Mental Health Nurses’ Experiences of Caring for Patients with Concurrent Disorders in Acute Inpatient Psychiatric Care Settings in Metro Vancouver, British Columbia

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Abstract

Individuals with concurrent mental health and substance use disorders are frequently admitted to acute urban inpatient psychiatric care settings. Yet, there are gaps in the literature investigating the experiences of point of care mental health nurses caring for this population in these settings. This study seeks to answer the question: “what are the experiences of point of care mental health nurses caring for those with concurrent disorders in acute urban inpatient psychiatric care settings?” Eight participants were recruited for this study from within Metro Vancouver of British Columbia using purposive snowball sampling. Descriptive phenomenology was used to increase the understanding of the shared features of the experiences of these participants. Semi-structured interviews were conducted, and the data were analyzed using Colaizzi’s (1978) seven procedural steps. From the analysis five major themes emerged: providing care is challenging, patient engagement, support and teamwork, transition from novice to expert, and emotional responses from nurses. The implications of these findings highlight the need for educational curricula and healthcare organizations to better prepare and improve support for our future and current mental health nurses caring for this population.

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Chapter 1: Introduction

Substance use disorders are common amongst those who also have mental health disorders. In a pan-Canadian study, Rush et al. (2008) found that 1.7% of Canadian residents or 435, 000 individuals in one-year experienced co-occurring mood or anxiety disorders and substance use issues. These findings did not include several mental health diagnoses that are commonly associated with experiencing co-occurring substance use issues including post-traumatic disorder, personality disorders, and schizophrenia spectrum disorders which suggests the prevalence is considerably higher (Rush et al., 2008). Other studies have found almost half of those with a schizophrenia spectrum disorder also have a co-occurring substance use disorder (Kessler et al., 1996; Reiger et al., 1990). This pattern of comorbidity is often referred to as co-occurring disorders, dual disorders, dual diagnosis, and concurrent disorders. In Canada, the term concurrent disorder (CD) is used to refer to this population, whereas the term dual diagnosis refers to individuals with co-occurring intellectual disabilities and mental health issues (Skinner et al., 2010).

Individuals with CDs are known to have complex and challenging care needs as well as poor care outcomes (Canadian Institute for Health Information [CIHI], 2013; Compton et al., 2003). Researchers from CIHI (2013) determined between 2010 and 2011, 35% of those hospitalized in Canada for mental health concerns also had a co-occurring substance use issue and more recently, researchers from CIHI (2019) reported that 43% of individuals hospitalized related to substance use also received care for mental health concerns while in hospital. In both of these documents from CIHI (2013; 2019), it was reported that these individuals were more likely to spend a greater total of time in hospital than those who only had one of these morbidities.

In acute care psychiatric inpatient settings, the point of care mental health nurses' (MHNs') duties often includes assessing for substance use issues, monitoring for signs and symptoms of withdrawal and intoxication, along with overall assessment of the effectiveness of prescribed treatments. Researchers have found that a history of substance use issues among those with schizophrenia is associated with an increased risk of violent behaviour (Camus et al., 2021; Costache & Cioara, 2016) and individuals with CDs admitted to inpatient psychiatric units are more likely to be verbally and physically aggressive (Camus et al., 2021; Howard & Holmshaw, 2010; Tripathi et al., 2014). Point of care MHNs are often responsible for managing these behaviours which subsequently puts them at greater risk for both psychological and physical injuries. Studies have identified that MHNs and mental health professionals (MHPs) are at a high risk of experiencing violence from patients (Edward et al., 2016; Privitera et al., 2005) and according to the British Columbia Nurses' Union (2019), violence towards nurses is on the rise and accounts for 31% of all injuries reported in British Columbia. Workplace violence, including verbal aggression, has been positively correlated to burnout and staff turnover amongst healthcare professionals (Chen et al., 2016).

A personal interest and experience with caring for this population pulled me towards seeking a greater understanding of the nurses' experiences caring for those with CDs. Shortly after becoming a registered psychiatric nurse in 2004, I started to work on the acute psychiatric inpatient units at a hospital in Vancouver, British Columbia. At the time, the use of methamphetamines among those who were being admitted was relatively new, but on the rise and it was having detrimental effects on our patients' health and putting strains on the healthcare system. More recently, I have witnessed the devastating effects opioid use has had on those experiencing CDs, including the loss of many patients we frequently provided care for due to opioid related overdoses.

Qualitative researchers believe that individuals understand phenomena in different ways (Streubert & Carpenter, 2011) and qualitative methods enable the researchers to gain a deep understanding of the emotions and thought processes of those involved (Broussard, 2006). The aim of this study was to investigate and describe MHNs' experiences of caring for patients with CDs in acute inpatient psychiatric care settings in Metro Vancouver, British Columbia. Descriptive phenomenology was used to answer the question: "what are the experiences of point of care mental health nurses caring for those with CDs in acute urban inpatient psychiatric care settings?" The following chapter will review the existing literature on this subject matter.

Chapter 2: Literature Review

The literature review started from a broad perspective of examining research on MHPs experiences working with those with CDs and then was narrowed to reviewing the literature on MHNs' experiences of caring for this population when admitted to inpatient psychiatric settings. The literature was retrieved from electronic databases using terms such as: concurrent, dual diagnosis, comorbidity, coexisting, co-occurring, healthcare professionals, nurses, experiences, attitudes, psychiatric inpatient, inpatient care, acute care, and hospitals. Studies reviewed were limited to those after the year 1999. Relevant literature was also identified and included by manually searching the references for subject-related studies. Numerous quantitative and qualitative studies that either directly or indirectly addressed the experiences of MHNs caring for this population were reviewed and in the process a number of common themes became evident. These themes included: attitudes and perceptions, training /education and knowledge, lack of support, barriers, therapeutic relationships, and affective responses.

Attitudes and Perceptions of Healthcare Professionals

There is a plethora of literature reporting healthcare professionals have negative attitudes and perceptions towards those who use substances (Gilchrist et al., 2011; van Boekel et al., 2013). The majority of studies investigating the attitudes and perceptions of MHNs and other MHPs caring for those with CDs, have had similar findings. Danda's (2012) review of the literature found attitudes towards those with CDs was predominantly negative. She also noted a lack of studies investigating this issue within Canada. Deans and Soar (2005), in a study describing the experiences of MHPs working with those with CDs in a rural Australian community setting, found the participants viewed this population negatively and this was attributed to the participants feeling inadequately prepared to care for this population. This relationship has been identified in other studies (Garrod et al., 2020; Howard & Holmshaw, 2010). In Ralley et al.'s (2009) study, involving 12 MHNs from a psychiatric inpatient setting in England, the participants made critical judgments towards their patients, such as patients with CDs had negative personality attributes, and the MHNs were more understanding of their patients' mental health issues rather than their substance use issues. Conversely, in another Australian study that surveyed 173 MHPs, it was found that in general the respondents viewed this population positively and were optimistic about patients' treatment (Pinikahana et al., 2002). The majority of the participants in this study were MHNs and had worked in mental health for greater than 10 years (Pinikahana et al., 2002).

Personal substance use and ones' level of education also appears to influence MHPs' attitudes towards this population. Richmond and Foster (2003) found a positive association between higher levels of education and less moralistic and more optimistic views towards those with CDs. In addition, these authors suggested MHPs personal use of addictive substances may decrease MHPs' perceived need for an intervention.

Training/Education and Knowledge of CDs

Researchers from several studies (Adams, 2008; Barry et al., 2002; Camuccio et al., 2012; Garrod et al., 2020; Mericle et al., 2007; Searby et al., 2017), including two qualitative studies on the experiences of community MHNs working with this population (Coombes & Wratten, 2007; Deans & Soar, 2005), have identified MHPs do not feel adequately trained or have the necessary education and/or knowledge for providing care to individuals with CDs. The participants in an Italian study (Camuccio et al., 2012) that investigated the thoughts and emotions of MHNs working with agitated patients in acute psychiatric settings, reported caring for patients with CDs evoked a significant amount of distress. This was attributed to the lack of training Italian MHNs receive in providing care to this population (Camuccio et al., 2012).

As cited earlier, it has been identified that training and education impacts MHPs' attitudes towards those with CDs, as well as their ability to provide care (Deans & Soar, 2005; Garrod et al., 2020; Howard & Holmshaw, 2010). A number of studies have demonstrated providing training and education on CDs care and substance use care to MHPs has a positive effect on MHPs' attitudes towards those with CDs. In a mixed methodology study involving MHPs from inpatient settings in England, the researchers found those who received more training in caring for this population had more positive attitudes towards them (Howard & Holmshaw, 2010). Researchers conducting a randomized control study in Scotland, involving MHNs, found providing education on CDs improved attitudes towards this population immediately after the intervention and six months later (Munro et al., 2007). Other quantitative studies have had similar findings (Cleary et al., 2009; Pinderup, 2017).

Lack of Support from Organizations and Supervisors

Researchers have identified MHPs either experience or perceive a lack of support from their organizations and from their supervisors when caring for those with CDs. Respondents in one quantitative study, including 230 MHNs and support workers working in forensic psychiatric inpatient settings in England, reported there was a lack of support and funding from their organizations in providing training for caring for those with CDs (Moore, 2013). Similarly, participants in a qualitative study by Carey et al. (2000), involving experienced MHPs working in an outpatient setting, reported that the leaders of their institutions and programs had not provided enough support, including providing adequate supervision and implementing a care model for this population that would optimize patient outcomes. In the mixed-methodology study by Howard and Holmshaw (2010), MHPs reported there was a lack of supervisors with expertise in substance use care, and their managers were difficult to access. Researchers of a qualitative study investigating community MHNs’ experiences caring for those with CDs found the participants felt they not only required greater support from their supervisors, but from some of their colleagues as well (Coombes & Wratten, 2007).

Barriers to Quality Care

MHNs and other MHPs have reported experiencing a number of barriers when caring for this population. In a study from the United States, Mericle et al. (2007) identified MHPs experienced the following barriers: system, environmental, client, and provider. System barriers included systematic access barriers, limited treatment options, and poor-quality treatment; environmental barriers included poverty and social isolation; client barriers included the lack of motivation and insight; and provider barriers included competing demands and the lack of training in substance use treatment (Mericle et al., 2007). Carey et al. (2000) and Sorsa et al. (2017) had similar findings. The latter study took place in Finland and over half the participants were MHNs and team managers. These participants reported CD clients were difficult to engage, were unreliable for attending appointments, and often disagreed with the treatment options (Sorsa et al., 2017). System barriers identified in this study included challenges accessing care, as it was difficult to access care on weekends, evenings and nights, and reportedly many clients dropped out of programs as these did not meet their care needs. Researchers from a recent Australian study found the lack of resources, unclear referral pathways, and inadequately trained staff were major barriers MHPs experienced when attempting to provide care for those individuals with CDs (Groenkjaer et al., 2017).

Therapeutic Relationships

A number of researchers have highlighted both the importance of and the challenges of developing therapeutic relationships with those with CDs. The participants in Carey et al.'s (2000) study emphasized the significance of this relationship, as well as their use of therapeutic skills to engage this population. This was also evident in Mericle et al.'s (2007) study along with some participants reporting concerns they would damage the relationship if they attempted to discuss substance use issues with their patients. Waddell and Skarsater (2007) also found in their study that investigated MHNs' experiences caring for individuals with co-occurring major depression and alcohol use issues, MHNs were hesitant to ask patients about their alcohol consumption as they were concerned, they may offend the patients and jeopardize the therapeutic relationship. In a Swedish study by Johansson and Wiklund (2016) that investigated the experiences of MHNs caring for this population in an inpatient psychiatric setting, participants described experiencing an 'internal struggle' as they strived to develop caring and trusting relationships while simultaneously attempting to maintain order and structure on the unit. Participants in another study (Howard & Holmshaw, 2010) reported difficulties with engaging patients therapeutically and over half reported experiencing violence and aggression which they contributed to substance use.

Affective Responses to CDs

In consideration of the studies reviewed, it is evident caring for those with CDs evokes a number of affective responses from MHNs and MHPs with frustration being the mostly commonly voiced. Participants in the Carey et al. (2000) study voiced frustration regarding the challenges of arranging care for both an individuals' mental health and substance use issues. Mericle et al. (2007) found the participants in their study experienced frustration, helplessness and hopelessness, related to barriers in the healthcare system, their perceived inability to improve the quality of life for their clients, and with the clients themselves. In Searby et al.’s (2017) investigation, the participants reported experiencing frustration due to the lack of client progress, and the feeling they should be doing more to help clients. Negative emotions, including frustration, resentment and powerlessness, were also evident amongst the participants in Deans and Soar’s (2005) study.

MHPs have reported experiencing frustration related to patients using illicit substances while admitted to hospital and bringing illicit substances onto the units for other patients (Howard & Holmshaw, 2010). Johansson and Wiklund-Gustin (2016) found MHNs experienced frustration as well as feeling ‘emotionally drained’ and disappointed. The perception that patients were demanding and ungrateful, along with patients relapsing, contributed to these feelings (Johansson & Wiklund-Gustin, 2016).

Summary

It is evident from reviewing the literature that there are many challenges MHNs and MHPs experience when providing care to those with CDs. The majority of studies included a number of healthcare disciplines and very few of these studies focused on the experiences of MHPs working in acute inpatient psychiatric settings in large urban centers. Furthermore, there were no Canadian studies investigating the experiences of MHPs or point of care MHNs caring for this population in any setting. In order to provide the necessary support for Canadian MHNs working with this population in acute urban settings, it is important to conduct further investigations to close these gaps.

