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Editor's Note

The **editorial board** was humbled by the support we received from NorQuest College executive, marketing department and the Faculty of Health and Community Studies during the launch of our first issue in February 2021. A special thank you to Canadian Association of Practical Nurse Educators (CAPNE) and all those who made the launch of our first issue a success. This is the *Journal of Practical Nurse Education and Practice* (JPNEP) second issue. This could not have been possible without the tremendous contributions from our valued authors and dedicated peer reviewers. Our diligent copy editor (Kay Rollans) was sponsored by NorQuest College Curriculum Department – thanks to Dawn Witherspoon for the generosity, greatly appreciated. JPNEP relies on volunteers who dedicate their valuable time to support the journal and I am very grateful for their support. JPNEP's objective is to publish high quality peer reviewed articles whose content is accessible to a variety of readers.

The articles submitted to **JPNEP** undergo a double-blind peer review process. We accept manuscripts of any length and authors can incorporate interactive media during the review process. Our focus is on practical nurse education and professional practice. Practical nurse educators, policy makers, healthcare professionals, nursing students and all practical nursing stakeholders are encouraged to submit manuscripts for review and publication with JPNEP. The manuscripts could be based on original research, literature review, policy analysis, thesis/book reviews, case studies or responses to previously published articles.

In this issue, we share articles that are thought provoking. Nichole Parker writes about "*Facilitating Trauma-Informed Pedagogy*". She presents an argument on some of the challenges faced by trauma survivors to achieve learning outcomes given that trauma can impact how learners learn. As educators, it important to gain some insights and understand how trauma survivors learn in order to provide relevant supports. In her second article, Parker reviewed literature related to addiction stigma and arts-based learning and pedagogical strategies that can reduce stigma and meet social justice learning outcomes. Parkers encourages educators to use artistic pedagogical technologies to design social justice learning outcomes with an anti-discriminatory framework. In the third manuscript, Lawrence Onwuegbuchunam reflects on the possibility that healthy

spirituality and healthy religious practices, together with psychotherapy and pharmacologic interventions, could be effective in the treatment of anxiety disorders and other mental health conditions. Lawrence challenges us to consider issues related to spirituality in healthcare. The fourth article is a literature review by Jamie Tycholiz where she presents an intriguing argument on the impact of role ambiguity in healthcare. Jamie pointed out that lack of clarity on roles creates challenges for nurses, employers, educators and regulatory bodies. The fifth manuscript by Carol Reid and her colleagues evaluates an innovative student nurse placement model developed in rural Australia through a multidisciplinary partnership. The authors challenge us to reflect on student nurse placement models that enhance students' learning experiences as they develop relevant knowledge and skills.

Authors are our valuable partners that determine the success of academic journals. I want to take this opportunity to thank our authors who keep providing oxygen for our journal. To all readers and contributors, please continue to share about our journals with your contacts. Our journal is open access and please help us disseminate the **link** with your peers. Thank you for your support!

Sincerely,

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Facilitating Trauma-Informed Pedagogy

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Abstract

Mental health issues are increasing globally, affecting health outcomes and health care resources. Understanding the andragogical implications for adult learners who are experiencing mental illness, including trauma-related mental illness, is vital for nurses, educators, and community support services. Experiencing abuse can cause mental health issues such as stress, anxiety, and posttraumatic stress disorder. In the context of this article, a trauma survivor is someone who has been the victim of abuse. Trauma survivors can be hard to identify, reach, connect with, and have difficulty reaching specific learning outcomes. This translates into poorer health outcomes within this vulnerable group as trauma survivors may not be able or ready to implement self-care efforts. Trauma also affects how people learn. Because of this, trauma survivors require focused teaching strategies that will support their growth, recovery, development, and integration into the community. Adult educators must hone their ethical pedagogical responsibility in a way that reflects trauma-informed care when providing care for a diverse student population. Understanding how these survivors learn will also help educators and healthcare providers understand the pedagogical philosophies, approaches, and strategies best suited to the andragogy of adult learners who have experienced trauma. To contribute to advancing pedagogical epistemology, the purpose of this literature review is to discuss how learning occurs in adult trauma survivors, and asks: What pedagogical philosophies and approaches are beneficial to understanding and best facilitating the andragogy of adult learners who have experienced trauma? This enhanced understanding leads to stronger advocacy for inclusive and trauma-informed teaching and learning environments.

Keywords*:* trauma AND learning, pedagogy AND trauma, andragogy AND trauma, trauma AND self-care, learning OR educational AND theory OR philosophy, trauma AND strategies

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Facilitating Trauma-Informed Pedagogy

Violent abuse causing trauma-related impairments for survivors is a global concern (Austin & Boyd, 2008). The Edmonton Police Service (EPS, 2019) defines abuse as attempts to control another individual through various means not limited to increasing dependency or vulnerability. Abuse can be physical, sexual, verbal, financial, isolation-related, emotional, and/or psychological (EPS, 2019) and can cause posttraumatic stress syndrome (PTSD). Understanding the andragogical implications for adult learners who are experiencing mental illness, including trauma-related mental illness, is vital for nurses. Trauma survivors can be hard to identify, reach, connect with, and have difficulty reaching specific learning outcomes. This translates into poorer health outcomes within this vulnerable group as trauma survivors may not be able or ready to implement self-care efforts. Understanding how these survivors learn will also help educators, healthcare providers, and community stakeholders understand the pedagogical philosophies, approaches, and strategies best suited to the andragogy of adult learners who have experienced trauma.

Current literature indicates that abuse changes a trauma survivors' construction of reality by distorting their core beliefs about the self, others, and the world around them (Austin & Boyd, 2008). This shift in core beliefs also has an impact on learning. Trauma's effect on learning should be considered when selecting teaching strategies that will best support trauma survivors in their growth, recovery, and development. Adult educators, which include healthcare professionals, must hone their ethical pedagogical responsibility in providing care for a diverse student population which reflects trauma-informed care. This is vital since trauma-informed care "shifts the focus from 'What's wrong with you?' to 'What happened to you?'" (Center for Health Care Strategies, 2021, para. 1). Therefore, critical reflection into which andragogical or

pedagogical approach we can use as educators is essential in providing trauma-informed care for our diverse group of learners. Hence, to contribute to advancing pedagogical epistemology (the study of knowledge), this literature review discusses how learning occurs in adult trauma survivors, and asks: What pedagogical philosophies and approaches are beneficial to understand and best facilitate the andragogy of adult learners who have experienced trauma? This enhanced understanding leads to stronger advocacy for inclusive and trauma-informed teaching and learning environments.

Literature Search Process

Initially, the publication date limiters during the research process ranged from 2015 to the present. However, the lack of research articles on this topic forced these limiters to be modified by omitting date limiters altogether. As well, the teaching approaches selected as the focus of this literature review were influenced by my ongoing course of graduate study. As the search progressed, it provided valuable insights into a wider angle of search terms. This was useful as this topic initially yielded a limited number of relevant research articles. As the research expanded, the articulation of related search topics was modified. For these reasons, this literature review used a large range of research search terms in order to appropriately address the andragogical (learning-related) and pedagogical (teaching-related) knowledge and applications of trauma-informed care.

The databases used were the Athabasca University Library catalogue, EBSCO, and ERIC. Other references were gathered from course content and related textbooks. Limiters used included the English language and full text availability.

The terms *trauma* and *trauma recovery* were searched using the Boolean "AND" with each of the following terms: *learning*, *learning theory*, *teaching*, *adult learning*, *abuse*, *violence*,

philosophy, *informed care*, *stabilization*, *systematic approach*, *psychological consequence*, and *rehabilitation*. Other search terms included: *stages of trauma recovery*, *learning models for PTSD*, *social reconstruction*, *trauma informed care*, and *complex trauma*. Lastly, the Boolean search terms *survivor OR trauma survivor AND self-care*; *universal AND learning*; *and impact trauma AND learning* were also used.

