RNs' Experiences of Enactment of *Psychotherapy Act, 2007*: A Mixed Methods Study

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Abstract

The College of Nurses of Ontario will comply with the *Psychotherapy Act, 2007* by requiring nurses to initiate psychotherapy by an order from a physician or NP. This study examines the possible constraints to RN psychotherapy service delivery.

Quantitative and qualitative date were gathered from 23 RNs using Barrett's PKPKCT to measure power of participants experience for the anticipated regulatory change.

Findings revealed concerns that RN's ability to practice psychotherapy would likely be negatively affected due to loss of autonomy, uncertainty and ambiguity. Research evidence has shown loss of autonomy and ambiguity in working environments is consistent with the findings in this study. Bureaucratic barriers to public access to RN psychotherapy, and the consequences of demoralization, devalued status and uncertainty regarding the changes to RNs practice are emotional factors that predict reduced ability for RNs to serve the already insufficient mental health care services in Ontario.

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Background and Significance

The upcoming regulation concerning the *Psychotherapy Act, 2007* (Service Ontario, 2007), will result in nurses no longer being allowed to autonomously initiate psychotherapy. In the *Council Meeting Minutes* (2014), CNO stated that psychotherapy was "a high risk activity and a new controlled act" (p. 58), and expressed concern that basic nursing programs do not provide theoretical or clinical education sufficient for safe performance. Although CNO noted that it may be in the public interest to support nurse psychotherapy together with College-mandated nurse education, they declined this pathway; however, they have not provided a rationale for how requirements for medical orders will ensure public safety. On proclamation of the controlled act, a doctor's or nurse practitioner's (NP) order will be required for a nurse to initiate psychotherapy with a patient. Alternatively, to practice autonomously, a Registered Nurse will need to also obtain membership with the College of Psychotherapy of Ontario (CRPO). The purpose of this study was to explore whether CNO's requirements could negatively impact effective delivery of RN psychotherapy services.

Nurses provide psychotherapy to a broad range of patients, from those with severe and enduring mental health problems to individuals in numerous health care contexts. The requirement of a medical order to initiate psychotherapy appears to disregard fundamental recommendations of the Canadian Nurses Association (CNA) to the Federal government to enable a health care system that is most cost-effective and efficient (CNA, November, 2010, p. 1). To provide effective care within the demands of a changing system, CNA advised the removal of barriers that prevent all health care practitioners to practice to their full scope. Mental health was mentioned as a neglected area that has been underserviced, resulting in over use of acute care facilities and escalated costs (p. 7). Specifically, the Ontario Ministry of Health and

Long-Term Care (MOHLTC, 2009) estimated costs of at least $39 billion dollars annually (p. 15) resulting from unmet mental health care needs, such as lost productivity, law enforcement, disability claims, drug costs, and employee assistance claims (p. 15-16).

According to recent statistics by CNO, there are 6,911 RNs working in the areas of mental health, psychiatric, and addiction services (CNO, 2016b, p. 77), of the total 104,140 RNs in the General Class in Ontario (CNO, 2016b, p. 7). Of those RNs who deliver psychotherapy services, the creation of impediments to this function would be a significant loss to public mental health treatments. Nurses are the largest body of health care providers for the most disenfranchised and vulnerable population suffering from mental disorders. They should have the autonomy needed to work effectively. This is in accord with the Ontario government mandate to improve mental health for all Ontarians; creating healthy, resilient communities; early identification and intervention of mental health and addiction problems; provision of timely, high quality, and integrated services to the public (Service Ontario, *Open minds, healthy minds*, 2011, p. 4).

It is incumbent on the nursing profession to improve their own educational in accord with current initiatives to regulate and improve standards for psychotherapy practice. The decision by the CNO not to provide suggestions for appropriate educational standards and guidelines for safe psychotherapy practice leaves the situation ambiguous regarding how RNs will provide safe and effective treatment for the public. In addition, dual membership with CRPO for those RNs who wish to maintain their own autonomy does not address the need for nurses as a profession to retain their identity as psychotherapy practitioners, as has been historically acknowledged. For these reasons, it is important to understand how RNs currently practicing psychotherapy are

experiencing the regulatory changes, and how the prescriptive order requirement for psychotherapy initiation could be a barrier to public access for these services.

Examining the contextual background of these legislative changes clarifies the problem concerning RN prescriptive requirements. This will include a brief overview of psychotherapy, which is a needed and effective treatment; the *Psychotherapy Act, 2007* and the College of Nurses of Ontario's (CNO) response; the problem of insufficient access to mental health services in Ontario; and prescriptive orders as a barrier to RN psychotherapy.

Psychotherapy as Needed and Effective Treatment

The American Psychological Association (APA, August, 2012a) has formally recognized psychotherapy effectiveness across a spectrum of population groups and psychological and physical problems. Psychotherapy was defined as:

> …the informed and intentional application of clinical methods and interpersonal stances derived from established psychological principles for the purpose of assisting people to modify their behaviors, cognitions, emotions, and/or other personal characteristics in directions that the participants deem desirable. (Norcross, 1990, p. 218)

The APA resolution on the *Recognition of Psychotherapy Effectiveness* (APA, 2012a) had its intention to advance psychotherapy as an evidence-based practice and advocate for increased public access to these cost-effective services (Campbell, Norcross, Vasquez & Kaslow, 2013). The APA's intensive research project (APA, 2012b) found that psychotherapy helps in reducing disability, morbidity and mortality, and psychiatric hospitalization. It improves work functioning and teaches patients self-care skills that last beyond the treatment, and notably, without the harmful side effects of medication.

Psychotherapy and counselling have been reported as the most unmet need for mental health treatment in Canada (Sunderland & Findlay, 2013). In order to create increased public access, the question arises about whether RNs in Ontario are well supported to provide effective care to align with current federal (Mental Health Commission of Canada, 2012) and provincial government (Service Ontario, 2011) policies to augment mental health care service delivery in Canada. In fact, the World Health Organization has encouraged a global initiative for nurses to expand their training and role in mental health services to assist with the severe shortage of nurses able to provide this service (WHO, 2007, p. 5).

Psychotherapy Act, 2007 **and its progression.** Preparation for regulating psychotherapy began in 2005 by the Ministry of Health in Ontario on advisement of the Health Professions Regulatory Advisory Council (HPRAC, 2005). The predominant reason for HPRAC regulatory advisement was out of concern that unregulated psychotherapy could cause harm to the public, and more particularly that individuals without appropriate qualifications could represent themselves as a "psychotherapist" (HPRAC, 2006, p. 207). Of added concern, there were few standards or qualifications outlined for members of regulated health professions who were practicing psychotherapy and this need was identified. A lengthy consultation process was initiated by HPRAC to involve stakeholders in a review of matters related to psychotherapy in Ontario that included extensive background documents, case law, written submissions and public presentations.

Due to the overall lack of access to psychotherapy treatment, it was recommended by HPRAC that the regulation of psychotherapy should include the unregulated practitioners who were qualified and experienced (HPRAC, 2006). Psychotherapy services were decreasing in mental health agencies and institutions. Therefore, to include qualified practitioners into the new

regulatory process was understood to be in the public interest. Most respondents agreed that public interest would best be served by "supporting continued access to psychotherapy services while requiring appropriate high minimum qualifications, standards of practice and public accountability for practitioners" (HPRAC, 2006, p. 214). A new *College of Psychotherapy of Ontario* (CRPO) would set standards and guidelines for unregulated psychotherapy practitioners, and each of the colleges of nurses, physicians, occupational therapists, psychologists and social workers would be responsible for developing standards and guidelines to ensure competency for its members.

In the early stages when HPRAC was seeking consultations from the regulated health care colleges about regulatory protocols, in October 2005 CNO responded that there should not be the need for dual membership with a new psychotherapy college, and this was acknowledged as follows:

> Many practitioners of psychotherapy are currently regulated within their foundational discipline (e.g. medicine, nursing). Dual registration as both a nurse/doctor and psychotherapist would be cumbersome, confusing, potentially contradictory and duplicative. These professionals should be able to access the authority to practice psychotherapy through a mechanism under the RHPA. (CNO, 2005, p. 3-4)

CNO has since dropped the above stated recommendation and instead reported that nurses will not be given standards and guidelines by CNO to determine if an RN is qualified to practice psychotherapy. The alternative available is joining CRPO, which means holding dual memberships in both colleges (CNO, 2014). This decision was made despite recommendations from HPRAC that each of the colleges should outline appropriate guidelines and standards for their members (HPRAC, 2006). CNO also announced, when the controlled act is proclaimed, that nurses will require a prescriptive order to initiate psychotherapy from a physician or NP

(CNO, 2014). In this way, Ontario RNs who have had significant education and expertise in psychotherapy will lose their ability to autonomously engage in their scope of practice. Nurses will not have the same opportunity as the other five regulated professions when they have been equally endorsed by the government to have access to the controlled act.

Insufficient Access to Mental Health Services and Unmet Needs

The restriction for RNs to initiate psychotherapy coincides with the government noting the importance of mental health responsiveness, and to create strategies to improve mental health and provide timely access to integrated and high-quality services for all Ontarians (Service Ontario, 2011). Mental disorders have too slowly been recognized for their impact – for the suffering, disability, and the risk for poor outcome without effective treatment, both physically and psychologically (Ratnasingham, Cairney, Rehm, Manson, & Kurdyak, 2012). In addition to personal and family hardship, the economic burdens due to lost productivity, unemployment and medical expenses are high and estimated at $50 billion per year in Canada (Mental Health Commission of Canada, 2012, p. 8).

Depression is the leading global contributor to disability and burden of disease, and this trend is rising (WHO, 2016). Although effective treatments are now available, the World Health Organization (WHO, 2016, para. 2) has attributed a scarcity of trained health providers and social stigma as barriers to effective treatment, resulting in only 10%-50% receiving needed treatment globally. In Canada, less than half the population with mental health disorders seek and receive psychotherapy treatment (Cohen & Peachey, 2014; Ratnasingham et al., 2012), despite its effectiveness with all forms of depression and a wide range of other mental disorders (Cohen & Peachey, 2014; Hunsley, Elliott, & Therrien, 2013). It is in this context of the current

insufficiency of psychotherapy treatments for Ontarians that these regulatory changes would create more barriers, and this is the concern examined in this study.

Gap in mental health services: a significant need not recognized. Mental illness has not had the same attention and funding as other health problems and has been referred to as an "orphan child" (Canada, 2002, p. 178) of health care. In part, this has been attributed to the initiation of universal health care in Canada and lack of integration of psychiatric services into insured hospital care (Romanow & Marchildon, 2003). Underfunding has remained a chronic problem for service provision. In the 1960s, new drug treatments, specifically chlorpromazine and lithium used for individuals suffering severe mental illnesses appeared to hold the vision of treatment for these people within the community (Davis, 2014). The goal of deinstitutionalization was to downsize the numbers of inpatients while increasing community care. However, this process was greatly underfunded and it was found that moving psychiatric patients from long-term institutional care into the community without sufficient treatment, supportive services, income or housing, did not achieve effective reintegration (Davis, 2014, p. 103-112). Many former patients were now in institutional-like boarding homes or returning to families without support. Homelessness and criminalization increased in this population (Canadian Mental Health Association, 2005; Davis, 2014; Ontario Human Rights Commission, 2012).

Currently, only the most serious mental illnesses with the greatest visible dysfunctions are being treated within the public health system, mainly by psychiatrists, and generally with medications (Davis, 2014; Dewa, Rogers, Kates, & Goering, 2002; Romanow & Marchildon, 2003). Less serious problems are less likely to be diagnosed and treated, despite statistics that one in five Canadians suffer from potentially disabling mental disorders (Romanow &

Marchildon, 2003). Davis (2014) commented on the diagnostic imprecision that defines 'seriousness' in mental disorders and that treatment requirement should be "individualized as much as possible, with functional impairment apart from diagnosis" (p. 8). In an Ontario study, Dewa et al. (2002) expressed concerns that individuals with moderate severity of mental illness do not receive necessary care. Among this category are 13-15% of the population whose diagnostic categories include anxiety, mood, and personality disorders, and self-harm behaviors. In this group, there are limitations of functional impairments and standard measures indicating a "need for treatment" (p. 5).

Unmet service needs for those suffering from mental health problems on a continuum of severity and dysfunction have been extensively documented in government reports (Goldner, 2002; Kirby, 2006; Mental Health Commission of Canada, 2012; Newman, 1998; Service Ontario, 2010, 2011, 2015; Ontario Human Rights Commission, 2012; Canada, 2002; Sunderland & Findlay, 2013; Canadian Mental Health Association, 1963). Examples of treatment gaps in the Ontario health system were described by members of the Select Committee on Mental Health and Addictions as follows:

- Access to acute care hospital beds for treatment is needed – bed availability became the criterion rather than need assessment;
- Consistent, age appropriate and evidence-based assessments for prevention and early identification and treatment is required for children;
- Increased staff expertise and anti-stigma education is necessary in Emergency Departments for patients with mental health crises;
- Primary care physicians and community nurses are the most consulted professionals and often do not receive relevant education during their formal training programs. (Service Ontario, 2010, p. 7-10)

There is recognition that many vulnerable groups are significantly underserviced in Canada and Ontario, including youth, elderly, Aboriginal people, individuals in correctional

facilities, refugees and immigrants, people who have experienced violence, LGBT community, Francophone and rural communities, and people with various disabilities (Service Ontario, 2011; Ontario Human Rights Commission, 2012). Moving forward to improve mental health and well-being for all Ontarians (Service Ontario, 2011) presents challenges that involve streamlining a fragmented system to increase timely access to appropriate services for a diverse population, while at the same time recognizing and working within fiscal limitations (Canadian Mental Health Association, 2012; Service Ontario, 2011; Ontario Human Rights Commission, 2012). This discussion highlights the importance of nurses being supported to work to their full scope of practice, as they are the largest group of health providers dealing with this underserviced population.

Prescriptive Orders as a Barrier to RN Psychotherapy

Prescriptive orders would appear to create barriers to timely access to RN psychotherapy through increased bureaucratic costs, increased wait times for patients, and increased time and responsibility for physicians who may have little understanding about psychotherapy. In a recent Ontario government discussion paper (Service Ontario, 2015) it was proposed that to ensure timely access, “Physicians, nurses and other health care providers would work in a system and structure that supports integration, helps them do their jobs, maintains their clinical autonomy, makes the most of their time and expertise, and sets clear accountabilities” (p. 21). RNs currently practicing psychotherapy with whom the researcher has been engaged with in anecdotal discussions, have expressed concerns about how CNO’s directives could increase barriers for the public. These RNs agreed with the need for increasing access to quality psychotherapy services and the continuation of their clinical autonomy through competencies. They agreed that clear

standards, practice guidelines, and educational requirements resulting in certification were important for ensuring safe practice.

In a discussion between this author and the Physician Advisory Manager at the College of Physicians and Surgeons of Ontario, Brian Goldig indicated that he had not been made aware of CNO's decision for an order to initiate psychotherapy, and stated that this would not be practical. He further stated that doctors in his case would more readily refer psychotherapy clients to social workers, psychologists or occupational therapists, where this constraint did not exist. Given that RNs have psychotherapy within their scope of practice, Mr. Goldig did not understand the rationale for this decision (personal communication, April 25, 2016).

Researcher's Position for the Study

The incentive for this study comes from both personal and professional motivations. As a nurse, I have always been keenly aware of the difference in status given to RNs compared to doctors by the public at large and by many other health care professionals. This is expressed overtly, and often it is unspoken. Although I have found that many doctors are respectful, appreciative and supportive of the roles that nurses perform in health recovery, these doctors are also aware of the unfair preconceptions and express apology for their less respectful colleagues. In addition, my sensitivity about this issue is historical. I was a child of refugee immigrants to Canada, after the Second World War. Many people showed their prejudice freely, and I learned what it was like to be marginalized. As a consequence, I am keenly aware of the demoralizing effect arising from the experience of 'lowered status', and the effects upon a human being of lack of recognition of personhood and expertise. These experiences add to my conviction that the requirement of prescriptive orders for RN psychotherapy initiation will diminish the quality and services that nurses will be able to provide.

From a professional perspective, I am an RN practicing psychotherapy who is being affected by this legislation. In order to retain my authority to initiate psychotherapy, I have joined the CRPO as a registered psychotherapist (RP), to maintain the timeliness and privacy of my service delivery. In my clinical experience, I have found that the immediacy of establishing myself as a trusted professional to whom the person can turn to and feel safe often provides the resource needed for stabilization and resilience building.