Chapter 3: Research Design

A qualitative study was undertaken to address the research question “what are the experiences of point of care mental health nurses caring for those with CDs in acute urban inpatient psychiatric care settings?” In this chapter, the methodology and philosophical underpinnings, researcher’s role, participant selection, ethical considerations, data collection, data analysis, and rigour/trustworthiness of this study will be discussed.

Methodology and Philosophical Underpinnings

Phenomenology was founded in the early 20th century by Edmund Husserl and is referred to as both a philosophy and as a research method (Richards & Morse, 2007). As a research method, “the goal of phenomenology is to describe lived experiences” (Streubert & Carpenter, 2011, p. 74). As this researcher was interested in the lived experiences of MHNs, phenomenology was a well-suited methodology for investigating and describing these experiences.

There are two major approaches to phenomenological research; descriptive as described by Husserl and interpretive-hermeneutic created by Heidegger (Matua & Van Der Wal, 2015; Streubert & Carpenter, 2011). Descriptive phenomenology offers a pure description of people’s experiences, whereas interpretive phenomenology, as in the name suggests, offers an interpretation of individuals’ experiences (Matua & Van Der Wal, 2015). Research using the former provides insights into poorly understood aspects of human experiences (Matua & Van Der Wal, 2015) and these researchers have the view there are similarities in all common lived experiences that permit a ‘generalized conception’ of the phenomenon (Lopez & Willis, 2004). As it was this researcher’s intent to increase the understanding of the experiences of point of care MHNs caring for those with CDs in acute psychiatric inpatient urban settings and to describe their shared features, the descriptive phenomenological approach was the most appropriate methodology.

Crucial to descriptive phenomenology is assuming the *transcendental phenomenological attitude* (Giorgi, 2007). This is achieved through *phenomenological reduction*, and by performing the *epoché* or otherwise referred to as *bracketing* (Giorgi, 2007). Phenomenological reduction "begins with a suspension of all beliefs, assumptions, and biases about the phenomenon under investigation" which enables the researcher to isolate the pure phenomenon (Streubert & Carpenter, 2011, p. 76). Bracketing refers to the cognitive process of the researcher maintaining a neutral view towards the phenomenon throughout the investigation (Streubert & Carpenter, 2011). Also critical to this approach is *intuiting* (Streubert & Carpenter, 2011). This consists of the researcher becoming immersed in the phenomenon (Streubert & Carpenter, 2011), searching through the data to discover common themes or *essences*, and using imagination "to determine which aspects are essential to the appearance of the phenomenon, and which are contingent" (Giorgi, 2007, p. 64). Subsequently, once the essence of the phenomenon has been determined, an 'exhaustive' description of these is provided (Giorgi, 2007).

Researcher's Role

As part of the requirements for the Master of Psychiatric Nursing (MPN) Program at Brandon University, this study was conducted by this researcher along with the support and mentorship of Dr. Dean Care and an advisory committee. This researcher has been a registered psychiatric nurse in British Columbia since 2004. Along with being enrolled in the MPN Program at Brandon University, the researcher has a Diploma in Psychiatric Nursing, and a Bachelor of Science in Psychiatric Nursing. Areas of practice include point of care and supervisory positions in acute and community settings. Currently, the researcher is a psychiatric nursing instructor at Douglas College, Coquitlam, British Columbia. The researcher will adhere to the ethical principles as outlined in the Tri-Council Policy Statement of Ethical Conduct for Research Involving Humans (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences Humanities Research Council of Canada, 2018). See Appendix A to view this researcher's *Certificate of Completion* of the Tri-Council Policy Statement.

In this study, the researcher assumed the transcendental phenomenological attitude through phenomenological reduction and by bracketing (Giorgi, 2007). To facilitate this process, the researcher reflected upon and documented biases, assumptions, and beliefs that were shaped and influenced from his own nursing experiences. These experiences include caring for patients who have been physically and verbally aggressive towards the researcher and/or colleagues, caring for patients who have overdosed on substances while the researcher has been involved in their care, hearing of former patients who have had fatal accidental overdoses while living in the community, and challenges with arranging and coordinating community follow up for patients. Frequently during the interviews, participants described experiences similar to those of the researcher and the researcher intentionally refrained from providing comments and/or opinions. Throughout the research process the researcher engaged in reflexive journaling. As well, the researcher did not work on acute psychiatric inpatient units while collecting the data and during the early steps of the data analysis which helped maintain a neutral view.

Participants

In phenomenological research, participants who have rich information about the subject of interest should be chosen (Sousa, 2014). Therefore, purposive snowball sampling was used to recruit participants. Both nurses and psychiatric nurses registered with the British Columbia

College of Nursing Professionals (BCCNP) were recruited for this study. To be eligible for the study participants were required to have at least two or more fulltime years of experience providing direct nursing care to those with CDs on one of Metro Vancouver’s acute inpatient psychiatric units and currently employed in this role. Rationale for this criterion was the researcher wanted to ensure the participants had a considerable amount of experience caring for this population in a large urban center.

To facilitate recruiting participants, the BCCNP was asked to distribute electronic letters of invitation (see Appendix B) to potential participants who met the criteria along with details about the study. This process did not recruit a sufficient number of participants, therefore, the researcher sent letters of invitation to current and former colleagues who had experience working on acute inpatient psychiatric units in Metro Vancouver and asked each potential participant who responded to name two other colleagues who may also meet the eligibility criteria. Letters of invitation were then sent to these potential participants.

In total, eight individuals consented to participating in the study and were interviewed. The sample included five females and three males ranging in age from 30 to 57 years old, with a mean age of 39.4 years old. There were two registered nurses and six registered psychiatric nurses. Of these, half were diploma trained and the other half degree trained. All of the participants worked in Metro Vancouver of British Columbia and were well versed in providing care to patients in acute urban inpatient psychiatric care settings. Years of practicing ranged from four and a half years to 27 years, including five of the participants who had 10 or more years’ experience. All of the participants had spent the majority, if not all of their careers, working in urban inpatient psychiatric care settings.

Ethical Considerations

This study received approval from the Brandon University Research Ethics Committee (see Appendix C). Permission to access nurses through the BCCNP was sought and agreed to (see Appendix D). Throughout the study informed consent, process consent, confidentiality and anonymity were maintained, including a signed confidentiality agreement with the paid transcriptionist (see Appendix E). Informed consent (see Appendix F) was obtained prior to data collection. At the beginning of each interview, the researcher reiterated participation was voluntary, and confidentiality and anonymity would be maintained. The study posed minimal risk to participants and a list of resources was provided if unanticipated troublesome feelings/thoughts emerged from the interviews (see Appendix G for a full list of services).

In qualitative research, presenting a rich descriptive qualitative analysis runs the risk of breaching participants confidentiality and anonymity (Streubert & Carpenter, 2011) and care was taken to prevent this from occurring. Only this researcher was aware of the identity of the participants and pseudonyms was used to keep their identities confidential. The computer files and transcripts of the interviews were kept confidential and were only be accessed by the researcher, and the transcriptionist. The computer files and transcripts of the interviews were saved on a password encrypted flashdrive, and safely stored with the notes in a locked filing cabinet and password protected computer in the researcher’s office at home in North Vancouver, British Columbia. All data will be destroyed after five years from the point of collection.

Data Collection

Prior to being interviewed, a demographic questionnaire was completed (see Appendix H). Data was collected using open-ended interview questions along with clarifying questions (Streubert & Carpenter, 2011) in a semi-structured format. The interviews were between approximately 30-70 minutes in length. The researcher asked the participants to describe their experiences caring for individuals with CDs in acute urban inpatient psychiatric care settings, including questions that addressed the factors that influenced their ability to care for this population (see Appendix I). Seven of the eight interviews were conducted using either Zoom or Google Meet and the other was conducted in person. A digital recorder was used to record the interviews, and these were transcribed verbatim by a paid transcriptionist. As recommended by Streubert and Carpenter (2011), the researcher made handwritten field notes throughout each interview as these along with verbatim transcriptions provide the most comprehensive description. The researcher listened to the recordings immediately after each interview and reviewed each verbatim transcription to ensure accuracy. Data was collected until it reached data saturation. This became evident when no new themes started to emerge (Streubert & Carpenter, 2011).

Data Analysis

To analyze the data, the researcher followed Colaizzi's (1978) seven procedural steps (as cited in Morrow et al., 2015). The first step, *familiarization*, includes reading the verbatim transcript multiple times (Morrow et al., 2015) and listening to the recordings of each of the interviews. During this step, the researcher read each of the transcripts and listened to each of the audio recordings three times. The researcher then entered into Colaizzi's second step of *identifying significant statements* (Morrow et al., 2015). This involved reading and rereading words and passages, as well as listening and relistening to the audio recordings to identify intonations and inflictions in the participants' voices. Handwritten notes were made to assist with this process as well as using the highlighter and comment functions within Microsoft Word. As recommended by Sanders (2003) once the significant statements were identified each statement was cut and pasted into a new document to enable the researcher to reread these with a "a new sense of openness" (p. 295). There were 215 of these statements in total and these were reviewed by the researcher's thesis advisor. The researcher then assigned *formulated meanings* to these statements, following Colaizzi's third procedural step (Morrow et al., 2015). This involved seeking and integrating feedback from the thesis advisor. This resulted in 223 formulated meanings as there were significant statements assigned more than one formulated meaning. To aid the researcher in Colaizzi's fourth step of *clustering themes* (Morrow et al., 2015), again handwritten notes were made along with using the highlighter and comment functions within Microsoft Word. These were shared and discussed with the thesis advisor until the common themes and organization of these were agreed upon. Five central themes emerged from this process along with subthemes within each of these. In accordance with Colaizzi's fifth procedural step (Morrow et al., 2015), the researcher wrote an *exhaustive* narrative taking in account all of the themes identified along with all of the components of the described experiences. As well, feedback from the thesis advisor was ascertained and included. Following Colaizzi's sixth procedural step (Morrow et al., 2015), these findings were then condensed into the essential components that represented the structure of the phenomenon and these were reviewed by the thesis advisor. In Colaizzi's last procedural step (Morrow et al., 2015), the condensed data was sent to participants via email for verification and feedback.

Rigour/Trustworthiness

As previously described, being immersed in the data and the consistent use of bracketing contributed to ensuring the rigour and trustworthiness of this study (Streubert & Carpenter, 2011). The credibility of the findings was established through prolonged engagement with the subject matter, member checking, and the researcher peer debriefed with the thesis advisor throughout the study (Streubert & Carpenter, 2011). Member checking involved returning the condensed findings to the participants to verify these were representative of their experiences. Six of the eight participants responded confirming the findings were accurate. Confirmability was established by carefully recording an audit trail (Lincoln & Guba, 1985; Streubert & Carpenter, 2011).

Chapter 4: Emergent Themes

In this chapter, an exhaustive narrative account of the themes identified from the interviews with the eight participants will be presented. During the data analysis of the interview transcripts five central themes emerged. These were: providing care is challenging, patient engagement, support and teamwork, transition from novice to expert, and emotional responses from nurses. Subthemes were identified within each of these themes. The following subthemes emerged from providing care is challenging: diverse and complex care needs, risk of injury, substance use care is demanding, bearing the weight of responsibility, and barriers in providing care. Under patient engagement the subthemes of accessibility and developing rapport, patient-centered care, and empathy, understanding, and patience emerged. In relation to support and teamwork, the following subthemes were identified: supportive practices, working as a team, and value of specialized teamwork. Transition from novice to expert was divided into uncertainty in developing one's practice, and increased confidence and intuition. The last theme, emotional responses from nurses, included increasingly frustrated, impact of repeated admissions, optimism and pride, the enduring effects of stress, and coping strategies. See Table 1 for a summary of emergent themes and subthemes.

Table 1: *Summary of Emergent Themes and Subthemes*

Themes	**Subthemes**
1) Providing Care is Challenging	a) Diverse and Complex Care Needs b) Risk of Injury c) Substance Use Care is Demanding d) Bearing the Weight of Responsibility e) Barriers in Providing Care

2) Patient Engagement	a) Accessibility and Developing Rapport b) Patient-Centered Care c) Empathy, Understanding, and Patience
3) Support and Teamwork	a) Supportive Practices b) Working as a Team c) Value of Specialized Teamwork
4) Transition from Novice to Expert	a) Uncertainty in Developing One’s Practice b) Increased Confidence and Intuition
5) Emotional Responses from Nurses	a) Increasingly Frustrated b) Impact of Repeated Admissions c) Optimism and Pride d) The Enduring Effects of Stress e) Coping Strategies

Providing Care is Challenging

When the participants were asked to describe the population of those with CDs, all provided details suggesting there were a number of challenges they encountered while providing care, including ones related to patients’ presentation and disposition, the nurses’ relationships and interactions with the patients, the participants’ personal challenges with delivering care, and system related issues. The five following subthemes emerged to make meaning of the participants’ experiences: diverse and complex care needs, risk of injury, substance use care is demanding, bearing the weight of responsibility, and barriers in providing care.

Diverse and Complex Needs

Although the focus of the study was not directly exploring the care needs of the patients, all of the participants described caring for patients with complex and diverse care needs. This was attributed to a number of factors including the patients' mental health and substance use issues, medical comorbidities, and socioeconomic issues. Participant 8 described caring for those with CDs as "tricky" as usually the primary concern of admissions to hospital were to treat the patient's acute mental health illness and during the hospitalization it was difficult to treat the longstanding psychological effects of their substance use. One participant remarked on the challenges of caring for those with both mental health and substance issues. "The difficult part of the assessments are whether or not the substances first had a huge part in decompensating the patient or if the patient was already decompensating from a mental health standpoint and using at the same time" (Participant 2). This participant also described managing the complexity of those experiencing CDs as time consuming and difficult. Participant 5 corroborated this and identified there were times when a patient's substance use issues were so demanding it detracted from their other care needs.

