DOHWA Confidential Demographic Data Sheet	2	02/03/2017
RGP00056 DOHWA Research Protocol	3	23/03/2017
RGP00056 DOHWA Master Participant Information Sheet	2	23/03/2017

Ethical approval of this project from Children and Adolescent Health Service Human Research Ethics Committee is valid from 16 February 2017 to 16 February 2020 subject to compliance with the 'Conditions of Ethics Approval for a Research Project' (Appendix A).

Child and Adolescent Community Health, Esperance Community Health, Kalgoorlie - Boulder Population Health Unit, Laverton Community Health Service, Leinster Community Health Service, Leonora Community Health Service, Norseman Community Health, Albany Primary Health Service, Gnowangerup Community Health Centre, Great Southern Primary Health Service, Katanning Primary Health Service, Ravensthorpe Community Health, Broome Community Health Service, Derby Community Health Service, Halls Creek Community Health Service, Kimberley Population Health Unit, Kununurra Community Health Service, Wyndham Community Health Service, Carnarvon Community Health



Government of Western Australia
Child and Adolescent Health Service

Service, Gascoyne Population Health Unit, Geraldton Community Health Service, Geraldton Population Health Unit, Pilbara Population Health, Bunbury / Harvey Community Health Service, South West Population Health Unit, Avon and Central Primary Health Service, Eastern Primary Health Service, Southern Wheatbelt Primary Health Service

[Note: If additional sites are recruited prior to the commencement of, or during the research project, the Coordinating Principal Investigator is required to notify the Human Research Ethics Committee (HREC). Notification of withdrawn sites should also be provided to the HREC in a timely fashion.]

A copy of this ethical approval letter must be submitted by all site Principal Investigators to the Research Governance Office or equivalent body or individual at each participating institution in a timely manner to enable the institution to authorise the commencement of the project at its site/s.

This letter constitutes ethical approval only. This project cannot proceed at any site until separate site authorisation has been obtained from the Chief Executive or Delegate of the site under whose auspices the research will be conducted.

The Children and Adolescent Health Service Human Research Ethics Committee is registered with the Australian Health Ethics Committee and operates according to the NHMRC National Statement on Ethical Conduct in Human Research and International Conference on Harmonisation – Good Clinical Practice.

The Children and Adolescent Health Service Human Research Ethics Committee Terms of Reference, Standard Operating Procedures, membership and standard forms are available from <http://www.pmh.health.wa.gov.au/development/resources/ethics.htm>. Should you have any queries about the HREC's consideration of your project, please contact the Ethics Office on pmhethics@health.wa.gov.au.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Mark Salmon'.

Dr Mark Salmon
Director of Clinical Services
On Behalf of the Children and Adolescent Health Service Human Research Ethics Committee



CONDITIONS OF ETHICS APPROVAL FOR A RESEARCH PROJECT

The following general conditions apply to the research project approved by the Human Research Ethics Committee (HREC) and acceptance of ethical approval will be deemed to be an acceptance of these conditions by all project investigators:

1. The responsibility for the conduct of this project lies with the Coordinating Principal Investigator (CPI).
2. The investigators recognise the reviewing HREC is registered with the National Health and Medical Research Council and that it complies with the current version of the National Statement on Ethical Conduct in Human Research.
3. A list of HREC member attendance at a specific meeting is available on request, but no voting records will be provided.
4. The CPI will immediately report anything that might warrant review of ethical approval of the project.
5. The CPI will notify the HREC of any event that requires a modification to the protocol or other project documents and submit any required amendments to approved documents, or any new documents, for ethics approval. Amendments cannot be implemented at any participating site until ethics approval is given.
6. The CPI will submit any necessary reports related to the safety of research participants in accordance with the WA Health Research Governance Standard Operating Procedures.
7. Where a project requires a Data Safety Monitoring Board (DSMB), the CPI's will ensure this is in place before the commencement of the project and notify the HREC. All relevant reports from the DSMB should be submitted to HREC.
8. For investigator-initiated and collaborative research group projects the CPI may take on the role of the sponsor. In this case, the CPI is responsible for reporting to the Therapeutic Goods Administration (TGA) any unexpected serious drug or device adverse reactions, and significant safety issues in accordance with the TGA guidelines.
9. If the project involves the use of an implantable device, the CPI will ensure a properly monitored and up to date system for tracking participants is maintained for the life of the device.
10. The CPI will submit a progress report to the HREC annually from the ethics approval date and notify the HREC when the project is completed at all sites. The HREC can request additional reporting requirements as a special condition of a research project. Ethics approvals are subject to the receipt of these reports and approval may be suspended if the report is not received.
11. The CPI will notify the HREC of his or her inability to continue as CPI and will provide the name and contact information of their replacement. Failure to notify the HREC can result approval for the project being suspended or withdrawn.
12. The CPI will notify the HREC of any changes in investigators and/or new sites that will utilise the ethics approval.
13. The HREC has the authority to audit the conduct of any project without notice if some irregularity has occurred, a complaint is received from a third party or the HREC decides to undertake an audit for quality improvement purposes.



**Government of Western Australia
Child and Adolescent Health Service**

14. The HREC may conduct random monitoring of any project. The CPI will be notified if their project has been selected. The CPI will be given a copy of the monitor's report along with the HREC and Research Governance (RG) Office at the site/s.
15. Complaints relating to the conduct of a project should be directed to the HREC Chair and will be promptly investigated according to the WA Health's complaints procedures.
16. The CPI should ensure participant information and consent forms are stored within the participant's medical record in accordance with the WA Health's Record Keeping Plan.
17. The CPI will notify the HREC of any plan to extend the duration of the project past the expiry date listed above and will submit any associated required documentation. A request for an extension should be submitted prior to the expiry date. One extension of 5 years may be granted but approval beyond this time period may necessitate further review by the HREC.
18. Once the approval period has expired or the project is closed, the CPI will submit a final report. If the report is not received within 30 days the project will be closed and archived.
19. Projects that do not commence within 12 months of the approval date may have their approval withdrawn and the project closed. The CPI must outline why the project approval should remain.
20. The CPI will notify the HREC if the project is temporarily halted or prematurely terminated at a participating site before the expected completion date, with reasons provided. Such notification should include information as to what procedures are in place to safeguard participants.
21. If a project fails to meet these conditions the HREC will contact the CPI to address the identified issues. If, after being contacted by the HREC, the issues are not addressed, the ethics approval will be withdrawn. The HREC will notify the RG Office at each site within WA Health that the project procedures must discontinue, except for those directly related to participant's safety.

APPENDIX H: CURTIN UNIVERSITY ETHICS APPROVAL

									
Office of Research and Development									
GPO Box U1987 Perth Western Australia 6845									
Telephone +61 8 9266 7863 Facsimile +61 8 9266 3793 Web research.curtin.edu.au									
18-May-2017									
Name:	Dianne Wynaden								
Department/School:	School of Nursing, Midwifery and Paramedicine								
Email:	D.Wynaden@curtin.edu.au								
Dear Dianne Wynaden									
RE: Reciprocal ethics approval Approval number: HRE2017-0280									
Thank you for your application submitted to the Human Research Ethics Office for the project A grounded theory study: Exploring the experiences of school health nurses who encounter young people with mental health problems..									
Your application has been approved by the Curtin University Human Research Ethics Committee (HREC) through a reciprocal approval process with the lead HREC.									
The lead HREC for this project has been identified as Child and Adolescent Health Service HREC.									
Approval number from the lead HREC is noted as RGS0000056.									
The Curtin University Human Research Ethics Office approval number for this project is HRE2017-0280 . Please use this number in all correspondence with the Curtin University Ethics Office regarding this project.									
Approval is granted for a period of one year from 18-May-2017 to 17-May-2018 . Continuation of approval will be granted on an annual basis following submission of an annual report.									
Personnel authorised to work on this project:									
<table border="1"><thead><tr><th>Name</th><th>Role</th></tr></thead><tbody><tr><td>Moyes, Anita</td><td>Student</td></tr><tr><td>Wynaden, Dianne</td><td>CI</td></tr><tr><td>McGough, Shirley</td><td>Co-Inv</td></tr></tbody></table>	Name	Role	Moyes, Anita	Student	Wynaden, Dianne	CI	McGough, Shirley	Co-Inv	
Name	Role								
Moyes, Anita	Student								
Wynaden, Dianne	CI								
McGough, Shirley	Co-Inv								
You must comply with the lead HREC's reporting requirements and conditions of approval. You must also:									
<ul style="list-style-type: none">• Keep the Curtin University Ethics Office informed of submissions to the lead HREC, and of the review outcomes for those submissions• Conduct your research according to the approved proposal• Report to the lead HREC anything that might warrant review of the ethics approval for the project									

- Submit an annual progress report to the Curtin University Ethics Office on or before the anniversary of approval, and a completion report on completion of the project. These can be the same reports submitted to the lead HREC.
- Personnel working on this project must be adequately qualified by education, training and experience for their role, or supervised
- Personnel must disclose any actual or potential conflicts of interest, including any financial or other interest or affiliation, that bears on this project
- Data and primary materials must be managed in accordance with the [Western Australian University Sector Disposal Authority \(WAUSDA\)](#) and the [Curtin University Research Data and Primary Materials policy](#)
- Where practicable, results of the research should be made available to the research participants in a timely and clear manner
- The Curtin University Ethics Office may conduct audits on a portion of approved projects.

This letter constitutes ethical approval only. This project may not proceed until you have met all of the Curtin University research governance requirements.

Should you have any queries regarding consideration of your project, please contact the Ethics Support Officer for your faculty or the Ethics Office at hrec@curtin.edu.au or on 9266 2784.

Yours sincerely



Dr Karen Heslop
Deputy Chair, Human Research Ethics Committee

APPENDIX I: COMMUNITY HEALTH GOVERNANCE APPROVAL



Government of Western Australia
Department of Health

Child and Adolescent Health Service

25 July 2017

Ms Anita Moyes
Clinical Nurse Specialist - Adolescent Mental Health
Child and Adolescent Community Health
233 Adelaide Terrace
PERTH WA 6000

Dear Ms Moyes

PRN: RGS0000000056
Project Title: A grounded theory study: Exploring the experiences of school health nurses who encounter young people with mental health problems
Protocol Number: Version 3.0 (23-3-17)

Thank you for submitting the above research project for governance review. I am pleased to advise you that the Child and Adolescent Health Service has granted authorisation for this research project to be conducted at the following participating site(s):

Child and Adolescent Community Health

Site authorisation of this project is valid from 25 July 2017 subject to continued ethical approval from the Children and Adolescent Health Service Human Research Ethics Committee and compliance with the 'Conditions of Site Authorisation for a Research Project' (Appendix A).

I wish you every success in your research.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Mark Salmon'.

Dr Mark Salmon
Director Clinical Services

CONDITIONS OF SITE AUTHORISATION FOR A RESEARCH PROJECT

The following general conditions apply to the research project, which has been authorised to be conducted at the above nominated site(s). The acceptance of site authorisation will be deemed to be an acceptance of these conditions by all investigators involved in the research project at the nominated site(s).