My experience is corroborated by current psychotherapy research focusing on attachment theory and its implication for adult healing of trauma (Fosha, 2000; Greenberg, 2010; Porges, 2011; Maunder & Hunter, 2016; Schore, 2003; Siegel, 2012; Wallin, 2007). Consultation with an unknown physician or NP may introduce additional stress and anxiety to a person in an emotionally vulnerable state. Of additional concern is the question of how potentially uninformed medical practitioners would understand psychotherapy as treatment given the current insufficient psychotherapy education in the curriculum for family physicians (Hameed, 2015) and NPs (Gallop, n.d.). Another barrier arises if the physician decides it is best to prescribe medication rather than psychotherapy, resulting in the client not getting psychotherapy, which may have been their treatment of choice.

An additional matter of significance that many of my patients have expressed is the benefit of privacy created by the private practice therapeutic situation. Stigma and shame are commonly experienced when an individual is seeking psychotherapy treatment, in addition to concern about being labelled with a formal diagnosis in the medical system. As a result, patients have expressed reluctance to reveal their psychotherapy treatment with their physician. In the private practice of an RN therapist, patients can be treated without formal diagnosis, which is not

the case for publicly funded services. In addition, a diagnosis by a psychiatrist or psychologist may expose people to restrictions from employment or insurance coverage limitations.

In my advocacy role on the Executive Board of the Mental Health Nursing Interest Group (MHNIG), I have been speaking with RNs who were becoming increasingly aware of the regulatory changes and the effects on the public as they anticipate losing their autonomy to initiate psychotherapy. While they welcomed regulation and increased standards through education and certification, many RNs expressed feelings of demoralization that their current expertise is not being recognized, and frustration that CNO will not be offering credentialing. I am deeply concerned about how RNs will be able to continue contributing to mental health in Ontario, already so underserviced, without support for clinical competence and autonomy to use their judgement and initiative.

Purpose

The primary purpose of this study is to explore how RNs practicing psychotherapy in Ontario are experiencing the changes in the legislation regarding the *Psychotherapy Act, 2007* (Service Ontario, 2007) and their perspectives on how this may impact public access to psychotherapy.

Literature Review

No published articles were found about how Ontario RNs are experiencing the legislative changes and anticipated effects on public access to RN psychotherapy. Studies were found that affirmed the overall effectiveness of psychotherapy as treatment, and others affirmed the effectiveness of RN psychotherapy. An unpublished pilot study (Dresher & Singh, 2015) was conducted with five RNs practicing psychotherapy, to describe their psychotherapy education

and practice experience and is part of the literature review. In addition, research about moral distress was relevant to feelings of powerlessness and demoralization that RNs expressed regarding prescriptive order requirements (Dresher & Singh, 2015). However, given the conceptual ambiguity related to moral distress described by researchers (McCarthy & Gastmans, 2015), Barrett's (2010) theoretical framework, *Power as Knowing Participation in Change,* was chosen for its conceptual specificity. It provides a developed, tested, and validated instrument for measuring the experience of power as individuals move through changes in life. It was also found probable that the structure of Barrett's instrument would protect against researcher bias.

Effectiveness of Psychotherapy

This study's significance is highlighted by the research finding that psychotherapy has been demonstrated to be effective for a wide range of mild and severe mental health disorders. The Canadian Psychological Association prepared an extensive review (Hunsley et al., 2013) based on APA (2012a) findings of hundreds of studies, including both random control trials (RCT) and examinations of psychological treatments provided in health care settings. Psychotherapy was proven to be effective treatment for most forms of anxiety and depression, comparable or superior to medication. Rates of premature pharmacotherapy termination were found to be lower when clients are engaged in psychotherapy. Bipolar disorder was particularly responsive, resulting in increased functioning with fewer relapses and lower suicide rates. In addition, psychotherapy was found to be effective for reducing anxiety and depression in people with coronary heart disease, and more effective than medical treatment for smoking reduction (Hunsley et al., 2013, p. 3). Cohen and Peachy (2014) added that in many cases both cost and relapse rates are lower from treatment with psychotherapy. Treatments have been found to

reduce personal and financial costs as well as reducing burdens on the Canadian workplace and economy (p. 126).

Nursing's History with Effective Psychotherapy Provision

RNs have a long history of providing psychotherapy and have been caring for the mentally ill since the asylum period. Nolan's (1993) article on the history and training of asylum nurses documented how nurses were recruited and trained to treat "lunatics" (p. 1193) by providing a healing environment in the institutions. He elaborated that "good nursing could calm disturbed patients, encourage the depressed and give hope to the hopeless" (p. 1195). Pertinently, nurses have been well placed due to their relationship focus with patients to provide effective psychotherapeutic services (Anderson, 1983; Dewa, Rogers, Kates & Goering, 2002; Flaskerud, 1984; Lego, 1973; Paykel, 1990; Peplau, 1994; Sampaio, da Cruz Sequeira, & Canut, 2015; Spunt, Durham, & Hardin, 1984; Wheeler, 2014).

In a study review, Flaskerud (1984) compared nurse psychotherapy to services of other disciplines. Nurse psychotherapy oriented toward facilitating and stabilizing relationships and support compared to psychiatrists that oriented toward drug treatment (p. 9). Nurse psychotherapy was favorable, and in one study was reported to be better appreciated because of its uninterrupted continuity, it was found to be less threatening, and it resulted in decreased hospitalization and decreased training costs (p. 12). Compared to therapy with psychiatrists and psychologists, outcomes were similar and costs were significantly lower (p. 13). Findings indicated that nurses had greater "appreciation of patients' day-to-day problems and of their home environment" (p. 13). These results were similarly described by Paykel (1990), who reviewed a number of studies in Britain where psychiatric nurses were trained in psychotherapy methods that were mostly delivered in patients' homes. Nurses achieved more discharges and

were more cost-effective than psychiatrists. In community settings nursing care was as effective as psychiatry. Dewa et al. (2002) compared studies of nurses trained in behavioral methods and also found them to be as effective as psychologists in addressing phobias, obsessive compulsive and sexual disorders (p. 24).

Similarly, Marks' (1985) study of nurse therapists providing behavioral psychotherapy in primary care settings found significant improvement for patients up to one year compared to control patients. Among treatment gains were: less time off work for patients and lower costs of using nurses versus psychiatrists; the ease of referral to nurse therapists by general practitioners and shortened time for service delivery to patients; increased learning about mental health issues for general practitioners provided by nurse therapists; as well as less dependency and adverse effects from psychotropic medications used to treat mental health problems. It was suggested that nurse therapists employed in primary care could offset referrals to psychiatric settings by managing medically related problems such as heart disease and rehabilitation of physical disabilities.

Later studies have demonstrated that patients receiving medically-based treatments were significantly assisted by supportive and cognitive therapies delivered by nurses in their psychological recovery related mainly to depression and anxiety (Arving et al., 2006; Badger, FSegrin, Meek, Lopez, Bonham, 2004; Leung et al., 2013; Ross, Davis, & MacDonald, 2005; Ruchiwit, 2012). A more recent study in London, Ontario (Forchuk et al., 2012) demonstrated that nurses assisting patients with serious psychological disorders to transition from hospital to community resulted in shorter hospitalizations, less relapses, and major cost savings.

Despite the substantial evidence that nurses have continued historically to provide effective psychotherapy it is curious that this is not fully 'owned' by the profession. Benner

(1984) suggested that expert nurses need to more clearly detail their clinical knowledge to create awareness about their accumulated refined skills through extensive patient observation and care. Benner added that until nurses document and study these learnings within their practice in systematic ways, they will not fully develop their knowledge base (p. 1-8).

Pilot Study

A recent pilot study (Dresher & Singh, 2015) used an open ended survey and focus group to describe the psychotherapy education and practice experience of five RN participants in Ontario. These RNs reported close compliance to CRPO competencies, based on their levels of experience, psychotherapy training, and expertise with the therapeutic relationship and effective use of self. They had all studied psychotherapy theories and techniques, had supervision and psychotherapy practice experience. They also expressed feelings of frustration that their psychotherapy education and expertise was invisible to CNO, and expressions of powerlessness that they were unable to actively participate in evolving RN psychotherapy practice. In addition, all had difficulty imagining how this decision would not be an impediment for psychotherapy delivery to the public.

Moral Distress

There is a strong association between the feelings of powerlessness, frustration and demoralization expressed by RNs and studies related to moral distress. Andrew Jameton (1984) first defined moral distress as emotional, psychological or physical suffering by nurses “when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action” (p. 6). Jameton (1992) discussed the ethics of justice and the allocation of scarce nursing resources that nurses must deal with on a regular basis (p. 102). In a

review of 20 studies, McCarthy and Gastmans (2015) summarized that moral distress involves elements of constraint from external sources, for example institutional policies and practices, nurse–physician conflicts, and staff shortages, that limit nurses' ability to act according to their values and beliefs. It was generally agreed that moral distress can arise from a number of different sources and that it negatively affects nurses' personal and professional lives, and is ultimately harmful to patients (p. 131). Moral distress effects the person across a large range of feelings from rage (anger, frustration and resentment) to feelings of anxiety and sadness (embarrassment, shame, guilt, dread, anxiety, grief and depression). It commonly includes physical responses such as heart palpitations, diarrhea, and sleeplessness. These symptoms can lead to withdrawal from work responsibilities and inadequate patient care, burnout and attrition.

Moral distress is often associated with a sense of helplessness and lack of power that can trigger self-blame and decreased self-worth. Jameton (1992) differentiated nursing ethics from that of medicine and institutions; whereas nursing ethics arise from a commitment to providing care for patients and maintaining an empathetic stance, health care institutions are ambivalent in this role of caring and are more concerned for the financial, technological and policy aspects of health care. With respect to physicians, Jameton (1992) compared medical ethics with its focus on the physician-patient relationship to that of nursing ethics, which requires the nurse to be attentive to physicians, supervisors, health care institutions, as well as take responsibility for patients. He pointed out that the emotional labor and concern by nurses for their patients' welfare, alongside their limited authority to make decisions created "delicate issues of conscience arising in balancing the needs of the patient against the limitation of the institution" (p. 102). Jameton (1992) made the point that these ethical imbalances need to be addressed to

improve efficiency of health care access, and enable nurses to work to their full scope of practice.

The issues of moral distress seem comparable to the feelings of powerlessness and demoralization that many RNs practicing psychotherapy had already expressed. Even though there is a variety of conceptualizations for the term moral distress, as discussed by McCarthy and Gastmans (2015), there appears to be enough core similarities to give validity to this concept. Many authors describe differences between their own concept of moral distress and that of Jameton (1984). To avoid concerns raised by this ambiguity of definition, Barrett's (2010) theoretical framework was used for this study because it provides a developed, tested, and validated instrument for measuring the experience of power as individuals move through changes. It appeared that by measuring participants' experience of power in the regulatory changes, they would provide data that would illustrate their sense of power and constraint.

Theoretical Framework

Barrett's Theory of Power as Knowing Participation in Change

Barrett (2010) defined power as "the capacity to participate knowingly in change" (p. 48) as an individual stays continually engaged in a change process. The distinction is made between power as freedom, and power as control. The assertion of power as control is associated with a predictable outcome that in reality may not often occur. Barrett suggests that power as freedom generates an unpredictable outcome, which is likely more innovative and creative as it is based on a "non-linear evolving mutual process" (p. 48). Most important, Barrett (1989) described power as a state where people can participate in creating change that is in line with their own belief of what would be positive and successful. Then they will engage themselves energetically

in making the best possible plans and committing themselves to the best possible outcomes. This appears by its definition to be consistent with an absence of moral distress.

Barrett's (2003, 2010) theories are derived from Rogers' (1986) ideas of the unitary nature of human beings, inseparable from their parts, and interdependent. Human beings are part of a universe of open energy systems, integral and in constant interaction with each other. Consequently, change is continuous and evolving (Rogers, 1986, p. 4-5). For example, a person in the ocean encountering a wave will rise and fall and be carried according to the nature of the wave and the energetic state of the individual. The interface between the person and the wave is in perpetual change. Similarly, the contexts within which individuals exist have patterns that continuously change as does the pattern of the individual; this will generate outcomes that may be probabilistic but are not predictable.

Within this context both Rogers (1986) and Barrett (2003, 2010) presume that individuals have the inherent desire and capacity to improve their well-being, which has been found to correlate positively with increased perceived power (Kim, Kim, Park, Park, & Lee, 2008). Barrett (2003, 2010) identified the capacity for individuals to engage with processes of change from four interrelated but distinct aspects as follows: The perspective of their awareness of life experiences; types of choices that can be made in relation to their situation; the degree to which they experience freedom to act intentionally; and the extent to which they are engaged in creating changes. Conscious awareness of one's situation precedes available options, which in turn precedes deciding the best options for the circumstance. Freedom is defined as the extent to which individuals are conscious of the nature of their circumstance, and from this standpoint, can view the best options for themselves and others. Only then can the fourth step, the effective involvement of self in the process, become a factor in the outcome. The range of how individuals

experience their power to make decisions and changes varies with their ability for heightened awareness and discernment (Barrett, 2003).

The intent of this study was to provide data about RNs' experiences of power in the context of the regulation of psychotherapy, how RNs understood their choices and constraints to make decisions, and how they viewed their involvement in making changes regarding the initiation of psychotherapy.

Research Questions

1. How are RNs who practice psychotherapy in Ontario experiencing the process of regulatory changes within the context of the *Psychotherapy Act, 2007*?
2. Do their reactions provide data that may predict impediments for public access to RN psychotherapy?

Research Design and Methods

This is a one-stage cross-sectional study using mixed methods design and includes quantitative (closed-ended and PKPCT instrument questions) and open-ended qualitative components. The design was chosen to gather information and learn about nurses' experiences in regards to the *Psychotherapy Act, 2007*. Johnson, Onwuegbuzie and Turner (2007) argued that this method is economical and has the flexibility to potentially include a wide range of data and to develop a stronger understanding of the research questions. As an increasingly used paradigm, mixed methods designs are recognized as the third major research approach alongside quantitative and qualitative research (p. 112). From a philosophical perspective, the mixed methods paradigm embraces the concept of "multiple or relative truths" (p. 113) and includes knowledge that can be attained by blending quantitative and qualitative research. The researchers

stated that mixed methods research is suitable for questionnaires because of its simplicity of instrumentation and adaptability for inclusion of data collection for both quantitative and qualitative responses (p. 118). An advantage of mixed methods is that biases and limitations unique to each of qualitative and quantitative data collection methods could be "neutralized" (Creswell, 2014, p. 15) by blending data from the two paradigms.

Researcher bias was addressed in this study by maintaining a self-reflective approach with mentors to raise awareness about my own preconceptions, beliefs and biases. I have endeavored to be conscious that my questions were not leading participants toward my biases. As I read the transcriptions, I remained attentive to avoid my biases and to capture the true intent of what was stated by participants as has been recommended (Streubert & Carpenter, 2011, p. 26-27).

Sampling and Ethics

A convenience sampling method was used with added snowballing to recruit 23 RNs across Ontario who identified that they currently practice psychotherapy and were aware of changes introduced by regulatory changes to psychotherapy practice. These factors were determined as the inclusion criteria and the reason for this sampling method was the need to select RNs who were knowledgeable about the subjects of concern (Polit & Beck, 2012). Most of the RNs were known to the researcher through shared interests and concerns about the upcoming CNO regulations about psychotherapy initiation, and others were referred. Since a small sample size and non-random sampling were used, this study has limited external validity and results cannot be generalizable.

Study participation was totally voluntary and anonymous. The questionnaires, audio-recordings, and transcribed interview notes were secured on a password protected hard drive and

kept in a locked cabinet in the researcher's office. Participants were asked to participate in the study and were informed that their names would not be used in order to protect privacy and encourage full disclosure. If they agreed, they were asked to sign informed consent, approved in advance by York University Ethics Review Board. The consent form included Ethics Review Board contact information. Each participant completed a paper version of the PKPCT Version II that was attached to the demographics survey. Participants each received a $10 Starbucks gift card as a token of appreciation for their time and effort.

Data Collection

Data collection was conducted from November 2016 to January 2017. Informed consent from participants preceded data collection. Out-of-town participants were asked to mail their consent forms to the researcher. Data was gathered by a questionnaire (see Appendix A), and followed by audio-recorded one-on-one interviews. The researcher met local participants in person; others were interviewed by phone. The questionnaire required the inclusion of participants demographic information (education and experience), and Barrett's PKPCT Version II instrument (included in Appendix A). Participants were informed that the questionnaire should take less than 20 minutes to complete and the interview would take 30-45 minutes. Audio-recorded interviews were transcribed and analyzed for thematic content.