Participants described it was common for individuals with CDs to have medical comorbidities which made providing care more complicated. Often these medical comorbidities were related to either their mental health issues or substance use issues. A participant provided the following description of the care needs of one patient he cared for:

> He … has a very bad addiction … He is also has a lot of medical issues, so it is not just a mixture of mental health but also a lot of medical issues like collapsed lung, he has like surgeries in his body, broken bones and these all came from the addiction part because he was high at one point and he fell and he broke a bunch of bones and he had collapsed

> lungs. He also has MRSA, he has VRE, but his main issue is he is a schizophrenic. He believes in a lot of delusions, he believes that he owns a chunk of property in the Vancouver area, six 60% of the Vancouver area he owns. (Participant 1)

Similarly, two participants reported caring for patients who required treatment for chronic infections and wounds related to their substance use. Participant 6 noted that those with CDs often have a history of a head injury which further complicated care.

Participants also described caring for patients with complex psychosocial issues. For instance, one participant described caring for the following patient: “He didn’t have housing. He had forensic involvement … he had been using opiates and crystal meth and also fentanyl opiates mixed in and I think just his system couldn’t hack it and he decompensated” (Participant 4). Another participant stated:

> So most of the patients that come through our doors, their socioeconomic status, most of them are homeless, or they live in SRO (single room occupancy), very little support out in the community, living off welfare, low education I guess, not many of them seem like they have graduated, tough family backgrounds and things like that. A lot of trauma.… (Participant 2)

Risk of Injury

All of the participants described having to manage behaviours that put nurses at risk of being injured while caring for those with CDs. Several participants described when patients were experiencing withdrawal and had cravings to use substances, nurses were at an increased risk of injury due to the agitation that often accompanied this. For instance, one participant stated:

> …watch for agitation, to catch it early because people who are withdrawing can go from zero to 60. If they have been crashing for 3 days and now finally, they have the energy to fight back they are going to fight hard. (Participant 5)

Another participant stated:

> … when people are withdrawing, they are not the most pleasant so the aggression and violence aspect, making sure that they are not in danger of hurting themselves or in danger of hurting us or other staff or patients on the unit … (Participant 2)

As well as experiencing agitation from cravings and withdrawal from substances, Participant 3 identified this population had a decreased frustration threshold, which predisposed patients to a greater likelihood of exhibiting "threatening or explosive" behaviours. Participant 8 also noted that the patients' lower frustration tolerance contributed to this. As well, this participant identified those with CDs were often "intrusive" with the staff and with other co-patients thus increasing the risk of injury not just to the nurses, but to themselves and other patients.

The findings suggest managing patients' valuables, passes, and privileges also put nurses at risk. Participant 8 reported when patients' passes were restricted it "creates a lot of agitation on the unit which in turn has us, you know, administering more prns, puts actually more patients and staff at risk". Similarly, Participant 7 described experiencing increased hostility as the result of restricting patients access to their cellular phones and having to wear hospital pajamas rather than their own clothing. This participant also reported when searching the belongings of those with CDs, nurses needed to be "much more careful" to avoid injury.

Substance Use Care is Demanding

Six of the eight participants directly addressed that substance use care was demanding. Most commonly identified were the demands associated with caring for patients experiencing withdrawal and cravings. Participant 8 noted at her work site there had been a shift to providing greater “hands on” care to those experiencing withdrawal and this was more demanding for nurses than providing care had been previously. Another participant described that nurses were so often consumed with attending to substance use issues, “… making sure people are getting their meds and their prns …” to manage their withdrawal and cravings, that it detracted from their other care needs (Participant 5). It was also identified there were times when patients were resistant to take the prescribed treatment for their opioid use disorder, as one of the medications, buprenorphine-naloxone could precipitate withdrawal. As well, one of the participants identified there are medications they administer to treat patients’ opioid withdrawal and cravings that can make them intoxicated and that it was not uncommon for this to occur. The following is an excerpt from a participant who experienced providing treatment for patients with an opioid use disorder. “…[A]t first it’s like you are keeping people comfortable so that they are not in pain and then sometimes it gets to the point where you are just keeping someone high their entire stay” (Participant 5).

The findings suggest in recent years nurses had to adapt to changing practices in the use of medications to treat opioid use disorders and they had to become proficient at administering ‘high-alert’ medications, including methadone, and hydromorphone. One participant described her experiences with this:

> … we see a lot of people on methadone maintenance. A lot of more Suboxone (buprenorphine-naloxone) inductions now so people with a history of opiate use … a lot

> of people are getting started on Suboxone … we still do have a lot of people on methadone, but Suboxone is kind of the way it seems that treatment is going now. (Participant 8)

Participant 3 and Participant 8 described a shift in practice of managing opioid use issues from using methadone and buprenorphine-naloxone to more recently using hydromorphone.

Without prompting, the majority of participants described the issues and challenges with caring for patients experiencing nicotine use withdrawal and cravings. Participants identified not being able to satisfactorily manage patients' nicotine use; withdrawal and cravings contributed to patients' irritability and intensified patients' discomfort of withdrawal from other substances. For instance, one participant stated:

> … he has an addiction and cigarettes are his only kind of form of comfort and then when we can't even offer that then it just makes for just specifically a horribly irritable person and it's just ... like we have lots of nicotine replacement that we constantly give out but for some people it just doesn't seem to quite be enough for them. (Participant 7)

Participant 6 provided a similar account and emphasized the value of being proactive with administering nicotine replacement therapies (NRTs) and providing education to patients about NRTs. Despite participants agreeing on the benefits of NRTs, it was identified by Participant 5 that some nurses were annoyed with patients when they asked for NRTs.

Bearing the Weight of Responsibility

During participants' interviews, it was evident nurses experienced a considerable amount of pressure and stress related to bearing the weight of responsibility associated with keeping the unit and the patients safe. One participant described experiencing pressure to have an agitated patient agree to taking oral medications:

> My job was really to try to get him on side with the prn medications … if it (his behaviour) reached the point where I felt that he was not using his own judgement and required security intervention instead of having the medications by mouth, get them by injection with security involvement to do that. (Participant 4)

In a similar situation, another participant described feeling relieved when an agitated patient she was caring for responded to "reassurance" rather than having to use more invasive interventions (Participant 3).

Managing patients' privileges and passes were described as challenging and the potential dire consequence of having to manage patients who had overdosed on the unit caused a significant amount of stress for participants. Two participants described nurses spending a considerable amount of time and effort attempting to mitigate this risk by assessing patients and searching belongings, but as several participants identified, overdoses do occur on the units. The weight of nurses' responsibility for keeping patients safe while providing care was illustrated in the following quote:

> I am worried about their safety, like that's my job is to keep people safe, so I mean, like for me, I am just mainly concerned about my people being safe. Like I want everybody to not overdose on my shift, so that is a huge concern. (Participant 6)

Another reported on the frequency of these: "It is kind of common. Sometimes it can be twice a month, three times a month" (Participant 7).

Barriers in Providing Care

The findings suggest there were a number of barriers nurses faced that made providing care challenging. Two of the participants reported there were insufficient resources nurses could connect patients with to support patients' recovery during their hospitalization and when in the community. For example, Participant 1 identified there was a lack of psychosocial programming (e.g., groups) offered by the inpatient psychiatric units he worked on and as well, there were not enough resources to support "rehabilitation" in the community. This participant also noted that not being required to be involved in group programming had decreased nurses' workload.

It was also suggested the amount of time nurses spent documenting and nurses' workload detracted from spending time with patients. One of the participants stated:

> I feel like sometimes there is just not enough time to do what I want to do, you know, provide certain care or sit down and have a long one to one with someone. There is just not enough time in the day because either our caseloads are too high or maybe we are short staffed. (Participant 8)

Although no other participants reported this, drawing on her previous experiences, one of the participants was adamant having patients with CDs on general inpatient psychiatric units complicated providing care for both populations:

> I think like having everybody mixed together isn't really helpful because if you've got like a 75-year-old lady and she is like, this is her first episode of depression and she is sitting in the corner acutely suicidal and then we have somebody coming in with like acute substance use who is like angry and being brought in under Section 21 by the police, like that's scary for her. So, I think, and then in that sort of dynamic, I think it becomes how do we contain this person with substance use right because we have this mix. So, I think it should be separate. (Participant 6)

Poor discharge planning was identified as a barrier for providing quality care and participants reported this contributed to patients being readmitted shortly after discharge.

Participant 2 identified patients were often discharged prematurely, and another participant suggested the coordination of care from the hospital to the community needed improvement.

> … there are resources it's just making those connections between the person and I think having them be approachable and having them be real and available when they are actually well, in hospital, and then then they have a vision of how their life is going to be when they leave. Or they just go home and then be like, we will call you because they are already at home. It's kind of too late. (Participant 6)

The state of the hospital's facilities and surrounding community impacted nurses' ability to provide care. Two participants described their hospitals' facilities and surrounding community in an unfavorable light and reported these had a negative impact on providing care. One of these participants stated:

> We have seen outside the hospital has changed so much too with the overdose prevention site so that, even though it's not at work, it's affecting all of us when we come in… It's contributing to difficulties maintaining empathy for the population. (Participant 3)

In contrast, two participants, whose inpatient psychiatric units had recently moved into new purpose-built facilities, highlighted the positive impact moving to new purpose-built facilities had on delivering care:

> … we got a new building. We moved from the dumpy old … building and that was like a game changer. It's just geared towards mental illness so it's just…there's no hooks that people can hang themselves on. It's just every room has natural light. It's just beautiful. And that we can close off the backend of the ward. There is a walking loop. It could just not be better. (Participant 7)

Participants also reported the patients could present barriers when delivering care. It was identified that often those with CDs lacked insight, were not forthcoming, and were not wanting treatment. For instance, one participant stated: "… often I find patients, if they are in the pre-contemplative phase, they are not always interested in being involved in their care…" (Participant 3). The same participant also identified the patients' objectives did not always align with the care team's goals.

Patient Engagement

Patient engagement emerged as a theme from the participants' descriptions of their approaches to patient care and experiences with developing therapeutic relationships. From this, three subthemes were identified: accessibility and developing rapport, patient-centered care, and empathy, understanding, and patience.

Accessibility and Developing Rapport

When describing caring for patients with CDs, the majority of the participants reported these individuals could be difficult to develop rapport with and were often not forthcoming. Participant 3 described having difficulties with conducting thorough mental status examinations with a patient who was experiencing "paranoia and hallucinations" and thus "was really guarded". Another participant described encountering similar issues when attempting to develop rapport with another patient who was also experiencing paranoia:

> [H]e was having paranoid and persecutory delusions, so he thought he was being monitored. He started to incorporate the staff in the hospital into his delusions as well, and so the fact that he was being hospitalized was part of his paranoid conspiracy. He was hard to get a rapport with. (Participant 5)

Participants described varying accounts of the patients' willingness to discuss their mental health and substance use issues. One participant expressed patients who are experiencing withdrawal:

> [A]re going to tell you how they are feeling … but they are not telling you that they are also sad or depressed or feeling suicidal. They are not saying those words out loud. They are not saying that they are hearing voices, that kind of thing. (Participant 5)

Participant 1 identified patients were sometimes unwilling to share their substance use history due to the "sense of guilt", but others were very open to discussing their use. It was also identified by Participant 3 patients who did not want help or recognized they needed help with their substance use were often difficult to engage.

Participant 1 described integrating mental health and substance use assessments and found patients became more forthcoming about their substance use issues as rapport increased. Other participants also described building rapport with patients as instrumental for making them more receptive to treatment. Strategies for developing this included consistency in approach and personnel, and perseverance. One of the participants provided the following anecdotal account:

> I worked with him over three days and the rapport increased incrementally, and he started listening more and believing why he needed the antibiotics. He was more accepting even though he was still paranoid about me he was at the same time accepting what I was trying to do. (Participant 4)

Similarly, another participant reported "having that consistency with the patient it builds trust and rapport with them which makes it easier for them to comply with treatment and medication …" (Participant 2). This participant also identified patients became easier to work with as their insight and judgment improved.

Patient-Centered Care

Participants described aspects of patient-centered care (i.e., nurses being responsive to and mindful of patient preferences when engaging with patients) when engaging with patients. For example, when managing agitated behaviours, one participant identified nurses often attempted to use the least restrictive interventions:

> If they are getting angry because they are being contained and don’t want to be there, we might give medications if it gets really bad. If they are threatening or you know, the environment is unsafe for their behaviour then we might need to seclude them and offer some reassurance, you know, the best that I can that this is temporary, we don’t want them to be there longer than they need to be either. We know that they are uncomfortable. We will do what we can to get you out of here as fast as we can. (Participant 3)

One participant described early on during the hospitalization, the care often focused on attending to patients’ basic care needs.