1. The responsibility for the conduct of this project at the nominated site(s) lies with the site Principal Investigator (PI).
2. The PI will inform the Research Governance (RG) Office of any event that requires a modification to the protocol or other project documents and submit any required amendments to approved documents, or any new documents, for site authorisation. Amendments cannot be implemented at this site until they have received ethics approval and site authorisation.
3. The PI will submit any necessary reports related to the safety of research participants to the Research Governance Office in accordance with the WA Health Research Governance Standard Operating Procedures.
4. The PI will submit a progress report to the RG Office annually from the ethics approval date and notify the RG Office when the project is completed at the site(s). The RG Office can request additional reporting requirements as a special condition of a research project. Site authorisation is subject to the receipt of these reports and authorisation may be suspended if the report is not received.
5. The PI will notify the RG Office of his or her inability to continue as PI at the site(s) and will provide the name and contact information of their replacement.
6. The PI will notify the RG Office of any changes in investigators at the site(s).
7. The site has the authority to audit the conduct of any project without notice if some irregularity has occurred, a complaint is received from a third party or the site decides to undertake an audit for quality improvement purposes.
8. The site may conduct random monitoring of any project. The PI will be notified if their project has been selected. The PI will be given a copy of the monitor's report along with the HREC and RG Office.
9. Complaints relating to the conduct of a project should be directed to the RG Office and will be promptly investigated according to the WA Health's complaints procedures.
10. The PI should ensure participant information and consent forms are stored within the participant's medical record in accordance with the WA Health's Record Keeping Plan.
11. Once the project has been closed at site, the PI will submit a final report. If the report is not received within 30 days the project will be closed and archived.
12. The PI will notify the RG Office if the project is temporarily halted or prematurely terminated at the site(s) before the expected completion date, with reasons provided. Such notification should include information as to what procedures are in place to safeguard participants.
13. If a project fails to meet these conditions the RG Office will contact the PI to address the identified issues. If, after being contacted, the issues are not addressed the site authorisation will be withdrawn.

APPENDIX J: WACHS GOVERNANCE APPROVAL



Government of **Western Australia**
WA Country Health Service

Our Ref: ED-CO-17-41746

Ms Anita Moyes
Child and Community Health
233 Adelaide Terrace
PERTH WA 6000

Dear Ms Moyes,

WACHS Project Reference: RGS56

Project Title: A grounded theory study: exploring the experiences of school health nurses who encounter young people with mental health problems.

On behalf of the WA Country Health Service I give authorisation for your research project to involve the following site(s):

- **WACHS Great Southern:** Albany Primary Health Service, Gnowangerup Community Health Centre, Great Southern Primary Health Service, Katanning Primary Health Service, Ravensthorpe Community Health.
- **WACHS South West:** Bunbury / Harvey Community Health Service, South West Population Health Unit,
- **WACHS Wheatbelt:** Avon and Central Primary Health Service, Eastern Primary Health Service, Southern Wheatbelt Primary Health Service
- **WACHS Goldfields:** Esperance Community Health, Kalgoorlie -Boulder Population Health Unit, Laverton Community Health Service, Leinster Community Health Service, Leonora Community Health Service, Norseman Community Health,
- **WACHS Midwest:** Carnarvon Community Health Service, Gascoyne Population Health Unit, Geraldton Community Health Service, Geraldton Population Health Unit,
- **WACHS Pilbara:** Pilbara Population Health
- **WACHS Kimberley:** Broome Community Health Service, Derby Community Health Service, Halls Creek Community Health Service, Kimberley Population Health Unit, Kununurra Community Health Service, Wyndham Community Health Service

This authorisation is based on the approval from **Children and Adolescent Health Service Human Research Ethics Committee** and the review from the Research Governance Office. This authorisation is valid subject to the ongoing approval from the HREC.

This authorisation is based on the compliance with the 'Conditions of Authorisation to Conduct a Research Project at Site' (attached) and with the compliance of all reports as required by the Research Governance Office and approving HREC. Non compliance with these requirements could result in the authorisation being withdrawn.

The responsibility for the conduct of this project remains with you as the Principal Investigator at the site.
Yours sincerely

Dr Tony Robins
Executive Director of Medical Services
WA Country Health Service

Working together for a healthier country WA

Our Values: Community | Compassion | Quality | Integrity | Justice

APPENDIX K: ADVERSE EVENT PROTOCOL

As outline in Section 7 of the Study Protocol.


There are no known risks to participating in the study, although some participants may experience discomfort or distress recounting difficult experiences (for example, the death of a student by suicide).

Should any participant experience distress during the interview, the interview will be paused to allow the participant to consider whether they would like to continue. Any participant who experiences distress either during or as a result of their participation will be provided with support to access the employee assistance scheme provided by the Department of Health.

Adverse events beyond discomfort and/or distress in the context of recounting difficult experiences are not anticipated. A log of participants who required support to access the Department of Health employee assistance scheme as a result of their participation in this research will be maintained throughout the project.

Participants who are referred to the Department of Health employee assistance scheme will be followed up one week after the initial referral to ascertain participant wellbeing and to offer further support to access the scheme should this be required.

APPENDIX L: CURTIN UNIVERSITY DATA MANAGEMENT PLAN

	
Research Data Management Plan	
A grounded theory study: Exploring the experiences of school health nurses who encounter young people with mental health problems.	
Supervisor	Dianne Wynaden
Data Management Plan Edited by	Anita Moyes
Modified Date	19/10/2016
Data Management Plan ID	WYNADD-HS02759
Faculty	Health Sciences
1 Research Project Details	
1.1 Research project title	A grounded theory study: Exploring the experiences of school health nurses who encounter young people with mental health problems.
1.2 Research project summary	Mental health problems are highly prevalent in young Australians (Lawrence, et al., 2015). In addition to the immediate impact on wellbeing and suicide risk, mental health problems have significant implications for young people's school attainment and subsequent life course (Bowman, McKinstry, & McGorry, 2018). In the international literature schools have been identified as a highly suitable setting for addressing mental health problems (Patalay, et al., 2016), yet little is known about the work of advanced practice school nurses with this cohort in the Western Australian State secondary school setting. The purpose of this study is to articulate how advanced practice secondary school nurses conceptualise and describe their clinical experiences with young people who present with mental health problems. The study will examine the role nurses' perceive they have, the clinical activities they undertake with this cohort and the factors that enhance or inhibit their capacity to deliver care to this group. Grounded theory methodology will be used (Glaser & Strauss, 1987). The study sample will comprise of advanced practice (level 2) registered nurses who work as autonomous clinicians in metropolitan and rural State secondary schools for the Department of Health in Western Australia. Data will be collected using semi-structured interviews. It is estimated that approximately 40-50 interviews will be conducted. Purposeful and theoretical sampling will guide the selection of participants. The significance of this research will be to develop a substantive theory of the work of advanced practice secondary school nurses with young people experiencing mental health problems. Knowledge generated will contribute to a better understanding of school nurse activities with this cohort. Findings will be of value to stakeholders both within and external to the health and education settings and are expected to inform strategies to optimise the capacity of the school nurse workforce to support young people with mental health problems who attend WA State secondary schools.
1.3 Keywords	school nursing; school nurse; youth mental health; adolescent mental health
2 Research Project Data Details	
2.1 Research project data summary	Research data generated comprises 40-50 digital audio recordings of semi-structured interviews with school health nurses employed by the WA Department of Health. The data will also include digital transcriptions of the audio recordings, together with field notes and memos generated in the course of the research program. Interview questions relate to the experiences of school nurses with young people who present with mental health problems; barriers and facilitators encountered in the provision of clinical care to this cohort will also be explored. Interviews will be de-identified at the point of transcription and grounded theory will be used to analyse the data. Ownership of the IP will remain with the principal investigator.
2.2 Will the data be identifiable	<ul style="list-style-type: none">• Re-identifiable — identifiers have been removed and replaced by a code, but it is possible to re-identify an individual
Curtin University is a trademark of Curtin University of Technology	
1	
CRICOS Provider Code 00301J	

2.3 Will data, including biospecimens, be sent overseas?

No

2.4 Data organisation and structure

The digital data will be located in two main directories: 1. Audio recordings 2. Transcriptions

Audio recordings of the interviews will be located in the first folder; file format will be mp3, WMA or similar. A twelve digit reference number in the form of the date and time the interview was conducted will be assigned as the file name. For example, an interview conducted at 1030 on February 15, 2017 will be denoted in the date/time format as 150220171030. Audio recordings may reference personally identifiable features such as participant given name, work location and voice, however interviews will be fully de-identified at the point of transcription and located in the second main directory. Transcriptions will be in Microsoft Word. As with audio recordings, transcriptions will be allocated a twelve digit reference number in the form of the date and time the interview was conducted. A physical diary will be held separately to indicate the name of the person who was interviewed on any given date and time. Only the principal researcher will have access to both sets of information.

3 Research Project Data Storage, Retention and Dissemination Details

3.1 Storage arrangements

All original audio source data will be transferred and held on the Curtin University Research Drive as soon as practicable after each interview, as per policy. All transcribed source data will be uploaded and held on the Curtin University Research Drive immediately after transcription.

The physical diary recording the date and time participants were interviewed will be held in a locked filing cabinet in the principal investigator's office at Child and Adolescent Community Health (Department of Health). The locked filing cabinet is on the eighth floor of East Point Plaza in the CBD; access to the office is by swipe card, and the filing cabinet key is held solely by the principal investigator.

3.2 Estimated data storage volume

Main data required is for 50 x 1 hour interviews at approx 160kbps = 28.8 gigabyte. Estimate approximately 30 gigabyte total storage required.

3.3 Safeguarding measures

Backup copies of original audio files and transcripts will be stored on an encrypted USB drive in the principal researcher's home office. Where possible, audio files will be stored on the USB in more than one format (eg: both WMA and mp3) to guard against media obsolescence. The USB will be password protected, and the password will only be known to the principal investigator.

3.4 Retention requirements

7 years

3.5 Collaboration

Only the principal investigator and the supervisor will have access to the source data.

3.6 Data dissemination

There are no plans to make the original source data available.

3.7 Embargo period

Not applicable.

APPENDIX M: GOOD CLINICAL PRACTICE RESEARCH TRAINING

Good Clinical Practice (GCP) Online Training

V.1

Name: Anita Moyes

Research Education and Training Program



WAHTN
Western Australian Health Translation Network

This ICH E6 GCP Investigator Site Training meets the Minimum Criteria for ICH GCP Investigator Site Personnel Training identified by TransCelerate BioPharma as necessary to enable mutual recognition of GCP training among trial sponsors.

