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Exploring How Alberta Health Services Nurses are Making Sense of Their Role in Relation to the Recent Changes to the Mental Health Act of Alberta

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Exploring How Alberta Health Services Nurses are Making Sense of Their Role in Relation to the Recent Changes to the Mental Health Act of Alberta

by

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ABSTRACT

The purpose of this qualitative study is to explore how Alberta Health Services nurses are making sense of their role in relation to the recent changes to the Mental Health Act of Alberta. The Mental Health Act (MHA) of Alberta was enacted to protect and ensure the rights of people suffering from mental disorders. The most recent MHA amendment, which was enacted in September 2020, includes expanded duties required of the hospital and health care providers. Social Constructivism, Carper's Ways of Knowing theory, and Uncertainty theory will provide the theoretical framework for this study. A Thematic Analysis method was utilized to elicit responses using a semi-structured interview tool. Data analysis will be conducted using the six-step thematic analysis as introduced by Braun and Clarke (2006). The way nurses make sense of their role contributes to the composition of ethically informed, safe, and effective care within the scope of professional practice and current legislation. This study helps address this gap in the context of mental health nursing practice in Alberta.

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DEDICATION

I dedicate this work to my mother, Adele, whose remarkable intellect shines brightly despite never having the opportunity for formal education. Her resilience and innate wisdom serve as a profound inspiration and reminder of the power of determination.

Special thanks to my husband, Abdula, for his unwavering support and encouragement throughout the countless hours devoted to this endeavor. To my cherished children, Sammy, Suzie, Billy, and Danny, your unwavering faith in me, especially during times of self-doubt, has been my greatest source of strength. And to the family I gained during this journey, my dear daughter-in-law, Nada, and grandson, Abdula Jr., your presence and love have enriched every step of this process. With all my heartfelt love and gratitude.

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LIST OF ABBREVIATIONS

AHE	Alberta Hospital Edmonton
AHP	Alberta Hospital Ponoka
AHS	Alberta Health Services
APN	Advanced Practice Nursing
CNA	Canadian Nurses Association
CNS	Clinical Nurse Specialist
CRNA	College of Registered Nurses of Alberta
CRPNA	College of Registered Psychiatric Nurses of Alberta
CTOs	Community Treatment Orders
MHA	Mental Health Act
MHPA	Mental Health Patient Advocate
RN	Registered Nurse
RPN	Registered Psychiatric Nurse
TA	Thematic Analysis

CHAPTER 1: INTRODUCTION

The *Mental Health Act* (MHA) of Alberta was enacted to protect and ensure the rights of people suffering from mental disorders by providing safeguards, supports, and direction for the provision of care (Angus, 1966; Boschma, 2011). The MHA of Alberta outlines the duties of health care professionals, including mental health nurses who are often responsible for supervision of patients and delivery of care.

Past amendments to mental health legislation in Alberta have been influenced by the social, political, and clinical contexts of mental illness. “Mental health laws can be heavy handed, even coercive. It is therefore critical that safeguards be built into these laws to ensure protection for the rights of those who suffer from mental illness” (Nelson, 2022, p. 563). Over the years, most revisions to the MHA result in changes to the specific duties and responsibilities of health care providers. The most recent amendment to the MHA of Alberta occurred in response to a 2019 Court of Queen’s Bench decision in the case JH v Alberta Health Services, which found some sections of the Mental Health Act, 2010 to be unconstitutional or incomplete and specified that changes must take effect within 12 months (Government of Alberta, 2020; JH v Alberta Health Services, 2019). As result, with minimal notification to the health care providers responsible for the delivery of care, The Mental Health Amendment Act, 2020 took effect on September 30, 2020. Many health care professionals, including myself, were forced to quickly familiarize ourselves with the amended act and the changes in our responsibilities according to the new legislation.

In my role as a Clinical Nurse Specialist on the Medical Psychiatry Unit at the Peter Lougheed Centre, it is my responsibility to provide education to nurses, including education about nursing responsibilities under the MHA; and to ensure our nursing practice adheres to our legal and ethical duties under the MHA. The sudden nature of these changes, the response

required to adapt to the new MHA, and the need to rapidly educate nurses on my unit, left me feeling unprepared to fulfill my role. This experience became the catalyst for further exploration of the research and practice literature, which informs my research question: How do Alberta Health Services (AHS) nurses make sense of their role in relation to recent changes to the Mental Health Act (MHA) of Alberta, included within the Mental Health Amendment Act, 2020. In this study, I undertake a qualitative thematic analysis to explore nurses' experiences in relation to the recent changes to the MHA. This research provides insights that contribute to recommendations for practice, education, and future research.

Background and Significance

Legislation and the reorganization of mental health services have had a significant influence on mental health nursing practice in Alberta, as nursing practice must shift in response to responsibilities and duties according to the MHA of Alberta. Over the last century, provincial mental health legislation has periodically been revised to improve and safeguard the rights of patients in accordance with the changing political and social context of the time (Angus, 1966; Barron 2015; Micale, 2014; Sealy et al., 2004). Some of these changes include the introduction of the Mental Health Patient Advocate (MHPA) and making it the duty of the hospital and health care providers to inform the patient, and their nearest relative, of their rights under the MHA. The most recent MHA amendment, enacted in September 2020, includes expanded duties required of the hospital and health care providers. Although the Alberta MHA primarily addresses involuntary admission procedures to psychiatric facilities for assessment and treatment, it also includes provisions for voluntary admissions and various community mental health services. These services encompass outpatient care, community support programs, Community Treatment Orders (CTOs), and initiatives dedicated to enhancing mental wellness

and preventing mental illness. While these community-based services are pivotal components of the provincial mental health care system, my research study concentrates specifically on involuntary inpatient admissions as governed by the MHA. In the legal case against AHS, which prompted the 2020 amendments, the failure of nursing staff to fulfill their legal and ethical obligations toward the patient in their care was cited. The resulting amendments have impacted mental health nurses in Alberta who play a central role in the delivery of inpatient mental health care. For nurses to fulfill their legal and ethical nursing role in the context of the MHA, it is crucial that they understand their legal and ethical nursing responsibilities and obligations.

Currently, there is little literature explaining how nurses make sense of and compose their practice roles in relation to mental health legislation. Such an understanding could contribute to the composition of ethically informed, safe, and effective care within the scope of professional practice and current legislation. This study addresses this gap in the context of mental health nursing practice in Alberta.

CHAPTER 2: LITERATURE REVIEW

This research helps provide context of how AHS nurses make sense of their role in relation to the recent changes to the MHA of Alberta. This literature review offers a summary of the current knowledge, concepts, theories, and data on the topic. Due to the novel nature of the topic, this research traces the etiology and history of mental health legislation in Canada and more specifically in the province of Alberta; the role of the nurse in the delivery of mental health care; and the social and political context of the subject.

Search Strategy

The literature search was undertaken using several electronic databases including Cumulated Index to Nursing and Allied Health Literature (CINAHL), Canadian Legal Information Institute (CANLII), MEDLINE, and APA PsycINFO, using variations of the search terms “Mental Health Act”, “Alberta”, “nursing role”, “psychiatric nursing”, “mental illness”, “psychiatric illness”, “mental disorder”, “containment”, “involuntary admission”, and “formal admission”. A targeted search of “Mental Health Act” and “nursing roles” and “mental health nursing” was completed using Google Scholar and ProQuest Dissertations. Snowball searching methods were employed by searching the reference lists of key articles. All literature searches were limited by English language, peer reviewed, and full-text availability. Duplicates were removed, and titles and abstracts were screened. Twenty-eight articles were deemed appropriate for this review.

History of Mental Health and Mental Health Legislation in Canada and Alberta

Mental illness has a long and complex history. Historically, mental illness was poorly understood and the treatment of the mentally ill was inhumane (Eghigian, 2017). In the Middle Ages, madness was considered to be evil, a curse, witchery, social deviance, or demonic possession, and as such, treatment often included isolation, violence, or torture (Barron, 2015;

Eghigian, 2017; Kumar et al., 2011a; Kumar et al., 2011b). Since ancient times, perspectives have shifted from evil to ill and from madness to mental illness. Over time, the care of the mentally ill has also shifted from being managed by government or the church, who used exorcism, punishment, or containment, to care being provided by medicine, where management has included investigation, treatment, and containment.

It is estimated that approximately 15% of the world's disease burden is attributed to mental disorders (Zolnierek, 2008), however, in a global context, there is a large discrepancy in the treatment of mental illness. According to the World Psychiatric Association (WPA), only 48% of member countries within the Commonwealth have a formal mental health policy. Of those countries with a formal policy, only 16% refer to equity of resources between physical and mental illness, 56% do not explicitly promote deinstitutionalization, almost half (44%) do not explicitly promote the integration of mental health services into general health services, and only half address mental health promotion and emphasize the need for research and evaluation in their mental health policies (2017). These findings highlight areas where improvements can be made in mental health policy to ensure that the needs of individuals with mental illness are adequately addressed, and that mental health care is integrated effectively into broader healthcare systems. An example illustrating the large discrepancy in the treatment of mental illness and the roles professional practitioners play in that treatment is that, while approximately 40% of the countries in the world do not have a government mental health policy to address mental health goals and strategies, nurses in the United Kingdom have legislated authority under the Mental Health Act to section patients, granting them the authority to hold patients involuntarily (Zolnierek, 2008; Hall, 2017). Canada's national and provincial mental health strategies lie somewhere between these two positions.

A historical tracing of the changes in psychiatric health care in Canada and Alberta establishes a relationship between the care of patients with mental illness, associated legislation, and political and social influences of the period (Angus, 1966; Barron, 2015; Boschma, 2011; Boschma et al., 2005; Browne, 2010; Micale, 2014; Sealy et al., 2004; Smith et al., 2013). Typically, media attention and public lobbying for individuals living with mental illness results in a government response demonstrated through legislative changes, funding, and changes to the structure of mental health care delivery. As an example, the Schizophrenia Society of Alberta advocates for individuals with enduring mental illness, not only by providing services, but through community education programs that promote awareness to influence positive change. These changes influence societal values such as equality and advocacy for vulnerable populations. As a result, there is an increase in the belief that advocacy matters and can have a positive impact on improving mental health strategies. This cycle of advocacy stimulates public awareness, influences societal perception and triggers advancements in the delivery of mental health care services. The current state of mental health care in Alberta can best be understood in the context of the historical perspective and evolution of mental health care in Canada and Alberta.

1900-1950s: The Mental Hygiene Movement

The Insanity Act (1907) was the first provincial mental health legislation in Alberta. The act allowed for those who were judged "insane" to be committed to an asylum. The prevailing opinion at the time was that insanity was curable and that kind, moral, and peaceful treatment provided in asylums would be curative (Rothman, 2002). Asylums were meant to provide needed stability through a disciplined routine to promote recovery without cruelty or punishment (Rothman, 2002). During this time Alberta did not have an asylum, so those deemed to require

institutionalization were sent to an asylum in Manitoba (Barron, 2015; Boschma et al., 2005). Alberta Hospital Ponoka (AHP), the first provincial facility for the mentally ill, opened in 1911. Similar to other Canadian asylums, AHP was a custodial institution, overcrowded, with mostly male patients who were considered chronic and incurable. After World War I when veterans returned in need of psychiatric care, AHP became much busier (Boschma et al., 2005). The burden of AHP overcrowding eased in 1923 when the Alberta Hospital Edmonton (AHE), was opened. Initially a custodial facility serving males, AHE became a treatment facility in 1940 (Boschma et al., 2005). The focus of custodial institutions was primarily to hold patients as opposed to treatment facilities which focus on facilitating recovery.

A significant shift occurred between 1922 and 1925, when Alberta Provincial legislation was amended to include the Insanity Act, the Mental Defectives Act, the Lunatics' Estates Act, and the Mental Diseases Act (Government of Alberta, 1922a; Government of Alberta, 1922b; Government of Alberta, 1925a; Government of Alberta, 1925b). These newly established acts referred to individuals diagnosed with mental illness as "mental defectives." During this period, several individuals and tactics played a key role in swaying public and government opinion toward the concept of eugenics.

In 1919, Lochhead, a Canadian botany professor, published an article about the science of genetics, reviving Francis Galton's work asserting that heredity determined intelligence (Grekul, 2002, McLaren, 2015). According to Galton, since intelligence is inheritable, heredity determines the quality of the general population (McLaren, 2015). Population studies from the late 1800s revealed that so-called undesirable populations were producing more rapidly than populations with desirable traits. These studies also revealed that as educated women entered the work force, they tended to have smaller families while the undesirable populations were

reproducing at greater rates (Grekul, 2002). This threatened to degrade the quality of the future population and it was deemed that there was a social responsibility to restrict the reproduction of those with undesirable traits. These ideas were being promoted in other parts of the world and were starting to be more widely accepted in Canada, which was further complicated with the influx of new immigrants to Canada. According to Grekul (2002), "consensus was building that something had to be done to encourage the fit to reproduce while restricting the defective from continuing to contaminate the human race" (p.16).

Many prominent scholars, public figures, physicians, anti-feminist groups, and politicians actively promoted these beliefs through published articles in magazines and newspapers, academic debates, university courses, scholarly works, and public investigations (Grekul, 2002, McLaren, 2015). A highly respected and influential Albertan who advocated for the compulsory sexual sterilization of those deemed to be "mentally defective' was Emily Murphy, a women's rights activist, the first female magistrate in Canada, and one of Alberta's Famous Five. Emily Murphy and other prominent individuals influenced public opinion and contributed to the socially constructed belief that 'defective' individuals, including those requiring psychiatric care, posed a societal threat. This perceived threat led to the general public's acceptance of a scientific solution to improve social conditions.

The concept that people requiring psychiatric care were "defective" led to the controversially legislated practice of sexual sterilization when The Alberta Eugenics Board passed the Sexual Sterilization Act in 1928 (Government of Alberta, 1928). The Eugenics Board had the role of ruling on cases for the sterilization of those deemed to be genetically inferior.

During this period, there was greater acceptance of the movement to cleanse the population of 'defective' individuals through compulsory sexual sterilization. The first

amendment to the Sexual Sterilization Act took effect in April of 1937 and was intended to provide clarification, further authority to practitioners, and provide practitioners with legal protection from wrongdoing (Kersten, n.d.a). This amendment was proposed by Dr. W. W. Cross, the Social Credit Minister of Health, who recommended a widened criterion under the act, as it was thought that not enough individuals were being sterilized (Grekul, 2002). In the years following the amendment, there was a substantial rise in the rates of sexual sterilization of Aboriginal Canadians. Under the authority of this act, and its two amendments, over 2700 people underwent involuntary sexual sterilization. Most often these procedures were performed on women who were not diagnosed with a mental illness, and without their consent (Kersten, n.d.a).

Further broadening of the criterion was added in the 1942 amendment to the act which allowed for sterilization of people with neurosyphilis, epilepsy, and Huntington's Chorea (Kersten, n.d.b). Other vulnerable populations were also subjected to sexual sterilization, including: the poor, people who had committed crimes, those identified as prostitutes, those labeled as "sexual deviants", people with pervasive developmental delays, and those diagnosed with alcohol use disorders (Boschma et al., 2005; Kersten, n.d.a; Kersten, n.d.b.).

Between 1915 and 1935, the AHP patient population had drastically increased from 445 to 1490 patients (Boschma, 2005). Severe overcrowding was jeopardizing patient safety, while new treatments, such as electroconvulsive therapy and insulin coma therapy were being introduced (Boschma, 2005). This meant that skilled nursing care became even more necessary. Formal training for psychiatric nursing began in Alberta in the 1930s during the depression, and AHP opened a nursing school with extra training in mental health nursing education. During this time, the nursing profession consisted primarily of women due the gendered belief that nursing work required a feminine nature (Boschma et al., 2005). The program was not open to males,

however AHP did employ untrained aides and male attendants (Boschma et al., 2005). During this period, the governing and treatment of mentally ill patients was influenced by the conservative political government in power, and the economic challenges following the Depression and World War II. The cultural influence of civil rights and patient advocacy movements prompted transformational changes in mental health care delivery in the second half of the twentieth century (Boschma et al., 2005).

1950s-1980s: Deinstitutionalization

In the early 1950s, Alberta and Canada saw positive changes in the field of psychiatry. These changes were due to the introduction of psychotropic drugs, as well as the beginning of deinstitutionalization (Barron, 2011; Boschma et al., 2005; Boschma, 2011; Micale, 2014; Sealy et al., 2004; Smith et al., 2013). The advent of psychotropic drugs meant that troubling psychiatric symptomatology became more "treatable" and thus containment became a less necessary and eventually a less desirable treatment option. During this time, "the focus of mental health care shifted from care provided in large, often remote institutions towards community-oriented services and general hospital psychiatry centralized in urban areas" (Boschma, 2011, p. 224). Deinstitutionalization was seen as a step toward supporting the rights of individuals with mental illness. This period, known as the *Post War Boom,* saw significant growth in gross domestic product (GDP), increased employment rates, and an increase in the Canadian population (Matteo, 2017). Government began to play an increased role in the delivery of social programs including healthcare. The Canadian Mental Health Association, the National Scientific Planning Council, and the World Health Organization agreed that health refers to physical, mental, and social well-being (Barron, 2011; Boschma, 2011). The Federal Provincial Fiscal

Arrangements Act (1957) gave the Alberta provincial government more of an interventionist role in the delivery of healthcare programs (Matteo, 2017), in which mental health care had a place.

Institutional models of mental health care did not fit comfortably within this broader definition of health. As perspectives on what constituted health expanded, Alberta's institutional model of care became too costly for the province to maintain. The federal government provided provinces with funding to support professional development and improve mental health care. However, this funding was not available for existing institutional care models, which further influenced the provinces to move mental health care into the general hospital system (Barron, 2011; Boschma, 2011; Smith et al., 2013). At the same time, the science and discipline of psychiatry were changing due to promising pharmacological advancements.

Psychotropic drugs, such as chlorpromazine, were first introduced in Alberta psychiatry in 1954, and supported the therapeutic management of patients (Boschma, 2011). Prior to the introduction of the new psychotropic drugs, nursing practice was focused on physical care and containment. While some patients had adverse, long-lasting side effects to new psychotropics, these medications made it possible for many patients to live in the community. During this time, families and the Canadian Mental Health Association began advocating for improved services for patients with the goal of reducing stigma associated with mental illness. Anti-stigma campaigns were launched, and increasing numbers of previously institutionalized patients were relocated to community settings.

Advocacy and public awareness became a catalyst for the first MHA of Alberta. The act was introduced in 1964 alongside the repealing of the Mental Defectives Act and the Mental Diseases Act. At the time, the MHA reflected, "the recent advances in mental health thinking and legislation" (Angus. 1966, p. 430). The MHA was amended again in 1972 to account for

additional patients' rights. At this time, the Sterilization Act was also repealed (Barron, 2011; Boschma, 2011; Government of Alberta, 1972a; Government of Alberta, 1972b; Kersten, n.d.a; Kersten, n.d.b). In 1972, the election of a Progressive Conservative government, strongly committed to protecting individual rights, led to the passing of the Individual Rights Protection Act and the Communal Property Act, and the repealing of the Sexual Sterilization Act (Boschma et al., 2005; Government of Alberta, 1972b). MLA David King referred to the act as a "a reprehensible and intolerable philosophy and program for this province and this government" (Dyrbye & Lyster, n.d.). While the social and political climate of this period prompted this appeal and positive changes in practice, sexual sterilization remains a part of Alberta's history of mental health care.

Media pressure also triggered change when an Edmonton journalist feigned schizophrenia and was admitted to AHE (LaJeunesse, 2002). The published story shed light on the conditions in custodial institutions, causing public controversy and debate. Findings of a government investigation into the conditions of mental health services in the province were published in the *Blair Report* (1967). The report contributed to the restructuring of mental health services, including the increase in psychiatry departments in general hospitals and increased community-based mental health services.

By 1988, there were 16 hospitals in Alberta with psychiatry departments with a rehabilitation focus (Boschma, 2011). In 1989, the Mental Health Patient Advocate was introduced (Government of Alberta, 1989). Advocacy for increased rights and services helped improve the delivery of mental health services largely attributed to vocal family and consumer advocacy groups that were very active in the 1980s. During this time in Alberta, the focus started to shift toward partnerships with families, community partners, and government, with the

goal of rehabilitation and overall improvement in the quality of life for individuals with mental illnesses. This partnership approach to improve patient outcomes was the first emergence of the family-centred approach that is presently ubiquitous in health care (Boschma, 2011). Deinstitutionalization and more specialized mental health services transformed nursing practice. Group therapies and psychodynamic interaction emerged as part of treatment, in the reorganization of treatment delivery, and nurses were primarily responsible for those activities and therapies (Barron, 2011; Boschma, 2011; Smith et al., 2013). By the 1950s and 60s male and female patients started to be treated on the same wards, and by 1967 there was a psychiatric nursing school for men at AHP (Boschma et al., 2005).