> [I]t’s literally just like making food for people and then picking up the food that they have dropped … giving them new food and making sure they are eating and hydrating” and it is not until later in the admission that the care shifts to focus on psychiatric and longer-term goals. (Participant 5)

Three participants identified patients’ behaviours made it difficult to maintain their objectivity and they needed to engage in self-awareness to provide patient-centered care. The following is an account of one of these participant’s struggle with this:

> I even fall into it where when they come on the unit I just like, ugh. I know the kind of stereotypical addict if you want to say it like that where it’s like, just so manipulative and so kind of intense and out for just getting what they want when they want it, and when

> you can see them as humans and as people and as like brothers or sisters or parents, then it just becomes, and not just seeing them for their addiction right? (Participant 7)

Similarly, Participant 5 described caring for verbally abusive patients and in order to remain patient-centered she needed to remind herself not to “take anything personally” as well as keeping cognizant of her “education” regarding substance use. One of the participants also described having difficulties adhering to his own values when providing care due to patient behaviours and voiced his philosophy towards care helping him remain patient-centered: “I believe every patient has inherent dignity and has a right to be treated as such and to receive care” (Participant 4).

Patient teaching was identified as an approach in which the participants provide patient-centered care. Participant 2 described providing education to patients at the time of discharge to optimize their health. Another participant described promoting and exploring alternative coping strategies and identified it is often the role of the nurse to be “explaining what the doctor tells them … because a lot of times the doctors speak in jargon and the patient doesn’t know what they are talking about” and “clarifying what the plan is” (Participant 6).

Providing patient-centered care was evident when Participants 1 and 3 described integrating harm reduction interventions into their practice. For instance, Participant 1 described educating patients on the use of Take-Home Naloxone kits was a “priority” and Participant 3 reported the practice of distributing these to patients has increased considerably in recent years.

Empathy, Understanding, and Patience

A number of participants described caring for patients with CDs requires being empathetic, understanding, and having patience. The findings suggest nurses are aware being in hospital is challenging for the patients and these patients often have a troubled history. For instance, one participant stated:

> With me I approach patient care with a lot of I would say compassion and understanding. I know that a lot of patients that are coming from the street, they have had it rough and most of the time they are very vulnerable, and they don't understand what their mental state is like at this time. So, I try and use the most gentle approach to care for these patients, a lot of reassurance, a lot of explanation, just try to I guess kind of put myself in their shoes. If I was in their shoes, how would I want to be treated? (Participant 2)

Another participant described being empathetic and understanding for the behaviours' patients exhibit while in hospital:

> [I]f they have trouble coping and then you take away their coping skill, which is substance abuse, and then you walk them onto a unit where they can't access their coping skill and then you tell them that they are stuck there and you tell them to take medications, I mean they are going to have trouble coping. (Participant 6)

Participants described being understanding and exercising patience with patients who are frustrated with their lack of autonomy and experiencing withdrawal. Participant 1 recognized it must be "emotionally draining" for patients to be "cooped up inside the hospital without any breaks to go outside" and Participant 7 identified patients experiencing withdrawal "are feeling horrible" which requires patience from nurses.

It was identified by Participant 6 that it could be difficult to be patient with patients due to their challenging and threatening behaviours. As well, another participant described similar challenges with remaining empathetic towards patients when "you are getting sworn at and ducking punches …" or when the patient “doesn’t care about their own wellbeing” (Participant 2).

Support and Teamwork

All of the participants identified the value of support and teamwork when caring for patients with CDs. Three subthemes encompassing this emerged from the data: supportive practices, working as a team, and value of specialized teamwork.

Supportive Practices

Five of the eight participants described documentation as a form of support when providing care to patients. Two participants specifically reported the Clinical Opioid Withdrawal Scale (COWS) form was beneficial in managing patients’ opioid withdrawal. Another participant put forth using electronic charting supports teamwork. At her work site, there were nursing interventions embedded within this.

> We don’t do any paper charting besides kind of the medication record, so we have got actually different interventions listed in our documentations. So if someone needs a care plan there is a care planning intervention, if someone needs de-escalation techniques, kind of risk assessment, there is a risk assessment intervention. There is a mental status intervention. So that can kind of help guide our practice with our documentation piece. (Participant 8)

Documenting patient care needs was also identified as supporting practice while caring for patients. It was remarked by Participant 5 when she observes a “patient isn’t being cared for well enough with the opiate withdrawal … documenting it” is essential “so then the team can see it and order more or adjust as needed”. As well, Participant 4 reported “written care plans and the ability to have that for other staff to see" supports communicating effectively within the healthcare team.

Working as a Team

The majority of the participants identified the importance of working as a team when providing care to patients with CDs. The value of this was described in respects to delivering direct care to patients. For example, one participant stated:

> … we really rely on each other and if we are uncomfortable about going into someone's room we always go in twos and when there is a new admission or someone who is specifically agitated, we all work together… you never feel alone or alone in kind of making the decision on what to do. (Participant 7)

Likewise, Participant 2 described when caring for a challenging patient often the point of care nurses developed a plan of care to optimize the care provided. However, Participant 4 acknowledged "some staff are easier to work with than others" and identified there are times nursing colleagues can be difficult to work with and may even attempt to "punish you".

Another participant identified teamwork is essential when managing larger system issues, such as working short-staffed: "…[W]hen we are having those hard times or we are short staffed, it's the people that you are working with. We all kind of band together, we work as a team …" (Participant 8).

The findings suggest working as a team includes those other than point of care nurses. A number of participants named working effectively with security personnel as crucial to providing care to patients when they are agitated. One participant expressed:

> We have security which is great so I have the tool of having other people around to help when a patient can't help themselves, so if someone is violent or angry or whatever

> against us or they are hurting themselves or whatever is happening we have security to help with that. (Participant 5)

Similarly, another participant stated:

> I need to feel like the environment is safe so that if I get into some difficulty with a patient that I have a team to become involved in the care to keep myself safe, keep the patient safe, keep the others safe. When we have a patient who's of course acting violently, we need to have security available to do that. (Participant 4)

Other members of the healthcare team and those in leadership roles were described as valued team members. Participant 4 emphasized the importance of interdisciplinary collaboration and of having "good leadership helping to connect the dots, help to keep good continuity of care". As well, Participant 2 also identified formal nursing leadership as a source of support for nurses when caring for patients.

Value of Specialized Teamwork

Half of the participants identified the value of having specialized services when providing care. Most commonly described were the advantages of the increased accessibility to specialized addiction services, and the support these services provide to the nurses when providing care to those with substance use issues. One of the participants provided the following description:

> The Addictions team coming in… at first you know, it was a Monday to Friday service and now it's 24/7 so they have become a lot more accessible, and they are very, very open to teaching us when we have any questions. So, they have been a great support to us. And the ways that they have offered treatment has changed over the years too. So you know, first we were seeing a lot of methadone, now we are seeing a lot more suboxone. We are noticing that they are really listening to patients more … (Participant 3)

Other participants also voiced similar views and their appreciation for this service. For instance:

> … nowadays … we have the tools now necessary for this withdrawal … And if for example you need more, you can call the doctor, you can call Addiction Medicine in the wee hours, like I said, 2 o'clock in the morning you can go and call them … get a prn order for something. (Participant 1)

Transition from Novice to Expert

The process of transitioning from novice to expert nurses when caring for those with CDs was a commonality expressed by most of the participants. The two subthemes of uncertainty in developing one's practice and increased confidence and intuition emerged as participants described their current and past experiences.

Uncertainty in Developing One's Practice

Participants in this study described experiencing uncertainty when performing new skills and/or when they were new to caring for this population. Participant 8 reported when buprenorphine/naloxone first started to be prescribed she "did not feel comfortable administering it because I just didn't feel like I had enough education …". This participant also voiced a similar experience when she first started regularly conducting opioid and alcohol withdrawal assessments. Likewise, despite being an experienced nurse, Participant 4 described experiencing some uncertainty when he first started caring for this population as a point of care nurse. He described learning to manage agitation and "knowing when to do seclusion" as "a lesson to learn".

Participants described factors assisting them with the transition along the continuum from novice to expert. Participant 4 expressed "[M]y skills have largely come about through mentorship" and Participant 5 reported observing colleagues helped shape her practice: "… there are certain people who recognize withdrawal better and then you are kind of watching what they are recognizing”.

Increased Confidence and Intuition

It was evident that as participants gained experience their confidence increased accordingly. As well participants described developing an intuitive grasp for clinical situations. One participant provided the following account:

> … working with these people every day you kind of get to know them quite well. You kind of, you are able to pick up on subtle cues of when they are starting to go into withdrawal and things like that so even with the help of these assessment tools, your own kind of clinical judgement kind of is a lot sharper when you have been working with this population ... (Participant 2)

Similarly, Participants 1 and 3 expressed confidence caring for patients and contributed their ability to do so to their experience:

> I think experience is my skill. I think the experience is what makes me feel better to take care of these patients. I have the knowledge as well, but the experience is much more the one that is telling you what to do. (Participant 1)

In response to the interview question: related to comfort level caring for this population Participant 3 stated:

> Very comfortable … Just experience over the years … I think just our population is very unique. The addictions we take care of are very severe and so we are thrown in and have to know how to manage in that population.

With increased experience, one of the participants described the transition from their practice being theory-based to shifting to rely more on their intuition:

> I think … you have your very much theory based when you come out of school and then you become very, obviously you are still using your theories, but you become very practical based and kind of follow your instincts so to speak. (Participant 8)

Participants who have developed an expertise in caring for this population described being able to see the ‘big picture’ when providing care. This was evident in the following description:

> I think, knowing the history of the patient. So their background and history of violence and things like that and how they work with nurses, doctors, police officers and things like that I think that is a huge indicator of how I approach patient care … for example a patient I just had yesterday who had been incarcerated for 9-1/2 years for manslaughter, I know I am going to go into that situation a lot more carefully than I am with someone who is depressed and is wanting to harm themselves right? (Participant 2)

Emotional Responses from Nurses

It was evident caring for this patient population evoked both negative and positive emotional responses. These responses were categorized under five subthemes: increasingly frustrated, impact of repeated admissions, optimism and pride, the enduring effects of stress, and coping strategies.

Increasingly Frustrated

Participants frequently described experiencing frustration while providing care to patients with CDs. Frustration was expressed in several different forms including irritation, distress, exasperation, and anger. This occurred when patients would not adhere to the treatment plan or follow unit and hospital policies. One participant described being incensed with the amount of time and resources required to monitor patients attempting to bring contraband onto the unit:

> I mean people were trying to bring drugs into the unit, which is a huge, huge, huge, I can't stress this enough, just drag on the resources of the nursing staff. Like having to spend so much time like, checking and searching and trying to get back drugs from people because they are so motivated to use, like on an in-patient setting it really is, it really impacts the care that other patients get which I think is also terrible. (Participant 6)

Similarly, Participant 3 described her frustration with a patient who also "was sneaking in drugs on the unit" as well as being frustrated with the patient's manipulative behaviour.

Participants described caring for this population can make you feel distressed and overwhelmed. For instance, a participant expressed:

> [E]xpect to feel like you are powerless, and you have been pushed to behave in a way that you don't want to be, and you are going to feel those negative emotions. You are going to judge yourself. You are going to feel like you had a shitty day and that nobody understands and realize that if that happens to you that it's happened to all of us. (Participant 4)

Another participant identified there had been times she could not provide quality care because she had become so incensed and exasperated with managing patients' behaviours:

> How I can go in and deal with it is sometimes you can't ... I got to the point where I was like oh shit. This is like countertransference. Like I was talking back to the patient and I was like nah. I'm done. And I just had to take one day off. I was like I can't do this anymore. It's too much. I have hit my limit. It's just, I gotta take a day away from this because I am not caring. I am not doing good care right now. (Participant 5)

Two participants described experiencing frustration regarding patients' treatment plans. One of these participants described being annoyed by a patient who presented as psychiatrically stable, and the care provided was predominantly for the patient's substance use issues:

> I have a patient right now who I was just working with her my last set and to me … her psychiatric illness isn't unstable. It's not something that needs an acute care hospital right now … I was like I am not even treating you psychiatrically. I am just keeping you high. Like I am going through bottles of hydromorphone with you and it's not doing anything, so I am like … and then I got to the point where I am like why are we treating you in an acute care hospital? … No psychiatric thing was coming out so that's ... (Participant 5)

Similarly, Participant 3 described nurses being frustrated and annoyed when their perception of the patient's care needs conflicted with the patient's view and treatment plan. In the example provided by this participant, she described the patient directed treatment plan resulted with the patient being "often over medicated, over sedated, nodding off throughout the day" due to the patient requesting and ingesting, in their view, an excess of opioid agonist medications.

Impact of Repeated Admissions

Six of the participants described emotions evoked related to providing care to patients who were frequently readmitted to hospital shortly after their discharge. Participants described being frustrated with patients who after discharge resumed using substances which lead to their psychiatric decompensation and subsequently being readmitted. This was described as occurring frequently. According to one participant:

> … your patient is going in and out, in and out of the hospital and you know that it is really frustrating if you just don't use that drug, if you don't use drug you aren't going to be coming back to the hospital like every time you are going to come in and out, in and

> out and usually it gets frustrated for me because you do a lot of things to this patient like when they are in your unit, once they get discharged after 3 days they come back and then they are like horrible again. (Participant 1)

Two participants identified there were times they experienced frustration with patients' discharge plans as they knew the patient had not been set up to succeed in the community. Participant 2 stated "I feel they (the patients) could spend a little more time in hospital and are being discharged a bit too early and most of the time that does happen …" and another participant expressed "we see a lot of the same people over and over who don't seem to be set up for success when we discharge them" (Participant 3). The latter participant also used the term "burnout" to describe how this affected her.

Another participant described experiencing frustration with the lack of community supports for patients and with larger societal issues when discussing the cycle of treatment, discharge, and readmission.