Power as Knowing Participation in Change Tool (PKPCT) Version II

Barrett (2003) created the Power as Knowing Participation in Change Tool (PKPCT) to measure an individual's experience of power as expressed by "awareness (A), choices (C), freedom to act intentionally (F), and involvement in creating change (I)" (p. 21) that she referred to as the "power profile" (p. 22). It is the continuous dynamic movements between A, C, F and I

that constitute power. The power profile provides information about how an individual's power could be strengthened. It is structured to measure and report on these four dimensions of power and it was used in this study to reveal data about the participants' experiences.

The PKPCT Version II (See Appendix A) consists of 7-point semantic differentials scoring 12 randomly ordered opposite adjective pairs for each of the four power subscales (Barrett, 2003). In each power subscale, one adjective pair is repeated in reverse order, for re-test reliability (p. 32). The word 'power' is not used on the instrument to avoid bias. Participants score each question by choosing the appropriate answer on a 7-point scale. Each answer is associated with numerical value 1 to 7. The scores are summed, the range for each power subscale is 12 to 84, and the total power score can range from 48 to 336. Lower scores indicate lower power and higher scores indicate higher power (scoring process is outlined in Appendix B). Use of the tool requires permission, which was given by Dr. Barrett's representative (Dr. Malinski, November, 2015, personal communication). Reliability (Cronbach's alpha) of the original PKPCT ranged from 0.63 to 0.99 for the four subscales and validity coefficients ranged from 0.56 to 0.70 (Barrett, 2010, p. 49). Psychometric evidence and support for the reliability and validity of the PKPCT has been reported in Barrett's (2003, 2010) earlier studies.

PKPCT Version II Research Questions

The following questions guided how the PKPCT Version II was used to provide study data:

1. What are demographic characteristics of RNs engaged in psychotherapy in Ontario?
2. How reliable **is** the Barrett PKPCT Version II instrument for measuring the experience of power for RNs?

3. Are there any associations between demographic characteristics (gender, age, education, experience, supervision hours, etc.) and the four subscales of the experience of power as measured by PKPCT tool?

Data Collection for PKPCT Version II

PKPCT Version II instrument was placed after the demographic section of the survey. The researcher gave participants the instructions (by phone and in person meeting) related to PKPCT portion of the questionnaire. It was explained in the following manner: “Here is the questionnaire I would like you to complete. It is about your experience with the upcoming psychotherapy regulatory changes and how you are feeling about how CNO is dealing with these changes concerning nurses. There are four sections. The first is about your own awareness of this situation. The next one is about the choices you feel you can make given this situation. The third section is about the freedom you have to act in this situation. The fourth is about how you feel you can create change in this situation. There are 13 questions in each section and for each question you choose where on the scale you find yourself between the 2 opposite adjectives. There are no right or wrong answers, so fill it in the way you think best fits for you”.

Interview Questions

After participants completed the questionnaire, the following open-ended questions guided the audio-recorded interviews by the researcher:

1. Please describe your awareness of the change related to the regulation of psychotherapy.
2. How do you see the choices you have been given in this situation?
3. How would you describe your freedom to act intentionally given this situation?

4. What do you see as your involvement in creating change given this situation?

Data Collection for Open-Ended Interviews – Researcher's Role

Stiles (1999) spoke about the necessity for "permeability" (p. 99) rather than "objectivity" (p. 99), a concept that does not seem possible in qualitative research. Rather than approaching the participant with the researcher's fixed assumptions, permeability challenges the researcher to sustain an open mind and receptivity to understand nuances of meaning and frames of reference of the participant. Stiles (1999) distinguished the tools of quantitative measurement, such as scales of data related to numbers, while qualitative data gathering requires the researcher to be the instrument using "their (imperfect) empathetic understanding of participants' inner experiences as data" (p. 99). Creswell (2014) summarized that the central guiding principle for the researcher is to seek the meaning of the problem *from the participants*, not the researcher's opinion nor that expressed in the literature (p. 186).

Researcher bias can have great impact on the validity of the data and its interpretation, and must be avoided to the extent possible. Creswell (2014) warned of "reflexivity" (p. 186) and how the researcher's background, experiences, and values may influence the direction and shape of the study. The researcher must be explicit about their own biases and personal opinions, and mindful about how this may be communicated to participants in a way that seeks support for the viewpoint of the researcher. As I reflected on my own process of inquiry, I noted my own biases and opinions, for example, that there was the need for a certification process to expand the competency of RNs. The participants in this study were familiar with my opinions because they knew of my role in advocating against the CNO decision. I would acknowledge my own opinions, at times by enthusiastically, more than I had intended, in agreeing with a participant's

statement. As I took note of these instances, I then would follow by deepening the discussion of the participant's experiences to gain further clarification. In the deepening process, I found that more themes emerged and extra dimensions and complexities of the problem developed, and became shared experiences and knowledge between us. Each participant contributed their unique experience about how the legislation was affecting them. As Creswell (2014) noted, the inquiry that started with core themes was expanding and changing (p. 185-186).

I would begin the interviews by asking the questions listed above. Given they had just finished Barrett's questionnaire, their minds were still focused on the topic of interest. I encouraged participants to use their own words. I avoided asking "why", and instead asked questions such as, "What was your experience about that?" I was often moved by their passion and dedication; at those points I focused more, used words and body language that expressed my interest, paraphrased, and encouraged further clarification. Many participants expressed a great deal of affect, some weeping, and others observing that they had not previously understood the extent of their feelings on this topic. Stiles (1999) referred to this as *testimonial validity*, where participants indicate feeling understood (p. 100), after which they reveal deeper material and substantiating anecdotes.

Analysis

Descriptive statistical analysis was used to summarize the results. The SPSS software package was used for analysis of the demographic survey questions and PKPCT Version II. Summary tables and graphs have been used to present the results. Associations between the four power subscales were explored using correlation analysis. Inferential statistical methods (t-test, one-way ANOVA) were used to check for relationships between demographic factors and power scores. Exploratory analysis was used for the interview questions and the results were qualitatively summarized with regard to themes that emerged.

Results

Question 1: Descriptive statistics

Descriptive characteristics are summarized in Table 1. Most participants in the sample were females (83%), middle-aged (mean age 47.78 years). Half (48%) have Master's Degree (or higher) for nursing education, all have some level of psychotherapy education (most common being Cognitive Behavior Therapy, Dialectical Behavior Therapy and Motivational Interviewing). Participants have between 5 and 39 years or practice (mean = 23.13 years), with 0.75 to 28 years being in psychotherapy (mean = 10.90 years). Most participants (70%) worked in the hospital or dealt with outpatients (61%). Participants varied in the amount of psychotherapy supervision received, with some having no supervision and some getting up to 150 hours per year (mean = 43.57 hours).

Table 1. Descriptive characteristics of the sample, $n = 23$

Descriptive characteristics	**N (%) or *Mean* ± *SD* (*range*)**
Gender	
Male	4 (17%)
Female	19 (83%)
Age, years	47.78 ± 10.63 (28 – 64)
Nursing Education	
RN Diploma	2 (9%)
BScN	9 (39%)
MScN or MN	11 (48%)
Education in psychotherapy[1]	
CBT	11 (48%)
DBT	7 (30%)
MI	7 (30%)
Others	23 (100%)
Other education	6 (26%)
Nursing practice (years)	23.13 ± 11.01 (5 – 39)
Psychotherapy practice (years)	10.90 ± 7.84 (0.75 – 28)
Current nursing practice[1]	
Hospital	16 (70%)
Outpatient	14 (61%)
Teaching	11 (48%)
Private practice	5 (22%)
Research	5 (22%)
Community	5 (22%)
Psychotherapy supervision (hours per year)	43.57 ± 42.37 (0 – 150)

[1] Percentages do not add to 100% since multiple modalities can be learned or nurse can have multiple practice activities/roles

Question 2: Instrumentation of Barrett PKPCT Version II

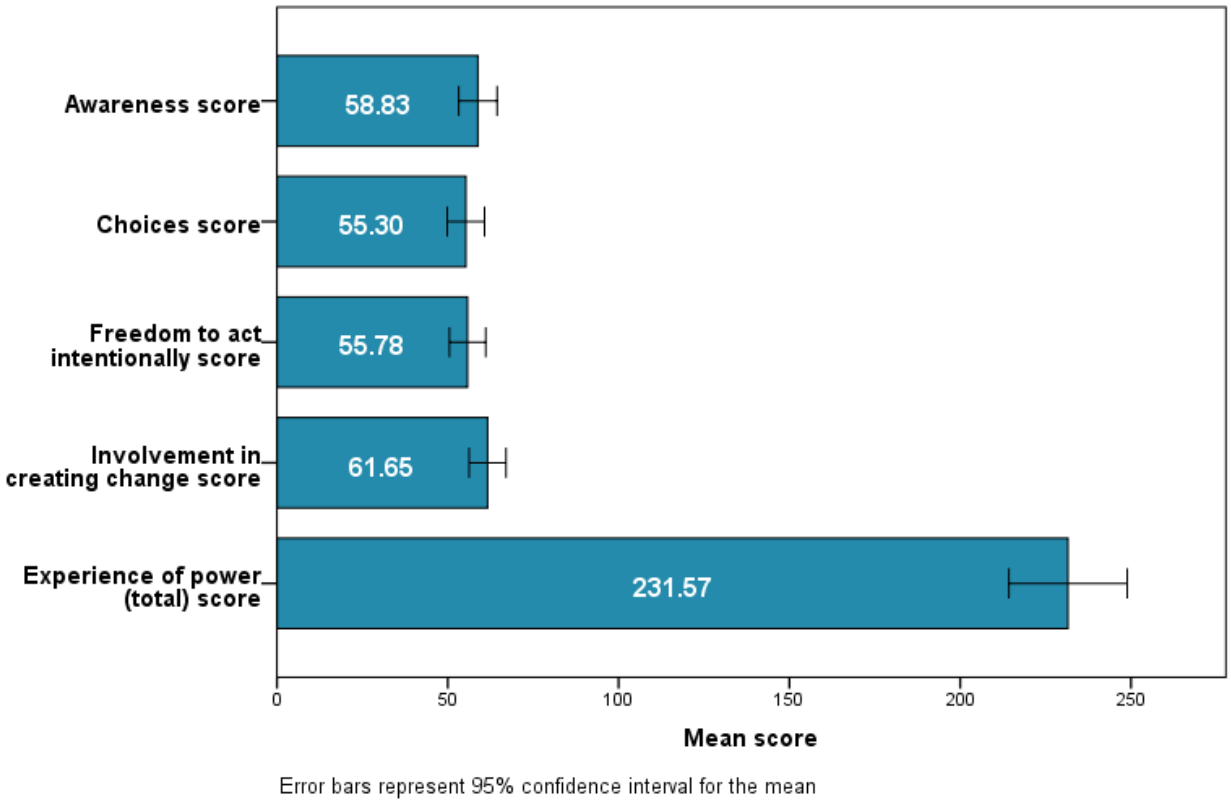
The Barrett PKPCT Version II tool scoring guide (see Appendix B) has 13 questions in each of the four domains/subscales: Awareness, Choices, Freedom to act intentionally, Involvement in creating change. Each item has two bipolar adjectives (for example, pleasant/unpleasant) and the participant chooses degree between these two words using a 7-point scale (value between 1 and 7). Half of items (24 out of 48) are reverse-coded and one (last) item in each subscale was ignored as it is a verification/validation question.

To address research question 2, the reliability of the instrument was assessed using Cronbach's Alpha as a measure of internal consistency. Typically, a value above 0.8 is considered reliable, and Barrett (2010) reported reliability of the PKPCT in the range between 0.63-0.99 (p.49).

Table 2. Reliability of Barrett PKPCT Version II instrument, $n = 23$.

Barrett PKPCT version II subscale score	*Number of items in the scale*	*Cronbach's Alpha*
Awareness	12	0.901
Choices	12	0.903
Freedom to act intentionally	12	0.879
Involvement in creating change	12	0.910
Experience of power score	48	0.950

Table 2 shows reliability of subscales and an overall score in the sample, with all values being 0.879 and above, and overall reliability of 0.95. This shows a high level of internal consistency, and responses to individual items can be consolidated and calculated for composite scores. The 12 responses in each of the 4 domains are summed together to make the composite scores. The composite score is a value between 12 and 84, with higher scores representing a greater perceived level of power. The total experience of power score is calculated by summing four subscale scores.



The diagram above shows average (mean) composite scores for four subscales of PKPCT domains as well as overall experience of power score. The error bars represent 95% confidence intervals for mean values. The diagram shows a higher mean score for involvement in creating change subscale compared to the other three subscales.

Question 3: Correlations of Demographic Characteristics and PKPCT Subscale

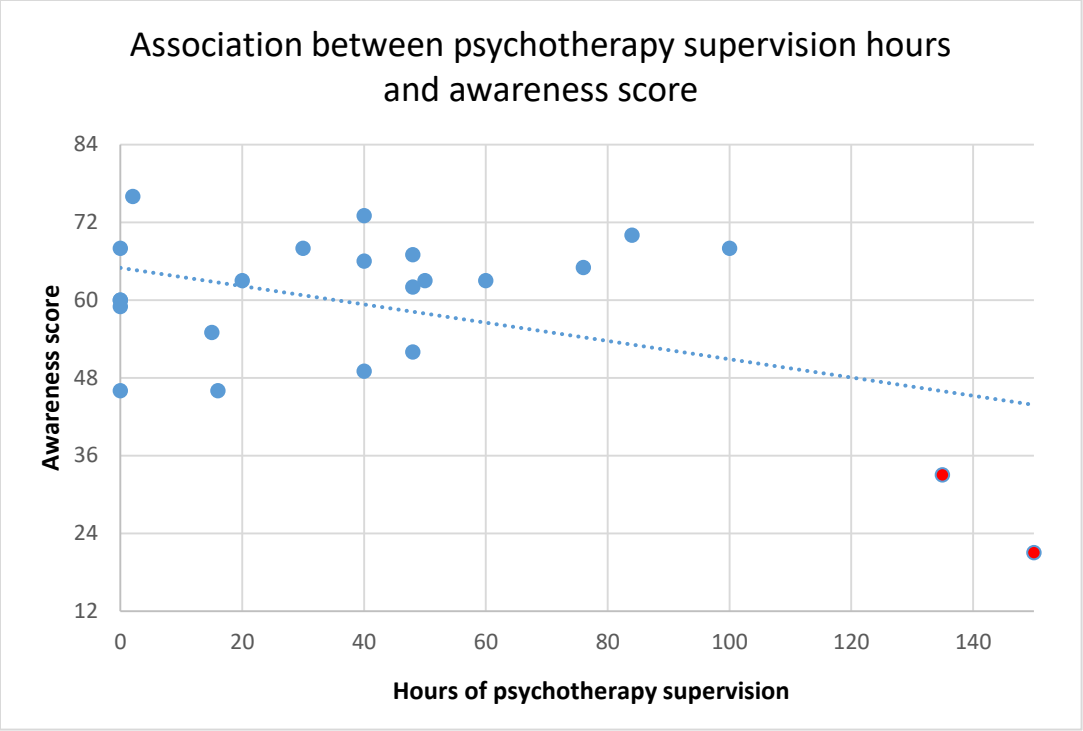
Table 3, 4, 5 and 6 summarize the correlations of demographic characteristics and the PKPCT subscales.

Table 3. Barrett PKPCT Version II instrument scores and their correlations with demographic characteristics of participants

Barrett PKPCT version II subscale score	*Mean* ± *SD* (*range*)	Correlation coefficient between subscale score and demographic characteristics below			
		Age	Nursing practice (years)	Psychotherapy practice (years)	Psychotherapy supervision (hours per year)
Awareness	58.83 ± 12.93 (21 – 76)	-0.165	-0.123	-0.187	-0.462*
Choices	55.30 ± 12.61 (31 – 70)	-0.105	-0.132	-0.036	0.071
Freedom to act intentionally	55.78 ± 12.29 (33 – 75)	0.135	0.053	0.201	-0.137
Involvement in creating change	61.65 ± 12.54 (33 – 77)	0.135	0.085	0.026	0.136
Experience of power score	231.57 ± 40.03 (157 – 290)	-0.003	-0.038	-0.002	-0.126

* statistically significant with $p < 0.05$

Correlational analysis showed only statistically significant association between psychotherapy supervision hours and awareness score, $r = -0.462$, $p = 0.027$. This suggests that participants with higher psychotherapy supervision hours are associated with lower awareness scores. However, the question arises when examining this relationship is that it might be due to two nurses who had a substantial amount of supervision hours.



An association between hours of psychotherapy supervision and awareness score was further explored after removing two outliers (two participants with an unusually large number of hours, 135 and 150). Correlation analysis was conducted using data for 21 remaining participants (instead of original 23) and we found weak positive association, $r = 0.28$ which is no longer statistically significant ($p = 0.21$). This suggests that original negative correlation was mainly attributed to two outliers, once they are removed the association is no longer present.