1990s-Present: Modern Perspectives

The gradual federal debt that had been accruing since the early 1970s, had progressed into a federal debt crisis which became a primary government focus by the early 1990s, marking a period of economic and policy reform (Matteo, 2017). The 1990s and early 2000s saw the onset of rapid changes in mental health care in Alberta including the adoption of involuntary admissions; CTOs; and the enactment of three new MHAs in 2000, 2010, and 2020 (Browne, 2010; Government of Alberta, 2000; Government of Alberta 2007; Government of Alberta, 2009; Government of Alberta, 2020). The amended MHAs have included adjustments to CTOs; changes to the involuntary admission criteria; and the introduction of the expanded role of the Mental Health Patient Advocate (Browne, 2010; Government of Alberta, 2000; Government of Alberta 2007; Government of Alberta, 2009; Government of Alberta, 2020; Gray et al., 2016; Kates, 2017; Marshall, 2020).

During this period, mental health issues were widely reported in the media. Several high-profile incidents were reported about individuals with enduring mental illness who had

committed murder while their illness was not well treated. In 2005, in response to public concerns for safety and the need for improved public education, the Mental Health Commission of Canada was introduced to establish strategic mental health objectives and priorities (Wilson, 2016). Educational strategies and priorities included leadership and funding, promotion and prevention, accessibility to services, and data and research (Advancing the Mental Health Strategy for Canada, 2016).

The most recent amendment to the MHA was enacted on September 30, 2020, (Government of Alberta, 2020) due to sections of the *Mental Health Act* that were found to be unconstitutional or incomplete. The changes include increased health care provider responsibilities that are designed to increase patients' rights. Section 14 of the MHA outlines duties toward patients. Some of these changes include:

- providing the patient with a written individualized treatment plan
- the reason, in simple language, for the issuance of the certificates
- providing summary of the assessment of competence to make treatment decisions, if applicable
- informing the patient of their right to contact the MHPA and offering to contact the MHPA on behalf of the patient
- if the patient requests that staff contact the MHPA on their behalf, then staff would forward the appropriate documents to the MHPA office
- unless the patient makes reasonable objection, contacting and informing the patient's nearest relative of formal certification and, if applicable, of incompetence to make treatment decisions

- providing the nearest relative with copies of the certificates, summary of the assessment, and explaining the rights under the authority of the MHA
- information about legal rights including right to legal counsel and how to obtain legal counsel, the right to a review panel hearing, the right to apply for a board ordered CTO, and the right to appeal to the Court of King's Bench
- informing the patient that they have the right to free and timely access to their medical record relevant to a hearing before the review panel or Court of King's Bench;
- review certificates for completeness as soon as possible and provide a copy and notification to the formal patient (Government of Alberta, 2020)

Presently, there are 13 different MHAs in Canada. While these acts are quite similar, they also differ in the broadness of the involuntary admission criteria. Alberta, Northwest Territories, Nunavut, and Ontario have more narrow admission criteria (Browne, 2010; Gray et al., 2016). Alberta's MHA is updated in response to changes in knowledge about mental illness, changes in sociopolitical context, and to reflect enhanced patient rights and increased legal responsibility and accountability toward the patient. As key mental health care providers, the practice of nurses is both enabled and constrained by mental health legislation. The MHA enables nurses to provide care including medication management, implementation of involuntary admission, mental status assessments, notification of MHA certification, implementing therapeutic interventions, and monitoring patients' progress. However, constraints include ensuring that all rights have been adhered to in the provision of care. For instance, nurses are responsible for ensuring the enforcement of patients' rights and the validity of MHA certificates, particularly regarding the delivery of care such as involuntary detainment, sharing of information, and administering

involuntary medication, among other facets of care provision. In order for nurses to fulfil their ethical and legal responsibilities, they need to be able to navigate and incorporate legislative changes into practice in ways that enable fulfilment of professional practice obligations.

The Nurse's Role in Mental Health Care Delivery in Alberta

In Canada, nurses are the largest group of healthcare providers and play a key role in the delivery of mental health services. Nurses' role in mental health is demanding, with competing workload demands and complex interpersonal dynamics. Registered nurses (RN) and registered psychiatric nurses (RPN) are responsible for assessing patients and developing, evaluating, and adapting holistic plans of care (CARNA, 2019; CRPNA 2014). Advocacy, patient safety, and maintaining a therapeutic environment are also the purview of RNs and RPNs (Thompson et al., 2019). Nurses are responsible for medication administration and must be able to monitor changes in symptoms of mental illness as well as medication side effects. They are responsible for formal observation, monitoring of off-unit "privileges," therapeutic engagement, and ensuring involuntarily admitted patients do not leave the unit without authorization from the attending psychiatrist. It is challenging for nurses to maintain therapeutic rapport when they must also, at times, contain and treat patients on an involuntary basis, perhaps leaving patients feeling coerced or distrustful of the healthcare professionals involved in their care. A study assessing satisfaction with services after voluntary and involuntary admissions revealed that individuals admitted involuntarily tend to report significantly lower levels of satisfaction with psychiatric care, perceive poorer therapeutic relationships, and are more likely to experience both perceived and physical coercion compared to those admitted voluntarily (Smith et al., 2014). The same conclusion was reached in similar studies including one that revealed "individuals who had been admitted involuntarily, diagnosed with a psychotic disorder, and reported higher levels of

perceived pressures on admission were more likely to have a poorer therapeutic relationship" (Roche et al., 2014, p. 186). Patients admitted involuntarily may experience feelings of anger, resentment, or fear since the non-consensual nature of their admission may create barriers to building trust and establishing a therapeutic alliance.

Behaviour Management

Nurses are responsible for ensuring a safe and therapeutic milieu is maintained, and are constantly scanning and monitoring the environment to ensure the physical and psychological safety of everyone on the unit (Stenhouse, 2013). The monitoring and containing of potentially problematic patient behaviours such as suicidal impulses, self harm, and aggression are nursing responsibilities and, at times, the use of chemical or physical restraints and the enactment of seclusion is necessary (Holmes et al., 2004; Stenhouse, 2013). Holmes et al. (2004) explained how "Restlessness, aggression, and even violence are issues well known to healthcare workers" (p. 561). Similarly, Goulet at al. (2018) described how aggressive behaviour is attributed to many psychiatric illnesses and can be exhibited verbally, physically, sexually, or passive-aggressively. These behaviours may account for the findings of a 2014 study where many nurses reported emotional strain, a sense of responsibility, stress of conscience, and worry associated with the nursing role in the psychiatric setting (Jackson et al., 2014). Due to the prevalence of violence and aggression in the psychiatric setting, behaviour management has become a nursing role in the inpatient mental health setting.

Gatekeeping and Policy

The literature describes how the role of nurses in mental health has evolved into the nurse becoming a *gatekeeper,* a term coined to describe the nurse's role in keeping patients out of the psychiatric setting (McArthur et al., 2004). This implies that nurses have responsibilities for

allocation of mental health resources including determining which patients are to be admitted to the unit. Nurses are in a unique position to understand the patient's healthcare needs and the resources available in the inpatient setting, as they are the only health care professionals present 24 hours a day on inpatient psychiatry units. Policy development and mental health legislation are emerging roles in mental health nursing. The Mental Health Commission of Canada encourages nurses to promote change in mental health policy by participating in policy development (O'Brien, 2010; Smith et al., 2013; Wilson, 2016; Zolnierek, 2008). Nurses are in a unique position to influence policy, as they can offer insights that can only be gleaned from practice.

Advocacy

While *advocacy* is a legal term that describes pleading on behalf of another person, it also has an important context in healthcare, especially in the field of mental health where patients can be particularly vulnerable (Jugessur et al., 2009). Nursing regulatory bodies require nurses to advocate on behalf of their patients, especially when patients are unable to exercise autonomy due to a mental condition, or when a nurse has knowledge of incompetent, unethical, or illegal practices in the healthcare setting. According to Jugessur et al., (2009):

> Nurses need to be made aware of the legal framework within which they practice, in terms of duty of care within their role of nurse advocate, maintaining standards of advocacy acceptable to their professional body, accountability relating to action and omission of actions, guidance on guarding against stepping beyond the boundaries of their professional practice of advocacy, and to have adequate knowledge of the law. (p.187)

Jugessur and colleagues underscore the importance of nurses understanding and having the knowledge and ability to fulfil their roles professionally, legally, and ethically. The MHA is a resource that, when utilized effectively, can be a source of advocacy and a mechanism to safeguard patient rights.

Legal Responsibilities

Nurses have a legal role to fulfil under the MHA, but they do not always clearly understand their legal responsibilities. In an article written from the Alberta Mental Health Patient Advocate, Orr (2013) explained, "While nurses play an invaluable role in the treatment and care of patients living with a mental illness, they also have legal responsibilities to involuntary mental health patients" (p.14). As such, the nurse is responsible for complying with the legislated responsibilities. These responsibilities include informing patients of their rights and options; providing copies and a basic explanation of why their mental health certificate was issued; informing patients of their right to appeal the certification to the Review Panel; their right to refuse treatment if they maintain legal competency; their right to a lawyer and that a lawyer can represent them at no cost; their right to appeal to a review panel decision to the Court of King's Bench; and, their right to contact the MHPA. Additionally, nurses are responsible for complying with the protocols and timing for admitting and detaining a formal patient (Orr, 2013). Given the nature and extent of nurses' responsibilities under the MHA, the fact that they might not understand their role under the legislation is concerning.

Nurses may not understand their role in relation to mental health legislation because their responsibilities are not clearly communicated to them by their employers or regulatory body. In the past, when new MHA changes were introduced, nurses in Alberta received minimal guidance regarding the changes. As an example, when the 2010 MHA changes were introduced, nurses were provided with only a quarter of a page of information published in a nursing journal, and the explanation of the changes was not directly related to nursing responsibilities under the MHA (Significant Amendments to the *Mental Health Act* are Now in Effect, 2010). It remains unclear

whether the responsibility for providing MHA information and guidance to nurses should be a responsibility of nurses' employers or professional regulatory body, or both.

There is only limited research available that explores nurses' understanding of their role in the context of mental health legislation. A study conducted at a psychiatric centre in Rajasathan, India, had the objective of identifying "the knowledge of staff nurses regarding legal and ethical responsibilities in the field of psychiatric nursing" (Kumar et al., 2011a, p. 110). The study revealed that approximately 90% of the nurses in the study possessed a "moderate" level of knowledge; with moderate category being demarcated as a having a mean score of 66.90% for knowledge regarding the area of legalities, and a mean score 63.55% for ethical knowledge (Kumar et al., 2011a). This would indicate a knowledge deficit in both the knowledge of legalities and knowledge of ethics (Kumar et al., 2011a). Kumar et al. (2011b) compared these findings with a similar study, also conducted in India, five years earlier, and found the results to be consistent (Kunjumon, 2006).

The complexity of the nursing role was illuminated in Wyder et al.'s (2017) literature review examining "nurses' experiences of providing care in acute mental health inpatient units" (p. 529). One of the five main areas that contributed to the complexity of the role was "enforcing aspects of the Mental Health Act" (p. 533). Nurses reported challenges reconciling the restrictive practices imposed by MHA legislation with principles such as patient autonomy and independence. Nurses reported feeling conflicted when their personal beliefs were not aligned with aspects of involuntary treatment. Additionally, many nurses explained that patients often directed the anger and frustration they felt about their involuntary admission, toward them. Nurses described feeling conflicted, scared, and unsafe in their role and worried that they were unnecessarily using coercion and control with patients (Wyder et al., 2017).

The mental health nursing role is complex and filled with competing, juxtaposed roles. Mental health nurses must promote patient rights and autonomy, but they must also act in opposing ways to safeguard patients' safety and the safety of others. For these reasons, nurses require a clear understanding of their responsibilities and obligations to the vulnerable patients in their care. Nurses who have a poor understanding of mental health legislation might cause harm to patients and practice in ways that compromise their professional standing and licensure. In the legal case that triggered the most recent 2020 changes to the MHA, nurses were named in the lawsuit for failing to fulfil their legal obligations.

Cumulatively, the history of mental health care, mental health legislation, and the role of nurses in providing care to people alongside mental health legislation leads to concerns that form the basis for the following research question: How do AHS nurses make sense of their role **and practice** in relation to the recent changes to the *Mental Health Act* (MHA) of Alberta according to the Mental Health Amendment Act, 2020.

Conclusion

This literature review demonstrated the importance of mental health legislation that protects and ensures the rights of people suffering from mental disorders, and also demonstrated the importance of the nurse's role as a patient advocate, and in upholding and promoting patient rights and safety. However, in order for nurses to fulfil their role, an understanding of the legal and ethical nursing responsibilities and obligations under the MHA is required. This research is timely and relevant based on the recent changes to the MHA and the lack of formal training/orientation being provided to AHS nurses regarding the changes. Research results will help inform the development of educational and training programs and policies.

CHAPTER 3: METHODOLOGY AND RESEARCH APPROACH

Research Design

This research study explores how nurses are making sense of their role in relation to recent changes in the MHA of Alberta. I have chosen a qualitative research study that employs a thematic analysis method, guided by a conceptual framework derived from social constructivism (Crotty, 1998), Carper's (1978) Ways of Knowing theory, and the principles of uncertainty in practice (Katz, 1984). The concept of *making sense* is based on Karl E. Weick's theory of sensemaking which was first introduced in Weick's influential book "The Social Psychology of Organizing," and emphasized the social nature of the ways in which individuals collectively construct and negotiate meaning within social groups and organizations. (Weick, 1979). Weick's works contribute to the understanding of organizational behaviour, decision-making, and the intricate process of sensemaking. For a visual representation of this study's thematic analysis, refer to the Concept Map in Appendix A.

Social Constructivism

Social constructivism is a theoretical perspective that asserts that knowledge is constructed through interaction with others and through each person's experience and interaction with the world. It focuses on how understanding is reached through social process (Crotty, 1998). Social constructivism is, then, the study of individual meaning making that occurs in context and in interaction (Crotty, 1998). This theoretical perspective will form the foundation for my research question which seeks to understand how nurses make sense of their role in relation to the recent changes to the MHA. According to the social constructivist perspective, I will consider how social context and interactions influence how study participants make sense of their roles and responsibilities within the MHA.

Weick's *Theory of Sensemaking* explains the process that occurs when "discrepant cues interrupt individuals' ongoing activity and involves the retrospective development of plausible meanings that rationalize what people are doing" (Maitlis & Sonenshein, 2010, p 551). This emphasizes the dynamic and interpretive nature of sensemaking as individuals actively construct meaning from their experiences. "Sensemaking involves turning circumstances into a situation that is comprehended explicitly in words and that serves as a springboard into action … to make sense of the disruption, people look first for reasons that will enable them to resume the interrupted activity and stay in action" (Weick, Sutcliffe & Obstfeld, 2005, p. 409). The process involves converting complex situations into understandable narratives expressed in words, which then motivates and guides subsequent actions.

According to Teherani et al. (2015), "Constructivist researchers believe that there is no single reality, but that the researcher elicits participant's views of reality" (p. 669). Furthermore, the interaction between the researcher, participants, and audience of the research is a social interaction, which may also influence the interpretation of the research (Holloway & Galvin, 2017). As a qualitative researcher, I aimed and continue to be aware of the social interaction between myself and the participant and kept a reflective journal to note my impressions, thoughts, and perspectives. I compared my analysis with the participant data to ensure I did not impose my perspectives on the data. I employed bracketing, a method that helps reduce the risk that a researcher's preconceptions related to the research may bias the research results (especially when the researcher is close to the research topic prior to the start of the research), and also as a result of the qualitative research process (Tufford & Newman, 2012, p. 81). I journaled my thoughts after each participant interview and reviewed the experiences with my supervisory committee for feedback, to ensure I represented the participant's voices rather than my own

thoughts and beliefs. This was accounted for in the research design and when viewing the generated data.

Mental health and illness and the practices that revolve around them are individual as well as social phenomena. This theoretical framework involves making meaning of and understanding of social processes and interactions (Crotty, 1998). These frameworks provide context for the changes in societal perception that were demonstrated in the historical tracing of mental health and mental health legislation in Canada and Alberta., in the way our society has changed their view of mental illness over the course of the last century. The social constructionist perspective is that experience, knowledge, and practice are constituted through historically specific interpersonal, institutional, and social processes (Crotty, 1998). As such, social constructivism provides a useful lens for understanding the ways mental health nurses makes sense of practice.

Carper's Ways of Knowing

Continual ongoing learning and application of knowledge are essential aspects of nursing practice. Ancient Greek philosopher Aristotle defined methods of comprehending the world "drew a distinction between practical wisdom and theoretical wisdom" (Johns, 2017, p. 41). In the mid-20th century, renowned psychologist Abraham Maslow, contributed significantly to nursing ways of knowing through his theory of human motivation and the hierarchy of needs. Aristotle and Maslow's theories may have paved the way for Carper's theory. In her seminal paper, *Fundamental Patterns of Knowing in Nursing*, Carper introduced a framework, known as *Carper's Ways of Knowing*, to address the question of "what it means to know and what kinds of knowledge are held to be of most value in the discipline of nursing" (Carper, 1978, p. 13). There is speculation that Maslow's theories might have impacted Carper's insights (Johns, 2017).

Carper introduced four fundamental patterns of knowing in nursing including *empirical*, *aesthetic*, *personal*, and *ethical*, which she described as essential for teaching and learning in the discipline of nursing (Carper, 1978; Johns, 1995). I concur and believe that these four patterns of learning and knowing influence nurses' understanding of the MHA and how they make sense of their role and responsibilities. Below I will describe each of these patterns and how it relates to my research.

Empirical knowledge is factual, objective, and based in the science of nursing. Empirical knowledge is acquired through research; it is generalizable; it is the basis for nursing theories; and is referred to as evidenced-based practice. This type of knowledge is verifiable, generally indisputable, and is the foundation of most nursing education.

Aesthetic knowledge is known as "the art of nursing" (Carper, 1978, p. 16). In contrast to empirical knowledge, this type of knowledge is gained subjectively and often through experience. Aesthetic knowing and aesthetic action refer to the nurse's response in a clinical situation as a result of perception and empathy (Carper, 1978; Johns, 1995). The art of nursing is the ability to perceive what is significant in a patient's behaviour and "what need is actually being expressed by the behaviour" (Carper, 1998, p. 17). The underlying principle is that nursing is a holistic practice that requires knowledge that is not always generalizable or transferrable. This research will focus on this type of knowing as it is variable between nurses.

The personal way of knowing not only refers to the cumulative knowledge a nurse has of herself and her experiences, but is also "concerned with the knowing, encountering and actualization of the concrete, individual self" (p. 18). It is an interpersonal process between nurse and patient and involves observation, engagement, reflection, and self-actualization (Carper,

1998). Personal knowing requires a nurse to be self aware in order to establish therapeutic relationships within the clinical situation.

Ethical knowing refers to more than just familiarity and adherence to professional codes of ethics. According to Carper (1998), moral and ethical knowing includes "all voluntary actions that are deliberate and subject to judgement of right and wrong" (p. 20). In practice, nurses are often required to make ethical and moral decisions, that are guided by personal ethics, responsibility to protect, and respect human life and personal autonomy.

Carper's Ways of Knowing is a framework that offers four distinct patterns of knowing, but it is essential to recognize that the patterns are interdependent, and all contribute to understanding how nurses come to *know* in practice. This framework provides a context for understanding the research data, as understanding how nurses make sense of their role is the objective of this research.

Uncertainty

Uncertainty is an inevitable part of healthcare and nursing practice. As a nurse in the acute mental health setting, I have often struggled with a sense of uncertainty, especially as it pertains to my responsibilities under the MHA. In my role as a clinical nurse specialist, I am responsible for providing education for staff nurses to ensure they have the knowledge and skills to perform their role legally, ethically, and competently. When the new MHA took effect, quite abruptly, I experienced a great deal of uncertainty in my practice and also wondered how my colleagues in other areas of mental health were feeling about the change and responding to it in practice.

Katz's model of uncertainty (1984) provides a framework for responding to the inherent uncertainty in health care (Thompson & Dowding, 2001; Katz, 1984). This model emphasizes

theoretical contemplation of uncertainty and how it is applied in the clinical setting. Thompson and Dowding (2001) explained three different types of uncertainty, with the first being a result of "an individual having incomplete or imperfect knowledge of the area" (p. 610). They note that nurses use three broad theoretical and strategic approaches to dealing with uncertainty: "rationality, bounded rationality, and intuition" (p. 609). The result is that nurses may feel over or under confident in their ability to make decisions when faced with uncertainty (Thompson & Dowding, 2001). Considering the Katz model of uncertainty when analyzing my research findings offers valuable insights for comprehending how nurses navigate uncertainty within their practice settings.