> I think just the aftercare after people are discharged, you know, really needs to meet their needs better. We are literally sending people to the street, so how are you going to expect any change there when, you know, we stabilized you, you are safe and now you are going to go back on the street and use again. (Participant 6)

In addition, this participant described feeling helpless at times knowing patients were being discharged into the community without the necessary supports in place.

Participants also described feeling disappointed and disheartened when patients were readmitted to hospital: "[W]e work really hard for them and once they leave those doors it's kind of out of your control and you get quite disappointed when they come back a day or 2 later kind of back at square one" (Participant 2). Similarly, Participant 8 expressed "I feel like I am not making much of a difference" as the patients keep getting readmitted "for the same reasons".

One participant described how the cycle of treatment, discharge, and readmission was emotionally draining for nurses: "Having seen so many patients with the same problem over and over and over is exhausting and sometimes it's hard to stay hopeful for them" (Participant 3). She also identified her perspective was "influenced" from seeing "the people who come back over and over" and not seeing those who are "doing well".

Optimism and Pride

Experiencing positive emotions while caring for this population was also described by the majority of participants. Participants identified that despite the challenges they experienced, they still remained optimistic. Participant 6 stated "I think it can be interesting and can be fulfilling work" and another participant highlighted the importance of this work and provided the following reflection:

> I am still committed to it. I still really do, I believe it is an important task we do and in some ways, you know it's irrelevant whether I, in the moment, really believe that…if I am really feeling positive vibe for someone or not I am still doing my job and I know that it works. It's going to tip the balance in some way. (Participant 4)

This participant also provided an example of remaining enthusiastic about providing patient care when one of his patients demonstrated insight and judgment into his care:

> He was actually coming up towards the end of the time I was with him and asking questions about that (the wound). That's really, actually in our line, those are breakthrough moments cause a lot of times they are not interested in that at all so it was a Wow!

A number of participants described being proud of the care they and their colleagues provided. Two participants voiced this when describing their roles in ensuring patients basic care needs were being met. For example, Participant 8 described taking pride in encouraging patients to attend to their activities of daily living and to participate in the unit’s community. Likewise, another participant described taking pride in providing individualized snacks for patients:

> [Y]ou get to know pretty quick what patient likes what things, and I know like, so one of the things that it’s doesn’t seem like much but like if you know the one patient likes you know, butter and jam and one likes this or whatever, and then like that little thing where you are making even a snack to cater what they like specifically versus just a generic thing, it’s like a small comfort that you are providing to them because there is not a lot of comforting that you can do... (Participant 5)

Participant 1 reflected on an interaction he had with one challenging patient who expressed his gratitude to him for the care he had received. The participant stated he had found this “really gratifying” and afterwards proudly shared this moment with his partner. He also identified that although he finds caring for this population “really hard and … really emotionally draining” it still could be satisfying.

The Enduring Effects of Stress

Five of the participants described experiencing emotional responses related to the enduring effects of stress from caring for patients with CDs in this setting. One participant identified caring for this population contributed to her becoming vigilant and hypersensitive when providing care:

> I am just so vigilant when it comes to checks at night and checking the respirations and just even naps during the day, and we have an hourly sheet where we check every patient

> every hour and I just, I do it much more than that. I am just very, very sensitive to that I would say. (Participant 7)

The same participant voiced “traumatic things” in “works situations” have made her “a little bit nervous” and “jumpier”. She also identified her experiences with caring for this population impacted her personal life: “… working in addictions. It makes you very vigilant. Even in my life I check my kids resps at night”.

Participants described coping with stressful situations by being emotionally detached and that the accumulation of these events have made them desensitized. This was evident with two participants who described their responses to being informed of the ever-growing number of former patients who had fatal overdoses in the community. Participant 3 stated nurses cope with this news as ‘it is what it is mentality’. Participant 1 reported that he had “grown numb” to hearing about these tragic events due to the high number of former patients he had heard of who had passed away.

The long-lasting effects of stress from caring for patients contributed to at least three of the participants developing more cynical perspectives. One participant expressed:

> I have become a bit cynical of the system. I don’t always feel as hopeful as I would like to be. I am not always as patient as I would like to be and I don’t always feel there is a reason to be hopeful for our patients when they leave our care. (Participant 3)

Another participant described developing a more cynical view of others when outside of work: “When I am out on the street or out with my kids or with other parents, I am constantly like checking and thinking, looking at people’s pupils and that kind of thing …” (Participant 7).

Coping Strategies

Participants described their coping strategies for managing the impact caring for this population has had on them. Strategies identified included practicing self-awareness, seeking support from others, and self-care activities. Participant 4 described being self-aware enabled him to manage his own distressing thoughts and negative emotions evoked by patients. “A lot of mindfulness” Participant 2 reported as beneficial in managing his “feelings and emotions”. Participant 3 reported practicing reflection and self-awareness helped her cope along with exercising regularly and maintaining good sleep hygiene.

Half of the participants identified support from other healthcare professionals helped them cope. Participant 3 expressed "talking to people who have worked a lot within this population for so long” helped her remain patient-centered. Two participants identified their colleagues at work were sources of emotional support. The value of this was described in the following: “I think it’s really important to feel like you are in step with your team and that we encourage each other. That you can be open when you are struggling, that you aren’t isolating yourself…” (Participant 4).

Another participant identified she connected with friends outside of work who are psychiatric nurses for support:

> Some of my best friends are psych nurses so you know you sit around sometimes and if something hit you hard or you know, you just feel like you are thinking about it at the end of the shift or maybe the next day, clearly it affected you and so you just need to talk about it. For me I am a talker so I just will call somebody up, Hey! … I just need to talk to you. Clearly this is hitting me hard. I don’t know why but just kind of talk it out. (Participant 8)

Summary of the Emerging Themes

The participants in this study were open and candid about their experiences caring for patients with CDs admitted to acute care psychiatric inpatient settings. In summary, the five major themes that emerged from the data analysis were: providing care is challenging, patient engagement, support and teamwork, transition from novice to expert, and emotional responses from nurses. The first major theme described the common challenges participants reported experiencing with providing care. Providing care to this population was complex and providing care to those experiencing withdrawal from and cravings for substances was demanding. As well, the participants identified that there was an increased risk of being injured while caring for this population. This risk was largely attributed to the agitation and hostility associated with caring for patients who were experiencing withdrawal and/or cravings. Other safety concerns included monitoring for contraband being brought onto the units and patients overdosing while admitted to hospital. In consideration of the safety concerns, the participants described experiencing a significant amount of pressure and stress related to keeping the unit and the patients safe.

It was identified that those with CDs could be difficult to engage and to develop rapport with. Strategies described to engage patients included an empathetic approach and exercising patience. However, participants did acknowledge there were times patient behaviours made it difficult to provide patient-centered care. Experience increased the participants’ confidence with caring for this population. As well, when delivering care collaborating with other healthcare professionals was described as invaluable.

The participants in this study endorsed experiencing both negative and positive emotions while caring for this population. Frustration was the most commonly expressed emotion and a number of reasons for this were identified. Strategies for coping with the stress associated with providing care for this population were also described.

The information gathered from the participants has provided valuable insights into the commonalities of the experiences of point of care MHNs caring for patients with CDs admitted to acute care psychiatric inpatient settings. The following chapter will discuss the findings of this study as well as its implications for MHNs, nurse educators, and healthcare and educational organizations.

Chapter 5: Discussion

As previously discussed, there are gaps in the literature regarding MHNs' experiences of caring for patients with CDs who have been admitted to acute care psychiatric inpatient urban settings in Canada. The descriptive phenomenological approach was used to increase the understanding of the experiences of these MHNs. To discover the commonalities from the experiences of the eight participants in this study, the writer immersed himself in the data (Giorgi, 2007) collected from semi-structured interviews and analyzed the data using Colaizzi's (1978) seven procedural steps (as cited in Morrow et al., 2015). Five major themes emerged from the data: providing care is challenging, patient engagement, support and teamwork, transition from novice to expert, and emotional responses from nurses. To present the findings of this study in relation to the reviewed literature this chapter has been divided into the following sections: providing care is challenging, attitudes and perceptions, and emotions evoked. As a significant amount of the available literature includes a number of disciplines these studies will be included in this discussion. The implications of this study will then be addressed, followed by a review of the strengths and limitations of the current study.

Providing Care is Challenging

Similar to the findings in the current study, a number of studies in the existing literature have reported MHPs providing care for those with CDs have described this as difficult, and challenging (Carey et al., 2000; Deans & Soar, 2005; Howard & Holmshaw, 2010; Johansson & Wiklund-Gustin, 2016; Mericle et al., 2007; Searby et al., 2017). To organize this discussion, this section has been divided into the following three subsections: patient characteristics, acuity and complexity of substance use care, and barriers to quality care.

Patient Characteristics

The intent of this study was not to describe the population of individuals who experience CDs and have been admitted to acute care psychiatric inpatient urban settings, however, discussing the findings in relation to the literature on the characteristics of this population will aid in providing context to MHNs' experiences. Reflective of the current literature (Becker et al., 2017; Bonnie et al., 2015; CIHI, 2013), the participants in the current study frequently described providing care to patients who were repeatedly discharged and readmitted to hospital. As well, participants identified that it was not uncommon for patients to require care for medical comorbidities in addition to their mental health and substance use issues. This was aligned with Becker et al.'s (2017) and Dickey et al.'s (2000) studies that found individuals who have CDs were more likely to require medical care when hospitalized. Participants in the current study often attributed the patients' medical issues arising from or compounded by either their mental health and/or substance use issues, including being injured when intoxicated and experiencing chronic infections and wounds due to intravenous substance use.

Consistent with the existing literature (Carey et al., 2000; CIHI, 2013; Khan, 2017; Mericle et al., 2007), the participants in the current study described providing care for patients who had significant socioeconomic issues, including poor housing (e.g., homeless, shelters, and single room occupancies) and limited income. Researchers from CIHI (2013) reported that those who experience CDs were at a greater risk of being homeless and living in marginalized neighborhoods than those who only had a mental health illness or a substance use issue and in Khan's (2017) study, it was determined individuals experiencing CDs were less likely to be employed than those with only a substance use disorder and had more precarious housing.

Acuity and Complexity of Substance Use Care

The literature suggests there is an increased risk of point of care staff experiencing verbal and physical aggression from substance users in psychiatric inpatient settings (Camus et al., 2021; Howard & Holmshaw, 2010; Tripathi et al., 2014). Hughes et al. (2018) reported psychiatric inpatients frequently use illicit substance during hospitalization and this contributes to increased aggression and violence among psychiatric inpatients (Howard & Holmshaw, 2010; Hughes et al., 2018). Howard and Holmshaw (2010) found nurses experienced violence and aggression when attempting to remove substances from patients after returning from authorized leave off the inpatient units (i.e., passes). The participants in the current study did not describe experiencing aggression from patients who were intoxicated or when attempting to remove substances from them. However, these participants described patients becoming agitated and hostile due to the restrictions on passes and privileges, such as access to their belongings and valuables, and identified they were at risk for being injured when checking patients' belongings and valuables. To provide context, the data for the current study were collected during the early stages of the COVID-19, and during the majority of this time day passes were not permitted. Undoubtedly, this impacted the participants' experiences with managing passes and privileges.

Participants in the current study also emphasized the importance of being vigilant with monitoring passes in order to mitigate the risk of patients' overdosing either on the unit or while out on pass. To this researcher's knowledge, there are no other studies investigating the experiences of MHNs caring for those with CDs that have identified this issue. Arguably, this is related to the opioid crisis in British Columbia that has seen a dramatic increase in the number of individuals who have had nonintentional overdoses.

The majority of the participants reported there was an increased risk of aggression from patients who were experiencing withdrawal and cravings. There is a dearth of literature on this in respect to caring for those with CDs, but Ford (2011) and Horner et al. (2019) had similar findings in their studies investigating nurses' experiences caring for patients with substance use issues in a broader acute care setting. In Ford et al.'s study, patients were described as "unpredictable" and "prone to violence" when in withdrawal (p. 247). The latter study specifically reported on the experiences of nurses caring for those with an opioid use issues and participants' descriptions of patients' behaviours were akin to some of those in the current study. For instance, one of the participants in Horner's study stated: "I've seen it go from zero to that [snaps fingers] because their desperation is like none other…" (p. 6). Although nurses caring for those with substance use issues described sharing these experiences when caring for those in withdrawal and/or experiencing cravings, the underlying etiology of this relationship between substance use withdrawal and/or cravings and aggression remains unclear (Gayman & Pietras, 2017). In studies involving nonhumans, opioid withdrawal has been shown to increase aggression (Kimbrough et al., 2020; Piccin & Contarino, 2020), but currently there are a lack of studies demonstrating this occurs with humans. To explain this behaviour, researchers have also suggested that in general, substance users are more aggressive due to their higher levels of impulsivity (Evren & Bozkurt, 2017; Seo et al., 2008).

Participants described spending a considerable amount of time administering opioid agonist therapies to patients to manage their opioid withdrawal and cravings. These are effective therapies (British Columbia Centre on Substance Use, 2017) which have been found to reduce the risks associated with relapse and illicit substance use (MacArthur et al., 2012; MacArthur et al., 2014). Although the benefits of these therapies are well-documented in the literature, there is a lack of studies addressing MHNs' experiences administering these therapies to patients with CDs. Participants in the current study described challenges with administering these medications: one being with administering buprenorphine-naloxone which can precipitate withdrawal, and another with administering hydromorphone which much to nurses' chagrin can be time consuming and have an intoxicating effect on patients.