Learning After Traumatic Experiences

Adult Learning Principles

Adult learning is a collaborative and cooperative process that occurs inside the learner through experience (Blais & Hayes, 2016). Bloom (1956, as cited in Blais & Hayes, 2016) identified three areas or domains of learning: cognitive, affective, and psychomotor. The cognitive domain includes intellectual skills such as remembering and comprehending (Blais & Hayes, 2016); therefore, an individual must have the ability to concentrate and think. The psychomotor domain revolves around motor activities such as yoga (Blais & Hayes, 2016). The affective domain mainly focuses on emotion, attitude, or value-laden learning outcomes (Blais & Hayes, 2016). Dirkx (2008) argues that human learning involves both logical and emotional ways of knowing and therefore asserts the high value of being aware of internal feelings and those around us. This awareness is called emotional intelligence and outlines the holistic and intentional process of understanding the emotional self (Dirkx, 2008).

Trauma Survivors as Learners

Unfortunately, as Dirkx (2008) states, emotions are "widely recognized as a kind of baggage that impedes effective teaching and learning" (p. 8). Educators must challenge this perspective when adopting a trauma-informed pedagogical approach. Adult learners are more likely to engage in learning when the purpose is to help them cope during a life event or difficult

transition, or to increase their sense of self-esteem (Zemke & Zemke, 1984). Overall, this learning principle substantiates self-care survivor groups as an appropriate strategy to promote learning within a trauma recovery platform.

Trauma changes the brain making it more difficult to learn (Perry, 2006). Brain systems coordinate affective and cognitive circuits to aid in learning; fear or anxiety can act as a break in this circuit, decreasing the ability to learn (Cozolino & Sprokay, 2006). Such negative emotions distract from learning (Blais & Hayes, 2016; Kerka, 2002; Perry, 2006) and dictate the quality of learning experience (Dirkx, 2008). Trauma impedes one's ability to concentrate and think (Blais & Hayes, 2016; Cozolino & Sprokay, 2006; Kerka; 2002; Kossurok, 2018; Perry, 2006). Moreover, motivation influences a learner's readiness to learn (Blais & Hayes, 2016) and is reduced when accompanied by poor mental health (Dirkx, 2008; Melrose et al., 2015; Zemke & Zemke, 1984). Furthermore, as Perry (2006) urges, the "capacity to internalize new verbal cognitive information depends on having portions of the frontal and related cortical areas activated, which in turn requires a state of attentive calm [which a] traumatized adult learner has difficulty reaching" (p. 25).

Adult Learning Theories

Humanism

Humanism focuses on the cognitive and affective states of learners—that is, their attitudes and emotions (Blais & Hayes, 2016). Within the humanist approach, Abraham Maslow's hierarchy of needs indicates that an individual's survival needs for air, water, and food, and their psychological safety needs for security and protection must be fulfilled before the psychological needs for esteem, belonging, and self-actualization can be met (Blais & Hayes, 2016). The hierarchy of needs requires a learner to be an active participant in order to meet their

personal needs (Blais & Hayes, 2016). Therefore, in order for trauma survivors to have the ability and readiness to learn and reach their potential, they must first have their psychological needs met, followed by a sense of safety, followed by feeling love and belonging. Only then can they meet their self-esteem needs (Blais & Hayes, 2016).

Barriers to a survivor's self-determination and learning, therefore, lie in the effects of trauma. The physiological and physical effects of trauma include hypervigilance, chronic pain, and chronic fatigue (BCMHSC, 2013). Moreover, the extreme stress of trauma creates mental, emotional, and physical distress within brain and body dynamics (BCMHSC, 2013). Ingrained learned behaviours such as all-or-nothing reactions, dissociation, and silence are common among trauma survivors (Kerka, 2002). Dissociation is a coping mechanism in response to trauma or a trauma-related trigger that is accompanied by the feeling of one's mind and body being separated (Kerka, 2002). Trauma survivors have a difficult time looking inward or reflecting on their experience (Kruczek & Smith, 2001). Moreover, survivors experience emotional disconnection from themselves (BCMHSC, 2013). This inability to identify and meet their own needs may inhibit survivors from moving up the hierarchy of needs. Pedagogical approaches that support these learners is vital. From a humanistic standpoint, supportive approaches include enhancing personal growth and development, being attentive to learner needs, and being aware of individual learner emotional and affective issues (Melrose et al., 2015).

Constructivism

Constructivism views learners as "builders who are continually creating mental representations of events and experiences" (Melrose et al., 2013, p. 65). In other words, learners are engaged in composing the knowledge they possess; this process is influenced by social interaction with peers (Melrose et al., 2013). Educators can facilitate learning through

scaffolding: the temporary support required for learners to construct personal meaning in relation to course concepts (Melrose et al., 2013). Constructivist learning is related to trauma insofar as trauma survivors are already engaged in constructivism. Specifically, they are building up a particular, personal meaning and knowledge about reality—that is, how they see themselves, others, and the world, including their learning environment.

Self. Trauma distorts one's sense of self (BCMHSC, 2013). Individuals who experience trauma are usually left with a negative perception of self (Au et al., 2017; Kerka, 2002; Kossurok, 2018). Au et al.'s (2017) experimental study revealed that self-compassion techniques used by individuals experiencing PTSD decreased shame and brought awareness to distorted thought patterns, which were serving to negatively frame their realities. Au et al. (2017) found that the first step towards self-care for trauma survivors was to become aware of their negative self-talk and use this awareness to fostered self-kindness, which enabled study subjects to connect with themselves. As self-compassion increased, so did the motivation to perform self-care activates (Au et al., 2017).

Fear, shame, and guilt are common among trauma survivors (Au et al., 2017; Austin & Boyd, 2008; BCMHSC, 2013; Kerka, 2002; Kossurok, 2018). It is common for survivors to feel that they are responsible for the traumatic event or events they have experienced. This can lead individuals to feel ashamed and isolate themselves further from others and the world (Au et al., 2017; Austin & Boyd, 2008). Unfortunately, isolation is a common reaction among survivors (Au et al., 2017; Austin & Boyd, 2008; Kerka, 2002; Kossurok, 2018) and is associated with negative health outcomes (Au et al., 2017; Austin & Boyd, 2008).

Others and the World. Trauma negatively affects one's sense of safety around others and within their environment (BCMHSC, 2013). Trauma survivors may have difficulty trusting

others (Kerka, 2002). Survivors are likely to feel a disconnection towards others and have difficulty navigating relationships (BCMHSC, 2013). Consequently, trauma negatively affects the capacity to see the world as a positive or helpful place (Kerka, 2002).

Learning Environment. Almost one-third of the adult student population has experienced some sort of trauma that negatively influences their capacity to learn (Perry, 2006). Optimal learning requires the individual to have the capacity to be curious and a willing to explore. These abilities are impeded by fear and anxiety (Perry, 2006). A learning environment that is perceived as threatening can retrigger a trauma survivor, which further negatively affects learning (Cozolino & Sprokay, 2006; Perry, 2006). Therefore, an understanding of the nature of learning is vital to seek andragogical resources which will benefit this diverse learning population (Kerka, 2002; Melrose et al., 2015). Since trauma survivors usually have a baseline of low-level fear, these adult learners require educators to intentionally reflect creative teaching strategies, respectful approaches, and the creation of safe learning environments (Perry, 2006). Furthermore, safe learning environments require educators to ensure structured and predictable syllabi or curricula (Perry, 2006).

Reconstructing Reality. Born from the progressive philosophy of education, social reconstruction urges that educational activities require socialization for learning (Sutinen, 2014). Socialized educational activities alter a learner's thinking and influence their social realities (Sutinen, 2014). Progressive perspectives assist learning through community involvement and focusing on real-life issue relevancy (Melrose et al., 2015). Therefore, a self-care class focusing on real-world issues related to trauma recovery would induce useful social learning.