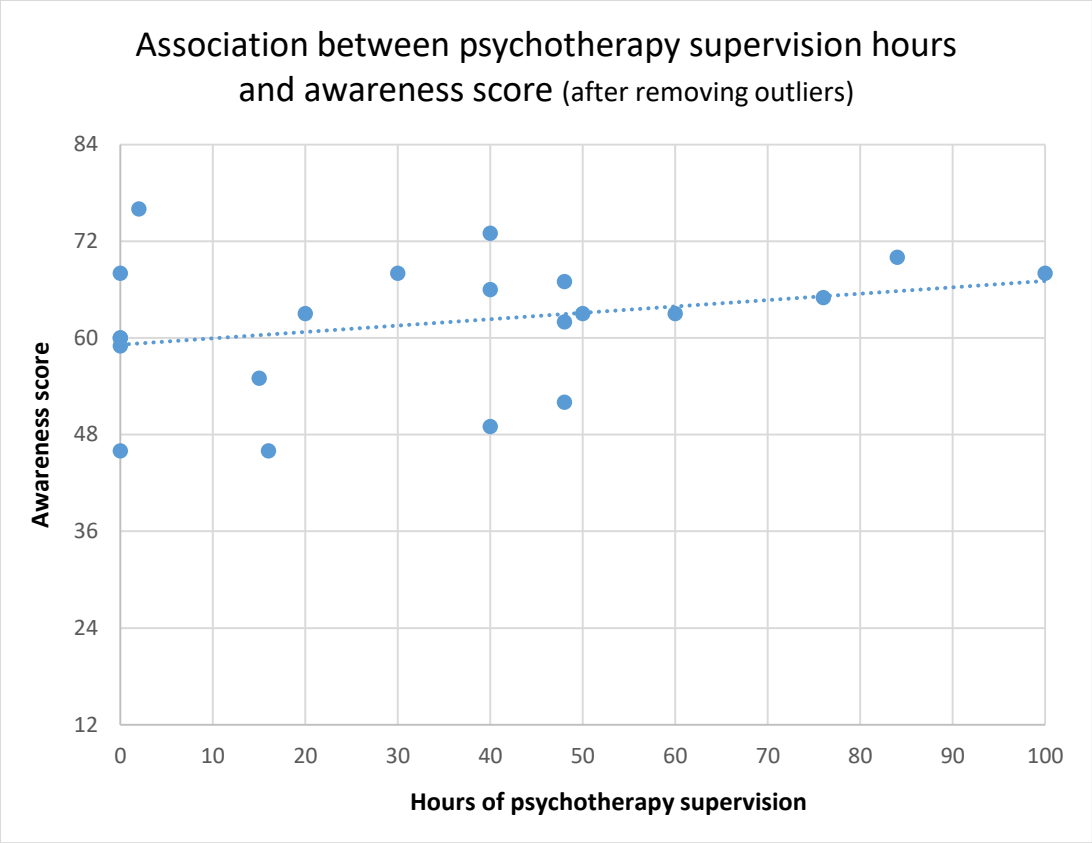


Table 4. Correlation coefficients between subscales

	Awareness score	Choices score	Freedom to act intentionally score
Choices score	0.358		
Freedom to act intentionally score	0.348	0.703*	
Involvement in creating change score	0.384	0.594*	0.680*

* statistically significant with $p < 0.05$

All subscales were found to have positive moderate-strong correlations, with choices, freedom to act intentionally and involvement in creating change having statistically significant correlations. Awareness scores do not correlate significantly with other three subscales, although the correlations are moderate and positive. The correlation between choices and freedom to act intentionally indicates that participants who feel they have more perceived power regarding their

choices (choices score) also have more power to act with those choices (freedom to act intentionally).

Exploring Factors that Impact Power Scores

A series of independent sample t-tests were conducted to explore differences in scores between various demographic groups. Female participants (n = 19, M = 64.16, SD = 11.37) were found to have significantly higher involvement in creating change score compared to males (n = 4, M = 49.75, SD = 12.18), $t(21) = 2.28$, p = .03. Participants working with outpatients have significantly lower involvement in creating change score (n = 14, M = 57.43, SD = 12.62) compared to RNs not working with outpatients (n = 9, M = 68.22, SD = 9.68), $t(21) = 2.18$, p = .04. No other statistically significant differences were found (for example, RNs working in the hospital versus not, or RNs involved in teaching versus not, etc.).

Participants were also categorized as teaching, private practice, research, and community versus not. It was found that 17 participants (74%) were working in multiples of these four practice categories. Independent samples t-tests shows no statistically significant difference in any of the four subscale scores or total power score among those 17 nurses who work in teaching, private practice, research, community compared to those 6 who do not.

Participants were classified based on years of psychotherapy practice into two categories: less than 10 years versus 10 or more years. An Independent samples t-test was conducted to explore differences in subscale scores between two groups of RNs based on their psychotherapy experience (Table 5). No statistically significant difference was found in either of four scales, as shown in the table below.

Table 5. Comparison of subscale scores between psychotherapy experience levels, $n = 23$.

Subscales	Years of psychotherapy practice		Independent samples t-test for comparison
	less than 10 years, $n = 10$	10 or more years, $n = 13$	
Awareness	$M = 61.90$, $SD = 7.39$	$M = 56.46$, $SD = 15.87$	$t(21) = 1.00$, $p = .33$
Choices	$M = 55.00$, $SD = 14.70$	$M = 55.54$, $SD = 11.38$	$t(21) = 0.10$, $p = .92$
Freedom to act intentionally	$M = 52.70$, $SD = 14.59$	$M = 58.15$, $SD = 10.16$	$t(21) = 1.06$, $p = .30$
Involvement in creating change	$M = 60.90$, $SD = 15.32$	$M = 62.23$, $SD = 10.55$	$t(21) = 0.25$, $p = .81$
Experience of power score	$M = 230.50$, $SD = 44.65$	$M = 232.38$, $SD = 37.95$	$t(21) = 0.11$, $p = .91$

RNs were classified based on education level into two categories: BScN or RN versus MScN, MN or PhD (undergraduate versus graduate level). An independent samples t-test was conducted to explore differences in subscale scores between two groups of RNs based on their level of education (Table 6). No statistically significant difference was found in any of the four scales, as shown in the table below.

Table 6. Comparison of subscale scores between levels of education, $n = 23$.

Subscales	Education level		Independent samples t-test for comparison
	BScN or RN, $n = 11$	MScN, MN or PhD, $n = 12$	
Awareness	$M = 57.45$, $SD = 17.02$	$M = 60.08$, $SD = 8.22$	$t(21) = 0.48$, $p = .64$
Choices	$M = 57.09$, $SD = 13.87$	$M = 53.67$, $SD = 11.72$	$t(21) = 0.64$, $p = .53$
Freedom to act intentionally	$M = 57.18$, $SD = 12.95$	$M = 54.50$, $SD = 12.07$	$t(21) = 0.51$, $p = .61$
Involvement in creating change	$M = 59.73$, $SD = 15.04$	$M = 63.42$, $SD = 10.09$	$t(21) = 0.70$, $p = .49$
Experience of power score	$M = 231.45$, $SD = 51.06$	$M = 231.67$, $SD = 28.88$	$t(21) = 0.01$, $p = .99$

Content Analysis of Interviews

The central purpose of the interviews was to explore how RNs are experiencing the changes regarding the *Psychotherapy Act, 2007,* and how this may create additional impediments for public access to psychotherapy. The interviews provided rich data by participants that was examined from the perspective of procedure and theoretical guidelines.

The content analysis began after the audiotapes were transcribed verbatim. Transcriptions were read at least three times and themes were recorded manually on an Excel spreadsheet. I endeavored to stay alert to my own reflexivity while identifying themes described by the participants. I carefully recorded all themes with any differences. Sixty themes were discerned with 2-23 participants mentioning each theme. The themes were then categorized into how each RN experienced the four power domains: awareness, choices, freedom to act with intention, and involvement in creating change. Next, themes were explored to find commonality between them, and further consolidated into subgroups. This was an iterative process; as I began to realize that participants were expressing similar themes using different words and anecdotes, I made a series of adjustments before the theme placements became final. For example, in the awareness domain, 5 themes were merged into the "lack of support by CNO" subgroup, and this process was also used for the other themes. Finally, I selected the most important themes, mentioned by most participants and having highest significance to service delivery. These are outlined in the discussion section.

Themes in awareness categories were grouped into the following four subgroupings: lack of support by CNO (5 themes), barriers to care (8 themes), lack of clarity (9 themes), lack of sufficient education with no guidelines to assess competency leaving patients unsafe (3 themes). Themes in involvement in creating change categories were grouped into the following three

subgroupings: advocacy about the issue of psychotherapy (8 themes), feeling discouraged (5 themes), desired outcome (4 themes).

The content analysis of the interviews was informed by the following principles. Stiles (1999) underscored that to achieve trustworthiness in qualitative studies there must be the perception that the researcher carefully weighed the data regarding the importance and pertinence to the themes, and the interpretation about the phenomenon under investigation (p. 100). This study was not designed for another researcher to provide validation for thematic analysis. However, I shared the 60 original themes with my supervisor and a colleague, asking for feedback as to whether the reduction of these themes appeared accurate. The data from Barrett's instrument provided a triangulated data source for additional validity, an advantage of mixed methods studies (Creswell, 2014). As also recommended by Creswell (2014) to enhance validity, I incorporated detailed descriptions of the participants' experiences to provide the reader with a rich contextualized impression.

Themes of Awareness Relating to Changes of Psychotherapy Initiation

Awareness about the regulatory changes varied amongst the participants. Some had been following the legislating process since the beginning, and others had been more recently informed. Four predominant subgroups of themes were expressed that included: lack of support by CNO; problems relating to barriers to care for the public; lack of clarity about the *Controlled Act of Psychotherapy* as it would affect their practice of psychotherapy initiation; and absence of sufficient education and guidelines to define competency for RNs, leaving RNs vulnerable and patients unsafe with regard to psychotherapy treatment.

1. Lack of support. The strongest theme expressed by participants was the general lack of support they were experiencing from their representative College. All participants (100%) stated they felt not backed up by CNO and confused about why CNO would restrict RNs' ability to initiate psychotherapy (100%). Participant 6 stated:

> It does leave us with a sense of fending for ourselves … it's not as secure. It makes me feel less important.

Participant 12, who is currently working on a master's degree in another healthcare discipline because she did not feel safe practicing psychotherapy as a RN commented:

> I am feeling pretty excited about going to a college that's supportive of psychotherapy for their members.

It was agreed by all participants (100%) that regulating psychotherapy was important and RNs needed appropriate education, experience and supervision to perform psychotherapy. However they expressed shock and disappointment that RNs who were already well educated and highly experienced in psychotherapy provision were not being treated in the same manner as their interdisciplinary colleagues who had been given access to the controlled act. Participant 19, who already had achieved advanced psychotherapy training and experience stated:

> I can't believe that [our] role would be narrowed down to medical monitoring and education and supportive work if we're such trained individuals who can adequately be doing psychotherapy like any other discipline … The fact that I will now need a doctor's order to make a decision for something that previously, with regard to my training, I had qualifications to be able to decide who would benefit from the different forms of treatment, I just find it very disillusioning and disheartening … I find that very disheartening in working with my students.

The lack of recognition that there is already strong representation of highly skilled practitioners of psychotherapy amongst RNs in Ontario, left all participants (100%) feeling their

competency was being unrecognized and devalued. Participant 9 pointed out the inequity of her situation. She is receiving the same training as others on the interdisciplinary team and stated:

> I would be the only one on the team that would have to get a doctor's order to perform it … it would mean a lot of running around looking for a physician … it devalues my clinical judgment.

Almost all participants (87%) commented that nursing is the only discipline with access to the controlled psychotherapy act requiring an initiation order and generally felt this was unfair.

2. Barriers to care for the public. Participants expressed concerns that initiation of psychotherapy requiring medical orders would have considerable impact on public service provision for mental health treatment. All but one participant (96%) commented that there would be increased bureaucratic requirements with related costs across health settings where RNs engage with various psychotherapy interventions in their practice. Amongst the anticipated problems was the dependence on physicians or NPs to write orders. About half of participants (52%) acknowledged that RNs practicing in independent psychotherapy roles (i.e. community, independent practice) may not have access to physicians or NP's, and this would delay public access. For example, Participant 7, who practices psychotherapy in a remote area of Ontario specified:

> A good majority of people here do not have access to a primary healthcare provider … Most people go to walk-in clinics.

A similar situation was reported by Participant 14, working in a predominately Francophone community and expressing similar concerns regarding barriers:

> In mental health everywhere but especially with the francophone population, there's been less resources, even less of French-speaking mental health providers to provide care … This issue of access is multiplied by ten for this population.

Participant 22 provides psychotherapy services in a rehabilitation center and stated:

> It's also very short-sighted because it creates other barriers for people being able to access needed services when the healthcare system is already strapped, especially around mental health supports for people and so we need to open up resources and possibilities for the public and for the clients, not limit that through added layers of paperwork or bureaucracy.

Another concern was raised by Participant 3 who worked in a community mental health team and noted the disruptive nature of an order requirement and how the nature of conversations with patients would change:

> Someone would be talking to me about something and I would have to say, "I'm not able to have any further conversations with you about this… I am going to have to refer you to somebody else to go a little bit deeper into these conversations".

Participant 3 was anxious about being unable to work to full scope of practice and leaving distressed patients without the support they needed while waiting for orders or another provider. This concern was similarly articulated by Participant 17 who noted the interruption within the RN-patient therapeutic alliance, as nurses would need to consider whether they are within the scope of the controlled act:

> We're not being able to practice our full scope, and that's the real concern I have with the CNO's mandate right now of a doctor's order or a nurse practitioner's because I think it's really limited our being able to address client concerns fully in the moment. We're not able to practice in the moment due to this ruling.

The concern that physicians or NPs with limited knowledge regarding mental health and psychotherapy who may not understand the complexities involved was voiced by a number of participants. Requiring prescriptive orders from health care providers who understood less than RNs providing this treatment was experienced as unfair to the public and the RNs (39%). Participant 14 was concerned about the lack of psychotherapy background of prescribers:

> The people who will be forced to prescribe it, don't understand what it is about and how it could benefit their clients … the NP on our unit didn't study mental health so she's here to look at the physical side of our patients.

About a quarter (26%) of the participants expressed unease for their own work safety that doctors may not be willing to write orders. Participant 21 questioned why physicians would take on the prescribing responsibility for themselves:

> Unless you have an established physician relationship, why would a doctor take on a nurse that's out in private practice to write an order? … I see that as a major barrier for nurses to practice in the community.

Participant 3 expressed similar unease:

> We're going to be doing border line psychotherapy and we're practicing in this gray area and you know, if it ever gets challenged legally, where would we stand?

Several participants (17%) suggested that some doctors may be inconsistent or lack the incentive to write orders as in this example by Participant 1:

> We also have different physicians every day coming in. Continuity of care and the orders for psychotherapy may not be consistent. You might have some doctors say "I'm not ordering that – it doesn't need an order".

A number of participants (43%) emphasized that the added measures to cover RNs to initiate psychotherapy will add more bureaucratic costs for mental health, and in addition, more costs for RNs to belong to two colleges. More than two thirds of participants (70%) believed that this would result in RNs performing less psychotherapy and consequently, access to psychotherapy would be limited for the public (65%).

3. Lack of clarity regarding controlled act of psychotherapy for nurses in Ontario.

Related to the concept of awareness, many participants (78%) reported a lack of clarity regarding changes in the proposed act, and how this will relate to RN practice. Most participants (87%) reported that as they have been reflecting on the process of instituting the Psychotherapy Act, there is growing realization that nurses do perform psychotherapy, and/or at least certain

components of psychotherapy either in formal treatment sessions or in daily interactions within their role of establishing therapeutic alliances with patients.

Participant 3 described a survey process his agency was using to enable more understanding about how RNs perceived differences between counselling and psychotherapy. This participant reported his own understanding to be in a "grey area", as he frequently used aspects of psychotherapy in his practice. While most RN colleagues similarly thought "grey area", they reported "counselling" on the survey. He was then interviewed by the supervisor because he had reported "psychotherapy" as he recognized the aspects of his work that extended beyond what he understood to be counselling. The supervisor told him that she was concerned that most nurses were considering that counselling was the extent of their work because: "Counselling is the easier way and it's going to cause less issues".

Three quarters of the participants (74%) reported similar concerns about the overlap between counselling and psychotherapy and how this has resulted in "lack of awareness" about what RNs are doing in their psychotherapeutic role. Participant 1 remarked:

> I'm not sure necessarily I identify it as psychotherapy. I do recognize that many parts of what I do are psychotherapy, but it's certainly not in that moment, I'm not thinking, this is a component of psychotherapy … I may not necessarily use all of the tools [i.e. CBT, DBT] in all of the different styles, but I might use a bit here and a bit there, depending on the client and their needs. So having orders if you're going to have those conversations might be a challenge.