Required minutes in course: 300

31 December 2016

REFERENCES

- Access Economics. (2009). *The economic impact of youth mental illness and the cost effectiveness of early intervention*. Retrieved from https://www.orygen.org.au/Policy-Advocacy/Policy-Reports/Economic-Impact-of-Youth-Mental-Illness/CostYMH_Dec2009
- Achenbach, T., & Ruffle, T. (2000). The Child Behavior Checklist and related forms for assessing behavioral/emotional problems and competencies. *Pediatrics in Review, 21*(8), 265-271. doi:10.1542/pir.21-8-265
- Adams, J., Mrug, S., & Knight, D. C. (2018). Characteristics of child physical and sexual abuse as predictors of psychopathology. *Child Abuse & Neglect, 86*, 167-177. doi:10.1016/j.chiabu.2018.09.019
- Aldridge, J., Fraser, B., Fozdar, F., Ala'i, K., Earnest, J., & Afari, E. (2016). Students' perceptions of school climate as determinants of wellbeing, resilience and identity. *Improving Schools, 19*(1), 5-26. doi:10.1177/1365480215612616
- American Psychiatric Association. (2013a). Anxiety disorders. In *Diagnostic and statistical manual of mental disorders*. (5th ed.). doi:10.1176/appi.books.9780890425596.dsm05
- American Psychiatric Association. (2013b). *Diagnostic and statistical manual of mental disorders*. (5th ed.). doi:10.1176/appi.books.9780890425596
- American Psychiatric Association. (2013c). Personality disorders. In *Diagnostic and statistical manual of mental disorders*. (5th ed.). doi:10.1176/appi.books.9780890425596.dsm18
- Anwar-McHenry, J., Donovan, R., Nicholas, A., Kerrigan, S., Francas, S., & Phan, T. (2016). Implementing a mentally healthy schools framework based on the population wide Act-Belong-Commit mental health promotion campaign: A process evaluation. *Health Education, 116*(6), 561-579. doi:10.1108/HE-07-2015-0023
- Arnett, J. (1999). Adolescent storm and stress, reconsidered. *American Psychologist, 54*(5), 317-326. doi:10.1037/0003-066X.54.5.317

- Artinian, B., Giske, T., & Cone, P. (2009). *Glaserian grounded theory in nursing research: Trusting emergence*. New York City, US: Springer Publishing Company.
- assimilation. (n.d.). *Cambridge English Dictionary Online*. Retrieved from <https://dictionary.cambridge.org/dictionary/english/assimilation>
- Association for Child and Adolescent Mental Health Special Interest Group in Youth Mental Health. (2013). *The international declaration on youth mental health*. Retrieved from https://www.iaymh.org/s/8909_Int-Declaration-YMH_print.pdf
- Australian Bureau of Statistics. (2018). *3303.0 - Causes of death, Australia, 2017*. Retrieved from <https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2017~Main%20Features~Intentional%20self-harm,%20key%20characteristics~3>
- Australian Government. (2014). *MindMatters*. Retrieved from <https://www1.health.gov.au/internet/publications/publishing.nsf/Content/suicide-prevention-activities-evaluation~positioning-the-nspp~mindmatters>
- Australian Government. (2016). *School education*. Retrieved from <http://www.australia.gov.au/information-and-services/education-and-training/school-education>
- Australian Government. (2019). *Comcare: Psychosocial hazards*. Retrieved from https://www.comcare.gov.au/preventing/hazards/psychosocial_hazards
- Bailey, V., Baker, A., Cave, L., Fildes, J., Perrens, B., Plummer, J., & Wearing, A. (2016). *Mission Australia's 2016 youth survey report*. Retrieved from <https://www.missionaustralia.com.au/documents/research/young-people-research/677-mission-australia-youth-survey-report-2016>
- Bains, R., & Diallo, A. (2015). Mental health services in school-based health centers: Systematic review. *Journal of School Nursing, 32*(1), 8-19.
doi:10.1177/1059840515590607

- Bakker, K. (2018). *School nurses' knowledge and perceived role in mental health issues*. (Honours thesis). The Eleanor Mann School of Nursing. Retrieved from: <https://scholarworks.uark.edu/nursuht/65>
- Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review*, 84(2), 191. doi:10.1037/0033-295X.84.2.191
- Bandura, A. (1995). *Self-efficacy in changing societies*. Cambridge, UK: Cambridge University Press.
- Bandura, A., & Walters, R. (1963). *Social learning and personality development*. New York, US: Holt Rinehart and Winston.
- Banfield, M., McGorm, K., & Sargent, G. (2015). Health promotion in schools: A multi-method evaluation of an Australian school youth health nurse program. *BMC Nursing*, 14(21). doi:10.1186/s12912-015-0071-0
- Bartlett, H. (2015). Can school nurses identify mental health needs early and provide effective advice and support? *British Journal of School Nursing*, 10(3), 126-134. doi:10.12968/bjsn.2015.10.3.126
- Benner, P. (1982). From novice to expert. *The American Journal of Nursing*, 82(3), 402-407. doi:10.2307/3462928
- Bergren, M. (2011). Does school nursing matter? School nurse-sensitive outcome measures. *NASN School Nurse*, 26(2), 72-73. doi:10.1177/1942602X10397053
- Bergren, M. (2016). The feasibility of collecting school nurse data. *Journal of School Nursing*, 32(5), 337-346. doi:10.1177/1059840516649233
- BeyondBlue. (2019). Download SenseAbility. Retrieved from <https://www.beyondblue.org.au/healthy-places/secondary-schools-and-tertiary/senseability/download-sensibility>
- Birks, M., & Mills, J. (2015). *Grounded theory: A practical guide*. (2nd ed.). London, UK: Sage Publications.
- Birleson, P. (2009). Should youth mental health become a specialty in its own right? No. *British Medical Journal*, 339, b3371. doi:10.1136/bmj.b3371
- Bitsch, V. (2005). Qualitative research: A grounded theory example and evaluation criteria. *Journal of Agribusiness*, 23(1), 75-91. Retrieved from <https://ageconsearch.umn.edu/record/59612/>

- Blakemore, S. (2018). *Inventing ourselves: The secret life of the teenage brain*. London, UK: Hachette.
- Blakemore, S., Burnett, S., & Dahl, R. (2010). The role of puberty in the developing adolescent brain. *Human Brain Mapping, 31*(6), 926-933.
doi:10.1002/hbm.21052
- Bohnenkamp, J., & Stephan, S. (2015). Supporting student mental health: The role of the school nurse in coordinated school mental health care. *Psychology in the Schools, 52*(7), 714-727. doi:10.1002/pits.21851
- Bolland, K., Bolland, J., Tomek, S., Devereaux, R., Mrug, S., & Wimberly, J. (2016). Trajectories of adolescent alcohol use by gender and early initiation status. *Youth & Society, 48*(1), 3-32. doi:10.1177/0044118x13475639
- Borbasi, S., & Jackson, D. (2012). *Navigating the maze of research: Enhancing nursing and midwifery practice* (3rd ed.). Chatswood, Australia: Elsevier.
- Bowman, S., McKinstry, C., & McGorry, P. (2016). Youth mental ill health and secondary school completion in Australia: Time to act. *Early Intervention in Psychiatry, 11*(4), 277-289. doi:10.1111/eip.12357
- Brewer, S., Godley, M., & Hulvershorn, L. (2017). Treating mental health and substance use disorders in adolescents: What is on the menu? *Current Psychiatry Reports, 19*(1), 5. doi:10.1007/s11920-017-0755-0
- Briggs-Gowan, M., Estabrook, R., Henry, D., Grasso, D., Burns, J., McCarthy, K., . . . Wakschlag, L. (2019). Parsing dimensions of family violence exposure in early childhood: Shared and specific contributions to emergent psychopathology and impairment. *Child Abuse & Neglect, 87*, 100-111.
doi:10.1016/j.chiabu.2018.06.006
- Buckley, C., & Waring, M. (2013). Using diagrams to support the research process: Examples from grounded theory. *Qualitative Research, 13*(2), 148-172.
doi:10.1177/1468794112472280
- burden. (n.d.). *Dictionary.com*. Retrieved from
<https://www.dictionary.com/browse/burden>

- Burns, N., & Grove, S. (2009). *The practice of nursing research: Appraisal, synthesis and generation of evidence*. (6th ed.). St Louis, US: Elsevier Health Sciences.
- Butler, A., Copnell, B., & Hall, H. (2018). The development of theoretical sampling in practice. *Collegian*, 25(5), 561-566. doi:10.1016/j.colegn.2018.01.002
- Carlisle, E., Fildes, J., Hall, S., Hicking, V., Perrens, B., & Plummer, J. (2018). *Mission Australia's 2018 youth survey report*. Retrieved from <https://www.missionaustralia.com.au/publications/youth-survey/823-mission-australia-youth-survey-report-2018>
- Casey, B., Jones, R., & Hare, T. (2008). The adolescent brain. *Annals of the New York Academy of Science*, 1124, 111-126. doi:10.1196/annals.1440.010
- Center on the Developing Child at Harvard University. (2014). *Excessive stress disrupts the architecture of the developing brain: Working paper no. 3. Updated edition*. Retrieved from www.developingchild.harvard.edu
- Center on the Developing Child at Harvard University. (2012). *The science of neglect: The persistent absence of responsive care disrupts the developing brain: Working paper no. 12*. Retrieved from www.developingchild.harvard.edu
- Chan, M. (2010). *Mental health and development: Targeting people with mental health conditions as a vulnerable group*. Retrieved from https://www.who.int/mental_health/policy/mhtargeting/en/
- Chanen, A. (2012, 18-2-2012). *Young people in transition: Continuities and discontinuities in developmental psychopathology from childhood through emerging adulthood*. Paper presented at the 'The Mental Health of Young People in the 21st Century: The Challenge for Australian Psychiatry', Melbourne, Australia.
- Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In N. Denzin & Y. Lincoln (Eds.), *Handbook of Qualitative Research* (2nd ed.). Thousand Oaks, US: SAGE Publications.
- Charmaz, K. (2008). Constructionism and the grounded theory. In J. Holstein & J. Gubrium (Eds.), *Handbook of Constructionist Research* (pp. 397-412). New York, US: The Guildford Press.