In British Columbia, as of 2008, smoking was banned in all public spaces and workplaces including hospitals. This has contributed to increased restrictions for patients to access tobacco products on psychiatric inpatient units. The presence of a mental health illness is known to complicate the effects of nicotine withdrawal (American Psychiatric Association, 2013) and the findings in the current study suggest managing nicotine withdrawal and cravings for patients who have CDs is particularly complex. The participants in the current study reported nicotine withdrawal contributed to patients' irritability and intensified patients' discomfort of withdrawal from other substances. One Australian study (Wye et al., 2010), investigating the views and management of nicotine withdrawal on psychiatric inpatient units, suggested nicotine replacement therapy "is provided selectively rather than systematically" (p. 320). The participants in the current study described nurses being diligent in administering nicotine replacement therapies, but despite this, it did not always satisfactorily alleviate the patients' withdrawal and/or cravings.

Barriers to Quality Care

Participants in the current study reported experiencing a number of barriers to providing quality care, including the lack of accessible resources for patients in the hospital and in the community, and poor discharge planning which often contributed to patients being readmitted. Similar issues have been identified in several other studies (Groenkjaer, 2017; Mericle et al., 2007; Searby et al. 2017; Sorsa et al., 2017). Mericle et al. (2007) termed these as *system-level barriers* and the overwhelming majority of the participants in Mericle et al.'s study reported experiencing these barriers. Several participants in the current study identified patients were often prematurely discharged and/or discharged without the necessary supports in place. Searby et al.'s (2017) study also found patients with CDs were frequently discharged "at the earliest opportunity" (p. 809). In light of this, it is not surprising other researchers have determined individuals with CDs have shorter admissions on average than those with just a mental illness, but unfortunately also have higher rates of readmission than either those experiencing only a mental illness or substance use issue (CIHI, 2013).

One participant in the current study, who had previous experience working on a tertiary CDs inpatient unit, was adamant that not having a dedicated inpatient psychiatric unit for only individuals with CDs was detrimental to both these patients' care and for the care of general inpatient psychiatric patients. Similar sentiments were voiced by participants in Carey et al.'s (2000) study. Although, an integrated approach to providing CDs care is often cited as the ideal (Canadian Centre on Substance Abuse [CCSA, 2009)]; Crockford & Addington, 2017; Drake et al., 2008; Mangrum et al. 2006; Substance Abuse and Mental Health Services Administration [SAMHSA], 2011), the proponents of this do not necessarily support caring for patients in silos.

Researchers have emphasized the importance of developing therapeutic relationships with individuals experiencing CDs, but have also found this population can be difficult to engage with therapeutically which subsequently creates barriers to providing care (Howard & Holmshaw, 2010; Mericle et al., 2007; Sorsa et al., 2017). This was reflected in the current study as participants reported patients were often not forthcoming and at times the patients' behaviours made it challenging to provide therapeutic care. Other researchers (Mericle, et al., 2007; Waddell

& Skarsater, 2007) found MHPs were often concerned they would damage the therapeutic relationship if they asked patients about their substance use, but the participants in the current study did not express this hesitation. Similar to other studies (Carey et al., 2000; Mericle et al., 2007; Sorsa et al., 2017), the participants in the current study reported it was challenging to provide care and treatment to individuals who did not understand they were ill and/or unmotivated to receive treatment. For instance, in Mericle et al. (2007) the researchers found "[T]the most frequently cited client-level barriers pertained to denial of substance use problems and to a lack of motivation" (p. 176).

Attitudes and Perceptions

As discussed in the literature review, the attitudes and perceptions of MHPs and MHNs caring for those with CDs were mixed. In the current study, participants acknowledged patients' behaviours made it difficult at times to remain objective while providing care and participants described developing more cynical perspectives towards those with CDs as a result of their experiences. Despite this, participants described being understanding, patience, and empathetic with their patients and like the participants in Carey et al.'s (2000) study "expressed strong personal commitment to the treatment and welfare" towards those with CDs (p. 197).

The participants in the existing study were relatively well-experienced in working in mental health and with those with CDs. The literature reporting on the relationship between experience and attitudes and perceptions is mixed. In Pinikahana et al.'s (2002) study, it was found MHPs viewed those with CDs positively. The majority of these participants in Pinikahana's study had ten or more years of professional experience, but findings from a study conducted by Richmond and Foster (2003) did not find an association between the length of one's experience and one's attitude. These authors suggested MHPs' personal use of addictive substances may give them more permissive attitudes (Richmond & Foster, 2003). Questions about the participants' own substance use were not asked in the current study and the participants did not disclose information regarding this. In Richmond and Foster's study they also found higher education credentials (e.g., post-graduate degrees) were positively correlated with more optimistic attitudes towards care. In the current study, half of the participants were diploma trained and the other half had degrees in psychiatric nursing. None of the participants acknowledged having post-graduate degrees, but optimism did emerge as a subtheme in the findings.

Shaw et al. (1978) developed a conceptual framework to understand the contributing factors underlying one's attitude when providing care to individuals with alcohol use issues. This framework has been utilized by several studies to gain a greater understanding of the attitudes of those caring for individuals with substance use issues including those with CDs. Central to developing a negative attitude is experiencing role insecurity (Shaw et al., 1978). Shaw et al. hypothesized three factors contribute to developing this: role adequacy, role legitimacy, and role support. Role adequacy refers to having the necessary skills and knowledge to work with this population (Shaw et al., 1978). Role legitimacy refers to healthcare providers believing if they have the right to intervene with individuals experiencing issues, uncertainty regarding whether it was their responsibility to respond to these, and uncertainty of their own competence (Shaw et al., 1978). Lastly, role support refers to having the necessary support from colleagues when providing care to this population, including somewhere to turn for information and advice (Shaw et al., 1978).

In respect to the literature, of these three factors, role adequacy and role support have been reported to have had the greatest impact on the attitudes of MHPs towards those with CDs.

Several studies in the literature identified MHPs do not feel adequately trained or have the necessary education and/or knowledge for providing care to individuals with CDs (Adams, 2008; Barry et al., 2002; Camuccio et al., 2012; Coombes & Wratten, 2007; Deans & Soar, 2005; Garrod et al., 2020; Mericle et al., 2007; Searby et al., 2017). In the current study participants identified caring for patients' substance issues were particularly challenging and three participants described themselves as initially not being adequately prepared to care for this population. The least experienced participant expressed she was inadequately equipped to care for patients' substance use care needs upon entry to practice and the two registered nurses in this study acknowledged there was a considerable amount of learning when they first started working with those with CDs. Not surprisingly, two of these participants described experiencing uncertainty and anxiety when this occurred. As previously cited, uncertainty of one's own competence is one of the characteristics of role legitimacy (Shaw et al., 1978). The participants in this study described gaining confidence as they transitioned from novice to expert nurses (Benner, 1982). In consideration of these findings from the current study and Shaw et al.'s (1978) framework, arguably the participants' attitudes towards those with CDs did improve as they developed confidence in their own ability to care for this population.

Researchers have reported MHPs have experienced or perceived to experience a lack of support from their organizations and from their supervisors when caring for those with CDs (Camuccio et al., 2012; Carey et al., 2000, Howard & Holmshaw, 2010). In the current study, participants identified experiencing organizational issues such as staffing shortages and the conditions of the hospital as problematic. In respect to role support as described by Shaw et al. (1978), the participants in the current study highlighted the value and appreciation of the support they had received from their colleagues, other disciplines, security personnel, and their leadership. As well, a number of participants identified they had a number of individuals to turn to in order to receive advice and information to aid with providing care, and in particular substance use care.

Emotions Evoked

Participants in the current study described experiencing a range of emotions when caring for those with CDs, with frustration being the most commonly voiced. This is consistent with the findings in the existing literature (Carey et al., 2000; Deans & Soar, 2005; Howard & Holmshaw, 2010; Johansson & Wiklund-Gustin, 2016; Searby et al., 2017). In the current study, participants described experiencing frustration related to patients' behaviours. Likewise, Johansson and Wiklund-Gustin's (2016) reported "[P]patients were sometimes perceived as demanding and hard to please, having unrealistic expectations. This contributed to nurses' experiences of frustration …" (p. 307). Horner et al.'s (2019) study of nurses caring for patients with substance use issues on general inpatient units also described nurses experiencing "frustration and exhaustion in working with what they considered a more 'demanding' patient population" (p. 16). Participants in Horner et al.'s study and the current study also described experiencing frustration with the "high care needs" of those with substance use issues which detracted from time that could have been spent with other patients (p. 245). In the current study, participants described their frustration with patients attempting to bring illicit substances onto the unit. This also was identified in Howard and Holmshaw's (2010) study as illustrated by the following quote: "I find that sometimes it's very frustrating as a nurse to work with clients who take drugs and especially the ones who bring drugs back to the ward and are then supplying drugs to others" (p. 867).

There are few studies in the literature that have reported on MHPs using harm reduction strategies when caring for those with CDs. The participants in the current study largely supported the principles of harm reduction, but as mentioned earlier participants described frustration with administering hydromorphone as an opioid agonist therapy due to the frequency of administering doses and sometimes patients presented as intoxicated after its administration.

In the studies by Deans and Soar's (2005) and Searby et al.'s (2017), it was found MHPs were frustrated with the slow response those with CDs had to treatment and in Dean and Soar's study it was noted frustration increased with the awareness an individual's substance use may contribute to a negative outcome. Although, the participants in the current study did not describe experiencing frustration related to the length of time in took patients to respond to treatment, they did express frustration with the awareness patients were likely to be readmitted shortly after discharge, due to their substance use. Participants also reported they found this cycle of treatment, discharge, and readmission as emotionally exhausting and experienced feelings of helplessness, and disappointment when patients resumed their substance use after discharge and were subsequently readmitted. The Johansson and Wiklund-Gustin (2016) study also described nurses experiencing disappointment when patients relapsed, and nurses intentionally concealed their disappointment from patients:

> However disappointed they were on the patients, the nurses strived to be vigilant regarding their own emotions so as not to reveal them to patients. Instead, they vented their frustration on each other. This too was challenging, as the need to be regulated to avoid peers becoming contaminated with negative feelings towards a patient. (p. 307)

The participants in the current study did not discuss or disclose efforts to hide their emotions from patients, but reported they coped by connecting with other colleagues and other MHNs.

Implications

The aim of this study was to investigate and describe MHNs' experiences of caring for patients with CDs in acute inpatient psychiatric care settings in Metro Vancouver, British Columbia. The occurrence of individuals experiencing CDs among those admitted to acute inpatient psychiatric care settings has been well-documented, and the current study provides valuable insights into MHNs' experiences of caring for this population. In this section, the implications for MHNs, nurse educators, and for healthcare and educational organizations will be discussed.

Implications for Mental Health Nurses

This study will bring awareness to the experiences of MHNs caring for this population. Aforementioned, these professionals often reported experiencing "frustration" while providing direct patient care, but demonstrated commitment to their work. Many MHNs care for or have cared for patients who have overdosed while under their care and have the knowledge of former patients who have accidentally overdosed and passed away in the community. Undoubtedly, these experiences have had an enduring effect on MHNs. Greater awareness of this may provide support to other MHNs who have had similar experiences while caring for this population. It is not uncommon for nurses to be negligent of addressing their own mental health (Chen & Cui, 2020). The participants in the current study described strategies used to promote and maintain their own well-being, including practicing reflection and self-awareness, exercising, and debriefing with other healthcare professionals in and outside of the workplace. It was also evident from the participants' descriptions of their experiences that self-awareness is paramount in providing patient-centered care as patients' behaviours often make it difficult to remain objective.

Implications for Nurse Educators

Attitudes are known to be predictors of behaviours (Ajzen, 2012) and a number of studies in healthcare settings have demonstrated the attitudes and perceptions of healthcare professionals contribute to the quality of care delivered (Hanson, 2014; Johnson et al., 2009; Vorasane, 2017). The existing literature suggests education and training on substance use affects healthcare professionals' attitudes towards those who use substances, including towards those who have a CD (Garrod et al., 2020; Munro et al., 2007; Pinderup, 2017). It appears the participants in this study felt better equipped to care for this population than many of those who participated in previous studies. However, at least three of the participants acknowledged they did not feel adequately trained when they initially started working with this population. As well, the participants in this study largely contributed the challenges and difficulties they had with providing care to patients' substance use issues rather than their mental health issues.

Implications for Organizations

Burnout is characterized by the following: "feelings of energy depletion or exhaustion", "feelings of negativism or cynicism related to one's job", and "reduced professional efficacy" (World Health Organization, 2019). Burnout has been positively correlated with job dissatisfaction and turnover intention among those employed within the mental health field (Scanlan & Still, 2019) and studies have found burnout and job dissatisfaction were predictors of poor-quality care (Aiken et al., 2012; Salyers et al., 2014). Given the amount of frustration and cynicism described by the participants in the current study, it would be prudent for employers to address this in order to mitigate the issues associated burnout. As well educational institutes should take measures to adequately prepare nursing students to adaptively cope with the challenges of caring for those with CDs.