A number of participants similarly commented that they experienced confusion about what was and what was not psychotherapy. Participant 15 commented:

> Like CBT, some people are saying its psychotherapy, but some people are doing it and not calling it psychotherapy – it's confusing.

Participant 7 elaborated that the lack of explanation by CNO regarding what constitutes psychotherapy, made it difficult to assess what RNs are actually doing within their therapeutic

relationships. Participant 7 gave the example of "supportive" psychotherapy as a therapy modality requiring advanced skills of active listening and compassion. Although this Participant has taught these skills to medical students, what remains confusing for RNs is that there is little guidance about how to differentiate psychotherapeutic approaches that RNs commonly use:

> From my perspective what is going to happen is that nurses will either just try and fly under the radar and say that they're not doing it [psychotherapy], or we're going to be setting up medical directives, because those that recognize that this is what nurses do are going to be trying to set up medical directives or loopholes or getting prescriptions in different, you know, creative ways. So it's not actually going to do what the college says that they're trying to do, which is protect the public.

A number of participants voiced their unease that the description of psychotherapy used in the *Psychotherapy Act, 2007* (as follows) so closely followed how they perceived their own work in nursing:

> In the course of engaging in the practice of psychotherapy, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to treat, by means of psychotherapy technique delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgment, insight, behavior, communication or social functioning. (2007, c. 10, Sched. R. s. 4.)

Participant 5 stated:

> To me psychotherapy is something I do regularly as a part of being a nurse. So, I've never really thought of that as psychotherapy … I see anybody working within mental health definitely is doing that.

Most participants (78%) agreed that RNs working within mental health would be performing the controlled act as they are working with the most severely diagnosed psychiatric patients.

Over half the participants (57%) thought that psychotherapy expertise is used for medical as well as psychiatric patients. As Participant 16 reflected on her experiences working in oncology, palliative and hospice care, homeless adults, primary care, and more recently student mental health, she believed it was the trauma experiences of many clients that required the

serious engagement of a therapeutic alliance. This participant was hired specifically to work with students with mental health problems:

> We're seeing a lot of clients with mental health issues on campus. I communicate with clients in terms of building a therapeutic relationship primarily, like a cornerstone for psychotherapy… There's a lot of scenarios I find that I'm using psychotherapy in some capacity, whether it be in a crisis where someone is presenting suicidal or presenting anxiety. It could be in a primary care kind of context, like anxiety could be related to a procedure that needs to occur.

Most participants (78%) agreed that the therapeutic relationship has historically been the cornerstone of RN practice, and some aspects of psychotherapy are part of every-day nursing practice (74%). Participant 6 summarized comments that were expressed by many participants:

> I think this speaks to the whole historical role of nursing of always being sort of the assistant looking for permission from other professions. Why don't we have confidence to not seek permission from other disciplines? … I think it goes back to the militaristic way of thinking when nurses looked to an authority to give us direction… if anything nurses are probably able to deliver psychotherapy better, or have the most qualifications and most therapeutic skills because of their therapeutic alliance, because of their therapeutic relationships with patients. … So if anything, nurses are probably positioned best of all of any profession because this is our focus … you might even be able to argue that psychotherapy is intruding into our practice [laughing].

Some participants stated that the processes required to incorporate psychotherapy prescriptions in their institutions and agencies would not be problematic as they worked in close proximity with doctors who could more easily write orders. Other participants (65%) were confused about how their administrative processes would change because they worked with interdisciplinary teams that did not necessarily link them to doctors or NPs. In addition, a number of participants (61%) reported a general lack of understanding and little discussion about how to create policies for enactment of psychotherapy in their clinical areas.

4. Role of sufficient education and guidelines to promote safe practice. Most participants (83%) recognized that while many RNs have extensive training in psychotherapy methods, many do not have "formalized" psychotherapy education pathways. Many participants

(65%) said more education and clinical supervision was needed for nurses to ensure competency, and generally more resources needed to be put in place. Almost as many (61%) expressed that developing competency through standardized education and training for RNs was more relevant to provide public safety and would result in better patient outcomes.

As with other interdisciplinary health providers of psychotherapy, participants described a range of psychotherapy experience and training obtained through hospital and/or interdisciplinary programs. Some participants had credentials in a variety of psychotherapy modalities including psychodynamic, cognitive-based, supportive, emotional and spiritually focused frameworks. Some of these RNs were actively training medical students, nursing students and/or RNs in these various approaches.

Participant 15 described the development of her own expertise that was similar to many other RNs, motivated by empathy and compassion to help their patients:

> You can't just do nothing with them if they're struggling with problems – you need to be able to help them if you already have those skills.

This participant described the progression of skill development over a nine-year period, starting with detailed assessments and gradually moving into supportive counselling, and using more interventions of CBT. From this point, she gradually developed diverse psychotherapy interventions:

> Over the years I've been doing more and more psychotherapy and I really like it… we get feedback at our clinic to keep us on track … the clients evaluate how they are doing …through the Outcome Questionnaire.

Themes Related to Choices

Themes relating to the concept of *choices* emerged as three subgroups. These included: no freedom of choices available for RNs for psychotherapy initiation from within nursing;

choices that were available outside of nursing; and the experience of lowered status and feeling devalued as professionals.

1. No choices about psychotherapy initiation within nursing. All participants (100%) agreed that there were no choices from a nursing perspective, and decisions about what was previously within their scope of practice would soon be made by others. CNO, doctors, NPs, and administrative policies would at that time be dictating how RNs could practice under new regulations. Several participants (26%) reported that doctors or NPs had already assured them that they will "cover" them by writing orders for their patients, however this seemed like a makeshift measure rather than a solution. Many participants (61%) expressed frustration and confusion that there are no structures in place, if any, to define what choices may be available to RNs. Some participants (30%) commented that many RN colleagues lack understanding of the issues in order to make appropriate choices to direct their practice. Several participants (22%) felt they had no protection regarding legal accountability given how ambiguous the regulations would be for nurses.

2. Choices outside of nursing. Overall many participants (65%) felt their only choices to maintain their autonomy regarding psychotherapy practice were outside of nursing and they were considering, or already had applied for grandfathering status as a registered psychotherapist from the College of Psychotherapy (CRPO). As Participant 7 commented:

> If my college doesn't trust me then yes, I have other means. It's embarrassing though, it is embarrassing as a nurse and it makes you want to join a different profession.

Participant 12, who was engaged with her Masters of Social Work studies ended the interview with the following statement:

> I guess I just feel really sad, and I think that a lot of nurses who want to practice psychotherapy aren't going to be able to stay nurses because we want independence. We're capable professionals and I don't know why we have to be tied to doctors all the

> time to do what we're capable of doing and have been doing for hundreds and hundreds and hundreds of years.

Several Participants (13%) who were near retirement made the choice to not continue working in private practice as they had previously planned.

3. Experience of lowered status as a nurse. Another theme that emerged from the diminished choices that participants (78%) experienced was the lowered status that RNs were feeling, and this motivated many to consider CRPO certification. A number of participants thought it would be good to be able to refer to themselves as 'psychotherapist', and additionally have the status that was provided by belonging to CRPO. Participant 23 articulated succinctly what many were voicing:

> Nurses have not been, I don't think, very valued or seen by insurance companies or members of the public necessarily as people who do psychotherapy. There's not a great understanding that nurses, and many nurses, can do that.

Participant 18 expressed her frustration about needing to explain to a client why she would need a doctor's order:

> It took three to four weeks to fix during the treatment. Because they [clients] were very suspicious about what's going on – [clients asking] do you have the qualifications for seeing patients?

This participant continued that the added piece required for RNs was harmful to her clients. In addition to their need for seeking psychotherapy to deal with their personal anxieties, they were needing to deal with bureaucratic processes that were anxiety provoking, and introducing an impediment distracting to the therapeutic relationship.

Participant 10, who had been practicing independently for 17 years was denied registration to become a member of CRPO, and felt unfairly treated by their assessment in the application process. This Participant felt that the intake panel did not understand how to assess the content of courses she had taken at University 39 years ago. She consequently sought legal

counsel to help negotiate a reassessment of her education and psychotherapy training. In describing her experience, she explained:

> I feel that the whole process of grand parenting is cloaked in guilty until proven innocent. So you are not safe to practice unless you can prove that you are safe to practice, and that very little validity or credibility is given that I have approximately10,000 client hours with no complaints to CNO for the last 17 years.

Participant 10 continued to summarize the impact of her experiences as follows:

> I used to have a great deal of pride in myself as a nurse and a psychotherapist. There's a sense of humiliation that comes from being denied. There's a sense of shame. I feel that I'm not able to tell people what my situation is, and the fact that for so many years I have acted in the role of a psychotherapist and have now been deemed, 'not safe to practice' because I could not obtain registration – to hear that was a huge blow to my self-esteem, and has resulted in grief, depression – not clinical depression, but certainly times of just feeling really down. Questioning myself, questioning my worth in the job that I love. I would say that it has had an impactful outcome for me.

The experience of lowered status as a nurse, losing their autonomy to practice to full scope was shared by most participants. The strongest comments were stated by Participant 3 in regard to how he understands and experiences the contradictions within the role of nursing:

> You fill in all the gaps that other people can't do, but yet you aren't recognized as a professional yourself, able to do it. So that to me is what nursing is… If something happened, heaven forbid, where something was mis-prescribed the majority of the fault for that goes to the RN. It always has. Right? So I have the hardest job, and none of the power or recognition, but when things go awry I'm the one that people come to… Nurses historically have always, from my perspective, just always accepted that. Well, we'll do that because we're good people, but you know what, I'm tired of that… I often think of nursing as a profession, having the battered wife syndrome.

Freedom to Act Intentionally

Themes that emerged within the concept of *freedom to act intentionally* were expressed within three subgroups; restrictions to freedom and accompanying risks, dependence on third party authority, and freedom to act intentionally.

1. Restrictions to freedom and risks. Overall, participants (100%) said that their experience of freedom to act intentionally with psychotherapy initiation would be restricted with the proclamation of the controlled act due to dependence on third party authority. The nuances of the themes were expressed in the following ways: Most (91%) thought that as an RN there would be no freedom or their freedom to act would be constrained; many (87%) remarked that their freedom would be limited; most participants (91%) reported that they were confused or uncertain about how specifically their freedom to practice will change. Participant 18 remarked about the risk to the therapeutic relationship by the intrusion of third party authority:

> When you practice psychotherapy, you need to be attuned to all the changes in the society that is interfering in your work. I think that the new regulation creates this climate of insecurities in terms of how you keep the genuine relationship that you have with your patients … the therapeutic alliance is also permeated by your concerns… So the problem is that with these regulations, you bring to the therapeutic encounter rules that are not necessarily clinically oriented.

Participant 20 expressed similar concerns that her own sense of limited choices would create a self-protectiveness and fear that would be picked up by her patients:

> If I am a trauma client then I know really well how to sniff the air for fear. I might not be able to read what it's about, but I will definitely read it, and that makes the world and that makes me unsafe… So the more anxious the clinician is about anything, the more of a tottering relationship you're going to have.

This highly skilled RN who otherwise felt fulfilled with an extensive hospital career, had decided to close her private practice due to the insecurities she felt regarding upcoming regulations.

2. Dependence on third party authority. One third of participants (35%) reported that organizations differ in levels of RN autonomy, so freedom to act would depend on policies of their establishments. Some participants (30%) stated that they would still maintain their freedom to act given the cooperative nature of physicians in their organizations, for example Participant 7, stated that she currently has access to physicians and NPs who trust her and would provide

prescriptive orders. Several other participants working mainly in acute care areas in hospitals acknowledged that they would similarly be covered by physicians or NPs who trusted them, however, they were concerned whether this would be lost if they changed their work environment or established an independent practice.

3. Freedom to act intentionally. Several themes emerged indicating participants experienced some degree of freedom to act with intention. The majority of participants (96%) stated they had freedom to advocate against the decision from CNO. Many participants (87%) spoke about the need to show that many RNs had psychotherapy skills, and many were involved in activities to increase their knowledge and skills. Several participants (22%) articulated that they had freedom to "influence" student nurses in their role as clinical teacher. They generally felt saddened that students were facing this kind of setback when nursing was increasing range and scope of practice in other areas, for example the inclusion of RN medication prescribing (CNO, 2017). They were remaining supportive to their students and hopeful that the CNO decision would be rescinded.

Involvement in Creating Change

The themes expressed by participants related to the concept of *involvement in creating change* were subdivided into three categories: advocacy against medical orders for psychotherapy initiation; feeling discouraged; and desired outcomes.

1. Advocacy against medical orders for psychotherapy initiation. Most participants (91%) wanted to give voice to their concerns by taking part in this study. Many (83%) were already working with, or planning to work with RNAO in their advocacy for RNs and psychotherapy, for example, through letter-writing campaigns to CNO and the Ontario Ministry of Health, expressing their opposition to medical prescriptions. In addition, most participants

(87%) agreed mental health nursing needs more recognition among health professionals and CNO, and it is urgent that RNs make their expertise with psychotherapeutic work visible. As Participant 19 remarked:

> It's just this feeling I have that mental health and mental health nursing is not as well-known maybe, or not as well understood, in terms of what actually happens behind the scenes in patient units. And I think the expertise of many nurses is not understood or acknowledged… I just think there is a lack of awareness of the expertise and roles that nursing can play alongside other professionals.

A number of participants (39%) expressed the need to emphasize the added value of RNs to patients given their dual role, integrating medical and psychological aspects of health care provision. Participant 19 articulated the range of opportunities where RNs could contribute from this unique perspective to enhance mental health through psychotherapy:

> We know many struggling clients are on different medications and there is a biochemical component to mental health conditions as well as addictions. And we have background and knowledge and skill in terms of dealing with those issues. We also have advantages I think within the nursing field – we have exposure to all sorts of different clients … there are certain types of psychotherapy that nurses would be in the prime position to do because they're by the bedside or they're actually with the clients as they follow them in through outpatient care…Totally across the health continuum… from youth to elderly care.

Most participants (87%) thought it was necessary to increase awareness of the regulatory changes amongst RNs themselves, and many were actively involved in doing so in their organizations. Some participants (39%) were actively promoting discussion to educate administrators. As noted by Participant 14:

> We have to find ways to address this issue more on a systems and organizational level – at local levels, regional, provincial, and national because if clinicians are ahead of the ball game but administrators aren't, and the people who create programs, provide funding, or who have the power to abolish obstacles are not on the same page, it doesn't matter how experienced we are, it doesn't matter how well versed we are and how many miracles we're able to create or contribute to, things are not going to change.

2. Feeling discouraged. Most participants (91%) voiced their frustration that CNO leadership has been missing, to decrease patient barriers and provide direction for RNs as the new psychotherapy regulations have been progressing. Generally, participants were left confused about the lack of information posted on the CNO website and "vagueness" they experienced when they directly asked questions of CNO representatives. About two-thirds of the participants (61%) commented there should have been more education from CNO. Participants involved within leadership positions, particularly within hospital settings, expressed their frustration about the overall lack of information. Participant 21 described her confusion as she tried to gain clarity:

> CNO gave no guideline as to what the order even meant. And when I called them, they would say, for example, "it's sort of like a massage – like getting a massage therapy order from the doctor for your insurance company", which didn't make sense, because you don't need an order to go to the massage therapist… that actually makes no sense to me. And so I was starting to try to anticipate, how often would there need to be an order? Would there need to be a doctor covering – if you write an order, presumably that physician is technically responsible for that psychotherapy.

Most participants (87%) felt frustrated and discouraged that they were not given any way to create change or actively participate in the process of these regulatory changes. A number of participants remarked that any efforts they attempted through letters or recommendations were rejected by CNO and the Ministry of Health and Long Term Care (MOHLTC). Almost half the participants (48%) stated they did not have much ability to create change either due to time constraints, or because they felt hopeless regarding a positive outcome. A third of participants (35%) were regretful that they had not chosen another profession that has autonomy more securely established.

3. Desired outcomes. All participants (100%) expressed the desire to raise the autonomy of RNs and put them on par with other professions who have access to the controlled act of psychotherapy. Almost all participants (87%) wanted psychotherapy education and standards

increased, and most (78%) thought that standardized certification provision would be helpful to raise RN status. Participants 3 and 21 (9%) raised the concern of legal protection for RNs given the ambiguous nature of the RN accountability with regard to a medical prescription for psychotherapy. Problems associated with nurses working within ambiguous circumstances is analyzed in the discussion.