Cozolino and Sprokay (2006) describe the brain as a "social organ innately designed to learn through shared experiences" (p. 11). When a learner is met with respect and acceptance in a

supportive environment, a sense of self-worth develops (Kossurok, 2018; Townsend, 2005). Social reconstruction is, therefore, a sound approach to trauma recovery since it emphasizes social support and social learning (Kossurok, 2018). This process changes beliefs that were created in response to trauma, including negative beliefs about the self and low self-worth (Kossurok, 2018). These beliefs are reconstructed and change the reality of trauma survivors. Survivors who attend social supportive recovery groups have an increased sense of self-worth and motivation which increases their probability to seek self-care activities (Kossurok, 2018). Socialization within trauma support groups creates positive beliefs about oneself (Kossurok, 2018). Moreover, these groups facilitate trauma survivor recovery and the integration of their participants into broader communities by allowing them to learn how to build healthy relationships and support systems (Kossurok, 2018).

Transformational Learning

Transformative learning is the process of learning new ways of looking at something and involves "meaningful and transformative shifts in…beliefs and assumptions" (Melrose et al., 2015, p. 10). Affective learning occurs from this learning experience (Dirkx, 2008). The way we see ourselves and the world can shift through transformational learning in ways that can have life-changing impact on a learner (Melrose et al., 2013). A class offering self-care to trauma survivors would allow for a learner to create new realities that are healthy instead of distorted.

Teaching Through a Trauma-Informed Care Lens

Teaching Models and Philosophies

Social Justice Teaching Model

Rogers-Shaw et al.'s (2018) Universal Design for Learning (UDL) seeks to provide a teaching and learning framework that emphasizes learner diversity. Although primarily designed

for online learning, UDL uses a holistic framework to promote social justice and learning accessibility for all learners despite their diverse backgrounds (Rogers-Shaw et al., 2018). UDL challenges educators and curricula developers to acknowledge learner diversity within their unique past experiences, cultures, strengths, and ways of being (Rogers-Shaw et al., 2018). Furthermore, the "epistemological shift that UDL facilitates is that the knowledge and truths that humans grow into are not abstract things existing independently of the sociocultural realities of the humans themselves" (Rogers-Shaw et al., 2018, p. 23).

Immediacy Theory

Feeling connected with a sense of belonging to an adult learners' environment is the heart of immediacy (Melrose et al., 2013). Instructional immediacy requires instructors to engage students through a warm and friendly embrace while intentionally using and modelling language and behaviour that promotes connection (Melrose et al., 2013). Some examples of instructional immediacy include identifying students by name, storytelling through personal experiences, initiating dialogue, encouraging students to participate in conversations, and providing positive feedback (Gorham, 1988, as cited in Melrose et al., 2013). Educators can facilitate neuroplasticity when they skillfully express empathy and positive emotion. Neuroplasticity deals with learning and memory and the ability for nerves to adapt to circumstances (Psychology Today, 2020). This process of rewiring the brain to adopt more healthy ways of thinking and being is why scientists refer to neuroplasticity as the *structural remodeling of the brain* (Psychology Today, 2020). Therefore, a learner's reality is influenced by their learning environment, educators, and community leaders.

Implementing Teaching Strategies That Reflect Trauma-Informed Care

Empowering learners, providing social opportunities, promoting self-care, and fostering trauma-informed learning cultures are all strategies that contribute to effective andragogy for adults that have experienced trauma. Since humans are in constant subconscious communication with one another, adult learning environments require educators who are intentional about expressing an art and science of teaching that supports neuroplasticity (Cozolino & Sprokay, 2006). Educators must have a heightened awareness and intuition of their learners, be caring, and provide choices when applicable (Cozolino & Sprokay, 2006). This ability to choose is empowering and constructs a sense of freedom within one's perception of their learning environment.

In addition to empowering learners, educators must provide social learning opportunities. Current trends in neuroscience are unveiling more evidence that suggests that human brain anatomy and it's neural plasticity requires social interaction (Cozolino & Sprokay, 2006). Social learning adds to the reality constructs of survivors and provides peer role models. Hearing about another's successes can be a profound experience for some trauma survivors that encourages and motivates them to continue in their recovery. When learners observe a narrative that reveals a successful means to a challenge, anxiety is reduced and neuroplasticity processes are strengthened (Cozolino & Sprokay, 2006). Narratives help reduce feelings of helplessness and powerlessness (BCMHSC, 2013) and play a vital role in self-esteem development and expression (Cozolino & Sprokay, 2006). Through this storytelling, adult learners can journey "from fear to courage, from confusion to clarity, and from crisis to triumph" (Cozolino & Sprokay, 2006, p. 17).

Recommendations for Future Education and Research

How can we advocate for trauma-informed teaching? In order to support social justice and allow learning to be accessible to all learners despite their histories, educators must change their way of thinking about education and adopt a universal approach that is accessible to all learners (Rogers-Shaw et al., 2018, p. 20). Educators and community supporters must advocate for social justice by supporting trauma-informed teaching and learning that is accessible to *all* learners. Societal change in this context starts with acknowledging and discussing abuse and trauma (Kossurok, 2018). More education regarding trauma-informed pedagogical approaches is required for health care providers, educators, and community resources. We must "create space within our educational environments where giving voice to emotion-laden issues becomes an integral part of a community of truth" (Dirkx, 2008, p. 16). Unfortunately, this paper's search process revealed the limited number of currently available scholarly articles that seek to disseminate pedagogical practices that support trauma-informed teaching approaches. Among the limited research available for trauma-informed andragogy and pedagogy, philosophy and theory are utilized to add a scholarly balance to this valuable triad. Moreover, the manuscript is written solely from a master-level student perspective and would be strengthened by further perspectives and a multidisciplinary lens. Overall, more research is required in this area to support a globally diverse learner audience and best pedagogical practices.

Conclusion

The nature of trauma and its effect on learning influences the teaching strategies that educator use to support trauma survivors, who have different needs than other learners in relation to their growth and development, as well as their trauma recovery. Adult educators must hone

their ethical pedagogical responsibility in ways that reflect trauma-informed care in order to provide a safe and effective learning experience for a diverse student population that includes trauma survivors. Critical reflection into which andragogical or pedagogical approaches educators should use in this context is essential. This literature review offers a considerable contribution to pedagogical epistemology through its articulation and curation of pedagogical strategies that are congruent with andragogical, trauma-related principles grounded in research, philosophy, and education and learning theory. Health care professionals, educators, and community supports must advocate for social justice by supporting learning that is accessible to all of our learners. Advocating for trauma-informed pedagogical practices is one step in this direction.

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An Arts-Based Antidiscriminatory Approach to Online Nursing Education: Reducing Addiction Stigma and Meeting Social Justice Learning Outcomes

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Abstract
Background. *Addiction stigma exists in health care systems among health care providers, including nursing students. It is often tied to knowledge deficits and acts as a barrier to those seeking supportive addiction services.*
Purpose. *To discuss innovative approaches that reduce addiction stigma and meet social justice learning outcomes in online nursing education.*
Methods. *A four-stage algorithm was used with 95 articles. Applying an exclusion and screening process yielded 17 articles. Another 10 articles were drawn from my recent graduate work.*
Results. *Online educators can use artistic pedagogical technologies to practice from a critical consciousness lens to design social justice learning outcomes with an antidiscriminatory framework.*
Conclusion. *An intentional and innovative framework to reduce addiction stigma in online nursing students is proposed, developed from artistic pedagogical technologies within a critical consciousness lens. This inclusive pedagogical approach is accessible to diverse twenty-first century learners, reduces addictions stigma, and leads to better-prepared nurses who deliver excellent nursing care for all.*

Keywords: social justice, online education, arts-based, addiction nursing, stigma

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An Arts-Based Antidiscriminatory Approach to Online Nursing Education: Reducing Addiction Stigma and Meeting Social Justice Learning Outcomes

One in 10 Canadians struggles with addiction and 83% of these individuals have experienced barriers to recovery (Canadian Centre on Substance Use and Addiction, 2017). The Canadian public health system has been increasingly impacted by addiction stigma, which has caused negative health outcomes to individuals and populations (Government of Canada, 2020a). Miller (2019) defines stigma as "a set of negative and often unfair beliefs that a society or group of individuals have about a particular circumstance, quality or person" (para. 1). Stigma can be expressed through behaviours that judge, label, or exclude groups based on negative attitudes and stereotyping (Government of Canada, 2018). Addiction stigma has acted as a barrier to the health and wellbeing of those struggling with addiction (Government of Canada, 2020a). Addiction stigma among health professionals places individuals struggling with substance use in a more vulnerable position (Volkow, 2020), particularly during the COVID-19 pandemic. Social justice strives to eliminate discrimination and inequities, and should therefore be at the core of nursing programs (Blanchet Garneau et al., 2018). Therefore, educators must hone innovative strategies to bridge the gap between nursing ethics and practice. Moreover, many nursing graduates will be placed in a position of influence over those who struggle with addiction. People, including nursing students, develop addiction stigma for various reasons, but it is often caused by a deficiency in knowledge on the matter (Knaak et al., 2019). It is therefore vital to address stigma (Cloyd et al., 2021) and educate students about addiction prior to entering the workforce.

