WHAT IS THE CULTURE (I.E., VALUES AND BELIEFS) OF A PEDIATRIC EMERGENCY DEPARTMENT (ED) IN PROVIDING CARE TO CHILDREN/YOUTH WHO ARRIVE IN THE ED PRIMARILY FOR CARE REGARDING A MENTAL HEALTH CONCERN?

by

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DEDICATION PAGE

I would like to dedicate this study to the twelve people who bravely volunteered to be interviewed for this study. It would not have been possible without their willingness to share these deeply personal, emotionally charged stories. They trusted me to enter their lives and I was very privileged, and am most appreciative.

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ABSTRACT

Children/youth with mental health concerns are presenting to Pediatric Emergency Departments (ED) at increasing rates. Staff in the ED feel ill equipped to provide care. The introduction of the Emergency Mental Health and Addiction Service (EMHAS) team in the IWK Health Centre ED, gave opportunity to explore the ED culture. This study posed 'what is the culture (i.e., values and beliefs) of a Pediatric ED in providing care to children/youth who arrive in the ED primarily for a mental health concern?' Ethnography was used and employed three methods of data collection. Themes reflecting *culture* emerged: *Shared history of Violence: Fear; Environment: Dismissive; Two cultures: Total Opposites but a Common Patient Goal; Shared Ideations, and Seeking Clarity*. Themes came together under an overarching theme, *Confusion: Seeking Meaning.* Introduction of the EMHAS has challenged the ED culture. While this has created confusion, both teams share a common patient goal.

LIST OF ABBREVIATIONS USED

AAP	American Academy of Pediatrics
ACEM	Australian College for Emergency Medicine
'BLUE DESK'	IWK Health Centre ED Nursing Station
CHEO	Children's Hospital of Eastern Ontario
CMH	Community Mental Health
CSP	Cultural Systems Paradigm
CTAS	Canadian Triage and Acuity Scale
DSM IV	Diagnostic and Statistical Manual of Mental Disorders
ECA	Ethnographic Content Analysis
ED	Emergency Department
EMHAS	Emergency Mental Health and Addiction Services
EAP	Employee Assistance Program
ERP	Emergency Room Physician
FTE	Full-Time-Equivalent
GP	General Practioner
ICU	Intensive Care Unit
OP3	One Province, One Process, One Policy
PHC	Primary Health Care
RN	Registered Nurse
'ROOM #5'	Assessment Room in ED Designated for EMHAS Team
UCC	Urgent Care Clinic
WHO	World Health Organization

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Chapter I

INTODUCTION

While Pediatric Emergency Departments (EDs) are designed to address urgent medical needs (physical and mental health), patients with mental health concerns who visit the ED often do not receive the necessary care for either their physical or mental health needs (Pope, 2011). Upon entry, children/youth with a mental health concern require care from emergency staff who are better equipped for, and feel more comfortable in dealing with, acute physical illness and injury than managing behavioral, psychiatric, or complex social issues (Ross, 2009). ED staff has been shown to have generalized uncertainty and lack of confidence in their interaction with mental health patients (Stewart et al., 2006). Many pediatricians feel responsible for recognizing mental health concerns in their patients but are uncomfortable initiating treatment (Grupp-Phelan et al., 2007).

Indeed, ED staff state that children/youth with mental health concerns present some of the most challenging clinical situations (Shafiei et al., 2011). The competing demands of caring for the acute medical emergencies along with limitations of time, inadequate psychiatric training, limited ED space, and limited access to inpatient and outpatient specialized psychiatric resources are significant barriers to ED professionals when trying to provide appropriate and necessary mental health care, and may discourage ED professionals from addressing mental health concerns in the ED (Cronholm et al., 2010., Grupp-Phelan et al., 2009., Santiago et al., 2006., Stewart et al., 2006). Once a psychiatric evaluation is complete, inpatient beds often are unavailable, requiring patients to 'board' in the ED for hours or days while awaiting placement in an appropriate inpatient setting (Meunier-Sham & Needham, 2003).

Two separate teams provide mental health care to children/youth in the ED at the IWK Health Centre, which is where I conducted this study. ED mental health and addictions assessment and

treatment was conducted collaboratively between the Emergency Mental Health and Addiction Service team (EMHAS) (registered nurses, masters prepared social workers) along with psychiatry (residents, psychiatrists) consultation, protection services, and ED staff (physicians, registered nurses) (IWK Health Centre, IWK Psychiatry Services, IWK Emergency Service, 2014). The difference between the two teams was that the EMHAS deals primarily with children/youth who arrived to the ED for both mental health assessment and intervention, while the ED staff dealt primarily with medical facets of presentations to the ED.

Studies have identified a perceived lack of knowledge and comfort in addressing children/youth with psychiatric problems as a source of distress for ED staff nurses (Falsafi, 2001). Limited access to psychiatric staff in the ED, lack of referral psychiatric services in the community, lack of knowledge and confidence among ED staff in caring for patients with mental health concerns, and minimal collaboration between the EMHAS staff and ED staff may contribute to this distress (Cronholm et al, 2010., Grupp-Phelan et al., 2009, Santiago et al., 2006., Stewart et al., 2006). In addition, most emergency physician training programs and pediatric emergency medicine subspecialty training programs do not require standardized training in psychiatric-related conditions. Thus care for children/youth with mental health concerns may be compromised (Mahajan et al., 2009).

There is a growing body of evidence suggesting that individuals with mental health concerns, compared to those without mental health concerns, receive less adequate physical care while in the ED (Pope, 2011). Longstanding reports that few children and youth receive timely and necessary mental health services have had limited effect on multilevel system changes, and a shortage of mental health services remains (Newton et al., 2011). There is value to both physical *and* mental health intervention for pediatric mental health ED visits. Physical assessments for mental health patients explored comorbid somatic concerns and underlying physiological complications and rule out differential

diagnoses, whereas mental health assessments address primary risks, and can identify needs not necessarily articulated by the child or family (Newton et al.).

In addition, while the ED environment is characteristically hectic, which may contribute to the inadequate physical care for children/youth with mental health concerns (Shafiei et al., 2011), the environmental chaos is not the only contributing factor. Other barriers also played a role; healthcare professionals' stigmatizing attitudes and their beliefs that the patient's complaints were psychosomatic (Goldman, 1999); and a disconnect between the expectations of mental health care in the ED between mental health patients, families, and ED staff.

Cloutier et al., (2010) reported that while most parents were unclear about which specific services they wanted or needed when they brought their child to the ED, they all expressed a need for immediate help. Cloutier et al.'s study also reported that parent's used ED services both as a center for information and advice, as well as the access point to other mental health services. Sealy & Whitehead (2006) also reported that the majority of patients and their families accessed mental health services because they wanted to learn about practical solutions to problems and/or about mental illness and the side effects of medication, to be given an opportunity to talk to others about similar experiences, and to seek help for their psychiatric disorders when their symptoms and disabilities interfere with their daily functioning.

Sadly, many children/youth with mental health concerns do not seek treatment at all for mental health concerns because of the associated stigma, or because they do not know where to turn for help, or because services simply do not exist (Canadian Alliance on Mental Illness and Mental Health (CAMIMH), 2000). Children with recognized mental health concerns often have had difficulty accessing mental health services due to inadequate numbers of providers, poor mental health service coverage, and inconvenient hours of service, making the ED at times the most accessible, or only,

route to services (Grupp-Phelan et al., 2007). The urban, inner-city Pediatric ED, with 24-hour availability of emergency and subspecialty services, is often the main point of access to health care for many families (Grupp-Phelan et al.). For families lacking primary care attachment, the ED may serve as the de facto mental health system for youths unable to access services elsewhere (Grupp-Phelan et al.).

At the IWK Health Centre, the EMHAS team provides a 24-hour crisis/ED service for youth in need of mental health and addictions crisis intervention up to the age of nineteen in the Halifax municipalities (IWK Health Centre, IWK Psychiatry Services, IWK Emergency Services, 2014). Emergency assessments are focused to address the emergency mental health and addictions issue and provided crisis intervention, as well as to help in organizing referral to longer-term mental health and addictions services, if required. When there is an acute psychiatric concern that required treatment in an inpatient setting, then an admission to the acute inpatient psychiatry unit takes place from the IWK ED (IWK Health Centre, IWK Psychiatry Services, IWK Emergency Services). This team also assists families experiencing stressful and difficult situations (IWK Health Centre, IWK Services, Emergency Department, 2014).

The ED physician consults EMHAS once the physician had identified that the patient's primary reason for arriving to the ED is for care regarding a mental health concern. There may be children/youth who present to the ED primarily for a physical health concern, but may also have a secondary or underlying mental health concern. It is often these children/youth whose mental health care needs may not be met or acknowledged (Grupp-Phelan et al., 2007).

Children and youth seeking mental health care in the ED typically do not fit the perceived treatment norm of the ED (Kirby and Keon, 2004). Pediatric mental health ED visits were suggested to be resource-intensive in a variety of ED settings based on a restricted number of clinical variables,

such as consultative services, restraint use, ancillary care, complex presentations, and length of stay in the ED (Newton et al., 2011). What remained unclear was an understanding of the internal values, beliefs and external influences, customs, traditions, and routines that impact staff that work with children/youth with mental health concerns in the ED, and how these influences impacted staff when caring for children/youth with mental health concerns.

Influence was defined by Merriam-Webster (2013) as the "act or power of producing an effect without apparent exertion of force or direct exercise of command". *Custom* referred to "a practice followed by people of a particular group or region" (Merriam-Webster). *Traditions* referred to "an inherited, established, or customary pattern of thought, action, or behavior" (Merriam-Webster), and lastly *routines* were defined as "a regular course of procedure" (Merriam-Webster). Identifying what influences, customs, traditions, and routines impact EMHAS and ED staff when providing care to children/youth with mental health concerns in the ED, brought awareness to professional norms, practices, and behaviors that took place in the ED setting when children/youth with mental health concerns sought care. No previous literature had sought to explore the culture (i.e. values and beliefs) of a pediatric ED as it related to mental health care.

This study used ethnographic methodology to answer the research question: *What is the culture of a Pediatric Emergency Department (ED) in providing care to children/youth who arrive in the ED primarily for care regarding a mental health concern?* Ethnography facilitated building an understanding of the culture of the ED by exploring social interactions, behaviors, and perceptions that occur within groups, teams, organizations, and communities (Reeves et al., 2008).

Literature review

Children/youth with mental health concerns in the ED

Pediatric EDs were designed to address physical and mental health emergencies. While they were designed to address urgent medical needs (physical and mental health), patients with both urgent and non-urgent mental health concerns who visit the ED often do not receive necessary care for either their physical or mental health needs (Grupp-Phelan et al., 2009, Pope, 2011., Santiago et al., 2006). However, descriptions varied internationally, nationally, provincially, and organizationally regarding the types of mental health care needs/services that a pediatric ED provided, and varied in use of language and definition to describe children/youths acuity when they arrived in the ED (i.e. urgent, non-urgent, life-threatening, non-life-threatening, emergency, non-emergency).

Health emergency

To truly understand the meaning of a *health emergency*, Australian researchers Morgans and Burgess (2011) defined a *health emergency* as "any condition that may result in death, permanent disability, or is potentially life-threatening, or causing severe physiological discomfort or distress" (pg. 288). This definition also applied to the term *physical emergency*, used later throughout the paper. The American Academy of Pediatrics (AAP) (2005) described that an ED was responsible for pediatric expertise to treat and screen emergencies involving children with special health care needs, psychological needs of children related to trauma; act as a referral center for care (for rehabilitation and local follow-up care); provide pediatric-specific primary and subspecialty care; and deal with public health emergency, disaster and terrorism responses.

The Australian College for Emergency Medicine (ACEM) (2003), described that the function of an ED was to receive, triage, stabilize and provide emergency management to patients who presented with a wide variety of critical, urgent and semi urgent conditions whether self or otherwise

referred. In addition to standard treatment areas, some departments may require additional specifically designed areas to fulfill special roles, such as: the management of pediatric patients, the management of major trauma patients, the management of psychiatric patients, the management of patients following sexual assault, the management of infectious patients, the extended observation and management of patients, the management of prisoners in custody, the management of patients affected by chemical, biological or radiological incidents, undergraduate, postgraduate teaching, transport and retrieval services, and telemedicine (ACEM).

Similarly, the AAP (2006) described ED standards of care of mental health concerns to include the following: safe, humane, and in a culturally and developmentally appropriate manner, care to manage pediatric patients with undiagnosed and known mental illnesses, including those with mental retardation, autistic spectrum disorders, and attention-deficit/hyperactivity disorder, and those experiencing a behavioral crisis. Pediatric patients with mood, anxiety, behavioral, and substance-abuse-related disorders also accessed the ED for emergency care (Ali et al., 2012). Accordingly, (Cloutier et al., 2010) noted that the ED has become a primary point for screening and/or evaluation of mental health concerns regardless of whether the concerns were considered to be mental health emergencies by the emergency health care system.

Ross (2010) noted that EDs in Nova Scotia were intended for the rapid assessment and management of patients with unknown concerns as well as those with deteriorating pre-existing illness or injury that required emergency care. The ED cannot be used for routine hospital admissions for stable patients or pre-operative preparation for elective surgery, holding areas for in-patients transferred from other hospitals, or scheduled outpatient procedures or appointments (Ross). The limited ED space and staffing has to be dedicated to dealing with the full spectrum of unexpected illness and injury to ensure timely access for high quality, safe ED patient care (Ross).

As noted in the IWK Health Centre, Mental Health Policy, the IWK Health Centre ED provides care to children, youth, and families with mental health issues in a concise, timely, and respectful manner in a non-stigmatizing environment. The IWK ED cares for children/youth with wide ranging illnesses and injuries, some of which were life threatening while others were less urgent and non-life threatening (IWK Health Centre Emergency Department, 2009). The IWK Health Centre, Mental Health and Addictions Program Clinical Policy Manual (2007) explained that, a mental health client emergency was usually one when a patient was at imminent risk of serious injury to self or others.

Children/youth with mental health concerns triage process using the Canadian Triage and Acuity Scale (CTAS)

Gravel et al., (2013) reported that with prolonged waiting time and crowding, triage has become a critical "safety net" for EDs. The authors noted that The Canadian Triage and Acuity Scale (CTAS) was a 5-level triage tool that used signs and symptoms assessed by a registered nurse to determine the urgency level of patients that presented to the ED (Gravel et al.). The scale, ranged from triage level 1 (resuscitation) to level 5 (non-urgent), and had been implemented for both adults and children. During the last decade, the CTAS had been implemented in many countries and had become a mandatory practice in pediatric EDs of most Canadian provinces (Gravel et al.).

The validity of a triage scale was defined by its capacity to measure the level of urgency for patients that presented to the ED (Gravel et al., 2013). To be useful, a triage scale had to be able to properly identify patients in need of immediate assistance. It also had to be able to safely identify less urgent patients who could not wait to optimize use of limited resources (Gravel et al). The CTAS attempted to more accurately define patients' needs for timely care and allowed EDs to evaluate their acuity level, resource needs and performance against certain operating objectives (CTAS National

Guidelines, 2008). In the absence of a criterion standard for triage, Gravel et al. looked to evaluate the validity of the CTAS by associating triage levels with surrogate markers of severity.

The primary marker of severity was hospitalization, as defined by all patients for whom the treating physician asked for a hospitalization to a hospital ward, Intensive Care Unit (ICU), or short-stay unit outside the ED Gravel et al). Secondary outcomes were other surrogate markers of severity, including admission to the ICU, proportion of patients leaving without being seen by a physician, and length of stay in the ED (Gravel et al). Gravel et al.'s study demonstrated an excellent association between the CTAS triage level and several surrogate markers of severity. Specifically, triage level was strongly predictive of hospitalization, admission to the ICU, the proportion of patients leaving without being seen, and length of stay in the ED. These data suggested the validity of the Canadian Triage and Acuity Scale tool and supported its implementation in EDs (Gravel et al.).

Every child/youth that presented to the IWK Health Centre ED for any type of concern (physical and mental health) was triaged according to this particular scale. The CTAS levels were designed such that level 1 represented the sickest and most medically unstable patients and level 5 represented the least ill group of patients:

Level 1 – Resuscitation: Conditions that threatened life or limb (or imminent risk of deterioration) required immediate aggressive interventions. Examples of types of conditions that were Level 1 included: Cardiac/Respiratory arrest, major trauma (i.e. self-harm acts), shock states, unconscious patients, severe respiratory distress, severe suicide attempt (CTAS National Guidelines, 2008).

Level 2 – Emergent: Conditions that were a potential threat to life limb or function, required rapid medical intervention or delegated acts. Examples of types of conditions that were Level 2 were altered mental states (i.e. psychosis, mania, delirium), head injury, severe trauma, and emergencies related to overdose (CTAS National Guidelines, 2008).

Level 3 – Urgent: Conditions that potentially progressed to a serious problem requiring emergency intervention; may be associated with significant discomfort or affecting activities of daily living. Examples of types of conditions that were Level 3 were moderate trauma, asthma, acute psychosis and/or suicidal thoughts, depression, eating disorders, overdose, and acute pain (CTAS National Guidelines, 2008).

Level 4 - Less Urgent (Semi urgent): Conditions that had the potential for deterioration or complications would have benefited from intervention or reassurance within 1-2 hours. Examples of types of conditions that were Level 4 were headache, signs or symptoms of psychosis (i.e. hallucinations), anxiety and/or panic attack, passive suicidal thoughts, behavioral concerns, self-harm, and chronic pain (CTAS National Guidelines, 2008).

Level 5 - Non Urgent: Conditions that were acute but non-urgent as well as conditions that were part of a chronic problem with or without evidence of deterioration. The investigation or interventions for some of these illnesses or injuries were delayed or even referred to other areas of the hospital or health care system. Examples of types of conditions that were Level 5 were mild physical pain, low mood, change in behavior, passive suicidal thoughts, and/or concerns with anxiety (CTAS National Guidelines, 2008).

Demographics of children/youth with mental health concerns who arrive in the ED primarily for a mental health concern

According to (Cloutier et al., 2010, Grupp-Phelan et al., 2009, Kalucy et al., 2005, Newton et al., 2009, Sills & Bland, 2002), an increasingly high number of children/youth presented to the ED with a wide range of mental health concerns and ranged from externalizing problems (aggressive behavior, behavioral disorders) to internalizing problems (suicidal attempt or ideation with symptoms of anxiety and mood). Kirby and Keon (2004) noted that individuals seeking mental health care in the

ED typically did not fit into the *perceived* treatment norm of the ED (i.e., rapid assessment and management of patients with unknown problems as well as those with deteriorating pre-existing illness or injury that required emergency care (Ross, 2010)) and thus, tended to 'disrupt the mandate or purpose of the ED'.

A recent Canadian study reported that parents sought mental health care for their children in EDs to stabilize acute situations, requested guidance for at-home management, and gained access to community resources (Cloutier et al., 2010). Children/youth that presented with vague, non-specific symptoms took a much longer time to assess. Collateral information from family, friends, schools, and/or community mental health services were difficult to access in a timely manner and community mental health resources were not available especially on weekends or evenings (Cloutier et al.). Studies have shown that factors associated with non-urgent use of the pediatric mental health ED and repeated visits to the ED included service-wait lists, dissatisfaction with primary care, perceived efficiency, and convenience.

While adult repeat users have been characterized as having chronic health and psychosocial problems (Yu et al., 2011, Ledoux & Miner, 2006), the pediatric repeat users have been less described. Studies have suggested that return visits occurred within a short time period particularly for patients with mood, anxiety/stress, psychosis related illnesses (Newton et al., 2010), and those that were already using health services (Goldstein et al., 2007). Yu et al. noted that it may be that repeated acute situations/visits to the ED experienced by families were not the result of increasing clinical acuity, but due to ongoing, stressful management of their child/youth's symptoms, and a desire to access community-based mental health resources that families were not aware of or experience as inaccessible.

Mental health services and care

Within the health care system as a whole, interventions to address the mental health needs of children/youth are limited, fragmented, and underfunded (Cappelli et al., 2012., Kirby & Keon, 2004). It was not surprising, therefore, to find children/youth with mental health concerns turned to the ED for help in a time of non-emergency, crisis, and/or emergency given that very few services were available.

Significant discrepancies (i.e., lack of community mental health services, appropriate referral, mental health funding, and/or mental health professionals) in the management of the children/youth with mental health concerns contributed to the increased presentation of this population in the ED setting as the only other route to mental health services in the public health system was through hospital EDs. However, there were also significant discrepancies (i.e., lack of mental health professionals in the ED, lack of appropriate referral to community mental health services) between the services provided in ED settings and current knowledge about effective children/youth mental health care and treatment, meaning, that care for children/youth with a mental health concern was less than optimal in multiple settings within our health care system.

According to studies from (Cooper & Masi, 2007., Dolan et al., 2011, Newton et al., 2014), the current health care system, however, does not meet the needs of families in the emergency care setting. Grupp-Phelan, 2009., Newton et al., 2014., Pope, 2011., Santiago et al., 2006., studies also noted that many children do not receive comprehensive treatment for pediatric mental health visits and are discharged without adequate recommendations for follow-up care. There was also increasing evidence for long waits for care and lengths of ED stay (LOS) (Grupp-Phelan, 2009., Newton et al., 2014., Pope, 2011., Santiago et al., 2006).

Factors that influence child/youth with mental health concerns to access an ED

Newton et al., 2009, noted that the demand for mental health care services in the ED was increasing. Approximately 15% of Canadian children and youth have lived with a mental illness, but as few as one in six have received necessary mental health services (Newton et al.). American studies have reported ED visits for pediatric mental health concerns cite varied presentation rates that have ranged from three-five percent up to 25%, and national statistics estimated at roughly two percent (Newton et al.). These studies have shown important trends in access to the health care system, however no such data has ever been reported for Canadian EDs (Newton et al).

There were many complex reasons for the increased use of ED, including family instability and malfunction, access to physical health care services when mental health services were not available, lack of funding allocated towards mental health, lack of mental health professionals with pediatric expertise, and lack of screening programs (Baren et al., 2008). While visits by children/youth for mental health concerns in general were less prevalent than visits by children/youth for physical health concerns, such visits did appear regularly in the ED setting, were less well recognized, and often needed multidisciplinary experts for diagnosis and management (Baren et al.).

Primary Health Care

Kates (2008) study found that most people, including parents of children with mental health concerns, sought help through the primary health care (PHC) system via their General Practitioner (GP) as, other than ED care, it was the only route to mental health services covered through public health care system and therefore other mental health services did not require a GP referral and were available at a direct cost to the family. Access to publicly funded mental health services (including clinics, community resources, or inpatient services) required a referral from the GP. However, because mental health services were often not available and wait times for children/youth were lengthy (Kates),

the majority of mental health services were provided by the GP and without support from mental health professionals (Kates). Yet, significant discrepancies existed between the services provided in PHC settings and current knowledge about effective pediatric mental health care and treatment. Such discrepancies were noted for example, around inappropriate prescription of medications or suboptimal referral systems for more specialized mental healthcare in community settings (Waraich et al., 2010).

Physical care of children/youth with mental health concerns in the ED

There existed longstanding clinical concerns surrounding the mental health care and physical health care for people with mental health concerns in the ED. Numerous issues have been raised about the need for improved triage, mental health assessment skills, and treatment of people with *acute* mental health concerns (Morphet et al., 2012., Newton et al., 2011., Stephenson, 2000). Acute mental health concerns were characterized by significant and distressing symptoms of a mental health concern requiring immediate treatment (State Government Department of Health, Victoria, Australia, 2008). For example, this might have been the child/youth's first experience with a mental health concern, a repeat episode, or the worsening of symptoms of an often-continuing mental illness. The onset was sudden or rapid and the symptoms usually responded to treatment.

Adult patients with mental health concerns argued that they faced more challenges in the ED setting than patients who presented with physical health concerns - in the way that care provided to a patient with a mental health concern had resulted in the patient feeling stigmatized; in the delays in accessing mental health assessments; and the lack of referrals to community mental health services (Morphet et al., 2012). The pediatric mental health system has been chronically underfunded, has had limited service options, and has a continued need for specially trained personnel (Newton et al., 2011). Longstanding reports that few children and youth receive timely and necessary mental health services concluded that a shortage of mental health services remains (Newton et al.).

Newton et al.'s (2011) study examined comprehensive clinical management of pediatric mental health visit trends across different mental health presentations and differently resourced EDs (i.e. one pediatric-resourced ED and one psychiatric-resourced ED). Results indicated that the psychiatric-resourced ED provided a wider range of clinical assessments including those for homicidality, mood, and reality testing (i.e. orientation to person, place, time; assessment of thought processes) (Newton et al.). The pediatric-resourced ED, in turn, provided more physical assessments and laboratory work (Newton et al). Observed differences in Newton et al.'s study were a function of training (i.e. pediatric-based vs. psychiatric-based) and/or ED environment (limited versus access to in-house psychiatric resources) (Newton et al.). For example, without having ED-based psychiatric resources, pediatric physicians working in the pediatric-based ED may have provided assessments considered standard for any pediatric presentation (i.e. full physical workup) because they relied on their physical training to make treatment and disposition decisions (Newton et al.). On the other hand, physicians in the psychiatric-based hospital may have initiated psychiatric care (versus standard care) and gave the resources immediately available to address the child/youth's presenting complaint (Newton et al.).

According to Goldman (1999) study, health care providers often overlooked the physical care needs of patients with mental health concerns in the ED due to their narrow focus on the patient's mental health conditions. In addition, the competing demands of caring for acute physical emergencies, time constraints, inadequate psychiatric training, and access to specialized psychiatric resources were significant barriers experienced by the ED professionals which discouraged them from addressing mental health concerns (Cronholm et al., 2010, Grupp-Phelan et al., 2009, Santiago et al., 2006., Stewart et al., 2006).

Issues affecting the care of children/youth with mental health concerns in the ED

Shafiei et al.'s (2011) Australian study identified barriers experienced by ED nurses when caring for adult patients with mental health concerns, including time, the nature of the ED environment and a lack of ownership over the mental health patient, meaning that it was unclear whether the patient was under the direct care of the mental health care team or the ED team. Similarly, there were many barriers to optimal pediatric mental health care (Baren et al., 2008). A report released by the Office of the Surgeon General estimated that many of the six to nine million children and adolescents with serious mental health disturbances were not getting the help they needed (Stephenson, 2000). There were significant barriers to the provision of ongoing evaluation and treatment after the identification of mental illness in an ED or other setting. Although many of the barriers to access were financial in nature, others were not (Baren et al.). Time constraints and attention to life-threatening priorities often hindered recognition and appropriate evaluation of mental illness in ED patients (Frame, 1992).

Mental health staff and ED staff in the ED

Ross (2009) noted that while patients with mental health concerns felt that their only option was to access the ED, they had to compete for the attention of ED staff who were better equipped for, and felt more comfortable in dealing with, acute physical illness and injury than managing potential symptoms of a patient with a mental health concern. ED staff have stated that patients with mental health concerns have presented some of the most challenging clinical situations (Shafiei et al, 2011) by reporting feelings of inadequacy in assessing and providing necessary care (both physical and mental health) to patients with mental health concerns (Kirby & Keon, 2004, p.126).

Many Pediatric EDs have a separate mental health team for patients with mental health concerns and the mental health team are often used as a consult service after the patient is triaged by

the ED staff. For example, the EMHAS team at the IWK Health Centre is a specialized consult service based out of the ED, utilized when children/youth presented to the ED with any type of mental health concern. When EMHAS is consulted, the team and/or clinician performed a mental health assessment, appropriate intervention (if needed), follow-up, and referral, coordinate an inpatient admission, or discharge as necessary. However, ED staff may not be present during the EMHAS assessment despite the child/youth still legally being a patient of the ED staff. This protocol has lead to confusion regarding the overall responsibility for the child/youth.

ED staff knowledge about children/youth mental health concerns

Studies have shown that ED nurses' lacked knowledge and confidence in assessing child/youth with mental health concerns and identified such patients as a source of great discomfort (Falsafi, 2001). An Australian study conducted by Gerdtz et al. (2012) raised concerns about the ability of ED staff to appropriately triage adult patients with mental health concerns. ED staff have also identified deficits in the education of triage nurses regarding mental health concerns and considered this a factor affecting the accuracy of triage level assessments and the identification of appropriate interventions (Gerdtz et al). Environmental factors have also contributed to inappropriate mental health triage in the ED setting. ED nurses identified that adult patients' mode of arrival, their behavior at triage, and the nature of their clinical condition as factors influencing the assessment of urgency (Gerdtz et al). Despite the high prevalence of mental health concerns, the agreement to screen for mental health concerns in the pediatric ED setting remained an unsettled argument, as some clinicians were for mental health screening in the ED, and others against it (Gerdtz et al). A recent survey of 576 pediatric emergency medicine physicians found that most identified *time constraints* as a significant limitation to carrying out mental health screening in the pediatric ED (Williams et al., 2011).

According to Mahajan et al., (2009), most emergency physician training programs and pediatric emergency physician subspecialty-training programs do not require standardized training regarding psychiatric related conditions. Further, in a recent Canadian study based out of the Children's Hospital of Eastern Ontario (CHEO), 63% of surveyed pediatric emergency medicine physicians reported that they did not receive adequate training in the evaluation and screening of pediatric mental illness (Cappelli et al., 2012).

However, in contrast, Dion et al., (2010) reported in their study evaluating pediatric crisis services within an ED at CHEO that 83% of ED physicians felt confident in dealing with patients with mental health concerns (Cappelli et al.). The results of the CHEO study also indicated that, beyond an appraisal of risk, ED physicians and nurses felt challenged to assess children/youth mental health concerns and determine appropriate clinical recommendations. These studies illustrated a discrepancy amongst physicians within the same institution regarding their perceptions of the adequacy of their mental health training and level of confidence in treating children/youth with mental health concerns, which has lead to variation in clinical care within the same institution and across institutions. Emergency nurses have reported treating patients with mental health concerns to be a challenge citing they did not possess the necessary skills. Sivakumar et al's, (2011) assessed the mental health related learning needs of adult clinicians working in an Australian ED and reported that that ED nurses had lower confidence levels and a greater perceived lack of skill and knowledge about mental health related concerns than about any other type of health related issue. It was evident that practitioner perspectives regarding mental health education vary; meaning that mental health education for the two professions who provided the most care to children/youth in the ED was inconsistent in some cases and often insufficient.

To date, there have been a number of studies that have used chart reviews to describe children/youth with mental health concerns basic clinical data (i.e. presenting problem, discharge diagnosis, consultation to other medical services) in pediatric EDs. Newton et al.'s (2011) Canadian study explored differences in the clinical management of pediatric mental health in the ED. Results concluded that consistent and comprehensive clinical management of pediatric mental health presentations were lacking in EDs that had pediatric and psychiatric resources (Newton et al.).

In Habis et al.'s (2007) study, 88% of ED physicians agreed that a standardized screening tool would improve their ability to detect child/youth mental health concerns in the ED, and ED staff have recognized the need for additional mental health education and training (Mahajan et al., 2009). ED staff members (both nurses and physicians) have reported regularly feeling frustrated in their efforts to provide care to adult patients with acute mental health concerns, and patients have also voiced frustrations with the quality of care provided (Wright et al., 2003). In many ways, these patterns reflected a basic tension between the nature of ED work and the clinical needs of patients with mental health concerns. ED nurses and other ED staff generally wanted to focus on the technological and scientific aspects of assessments, treatment and making arrangements for follow-up care (Wright et al.).

In contrast, patients with mental health concerns required less technological aspects of assessments and treatments, and typically needed more time-intensive, psychosocial support in addition to traditional physical emergency services (i.e., acute medication management and treatment of injuries resulting from self-inflicted harm) (Wright et al.).

Attitudes about mental health

ED physicians and ED nurses in Gerdtz et al.'s (2012) study have commented on how social stigma associated with mental health concerns resulted in the assessment of urgency in adult patients

as being underestimated. In this study, nurses consistently showed a heightened level of awareness about how their own attitudes about mental illness might have lead to negative consequences for the patient, including an underestimated assessment of urgency during triage. Nurses also perceived knowledge and experience in caring for people with mental health concerns as critical factors influencing the quality of triage outcomes (accuracy of the urgency decisions and patient safety) (Gerdtz et al.). In addition, in this study, both ED physicians and ED nurses recognized that social stigma associated with a mental health diagnosis represented a significant barrier to accurate decision-making (Gerdtz et al.). A number of the nurses indicated awareness of the possible social implications of attributing behavioral signs and symptoms to mental health concerns and agreed that their negative attitudes towards patients with mental health concerns (at times) had impacted their triage decisions (Gerdtz et al.).

In another study, ED staff (without a specific mental health team/staff) rated themselves as holding negative attitudes and having minimal knowledge, training and confidence to have assessed and treated adult patients presenting with mental health concerns and related co-morbid conditions (Stuhlmiller et al., 2004). Further, in a study by Wright et al. (2003) on the effects of organizational climate on the clinical care of adult patients with mental health concerns, ED nurses and other personnel assumed and verbalized that psychosocial care was the primary responsibility of the community mental health team, not the ED team, despite the fact that patients typically had more contact with ED staff than with the psychiatric clinicians. While literature did not exist regarding triage and care of pediatric mental health patients, for adult patients, studies suggested that patient care was compromised because of staff anxiety, fear and avoidance (Stuhlmiller et al.).

Lack of community mental health services

Previous studies have identified many reasons why children/youth with mental health concerns

sought care in the ED, including lack of access to care elsewhere, inability to see their family doctor in a timely manner, long waiting lists for mental health services, stigma from community health care professionals, and lower levels of support (Fleury et al., 2011). In addition, children/youth with mental health concerns not only come to the ED for a variety of reasons but they come often (Fleury et al., Newton et al., 2010). Longitudinal studies that looked at repeat visits to the ED reported that most return visits occurred within a short period.

Goldstein et al.'s (2007) study of factors associated with a six month return to emergency services among children/youth with mental health concerns noted that 50% of return visits occurred within the same month of the initial visit, 85% occurred within six months and 45% reported a history of psychiatric hospitalization. One possible explanation given by the respondents of Goldstein et al.'s study was that the community-based service alternatives were not available, accessible, or adequate (in terms of available crisis intervention, mobile treatment, and family support services) or that inpatient admission was an easier disposition from the ED (p. 1492). Repeat ED visits suggested that the needs of these children/youth were not being met/stabilized.

Newton et al., 2010 Canadian study data on 16,154 presentations by 12,589 pediatric patients less than 17 years old were examined from 2002 to 2006 looking at identified predictors and estimated time to ED return-visits. Among children/youth who accessed the ED for mental health concerns, being female, older in age, in receipt of social assistance, and having an initial visit for a mood disorder or psychotic-related illness were associated with return for further care (Newton et al.). How patient presentations were triaged and whether visits were made to a pediatric or general ED also affected the likelihood of return (Newton et al.).

Canadian mental health systems-based approaches have focused on access to, and sustained use of, community mental health care, including implementation of mobile crisis services to divert

children/youth from the ED (Frosch et al., 2011). However, such approaches have not led to a decrease in the number of child/youth with mental health concerns seeking ED care (Frosch et al.). Mental Health Mobile Crisis services provide mental health assessments, crisis interventions and crisis stabilization via telephone (twenty-four hour hotline) and in person (for example, if the individual is within a certain proximity). Specifically, the IWK Health Centre Mobile Crisis Team is a partnered service between the IWK, Halifax Regional Police, Capital Health and Emergency Mental Health Services. Mobile Crisis provides 24 hours per day, 7 days per week telephone support to individuals and families across the age spectrum who are experiencing a mental health crisis (IWK Health Centre, Mobile Crisis, 2009). The mobile teams are available daily within most of the HRM, between 1 p.m. and 1 a.m. Mobile services are set up through the telephone support line. The team helps individuals of any age experiencing a mental health crisis by providing mental Health assessment and crisis intervention/stabilization. The team consists of social workers and nurses teamed with plain-clothed, specially trained police officers (IWK Health Centre, Mobile Crisis).

Mobile crisis services are a mental health community service intended to help to reduce children/youth with mental health concerns visits to the ED. Parents and children/youth with mental health concerns, however, may still have feel that they warrant ED care and may access both services. Frosch et al., (2001) have noted that many children/youth who visit an ED are already known to the mental health system, however, research has not examined the relationship between use of the ED and use of community mental health services including outpatient care and crisis services before and after an ED visit.

Lack of referral and lack of access to children/youth specialty mental health services

There is a great inequality in the distribution of mental health specialty services throughout Canada (Kirby and Keon, 2004). The lack of access to specialist services means that Primary Health

Care (PHC) staff (usually GPs and/or other health care staff in a primary care community clinic) is disproportionately responsible for the care of 'secondary' (i.e., not the primary reason for seeking help/care) health care needs (Parr and Philo, 2003). Thus, under-treatment and under-service is to be expected and access to appropriate publicly funded mental health care is difficult to gain (Fuller et al., 2000). This raises concerns about adequate levels of expertise, training and treatment decisions.

In Canada, the PHC medical system is the most widely used service for mental health needs (Canadian Psychiatric Association, Collaborative Mental Health Initiative, 2006). GPs are the main access point for all health needs, both physical and mental health. Although GPs are the most frequent contact with patients with mental health problems, GPs do not always recognize mental health concerns and the care given might not be completed or appropriate (Yuen et al., 1996).

While a GP is undoubtedly an important figure in the provision of mental health services, mental health is not the specialty of PHC providers (Parr and Phillo, 2003). A number of studies have suggested that GPs considered themselves unskilled, reluctant to diagnose mental health conditions among children/youth, and perceived that they have a limited range of treatment options (Roberts & Bernard, 2012). Current data indicated that diagnosis and treatment of common mental health concerns in primary care was highly variable and detection rates were often poor (Thompson et al., 2004). Referrals to mental health services have tended to focus on acuity, or severe mental health concerns, meaning that many people with high prevalence disorders such as anxiety, depression, and early psychosis were not seen by mental health specialists until a crisis occurred (Fuller et al., 2002).

Given that the GP may be the entryway to specialist care in Canada, it was not surprising that the majority of patients with mental heath concerns who engaged in treatment did so through a GP. However, Van Voorhes et al., (2003) noted that even when a GP saw patients, referrals to psychiatrists or other mental health professionals was low. Indeed, Van Voorhes et al. also noted that GPs provided

referrals to mental health specialist services much less frequently than to physical care services, and noted that multiple contacts within primary care services may have disproportionately affected access to mental health specialty providers. Referral process complexity also has been shown to adversely affect access to mental health services (Van Voorhes et al.). The presence of multiple managed care organizations with varying contractual requirements may have fragmented traditional referral networks (Van Voorhes et al.). The authors suggested that perhaps GPs have a larger personal network of physical care specialists to call upon than they did for mental health specialists.

Despite collaborative care (i.e. consultation/information sharing about a specific patient) between GPs and specialty mental health services, Hodges et al., (2001), reported that some children/youth with mental health concerns were more comfortable with only having a GP provide mental health care and wanted to avoid having a mental health referral and being labeled as mentally ill. Although GPs played a pivotal role in pediatric mental health care, there was some evidence that they may not have provided effective diagnosis, documentation, prescription of psychotropic medications, and treatment of illness (Hartley et al., 2004). This mismanagement may also have created an increase of children/youth with mental health concerns who visited the ED more frequently.