Relationship Between PKPCT and Interviews

A total of 60 themes were identified by participants in the interviews. However, each participant appeared to address themes depending on their particular work context and how they experienced this change process. A series of independent samples t-tests was conducted for each theme to compare the mean score on the tool between two subgroups of participants, those who did and did not mention the theme. Four themes had significantly different scores.

- Participants who mentioned theme “RNs working within mental health would be performing controlled act” had significantly lower *awareness of change* score (M = 55.44, SD = 12.57) compared to those who did not mention this theme (M = 71.00, SD = 3.46), p = 0.013.
- Participants who mentioned theme “therapeutic relationship has always been cornerstone of nursing/ just part of our job/ RNs don't see themselves as doing psychotherapy” have significantly higher *awareness of change* score (M = 61.94, SD = 8.21) compared to those who did not mention this theme (M = 47.60, SD = 20.78), p = 0.024.
- Participants who mentioned theme “confusion/uncertainty to know how practice will change re freedom to act” had significantly lower *freedom to act intentionally* score (M =

54.10, *SD* = 11.47) compared to those who did not mention this theme (*M* = 73.50, *SD* = 2.12), *p* = 0.029.

- Participants who mentioned theme "not much ability to create change due to time and effort constraints/ or hopeless re outcome" had significantly lower *involvement in creating change* score (*M* = 55.91, *SD* = 11.46) compared to those who did not mention this theme (*M* = 66.92, *SD* = 11.49), *p* = 0.032.

For each participant the researcher counted the number of themes mentioned for each of the four aspects/questions of the tool. Then a correlation analysis was performed between the number of themes mentioned and the power score. A negative statistically significant correlation was found only between *freedom to act intentionally* score and the number of themes mentioned in that group, *r* = -0.47, *p* = 0.03. This suggests that participants who mentioned more themes related to *freedom to act intentionally* also have lower score, indicating they have less power to act intentionally. Examining the language used in these themes, we found it to be negative, indicating the more themes mentioned by participant, the more restrictions/limits they perceive in acting freely.

It appeared that the PKPCT set the stage for the interviews that followed, thus participants had broadened frames of reference to provide more specific data regarding the themes. An analysis was performed to explore a relationship between power scores (obtained through Barrett tool) and themes identified in the content analysis. A series of t-tests was conducted comparing power scores between participants who did and did not mention a particular theme. Results are summarized in Tables 10-17 (please see Appendix C), with Tables 14-17 focusing on overall (total) power score. The finding was, the lower the power score, the more themes were mentioned by that participant; this was especially true for four themes where

the differences were statistically significant (themes AC17, CH3, FAI9, ICC13, please see Appendix C). This kind of pattern suggests that participants with less perceived power (lower Barrett power score) are more likely to mention certain themes. These statistics indicate that this situation for RNs regarding regulation is causing participants to feel less powerful and more worried.

Discussion

The central purpose of this study was to explore how RNs who practiced psychotherapy were responding to the regulatory changes, and how their responses may predict impediments for public access to psychotherapy treatments by RNs. Barrett's (2010) PKPCT questionnaire and interview process were used to gather data about participants' experience of power in this regulatory change process. According to Barrett (1989), as people experience their subjective power in a change process, they first demonstrate awareness of details involved with matters regarding the change. Next, they feel varying degrees of confidence both about their choices to make decisions and then, about their ability to act regarding those choices and decisions. Finally, they demonstrate the extent of their personal involvement with these changes (Barrett, 1989).

The interviews provided extensive data illustrating an overall sense of disenfranchisement of the participants, and indicated likely barriers to public access with regard to RN psychotherapy treatments. Participants all agreed that from a nursing perspective, they were losing autonomy to make effective interventions within their therapeutic relationships, and being restricted from what they believed was their legitimate scope of practice. This resulted in feelings of discouragement and disappointment. These RNs reported that there was no opportunity for participatory involvement in the decision-making process, and this made them feel devalued, disempowered and demoralized. Apart from advocating against the decisions

made by CNO, their only option to maintain autonomy in their psychotherapy practice would come from acquiring membership with another college, which left them feeling frustrated. Many participants were confused about the meaning of the controlled act of psychotherapy and how their practice may be changed. They were also concerned about the lack of leadership by CNO and their own administrators to direct these changes. What was missing were guidelines for nurses to understand how they could continue to practice safely, and how administrators could provide appropriate policies that supported them without interruption of services to the public. Overall, participants felt pessimistic about the consequences of a prescriptive order and its burden on mental health services.

Key themes expressed in this study comprise low professional autonomy, devalued, humiliated, professionally unrecognized, unfairly treated, and confused about practice implications. These problems have been documented in nursing literature and related to topics of demoralization, work stress, burnout, and attrition (Woods, 2014; Browne, Cashin, & Graham, 2012). Negative work experiences of nurses are associated with deterioration of performing to full capacity and the consequent reduction of effective service delivery (Ballou, 1998; Enns, Currie, & Wang, 2015). This discussion will focus on the participants' experiences of loss of autonomy, the ambiguity and uncertainty regarding how to proceed with their psychotherapy role, and how these factors may affect mental health treatments for the public.

Importance of Professional Autonomy for Nurses

The importance of autonomy and its loss is central to the experience of participants in this study. The RNs in this study were confounded as to why their college had not provided similar supports for its members, comparable to those of other colleges that gained access to the

controlled act. Participants also expressed a desire for similar autonomy, to that being granted to the other colleges, to initiate psychotherapy, which has always been within RN scope of practice. Participants were in the process of making decisions to proceed in various compensatory and alternative directions; some had already stopped their private practices and others, who had planned to engage in private practice after they retired from hospital nursing, had now decided against this plan. Others were looking to alternate college memberships to feel supported in their work.

Professional autonomy, defined as control over nursing practice actions (Kramer, Maguire & Schmalenberg, 2006, p. 489), has been studied for decades and attributed as the most important feature associated with job satisfaction (McCloskey 1990; Weisman, Alexander & Chase, 1980). Karasek's (1979) research indicated that work with high demand and little latitude for decision making appears to cause mental strain and job dissatisfaction, with results such as absenteeism and depression. The opposite appears important – that workers with heavy workloads who are given the authority to make significant and complex decisions about how to achieve the goals of their job are much more stress-free, demonstrate greater work adherence, and report much higher job satisfaction (p. 285). Nurse autonomy has been strongly associated with positive patient outcomes and increased nurse retention (Ballou, 1998; Ellerbe & Regen, 2012; Enns et al., 2015; Finn, 2001; Kramer & Schmalenberg, 2003; Laschinger, 2008; Manojlovich, 2007; Weston, 2008). Extensive research has indicated that work structures empowering nurses to control decision-making in their practice, is an importance distinction of autonomy, and is associated with high quality nursing care (Laschinger, Sabiston, & Kutszcher, 1997; Kelly, McHugh & Aiken, 2011; Kramer & Schmalenberg, 2003).

Ballou's (1998) concept analysis defines autonomy in nursing as "the capacity of an agent to determine its own actions through independent choice within a system of principles and laws to which the agent is dedicated" (p. 105). Ballou asserted that autonomy is accompanied by the confidence that one is delivering something of value, and that it is being recognized. This carries professional status, personal satisfaction and a sense of freedom of action. Ballou clarified that autonomy must be cultivated from within the person rather than dictated by an authority, emphasizing the requirement for ongoing commitment by nurses for certification, continued education and ongoing competency development. This is their own contribution towards autonomy and status.

These same principles were initiated by hospitals that have been accredited the "magnet" standard of nursing excellence. Magnet Hospital status was developed in the United States in the early 1990s in response to organizational downsizing in attempts to offset the uncertainty and mistrust that was developing in health care environments (Laschinger, Finegan, & Shamian, 2001; Kramer & Schmalenberg, 1993). Kramer and Schmalenberg (1993) noted the organizational commitment of magnet hospitals to support nurses to engage with "creativity, collaboration and innovation" (p. 58). Autonomy was described as "the freedom to act on what you know" (p. 59), and nurses were expected to continually increase their skills through certification, ongoing education and career development. A trusting work environment that encourages open communication, along with a high degree of nurse competency, were important qualities to establish in these institutions in order to minimize the risks. Bureaucratic processes have subsequently been minimized and collaborative nurse-physician relationships have been strengthened to support nurse autonomy (Kramer & Schmalenberg, 1993). Such forms of

organizational leadership-enhancing nurse empowerment have been associated with positive performance outcomes (Drenkard, 2010; Laschinger, 2008; Kelly, McHugh & Aiken, 2011).

There are a number of studies that address nursing empowerment, in parallel with the magnet hospitals. For example, Laschinger & Havens' (1996) research that followed Kanter's (1983) theory of structural power, and Teasely's (1987) work on situational leadership offer theoretical frameworks for practical leadership guidance. When nurses have developed recognized expertise, management must then allow freedom for nurses to use their own judgment and decisions to perform their job. At this point management limits their role to receiving reports, giving recognition, and consultation.

Manojlovich (2007) described autonomy as one kind of power that enables nurses to act on their knowledge and judgment, noting that this kind of power is required for professional efficacy. She argued that most often nurses, given their proximity, are best able to fully appreciate and assess patient care, "To identify the appropriate course of action and effectively function, professionals must have understanding and control over the entire spectrum of activities associated with the job at hand" (p. 5). This is illustrated by an expert RN psychotherapist, Kathleen Wheeler (2014), in her description about how to approach the initial psychotherapy session. Wheeler noted the significance of the nurse to first establish the "emotional safety" (p. 169) for the patient that sets the foundation for successful treatment. She emphasized the immediacy required to create this safe and healing environment that enables the emotional intensity of the therapy process and clinical improvement. The initial session sets the stage for patient and therapist to deal with boundaries and structures of the therapy, while maintaining a caring and non-judgmental stance that allows for therapeutic attachment. It is

important to establish this trusting relationship to avoid the usual high rate of patient drop-out (p. 170).

Similar to Wheeler's (2010) management of the initial psychotherapy session, the participants of this study expressed concerns about relationship-building interruptions due to the delay involved with seeking a medical order. Importantly, this also risks inference to the patient that the RN does not have the required competence, and needs a higher power to give "permission". In effect, this puts bureaucratic requirements ahead of patient care.

Loss of Autonomy and Impact on Patient Outcomes

Most study participants had already received extensive education and certifications outside of nursing and were actively engaged with further psychotherapy training. Most were engaged with supervision. They felt that the medical orders to initiate psychotherapy overlooked their competencies. They realized there are gaps in formal psychotherapy education and ongoing supervision for RNs, and wanted certification to be established that qualified their psychotherapy practice and maintained their autonomy. Most participants felt anger and betrayal that their expertise was not being recognized or supported. In fact, many commented this felt like "a step backwards" for nursing.

In a recent Canadian study, Enns et al. (2015) found that low professional autonomy was associated with high rates of major depression in Canadian nurses, twice the national average than other working women (p. 269). This is underscored by the risk of deteriorating work performance of depressed workers, resulting in negative impacts on both the public and nurses (p. 270). Another Canadian study (Dery, D'Amour, Blais, & Clarke, 2015) discussed the importance of an optimal scope of nursing practice to positively impact health care as well as to support nurses' decision latitude, which is associated with autonomy. Optimal scope relates to

the range of activities nurses are educated and certified to perform. Dery et al. (2015) remarked on the high degree of tasks performed by nurses, as opposed to their applying expertise in practice. This resulted in negative consequences of increased organizational costs and poor patient outcomes when nurses spend time on tasks unrelated to their skillsets. Peplau (1994) also highlighted this problem in regard to psychotherapy practice for psychiatric nurses. She expressed the concern that the focus on custodial tasks rather than the intensive relationship work required for optimal patient outcomes would divert nurses from deepening their knowledge and expertise (p. 177-178).

Ambiguity and Uncertainty Related to the Controlled Act of Psychotherapy.

While job autonomy has been reported to reduce work stress and uncertainty (Jong, 2016, p. 815), role ambiguity, defined as a lack of clarity of one's role and performance expectations, has been associated with occupational strain, anxiety and tension, reduced job satisfaction and performance, as well as attrition (Bedeian & Armenakis, 1981; Jong, 2016; O'Brien-Pallas, Murphy, Shamian, Li, & Hayes, 2010). Jong (2016) found that negative effects of role ambiguity were mitigated by high performance feedback and high levels of job autonomy. Although nurses are required to be able to tolerate uncertainty and ambiguity in today's high acuity and complex health care environments, these qualities are also associated with decreased mental health of nurses and low quality patient care (O'Brien-Pallas et al., 2010; McMahon & Dluhy, 2017). From a psychoneurological perspective, research has shown that the experience of ambiguity stimulates the amygdala, a primitive brain structure within the temporal lobes. This is associated with the experience of fear and survival anxiety (Bach, Seymour & Dolan, 2009; Gelder et al., 2014; Whalen, 1998).

In a concept analysis of ambiguity, the review suggested that increased ambiguity and/or low tolerance for ambiguity within a clinical situation could influence the thinking and performance of the nurse, which in turn could compromise patient safety and quality of care (McMahon & Dluhy, 2017, p. 69). McMahon & Dluhy (2017) differentiated ambiguity from uncertainty. Ambiguity is situated with the clinical situation, whereas uncertainty is the emotional experience of the nurse in response to the situation (p. 69). The authors noted negative practice consequences of ambiguity that could include delayed action or reluctance to take action, and medical error (p. 69).

Concern about the ambiguous nature of the upcoming legislation was expressed by all the study participants leaving them feeling confused, uncertain and uneasy about their future psychotherapy practices. A number of questions expressed by participants emerged as themes: How to understand the controlled act of psychotherapy; how psychotherapy and counselling are different; how their roles with clients would change; would policies support their practice? Overall, participants acknowledged that all RNs working in mental health practiced at least some elements of psychotherapy. However, there were differences about how they perceived their nursing role regarding psychotherapy practice. For example, some thought all nurses in acute mental health would be practicing the controlled act because it was within active care services that patients with the greatest acuity were treated. Others noted that psychotherapy skills were practiced by nurses across health care services, such as primary care, palliative, oncology and forensic nursing. Some participants argued that psychotherapy interventions were “just what nurses do” and expressed confusion and anger that their scope of practice appeared to be “taken over”. The therapeutic relationship as a central component to psychotherapy has historically been the cornerstone of nursing. Another related concern expressed by participants was that many of

their RN colleagues are using psychotherapy methods and not aware they are in fact doing so. Many expressed concerns about the inadequate understanding of the differences between counselling, psychotherapy, use of the therapeutic relationship, and other psychotherapeutic interventions. This uncertainty was stressful for participants, resulting in their feeling further unprepared for these regulatory changes. Many felt frustrated and abandoned by nursing leadership, who also appeared not to understand the complexities and subtleties of psychotherapy in practice.

Ambiguity Related to Multiple Revisions to the Act

During the process of this study, there have been two revisions that CNO posted on the website regarding the Act (March 24, 2016). The first was that the title "psychotherapist" could no longer be used by an individual except members of CRPO (CNO, March 24, 2016a, para. 10). The second revision defined the "component of psychotherapy considered to be the highest risk to the client" (CNO, March 24, 2016a, para. 3), as opposed to including all psychotherapy practices. This will define the context in which nurses would need a prescriptive order. On the website, CNO has outlined the following five components that must all be met to determine whether psychotherapy falls within the controlled act:

1. You are treating a client
2. You are applying a psychotherapy technique
3. You have a therapeutic relationship with the client
4. The client has a serious disorder of thought, cognition, mood, emotional regulation, perception or memory
5. This disorder may seriously impair the client's judgment, insight, behavior, communication or social functioning (CNO, March, 2016a, para. 5)

This new revision of the Act was made towards the end of this researcher's fieldwork so only a few participants were aware of this change and able to comment. They commented that

these distinctions still left ambiguity as to when they might be practicing within the controlled act. For example in the definition of components that must all be met, the word “serious” lacks specificity, and some disorders of “thought, cognition, mood, emotional regulation, perception or memory” that impair “the client’s judgment, insight, behavior, communication or social functioning” are present in virtually all instances where the patient is engaged in any kind of psychotherapy. For this reason, it may be very difficult for a nurse to have confidence about practicing within a defined ‘safe’ boundary.

Ambiguity Involved with Psychotherapy and Psychotherapeutic Methods

Psychotherapy is by nature ambiguous in its broad range of definitions. It is widely acknowledged that psychotherapy is difficult to define due to its overlap with many forms of counselling, spiritual, mental health and healing practices – no one definition has been universally accepted (Frank, 1999; Prochaska & Norcross, 2010; Ennis, 1998). Frank (1999) noted the growing recognition that all psychotherapeutic methods share healing components that make them effective and many professionals and non-professionals bring varying methods to their practices. Psychotherapy is often used interchangeably with counselling (Bond, 2004; Cooper & McLeod, 2007; Peplau, 1989; Stiles, 2007; Wheeler & Richards, 2007), and even psychoeducation has been referred to as a specific form of psychotherapy (Bauml, Frobose, Kraemer, Rentrop, & Pitschel-Walz, 2006; Sampaio et al., 2015).