This paper summarizes evidence from credible scholarly literature related to addiction stigma, social justice concepts, inclusive pedagogies, nursing education, and arts-based learning

strategies in order to discuss innovative approaches that can reduce addiction stigma and meet social justice learning outcomes in online nursing education. Artistic pedagogical technologies (APTs) are creative aesthetic strategies that are beneficial for online postsecondary students and instructors (Janzen et al., 2017) and are discussed as they relate to innovative teaching methods for social justice learning outcomes. Narrative photography—a type of APT in which students self-reflect and tell a story using images, videos, and various forms of art (Leyva-Moral et al., 2021)—is asserted to be an inclusive and effective approach to reduce addiction stigma among and meet social justice learning outcomes for online nursing students.

Theoretical Framework

Nursing education and practice are limited in their understanding of how to demonstrate social justice (Blanchet Garneau et al., 2018). It is becoming increasingly clear; however, that nursing must seek ways to teach and practice the constructs of antidiscrimination and equity. I therefore use Blanchet Garneau et al.'s (2018) critical antidiscriminatory pedagogy (CADP) as a theoretical backdrop for this discussion. The CADP is built on antiracist and antidiscrimination approaches (Blanchet Garneau et al., 2018). Moreover, the CADP "pushes beyond culturally sensitive, tolerant, and respectful attitudes promoted by multiculturalist approaches toward a critical cultural perspective" (Blanchet Garneau et al., 2018, p. 3). It promotes transformational learning, which allows for "a transformation of the learners' frame of reference, which means that learners experience a deep, structural shift in the basic premises of their thought, feelings, and actions" (Blanchet Garneau et al., 2018, p. 4). The CADP encourages educators to be critically conscious and reflective of the pedagogical methods they employ to limit social inequalities within the classroom and focus on promoting awareness of the power and knowledge dynamic (Blanchet Garneau et al., 2018). Practicing from a critical conscious perspective,

educators should discuss health equity, population statistics, assumptions or stereotypes, and how these impact nursing practice and patient outcomes (Blanchet Garneau et al., 2018).

Methods

This scoping review was completed as a curated master's degree project within the Athabasca University (AU) Master of Nursing program. References from previous graduate work and the AU Discovery Library Database make up the foundation of this literature search. Keywords used in the AU Discovery Database were:

> (art*-based or art* based or art*) and (online or distance or education or learn* or teach* or pedag*) and (addict* or substance*) and (stigma or bias or social justice or discr*) and (nurs* or med* or health*)

The search was restricted to peer-reviewed articles published in or after 2015 with English and full-text availability. The search strategy yielded 95 articles. A review of title relevance eliminated 27 articles. The abstracts of the remaining 68 articles were reviewed, and a further 31 articles were eliminated. The remaining 37 were read for their relevance, and 17 were selected as references in addition to 10 articles previously used in my graduate work.

Prevalence of Addiction Stigma and a Call for Action

Prevalence of Addiction and Addiction Stigma

About one in five Canadians older than 15 years will struggle with addiction at least once in their lifetime (Government of Canada, 2018). Addiction is strongly associated with an individual's social determinants of health, discrimination, and historical trauma (Government of Canada, 2018). Individuals who have experienced abuse, trauma, exposure, inability to manage stress, and adverse childhood experiences have an increased probability of experiencing problematic substance use (Government of Canada, 2018).

Addiction stigma is a Canadian public health problem (Government of Canada, 2020c). Canada has tried to address addiction stigma within health care through equity-oriented interventions, trauma-related stress and burnout initiatives, education initiatives, and policy changes (Government of Canada, 2020b). Unfortunately, addiction stigma is still evident within the Canadian health care system (Government of Canada, 2020b). Addiction stigma may be tied to knowledge deficits around or misconceptions of addiction (Miller, 2019).

Addiction stigma exists within the nursing and general health care population (Lanzillotta-Rangeley et al., 2020). Volkow (2020) asserts that many health care providers view addiction "as a result of moral weakness and flawed character" (para. 2). A Canadian phenomenological study involving interviews with 23 participants from a Toronto community health centre (including senior staff, peer workers, and front-line health workers) found multiple forms of stigma and discrimination towards substance use issues (Murney et al., 2020). Murney et al. (2020) explain that substance users are "popularly believed to be choosing an unhealthy, dangerous lifestyle as part of an irresponsible but nonetheless conscious decision-making process" (p. 5).

Nursing education faces a challenge: preparing nursing graduates who can provide excellence in nursing care to those struggling with addictions (Lanzillotta-Rangeley et al., 2020). Addiction stigma is prevalent in nursing student communities as they are made up of diverse learners who bring their own set of beliefs, attitudes, and biases. For instance, after surveying 88 nursing students attending a southwestern US University, Cloyd et al. (2021) found that the social status of substance users influenced the amount of stigma nursing students felt towards them. At the same time, the perception of substance use led most nursing students to assume that the patient also had a low social status (Cloyd et al., 2021).

Nursing curricula lack sufficient experiences and knowledge related to caring for patients with addictions (Farrell, 2020). Moreover, nursing educators often lack addiction nursing experience, limiting their capacity to strengthen related curricula (Farrell, 2020). It is clear that nursing instructors must intentionally address nursing student addiction stigma, but this gap in pedagogical capacity presents a health care crisis and requires nursing educational leaders to collaborate with external stakeholders (Farrell, 2020).

The Impact of Addiction Stigma and a Call for Action

Addiction stigma has a profound negative effect at a variety of levels. Stigma leads to discrimination and fails to uphold fundamental human rights (Government of Canada, 2018). Addiction stigma can distort one's perception of others (Knaak et al., 2019). Stigma creates disadvantages and inequitable social outcomes (Government of Canada, 2020a). Inequities are widened among groups who have experienced addiction stigma and marginalization, thus limiting the accessibility of housing, income, social support, and health care (Government of Canada, 2020a).

The Canadian public health system has been increasingly impacted by addiction stigma, which is a barrier to the health and wellbeing of those struggling with substance use (Government of Canada, 2020a). Those who experience addiction stigma are less likely to seek or obtain the health care services they require (Volkow, 2020). Knakk et al. (2019) conducted a focus group study in which the participants were individuals who had experienced addiction stigma. One participant shared their experience by stating, "addiction is one of the only health-care problems where you're more likely to be thrown out of a hospital for showing symptoms of your illness than you are to receive care" (p. 5). Discrimination and stigma within nursing practice negatively affect patient and population health outcomes (Blanchet Garneau et al., 2018)

and have had an impact on deaths attributed to untreated drug and alcohol use (Volkow, 2020). When the nursing profession demonstrates discriminatory behaviours and stigma, it acts as a barrier for those struggling with substance use to access health care resources that seek to reduce morbidity and mortality rates amongst these patients (Volkow, 2020).