Research Methods

In this section, I outline the methods used in the study as they pertain to locating and recruiting participants, data collection, and data analysis. Issues of research ethics and rigour are also presented.

Recruitment and Participants

Letters of support were requested and received from the Patient Care Managers of the Inpatient Mental Health Units at each of the four main healthcare centres in Calgary, including the Foothills Medical Centre, the Peter Lougheed Centre, Rockyview General Hospital, and South Health Campus (See Appendix G). Recruitment posters were advertised on each of the units (See Appendix H). Each participant received a $15 coffee shop gift card at the end of the interview, to thank them for their time. A preliminary letter was sent to individuals who expressed interest in participating in the research study. This letter of initial contact cand be found in the appendix. (Appendix I).

A convenience sample of 12 participants was chosen based on qualitative research sample sizes, which are generally small yet produce rich data (Holloway & Galvin, 2017). See Appendix J for a breakdown of participant demographics. The sample was studied in depth, and theoretical saturation was achieved. Data saturation was achieved when interviews started to yield redundant data and theoretical saturation indicating that new concepts were no longer emerging (Holloway & Galvin, 2017). Once saturation was achieved, I realized that adding more participants would not contribute any new data than what was already ascertained from prior participants. According to Terry et al. (2017), the Braun and Clarke project sample size recommendations for a Masters or Doctorate project is six to 15 interviews. According to Holloway and Galvin (2017), six to eight data units are sufficient for a homogeneous sample and 14 -20 data units for a heterogeneous sample. Dufrene (2020) conducted research examining the perceptions of marginalization experienced by psychiatric mental health nurses and found that a sample size of 10 nurses provided an adequate amount of rich data necessary and achieved saturation for thematic conclusions.

Inclusion criteria was that participants must be registered nurses or registered psychiatric nurses with at least two years experience working on an inpatient mental health unit. Nurses with less than two years experience are considered novice nurses and research findings may be attributed to inexperience as opposed to changes to the MHA or other themes which may emerge. As an example, a recent study found that most novice nurses lack confidence and feel unprepared for clinical work with the majority of novice nurses expressing feeling insufficiently prepared for practice (Najafi & Nasiri, 2023). Qualitative research exclusion criteria should include individuals that “have certain traits that might make the research problematic” (Holloway & Galvin, 2017, p. 150). The inclusion of novice nurses could introduce variability that might

confound the results, which may make the research problematic. Focusing exclusively on nurses with a certain level of experience provides a more accurate representation of the factors under investigation. Additionally, staff from the unit where I work were not be permitted to participate in the study, as I serve on the leadership team, and it is my responsibility to provide staff education. This may result in staff feeling pressured or coerced into participating in the study, or staff providing biased responses due to my dual role as Unit Clinical Nurse Specialist (CNS) and as a researcher.

Data Collection

The study consisted of one 45-to-60-minute semi-structured interview with each participant (see Appendix C for semi-structure interview questions). The interview starts with set of standardized questions that were asked of each participant to guide the conversation. This type of interview promotes an interactive discussion that provides an opportunity for the respondent to discuss concerns of primary importance related to the research (Ahlin, 2019). Semi-structured interviews have the "potential to elicit rich, thick descriptions" (Bloomberg & Volpe, 2018, p. 193). The semi structured interview is supported by Thematic Analysis (TA). According to Braun and Clarke (2017), "TA can be used to analyze large and small data-sets from case study research with 1–2 participants to large interview studies with 60 or more participants and homogenous and heterogeneous samples" (p. 297). TA is a flexible methodology that supports the analysis of many data types, "from widely used qualitative techniques such as interviews and focus groups, to emerging methods such as qualitative surveys and story completion" (Braun & Clarke, 2017, p. 297). Interviews were conducted in person and audio recorded once written and oral consent were obtained, then transcribed. A copy of the written Consent Form is as available in the appendix (Appendix B).

Data Analysis

Data was transcribed verbatim, and transcripts were checked against recordings for accuracy and for me to become familiar with the data. Data was then analyzed according to Braun and Clarke's (2006) TA methodology.

Braun and Clarke's Thematic Analysis

Thematic Analysis (TA) is an applied qualitative research methodology which first emerged in the 1970s and has historical origins in Content Analysis (Braun & Clarke, 2006). It is used for identifying, analysing, and reporting themes and patterns within data. TA is a flexible analytic method used to identify patterns and themes in the data (Braun & Clarke, 2006; Braun & Clarke, 2014; Joffe, 2011; Terry et al., 2017; Nowell et al., 2017). The TA methodology was more clearly defined and popularized by Braun and Clarke (2006), who used a six-phase approach and a systematic framework that facilitates the emergence of salient themes across the data set. The six phases of analysis are: (a) Familiarizing Yourself with Your Data; (b) Generating Initial Codes; (c) Searching for Themes; (d) Reviewing Themes; (e) Defining and Naming Themes; and (f) Producing the Report (see Appendix D for a complete breakdown of the phases of analysis). The phases have incorporated activities to ensure the rigor and trustworthiness of a qualitative inquiry. These activities meet the four criteria for developing trustworthiness as described in Lincoln and Guba's Framework (1985) and include credibility, dependability, confirmability, and transferability (Polit & Beck, 2017) and will be described further in the subsequent section on research rigor. This provides an opportunity to demonstrate transparency, intellectual honesty, objectivity, and methodological adequacy, which suggests that the research can be trusted.

Thematic Analysis is an iterative and reflective process that allows researchers to go back and forth between phases as new ideas and themes emerge (Nowell et al., 2017). Although Braun and Clarke (2006) reference the use of TA in psychology, it is used extensively across many disciplines including healthcare. It is accessible, flexible, pragmatic, easily modified, and inductive. TA is flexible in terms of the research question, sample size, data collection method, and approaches to analysis (Braun & Clarke, 2006). Nowell et al. (2017) described TA as an easy-to-learn methodology for novice researchers, and useful in identifying similarities and differences within participants in a data set. As a novice researcher, this methodology is suitable and compatible with my research question, the generated data, and the required analytic techniques. Themes from this research will provide insight and further understanding for nurses to inform practice and guide future research initiatives.

Research Rigor

In qualitative research, rigor serves as a critical means of fostering trust and confidence, and maintaining integrity and credibility of study findings (Holloway & Galvin, 2017). "Rigor is useful for establishing consistency of the study methods over time and provides an accurate representation of the population studied" (Thomas & Magilvy, 2011, p. 151). Additionally, "rigor provides details as a means to replicate a study with a different research sample" (Thomas & Magilvy, 2011, p. 151). In this section, I explore the foundational principles of research rigor, which serve as guiding principles to enhance the trustworthiness and validity of qualitative inquiries. Lincoln and Guba (1985) identified four primary criteria essential for ensuring the trustworthiness of qualitative inquiries: credibility, dependability, confirmability, and transferability.

Credibility

In qualitative research, credibility ensures that findings are not only perceived as genuine, trustworthy, and believable from the participants' standpoint, but also accurately capture the complexities and nuances of their experiences. This entails establishing a strong rapport with participants, employing rigorous data collection methods, and transparently documenting the research process to enhance the credibility of the study outcomes (Forero et al., 2018; Holloway & Galvin, 2017; Lincoln & Guba, 1985). “A qualitative study is considered credible when it presents an accurate description or interpretation of human experience that people who also share the same experience would immediately recognize” (Krefting, 1991, p. 218). The researcher can employ various strategies or methods to enhance the credibility of the research study, such as member checking, triangulation, reflexivity, prolonged engagement, and peer debriefing or examination (Thomas & Magilvy, 2011). I incorporated many of these strategies to uphold the credibility of the study, which included meticulous field notes, audio recording interviews, coding, ensuring data saturation, independently analyzing transcripts, reviewing findings with members of my Master’s supervisory committee, and engaging in regular discussions with them regarding analysis-related matters. The iterative process of TA further solidifies the credibility of this research study by enabling ongoing validation and refinement of themes, thereby fostering a deeper and more nuanced interpretation of the data (Nowell et al., 2017). Furthermore, in composing my findings report, I directly incorporated verbatim expressions from participant interviews. This approach, as highlighted by Thomas and Magilvy (2011), serves to enhance the credibility of the study.

Dependability

In qualitative studies, research dependability refers to the consistency and reliability of the study's findings over time and across similar contexts. It ensures that consistent outcomes would be achieved if the research were replicated under comparable circumstances (Forero et al., 2018; Holloway & Galvin, 2017; Lincoln & Guba, 1985; Thomas & Magilvy, 2011). I ensured the dependability of my research study by adhering to recommendations from Forero et al. (2018). This involved providing detailed descriptions of the study methods, research design, and analysis techniques utilized. Throughout the study, I diligently drafted and refined the study protocol while maintaining an audit trail to document the research process. Meticulous attention to detail and transparency in reporting were key aspects of my approach. Thematic Analysis further supported dependability by outlining systematic steps for replicating data collection and analysis procedures. In line with Holloway and Galvin (2017), I am confident that readers will find it easy to trace the progression of my conclusions. Moreover, should another researcher undertake a similar study with comparable participants, they could readily follow the study model.

Confirmability

Confirmability pertains to the objectivity of the data, ensuring that it accurately reflects the viewpoints of the participants rather than being influenced by the researcher's biases or preconceptions (Holloway & Galvin, 2017; Lincoln & Guba, 1985). To promote confirmability, researchers can utilize methods such as reflexivity and member checking. Reflexivity involves critically examining one's own biases and assumptions throughout the research process, while member checking entails validating interpretations with participants to ensure accuracy and credibility of the findings (Forero et al., 2018; Holloway & Galvin, 2017). During the research

process, I employed member checking to validate my understanding, ensuring accuracy by asking research participants if I had accurately captured their perspectives. I also engaged in reflexivity by critically examining my own assumptions, biases, and perceived notions regarding the research topic. Being self-aware of the assumptions I may hold due to my background and experiences working as a nurse in inpatient mental health, I engaged in critical reflection and consistently sought feedback from my supervisory committee. I journaled my thoughts after each participant interview and reviewed these reflections with my supervisory committee. Their guidance empowered me to question assumptions and explore alternative viewpoints or interpretations, aligning with recommendations found in the research literature (Forero et al., 2018; Holloway & Galvin, 2017; Thomas & Magilvy, 2011). This approach extended to interpretations of both the data and interactions with participants.

Transferability

In qualitative research, transferability pertains to the extent to which the insights and conclusions drawn from a study can be relevantly applied to similar scenarios or settings across various contexts, thereby gauging the broader applicability of the findings (Holloway & Galvin, 2017; Lincoln & Guba, 1985;Thomas & Magilvy, 2011). To enhance transferability in my research, I employed purposeful sampling and ensured data saturation. Specifically, I deliberately included participants from all four hospital sites in my sample to mitigate the risk of data skewing attributable to unique factors at individual sites. Data saturation was confirmed when interviews yielded redundant information, signifying the absence of new concepts (Holloway & Galvin, 2017). Recognizing this, I determined that further participants would not yield additional insights beyond those already obtained from existing participants. In conclusion, although transferability holds significance in qualitative research, Lincoln and Guba (1985)

cautioned that it should be approached with care and reflexivity, acknowledging the contextual and interpretive aspects inherent in qualitative inquiry.

Ethical Considerations

This research proposal was subjected to review by the Conjoint Health Research Ethics Board (CHREB) at the University of Calgary.

Participant information will remain confidential and is stored securely and privately. Participant names and other identifiers are stored separately from the research data and were replaced with a unique numerical code. As part of their consent, participants were informed that they have the right to withdraw from the study at any time prior to the start of data analysis.

All transcripts and audio recordings of participant interviews will be stored on a password-protected computer and permanently deleted within five years.

Timeline

The initially proposed timeline can be found in the appendix. However, it should be noted that the study timeline deviated from the proposed schedule due to unforeseen circumstances such as the impact of Covid-19 and other barriers. See Appendix E for a full illustration of the initially proposed study timeline.

Budget

This is a self-funded research project. Required resources included a voice recorder, office supplies, printing fees, and participant gift cards. See Appendix F for a full breakdown of costs.

CHAPTER 4 - FINDINGS

The aim of this qualitative research study, which utilized a thematic analysis method, was to gain an understanding of how AHS nurses make sense of their role in relation to the recent changes to the MHA of Alberta. This chapter presents the results of an analysis conducted on twelve participant interviews. All twelve participants were registered nurses or registered psychiatric nurses with a minimum of two years experience working in an inpatient mental health unit at one of the four hospitals in Calgary. Analysis revealed three prominent themes: Navigating Uncertainty, Institutional Practice, and Relational Practice, which reflect significant areas of concern for nurses struggling to navigate the complexities and intricacies of the new MHA.

Navigating Uncertainty

Many research participants expressed feeling uncertain about their nursing roles and responsibilities in light of and in relation to recent changes to the MHA. However, the data analysis also revealed that participants employed a variety of strategies to manage this uncertainty. In healthcare, similar to any other profession, the act of exercising autonomous judgment and making decisions is characterized by inherent uncertainty. Often, participants expressed feeling that they lacked knowledge of the exact course of action to be taken. Nevertheless, participants noted that when the nursing team had a clear understanding of the objective, they were able to take actions that effectively lead them towards their desired goal. During uncertainty surrounding the most suitable course of action, some participants found solace in their colleagues, drawing strength from their support and seeking reassurance. Conversely, some opted for a more cautious strategy, adopting a "wait and see" approach, observing the situation before committing to any definitive actions.

Specifically, data analysis revealed three themes that describe the overarching strategies used by nurses to navigate uncertainty: taking proactive steps and seeking knowledge; providing mutual support and seeking assistance; and avoiding uncertainty through passivity and inaction.

Taking Proactive Steps and Seeking Knowledge

Several participants reported taking proactive steps to seek out knowledge and manage their feelings of uncertainty. For example, one participant recounted an evening on an inpatient mental health unit where their team faced uncertainty, and shared how they navigated the situation. The participant's account provides an example of how nurses used their knowledge and past experience with the MHA to respond to uncertainty in clinical settings.

> **P2 68:** *So we had someone come from a site with one of the certs that didn't have the signature at the bottom… it was the form 11. Wasn't signed by a representative of the facility from a Connect Care site, when they arrived here...* [name of acute care facility] *…We ended up calling the mental health board, I think, but they didn't get back to us straight away. So in the end, a second form 11 or a third one at this point, was done.*
>
> **P2 48:** *I think there's a lot of time I spend looking up people's questions to Mental Health Act.*

The MHA amendment mandates the staff member who is providing notification of certification, also offer to initiate contact with the Mental Health Patient Advocate on behalf of patients by submitting a request form. During discussion regarding this change, a participant recognized the updated regulation but conveyed uncertainty about how to comply with the new requirement. The participant suggested a potential source for guidance on fulfilling the requirement.

> **P7 80-84:** *That is a new thing. I haven't done it, but I remember … hearing about that. But I haven't personally done that…. I think I would just call the patient advocacy line.*

Another participant recounted an instance illustrating their response to feelings of uncertainty. Specifically, they described how they navigated the challenge of not knowing exactly where to locate the new MHA forms since they moved to an online format. The participant accounts highlight the resourcefulness and problem-solving skills required to manage uncertainty in nursing practice.

> **P4 252:** *We have printed Form 12s on unit. So I would go and find the preprinted one. I know that there is a place online to get them. It would probably take me a little bit of time, but I could probably find it. I just assume that they're on Insite somewhere.*
>
> **P12 315:** *That's a good question. Probably, I'm assuming there's stuff on Insite. Yeah, that's probably where I would initially go for anything I'd want to know. I mean there's probably information online.*

Uncertainty is an inherent component of healthcare and nursing practice. As discussed in Chapter III, Katz's model of uncertainty (1984) provides a framework for responding to the inherent uncertainty in health care (Katz, 1984; Thompson & Dowding, 2001). This model emphasizes theoretical contemplation of uncertainty and how it is applied in the clinical setting. One of the types of uncertainty that Thompson and Dowding (2001) discuss in this framework is related to "an individual having incomplete or imperfect knowledge of the area" (p. 610). Most study participants indicated that they felt they had incomplete and imperfect knowledge of the changes to the MHA. Additionally, a number of participants expressed a sense of being inundated with the sheer volume of information they had to navigate in order to effectively fulfill their roles amidst the changes brought about by the Mental Health Amendment Act, 2020. The amendments to the MHA encompass a wide range of additional responsibilities placed upon hospitals and healthcare providers, including but not limited to:

(a) changes to the MHA forms

(b) introduction of a new MHA form to cancel MHA certification

(c) definition changes which impact criteria

(d) expanded duties when providing notification of MHA certification

(e) duty to offer to contact the mental health patient advocate on behalf of certified patients

(f) changes to the admission and detention criteria

(g) the obligation to notify the patient's nearest relative unless the patient makes a reasonable objection

(h) the obligation to provide patients with a summary of the assessment of competence to make treatment decisions

(i) the expansion of the definition of Qualified Health Professionals to include nurse practitioners who qualify to write MHA certificates and manage Community Treatment Orders

(j) the requirement to provide patients with a written individualized treatment plan within one month after a second admission certificate is completed

(k) the obligation to ensure each MHA certificate is reviewed for completeness

(l) the obligation to notify patients of their status under the MHA after one certificate is competed

(m) changes to the process of enforcing treatment under a Certificate of Incompetence

(n) changes to who is eligible to request a Review Panel Hearing on behalf of a patient

(o) changes to the Criteria for a Community Treatment Order (CTO)

(p) the addition of a fourth criterion for MHA certification

(q) the right to free and timely access to the patient's medical records relevant to an appeal

Many participants found it challenging to determine which information to prioritize, given the complex and constantly evolving nature of their role and responsibilities especially as it pertains to the legislative context. The data suggest that managing the influx of information represented a significant challenge for some participants.

P8 25: *It's a lot of material, so it's kind of hard to know if you have a question just by reading the emails until you actually start doing it, start using the new protocols, the new act.*

P8 258: *We're overworked and … increasing every day. And so to go looking for answers* [about changes to the MHA] *that we think we already have the answer to, but best educated guess. You got to pick and choose your priorities, that we can't do that for every last thing.*

P3 164: *Honestly, I think it's just that a simpler breakdown would've helped because we were getting bombarded with these emails and it's all very technical jargon or these long documents. You're already busy enough… I feel like a lot of times, it's easy to get overlooked. If it was like, "Here are the most important parts you need to know..."*

Although participants expressed feeling overwhelmed by the complexity of their roles and the information shared, many also expressed a desire to improve and expand their knowledge and skills. Specifically, several participants reported wanting additional resources to help them address their knowledge gaps and fulfill their roles more effectively. Participants emphasized the importance of ongoing education and professional development in nursing practice, particularly in the context of complex and evolving healthcare systems.

P6 219: *So even though experienced colleagues,* [were] *most helpful initially for me, I actually don't think it was... the best source necessarily. And I think, as a nurse, we always should still do our own looking into things just to make sure that we're not learning the wrong thing.*

P2 244-248: *So an in-service related to the forms and changes in the act would've been helpful leading up to the initiation of both changes happening, and when they were put into place on the units…. I think they would still benefit from it greatly.*

A number of the respondents indicated that they believed their employer could have been more effective in distributing information regarding the amendments to the MHA. In this context, the *employer* refers AHS and AHS Addictions and Mental Health management representatives. Several participants provided suggestions on learning aids and resources that would have facilitated their comprehension and acquisition of knowledge regarding the changes to the MHA.

P3 168: *Maybe something a little bit more simple, or a simple resource or guide that you can almost go to when you have questions.*

P4 100: *I think it would be better if there was an actual in-service that was done. I don't know how long it would take, but even if it was a couple hours to go over it and get to see the actual pieces that had been changed.*

P4 244: *Maybe a class kind of scenario. You could call it an in-service. You could call it an education day, whatever makes sense. But something that's more than just, "Hey, come an hour before shift change for this in-service that somebody will just talk at you about the changes." I'm the kind of person that really needs to take a little bit of time. A, to think of questions and B, I kind of need to look at the sheets and maybe use them in a certain way. I don't know a scenario type of way.*

Although several participants reported feeling underprepared to navigate the changes to the MHA, the majority acknowledged that it was their responsibility to stay informed and up-to-date with current standards of practice. Many participants recognized the need for ongoing education and training to enhance their understanding of the new MHA and the implications for their work.