All of these skill sets are widely used by RNs, and participants of this current study expressed concern about when specifically a nurse was entering into the controlled act. The question remains, at what point in a dialogue between nurse and patient does the controlled act of psychotherapy begin, for which the nurse requires a prescriptive order to continue with the patient?

Sampaio et al. (2015) similarly referred to this lack of clarity in their 10 year review of nursing psychotherapeutic interventions. The authors emphasized that while nurses were generally effective with counselling and psychotherapy interventions, particularly the therapeutic nurse-patient relationship, there was not a clear understanding of differences between psychotherapy and psychotherapeutic interventions (p. 2096). It was concluded that this lack of understanding seriously hampered nurses' ability to study and research their use of psychotherapy. This inability to define interventions in specific terms has the negative effect of restraining the developing nurses' abilities to better serve their patients psychological needs (p. 2103) and additionally would hamper their ability to define their interventions with colleagues. This gap in the articulation of their knowledge was similarly voiced by Benner (1984), as a general impediment for nurses, consequently preventing them from taking 'ownership' of their nursing expertise. Sampaio et al. (2015) emphasized the need for nurses to articulate and distinguish their psychotherapeutic work in order to build their professional confidence.

Similarly, it appeared that in this current study, the participants who did not have formalized psychotherapy training expressed a lack of confidence because there is no way to assess their current psychotherapeutic skills. In contrast, those participants who had studied formal psychotherapy methods alongside physicians, psychologists and social workers, had acquired an understanding of psychotherapy terminology that was shared by their interdisciplinary colleagues. It seemed apparent that discussions with their fellow colleagues gave them confidence that they were as therapeutically competent as other psychotherapists, and that nursing was indeed a discipline that included psychotherapy as a fundamental part of its craft. From this perspective, it seemed truly wrong to them that a prescriptive order should be required, rather than education and competency.

Barriers for RN Psychotherapy for the Public

There were two kinds of barriers described by the study participants. The first refers to increased bureaucratic processes and health care services that functionally impede the delivery of psychotherapy by nurses. The second is attributed to the emotional-psychological impact to nurses that leaves them feeling disempowered and unable to deliver "self at best". Firstly, increased bureaucratic processes and costs requiring medical orders would delay and inhibit public and private access to RN treatments. RNs in private practice or remote areas may not have easy access to physicians or NPs. In addition, hospital or agency administrators would need to create appropriate policies to govern standards for safe psychotherapy practices by RNs who work in these situations. A number of participants stated that their administrators do not adequately understand the matters involved within the controlled psychotherapy act. These functional problems predict impeded access to services and added costs to health care.

Secondly, the emotional-psychological experiences of the participants appear to be a significant impediment. The disregard for their therapeutic expertise and reluctance to consider proposals for educational pathways for a certification process for RN psychotherapy was disheartening and demoralizing to all participants. There was a pervading feeling of loss of hope that RNs would continue to be significant contributors to the wellbeing of their patients. These feelings are similarly expressed by Woods (2014), who referred to nurses' experience with moral distress that arises through external constraints, where they are unable to do what they know is right, and are held back because of these constraints. Woods emphasized, "It is not that there is even the illusion of choices in this instance because many of the constraints are related to factors outside the control of nurses" (p. 127). Nursing literature is replete with studies having similar themes, comparing the negative consequence to nurse-demoralizing circumstances, especially

impediments to their ability to deliver effective service, contrasted with the enhancement of wellbeing of nurse and patient which occurs when these supports are functioning effectively (Schmalenberg & Kramer, 2008; Laschinger & Leiter, 2006; Laschinger et al., 2001).

Nursing Implications

Evidence has suggested that when nurses are provided with optimal resources they are motivated and enabled to deliver their best service to the public. Data from participants in this study suggest that the enactment of the controlled act of psychotherapy is likely to result in a predictable decrease in the effectiveness of delivery of RN psychotherapy services due to their lowered autonomy, and predicted role ambiguity upon legislative proclamation. RNs lack a clear definition of their role in relationship to human interactions involved in nursing. There are no specific educational guidelines or standards that allow RNs to have confidence that they are qualified to practice either psychotherapy, or the controlled act of psychotherapy. This has already resulted in discouragement and pessimism regarding job satisfaction, and many are turning to other colleges for support. This shift may result in more RNs interested in providing psychotherapy leaving nursing, resulting in a significant gap in this level of expertise within the nursing profession.

Another important consideration is the professional confidence that is required in mental health nursing. Rolfe and Cutcliffe (2005) very bluntly referred to nurses' professional esteem problem, "they remain the children of the psychiatric field, allowing their parent figures – medicine and psychology – to do most of the talking" (p. 254). With the increase of RN specialization in healthcare, nurses are challenged to distinguish themselves through obtaining professional recognition by way of increased skills and abilities. As evidence suggests, mental health nurses must speak to their unique abilities to demonstrate and cultivate their expertise, and

receive recognition for it (Browne et al., 2012; Peplau, 1989; Sampaio et al., 2015; Stickley et al., 2009; Wheeler, 2014).

As this study indicates, there may be serious consequences to the quality of mental health care provided by RNs after the psychotherapy act proclamation, without greater effort to qualify RNs through established standards of education, supervision and support for autonomy. The RNs in this study are seeking ways to obtain recognition for their expertise and maintain professional autonomy and identity while providing excellent psychotherapy treatment for patients. There is no evidence that the requirement for medical prescription to initiate psychotherapy will protect the public nor improve the quality of mental health care provided by RNs in Ontario. We can expect that this mandate will contribute to the attrition of RNs most qualified to practice psychotherapy, decreasing education of nurse-psychotherapy expertise and skills. This vacuum will likely be filled by other psychotherapy professionals with newly established professional guidelines, eager to provide services.

Meeting the Research Objectives

The overall objective of the research was to explore how the changes for RN psychotherapy would affect public access to psychotherapy. This study offers evidence that the CNO's response to the *Psychotherapy Act, 2007* will reduce nurses' autonomy, create ambiguity, and could have negative consequences for the public. It appears that these losses to the nursing profession predict less RN psychotherapy and attrition of nurses with psychotherapy expertise. From this perspective, the purpose of the study has been met.

Study Limitations

There are a number of limitations in this study. There has been no previous research to guide this study in Ontario since this problem is an emerging issue. The study has a relatively small sample size (n = 23) and non-random selection of participants (RNs were approached based on professional contacts of researcher). In general, participants were aware of the *Psychotherapy Act, 2007* and had varying levels of involvement in the process. As a result, the study findings have limited external validity, and outcomes cannot be generalized to the experiences of all RNs. Since this researcher herself conducted all the interviews and content analysis, there is potential confirmation bias where researcher's views may influence participants' opinions and content analysis themes. The themes and their groupings were done by the researcher and were not further validated. Ideally it would be prudent to have multiple researchers conducting content analysis independently and then reconciling their findings. Since the surveys and interviews were not anonymous, the participants' responses may not be as frank as with an anonymous survey.

A broader sample would be needed to understand RNs' experiences of the psychotherapy act more fully. Recommendations for future research include a more structured approach with themes converted into close-ended questions and a survey administered online. This could be helpful in further exploring this emerging topic. This would help not only to simplify the study, but also allow more efficiency in participation (especially with online format), which could result in a larger sample size. Given this is preliminary work, more research would be needed to further explore the impact of this legislation on nurses and how a regulatory change in RN psychotherapy might impact care received by the public.

Conclusion

Despite the small sample size of this study and its limitations, this study provides an impactful insight that an apparently "simple" regulatory change is resulting in a complex chain of events that is predicting negative effects for RNs in providing quality psychotherapy treatments for the public in Ontario. The study further clarifies the complexity of how RNs receive support to work in mental health contexts and the significance of sustaining their professional autonomy. Organizational structure which decreases autonomy and increases ambiguity predict negative impacts on employees, their performance, and their job outcomes. It is imperative that legislators and nursing leadership understand that the provision of excellence in psychotherapy services to the public will require strategic management and support for RNs to deliver effective service from a position of "self-at-best".

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Appendix A: Survey for RNs Practicing Psychotherapy

Age _____ Gender □ Male □ Female

Highest education in nursing □ RN Diploma □ BScN □ MScN □ PhD

Education in psychotherapy

_____

_____

_____

_____

_____

_____

Please specify other education (current and obtained)

_____

_____

_____

Years practiced in nursing _____ Years practiced doing psychotherapy _____

Current nursing practice (please check all that apply)

□ hospital □ outpatient

□ teaching □ private practice

□ research □ community

How many hours of supervision on average per year have you had in the context of practicing psychotherapy? _____

The following two pages contain Barrett's PKPCT with four indicators: awareness, choices, freedom to act intentionally and involvement in creating change. For each indicator, there are 13 lines with words at both ends of each line. The meanings of the words are opposite to each other. There are 7 spaces between each pair of words which provide a range of possible responses. Place an "X" in the space along the line that best describes the meaning of the indicator (awareness, choices, freedom to act intentionally, or involvement in creating change) for your experience regarding changes brought by Psychotherapy Act.

INSTRUCTIONS FOR COMPLETING BARRETT'S PKPCT

For each indicator, there are 13 lines. There are words at both ends of each line. The meaning of the words are opposite to each other. There are 7 spaces between each pair of words which provide a range of possible responses. Place an "X" in the space along the line that best describes the meaning of the indicator **(AWARNESS, CHOICES, FREEDOM TO ACT INTENTIONALLY, OR INVOLVEMENT IN CREATING CHANGE)** for you at this time.

For example:

Under the indicator CHOICES, if your CHOICES are quite closely described as "informed," your answer might look like this:

informed ___ | __X_ | ___ | ___ | ___ | ___ | ___ uninformed

If your CHOICES are quite closely described as "uninformed," your answer might look like this:

informed ___ | ___ | ___ | ___ | ___ | _X_ | ___ uninformed

If your CHOICES are equally "informed" and "uninformed," place an "X" in the middle space on the line. Your answer might look like this:

informed ___ | ___ | ___ | _X_ | ___ | ___ | ___ uninformed

REMEMBER:

- There are no right or wrong answers.
- Record your first impression for **each** pair of words.
- You can place an "X" in any space along the line that best describes the meaning the indicator has for you at this time.
- Mark only one "X" for each pair of words.
- Mark an "X" for every pair of words.

MARK AN "X" AS DESCRIBED IN THE INSTRUCTIONS

MY AWARENESS IS

profound	____	____	____	____	____	____	____	superficial
avoiding	____	____	____	____	____	____	____	seeking
valuable	____	____	____	____	____	____	____	worthless
unintentional	____	____	____	____	____	____	____	intentional
timid	____	____	____	____	____	____	____	assertive
leading	____	____	____	____	____	____	____	following
chaotic	____	____	____	____	____	____	____	orderly
expanding	____	____	____	____	____	____	____	shrinking
pleasant	____	____	____	____	____	____	____	unpleasant
uninformed	____	____	____	____	____	____	____	informed
free	____	____	____	____	____	____	____	constrained
unimportant	____	____	____	____	____	____	____	important
unpleasant	____	____	____	____	____	____	____	pleasant

MARK AN "X" AS DESCRIBED IN THE INSTRUCTIONS

MY CHOICES ARE

shrinking	____	____	____	____	____	____	____	expanding
seeking	____	____	____	____	____	____	____	avoiding
assertive	____	____	____	____	____	____	____	timid
important	____	____	____	____	____	____	____	unimportant
orderly	____	____	____	____	____	____	____	chaotic
intentional	____	____	____	____	____	____	____	unintentional
unpleasant	____	____	____	____	____	____	____	pleasant
constrained	____	____	____	____	____	____	____	free
worthless	____	____	____	____	____	____	____	valuable
following	____	____	____	____	____	____	____	leading
superficial	____	____	____	____	____	____	____	profound
informed	____	____	____	____	____	____	____	uninformed
timid	____	____	____	____	____	____	____	assertive

(Please go to NEXT PAGE and continue)

BARRETT PKPCT, Version II, PART 2

MARK AN "X" AS DESCRIBED IN THE INSTRUCTIONS

MY FREEDOM TO ACT INTENTIONALLY IS

timid	____	____	____	____	____	____	____	assertive
uninformed	____	____	____	____	____	____	____	informed
leading	____	____	____	____	____	____	____	following
profound	____	____	____	____	____	____	____	superficial
expanding	____	____	____	____	____	____	____	shrinking
unimportant	____	____	____	____	____	____	____	important
valuable	____	____	____	____	____	____	____	worthless
chaotic	____	____	____	____	____	____	____	orderly
avoiding	____	____	____	____	____	____	____	seeking
free	____	____	____	____	____	____	____	constrained
unintentional	____	____	____	____	____	____	____	intentional
pleasant	____	____	____	____	____	____	____	unpleasant
orderly	____	____	____	____	____	____	____	chaotic

MARK AN "X" AS DESCRIBED IN THE INSTRUCTIONS

MY INVOLVEMENT IN CREATING CHANGE IS

unintentional	____	____	____	____	____	____	____	intentional
expanding	____	____	____	____	____	____	____	shrinking
profound	____	____	____	____	____	____	____	superficial
chaotic	____	____	____	____	____	____	____	orderly
free	____	____	____	____	____	____	____	constrained
valuable	____	____	____	____	____	____	____	worthless
uninformed	____	____	____	____	____	____	____	informed
avoiding	____	____	____	____	____	____	____	seeking
leading	____	____	____	____	____	____	____	following
unimportant	____	____	____	____	____	____	____	important
timid	____	____	____	____	____	____	____	assertive
pleasant	____	____	____	____	____	____	____	unpleasant
superficial	____	____	____	____	____	____	____	profound

THANK YOU

Appendix B: Barrett's PKPCT Version II scoring guide

SCORING GUIDE

Scores are computed by assigning numbers from the scoring guide that correspond to participants' responses on the instrument.

BARRETT PKPCT, Version II

MARK AN "X" AS DESCRIBED IN THE INSTRUCTIONS

MY AWARENESS IS

profound	7	6	5	4	3	2	1	superficial
avoiding	1	2	3	4	5	6	7	seeking
valuable	7	6	5	4	3	2	1	worthless
unintentional	1	2	3	4	5	6	7	intentional
timid	1	2	3	4	5	6	7	assertive
leading	7	6	5	4	3	2	1	following
chaotic	1	2	3	4	5	6	7	orderly
expanding	7	6	5	4	3	2	1	shrinking
pleasant	7	6	5	4	3	2	1	unpleasant
uninformed	1	2	3	4	5	6	7	informed
free	7	6	5	4	3	2	1	constrained
unimportant	1	2	3	4	5	6	7	important
unpleasant	1	2	3	4	5	6	7	pleasant

MARK AN "X" AS DESCRIBED IN THE INSTRUCTIONS

MY CHOICES ARE

shrinking	1	2	3	4	5	6	7	expanding
seeking	7	6	5	4	3	2	1	avoiding
assertive	7	6	5	4	3	2	1	timid
important	7	6	5	4	3	2	1	unimportant
orderly	7	6	5	4	3	2	1	chaotic
intentional	7	6	5	4	3	2	1	unintentional
unpleasant	1	2	3	4	5	6	7	pleasant
constrained	1	2	3	4	5	6	7	free
worthless	1	2	3	4	5	6	7	valuable
following	1	2	3	4	5	6	7	leading
superficial	1	2	3	4	5	6	7	profound
informed	7	6	5	4	3	2	1	uninformed
timid								assertive

SCORING GUIDE

BARRETT PKPCT, Version II, PART 2

MARK AN "X" AS DESCRIBED IN THE INSTRUCTIONS

MY FREEDOM TO ACT INTENTIONALLY IS

timid	1	2	3	4	5	6	7	assertive
uninformed	1	2	3	4	5	6	7	informed
leading	7	6	5	4	3	2	1	following
profound	7	6	5	4	3	2	1	superficial
expanding	7	6	5	4	3	2	1	shrinking
unimportant	1	2	3	4	5	6	7	important
valuable	7	6	5	4	3	2	1	worthless
chaotic	1	2	3	4	5	6	7	orderly
avoiding	1	2	3	4	5	6	7	seeking
free	7	6	5	4	3	2	1	constrained
unintentional	1	2	3	4	5	6	7	intentional
pleasant	7	6	5	4	3	2	1	unpleasant
orderly								chaotic

MARK AN "X" AS DESCRIBED IN THE INSTRUCTIONS

MY INVOLVEMENT IN CREATING CHANGE IS

unintentional	1	2	3	4	5	6	7	intentional
expanding	7	6	5	4	3	2	1	shrinking
profound	7	6	5	4	3	2	1	superficial
chaotic	1	2	3	4	5	6	7	orderly
free	7	6	5	4	3	2	1	constrained
valuable	7	6	5	4	3	2	1	worthless
uninformed	1	2	3	4	5	6	7	informed
avoiding	1	2	3	4	5	6	7	seeking
leading	7	6	5	4	3	2	1	following
unimportant	1	2	3	4	5	6	7	important
timid	1	2	3	4	5	6	7	assertive
pleasant	7	6	5	4	3	2	1	unpleasant
superficial								profound

Appendix C: Tables 10-17

Table 10.