Stigma

According to the (Canadian Alliance on Mental Illness and Mental Health (CAMIMH), 2000), study findings suggested that many Nova Scotians with mental health concerns do not seek treatment of any kind (ED or regular health services) for mental health concerns because of the stigma attached to mental illness, because they do not know where to turn for help, or because services simply do not exist. The stigma of being labeled as 'people with mental illness' has been identified as having disabling real-life consequences in the form of social exclusion (Dickens & Picchioni, 2011). Mental health is an important health issue for all individuals but particularly for youth as most mental

illnesses begin during adolescence and young adulthood and, many of these affected youth do not tend to seek help for their mental health concerns (Browne et al., 2004). According to Corrigan & Penn (1999), there were a number of reasons why this occurred; individuals may not have wanted to recognize they have a problem; they may not have wanted to believe that treatment would work. They also may have been embarrassed or worried about what others would think of them, which could have lead to stigma.

Crawford & Brown's (2002) study about stigma found that stigma, generally, was seen as something that was the fault of the mental health system. Stigma involved an individual suffering social disapprobation and reduced life chances as a result of having been given a diagnostic label and an identity as a 'patient'. Stigma affected a person both directly and indirectly via mechanisms of discrimination, bullying, reduced academic achievement possibilities, automatic stereotype, and threats to personal and social identity (Major & O'Brien, 2005).

With this discrimination, children/youth as they age will face some of the same challenges that other marginalized populations experience, such as inequality in jobs, education, housing, income and health care (Dickens & Picchioni, 2011). Labeling also played a key role in the help-seeking process, as those living with mental illness were often fearful to seek help due to stigma and negative attitudes associated with mental illness. This is of particular importance for children/youth, as this is the developmental stage when identity is formed (Dickens & Picchioni).

Children/youth with mental health concerns perspectives of stigma experienced in the ED

Thompson et al., (2004) study found that attitudes toward, and beliefs about, mental health and treatment services were predictive of people's actual contact with mental health services. In addition, lack of public mental health literacy (the knowledge, beliefs, and abilities that enabled the recognition, management, prevention of mental health concerns) contributed to slow problem recognition. People

who had not yet sought treatment for their symptoms, therefore, may have accounted for a significant proportion of the unmet need for treatment in the population at any given time (Thompson et al.). Outside of a handful of studies, little was documented about the stigma related to child mental disorders and the consequences of this stigmatization process in the ED (Mukalo, et al., 2010). Furthermore, although it was thought that children suffer many of the consequences of stigma directly, they rarely sought professional help on their own-parents or other family caregivers act as their agents and, thus, played a unique role that must have been acknowledged and examined (Mukolo et al). Self-stigmatization by the person with the disorder has also been the subject of recent research and publications in adult mental health, but few such studies have involved children/young adolescents (Mukolo et al.).

Clarke et al. (2007) explored the perspectives of adult patients with mental health concerns regarding ED services. Participants reported that the wait times to be assessed in the ED were too long and that mental health presentations were triaged as being less urgent and less important compared to physical health presentations. Some participants reported feeling "abandoned" in the waiting rooms and that after a lengthy wait "gave up" and went home (p. 128). The typical ED environment was considered over stimulating and frightening and often added to feelings of agitation (Clarke et al.). Individuals often reported that they waited until they were in a crisis before presenting to the ED. In sum, patients felt particularly unwelcome in the ED setting (Clarke et al.).

It has been acknowledged, though not empirically verified, that the institutional context for stigmatization goes far beyond attitudes of professionals in direct contact with children/youth and their families but is reflected also in policies and practices of public institutions that have resulted in the devaluation and discrimination of participants in the mental health sector (Mukolo et al., 2010). Examples have included policies and practices that resulted in lack of parity between physical and

mental health, and the critical shortage of mental health professionals (perhaps linked to disparities in the attractiveness of careers in mental vs. physical healthcare) (Mukolo et al.).

A growing body of evidence has also suggested that adult patients with mental health concerns receive less adequate physical care when compared to individuals without mental health concerns (Pope, 2011). While the ED environment was characteristically hectic, which may have contributed to the inadequate physical care for adult patients with mental health concerns (Shafiei et al., 2011), the environmental chaos was not the only contributing factor. Two other barriers included health care professional's stigmatizing attitudes and their belief that their patients' complaints were psychosomatic (Goldman, 1999).

Clarke at al. (2007) also noted that adult patients with mental health concerns in the ED reported feeling "labeled as psychiatric" regardless of whether their presenting complaint involved mental health or physical health concerns. However, patient's reported continuing to access the ED because there was "nowhere else to go" as community services were limited. Indeed, despite feeling stigmatized, patients with mental health concerns often ended up in EDs because it was the most accessible route to services (Ross, 2009).

Environmental factors experienced by children/youth with a mental health concern in the ED

Lack of time experienced by ED staff

According to Morphet et al., (2012), the authors noted that overcrowding that resulted from a high census of non-urgent cases (both physical and mental health) within the ED hindered the ability of medical professionals to provide adequate care to all patients, resulted in long patient wait times, patient dissatisfaction, and adverse effects on patient health. People with both physical and mental health concerns reported frustrations with the ED triage process (Morphet et al.). They were often unsure about how care was prioritized, and did not understand why some patients' who arrive later

were seen first. The long waits that often followed arrival to ED, and a lack of provision to address basic needs, such as food, drink and bathroom facilities, lead to dissatisfaction among many ED consumers (Morphet et al.). This was particularly the case for children/youth with mental health concerns.

Violence and children/youth with mental health concerns in the ED

Caring for children/youth with mental health concerns in an ED is a complex process when trying to address a wide range of presenting concerns that require varying levels of care and supervision. It was widely recognized and recommended in the literature that EDs need to provide a quiet, non-stimulating environment for people with mental health concerns to ensure optimal quality of care and delivery of services (Morphet et al., 2012). Yet the busy nature of ED makes limiting such stimuli difficult and a constant challenge. This noisy environment, combined with frustration over wait times, may often sparked aggression and violence from patients with mental health and/or physical concerns waiting in the ED (Morphet et al.).

Although workplace violence occurs in every area of health care, certain settings of practice are notorious for their increased risk. The Federal Bureau of Investigation (2002) noted that this risk was highest in adult EDs, psychiatric units, admission departments and acute care units. A study of 6800 randomly selected Minnesota nurses (Gerberich et al., (2005) concluded that nurses working in long-term care, adult psychiatric and ED settings were at highest risk for workplace violence from adult patients with both physical and/or mental health concerns.

Children and adolescents were most often secluded and restrained in response to identifiable patterns of dangerous behavior (Allen et al., 2014). Adolescents were generally more physically intimidating and may have exhibited more dangerous behaviors than younger children; increasing the likelihood that seclusion or restraint was used and sustained for longer periods of time (Allen et al.). A

child's behavior, in comparison, typically escalated quickly to a dangerous level for specific behavioral reasons, yet the child would often calm just as quickly, once a restrictive intervention had been implemented (Allen et al.).

Lack of space may have explained why children and adolescents had a larger percentage of episodes of seclusion and restraint linked to interpersonal conflicts than adults (Allen et al., 2014). Cultural and social norms of acceptable aggression across all age groups were also factors in the way staff responded (Allen et al.). Cognitive, developmental, cultural, and societal differences among children, adolescents, and adults required that staff have different expectations and approaches for the different age groups (Allen et al.).

Attempts to categorize reasons for seclusion and restraint were complicated by a variety of factors. Department rules and staff who interpreted them in an inflexible manner sometimes set the stage for negative interactions and power struggles that lead to more restrictive interventions for patients of all ages (Allen et al.).

A relationship-based nursing model (Allen & Vitale-Nolen, 2005) taught staff to engage in frequent, respectful interactions with patients to develop therapeutic relationships. Staff education was provided to help avoid situations that lead to assaults of staff and the subsequent need for physical interventions (Allen, de Nesnera, Cummings, & Darling, 2011; Johnson & Delaney, 2007). Despite these significant and sustained efforts, hospitals have not been able to eliminate the use of seclusion and restraint. Dangerous emergencies continue to occur, and although risks to patients can be severe, failing to use seclusion or restraint in emergency situations have resulted in adverse outcomes for the patient or others in the milieu (Moylan, 2009; Recupero et al., 2011).

It is not surprising that adults have a large percentage of episodes of seclusion or restraint linked to their psychiatric symptoms. Adults are typically physically larger and stronger than children

or adolescents; therefore, threats may be taken more seriously and attempts to harm themselves or staff may be more likely to be perceived as imminently dangerous (Allen et al., 2014).

ED staff workload

One of the difficulties faced by children/youth with mental health concerns in the ED is the amount of time the patients spend there, in an environment that is generally not considered optimal for people with mental health concerns. Wait times and duration of stay are influenced by a number of factors including the general workload in the ED, delays given that often no specialist mental health staff are employed in the ED, and problems with lack of available beds in psychiatric wards for those child/youth who need to be admitted (Kalucy et al., 2005., Baren et al., 2004).

Both ED medical personnel and mental health clinicians, however, have questioned the appropriateness and effectiveness of providing emergency mental health care in general hospital EDs, as opposed to having a separate mental health ED (Wright et al., 2003). The high volume of patients seen in many EDs have limited staffs opportunities to provide care beyond that which is minimally required to stabilize and triage patients with mental health concerns for follow-up care (Wright et al.).

Conflicting perceptions of children/youth with mental health concerns, families, and ED staff about specific ED treatment/services provided

Cloutier et al. (2010) studied caregiver and youth perceptions and expectations of ED services provided at the Children's Hospital of Eastern Ontario (CHEO) from April 2007 to March 2008. The five main reasons reported by both child/youth and caregivers for presenting to the ED included suicidal thoughts, depression/low mood/unstable mood, suicide attempt, anxiety, and self-injury. While all of these reasons encompassed mental health concerns, the level of acuity was unknown. Three main stressors were identified, all adolescent issues: school (grades, learning difficulties, problems with teachers), issues with parents (fighting with parents, lack of communication, lack of

involvement), and problems with friends/peers (no friends, not getting along with friends, dating issues, bullying) (p.103).

Cloutier et al.'s (2010) study of expectations from parents of children/youth with mental health concerns in the ED setting revealed that assessment, evaluation and diagnoses made up 29% of caregiver expectations of emergency services provided in the ED, and 19.2% expected immediate referral to health care/professional community resources. Nearly 13% of people expected medication adjustment or prescription, and nine-percent expected admission to hospital inpatient unit. People may not have known that medication (adjustment or prescription) was not a service that was provided by emergency services. People thought that they might have experienced shorter wait times by accessing ED services for medication (adjustments or prescriptions) as opposed to getting them through other means. Interestingly, admission to the hospital was a relatively low expectation from parents, indicating that parents themselves may have not considered the conditions of their child/youth severe enough to warrant hospitalization, but instead, expected the ED to provide immediate help or guidance on an outpatient basis, particularly when no other services may be available – one more indicator that child/youth who accessed the ED were doing so because other alternatives were not readily available.

There exists a disconnect between ED staff and parent/caregiver expectations of services received or desired in the ED setting. Limited access to mental health staff in the ED, lack of referral psychiatric services in the community, lack of ED staff's knowledge and confidence in caring for children/youth with mental health concerns, and minimal collaboration between mental health staff (on site in the ED) and ED staff, contribute to the tension between parents of children/youth with mental health concerns, ED staff, and mental health staff (Cronholm et al., 2010). Lack of knowledge and consensus between parents and children/youth in terms of desired treatment outcomes are critical issues to be addressed as they may limit engagement in treatment and the ability of working together

in the pursuit of therapy goals (Garland et al., 2004; Yeh and Weisz, 2001).

Cloutier et al.'s (2010) study reported that parents used ED services as a center for information and advice, as well as access to other mental health services. Caregivers' expectations for clinical service were also most often general requests for help for their children/youth as well as request for help/guidance for themselves to help their children. As Cloutier et al. noted, asking for help was not an inappropriate request; however, the vague responses likely suggested that parents were not aware of what services, if any, were available to them within the community, or how to access those services. It was evident that the use of the ED can reflect both a difficulty in accessing appropriate outpatient resources, a lack of awareness of available resources, or a need when resources/services were either not available or accessible only after long wait times.

Implications for research

Very little was known about the culture (i.e. values and beliefs) of a pediatric ED in terms of providing care to children/youth with mental health concerns. By building an understanding of the culture of a pediatric ED, factors such as staff member's attitudes, staff morale, staff roles in working with children/youth with mental health concerns, and ED management practices regarding children/youth with mental health concerns, helped to clarify the process/trajectory of care that children/youth with mental health concerns received in the ED setting.

Culture is a shared phenomenon. Members of a cultural group often share knowledge and meaning systems, or a common sense of reality (Whitehead, 2002). The meanings and interpretations provided by a cultural system not only facilitate communication between those who share various aspects of such systems, but they may also give rise to miscommunications and misunderstandings between members who are from different systems (Whitehead).

Wright et al., (2003) reported that recent health services theory emphasized the importance of understanding the organizational climate and culture of health care facilities as an important determinant of both staff members' attitudes about their work and the quality and effectiveness of the care they provided. Organizational factors, such as staff morale, management practices, and organizational culture and climate have a long history in organizational research as major predictors in understanding efficiency and effectiveness of providing care in the ED setting (Wright et al.). No previous literature has looked at identifying the culture of a pediatric ED in terms of its role in providing care to children/youth who arrived in the ED primarily for a mental health concern. This research has brung awareness of the culture regarding care for children/youth with mental health concerns at the IWK Health Centre ED by having answered the following:

Study question: *What is the culture (i.e. values and beliefs) of a pediatric emergency department (ED) in providing care to children/youth who arrive in the ED primarily for care regarding a mental health concern?*

Proposal Terminology

For the purposes of this proposal, the term *mental health concern* included the terms*, mental health crisis*, *mental health emergency and mental health non-emergency.*

These terms were predominant in the literature of children/youth with mental health concerns in the ED setting. I used the terms to differentiate the specific differences as to the state of how children/youth may have arrived and/or sought help for mental health concerns in the ED. I also defined the term mental illness/disorder (as the two terms were often used interchangeably) as in many instances children/youth were presenting to the ED due to exacerbating symptoms of a current mental illness/disorder that they were living with, or their presentation in the ED was an indication that perhaps the child/youth was at risk of developing a mental illness/disorder.

Mental health crisis

The concepts of *mental health emergency* and *crisis* have been frequently confused or erroneously used interchangeably (Chan & Noone, 2000). A *crisis* was defined by Chan & Noone as a serious disruption of the child/youth's baseline level of functioning, such that coping strategies are inadequate to restore equilibrium (a loss of psychological equilibrium). It is an emotionally significant event in which there may be a turning point for better or worse (Chan & Noone) but does not necessarily imply danger of serious physical harm or life threatening danger (as in an emergency) (Chan & Noone). Those who work in emergency mental health services assess a variety of psychological crises and the challenge is to identify those crises that may also be emergencies.

Mental health emergency

The American Academy of Pediatrics (2006) defined a *mental health emergency*, as "an acute clinical situation in which there is an imminent risk of serious harm or death to self or others unless there is some immediate intervention" (Kleespies, 1998). These included serious suicidal and violent states, and states of impaired judgment in which an individual is endangered (e.g., acute psychosis) (Chan & Noone, 2000). During such times, emergency mental health intervention is required. The term *mental health non-emergency* referred to everything in the above-identified criteria, without the imminent and acute risk present.

Mental health

The WHO (2012) referred to *mental health* as a "broad array of factors that are directly or indirectly related to one's mental well-being - a state of complete physical, mental and social well-being, and not merely the absence of disease". It included the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders.

Mental illness/disorder

The Canadian Mental Health Association (2012) defined *mental illness* as a variety of psychiatric conditions, which typically included thought, behavioral or emotional impairments as a result of genetic, environmental, biological and psychosocial factors. Mental illness can cause distress and can interfere with a person's ability to cope with daily life and may disrupt work, social and family life. Children/youth experiencing a mental illness may have problems with behavioral and emotional control, communication, and sense of reality (distorted). Mental illnesses included a number of different conditions that varied in nature and intensity; usually were identified (diagnosed) by a collection of symptoms; often co-existed with other health problems; tended to affect mood, thought and behavior; and ranged in impact from mild-to-moderate distress at one end of the continuum to seriously impaired functioning, loss of freedom, and even death at the other end of the continuum. Children/youth have presented to the ED with symptoms of and/or in accordance to criteria met for a psychiatric diagnosis from the Diagnostic and Statistical Manual of Mental Disorders IV (DSM IV).

Children/youth

For the purpose of this proposal, given the population that the IWK Health Centre ED treats, the term *child/children* was considered anything under the age of 15and youth was considered between the ages of 15-19 years old; 19 is the maximum age for youth to seek pediatric mental health services in Nova Scotia.

Chapter II

METHODS

This chapter will discuss the purpose of the study, the research question, design, methodology, sampling data collection, procedure, data analysis, and ethical considerations.

Purpose

The purpose of this ethnographic study was to understand the culture (i.e. values and beliefs) of a pediatric Emergency Department (ED) in terms of how care was provided and what influences affected providing care to patients regarding mental health concerns. The research took place at the IWK Health Centre ED in Halifax, Nova Scotia. Internal and external factors that may have influenced how care was provided to children/youth with mental health concerns in the ED that were considered included those related to *staff* (i.e. attitudes, morale, roles in working with patients with mental health concerns), *institutional factors* (i.e. organizational climate, structural environment/ physical layout of the ED, interpersonal environment), and *employment guidelines* (i.e. written ED practices and customs, provincial and national mental health and ED policies, protocols, standards, and child/youth mental health referral documents).

Whitehead (2002) defined culture as being a holistic, flexible and non-constant system with continuities among its interrelated components, including shared ideational systems (knowledge, beliefs, attitudes, values), preferred behaviors and structural relationships (social). Culture provides rules and routines that facilitate order, regularity, familiarity, and predictability (Whitehead). Culture provides meaning in the interpretation of peoples' behavior, items in the physical environment, events, and occurrences that people construct and use to communicate their realities (Whitehead). Culture is a shared phenomenon. Members of a cultural group often share knowledge and meaning systems, or a common sense of reality, which is referred to as inter-subjectivity (Whitehead). The meanings and

interpretations provided by a cultural system not only facilitate communication between those who share various aspects of such systems, but they may also give rise to miscommunications and misunderstandings between members who are from different systems (Whitehead).

By exploring the culture of a pediatric ED as it related to mental health, I was able to identify the internal and external influences that warranted improvement or change in order to provide optimal care to a child/youth with mental health concerns. Such influences included: social systems within which individuals interacted, were influenced by, and/or had an influence on (community or societal organizations and agencies); individual and behavioral patterns; knowledge, attitudes, beliefs, values, and meanings held by individuals and social systems; expressive culture (language); technologies and physical environments; human needs; and the human groups' shared history of significant events and processes (Whitehead, 2002).

Research question

This qualitative study gathered cultural knowledge from observations, interviews and a document review in response to the question: *What is the culture of a pediatric ED in providing care to children/youth who arrive in the ED primarily for care regarding a mental health concern?*

Design

An *ethnographic* approach was used to gain an understanding of the culture of the IWK Health Centre ED, as it related to caring for children/youth with mental health concerns using three types of data collection: observation, interviews, and a document review. In order to understand the mental health needs of children/youth within the ED setting, it was important to first understand the culture of the setting of the ED in which they received care, and understand and identify internal/external factors of the ED (staff member's attitudes, staff morale, staff roles when working with patients with mental health

concerns, mental health and ED policies, procedures, guidelines, and standards) that may have influenced that care.

Ethnography is the primary research tradition within anthropology and provides a framework for studying the meanings, patterns, and experiences of a defined cultural group in a holistic fashion. It focuses on culture with particular attention on shared meanings that shape people's behavior (Loiselle et al., 2004). The aim of the ethnographer is to *learn from*, rather than to *study*, members of a cultural group (Loiselle et al.) (i.e., the ED and EMHAS staff who provide care to children/youth who arrive in the ED primarily for care regarding a mental health concern). It is important to recognize that the researchers bias and understanding of the culture was influenced based on how the researcher *perceives* the findings within a culture, as I acted as an integral component of the outcomes. The methods selected for a particular ethnographic study and the ways the methods are used are dependent on the purpose of the research as well as the particular social settings upon which the research focuses (Whitehead, 2006).

The design for this qualitative study was an emergent design - a design that evolved as I made ongoing decisions reflecting on what had already been learned (Loiselle et al., 2004). As noted by Lincoln & Guba (1985), an emergent design in qualitative research is not the result of researchers' sloppiness or laziness, but rather of their desire to base the inquiry on the realities and viewpoints of those under study; that is, realities and viewpoints that are not known or understood at the outset. As Loiselle et al. explain, a qualitative design has the following characteristics: It is flexible and elastic, capable of adjusting to what is being learned during the course of data collection; It typically involves a merging together of various data collection strategies; It tends to be holistic, striving for an understanding of the whole; It requires the researcher to become the research instrument; and it requires ongoing analysis of the data to formulate subsequent strategies and to determine what field

work is carried out.

Methodology

Ethnography

Ethnography facilitated building an understanding of the culture of the ED by exploring social interactions, behaviors, and perceptions that occurred within groups, teams, organizations, and communities (Reeves et al., 2008). The central ethnographic methods included carrying out fieldwork and observing in the communities of their hosts (ED setting), observing activities of interest, and recording field notes and observations. There were three different approaches used to explore the process of observation through ethnography (Reeves et al., 2008; Spradley, 1980; & Whitehead, 2006). Whitehead's template builds on the templates of Reeves and Spradley, and therefore was the most thorough and encompassing.

The template of Reeves et al., (2008) included multiple observations of (1) the physical layout of the place(s), (2) the range of people involved, (3) related activities that occur, (4) the physical things that were present, (5) single actions people undertook, (6) activities that people carried out, (7) the sequencing of events that occurred, (8) objectives that people were trying to accomplish, (9) and emotions felt and expressed.

Spradley's (1980) template added six other ethnographic domains to those of Reeves et al., (2008) including: (1) the actors in the setting; (2) the space occupied by these actors, and how these actors were situated in the space; (3) the objects in that space, and how these objects were situated or arranged; (4) the time of observations (hours of the day, days of week, specific months or seasons of the year); (5) whether there seemed to be any goals associated with the behavior of the actors; (6) whether behaviors seemed to be carried out with any level of emotions or feelings. The differences between the Spradley and Reeves et al.'s templates of ethnography were that Spradley offered more

specific domain criteria (i.e., explored the actors in the setting, as opposed to just acknowledging the setting) and explored more domains when attempting to understand culture.

Whitehead (2006) added several other categories to Spradley's (1980) fifteen observational criteria, including: (1) the language; (2) other forms of expressive culture found in the social setting beyond general language, such as sounds, activities, and technologies; (3) the interactive patterns between the actors in the setting; (4) the presence of actor group differentiation in the setting, or persons who can be differentiated by some shared similarity, such as by gender, age, family or kinship, vocation or some other type of affiliation (such as persons in a hospital setting differentiated by administration, doctors, nurses, non-medical staff, patients, etc.); (5) ideational elements (beliefs, attitudes, values, or any other cognitive constructs) suggesting various socio-cultural meanings that might have been present in, or attached to, any of the other ethnographic domains in the setting; (6) broader social systems that might have influenced the actors, behaviors, and ideations found in the socio-cultural scene being studied; (7) physical environmental elements that were present within or surrounding a specific social scene; (8) human need fulfillment that was attempted or met within the social setting or the interactions that took place there.

In the context of ethnography, Whitehead (2002) defines culture as being a holistic, flexible and non−constant system with continuities among its interrelated components, which includes shared ideational systems (knowledge, beliefs, attitudes, values), preferred behaviors, and structural (social) relationships. Culture provides rules and routines that facilitate order, regularity, familiarity, and predictability (Whitehead). Culture provides meaning in the interpretation of people's behavior, things in the physical environment, events, and occurrences that people can construct and through which they communicate their realities (Whitehead).

Culture is a shared phenomenon. Members of a cultural group often share knowledge and meaning systems, or a common sense of reality, which is referred to as inter-subjectivity (Whitehead, 2002). The meanings and interpretations provided by a cultural system not only facilitate communication between those who share various aspects of such systems, but may also give rise to miscommunications and misunderstandings between/among members who are from different systems (Whitehead).

Multiple definitions of ethnography existed throughout the literature. Whitehead (2002) describes ethnography using the *Cultural Systems Paradigm (*CSP). The CSP involved multiple phenomena (cultural, social, ecological, and psychological) found in all human societies and was based on four underlying ethnographic principles: The principle of universal *human cultural* categories; the principle of *human ecosystems*; the principle of *paradigmatic flexibility*; and the principle of *interrelationships* among socio-cultural contexts, processes, and meaning systems.

Cultural Systems Paradigm principles

The principle of universal human cultural categories

This first principle, *The Principle of Universal Human Cultural Categories*, suggested that there were certain categories of phenomena that are universally relevant to all human communities, but differ in terms of how they were expressed (culture) in each human community. This assumption was in contrast with the epistemology that drives most positivist and ethnographic research paradigms in that it suggested that we look for ways in which humans and their cultures are similar, before we begin to look for how they vary. It is important to first acknowledge our similarities, strengths, and our resemblances prior to looking at our differences. Acknowledging our strengths and developing a curiosity about human communities and what influences culture, may provide more clarity and understanding when trying to understand one's particular culture and how the culture came to be.

According to the CSP (Whitehead, 2002), universal phenomena included four categories of phenomena: individual and normative behavioral patterns, individual and shared ideational structures, significant social systems, and expressive culture. The first category, *individual and normative behavioral patterns*, included behavioral activities and their sociocultural descriptions (their nature, how these behaviors were carried out, where these behaviors were carried out, who carries out these behaviors, when these behaviors were carried out, and whether they were routinized behaviors).

The second category, *individual and shared ideational structures,* included those factors which framed interpretations and meanings that underlie behaviors (knowledge, beliefs, attitudinal systems, values, and significant symbols). The third category, *significant social systems*, included domestic units (households or residential compounds), extra-residential groupings and dyads (ethnic groups, social networks and kinship systems, coworkers or patron-client, etc.), and the policies and practices of institutions and agencies of the wider community/society. Lastly, the fourth category, *expressive culture,* included different forms for expressing cultural meanings and symbols (language, music, song, dance, talk, literature, proverbs, sermons, artistic expression, etc.).

The principle of human ecosystems.

The second principle of the CSP (Whitehead, 2002), *The Principle of Human Ecosystems*, argued that if cultural systems were going to be properly understood, they must be studied as components of their own *Human Ecosystems*. Three categories were considered: The *physical environment*, the *real and perceived needs* of human groups, and significant *historical processes and events*. Three categories, either biophysical or sociocultural, that either institutionalized or sustained a cultural system and/or a part of that system were considered when I was collecting data through observation, interviews with ED/EMHAS staff, and documentation review.

The principle of paradigmatic flexibility.

The third principle of the CSP (Whitehead, 2002), *The Principle of Paradigmatic Flexibility*, held that conceptual frameworks that informed the study of cultural systems must be flexible, and not rigid, because of the differences in behavioral and ideational expressions - both across human groups and individuals, as well as within the individual. I upheld this principle by maintaining an emic view - one that maintains the insider's interpretation of the experiences of that culture their world (insider's view) (Loiselle et al., 2004) during data collection. By contrast, the *etic* perspective is the outsiders' interpretation of the experiences of that culture (Loiselle et al.)

The principle of the interrelationship between socio-cultural contexts, processes, and meaning systems.

The last principle of the CSP (Whitehead, 2002), *The Principle of the Interrelationship between Socio-cultural Contexts, Processes, and Meaning Systems***,** argued that if I wanted to understand correctly why certain behaviors, including health risk and resiliency behaviors, emerged and persisted in human populations, then I would have had to have a better understanding for the socio-cultural contexts in which these behaviors occurred, the socio-cultural processes of these contexts, and the socio-cultural meaning of these contexts and processes for those who practiced such behaviors.

This principle also helped to understand the socio-cultural *processes* of the relationship between individuals and their social systems and the relationship between individuals and their significant social systems. In order to understand these relationships, I had to examine the physical environments that they occupied, looked at individual and shared histories, and identified patterns of need and fulfillment within their social systems. Lastly, this principle helped to understand the socio-cultural *meanings* that individuals and their significant social systems applied to social systemic

relationships, the physical environments they occupied, and individual and shared historical patterns, and patterns of basic human need fulfillment.

According to Loiselle et al., (2004), an underlying assumption of an ethnographer is that every human group evolves a culture that guides the members' view of the world and the way he/she structures his/her experiences. Two of these views that can guide members experiences of how they view the world are sometimes referred to emic and etic perspectives. Ethnographers strive to acquire the *emic* perspective of cultures one that includes both explicit and tacit knowledge. Tacit knowledge is that which is so deeply embedded in cultural experiences that members may not be able to describe or even be consciously aware (Loiselle et al.). Argyris & Schon (1992/1974) described tacit knowledge as that which we display when we recognize a particular face from many others without being able to explain how we did so, or when we demonstrate a skill about which we cannot explain when/how we developed it, or when we experience the intimation of a discovery that we cannot put into words (p.10).

The authors noted that tacit knowledge was particularly useful for understanding theories-in-use. They argued that each practitioner develops a theory of practice, regardless of whether he or she is aware. Such a theory is composed of both explicit tacit knowledge, which one is able to describe, and theories-in-use, which may be unconscious and only revealed in behavior (Argyris & Schon, 1992/1974). Theories-in-use tend to be tacit structures whose relation to actions compare to the relation of grammar-in-use of speech. They contain assumptions about self, others, and the environment, which constitute a microcosm of everyday life (Argyris & Schon).

The study of culture requires a certain level of intimacy with members of the cultural group, and such intimacy can only be developed over time and by working directly with those members (i.e. through observation and interviews). Three types of information are usually sought by ethnographers:

cultural *behavior* (what members of the culture do), cultural *artifacts/products* (what members of the culture make and use), and cultural *speech* (what people say), implying that the ethnographer relies on various types of data to gather critical information, including observations, in-depth interviews, and a range of physical evidence (records, charts, etc.) (Loiselle et al., 2004).

By having explored the culture of a pediatric ED, as it related to working with children/youth with mental health concerns, I sought to identify the internal and external influences that have identified strengths between ED and EMHAS staff (i.e., enhanced collaboration, role clarity, knowledge, mental health training for staff, and ED and mental health documents that aided in the provision of care), challenges, or barriers. Such influences included;

- *Social systems* in which individuals interacted, were influenced by and have an influence on (community or societal organizations and agencies)
- *Individual and behavioral patterns*
- *Knowledge, attitudes, beliefs, values, and meaning* held by individuals and social systems
- *Expressive culture* as represented in such forms as language
- *Technologies* and the *physical environments* in which humans interacted
- *Needs* that ED staff must meet in order to have achieved the level of physical functioning necessary to the survival of the individual and group
- The human groups *shared history* of significant events and processes (Whitehead, 2002).

Setting

The IWK Health Centre ED had eight individual treatment rooms and three curtained cubicles. In addition, there was an assessment room behind the triage area (Appendix I). There was one room that was designated primarily for patients with mental health concerns (commonly known as the assessment room, or room #5), but can be used as a medical room as well. Children/youth with a

mental health concern in the ED may/can be assessed in any other assessment room in the ED. There was one trauma room with space for two patients. There was also one seclusion room. The triage desk with a trained health professional (Registered Nurse) was located at the front of the ED, overlooking the waiting room, and was the first point of contact for patients and families entering the ED, no matter what their concern (i.e. physical or mental health). There was a desk directly adjacent to the triage desk where a protection services officer was posted 24/7.

Next to the protection services desk was a door leading to the ambulance bay, a common route that was used for patients who accessed ED services from rural areas and/or in emergency circumstances. The 'blue desk' (i.e. formally known as the nursing station) was located behind the triage area and was surrounded by assessment rooms and curtained cubicles. Down a side corridor sat many offices of ED, EMHAS, and Poison Control staff. One family room was located near the back of the ED and was used by families with children with both physical and/or mental health concerns. The EMHAS team (formally known as The Crisis Team) was implemented in the ED in 1997. The team consisted of 1 full-time social worker, 1 part-time social worker, and 1 casual staff member. All workers worked twelve-hour shifts and were on-call at night (i.e. could leave the premises at midnight if no children/youth were present for assessment) (Susan Mercer, 2014).

The Crisis Team was created when IWK Health Centre merged care with the Nova Scotia Hospital, which allowed youth up to age nineteen to present to the IWK Health Centre for their mental health concern. ED consultations were supposed to be followed-up by community mental health (CMH) clinicians and psychiatry, but it soon became clear that CMH clinics could not respond as quickly as would have been preferred due to their workload and booked patients. This often left patients and families waiting for hours in the ED (Susan Mercer, 2014).

At that time, discussion about implementing a Crisis Team occurred and Susan Mercer became team leader in 1998. There was a lot of opposition to the age increase (i.e. children/youth with mental health concerns were seen up until age nineteen and children/youth with physical health concerns were seen up until age sixteen) in the ED. Susan Mercer worked closely with Protection Services, Emergency room physicians, and ED staff to develop patient protocols, response steps, response times, etc. As a result, all worked as a team to respond to the needs of the patients. There was a limited budget, however to extend the Crisis Team service Health Centre wide after hours, casual social workers, psychologists, and a nurse covered the remainder of the time. The Crisis Team also did Child Protection after hours and on weekends, and developed protocols for mental health assessments, when to consult psychiatry, hiring qualifications, etc. (Susan Mercer, 2014).

ED and EMHAS Staff

The IWK Health Centre ED staff was composed of twenty-four registered nurses (RNs), 14 in full-time positions and 16 in part-time positions, and 1 full-time child life specialist. The majority of RNs work 12 hour shifts, from 8am-8pm, or vice versa (Barb Bergeron, Manager of IWK ED, August 2014). As of August 28th, 2014, the EMHAS team (RN and Masters prepared Social Worker) had four full-time RN's and two full-time Social Workers. There was 1 RN in a part-time position, 1 RN in a 'casual' position, five part-time Social Workers and thirteen 'casual' Social Workers (Kristi Kempton, Manager of the EMHAS Team). The EMHAS Team provided 24/7 coverage.

There were 15 full-time employed physicians in the ED (spread out over 22 physicians working part-time). Approximately 50% were full time dedicated physicians to the Department, and the other fifty percent combined emergency medicine with a community pediatric practice. It is important to note that this staffing complement was very different than other pediatric EDs in Canada where the majority of coverage would be by strictly pediatric emergency physicians. Most physicians

worked 8 hour shifts, varied in times, and days of the week (Shannon MacPhee, Chief of Emergency Medicine, IWK Health Centre, and April, 2013).

The educational background of 20 of the 22 physicians was at baseline a Royal College certification in Pediatrics (4 year program) or Emergency Medicine (5 year program). Some physicians at the IWK Health Centre also had an additional two-year fellowship in pediatric emergency medicine. There was one GP that did casual shifts in the ED and one GP that worked in a 'casual' position, and had one year of emergency training (Shannon MacPhee, April, 2013).

Procedure

I immersed myself in the culture (values and beliefs) of the IWK Health Centre ED using three approaches to data collection: observation of child/youth while the received care, interviews with ED and EMHAS staff, and document review. In seeking to understand culture of the IWK Health Centre ED, it is noteworthy to mention the IWK Health Centre core Values, Mission, and Vision, in accordance with their most recently updated website via Pulse, as the organizational culture of the IWK Health Centre as whole influences and grounds ED and EMHAS staff to have a fundamental foundation in the provision of care to children/youth (IWK Health Centre, Values, Mission, and Vision, 2014). *Core Values* and *Beliefs* include: *Care and Passion*: taking pride in providing safe, high quality care to the populations we serve, building successful relationships with patients and families as partners in decision-making and care, making a positive difference in people's lives, contributing to a culture of inclusion and diversity (IWK Health Centre, Values, Mission, and Vision).

Excellence in Leadership: building our reputation for excellence in the Maritime community and beyond, contributing to a sustainable health care system through formal and informal partnerships, pursuing excellence in care, teaching and research through a spirit of discovery and innovation, leveraging our reputation and influence to advocate for the health of the population, being accountable

for our relationships, decisions, and actions (IWK Health Centre, Values, Mission, and Vision, 2014).

Worklife and Relationships: bringing collaboration and teamwork to all that we do, creating a supportive work environment that values and respects all members of our team, being open and honest, supporting employees, physicians and volunteers in achieving and maintain a healthy lifestyle (IWK Health Centre, Values, Mission, and Vision, 2014).

Our Mission: to make a difference in the health and well-being of women, children, youth and families, to bring together care, research, teaching and advocacy for the best possible results, to be global leaders in research and knowledge sharing. *Our Vision:* healthy families. The best care (IWK Health Centre, Values, Mission, and Vision, 2014).

The research design consisted of three sections: observation; staff interviews; and document review. The purpose of this ethnographic study was to understand *culture* of an ED when providing care to children/youth with mental health concerns. My expectation going into the ED setting was to *learn from* staff and build an understanding of how culture influences the provision of care. As Whitehead (2002) notes, It is important to first acknowledge our similarities, strengths, and our resemblances prior to looking at our differences. Acknowledging our strengths and developing a curiosity about human communities and what influences culture, may provide more clarity and understanding when trying to understand one's particular culture and how the culture came to be.

The Cultural Systems Paradigm (CSP) (Whitehead, 2002) provided a useful understanding of culture using social, ecological, and psychological lenses. The CSP examined the socio-cultural *contexts* holistically (e.g., households and family, formal and informal networks, organizations, groups, and dyads, and institutions and relationships of the wider community, society, and inter-societal linkages), the physical environments occupied by individuals and their significant social systems, and significant individual and commonly shared historical patterns Whitehead).

The researcher captured all four cultural categories of phenomena previously mentioned in CSP principle one, through the three processes of data collection previously mentioned.

The focus of this research was to understand the culture of a pediatric ED in terms of providing care to children/youth regarding mental health concerns. Data collection was an iterative process, as I interchanged the processes of *observation, interviewing* and *document review* depending on whether a patient with a mental health concern was present in the ED (i.e., awaiting assessment, during assessment, or post assessment). I also interchanged types of data collection if, during analysis, it became evident that certain aspects of data collection were not capturing all that was needed. This process allowed me to truly immerse myself within the processes of ethnography. A maximum of four months was allotted for data collection or until saturation was reached.

Observation

In order to understand the culture of a pediatric ED in terms of providing care to children/youth who accessed ED services primarily regarding a mental health concern, I observed children/youth with mental health concerns in the assigned assessment room, during assessment by ED and/or EMHAS staff (Appendix N). It is essential to stress that I strictly *observed* and did *not engage* in any discussion or interaction with the staff, patient or family during observation time. Written consent from patient (and family if present) and verbal assent from staff was obtained for observation (Appendix C-G). Observation also took place at the *ED 'blue desk'* while waiting for/ and/or during/ and/or after assessment of a child/youth with mental health concerns.