> **P6 60:** *Like there's two different things, right? There's not knowing something, but there's also not knowing what you don't know. And so working on a mental health unit, I think, of course, it's very important to know those things and to keep abreast of that and just stay informed. And I think it's also our responsibility to seek out that information.*
>
> **P7 160***: It actually made me kind of realize that we need to be more diligent. And, because I know sometimes I think, "Oh, I gave the NOC* [Notice of MHA Certification]*" and would like write, "This patient didn't sign." But no documentation… about that. So just be more diligent in my documentation for legal purposes.*

Certain participants conveyed a sense of apprehension with the significant responsibility of performing their duties in a lawful and ethical manner. They also expressed concern that they might, in retrospect, regret not adhering to the highest standards of practice. These participants recognized a sense of responsibility to take proactive steps by actively pursing knowledge and comprehension in order to adapt their practices in accordance with the legislative changes.

> **P11 24: …** *It's a very big responsibility to make sure that you're following all of the different aspects of the Mental Health Act. So, I always want to be following it by the book.*
>
> **P11 68:** *I would never want to have looked back and realized that I wasn't following the act the way I was supposed to be. If I wasn't giving every patient their right, all the rights, I think that would really affect me and that would be terrible, to be honest.*

Some participants expressed a sense of personal accountability as professionals to actively seek out the necessary knowledge to carry out their role effectively and competently.

> **P6 76:** *But I think, if there's changes, there should be some way of alerting us that there's changes, but like what we did receive an email, but I also think then that it is the nurse's responsibility too to say, "Hey, well I don't know about that." And then seek out the resources. I mean, we are supposed to be adept at looking at our knowledge gaps and then taking initiative to seek out information when we realize we don't know something.*

> **P3 58:** *I don't know everything that has changed. I think that I take personal responsibility for some of that, in that I could have found just more educational opportunities to learn more.*

Overall, participants who employed the strategy of Taking Proactive Steps and Seeking Knowledge exhibited a strong sense of self-confidence and accountability in navigating uncertainty. These nurses took an active role in seeking out information and resources to help them manage the complexities of their work, demonstrating a proactive approach to their professional development. In contrast, other nurses in the study found it helpful to provide mutual support and seek assistance from their colleagues when grappling with uncertainty.

Providing Mutual Support and Seeking Assistance

Several participants reported finding comfort in seeking support from others when experiencing feelings of uncertainty. Some participants sought out support from colleagues who shared their feelings of uncertainty, while others sought support from those who appeared to them to have a better understanding of the changes to the MHA.

> **P4 144:** *I definitely don't think that there's anybody in particular that has a really good grasp of it. But I don't think anybody has a really terrible understanding of the Mental*

Health Act in general… I feel like some conversations I've had with other people, I feel like we're all kind on a same page where we know that there's been changes and we have a vague understanding of the big ones. But the smaller, maybe if there's more detailed ones, I'm not sure that anybody really quite understands or maybe even knows about them.

P6 215: *I think discussions with colleagues like when I started... I had worked on the medical unit in question from that law thing, that lawsuit thing. But I didn't really know all of the ins and outs. And so asking colleagues who were experienced, helped me a lot, at least to get the basis* [fundamental or underlying principles].

P11 168: *Especially during COVID, we would do the NOCs at the door, and somebody would have to witness the nursing staff that was doing the notice of certification with the patient. So, I did get to observe different styles of it and different comfort levels. But yeah, I think some are more comfortable with doing it than others.*

I asked participants about their comfort level with completing a MHA Form 12 Application for a Review Panel Hearing and heard that many participants expressed confusion about the process. One participant stated:

P9 144-148: *If you asked me this a few years ago, I would've said very comfortable. But now I am very uncomfortable, and I often request help from my colleagues…Because* [the Review Panel] *refuses* [the forms] *now. If there's a part of it that has been completed incorrectly, they will refuse to accept that form, which further delays the patient getting their due process.*

During the study, another participant was presented with a hypothetical scenario in which a patient appeals their MHA Form 11 Certificate of Incompetence to Make Treatment Decisions.

The participant correctly identified that the medications should be held pending the review panel decision. However, when asked whether they would have the authority to enforce the prescribed treatment if the patient chose to appeal the Review Panel decision at the Court of Kings Bench, the participant mistakenly believed that the treatment should be halted, whereas, in reality, the treatment should be administered, even if the patient is appealing the decision made by the Review Panel:

> **P11 284:** *Yes, that's what I would think. I have no problem asking questions at work, so I would definitely be asking somebody about that, but I want to assume that we would have to pause on it again if they were appealing to the Court of the King's Bench.*

Participants identified several sources of support, including charge nurses, nurse colleagues, and unit clerks. The healthcare team collaborated to navigate uncertainty and prioritize delivering the best possible care to patients. Below is an illustrative instance shared by a participant, outlining their collaborative approach and utilization of additional resources to effectively navigate an ambiguous scenario.

> **P2 72- 80:** *The unit clerk called the Mental Health Act board … then we'd heard from the emergency department of the Connect Care site that said, because the certs are now scanned in with Connect Care and timestamped, there's no way that they could sign the original by a representative their site.*

Upon seeking input from the participants regarding recommendations for types of support they would find helpful, I received valuable feedback. Notably, one participant offered the following suggestion:

P2 244-248: *I think just the site in-services would be nice to have for charge nurses, in order to be able to answer the questions for unit clerks, or helpful go-to resource people as well. They deal with a lot of the forms and stuff.*

When I asked about whether they had received sufficient information regarding their responsibilities under the MHA and how to fulfill them, another participant provided the following response:

P12 327-329: *Probably not. I think a lot of what I've learned is just over working on the unit. And a lot of it, like I said, every time you ask me where I heard something, it was from another nurse. But I've definitely had many questions … and I know that people have been complaining that new staff don't know really anything about the Mental Health Act. And I don't remember being told anything as a new staff about it. I knew a little bit because I preceptored. But yeah, I think most of everything I learned was just through the grapevine or I was in a situation where I wasn't sure and then I clarified with somebody who knew, but I wasn't really ever educated on it, in my opinion.*

Generally speaking, teamwork is essential in nursing practice as working in teams allows nurses to leverage their individual strengths, knowledge, and skills while compensating for each other's weaknesses. Participants provided examples of how they worked well as a team, shared information, and supported each other. Below are a few examples that demonstrate the teamwork approach:

P8 492-502: *I would say that these days, someone's getting their notifications done, their completeness review done, everyone knows about it, and everyone's asking if you have questions or putting in their two cents about any rapport that they have with this patient or we're helping each other and we're all continuing to evolve our learning…. That's a*

nice culture because it's not just what you know and maybe you don't know, maybe you're wrong. We're asking questions, we're working together, and we're supported by our colleagues. And I think patients are feeling more supported with that as well…. The patients feel like they can have questions answered or discuss it more with any of the nurses because… we're all supporting them…. And just gives us another tool to align with the patients and give them evidence that indeed, we are their advocate. And so in caring for them, but also in information, encouraging and furthering their rights. It's another tool in the toolbox. I think it adds overall to a therapeutic experience as a patient.

P8 447: *And then we're all learning together. If we don't know, then we all wait for the answer from the educator or search it up or whatever. So it's an ongoing learning experience, but it's never just you alone. So I think, yes, I feel confident and I feel supported because especially the culture of [participant's hospital site] that it's like that. I like that culture.*

P8 394: *Yeah. I think before the Amendment Act, with the focus on the... I think my understanding of in a timely manner, is more focused on for me and my colleagues. So there's more of a concerted team effort to give notification and do the completeness review, and try to make the patient understand why they're in hospital and what that means.*

During the interview, one participant referenced the "three criteria for certification" and was informed that there are now four criterion. The participant recalled being told of this change "just the other day" and followed up with:

P12 261: *Yeah, no, it was a nurse. A nurse was telling me, she was like, "Isn't there four now?"*

During the study, I asked participants if their confidence level in their ability to fulfill their role had changed since the implementation of changes to the MHA. While a majority of participants expressed a decline in confidence since the alterations, a few highlighted an increase in confidence attributed to the collaborative efforts within their team. One participant elaborated on this principle as follows:

> **P8 442-443:** *I think increased because I think it has caused our team at (participant's hospital site] to have more dialogue amongst ourselves. So, like I said, it's become rather than me, as a single nurse, as an island, doing this for my patient, it's more of an ongoing team effort… And it's not so overwhelming or disconcerting because I have to do it on my shift. It's more another attempt by me. And it's not so much I do it right, I do it wrong, I do it, I don't do it. Because you know there's still others also focused on this. So, it's a consistency of care and a team effort. So, I'd say there's more dialogue among the staff members rather than less.*

Avoiding Uncertainty through Passivity and Inaction

When faced with uncertainty and their responsibilities under the MHA, some participants in the study identified a tendency towards passivity and inaction as a way of dealing with uncertainty. Passive and inactive behaviour was recognized as a means of avoiding uncertainty. Some participants acknowledged continuing to carry out tasks in their role without feeling certain that they were taking the correct actions. Many of these participants expressed feeling uncertain about aspects of their role since the MHA changes, however they continued to passively practice without seeking knowledge, assistance, or support. In this context, the terms

passive and *inactive* were used to describe activities inherent to the participants' roles. Despite this passivity in seeking knowledge acquisition, participants actively engaged in tasks related to their roles, even if these actions did not align with the directives outlined in the MHA. Among the participant responses I received, there are indications of uncertainty, as illustrated below.:

P2 128-132: *We have to submit the request for the health advocate to call now…. Fax it along with the certs, I believe.*

P2 220: *I don't think I'd be able to clearly explain that* [changes to MHA to a colleague] *to be honest with you*.

P2 232-236: *Less comfortable with anything related to Mental Health Act…. because I don't think I clearly understand all of the changes that happened.*

P5 136: *Like 60, 70 percent, versus a hundred percent, because I haven't filled it out. I don't fill it out.* [on confidence level completing a Form 12 Application for Review Panel Hearing]

P7 88: *I am like 80% comfortable doing it.* [on confidence level completing a Form 12 Application for Review Panel Hearing]

During the participant interviews, I posed a series of questions regarding decisions participants might encounter in their daily nursing practice, which would require an understanding of the changes to the Mental Health Act (MHA). A significant number of the responses I received indicate a prevailing sense of uncertainty when it comes to practical implementation. Some examples of uncertainty in practical application include:

P7 124-132: *At eight o'clock until, I think, the end of that whole day. I think it just needs to be done that day… I think it'd be... Before, it used to be, it had to be done before two*

o'clock. But now, I think they can just do it just before the end of that day, I thought… I could be mistaken, but. [on expiration times of MHA certificates]

P12 201: *No. They signed it, both doctors signed it. Why do I feel like they have to have a review panel in order for them to do treatment? I might be wrong. I might be wrong.*

P12 253: *Actually, I don't know the exact answer. I don't know if I'm actually allowed to or not.*

P11 292: *I believe it's within 24 hours, but I'm not a hundred percent certain, but I think it's maybe 24 hours it needs to be completed or at least attempted.*

P11 256-272: [On whether medications can be offered after the patient is awaiting the review panel hearing] *Yes, from my understanding you can, but if they don't want to take it then we can't force the medication on them if they've applied to appeal the Form 11…. I mean, that's a really good question. I want to say yes. I haven't had a lot of situations like that, if any actually where there's an appeal going on with the Form 11, and so, I actually don't really know. But I think, I want to say we could still offer if it was still scheduled to be given because the psychiatrist does believe that they would potentially benefit from that medication, but that might be very, very wrong.*

Participants reported feelings of being unable to fulfill their role due to the way the MHA changes were introduced, often resulting in a sense of vulnerability and inaction. This sentiment is exemplified in the following quotes from the participants.

P3 196: *It just kind of felt like a lot of information thrown at once and then it was like, "Figure it out."*

P4 72: *Some of it is repeated. But then I can't remember if it was repeated. It just seems like it is because there's little bits and pieces, but then also new information in the same...*

In different emails from that seem to be from other emails as well. Yeah. It's just confusing sometimes.

P3 152: *I still feel like I'm not aware of all of the changes…. Before, to cancel them, the doctors would just draw lines through it and write canceled. And so sometimes, I still look for that and then I see the Form 2.1, I think it is, to cancel.*

P3 59: *I guess it just feels like things at work are just so busy and trying to stay on top of everything, and things are constantly changing.*

Several participants shared their experiences of feeling vulnerable while still being required to fulfill their roles. They expressed a range of emotions such as confusion, frustration, and fear. For example, one participant said,

P8 230 – 233*: Well, it's feeling like the rug's pulled out from under you because here, you're thinking you're following protocol and you're doing what's necessary. But there are gray areas, and it's case-by-case with patients. And are you on shaky ground if it's not following protocol, exactly the way textbook notification of certs or textbook completeness review? In this day and age, how many things are textbook? … So there's a little bit of gray area.*

Others shared that they felt vulnerable and uneasy about being legally responsible to act according to the MHA, especially when they did not feel fully knowledgeable about the changes and their implications.

P9 368: *Yeah, it's a bit terrifying.*

P11 208 – 212: *I would want to say that the confidentiality one would trump it, but that might be wrong…. I mean, I guess because the Mental Health Act specifies that if there isn't sort of a reasonable reason for not contacting the family, then I could see how*

maybe I might not be in trouble if I did that. Yeah, I don't know. But I think the Mental Health Act would potentially protect me. It's not meant to protect that, but yeah, I don't really have a great answer for you on that one. Sorry.

P6 56: [on nurses being named in lawsuit] *I mean, obviously within our profession, we do deal with things that can have consequences legally.*

Several participants observed that many of their colleagues were also struggling to navigate the changes in the Mental Health Act without sufficient information, leading to a sense of solidarity in uncertainty.

P2 252: *I think with the changes, we're* [participant and participant's co-staff] *all in the same confused boat.*

P3 176: *I do find even with... Because they believe that before certs used to expire at the same time that they were issued, and now it's midnight of the date they expire. And there's still a lot of confusion about that at work.*

P12 217-225: *No, they can't do the treatment until they've had the review panel because if they take the medication, that means that they are willing to take the medication….I'm pretty sure on that answer because I've experienced this and I feel we got in trouble one time because we were treating someone while we were waiting for the review panel…. Partly, because if they're taking the medication then that means why are we forcing the medication on them? Because they're consenting to take the medication, but we're saying that they're incompetent, and we have to force medication on them.*

P7 196: *Yeah, we've been having a lot of issues lately, I noticed, on the unit with the panel and needing certain things being signed, and just there's a big lack of communication actually between the staff and the panel and what they are wanting, so*

like the lawyers leading the panel. So, we've had numerous panels canceled the day of for something that was missed or that should have been caught by then.

P9 344: *That's a toughie because previously we've been able to fill out a Form 12 on the patient's behalf. And just based on the fact that they are refusing medications, even if they don't want to actually fill out an appeal. However, we've been directed that we cannot do that anymore by the review panel board. So now if they refuse to fill out the appeal, then we would force medication on them.*

In addition to navigating uncertainty, mental health nurses must also consider institutional practice, which encompasses the complexities of the law, policies, and accepted and informal conventions.

Institutional Practice

Institutional practice in the context of mental health nursing refers to the policies, laws, regulations, and other formal and informal practices that govern mental health care delivery within a particular healthcare setting or institution. It includes an understanding of the legal and ethical frameworks within which mental health nurses must operate, such as the MHA, and the organizational structures and systems that support mental health care delivery. Institutional practice also encompasses the cultural and social norms and values that shape mental health care practices within a specific healthcare setting. In short, institutional practice refers to the formal and informal rules and practices that guide and shape mental health nursing practice within a particular institutional context.

Laws

Aligning nursing practice with the responsibilities and duties outlined in the MHA is essential yet challenging due to the complexity of the legal language and the expanded duties

required of healthcare providers. Additionally, as nurses may not be legal experts, translating and interpreting the law can be difficult. Some participants expressed the difficulty of aligning their nursing practice with the MHA, particularly following the recent changes made to the act.

> **P6-352:** [on applying the MHA in practice] *I'm realizing there's a lot of intricacies.*
>
> **P8 363-364:** *So, I'd say that's another gray area that we've been up against for a while. And so, it's not clear. We're in the middle of Canada, so you're not supposed to force anything on the person. They have their right to refuse, unless it's in the case of there's some kind of harm being done, the person's very agitated. … And then that kind of trumps whether you give something or not. Because at that point, you might have to call security and get the situation under control. But if it's just a matter of appeal medication, then that's a completely different can of worms.*
>
> **P11 336:** *No, I don't think so. I think they... Or I might be wrong, but I thought they had to both be completed before the expiry of the first Form 1s.*
>
> **P7 64-68:** *I think there was, one of the biggest changes was, I think it was the criteria with someone needing to have a diagnosis that will be treatable with medication. But then... Oh, now that I'm talking about this more, so another big thing, from a nursing perspective, is the aspect of the AGTA…. All we kind of really know about it is it seems like it's a loophole for people with PDD to still be on, in hospital, essentially, even though they don't suffer from a mental health diagnosis that will get better with medication.*
>
> **P6 259-261:** *I think if they say they want to appeal... See the thing is they're... That's difficult, because if they're incompetent to make those decision then... But then if they*

want to appeal the form 11, then they still have the right, I think, to appeal that and then you wouldn't be able to give the patient the medication until the appeal was done.

P7 208 – 216: *I don't think that we couldn't. I think, well now, that... I think in order to treat, though, you'd have the Form 11…. We just had this actually. So yeah. Okay. So, what had happened, this is actually all new to me. So, we had a client who was refusing treatment, didn't want to appeal, but the doctor appealed on his behalf. And he was like, "I don't want to go." And the panel said that they were going to have it. So, we had a panel without him for treatment*.

A few participants appeared to have a clearer comprehension of the modifications made to the MHA and the underlying reasons behind those changes.

P8 95: *…But the whole Mental Health Act, apparently, the courts decided that there were some gaps and some unconstitutional parts in it. And so, the Amendment Act that just came into play addresses, tries to address and fill in some of those issues and gaps and fix things in the original Mental Health Act.*

P8 117-118: *Yeah. So supposedly, they made the Amendment Act so that it's just more efficient between facilities. So, in Alberta, to go between two facilities, you don't need to do different forms to transfer the patient. There's I think definite patient rights focus… Before, we were told you need to notify the patient what their status is, that they're here as a formal patient and all the information around that. What the cert say, review it with them, and what this means and that they can have a review panel. But there was never really a clear-cut definitive timeframe. So, I think now there is more of a focus on that.*

P11 80: *So, I know, for example, when we do NOCs or the notification of certification, always now we have to include if the patient would like us to let the Mental Health*

Patient Advocate know that they would like to be contacted. I think before it was just we would inform the patients about the Mental Health Patient Advocate and let them know they could contact them at any time, but now we have a responsibility to ask them and then to submit a request to the Mental Health Patient Advocate.

P7 40-44: *I know that now there's, I think, a fourth box that everything needs to be filled out from the doctors. Whereas I know before, they would leave parts blank….I think it's now within 24 hours, not before the time of the second certificate. I think the biggest one that there was the four components, like the four boxes they had to fill out.*

P9 76: *It was the criteria, the four criteria needed in order for a Form one to be initiated.*

P4 120: *When you're going in to do your notice certification, just be aware that the paperwork has changed and now you really have to actually ask them if they want the advocate, you have to really tell them that we can call them on their staff. You have to actually fill out the entire thing instead of just blazing over that part. And that... Yeah. I feel like that would be the biggest part. Because I feel is like our biggest, not role, but kind of job that we have to do.*

Participants reported feeling fearful that they were not complying with the MHA, in addition to feeling confused about whether they understood the amendments and how to translate those changes into their practice.

P8 232 – 234: *A nurse can always be called into court. And here, you're charting and you're reading the protocols and you're following everything you think to a professional expectation.*

P6 56: *Well, I think that's... I mean, of course, I know that nurses can be involved in lawsuits. I find that a little disturbing and concerning actually, especially that those*

names are now published online now, whatever. And I mean, I recognize the name. So, I think that's, kind of, concerning for privacy issue.

Numerous participants expressed a desire for a simplified means of comprehending the MHA amendments, as well as more guidance to assist them in understanding the changes that pertain to their nursing responsibilities.

P9 376: *I think streamlining the Mental Health Act process, the forms, the appeal process, all of that kind of stuff. I think it is way too complicated the way that it is right now for somebody who has no background in law to be able to navigate as well as our patients who are generally quite unwell. And to expect them to understand all of the legal jargon that we're going on about and asking them to sign forms to appeal, I think, is a huge detriment to them. So, I think that's kind of the first step is simplifying the process. And then I think it would be easier to roll out information from the educator's perspective to, again, have common knowledge about all of these things because there wouldn't be all these intricacies to it. Does that make sense?*

P4 204: [on helping patients to complete Form 12 Application for Review Panel Hearing] *There's like a lot of legal jargon on it and we use that form for many different types of review panels. I do kind of point out to them, "Hey, you want this part? The other part don't actually apply to you. If you want to appeal just your certifications or something. So don't check the boxes that don't apply to you".*

In addition to laws, another form of institutional practice that emerged in the data is the importance of policy. While policies and laws are both regulatory frameworks that guide behaviour, policies are typically created by organizations to guide internal decision-making and

behaviour. Policies are usually more specific than laws and apply only to the particular organization, and as such can be updated or changed more easily as circumstances change.