Strengths and Limitations

This study addresses the gaps in the literature regarding the experiences of MHNs caring for patients with CDs in acute urban inpatient psychiatric care settings, and in particular for an urban center in Canada. The participants in the current study had a considerable amount of experience with the phenomenon under investigation, were open and forthcoming, and provided rich and detailed descriptions of their experiences. The researcher's own experience with caring for this population in this setting aided with the discussion, but also posed as a possible limitation when attempting to gather and report on the findings in an unbiased manner. Other methodological limitations included the small sample size and the possibility of selection bias. An unforeseen limitation of the study was that it was conducted during a worldwide pandemic. The COVID-19 pandemic contributed to the decision to conduct seven out of the eight interviews on videocalls for safety measures. As a result, the researcher was not able to able to fully view participants' nonverbal language and fully identify intonations in their voices. Fortunately, the quality of the recordings was for the most part excellent and there were only rare incidences when participants' responses were unintelligible. As well, the pandemic impacted hospital policies and the delivery of care which undoubtedly affected the participants' experiences and responses to the questions during the interview. For instance, at the onset of the data collection hospitals in Metro Vancouver had suspended all passes for patients, and as the data collection progressed these were being re-introduced which was a source of frustration for some of the participants.

Chapter 6: Recommendations and Conclusion

Taking into account the findings and the discussion, this researcher has formulated a number of recommendations for MHNs, nurse educators, and healthcare and educational organizations. As well, recommendations for areas requiring further research have been put forth.

MHNs should integrate mindfulness into their daily practice and their ‘way of being’. Mindfulness in nursing has been described as “a transformative process, where one develops an increasing ability to experience being present with awareness, acceptance and attention” and it “can support improving physical, emotional, psychosocial and spiritual well-being” (White, 2014, p. 283). Studies have demonstrated practicing mindfulness can enhance the mental health of nurses (Chen & Cui, 2020; Yang et al., 2018). As well, practicing mindfulness may improve the delivery of care as it can increase one’s “awareness, acceptance and attention” (White, 2014, p. 283) which will aid nurses in remaining objective while providing care. In order to be better equipped for caring for those with CDs, MHNs, as part of their self-directed professional development, should participate in the available learning opportunities on substance use and substance use care. In British Columbia, this includes several relevant online learning modules on the *Learning Hub* that are available to the employees of the province’s health authorities, including the Addiction Care and Treatment Online Course offered in partnership by the BC Centre on Substance Use, the UBC Continuing Professional Development Faculty of Medicine, and the UBC School of Nursing.

It is recommended for nurse educators to allocate more time and resources to provide education on substance use issues. Educational approaches should include both didactic and experiential teaching methods, including content on harm reduction interventions and strategies, assessing and managing substance use withdrawal and cravings, and as one of the participants in the current study reported as finding beneficial was additional training on Code Whites and Code Blues. Livingston et al. (2011) found the greater exposure healthcare professionals and healthcare trainees had with individuals with substance use issues was positively associated with improved attitudes. Including those with ‘lived experience’ would be invaluable for mental health nursing students and consideration should be given to including individuals who have had success with their recovery to potentially foster greater optimism among experienced MHNs. This training and education should be provided to all MHNs along with identifying experienced MHNs to provide mentorship to entry to practice nurses. Nursing educators should also promote and support MHNs and mental health nursing students utilize online learning resources related to substance use care such as the previously mentioned Addiction Care and Treatment Online Course.

Healthcare organizations should offer resiliency training and mindfulness-based stress reduction therapy programs to MHNs in these settings, and these should be introduced by educational institutes to undergraduate student nurses. A resilient individual is when one can effectively manage stress (Matos, 2010) and resiliency training has been shown to be successful in increasing MHNs’ resiliency (Foster et al., 2018; Foster et al., 2019). As well, resiliency has been positively correlated with job satisfaction (Matos et al., 2010; Zheng et al., 2017). Potentially, these programs will improve the health of their MHNs and the care these nurses provide. Although it would be educators providing the training, along with arranging for further education and training on substance use, it would be the responsibility of each of the health authorities and educational institutions to implement these initiatives. Arguably implementing these measures would also have a positive effect on health authorities' operational budgets as these would likely reduce employee absenteeism, and employee turnover.

Although the participants in this study reported using harm reduction interventions and strategies to manage the care of patients with CDs, it is evident there is a scarcity of literature reporting on this, particularly within acute care psychiatric inpatient settings. In recent years, harm reduction interventions have needed to change and evolve in order to reduce the risks associated with substance use and in particular to mitigate the risks of unintentional overdoses related to opioids. The participants in this study largely supported these strategies and interventions, but the findings of this study also suggest providing this care can be at times demanding and frustrating. Qualitative investigations into the experiences of MHNs providing harm reduction interventions to those with CDs may increase the understanding of these experiences. In light of the current public health crisis in British Columbia and that a number of participants in the current study reported caring for patients who had unintentional opioid overdoses, it is recommended to further investigate MHNs' experiences with this phenomenon. Explorative studies into MHNs' and MHPs' attitudes and perceptions towards those with CDs may provide greater clarity to the findings in the current study and aid in identifying areas to further support those caring for this population. Lastly, it is recommended to investigate the effectiveness of mindfulness-based training interventions and resiliency training for MHNs who primarily care for patients with CDs. Although there were studies supporting the use of mindfulness-based training interventions and resiliency training for MHNs, there were no studies identified specifically measuring the effectiveness of these on MHNs caring for individuals with CDs.

In conclusion, this study has provided valuable insights and knowledge into the experiences of MHNs caring for those with CDs who have been admitted to acute care psychiatric inpatient urban settings. It is evident there are a number of challenges MHNs experience while caring for this population and to address these, the researcher has made a number of recommendations to support MHNs.

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Appendix A

PANEL ON
RESEARCH ETHICS
Navigating the ethics of human research

TCPS 2: CORE

Certificate of Completion

This document certifies that

colin mcwilliams

has completed the Tri-Council Policy Statement:
Ethical Conduct for Research Involving Humans
Course on Research Ethics (TCPS 2: CORE)

Date of Issue: **26 April, 2020**

Appendix B

Letter of Invitation

(Email of information to be sent on my behalf by the British Columbia College of Nursing Professionals working in acute care mental health settings in the Lower Mainland of British Columbia)

Dear Registered Nurse/Registered Psychiatric Nurse,

My name is Colin McWilliams. I am a student in the Master of Psychiatric Nursing Program in the Faculty of Health Studies at Brandon University. I am conducting a research study as part of the requirements of my program and I would like to invite you to participate in my study. My thesis advisor is Dr. Dean Care. The title of my thesis is “Mental Health Nurses’ Experiences of Caring for Patients with Concurrent Disorders in Acute Care Psychiatric Inpatient Urban Settings”.

I am inviting both nurses and psychiatric nurses registered with the British Columbia College of Nursing Professionals (BCCNP) to participate in this study. The inclusion criteria includes nurses who have two or more fulltime years of experience providing direct nursing care to those with co-occurring mental health and substance use issues in one of the Lower Mainland’s acute care psychiatric inpatient units and is currently employed in this role.

The knowledge gained through this research will increase our understanding of the experiences of mental health nurses caring for individuals with co-occurring mental health and substance use disorders. Identifying and describing these experiences will potentially aid nurse educators and administrators with implementing the necessary supports and resources to support mental health nurses caring for this population. Additionally, this study may identify gaps within the service delivery system that may provide administrators with greater understanding of system issues. Results of this study will be presented at scholarly conferences and in publications. When the study is complete, I will share the findings with you and will email you a link to my thesis.

If you accept the invitation to participate in this study, the interview will be conducted at a time and place of your convenience and may involve the use of videotelephony (e.g., Zoom) to conduct the interview. The initial interview will be 45-60 minutes in length. If necessary, a second interview may be requested. You may refuse to answer any of the questions and/or withdraw from the study at any point of time. The interview will be recorded and transcribed by a transcriptionist. Your participation will be kept confidential and anonymity will be maintained through the use of a pseudonym. The findings from the study will be shared with you for verification prior to being finalized.

Timeline:

If you agree to participate in the study, I will ask to meet you at a location of your choosing, that is comfortable for you or if public health guidelines are not permitting this we will meet on Zoom at a time convenient for you. Interviews will start this summer 2020 and likely will run thru to November of this year. The study is expected to be completed by summer 2021.

If you have any questions about participating in the study, please contact me or my supervisor, Dr. Dean Care. I may be reached at (778) 288-8386 or MCWILLC58@brandonu.ca and Dr. Dean Care, is available via email cared@brandonu.ca or (204) 727-7456.

Copies of the consent forms will be provided upon request.

Thank you in advance for your time and interest in enhancing nursing research and studies.

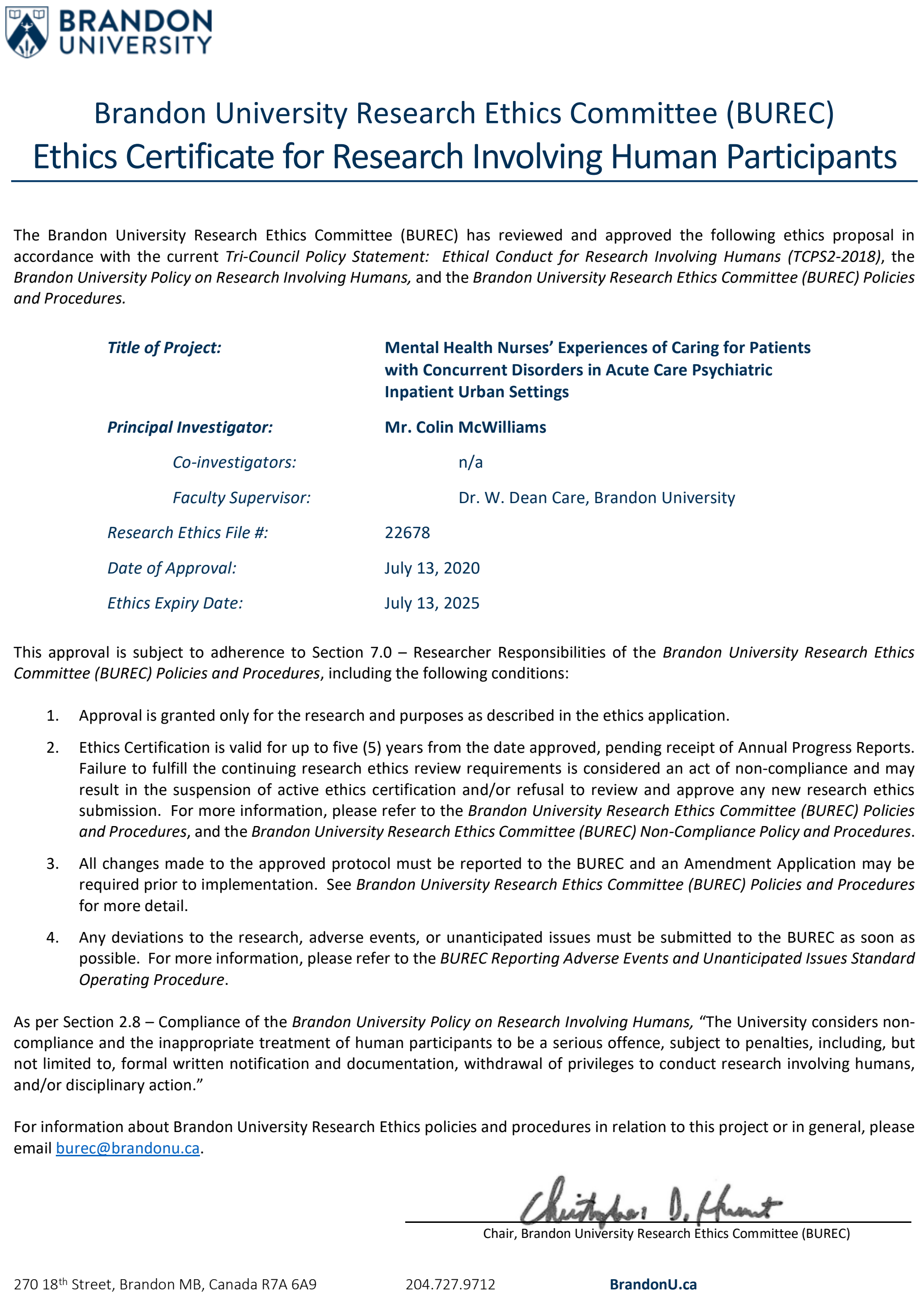
Colin McWilliams, RPN, BScPN

Master of Psychiatric Nursing Student

(778) 288-8386

MCWILLC58@brandonu.ca

Appendix C



BRANDON UNIVERSITY

Brandon University Research Ethics Committee (BUREC)

Ethics Certificate for Research Involving Human Participants

The Brandon University Research Ethics Committee (BUREC) has reviewed and approved the following ethics proposal in accordance with the current *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2-2018)*, the *Brandon University Policy on Research Involving Humans,* and the *Brandon University Research Ethics Committee (BUREC) Policies and Procedures.*

Title of Project:	**Mental Health Nurses' Experiences of Caring for Patients with Concurrent Disorders in Acute Care Psychiatric Inpatient Urban Settings**
Principal Investigator:	**Mr. Colin McWilliams**
Co-investigators:	n/a
Faculty Supervisor:	Dr. W. Dean Care, Brandon University
Research Ethics File #:	22678
Date of Approval:	July 13, 2020
Ethics Expiry Date:	July 13, 2025

This approval is subject to adherence to Section 7.0 – Researcher Responsibilities of the *Brandon University Research Ethics Committee (BUREC) Policies and Procedures*, including the following conditions:

1. Approval is granted only for the research and purposes as described in the ethics application.
2. Ethics Certification is valid for up to five (5) years from the date approved, pending receipt of Annual Progress Reports. Failure to fulfill the continuing research ethics review requirements is considered an act of non-compliance and may result in the suspension of active ethics certification and/or refusal to review and approve any new research ethics submission. For more information, please refer to the *Brandon University Research Ethics Committee (BUREC) Policies and Procedures*, and the *Brandon University Research Ethics Committee (BUREC) Non-Compliance Policy and Procedures*.
3. All changes made to the approved protocol must be reported to the BUREC and an Amendment Application may be required prior to implementation. See *Brandon University Research Ethics Committee (BUREC) Policies and Procedures* for more detail.
4. Any deviations to the research, adverse events, or unanticipated issues must be submitted to the BUREC as soon as possible. For more information, please refer to the *BUREC Reporting Adverse Events and Unanticipated Issues Standard Operating Procedure*.