In addition, observation occurred at the *'blue desk'* during nursing shift change while information was being shared about children/youth with mental health concerns in the ED who have been assessed/were awaiting assessment/or were on their way into the ED to be assessed. Observation also occurred in the EMHAS office, where collaboration occurred between the EMHAS and ED staff,

and treatment plans of care for children/youth with mental health concerns were developed and discussed.

I wish to acknowledge that not all areas of the ED were observed during this study. For the purpose of this research study, the focus was strictly on understanding the culture, processes and influences that affected the provision of care to children/youth with mental health concerns. Therefore, the three areas that were observed were those that were most often used by children/youth with mental health concerns in the ED and by staff who provided their care.

Observation in the assessment room (i.e. room #5), the EMHAS office, and the 'blue desk' provided an opportunity to view holistically, the socio-cultural contexts of social systems in the ED (i.e. social networks, relationships, groups, and dyads), the physical environment of the ED (i.e. occupied by individuals and other significant social systems, and shared historical patterns that happened in the physical environment), the socio-cultural processes shared between individuals and their social systems to the physical environment (i.e. individual and shares stories, and patterns of need and fulfillment), and lastly the socio-cultural meanings that individuals applied to their relationships within the physical environment (i.e. assessment room, EMHAS office, and 'blue desk') which they occupied.

The researcher observed the physical environment in which the group resided (i.e. the ED). The real and perceived needs that human groups (i.e. ED and EMHAS staff) and individual members had to meet in order to achieve physical and socio-psychological functioning (i.e. provide care to children/youth with mental health concerns) was explored through observation. Lastly, factors of significant historical processes and events, either biophysical or sociocultural, that either institutionalized or sustained a cultural system or a part of that system, was considered when I was collecting data by observation.

I maintained an emic view; that was, understand the culture from the member's perspective (insider's view) (Loiselle et al., 2004) during observation and be truly aware that I was in the ED setting to *learn from* ED and EMHAS staff. In order to maintain an emic perspective, I answered three questions at the end of each observation period and staff interview to enable self-reflection; (1) What did the staff help me learn about their perspective that I didn't know before? (2) How did I listen in an emic way? (3) What was my biggest challenge of being emic and not etic?

Staff in the ED who was observed included any discipline. The purpose of observing staff was to observe whether/how the interactions influenced the culture of the ED in terms of providing care for child/youth with mental health concerns. I allotted one-to-two hour time periods, three times a week for observation, at fluctuating hours, and according to whether a child/youth with a mental health concerns was present in the ED. Within these time periods, I acknowledged that my time may be spent moving within all three above mentioned observation sites, depending on the whether a child/youth with a mental health concern was present in the ED (i.e. was waiting or was being assessed) at that time.

Observation setting

Observation took place in the IWK Health Centre ED (Appendix I). The researcher observed the transactions in three settings: the assigned assessment room, the 'blue desk' and the Emergency Mental Health Service (EMHAS) office. The assigned assessment room of the ED (room #5) was where ED and EMHAS staff carried out assessments, intervention, and provided care to children/youth with mental health concerns and their families. I also observed interactions at the ED 'blue desk' among *any* staff (i.e. physicians, residents, clinical clerks, child-life specialists, occupational therapy, etc.). Likewise, I observed interactions in the EMHAS office (often where ED and EMHAS staff members discussed children/youth with mental health concerns plan of care). Prior

to observing in any of these settings, I asked staff, the child/youth, and if applicable, family/caretaker, if each person gave verbal assent for me to be present for observation. If anyone opposed to me observing at any time, observation was not able to proceed at that particular time.

Assessment room observation.

Children/youth with mental health concerns were initially triaged by a registered nurse upon their immediate arrival to the ED. After the triage nurse assessed the child/youth and identified and/or assessed that the child/youth was presenting with a mental health concern, EMHAS was alerted. While awaiting assessment from the EMHAS, the child/youth was placed in an assessment room. The EMHAS team often assessed the child/youth prior to the Emergency Room Physician (ERP) seeing the child/youth. After the EMHAS assessed a child/youth, EMHAS staff asked an ERP to fill out a consult form to psychiatry and medically assess the patient.

Once the EMHAS and/or ED staff entered the room/meet to meet with the child/youth, I entered the room and requested written consent to observe the assessment if the children/youth permitted (Appendix C). If permission was granted, I sat in the room, visible to the child/youth, quietly observed the interaction and recorded field notes as the assessment progressed. I did not speak but only observed staff interactions with the child/youth and language used, looking at how the physical environment was used in the care setting, etc. (see Appendix J).

Emergency Mental Health and Addiction Service office observation.

The Emergency Mental Health and Addiction Service (EMHAS) office was located in the ED (see Appendix I). No child/youth with mental health concerns was taken to, or assessed, in this room. Team members, psychiatric residents, and psychiatrists used the EMHAS office for documentation of child/youth mental health assessments. The EMHAS office was also where ED staff would come and collaborate with the EMHAS team about providing care to children/youth with mental health concerns.

Verbal assent was obtained from EMHAS and ED staff prior to each observation period (Appendix D). Again, the process of the observation was explained prior to obtaining verbal assent for each observation period. If any staff present during that time declined to be observed, then observation was not able to commence.

During observation, I sat in the EMHAS office recording field notes as needed, looking at criteria mentioned in (Appendix J). I acknowledged that writing field notes and observations may have been distracting to staff and/or the patient. I was aware that field note writings may have been leading, and tried not to interfere with the circumstance of the observation at the time. I observed staff interactions, collaboration with ED staff and other multi-disciplinary staff involved with children/youth with mental health concerns provision of care, information sharing between teams, language used, influences that impacted decisions for child/youth care, etc.

'Blue desk' observations.

The 'blue desk' was located at the center of the ED (Appendix I). I obtained verbal assent from ED staff present prior to each observation period (Appendix E). I acknowledged that it would be extremely challenging to obtain verbal assent from all ED staff members present due to the influx of staff, students, housekeeping, and administrative staff entering/exiting the ED at various times. I observed primarily staff assigned to child/youth working with mental health concerns in the ED, looking at how staff interacted with children/youth, looking at language used during interactions, observing discussions about how the physical environment influenced the care of children/youth with mental health concerns, and observed the role of the staff member in the child/youth's trajectory of care. I also observed how staff interaction, communication, and collaboration occur and influenced the culture of the ED as it pertained to providing care to children/youth with mental health concerns.

Observation took place at the ED nursing station *only* during and/or after periods of time in which children/youth with mental health concerns had just finished being assessed by the ED and/or EMHAS, was in the process of being assessed, and/or was waiting to be assessed, as well as during nursing shift change. Times for these specific observations in the nursing station were identified as those during which there was a high likelihood that ED staff would be communicating/collaborating with one another and/or about children/youth with mental health patients. It was thought to be less likely that staff would be discussing a child/youth with mental health concerns when one was not present in the ED.

During observations, I did not talk but did sit or stand in the ED nursing station, and recorded notes accordingly. I observed contextual factors of the ED, roles of staff that were working with children/youth with mental health concerns, observed the process of care for a child/youth with mental health concerns in the ED, observed language and decision making used to describe these patients and guide decision making for their care, etc. (Appendix A).

I observed at the 'blue desk' multiple times throughout the week depending on ED activities and whether a child/youth with a mental health concern was in the ED (either waiting to be assessed, was being assessed, or had been assessed and was awaiting admission/discharge). In order to understand the culture, I observed in the ED for different durations of time and at different times during the 24/7 ED environment, while taking into account certain components such as time of day, day of the week, staffing compliments, trends of children/youth with mental health concerns presenting to the ED, etc. I also looked for diversity in terms of staff members and timing of shifts (day of the week, and time of the day), looked at the structure of the physical environment of the ED, and looked for similarities and differences amongst staff elements of the ED and EMHAS team as they pertained to providing care to children/youth with mental health concerns.

During observation periods, I rotated among the assigned assessment room, EMHAS office, and the ED 'blue desk'. I want reiterate that these time limits were not set in stone, point out that maximum time limits of two hours of observation per shift may have been exceeded, and that data collection depended at times on contextual factors of the ED and children/youths presentation to the ED. The nature of the encounter determined the length of the observation.

Observation ended once data saturation was obtained; i.e., when an understanding of the culture had been gained. The time of day and day of the week varied in order to provide an encompassing view of children/youth with mental health concerns as they presented to the ED. Chosen time of day and day of the week was also influenced by the EMHAS and ED staff members' recommendations as to peak times and quiet times that children/youth with mental health concerns presented to the ED.

I spread my observation times, directed at specific activities within the ED (i.e. observing full child/youth mental health assessments, observing nursing shift report, observing collaboration and information sharing between the EMHAS and ED staff discussing particular child/youth mental health cases), according to the contextual factors of the ED and frequency of children/youth who presented with mental health concerns (i.e. I continued to observe if there were children/youth with mental health concerns in the ED as the ED staff were providing care and/or discussing that patient).

Recognizing that plans may have changed, initially three shifts were conducted each week for observation, and continued until data saturation was obtained. During observation periods, I rotated among the assigned assessment room, EMHAS office, and the ED 'blue desk', again depending on the activities and contextual factors of the ED. The nature of the encounter was determined by the length of the observation.

Staff interviews

Sample

ED staff

Eligible participants for interviewing in this study included ED, EMHAS, and Protections Services staff who most frequently worked with children/youth who accessed the ED primarily for a mental health concern, were employed full-time in the ED at the IWK Health Centre, and had at minimum six-month work experience in *any* ED setting (adult and/or pediatric), in any province in Canada. I wish to acknowledge that for the purposes of this research, no children/youth with mental health concerns were interviewed during this study as the objective was to understand the culture of a pediatric ED in terms of *providing* care (i.e. by staff), to children/youth who accessed ED services primarily for a mental health concern.

Full-time staff working with children/youth with mental health concerns in the ED included the following disciplines: registered nurses (RNs), social workers, physicians (ED, pediatricians, or psychiatrists), protection services officers, and administrative registration clerks. Administrative Registration clerks working in the ED were eligible for interview due to their frequent contact and interaction with children/youth with mental health concerns in the ED. It is important to note that protection services officers worked in the ED with children/youth with mental health concerns but, administratively, were part of a different department within the IWK Health Centre. Protection services reports to their own separate management team, separate from the ED and EMHAS management.

I was expecting different perspectives from different disciplines, and noted that certain staff interacted with, and observed, children/youth with mental health concerns in the ED at different times during the experience and process of children/youth within the ED thus provided different

perspectives, and potentially, data with maximum variation. Consulting staff, paramedics, residents etc., or any staff employed less than full-time were not included as they: (1) had minimal contact with children/youth with mental health concerns in the ED, and/or (2) may not have been sufficiently engaged in the ED culture as it pertains to the provision of care to patients with mental health concerns.

A purposive sample was used to recruit interview participants. Purposive sampling was based on the assumption that my knowledge about the population was used to "hand pick" the cases that were included in the sample and was defined as a non-representative subset of some larger population, as it was constructed to serve a very specific need or purpose (Loiselle et al., 2004). The goal was to strive for maximum variation within the study sample. Maximum variation sampling involved purposefully selecting cases with a wide range of variation on dimensions of interest (Polit & Beck, 2004). By selecting participants from different disciplines, it provided diverse views and perspectives and invited challenges to preconceived or emerging conceptualizations (Polit & Beck). Maximum variation was reached when eligible staffs from the multi-disciplines, noted above, were represented within the sample that consented to be interviewed.

Sample size for staff interviews

Marshall, (1996) noted that an appropriate sample size for a qualitative study was one that adequately answers the research question. In practice, the number of required subjects usually became obvious as the study progressed and as new categories, themes, or explanations stopped emerging from the data, also known as data *saturation*. This required a flexible research design and a cyclical approach to sampling, data collection, analysis and interpretation (Marshall). Therefore, the exact number of study participants who were needed for data saturation was unknown at that time. The study included document review as well as periodic observations and interviews with eligible

participants who consented to be interviewed. It is important to acknowledge that I interviewed eligible participants regardless of whether they had been part of the observation phase in the ED. Morse (1991) recommended that, to have a meaningful account (that is, a large enough dataset to bring a rich set of experiences into the interview), studies aim to recruit a sample of six to ten participants. Data was collected until the dataset had captured sufficiently rich descriptions to understand the culture of the group of interest.

Eligibility criteria for staff interviews.

Morse (1991) identified qualities of a good informant as someone who has undergone, or who is undergoing, the experience; is able to reflect and provide detailed experiential information about the phenomenon; is willing to critically examine and self-reflect on the experience and his/her response to the situation; and is able to participate in a lengthy interview process that will take considerable uninterrupted time.

Individuals were eligible to participate if:

(1) They were a health professional (RN, Social Worker, and Physician), Registration Clerk, or Protection Services officer currently employed full-time in the IWK Health Centre ED, with a minimum of six-months work experience in any ED.

(2) They were willing to be interviewed and audiotaped for about 1.5-2 hours.

(3) They were able to understand and converse in English.

Individuals were not eligible to participate if:

(1) They had any previous contact with me in the context of a clinical relationship.

Upon ethical approval, I requested several meetings with all clinicians (i.e. Chiefs of ED, management staff of the ED, EMHAS team, and Protection Services) and provided a discussion about my research study, sought permission to conduct my study in the ED, and requested assistance in the

recruitment process by distributing a letter of invitation to all ED and EMHAS staff, and the Protection Services Department at the IWK Health Centre (Appendix A). An overview of the study was presented, along with a letter outlining the process, followed by a question and answer session during the meetings with clinicians and management staff. Following approval, I arranged to have recruitment letters for the interview portion of my study delivered to staff.

A letter of invitation was sent to all ED, EMHAS, and Protection Services staff (Appendix B). Eligible participants were asked to contact the researcher primarily by work e-mail and secondary by work telephone, if interested in finding out more about, or participating in the interviews included in, the study. I contacted all staff members who indicated an interest and provided contact information by telephone to discuss the study in more detail and answer any related questions. For staff wishing to proceed with the interview, a mutually agreed private meeting time and location was established to discuss the consent form and to begin the interview process.

The interview setting.

The interviews were conducted at a time and in an office in the Department of Psychiatry at the IWK Health Centre, mutually agreed upon by the staff and me. Privacy, comfort, and safety guided the decision.

Interview procedure.

I wish to reiterate that Whitehead's (2002) CSP framework was used to guide my data collection period, as Whitehead's framework provided a thorough approach to specific elements of data collection in ethnography and encompassed four principles of cultural phenomena in an attempt to truly understand culture.

At the beginning of each interview, I reviewed with the study participant the purpose and nature of the study and answered any questions. Once the participant agreed to proceed, consent forms

were reviewed and signed (Appendix H). The copy of the completed consent form was kept with me and stored securely in accordance with current tri-council ethical guidelines. Study participants were asked in the consent process if they wished to receive a summary of the study results upon completion of the study. I also acknowledged the study participant that if they would have liked to end the interview, pause, or stop at some point during, that they have done so. No study participants did so.

The interview was set up in a naturalistic way so that participants did not feel awkward or constrained by the discussion or language (Benner, 1994). Framing answerable, open-ended questions and using plain language were strategies that were used to enhance the narrative account. I used questions that were non-suggestive/leading, non-guiding and non-interpreting for the study participant in order to have achieved the most subjective responses. I used a semi-structured interview guide to help navigate the interview (Appendix K).

I reviewed the explicit purpose of the interview and provided explanations about the goal of ethnography: to gather the study participant's knowledge of the ED culture regarding what is the culture of the ED as it pertains to providing care to children/youth who arrive in the ED primarily with a mental health concern? I encouraged the study participant to speak in their *native language (*Spradley, 1979) (in the way they would talk to others in their cultural scene), since the goal of ethnography is to describe a culture in its own terms.

Writing is part of the intellectual work of doing interpretation (Benner, 1994). Therefore, I recorded field notes to aid in documenting reminders and cues and to prompt new questions that might have added clarification during interviews, as well as documented any significant observations about the interview, such as participant's non-verbal communication, interruptions, etc. Personal reflections were also recorded as part of the notes. The notes were dated and written in a ruled notebook for ease of access and organization. Following each interview, I graciously thanked the study participant and I

spoke with the participant about future contact re: research findings and member checking if necessary.

Again, it is important to note that the eligible participant did not have to be observed in the ED setting in order to be interviewed. It is also important to note that four of the ten staff members interviewed, ranging between the EMHAS and Protection Services team, have had previous working relationships with me, due to the fact that I work within the IWK Health Centre Mental Health and Addictions Services.

Semi-structured interview guide.

The semi-structured interview guide consisted of open-ended questions developed for the purpose of this study, posed by me (Appendix K). I followed the questions, with flexibility for probes, and returned to questions as needed. Participants were given the opportunity to answer all the questions and talk about other issues that they considered important and relevant to their experiences and circumstances.

Spradley (1979) identified three major types of ethnographic questions: *Descriptive, structural* and *contrast*. The first question I asked was a *descriptive* question, one that enabled a person to collect an ongoing sample of a study participant's language (i.e. Could you tell me about ***your role*** in the ED in providing care for children/youth with mental health concerns?). The second question I posed was a *structural* question, which enabled the ethnographer to discover information about *domains*, the basic units in a study participant's cultural knowledge (Spradley). Structural questions allowed us to learn about *how* study participants have organized their knowledge.

The second interview question was "Tell me about how care is provided to children/youth with mental health concerns in the ED"? A probe to this question was "How do people work together to provide care for children/youth with mental health concerns in the ED?" The third question was a *contrast* question, as a contrast question helped to find out what a study participant *means* by the

various terms used in his/her native language. Contrast questions enabled the ethnographer to discover dimensions of meaning which study participant's employed to distinguish the objects and events in their world (Spradley, 1979). The contrast question was "What is the difference between providing care in the ED for a child/youth with a mental health concern and providing care to a child/youth with a physical health concern"?

I conducted the interview by asking the three main research questions mentioned above. I used probes (Appendix K) if needed to keep the interview going and explored specifics of what the interviewee was sharing. I knew when to stop when I felt that I had truly gained the perspective and lens of the interviewee in terms of understanding the culture of the ED in terms of providing care to children/youth with mental health concerns.

Document review

I conducted a review of all IWK Health Centre mental health and ED documents, specifically concerning any ED or mental health-related issues of care (i.e. policies, procedures, protocols, guidelines, practice guidelines, standards of practices, work instructions, and/or guiding principles) as they related to providing care to children/youth.

According to the Definitions for Policies and Procedures Provincial Policy Working Group Document from the One Province, One Process, One Policy (OP3) (2010) committee adopted by the IWK Health Centre, the definitions of the previously mentioned documents were as followed (Appendix L): A policy is a clear formal and authoritative statement (s) directing practice. They enable informed decision-making, prescribe limits, assign responsibilities/accountabilities and are secondary to legislation and by-laws. Policies reflect the vision, mission, values and strategic directions of the Health Centre. They can be brief broad statements or longer and detailed documents if required by the subject matter (OP3). They must be realistic, achievable and evidence informed

(OP3). They are non-negotiable; Procedures describe a detailed series of steps, or outline a sequence of activities (OP3). They can be differentiated from policies in that they may be altered in view of professional judgment (OP3).

A *protocol* is a written plan specifying steps to be followed in a study, investigation, or a patient care intervention. They focus on process, assessment, intervention and evaluation and deal with issues requiring professional judgment and decision-making (OP3, 2010).

Guidelines are written principles that guide actions or decisions. They allow flexibility in the sequence and/or inclusion of specific steps in the process and encourage professional judgment (OP3, 2010).

Practice guidelines are systematically developed statements to assist the practitioner and patient in decisions about appropriate health care for specific clinical circumstances. Practice guidelines offer concise instructions on how best to manage health conditions (0P3,2010).

Standards of practice are statements that describe the desirable and achievable performance expected of health disciplines in their practice and against which actual performance can be measured. Standards range from broad, profession-specific standards established by a professional organization to more detailed practice-specific standards established by a particular agency. The policies and procedures of a health care organization need to be consistent with the standards of practice for the health disciplines employed by that organization (OP3, 2010).

Work instructions define the activities in terms of who is to perform it, when it is to commence and when it is to be completed. They may also specify the standard the work has to meet and any other instructions that constrain the quality, delivery and cost of the work required. Work instructions outline the work to be carried out; procedures define the sequence of steps to execute the work (0P3, 2010).

Lastly, the Definitions for Policies and Procedures Provincial Policy Working Group (2010) defined *guiding principles* as negotiable statements that serve to further outline practice and encompass points of emphasis to remember in implementing the policy or procedure. Differences within the above mentioned types of documents varied by specific direction and guidance that they offered in the clinical setting. Some documents such as guidelines and practice guidelines served to help navigate a healthcare provider decision-making process in a particular situation, compared to a protocol that served as a tool to address specific steps of handling a specific case in a particular setting. Other documents, such as standards of practice were not as flexible, and were a requirement of practice.

The purpose of conducting a document review was to determine whether such documents exist, and if the culture of the ED, as seen through the eyes of ED and EMHAS staff, in the provision of care to children/youth with mental health concerns, reflected such documentation. Identifying organizational specific ED and mental health documents helped bring awareness about successes and congruencies about the way in which staff practice in providing optimal care to this population as well as incongruences, within policies and standards of care that were being practiced, any gaps in specific documents that affected care to child/youth with mental health problems, or identified possible new needs for policies, guidelines, and standards within the IWK Health Centre organization to best provide care to children/youth with mental health concerns.

I gathered internal documents specific to the IWK Health Centre via the Quality and Patient Safety Coordinator for the IWK Health Centre, Karen Comeau, and navigated through ED specific documents via Lois Wyatt, RN, and Clinical Leader of Development in the IWK Health Centre ED. The I also collaborated with Karen Comeau and Lois Wyatt to determine what internal documents were best utilized for the purpose of this research study and accessed them appropriately (i.e. through

library access, archives, online, etc.).

Data collection was collected by means of having reviewed all types of documents previously mentioned between pages 71-73. After having reviewed each specifically, I compared aspects of each document in accordance with the others. See (Appendix M) for specific criteria used to review mental health and emergency department documents.

Data analysis

The process of qualitative analysis is not linear. It is an iterative (a cycle that keeps repeating), progressive, recursive (one part can call you back to a previous part), and holographic (each step in the process contains the entire process) (Seidel, 1998). I used Altheide's (1987) methods of Ethnographic Content Analysis (ECA) to guide analysis of data collected from observation, staff interviews, and document review.

Ethnographic content analysis (Altheide, 1987) was used to document and understand the communication of meaning, as well as to verify theoretical relationships. Its' distinctive characteristic was the reflexive and highly interactive nature of the investigator, concepts, data collection and analysis. Like all ethnographic research, the meaning of a message was assumed to be reflected in various modes of information exchange, format, rhythm and style (e.g., language and visual style) as well as in the context of the report itself, and other nuances.

Data analysis of interview procedure

I transcribed the audiotaped interviews, omitting identifiers (i.e. names, places, etc.). Prior to analysis, I determined transcript accuracy by reading all the transcripts while listening to the tapes for 100% accuracy. All typed transcripts were also checked for accuracy of verbal (i.e. anger, crying, etc.) and non-verbal (i.e. pauses) expressions. Punctuations accurately reflected breaks, termination of thoughts and/or pauses in communication.

Coding

ECA was used to code data collected from observation, staff interviews, and documentation review. ECA consisted of reflexive movement between concept development, sampling, data collection, data coding, data analysis, and interpretation. The aim was to be systematic and analytic, but not rigid. Although categories and labels initially guided the study, others were allowed and expected to emerge throughout the study. Thus, ECA was embedded in *constant discovery* and *constant comparison* of relevant situations, environment settings, styles, images, processes, meanings and nuances (Altheide, 1987).

I was essentially the main "measurement device" in the study. Most analysis was done with words. The words and language from my observations were assembled, sub-clustered, and broken into segments. They were organized to permit me to contrast, compare, analyze, and bestow patterns upon them. These created a core of recurring themes. To this end, ECA drew on and collected narrative data. Further, data were often coded conceptually so that one item was relevant for several purposes. In short, while items and topics were still counted and put in emergent categories, ECA also provided good descriptive information that I acknowledged in her findings.

Coding observation.

My field notes were reviewed to identify factors related to culture of the ED and content were coded according to context, regardless of where it occurred in the observation text. Statements were analyzed for latent (underlying meaning of subject content) and manifest (literal subject matter) content. The text was reviewed for words, phrases, descriptors and topics, and then the underlying meaning of the communications was interpreted.

Text segments from my field notes were identified with codes to reflect the meanings of the study participants' responses, questions, attitudes and behaviors. Codes helped to reorganize the data

and give different views of the data. Comparisons were made with previously coded material in the same category. Code words changed and evolved as the data analysis developed. As well, code words changed and transformed me who, in turn, changed and transformed the code words as the analysis proceeded (Seidel, 1998).

Coding interview.

The whole transcript was reviewed to identify factors related to culture of the ED and content was coded according to context, regardless of where it occurred in the interview text. Statements were analyzed for latent (underlying meaning of subject content) and manifest (literal subject matter) content. The text was reviewed for words, phrases, descriptors and topics, and then the underlying meaning of the communications was interpreted.

Text segments were identified with codes to reflect the meanings of the study participants' responses. Codes helped to reorganize the data and gave different views of the data. Comparisons were made with previously coded material in the same category. Code words changed and evolved as the data analysis developed. As well, code words changed and transformed me who, in turn, changed and transformed the code words as the analysis proceeded (Seidel, 1998).

Coding documentation review.

I reviewed relevant internal (within the IWK Health Centre Organization) ED and mental health documents pertaining to children/youth in an attempt to discover what/if any documents existed that may influence, guide, impact and/or direct the ED and EMHAS staff in the provision of providing care to children/youth who arrive in the ED primarily for a mental health concern. Most analysis was done with words. The words from the documents were assembled, sub-clustered, and broken into segments. They were organized to permit me to contrast, compare, analyze, and bestow patterns upon them. These created a core of recurring themes that were then coded accordingly.

Sorting and clustering codes.

Patterns appearing in the coding were identified through repeated analysis of the content and context of the study participants' statements and through the visual identification of overlapping codes. Comparisons were made with previously coded material. The interviews were analyzed using content analysis in which both manifest and latent themes were identified. With manifest analysis the interview text was reviewed for words, phrases, descriptors and topics that were central to the study participants' responses. Latent analysis considered the underlying meanings of communication. Specific codes were then created to represent groups of related data.

The final framework for analysis was data-driven. The study findings were analyzed according to the sequenced trajectory of the understanding the culture of the IWK Health Centre ED in terms of providing care to child/youth with mental health concerns by: processes, internal/external influences, behaviors, language, staff attitudes, customs, traditions, and ED and mental health mandates that influenced providing care to children/youth with mental health concerns. I assumed that there would be an overlap within this trajectory, as events did not always unfold sequentially.

Linking the analyses from observations, interviews, and document reviews.

I compiled all findings from analysis by first starting with themes that emerged from documentation review, as documents specific to mental health and the ED should have provided and influenced the ways in which ED and EMHAS staff provide care to children/youth with mental health concerns in the ED. Themes from the documentation review were then compared with themes identified from observations and staff interviews. I identified these themes, compared themes from observations and staff interviews in accordance with themes from the documentation review, and discussed influences, incongruences, and similarities amongst all themes identified. I attempted to link analysis in this order, but wish to acknowledge that I was open to mixing back and forth with all the

analyses to pull things together to answer-so what does this all mean?

Trustworthiness

In any qualitative research project, four issues of trustworthiness demand attention: *credibility, transferability, dependability,* and *confirmability*. *Credibility* is an evaluation of whether the research findings represent a "credible" conceptual interpretation of the data drawn from the participants' original data (Lincoln & Guba, 1985). I addressed the *credibility* my research findings and data analysis by member checking the content retrieved from staff interviews (to ensure that the findings reflected the study participants perspectives conveyed in their interviews) with ED staff, EMHAS staff and Protection Services. Once completed, I will check the cultural findings with ED and Emergency Mental Health Service Team staff individually (general themes and codes) regarding the IWK Health Centre ED in terms of providing care to children/youth with mental health concerns to the above-mentioned teams.

Transferability is the degree to which the findings of this inquiry can apply or transfer beyond the bounds of the project (Lincoln & Guba, 1985). To address transferability, I created a "paper trail" of procedures and conclusions drawn ensuring the ability to transfer the conclusions of this inquiry to other cases, or to repeat, as closely as possible the procedures of this project.

Dependability is an assessment of the quality of the integrated processes of data collection, data analysis, and theory generation (Lincoln & Guba, 1985). *Confirmability* is a measure of how well the inquiry's findings are supported by the data collected. (Lincoln & Guba). To address the issues of dependability and confirmability, I relied on an independent rater, my thesis supervisor, to audit my research methods and data analysis. Following the original coding of data collected from staff interviews, I re-coded two randomly selected transcripts. Intra-rater reliability was reflected by the degree of agreement among multiple repetitions of a diagnostic test performed by a single rater. My

personal reflection of data collection and were reflected upon in order to label codes and find major themes in the data. My thesis supervisor and me determined inter-rater reliability. Each rater coded two randomly selected transcripts. Once coding consensus was reached, the coded transcript was given to thesis committee members for general consensus and approval.

Ethical Considerations

Ethical approval for the study was obtained from the IWK Health Centre Research Ethics Board, Halifax, Nova Scotia. I hold high social regard for the research project and was aware of the moral and professional responsibilities to carry out research involving human participants in such a manner as to respect and protect the dignity of the study participants.

I requested a meeting with ED, EMHAS staff and Protection Services management to present the research study and secure entry-level approval into the ED (Appendix A). Once approved, I made staff aware of my presence in the ED, and addressed any questions/concerns that staff may had. I also put up a poster with information about the study in the ED staff room once I was approved by ethics. I also requested that management sent a letter to all staff introducing the ethically approved study and invited eligible staff that was interested in learning more about, or participating in the study to contact me via e-mail or telephone (Appendix B).

Children/youth with mental health concerns signed a written form of consent prior to being observed (Appendix G). I also encouraged children/youth to speak up and voice any concerns indicating if at any time during the observation process they wanted to stop, and also reminded the children/youth prior to the beginning of an observation that consent could have been withdrawn at any time and that the care they received was *not* jeopardized in any way. In addition, if I noticed, or experienced tacit knowledge that my presence was affecting the child/youth in a negative way (i.e. contributing to and/or exacerbating any presenting symptoms), I would cease observation of that

child/youth. No observations were ceased because of my presence.

I also acknowledged that a child/youth might have become progressively agitated and/or aggressive during an assessment and may have required moving into a seclusion room. Even if the patient did not raise concern about me continuing to observe, I would have depended on my clinical judgment, and ED/ EMHAS staff experience, to determine whether to continue observation. This scenario did not occur. If a situation began to escalate, or I worried that I was interfering with routine clinical care, or the child/youth or ED/ EMHAS staff asked me to leave, I would stop observation. Clinical care was *always* the priority. This scenario did not occur. I did not withdraw from the assessment of the child/youth until it was complete.

A parent/family member was present in the assigned assessment room with the child/youth during five observations. When a parent/family member was present in the assigned assessment room with the child/youth, I provided an explanation of the purpose of the observation, and obtained written consent prior to the assessment beginning. I explained that I was observing in the assessment room throughout the duration of the assessment. I also explained that, during the process of observation, I would not be engaging in, or contributing verbally and/or physically, in any way during the assessment. If there were any discrepancy (i.e. family member declined to have me present while the child/youth consented to being observed), I would politely remove myself from the room. This scenario did not occur. If a child/youth presented to the ED unaccompanied (no matter what age), written consent (Appendix G) was obtained by an ED/ EMHAS staff member, and/or myself. Capacity of the child/youth was assumed and discussed in collaboration with the assigned staff and/or healthcare team.

I also wish to acknowledge that I did not join any assessments that were already in session and, that after each assessment, I allotted time to personally debrief each case by answering questions that

enabled self-reflection (described above) and ensured an effort that an emic perspective was maintained throughout observation, and took time to write any notes from the observation period. Informed, voluntary, written consent (Appendix H) was obtained from all study participants who were interviewed and from children/youth who were observed (and if applicable from parents/guardians).

Verbal assent (Appendix C-E) from ED and EMHAS staff present was obtained prior to any observation period. I ensured that consent was not influenced by a prior relationship with the study participant or undue influence to participate, by making all potential participants fully aware of the my identity in the initial letter of invitation. If all individuals present verbally assented, then the observation proceeded. No staff opposed, so I did not have to come back at a different time, or different day (i.e., perhaps a day that staff member was not working, depending on the reason for declining to be observed).

All staff of the ED, EMHAS and Protection services were informed of the following in the letter of invitation (Appendix B): (a) that participation was voluntary and study participants may withdraw at any time without affecting their current or future employment status, (b) the purpose and significance of the study, (c) my professional background, (d) the inclusion and exclusion criteria, (e) the length of the interview, (f) that the interview would be audio-taped and later transcribed verbatim.

I also wish to make it known that (g) that all information was confidential and stored securely in a locked cabinet in my home, any online files used for data analysis were password protected, and that interviews were accessible only to the investigator, transcriber and thesis team, (h) that identifiers (names, job position) were substituted with codes on the interview tape and transcription, and would not appear in any reports or publications of the study (consents were kept separate from any data), (i) that participants would have the opportunity to ask questions related to their participation in the study, (j) that if the interview became upsetting, options would be given to stop, take a break, resume, re-

schedule, terminate the interview, and/or connect with support services, (k) that upon completion of the study, the audio-tapes and transcripts would be destroyed according to the current tri-council ethical guidelines, (l) if a study participant chose to withdraw from the study prior to the audio-tapes being transcribed, the audio-tapes and transcripts would be destroyed immediately, (m) if a study participant chose to withdraw from the study after audio-tapes have been transcribed and coded, the study participant would be assured that none of their quotes would be used in publications, and because coding will have already taken place, they would not be contacted for any follow-up of any kind pertaining to study findings, (n) that all information was kept confidential unless the investigator is subpoenaed to testify in court, in which chase the investigator would notify the participant.

Confidentiality was assured. It will also be stressed that direct benefits were not expected for the participant. However, an opportunity to talk about their experience of working with children/youth with mental health concerns in the ED setting could be helpful in understanding the culture of the ED and that others could benefit from the findings, and that the findings could lead to further implications for future research.

It is also important to acknowledge that during the processes of observation, that in extreme situations in the ED involving a child/youth with a mental health concern and/or ED/ EMHAS staff (i.e. aggression, violence, medication administration, physical restraint, etc.) where my mental health expertise is needed, I may have had to act as a mental health clinician as opposed to the student role for which I am in the ED setting conducting research. This scenario did not occur.

Participants were informed that if they wish, they could receive a summary of the research findings. Research results used anonymized quotes with permission from the participants with no profile analysis of individuals, since such profiles could be identifiable. Participants were also informed that I would publish my findings in scientific publications as well as reports for key

stakeholders (health professionals, decision-makers and policy makers, the public). The consent forms obtained a signature for 2 separate consents: (1) to participate in the study, to be audio-taped, to allow the use of aggregate data for educational and publication purposes, (2) and to allow the use of direct anonymized quotes in the publication of my results in the future.

Summary

My work with children/youth (predominantly admitted through the IWK Health Centre ED) with mental health concerns on a psychiatric inpatient unit for the past six years has continuously challenged me to understand *what is* the process of caring for, and what *influences* (both internal and external of the IWK Health Centre ED) impact providing care for children/youth with mental health concerns in the ED. The final two years of my inpatient work consisted of solely night shifts. The majority of overnight admissions came directly from the ED. When children/youth would arrive on the inpatient unit, part of my care consisted of learning about their experience that had led them to be admitted. Children/youth would share their process that day of having come to the ED and the trajectory of their care that followed. They would identify successes of the ED, challenges, and were quick to identify gaps that needed to change. I began to recognize that each child/youth had extremely different experiences in the ED and note the inconsistency in the process of their care. I became extremely curious.

I began to start to ask myself what specifically was it that I wanted to find out about providing care in the ED. My curiosities included internal and external factors that may have influenced *how* care was provided to children/youth with mental health concerns in the IWK Health Centre ED and included; staff (i.e. attitudes, morale, roles in working with patients with mental health problems); institution (i.e. organizational climate, structural environment/ physical layout, interpersonal environment); and guidelines (i.e. written ED practices and customs for patients with mental health

concerns, IWK Health Centre organizational mental health and ED policies, protocols, standards, and child/youth mental health referral documents).

An ethnographic approach was selected as the most appropriate research method because my primary goal was to understand the culture, as defined by Whitehead (2002), as being holistic, flexible and non-constant system with continuities between its interrelated components, which included shared ideational systems, preferred behaviors and structural relationships.

By exploring the culture of a pediatric ED as it related to providing care to children/youth with mental health concerns, I could identify the internal and external influences that warranted improvement or change in order to provide optimal care to children/youth with mental health concerns. Such influences included; social systems that individuals interact within, are influenced by, and have an influence on; the knowledge, attitudes, beliefs, values, and meaning held by individuals and social systems; expressive culture as represented in language; physical environments in which humans interacted; needs that humans must meet in order to achieve the level of physical functioning necessary to the survival of the individual and group; and the human groups shared history of significant events and processes (Whitehead, 2002). It is important to stress that I was in the ED environment to *learn from* rather than *study* the staff and culture, while recognizing that I was an integral part of the process.

Chapter III

FINDINGS

This chapter reports the findings regarding the culture of the IWK Health Centre ED using three approaches to data collection: observation of children/youth with mental health concerns while receiving care; official document review of ED and mental health standards, guidelines, policies, etc.; and interviews with ED staff and EMHAS staff. Direct quotes from staff interviews have been interspersed throughout all sections. Every attempt was made to protect anonymity of staff interviewed, however it was important to clarify the two teams (i.e. ED or EMHAS staff) when direct quotes were used. Data were collected between February-June, 2014. The data helped to answer the research question- *What is the culture (i.e. values and beliefs) of a pediatric ED in terms of providing care to children/youth who arrive primarily to the ED for a mental health concern?*

Observation

Procedure

Observations took place in the three areas of the IWK ED: the assessment room (#5); the EMHAS office; and the blue desk (i.e. nursing station). Fourteen observations were completed over two weeks from February-March, 2014. I observed children/youth with mental health concerns in the *assessment room* (n=4) during assessment by ED staff and/or EMHAS staff. Observation also took place at the *ED blue desk* (n=3) if a child/youth with a mental health concern was either waiting to be assessed, was being assessed, or had just been assessed by the care team. Observation also occurred in the *EMHAS office* (n=5) where collaboration occurred between the EMHAS and ED staff, and where plans of care for children/youth with mental health concerns were developed and discussed. Two observations were completed in medical rooms of the ED (i.e. room #6 and room 'A'). Room #6 was used because the patient being assessed had been admitted primarily for a medical reason, prior to

psychiatry being consulted, and room 'A' was used because the mental health assessment room (#5) was being used. I engaged only in observation and not in any discussion or interaction with the staff, patient, or family during observation time. Written consent from patient and guardian (if present) and verbal assent from staff were obtained prior to observation.