Awareness of change theme	% participants who mentioned this theme	Awareness of change score		p-value
		No	Yes	
AC1: RNs do less psychotherapy despite being largest provider group	70%	57.14 ± 14.96	59.56 ± 12.40	0.69
AC2: access limited clients will receive less psychotherapy	65%	56.63 ± 14.49	60.00 ± 12.39	0.56
AC3: doctors will be inconsistent/ lack incentive to write orders	17%	57.32 ± 13.61	66.00 ± 5.72	0.23
AC4: lack of recognition, devalue RNs	100%			
AC5: restrict scope of practice despite education	100%			
AC6: confusion about change in hospital/outpatient process	65%	64.38 ± 7.95	55.87 ± 14.29	0.14
AC7: some aspects of psychotherapy are part of every-day nursing practice	74%	54.17 ± 12.27	60.47 ± 13.11	0.32
AC8: need more clinical supervision and lack of resources/need more education	65%	58.50 ± 14.14	59.00 ± 12.76	0.93
AC9: psychotherapy expertise used for medical patients as well as psych pts	57%	58.70 ± 11.96	58.92 ± 14.12	0.97
AC10: definition of psychotherapy unclear about whether nurses do this vs counselling / overlap	74%	54.83 ± 12.94	60.24 ± 13.02	0.39
AC11: process of instituting Psych. Act has brought more considerations that nurses do psychotherapy	87%	49.67 ± 17.01	60.20 ± 12.16	0.20
AC12: RNs trained in psych. methods but do not have "formal psychotherapy education"	83%	64.25 ± 8.26	57.68 ± 13.61	0.37
AC13: doctors may not back RNs legally-scapegoating RNs	26%	59.47 ± 11.13	57.00 ± 18.28	0.70
AC14: confusion that CNO has restricted nurses' ability to initiate psychotherapy and why	100%			
AC15: more cost for health care system and RNs for 2 Colleges	43%	60.46 ± 8.98	56.70 ± 17.10	0.50
AC16: lack of clarity and communication about meaning of Psychotherapy Act	78%	57.00 ± 14.88	59.33 ± 12.77	0.73
AC17: RNs working within mental health would be performing controlled act	78%	71.00 ± 3.46	55.44 ± 12.57	0.013
AC18: some physicians/NPs have limited knowledge re mental health - unfair	39%	55.93 ± 15.67	63.33 ± 4.82	0.19
AC19: more independent RN roles may not have physicians/NP's available	52%	61.36 ± 9.48	56.50 ± 15.51	0.38
AC20: CNO not backing RNs	100%			
AC21: nursing is the only discipline with access to controlled psychotherapy act requiring an initiation order	87%	63.67 ± 4.04	58.10 ± 13.70	0.50
AC22: order for initiation of controlled act of psychotherapy will not protect public or result in better outcomes	61%	58.22 ± 13.87	59.21 ± 12.81	0.86
AC23: lack of discussion in clinical areas about how to create policies for enactment of psychotherapy act	61%	62.22 ± 12.29	56.64 ± 13.31	0.32
AC24: more bureaucracy in practice	96%	59.00	58.82 ± 13.24	0.99
AC25: therapeutic relationship has always been cornerstone of nursing - being used by psychotherapy/ just part of our job/ RNs don't see themselves as doing psychotherapy.	78%	47.60 ± 20.78	61.94 ± 8.21	0.024

Table 11.

Choices theme	% participants who mentioned this theme	Choices score No	Choices score Yes	p-value
CH1: no choices given from nursing perspective	100%			
CH2: decision made by others-others "bestow" whether there will be autonomy for RNs	100%			
CH3: have no choices and no protection re accountability	22%	56.06 ± 12.19	52.60 ± 15.24	0.60
CH4: have to be aware of the issue to make proper choices - this is problem as RNs lack understanding	30%	56.81 ± 12.60	51.86 ± 12.92	0.40
CH5: considering to/or joining CRPO or another college	65%	51.25 ± 12.80	57.47 ± 12.40	0.27
CH6: physicians and NPs will cover for me by writing an order for whoever I want	26%	54.76 ± 13.40	56.83 ± 11.05	0.74
CH7: choices diminished re clients due to lowered status now if not certified by CRPO	78%	57.80 ± 12.87	54.61 ± 12.83	0.63
CH8: No structure defined about how process will affect choices - don't understand choices	61%	53.33 ± 11.57	56.57 ± 13.51	0.56

Table 12.

Freedom to act intentionally theme	% participants who mentioned this theme	Freedom to act intentionally score No	Freedom to act intentionally score Yes	p-value
FAI1: advocate against decision	96%	60.00	55.59 ± 12.54	0.73
FAI2: organizations differ in levels of autonomy	35%	56.73 ± 13.33	54.00 ± 10.66	0.62
FAI3: show that nurses have skills to do psychotherapy (and increase their knowledge/skills)	87%	60.33 ± 9.50	55.10 ± 12.71	0.50
FAI4: limited freedom - "will need to refer you"	87%	65.33 ± 5.03	54.35 ± 12.47	0.15
FAI5: lack of information barrier to freely acting	26%	58.35 ± 10.89	48.50 ± 14.10	0.09
FAI6: Won't change now in my practice (could with PP) because doctor's cooperative	30%	55.50 ± 14.42	56.43 ± 5.74	0.87
FAI7: No freedom (or freedom constrained) to act intentionally as an RN	91%	68.50 ± 2.12	54.57 ± 12.17	0.13
FAI8: freedom of influence given in role of clinical teaching	22%	58.00 ± 11.69	47.80 ± 12.15	0.10
FAI9: confusion/uncertainty to know how practice will change re freedom to act	91%	73.50 ± 2.12	54.10 ± 11.47	0.029
FAI10: Restricted due to third-party authority	100%			

Table 13.

Involvement in creating change theme	% participants who mentioned this theme	Involvement in creating change score		p-value
		No	Yes	
ICC1: increase awareness of changes with other RNs	87%	57.33 ± 16.62	62.30 ± 12.23	0.54
ICC2: work with RNAO to engage with changes	83%	57.50 ± 13.82	62.53 ± 12.48	0.48
ICC3: increase psychotherapy education and standards of RNs	87%	63.00 ± 11.79	61.45 ± 12.93	0.85
ICC4: make visible that nurses do psychotherapeutic work and have expertise	87%	59.00 ± 16.52	62.05 ± 12.33	0.70
ICC5: put pressure on CNO for support and recognition, prevent public confusion about nursing roles	91%	51.00 ± 12.73	62.67 ± 12.35	0.22
ICC6: mental health nursing needs more recognition among health professionals and CNO	87%	70.00 ± 8.66	60.40 ± 12.71	0.22
ICC7: choose another profession that has autonomy established	35%	64.13 ± 12.18	57.00 ± 12.63	0.20
ICC8: change fatigue by nurses	4%	62.68 ± 11.80	39.00	0.06
ICC9: how to protect RNs legally?	9%	62.71 ± 12.09	50.50 ± 16.26	0.20
ICC10: as a leader in my organization angry & frustrated there should have been more education re this issue from CNO	61%	60.56 ± 11.19	62.36 ± 13.70	0.75
ICC11: frustration that CNO leadership missing re provide standards and to decrease patient barriers	91%	67.50 ± 10.61	61.10 ± 12.79	0.50
ICC12: need adequate education/discussion for RN employers/organizations	39%	60.29 ± 11.92	63.78 ± 13.90	0.53
ICC13: not much ability to create change due to time and effort constraints/ or hopeless re outcome	48%	66.92 ± 11.49	55.91 ± 11.46	0.032
ICC14: increase psychotherapy education certification	78%	63.00 ± 11.90	61.28 ± 13.02	0.79
ICC15: participate in this study	91%	51.00 ± 12.73	62.67 ± 12.35	0.22
ICC16: Not given any way to create change -frustrated	87%	55.00 ± 19.98	62.65 ± 11.49	0.34
ICC17: advocate/teach importance of dual role of nursing - holistic integration of physical and psychological nature	39%	62.00 ± 12.09	61.11 ± 13.94	0.87
ICC18: Raise autonomy of RNs, put them on par with others	100%			

Table 14.

Awareness of change theme	% participants who mentioned this theme	Total power score		p-value
		No	Yes	
AC1: RNs do less psychotherapy despite being largest provider group	70%	238.57 ± 45.24	228.50 ± 38.70	0.59
AC2: access limited clients will receive less psychotherapy	65%	237.00 ± 40.43	228.67 ± 40.92	0.47
AC3: doctors will be inconsistent/ lack incentive to write orders	17%	230.95 ± 39.69	234.50 ± 47.77	0.88
AC4: lack of recognition, devalue RNs	100%			
AC5: restrict scope of practice despite education	100%			
AC6: confusion about change in hospital/outpatient process	65%	248.25 ± 36.55	222.67 ± 40.07	0.15
AC7: some aspects of psychotherapy are part of every-day nursing practice	74%	220.67 ± 35.32	235.41 ± 41.86	0.45
AC8: need more clinical supervision and lack of resources/need more education	65%	243.38 ± 37.71	225.27 ± 41.04	0.31
AC9: psychotherapy expertise used for medical patients as well as psych pts	57%	227.60 ± 39.34	234.62 ± 41.87	0.69
AC10: definition of psychotherapy unclear about whether nurses do this vs counselling / overlap	74%	222.83 ± 35.30	234.65 ± 42.13	0.55
AC11: process of instituting Psych. Act has brought more considerations that nurses do psychotherapy	87%	203.67 ± 37.90	235.75 ± 39.53	0.20
AC12: RNs trained in psych. methods but do not have "formal psychotherapy education"	83%	252.75 ± 19.00	227.11 ± 42.16	0.25
AC13: doctors may not back RNs legally-scapegoating RNs	26%	233.12 ± 41.83	227.17 ± 37.67	0.76
AC14: confusion that CNO has restricted nurses' ability to initiate psychotherapy and why	100%			
AC15: more cost for health care system and RNs for 2 Colleges	43%	234.15 ± 44.34	228.20 ± 35.67	0.73
AC16: lack of clarity and communication about meaning of Psychotherapy Act	78%	237.80 ± 48.89	229.83 ± 38.68	0.70
AC17: RNs working within mental health would be performing controlled act	78%	276.40 ± 11.68	219.11 ± 35.86	0.002
AC18: some physicians/NPs have limited knowledge re mental health - unfair	39%	234.64 ± 42.81	226.78 ± 37.22	0.66
AC19: more independent RN roles may not have physicians/NP's available	52%	234.45 ± 44.35	228.92 ± 37.42	0.75
AC20: CNO not backing RNs	100%			
AC21: nursing is the only discipline with access to controlled psychotherapy act requiring an initiation order	87%	244.33 ± 32.33	229.65 ± 41.42	0.57
AC22: order for initiation of controlled act of psychotherapy will not protect public or result in better outcomes	61%	245.11 ± 39.95	222.86 ± 38.99	0.20
AC23: lack of discussion in clinical areas about how to create policies for enactment of psychotherapy act	61%	239.89 ± 48.38	226.21 ± 34.52	0.44
AC24: more bureaucracy in practice	96%	207.00	232.68 ± 40.60	0.54
AC25: therapeutic relationship has always been cornerstone of nursing - being used by psychotherapy/ just part of our job/ RNs don't see themselves as doing psychotherapy.	78%	220.40 ± 42.93	234.67 ± 39.91	0.49

Table 15.

Choices theme	% participants who mentioned this theme	Total power score		p-value
		No	Yes	
CH1: no choices given from nursing perspective	100%			
CH2: decision made by others-others "bestow" whether there will be autonomy for RNs	100%			
CH3: have no choices and no protection re accountability	22%	241.44 ± 37.17	196.00 ± 30.29	0.02
CH4: have to be aware of the issue to make proper choices - this is problem as RNs lack understanding	30%	238.81 ± 38.54	215.00 ± 41.24	0.20
CH5: considering to/or joining CRPO or another college	65%	217.38 ± 41.86	239.13 ± 38.27	0.22
CH6: physicians and NPs will cover for me by writing an order for whoever I want	26%	232.65 ± 41.01	228.50 ± 40.64	0.83
CH7: choices diminished re clients due to lowered status now if not certified by CRPO	78%	226.80 ± 44.25	232.89 ± 40.05	0.77
CH8: No structure defined about how process will affect choices - don't understand choices	61%	230.78 ± 42.96	232.07 ± 39.68	0.94

Table 16.

Freedom to act intentionally theme	% participants who mentioned this theme	Total power score		p-value
		No	Yes	
FAI1: advocate against decision	96%	223.00	231.95 ± 40.92	0.83
FAI2: organizations differ in levels of autonomy	35%	228.60 ± 45.91	237.13 ± 27.67	0.64
FAI3: show that nurses have skills to do psychotherapy (and increase their knowledge/skills)	87%	239.67 ± 18.77	230.35 ± 42.50	0.72
FAI4: limited freedom - "will need to refer you"	87%	244.00 ± 25.94	229.70 ± 41.91	0.58
FAI5: lack of information barrier to freely acting	26%	241.12 ± 38.89	204.50 ± 31.93	0.052
FAI6: Won't change now in my practice (could with PP) because doctor's cooperative	30%	232.88 ± 46.42	228.57 ± 21.72	0.82
FAI7: No freedom (or freedom constrained) to act intentionally as an RN	91%	255.00 ± 26.87	229.33 ± 40.82	0.40
FAI8: freedom of influence given in role of clinical teaching	22%	236.33 ± 39.66	214.40 ± 40.67	0.29
FAI9: confusion/uncertainty to know how practice will change re freedom to act	91%	284.50 ± 7.78	226.52 ± 38.11	0.048
FAI10: Restricted due to third-party authority	100%			

Table 17.

Involvement in creating change theme	% participants who mentioned this theme	Total power score		p-value
		No	Yes	
ICC1: increase awareness of changes with other RNs	87%	223.67 ± 14.98	232.75 ± 42.66	0.72
ICC2: work with RNAO to engage with changes	83%	220.25 ± 12.37	233.95 ± 43.57	0.55
ICC3: increase psychotherapy education and standards of RNs	87%	232.67 ± 24.01	231.40 ± 42.36	0.96
ICC4: make visible that nurses do psychotherapeutic work and have expertise	87%	222.00 ± 14.53	233.00 ± 42.62	0.67
ICC5: put pressure on CNO for support and recognition, prevent public confusion about nursing roles	91%	215.00 ± 11.31	233.14 ± 41.54	0.55
ICC6: mental health nursing needs more recognition among health professionals and CNO	87%	244.00 ± 25.94	229.70 ± 41.91	0.58
ICC7: choose another profession that has autonomy established	35%	236.07 ± 42.82	223.13 ± 35.26	0.47
ICC8: change fatigue by nurses	4%	234.09 ± 39.05	176.00	0.16
ICC9: how to protect RNs legally?	9%	235.81 ± 39.15	187.00 ± 15.56	0.10
ICC10: as a leader in my organization angry & frustrated there should have been more education re this issue from CNO	61%	231.89 ± 43.16	231.36 ± 39.56	0.98
ICC11: frustration that CNO leadership missing re provide standards and to decrease patient barriers	91%	248.00 ± 35.36	230.00 ± 40.87	0.56
ICC12: need adequate education/discussion for RN employers/organizations	39%	230.29 ± 42.53	233.56 ± 38.19	0.85
ICC13: not much ability to create change due to time and effort constraints/ or hopeless re outcome	48%	247.67 ± 37.98	214.00 ± 35.88	0.04
ICC14: increase psychotherapy education certification	78%	218.80 ± 37.02	235.11 ± 41.10	0.43
ICC15: participate in this study	91%	215.00 ± 11.31	233.14 ± 41.54	0.55
ICC16: Not given any way to create change -frustrated	87%	219.67 ± 61.07	233.35 ± 37.90	0.59
ICC17: advocate/teach importance of dual role of nursing - holistic integration of physical and psychological nature	39%	230.50 ± 36.26	233.22 ± 47.59	0.88
ICC18: Raise autonomy of RNs, put them on par with others	100%			