Nurses are required to demonstrate ethical practice that refrains from stigmatizing behaviours, such as labelling or judging, toward persons receiving care (Canadian Nurses Association, 2017). Moreover, "nurses foster a moral community in which ethical values and challenges can be openly discussed and supported" (Canadian Nurses Association, 2017, p. 13). Education has already played a vital role in reducing addiction stigma among nursing students yet nursing graduates are not prepared to handle patients influenced by the opioid crisis (Lanzillotta-Rangeley et al., 2020). Nursing education must focus on increasing student capacity to uphold social justice principles within their practice (Blanchet Garneau et al., 2018) and must develop innovative ways to address addiction stigma among nursing students.

Blanchet Garneau et al.'s (2018) CADP emphasizes the importance of social justice in the nursing curriculum with a critical intersectional perspective that promotes transformative learning with praxis-oriented critical consciousness. Through praxis-oriented critical consciousness, transformational learning bridges the gap between theory and practice, fostering insights into our practice environments and our ability to change them (Blanchet Garneau et al., 2018). Furthermore, educators must seek pedagogical approaches that reflect positive core values related to diversity, inclusion, and cultural responses (National League for Nursing, 2016).

Blanchet Garneau et al. (2018) suggest that collective learning activities offer a fitting opportunity to develop transformational learning experiences that foster a praxis-oriented critical consciousness among learners. The link between social-emotional learning and intercultural

education requires educators to acknowledge the role of emotions in learning (Rodríguez-Izquierdo, 2018). Intercultural education initiatives promote empathy toward and emotional understanding of others (Rodríguez-Izquierdo, 2018). Intercultural education encourages critical thinking by having nursing students participate in uncomfortable learning activities that discuss fundamental societal issues and inequalities (Rodríguez-Izquierdo, 2018). Overall, "the idea is that students are encouraged to develop the ability to reflect upon their own experiences and emotions when they think and act in relation to cultural diversity" (Rodríguez-Izquierdo, 2018, p. 614).

APTs as an Intentional Strategy within Online Nursing Education

The National League for Nursing (2016) emphasizes that diversity and excellence in nursing are synergistic and undividable. The digital age has expanded the role of nurses. It has provided nurse educators with a geographically and culturally diverse set of learners who learn about caring within a unique social environment (Sitzman, 2017). Art offers multiliteracies, or broad modes of representation; this allows for the engagement of a diverse set of learners (Pauly et al., 2019). Therefore, using APTs in online nursing environments demonstrates synergistic learning while acknowledging each student's uniqueness and diversity.

Nursing education is limited in its understanding of how to demonstrate social justice (Blanchet Garneau et al., 2018). An arts-based learning approach may be one way of solving this problem. Using art as a pedagogical strategy reflects a culturally responsive learning approach (Pauly et al., 2019; Reif & Grant, 2010). Using art within classrooms allows for inclusion as it provides an opportunity to recognize that each person has a unique perspective and is empowered to express themselves through the artistic medium (Favella, 2017). Moreover, using art as a culturally sustaining pedagogy promotes "inclusive ways of knowing and

communicating" (Pauly et al., 2019, p. 205). This recognition of individual differences promotes diversity.

APTs offer innovative collective learning strategies in online nursing education, which can be utilized for social justice learning outcomes. APTs offer a low-cost addition to online education platforms that seek to meet the needs of students and educators within this fast-paced digital age (Janzen et al., 2017). Additionally, APTs promote creativity, interaction, and community building within online postsecondary classrooms (Janzen et al., 2017). Janzen et al. (2017) conducted a study in which they asked 15 graduate students to share their experiences using APTs. The results showed that the majority of participants felt that APTs positively influenced their learning. Of these participants, 92% reported feeling comfortable interacting with other classmates in the online classroom when participating in APTs. APTs empower learners, thereby allowing them to control their learning and choices on how to participate (Janzen et al., 2017). Furthermore, Janzen et al. (2017) found that with APTs, "diversity becomes evident and valued by the class community" (p. 13).

Arts-Based Learning as an Effective Strategy to Decrease Addiction Stigma in Online Nursing Students

Using Art to Reduce Existing Prejudices

Art invites participants to stop and reflect, which can yield valuable insights and transformational learning. Creating and reflecting on art initiates deep reflection and critical thinking (Formato, 2020). Paivinen and Bade (2008) used Voice—a collection of art created by women who have a history of addiction—as a teaching and learning tool. The author's found that Voice offered a valuable method of challenging stigma and exploring the experiences of individuals who have been historically silenced—specifically, in this case, women who have

suffered from addiction. Overall, Voice showed a unique, in-depth understanding of the experience of addiction (Paivinen & Bade, 2008).

Similarly, Lanzillotta-Rangeley et al. (2020) studied first-year nursing students' perceptions of individuals struggling with addiction. They used a pre-test/post-test design that involved an interactive presentation following a personal recovery story. The author's found that nursing students' perceptions changed with regard to their knowledge, attitude, and judgement following the interactive presentation. Original views about patients struggling with addiction included assumptions that these individuals were selfish, inconsiderate, and "not trying hard enough to give up drugs" (Lanzillotta-Rangeley et al., 2020, p. 438). Participants stated that the presentation helped change their views; they reported less bias and increased patient understanding. One participant stated that hearing a recovery story changed their bias since they were "much more understanding of addictions…[and therefore able] to be more sympathetic and more able to help them" (Lanzillotta-Rangeley et al., 2020, p. 438). The experience of hearing the story was described as "powerful." Moreover, participants said it allowed them to further develop their knowledge of disease processes and the impact their professional role can have in the lives of individuals who struggles with addiction (Lanzillotta-Rangeley et al., 2020).

Leyva-Moral et al. (2021) used narrative photography to study nursing students' empathy using real-life stories and videos of a patient population experiencing a specific medical diagnosis commonly linked with existing prejudices. The students were encouraged to reflect on how they would feel if they were a patient with a specific medical diagnosis. The students were then asked to provide three photographs or drawings that portrayed this reflection along with an explanation and to present this to a learning group (Leyva-Moral et al., 2021). Leyva-Moral et al. (2021) found that 88% of respondents reported that narrative photography helped them reduce

existing prejudices, consider other ways of looking at things, and understand the role of humanized care. This is vital since problematic substance use is not a choice but a health condition and requires a compassionate approach (Canadian Centre on Substance Use and Addiction, 2017). Furthermore, having a deep understanding of addiction can help health care providers decrease addiction stigma (Government of Canada, 2020a).

Assessing Arts-Based Learning Outcomes

Antistigma interventions have been evaluated based on improved attitudes, behaviours, and knowledge (Khenti et al., 2019). Assessing arts-based reflective assignments is challenging; therefore, educators can encourage authentic work through self- or peer evaluations (Rieger et al., 2020). Asfaw et al. (2019) discuss graduate counsellor education and the measurement of assessments in addiction-related learning outcomes. The authors used student attitudes as a measurement of evaluation in assessing student beliefs about addictions. They used Wordle—a program that graphically represents chosen words to show a meaning, insight, or change (Asfaw et al., 2019). Students at an American university were assessed before and after they completed the Wordle. After the Wordle, the researchers recorded significant change in attitudes and beliefs about addictions in 17 master's-level counselling students. Asfaw et al. (2019) concluded that "the counseling students in this study increased their creative and critical thinking, evidenced by their ability to move beyond the view of addictions as only alcohol and drugs and evolving into a recovery and support-based mindset" (p. 122).

Expecting nurses to care for complex patients without adequate training would never be seen as acceptable; the same lens should be applied to addiction. The current opioid crisis requires nurses to provide excellent care to patients with addictions at an increased rate (Lanzillotta-Rangeley et al., 2020). Nursing educators must seek pedagogical approaches that

reflect positive core values related to diversity, inclusion, and cultural responses (National League for Nursing, 2016). Therefore, a deep shift is needed, and a social justice framework is required to translate knowledge that has a profound, meaningful, and transformational effect on students. As an APT in online education, narrative photography transforms how we see the world in a way that other forms of communication cannot (Formato, 2020).