Observation Settings

Observation took place in three specific locations the IWK Health Centre ED and included: the assessment room (#5); the EMHAS office; and the blue desk (i.e. nursing station). The three areas observed were those that are most often used by child/youth with mental health concerns in the ED and by staff who provide their care (Appendix I). It is important to acknowledge that not all areas of the ED were observed during this study.

Observation in the assessment room, the EMHAS office, and the 'blue desk' provided opportunity to view, holistically, the socio-cultural contexts of social systems in the ED (i.e., social networks, relationships, groups, and dyads), and the physical environment of the ED (i.e., layout). Observation in the 3 specific areas of the ED also revealed the expressive-cultural processes shared among individuals (i.e. languages, behavior, gestures), and lastly the socio-cultural meanings that individuals applied to the three spaces within the physical environment (i.e. assessment room, EMHAS office, and blue desk area).

I maintained an emic view during observation to *learn from* ED staff and EMHAS staff. In order to maintain an emic perspective, I answered three questions at the end of each observation period to enable self-reflection: (1) What did the staff help me learn about their perspective? (2) How did I listen in an emic way? (3) What was my biggest challenge of being emic and not etic?
Staff observed in the ED included those from multiple disciplines (i.e. nurses, social workers, physicians, etc.). The purpose was to observe whether/how the interactions influenced the culture of

the ED in terms of providing care for child/youth with mental health concerns.

I allocated three-four hours at varied time periods, during seven days a week for two-weeks when a child/youth with a mental health concern was present in the ED. Within these time periods, I spent time moving within all three above mentioned observation sites, depending on whether a child/youth with a mental health concern was present in the ED (i.e. waiting or being assessed).

Assessment (room #5) observation

The assessment room is located in the IWK Health Centre ED and is 151 square feet in size. Children/youth with mental health concerns are seen and assessed by the EMHAS and ED staff. After the triage nurse assessed the children/youth (at the triage desk in the ED upon arrival) and psychiatry was consulted, the child/youth was placed in the assessment room to await assessment and/or intervention from the EMHAS or ED staff. The child/youth was usually accompanied to the assessment room by their assigned ED staff health RN. The child/youth may have spent upwards of fifteen minutes alone, with family, or a friend, prior to the start of the assessment, as the EMHAS staff often reviewed the patient's visit history to the ED via their online health records.

Once the EMHAS staff and/or ED staff entered the room/meet with the child/youth, I then entered the room and requested consent to observe the assessment. If permission was granted, I would sit in the room, visible to the child/youth, and quietly observe the interaction and recorded field notes as the assessment progressed. I did not speak, but only observed, staff interactions (physical and verbal) with the child/youth (Appendix J).

I completed 14 observations during varying days of the week; time of day, and locations throughout the ED. Observations also included a variety of disciplines in the setting (Appendix N). Throughout my 14 observations, the layout of the space remained relatively the same, with slight variation at times in terms of certain equipment that was present in the room (e.g., medical supplies,

gauze, stethoscopes, tongue depressors, etc.). The assessment room walls were bright (green, orange, and purple) and the floor was also purple. There was no medical equipment or pictures on the walls.

There were two entrances into the assessment room, both with swipe access mounted to the walls. The assessment room had magnetic locks in case patients become agitated and needed to deescalate (this scenario did not occur during my observations). There was one security camera located in the room. Staff informed me that the camera was not on and that patients were not being monitored by any staff. However, unless asked, this information was not given to patients and/or families.

There was a gurney horizontally located against the back wall of the assessment room, where all children/youth sat during assessment, without invitation to sit in a chair. Adjacent to the gurney were two chairs (usually used by family members, or in this case by me) and there was another chair at the foot of the gurney where the assessor on the EMHAS staff sat. A brown paper garbage bag and a cart with medical supplies (i.e. swabs, gloves, thermometers, cotton balls, band-aid's, tongue-depressors, etc.) may/ or may not have been present, depending on staff assessment of the child/youth at that time. Some staff (both EMHAS and ED staff) preferred not to leave any equipment in the room with a child/youth based on their risk and safety level at that moment.

The number of people in the assessment room ranged from two-to-six and included members of the EMHAS team (i.e. a social worker or a nurse), members of the ED staff (i.e. nurse or physician), and learners (i.e. psychiatry residents, medical students, and emergency residents). Typically, the EMHAS staff spent roughly one-hour or more with the child/youth addressing their initial concerns that caused them to seek care in the ED. The parent/guardian, or person who accompanied the child/youth may or may not have been present during the initial assessment. Following the assessment, the EMHAS staff typically returned to the EMHAS office and provided a brief update to their

EMHAS colleagues who were not involved in the assessment, and notified them that they are going to be meeting separately with the family member of the youth, usually around the corner in the family room.

Throughout nine of my 14 observations, EMHAS staff informed the assigned ED RN that the child/youth was going to be left unattended while the EMHAS staff met with family. In those nine instances, the assigned ED RN told EMHAS staff that they would "go and check-in" with the patient at some point, but the manner in which it was conducted varied. After the EMHAS member returned from meeting with family, the decision was made whether to consult psychiatry. The EMHAS member would then alert an Emergency Room Physician (ERP) that a medical clearance of this child/youth was needed. It was observed that for the majority of the time, EMHAS staff would seek out an ERP without notifying or communicating with the ED RN. Depending on other contextual factors of the ED (acuity of other patients in the ED at that time, staff availability, etc.), the ERP performed a medical clearance exam when available (range 10-25 minutes).

I observed six physical exams performed by ERP's. All assessment exams varied in their approach and were performed by six different physicians. Some medical clearances involved physical touch, palpations, vital signs, and bloodwork, while others consisted of the ERP asking physical health questions. In four of the observed physical exams, the child/youth seemed slightly reluctant to have the procedure done and asked "why" they needed to be physically assessed. However, no child/youth refused to be physically assessed.

Other audible activities occurring throughout the ED setting during my observations commonly included babies crying, full waiting room area, a relatively noisy environment, phones ringing, family members and children pacing in the hallways, and during five observation sessions, two mental health assessments occurring in different spaces at the same time. While a waiting list was

infrequent, on three occasions, one-or-two children/youth with mental health concerns were waiting to be assessed by the EMHAS team.

Conversations that I observed included ED and EMHAS staff concerns for the overall well-being of the child/youth and family, curiosity, sympathy, validation, respect, and compassion. Common language used by ED and EMHAS staff when working in collaboration with each other reflected respect and relevant information sharing about the child/youth. On multiple occasions, interactive patterns between the assigned ED RN and the EMHAS staff involved the ED RN coming to the EMHAS office and asking "what's the plan with room #5?" This common question would often begin a conversation in which the child/youth was discussed and a plan of care was established.

Throughout the periods of observations, I noted that the culture of the ED in terms of caring for a child/youth with a mental health concern was functional, predictable, and routine. Both ED and EMHAS staff had notable patterns, routines, and preferred behaviors, that made the process of providing care to children/youth with mental health concerns, familiar. From the patient's point of entry into the ED (i.e., triage) to the time of disposition (i.e., discharge or admission), the process and behaviors of providing care seemed routinized. Rules and routines seemed to have reflected a particular order and regularity in the approach used through the trajectory of care for a child/youth with a mental health concern in the ED.

Collaboration and information sharing between the EMHAS and ED staff occurred inconsistently. Any collaboration and information sharing between EMHAS staff and the ED RN, assigned to the child/youth with a mental health concern, depended solely on the staff's comfort level in doing so. One EMHAS staff noted;

> I will talk to the ERP to let them know they need to come over and see this kid. The doctor has to clear the patient so I almost never give information to the ED nurse. It's not because I don't like the nurse, it's because they almost never know, or don't need to know, unless it's salient to their care.

I also observed that ED staff and EMHAS staff work as two separate teams to provide care to a child/youth with a mental health concern. One ED staff explained;

> The EMHAS team takes over and starts their assessment with the patient. I think that the kids are here for a mental health assessment and the EMHAS team is the ones who do the mental health assessments. I am here if anyone has questions, I can show them where the kitchen is, I can do other things if they need it, but I am not going to go ask the nurse 'what can I do for you? They don't ask us what we need them to do or come and check-in on the other patients we are looking after. It is 'our' team and 'their' team. There is that division there and I think that is okay.

I observed a level of comfort and familiarity with staff between the ED and EMHAS team through their conveyed respect and professionalism while they interacted with one another. One ED staff member explained that:

> I am more comfortable now going in to speak with the EMHAS team than I have ever been and I will want to go in and talk about the kids and problem solve together. I think what has changed is that the number of mental health staff in the program has evolved, and there are nurses on the team that I think know where we are coming from, and I think that the respect is there.

Contextual factors of working in the ED (i.e. noise, acuity of patients, worry of family members, short staffing complement, etc.) led to tensions and frustrations between the two teams. Despite tensions and frustrations at times of specific care providers, it was evident by observation that the ED and EMHAS staff shared a common goal of providing best care to children/youth with mental health concerns in the ED. One EMHAS staff shared;

> I think we often get frustrated with the medical staff and them with us. The common goal though is making this patient better of giving this patient a positive emergency department experience. As frustrated as people can get [in the ED], I don't think anyone is bad intentioned. Our biggest similarity is that we all do want that patient to have the most positive outcome and experience while in our care.

In seeking to understand the culture (i.e. values and beliefs) of staff that provided care to children/youth with mental health concerns, my 14 observations have revealed that ED and EMHAS worked collaboratively to provide a common goal to achieve optimal mental health care and ED

experience to these children/youth and their families. Despite contextual factors of the ED that can lead to frustrations between the two teams at times, the processes of care to children/youth with mental health concerns were delivered in an organized, predictable, and familiar fashion. Meanings of certain behavioral patterns and expressive culture (i.e. language used) by ED and EMHAS staff when working with children/youth with mental health concerns varied depending on the individual and the team. One EMHAS staff explained that certain language could be misunderstood as stigma depending on the circumstance:

> You hear a lot of 'this is behavior' or 'this is all personality'. I mean, what does that even mean? You hear 'attention seeking' and 'manipulative' a lot. It depends, if I'm talking to psychiatry and the patient actually has borderline traits, well then that's important to know. As a whole, we all have to be more mindful of our language.

There existed a shared knowledge between the EMHAS and ED staff that comes from working in the same environment, the ED. Some members of each team shared a history of significant events and processes that influenced the way in which they provided care. I observed staff discuss past shared experiences in the ED. There were also knowledge, beliefs, attitudes, and values from ED and EMHAS staff that were shared in hopes of providing a more thorough understanding of culture within the ED. Emergency Department and EMHAS staff shared knowledge to provide holistic care to children/youth with mental health concerns in the ED. One EMHAS staff member commented on the strength of the two teams in providing care based on staff's knowledge amongst both teams:

> It's always nice to draw from strengths of different staff. For example, an emergency nurse may not be delving too much in the mental health history, but may have been able to make a different rapport and have been able to note some of the medical things that are going on, or pick-up on some dynamics within the family. It's always great to get other people's perspectives and expertise.

Over 14 observations, in three specific care areas of the ED (i.e., assessment room, EMHAS Office, and blue desk), I saw the same amount of care being provided to children/youth with mental health concerns. Care was provided in a routine manner that staff seemed familiar and comfortable

with. Care provided did not vary depending on time of the day, day of the week, location of where providing care occurred, and/or discipline of the staff whom was providing care.

Emergency Mental Health and Addiction Service (EMHAS) Team Office

The EMHAS office was located in the ED, adjacent to the 'blue desk', nursing station. No child/youth with a mental health concern was taken to, or assessed, in this room. The EMHAS members, psychiatric residents, and psychiatrists used the room for documentation of children/youth mental health assessments, discussed referrals, and coordinated plans of care. The EMHAS room was also where ED staff came and collaborated with the EMHAS staff about providing care to child/youth with mental health concerns. I obtained verbal assent from EMHAS members and ED staff prior to each observation period in the EMHAS office.

The EMHAS office is 115 square feet in size (Appendix I). The EMHAS office had one door that was usually closed to ensure privacy and confidentiality. The room had one small window with a blind on it, which also was often closed for privacy. Some staff opened the window as soon as they saw it shut in order to promote collaboration with ED staff and a more welcoming environment. ED staff have acknowledged that the location of the EMHAS office was being a "barrier" and "obstructive" to collaboration. One staff member continued to explain,

"You know, it's a door, knock on it. It's a heavy door when you knock on it you don't even know if your knock was heard. The blind open is the only way to let us know that they are in there".

The walls of the office had two bulletin boards that were managed (infrequently) by EMHAS staff and were full of information, brochures, contact numbers of certain mental health services, posters, upcoming research opportunities, etc. There was one small fridge for staff to use. There were three computers in this small space and four chairs. The room accompanied two people comfortably, but any more and the room felt quite cramped. "The crisis office is horrendous. I actually have no

problem with small offices or shared offices, but it doesn't meet the need. We can't speak confidentially either on the phone; it's very difficult".

On three of the five occasions that I observed in the EMHAS office, at least one EMHAS member left the room to go elsewhere (i.e. chart, make a phone-call, etc.) if there were too many learners or multiple ED physical health staff, present who were collaborating about a particular child/youth with whom they may not have been involved.

During observations, I sat in the EMHAS office and recorded field notes as needed, looking at criteria mentioned in the Grid of Observations (Appendix J). I observed staff interactions; collaboration with ED physical health staff, and other multi-disciplinary staff involved in the care of children/youth with mental health concerns. I also observed information sharing between teams, language used, influences (i.e. internal or external), and routines (i.e. paperwork, practices, communication, etc.) that affected decisions for child/youth care. Five observations in the EMHAS office were completed at different times of the day, and during different days of the week, in order to achieve as much variation amongst staff and contextual factors of the ED.

During all of my five observations in the EMHAS office, at least one member of the EMHAS criticized the size and layout of their workspace. Common frustrations amongst EMHAS staff included their lack of privacy and confidentiality within their office. There are two telephones in the EMHAS office. If two EMHAS staff were on the phone at the same time discussing two different children/youth, confidentiality was compromised. EMHAS staff acknowledged that their workspace acted as a barrier to promoting communication and collaboration with ED staff.

On two occasions, I observed a member of the ED staff (i.e. ERP or RN) come into the EMHAS office and share information about a particular patient in front of uninvolved staff. During both of those instances, the ED staff stood because there was no available space. On two other

occasions, the ED RN stood at the door, and another incidence involved the ED RN saying “I will come back later when it isn’t so loud in here and there aren’t so many people”.

The RN and Social Worker that were on shift that day predominantly occupied the EMHAS space. The psychiatry resident and psychiatrist frequently came down to check-in, but had offices of their own that they could resort to if they were not needed in the ED at that particular time. Communication in the EMHAS office centered on children/youth with mental health concerns that were being seen, had been seen, and/or were waiting to be seen. Prior to the EMHAS staff going in to assess a child/youth, they often looked up their visit history and any additional information (medical information, current clinician, etc.) on the IWK Meditech system. On one occasion, staff went directly in to meet with the patient prior to reviewing any history. In that particular case, the EMHAS staff knew the patient from previous visits to the ED.

Common behavioral patterns and routines that I observed in the EMHAS office, included EMHAS staff coming into the office to update their EMHAS colleague regarding their initial impression after having assessed the child/youth and informing their colleague of their plan of care (meet with family, consult psychiatry, have the child/youth medically assessed by the ERP, obtain collateral from a third source, etc.) During four of the five observations, an EMHAS staff asked their assigned colleague, if available, to look up some educational information pertaining to the reason for their presentation to the ED and gave it to the child/youth (information about self-harm behaviors, self-esteem building strategies, medication pamphlets, etc.).

When the EMHAS staff consulted psychiatry, the EMHAS staff, psychiatry resident, and/or psychiatric met in the EMHAS office and discussed the child/youth’s assessment and history that he/she had obtained thus far, gave an impression, opinion as to initial impressions re: the underlying issue, and treatment recommendations. This collaboration between EMHAS staff (i.e. nurse, social

worker, psychiatry resident, psychiatrist) occurred on all five of my observations (three times on-site, twice by telephone). This interaction and information sharing which was a normative routine, on average, took 25 minutes. Throughout the day (until 5pm), once psychiatry was consulted, the resident or psychiatrist would be in the EMHAS office within minutes if not already there. However, at night (after 5pm), the psychiatry resident on-call had up to 30 minutes to get into the hospital, so this can delayed the process slightly.

I was able to observe EMHAS and ED staff in the EMHAS office on five separate occasions, at different times of the day, and varying days of the week. It became evident that EMHAS and ED staff viewed the current workspace to be inadequate for two main reasons: lack of privacy, and lack of confidentiality for the child/youth with a mental health concern. Another notable concern was the limited physical office space that acted as a barrier to facilitate collaboration between the EMHAS and ED staff.

Interactive patterns between EMHAS staff involved information sharing and collaboration pertaining to the child/youth with a mental health concern. These interactive patterns appeared routine and predictable, occurring during each of my observations. Similarly, EMHAS staff's knowledge and attitudes were shared and voiced during all of my observations. Issues discussed related to the process of care of a particular child/youth, the mental health issues or illness, the availability of education resources, community resources for the child/youth, and disposition of care. During these interactions among EMHAS staff, I generally observed that they proceeded in a routine way and involved concern for the child/youth, active listening when other staff were speaking, and willingness to provide optimal care to this child/youth.

Interaction patterns among EMHAS staff entailed the search for a particular ERP or ED staff with whom to consult for the child/youth's presenting symptoms/medical clearance, or discussions of

how staff interact when ED staff took the child/youth for admission to the inpatient unit. Emergency Department staff often word 'code language' when transferring to the EMHAS team (e.g. 'room #5', 'the patient watch', 'the involuntary patient', etc.). Emergency Department staff was not purposefully bypassing the protocol of processing a child/youth with a mental health concern, but it was clear through their actions that they were trying to have the child/youth worked through the ED in a manner as efficient as possible.

In contrast, collaboration and information sharing between the ED and EMHAS staff was inconsistent. On two-of-the-five observations in the EMHAS office, no ED staff were involved in discussing the child/youth's plan of care. During two-of-the-three observations when ED staff were present, the child/youth had first been seen and assessed by the ED staff (i.e., the child/youth was admitted for a medical reason first, then consulted to psychiatry).

During every interaction, the ED staff's concern for the child/youth and willingness to help provide care in whatever way was clear. However, I noted that some ED staff often asked EMHAS staff 'what can I do?' or 'what do you need?' without necessarily checking on the child/youth themselves. While other ED staff would sit-with, speak with, assess, and/or check-in with the child/youth in the assessment room.

I also observed separate conversations within the ED team and EMHAS team about the lack of clarity regarding the other team roles. Emergency Mental Health and Addition Services staff talked about not knowing how involved ED staff needed to be, or should be, while ED staff raised similar concerns regarding the specifics of the EMHAS team role and the care that they provide. Discussions at times centered on opposing beliefs and attitudes felt from both teams regarding who had/should have the legal responsibility for the child/youth with a mental health concern in the ED. One ED staff noted "I think that the Crisis Team should be able to take ownership of their patients and consult

emergency if they want an emergency physician's assessment. When they come seeking mental health, I am not the person to see them". Similarly, one EMHAS staff shared,

> Sometimes I find that because of my nursing background it's hard to get my head around the fact that I'm technically not my patient's staff even though I have been the primary clinician with them throughout their entire experience in the ED. That process needs to change.

Despite the confusion, both ED and EMHAS staff argue that the process of communication and collaboration between the two teams has improved throughout the past couple of years, and are confident that this positive change will continue to take place. One ED staff member stated:

> If you asked me five years ago if I thought this process of working together was good, I would have said 'probably not'. Now, I would definitely say we are much better. Seventy-percent of the time we work together. To be 100%, the other 30% would be attributed to the fact that I think we would need to figure out how much of a role do we need to have.

'Blue desk' (i.e. nursing station) observations

The ED blue desk was located at the center of the ED (Appendix I) and is 330 square feet in size. The blue desk was the area that all ED staff members use to document, collaborate, and plan care for their patients.

I obtained verbal assent from ED and EMHAS staff located at the blue desk prior to each observation period. I acknowledged that it would have been extremely challenging to obtain verbal assent from all ED and EMHAS staff members present due to constant flow of staff, students, housekeeping, and administrative staff entering/exiting the ED at various times. I was accompanied to the blue desk with an EMHAS worker during every observation at the blue desk. I obtained assent from staff present at the blue desk *prior* to observation but would not stop for assent of staff that came to the blue desk *during* observation/interaction between the ED and EMHAS staff. I focused primarily on staff assigned to children/youth with mental health concerns in the ED, observing how staff interacted with children/youth, language used during interactions, discussions about how the physical environment influences the care of children/youth with mental health concerns, the process of a

child/youth with a mental health concern in the ED, and the roles of staff members in the child/youth trajectory of care. I also observed how staff interaction, communication, and collaboration occurred and how it influenced the culture of the ED as it pertains to providing care to children/youth with mental health concerns.

I completed three observations at the blue desk. Observations took place at the ED blue desk *only* during and/or after periods of time during which children/youth with mental health concerns were undergoing assessment by the ED and/or the EMHAS, as well as during nursing shift change. These times were identified as those during which it would be most likely that ED and EMHAS staff would be collaborating with one another.

During these observations, I did not engage in conversation but instead stood in the ED nursing station and recorded field notes. Emergency Mental Health and Addiction Services staff was present during all three of my observations at the blue desk. There were five chairs at the blue desk that were mostly occupied by nurses who were charting. Physicians, nurses, and other staff members were observed to be standing while documenting or discussing other children/youth. Depending on if chairs were available and the length of time needed to share information with the ED staff about the child/youth with a mental health concern, EMHAS staff would often stand when sharing this information. On one occasion, the EMHAS staff sat down at the blue desk to share information with the ED staff nurse assigned. On each occasion, the EMHAS worker went to the blue desk area to notify the assigned ED RN or ERP that the patient needed to be medically assessed. This message would either result in further conversation pertaining to the child/youth (i.e., disposition plan or presenting symptoms) or the ED staff would acknowledge the request and let the EMHAS staff know when he/she would be available.

However, how the process was carried out was not consistent, as some EMHAS staff would seek out any ED staff available (RN of ERP), while other EMHAS staff would only speak with the ED staff assigned to the child/youth with the mental health concern.

I did observe on one occasion an ED staff become visibly frustrated when asked to medically assess a child/youth with a mental health concern, as the ED team was short-staffed, had an over-crowded waiting room with complex physical health children/youth cases. The frustration expressed by the ED staff was the sole occurrence that the researcher observed pertaining to ED staff involvement with a child/youth with a mental health concern. The process proceeded differently depending on the staff (ED or EMHAS) member involved, complexity of the child/youth, and/or the ERP available for clearance. The process of providing care to a child/youth with a mental health concern was affected by the very busy nature of the ED that provides care to children/youth with physical health concerns. It was observed that when the physical health children/youth required care, ED staff was not available (i.e. RNs and ERPs).

On one occasion during my observations, I observed a youth be admitted to the inpatient psychiatric unit. Interestingly, the assigned ED reluctantly (as evidenced by the ED staff member saying "I don't know why I have to walk this kid up, I don't even know him/her"), was the staff that accompanied this youth upstairs. On this particular occasion, the ED RN had no prior contact to this child/youth. I sought to find a document or rational for this process. I could not find a document that addresses this process. As per verbal communication from Kristi Kempton, Manager of the EMHAS team at The IWK Health Centre, I learned that "I am not aware of any written policy or memo that requires ED staff to transport patients as it is the ED's patient (we are a consulting service) and they would be expected to accompany any ED patient to the unit if admitted. Having said that I know if things are quiet, that the EMHAS may take the patient to The Garron Centre. If they do, the ED nurse

should still give a telephone report to the nurse on the unit". This is noteworthy, as it would be of worth questioning as to 'is this the most efficient use of the ED RN's time and is it in the best interest of the patient?

The blue desk was a medically dominant area where ED and EMHAS staff hand-over information pertaining to children/youth with mental health concerns in the ED. However, I observed minimal collaboration between the ED and EMHAS team at the blue desk. Instead, most collaboration occurred in the EMHAS office. I did note that when ED and EMHAS staff did reporting at the blue desk, other members of the ED team listened, showed concern and active interest in the presenting circumstances of the child/youth with a mental health concern.

Not surprisingly, I observed tangible differences in practice routines and behaviors between ED staff and EMHAS staff. Issues discussed by ED staff at the blue desk involved physical illness and symptomology of children/youth with presenting physical concerns predominantly. Emergency Department staff assigned to a child/youth with a mental health concern was also assigned to multiple other patients with physical health concerns. Emergency Department staff is at the blue desk all of the time, while EMHAS staff only is at the blue desk for hand off of a particular patient. When EMHAS staff were at the blue desk to engage with ED staff, most interactions about a particular child/youth were brief. In comparison, interactions between EMHAS staff involved and not involved in the child/youth's care were longer, more descriptive, and more collaborative (i.e., problem solving, finding additional resources, suggestions for community resources and follow-up, medication advice, diagnosis, and disposition).

I concluded that the process of providing care to children/youth with mental health concerns in the ED followed predictable routines. Emergency Department and EMHAS staff provided care to these children/youth, engaged in familiar behaviors, utilized common code language (i.e., room #5,

crisis patient, patient watch, etc.,) shared interactive patterns of communication and collaboration, with the shared ideational goal of providing a positive ED experience and optimal mental health care to children/youth with mental health concerns in the ED.

I observed that the process of providing care to a child/youth with a mental health concern in the ED proceeded in the following ways: the child/youth was initially triaged by the ED nurse and accompanied to room #5 by the ED staff; the triage nurse paged the ward clerk to register the child/youth in the ED; the ward clerk paged the EMHAS team and notified them that a patient was awaiting assessment; EMHAS staff walked out to the blue desk area and collected relevant paperwork (triage form and additional notes by the triage nurse) about this child/youth from the triage box; EMHAS staff reviewed Meditech and the 'H drive' and reviewed visit history (if applicable); EMHAS assessed the child/youth; EMHAS staff discussed initial impressions with another member of the EMHAS team who were not involved in the assessment; EMHAS decided disposition (this step looked different at times depending on whether psychiatry was going to be called, whether EMHAS staff wanted to meet with parents/family, whether the child/youth was admitted or discharged, whether EMHAS updated ED staff or ED staff came to make inquiries); EMHAS staff went to the blue-desk area to find an ERP and request medical clearance; child/youth was medically assessed by the ERP; EMHAS staff (at times) went to the blue desk to update the ED nurse of the status of the child/youth and disposition plan; ED or EMHAS staff would transport the child/youth to the inpatient unit if admitted.

My observations concluded that steps in the process of providing care to children/youth with mental health concerns in the ED varied. Challenges, successes, gaps, frustrations, and areas to be most efficient in the process of providing care to this population were raised by ED and EMHAS staff in the staff interview section of the research design. Such findings from the staff interviews spoke to

issues such as communication/collaboration, medical clearance, role clarity (i.e., who is involved in providing care and what is their role), and lack of directives and policies guiding care. Documents and protocols specific to the IWK Health Centre ED and mental health policies that may influence the way in which staff provided care to children/youth with mental health concerns in the ED were explored.

Documentation Review

I reviewed over a four-week period (May-June, 2014), a total of 27 IWK Health Centre ED and mental health policy-related documents specific to providing care to children/youth with mental health concerns in the ED. I accessed Quality Improvement Consultant within the EMHAS team at the IWK Health Centre, Karen Comeau, to ensure that I had access to all pertinent documents pertaining to mental health and the ED, and that none were missed. I also met with Lois Wyatt, Clinical Leader of Education, at the IWK Health Centre ED, to navigate through relevant ED documents pertaining to mental health care in the ED. Documents reviewed are listed in (Appendix O). Lastly, I reviewed Adverse Events statistics that have occurred within the ED pertaining specifically related to staff working with children/youth with mental health concerns between February 1st, 2014-September 30th, 2014. I obtained the statistics from Nida DeChamp, Occurrence Systems Coordinator for Quality and Patient Safety, and Strategy and Organizational Performance at the IWK Health Centre. The statistics of the adverse events filed from ED, EMHAS, and Protection Services staff are categorized according to the particular related event and will be identified in the latter part of this chapter.

Twenty-seven IWK Health Centre ED and mental health related documents were reviewed in order of their hierarchal rank: 18 policies, 2 protocols, 2 guidelines, 2 memorandums, 1 algorithm, and 1 legal document. Documents can be ranked according to authority. In brief review, a policy is a clear formal and authoritative statement (s) directing practice. Policies enable informed decision-making, prescribe limits, assign responsibilities and accountabilities, and are secondary to legislation and by-

laws. Policies reflect the vision, mission, values and strategic directions of the Health Centre. They are non-negotiable (One province, One process, One policy (OP3), 2010). Procedures, protocols, guidelines, practice guidelines, standards of practice, work instructions, guiding principles, memorandums, and algorithms follow in their clinical relevance. Policies, standards of practice, practice guidelines, and procedures/protocols have more authority than documents such as work instructions, guiding principles, memorandums, and algorithms.

Thirteen of the 27 documents reviewed addressed an adverse event in the ED. Adverse events included situations of having to restrain a child/youth, what to do if a child/youth goes absent without leave (AWOL) from the ED, is intoxicated, personal searches of children/youth, working with a child/youth who has been sexually assaulted, how to enact the IPTA, what to do if a child/youth presents with a police officer, staff having to use a rescue hook due to imminent safety concerns, and the safe monitoring children/youth if locked in assessment room (#5).

Fourteen of the 27 documents related to procedures and policies of ED and EMHAS staff that could affect the process of care to children/youth with mental health concerns. These involve, for example, EMHAS end of shift coverage (i.e. noting that EMHAS staff should not commence a mental health assessment, 90 minutes prior to the end of their shift), algorithms and directives regarding patients seeking physical health care, triage scores, mental health triage forms, information pertaining to medication administration, and a mental health policy highlighting that ED staff will see children/youth with mental health concerns until their nineteenth birthday, and that children/youth will receive mental health emergency care in a timely and safe manner.

There are no policy related documents that describe a vision regarding the provision of care to a child/youth with a mental health concern in the ED. There was one algorithm that showed what the anticipated trajectory of care was 'supposed' to look like. However, the algorithm failed to identify

staff expectations, roles, and tasks involved in each step of providing care, estimated time frames for each step, nor did it indicate when collaboration between ED and EMHAS staff was to occur, and I observed that steps from this algorithm varied immensely throughout the provision of care.

I retrieved 14 of the 27 documents reviewed online via the IWK Health Centre (Pulse) website, in the 'Mental Health' Department tab. Nine of the documents under review were obtained in person via Karen Comeau, Quality Improvement Consultant for the Mental Health and Addiction Program at the IWK Health Centre. Four documents were retrieved in person via Lois Wyatt, Clinical Leader of Development in the IWK Health Centre ED. All documents pertaining to patient care in the ED are kept in a red binder, located at the blue desk. I reviewed the binder and noted that the documents are kept in alphabetic order, with one tab for mental health. I obtained the ED documents pertaining to mental health care in multiple different tabs throughout the binder (medication administration, triage, involuntary treatment act, etc.). It remains unknown as to (how often and by whom) whether the red binder is updated, revised, and used.

According to Glenna Rose-Williams, Clinical Leader of the EMHAS team, The EMHAS team have a book of policies located in their office space as well as the 'H' drive located on The IWK Health Centre website. Both EMHAS and ED staff generate administrative changes in processes that may not be available online via Pulse but be sent via email, eSource, team meetings, and memos. Patient protocols used to be located in a binder. With the development of the Complex Care Management Plan, Ms. Williams has steered her team away from the binder to look at the patient protocol via Meditech, an online system used at the IWK Health Centre that holds patient information. Some old patient protocols continue to be located in the binder as transition to the new system is still under development.

Although directive policies, guidelines, protocols, etc., are located in the ED regarding specific situations and events that may occur when working with a child/youth with a mental health concern, gaps still exist regarding a number of care areas (ED and EMHAS staff have identified). For example, one staff acknowledged uncertainty surrounding how care is to be provided to these children/youth with mental health concerns and said "There's no specific policy as to how the process of a mental health patient in emerge should occur. I guess through evolutions of meetings, it was decided that this was how the process is done".

One ED staff voiced frustration that such policies do not exist and if they do exist, tend to be interpreted individually. The staff shared:

> The lack of clarity of policy and decision-making processes plays on me and is quite confusing at times. If we are told that one of the policies is that if [children/youth] show up on our doorstep then we should see them, even if they are overage. If they are here for mental health and there are physical issues after 16, then we can see them. I think there is an actual policy on that somewhere. Again, that policy is interpreted individually.

Another frustration that an EMHAS staff questioned was the lack of existing or conflicting rules regarding the ED within specific documents. The staff stated, "In the ED, there is no kid without a parent. But yet, our patients are there without a parent. Why aren't the parents called and asked to come? That's the rule in emerge. Why doesn't that happen to our kids? Why don't we enforce that protocol"?

The most recent document I received pertaining to all employees at the IWK Health Centre spoke to a new 'Staff Turnover: Exit and Retention Survey'. The email read "As of September 29th, 2014-The IWK is excited to announce the re-launch of the online Exit and Retention Survey for all employees who voluntarily leave the Health Centre and employees who permanently transfer or change roles within the IWK. The purpose of this online survey is to learn more about our workplace and to incorporate employees' feedback in supporting the programs and initiatives that make the IWK

a great place to work. A summary of the results from the survey will be compiled and shared with leadership on a quarterly basis". This is interesting to note as a new strategy, given the amount of ED and EMHAS staff that have left the IWK Health Centre Organization, since the EMHAS team implemented full-time staff in May 2013. Staff turnover rates will be explored in the following chapter.

The purpose of reporting findings from the adverse events filed from ED, EMHAS, and Protection Services throughout February 1st, 2014-September 30th, 2014, identified 'who' was filing events (which team), and also identified particular themes from the events that were filed, as the events are categorized to reflect the particular nature of the adverse event. The content of the majority of the adverse events filed also reflect the content identified in the themes from the staff interviews, which will later be discussed. The findings of the adverse events filed include the following:

The EMHAS team filed 44 events for the above-framed time period related to children/youth with mental health concerns in the ED. The majority of events filed by the EMHAS team were related to communication issues between physicians, ED staff, outside agencies, staff scheduling issues, pager issues, and registration issues. Documentation issues reported related to reports not being faxed to Central Referral, incomplete or conflicting information, and involuntary paperwork not being completed. Safety related issues included aggression, patient watch, and assessment rooms not being available. Surgical and procedural related events related to delays in care and treatment. The categories of the adverse events filed by the EMHAS team occurred in the following ranking based on frequency of the particular occurrence: Communication; confidentiality; documentation/health records; employee injury; patient and family feedback; safety/security issues; and surgical procedure.

Eleven events were filed for the above noted time frame by the ED team in relation to children/youth with mental health concerns in the ED. Communication issues related to children/youth

with mental health concerns included delays in admitting, involuntary status not being communicated, miscommunication between external agencies to the IWK Health Centre, and miscommunication/lack of communication among ED and EMHAS teams. Documentation issues reported included scanning issues and reports not being received. Infrastructure issues included magnetic locks not working, and safety security issues included patient's fleeing the ED, engaging in self-harm acts, physical and verbal aggression. The categories of the adverse events filed by the ED team occurred in the following ranking based on frequency of the particular occurrence: Communication; documentation/health records; essential utility/infrastructure; and safety/security.

The Protection Services team filed 37 adverse events related to children/youth with mental health concerns in the ED, between February 1st, 2014-September 30th, 2014. Issues reported from Protection Services were primarily safety/security related and included Code White (violent persons), physical aggression to staff, property, and/or family, assisting health care professionals, and conducting patient watches. The categories of the adverse events filed by the Protection Services team occurred in the following ranking based on frequency of the particular occurrence: Communication; safety/security; and documentation.

In total, 92 adverse events were filed by staff who work with children/youth with mental health concerns in the ED within roughly an eight-month time frame. Predominantly, EMHAS staff and Protection Services staff were the teams that were filing the adverse events. Among all three teams, communication was the most frequently reported category, meaning that communication issues seem to be the most recognized 'adverse event' that occurs among staff members when providing care to children/youth with mental health concerns in the ED. Lack of communication among teams will be explored further within content extracted from staff interviews and specific study themes.

Both ED and EMHAS staff both acknowledge the need for future policies and directives to provide clarity regarding the provision of care to children/youth with mental health concerns in the ED. Throughout my observations in the blue-desk area, no ED or EMHAS staff were noted to be using or searching for any policy-related documents regarding a child/youth with a mental health concern. On one occasion in the EMHAS office, an EMHAS staff looked up a patient protocol that had been applied for a particular child/youth due to frequent presentations to the ED.

On four occasions throughout my observations, I observed both ED and EMHAS staff questions whether a certain policy-related document existed. On all four of these occasions, it was assumed that the document did not exist and no attempt was made to look for the policy-related document. During my 14 observations, I observed that ED and EMHAS staff provided care to children/youth with mental health concerns in the ED with no reference to mental health or ED policy-related documents, except for on one occasion previously mentioned. ED and EMHAS staff both acknowledged the need for future policies and directives to provide clarity regarding the provision of care to children/youth with mental health concerns in the ED.

Staff Interviews

For the third section of the research design, I interviewed ED and EMHAS staff. Interviews were conducted in a location agreed upon by both the interviewee and me. Interviews were audio-tape, later transcribed verbatim, and anonymized. The average length of each interview was 75 minutes (range 72-120 minutes). I reviewed the written consent forms with the interviewee had the interviewee sign them prior to the start of the interview.

Twelve staff were interviewed. However, two completed interviews were lost due to recording difficulties with the audio-tape, therefore data collected in those two interviews was not used in the research finding. Of the ten staff who were interviewed: 4 members from the EMHAS team, 4 staff

from the ED team, and 2 Protection Services officers. Amongst the ten study participants interviewed, 2 were physicians, 5 were RNs, 1 was a social worker, and 2 were protection services officers. I wish to acknowledge that two people that I interviewed (approximately five months ago) have since left their position that they held at that time and are no longer members of either the EMHAS or ED team.

The researcher used a semi-structured interview guide, which consisted of open-ended questions developed for the purpose of this study (Appendix K). The interview was centered on 3 questions; a) 'Could you tell me about ***your role*** in the ED in providing care to children/youth with mental health concerns?' b) 'Can you tell me about how care is provided to children/youth with mental health concerns in the ED?' c) 'What is the difference between providing care in the ED to a child/youth with a mental health concern and providing care to a child/youth with a physical health concern?' The interviewees were asked these 3 questions, with flexibility for probes, and return to questions as needed. Participants were given the opportunity to answer all questions and talk about other issues that they considered important and relevant to their experiences and circumstances.

Following each interview, I transcribed the recording verbatim and proceeded with analysis. The whole transcript was reviewed to identify factors related to the culture of the ED. Statements were analyzed for latent (underlying meaning of subject content) and manifest (literal subject matter) content. The text was first reviewed for manifest content (words, phrases, descriptors and topics) and then the latent (underlying) meaning of the communications was interpreted.