Policy

Policies are guidelines or rules created by organizations, institutions, or government bodies to guide decision-making and actions within that organization. While they are not necessarily legally binding, policies can have important implications for the actions of individuals and organizations. Although some information from the MHA has been incorporated into AHS policies, some participants felt there was a lack of policy or that the policies were not comprehensive enough and did not provide clear guidance on how to implement the changes outlined in the MHA.

> **P5 124-128:** [referencing contacting the patient advocate on behalf of the patient] *I've never had to do it…. Or I haven't assumed that to be my responsibility to do it, I guess*.
>
> **P6 80:** *Well, I may look at the Mental Health Act. I would look and see if there's any policies around something, but if there's something that's being changed recently, those policies may not be there.*
>
> **P9 228-232:** [on who is responsible for NOCs by policy] *I think that that's just been the expectation of our job since I've worked here and we've just kind of run with that expectation. … I do know just from something that was kind of unrelated is that I was going through the list of the delegates for the Mental Health Act. So, I know that it's actually the responsibility of the unit manager. However, they've delegated that task to us nurses, and I'm not sure where that stands with any of the regulatory bodies or the union.*

Participants reported feeling confused and uncertain due to discrepancies and inconsistencies between institutional policies, the MHA, and ethical considerations. Some of these ethical

considerations included patient autonomy, maintaining confidentiality, not doing harm, professional integrity and managing conflicts of interest. The discrepancies between institutional policies, the MHA, and ethical considerations created ambiguity and a lack of clarity in nursing practice.

> **P6 340-344:** *That leaves a lot of gray area, right? Because, and then also like how do you balance conflict to confidentiality, right? … Because we're not supposed to release any information about a person at all, unless they've given consent. So like, how do you balance that if that's required, but then we're also required to maintain that confidentiality. I'm not sure which one trumps what then.*
>
> **P11 96:** *I know that the mental health patient advocate can now sort of investigate any sort of complaints that a patient may tell them, and they also are able to request for any sort of documents that would be relevant to that patient's complaint… I would assume we would need to get consent from the patient prior to doing that, but again, I'm not actually sure.*
>
> **P9 160:** *Not that it's complicated, but that there's more pressure to have it done. All your I's dotted and T's crossed.*

Several participants reported a sense of inadequacy or incompleteness in existing policies and expressed a need for more comprehensive and specific guidelines to help them better understand and fulfill their duties.

> **P11- 136:** *I don't really like the idea of them because it's included on the form that I'm bringing the patient and I'm letting them know that they're formal and going through all that, and then if it's not being given to the patient or it hasn't been completed, it kind of puts me in a weird position and kind of an uncomfortable position. I just think it would*

probably be best if we're using those forms or if we're supposed to be using them that they are used and done properly, and I know they get forgotten and stuff. But I do feel like it kind of puts us in a little bit of a sticky situation because I remember feeling kind of uncomfortable because the patient was quite distressed about this because they didn't agree with being formal and then they also didn't receive a summary of competence forms. So, yeah, that's how I feel about that.

P6- 92: *I'm not sure if it actually says that. I do know that in practice it's always been the nurses, but I don't actually know if it says that in the Mental Health Act, specifically. I think it probably is just... It's probably not specifically a nurse, but a responsible care provider such as a nurse or maybe even a physician, but that I don't know, actually.*

P3 -67- 68: *Sometimes when we get a new patient from other site, we're missing a page and stuff. I feel like that's happening a lot more often. There's the completeness review of certifications that the physicians are supposed to fill out… And it's nursing's responsibility to inform the day charge nurse, who then informs the physicians that this completeness review needs to get done. But quite often, it's more often than not, it's not done.*

P8 282: *The other thing is it's more in the forefront of people's minds, but it would be nice to have some kind of protocol or something where if you don't finish it, or how many times you attempt it, is passed on in a more formal way to the next shift, rather than guessing or hoping that someone gets to it.*

Several participants conveyed their preference for the newly introduced paperwork established by the organization, as they believed it aided them in ensuring they did not overlook any essential aspects of their responsibilities.

P4 176: *I mean it's changed because, the way that the notice of certifications now the format is new. So yeah. For sure, it's changed because I definitely complete that entire thing when I do them. I know before, sometimes I might have forgotten to ask if they wanted to talk with the Mental Health Act or the patient advocate just because it wasn't on the form. So now, I remember because it's prompting, so that's kind of nice. Because I feel like I complete the entire thing legally, it's all done.*

P4 208-216: *…because now everything that's on the form, so I know I won't forget anything.* [prompts such as] *That kind of thing. "Do you want us to talk to the Mental Health Act or the patient advocate on your behalf? Yes or no?" So I don't forget things. So I feel more confident that I'm actually completing everything properly. And sometimes I actually feel like I do have better conversations with patients when I have these new forms as opposed to before. Because there's also part kind of a script on it, which is nice.*

An additional institutional practice that is less structured than laws or policies is the use of accepted and informal conventions. This was a prevalent topic among the participants, who mentioned adhering to established norms and traditional practices when discussing how they carry out their nursing duties.

Accepted and Informal Conventions

Accepted and informal conventions differ from laws and policies as they are unwritten practices that have developed over time through common agreement or tradition rather than through formal regulation or legislation. In nursing practice, this may refer to unwritten, informal rules and expectations that have developed within the profession over time. These conventions are often based on shared experiences and traditions and are seen as accepted ways of doing things, even though they may not be explicitly outlined in laws or policies. In mental health

nursing, examples of accepted and informal conventions may include the use of therapeutic communication techniques, specific approaches to managing patient aggression, and ways of addressing patient autonomy and rights. However, it's important to note that while these conventions can be valuable, they should not be used as a substitute for following laws and policies, which are legally binding and hold nurses accountable for their actions.

During interviews, participants shared some workplace-specific informal practices and knowledge that they attributed to accepted conventions. One participant shared an example of an instance where an accepted and informal convention proved to be effective,

> **P9 380:** *So, for us, the timely manner would be within 24 hours of having the second certificate done. That's us on the units. I know that* [the emergency department] *is very different and there's circumstances where we can't notify them. Or I shouldn't say that, where they are not functioning well enough to be able to understand what we're saying to them. So if that's somebody who is extremely psychotic and can't understand, or if somebody is too agitated or dangerous to sit down and have that conversation without a risk towards yourself or to other patients, those are also times that we've gone beyond the 24 hours.*

On the other hand, participants reported situations where relying on accepted and informal conventions proved to be inadequate or misguided. These include:

> **P6 187-199:** *Yes, because my understanding was always that the time it was like signed or whatever, is the time that it expires. So is that... Has that changed? … Wow. Okay. I didn't know that. And I think everybody still had been going by the,* [time] *it's signed.*
>
> **P8 72:** *I think it's case-by-case with the doctors, but it's also case-by-case with the patients. We keep attempting to redo it. But another question is, how many times do you*

reattempt? So some reattempt. If I had a patient for five days in a row, am I doing it every day? Is everyone doing it every shift? Or how do we go forward? Because it's not going as it's prescribed to go.

P11 100: *I mean, I feel like it kind of has been the same for me, the way I've done it at least since I first started working on that unit. Just I would go give them their copies of the Form 1s and explain to them what it means to a formal patient, how long they could be formal on the first Form 1s, and I explain all of their rights to them, but I don't really know if it has, and maybe that's a really bad thing because maybe it should be changing my practice. But yeah.*

P12 278: *So it would be March 12th and before it had to be done before 2:00 PM, but then I remember someone saying that there was a change, that it just has to be done by that day. But I don't know if that's still true because a lot of doctors are still doing it by the time.*

P12 144: [On the Completeness Review] *I remember them doing it at the beginning, but now I don't know that I've been seeing it.*

These instances of confusion and inconsistency highlight the significance of having clear guidance from a law or a formal policy.

Another theme that emerged from the research data, is that the participants comprehend and make sense of their role through relational practice.

Relational Practice

Relational practice is related to social constructivism in that it recognizes the importance of social interactions and relationships in the construction of knowledge and understanding in

healthcare. This approach acknowledges that knowledge is not solely acquired through individual experience, but rather through the collective experience of a group and the interactions and relationships within that group. In this way, relational practice aligns with the social constructivist perspective, which asserts that knowledge is constructed through interaction with others and through each person's experience and interaction with the world. Three sub themes of relational practice emerged including knowing informants, advocacy, and relationship to medicine.

Knowing Informants

Relational practice includes additional sources of information that nurses may depend on, and these resources will be explored as knowing informants. A knowing informant is a source of information that a nurse relies on to enhance their understanding of a patient's health status, condition, or needs. It can be a family member, a caregiver, or anyone who has knowledge about the patient's history or current situation. In practice, nurses can use this information to inform their clinical decision-making and ultimately provide better care for the patient. I heard from participants that they identified educators, managers, nurse colleagues, and unit clerks as knowing informants.

> **P8 66:** *Well, that's where the gray area is. That's where you reach out and talk to your colleagues, the other senior nurses or the charge nurse. Or if you don't get the satisfactory answer, then leave a message for the educator or the manager.*
>
> **P6 132:** *I mean, you can always ask the educator or manager or ask colleagues or even talk to the doctors and kind of discuss it. But I haven't actually seen like a formal training on it, unless... I mean, I don't know if new hired... Obviously* [the nurse educator] *would*

go through and I'm sure they would discuss those things ... And like when I have students, I kind of discuss the things I know and about how the certs work.

P7 252: *I would probably ask my colleagues to see if they found out or if they knew. And if not, I might ask one of the, I would ask one of the educators. But I find that all of their information is just kind of like look up this or like a website.*

P2 72- 80: *They called... The unit clerk called the Mental Health Act board.*

P11 127 -128: [on the Completeness Review] *I did follow up with charge nurse, I remember, and then we found it together, the form on Insite or was it in an email or somewhere that the educator had sent out, but I haven't seen it a whole lot.*

P2 92-100: *Most of the time we just look it up or speak to educators… Calling other educators, I guess, or calling the Mental Health Act board to see if they have a recommendation… I don't think I've looked on Insite for... I hate Insite. I find Insite really user-unfriendly, so I don't tend to gravitate towards Insite for questions.*

P7 100: [on who taught participant to complete a Form 12] *Our unit clerk.*

P7 168: [on where participant learned to provide NOCs] *Probably from one of my buddy nurses. Or I was a student there first. So probably I was, would've been with my preceptor.*

P7 224-228: [on who to ask if participant was uncertain of how to proceed under the MHA] *My colleagues, probably. Management*?

P12 40: *If I can remember, I think I remember getting emails. I'm not sure if it was educators. I want to say it was probably management sending it out. I think it was probably brochures and stuff about the change, but that's all I remember.*

P12 245: [on how they learned to present at a review panel hearing] - *I just went to the review panel and was told probably by a staff nurse what you should be saying.*

P6 171: *And so like, if it was on a day shift, when [nurse educator] was around or a manager, I would ask one of them. If it was on an evening, I would first ask the charge nurse and if the charge... But I mean, I do charge too. And I didn't know that. So, maybe the manager on call might even be a resource, but I would definitely try and get information. And then if somebody told me, "Oh, there's a form to be filled out." If that was something that was told to me, then I would probably ask the unit clerk, "Hey, do you know where the form is for nurses to contact?"*

Participants shared instances where they felt strongly supported by knowing informants, citing how much they had learned from these resources. They expressed a sense of assurance and confidence in having these resources to rely on in moments of uncertainty. Participants described knowing informants as invaluable resources and sources of knowledge that have enhanced their practice. Participants expressed a sense of empowerment in working as part of a team.

P8 181: *It's dry, legal jargon. It's a law. That's where talking with your colleagues, your other nurses maybe is beneficial to flesh out what exactly they're saying or the time period or whatnot.*

P9 92-96: *My unit clerk. She's the go-to with the review panel board. … So we get a lot of information directly from them, mostly when we've done things incorrectly.*

P9 300-304: *Through my unit clerk… she just knows everything.*

P11 84: *I can say that for sure, I don't. I know the unit clerks, most of them probably do because I have had to do that, but I asked the clerks to help me. I didn't help them out with it at all. They did it all, so I don't know how to do that.*

P11 152: [on Unit Clerk as a source of information] *A very good source actually. There's one in particular on our unit, but they're very knowledgeable about the Mental Health Act too. Yeah, I do go to them quite, a bit along with the other nursing staff, but they are actually excellent.*

P11 164: *I never learned that in nursing school. I think it was in orientation that they showed us how once I was hired onto the unit. But I think it did take a little while for me to kind of be more comfortable with it just because it is I wasn't taught in school and then your orientation isn't super, super long. So, I kind of learnt just by working and doing and asking questions.*

P11 312: *I think it would've just been other nurses during my orientation, but also just my time working there. I've gotten a lot of support from the nursing staff there, just my colleagues, and also the charge nurse has been really, really helpful as well, so yeah.*

Although there were situations when the knowing informants provided valuable information, participants also expressed concerns about the possibility of incorrect information being disseminated by nurse colleagues or unit clerks.

P6 215: *I think discussions with colleagues like when I started... Before I came to [unit #]. And so I didn't... I mean, I had worked in ICU. I had worked on the medical unit in question from that law thing, that lawsuit thing. But I didn't really know all of the ins and outs. And so asking colleagues who were experienced, helped me a lot, at least to get the basis. But the thing is here's then the problem that I'm seeing, is this, if people don't know and if changes has happened and you go and you ask somebody and they give you wrong information then it perpetuates the wrong information.*

P11 312: *I think I kind of put a lot of faith in what I was told and really trusted that because a lot of the nurses that orientated me too had been working there for several years and they're very strong nurses. So, I never really worried about that, although that probably should have been something I thought about. And another thing is I've kind of gotten a lot of information from different nurses I work with and it's kind of a lot of same instruction. So, that's one way, I guess, I kind of know it should be accurate.*

Participants stressed the significance of verifying the accuracy of information obtained from knowing informants.

P6 219: *So even though colleagues, like experienced colleagues, that was most helpful initially for me, I actually don't think it was... It's the best source necessarily. And I think, as a nurse, we always should still do our own looking into things just to make sure that we're not learning the wrong thing.*

In general, participants expressed a need for more educational opportunities to better understand their nursing role and how it relates to the MHA. However, the majority of participants reported feeling supported in their work environment and emphasized the importance of mentorship in navigating the complexities of caring for patients in accordance with the MHA.

Advocacy

Numerous participants expressed a desire to promote the welfare of the patients and acknowledged the significance of comprehending the MHA and organizational regulations to provide better support and advocate for the patients' rights and enhanced care.

P4 116: *When somebody has a Form 11, now the psychiatrist can't just automatically go to a review panel, whether or not the patient wants it. They have to wait for the patient to*

request one. And I don't really understand why. Because I guess another piece of it is that I think the Mental Health Act changed so that there's less barriers for patients to act on their rights. But I feel like that part actually needed... There's actually a bigger barrier now.

P3 33: *We were kind of worried about some of our patients who, like our PDD patients, and if they would still be certifiable… are they just going to put them out on the street?*

P5 48: *Probably as an advocacy for people with mental health problems? I think it just makes sense that if you are going to form them and have them stay in an institution against their will, we need to deem that keeping them in hospital will benefit them. And yeah, I don't know, maybe there was data, maybe people applied for mental health review panels, and they must have analyzed that.*

P7 140: *I've actually always advocated for my patients. And even when I get the NOCs, I'll let them know that signing them doesn't mean you agree. It doesn't mean you disagree. It just means you've been given information. And I always am open to helping them fill out whatever they need to get a lawyer, speak with advocacy, and all that stuff.*

P5 104: *Yeah, and then, I will tell them that, "We think that you will improve from staying here. You'll benefit from the stay, and you're not safe for yourself, for other people, suffering from some kind of mental health illness." And so, yeah. And when I explain to them, I'll explain that to them.*

A few participants expressed reservations about ambiguous aspects of their practice.

P8 57-58: *Well, it's definitely not filled out at the beginning, which was the nurse's understanding for when all this stuff was supposed to be done. Because it emphasizes it needs to be done in a timely manner, it needs to be done within the first couple of days,*

definitely… But then the problem is that it's not that black and white when you're actually doing it, because we get a lot of gray area in our patients. Sometimes they're too agitated or too sedated or just can't comprehend because of their mental health issues.

P9 392: [on documents that are not regularly being completed] *I usually just cross off given the documents that I can't give them, so the letter, the incompetence form. I just cross it off and have them initial that and then also initial it so that I'm not saying I gave them something that doesn't exist*.

P12 69- 74: *I find the only change that I've noticed since it's changed is with review panels. I find a lot more patients are winning their review panels than before. They used to be that nobody did and now it seems like lots of people are winning. And we've actually had a lot of situations where they shouldn't have won… even recently we had a patient that I would say her main diagnosis was being on the autism spectrum, but there was definitely some safety concerns, self harm concerns, agitation. She definitely wasn't ready to be discharged. But she presented really well at her review panel and she actually ended up winning. And they ended up actually having to then inform her immediately after. And it was a whole discussion with the chair of the review panel and everything because it was a safety concern that they had allowed her cert to lapse.*

P2 188- 192: *I think some of the patients that maybe would've been formal before are less... Some patients that I think would've been formal before are no longer formal patients …. I think at times people can sign themselves out of AMA when I think they're still pretty unwell.*

A number of participants expressed a desire for certain changes, while others discussed specific alterations they wished to see implemented to improve patient care and ensure the utmost protection of patient rights.

P8 475: *And they think that somehow that's going to change the situation, change the status. But they don't seem to understand, even though you've just finished going through it all and telling them why they're signing and what that means, they don't seem to hear that part. So I don't know how that could be changed, but that's definitely still a problem.*

P8 483: *So I agree that patients have more information, they have better access to it, it's more timely. It's just somehow we're still having some gaps in there, and I don't even know what a fix would be to change that.*

Several participants shared examples of how they make additional efforts to advocate for patients, particularly in situations where the prevailing standard of practice may not be in the best interest of the patients. A few participants discussed how they supported patients by collaborating with them and assisting them in maneuvering the complexities of the MHA.

P6 158: *I would think that, on the one hand, we are to help the patient and advocate for the patient. And so I think from that standpoint, we should be able to help. But on the other hand, I also kind of feel like that it's a conflict of interest almost to be the one calling because they should be the one reaching out if they want that help. And then they can voice their concern, because I can't really say exactly what their concern is, right, when I talk to the advocate. I don't know.*

P6 223: *I'll even sit with them and go through it. And I mean, obviously, sometimes people are not able to write or that kind of thing or read. So then I think they should still be able to access that, right? Access to review panel. So then of course I would help.*

P7 148: [on whether participant would inform nearest family of patient's formal status if a patient objected – due to undefined term "reasonable grounds"] *I just feel like if they objected, I would just say they objected. I think that's reasonable enough for me, personally.*

P9 216: *No, because to me that's huge. If a family member doesn't want their family to be aware that they're certified, that should be their choice. They haven't been deemed incompetent in their treatment decisions. So my personal practice would be that I go by what the patient wants under the policy of patient centered care and let them decide if that changes for any reason. So I generally do not tell family members unless the patient asks me to.*

P8 397: *Because if you only hear the information once, it's overwhelming. They're in hospitals, a crisis situation. Again, they probably don't even know that they have a question, or that they didn't understand, or they understood it differently than what it is. So I think there's more of a team effort with multiple efforts to give information and to do it in a timely manner so it's more complete for the patient. I think that's a good thing.*

P8 403: *I'll actually revisit it with the patient and see how they're feeling about it, if they have any questions that have come up since they first heard about the information, if there's any further information on... When their review panel is pending, when it's coming up, I'll offer to help them write down some of their thoughts or give them paper and pen and encourage them to think about what they want to say or why they think that they don't need to be on this medication or don't need to be in hospital.*

P8 407-409: *So I don't know. I think that I, personally, do more focus on the whole mental health stuff and just making my patients aware. And I think I use it as a time to let*

the patients know that I'm working with them and partnering with them… And I want to advocate for them in what they're thinking and what their rights are and if they have any questions. So I think I emphasize that rather than, "Here's your cert, see you later." It's more of a chance to build rapport, and find out more about what the patient's thinking and why… But also let them know that I'm here for them, I want to advocate for them. And this is one of the ways. So if you have questions, if you want me to review things, whatever. And I think it causes less agitation with that approach.

P8 131- 132: *I think there's more focus on encouraging patients to exercise their right to do a review panel, whereas before that, there was less focus on that. I don't know. I think that's a change anyway. When patients are coming in, they're in crisis, so they might not be thinking the best. And so if they get this information and maybe sometimes they need some encouragement as to why they want to exercise their rights. I just think that that's advocating for the patients more.*

A participant shared their perspective on the potential feelings they might experience if they retrospectively examined their practice and realized they had not acted in compliance with the MHA. Such a realization would not align with their values, and therefore, it motivated them to practice fairly and ethically.