As per Section 2.8 – Compliance of the *Brandon University Policy on Research Involving Humans,* "The University considers non-compliance and the inappropriate treatment of human participants to be a serious offence, subject to penalties, including, but not limited to, formal written notification and documentation, withdrawal of privileges to conduct research involving humans, and/or disciplinary action."

For information about Brandon University Research Ethics policies and procedures in relation to this project or in general, please email burec@brandonu.ca.

Chair, Brandon University Research Ethics Committee (BUREC)

270 18th Street, Brandon MB, Canada R7A 6A9   204.727.9712   **BrandonU.ca**

Appendix D

Request for Permission to Access Nurses

(to be placed on Brandon University letterhead)

Re: Request for permission to access mental health nurses through the British Columbia College of Nursing Professionals (BCCNP)

Attention BCCNP:

I am a student in the Master of Psychiatric Nursing Program in the Faculty of Health Studies at Brandon University. I am conducting a research study as part of the requirements of my graduate program and I would like to request an email letter of invitation be forwarded to mental health nurses through the BCCNP on my behalf. My thesis advisor is Dr. Dean Care and the title of my thesis is “Mental Health Nurses’ Experiences of Caring for Patients with Concurrent Disorders in Acute Care Psychiatric Inpatient Urban Settings”.

The knowledge gained through this research will increase our understanding of the experiences of mental health nurses caring for individuals with co-occurring mental health and substance use issues. Identifying and describing these experiences will potentially aid nurse educators and administrators with implementing the necessary supports and resources to support mental health nurses caring for this population. Additionally, this study may identify gaps within the service delivery system that may provide administrators with greater understanding of system issues. Results of this study will be presented at scholarly conferences and in publications. There is no possibility of commercialization of the research findings.

My sample will include both Registered Psychiatric Nurses and Registered Nurses, registered with the BCCNP who currently work on acute care inpatient psychiatric units in the Lower Mainland of British Columbia. The participants will have two or more fulltime years of experience providing direct nursing care to those with co-occurring mental health and substance use issues in the Lower Mainland’s on acute care psychiatric inpatient units. A Letter of Invitation will be emailed to potential participants.

Participation in this study is completely voluntary and it will be made clear that it is not in any way associated with the BCCNP. Participants can withdraw from the study up until the data has been analyzed. Prior to this, if the participants withdraw from the study, all associated data collected will be immediately destroyed wherever possible.

The interview will be conducted at a time and place of the participants convenience and may involve the use of videotelephony (e.g., Zoom) to conduct the interview. The initial interview will be 45-60 minutes in length. If necessary, a second interview may be requested. The interview will be recorded with a digital recorder and will be transcribed by a transcriptionist. Participation will be kept confidential and anonymity will be maintained through the use of a pseudonym. The findings from the study will be shared with the nurses for verification prior to finalized.

The study will pose minimal risk to participants. If unanticipated troublesome feelings/thoughts emerge from the interviews, the researcher will support the nurses in connecting with the appropriate resources for support, including the Employee Family and Benefit Programs offered through their health authority and crisis support lines. A service guide will be provided to the participants prior to being interviewed.

I understand that there may be a cost associated with third party mailings and I am prepared to cover these costs. This research has been submitted to the Brandon University Research Ethics Board for approval. Confirmation of ethics approval has been attached.

Thank you for taking the time to read this information. If you have any questions about participating in the study, please contact me or my supervisor, Dr. Dean Care. I may be reached at 778 288-8386 or MCWILLC58@brandonu.ca and my thesis advisor, Dr. Dean Care, is available via email cared@brandonu.ca or (204) 727-7456.

Sincerely,

Colin McWilliams, RPN, BScPN

Appendix E

Transcriptionist Confidentiality Agreement

(to be placed on Brandon University letterhead)

Thank you for your participation in the research project "Mental Health Nurses' Experiences of Caring for Patients with Concurrent Disorders in Acute Care Psychiatric Inpatient Urban Settings". Protecting the confidentiality of the research participants is essential and you are therefore asked to sign the following confidentiality agreement.

I, ______________________________, agree to maintain full confidentiality in regard to any and all verbal information and audio recordings received from the research team for the above project. Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual and the content of any discussion that may be revealed during transcription.

2. To not make copies of any audio files or computerized files of the transcribed interviews, unless specifically approved to do so by the Research Team leader Colin McWilliams.

3. To store all audio files and materials in a password protected computer or safe, secure location as long as they are in my possession.

4. To return all materials to Colin McWilliams in a complete and timely manner at the completion of transcription.

5. To delete all electronic files containing study-related documents or audio files from my computer hard drive and any back-up devices on completion of transcription.

I am aware that I can be held legally responsible for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audio files and/or files to which I will have access.

Name (printed) ____

Signature ____

Date ____

Witnesses Name (printed) ____

Signature ____

Date ____

Appendix F

Informed Consent Form

(to be placed on Brandon University letterhead)

I am inviting you to participate in a research study conducted by myself, Colin McWilliams, and my thesis committee as part of my requirements to complete the Master of Psychiatric Nursing Program in the Faculty of Health Studies at Brandon University. The title of the research study is "Mental Health Nurses' Experiences of Caring for Patients with Concurrent Disorders in Acute Care Psychiatric Inpatient Urban Settings". The purpose of the study is to increase the understanding of point of care mental health nurses' experiences of caring for patients with co-occurring mental health and substance use disorders in acute care psychiatric inpatient urban settings. I plan to publish the findings of this study in my thesis and to present the findings through other scholarly activities. The research findings may be shared with study participants following the completion of the study through an email link to the thesis.

Both nurses and psychiatric nurses registered with the British Columbia College of Nursing Professionals (BCCNP) are invited to participate in this study. The inclusion criteria includes nurses who have two or more fulltime years of experience providing direct nursing care to those with co-occurring mental health and substance use issues in one of the Lower Mainland's acute care psychiatric inpatient units and is currently employed in this role.

Participation will include an interview between 45 minutes and 60 minutes. This may be at a place and time of your choosing and convenience or if meeting in person is not possible, we will use videotelephony (e.g., Zoom) to conduct the interview. If necessary, a second interview may be requested. The interview(s) will be recorded using a digital recorder and will be transcribed by a transcriptionist. The transcriptionist will sign a confidentiality agreement prior to receiving any data collected from your interview. During the interview, I may be taking hand notes. The findings from the study will be shared with you for verification prior to being finalized. Reviewing the transcriptions and the findings of this study are completely voluntary. If you are interested in being involved in this process, this can be done either by phone or email. At times, I may quote your words in my thesis report, but your name and any identifying information will not be shared. Your participation will be kept confidential and anonymity will be maintained through the use of a pseudonym. Your participation could only be identified through indirect means. Your identity will be protected by the use of codes. The computer files and transcripts of our conversations will be kept confidential and only accessed by myself, Colin McWilliams, my thesis advisor, and the transcriptionist. The computer files and audio recordings will be saved on an encrypted flashdrive, and safely stored with the notes in a locked filing cabinet and password protected computer in my office at home in North Vancouver, BC that can only be accessed by myself. These will be destroyed after five years.

You will not incur any financial costs in participating in this research. The study will pose minimal risk to participants. There are no known risks and/or discomforts associated with this study. If unanticipated troublesome feelings/thoughts emerge from the interviews, the researcher will support you in connecting with the appropriate resources for support, including the Employee Family and Benefit Programs offered through your health authority and crisis support lines. A service guide will be provided to participants prior to being interviewed.

Participation in this study is voluntary. You may stop at any time without any consequence or any explanation. You may decline to answer any question or you may withdraw from participating in this study by letting me know directly any time during the interview. You may also withdraw from participating following the interview (up to two weeks following the interview) by contacting me by phone (778) 288-8386 or by email MCWILLC58@brandonu.ca. If you withdraw from the study, your data will not be used and it will be destroyed. Your decision to stop participating, or to refuse to answer particular questions, will not affect your relationship with the researchers, or Brandon University.

As I am a member of the British Columbia College of Nursing Professionals (BCCNP), any disclosure of mandatory reportable nursing actions will be alerted to the BCCNP or the respective authoritative body as determined by legislation. If there is an abuse disclosure I will:

a) Discuss directly with the individual involved;
b) Contact the appropriate regulatory body to determine what information should be included in my written report;
c) Provide details of specific incidents including dates, names and a specific description of what occurred.

Thank-you for taking the time to read this information. If you have any questions about participating in the study, please contact me or my supervisor, Dr. Dean Care. I may be reached at 778 288-8386 or MCWILLC58@brandonu.ca and my thesis advisor, Dr. Dean Care, is available via email cared@brandonu.ca or (204) 727-7456. If you have any ethical concerns or issues you can contact Brandon University Research Ethics Committee (BUREC) at (204) 727-9712 or burec@brandonu.ca.

If meeting in person, I will offer to purchase a non-alcoholic beverage of your choice to consume during the interview. **There is no possibility of commercialization of the research findings. There is no perceived conflict of interest on part of the researcher, their institutions or the research sponsors.**

Consent Signatures:

1. I have read the entire consent form.
2. I have had a chance to ask questions and have received satisfactory answers to all of these questions.
3. I understand that by signing this consent form I have not waived my legal rights as a participant of this study, nor release the researchers, sponsors, or the involved institutions from their legal and professional responsibilities.
4. I understand that I may decline to participate at any time during the interview. I understand that I am free to withdraw from the study at any time, and/or refrain from answering any questions I prefer to omit, without prejudice or consequence.
5. I understand that I may withdraw my interview at any time prior to the completion of the data analysis.

6. I understand that my continued participation should be as informed as my initial consent.
7. I understand I can ask for clarification or new information throughout participation in the study at any time.
8. I understand I will be provided with a copy of the consent form for my records.
9. I agree to participate in the study.
10. I agree to having the interviews audio recorded.

Signature________________________ **Date______________________**
Participant

Signature________________________ **Date______________________**
Researcher

Appendix G

Service Guide

Mental Health Nurses' Experiences of Caring for Patients with Concurrent Disorders in Acute Care Psychiatric Inpatient Urban Settings

(to be placed on Brandon University letterhead)

Employees and Families of Employees of Health Authorities

Employee & Family Assistance Program (EFAP)
Counselling & Wellness Services, Multiple locations
Appointments are booked by calling: 604-872-4929 or 1-800-505-4929

Crisis Intervention Phone Numbers

Anywhere in BC 1-800-SUICIDE: 1-800-784-2433
BC Crisis Line: 310-6789
Vancouver, Richmond, North Shore and Sea to Sky Regional Distress Line: (604) 872-3111

General Public Access

Access & Assessment Center (AAC)
Vancouver General Hospital
Joseph & Rosalie Segal & Family Health Centre, Level 1 East Entrance
Hours of operation: 0730-2300
803 W 12th Ave, Vancouver, BC V5Z 1M9
(604) 675-3000

Surrey Mental Health and Substance Use Urgent Care Response Centre
Surrey Memorial Hospital
Charles Barham Pavilion, access from 94A Ave
Hours of operation: 0730-2330
13750 96 Ave, Surrey, BC V3V 1Z2
(604) 953-6200

Appendix H

Demographic Questionnaire

(to be placed on Brandon University letterhead)

Nursing Background	☐ Registered Nurse ☐ Registered Psychiatric Nurse
Gender	☐ Female ☐ Male ☐ Other
Age in years	
Highest level of nursing education attained	☐ Diploma Year completed ___________ ☐ Degree Year completed ___________ ☐ Masters Year completed ___________ ☐ PhD Year completed ___________
Years as a practicing nurse	
Currently employed	☐ Full-Time ☐ Part-Time
Years practiced in acute psychiatric inpatient settings?	
How long have you been employed in this current setting?	

Appendix I

Interview Guide

Data will be collected using open-ended interview questions along with clarifying questions in a semi-structured format. An adaptation of the following interview format is anticipated.

Research Question: "What are the experiences of point of care mental health nurses caring for those with CDs in acute care psychiatric inpatient urban settings?"

Professional History

I would like to discuss your experience as a mental health nurse working with adult patients in acute care inpatient settings.

1) From your perspective as a psychiatric nurse, tell me about the acute care setting in which you are currently employed?
2) Tell me about other mental health settings where you have practiced.

Acute Care Psychiatric Nursing Experience

I would like to understand your experiences working with patients in acute care psychiatric inpatient settings who are experiencing concurrent disorders (CDs).

1) Tell me about your mental health nursing practice? For instance, what is your nursing philosophy?
2) Describe to me in your own words, what is CDs?
3) What are your experiences caring for patients with CDs? Please give me specific examples.
4) Describe to me your educational preparedness or training for caring for this population? Tell me, what do you find the most useful for working with this population?

5) What factors influence your ability to care for patients experiencing CDs? If possible, please provide examples.
6) Over time, what changes have you noticed in providing care to patients with CDs? For instance, has it become easier or more challenging?
7) Tell me how caring for patients with CD affects you personally? How has it affected you professionally? How do you feel about working with this population?
8) Is there anything else that you would like to add?