Patterns that appeared in the coding were identified through repeated analysis of the content and context of the study participants' statements and through the visual identification of overlapping codes. Comparisons were made with previously coded material. The interviews were analyzed using content analysis in which both manifest and latent themes were identified. Specific themes were then created to represent groups of related data. After having compiled all three sets of data (observations,

document review, and staff interviews) using an iterative process and analyzing data to extract themes seeking to understand the culture in the ED in providing care to children/youth with mental health concerns, five themes and sub-themes emerged:

Confusion: Seeking Meaning

1) ***Shared History of Violence: Fear***

2) ***Environment: Dismissive***

-social systems

-physical infrastructure

-expressive spoken culture

3) ***Two Cultures: Total opposites but a common patient goal***

-providing care

-triage

-flow

-frustrations

4) ***Mental Health in the ED: Emerging Vision...***

5) ***Seeking Clarity***

-culture shift

-systems change

The final frameworks for analysis were data-driven. The study data were analyzed according to the sequenced trajectory of the understanding the culture of the IWK Health Centre ED in terms of

providing care to child/youth with mental health concerns. Issues considered included processes, internal/external influences, behaviors, language, staff attitudes, customs, traditions, and ED and mental health policies that influence providing care to children/youth with mental health concerns.

To address issues of dependability and confirmability, I relied on an independent rater, my thesis supervisor, to audit my research methods and data analysis. Following the original coding of data collected from staff interviews, the researcher re-coded two randomly selected transcripts. Intra-rater reliability is reflected by the degree of agreement among multiple repetitions of a diagnostic test performed by a single rater. My thesis supervisor and I determined inter-rater reliability. Each member of my Thesis Supervisory Committee was given two randomly selected uncoded transcripts to code. Following their coding, I presented my codes and discussion was held as to whether they disagreed or agreed with my analysis. My committee agreed with my coding and consensus was reached.

The study data revealed five themes that served as influencing factors underlying the meaning of culture in an ED while providing care to children/youth with mental health concerns. Themes that emerged from the study data included: *Shared history of Violence: Fear; Environment: Dismissive; Two cultures: Total Opposites but a Common Patient Goal; Shared Ideations, and Seeking Clarity*. These themes came together under an overarching theme, *Confusion: Seeking Meaning.*

Shared History of Violence: Fear

The theme *Shared History of Violence: Fear,* was described by staff who often recounted certain processes, protocols, experiences, and particular patient cases that had occurred in the past. These past had experiences (involved violence and aggression) and had come to shape their current practice. One staff member recounted that:

> The old crew has seen us do restraints for 8 hours. In the last 2 years, there have been no patients to that level of intensity that we used to see. The new crew hasn't seen us jump in front of nurses, take the punches, get them out of the way, and do the restraints.

Another staff member noted that public awareness and the media's reaction to staff handlings of past experiences in the ED involving children/youth with mental health concerns have greatly influenced the way in which staff currently provide care, noting:

> I find myself getting nervous to deal with [children/youth with mental health concerns]. We've had cases that have been in the public eye and have had people judge us for what they think our interaction was. Social media is saying that [health discipline] should be arrested and charged with a crime.

Some staff recalled that past history of significant events in the ED with children/youth involving mental health concerns has lead them to practice out of fear at times. One ED staff explained, "A lot of nurses [in the ED] are fearful of mental health patients. I don't know if it is their own personal experience or their own insecurities". Another ED staff member shared,

> There is an absolute discomfort amongst ED staff when working with mental health kids. What we see here is what we remember and what we retain. If we see violence and aggression, we are going to remember that and it is going to be hard for us to let go of that. I think it comes from our personal experiences.

Environment: Dismissive

The theme *Environment: Dismissive,* included the contextual factors of the ED that influence the way in which care is provided to children/youth with mental health concerns. Sub-themes identified from the data were *social systems* (i.e., lack of community resources that lead to the ED becoming a dumping ground for children/youth with mental health concerns), *physical infrastructure* (i.e., lack of physical space and privacy in the ED), and *expressive spoken culture* (i.e., language, stigma and labeling).

Social systems refers to the leave children/youth with mental health concerns no other alternative but to seek mental health services in the ED, often resulting in the ED serving as a 'dumping ground'. One EMHAS staff shared reasons as to why the ED has become such a 'dumping ground', sharing:

> The ED has become the mental health system. All mental health cases come to the ED. They can't get in to see their family physicians or their pediatricians. They've tried to go through the school or, you know, they haven't known how to access services, or they have and it hasn't worked out. People usually come in the ED because they need help. The economy certainly doesn't help. There is a lot of poverty, a lot of parents who are single parents. Our volume in the ED has tripled. Kids can't access care in community. I think there are a lot of situations that probably in places with more resources might be able to be handled out there in the world, but not here. So, they end up in the ED because they don't need to be in the ED, they need someone to talk to and support them. But right now, this is walk-in therapy.

Emergency department staff identified the same factors that lead to the increased numbers of children/youth presenting to the ED with mental health concerns.

> There has definitely been an increase in the number of kids with mental health concerns presenting to the ED. We have had a lot of patients that repeatedly come back to the ED two or three times and I think that speaks to lack of structure in community resources. I think family physicians are ill equipped to deal with a lot of mental health based things. You're also dealing with a societal component and we are seeing it in the ED. The other factor to play close attention to is the fact that North America has undergone a recession in the past couple of years. We know that populations that are very poor and socio-economically deprived use the ED a lot. There are also fewer stigmas against mental health and the structure is not there in the community to support people long-term.

Physical infrastructure included the lack of physical space and lack of privacy in the ED (i.e., room 5, the EMHAS office, and the blue desk) both of which send messages regarding the lack of importance of mental health and significantly influence the way in which care is provided by staff to children/youth with mental health concerns in the ED. One EMHAS staff spoke of the environment of the ED as a whole, stating:

> I try to imagine myself as if I was the one going through such a vulnerable, and scary time. If I were placed in that room (Room 5) especially if that was my first contact with mental health, I think I would be very turned off. [Children/youth with mental health concerns] are put into a room with locked doors, a camera on the wall, nothing in the room, scratches on the wall, it's terrible. Our ED is clinical, cold, routinized, and systematized. Nurses are wearing their uniforms and it's obviously a medical environment. It's cold, there are no windows, room 5 is atrocious, it has a terrible echo, and there is absolutely no reason that a gurney should be in there. The office is horrendous and it doesn't meet the need. We can't speak confidentially either on the phone.

Another EMHAS staff spoke of how the lack of space interferes with ability to respect confidentiality while obtaining patient collateral (from family, teachers, peers, etc.). The staff

explained:

> [The ED] is an inadequate space and doesn't have the standard security entrance that many EDs have or a locked door from the triage area into the ED. I don't like room 5 and I don't like the idea of mag-locks. The office space that we occupy is ridiculous. It's not sane and it's not humane to put so many people in such a small space especially when we are trying to get collateral. I think that there is such a compromise in privacy for patients [in the ED].

Emergency Department staff voiced strong concern about how the ED physical environment interfered with the processes of collaboration between ED and EMHAS teams noting,

> There is so much wrong with our space in terms of how it is currently set-up. [EMHAS] are crammed in this little space and it's terrible. If you pull that person outside the room to talk to them, it's not confidential for the people in room 6 or the people around the corner. Where are you going to go? To the hallway around the corner where you aren't in view anymore? You can't do collaboration quickly so we pull them into the nursing station. There are times when you just want to have a conversation with the (EMHAS) privately, but you just can't.

The physical space is poorly organized, providing no dedicated area for collaboration between the ED and EMHAS teams. One ED staff member explained, "We are really all over the place [in the ED]. There is no common ground. We are in a constant struggle because in order to communicate effectively, we need to be in an area that is within proximity, and we just aren't. We are too widespread".

Expressive spoken culture included the language, behaviors, views, processes, and/or actions used to describe, and/or interact with, children/youth with mental health concerns in the ED. Both teams acknowledged that they use language to describe behaviors of children/youth with mental health concerns in the ED as a way to cope with a situation that may be extremely difficult for staff involved. Both teams acknowledged that language used is not meant to judge children/youth, or to provide care for them differently. One ED staff explained "We will say things like 'attention seeking' or 'behavior' or 'poor parenting'. I think that we judge the behavior more so than the person. We never make judgments, or conclusions, or blame someone for presenting to the emerge".

Similarly, EMHAS staff acknowledged that,

> There has to be a line as well where you need to know that you're safe to say. You have to be because it has to come out hat you are safe and you're amongst your own to say 'that woman is out of her mind, she is crazy', 'no wonder that girl is the way she is'. There is a place and time but you have to know when you've reached your limit.

Both the ED and EMHAS team noted that stigma (towards children/youth with mental health concerns) exists in the ED. However, they did not speak specifically as to whether, or if, stigma affects the care provided. EMHAS staff spoke about the fact that for the most part, they feel as though stigma isn't a concern in the ED. One staff shared:

> I really haven't heard any derogatory or stigmatizing language used to describe our kids. I get a lot of sympathy from the ED staff about our kids, saying things like "that's so sad", or "I'm glad you're admitting them". A lot of the ED staff is amazed at how honest our kids are. I was really glad to hear that because my sense was that they all 'hated psych patients'. I think there is this perpetuated myth somewhere.

When talking about stigma in the ED, some ED staff recognized that we are all human and that any of us can experience mental health concerns. One ED staff explained:

> At the end of the day it comes down to being a human being, mental health patient or not. Someone thinks that somewhere, that all mental health patients are going to kill you or something. You can put certain stressors on me and I might want to kill someone. There is only one breathe between us and having a mental breakdown. We are all human beings, plain and simple.

Two cultures: Total Opposites but a Common Patient Goal

The third theme identified, *Two cultures: Total Opposites but a Common Patient Goal* described the cultural knowledge, attitudes, beliefs, values, and meaning that influence staff, both internal and external influences, when providing care to children/youth with mental health concerns. Sub-themes that emerged from the data included: *providing care* to children/youth with mental health concerns, *triage*, patient *flow* through the ED, and *frustrations* that both teams experience while providing care to this population.

Providing care described the cultural influences and obstacles encountered by staff who provide care to children/youth with mental health concerns in the ED. Both ED and EMHAS staff admitted that cultural differences (within each team exist and influence the way in which they provide care) in terms of how they view the primary function of the ED. One ED staff shared:

> There is quite a bit of variation of handover and collaborative care between [ED and EMHAS] teams. I think that there are a lot of obstacles to providing that care. I think that mental health is a really tiny part of what we do and a big focus of the ED is on efficient care and that we manage acute problems, and that we need to get you in and out of this place. The ED is really strapped for space, for nursing care, for physician care, and so every little hick-up along the way is a problem. In contrast to mental health, which often involved lengthy periods of time, cultural differences are huge.

Members of the EMHAS team shared that they too felt the cultural differences between the two teams, noting:

> I do feel an aversion that the ED staff really does try to avoid our patients and let us handle them. It seems like there are things that they don't like about dealing with our population but I don't know what those things are. I've just felt that cultural approach, which I think is tradition. So whether they actually believe it, I don't know but I think it is just something that they do.

Members of the ED and EMHAS teams recognized that both teams have different philosophical approaches in terms of *how* each team provides care. EMHAS staff noted that their process of providing care "looks different" than that of ED staff. Both teams acknowledged that working together in one environment and providing care to the same patients (children/youth with mental health concerns) with two philosophical approaches can be challenging. One EMHAS staff noted the "fast-paced" nature of the ED, stating:

> For the most part our team tried very hard to approach and establish rapport [with children/youth with mental health concerns] and I think that that isn't usually what you do in an ED when you're in there and trying to 'get to it' and 'get things done'. That's the nature of the people who work down there; they are very fast-paced. I think there is still a lot of room with the ED docs in terms of their philosophical approach to mental health and I think that it is just culture. It's hard to change something that you are used to.

Similarly, one ED staff spoke to the nature of staff who work in the ED and commented on

particular patient situations they are exposed to at times:

> That's our nature. We want it now, we want it fast, we want the best you have, and actually we wanted it yesterday. It's the nature of the beast. That's one thing that is actually a bit of a challenge and that a lot of nurses find is the challenging, is that we run around like a chicken with our head cut off all of the time. We are multi-tasking and re-prioritizing all of the time, running up and down the hallways, in-and-out-of patients' rooms. It's hard to imagine what our workday looks like especially if you haven't worked in emerge. That's the kind of people that are drawn to this environment. People who can flip on a dime, people who have ADHD, people who are hooked to the adrenaline and need a rush. Then you have the mental health patient and [ED staff] might just be coming out of the trauma room where the [ED staff] might have just resuscitated a patient, was doing compressions, defibrillated a patient, and then you have to come out and turn right around and deal with a mental health patient. Sometimes, [ED staff] find themselves standing at room #5 and your mind is elsewhere.

The sub-theme *triage* emerged the data and involved the triage process of children/youth with mental health concerns in the ED in comparison with the process is similar to the process of children/youth with physical health concerns that present to the ED. The EMHAS staff did not identify clear differences in the way in which the specific process of triage was completed. However, ED staff did note "mental health triage tends to be a bit longer because we have to fill out two forms". In addition, ED staff noted that they would benefit from more mental health education that may help to improve their triage assessment skills. One staff stated, "I think all of our existing nurses could do with more mental health education or we could have more questionnaires and/or triggers on our triage sheet. It would be great to have the confidence to identify the patients who need to get to care faster".

Some staff believed that EMHAS should be triaging their own patients, stating that: "If someone comes in looking for a mental health assessment, they are there to get a mental health assessment. Sure, we can do vitals, or whatever, but I think that [EMHAS] should be triaging their own. They are the experts, not us".

Emergency department staff also noted that the process of having mental health on the front line in the ED is recognized as being an exemplary service throughout the nation. One staff explained,

> No matter what meeting I go to, [the IWK] is still looked at as the gold standard because we are providing mental health at the door instead of having to go through the regular cue that

> has an average wait time of between 6-8 hours. Almost all of the other EDs would like to have our set-up.

Another sub-theme, *Flow*, described the length of time it takes to provide care to children/youth with mental health concerns in the ED. Both the ED and EMHAS staff agreed that children/youth with mental health concerns seem to have a quicker trajectory and have shorter wait times than children with physical health concerns in the ED. One ED staff explained "the wait times are a lot less for mental health patients because they pretty much have immediate access at the door, so they are pretty much getting red-carpet treatment in terms of wait times".

Similarly, EMHAS staff noted:

> Sometimes physical health patients may wait much longer because there may be 10 people waiting but there's no one here for mental health, so mental health kids can come in and be seen right away. Sometimes we can see people slower if we have 4 mental health patients back to back. I've rarely seen people leave because of the wait for mental health.

The final sub-theme of *frustrations* included common frustrations individually identified by both teams that influence the way in which they provide care to children/youth with mental health concerns in the ED. The most common frustrations from staff have centered on the 'medical clearance' (i.e., medical assessment that needs to be performed by the emergency room physicians prior to discharge/admission), the age-cut off (i.e., that mental health care can be provided until age nineteen, and physical care only until age sixteen), the repetitive process (i.e., having the child/youth share his/her story multiple times), having too many staff involved in the process of providing care, lack of communication and collaboration between ED and EMHAS staff, and lastly 'ownership' of the child/youth with a mental health concern while in the ED.

One EMHAS staff shared that, "Some of the ERPs feel that they have been relegated to just a signature on the consult note rather than actually participating in kids care. For many of them, I just want the ERPs to get in that habit to go in and work with our kids".

Some EMHAS and ED staff challenged the existing process of providing 'medical clearance' to children/youth with mental health concerns in the ED. They argued that it can extend the patient's visit in the ED and does not often address the need with which the child/youth has presented. One EMHAS staff stated that:

> If a kid comes in with anxiety and we are ready to see them, and after assessment by our team they are ready to be discharged, they may have to wait another two hours to get medical clearance by the ERP. The ERPs get frustrated too because some of them don't see the need for medical clearance.

Frustration pertaining to the age-cut-off for only mental health care (age 19) was predominantly expressed by ED staff, as they are the staff who have to deal with both populations. Every ED staff interviewed voiced this frustration. One staff passionately relayed:

> I will tell you that I think it is the single biggest mistake this institution has ever made. The reason that I say that is because there is an awful lot of conflict between patients, [ED and EMHAS] staff, inpatient medical staff, and a whole lot of time is wasted from an administrative perspective on the floor and also after hours because of the different age cutoffs. It really has done more to stigmatize mental health than any other decision made in this institution. Every other ED in the country goes to age nineteen for physical and mental health. They don't fragment services at all. It is definitely a recognized frustration here within the IWK.

Emergency department and EMHAS staff both expressed frustration in terms of having too many people involved in the process of providing care to children/youth with mental health concerns in the ED. Frustration expressed in relation to the repetitive process that children/youth have to endure by sharing their stories in the ED was expressed pre-dominantly by EMHAS staff, as they are most frequently the ones who are present for parts of the repetitive storytelling and most often hear the frustration about such a process from the patient themselves. One EMHAS staff said,

> [Children/youth with mental health concerns] have had to tell your story to triage, to registration, to the person putting you into the assessment room, plus the EMHAS team, plus the ERP, plus the psychiatrist, and some of the staff will ask tons of questions. By the time you've left, you've told your story at least 6 times. It's crazy to me.

ED staff spoke often about their frustration in terms lack of role clarity in providing care to

children/youth with mental health concerns in the ED and questioned if their role was necessary. One staff shared: "What is our role? We need to define the ED nurse role in relation to mental health patients. Do we need to be involved? I don't know if I'm helpful in any mental health situation, I don't know what I'm adding that would be of benefit for the youth".

One staff stated: "I think if we each have a function, and are respectful of each other's function and the kids, then that's fine. Not everybody needs to be involved in the same way. Sometimes, I don't necessarily feel like there is a role for emerge nurses and docs".

Lack of role clarity, was linked to confusion pertaining to "ownership" of a child/youth with a mental health concern in the ED. Both ED and EMHAS staff were able to identify, and agreed to the fact, that legally, the child/youth 'belongs' to the ED. However, in a practical manner (i.e., providing care to these children/youth), both the ED and EMHAS staff acknowledged that the patient responsibility, more responsibly rested with the EMHAS team. One staff stated,

> When the EMHAS team takes over and starts their assessment with the patient, I truly feel like then it has become their own patient and they can take full ownership over that patient. I think that the kids are here for a mental health assessment. Well you know what, the EMHAS team does the mental health assessments.

Mental Health in the ED….Emerging Vision

The fourth study theme, *mental health in the ED…emerging vision,* included shared beliefs, values, attitudes, expressed by both the EMHAS and ED teams in terms of positive experiences, processes, and mutual goals when working with children/youth with mental health concerns in the ED. Every staff member interviewed acknowledged positive attributes about their team, the other team, the patients, and/or providing care to this population in the ED. Both teams spoke frequently of the improvement in terms of collaboration and communication that has occurred over the past couple of months, with some staff identifying the major reason for this improvement as the addition of the nurse role to the EMHAS team. One ED staff noted:

> I think on the floor, the two teams are working better than they ever have, even though they may be slightly separate. It's not the best, but really when you are working with two separate cultures and two different populations, what are the expectations? Is it supposed to flow smoothly 100% of the time? I don't think so; it doesn't even do that inter-professionally within the department.

Similarly, an EMHAS staff member shared, "I've noticed within the past 3-4 months that ED nurses have been asking much more about what's going on with our kids and seem much more curious. We catch each other on the run and we check-in, so to me that feels a lot better".

While recognizing such improvements, staff still acknowledged that there is room for growth to make the process of providing care to children/youth the most efficient it can be.

> There is always room to grow and improve but I think that we do work together. When I work, I access them. I know where to go and consult with them. I make myself available to them, checking-in, and touching base. If I'm going to be a good advocate for my patients-and they are my patient-I have to collaborate and provide best care.

Specifically, both ED and EMHAS staff shared that having a matched discipline (nurse) on both teams has been a contributing factor that has lead to increased collaboration, understanding, and respect. One ED shared that,

> I think what has changed is that the number of mental health staff in the program as evolved. There are nurses on the team now that I think know where we are coming from, appreciate our lens, and I think that the respect is there. There is a common understanding that if we are concerned about a patient, then they should be concerned about the patient.

Each team conveyed praise, respect, and recognition for the other's roles and responsibilities in providing care to this population and were vocal in relaying that their common goal is to provide best care to these patients from the moment they walk through the ED door. An ED staff member noted, "I trust that the mental health team knows what they are doing and I sing their praise to our medical health families. I trust that they provide definitive care and get the processes in place to help. They are highly trained to do what they do". Another staff reiterated, "The common goal we all share is making the patient better or giving this patient a positive ED experience. That's our biggest

similarity".

One EMHAS staff member spoke highly of the ED staff's role of providing excellent physical care to children/youth, and recognized the reputation that the IWK holds because of the care that these staff provide.

> I think that the IWK's 'claim to fame' is that they are known for advanced, specialized pediatric care. The IWK has a reputation as being the best of the best in terms of providing physical care to kids. The ED staff are pros. They deal with everything. There is a huge amount of respect for ED staff. I hope that they know and feel that from us.

EMHAS staff were also quick to share that the respect that the ED staff displays towards their team is recognized. One EMHAS staff recalled a favorite interaction with an ED staff member and shared, "Emerge staff say to me all of the time, 'I don't know how you do what you do' or 'you guys do the real healing', that one is my favorite".

Seeking Clarity

The final theme that the study data revealed was *seeking clarity,* which included ED and EMHAS staff's 'wish-list' of 'wants' and 'needs'; moving forward in the future to ensure that the way in which they provide care to children/youth with mental health concerns in the ED can be most positive. Sub-themes identified by both ED and EMHAS staff were *culture shift (*micro) and *systems change* (macro).

A *culture shift* refers to changes at the micro unit level (i.e., individual, team, clinical leaders, and management level changes) that staff has considered could make the process of providing care to this population most efficient and effective. ED and EMHAS staff identified that such micro changes could include clear expectations of how care *should be* provided (process), a clear vision for both teams in terms of their role, and clear expectations from leadership (i.e., clinical leaders, managers, directors, etc.,) in terms of visions, goals, services provided from each team, with consistent communication shared between both ED and EMHAS teams. One EMHAS staff shared:

> I wish we were completely embedded in the ED as opposed to this satellite mental health office down there. It doesn't feel like we are part of the ED team. We still report under mental health lines and we aren't under ED leadership so I think that separation makes it hard because they think that we are foreigners down there. We aren't really part of their community because leadership and administration structure still exists entirely within mental health and psychiatry. A transforming of that would be helpful.

Emergency department staff supported the need for clearly defined roles and expectations, stating "I think we need clear expectations on both sides and a mutual understanding. I think it is a huge problem on an individual level that the left hand really doesn't know what the right hand is doing".

The sub-theme, *system change*, referred to macro level changes at the hospital administration level requested by both teams that could make the process of providing care to children/youth with mental health concern in the ED most efficient. The two most common system changes raised by staff were the proposal of a mental health 'drop-in' center, and that the ownership of the child/youth with a mental health concern in the ED would be completely assigned to the EMHAS staff, meaning that the patient would be triaged and registered to the EMHAS team, and the ED team would be consulted if needed.

One EMHAS staff shared, "There are kids who come to the ED and don't feel the need to be seen by a medical person, they just want the psychiatric help and I think it is reasonable to pitch the idea for a mental health walk-in clinic". In a somewhat alternative view, an ED staff stated:

> If I really had it my way, I would just get rid of the current system. I think that all of the patients who want to see a doctor, have used drugs, are medically unwell, should be registered to the ED team, and seen by the doc like all of the other patients. If you haven't used drugs, haven't overdosed, haven't or don't want to see a doctor, well then you wouldn't be registered in the ED at all. I think that there could be some co-location or sharing of registration but that this person should be right off the bat registered to the EMHAS team because I don't think there youth are ED patients.

Study findings added to my pursued attempt of understanding the culture of the ED in providing care to children/youth with mental health concerns. Although it is recognized that one cannot generalize from the data of a qualitative study, the findings that emerged from this three-part (observations, interviews, document review) research design are noteworthy. Observations concluded that steps in the process of providing care to children/youth with mental health concerns in the ED varied. Challenges, successes, gaps, frustrations, and areas to be most efficient in the process of providing care to this population were raised by ED and EMHAS staff in the staff interview section of the research design and immensely influence the way in which care is provided.

Observations reflected the five themes that arose from ED and EMHAS staff interviews that pursued an understanding of the culture of the ED in providing care to children/youth with mental health concerns and included: *Shared history of violence; Fear; Environment: Dismissive; Two cultures: Total opposites but a common patient goal; Mental Health in the ED….an emerging vision;* and *Seeking clarity.* Five independent themes encompassed an overarching theme of how the culture of the ED was understood, and was identified as *Confusion: Seeking meaning.*

I observed that ED and EMHAS staff provided care to children/youth with mental health concerns in the ED with no reference to mental health or ED policy-related documents, except for on one occasion previously mentioned. Emergency Department and EMHAS staff both acknowledge the need for future policies and directives to provide clarity regarding the provision of care to children/youth with mental health concerns in the ED. It is important to stress that all three sections of the research design greatly reinforced each other. There was a huge overlap in study findings in terms of what I would observe, what would then be discussed in staff interviews, and what may or may not have been reflected in written documents. Moving forward in an attempt of understanding the culture

of the ED, the question of 'what does this all mean?' will be discussed.

Chapter IV

DISCUSSION

This chapter will discuss the study findings found in The IWK Health Centre ED in terms of how *culture* (i.e. values and beliefs) influenced the way in which staff provided care to children/youth with mental health concerns. Five themes emerged from the study findings: *Shared History: Fear; Environment: Dismissive; Two Cultures: Total Opposites but A Common Patient Goal; Mental Health in the Emergency Department…Emerging Vision; Seeking Clarity.* The five themes that emerged from the study help to describe the overarching theme of the study; *Confusion: Seeking Meaning.* The five themes and overarching theme fell naturally into Whitehead's (2002) framework for ethnography and into the four patterns of Whitehead's *Cultural Systems Paradigm* model. Study findings will be discussed in accordance with Whitehead's framework, the literature, and my own conclusions. It is important to remind the reader that data analysis was done in an inductive way.

No study has sought to understand the culture of a pediatric ED in providing care to children/youth with mental health concerns. The purpose of this study was to identify influences that underlie culture for the study population and provide direction to the provision of care that ED and EMHAS staff provide. Observations were conducted in three specific care areas of the IWK Health Centre ED most frequented by children/youth with mental health concerns. Staff interviews were conducted using semi-structured interviews designed from the literature that asked ethnographic questions that included *descriptive*, *contrast*, and *structural* questions. The study findings helped to answer the research question: *What is the culture of a pediatric ED in providing care to children/youth with mental health concerns that arrive in the ED primarily for a mental health concern?*

Whitehead (2002) defined culture as being a holistic, flexible and non-constant system with continuities among its interrelated components, including shared ideational systems (knowledge, beliefs, attitudes, values), preferred behaviors and structural relationships (social). Culture provides rules and routines that facilitate order, regularity, familiarity, and predictability (Whitehead). Culture provides meaning in the interpretation of peoples' behavior, items in the physical environment, events, and occurrences that people construct and use to communicate their realities (Whitehead). Culture is a shared phenomenon. Members of a cultural group often share knowledge and meaning systems, or a common sense of reality, which is referred to as inter-subjectivity (Whitehead). The meanings and interpretations provided by a cultural system not only facilitate communication between those who share various aspects of such systems, but they may also give rise to miscommunications and misunderstandings between members who are from different systems (Whitehead).

The *Cultural Systems Paradigm* that Whitehead (2002) used to understand culture centered around four principles: *The principle of universal human cultural categories*; *individual and shared ideational structures*; *the principle of paradigmatic flexibility; the principle of the interrelationship between socio-cultural contexts, processes, and meaning systems*.

The principle of universal human cultural categories.

This first principle, *The Principle of Universal Human Cultural Categories*, suggested that there were certain categories of phenomena that are universally relevant to all human communities, but differ in terms of how they were expressed (culture) in each human community. Universal phenomena included four categories of phenomena: *individual and normative behavioral patterns*; *individual and shared ideational structures*; *significant social systems*; and *expressive culture.*

The principle of human ecosystems.

The second principle of the CSP (Whitehead, 2002), *The Principle of Human Ecosystems*, argued that if cultural systems were going to be properly understood, they must be studied as components of their own *Human Ecosystems*. Three categories were considered: The *physical environment*, the *real and perceived needs* of human groups, and significant *historical processes and events*. The three categories, either biophysical or sociocultural, that either institutionalized or sustained a cultural system and/or a part of that system was considered when I was collecting data through observation, interviews with ED/EMHAS staff, and documentation review.

The principle of paradigmatic flexibility.

The third principle of the CSP (Whitehead, 2002), *The Principle of Paradigmatic Flexibility*, held that conceptual frameworks that informed the study of cultural systems must be flexible, and not rigid, because of the differences in behavioral and ideational expressions - both across human groups and individuals, as well as within the individual.

The principle of the interrelationship between socio-cultural contexts, processes, and meaning systems.

The last principle of the CSP (Whitehead, 2002), *The Principle of the Interrelationship between Socio-cultural Contexts, Processes, and Meaning Systems***,** argued that if I wanted to understand correctly why certain behaviors, including health risk and resiliency behaviors, emerged and persisted in human populations, then I would have had to have a better understanding for the socio-cultural contexts in which these behaviors occurred, the socio-cultural processes of these contexts, and the socio-cultural meaning of these contexts and processes for those who practiced such behaviors.

Five themes emerged from the study findings: *Shared History: Fear; Environment: Dismissive; Two Cultures: Total Opposites but A Common Patient Goal; Mental Health in the*

Emergency Department…Emerging Vision; Seeking Clarity. The five themes helped to describe the overarching theme of the study; *Confusion: Seeking Meaning.* The five themes and overarching theme fell effortlessly into Whitehead's (2002) framework and into the four patterns of Whitehead's *Cultural Systems Paradigm* model. Findings from each theme and overarching theme will be discussed according to Whitehead's four principles according to the *Cultural Systems Paradigm*.

Shared History of Violence: Fear

The theme *Shared History of Violence: Fear,* was described by staff who often recounted certain processes, protocols, experiences, and particular patient cases that had occurred in the past. These past had experiences (involved violence and aggression) and had come to shape their current practice.

Whitehead's (2002) *Principle of Human Ecosystems* mentions phenomena of *historical processes and events* between shared groups (ED and EMHAS staff). Following four of my interviews, two members from the EMHAS team and two members from the ED team, wrote to me via email to express their sincere gratitude for having the opportunity to discuss providing care to children/youth with mental health concerns in the ED. One ED staff became tearful near the end of an interview and recalled past historical events pertaining to aggressive, frustrating, and at times violent events that he/she had shared with his/her colleagues:

> You know, we just never talk about mental health. I don't talk about what I do outside of work, outside of here, especially in terms of mental health because I think you get a skewed perspective. If something really bother me, or I go home thinking about something in a day, that means I need to somehow get it out. I may not be able to get it out that day. The only people who really understand the crap you go through are the people you work with. I can't tell you how validating this chat has been.

The Principle of Human Categories was also apparent in this theme, as one ED staff spoke to the phenomena of *significant social systems* in the context of domestic units within his/her household became tearful near the end of the interview and tearfully stated:

> My child lives with a mental health issue. I am terrified that every time I go into room #5, I am going to see a parent that is going through the same thing I am. I'm afraid I'm going to lose it and see myself in them. It scares me to be able to relate to people in crisis, especially when you know that you and your family might be the one's coming into room #5 the next night.

One EMHAS staff became tearful when discussing a particular patient case from the past that has had a significant influence to way that this staff member currently provides care. *The Principle of Human Ecosystems* speaks to the *historical process and event* that this EMHAS staff describes, as does *The Principle of Paradigmatic Flexibility* by way of the *flexible* and *non-rigid differences in behavior and ideational expressions* between ED and EMHAS staff. The EMHAS staff shared the following past event and ED staff's response following the event:

> There have definitely been times where I have cried in the office after an assessment or have cried during an assessment. There was a girl who was brought in and her boyfriend, and first sexual partner had committed suicide and she did not know. This boy had committed suicide the day before and her parents had brought her to the ED for a mental health assessment. I could not send this child home without her knowing this information. We were sitting on a time bomb. We all sat in room #5 and her parents told her. The first thing that child said was "it's my fault". It was just awful. I feel like I get canonized as a Saint, that somehow I'm really strong and a complete Saint. Emergency Department staff says, "I can't believe you do what you do". My favorite is when other staff starts disclosing to me, like 'my niece saw the [EMHAS] team a few weeks ago. I feel like, whoever is in the office for the most part, we have the biggest respect for the fact that we are all listening to the same types of things and we are all affected by them.

The process of debriefing became a popular point of discussion, as every single EMHAS staff member interviewed spoke to the fact that they feel that they warrant more debriefing as a team. One EMHAS staff shared,

> Debriefing is a huge, huge problem on our team. We involve the Employee Assistance Program (EAP) only after the death of a kid. This is by far the craziest job I've ever had and I've had a lot of jobs. It's too one-sided; it's all bad stuff. All we get is three hours of why their life is hell and why they want to kill themselves, and then we send them on their way. It Is really intense. Over and over again you see really sad and heartbreaking, awful stories. Then, the kid goes and you still have five hours left on your shift. How do you manage that? I wish we had management who could communicate and understand, or convey that they understand, what it is that we do and the impact that it has on us. One of the casuals has said to us full-timers; you guys are going to burn out.

Another EMHAS staff supported the idea for more debriefing and stated:

> I also wish we debriefed more as a team too, had more staff meetings, and I wish when they were scheduled they didn't get cancelled so often too. We need to sit in a room, people on the front line with their clinical leaders, mangers, etc. and talking about what's going on and whether it's working.

Although many of the pressures faced by mental health nurses are similar to those reported by staff in other nursing specialties (Riding & Wheeler, 1995), a number of demands relate specifically to mental health settings. These include the often-intense nature of nurse–patient interaction (Cronin-Stubbs & Brophy, 1985) and the confrontation of difficult and challenging behaviors on a regular basis (Sullivan, 1993). An increasingly diverse patient population (acute psychiatric episodes, compulsory detentions, and alcohol- and drug-related emergency admissions), a growing volume of administrative duties, weakness in multidisciplinary team working, and a mismatch between the skills learned in training and those now required by the current work environment have been identified as posing particular problems for nursing staff in acute care areas (Higgins et al., 1999).

Previous studies of mental health nurses have identified a variety of stressors in the work environment. These include administrative and organizational issues such as the volume of paperwork and lack of consultation over work-related changes (Dawkins et al., 1985), inadequate staffing (Carson et al., 1995), dealing with potentially violent and/or suicidal patients (Sullivan, 1993) and conflict between staff (Trygstad, 1986).

The experience of burnout can be alleviated by the availability of coping resources, one of which is social support (Melchior et al., 1997). Support can be emotional, such as the action of caring or listening sympathetically, or instrumental, involving tangible assistance such as help with a work task (Fenlason & Beehr, 1994). High levels of support have been associated with low levels of burnout in a number of mental health nursing studies (Cronin-Stubbs & Brophy, 1985, Firth et al.

1986, Sullivan 1993, Kilfedder et al., 2001).

It is noteworthy to mention as it speaks to the turnover of staff at the IWK Health Centre, which has been prevalent within both the EMHAS and ED teams. The EMHAS team introduced nursing to the team 17 months ago (May, 2013). Since then, the team has filled two full-time RN positions (one resigned and one went to a casual position) and one Social Worker Position (two times). One RN has recently left and the position has not been filled. Affiliated with the EMHAS team is the Urgent Care Clinic (UCC), currently made up of one RN and one Social Worker. Originally, two RNs were hired for these rolls. Since it has been up and running (approximately one year), one RN has left and was filled with the position of a Social Worker (Kristi Kempton, 2014). Although the specific cause of staff departures remains unknown, EMHAS and ED staff have commented that such high staff turnover acts as a barrier to consistent work practices, clear vision among the team and department, and enables varying levels of work experience, as most new hires on the EMHAS team tend to be new graduates.

Throughout the Department of Psychiatry, staff turnover is also evident. Most recently, the Chief of Psychiatry resigned in August, 2014, while two other psychiatrists have left the organization completely within the past two years. Two other IWK Health Centre affiliated psychiatrists have retired within the past six-months. Specifically in the ED, one psychiatrist recently reduced to 0.4 full-time-equivalent (FTE) (Wednesday/Thursday) to take on a Clinical Co-Leadership Role within the ED, and one psychiatrist reduced to 0.1 FTE (from 0.5 FTE) (alternate Fridays) due to re-locating to an IWK affiliated community mental health clinic. As of September, 2014, another psychiatrist took over 0.4 (Monday/Tuesday) of the staff member's portion who left for community clinic. At present there is no standing coverage for the alternate Fridays. In terms of ED turnover, there have been five resignations this year, all nursing (roughly 19% of their total staff) (Barb Bergeron, 2014).

Specifically throughout the Department of Psychiatry, staff departures have resulted in other staff to temporarily 'fill-in' in for the interim. Emergency Department and EMHAS staff have voiced that they feel that temporary leadership within the department may cause a further delay in any pending changes that were going to occur with under the previous leadership, enable miscommunication between leadership among ED and EMHAS teams, and perhaps create discrepancies' among a clear directive and vision for the team. Such concerns from both teams may lead to significant job dissatisfaction among both groups and can significantly influence staff turnover rates.

Increasing the rates of full-time employment among nurses especially is one way of reducing turnover. A higher proportion of full-time hours are associated with lower nurse turnover rates (O'Brien-Pallas et al., 2008). It is interesting to note that one in five nurses leave their jobs in Canadian hospitals each year, and the average cost associated with nurse turnover is $25,000 per nurse (O'Brien-Pallas et al.)

The Principle of the Interrelationship between Socio-Cultural Contexts, Processes, and Meaning Systems applied within the theme of *Shared History: Fear,* as one EMHAS staff shared that both ED and EMHAS staff are trying to seek meaning in the work that they do, by seeking meaning in the process of providing care to children/youth with mental health concerns in the ED. This EMHAS staff noted:

> You have to get buy in and you have to communicate with people on the ground. You have to get their voice in the mix and make them understand why the change is valuable. If leadership perceives a change is important, and they just embark upon that change without significant tending to the stakeholders on the ground, it's not going to work. What happens here in our department is that people quit when that happens. When there doesn't seem to be any rom to communicate, or any flexibility higher up on the chain, people on the ground leave because they are frustrated and feel like their voices don't count. All of their hard work-they are just sort of seen as "filling jobs" and the quality of work that they do and who they are as people is not valued or meaningful. Overtime, people respond to that with their feet and they

leave.