- Cheer, K., MacLaren, D., & Tsey, K. (2016). The use of grounded theory in studies of nurses and midwives' coping processes: A systematic literature search. *Contemporary Nurse*. doi:10.1080/10376178.2016.1157445
- collegial. (n.d.). *Merriam-Webster.com*. Retrieved from <https://www.merriam-webster.com/dictionary/collegial>
- Commission on the Social Determinants of Health. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health*. Retrieved from https://www.who.int/social_determinants/final_report/csdh_finalreport_2008.pdf
- Commissioner for Children and Young People WA. (2011). *Report of the inquiry into the mental health and wellbeing of children and young people in Western Australia*. Retrieved from <https://www.cyp.wa.gov.au/media/1452/report-mental-health-inquiry-april-2011.pdf>
- Commonwealth of Australia. (2013). *A national framework for recovery-oriented mental health services: Guide for practitioners and providers*. Retrieved from <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovgde>
- Community Health Nurses Western Australia. (2019). CHNWA. Retrieved from <https://www.chnwa.org.au/>
- Corley, M. (2002). Nurse moral distress: A proposed theory and research agenda. *Nursing Ethics*, 9(6), 636-650. doi:10.1191/0969733002ne557oa
- Coughlan, H., Cannon, M., Shiers, D., Power, P., Barry, C., Bates, T., . . . McGorry, P. (2013). Towards a new paradigm of care: The International Declaration on Youth Mental Health. *Early Intervention in Psychiatry*, 7(2), 103-108. doi:10.1111/eip.12048
- Council on School Health. (2016). Role of the school nurse in providing school health services. *Pediatrics*, 137(6). doi:10.1542/peds.2016-0852

- Crawley, S., Caporino, N., Birmaher, B., Ginsburg, G., Piacentini, J., Albano, A., . . . Kendall, P. (2014). Somatic complaints in anxious youth. *Child Psychiatry & Human Development, 45*(4), 398-407. doi:10.1007/s10578-013-0410-x
- Cresswell, J., & Plano Clark, V. (2011). *Designing and conducting mixed method research*. California, US: Thousand Oaks Publishing.
- Cross, S., Hermens, D., & Hickie, I. B. (2016). Treatment patterns and short-term outcomes in an early intervention youth mental health service. *Early Intervention in Psychiatry, 10*(1), 88-97. doi:10.1111/eip.12191
- Cross, S., Hermens, D., Scott, E., Ottavio, A., McGorry, P., & Hickie, I. (2014). A clinical staging model for early intervention youth mental health services. *Psychiatric Services, 65*(7), 939-943. doi:10.1176/appi.ps.201300221
- Curtin University. (2014). *Research data and primary materials policy (Amended 2015)*. Perth, Australia: Author. Retrieved from https://policies.curtin.edu.au/local/docs/policy/Research_Data_and_Primary_Materials_Policy.pdf
- Curtin University. (2018). Research data management: Introduction. Retrieved from <http://libguides.library.curtin.edu.au/c.php?g=202401&p=1332990#8871204>
- Curtin University. (2019). *Curtin University Courses Handbook 2019*. Retrieved from <http://handbook.curtin.edu.au/courses/31/319678.html>
- Davey, C., & McGorry, P. (2018). Early intervention for depression in young people: A blind spot in mental health care. *The Lancet Psychiatry*. doi:10.1016/S2215-0366(18)30292-X
- De Goede, I., Branje, S., & Meeus, W. (2009). Developmental changes in adolescents' perceptions of relationships with their parents. *Journal of Youth and Adolescence, 38*(1), 75-88. doi:10.1007/s10964-008-9286-7
- de Wilde, E., van de Looij, P., Goldschmeding, J., & Hoogeveen, C. (2011). Self-report of suicidal thoughts and behavior vs. school nurse evaluations in Dutch high-school students. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 32*(3), 121-127. doi:10.1027/0227-5910/a000064
- Deane, F., Wilson, C., & Ciarrochi, J. (2001). Suicidal ideation and help-negation: Not just hopelessness or prior help. *Journal of Clinical Psychology, 57*(7), 901-914. doi:10.1002/jclp.1058

- Department of Education Western Australia. (2015). *Competency Framework for school psychologists*. Retrieved from http://det.wa.edu.au/studentsupport/behaviourandwellbeing/detcms/cms-service/download/asset/?asset_id=25290450
- Department of Education Western Australia. (2018a). *Annual Report 2017–18*. Retrieved from <https://www.education.wa.edu.au/web/annual-report/downloads>
- Department of Education Western Australia. (2018b). School response and planning guidelines for students with suicidal behaviour and non-suicidal self-injury. Retrieved from <http://det.wa.edu.au/policies/detcms/policy-planning-and-accountability/policies-framework/guidelines/school-response-and-planning-guidelines-for-students-with-suicidal-behaviour-and-non-suicidal-self-injury.en?cat-id=3458013>
- Department of Education Western Australia. (2019a). Enrolling in school. Retrieved from <https://www.education.wa.edu.au/enrolling-in-school>
- Department of Education Western Australia. (2019b). School psychology services: Behaviour and wellbeing. Retrieved from <http://det.wa.edu.au/studentsupport/behaviourandwellbeing/detcms/navigation/school-psychology-services/>
- Department of Education Western Australia. (2019c). Pastoral care - behaviour and wellbeing. Retrieved from <http://det.wa.edu.au/studentsupport/behaviourandwellbeing/detcms/school-support-programs/behaviour-and-wellbeing/wellbeing/pc/pastoral-care.en?cat-id=6880976>
- Department of Education Western Australia. (2019d). Additional support for delivering mental health programs in schools. Retrieved from http://det.wa.edu.au/studentsupport/behaviourandwellbeing/detcms/navigation/wellbeing/http--detwaeduau-detcms-school-support-programs-admin-itemjspitem_id19802136-set_tab1-/

- Department of Health Western Australia. (2007). *Community health manual*. (4.5.3.1 Identifying students with mental health problems [SUPERCEDED]). Perth, Western Australia: Author.
- Department of Health Western Australia. (2010). *Community health manual*. (4.5.3.5 Brief interventions in social and emotional wellbeing. [SUPERCEDED]). Perth, Western Australia: Author.
- Department of Health Western Australia. (2018). *WA Youth Health Policy 2018–2023*. Retrieved from https://ww2.health.wa.gov.au/~/_media/Files/Corporate/general%20documents/Youth-Policy/PDF/Youth-policy.pdf
- Department of Health Western Australia. (2019a). *Community health manual: School health*. Retrieved from <https://ww2.health.wa.gov.au/About-us/Child-and-Adolescent-Health-Service/Child-and-Adolescent-Community-Health/Professional-resources/Community-Health-Manual>
- Department of Health Western Australia. (2019b). *Community health manual: Mental health*. (School-aged children). Retrieved from <https://ww2.health.wa.gov.au/About-us/Child-and-Adolescent-Health-Service/Child-and-Adolescent-Community-Health/Professional-resources/Community-Health-Manual>
- Department of Health Western Australia. (2019c). Become an enrolled nurse. Retrieved from <https://ww2.health.wa.gov.au/Careers/Occupations/Nursing-and-midwifery/Become-a-nurse-or-midwife/Become-an-enrolled-nurse>
- DeVylder, J., Yang, L., Harkavy-Friedman, J., Azimov, N., Walder, D., & Corcoran, C. (2014). Assessing depression in youth at clinical high risk for psychosis: A comparison of three measures. *Psychiatry Research*, *215*(2), 323-328. doi:10.1016/j.psychres.2013.12.002
- Dey, I. (1999). *Grounding grounded theory: Guidelines for qualitative enquiry*. California, US: Academic Press.
- Dowdy, E., Furlong, M., Raines, T., Boverly, B., Kauffman, B., Kamphaus, R., . . . Murdock, J. (2015). Enhancing school-based mental health services with a preventive and promotive approach to universal screening for complete

- mental health. *Journal of Educational and Psychological Consultation*, 25(2-3), 178-197. doi:10.1080/10474412.2014.929951
- Downie, J., Chapman, R., Orb, A., & Juliffe, D. (2002). The everyday realities of the multi-dimensional roles of the high school community nurse. *Australian Journal of Advanced Nursing*, 19(3), 15-24. Retrieved from https://espace.curtin.edu.au/bitstream/handle/20.500.11937/12261/19817_downloaded_stream_335.pdf
- Dreyfus, S., & Dreyfus, H. (1980). *A five-stage model of the mental activities involved in directed skill acquisition*. Retrieved from https://www.researchgate.net/publication/235125013_A_Five-Stage_Model_of_the_Mental_Activities_Involved_in_Directed_Skill_Acquisition
- Elliott, N., & Lazenbatt, A. (2005). How to recognise a 'quality' grounded theory research study. *Australian Journal of Advanced Nursing*, 22(3), 48-52. Retrieved from <http://www.ajan.com.au/Vol22/Vol22.3-8.pdf>
- Erskine, H., Moffitt, T., Copeland, W., Costello, E., Ferrari, A., Patton, G., . . . Scott, J. (2015). A heavy burden on young minds: The global burden of mental and substance use disorders in children and youth. *Psychological Medicine*, 45(7), 1551-1563. doi:10.1017/S0033291714002888
- Fagerholt, G. (2009). An overview of the school nursing role in Sweden. *British Journal of School Nursing*, 4(10), 511-514. doi:10.12968/bjsn.2009.4.10.45600
- Federal Government of Australia. (2018). *Disability Discrimination Act 1992. Compilation No. 33*. Retrieved from <https://www.legislation.gov.au/Details/C2018C00125>
- Ferreiro, F., Seoane, G., & Senra, C. (2012). Gender-related risk and protective factors for depressive symptoms and disordered eating in adolescence: A 4-year longitudinal study. *Journal of Youth and Adolescence*, 41(5), 607-622. doi:10.1007/s10964-011-9718-7

- Forlin, C. (2006). Inclusive education in Australia ten years after Salamanca. *European Journal of Psychology of Education, 21*(3), 265. doi:10.1007/bf03173415
- Gearing, R., Schwalbe, C., Lee, R., & Hoagwood, K. (2013). The effectiveness of booster sessions in CBT treatment for child and adolescent mood and anxiety disorders. *Depression and Anxiety, 30*(9), 800-808. doi:10.1002/da.22118
- Gesell, A. (1930). A decade of progress in the mental hygiene of the preschool child. *The Annals of the American Academy of Political and Social Science, 151*(1), 143-148. doi:10.1177/000271623015100119
- Giedd, J., Blumenthal, J., Jeffries, N., Castellanos, F., Liu, H., Zijdenbos, A., . . . Rapoport, J. (1999). Brain development during childhood and adolescence: A longitudinal MRI study. *Nature Neuroscience, 2*, 861-863. doi:10.1038/13158
- Giedd, J., Keshavan, M., & Paus, T. (2008). Why do many psychiatric disorders emerge during adolescence? *Nature Reviews Neuroscience, 9*(12), 947-957. doi:10.1038/nrn2513.
- Glaser, B. (1965). The constant comparative method of qualitative analysis. *Social Problems, 12*(4), 436-445. Retrieved from <https://www.jstor.org/stable/798843>
- Glaser, B. (1978). *Theoretical sensitivity*. Mill Valley, US: Sociology Press.
- Glaser, B. (1992). *Basics of grounded theory analysis: Emergence vs forcing*. Mill Valley, US: Sociology Press.
- Glaser, B. (1994). *More grounded theory methodology: A reader*. Mill Valley, US: Sociology Press.
- Glaser, B. (1998). *Doing grounded theory: Issues and discussions*. Mill Valley, US: Sociology Press.
- Glaser, B. (2001). *The grounded theory perspective: Conceptualisation contrasted with description*. Mill Valley, US: Sociology Press.
- Glaser, B. (2002a). Conceptualization: On theory and theorizing using grounded theory. *International Journal of Qualitative Methods, 1*(2), 1-31. Retrieved from <http://www.ualberta.ca/~ijqm/>