P11 68: *Yes, it really does because that's just a situation I would never, never want to be in, and I also would never want to have looked back and realized that I wasn't following the act the way I was supposed to be. If I wasn't giving every patient their right, all the rights, I think that would really fit with me and that would be terrible, to be honest.*

In summary, the overall agreement among the participants was that they made efforts to adhere to the MHA to advocate for their patients. Their motivation to be effective patient

advocates remained undeterred despite the complexity of the MHA. Nonetheless, the nurse participants recognized that their practice was not in isolation from their physician colleagues and deliberated on the relationship between their practice and medicine.

Relationship to Medicine

Nursing practice is interrelated with medicine, and the choices made by physician colleagues can have consequences that affect nursing practice. Here are some instances that participants shared:

> **P1 88:** *such an important aspect of my job, because it's very important to know the changes so that we don't have the wrong patient as a formal patient.*
>
> **P3 88- 99:** *It is still kind of a tricky spot though, because I feel like physicians have so much of a say over some of the changes, that it almost feels a bit, "Is it my place to start telling a physician if I think someone should be certified or not?" Does that make sense?... It kind feels like it's a tricky role to be in this, not... I don't certify people, so I don't know if I should be telling the people who do, that there's a concern.*
>
> **P8 368:** *Well, my understanding is that if they're appealing, our doctors tell us to not give the medication. So we've run into the situation where they want the medication and the doctors are saying to not give it until after the review panel.*
>
> **P8 376-377:** *Well, my own personal opinion is that I've seen, and it's not all of the doctors, but some of the doctors go gung-ho on putting in a review panel for all their patients. And I guess, it would be to speed up incompetency if it's needed. But sometimes I feel it's aggressive to just jump on the patient's new situation to the unit and do it right away. I don't know. I feel it's more ethical to give them some breathing space to make a*

decision. And I know that some of our doctors I've seen be more aggressive and jump on it immediately. So I don't know that that's the right way.

P1 56: *My own practice as a nurse is to follow through based on what the doctor has told me.*

P4 184: *I feel like we kind of leave that up to the doc to decide what's to do next. But I mean, if they're refusing their medication and I have no... They haven't had their review panel yet. I can't give their medication to them. I know that we recently had an issue like that.*

P6 261-263: *Well, I would feel reasonably confident, but what I would do, just to make sure, is I would talk to the doctor and just clarify the situation. Like I wouldn't say, "Well, what do I do?" I would just say, "Well, the patient... This is all done now, but the patient is wanting to appeal."*

P12 144: [On the Completeness Review that physicians are to complete] *I remember them doing it at the beginning, but now I don't know that I've been seeing it. Again, it connects there too. I don't know if I've even seen that in the form.*

P6 279: *So, I don't think you can go ahead and treat if they are appealing the form elevens. But what I would do is I would inform the doctor and clarify with them as well, just to cover all my bases.*

Participants appeared to possess a greater comprehension of the MHA from the physician standpoint. When I asked participants to share what information they initially received about changes to the MHA, a significant portion of the information participants shared was related to medicine and not to changes from a nursing perspective.

P1 40: *The people that were certifiable, so defining the admission and retention criteria to ensure that the act is only used to retain those whose mental disorders can be improved by treatment. People that had chronic diseases like FASD, that's fetal alcohol syndrome, were no longer certifiable because they felt there is not something that could improve their mental disorder via treatment. That was the field that was highlighted to me, the major thing that was highlighted to me under the change in the Mental Health Act.*

P3 54: *That was the biggest one* [criteria for certification]. *You know, to be completely honest with you, I feel like that is where the majority of the conversation was around that piece.*

P4 112: *I know that it's sort of changed in a way that it deems anyways, it prevents maybe people who have intellectual disabilities from maybe being formed just because of their intellectual disabilities. That kind of more of what I got from it anyway.*

P6 36: *Well, I heard the doctors talking too, so I heard that like the requirements for certification would be different. There would be an added criteria, basically. Or that it would be a fourth thing that it would be that the person was thought to would benefit, like not the person think to benefit, but that there would be benefit from the third person to be receiving the treatment.*

P8 99-100: *So a big one would be that before, it was any patient or a person with a serious mental health illness, but it wasn't. But now it's a more narrow definition of who that is. So it has to be a treatable disorder. So it can't be somebody with a permanent brain injury, like a stroke victim or a fetal alcohol syndrome, something like that. They have to have also an identifiable mental health issue, such as schizophrenia or bipolar or*

depression, something that can be actually treated as not a permanent brain issue that can't be treated.

P9 32: *So I heard that due to a concern at one of the other sites about a patient who was certified for an extended length of time that they were going to make revisions to the Mental Health Act so that you couldn't certify somebody primarily for a brain injury or any kind of illness that was not treatable.*

P11 72: *I know they changed the definition of a mental disorder to include... I think the beginning portion is very similar, but then I believe the change was specifying that it doesn't include certain conditions that may have been the result of a traumatic accident and isn't likely to benefit from treatment or isn't likely to change at all, or congenital disorders. What else to do? I know there's lots of things they changed. I know the criteria for being a formal patient did change as well. I could be wrong, but I think the change was there's four criteria, but one of them is now the patient has the potential to benefit from treatment. I don't know if that one's... Maybe that wasn't the one that changed, but anyways. Yeah, and then some of the... Oh, so qualified healthcare professionals are now, I believe, including nurse practitioners.*

P12 32: *From my understanding, the changes that I recall were regarding PDD, developmental delayed patients… And how they're not really part of the Mental Health Act as much. We can't admit them under the Mental Health Act under certain, what it's called? Like stipulations. That was the main change that I remember being told.*

P12 90-91: *I guess we would need to know what type of patients now wouldn't fall under the criteria anymore. I find, again like I said, a lot of patients are winning their review panels, especially when their main concern is something like being PDD… But a lot of*

the time those people don't end up being able to leave because they have a guardian. They're voluntary but their guardian doesn't let them leave. But yeah, I mean we'd have to know the updated criteria in order to know which patients actually really shouldn't be form.

P5 36: [Referencing the new/fourth criteria for MHA certification] *That they need... That we need to gain, that they need to be... They will benefit from a hospital stay or being admitted to institutions.*

P11 120 -127: [on the Completeness Review] *So, basically from my understanding, it's a form that would be completed when someone has two Form 1s, and it's supposed to be completed to ensure that the formal certifications are actually complete and valid, and on our unit, I believe the psychiatrists are that fill them out…. If I'm being honest, I actually don't know if I've really seen it that frequently, but maybe I haven't been looking for them very frequently, but I haven't really seen them a whole lot.*

[On the Summary of Competence] *is it the summary of competence or I forget what it's actually called…. But yeah, so that one is another one I haven't really seen it a whole lot, and I have had questions from patients because in the notice of certifications form that the patient chooses to sign or not sign, it does say in the form that they're agreeing that they have been provided with their summary of competence, and I've had definitely, on one occasion, one patient asked a lot about that and say, "I don't know what this is, I never received this." if I'm being very honest, I didn't really know either, and I did check the chart. Yeah, I haven't really seen them a whole lot.*

Although nursing practice is not independent of medicine, it is a distinct profession with its own distinct responsibilities, and having a clear understanding of the nursing role is essential.

CHAPTER 5: DISCUSSION AND RECOMMENDATIONS

In this chapter, I present a comprehensive discussion of the findings of this qualitative thematic analysis, which centres on exploring how AHS nurses are making sense of their role in relation to the recent changes to the MHA of Alberta. A comprehensive review of the existing literature revealed the historical significance of legislative changes and the reorganization of mental health services, both of which have influenced the landscape of mental health nursing practice in Alberta. This study adds to knowledge for practice by investigating how changes in MHA legislation influence nurses' understanding of their role.

The MHA of Alberta was established to safeguard and guarantee the rights of individuals coping with mental disorders. On September 30, 2020, when the revised act was introduced, numerous healthcare professionals had to promptly acquaint themselves with the amended act and the alterations to their roles in line with the new legislation.

In my role as a CNS, one of my responsibilities is to educate nurses, including education about nursing responsibilities under the MHA, and to ensure nursing practice adheres to legal duties under the MHA. The sudden implementation of the MHA changes prompted me to question whether nurses would feel sufficiently prepared for practice in the context of new legislation, how these changes might influence an understanding of their roles, and it raised the question of whether patients' rights would remain safeguarded.

By analyzing the participant data, several areas of improvement for nursing practice were uncovered. Consequently, a crucial aspect of this study is its capacity to provide valuable insights, facilitating the implementation of more effective strategies and seamless integration of future changes into the MHA for nurses.

The forthcoming discussion is based on the analysis of data presented in the previous chapter. This analysis was derived from data collected with 12 participants, all of whom were

registered nurses or registered psychiatric nurses, with a minimum of two years' experience, working in an inpatient mental health unit at one of the four hospitals in Calgary. Demographic information may be found in Appendix J. The following discussion is structured according to the themes and subthemes derived in the analysis: *Navigating Uncertainty, Institutional Practice*, and *Relational Practice.*

Theme 1: Navigating Uncertainty

Several participants reported taking proactive steps to seek out knowledge and manage their feelings of uncertainty. Uncertainty is an inherent component of healthcare. As discussed in Chapter 3, Katz's model of uncertainty (1984) provides a framework for responding to the inherent uncertainty in nursing practice (Katz, 1984; Thompson & Dowding, 2001). This model emphasizes theoretical contemplation of uncertainty and how it is applied in the clinical setting. One type of uncertainty that Thompson and Dowding (2001) discuss in this framework is related to "an individual having incomplete or imperfect knowledge of the area" (p. 610). Most study participants indicated they felt they had incomplete and imperfect knowledge of the changes to the MHA. Additionally, a number of participants expressed a sense of being inundated with the sheer volume of information they had to navigate in order to effectively fulfill their roles amidst the changes brought about by the Mental Health Amendment Act (2020). The amendments to the MHA, as outlines in Chapter 4, encompass a range of additional responsibilities paced on hospitals ad healthcare providers.

Taking Proactive Steps and Seeking Knowledge

Some participants identified resourceful decision-making strategies when faced with uncertainty in implementing the changes to MHA. They expressed difficulty processing the extensive new information, emphasizing the need for simplified breakdowns, yet employed

strategies to facilitate decisive action. Based on a comprehensive Canadian study delving into nurses' experiences with uncertainty, the findings unveiled a prominent strategy employed by nurses which involves independently navigating through uncertainty by "using analytical reasoning skills and intuitive judgments to take action" (Cranley et al, 2012, p, 154). Participants who proactively took steps such as drawing upon previous experiences, critical thinking, or reaching out to available resources, exhibited self-confidence, accountability, and skillful maneuvering through uncertain situations.

Providing Mutual Support and Seeking Assistance

Amidst uncertainty, certain participants sought comfort by seeking support from colleagues. Some turned to nurse colleagues with a deeper understanding, while others sought solace in those who shared similar feelings of uncertainty. The research refers to this as *colleague solidarity*, which is "the mutual support of individuals who are practitioners of a certain profession, and it refers to both their professional sharing of knowledge and skills" (Uslusoy & Alpar, 2013b, as cited in Kilic & Altuntas, 2019, p. 356). A recent study determined that "collegial solidarity among nurses has a positive effect on organizational commitment, teamwork, supportive climate, stress, negative interaction, human relations, job satisfaction, hierarchy, communication and an innovative climate" (Kilic & Altuntas, 2019, p. 364). Co-workers often exhibit greater support and assistance when confronting challenges, experiencing a stronger sense of solidarity among themselves compared to interactions with individuals outside the team (Uslusoy & Alpar, 2013a). Most participants discovered that the support of their colleagues significantly bolstered their confidence in fulfilling their roles in effectively implementing changes to the MHA.

Avoiding Uncertainty through Passivity and Inaction

Some participants expressed vulnerability, leading to passivity and inaction, as they felt overwhelmed by the extensive information, experiencing emotions like confusion, frustration, and fear. This apprehension was intensified by the concern of potential legal responsibility if their practice was not aligning with the changes to the MHA. Despite this, several participants found a sense of solidarity with colleagues facing similar challenges in navigating the changes. This concept is supported by the research which emphasizes the importance of "having collegial support to manage uncertainty" (Cranley et al, 2012, p. 156). However, some nurse participants in the Cranley et al. study expressed feeling vulnerable when seeking support as they "feared asking a stupid question" (Cranley et al, 2012, p. 154). One of the outcomes of the Cranley et al. (2012) study was continuous uncertainty, which included lingering doubt or unresolved uncertainty usually related to having incomplete information. Participants in the study resonated with the research findings on experiencing vulnerability and embracing the concept of unresolved uncertainty, subsequently resulting in a state of passivity and inaction.

Navigating Uncertainty by Implementing Change in Nursing Practice

The Navigating Uncertainty theme shows that participants experienced substantial uncertainty in their roles in relation to the MHA changes. Their responses revealed diverse strategies they employed to address this newfound uncertainty. A general feeling of being unprepared for the practice-related effects of changes in the MHA contributed to uncertainty for participants in this study. According to Bastable (2019), the educational process parallels the nursing process by necessitating assessment, planning, implementation, and evaluation for achieving success. This educational process encompasses several key components, including the need to "ascertain learning needs, readiness to learn, and learning styles; develop teaching plan

based on mutually predetermined behavioral outcomes to meet individual needs; perform the act of teaching using specific teaching methods and instructional materials; determine behavior changes (outcomes) in knowledge, attitudes, and skills" (Bastable, 2019, p. 14). As such, nurses in the study used different approaches to educate themselves, in the absence of helpful or timely education to meet their practice needs.

The principles of effective teaching and learning underscore the importance of tailoring education to the unique needs of learners and employing a wide range of educational methods to optimize learning outcomes. This sentiment was common among study participants, who often shared examples of their preferred methods for receiving information regarding the changes to the MHA. Several participants expressed their preference for in-services and workshops, which is supported by Mukurunge et al. (2021), who found that interactive workshops have the potential to bring about significant changes in knowledge acquisition and participant satisfaction.

Changes in practice, such as those involving the MHA, demand both structured educational planning and a transitional phase for staff to seamlessly incorporate these changes into their daily routines (Arsenault et al., 2021). This principle is substantiated by a recent study in the Journal of Clinical Nursing, where participants, "described making practice changes as time intensive; both to do the new practice and to fully integrate the practice change into how they provide care" (Arsenault et al., 2021, p. 1423). The study's findings showed that practice change is a recurring and integral aspect of a nurse's role, where nurses employ strategies like careful planning, involving their colleagues, and transparently communicating the reasons for and expected results of these changes to effectively facilitate practice transformation (Arsenault et al., 2021). The findings from Arsenault et al. and this current research corroborate the idea that a prolonged schedule for implementing the changes to the MHA might have provided the time

required for planning and communicating the changes to increase the likelihood that nurses would comprehend their roles before changes became effective.

While most participants in this study felt underprepared to navigate the changes in the MHA, many acknowledged it was their professional responsibility to stay informed and up to date with current standards of practice. This finding underscores the crucial role of proactive engagement by nurses in their professional development and emphasizes the essential provision of readily available, continuous education and training opportunities to support their ongoing learning and development. This principle aligns with the guidelines set forth by the College of Registered Nurses of Alberta (CRNA), as articulated in their practice standards document, which emphasizes that "the nurse continually acquires and applies knowledge and skills to provide competent, evidence-informed nursing care and service" (CRNA, 2013, p. 7). Furthermore, the CRNA highlights the importance of adhering to current legislation, standards, and policies relevant to their practice setting (CRNA 2013, p. 7). The College of Registered Psychiatric Nurses of Alberta (CRPNA) underscores the significance of professional conduct, emphasizing that nurses must consistently demonstrate knowledge, skill, and judgment in delivering professional services, and adhere to all relevant acts governing the profession (CRPNA, 2022). While nurses bear the responsibility of adhering to legal requirements and actively seeking out educational resources for their professional growth, it is equally necessary that their employers facilitate access to education through timely and tailored continuous learning opportunities that address the specific needs of their staff.

While uncertainty is an inherent component of healthcare, research has shown that, "frustration, anger, agitation and fear were the unfavourable feelings that accompanied the experience of uncertainty in nursing practice" (Vaismoradi et al., 2011, p. 997). This is relevant

as every participant in the study indicated that they felt they had incomplete and imperfect knowledge of at least some of the changes to the MHA. The most commonly cited areas of uncertainty were related to the process of enforcing treatment under a Certificate of Incompetence, expanded duties under the MHA, and providing NOCs. Given the study's discovery that all participants expressed a sense of incomplete and imperfect understanding of the changes to the MHA, it becomes imperative to proactively acknowledge and mitigate the emotional impact stemming from uncertainty. Anticipating and addressing these emotional repercussions is crucial for enhancing nursing practice and ultimately improving patient care.

Participants frequently referenced seeking support and assistance from colleagues, actively participating in collaborative efforts, and emphasizing the importance of teamwork within their nursing practice. The significance of participants learning from their colleagues and the emphasis on teamwork were evident as essential learning methods in their daily professional routines. Collaboration is a fundamental competency for registered nurse practice (CRNA, 2019). A collaborative practice milieu enables healthcare professionals to leverage their unique strengths, knowledge, and skills while mitigating each other's weaknesses. Existing literature reinforces the significance of teamwork, learning from colleagues, and collaborative practices in nursing (Cleary et al., 2011; Jantzen, 2019; Samko et al., 2020; Wagner et al., 2015). As relational practices, collaboration and ongoing learning need to be supported and fostered. Jantzen (2019) suggested that, “Healthcare leaders, across institutions, can support workplace learning by fostering, valuing and recognising mentor-guides” (p. 2573). In a collaborative learning and practice context, it may be helpful to leverage the strengths of certain nursing colleagues, especially those who readily embrace new initiatives and possess extensive experience. These nurses can play a supportive role for their peers. Working in this way

underscores the value of utilizing nurse colleagues as a means of mutual learning, contributing to the development of confidence.

Recommendations Arising from this Theme

a. Recognizing the importance of information pertaining to the MHA, it is recommended that its dissemination should follow a gradual implementation approach, aligning with established standards in nursing education.
b. The findings from this study support a more holistic strategy that combines interactive workshops with other teaching modalities that would further enhance the overall learning and teaching experience.
c. The study findings suggest that it would be helpful to leverage the strengths of specific nurse colleagues, especially those who are early adopters of new initiatives, as these nurses can effectively support others through teamwork and collaboration.

Theme 2: Institutional Practice

In this section, I discuss the research findings exploring the intricacies of institutional practices related to policies, laws, regulations, and a spectrum of formal and informal norms, that govern and guide the delivery of mental health care. In this discussion, I aim to provide a nuanced understanding of the multifaceted framework that shapes mental health care delivery.

Laws

The legal structures in place that establish and prescribe the formal legal criteria that must be satisfied. In Alberta, the MHA serves as the overarching legal framework governing mental health law, and nurses are obligated to operate within its prescribed parameters. Participants expressed a desire to uphold patient rights under the MHA, yet concurrently conveyed a sense of apprehension, fearing inadvertent violations. Many participants admitted feeling confused about

the recent changes to the MHA and struggled with translating these modifications into their professional practice.

Policy

Policies are guidelines or rules established by an organization to direct decision-making, often without strict legal obligations. Policies may align with laws, such as those outlined in the MHA. Participants voiced concerns regarding the insufficient number of policies available to guide their practice. Moreover, they noted perceived discrepancies and inconsistencies between the existing policies and the Mental Health Act. This discord created ambiguity, leaving participants without a clear framework for navigating their professional responsibilities.

Accepted and Informal Conventions

Accepted and informal conventions associated with the provision of care differ from laws and policies as they are unwritten practices that have developed over time. Accepted and informal conventions are the unspoken norms, traditions, and practices which are not explicitly set out in policy, procedure, or other documentation. These practices are not guided or dictated by legal requirements; instead, these conventions are a product of shared understanding, collective experiences, and historical practices that have become the current operational norms.

Some participants highlighted instances whereby relying on informal accepted practices led to misconceptions. They pointed out situations where practices were perpetuated simply because 'that's the way it had always been done' or how senior nurses had traditionally handled them. This underscores the crucial need to ensure that mentor nurses possess the most up-to-date information to avoid the risk of mentoring others with outdated or incorrect information. The results of this study revealed that many nurses rely on more experienced nurses for support and guidance when they are uncertain about a process. This was also supported in the literature that

found that while educators and scholars in nursing have highlighted the significance of mentorship, to tap into the wisdom of experienced nurses, there needs to be a shift in organizational culture (Cleary et al., 2011; Jantzen, 2019; Samko et al., 2020; Wagner et al., 2015). This transformation involves recognizing, valuing, and respecting the contributions of nurses (Jantzen, 2019).