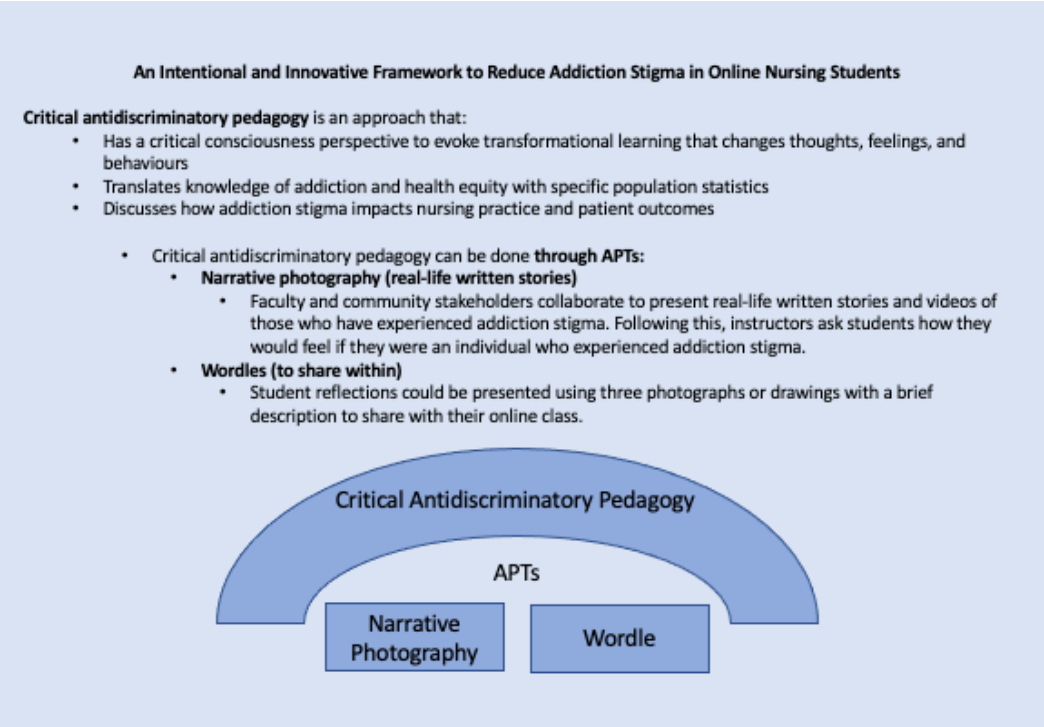
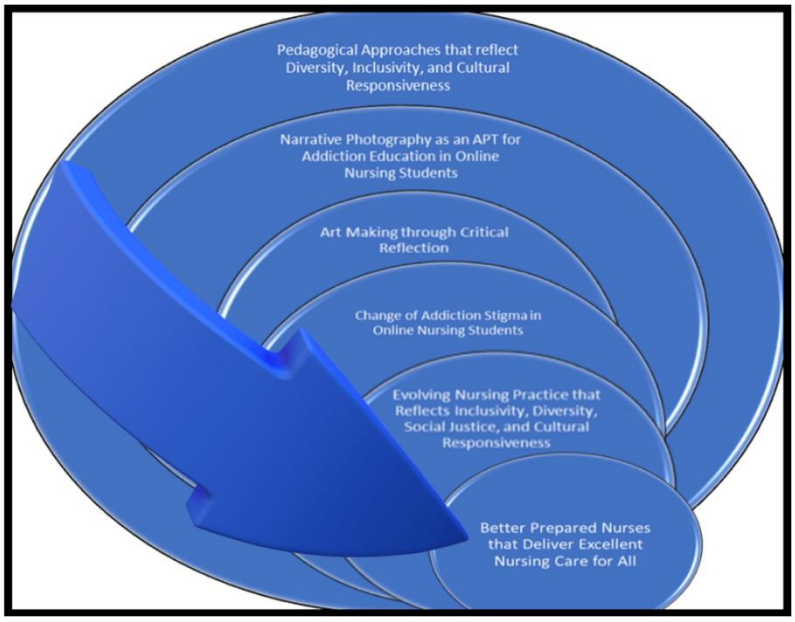


Figure 1. An Intentional and Innovative Framework to Reduce Addiction Stigma in Online Nursing Students. Adapted from Asfaw et al. (2019); Blanchet Garneau et al. (2018); and Leyva-Moral et al. (2021).

Educators should practice from a critical consciousness perspective that aims to provide students with knowledge of addiction and health equity for populations, as well as to help students explore how their attitude can curtail stigma in nursing practice (Blanchet Garneau et al., 2018). This in itself can improve patient experience and outcomes. With this lens, arts-based learning strategies can be used as a disruptive pedagogy that transforms the way we teach, our ways of knowing, and how we are practicing nursing. It is plausible that narrative photography provides an authentic approach to sharing real-life substance use stories with nursing students. It

is equally asserted that online nursing education is a suitable platform to use narrative photography to unveil the prevalence and impact of addiction stigma in health care. Similar to



Leyva-Moral et al. (2021), nursing students could present three photographs or drawings of their reflections alongside brief, innovative teaching methods. This approach benefits future nursing student practice through increasing understanding, and potentially empathy, based on student reflections. This leads to awareness of health system inequities for certain populations, guiding nurses to consider what diversity means and how to achieve person-centred care for patients in the wake of the opioid epidemic and ongoing addiction stigma. At least one of the three assigned reflections should be a Wordle. As Asfaw et al. (2019) discussed, the words chosen for the Wordle can depict students' attitudes and stigma associated with addiction and graphically "illustrate meaning, perception, and change" (p. 115). Figures 1and 2 provide a framework and practical strategies for educators who wish to adopt this innovative and intentional approach to \ addiction stigma reduction in online nursing student education.

Figure 2. A Framework for Better Prepared Nurses who Deliver Excellent Nursing Care for All. Adapted from Asfaw et al. (2019); Blanchet Garneau et al. (2018); and Leyva-Moral et al. (2021).

This recommended inclusive pedagogical approach to addiction stigma would focus on learning outcomes and competencies that allow this type of learning to be accessible to diverse twenty-first-century learners within an antiracist and antidiscriminatory context. As an innovative teaching method, the learning could benefit nursing students' future practice through increased patient understanding, thus leading to better health outcomes for a diverse patient population while increasing systemic health equity. Moreover, this framework leads to better-prepared nurses that deliver excellent nursing care for all.

Limitations

Using arts-based learning to discuss sensitive topics comes with a unique set of challenges (Rodríguez-Izquierdo, 2018). Rodríguez-Izquierdo (2018) suggests that diverse classrooms "need to ensure that students develop pro-social and emotional skills and can create positive peer relationships when students learn to communicate openly expressing their emotions, needs at the same time to recognize that they are capable of acknowledging those of others" (p. 614). Arts-based teaching methods can pose challenges for students and instructors who are supporting their learners' creative processes. To alleviate disorientating experiences for students, educators need to facilitate the process by clarifying, engaging, planning, presenting, and evaluating (Rieger et al., 2020). The proposed framework (Figures 1 and 2) should be evaluated further and would benefit from more research on how these actions align. Creative learning processes can create emotionally charged conditions for students, leading to vulnerability and stress that educators must plan into their teaching environment (Rieger et al., 2020). Furthermore, educators should ensure that students are aware of their control over what they share (Rieger et al., 2020) and can balance this against their comfortability and disclosure considerations.

There is limited research on the process of using emotion-laden pedagogy, such as arts-based practices in intercultural education (Rodríguez-Izquierdo, 2018). Although art can be used to meet social justice outcomes, it can also unintentionally reinforce stereotypes (Formato, 2020). Therefore, discretion and discernment are required to appropriately use the arts as an inclusive pedagogical application (Formato, 2020). Intentional educational curriculum designs that use a critical, antidiscriminatory pedagogical approach are essential (Blanchet Garneau et al., 2017).

The long-term learning effects of using APTs in education are not well documented in current scholarly peer-reviewed literature. Further research is recommended to assess the long-term effects of learning when teachers employ culturally sustaining and inclusive environments that seek to promote transformative learning with praxis-oriented critical consciousness. Incorporating APTs in online classrooms presents a unique opportunity to develop studies to bridge these gaps and study the long-term effects.