Job satisfaction has been described as an affective state that depends on the interaction of employees, their personal characteristics, values and expectations with the work environment and the organization (Mueller & McCloskey 1990). Job dissatisfaction is often construed as a source of and an outcome measure of stress and burnout (Cooper & Baglioni, 1988). Early studies have shown an inverse relationship between job satisfaction and burnout; for example, higher job satisfaction tends to be accompanied by lower levels of burnout (Dolan, 1987; Pines et al., 1981). Research evidence consistently shows that structure, organizational atmosphere, job tasks, pay, potential for advancement, personal recognition, leadership style and leadership effectiveness are the major factors to impact on job satisfaction in nursing (Gillies et al., 1990; Mansen, 1993; Wells, 1990). Oermann and Bizek (1994) found that organization of the work environment, autonomy, involvement in decision-making, interpersonal relationships and recognition from others influenced job satisfaction.

Environment: Dismissive

The theme *Environment: Dismissive,* included the contextual factors of the ED that influence the way in which care is provided to children/youth with mental health concerns. Sub-themes identified from the data were *social systems* (i.e., lack of community resources that lead to the ED becoming a dumping ground for children/youth with mental health concerns), *physical infrastructure* (i.e., lack of physical space and privacy in the ED), and *expressive spoken culture* (i.e., language, stigma and labeling).

One concern put forth by ED and EMHAS staff, spoke to the physical environment of the ED and the influence that this environment has on staff when providing care to children/youth with mental health concerns. This staff member's *individual ideation structure* (beliefs and values) that he/she was

not doing justice by the patient, speaks to Whitehead's (2002), *The Principle of Human Categories*.

The ED staff notes:

> A lot of people feel like we aren't doing mental health patient's justice because of the environment of being in here with all of these little kids crying and vomiting. I mean, a teenager who may need some more serene environment, requiring a little more tender loving care, well the ED is not the environment for them.

The Principle of Human Ecosystems is relevant, as the *physical environment* (ED) in which children/youth with mental health concerns receive care, may not be as known to the public as it should be. One EMHAS staff notes,

> Mental health sees adolescents up until 19-years-old. Sometimes, people don't know that. Heck, the ED sign says "Children's Emergency Department". We don't have any books or resources in the waiting room but I think that would be a huge way to bring way brining awareness and change the culture of the ED environment. We have to try and make it known exactly whom we serve.

This ED staff voiced frustrations that spoke to the confusion of the large number of mental health related documents that exist to address specific symptoms of illness that a child/youth with a mental health concern in the ED may present with. Whitehead's (2002) *Principle of Paradigmatic Flexibility* speaks to the *differences in behavior/ideational expressions* that the ED and EMHAS staff exudes at times; especially in the context of providing care this population. This ED staff member noted,

> Do all staff love all aspects of mental health patients in emerge? Well to be honest with you, it's a pain in the ass to pull out five different protocols to deal with an issue. If there's distaste, it's because of the confusion. There are a million different protocols. We can manage you here up until a certain point and then we have to transfer you to the QE2, but if you're anorexic we manage you completely here and all issues with your body even if you are over 16. It's hard to keep track of and there are a lot of patient complaints about it. That hits our nursing staff hard, especially when there are about ten different loopholes in the system with the 16-19 year olds.

The 'Overage Patient' (March, 2004) document addresses some of the 'loop holes' that ED staff have voiced as a frustration and seeks to clarify who the ED serves according to specific age and

reads: “The ED health care team will provide care to overage patients until their condition is stabilized sufficiently to permit safe transfer to an Adult Care Facility. The ED health care team will perform a focused assessment on all overage patients presenting to the ED and will provide service to overage patient who are currently under the care of a pediatric specialist regardless of the presenting problem”.

The physical space and structural layout of the ED, specifically where the EMHAS team and assessment room #5 were located, were commented upon by every single staff (both ED and EMHAS) interviewed. The most common feeling that was expressed was that their needed to be more assessment rooms designated specifically for mental health. It was explained that if the rooms were designated specifically towards children/youth with mental health concerns, rooms could be tailored to providing a more tranquil and therapeutic space.

The psychiatric hospital environment plays a significant, though often underappreciated, role in-patient and staff functioning (Karlin & Zeiss, 2006). Ambient features include attention to lighting, air quality, and noise. For lighting, soft, indirect, and pervasive or full-spectrum lighting are generally recommended. Ample natural daylight has been recommended by many authors and is highly valued by patients. In addition, highly reverberant spaces should be avoided. Long and echoic corridors are discouraged by environmental psychologists because of perceptual distortions experienced by some psychiatric patients (Karlin & Zeiss).

The proximity of seclusion rooms to nursing stations should be carefully considered. Close proximity may promote safety but may raise concerns over disruption, whereas greater distance may reduce environmental disruption but decrease staff responsiveness and available staffing resources (Karlin & Zeiss, 2006). Planning for interior design should take into account the unit's symbolic meaning or the set of messages that the environment sends to its users. For example, having a clearly identifiable reception area and a method of greeting patients and visitors reflects customer service

values and patient centeredness. Especially important in this regard is that interior design reinforces treatment goals and positive expectations of patients and staff (Karlin & Zeiss).

One of the most consistent recommendations in the body of literature on psychiatric hospital design is the importance of reducing the institutional feel of the facility and incorporating a homelike environment whenever possible. This type of atmosphere has been associated with enhanced emotional and intellectual well-being and improved patient behavior. Medical staff has also been noted to prefer non-institutional environments (Karlin & Zeiss, 2006). Artwork (soothing, not exciting) is recommended. Images of nature can reduce anxiety.

Studies of wall color choice have yielded inconsistent results. However, there are some fairly consistent general recommendations. First, monochromatic, bland color schemes and fashionable or trendy palettes or pastels should be avoided (Karlin & Zeiss, 2006). Brighter colors may be preferred for patients with depression and some older adults, but they could be over stimulating for highly agitated patients. Second, warm blue tones often have a soothing or sedating effect, presumably because of their shorter wavelengths, and they may be particularly suitable for the calmest areas. Using closely related colors of the same value and intensity also has been reported to have a calming effect. Third, blue-green colors can have a negative effect on mood for patients with depression and less energy. And finally, seclusion room walls should be a calm, but definitive color, not white or gray (Karlin & Zeiss).

Two Cultures: Total Opposites but with A Common Patient Goal

The third theme identified, *Two cultures: Total Opposites but a Common Patient Goal* described the cultural knowledge, attitudes, beliefs, values, and meaning that influence staff, both internal and external influences, when providing care to children/youth with mental health concerns. Sub-themes that emerged from the data included: *providing care* to children/youth with mental health

concerns, *triage*, patient *flow* through the ED, and *frustrations* that both teams experience while providing care to this population.

Role clarity of the ED RN was identified as being a major concern for both the EMHAS and ED teams. The notion of *providing care* was also troubling for some ED staff members, as staff explained they were not sure as to what providing care 'looks like'. *The Principle of the Interrelationship between Socio-Cultural Contexts, Processes, and Meaning Systems* is applicable, as both teams are *seeking meaning* in the context of these processes of providing care and *what* providing care entails. One ED staff explained,

> Because [EMHAS] has a nurse, some of our nurses waive responsibility. Yes, the EMHAS team does have a nurse that provides a different type of care than we do, but we are still their nurses. They are our patients and they come to the ED first. I think our staff is taking responsibility of mental health patients as best that can. I think what they struggle with is this expectation and feeling that they need to be doing more and we aren't really sure what 'more' looks like.

Whitehead's (2002) *Principle of Human Ecosystems* phenomena, the *real and perceived needs of groups*, became evident as one EMHAS staff confirmed the ED staff's concern and frustration about the lack of role clarity is challenging due to the conflicting ideation of wanting to become involved in the process of providing care, but not knowing how to. This EMHAS staff shared that,

> I've heard a lot of feedback from ED nurses that say, "It's not that we don't want to be involved but that we don't know what our role is". I totally believe that 100%. I mean if we are in a room with a patient for two hours and aren't communicating with them, how would they know to come in the room? Of course they would be hesitant to come in; they don't know what's going on with that patient. Ongoing communication needs to get better.

Nurses function in a complex web of relationships including other nurses, supervisors, patients, and physicians. They are guided through these challenges with the task of managing these relationships by professional standards; yet often experience role confusion, conflict, and incompatible goals (Arthur & Randle, 2007; Gardner & Chang, 2007; Nicotera, Mahon, & Zhao, 2010).

Willingness to actually confront conflict is important to end cycles of learned helplessness, as these cycles begin when an individual feels helpless to alter a typically negative course of action or consequence. Nurses experience intergroup conflict inside the nursing unit and this frustrates their goals and hinders patient care (Cox, 2003; Swearigen & Liberman, 2004). Nurses highly identified with their profession, role, and unit/floor/small group may desire to stay with theses respective groups and are those most willing to counteract negative group norms and feel less of a sense of helplessness on the job (Moreland, 2012).

A sub-theme that emerged from the study findings, *flow,* referred to the care trajectory that a child/youth with a mental health concern encounters when in the ED. The ED and EMHAS team voiced frustration at time concerning 'how long' it takes to do a mental health assessment and plan a disposition of care. In keeping with Whitehead's (2002) *Principle of Paradigmatic Flexibility* due to the differences in ED and EMHAS *behavior and ideational expressions*, both teams acknowledged that they share philosophical differences in *how* they provide care and some spoke to having completely different views of what they would consider an optimal outcome for this population. One EMHAS staff stated:

> I'd like there to be a greater understanding in the system that efficiency and safe risk assessment are not the same thing. I would like to have the understanding of the system that it takes hours sometimes to do this well. Getting a kid in and out of the ED in the hour can't be the priority and unfortunately, that's the mandate to move faster and faster.

Similarly, another EMHAS staff went on to note that,

> We feel pressure from ED staff all of the time, especially if there is a lineup. I get it, and we aren't always communicating where we are in the process of our assessment either. They might have parents in the waiting room bombarding them about when their kid is going to be seen, so I don't blame them for asking us 'how long until you can see the next one?' I've also felt pressure, especially if there are kids waiting, to just push through and see the next kid without documenting on the other first. I don't think they understand how important that part of our job is. That can be stressful. If I see three kids in a row, I start to forget the specifics. You really need to capture someone's story and what they have shared with you.

Interestingly, frustrations voiced by ED staff in particular about the length of time that it takes from the time a child/youth with a mental health concern enters the ED until discharge or admissions is at times enabled by a specific End of Shift Coverage policy (2007). This policy reads that "the on duty [EMHAS worker] does not begin mental health assessments or lengthy child protection matters within 90 minutes of the end of a Crisis Worker's shift; the exception being in cases which are medical emergencies (trauma or sudden death), urgent request for resources, or mental health emergencies during that 90 minute period. Purpose: to ensure quality and continuity of client care by having a single clinician begin and complete a mental health assessment.

It also appears that some members of the EMHAS strongly disagree with such a policy, as one EMHAS staff stated:

> I know you will have some staff downstairs that talks about the therapeutic relationship, the therapeutic milieu and the rapport that you've established from doing your assessment. I hear that more from social work, some from nursing, but I think we can handover that care. If we set up our patients upfront that your shift ends in a half-an-hour, and that I am going to hand you over to someone else at that time, I think that can happen. While I think you need to impart some tips on how you might use resources like validation and support, I'm not sure that you need to do counseling. I think some of our EMHAS staff thinks they need to be their counselors. Our policy from 2007 looks at this specific issue. Back then; it looked different because the EMHAS worker might be coming in from home. Back then, if I was going to call you in from home 90 minutes before the end of your shift, could you make it in and do some work with this kid in 90 minutes? Probably not, but now that we are all here and present in the ED, the policy needs to go.

The Principle of Human Categories was also evident within this theme due to ED and EMHAS *shared ideational beliefs*, as some ED and EMHAS team members perceive not admitting a child/youth with a mental health concern as a measure of an optimal outcome, as it requires (potentially) less disciplines becoming involved and decreases overall time in the ED. One EMHAS staff shared,

> I've got the impression from psychiatry residents and ED staff that it is almost an accomplishment to not admit someone. Is that an accomplishment? The accomplishment for me is did we do the best thing that we could for that child/youth? Not, okay we were able to make a safety plan and get them out the door. From other team members on both sides, it

> seems to be a really positive thing for them to wrap up the case where they don't have to see psychiatry.

Whitehead's (2002) *Principle of Human Categories* notes that individuals possess *normative behavioral patterns* that become routine and familiar. However, *The Principle of Paradigmatic Flexibility* became apparent through my observations, as they revealed that the process of providing care was routine and familiar to both teams. What varied at times in the process of providing care included contextual factors of the ED (i.e., hectic ED environment), handing off of the child/youth with the mental health concern between the EMHAS and ED team, and role clarity of the staff involved.

Despite ED and EMHAS staff having different roles in providing care to children/youth with mental health concerns, staff relayed a sense of confusion when trying to identify whether collaboration occurs. One EMHAS staff noted,

> What I find is that the way we work together is more what needs to be done on paper. I don't know if that's actually working together or what the system dictates that we should be doing. We are working together in terms of the ED nurse putting the patient in their room and checking on them a few times, or if they need bloodwork or vitals, and the ERP is signing off on the discharge of the patient. I mean, is that really working together or is that just kind of doing out separate rolls and our rolls that we are told to do in the ED?

ED and EMHAS staff noted significant *differences among social systems* (co-workers) about the processes of collaboration and handover as a major influence on the way in which they provide care. One ED staff shared,

> I think that lack of role clarity is huge in terms of where someone's job begins and ends. There is still some variation in terms of what kind of handover is given between [EMHAS] and the ERP. There is quite a bit of variation in terms of handover and collaborative care between the [EMHAS] worker and the ED nurse on the floor. I think there are a lot of obstacles to providing that care.

As role clarity and processes of communication and collaboration were identified as frustrations that negatively influence the way in which each team provides care to children/youth with

mental health concerns in the ED, many staff from each team questioned whether ED staff, RNs specifically, need to be involved (in any capacity) in the process of providing care.

One ED staff stated:

> I actually can't think of one reason why our [ED] nurse would be involved when a psych-nurse is involved with a mental health patient. This institution doesn't feel that way though and psych-nurses don't feel comfortable giving meds. I think it's bullshit. I think it is a disservice to patients. To have the Chief of Nursing or nursing themselves say "we don't give meds often" is bullshit and ludacris. I have a hard time with how that issue is being managed.

Both the ED and EMHAS staff *expressed shared beliefs* that the role of the ED RN may not be required for mental health care, as the EMHAS RN can fulfill the role. Each team believed that having two RNs involved might be a redundant process and not the most efficient use of the ED RNs time. Lack of role clarity from the ED RN also resulted in an *expressed feeling* of helplessness. Such feeling could negatively influence the way that ED RNs provide care. On the other hand, Emergency Department staff had *differences in ideational expressions* within their own team pertaining to the triage process, as some ED members voiced the need for further mental health education in order to feel competent in delivering care while other ED members expressed that no further education was necessary.

Both teams expressed differences among philosophical approaches to managing the flow of a child/youth with a mental health concern through the ED. It is important to note that although each team expressed different opinions (*differences in ideations)* about the length of time the process of providing care should entail, both teams *shared a common belief* that optimal care to this population was justified and expressed a shared desire for optimal outcomes and positive ED experience for these children/youth. Both teams shared confusion and frustrations pertaining to the lack of communication and collaboration.

Mental Health in the Emergency Department…Emerging Vision

The fourth study theme, *mental health in the ED…emerging vision,* included *shared beliefs, values, and attitudes,* and was expressed by both the EMHAS and ED teams in terms of a common desire for a positive experience, processes, and mutual goals when working with children/youth with mental health concerns in the ED.

This theme reflects Whitehead's (2002) *Principles of Human Categories and Human Ecosystems,* describing the critical role within each team that *shared ideation* and the *real and perceived needs* among diverse groups within the same environment plays in creating their culture. While both ED and EMHAS teams shared mutual respect for one another, the unique role of each team (*shared ideation*), and their successes, they also recognized the need for ongoing collaboration in building a common vision and goals, to provide the most effective and efficient care to children/youth with mental health concerns in the ED.

Emergency Department and EMHAS staff spoke highly of one another, specifically in terms of how each team has begun to engage in discussions (*expressive culture* (language)) to facilitate collaboration and communication and also note that there is a growing (*shared ideation)* regarding staff *attitudes.* One ED staff shared,

> I think that we are probably in one of the best places that we have ever been before based on the quality of the staff, the attitudes of our staff that we have too. We don't take new grads. We need the staff to have at least two years' experience and two years pediatric emergency experience before you can go to triage, and one more year on-top of that before you can be in charge.

One ED staff noted that there are (*differences of behavioral and ideational expressions*) among the ED staff and acknowledged that there are different individual requirements in terms of the level of work experience specifically from the RN perspective despite both teams working with the same youth in the same *physical environment*. One ED staff shared,

> I feel like there is an awesome group on the EMHAS team and I feel that some of their hires shouldn't have been hired though. I think it is a highly acute area and if you are going to be a nurse working in that hectic environment, you have to come with some experience. I think

> that you shouldn't be a new grad going to work there. It's not a place for the faint of heart. You have to be able to hit the ground running because you are dealing with the sickest patients.

It is interesting to note that RNs employed in the ED have to have a minimum of two years pediatric experience prior to being employed in the ED. However, RNs employed on the EMHAS team that share an environment and work with the same population (in a different role), do not require any previous experience. Indeed, one EMHAS staff noted "I've never been told to use a particular model when working with a kid or doing an assessment. I really haven't had any training in this job at all or guidance on approaches, or techniques at all".

The EMHAS team initiated the RN role in May, 2013 (sixteen-months-ago). Both teams have acknowledged the benefits of having similar disciplines on each team. Both teams also noted the importance of stable work force (*shared ideational structures* and *attitudes)*. One ED staff spoke to the importance of having full-time staff employed on both teams as a more consistent approach to care. This staff stated,

> I think that when there are more consistent care providers things go much better. I don't think it is useful when there are too many 'casual' people working in the ED. We have docs coming from everywhere, inconsistent nursing staff, and I think we do our best work when it is a stable person that is in the office. From a nursing perspective we have had a lot of turnover in the past two years because our manager is moving away from all of the 0.1 and 0.2 positions and trying to get everybody full-time. We are getting there and we are trying to do the same with physicians. We have far too many casual staff on the physician roster but you don't switch over physician staff quickly, it's a bit different than nursing staff.

The Principle of Human Ecosystems addresses the *real and perceived needs* of groups, and both ED and EMHAS staff spoke of the importance of a weekly meeting that was to include each team in an open forum type way to discuss the week's events (patients, adverse events, complex situations, successes) as a way to begin to know team members personally in hopes of establishing *patterns of needs and fulfillments* from staff. One ED staff member explained,

> To discuss process, we are starting a 'mental health check-up rounds'. It's new and going to

> be on every second Friday. We are going to have just a couple of meetings with leadership to figure out what we are going to talk about at these meetings and then we will hit the ground running and have these meeting every two weeks, even though really it should be weekly. Anyone on the ED and EMHAS team can come together and discuss anything that came up in the past week or two weeks. Issues that worked well, check-in, challenging kids, issues with forms, and an opportunity to continue to educate both ways and share experiences. I think it will be great. Also, new EMHAS members hired will go out and spend a day with an ED nurse to shadow. This process will be vice-versa as well.

The literature supports inter-professional education (IPE) in healthcare. Inter-professional education occurs when two or more professions learn with, from, and about each other to improve collaboration and the quality of care (Freeth et al., 2005). IPE is distinct from multi-professional education, where people from different professions learn common material side by side, but do not necessarily engage in any shared activity or collaborative tasks. There are many advantages to IPE; not the least, of which includes opportunities for education providers and clinicians to forge close relationships as the foundation for developing effective inter-professional care (Finch 2000).

Many other benefits have been identified, including inter-professional awareness and empathy; changed attitudes and perceptions; the reduction of negative stereotypes; enhanced motivation to collaborate in practice; the cultivation of interpersonal, group and organizational relations; the establishment of common values, knowledge, and terminology; and understanding differing theoretical perspectives (Centre for the advancement of interprofessional education, 1996, Barr et al. 2000, Finch, 2000). There is also some evidence that increased collaboration reinforces clinical competencies (Barr et al., 2000), and improves patient outcomes (Zwarenstein & Bryant, 2000).

To enhance trustworthiness of the study findings, I conducted individual emails and telephone calls with five study participants to check the accuracy of the analyzed findings, and to follow-up on specific topics identified in first interviews as to whether they were implemented. One planned item of particular note that staff had identified as critical, ‘mental health check-up rounds’, never occurred. I spoke with a staff member who was interviewed who confirmed that EMHAS management wanted to

be directly involved in facilitating a more "structured" meeting that would have specific content. As structured meetings were not the original vision that arose from 'floor staff' (on both teams) therefore, the well-intentioned meetings never occurred.

Each team expressed that the *current culture of the ED* in terms of providing care to children/youth with mental health concerns *"needs to change"* and identified *how to* change it. One EMHAS staff spoke of the need to change the culture of the ED stressing the importance of including floor staff in the decision making process to allow the staff to find *meaning* and *fulfillment* in the processes of providing care to children/youth with mental health concerns. The EMHAS staff stated:

> Culture is very hard to change and medicine is very slow to change everywhere. I think it is a culture that is very slow to move and I think you have to be able to really clearly explain your rational for wanting whatever it is that you are wanting to change and explain it to the people who do the job and who do the work because they are the ones who will be able to tell you if that makes sense, or not, but they can also see that this is really going to improve the quality of care that we provide to these kids or that these things may make the process more efficient for us. I think it needs to be within very clear reasoning and communication to front line staff and I think that didn't happen last year when a lot of changes were made to the EMHAS team. My understanding was that very little communication occurred to the ED staff and the docs received very little information. I know that the ED staff were very confused. Intention, feeling *empowered*, and mindfulness, that's what changes culture.

The meaning of *power* was explored throughout the literature. In its simplest form, power is defined as: "the ability to do or act; the capability of doing or accomplishing something; a great or marked ability to do or act; strength; might; and force" (Allen, 2006, p.374). It is perhaps time for mental health staff to rediscover Peplau's (1988) seminal work on interpersonal relations and review how it might be possible for the staff's narrative to be facilitated by a human process of *meaningful* engagement. This might only happen in a context that allows alternative views, most especially the staff's own explanations and views, to be explored as a way to *find meaning* and subsequent solutions for someone who is *seeking meaning* (Cutcliffe & Happell, 2009).

The most common *shared ideational structures* shared between *significant social systems*

(coworkers) were the common *attitudes, beliefs, and values* held about children/youth with mental health concerns in the ED.

> I certainly walk-in to a room and assume that these kids are amazing and innocent. I allow them to see that because most teenagers don't feel that about themselves and often feel so misunderstood and judged. These kids are resilient and amazing. There is always hope that you can intervene, that they will get better, conveying that someone has cared for them, and affirmed them that things will get better.

Similarly, one ED staff stated that "at the end of the day, if the kids are happy and healthy as they can be, we know we are doing something right".

While both ED and EMHAS teams share mutual recognition that there is ongoing need for more efficient processes in the ED, each team holds the belief that optimal care is desired for children/youth with mental health concerns in the ED.

Seeking Clarity

The final theme that the study data revealed was *seeking clarity,* which included ED and EMHAS staff's 'wish-list' of 'wants' and 'needs'; moving forward in the future to ensure that the way in which they provide care to children/youth with mental health concerns in the ED can be most positive. Sub-themes identified by both ED and EMHAS staff included *culture shift (*micro) and *systems change* (macro).

This theme reflects Whitehead's (2002) *Principle of Paradigmatic Flexibility and Principle of the interrelationship between socio-cultural contexts, processes, and meaning systems*, as each describes the critical role of culture among two diverse groups that occupy the same environment in creating their culture. Both ED and EMHAS teams expressed a shared interest to *seek clarity* in the process of providing care by suggesting strategies to evoke a *culture shift* and *systems change*. Emergency Department staff noted that one of their biggest frustrations of working with the EMHAS team stems from *systemic social systems differences in behavior and ideational expressions*. ED staff

voiced that they believe that the EMHAS staff possess no understanding as to 'what' the ED team does, while also pointing out that the current system does not necessarily facilitate care to children/youth over age 16. ED staff also noted that the EMHAS staff lack, at times, an ability to use plain words to provide clarity (*expressive language and talk*).

One ED staff shared,

> The EMHAS team and communication within that team is completely un-oriented. They've had 100% turnover in the team. I find that the EMHAS team itself, the workers, and from a management perspective, have no idea. They have no idea that medical clearance should happen at another hospital, they are completely unaware of policies that could make communication go more easily and it is extremely frustrating. Every single person that they have hired has been completely un-oriented. There are a lot of things that could make this environment better. If [EMHAS] understood or saw our flowsheets and saw whom we actually see, we aren't stigmatizing the 18 year old, but the system is actually set-up that the 18-year-olds medical care be provided at a different institution.

Another ED staff expressed *differences in ideational expressions* between the two teams and noted cultural differences among each team. The ED staff said,

> I don't know if it's the Director or what, but it just feels like they are very much functioning in a silo by themselves and we are very much-team oriented place where almost nothing happens in emerge without discussing it in some formal capacity. In mental health, it just seems like something happens and boom, there it is. That's not our culture. We aren't used to working like that because we talk to each other. We plan things together. We have our Chief and Clinical Leaders who are part of everything. You can't put things in place for your team because that impacts our team and we need to know. I don't know if that is their culture, but I don't think it works for them.

Both the ED and EMHAS staff shared the belief that *confusion* exists in the ED when caring for children/youth with mental health concerns, specifically in terms of the EMHAS team being able to express a clear vision for the EMHAS team and how the ED should mix-into the process. "That attention to detail is never done and 10-15 years down the line we will be paying for it because nobody knows where things stop and begin. No one seems to know the rules and this is one of the major issues".

While ED staff seem to be *seeking meaning* within their role of providing care to

children/youth with mental health concerns, there is also frustration as to how long the changes (on a micro and macro level) within the system have taken. One ED staff shared,

> I think that there has been a tsunami of mental health information thrown at us in the ED and a really big lack of insight in terms of the fact that this population takes up a very small portion of what we do and whom we see. I think that mental health within this department has been under chaos and has really crippled our ability to move forward with certain projects. I think that mental health is overstated at the moment and it's frustrating. I think that we are happy to help mental health through their transition because the system is being transformed from the ground up but we have been happy to move that, but the giving is only going to go on for so long. I think that people are frustrated in terms of how long some of these changes have occurred over and I think it is a huge problem.

From a systems (macro) perspective, both teams expressed that they are *seeking clarity* in terms from leadership to ensure consistent care, *routine* processes, increased *shared ideations structures*, and obtain *meaning* from the process of providing care to children/youth with mental health concerns in the ED. One EMHAS staff shared,

> I think what is lacking from a leadership perspective is that same thing that people need to explain that there is a different take [in the ED], that there are different rewards to this job, that you will not provide definitive care, you are going to do your best to manage this crisis and as a system we are going to put some things in place to ensure that more definitive care will happen down the road. This all comes back to role clarity. If you haven't defined the function of the Social Worker on the EMHAS team, you won't get consistency. It needs to be a priority of the on-the-ground leadership team to make a decision as to what the goal, function, and vision of the EMHAS team needs to be. Will you lose people along the way? Maybe, but there is no clear vision of what that goal is looking like.

While each team was able to express the need for micro and macro interventions in an attempt to evoke micro and macro changes in the ED, each team spoke strongly of the need for the EMHAS team to express a clear vision, description, and goal of the team as a whole. Every ED staff member interviewed requested such clarity. Emergency Department staff suggested that a clear vision from the EMHAS team would alleviate some of their frustration and also provide clarity to the ED team, while also helping to instill the EMHAS team with "more leadership capabilities". The EMHAS team also noted the need for such clarity, as three of the four EMHAS participants interviewed requested the

same outcome.

The following chapter will note implications moving forward, and seek to answer the question, why does this happen?

Chapter V

CONCLUSION

This chapter explores the implications of these findings and link with (Whitehead's (2002) Cultural Framework). The purpose of this study was to understand the culture of a pediatric ED in providing care to children/youth with mental health concerns. The three-part study design included observations in the ED; a document review of pertinent IWK Health Centre mental health and ED policies, standards, guidelines, etc.; and lastly a semi-structured interview with ED, EMHAS, and Protection Services staff. Data were recorded and then analyzed using content analysis. Five themes emerged during analysis of study data regarding the factors influencing the culture of the ED in providing care to this population: *Shared history of violence: Fear; Environment: Dismissive; Two cultures: Total opposites but a common patient goal; Mental health in the ED…Emerging vision;* and *Seeking clarity.* These themes came together under an overarching theme, *Confusion: Seeking Meaning.*

It is first important to stress how many positive provisions of care exist in the IWK Health Centre ED. Both teams work diligently to provide the most optimal care, while having to endure multiple challenging factors within the context of the ED environment. It is evident from both teams that staff truly care about the well-being of children/youth with mental health concerns. It is also clear that neither team has any ill will towards the other team. In fact, both would like an opportunity to discuss issues with one-another on a regular basis. A topic that has been identified by both teams that would be of benefit to discuss is the vision of the EMHAS service. Role clarification was also identified as a critical need for the EMHAS team to articulate and then communicate to the ED team.

The EMHAS team identified the need for EMHAS team managers to assist the team in

identifying the vision and roles of their service. They also identified the lack of communication between front-line staff and management within EMHAS, as well as physical space barriers that lead to lack of privacy when providing care in the ED. These identified gaps have led to the EMHAS team voicing frustration and feelings of being dismissed, which have greatly influenced individual members overall job satisfaction. With such gaps identified by staff working in the ED environment, it is important to ask the question, how does one achieve a culture change?

Both ED and EMHAS staff identified that once the EMHAS vision has been identified then it could work with the ED team to collectively articulate a shared vision of the partnered ED. This would also include role clarity and a revision of space utilization. Transforming organizations requires two fundamental elements; engaging the personal commitment of individual staff and ensuring that both management and staff share beliefs about the chosen care models (Sheard, 2014). Achieving an organizational culture change will require a complete unraveling of current confusions about the basic beliefs held by many clinical leaders and management. Often, instead of addressing these core confusions in specific care organizations, attention has been diverted onto training the front line staff as being the answer to solve the crisis' in care (Knocker, 2014).

Culture change can also reflect a bureaucratic organization which leaves little room for decisions to be made by patients or front line staff caring for them daily (Millor et al., 2008). Most culture change enthusiasts believe that the key to improvement is taking into consideration the needs and preferences of the patient, the staff, and systems of care (Miller et al.). Advocates stress the importance of adopting workplace environments that value and respect the contributions of direct care staff in promoting workforce stability (Millor et al.).

Sheard (2014) notes that any delivery of specific care training (e.g., mental health assessments) needs to be set within an overall program of organizational as well as internal reflection and

examination. The nature of the service and its model of care, manager's grasp of the new culture belief systems, and the leaders' leadership styles all require review to ensure consistency.

To achieve a "congruent organization" (Sheard, 2009, p. 330), the author recommends regularly facilitating staff group discussions regarding best ways of building positive cultures of care, involving all competing perspectives. If not, managers and staff will always struggle to change cultures of care where there is no clarity (Sheard, 2014). Equally important, organizations need to ensure a core set of values and a specific care model (Sheard).

Tom Kitwood's (1997) work on evoking culture change recommends the following areas to consider, specifically in the early stages of implementing change: 1) get rid of the institution-no 'us and them'; 2) create a team/family approach (Bell and Troxell, 2003); 3) value staff's life history and recreate parts of this; 4) accept staff as they are-go with people's reality; 5) acknowledge the feeling behind expressions and actions; 6) involve staff in running their own environment; 7) focus on what people can do and not on what is missed; 8) and help patients to be less like guests in your environment and more like 'family'.

From these initial ideas, it may become clear that environments, such as the ED, can only flourish when there is buy-in from management (senior level). It is also recommended that delivering ongoing educational and monitoring programs regarding the shift for areas is essential for achieving a culture change. It is evident that without such project management, environments may be limited in achieving the implementation and care outcomes desired. A culture change is rigorous; as it monitors fundamental strategic practices about how an environment will be configured in terms of daily practice (Rahimi, 2014).

Emergency department staff have voiced a level of frustration pertaining to the lack of clarity regarding the vision of the EMHAS service. In addition, ED staff have voiced that one of their biggest

frustrations is the lack of communication between the two teams and lack of clarity re the EMHAS role vis-a-vis the ED role regarding the provision of care to a child/youth with a mental health concern. Staff has also questioned the redundancy of some of the tasks (e.g., medication administration) that they perform when the same discipline (nursing) is working with the child/youth but on a different team. The EMHAS leadership and management teams may want to explore role clarity for their team as a whole, for their individual team members, and for their team in terms of specific disciplines. Such clarity has been requested from staff members of both teams.

Kotter (1990) stated that management work with staff to produce predictability and order by: setting operational goals, establishing action plans, allocating resources, organizing and staffing, solving problems and monitoring results. Leadership processes on the other hand, seeks to produce necessary changes by developing a vision of the future and strategies to reach that vision (Kotter). This includes communicating the vision and motivating and inspiring the staff to attain the vision (Kotter). Based on such concerns brought forth from both teams, the leaders from both EMHAS and ED teams may benefit from collaboratively identifying a team vision, clarifying roles, team vision, and engaging in an ongoing communication, both vertically and horizontally.

The need for frequent meetings (individual and both teams together), both structured and non-structured, has been recognized and seems to be a priority for staff members. Structured and open forum staff meetings may be important to consider both within and among individual teams, as group cohesion is found to be important (Tourangeau & Cranley, 2006). The EMHAS staff identified frequent cancellations of staff meetings that have led to them experiencing feelings of "disappointment" and "undervalued", which may contribute to their overall job satisfaction. McNeese-Smith (1996) found that perceptions of staff toward the leadership behavior of their management teams were significantly related to their job satisfaction. Supportive leadership behavior

includes creating opportunities that lead to staff perceiving their work as meaningful, stimulating and giving a sense of coherence (Antonovsky, 1979).

Professionals need opportunities to communicate, debrief, and collaborate about concerns that they bring forth (Antonovsky, 1979). Both teams identified the need for debriefing in structured and non-structured formats. It was evident that an open forum to discuss past experiences, present situations, and future fears, are extremely important to team members and greatly influence the way that staff provide care to these children/youth. Both teams also identified the need for future learning and team building together, as a means of building team cohesion and striving to achieve a greater likelihood of consistency among knowledge and practical applications of providing care. It may be worth considering having educational days, in services, workshops, etc., intertwined with individuals from both teams.

Organizational climate has been discussed simultaneously with organizational culture (Schneider, 1990). Verbeke et al., (1998) describe organizational climate as the attitudes, feelings and behaviors which characterize life in an organizational (Glisson & James, 2002, Isaken & Ekvall, 2006). A climate must be more innovative for the focus to be on renewal and change. According to Ekvall et al. (1996), a climate that emulates innovativeness includes: a) maintaining support for ideas, b) open relationships, c) mutual trust and confidence, d) challenge and motivation, e) commitment to the goals and operations of the organization, f) the freedom to seek information and show initiative, g) maintain pluralism in views, knowledge and experiences, h) and having an open exchange of opinions and ideas.

A study by Hellriegel and Slocum (2004) clearly indicates the existence of a relationship between work climate and job satisfaction. As‘burnout’ was a topic that was brought up frequently by both teams, leadership may wish to consider ways to increase job satisfaction within their respective teams and seek opportunities to alter the current organizational climate. Role clarity, clear team

visions (EMHAS and ED partnered), and enhanced communication between leadership and front-line staff have been previously identified as particular areas that may help improve job satisfaction.

The physical environment of the ED was a huge influence and according to staff that work in the environment, acts as a barrier to providing the most optimal care to children/youth with mental health concerns. Based on concerns brought forth by both teams, more predominantly EMHAS staff, leadership teams may want to consider examining the current structural layout and space allocated to the EMHAS teams, specifically taking note of issues stemming around privacy and confidentiality.

Despite the recognized 'confusion' that staff have raised pertaining to those 3 areas (role clarity, team visions, and enhanced communication), there exists a number of potential possibilities to act upon that may assist un creating more efficient care for this population. Both teams acknowledge that there have been many successes of collaboration within the past couple of years, more specifically the past seventeen months due to the addition of the RN to the EMHAS team. Emergency department staff have voiced that having the same discipline work on the other team has added a new found level of respect and understanding between the teams. Both teams have spoken about seeing "glimmers of hope" in terms of noting positive changes, perhaps subtle though noteworthy, that have taken place within their organizational climate.

This study has examined ED and mental health policies, specific to the IWK Health Centre organization. The majority of documents pertaining to children/youth with mental health concerns in the ED deal with adverse events. While there is some policy on risk aversion which every organization needs, such documents may cause us to forget to look at 'how do we do good?' Future research or policy development may be warranted in developing/strengthening future correlation between mental health and ED documents. If we want to do something positive, we need to embed it in policy. Similarly, policy should not focus solely on what we are trying to avoid, but also on what we are

trying to achieve. The EMHAS team may wish to consider that policy can act as a foundation for creating a vision, especially while trying to establish/clarify a service vision. It is important to note that the ED team is begging for an EMHAS vision, not opposing it.

Developing a dissemination plan is a key part of research (Canadian Health Services Research Foundation, 2004). A project is of little value if the results are not communicated to others. It is the researcher's professional accountability to make certain that results are published as soon as possible upon completion of the project (Gillis & Jackson, 2002). Dissemination of the research findings will add to the knowledge base of culture within the ED, specifically from a pediatric lens. In the long term, it may indirectly contribute to changing specific influences of a culture to one of providing the most efficient care to children/youth with mental health concerns.

The key messages previously mentioned include: a) increasing communication and collaboration between the ED and EMHAS teams; b) EMHAS leadership clarifying and establishing a vision for the EMHAS service, which in hope will further clarify the role of the ED RN; c) taking particular note of the space that the EMHAS currently occupy in the ED setting; and noting positive 'glimmers of hope' of successes that are improving the organizational and cultural climate of the ED, which positively improve the overall job satisfaction of staff who provide care to children/youth with mental health concerns. These key messages can be tailored and expanded upon, depending on what each target audience wants to know, rather than on what I think it should hear.

The results of this research will be disseminated through traditional vehicles such as publication in scholarly journals, and presentations at professional conferences and within the IWK Health Centre. Face-to-face meetings involving an interactive two-way dialogue with the stakeholder groups will be undertaken at the sites of select targeted audiences upon request. A written summary of results will be distributed at all meetings and mailed to those study participants who indicated that

they would like to receive a summary of the study results at the end of the study. Eleven of the twelve study participants indicated that they would like to receive a summary of the study results.

Several limitations to my analysis should be acknowledged. I conducted observations and interviews with a diverse sample of ED and EMHAS staff that varied in terms of their team, discipline, gender, position hierarchy, and years or work experience. As I did not interview everyone, I gathered a perspective of those who were willing to come forward. Of the roughly 35 full-time staff members (physicians, nurses, and social workers) among the ED and EMHAS teams, I interviewed 12. Roughly 29 positions occupied among the above noted disciplines on the ED and EMHAS teams are part-time, and roughly 14 positions are filled as 'casual' positions. Part-time and casual staff did not get their perspective shared in terms of what it is like to come in and work within the culture of the ED. However, I specifically chose inclusion criteria that provided the opportunity for diversity of demographics among the study sample chosen. Despite these limitations, ethnography was chosen because all three types of data (observation, staff interviews, and document review); all reinforced one another, which was a strength of the study.