In order for seasoned nurses to serve as effective mentors, it is crucial for organizations to allocate the necessary time and resources to facilitate impactful mentorship programs. A recent literature review examined the support needs of nurse mentors emphasized the importance for nurse managers and policymakers to promptly develop guidelines and policies that clearly define the roles of nurse mentors, and that institutions should play a crucial role by providing support and workshops to nurse mentors. Additionally, the study found that in order to motivate nurse mentors, it is essential for the mentoring role to be recognized through incentives, whether they are financial rewards or promotional opportunities (Khunou & Matlhaba, 2023). To ensure that nurse mentors are equipped to support other nurses with up-to-date information, several measures at the system level are necessary, in addition to leadership support. These measures should include accessible resources such as updated clinical guidelines, evidence-based practices, and educational materials, which should be easily accessible to nurse mentors. Additionally, continuous education, including regular training sessions, workshops, and continuing education programs, is essential to help nurse mentors stay updated on the latest advancements, best practices, and changes in healthcare policies and procedures. Other important aspects include mentorship training, technological integration, and collaborative networks, followed by opportunities for evaluation and feedback. Through the implementation of these

types of measures, healthcare systems can ensure that nurse mentors are well-equipped with the latest information and resources to support other nurses effectively.

Another crucial avenue for mentorship lies in leveraging Advanced Practice Nursing (APN), roles such as the CNS. Increasing the presence of APNs, especially CNSs, in critical settings such as inpatient mental health units is imperative for several reasons. APNs are recognized leaders within healthcare organizations and communities, equipped with the skills and expertise to drive positive change and innovation in patient care delivery. CNS practice includes "the management and care of complex and vulnerable populations, the education and support of interdisciplinary staff, and the facilitation of change and innovation within healthcare systems" (Staples, Ray, & Hannon, 2016, p. 4). According to the Canadian Nurses Association (CNA) Advanced Nursing Practice Pan-Canadian Framework (2019), the CNS should actively engage in mentorship, providing guidance, support, and expertise to nursing colleagues, other healthcare team members, and students, fostering their professional growth and development. This was further stressed in the CNA CNS Position Statement (2016) which emphasized that the CNS plays a pivotal role in exemplifying, mentoring, and providing support to nurses, contributing significantly to their professional development and growth. By augmenting the number of CNSs working on inpatient mental health units, healthcare facilities can harness their leadership and mentorship capabilities.

Advanced practice nurses, including CNSs, are committed to seeking new and effective ways to deliver care, ensuring that individuals with mental health conditions receive the highest quality of treatment. This dedication is further underscored by the expectation that the CNS "serve as a leader, consultant, mentor, and change agent among nurses and across systems" (Fulton, Lyon, & Goudreau, 2014, p. 21). CNSs serve as invaluable mentors, providing guidance

and support to other healthcare professionals in the unit, particularly during times of change, such as revisions to the Mental Health Act (MHA) that require increased support for staff to understand the changes, and to help them navigate the complexities of policy revisions, However, to fully realize the potential of CNSs in mental health care settings, enabling funding mechanisms must be established to support the dedicated implementation of these roles. By promoting the augmentation of CNSs into inpatient mental health units, healthcare organizations can advocate for the expansion of other advanced practice roles, further enhancing the interdisciplinary care team and ultimately improving patient outcomes.

Integrating Laws, Policies, and Informal Practices for Effective Care

Mental health nurses play a crucial role in providing optimal and lawful care for their patients, necessitating a profound understanding of legal frameworks. The most recent amendment to Alberta's MHA was prompted by a 2019 Court of Queen's Bench verdict in the JH v Alberta Health Services case. This legal ruling highlighted constitutional or procedural deficiencies in certain sections of the MHA 2010 (Government of Alberta, 2020; JH v Alberta Health Services, 2019). Booth and Forester (2017) provide a comprehensive exploration and analysis of the legal ramifications of the constitutional implications of psychiatric detention. "The involuntary detention provisions of the Alberta MHA are intended to protect individuals suffering from mental illness and the public from harm. Review boards and those in the mental healthcare profession are tasked with the responsibility of making decisions about whether individuals are capable of exercising their rights to liberty without this risk of harm" (p. 4).

It is crucial to acknowledge that nurses were implicated in this legal action, including that the "earliest indication that JH was given information about challenging his certification was in a record from January 2015, four months into his detention" (JH v Alberta Health Services, 2019,

p. 2). Initially, nursing staff failed to assist JH to complete his Form 12 Application for Review Panel Hearing and did not support him with the necessary steps required to enact his rights under the MHA, including failing to provide him with copies of his MHA certificates and providing him with assistance to retain Legal Aid counsel. As a registered nurse, it is concerning to me that legal consequences may result from not adequately fulfilling a role for which I have not received adequate training. Several participants reiterated this viewpoint, expressing unease about the potential outcome and characterizing it as“disturbing” and “concerning.”

It has been my experience that the intricate aspects of mental health law, particularly under the MHA, are not adequately addressed in nursing school curricula. Despite this gap, nurses are expected to navigate and interpret these legal complexities effectively.

In Alberta, the challenge of practicing without knowledge of how changes in the MHA affect practice are further exacerbated by the absence of clear policies within AHS. Thus, mental health nurses lack a comprehensive guide to fulfill their responsibilities to the institution and their accountabilities in law. While the MHA outlines the duties of *the board*, of the organization, it refrains from expressly specifying which healthcare discipline bears the responsibility for fulfilling these duties. This determination is left to the discretion of AHS. However, in the absence of a policy explicitly defining these duties, the current approach relies on accepted and informal conventions. This approach is inadequate for a role of such significance, underscoring the need for a well-defined and formalized framework. There is a clear need for a formalized policy that precisely outlines the responsibilities, ensuring a more structured and appropriate approach to this pivotal aspect of healthcare. Yet, in the absence of a formal policy clarifying these responsibilities, the current approach relies on accepted and informal conventions.

Recommendations Arising from this Theme

a. In light of the gravity of these responsibilities, there is a pressing need for AHS to establish explicit policies. This would provide mental health nurses with a structured framework, formalizing their duties and ensuring a consistent and legally compliant approach.
b. There is also a crucial need for educational initiatives that integrate mental health law into nursing school curricula in Alberta. This proactive educational strategy would ensure that nurses enter the workforce prepared to navigate the legal intricacies of mental health care, ultimately fostering a more proficient and legally informed healthcare system.
c. Healthcare leaders can enhance workplace learning by promoting mentorship among experienced nurses, as they play a crucial role in supporting the learning process of their fellow nurse colleagues. Training must be provided for these mentors to ensure they impart accurate practices and avoid the dissemination of incorrect information. Additionally, it is important to foster an environment where mentors are approachable and collaborative, so that mentees will participate in the initiatives.
d. Organizations should maximize the use of APN positions, including the CNS, acknowledging their critical role in embodying, mentoring, and providing support to nurses. This is especially crucial during periods of change, such as revisions to the MHA. In order to fully realize the potential of CNSs in mental health care settings, funding must be established to support the dedicated implementation of these roles.
e. Considering the participant data revealing some inaccuracies in the knowledge base of participants, it is recommended for healthcare institutions to evaluate current comprehension levels among their staff. This includes identifying any preconceived

notions or incorrect practices that may need correction before initiating the teaching of accurate information.

Theme 3: Relational Practice

Relational practice emphasizes the significance of social interactions and relationships in shaping knowledge and understanding within the healthcare domain. Relational practice underscores the collective nature of knowledge acquisition and the influential role of interpersonal dynamics in healthcare contexts. Relational practice is “an approach that gives priority to interpersonal relationships in both in relation to external (organisational contexts) and internal (how this is received by workers and service users) aspects. It is the foundation upon which effective interventions are made, and it forms the conditions for a healthy relational environment” (Lamph et al., 2023, p. 2) Healthcare is a complex, collaborative field where the quality of relationships between healthcare professionals, patients, and other stakeholders greatly influences the outcomes of care. The insights gained from knowing informants promotes collaborative learning and fosters a shared understanding among team members.

Knowing Informants

In the course of nursing practice, informants who possess valuable knowledge are additional sources of information that nurses may turn to, to enhance their understanding of a patient's health status, condition, or needs. In clinical practice, participants reported leveraging this information to guide their clinical decision-making processes. This study revealed that nurse participants identified educators, managers, nurse colleagues, physician colleagues, and unit clerks as key knowing informants.

Advocacy

Nurses assume the role of advocates, acting on behalf of their patients to ensure that their rights, preferences, and needs are not only acknowledged but also respected and met within the healthcare system. Patient advocacy "is a dynamic concept, beyond mere support, compassionate care, and empathy. The attributes of patient advocacy included safeguarding, apprising, valuing, mediating, and championing social justice in the provision of healthcare" (Abbasinia et al., 2020, p. 146). In this study, participants expressed a desire to embrace their role as advocates for patients. "Advocacy for vulnerable patients is a complex process that requires professional nurses, rules, and supportive managers" (Abbasinia et al., 2020,p. 148). Participants underscored the importance of understanding both the MHA and organizational record regulations to enhance their ability to advocate effectively and comprehensively for their patients.

Relationship to Medicine

Nursing practice is intricately linked with the practice of medicine. Although nursing practice is not directed by physicians, the decisions physician colleagues make can have a significant impact on nursing practice. Physicians do not supervise nurses, and while nurses receive and enact medical orders for patient care, it is essential to recognize that registered nurses are individually accountable for our own practice.

> Medicine and nursing have an interdependent relationship and are mutually dependent on one another … Although medicine and nursing have an interdependent relationship, they are also distinctive from one another … nursing demands independent thinking and a separate educational system, theoretical system, and so on. (Zhu et al., 2019, p. 54)

However, the choices and actions of physicians reverberate throughout the healthcare team, influencing the roles and responsibilities of nurses. Participants explained how the determination of physicians to certify a patient under the MHA, or to deem them incompetent to make treatment decisions under the MHA, significantly impacts the participants' next actions. Furthermore, participants explained that when they support a patient to appeal the physician decision, then as a result, the ordered treatment would be suspended pending the Review Panel outcome. This interconnectedness underscores the importance of effective communication, collaboration, and mutual understanding between nurses and physicians to optimize patient outcomes.

Collaborative Knowledge

This type of collaborative approach supports health team members in their coming to *know* how to practice. While participants acknowledged feeling supported by colleagues such as other nurses, physicians, and unit clerks, there was also a shared concern about the possibility of receiving inaccurate information. This highlights the delicate balance between the support network and the need for accurate and reliable communication within the healthcare team. Participants frequently sought guidance from their physician colleagues, occasionally encountering situations where they accepted information that, at times, proved to be incorrect. As well as nurses, physician colleagues may also not have fulsome knowledge of the MHA and may not fully understand the nursing responsibilities pertaining to the MHA.

In this study, participants identified unit clerks as a crucial source of knowledge and their "go-to" resource when navigating the complexities of the MHA. This is noteworthy because, despite the valuable role played by unit clerks in healthcare teams, they lack clinical training and formal licensure. Nearly every participant emphasized that, despite not being a health care

provider, the unit clerks had extensive knowledge of the MHA. However, literature, as articulated by Kennedy (2016), highlights the potential safety implications of relying on inadequately prepared staff in healthcare settings.

> Ill-prepared employees pose a significant threat to patient safety, even if those employees do not provide direct patient care. Despite this, many acute care institutions do not offer a formal orientation and ongoing education program to ward clerk staff, nor require formal post-education training for this administrative role. (p. 43)

This study shows that unit clerks have a pivotal role as valuable knowledge resources. Participants in this study accessed their expertise to support their practice. On a broader practice landscape there is, then, an opportunity to harness their expertise as knowing informants. This potential can be fully realized through the implementation of proper training, ensuring that the information they possess remains current and accurate. In my own professional experience, I have observed that the administrative skills possessed by unit clerks are beneficial and easily adaptable when addressing the demands of the MHA. However, the unique duties of unit clerks in inpatient mental health units necessitate additional training. As Kennedy (2016) asserts,

> The complexity of the ward clerk position warrants structured orientation and ongoing educational programs to ensure these employees successfully meet the responsibilities and role-based decision-making requirements of their job, in turn influencing the timeliness of patient care, productivity on the unit, and patient safety. (p. 47)

Empowering unit clerks to handle certain administrative tasks associated with the MHA could potentially enhance efficiency by allowing nurses to dedicate more time to direct patient care.

Training unit clerks for these responsibilities is a straightforward process, as there is typically only one unit clerk assigned per shift. As well, it is necessary to acknowledge, validate, and affirm the role that unit clerks play through formalizing communication procedures to include them in MHA-related practices and decision making.

I found it intriguing that nearly every participant in the study exhibited a more comprehensive understanding of the MHA through the lens of physicians rather than from a nursing perspective. That is to say, when asked about their knowledge of MHA updates, most participants emphasized details about criteria for certifying or decertifying individuals under the MHA. It was interesting to note that nurses, who do not possess the authority to certify patients or cancel MHA certifications, showed a pronounced focus on information changes primarily relevant to healthcare practitioners involved in the certification process. There appeared to be a significant emphasis on information less pertinent to nursing roles, detracting from the essential knowledge that is crucial for nurses to comprehend. While the provided information is valuable, the primary focus of education for nurses should have centered on its relevance to their roles and the effective execution of their responsibilities. Participants often mentioned the overwhelming volume of information they had to absorb. If the content had been more specifically tailored to their roles, it might have facilitated a better understanding of the changes, enabling nurses to execute their duties more effectively and align with the requirements of the MHA.

Recommendations Arising from this Theme

a. By acknowledging the collaborative nature of knowledge formation, healthcare institutions can create a more supportive environment for relational practices, fostering effective communication and shared learning experiences among staff members.

b. Recognizing the crucial role of unit clerks as valuable sources of knowledge, it is advisable to implement a dedicated training program on the MHA for unit clerks employed in mental health settings. This targeted training would aim to equip unit clerks with the necessary skills to provide effective MHA support to unit nurses.
c. Employers should prioritize nursing education on the MHA by focusing predominantly on their specific roles and responsibilities. While a foundational understanding of all changes is essential, the emphasis should be directed toward equipping nurses with in-depth knowledge and skills directly pertinent to their roles and duties.

CHAPTER 6: CONCLUSION

Summary of the Recommendations

The following is a summary of the recommendations that emerged from the research findings:

a. Recognizing the importance of information pertaining to the MHA, it is recommended that its dissemination should follow a gradual implementation approach, aligning with established standards in nursing education.

b. The findings from this study support a more holistic strategy that combines interactive workshops with other teaching modalities that would further enhance the overall learning and teaching experience.

c. Study findings suggest that it would be helpful to leverage the strengths of specific nurse colleagues, especially those who are early adopters of new initiatives, as these nurses can effectively support others through teamwork and collaboration.

d. In light of the gravity of these responsibilities, there is a pressing need for AHS to establish explicit policies. This would provide mental health nurses with a structured framework, formalizing their duties and ensuring a consistent and legally compliant approach.

e. There is a need for educational initiatives that integrate mental health law into nursing school curricula in Alberta. This proactive educational strategy would ensure that nurses enter the workforce prepared to navigate the legal intricacies of mental health care, ultimately fostering a more proficient and legally informed healthcare system.

f. Healthcare leaders can enhance workplace learning by promoting mentorship among experienced nurses, as they play a crucial role in supporting the learning process of their fellow nurse colleagues. It is necessary to provide training for these mentors to ensure they impart accurate practices and avoid the dissemination of incorrect information.

Additionally, it is important to foster an environment where mentors are approachable and collaborative, so that mentees will participate in the initiatives.

g. Organizations should maximize the use of APN positions, including the CNS, acknowledging their critical role in embodying, mentoring, and providing support to nurses. This is especially crucial during periods of change, such as revisions to the MHA. In order to fully realize the potential of CNSs in mental health care settings, funding must be established to support the dedicated implementation of these roles.

h. Considering participant data revealed some inaccuracies in the knowledge base of participants, it is recommended that healthcare institutions evaluate the current comprehension levels among their staff. This includes identifying any preconceived notions or incorrect practices that may need correction before initiating the teaching of accurate information.

i. By acknowledging the collaborative nature of knowledge formation, healthcare institutions can create a more supportive environment for relational practices, fostering effective communication and shared learning experiences among staff members.

j. Recognizing the crucial role of unit clerks as valuable sources of knowledge, it is advisable to implement a dedicated training program on the MHA for unit clerks employed in mental health settings. This targeted training would aim to equip unit clerks with the necessary skills to provide effective MHA support to unit nurses.

k. Employers should prioritize nursing education on the MHA by focusing predominantly on their specific roles and responsibilities. While a foundational understanding of all changes is essential, the emphasis should be directed toward equipping nurses with in-depth knowledge and skills directly pertinent to their roles and duties.

Understanding the significance of information regarding the nursing role in relation to the MHA, it is recommended that the implementation of information sharing should follow established standards in nursing education, incorporating a gradual approach. Furthermore, the findings advocate for a holistic learning strategy that combines interactive workshops with various teaching modalities, leveraging the strengths of experienced nurse colleagues. Healthcare leaders are encouraged to promote mentorship among experienced nurses, with a focus on providing accurate practices through mentor training. This collaborative approach enhances the overall learning experience and encourages teamwork and collaboration among nurses. Explicit policies by AHS to formalize duties, ensuring consistency and legal compliance are recommended. Beyond policies, proactive educational initiatives are recommended to integrate mental health law into nursing school curricula in Alberta, providing nurses with a solid foundation in navigating legal intricacies. Additionally, healthcare institutions are advised to assess the current understanding of their staff, correcting any preconceived notions or incorrect practices. Given the collaborative nature of knowledge formation, creating a supportive environment for relational practices is crucial. The role of unit clerks as knowledge sources necessitates a dedicated MHA training program, while employers should prioritize nursing education, focusing on roles and responsibilities. These comprehensive recommendations collectively aim to enhance mental health nursing practice, ensuring a proficient, legally informed healthcare system.

To better navigate future interactions or changes to the Mental Health Act (MHA), it is suggested that AHS adopts a proactive strategy, allowing ample time for thorough planning and a strategic implementation of any modifications. This approach ensures that staff members are

adequately prepared to practice competently, adhere to legal requirements, and effectively advocate for their patients, and would contribute to alleviating some of the feelings of uncertainty among nurses.

Reflections in the Process

As a mental health nurse, my longstanding suspicions regarding the presence of significant uncertainty and occasional moral distress in navigating complex MHA decisions surrounding patient care were not only affirmed but also emphasized through this research. There is an urgent need for enhanced training for nurses, specifically in upholding the rights of patients admitted to inpatient mental health units. My decision to delve into this research stemmed from the abrupt changes to the MHA, particularly the Mental Health Amendment Act, 2020, which left me feeling unprepared to fulfill my role effectively. This experience became the catalyst for my research question: How do AHS nurses make sense of their role in relation to the recent changes to the MHA of Alberta - the Mental Health Amendment Act, 2020. While some of my initial hypotheses were confirmed, numerous unexpected findings emerged, significantly influencing my recommendations for practice, education, and future research. Notably, amidst the additional workload required to fulfill these responsibilities, participants consistently reaffirmed their commitment to prioritizing the well-being and rights of our patients, offering a positive and encouraging insight into the challenges they face.

A key takeaway for me has been the affirmation that nursing is not merely a supportive role for physicians but a distinct and invaluable profession within the healthcare team. This realization emphasizes our responsibility to advocate for our patients independently. Throughout this process, I confronted the challenge of humbly acknowledging that, despite our sincerest intentions as nurses to act in the best interests of our patients, we may not always

possess the necessary tools and knowledge. This acknowledgment highlights the ongoing need for continuous education and training in our profession.

Through the course of this research, I came to a realization that had previously eluded me, which is that the driving force behind amendments to the MHA often stem from societal influences and prevailing social attitudes. Despite recent updates in 2020, it became evident that there is an ongoing need for substantial changes to better serve our patients.

Strengths and Limitations

This study was a small-scale qualitative thematic analysis, contributing data on a shift in MHA legislation which impacts the nursing delivery of care. However, I found that there was limited existing literature available for comparison. The study was conducted during the COVID-19 pandemic, a period marked by nurses working extended hours and frequently facing mandatory overtime. As such, the study faced potential obstacles in recruiting participants due to the strain on their time and availability. Moreover, the dynamic nature of information related to COVID-19 protocols likely diverted attention and resources away from the rollout of the changes to the MHA. This diversion may have affected the study results as the continuous influx of pandemic-related updates might have taken precedence over information about the changes to the MHA in the nurses' priorities. Additionally, the timing of the MHA changes coincided with the suspension of in-person education, a consequence of pandemic-related restrictions. This suspension could have adversely affected the dissemination of information and education pertaining to the alterations in the MHA, potentially hindering the overall awareness and understanding among the nursing community.