- Glaser, B. (2002b). Constructivist grounded theory? *Forum: Qualitative Social Research*, 3(3). Retrieved from <http://www.qualitative-research.net/index.php/fqs/article/view/825/1792>
- Glaser, B., & Holton, J. (2004). Remodeling grounded theory. *Forum: Qualitative Social Research*, 5(2). doi:10.17169/fqs-5.2.607
- Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New York, US: Aldine de Gruyter.
- Goldenring, J., & Cohen, E. (1988). Getting into adolescent heads. *Contemporary Pediatrics*. Retrieved from <https://www.contemporarypediatrics.com/sites/default/files/legacy/mm/Resource-Centers/GettingintoTeensHeads.pdf>
- Government of Western Australia. (2016). *Department of Health: Code of conduct*. Retrieved from <https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Employment/Mandatory-requirements/Conduct-Ethics-and-Integrity/Code-of-Conduct>
- Government of Western Australia. (2017). *Review of the morale and engagement of clinical staff at Princess Margaret Hospital*. Retrieved from <https://ww2.health.wa.gov.au/Reports-and-publications/Review-of-the-morale-and-engagement-of-clinical-staff-at-Princess-Margaret-Hospital>
- Government of Western Australia. (2018). *Memorandum of Understanding between: The Department of Education and the Department of Health for the provision of school health services for students attending public schools*. Retrieved from <http://det.wa.edu.au/studentsupport/behaviourandwellbeing/detcms/navigation/wellbeing/student-health-care/?tab=Main&page=9#toc9>
- Graff, J. (2014). Mixed methods research. In H. Hall & L. Roussel (Eds.), *Evidence-based practice: An integrative approach to research, administration and practice* (First ed., pp. 45-64). Burlington, US: Jones & Bartlett Learning.
- Graham, A., Phelps, R., Maddison, C., & Fitzgerald, R. (2011). Supporting children's mental health in schools: Teacher views. *Teachers and Teaching*, 17(4), 479-496. doi:10.1080/13540602.2011.580525

- Graham, L., Van Bergen, P., & Sweller, N. (2015). 'To educate you to be smart': Disaffected students and the purpose of school in the (not so clever) 'lucky country'. *Journal of Education Policy*, *30*(2), 237-257.
doi:10.1080/02680939.2014.953596
- Greeson, J., Briggs, E., Kiesel, C., Layne, C., Ake, G., Ko, S., . . . Fairbank, J. (2011). Complex trauma and mental health in children and adolescents placed in foster care: Findings from the National Child Traumatic Stress Network. *Child Welfare*, *90*(6), 91-108. Retrieved from https://works.bepress.com/johanna_greeson/9/
- Gulliver, A., Griffiths, K., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: A systematic review. *BMC Psychiatry*, *10*(1), 113. doi:10.1186/1471-244x-10-113
- Hagell, A., & Rigby, E. (2015). Looking at the effectiveness of prevention and early intervention. *British Journal of School Nursing*, *10*(1), 26-30.
doi:10.12968/bjsn.2015.10.1.26
- Hawton, K., Saunders, K., & O'Connor, R. (2012). Self-harm and suicide in adolescents. *The Lancet*, *379*(9834), 2373-2382. doi:10.1016/S0140-6736(12)60322-5
- headspace. (2019a). Psychosocial assessment. Retrieved from <https://headspace.org.au/health-professionals/clinical-toolkit/psychosocial-assessment/>
- headspace. (2019c\b). Welcome to headspace centres. Retrieved from <https://headspace.org.au/welcome-to-headspace-centres/>
- headspace. (2019c). Funding will help more young Australians seeking mental health support. Retrieved from <https://headspace.org.au/blog/funding-will-help-more-young-australians-seeking-mental-health-support/>
- Health Workforce Australia. (2013). *Australia's health workforce series: Nurses in focus*. Retrieved from <http://pandora.nla.gov.au/pan/133228/20150419-0017/www.hwa.gov.au/sites/default/files/Nurses-in-Focus-FINAL.pdf>
- Hepburn, L., Azrael, D., Molnar, B., & Miller, M. (2012). Bullying and suicidal behaviors among urban high school youth. *Journal of Adolescent Health*, *51*(1), 93-95. doi:10.1016/j.jadohealth.2011.12.014

- Hickie, I., Scott, E., Hermens, D., Naismith, S., Guastella, A., Kaur, M., . . . McGorry, P. (2013). Applying clinical staging to young people who present for mental health care. *Early Intervention in Psychiatry*, 7(1), 31-43. doi:10.1111/j.1751-7893.2012.00366.x
- high stakes. (n.d.). *Cambridge English Dictionary Online*. Retrieved from <https://dictionary.cambridge.org/dictionary/english/high-stakes>
- Hilferty, F., Cassells, R., Muir, K., Duncan, A., Christensen, D., Mitrou, F., . . . Katz, I. (2015). *Is headspace making a difference to young people's lives? Final report of the independent evaluation of the headspace program*. Retrieved from <https://headspace.org.au/assets/Uploads/Evaluation-of-headspace-program.pdf>
- Hirani, K., Cherian, S., Mutch, R., & Payne, D. (2018). Identification of health risk behaviours among adolescent refugees resettling in Western Australia. *Archives of Disease in Childhood*, 103(3), 240. doi:10.1136/archdischild-2017-313451
- Holloway, I. (2008). *A-Z of qualitative research in healthcare*. Chichester, UK: Blackwell Publishing.
- Holman, C., & Coster, H. (1991). *Report of the special consultant on community and child health services*. Perth, Western Australia: Government of Western Australia.
- Holton, J. (2010). The coding process and its challenges. *The Grounded Theory Review*, 9(1), 20-40. Retrieved from <http://groundedtheoryreview.com/2010/04/02/the-coding-process-and-its-challenges/>
- Holton, J., & Walsh, I. (2017). *Classic grounded theory: Applications with qualitative & quantitative data*. doi:10.7748/nr.24.1.8.s5
- Humphrey, N., & Wigelsworth, M. (2016). Making the case for universal school-based mental health screening. *Emotional and Behavioural Difficulties*, 21(1), 22-42. doi:10.1080/13632752.2015.1120051
- Husky, M., Kaplan, A., McGuire, L., Flynn, L., Chrostowski, C., & Olfson, M. (2011). Identifying adolescents at risk through voluntary school-based mental

- health screening. *Journal of Adolescence*, 34(3), 505-511.
doi:10.1016/j.adolescence.2010.05.018
- Husky, M., Sheridan, M., McGuire, L., & Olfson, M. (2011). Mental health screening and follow-up care in public high schools. *Journal of the American Academy of Child & Adolescent Psychiatry*, 50(9), 881-891.
doi:10.1016/j.jaac.2011.05.013
- Illback, R., & Bates, T. (2011). Transforming youth mental health services and supports in Ireland. *Early Intervention in Psychiatry*, 5(Suppl 1), 22-27.
doi:10.1111/j.1751-7893.2010.00236.x
- Ingham-Broomfield, R. (2015). A nurses' guide to qualitative research. *The Australian Journal of Advanced Nursing*, 32(3), 34-40. Retrieved from <http://www.ajan.com.au/Vol32/Issue3/4Broomfield.pdf>
- Insel, T., & Fenton, W. (2005). Psychiatric epidemiology: It's not just about counting anymore. *JAMA Psychiatry*, 62(6). doi:10.1001/archpsyc.62.6.590
- International Association for Youth Mental Health. (2011). *The international declaration on youth mental health*. Retrieved from www.iaymh.org/f.ashx/IDYMH_Long-Version_Oct2013-1-.pdf
- International Association for Youth Mental Health. (2019). IAYMH 2019 Youth Co-Convenors. Retrieved from <https://www.iaymh2019.com/2019-youth-co-convenors/>
- International Union for Health Promotion and Education. (2009). *Achieving health promoting schools: Guidelines for promoting health in schools*. Retrieved from http://www.iuhpe.org/images/PUBLICATIONS/THEMATIC/HPS/HPSGuidelines_ENG.pdf
- Jackson, M. (2009). Understanding links between adolescent health and educational attainment. *Demography*, 46(4), 671-694. doi:10.1353/dem.0.0078
- Jameton, A. (1984). *Nursing practice: The ethical issues*. Englewood Cliffs, US: Prentice-Hall.
- Jameton, A. (2017). What moral distress in nursing history could suggest about the future of health care. *AMA Journal of Ethics*, 19(6), 617-628.
doi:10.1001/journalofethics.2017.19.6.mhst1-1706

- Jorm, A. (2015). How effective are 'headspace' youth mental health services? *Australian and New Zealand Journal of Psychiatry*, 49(10), 861-862. doi:10.1177/0004867415608003
- Jorm, A. (2018). Concerns about the headspace model of youth mental health services. *Psychiatric Services*, 69(7), 838-839. doi:10.1176/appi.ps.69701
- Jorm, A., Korten, A., Jacomb, P., Christensen, H., Rodgers, B., & Pollitt, P. (1997). "Mental health literacy": A survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. *Medical Journal of Australia*, 166(4), 182-186. doi:10.5694/j.1326-5377.1997.tb140071.x
- Kaess, M., Brunner, R., & Chanen, A. (2014). Borderline personality disorder in adolescence. *Pediatrics*, 134(4), 782-793. doi:10.1542/peds.2013-3677
- Kalafat, J. (2003). Adolescents' views of seeking help from school-based adults. *The Prevention Researcher*, 10(4). Retrieved from www.TPRonline.org
- Kaushik, A., Kostaki, E., & Kyriakopoulos, M. (2016). The stigma of mental illness in children and adolescents: A systematic review. *Psychiatry Research*, 243, 469-494. doi:10.1016/j.psychres.2016.04.042
- Kavanaugh, K., & Ayres, L. (1998). "Not as bad as it could have been": Assessing and mitigating harm during research interviews on sensitive topics. *Research in Nursing & Health*, 21(1), 91-97. doi:10.1002/(SICI)1098-240X(199802)21:1<91::AID-NUR10>3.0.CO;2-C
- Keleher, H. (2000). Repeating history? Public and community health nursing in Australia. *Nursing Inquiry*, 7(4), 258-265. doi:10.1046/j.1440-1800.2000.00076.x
- Keleher, H. (2001). Why primary health care offers a more comprehensive approach to tackling health inequities than primary care. *Australian Journal of Primary Health*, 7(2), 57-61. doi:10.1071/PY01035
- Keleher, H. (2003). Public health nursing in Australia - historically invisible. *International History of Nursing Journal*, 7(3), 50-55. Retrieved from <https://search.proquest.com/openview/ed12a661563328ff833eaea8096f190b>