Conclusion

Addiction stigma is evident in health care professionals and nursing students in Canadian health care systems. Nursing education must address this issue due to its profound negative impact on individuals, populations, and health care systems. It is vital to address addiction stigma to improve nursing practice and patient outcomes. Online nursing platforms offer a suitable approach to a culturally sustaining and inclusive pedagogy that effectively educates on social justice issues. Arts-based learning is an effective teaching method for decreasing addiction stigma in online nursing students. Narrative photography is a potential candidate in developing inclusive and effective approaches to reduce addiction stigma and meet social justice learning outcomes in online nursing education. Extending its contribution to nursing academia, arts-based

activities such as narrative photography provide an opportunity to employ culturally sustaining and inclusive environments that seek to promote transformative learning within praxis-oriented critical consciousness.

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"Be Not Afraid": A Statement of Fact and a Statement of Faith

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Abstract

The reality of ambivalence and resistance around the incorporation of spirituality and religious beliefs in the treatment of fear and anxiety disorders and other mental health conditions cannot be denied. The overall purpose of this scholarly article is to advance thoughtful deliberations and discussions around the possibility that healthy spirituality and healthy religious practices, together with psychotherapy and pharmacologic interventions, could be effective in the treatment of anxiety disorders and other mental health conditions. Through a review of scholarly articles and reflections on his experience in clinical nursing practice, the author demonstrates with clarity of thought, acute insight, and academic rigor the necessity and relevancy of including healthy spirituality and healthy religious beliefs, together with psychotherapy and pharmacology, in the management of fear and anxiety disorders and other mental health conditions. The article is a call for engagement in this issue, not a conquest.

Keywords*:* spirituality, religious beliefs & practices, mental health, addictions recovery, nursing

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"Be Not Afraid": A Statement of Fact and a Statement of Faith

Evident in most religious worldviews including Judaism, Buddhism, and Christianity is the admonition not to be afraid. This scholarly article examines this admonition and its relation to anxiety and other mental health disorders through the lens of Christian worldview. The assertions made here are informed and influenced by both a Christian and an empirical worldview.

Fear and anxiety often manifest simultaneously and frequently overlap in the ways we describe them and how we perceive their presentations, but there is a distinction between fear and anxiety. Fear is the emotional and cognitive reactions to anticipated or real threat or danger, while anxiety is the prediction, expectation, and anticipation of future threat or danger (American Psychiatric Association, 2013). More often than not, fear triggers the autonomic response in a human person to fight or to run away from a threat or a danger, whether the danger is perceived or real. Anxiety, on the other hand, is often associated with symptoms such as rigidity of the muscles, hypersensitivity, and hypervigilance with regard to future perceived danger, as well as self-seclusion and avoidant behaviours (American Psychiatric Association, 2013). Often, an anxious and fearful person tends to withdraw from or pervasively avoid the thoughts or events that they associated with fear and anxiety as a way to escape or to mitigate their disturbances.

People do not have to practice being afraid because it is an automatic response. Fear and anxiety are autonomic responses that manifest in the very nature of human person in response to danger or threat. Through cognitive process such as discernment, human beings could gain insight into what or how to respond to fear and anxiety. The insight could come from their value system, spirituality, belief system, ethics, and morals (Dreyer, 2018). The Christian nurse could tap into the empirical knowledge of how fear and anxiety manifest, including how they are

managed. The Christian nurse in particular can also could draw from the biblical worldview on how to respond to fear and anxiety. Insights about fear and anxiety from both the biblical worldview and the empirical worldview could translate to healthy responses to and management of anxiety and fear.

Based on my professional experience and significant years of work in adult in-patient mental health and addictions programs, using avoidance techniques such as self-isolation, self-seclusion, and withdrawing from the object or thought that triggers fear may be convenient for the fearful person, but do not translate to effective coping skills for long-term management of anxiety disorders. The reality is that addressing anxiety through self-seclusion, self-isolation, and avoidance can trigger depression and loneliness. There is a critical relationship evident in the psychopathology of these illnesses. Anxiety and depression often present together, and their symptoms are usually inseparable (Kaitlin, 2020). From my clinical practice, depression often presents with emptiness and a sense of failure while anxiety presents as fixation on and preoccupation with that emptiness and failure through worrying.

Insight From Different Religions

Religion has been perceived by many scholars as a meaning-making system that provides people with meaning and purpose in their lives (Xu, 2018), especially when people are confronted with realities of sickness, anxiety, hopelessness, and acute stress. For some people, religion provides hope in the midst of doubt and hopelessness, sheds light in the midst of darkness, and serves as a coping mechanism and meaningful survival strategy.

Different religions have explored, taught, and elaborated on the dangers of succumbing to fear and anxiety. Eastern religions such as Buddhism underscore the usefulness of mindfulness, a

practice similar to cognitive behavioural therapy (CBT), a psychotherapy that is commonly used by professionals in the treatment of fear and anxiety disorders. CBT helps individuals to be aware of distressing thoughts that bring fear and anxiety in order to regulate them. Mindfulness teaches individuals to shift awareness from distressing thoughts and emotions and "adopt a perspective that distressing thoughts and sensations contributing to anxiety and stress are merely events that come and go in human experience that is constantly in flux" (Davis et al., 2007, p. 24).

The idea of interconnection and interdependence between human thoughts, human emotions, and human actions is not strange to Judaism. Judaism underscores a significant correlation between and puts strong emphasis on the impact of human actions on human thoughts and feelings. This is consistent with the philosophy of CBT. Jewish traditions and teachings acknowledge the reality of struggles in human life, including struggles with fear and anxiety, but maintain that, despite these realities, one should develop both the strength and the fortitude to engage in positive adaptive behaviours (Shabtai et al., 2016).

There are several instances in the Christian bible where Christians were advised not to be afraid or anxious. Evident in the synoptic gospels, and in the gospel of John, are examples of the admonition: "Be not afraid" (King James Bible, 2002, Mk. 5:36); "Let not your heart be troubled" (Jn. 14:1). In the gospel of Matthew in particular, the apostles of Jesus were afraid when they saw Jesus walking on the lake, and Jesus spoke out to them and said: "Take courage. It is I. Do not be afraid" (Matt. 14:27). Peter, one of the apostles, replied: "Lord if it be thou, bid me come unto thee on the water" (Matt. 14:28). And Jesus replied: "Come" (Matt. 14:29). Peter was able to walk on the water, but started to sink as soon as he became afraid and began to worry.

As a matter of fact, we have different types of anxiety disorders that disturb the functions of the brain, triggering disturbances to one's activities of daily living and affecting one's level of functioning (American Psychiatric Association, 2013). The reality is that fear and anxiety can interfere with an individual's day-to-day functioning (e.g., at school and work), can negatively affect their level of functioning, and can rob them of their internal and external peace.

The Christian nurse should be aware that fear and anxiety are automatic responses that people experience when faced with real or perceived danger, and that it is both normal and natural, despite the biblical admonition to "not be afraid." Interpreting this biblical statement in the context of today, drawing on what we know about human nature, we can understand that despite the fear and the anxiety we encounter, we should neither succumb nor surrender to fear and anxiety. There is hope. There is treatment. This assertion is similar to the definition of moral courage: despite the fear and the anxiety we may encounter in the process of doing the right thing, we overcome the fear and the anxiety, and we still do what we know is morally right.

Therapeutic Interventions for the Management of Fear and Anxiety

There are interventions that help with the management of anxiety disorders. These include psychoeducation and psychotherapy, pharmacologic interventions, self-help, and genuine and constructive spirituality and religious beliefs.