Another notable limitation of this study was the lack of diversity in the participant sample, with all participants being female and the majority, 10 out of 12, being white.

Future Considerations

The existing flaws in the system, even after the recent revisions, prompt me to question the prudence of excluding nurses from actively identifying weaknesses in the current MHA. As a future consideration, it is necessary that nurses to play a more integral role in this process to ensure a comprehensive and nuanced perspective on the improvements needed in mental health legislation.

Future research in this area may involve a comprehensive exploration of the positive and unintended negative effects resulting from the changes in the MHA and could extend to assessing the extent to which these changes fulfilled their intended objectives. Additionally, there is potential for longitudinal assessments of nurses to gain insights into their experiences over time. Furthermore, the investigation may delve into effective knowledge management strategies tailored specifically for nurses in light of the MHA changes.

Acknowledging the critical importance of prioritizing diversity in future research endeavors, particularly concerning race, ethnic identity, and gender identity, it's crucial to actively pursue a more inclusive participant sample. This involves proactively seeking individuals from diverse racial and ethnic backgrounds to ensure comprehensive representation across various demographic groups. Additionally, efforts should be made to include individuals with diverse gender identities, to capture a comprehensive understanding of experiences and perspectives. Implementing inclusive recruitment strategies and creating a welcoming and safe environment for participation can help facilitate the inclusion of a broader range of participants in future studies.

Conclusion

In conclusion, this research sheds light on a significant paradox: although participating nurses genuinely aspire to act in the best interests of their patients, they encounter challenges in comprehending and navigating their roles, especially when confronted with abrupt changes in practice related to the MHA. Recognizing the integral role of nurses in ensuring the well-being of patients, it is essential that we strive to be strong and confident advocates for patient rights. The pivotal factor in empowering these participants to enhance patient support and effectively fulfill their advocacy roles lies in improving access to information so that AHS nurses can better make sense of and fulfill their roles. Concluding this study, I take pride in knowing that my research essentially serves as an advocacy platform for patients who find themselves in vulnerable situations during the course of their illness.

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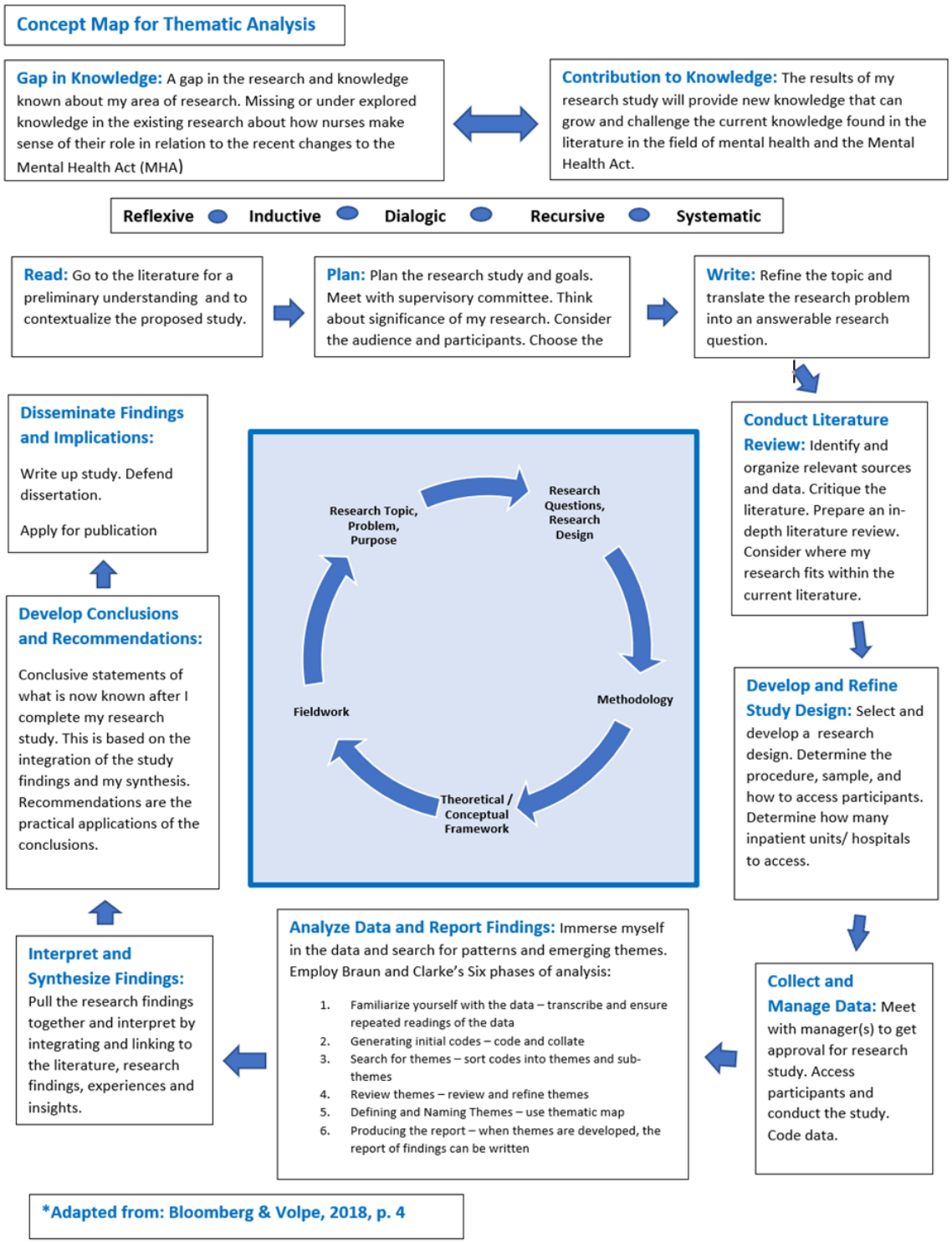
APPENDICES

APPENDIX A: Concept Map



APPENDIX B: Consent Form

UNIVERSITY OF CALGARY
CONSENT TO PARTICIPATE IN RESEARCH

TITLE: Exploring how Alberta Health Services Nurses are Making Sense of their Role in Relation to the Recent Changes to the Mental Health Act of Alberta

SPONSOR: University of Calgary

INVESTIGATORS: Principal Investigator (PI)- Jacqueline Smith 403 681-1298
Co-Investigator Dr. Andrew Estefan
Co- Investigator Dr. Gina Dimitropoulos
Co-Investigator: Wafa Mustapha 403 617-7324

INTRODUCTION

Dr. Jacqueline Smith, and associates from the Faculty of Nursing, at the University of Calgary are conducting a research study.

This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form for your records.

You were identified as a possible participant in this study because you are a registered nurse or registered psychiatric nurse with at least two years experience working on an inpatient mental health unit at one of the four hospitals Calgary. Your participation in this research study is voluntary.

WHY IS THIS STUDY BEING DONE?

The most recent changes to the Mental Health Act (MHA) of Alberta, include new duties required of the hospital and health care providers. These changes have an impact on mental health nurses in Alberta who play an important role in the delivery of mental health care. It is important that nurses understand their legal and ethical responsibilities.

This study is being done to gain insight into how nurses are making sense of their role since the changes to the MHA. The purpose of this research study is to identify gaps in

the way nurses understand their responsibilities under the MHA, to improve the care nurses can provide to their patients admitted to inpatient mental health units.

HOW MANY PEOPLE WILL TAKE PART IN THIS STUDY?

About 10- 15 nurses will take part in this study in Calgary. Up to 10-15 nurses who work on a mental health unit at one of the four hospital sites in Calgary will be enrolled in the study.

WHAT WILL HAPPEN IF I TAKE PART IN THIS STUDY?

You will be asked open ended questions about your role as nurse working on an inpatient mental health unit and your understanding of your role.

This interview will be done in person or by Zoom, an online secure video meeting platform. The interview will be audio-recorded and will last about 45-60 minutes. The interview will take place outside of scheduled work hours.

ARE THERE ANY POTENTIAL RISKS OR DISCOMFORTS THAT I CAN EXPECT FROM THIS STUDY?

There are very few risks associated with this study. The interview may trigger emotions or feelings about your nursing practice or experience with the new MHA. You will have the option to pass on any questions during the interview. If you become upset, we will support your immediate distress and suggest a referral.

ARE THERE ANY POTENTIAL BENEFITS IF I PARTICIPATE?

If you agree to participate in this study, there may or may not be a direct benefit to you.

The information you provide for this study may be used in the future to help inform nursing practice. The research might contribute to changes in policy and protocol.

CAN I STOP BEING IN THE STUDY?

Taking part in this study is voluntary. You may choose whether or not to take part. If you choose to participate, you may withdraw at any time by stopping the interview.
You may choose to withdraw from the study at any time before the data starts being analyzed and for up to 3 days after the interview session. If you decide to withdraw from the study, all information collected from and about you will be destroyed.

WILL I BE PAID FOR PARTICIPATING, OR DO I HAVE TO PAY FOR ANYTHING?

You will receive a $15 gift card after completing the interview.

WILL INFORMATION ABOUT ME AND MY PARTICIPATION BE KEPT CONFIDENTIAL?

The data you provide will be given a study identifier and will be entered into a master list. The master list will be stored for 5 years on the researcher's password protected personal computer. Consent forms, digital audio-recordings and transcripts will be stored in a locked filing cabinet in the research office. All study data will be destroyed and/or shredded after 5 years.

Interviews will be audio recorded. Participants will have the opportunity to choose in person or Zoom interviews. Zoom interviews will require a password to join the meeting. In person interviews will be audio recorded on a digital voice recorder. Zoom Interviews will be recorded according UCalgary Guidelines, by turning off Cloud recording and enabling local recording and then saved to an encrypted and password protected file and stored on a secure AHS server.

Any future use of this research data must be reviewed by a Research Ethics Board.

The researchers will do their best to make sure that your private information is kept confidential. Information about you will be handled as confidentially as possible, but there is always the potential for an unintended breach of privacy. The research team will handle data according the Data Management Plan. There will be no identifiable information about you kept with the research data.

The data will be analyzed for similarities and differences and presented as themes and patterns in the research findings. Some participant quotes will be presented in the research findings, however any quotes that might allow for identification of any of the participants will not be used.

WHOM MAY I CONTACT IF I HAVE QUESTIONS ABOUT THIS STUDY?

The Research Team:

You may contact Dr. Jacqueline Smith 403 681-1298 Jacqueline.smith1@ucalgary.ca with any questions or concerns about the research or your participation in this study.

Conjoint Health Research Ethics Board (CHREB):

If you have any questions concerning your rights as a possible participant in this research, please contact the Chair, Conjoint Health Research Ethics Board, University of Calgary at 403-220-7990.

WHAT ARE MY RIGHTS IF I TAKE PART IN THIS STUDY?

Taking part in this study is your choice. You can choose whether you want to participate. Whatever decision you make, there will be no penalty to you.

- You have a right to have all your questions answered before deciding whether to take part.

HOW DO I INDICATE MY AGREEMENT TO PARTICIPATE?

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to take part in the study. In no way does this waive your legal rights nor release the investigators or involved institutions from their legal and professional responsibilities.

SIGNATURE OF STUDY PARTICIPANT

_____
Name of Participant

_____ _____
Signature of Participant Date

SIGNATURE OF PERSON OBTAINING CONSENT

_____ _____
Name of Person Obtaining Consent Contact Number

_____ _____
Signature of Person Obtaining Consent Date

SIGNATURE OF THE WITNESS

_____
Name of Witness

_____ _____
Signature of Witness Date

A signed copy of this consent form has been given to you to keep for your records and reference.

APPENDIX C: Semi-structured Interview Questions

General Demographic Data

1. How many years have you been a registered nurse?
2. How long have you worked in the area of Mental Health and Addictions?
3. Which site is your primary place of employment?

MHA Education

1. Have you heard about the recent changes to the MHA? If so, when did you first hear about the changes?
2. In relation to work, can you tell me a little bit about how your first learned about the changes to the MHA?
3. Where did the information about the changes come from and how were the changes communicated?
4. Is there any ongoing education or resources that you can access?
5. Do you recall what you were told about why there were changes to the MHA and which changes were most highlighted?
6. Do you feel you have had enough educational opportunities to learn about the changes?

Mental Health Act in Practice

1. How is it working for you and what have you noticed is different now?
2. Do you think about any particular aspect of practice differently than you did before?
3. Have you noticed a difference in the way you interact with patients since the changes?
4. Do you think your advocacy role has changed or will change as a result of the changes?
5. What is your understanding of your nursing obligations under the Mental Health Act of Alberta?
6. How confident are you in your ability to fulfill your role?

APPENDIX D: Phases of Analysis

Phase One: Familiarizing Yourself with your Data.

In this phase, the data has already been collected, and the researcher must repeatedly read and immerse themself in the data. This includes transcribing the data.

Phase Two: Generating Initial Codes.

Once the reader is fully immersed in the data, initial ideas and coding can be pulled from the data.

Phase Three: Searching for Themes.

Once all initial coding is complete, the researcher can start to identify overarching and subthemes. Thematic maps can be developed.

Phase Four: Reviewing Themes.

This phase involves two levels of reviewing and refining themes. This is an iterative process. Braun and Clarke advise that once refinements in the process are no longer adding anything substantial to the coding, then the researcher should move to the next phase.

Phase Five: Defining and Naming Themes.

Once a well refined thematic map has been developed, the researcher writes an analysis for each theme. By the end of this phase, the researcher should be able to define each theme clearly and concisely.

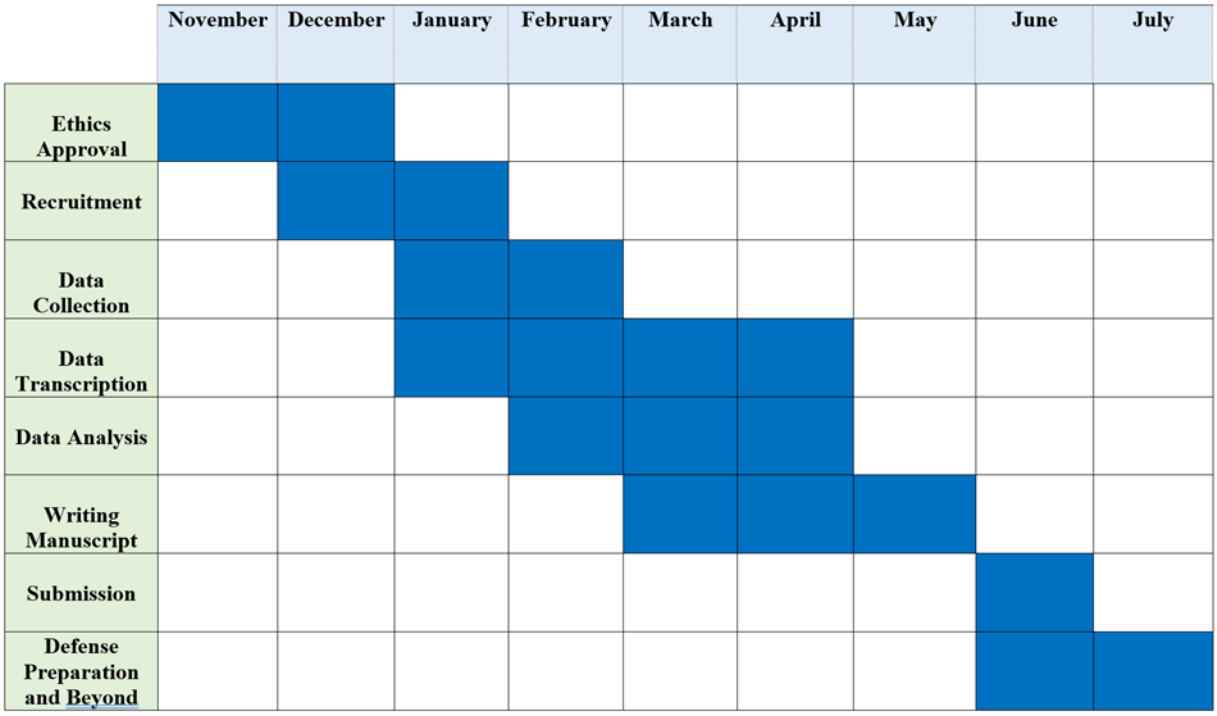
Phase Six: Producing the Report.

This is the final analysis, and the actual write up to produce the report.

APPENDIX E: Study Timeline

2022-2023

Study Timeline



APPENDIX F: Budget

Budget	Amount
Voice Recorder	**$100**
Office Supplies • **Paper** • **Printer ink** • **Pens** • **USB Flash drive**	**$250**
Printing	**$50**
Participant Gift Card • **$15 x 10-15 participants**	**$225**
Total	**$625.00**

APPENDIX G: Letter of Support

Alberta Health Services

Healthy Albertans.
Healthy Communities.
Together.

September 28, 2021

Wafa Mustapha
Clinical Nurse Specialist
Medical Psychiatry
Unit 43 Peter Lougheed Centre

Dear Wafa

I have reached out to each of the Addiction & Mental Health Directors in Calgary Zone and they confirm their support of your research study.

Based on this, I am pleased to write this letter of support for the proposed research study "Exploring how Alberta Health Services Nurses are Making Sense of their Role in Relation to the Recent Changes to the Mental Health Act of Alberta". The research study findings will provide insights into practice that will help guide practice and education needs for the future.

I endorse the ethics application for this research study.

Sincerely,

Janet Chafe
Executive Director
Addiction & Mental Health, Calgary Zone
Correctional Health Services, Provincial

Addiction & Mental Health Calgary Zone
10101 Southport Road SW
Calgary, AB T2W 3N2

APPENDIX H: Recruitment Poster

Participants Needed

A STUDY EXPLORING HOW NURSES ARE MAKING SENSE OF THEIR ROLE IN RELATION TO THE RECENT CHANGES TO THE MENTAL HEALTH ACT OF ALBERTA

ARE YOU AN RN/RPN WITH AT LEAST TWO YEARS OF INPATIENT MENTAL HEALTH EXPERIENCE?

PARTICPATION INVOLVES A 45-60 MINUTE INTERVIEW.

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*Participants will receive a $15 coffee gift card in appreciation of their time

If you are interested in participating or would like more information, please contact Wafa at 403 617-7324
wafa.mustapha1@ucalgary.ca

Ethics ID: REB21-1056
This study has been approved by the University of Calgary Conjoint Health Research Ethics Board.

UNIVERSITY OF CALGARY

APPENDIX I: Letter of Initial Contact

UNIVERSITY OF CALGARY

Hello [name of potential participant],

I am reaching out as you recently expressed interest in learning more about the research study **Exploring how Alberta Health Services Nurses are Making Sense of their Role in Relation to the Recent Changes to the Mental Health Act of Alberta.**

I am a graduate student in the Master of Nursing program at the University of Calgary and this research is part of my degree requirements.

The purpose of this qualitative study is to explore how Alberta Health Services nurses are making sense of their role in relation to the recent changes to the Mental Health Act of Alberta. The way nurses make sense of their role contributes to the composition of ethically informed, safe, and effective care within the scope of professional practice and current legislation.

The data collected in this study may be used in the future to help inform nursing practice. The research might contribute to changes in policy and protocol. This research may provide insights that will contribute to recommendations for practice, education, and future research.

If you have any additional questions or are interested in participating in the **Exploring how Alberta Health Services Nurses are Making Sense of their Role in Relation to the Recent Changes to the Mental Health Act of Alberta** study, please email me at wafa.mustapha1@ucalgary.ca or by phone at **403 617-7324.**

This study has been approved by the University of Calgary Conjoint Health Research Ethics Board (REB21-1056).

I have attached a consent form for you to complete if you are interested in participating in this study.

Thank you for your interest in this study.

Kind regards,

Wafa Mustapha

APPENDIX J: Study Sample Demographic Profile of 12 Participants

Number of Participants by Site

Acute Care Centre	Number of Participants
Foothills Medical Centre (FMC)	2
Peter Lougheed Centre (PLC)	4
Rockyview General Hospital (RGH)	3
South Health Campus (SHC)	3

Years as a Nurse

Number of Years as a Nurse	Number of Participants
2 - 4.5 years	3
5 - 7.5 years	1
8 -13.5 years	6
14 or more years	2

Years Employed as a Nurse in the Area Mental Health (MH)

Number of Years Employed in MH	Number of Participants
2 - 4.5 years	3
5 - 7.5 years	2
8 - 13.5 years	5
14 or more years	2

Race and Ethnic Identity	Number of Participants
African Canadian	1
South Asian	1
White	10

Gender Identity	Number of Participants
Female	12
Male	0
Other	0

Participant	Age
Youngest	26
Oldest	54