This study has added to the knowledge base of culture in terms of values and beliefs that influence staff when working with children/youth with mental health concerns in a pediatric ED. The study findings suggest that culture change is a complex and ongoing process that requires a combination of influencing factors and working mechanisms. It is not an endpoint, but a process. The staff interviews in particular, speak to the volume of possibility and opportunity that exists in the ED to provide the most optimal and dignified care to children/youth with mental health concerns. With certainty, both teams are committed to the well-being of children/youth with mental health concerns in the ED and providing the most optimal care.

The study findings also suggest that health care professionals and systems have a responsibility

to bridge the gap between what we know we can do and what we are actually doing to ensure that children/youth with mental health concerns in the ED are receiving the most optimal care in the ED.

My research question was answered, as five themes were identified that influence the culture while ED and EMHAS staff provide care to children/youth with mental health concerns. Indeed, the culture was more complex than I had originally thought, as I did not envision that five themes would be identified as meaningful factors that influence the organizational climate of the ED. This study has sought to articulate what the 'confusion' within the culture in the ED, is all about.

Moving forward, future studies may wish to explore the culture of the ED as experienced by specific disciplines (e.g., solely physicians or solely nurses, etc.), varying employment status' (e.g., full-time, part-time, and casual positions), and explore the cultural lenses by way of involving multiple stakeholders views (e.g., senior management, directors, chiefs, etc.).

I wish to acknowledge all ED and EMHAS staff that participated in my research study. Your courage and resiliency to come forward is recognized and greatly valued. In spite of the 'confusion', people still come to work and are committed to providing the most optimal care to these children and youth.

References

Ali, S., Rosychuk, R., Dong, K., McGrath, P., & Newton, A. (2012). Temporal trends in pediatric mental health visits: using longitudinal data to inform emergency department health care planning. *Pediatric Emergency Care.* 28(7), 620-625. doi:10.1097/PEC.0b013e31825cf93b.

Allen, D.., de Nesnera, A., Cummings, K., & Darling, F., III. (2011). Transforming the culture of caring: Getting hurt is not part of the job. *Journal of Psychosocial Nursing and Mental Health Services, 49*(1), 45-49.

Allen, D., deNesnara, A., Moreau, M., & Barrnett, R. (2014). Seclusion and restraint use in children and adults. *Journal of Psychosocial Nursing and Mental Health Services.* 52(3), 100-125.

Allen, D., & Vitale-Nolen, R. (2005). Patient care delivery model improves nurse work satisfaction. *Journal of Continuing Education in Nursing, 36,* 277-282.

Allen, R (2006). The Concise Oxford Dictionary of Current English, 10th edition. London: BCA.

Altheide, D. (1987). Ethnographic Content Analysis. *Qualitative Sociology,* 10 (1). 65-77.

American Academy of Pediatrics. (2005). The role of the pediatrician in rural medical emergencies for children. 116, 1153-1156. DOI: 10.1542/peds.2005-2276

American Academy of Pediatrics. (2006). Pediatric mental health emergency medical services system. 1764-1768. DOI: 10.1542/peds.2006-1925

Antonovsky, A. (1979). Health, stress, and coping. *New Perspectives on Mental and Physical Well-Being.* Jossey-Bass, San Francisco, CA.

Argyris, C., & Schon, D. (1992/1974). *Theory in Practice: Increasing Professional Effectiveness.* Josey-Bass, San Francisco, CA

Arthur, D., & Randle, J. (2007). The professional self-concept of nurses: A review of the literature from 1992-2006. *Australian Journal of Advanced Nursing,* 24(1), 60-64.

Australian College of Medicine. (2003). Guidelines on emergency department design. 1-25. Retrieved March 14th, 2013 from http://www.acem.org.au/media/policies_and_guidelines/g15_ed_design.pdf

Baren, J.M., Mace, S., Hendry, P., Dietrich, A.M., Grupp-Phelan, J., & Mullin, J. (2008). Children's mental health emergencies-Part 1.*Pediatric Emergency Care,* 24 (6), 399-408.

Barr, H., Freeth, D., Hammick, M., Koppel, I., & Reeves, S. (2000). Evaluation of interprofessional education. *The British Research Association,* 1-42.

Benner, P. (Ed.) (1994). Interpretive phenomenology: Embodiment, caring, and ethics in health and illness. Thousand Oaks, CA: Sage Publications

Bergeron, B. (2014). IWK Health Centre, Emergency Department Manager. Personal communication via email re: current staff compliment and staff turnover.

Browne, G., Gafni, A., Roberts, J., Byrne, C., & Majumdar, B. (2004). Effective/efficient mental health programs for school-age children: A synthesis of reviews. *Social Science and Medicine,* 58, 1367-1384.

Canadian Alliance on Mental Illness and Mental Health. (2000). *A call for action building consensus for a national action plan on mental illness and mental health.* A discussion paper, September, 2000.

Canadian Health Services Research Foundation. (2004). Communicating evidence to stakeholders. Retrieved October 20th, 2014 from http://www.nccmt.ca/registry/view/eng/50.html

Canadian Mental Health Association Calgary Region. (2012). Mental health and mental illness. Retrieved July 20th, 2012 from http://cmha.calgary.ab.ca/mentalhealth/Types_of_Mental_Illness/Index.aspx

Canadian Psychiatric Association. (2006). Collaborative mental health initiative. Retrieved May 10th, 2014 from http://www.mentalhealthcommission.ca/SiteCollectionDocuments/boarddocs/15507_MHCC_EN_final.pdf

Canadian Triage and Acuity Scale (CTAS) National Guidelines. (2008). Retrieved February 5th, 2013 from http://www.calgaryhealthregion.ca/policy/docs/1451/Admission_over-capacity_AppendixA.pdf

Cappeli, M., Glennie, E., Cloutier, P., Kennedy, A., Vloet, M., Newton, M., Zemek, R., & Gray, C. (2012). Physician management of pediatric mental health patient in the emergency department. *Pediatric Emergency Care,* 28 (9), 835-841.

Carson, J., Leary, J., de Villiers, N., Fragin, L., & Radmall, J. (1995). Stress in mental health nurses: comparison of ward and community staff. *British Journal of Nursing*, 4(1), 579-582.

Centre for the advancement of interprofessional education (CAIPE). 2006. Principles of Interprofessional Education. London: CAIPE. Retrieved October 10th, 2014 from http://caipe.org.uk/resources/publications/

Chan, A., & Noone, J. (2000). Emergency mental health manual. *British Colombia Mental Health Evaluation & Community Consultation Unit.* Retrieved January 15th, 2013 http://www.carmha.ca/publications/documents/Emergency%20Mental%20Health%20Educational%20Manual%20-2000.pdf

Clarke, D., Dusome, D., & Hughes, L. (2007). Emergency department from the mental health client's perspective. *International Journal of Mental Health Nursing,* 16, 126-131.

Cloutier, P., Kennedy, A., Maysenhoelder, H., Glennie, E., Cappelli, M., & Gray, C. (2010). Pediatric mental health concerns in the emergency department. *Pediatric Emergency Care,* 26 (2), 99- 106.

Comeau, K. (2014). IWK Health Centre, Quality Improvement Consultant for Mental Health and Addiction Services. Personal communication via email and in person re: Emergency Department and Emergency Mental Health and Addiction Services (EMHAS) documents.

Cooper, C., & Baglioni, A. (1988). A structural model approach towards the development of a theory of the link between stress and mental health. *British Journal of Medical Psychology,* 61(1), 87-103.

Cooper, J., & Masi, R., (2007). Child and youth emergency mental health care: A national problem. National Centre for Children in Poverty, Colombia University. *Unclaimed Children Revisited (Isuue Brief No. 1).*

Corrigan, P., & Penn, D. (1999). Lessons from social psychology on discrediting psychiatric stigma. *The American Psychologist,* 54, 765-776.

Cox, K. (2003). The effects of intrapersonal, intragroup, and intergroup conflict on team performance effectiveness and work satisfaction. *Nursing Administration Quarterly,* 27(1), 153-163.

Crawford, P., & Brown, B. (2002). Like a friend going round': reducing the stigma attached to mental healthcare in rural communities. *Health and Social Care in the Community*, 10 (4), 229-238.

Cronholm, P., Barg, F., Pailler, M., Wintersteen, M.B., Diamons, G., & Fein, J. (2010). Adolescent depression: views of health care providers in a pediatric emergency department. *Pediatric Emergency Care.* 26(2), 111-117.

Cronin-Stubbs, D. & Brophy, E. (1985). Burnout: Can social support save the psychiatric nurse? *Journal of Psychosocial Nursing and Mental Health Services,* 35 (1), 279-295.

Cutcliffe, J., & Happell, B. (2009). Psychiatry mental health nurses and invisible power: Exploring a perturbed relationship within contemporary mental health care. *International Journal of Mental Health Nursing,* 18, 116-125.

Dawkins, J., Depp, F., & Selzer, N. (1985). Stress and the psychiatric nurse. *Journal of Psychosocial Nursing and Mental Health Services,* 23(11), 8-15.

DeChamp, N. (2014). IWK Health Centre, Occurrence Systems Coordinator for Quality and Patient Safety, and the Strategy and Organizational Performance. Personal communication via email.

Dickens, G., &Picchioni, M. (2011). A systematic review of the terms used to refer to people who use mental health services: User perspectives. *International Journal of Social Psychiatry,* 58 (2), 115-122.

Dion, J., Kennedy, A., Cloutier, P., & Gray, C. (2010). Evaluating crisis intervention for youth within an Emergency Department. *Child Care in Practice,* 16 (1), 241-256.

Dolan, N. (1987). The relationship between burnout and job satisfaction in nursing. *Journal of Advanced Nursing,* 22, 347-358.

Dolan, M., Fein, J., Shaw, N. et al. (2011). Technical report-pediatric and adolescent mental health emergencies in the medical services system. *Pediatrics,* 127(5), 1356-1366.

Ekvall, G. (1996). Organizational climate for creativity and innovation. *European Journal of Work and Organizational Psychology,* 5(1), 105-123.

Falsafi, N. (2001). Pediatric psychiatric emergencies. *Journal of Child and Adolescent Psychiatric Nursing,* 14 (2). 81-88.

Fenlason, K. & Beehr, T. (1994). Social support and occupational stress: effects of talking to others. *Journal of Organizational Behavior*, 15(1), 157-175.

Finch, J. (2000). Interprofessional education and team working: A view from the education providers. *British Medical Journal,* 321(1), 1138-1140.

Firth, H., McIntee, J., McKeown, P., & Britton, P. (1986). Interpersonal support amongst nurses at work. *Journal of Advanced Nursing*, 11(1), 273-282.

Fleury, M.J., Grenier, G., Bamvita, J.M., & Caron, J. (2011). Mental health service utilization among patients with severe mental disorders. *Community Mental Health Journal,* 47, 365-377

Frame, P. (1992). Health maintenance in clinical practice: Strategies and barriers. *American Family Physician,* 45, 308-313.

Freeth, D., Hammick, M., Reeves, S., Koppel, I. & Barr, H. (2005). Effective interprofessional education: Development, delivery & evaluation. Oxford: Blackwell, 1-228.

Frosch, E., dosReis, S., & Maloney, K. (2011). Connections to outpatient mental health care of youths with repeat emergency department visits for psychiatric crisis. *Psychiatric Services,* 62 (6), 646-649.

Fuller, J., Edwards, J., Procter, N., & Moss, J. (2000). How definition of mental health problems can influence help seeking in rural and remote communities. *Australian Journal of Rural Health,* 8 (3), 148-153.

Fuller, J., & Broadbent, J. (2002). Mental health referral role of rural financial counselors. *Australian Journal of Rural Health,* 14 (2), 79-85.

Gardner, L., & Chang, C. (2007). Making nursing work: Breaking through the role confusion of advanced practice nursing. *Journal of Advanced Nursing,* 57, 382-391.

Garland, A.F., Lewczyk-Boxmeyer, C., Gabayan, E.N. and Hawley, K.M. (2004). Multiple stakeholder agreement on desired outcomes for adolescents' mental health services. *Psychiatric Services,* 55, 671–676.

Gerdtz, M., Weiland, T., Jelinek, G., MacKinley, C., & Hill, N. (2012). Perspectives of emergency department staff on the triage of mental health-related presentations: Implications for policy and practice. *Emergency Medicine Australasia,* 24, 492-500.

Gillies, D., Franklin, M., & Child, D. (1990). Relationship between organizational climate and job satisfaction of nursing personnel. *Nursing Administration Quarterly,* 14(1), 19-22.

Gillis, A. & Jackson, W. (2002). Research for Nurses: Methods and interpretation. (p. 1-752). Philadelphia: F.A. Davis.

Glisson, C. & James, L. (2002). The cross level effects of culture and climate in human service teams. *Journal of Organizational Behavior,* 23(1), 767-794.

Goldman, L.S. (1999). Medical illness in patients with schizophrenia. *Journal of Clinical Psychiatry,* 60 (21), 10-15.

Goldstein, A., Frosch, E., Davarya, S., & Leaf, P.J. (2007). Factors associated with a six-month return to emergency services among child and adolescent psychiatric patients. *Psychiatric Services,* 58 (11), 1489-1492.

Gravel, J., Gouin, S., Bailey, B., Roy, M., Bergeron, S., & Amre, D. (2007). Reliability of a computerized version of the Pediatric Canadian Triage and Acuity Scale. *Academic Emergency Medicine.* 14, 864–869.

Grupp-Phelan, J., Harman, J., & Kelleher, K. (2007). Trends in mental health and chronic condition visits by children presenting for care at U.S. emergency departments. *Public Health Report*. 122(1). 55-61.

Grupp-Phelan, J., Wade, T., Pickup, T., Ho, M., Lucas, C., Brewer, D., & Kelleher, K. (2007). Mental health problems in children and caregivers in the emergency department setting. *Journal of Developmental and Behavioral Pediatrics,* 28(1), 16-21.

Grupp-Phelan, J., Mahajan, P., Foltin, G., et al. (2009). Referral and resource use patterns for psychiatric-related visits to pediatric emergency departments. *Pediatric Emergency Care,* 25, 217-220.

Habis, A., Tall, L., Smith, J., & Guenther, E. (2007). Pediatric emergency medicine physicians'current practices and beliefs regarding mental health screening. *Pediatric Emergency Care.* 23 (1), 387-393.

Hartley, D., Hart, V., Hanrahan, N., Loux, S. (2004). Are advanced practice psychiatric nurses a solution to rural mental health workforce shortages? Maine Rural Research Center. University of Southern Maine

Hellriegel, D. & Slocum, J. (2004). Organizational behavior: contingency views. 10th Edition, South Western College Publishing, Cincinnati, OH.

Higgins, R., Hurst, K., Wistow, G., & Henderson, M. (1997). The Mental Health Nursing Care Provided for Acute Psychiatric Patients: Final Report for the Department of Health. *Nutfield Institute for Health, Leeds.*

Hodges, B., Inch, C., & Silver, I. (2001). Improving the psychiatric knowledge, skills, and attitudes of primary care physicians, 1950-2000: A review. *American Journal of Psychiatry.* 158, 1579-1586.

Isaken, S. & Ekvall, G. (2006). Assessing your context for change: A technical manual for the situational outlook questionnaire. The Creative Problem Solving Group, Inc. Orchard Park, New York, NY.

IWK Health Centre. (2007). Mental Health and Addictions Program Clinical Policy Manual. Mental Health and Addictions Program: Ambulatory Mental Health Emergencies. 1-2.

IWK Health Centre. (2009). Children's Health Program Clinical Policy. Policy #1367: Mental Health Policy. 1-9.

IWK Health Centre. (2009). Department and Services, Mental Health and Addictions, Mobile Crisis. Retrieved September 2nd, 2014 from https://iwkpulse.nshealth.ca/go/pulse.iwk.nshealth.ca/

IWK Health Centre. (2009). Your visit: Emergency services. Retrieved February 5th, 2013 from http://www.iwk.nshealth.ca/index.cfm?objectid=5757494D-FEF4-C921-95A5F2F9192AD4BF.

IWK Health Centre. (2014). IWK Services, Emergency Department. Retrieved August 27th, 2014 from http://www.iwk.nshealth.ca/childrens-health/services/being-admitted#chilrens-health/services/emergency-department

IWK Health Centre. (2014). IWK Psychiatry Services, IWK Emergency Service. Retrieved August 27th, 2014 from http://www.iwk.nshealth.ca/mental-health/iwk-psychiatry-services

IWK Health Centre. (2014). Our Core Values, Mission, and Vision. Retrieved October 8th, 2014 from http://www.iwk.nshealth.ca/page/our-core-values-mission-and-vision

Johnson, M., & Delaney, K. (2007). Keeping the unit safe: The anatomy of escalation. *Journal of the American Psychiatric Nurses Association, 13,* 42-52. doi:10.1177/1078390307301736

Kalucy, R., Thomas, L., & King, D. (2005). Changing demand for mental health services in the emergency department of a public hospital. *Australian and New Zealand Journal of Psychiatry,* 39, 74-80.

Karlin, B., & Zeiss, R. (2006). Environmental and therapeutic issues in psychiatric hospital design: Toward best practices. *Psychiatric Services,* 57(10), 1376-1378.

Kates, N. (2008). Promoting collaborative care in Canada: the Canadian Collaborative Mental Health Initiative.*Families, Systems and Health,* December.

Kempton, K. (2014). IWK Health Centre, Manager of the Emergency Mental Health and Addiction Services (EMHAS) Team. Personal communication via email re: EMHAS staff compliment and staff turnover.

Kirby, M.J.L., Keon, W.J., & The Standing Senate Committee on Social Affairs, Science and Technology. (2004). Mental health, mental illness and addiction: Issues and opportunities for Canada. Retrieved from The Parliament of Canada: http://www.parl.gc.ca/Content/SEN/Committee/381/soci/rep/report3/repintnov04vol3-e.htm

Kilfedder, C., Power, K., & Wells, T. (2001). Burnout in psychiatric nursing. *Journal of Advanced Nursing*, 34(1), 383-396.

Kitwood, T. (1997). Dementia reconsidered: The person comes first. Open University Press, London, UK.

Kleespies, P. (1998). Psychiatric emergencies; Crisis intervention; Emergencies; Suicide; Violence; Self-injurious behavior; Substance abuse; Prevention & control. Emergencies in Mental Health Practice: Evaluation and Management. Guilford Press: 2000. 1-450.

Knocker, S. (2014). Achieving culture change in care homes-is training the answer? *The Modern Registered Manager Journal,* 2(1), 8-12.

Kotter, J. (1990). What leaders really do? *Harvard Business Review,* 68(3), 103-111.

Ledoux, Y., & Minner, P. (2006). Occasional and frequent repeaters in a psychiatric emergency room. *Social Psychiatry and Psychiatric Epidemiology*. 41, 115–121.

Lincoln, Y. S., & Guba, E. G. (1985). Naturalistic inquiry. Beverly Hills, CA: Sage Publications, Inc.

Loiselle, C., Profetto-McGrath, J., Polit, D., & Beck, C. (2004). Canadian Essentials of Nursing Research. Lippincott Williams & Wilkins. 1-537.

MacPhee, S. (2014). IWK Health Centre, Chief of Emergency Medicine. Personal communication via email re: ED staff compliment.

Mahajan, P., Alpern, E., Grupp-Phelan, J., Dong, L., Holubkov, R., et al. (2009). Epidemiology of psychiatric-related visits to emergency department in a multicenter collaborative research pediatric network. *Pediatric Emergency Care,* 25 (11), 715-720

Major, B. & O'Brien, L.T. (2005). The social psychology of stigma. *Annual Review of Psychology,* 56*,* 393-421.

Mansen, T. (1993). Role taking abilities of nursing education administrators and their perceived leadership effectiveness. *Journal of Professional Nursing,* 9(1), 347-357.

Marshall, M. (1996). Sampling for qualitative research. *Family Practice*, 13, 522- 525.

Mayer, B., Smith, F., & King, C. (1999). Factors associated with victimization of personnel in emergency departments. *Journal of Emergency Nursing,* 25, 361-366.

McNeese-Smith, D. (1996). Increasing employee productivity, job satisfaction and organizational commitment. *Hospital Health Service Administration,* 41(2), 160-175.

Melchior, M., Bours, G., Schmitz, P., Wittich, Y. (1997). Burnout in psychiatric nursing: a meta-analysis of related variables. *Journal of Psychiatric and Mental Health Nursing,* 4(1), 193-201.

Mercer, S. (2014). Former Director of the Mental Health and Addiction Department at the IWK Health Centre. Personal communication via email re: origin of the Emergency Mental Health and Addiction Service (formerly known as The Crisis Team).

Merriam-Webster Online Dictionary. (2013). Retrieved March 22nd, 2013 from http://www.merriam-webster.com/dictionary/influence

Meunier-Sham, J., & Needham, M. (2003). Increased volume/length of stay for pediatric mental health patients: one ED's response. *Journal of Emergency Nursing*. 29, 229-239.

Miller, R., Baird, T., Littlefield, C., Kofinas, G., Chaplin, F., & Redman, C. (2008). Epistemological pluralism: Reorganizing interdisciplinary research. *Ecology and Society,* 13(2), 74-80.

Moreland, J. (2012). Nursing the identity: the mediating roles of learned helplessness and interaction involvement in predicting willingness to confront conflict an anticipated turnover. *Ohio State University Graduate Program in Communication,* 1-140.

Morgans, A., & Burgess, S. (2011). What is a health emergency? The difference in definition and understanding between patients and health professionals. *Australian Health Review,* 35 (3), 284-289.

Morphet, J., Innes, K., Munro, I., O'Brien, A., Gaskin, C., Reed, F., & Kudinoff, T. (2012). Managing people with mental health presentations in emergency departments- A service exploration of the issues surrounding responsiveness from a mental health care consumer and carer perspective. *Australasian Emergency Nursing Journal,* 15, 148-155.

Morse, J.M. (1991). Approaches to qualitative-quantitative methodological triangulation. *Nursing Research,* 40, 120-123.

Moylan, L. (2009). Physical restraint in acute care psychiatry: A humanistic and realistic nursing approach. *Journal of Psychosocial Nursing and Mental Health Services, 47*(3), 41-47.

Mukolo, A., Heflinger, C., & Wallston, K. (2010). The stigma of childhood mental disorders: A conceptual framework. *Journal of American Academy of Child and Adolescent Psychiatry,* 49(2), 92-198.

Newton, A., Ali, S., Johnson, D., Haines, C., Rosychuk, R., Keaschuk, R., Jacobs, P., & Klassen, T. (2009). A four-year review of pediatric mental health emergencies in Alberta. *Canadian Journal of Emergency Medicine,* 11, 447–55.

Newton, A., Ali, S., Johnson, D., Haines, C., Rosychuk, R., Keaschuk, R., Jacobs, P., Cappelli, M., & Klassen, T. (2010). Who comes back? Characteristics and predictors of return to emergency department services for pediatric mental health care. *Academic Emergency Medicine,* 17, 177-186.

Newton, A., Ali, S., Hamm, M., Haines, C., et al. (2011). Exploring differences in the clinical management of pediatric mental health in the emergency department. *Pediatric Emergency Care.* 27(4), 275-83. doi: 10.1097/PEC.0b013e31821314ca.

Newton, A., Rathee, S., Grewal, S., Dow, N., & Rosychuk, R. (2014). Children's mental health visits to the ED: Factors affecting wait times and length of stay. *Emergency Medicine International,* Article ID#897904, 1-10.

Nicotera, A., Mahon, M., Zhao, X. (2010). Conceptualization and measurement of structural divergence in the healthcare setting. *Journal of Applied Communication Research,* 38(1), 362-385.

O'Brien-Pallas, L., Tomblin-Murphy, G., & Shamian, J. (2008). *Understanding the costs and outcomes of nurses'turnover in Canadian hospitals: Final report.* University of Toronto: Nursing Health Services Research Unit. Retrieved August 20th, 2014, from www.hhrchair.ca/research.cfm

Oermann, M., & Bizek, K. (1994). Job satisfaction and burnout among critical care preceptors. *Critical Care Nursing,* 14(1), 3-6.

One Province, One Process, One Policy (OP3). (2010). Retrieved March 20th, 2013 from http://policy.nshealth.ca/Site_Published/Provincial/Nova_Scotia_Home_Page.asp

Parr, H., Philo, C.(2003). Rural mental health and social geographies of caring. *Social and Cultural Geography*, 4, 471-488

Peplau, H. (1988). Interpersonal Relations in Nursing. NewYork: Putnams.1-365.

Pines, A., Aronson, E., & Kafry, D. (1981). Burnout: From tedium to personal growth. New York: Free Press, Macmillan.

Pittsenberger, Z., & Mannix, R. (2014). Trends in pediatric visits to the ED for psychiatric illnesses. *Academy Emergency Medicine.* 21, 25-30.

Polit, D., & Beck, C. (2004). Nursing Research: Principles and Methods, 7th edition. Lippincott Williams & Wilkins. 1-758.

Pope, W. (2011). Another face of health care disparity. *Journal of Psychosocial Nursing,* 49 (2), 27-31.

Rahimi, S. (2014). Power, change, and 'the culture of psychiatry'. *Anthropology & Medicine,* 21(3), 312-324. DOI: 10.1080/13648470.2014.931096

Recupero, P., Price, M., Garvey, K., Daly, B., & Xavier, S. (2011). Restraint and seclusion in psychiatric treatment settings: Regulation, case law, and risk management. *Journal of the American Academy of Psychiatry and the Law, 39,* 465-476.

Reeves, S., Kuper, A., & Hodges, B.D. (2008). Qualitative research methodologies: ethnography. *British Medical Journal.* doi: http://dx.doi.org/10.1136/bmj.a1020

Riding, R., & Wheeler, H. (1995). Occupational stress and cognitive style in nurses: 2. *British Journal of Nursing,* 4(1), 160-168.

Rose-Williams, G. (2014). IWK Health Centre, Clinical Leader of Operations for the Emergency Mental Health and Addiction Services (EMHAS) Team. Personal communication via email re: EMHAS policies.

Ross, J. (2009). The patient journey through emergency care in Nova Scotia. A prescription for new medicine. 1-85.

Ross, J. (2010). Nova Scotia Emergency Care Standards. 1-23.

Santiago, L., Tunik, M., Foltin, G., et al. (2006). Children requiring psychiatric consultation in the pediatric emergency department. *Pediatric Emergency Care*. 22, 85-89.

Schneider, B. (1990). Organizational climate and culture. Jossey-Bass, San Francisco, CA.

Seidel, J.V. (1998). *The Ethnograph* (Version 5). Qualis Research. http://www.qualisresearch.com

Sealy, P., & Whitehead, P. (2006). The impact of deinstitutionalizing psychiatric services on the accessing of mental health services by people with higher levels of psychological distress. *Canadian Journal of Community Mental Health,* 25 (1), 1-14.

Shafiei, T., Gaynor, N., & Farrell, G. (2011).The characteristics, management and outcomes of people identified with mental health issues in an emergency department, Melbourne, Australia. *Journal of Psychiatric and Mental Health Nursing,* 18 (1), 9-16.

Sheard, D. (2009). Nurturing: Emotions at work in staff. Alzheimer's Society, London, UK.

Sheard, D. (2014). Achieving culture change: a whole organization approach. *Care Analysis,* 16(6), 329-332.

Sills, M., Bland, S. (2002). Summary statistics for pediatric psychiatric visits to US Emergency Departments, 1993–1999. *Pediatrics*. 110(4), 40.

Spradley, J. (1979). The ethnographic interview. *The Developmental Research Sequence: Anthropology,* 1-247.

Spradley, J. (1980). Participant observation. *The Developmental Research Sequence: Anthropology,* 1-195.

State Government Department of Health, Victoria, Australia. (2008). Victoria government health information: Victoria health services. Site last updated October 3rd, 2008. Retrieved January 12th, 2013 from http://www.health.vic/gov.au/mentalhealth/termnlgy.htm

Stephenson, J. (2000). Children with mental health problems not getting the care they need. *Journal of American Medical Association*. 284, 2043–2044.

Stewart, C., Spicer, M., & Babl, F.E. (2006). Caring for adolescents with mental health problems: challenges in the emergency department. *Journal of Pediatric Child Health*. 42. 726-730.

Stuhlmiler, C., King, D., Kalucy, R., DeCrespingny, C., and Thomas, L. (2004). Mental health and alcohol and other drug training for emergency department workers: One solution to help manage increasing demand. *Emergency Medicine, Australia.* 16 (2). 155-160.

Sivakumar, S., Weiland, T., Gerdtz, M., Knott, J., & Jelink, G. (2011). Mental health-related learning needs of clinicians working in Australian emergency departments: a national survey of self-reported confidence and knowledge. *Emergency Medicine Australasia.* 23(6), 697-711. doi: 10.1111/j.1742-6723.2011.01472.x.

Sullivan, P. (1993). Occupational stress in psychiatric nursing. *Journal of Advanced Nursing,* 18(1), 591-601.

Swearigen, S., & Liberman, A. (2004). Nursing generations: An expanded look at the emergence of conflict and it's resolution. *Health Care Manager,* 23(1), 54-64.

Thompson, V., Noel, K., & Campbell, J. (2004). Stigmatization, discrimination, mental health: The impact of multiple identity status. *American Journal of Orthopsychiatry,* 74 (4), 529-544.

Tourangeau, A. & Cranley, L. (2006). Nurse intention to remain employed: understanding and strengthening determinants. *Journal of Advanced Nursing,* 55(4), 497-509.

Trygstad, L. (1986). Stress and coping in psychiatric nursing. *Journal of Psychosocial Nursing and Mental Health Services,* 24(10), 23-27.

Van Voorhees, B., Wang, N-H., & Ford, D. (2003). Managed care organizational complexity and access to high-quality mental health services: Perspective of U.S. primary care physicians. *General Hospital Psychiatry,* 25 (1), 149-157.

Verbeke, W., Volgering, M. & Hessels, M. (1998). Exploring the conceptual expansion within the field of organizational behavior: organizational climate and organizational culture. *Journal of Management Studies,* 35(1), 303-329.

Waraich, P., Saklikar, R., Aube, D., Jones, W., Haslam, D., &Hamil, K. (2010). Quality measures for primary mental healthcare. *Quality Safe Health Care,* 19, 519-525.

Wells, G. (1990). The influence of organizational structure on nurse manager job satisfaction. *Nursing Administration Quarterly,* 14(1), 1-8.

Whitehead, T.L. (2002). What is ethnography? Methodological, ontological, and epistemological attributes. *Ethnographically Informed Community and Cultural Assessment Research Systems Working Paper Series*. Retrieved November 22nd, 2012 from http://www.cusag.umd.edu/documents/WorkingPapers/EpiOntAttrib.pdf

Whitehead, T. (2006). Workbook for descriptive observations of social settings, acts, activities & events. *Cultural Ecology of Health and Changes: Ethnographically Informed Community and Cultural Assessment Research Systems (EICCARS) Workbooks,* 1-11.

Williams, J., Mona, L., & Grupp-Phelan, J. (2011). The acceptability of mental health screening in a pediatric emergency department. *Pediatric Emergency Care,* 27 (7), 611-615.

World Heath Organization. (2012). Health topics: Mental health. Retrieved July 20th, 2012 from http://www.who.int/topics/mental_health/en/

Wright, E., Linde, B., Rau, L., Gayman, M., & Viggiano, T. (2003). The effect of organizational climate on the clinical care of patients with mental health problems. *Journal of Emergency Nursing,* 29 (4), 314-321

Wyatt, L. (2014). IWK Health Centre, Clinical Leader of Development for the Emergency Department (ED). Personal communication via email and in person re: ED documents.

Yeh, M. and Weisz, J. (2001). Why are we here at the clinic? Parent–child (Dis) agreement on referral problems at outpatient treatment entry. *Journal of Consulting and Clinical Psychology,* 69, 1018–1025.

Yu, A., Rosychuk, R., & Newton, A. (2011). Clinical acuity of repeat pediatric mental health presentations to the emergency department. *Journal of Canadian Academy of Child and Adolescent Psychiatry.* 20(3), 208-213.

Yuen, E., Gerdes, J., & Gonzales, J. (1996). Patterns of rural mental health care: An exploratory study. *General Hospital Psychiatry,* 18, 14-21.

Zwarenstein, M., & Bryant, W. (2000). Interventions to promote collaboration between nurses and doctors. *Cochrane Database for Systematic Review.* (2),

APPENDIX A

Letter to Management/Clinical Leaders/Site Chief
(Emergency Department, Emergency Mental Health Team, and Protection Services)

Laura Gough, RN, BScN
Graduate Student
Masters of Nursing Program
School of Nursing
Dalhousie University
Halifax, Nova Scotia

January 16th, 2014

Dear Colleague,

I am a graduate student in the Master's of Nursing Program at Dalhousie University. I am a mental health nurse with 6 years experience in inpatient, outpatient, and community mental health care. During my experience as a mental health nurse in the inpatient setting, I have noted that the majority of our admissions come from the Emergency Department (ED), where the literature shows that ED staff feel more comfortable in dealing with patients with physical trajectory. This observation has led to my interest in understanding the culture (i.e. values and beliefs) of the ED as it pertains to providing care to children/youth with a mental health concern.

I am conducting a study to learn more about *the culture of the ED in terms of providing care to children/youth who arrive in the ED primarily for a mental health concern* and what internal/external influences affect them. Data collection for this study will involve observation of staff and staff/patient interactions, staff interviews, and a document review at the IWK Health Centre ED. This information will assist nurses; other health care professionals and decision makers to better understand the culture with the hopes of assisting in the improvement of mental health care in the future.

This study has been approved by the IWK Health Centre Research Ethics Board and has also been approved by my Thesis Advisory Committee (Dr. Jean Hughes, RN, PhD, Norma Murphy, RN, PhD(c), Dr. Amanda Newton, RN, PhD, and, Dr. Herb Orlik MD, FRCPC). Consultants for my research are Dr. Sabina Abidi, MD, FRCPC and Lois Wyatt, RN, IWK ED.

I will be contacting you in the near future to discuss my proposed study and your willingness to allow the research to be conducted in the ED. With your approval I will also need your assistance to distribute letters of invitation to your department members.

If you have any concerns or questions I may be contacted at my work phone (902) 470-8375 or via work e-mail at Laura.Gough@iwk.nshealth.ca.

Thank you for your time and consideration.

Sincerely,

Laura Gough, RN, BScN
Masters Student, School of Nursing, Dalhousie University

APPENDIX B

Letter of Invitation to Staff for Interview

Laura Gough, RN, BScN
Graduate Student
Masters of Nursing Program
School of Nursing
Dalhousie University

January 16th, 2014

Dear Staff Member,

I am a graduate student in the Master's of Nursing Program at Dalhousie University. I am a mental health nurse with 6 years experience in inpatient, outpatient, and community health care. This letter is being sent with the approval from your Manager/Clinical Leader/Site Chief on my behalf.

I am conducting a study to learn more about the culture (i.e. values and beliefs) of a pediatric ED in terms of providing care to children/youth who arrive primarily for a mental health concern. I will be collecting data in the form of observation, staff interviews, and a documentation review at the IWK Health Centre ED. The focus of this study is observation of staff interaction. I am seeking only permission to observe and no information about the child/youth or those accompanying them are being collected. This information will assist nurses, other health care professionals and decision makers to understand what internal/external influences affect providing care to children/youth with mental health concerns in the ED, understand the process by which care is provided to this population in the ED, and what mandates (i.e. mental health and/or ED) influence providing care to this population in hopes of assisting in the improvement of mental health care in the future.

As per the staff interview section of my research design, I am interested in talking with you to understand the culture of the ED as it pertains to providing care to children/youth who seek help for a mental health concern. I am also interested in learning more about what *your* role is and what *influences* the care that *you* provide to children/youth with mental health concerns. I am also interested in learning more about the *role* that other staff and the health system play in providing care to this population. Being involved in this study would include one interview lasting no more than 2 hours. The interview will be conducted at a private and comfortable location on which we both agree.

The research study also includes periods of observation at the IWK Health Centre ED in the assessment room, the Emergency Mental Health Team office and the 'blue desk' (i.e. nursing station). You may be asked to give verbal assent to being observed at some

point throughout the course of the research study. You have the right to decline. It is also important to point out that I can interview you, without you participating in the observation part of the study.

Your participation is completely voluntary. You are free to withdraw at any time without any effect on your employment status. You do not have to answer all the questions. The interview will be audio-taped and then typed-out (transcribed and anonymized). All information will remain private and locked in a secure place. The only people to have access to the information will be my Dalhousie University Thesis Advisory Committee and me. No names or identifiable information will appear in any report of the study. Interviews and audio-tapes will be destroyed following the study and according to the rules of research of the IWK Health Centre Research Guidelines. A summary of the study results will be sent to you, if you wish.

Some people find that having the opportunity to talk about their experiences is helpful. If at any time you find the discussion too upsetting, you may stop the interview, take a break, resume, re-schedule or terminate the interview. While there is no direct benefit to you from this interview, we might learn things that will benefit others.

If you are interested in finding out more about the study, please contact me by work phone or work e-mail within the next week. I will then contact you by phone or e-mail to arrange a convenient time and place to meet. You may contact me at (902) 470-8375 or Laura.Gough@iwk.nshealth.ca if you have any questions.

Thank you for your time and consideration.

Sincerely,

Laura Gough

APPENDIX C

Verbal Assent Form for Staff -Observation in the Assessment Room

Introduction

My name is Laura Gough. I am a registered nurse, who is a graduate student at Dalhousie University. I would like to invite you to take part in my research study, as part of my Master of Nursing Program thesis work.

Purpose of the Study

The purpose of this study is to understand the culture (i.e. values and beliefs) of a pediatric emergency department (ED) when providing care to children/youth who arrive in the ED primarily for a mental health concern. The focus of this study is observation of ED staff's interaction with children/youth. I am asking for your permission to observe your interaction with children/youth with mental health concerns in the ED. No identifiable information about you, the child/youth or those accompanying them is being collected. This information will help health care professionals understand what influences the way in which ED staff provide care, in hopes of improving future care.

Research Design

Staff's interaction with children/youth with mental health concerns in the ED is one part of my three-part research design. Staff interviews and documentation review of ED and mental health documents are the others. You do not have to participate in any other parts of my study.

Procedure

Once the Crisis Team has been consulted and the child/youth is awaiting assessment, I will enter the assessment/ waiting room and ask for their consent to observe the assessment. If permitted, I will sit in the room, be visible to the child/youth, and observe the interaction and record notes. I will not speak but only observe your interactions with the child/youth. I will observe in the ED for different durations of time and at different times of the day/night. I will be rotating among the assigned assessment room, Crisis Team office, and the ED nursing station.