- Kellam, S., & Langevin, D. (2003). A framework for understanding “evidence” in prevention research and programs. *Prevention Science, 4*(3), 137-153. Retrieved from <https://link.springer.com/article/10.1023/A:1024693321963>
- Kemp, L., Harris, E., & Comino, E. (2005). Changes in community nursing in Australia: 1995–2000. *Journal of Advanced Nursing, 49*(3), 307-314. doi:10.1111/j.1365-2648.2004.03289.x
- Kendall, P., Compton, S., Walkup, J., Birmaher, B., Albano, A.-M., Sherrill, J., . . . Piacentini, J. (2010). Clinical characteristics of anxiety disordered youth. *Journal of Anxiety Disorders, 24*(3), 360-365. doi:10.1016/j.janxdis.2010.01.009
- Keshaviah, A., Edkins, K., Hastings, E., Krishna, M., Franko, D., Herzog, D., . . . Eddy, K. (2014). Re-examining premature mortality in anorexia nervosa: A meta-analysis redux. *Comprehensive Psychiatry, 55*(8), 1773-1784. doi:10.1016/j.comppsy.2014.07.017
- Kessler, R., Amminger, G., Aquilar-Gaxiola, S., Alonso, J., Lee, S., & Ustun, T. (2007). Age of onset of mental disorders: A review of recent literature. *Current Opinion in Psychiatry, 20*(4), 359-364. doi:10.1097/YCO.0b013e32816ebc8c
- Kessler, R., McLaughlin, K., Green, J., Gruber, M., Sampson, N., Zaslavsky, A., . . . Williams, D. (2010). Childhood adversities and adult psychopathology in the WHO World Mental Health Surveys. *The British Journal of Psychiatry, 197*(5), 378. doi:10.1192/bjp.bp.110.080499
- Kezelman, C., & Stavropoulos, P. (2012). *Practice guidelines for treatment of complex trauma and trauma informed care and service delivery*. Retrieved from <https://www.childabuseroyalcommission.gov.au>
- Kiefer, G. (1910). The school nurse as an aid to medical inspection of schools. *American Journal of Public Hygiene, 20*(2), 279-281. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2543693/>
- Killackey, E. (2015). Resignation not accepted: Employment, education and training in early intervention, past, present and future. *Early Intervention in Psychiatry, 9*, 429-432. doi:10.1111/eip.12292

- Kitzmann, K., Gaylord, N., Holt, A., & Kenny, E. (2003). Child witnesses to domestic violence: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 71*(2), 339-352. doi:10.1037/0022-006X.71.2.339
- Klein, D., Goldenring, J., & Adelman, W. (2014). HEEADSSSS 3.0: The psychosocial interview for adolescents updated for a new century fueled by media. *Contemporary Pediatrics, 16*-28. Retrieved from <https://www.contemporarypediatrics.com/article/heedsss-30-psychosocial-interview-adolescents-updated-new-century-fueled-media>
- Kolb, S. (2012). Grounded theory and the constant comparative method: Valid research strategies for educators. *Journal of Emerging Trends in Educational Research and Policy Studies, 3*(1), 83-86. Retrieved from https://journals.co.za/content/sl_jeteraps/3/1/EJC135409
- Kongerslev, M., Chanen, A., & Simonsen, E. (2015). Personality disorder in childhood and adolescence come of age: A review of the current evidence and prospects for future research. *Scandinavian Journal of Child and Adolescent Psychiatry and Psychology, 3*(1), 31-48. Retrieved from <https://tidsskrift.dk/sjcapp/article/view/20828/18368>
- Konrad, K., Firk, C., & Uhlhass, P. (2013). Brain development during adolescence: Neuroscientific insights into this developmental period. *Deutsches Arzteblatt International, 110*(25), 425-431. doi:10.3238/arztebl.2013.0425
- Korstjens, I., & Moser, A. (2018). Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice, 24*(1), 120-124. doi:10.1080/13814788.2017.1375092
- Lambert, N. (1964). The high school dropout in elementary school. In *Guidance and the school dropout*. Washington, US: National Education Association of the United States.
- Langford, R., Bonell, C., Jones, H., Poulou, T., Murphy, S., Waters, E., . . . Campbell, R. (2015). The World Health Organization's Health Promoting Schools framework: A Cochrane systematic review and meta-analysis. *BMC Public Health, 15*, 130. doi:10.1186/s12889-015-1360-y

- Lawrence, D., Johnson, S., Hafekost, J., Boterhoven De Haan, K., Sawyer, M., Ainley, J., & Zubrick, S. (2015). *The mental health of children and adolescents. Report on the second Australian child and adolescent survey of mental health and wellbeing*. Retrieved from <https://www.health.gov.au/internet/main/publishing.nsf/Content/9DA8CA21306FE6EDCA257E2700016945/%24File/child2.pdf>
- Lazarus, R., & Folkman, S. (1984). Coping and adaptation. In W. D. Gentry (Ed.), *The handbook of behavioral medicine* (pp. 282-325). New York, US: Guildford Press.
- left holding the baby. (n.d.). *Collins English Dictionary*. Retrieved from <https://www.collinsdictionary.com/dictionary/english/be-left-holding-the-baby>
- Levitt, J., Saka, N., Hunter Romanelli, L., & Hoagwood, K. (2007). Early identification of mental health problems in schools: The status of instrumentation. *Journal of School Psychology, 45*(2), 163-191. doi:10.1016/j.jsp.2006.11.005
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Washington, US: Sage Publications.
- Madsen, W. (2008). Looking to the future: Early twentieth-century school nursing in Queensland. *Contemporary Nurse, 30*(2), 133-141. doi:10.5172/conu.673.30.2.133
- Mareš, J. (2016). Moral distress: Terminology, theories and models. *Kontakt, 18*(3), e137-e144. doi:10.1016/j.kontakt.2016.07.001
- Marmot, M. (1993). Epidemiological approach to the explanation of social differentiation in mortality: The Whitehall Studies. *Sozial-und Präventivmedizin, 38*(5), 271-279. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/8256529>
- Marmot, M. (2005). Social determinants of health inequalities. *The Lancet, 365*, 1099-1104. doi:10.1016/S0140-6736(05)71146-6
- Marmot, M. (2015). The health gap: The challenge of an unequal world. *The Lancet, 386*(10011), 2442-2444. doi:10.1016/S0140-6736(15)00150-6

- Marmot, M., Friel, S., Bell, R., Houweling, T., & Taylor, S. (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. *The Lancet*, *372*, 1661-1669. doi:10.1016/S0140-6736(08)61690-6
- Marmot, M., Stansfeld, S., Patel, C., North, F., Head, J., White, I., . . . Smith, G. (1991). Health inequalities among British civil servants: The Whitehall II study. *The Lancet*, *337*, 1387-1393. doi:10.1016/0140-6736(91)93068-K
- Maternal, Child and Family Health Nurses Australia. (2019). MCaFNA. Retrieved from <https://www.mcafhna.org.au/>
- Maughan, E., Bobo, N., Butler, S., Schantz, S., & Schoessler, S. (2015). Framework for 21st century school nursing practice: An overview. *NASN School Nurse*, *30*(4), 218–231. doi:10.1177/1942602X15589559
- Maughan, E., Johnson, K., & Bergren, M. (2018). Introducing NASN’s new data initiative: National school health data set: Every student counts! Make this your year of data. *NASN School Nurse*, *33*(5), 291-294. doi:10.1177/1942602X18791572
- Mazzer, K., & Rickwood, D. (2015). Teachers' role breadth and perceived efficacy in supporting student mental health. *Advances in School Mental Health Promotion*, *8*(1), 29-41. doi:10.1080/1754730X.2014.978119
- McCann, T., & Clark, E. (2003a). Grounded theory in nursing research: Part 1 - Methodology. *Nurse Researcher*, *11*(2), 7-18. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/14708425>
- McCann, T., & Clark, E. (2003b). Grounded theory in nursing research: Part 2 - Critique. *Nurse Researcher*, *11*(2), 19-28. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/14708426>
- McCluskey, A. (2015). *The formative evaluation of a practice framework for nurses working in secondary schools*. (PhD). Curtin University. Retrieved from: https://espace.curtin.edu.au/bitstream/handle/20.500.11937/998/234319_McCluskey%202015.pdf
- McCluskey, A., Kendall, G., & Burns, S. (2018). Students’, parents’ and teachers’ views about the resources required by school nurses in Perth, Western

- Australia. *Journal of Research in Nursing*, (Online first).
doi:10.1177/1744987118807250
- McGorry, P. (2009). Should youth mental health become a specialty in its own right? Yes. *British Medical Journal*, 339(b3373). doi:10.1136/bmj.b3373
- McGorry, P. (2017). Youth mental health and mental wealth: Reaping the rewards. *Australasian Psychiatry*, 25(2), 101-103. doi:10.1177/1039856217694768
- McGorry, P., Bates, T., & Birchwood, M. (2013). Designing youth mental health services for the 21st century: Examples from Australia, Ireland and the UK. *The British Journal of Psychiatry*, 202(s54), s30.
doi:10.1192/bjp.bp.112.119214
- McGorry, P., & Nelson, B. (2016). Why we need a transdiagnostic staging approach to emerging psychopathology, early diagnosis, and treatment. *JAMA Psychiatry*, 73(3), 191-192. doi:10.1001/jamapsychiatry.2015.2868
- McGorry, P., Purcell, R., Hickie, I., Yung, A., Pantelis, C., & Jackson, H. (2007). Clinical staging: A heuristic model for psychiatry and youth mental health. *Medical Journal of Australia*, 187(7), 40. doi:10.5694/j.1326-5377.2007.tb01335.x
- McGorry, P., Tanti, C., Stokes, R., Hickie, I., Carnell, K., Littlefield, L., & Moran, J. (2007). headspace: Australia's National Youth Mental Health Foundation - where young minds come first. *Medical Journal of Australia*, 187(7 Suppl), S68-70. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/17908032>
- McGorry, P., & van Os, J. (2013). Redeeming diagnosis in psychiatry: Timing versus specificity. *The Lancet*, 381(9863), 343-345. doi:10.1016/s0140-6736(12)61268-9
- McMurray, A., & Clendon, J. (2011). *Community health and wellness: Primary health care in practice*. Sydney, Australia: Elsevier.
- Meltzer, H., Vostanis, P., Ford, T., Bebbington, P., & Dennis, M. S. (2011). Victims of bullying in childhood and suicide attempts in adulthood. *European Psychiatry*, 26(8), 498-503. doi:10.1016/j.eurpsy.2010.11.006
- Mental Health Commission Western Australia. (2015). *Better choices. Better lives. Western Australian mental health, alcohol and other drug services plan*

- 2015-2025. Retrieved from https://www.mhc.wa.gov.au/media/1301/the-plan_final.pdf
- Mental Health Coordinating Council. (2014). *Recovery for young people: Recovery orientation in youth mental health and child and adolescent mental health services (CAMHS): Discussion Paper*. Retrieved from <https://www.mhcc.org.au/wp-content/uploads/2018/05/mhccrecoveryforyoungpeople-discussionpaper.pdf>
- Meyer, N., & MacCabe, J. (2016). Schizophrenia. *Medicine*, *44*(11), 649-653. doi:10.1016/j.mpmed.2016.08.003
- Michael, S., Merlo, C., Barsch, C., Wentzel, K., & Wechsler, H. (2015). Critical connections: Health and academics. *Journal of School Health*, *85*(11), 740-758. doi:10.1111/josh.12309
- Millan, M., Andrieux, A., Bartzokis, G., Cadenhead, K., Dazzan, P., Fusar-Poli, P., . . . Weinberger, D. (2016). Altering the course of schizophrenia: Progress and perspectives. *15*(7), 485-515. doi:10.1038/nrd.2016.28
- Morse, W. (1964). *Public school classes for the emotionally handicapped: A research analysis*. doi:10.1177/001440296703300611
- Mrazek, P., & Haggerty, R. (1994). *Reducing risks for mental disorders: Frontiers for preventive intervention research*. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/25144015>
- Nathaniel, A. (2006). Moral reckoning in nursing. *Western Journal of Nursing Research*, *28*(4), 419-448. doi:10.1177/0193945905284727
- National Health and Medical Research Council. (2018). *National statement on ethical conduct in human research 2007 (Updated 2018)*. Retrieved from <https://www.nhmrc.gov.au/about-us/publications/national-statement-ethical-conduct-human-research-2007-updated-2018>
- Nelson, B., Yuen, H., Lin, A., Wood, S., McGorry, P., Hartmann, J., & Yung, A. (2016). Further examination of the reducing transition rate in ultra high risk for psychosis samples: The possible role of earlier intervention. *Schizophrenia Research*, *174*(1-3), 43-49. doi:10.1016/j.schres.2016.04.040

- Newton-Howes, G., Clark, L. A., & Chanen, A. (2015). Personality disorder across the life course. *The Lancet*, 385(9969), 727-734. doi:10.1016/S0140-6736(14)61283-6
- Nicholson, W. (2012). Introducing the new vision and model for school nursing. *British Journal of School Nursing*, 7(3), 114-116. doi:10.12968/bjsn.2012.7.3.114
- Nieswiadomy, R. (2014). Qualitative research designs. In *Foundations of Nursing Research* (6th ed., pp. 171-184). Harlow, UK: Pearson New International Edition.
- O'Hara, M. (1988). Child health in the interwar years, 1920-1939. In P. Hetherington (Ed.), *Childhood in Society in Western Australia* (pp. 174-186). Perth, Western Australia: University of Western Australia.
- Ombudsman Western Australia. (2014). *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people*. Retrieved from <http://www.ombudsman.wa.gov.au/Publications/Documents/reports/Suicide-by-young-people/Ombudsman-WA-Suicide-by-Young-People-Investigation-Report-2014.pdf>
- opening Pandora's Box. (n.d.). *Collins English Dictionary*. Retrieved from <https://www.collinsdictionary.com/dictionary/english/open-pandoras-box>
- Orygen Youth Health Research Centre. (2014). *Tell them they're dreaming: Work, education and young people with mental illness in Australia*. Retrieved from <https://www.orygen.org.au/Policy-Advocacy/Policy-Reports/Work-Education-Young-People/tell-them-theyre-dreaming-view?ext=>.
- Orygen Youth Health Research Centre. (2016). *How to partner with young people*. Retrieved from <https://www.orygen.org.au/About/Youth-Engagement/Resources/YouthPartnershipToolkit.aspx>
- Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health*, 42(5), 533-544. doi:10.1007/s10488-013-0528-y

- Patton, G., Coffey, C., Romaniuk, H., Mackinnon, A., Carlin, J., Degenhardt, L., . . . Moran, P. (2014). The prognosis of common mental disorders in adolescents: A 14-year prospective cohort study. *The Lancet*, 383(9926), 1404-1411. doi:10.1016/S0140-6736(13)62116-9
- Patton, G., Sawyer, S., Santelli, J., Ross, D., Afifi, R., Allen, N., . . . Viner, R. (2016). Our future: A Lancet commission on adolescent health and wellbeing. *The Lancet*, 387. doi:10.1016/S0140-6736(16)00579-1
- Pinquart, M., & Shen, Y. (2011). Behavior problems in children and adolescents with chronic physical illness: A meta-analysis. *Journal of Pediatric Psychology*, 36(9), 1003-1016. doi:10.1093/jpepsy/jsr042
- Popovic, D., Benabarre, A., Crespo, J. M., Goikolea, J. M., González-Pinto, A., Gutiérrez-Rojas, L., . . . Vieta, E. (2014). Risk factors for suicide in schizophrenia: Systematic review and clinical recommendations. *Acta Psychiatrica Scandinavica*, 130(6), 418-426. doi:10.1111/acps.12332
- Powell, S., Engelke, M., & Swanson, M. (2018). Moral distress among school nurses. *The Journal of School Nursing*, 34(5), 390-397. doi:10.1177/1059840517704965
- prioritising. (n.d.). *Collins English Dictionary*. Retrieved from <https://www.collinsdictionary.com/dictionary/english/prioritising>
- Prymachuk, S., Graham, T., Haddad, M., & Tylee, A. (2012). School nurses' perspectives on managing mental health problems in children and young people. *Journal of Clinical Nursing*, 21(5-6), 850-859. doi:10.1111/j.1365-2702.2011.03838.x
- QSR International. (2016). NVIVO 11 qualitative data analysis software (Version 11.4.1.1064 (64 bit)). Retrieved from <http://www.qsrinternational.com/>
- Rafael, A. (2000). Watson's philosophy, science, and Theory of Human Caring as a conceptual framework for guiding community health nursing practice. *Advances in Nursing Science*, 23(2), 34-49. doi:10.1891/9780826171122.0030

- Ravenna, J., & Cleaver, K. (2016). School nurses' experiences of managing young people with mental health problems: A scoping review. *Journal of School Nursing, 32*(1), 58-70. doi:10.1177/1059840515620281
- reading between the lines. (n.d.). *Cambridge English Dictionary Online*. Retrieved from <https://dictionary.cambridge.org/dictionary/english/read-between-the-lines>
- Reupert, A., Maybery, D., & Kowalenko, N. (2012). Children whose parents have a mental illness: Prevalence, need and treatment. *Medical Journal of Australia, 199*(3), S7-S9. doi:10.5694/mjao11.11200
- Rickwood, D., Mazzer, K., & Telford, N. (2015). Social influences on seeking help from mental health services, in-person and online, during adolescence and young adulthood. *BMC Psychiatry, 15*(1), 40. doi:10.1186/s12888-015-0429-6
- Rickwood, D., Mazzer, K., Telford, N., Parker, A., Tanti, C., & McGorry, P. (2015). Changes in psychological distress and psychosocial functioning in young people visiting headspace centres for mental health problems. *Medical Journal of Australia, 202*(10), 537-542. doi:10.5694/mja14.01 696
- Rimal, D., Huang Fu, J., & Gillett, D. (2017). Our experience in using telehealth for paediatric plastic surgery in Western Australia. *ANZ Journal of Surgery, 87*(4), 277-281. doi:10.1111/ans.13925
- Rittel, H., & Webber, M. (1973). Dilemmas in a general theory of planning. *Policy Sciences, 4*(2), 155-169. doi:10.1007/BF01405730
- Robinson, J., McCutcheon, L., Browne, V., & Witt, K. (2016). *Looking the other way: Young people and self-harm*. Retrieved from <https://www.orygen.org.au/Policy-Advocacy/Policy-Reports/Looking-the-Other-Way/Orygen-Looking-the-Other-Way-Young-People-and-Self>
- Rockhill, C., Kodish, I., DiBattisto, C., Macias, M., Varley, C., & Ryan, S. (2010). Anxiety disorders in children and adolescents. *Current Problems in Pediatric and Adolescent Health Care, 40*(4), 66-99. doi:10.1016/j.cppeds.2010.02.002
- Rutter, M., Graham, P., Chadwick, O., & Yule, W. (1976). Adolescent turmoil: Fact or fiction? *Journal of Child Psychology and Psychiatry, 17*(1), 35-56. doi:10.1111/j.1469-7610.1976.tb00372.x

- Sabbioni, D., Feehan, S., Nicholls, C., Soong, W., Rigoli, D., Follett, D., . . . Waters, F. (2018). Providing culturally informed mental health services to Aboriginal youth: The YouthLink model in Western Australia. *Early Intervention in Psychiatry, 12*(5), 987-994. doi:10.1111/eip.12563
- Santelli, J., Klein, J., Song, X., Heitel, J., Grilo, S., Wang, M., . . . Schneider, M. (2019). Discussion of potentially sensitive topics with young people. *Pediatrics, 143*(2), e20181403. doi:10.1542/peds.2018-1403
- Sawyer, M., Harchak, T., Spence, S., Bond, L., Graetz, B., Kay, D., . . . Sheffield, J. (2010). School-based prevention of depression: A 2-year follow-up of a randomized controlled trial of the 'beyondblue' schools research initiative. *Journal of Adolescent Health, 47*(3), 297-304. doi:10.1016/j.jadohealth.2010.02.007
- Sawyer, M., Pfeiffer, S., Spence, S., Bond, L., Graetz, B., Kay, D., . . . Sheffield, J. (2010). School-based prevention of depression: A randomised controlled study of the 'beyondblue' schools research initiative. *Journal of Child Psychology and Psychiatry, 51*(2), 199-209. doi:10.1111/j.1469-7610.2009.02136.x
- Schmidt, A., Cappucciati, M., Radua, J., Rutigliano, G., Rocchetti, M., Dell'Osso, L., . . . Fusar-Poli, P. (2016). Improving prognostic accuracy in subjects at clinical high risk for psychosis: Systematic review of predictive models and meta-analytical sequential testing simulation. *Schizophrenia Bulletin, 43*(2), 375-388. doi:10.1093/schbul/sbw098
- Scollo, M., & Winstanley, M. (2019). *Tobacco in Australia: Facts & issues*. Retrieved from <https://www.tobaccoinaustralia.org.au>
- Sendall, M., Fleming, M., & Lidstone, J. (2011). Conceptions of school-based youth health nursing. *British Journal of School Nursing, 6*(6), 294-303. doi:10.12968/bjsn.2011.6.6.294
- Sendall, M., Fleming, M., Lidstone, J., & Domocol, M. (2014). School based youth health nurses and attrition: The reasons for moving on. *Community Practitioner, 87*(8), 30-34. Retrieved from <http://www.proquest.com>