Participation in the Study

Taking part in this study is voluntary. Participation in this study might not benefit you directly, but information might be gained that will benefit others. You can withdraw from the study at any time. Your employment status will not be affected.

Do you give verbal permission to be observed for the purpose of this research study for observation in the assessment room?

APPENDIX D

Verbal Assent Form for Staff - Observation in the Emergency Mental Health and Addiction Service (EMHAS) Office

Introduction

My name is Laura Gough. I am a registered nurse, who is a graduate student at Dalhousie University. I would like to invite you to take part in my research study, as part of my Master of Nursing Program thesis work.

Purpose of the Study

The purpose of this study is to understand the culture (i.e. values and beliefs) of a pediatric emergency department (ED) when providing care to children/youth who arrive in the ED primarily for a mental health concern. The focus of this study is observation of ED staff's interaction with children/youth. No identifiable information about you, the child/youth or those accompanying them is being collected. This information will help health care professionals understand what influences the way in which ED staff provide care, in hopes of improving future care.

Research Design

Staff's interaction with children/youth with mental health concerns in the ED is one part of my three-part research design. Staff interviews and documentation review of ED and mental health documents are the others. You do not have to participate in any other parts of my study.

Procedure

I am asking for your permission to observe your interaction with other ED staff when you are discussing care of a child/youth with a mental health concern. If a staff present declines to be observed, I will not be able to observe. During observation, I will sit in the Crisis Team office and take notes. The focus of my observation will be to observe staff interactions, collaboration with other ED staff and other multi-disciplinary staff involved with children/youth with mental health concerns. I will observe in the ED for different durations of time and at different times of the day/night. I will be rotating among the assigned assessment room, Crisis Team office, and the ED nursing station.

Participation in the Study

Taking part in this study is voluntary. Participation in this study might not benefit you directly, but information might be gained that will benefit others. You can withdraw from the study at any time. Your employment status will not be affected.

Do you give verbal permission to be observed in the Crisis Team office during the information sharing regarding a patient for the purpose of this research study?

APPENDIX E

Verbal Assent Form for Staff -Observation in the ED nursing station (i.e. 'blue desk')

Introduction

My name is Laura Gough. I am a registered nurse, who is a graduate student at Dalhousie University. I would like to invite you to take part in my research study, as part of my Master of Nursing Program thesis work.

Purpose of the Study

The purpose of this study is to understand the culture (i.e. values and beliefs) of a pediatric emergency department (ED) when providing care to children/youth who arrive in the ED primarily for a mental health concern. The focus of this study is observation of ED staff's interaction with children/youth. No identifiable information about you, the child/youth or those accompanying them is being collected. This information will help health care professionals understand what influences the way in which ED staff provide care, in hopes of improving future care.

Research Design

Staff's interaction with children/youth with mental health concerns in the ED is one part of my three-part research design. Staff interviews and documentation review of ED and mental health documents are the others. You do not have to participate in any other parts of my study.

Procedure

I am asking for your permission to observe you/staff assigned to children/youth with mental health concerns in the nursing station, to gain an understanding of the routine/norms. Observation will take place *only* before, during, and/or after children/youth with mental health problems are assessed, or during shift change. Observations will also take place when there is a high likelihood that ED staff will be communicating/collaborating with one another about children/youth with mental health concerns. During the observations, I will not talk but will sit or stand in the nursing station and record notes. I will observe in the ED for different durations of time and at different times of the day/night. I will be rotating among the assigned assessment room, Crisis Team office, and the ED nursing station.

Participation in the Study

Taking part in this study is voluntary. Participation in this study might not benefit you directly, but information might be gained that will benefit others. You can withdraw from the study at any time. Your employment status will not be affected.

Do you give verbal permission to be observed in the ED nursing station for the purpose of this research study?

APPENDIX F

Health Information Sheet for Child/Youth Observation

What are staff values and beliefs when providing care to kids with mental health concerns in an Emergency Department (ED)?

Official Study Title: What is the culture (i.e. values and beliefs) of a Pediatric Emergency Department (ED) in providing care to children/youth who arrive in the ED primarily for a mental health concern?

Investigator: Laura Gough, RN, BScN
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Research Supervisor: Jean Hughes, RN, PhD
Professor, School of Nursing
Dalhousie University
Halifax, NS, B3H3J5
(902) 494-2456
Jean.Hughes@Dal.ca

Introduction
My name is Laura Gough. I am a student at Dalhousie University. I would like to invite you to take part in my research study, as part of my Master of Nursing Program.

Why am I doing this study?
I am doing this study to understand what influences staff who work in the ED when they take care of kids who come into the ED with a mental health problem.

Study Design
There are three parts of my research study; observation of staff and staff/patient interactions; staff interviews; and a document review. The focus of this part of the study is to observe the way that your ED staff talks with you during your visit to the ED. I am asking for your permission to observe you when your staff talks with you. No information about you or anyone who brought you in will be written down.

What will you be asked to do?
If you and your parent/guardian both give me permission to observe you talk with your ED staff, I will sit in the room where you will be able to see me and write down notes about the way that your staff is talking with you during your assessment.
I won't talk. I want you to know that my being there will not change the way that you get cared for in the ED. Your care while you're in the ED will be the priority.

Are there any good or bad things about this study?
There are no bad things that could happen to you from being in this study. You can say 'no' to me being in the room while you talk with your ED staff. If I am in the room with you and you feel like I'm

making you uncomfortable in any way, you can ask me to leave
and I will. The good things about being in this study are that you will help provide
healthcare professionals with an understanding of the way that staff care for kids with mental health problems in the ED. By knowing this we can make caring for these kids much better in the future.

Will people know that I have been in this study?
People won't know you have been in this study because I won't be collecting your name or any other information about you or anyone who brought you to the ED. I won't be reading your chart or any other information about you. Notes that I take about the way that ED staff interact with you during your visit to the ED will be locked in a cabinet for 5 years. Only my research supervisor and I will have access to the cabinet. After 5 years, those notes will be destroyed according to IWK Research Guidelines.

Do I have to be in this study?
Your participation in this study is voluntary-up to you. If you say yes, you can change your mind at any time and not be in the study anymore. Saying 'no' will not affect the way that the ED staff treat you.

What if I have questions?
If you have any questions about the study, you can contact my research supervisor or me.

Problems or Concerns
If you have any questions about research in general at any time either during, or after, the study is finished you can call the Manager of the IWK Health Centre Research Ethics Board: (902) 470-8520.

APPENDIX G

Consent Form for Child/Youth Observation

Official Study Title: What is the culture (i.e. values and beliefs) of a Pediatric Emergency Department (ED) in providing care to children/youth who arrive in the ED primarily for a mental health concern?

Investigator: Laura Gough, RN, BScN
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Research Supervisor: Jean Hughes, RN, PhD
Professor, School of Nursing
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Jean.Hughes@Dal.ca

Introduction

My name is Laura Gough. I am a registered nurse, who is a graduate student at Dalhousie University. I would like to invite you to take part in my research study as part of my Master of Nursing Program thesis work.

It is your choice whether you participate in this study. You may withdraw at any time. Your health care will not be affected by whether you participate. You might not benefit directly from being in this study, but information might be gained that will benefit others. You should discuss any questions you have about this study with my research supervisor, Dr. Jean Hughes, or me.

Purpose of the Study

The focus of this study is on observation of staff interaction with children/youth who come to the ED primarily for a mental health concern. I am asking for your permission to observe staff's interaction with you. No information about you or those accompanying you is being collected. I am interested in understanding the culture of the ED in terms of what influences staff when they provide care to children/youth with mental health concerns in the ED, the role of staff in the provision of care to this population, and how care is provided to children/youth with mental health concerns in the ED. A summary of final study results will be sent to you if you wish.

Study Design

I want to understand what factors influence staff when they provide care to children/youth with mental health concerns to truly understand the culture of the ED. This research study design involves three parts: observation of staff and staff/patient interactions; staff interviews; and documentation review of ED and mental health documents. If you agree to the observation of staff/patient interactions in the assessment
room, written consent will be obtained from both you and your parent/guardian.

Who will be Conducting the Research?
I, Laura Gough, will be the primary researcher. My thesis committee has approved this study and will continually monitor this study. Committee members include: Jean Hughes, RN, PhD (supervisor), Herbert Orlik, MD, FRCPC, Amanda Newton, RN, PhD, and Norma Murphy, RN, PhD (c).

What will my participation in this study look like?
Children/youth with mental health concerns will be seen and assessed by the healthcare team of the ED. You will be placed in the assessment room to await assessment and/or intervention. Once the healthcare team staff enters the room/meet with you, I will enter the room and request both you and your parent/guardian give me permission to observe your assessment. If both of you agree, I will sit in the room, be visible to you (and possibly family members), and quietly observe the interaction and record notes as the assessment progresses. I will not speak, but only observe staff interactions with you. Observation will not interfere with, or influence, any treatment decisions, or care to you. Optimal care for you will always be the priority. No personal identifying information will be collected from you.
If you wish to receive a summary of the study results, please check 'yes' in answer to the question at the end of the consent form and write your mailing address.

Possible Harm and Discomforts
There are no anticipated risks involved with your participation in this study. Consent can be withdrawn at any time and care you receive will not be affected in any way. In addition, if I think that my presence is affecting you in a negative way, I will leave the room. If a situation begins to escalate, or I think that I might be interfering with routine clinical care, or you or the ED/healthcare team asks me to leave, I will. Ideally, I will stay in the room until your assessment is over.

Participation in the Study
Taking part in this study is voluntary. You have the right to ask questions about the study, to refuse to answer questions during the interview, and to withdraw from the study at any time. Your care and/or treatment plan will not be affected in any way.

Possible Benefits
You may not benefit directly by taking part in this study; however, the information gathered during observation may build a better understanding of culture within the ED as it pertains to improving future care to children/youth with mental health concerns.

Confidentiality
You will not be identified as a study participant in any reports, publications, or presentations of this research, as no information that could identify you will be collected. Notes from observations will be kept in a locked cabinet for 5 years and then destroyed according to IWK Research Guidelines. The only people who have access to the cabinet will be my research supervisor and me. The information obtained from the research will be kept confidential unless required by law.
It is not possible to guarantee absolute anonymity.

Questions
If you have any questions about the study, please contact me and/or my research advisor.

Problems or Concerns
If you have any questions at any time during or after the study about research in general you may contact the Manager of the IWK Health Centre Research Ethics Board: (902) 470-8520.

I have read the explanation about the study "**What is the culture (i.e. values and beliefs) of a pediatric emergency department (ED) in providing care to children/youth who arrive in the ED primarily for a mental health concern? ".** I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I consent to take part in this study. However, I realize that my participation is voluntary and that I am free to withdraw from the study at any time.

Consent Form for Child/Youth Observation
What is the culture (i.e. values and beliefs) of a pediatric emergency department (ED) in providing care to children/youth who arrive in the ED primarily for a mental health concern?

You are asked to answer the following questions. Please check 'yes' or 'no' for the following questions. In order to participate in this study, it is necessary to answer *yes* to the following questions. You will be provided with a signed copy of the consent form for your records.

- Do you agree to participate in the study?
  Yes _____ No_____

_____ _____
Signature of Participant Date/Time

_____ _____
Signature of parent or SDM (if applicable) Date/Time

I have explained the nature and demands of the research study and judge that the participant named above understands the nature and demands of the study. I have explained the nature of the consent process to the participant and judge that they understand that participation is voluntary and that they may withdraw at any time from participating.

_____ _____
Signature of Researcher Date/Time

Do you wish to receive a summary of the study results at the completion of the study?
Yes_____ No_____

If yes, please list your mailing address:

_____
_____
_____
_____
_____

APPENDIX H

Consent Form for Staff Interviews

Study Title: What is the culture (values and beliefs) of a Pediatric Emergency Department (ED) in providing care to children/youth who arrive in the ED primarily for a mental health concern?

Investigator: Laura J. Gough, RN, BScN
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Research Supervisor: Jean Hughes, RN, PhD
Professor
School of Nursing
Dalhousie University
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(902) 494-2456
Jean.Hughes@Dal.ca

Introduction

My name is Laura Gough, RN, BScN. I am a registered nurse, who is a graduate student at Dalhousie University. I would like to invite you to take part in my research study, as part of my Master of Nursing Program thesis work.

Your participation in this study is voluntary and you may withdraw at any time. Your current employment status will not be affected by whether you participate or not. Participation in this study might not benefit you, but information might be gained that ill benefit others. The study is described below. This description tells you about the risks, inconvenience, or discomfort that you might experience. You should discuss any questions you have about this study with Laura Gough or her research supervisor, Dr. Jean Hughes.

Purpose of the Study

The purpose of this study is to understand the culture of a pediatric emergency department (ED) in providing care to children/youth who arrive primarily in the ED for a mental health concern. The focus of this study is observation of staff interaction. The

researcher is seeking permission to observe and no information about the child/youth or those accompanying them is being collected. This information will help health care professionals understand what influences the way in which ED staff provide care, both physical and mental health, to children/youth with mental health concerns in the ED in hopes of improving future care. The study will involve an interview of no more than two hours. Laura Gough will ask you to tell her, in as much detail as you can, about your understanding of *what is* the culture of the ED in terms of providing care to children/youth with mental health concerns in the ED, what your role is in the ED in providing care to this population, how care is provided to children/youth with mental health concerns in the ED, and what is the difference between providing care to children/youth with a mental health concern in the ED and providing care to a child/youth with a physical health concern in the ED? A summary of final study results will be sent to you if you wish.

Study Design

This research study design involves three parts: observation of staff and staff/patient interactions, staff interviews, and documentation review of ED and mental health documents (i.e. i.e. mental health and/or ED policies, procedures, protocols, guidelines, practice guidelines, standards of practices, work instructions, and/or guiding principles). Verbal assent will be obtained to observe staff at the IWK Health Centre ED in the assessment room (room #5), the Crisis Team office, and the nursing station. Written consent will be obtained from staff that is interested in being interviewed by the researcher. The study involves one interview in which participants are asked to describe their understanding of the culture of a pediatric emergency department in providing care to children/youth with mental health concerns. There will be 6-12 people interviewed individually (not in a group) for this study. In order to understand the culture of a pediatric ED in providing care to children/youth with mental health concerns, it is important to hear the opinions and views of people who work with this population and can assist in building this understanding. We need to understand what factors influence providing care to children/youth with mental health concerns in the ED to truly understand culture.

Who Can Participate in this Study?

You may participate in this study if you received the letter of invitation from your manager. You may participate in this study if you:

(1) are a health professional (RN, Social Worker, and Physician), Registration Clerk, or Protection Services officer currently employed full- time in the IWK Health Centre ED, with a minimum of six-months work experience in any ED.

(2) are willing to be interviewed and audiotaped for about 1.5-2 hours.

(3) are able to understand and converse in English.

Who will be Conducting the Research?

Laura Gough will be the primary researcher. Her thesis committee has approved the proposed study and will also be involved in this study. These people include: Dr. Jean Hughes, PhD (supervisor), Dr. Herbert Orlik, Dr. Amanda Newton, PhD, and Norma Murphy, PhD (c).

What will you be asked to do?
The study interview will be conducted at a time and in a private and comfortable location that both you and Laura Gough agree on and will take no more than two hours to complete. Participation will involve one in-person interview. During the in-person interview you will be asked to tell Laura Gough in as much detail as you can, about your understanding the culture of a pediatric ED in providing care to children/youth with mental health concerns? A set of additional questions may be asked that include: a) What your role is in the ED in providing care to this population? b) How care is provided to children/youth with mental health concerns in the ED? c) What is the difference between providing care to children/youth with a mental health concern in the ED and providing care to a child/youth with a physical health concern in the ED? You will not be identified as a study participant in any reports but direct quotes will be used.
A focus group will present the findings of the analyzed interviews and will occur after all in-person interviews have been completed and analyzed. The focus group may take up 1-2 hours. You will be asked whether the findings reflect your ideas from the in-person interviews. To help cover the costs to undertake the interview, 15$ will be given to each participant interviewed.
If you wish to receive a summary of the study results, at the end of the study please check 'yes' in answer to the question at the end of the consent form and list your mailing address. Contact between you and Laura Gough will end after the follow-up focus group.

Possible Harm and Discomforts
There are no anticipated risks involved with your participation in this study. You do not have to answer any or all of the questions. If you should find the interview upsetting, it will be stopped and you will have the option of continuing, taking a break, resuming the interview at another time, or terminating the interview.

Withdrawal from the Study
You do not have to participate in this study. Taking part in this study is voluntary. You have the right to ask questions about the study, to refuse to answer questions during the interview, and to withdraw from the study at any time. Your employment status will not be affected in any way.
If you withdraw from the study immediately after the interview, all information collected before this point and the audio-tape will be withdrawn and destroyed. If not, the audio-taped interview will be analyzed and all data will be anonymized. Every effort will be made to protect confidentiality. If you withdraw from this study without informing Laura Gough, and it is not possible to reach you to determine what you wish to be done with your information collected thus far, your data will be retained and appropriate steps will be taken to de-identify the data in reporting and storing it.

Possible Benefits
There is no guarantee you will benefit personally by taking part in this study. Participation in this study is not therapy. Some people may find it helpful to talk about what factors influence the way care is provided to children/youth with mental health concerns in the ED in attempt to understand the culture of a pediatric ED in hopes of improving future care. On the other hand, your participation in the study may not benefit you; however, the information gathered during the interviews may benefit other people in your workplace setting or in the future.

Confidentiality
You will not be identified as a study participant in any reports, publications, or presentations of this research, as all identifiers will be removed. A coding number will be used instead of your name and profession on the taped and typed copies of the interview. None of the quotes used in reporting results will include material that could identify you.

Your interview will be kept in a secure locked area. Study information will be reviewed by Laura Gough and the thesis committee. In keeping with the University Policy on Scholarly Integrity, data will be held securely for 5 years and then destroyed according to IWK Health Centre Research Guidelines. This includes audio-tapes, field notes and all data transcripts.

The information obtained from the research will be kept confidential with the following exceptions: It will be disclosed as required by law (for example, if the researcher was served a subpoena to appear in court, a participant disclosed intent to harm self or others) and as a required regulation of research to the Research Ethics Board (all studies may be audited at random by the Research Ethics Board). If the researcher is required to disclose information about you, she will attempt to inform you.

There are, however, limits of confidentiality: a) in cases of suspected child abuse or neglect or in certain cases of suspected abuse or neglect of adults, b) all information must be made available in response to a subpoena, court order, or search warrant, or c) in circumstances of actual or possible harm or death, appropriate individuals or authorities must be informed. If the researcher is required to disclose information about you, she will attempt to inform you.

Anonymity
It is not possible to guarantee absolute anonymity. Laura Gough will promise to report only information about groups of people and not to identify individual participants in the study. Although it is extremely unlikely, it is possible that individuals may be identifiable in reports, presentations, or publication of research findings, due to the uniqueness of the information, the small number of participants (6-12), and the organizational specific context.

Questions
If you have any questions about the study, please contact the investigator and/or research advisor below.

Investigator: Laura J. Gough, RN, BScN
Graduate Student
Master of Nursing Program
School of Nursing
Dalhousie University
Halifax, NS B3H 3J5
902(470-8375)
Laura.Gough@iwk.nshealth.ca

Research Supervisor: Jean Hughes, RN, PhD
Professor
School of Nursing
Dalhousie University
Halifax, NS, B3H3J5
(902) 494-2456
Jean.Hughes@Dal.ca

If you have any questions about your rights as a research participant, you may contact the above listed investigator and/or research advisor.

Problems or Concerns
If you have any questions at any time during or after the study about research in general you may contact the Manager of the IWK Health Centre Research Ethics Board: (902) 470-8520.

Consent Form for Staff Interviews
What is the culture of a pediatric emergency department (ED) in providing care to children/youth who arrive in the ED primarily for a mental health concern?

You are asked to answer the following questions. Please check 'yes' or 'no' for the following questions. In order to participate in this study, it is necessary to answer *yes* to the following questions. You will be provided with a signed copy of the consent form for your records.

- Do you agree to participate in the study given that it will be audio-taped?
  Yes _____ No_____

- Do you give permission for the researcher to use direct quotations for educational and publication purposes?
  Yes _____ No_____

I have read the explanation about the study "**What is the culture of a pediatric emergency department (ED) in providing care to children/youth who arrive in the ED primarily for a mental health concern? ".** I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I hereby consent to take part in this study. However, I realize that my participation is voluntary and that I am free to withdraw from the study at any time.

_____ _____
Signature of Participant Date/Time

I have explained the nature and demands of the research study and judge that the participant named above understands the nature and demands of the study. I have explained the nature of the consent process to the participant and judge that they understand that participation is voluntary and that they may withdraw at any time from participating.

_____ _____
Signature of Researcher Date/Time

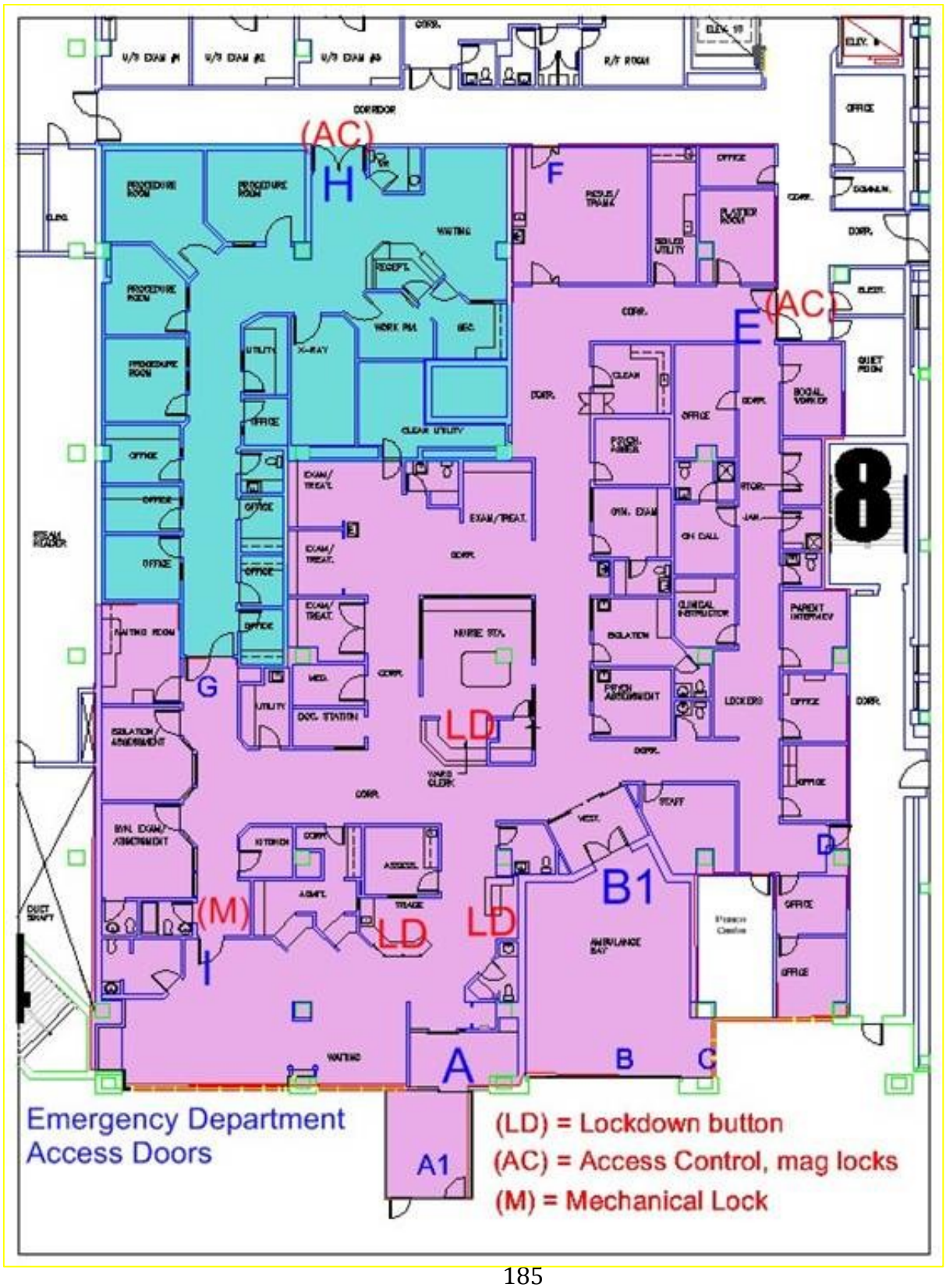
If you wish to receive a summary of the study results at the end of the study, please check 'yes' in answer to the question asking this at the end of the consent form.

Do you wish to receive a summary of the study results at the completion of the study?
Yes_____ No_____

If yes, please list your mailing address:

_____
_____
_____
_____
_____

APPENDIX I
Floor Map of the IWK Health Centre ED (2014)



APPENDIX J

Grid of Observations: Looking at the culture in the Emergency Department Setting using ethnography templates from (Reeves et al., 2008; Spradley, 1980; & Whitehead, 2006).

Date and time:

Place being observed:

The physical layout of the space:
The range of people involved:
Staff disciplines in the setting:
Space occupied by these disciplines and how are they situated in space:
Objects in that space and how these objects are situated or arranged:
Related activities occurring in the ED setting at present:
Single actions/activities people undertake:
The sequencing of events that occur:
Objectives that people are trying to accomplish:
Whether there seem to be any goals associated with the behavior of the disciplines:
Emotions felt and expressed by people in the setting:
The language:
Other forms of expressive culture found in the social setting beyond general language, such sounds, activities, and technologies
The interactive patterns between the actors in the setting:
The presence of actor group differentiation in the setting, or persons that can be differentiat some shared similarity, such as by gender, age, family or kinship, vocation or some other ty affiliation (such as persons in a hospital), ideational elements (beliefs, attitudes, values, or a other cognitive constructs) suggesting various socio-cultural meanings that might be presen or attached to, any of the other ethnographic domains in the setting:
Broader social systems that might influence the actors, behaviors, and ideations found in th socio-cultural scene being studied:

APPENDIX K

Semi-structured interview guide

1) What is an Emergency Department?

- What is the purpose of an ED?
- Can you tell me about how the Emergency Mental Health Team (EMH) came to be?
- What does the EMH Team do?
- Is the meeting EMH Team meeting the need?
- How can the EMH Team and ED staff work together?
- Are there challenges that come with working together?
- What would be the strength that comes with working together?
- If things could be different, how could things be most effective?
- How would the physical environment be re-designed?
- What would you change about the ED environment?
- Can you tell me about how you view the culture of the ED?
- Have you ever worked at a different ED?
- Did it look different?
- Did patients receive better care when care was provided in different sectors?

2) Could you tell me about *your role* in the ED in providing care for children/youth with mental health concerns?

- Could you tell me what you do at work?
- Could you tell me whom you work with?
- How do you talk about what ***you*** do? How do you see your work, your patients, yourself? How do you think your view may be different than someone else's?

- Could you describe for me what you do when you provide care to a child/youth with a mental health concern in the ED?
- Could you give me a sentence a staff might use when reporting to another staff about a child/youth with a mental health concern in the ED?
- Can you think of any other things you do on a typical shift when providing care to a child/youth with mental health concerns?

3) Can you tell me about how care is provided to children/youth with mental health concerns in the ED?

- How do people work together to provide care for children/youth with mental health concerns in the ED?
- Can you tell me about the stages in providing care to a child/youth with a mental health concern in the ED?
- Can you tell me what is the process that a child/youth with mental health concerns goes through in the ED receiving care? (i.e. stages of triage, assessment, etc.)
- What internal/external influences affect the way in which you provide care to children/youth with mental health concerns in the ED?

4) **What is the difference between providing care for children/youth with a mental health concern in the ED and providing care to children/youth with a physical concern**?

- What is the difference between the care ***you*** provide to children/youth with mental health concerns and that provided by other (i.e. same discipline and/or other disciplines)? What are the biggest similarities?
- What is the biggest challenge of caring for a child/youth with a mental health concern in the ED?
- What is the biggest strength of caring for a child/youth with a mental health concern in the ED?
- Who is mostly involved in providing care to a child/youth with a mental health concern?

- Who is primarily responsible for providing care of a child/youth with a mental health concern in the ED?
- When you're meeting a patient with a mental health concern for the first time, what might you say? Is it different from what you might say to a patient with a physical health concern?
- Can you think of any kind of activities you do specifically with this population that you might not do with a child/youth with a physical concern?
- Is there anything you would change about the process of providing care to a child/youth with a mental health concern in the ED?

APPENDIX L

Definitions for policies and procedures provincial policy working group (2010)

Policy: A clear formal and authoritative statement (s) directing practice. They enable informed decision-making, prescribe limits, assign responsibilities/accountabilities and are secondary to legislation and by-laws. Policies reflect the vision, mission, values and strategic directions of the Health Centre. They can be brief broad statements or longer and detailed documents if required by the subject matter. They must be realistic, achievable and evidence informed. They are non-negotiable.

Procedures: Describe a detailed series of steps, or outline a sequence of activities. They can be differentiated from policies in that they may be altered in view of professional judgment.

Protocol: Written plan-specifying steps to be followed in a study, investigation, or a patient care intervention. They focus on process, assessment, intervention and evaluation and deal with issues requiring professional judgment and decision-making.

Guidelines: Written principles that guide actions or decisions. They allow flexibility in the sequence and/or inclusion of specific steps in the process and encourage professional judgment.

Practice guidelines: Systematically developed statements to assist the practitioner and patient in decisions about appropriate health care for specific clinical circumstances. Practice guidelines offer concise instructions on how best to manage health conditions.

Standards of practice: Statements that describe the desirable and achievable performance expected of health disciplines in their practice and against which actual performance can be measured. Standards range from broad, profession-specific standards established by a professional organization to more detailed practice-specific standards established by a particular agency. The policies and procedures of a health care organization need to be consistent with the standards of practice for the health disciplines employed by that organization.

Work instructions: Define the activities in terms of who is to perform it, when it is to commence and when it is to be completed. They may also specify the standard the work has to meet and any other instructions that constrain the quality, delivery and cost of the work required. Work instructions outline the work to be carried out, procedures define the sequence of steps to execute the work.

Guiding principles: Negotiable statements that serve to further outline practice and encompass points of emphasis to remember in implementing the policy or procedure.

APPENDIX M

Document review-Comment sheet

Document Title:
Document Reference:
Document Version:
Document Date:
Date By Which Document Reviewed:

Template for document review

Does the document identify information on: • Purpose • Objectives • Target group • Mode of service delivery • Service entry mechanisms • Service leaving mechanisms		
Is there accountability for the document in terms of: • Whether it would be reviewed regularly and fo how often, and/or under what circumstances it would reviewed • The person or post or committee responsible fo review • When the document was last reviewed and upd		
Is the specific document consistent with other IWK Hea Centre/provincial/federal regulations and policies?		
Are job descriptions clearly outlined for staff and other stakeholders, which clearly set out their duties, responsibilities, and accountabilities?		
Is there a link (direct/indirect) of documented policy fo staff training and development in terms of caring for a child/youth with a mental health problem in the ED at organizational level?		
Are there documented procedures within the IWK Heal Centre organization to ensure compliance with the rele legislation?		
Is there documented policies and procedures upon orientation for new staff?		
Is there documented procedures and policies for responding to an emergency?		
Is there documented policy and procedures on entry specifying the criteria for patients entering the service?		
Is there documented policy and procedures on exiting specifying the criteria for patients entering the service?		
The entry policy: • Is non-discriminatory • Clearly identifies the target group • Clearly identifies the criteria for determining priority for entry		

Having documented policy and procedures for assessin and meeting the service users' needs which incorporat • Designated responsibilities for assessment, pla and review • Parties to be involved • Regular review and updating • Methods of assessment • Maintenance of records • Communicating decisions to relevant people		
Having documented policy and procedures spelling out • Under what circumstances and how to provide service users with the information about operations th affect them • Timing required and how to provide service us with such information		
Having documented policy and procedures by which: • Service users' needs for privacy and dignity are respected and upheld • Service users are informed of their rights in rel to privacy and dignity		
Having documented policy and procedures to ensure th all information collected about service users, both writ and verbal, is treated as confidential and identifies who access to such information		

APPENDIX N

Table of Observation Periods

Location of Observation	Month	Day	Time	Gender of patie	Age	People Involved in providing care
1-Assessment R	February	Tuesday	Evening	Male (accompanied by police)	18	Police, EMHAS Social Wor ERP, ED RN, Protection Services
2-Assessment R	February	Wednesday	Morning	Female (mother present room)	14	EMHAS Social Worker, ER Psychiatry Resident, Psychiatrist
3-Assessment R	February	Wednesday	Afternoon	Female (father present i room)	16	ERP, EMHAS Social Work ED RN, Psychiatry Reside
4-Assessment R	February	Thursday	Evening	Male (mother present room)	18	EMHAS Social Worker, ED ERP, Protection Services
5-EMHAS Office	February	Friday	Night	Female (brought in by mother and fathe	13	EMHAS Social Worker, ER ED RN
6-Room #6 (Me Room)	February	Saturday	Afternoon	Female (mother and aun present in room)	13	Psychiatry Resident, ED R ERP, Psychiatrist
7-Room A (Med Room)	February	Saturday	Evening	Female (mother present room)	12	EMHAS RN, Psychiatry Resident, ERP
8-EMHAS Office	March	Monday	Night	Male (brought in by mother)	16	EMHAS RN, ERP, Psychiat ED RN
9-EMHAS Office	March	Thursday	Evening	Male (brought in my mother and siste	15	EMHAS Social Worker, ED ERP, Psychiatrist
10-EMHAS Offic	March	Sunday	Afternoon	Female (brought in by mother)	16	EMHAS RN, ERP, ED RN
11-EMHAS Offic	March	Wednesday	Morning	Female (brought in by gr mother)	17	EMHAS Social Worker, Psychiatrist, ERP
12-Blue Desk	March	Friday	Evening	Male (brought in by mother)	18	EMHAS Social Worker, Psychiatry Resident,
13-Blue Desk	March	Tuesday	Night	Male (brought in by mother and fathe	15	EMHAS RN, ED RN, Psych Resident, ERP

14-Blue Desk	March	Monday	Evening	Female (brought in by mother and step-father)	14	EMHT Social Worker, ERP Psychiatry Resident, Psychiatrist

APPENDIX O

Mental Health and Emergency Department Documents Reviewed (2014)

Type of Document	Date of Last Revisio	Document Reviewed	Addressed to which care team in the
Legal Document	November 21st, 2012	Involuntary Psychiatri Treatment Act	Mental Health and Addictions (EMHAS staff
Clinical Policy/Object Manual #1234	July 28, 2005	Least Restraint Policy	ED and EMHAS staff
Clinical Policy Manual	January 8th, 2007	Mental Health and Addictions Program Absent without Leave (AWOL)	Mental health and Addictions (EMHAS staff
Clinical Policy Manua	January 8th, 2007	Crisis Team-End of Sl Coverage	Mental Health and Addictions (EMHAS staff
Clinical Policy Manua	January 8th, 2007	Mental Health and Addictions Program Ambulatory Mental H Emergencies	Mental Health and Addictions (EMHAS staff
Clinical Policy Manua	January 8th, 2007	Mental Health and Addictions Program Forensic-Intoxicant U	Mental Health and Addictions (EMHAS staff
Clinical Policy Manua	January, 2008	Assessment Policy	Children's Health Program (ED staff)
Clinical Policy Manua #1363	March, 2008	Follow-up Care Policy	Children's Health Program (ED staff)
Clinical Policy Manua #1367	October, 2009	IWK Health Centre M Health Policy	Children's Health Program (ED staff)
Clinical Policy Manua #1367	October, 2009	Psychiatric Triage Classification Guideli	Children's Health Program (ED staff)
Clinical Policy Manua #1367	October, 25th, 2012	Mental Health Flow Charts: Seeking Menta Health Assessment (< 19)	Children's Health Program (ED staff)
Clinical Policy Manua #1367	October, 2009	Current IWK Mental Health Clients Seekin Mental Health Assess (<Age 19)	Children's Health Program (ED staff)
Clinical Policy Manua #1367	October, 2009	Consultation Process between ED and EMH staff	Children's Health Program (ED staff
Clinical Policy Manua #1367	October, 2009	Guidelines for Persona Search	Children's Health Program (ED staff
Policy/Procedure #137	January, 2010	Observation in the ED	ED staff
Clinical Policy Manua #1373	March, 2004	IWK Health Centre Overage Patient	Children's Health Program (ED staff)

Policy	May, 2014	Prohibited Items Polic	ED and EMHAS staff
Policy/Procedure #137	September, 2013	Sexual Abuse/Assault Policy	Registered Nurses in the ED, ERPS, and Child Protection Team
Policy	April 7th, 2014	Policy Addressing Individuals Presenting the IWK ED by a Poli Officer under Section (IPTA)	ED and EMHAS staff
IWK Health Centre Permanent Record For **Documents currently under Status Review**	August, 2014	Triage Assessment EMHAS	ED and EMHAS staff
Guideline	May, 2014	ED Use of Environme Restraint: Guidelines Safe Monitoring of Patients while in Lock Room 5	ED and EMHAS staff
Guideline	April 9th, 2014	Guiding principles for Medication Administr to ED Patients that are Consulted to EMHAS	ED and EMHAS staff
Protocol	May, 2014	Rescue Hook Protocol	ED and EMHAS staff
Protocol/Algorithm	December 16th, 2013	Enacting Involuntary Psychiatric Treatment (IPTA) in the ED	ED and EMHAS staff
Algorithm	April 7th, 2014	Section 14-When a Pa with a Primary Mental Health Issue Presents Law Enforcement: Decision Making Algorithm	ED and EMHAS staff
Children's Health Pro Memorandum	August 12th, 2014	All Referral Calls to E	ED and EMHAS staff
Clinical Policy Manua #1373 Memorandum	March, 2004	Medical Assessment o Patients with Mental Health Complaints-Ag 16-18	All ED staff

IWK Health Centre

APPENDIX P

Summary Letter of Themes to Participants

Date

Dear

It has been some time since we met and talked about your understanding of culture (i.e. values and beliefs) of providing care to children/youth with mental health concerns in the ED. I have spoken with a number of other people about their understanding of culture and what influences the culture in the ED. I would like to share with you the five common themes that I heard in all of the interviews with staff.

I noticed that people talked a great deal about content that pertained to five factors (themes) that I have described on the attached page. I would like to know whether you think your story fits with these ideas and if you think I have missed anything important you shared during our conversation.

As we agreed during your interview, I will call you in a couple of weeks to see if you are interested in talking with me about my findings.

Please be assured that our phone conversation is completely voluntary and that you are not required to talk with me about this study again. If you are not interested in talking with me you can simply say 'no' when I call. If you would like to contact me before I call, you may reach me at Laura.Gough@Dal.ca

I thank you once again for participating in my study about 'what is the culture of a pediatric ED in providing care to children/youth who arrive in the ED primarily for care regarding a mental health concern?' I look forward to contacting you soon.

Sincerely,

Laura Gough, BScN, RN
Graduate Student
Masters of Nursing Program, Dalhousie University