- Sendall, M. C. (2009). *Conceptions of school based youth health nursing: A phenomenographic study*. (PhD). Queensland University of Technology. Retrieved from: <https://eprints.qut.edu.au/29653/>
- Shanahan, L., Zucker, N., Copeland, W., Bondy, C., Egger, H., & Costello, E. (2015). Childhood somatic complaints predict generalized anxiety and depressive disorders during young adulthood in a community sample. *Psychological Medicine*, 45(08), 1721-1730. doi:10.1017/s0033291714002840
- Sharp, T. (2018). The virtual meeting room: Telehealth antenatal education and networking for rural women. *Women and Birth*, 31(1), S7. doi:10.1016/j.wombi.2018.08.030
- Sharpe, H., Ford, T., Lereya, S., Owen, C., Viner, R., & Wolpert, M. (2016). Survey of schools' work with child and adolescent mental health across England: A system in need of support. *Child and Adolescent Mental Health*, 21(3), 148-153. doi:10.1111/camh.12166
- Simmons, D. (2002). Autonomy in practice: A qualitative study of school nurses' perceptions. *Journal of School Nursing*, 18(2), 87-94. doi:10.1177/10598405020180020501
- Smink, F., van Hoeken, D., & Hoek, H. (2012). Epidemiology of eating disorders: Incidence, prevalence and mortality rates. *Current Psychiatry Reports*, 14(4), 406-414. doi:10.1007/s11920-012-0282-y
- Smith, C. (2012). Mental health and help-seeking in adolescence. *Australian Epidemiologist*, 19(1), 5-8. Retrieved from <https://search.informit.com.au/documentSummary;dn=851777256865445;res=IELHEA>
- Soliman, J., & Kan, M. (2004). *Grounded theory and NVIVO: Wars and wins*. Paper presented at the Proceedings of QuallT2004: International conference on qualitative research in it & it in qualitative research: 24-26 November 2004, Brisbane, Australia. Retrieved from <https://opus.lib.uts.edu.au/bitstream/10453/7157/1/2004001837.pdf>
- Sonuga-Barke, E., Kennedy, M., Kumsta, R., Knights, N., Golm, D., Rutter, M., . . . Kreppner, J. (2017). Child-to-adult neurodevelopmental and mental health trajectories after early life deprivation: The young adult follow-up of the

- longitudinal English and Romanian adoptees study. *The Lancet*, 389(10078). doi:10.1016/S0140-6736(17)30045-4
- Spencer, N. (2018). The social determinants of child health. *Paediatrics and Child Health*, 28(3), 138-143. doi:10.1016/j.paed.2018.01.001
- Stirrups, R. (2018). The storm and stress in the adolescent brain. *The Lancet Neurology*, 17(5), 404. doi:10.1016/S1474-4422(18)30112-1
- strategic. (n.d.). *Cambridge English Dictionary Online*. Retrieved from <https://dictionary.cambridge.org/dictionary/english/strategic>
- Strauss, A., & Corbin, J. (1994). Grounded theory methodology: An overview. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (pp. 273-285). Thousand Oaks, US: Sage Publications.
- Strauss, P., Cook, A., Winter, S., Watson, V., Wright Toussaint, & Lin, A. (2017). *Trans Pathways: The mental health experiences and care pathways of trans young people. Summary of results*. Retrieved from <https://www.telethonkids.org.au/globalassets/media/documents/brain--behaviour/trans-pathwayreport-web2.pdf>
- Swanson, M. (1939). What does a school nurse do, anyway? *The American Journal of Nursing*, 39(956). Retrieved from <https://www.jstor.org/stable/3413433>
- tactical. (n.d.). *Merriam-Webster English Dictionary*. Retrieved from <https://www.merriam-webster.com/dictionary/tactics>
- Thapar, A., Collishaw, S., Pine, D., & Thapar, A. (2012). Depression in adolescence. *The Lancet*, 379(9820), 1056-1067. doi:10.1016/S0140-6736(11)60871-4
- Tsiachristas, A., Thomas, T., Leal, J., & Lennox, B. (2016). Economic impact of early intervention in psychosis services: Results from a longitudinal retrospective controlled study in England. *British Medical Journal Open*, 6(10). doi:10.1136/bmjopen-2016-012611
- Turunen, H., Sormunen, M., Jourdan, D., von Seelen, J., & Buijs, G. (2017). Health promoting schools — A complex approach and a major means to health improvement. *Health Promotion International*, 32(2), 177-184. doi:10.1093/heapro/dax001

- United Nations Educational, Scientific and Cultural Organization. (2016a). Youth definition: UNESCO. Retrieved from <http://www.unesco.org/new/en/social-and-human-sciences/themes/youth/youth-definition/>
- United Nations Educational, Scientific and Cultural Organization. (2016b). The right to education. Retrieved from <http://www.unesco.org/new/en/right2education>
- United Nations Population Fund. (2016). Adolescent and youth demographics: A brief overview. Retrieved from <http://www.unfpa.org/sites/default/files/resource-pdf/One%20pager%20on%20youth%20demographics%20GF.pdf>
- untenable. (n.d.). *Dictionary.com*. Retrieved from <https://www.dictionary.com/browse/untenable>
- van der Gaag, M., Smit, F., Bechdolf, A., French, P., Linszen, D., Yung, A., . . . Cuijpers, P. (2013). Preventing a first episode of psychosis: Meta-analysis of randomized controlled prevention trials of 12 month and longer-term follow-ups. *Schizophrenia Research, 149*(1-3), 56-62. doi:10.1016/j.schres.2013.07.004
- van der Kolk, B. (2005). Developmental trauma disorder: Towards a rational diagnosis for children with complex trauma histories. *Psychiatric Annals, 35*(5), 401-408. Retrieved from <https://psycnet.apa.org/record/2005-05449-005>
- Van Orden, K., Witte, T., Cukrowicz, K., Braithwaite, S., Selby, E., & Joiner, T. (2010). The interpersonal theory of suicide. *Psychological Review, 117*(2), 575-600. doi:10.1037/a0018697
- Velasquez, A., West, R., Graham, C., & Osguthorpe, R. (2013). Developing caring relationships in schools: A review of the research on caring and nurturing pedagogies. *Review of Education, 1*(2), 162-190. doi:10.1002/rev3.3014
- Viner, R., Ozer, E., Denny, S., Marmot, M., Resnick, M., Fatusi, A., & Currie, C. (2012). Adolescence and the social determinants of health. *The Lancet, 379*(9826), 1641-1652. doi:10.1016/s0140-6736(12)60149-4
- Volpe, U., Tortorella, A., Manchia, M., Monteleone, A. M., Albert, U., & Monteleone, P. (2016). Eating disorders: What age at onset? *Psychiatry Research, 238*, 225-227. doi:10.1016/j.psychres.2016.02.048

- Walker, D., & Myrick, F. (2006). Grounded theory: An exploration of process and procedure. *Qualitative Health Research, 16*(4), 547-559.
doi:10.1177/1049732305285972
- Ward, K., Gott, M., & Hoare, K. (2015). Participants' views of telephone interviews within a grounded theory study. *Journal of Advanced Nursing, 71*(12), 2775-2785. doi:10.1111/jan.12748
- Watson, J. (1979). Nursing: The philosophy and science of caring. *Nursing Administration Quarterly, 3*(4), 86-87. Retrieved from <http://www.ovid.com>
- Watson, J. (1988a). Nursing: Human science and human care. A theory of nursing. *NLN Publications, 1*-104. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/3375032>
- Watson, J. (1988b). *Nursing: Human science and human care. A theory of nursing.* Sudbury, US: Jones & Bartlett Learning.
- Watson, J. (1997). The theory of human caring: Retrospective and prospective. *Nursing Science Quarterly, 10*(1), 49-52. doi:10.1177/089431849701000114
- Weare, K., & Nind, M. (2011). Mental health promotion and problem prevention in schools: What does the evidence say? *Health Promotion International, 26*(suppl 1), i29-i69. doi:10.1093/heapro/dar075
- Wei, Y., Hayden, J., Kutcher, S., Zygmunt, A., & McGrath, P. (2013). The effectiveness of school mental health literacy programs to address knowledge, attitudes and help seeking among youth. *Early Intervention in Psychiatry, 7*(2), 109-121. doi:10.1111/eip.12010
- Western Australian Legislation. (1984). *WA Occupational Health, Safety and Welfare Act 1984.* Retrieved from https://www.legislation.wa.gov.au/legislation/statutes.nsf/main_mrtile_650_homepage.html
- Whear, R., Marlow, R., Boddy, K., Ukoumunne, O. C., Parker, C., Ford, T., . . . Stein, K. (2013). Psychiatric disorder or impairing psychology in children who have been excluded from school: A systematic review. *School Psychology International, 35*(5), 530-543. doi:10.1177/0143034313517451

- White, J. (2012). Youth suicide as a “wild” problem: Implications for prevention practice. *Suicidology Online*, 3, 42-50. Retrieved from <http://www.suicidology-online.com/pdf/SOL-2012-3-42-50.pdf>
- Wilkinson, R., & Marmot, M. (2003). *Social determinants of health: The solid facts*. Retrieved from http://www.euro.who.int/__data/assets/pdf_file/0005/98438/e81384.pdf
- Willig, C. (2013). Chapter 7: Grounded theory methodology. In *Introducing Qualitative Research in Psychology* (3rd ed., pp. 69-82). Milton Keynes, UK: Open University Press.
- Wolff, J. (2011). How should governments respond to the social determinants of health? *Preventive Medicine*, 53(4), 253-255. doi:10.1016/j.ypmed.2011.07.008
- World Health Organisation. (1978). *Declaration of Alma-Ata*. Paper presented at the International Conference on Primary Health Care, Alma Ata, USSR.
- World Health Organisation. (1986). *The Ottawa Charter for health promotion*. Retrieved from https://www.healthpromotion.org.au/images/ottawa_charter_hp.pdf
- World Health Organisation. (2014). *Health for the world's adolescents: A second chance in the second decade*. Retrieved from www.who.int/adolescent/second-decade
- World Health Organisation. (2016). *International statistical classification of diseases and related health problems*. (10th ed.). Geneva, Switzerland: World Health Organisation.
- World Health Organisation. (2019). *WHO: Suicide data*. Retrieved from https://www.who.int/mental_health/prevention/suicide/suicideprevent/en/
- Wright, J. (2011). Public health reform and the emergence of school nursing. *British Journal of School Nursing*, 6(6), 304-305. doi:10.12968/bjsn.2011.6.6.304
- Zimmerman, E., & Woolf, S. (2014). *Understanding the relationship between education and health. Discussion Paper*. Retrieved from <https://nam.edu/wp-content/uploads/2015/06/BPH-UnderstandingTheRelationship1.pdf>

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ORAL PRESENTATIONS

1. Candidacy Presentation
Curtin University, November 30, 2016
2. Mark Liveris Research Seminar
Curtin University, September 27, 2018
3. Professorial Meeting
Curtin University, October 16, 2018
4. Mark Liveris Research Seminar (Winner of the Judges Award)
Curtin University, March 27, 2019
5. PhD Milestone Two (Study Implementation)
Curtin University, May 15, 2019
6. Community Health Nursing Leadership Group
Child and Adolescent Health Service, August 9, 2019
7. Community of Practice
Child and Adolescent Health Service, August 21, 2019
8. PhD Milestone Three (Study Findings)
Curtin University, September 18, 2019
9. School Nursing Australia Conference
Marriott Hotel, Sydney, October 1, 2019
10. (*Upcoming*) Nursing and Midwifery Leadership Conference,
Crown, Perth, November 28 & 29, 2019