In his seminal book *Man's Search for Meaning,* Viktor Frankl (1946/2006), a psychiatrist and the founder of logotherapy, which underscores the importance of finding meaning in life, introduces, while elaborating on how fear and anxiety affect patients, the concept of anticipatory anxiety: an anxiety that produces or brings to fruition that which one is afraid of. In other words, hyperfixation or excessive focus on and anticipation of the event of which one is afraid gives rise

to that event. Frankl further introduced paradoxical intention in the context of attitude reversal as a possible treatment technique for this type of anxiety: the object of fear is replaced by a paradoxical wish and, with humor, one attempts to ridicule it, to do the opposite, or to minimize the object of fear to the point that it loses its grip on the individual. This treatment approach encourages individuals to deal with the object of fear and anxiety, not by avoidance or by fighting with it, but by addressing the fear and anxiety in an ironical way through paradoxical intention. This causes the fear to slowly diminish and dissipate. Frankl used this technique to effectively treat patients who had fear and anxiety issues, as well as other mental health conditions.

The Psychotherapeutic approach CBT is also an effective treatment for anxiety disorders. The philosophy of CBT is grounded in the knowledge that our thoughts, feelings/emotions, and behaviours are all interconnected. CBT emphasizes cognitive restructuring and underscores self-monitoring of emotions in order to identify the cognitive distortions that trigger anxiety and replace them with realistic and balanced thinking (Simos & Hofmann, 2013).

There are pharmacologic options for the treatment of anxiety disorders. Selective serotonin reuptake inhibitors (SSRIs), and serotonin norepinephrine reuptake inhibitors (SNRIs), although classified as antidepressants, are very commonly used as the first line of treatment for anxiety disorders, and are believed to be effective (Garakani et al., 2020).

Tricyclic antidepressants (TCAs) are also used in the treatment and management of anxiety disorders. This class of medications, although efficacious in the treatment and management of anxiety disorders, are less frequently prescribed due to potential side-effects such as weight gain, arrhythmias, urinary urgency or retention, and others (Garakani et al., 2020).

Incorporating Healthy Religious and Spiritual Practices in Therapy

Healthy, genuine, rational, and constructive faith, spirituality, and religious beliefs, could help with the management of anxiety, in combination with openness to other treatment options such as pharmacologic intervention when necessary. A study conducted by Zagozdon and Wrotkowska (2017) concluded that the incorporation of religious beliefs in some patients with anxiety and depression translated to better medication compliance among the participants, resulting in better treatment outcome. The study also found that spiritual orientation played an important role in recovery from addictions and in treatment adherence in people with substance and addiction issues. Indeed, several scholarly works show modest but positive correlation between spirituality and religiosity on psychological health, especially, but not exclusively, in the areas of anxiety and depression (Reuter & Bigatti, 2014).

There are significant empirical studies that have suggested a positive impact, and a strong correlation between spirituality and religious beliefs on mental health (Kennedy et al., 2015). A study done by Rosmarin et al. (2013) found that, in 159 patients who participated in a CBT day-hospital psychiatry program, belief in God played a positive role in the improvement of their mental health—especially, but not exclusively, in reducing depression.

However, there seems to be a rocky relationship between spirituality and psychiatry. Some mental health professionals often perceive spirituality and religious beliefs as barbaric or primitive and lacking empirical justification. Some believe, too, that spirituality and religion induce guilt that negatively impacts patients' mental health. As such, spirituality and religion are often ignored as viable treatment options (Dein, 2018). Kahle and Robbins (2014) perceive the dismissal of spirituality and religion as therapeutically relevant as a fundamental flaw and bias that renders therapy rarely effective in those for whom religion and spirituality already play a

central role. The authors argue for the inclusion of spirituality in psychotherapy. It is a fact worth mentioning that unhealthy or distorted religious faith and spirituality, devoid of human reason, could exacerbate anxiety disorders and add to the struggles of those already afflicted with anxiety (Huguelet & Koenig, 2010). However, I believe that healthy religious beliefs and healthy spiritual practices could help to mitigate the symptoms of fear and anxiety.

Practical, Hypothetical Case Studies for Illustration

The following two hypothetical case studies are anchored in the my clinical practice experience. They do not reproduce any one person's personal experience. The case studies are meant to illustrate how spirituality and religious beliefs can be both constructive and destructive depending on the circumstances of an individual's illness trajectory and recovery.

James

James, a 19-year-old, first-year university nursing student, was born and raised in a strong Christian Roman Catholic family. He considers himself a practicing Christian, and perceives his Christian faith as his protective factor, coping skill, and support system. During his first year of university, James became sick. He was fearful and anxious due to the significant stress of his school work. This negatively impacted his level of functioning and interfered with his activities of daily living. James resorted to prayer alone. He prayed without ceasing, asking God to heal him. James wondered why God has allowed him to go through this awful experience. He avoided going to classes due to his poor performance. He was anxious about meeting students he didn't know. He had poor concentration, thought blocking, and flight of ideas when expressing himself at school due to his anxiety. He believed that he was a loser and

that God has abandoned him. He became angry at God and was struggling with his faith. He ignored the suggestions from his professors and colleagues to seek professional help through the counselling services in the school. His anxiety disorder translated to depression and suicide attempts. He was hoping for a miracle to happen, waiting for God to heal him and make him whole again, and believing that seeking professional help was a sign of lack of faith in God—but the fear and the anxiety persisted. Finally, he withdrew from everyone, dropped out of school, and refused to seek professional help. He abandoned his faith and is currently struggling alone without support.

A nurse working with James would have the professional obligation in the context of patient teaching, using therapeutic communication skills and through the establishment of therapeutic relationship and rapport, to provide James with right information and credible resources that could facilitate his seeking evidence-based professional therapy and pharmacological intervention in combination with the application of genuine spirituality and constructive religious practices.

Sara

Sara is a newly graduated nurse who is currently in her first year of nursing practice. Sara is a practicing Christian whose faith in God informs and influences her nursing practice. Sara works in the in-patient mental health and addictions unit in a fast-paced acute care hospital. Until recently, she has felt that experienced staff are not supportive to new staff. Sara described her work environment as “overwhelming, oppressive, and unsupportive.” Thoughts of going to work triggered fear and anxiety in Sara. At work, she sweat profusely, appeared hypervigilant, and

second-guessed herself frequently. She isolated from other staff and was afraid to ask colleagues questions due to fear of being judged.

Through the information, resources, and professional colleagues available to her at work, she was able to recognize the right thing to do. Sara connected with an independent psychiatrist outside of her work who assessed her and diagnosed her with anxiety disorder. Sara was introduced to CBT and psychotropic medication to manage her anxiety disorder.

Through psychotherapy and pharmacologic intervention, Sara realized the cognitive distortions that she had about her colleagues. Sara was able to change her unhelpful thinking styles and thought distortions, which was effective in the management of fear and anxiety at work. Sara complemented her treatments with mental health professional with her faith: she prayed, asking God to heal her, while at the same time accessing other credible resources available to her. Today, Sara has no issues with fear and anxiety at work, and she effectively manages the normal stress in life that everyone experiences.

Implications for Christian Nurses in Their Practice

For Christian nurses, it is important to be consciously aware that no one is immune from getting sick. Sickness in this context includes experiencing mental health crises such as, but not limited to, fear, anxiety disorders, and depression. The nurse can become a patient tomorrow, and there is nothing wrong with that. Therefore, in caring for patients, knowledge and empathy are indispensable for competent nursing practice (Onwuegbuchunam, 2020). It is important to understand empathy in the context of role-playing, where nurses put themselves in their patients' shoes to try to understand patients' experiences (Onwuegbuchunam, 2020). This immersion of self in other could translate to practical accomplishment and the adherence to the biblical

admonition, “as you would that [people] should do to you, do ye also to them likewise” (King James Bible, 2002, Lk. 6:31). In other words, it encourages nurses to treat their patients the way they would like to be treated.

The Christian nurse could complement empirical knowledge with their Christian belief. They should understand that faith and reason, although distinct, complement one another and should be inseparable in both the nurse’s self-care and in the care of their patients. The two case studies used above for illustration should serve as practical examples of both the positive and negative impacts—the constructive and the destructive components—of spirituality and religious beliefs in illness and recovery journeys. The Christian nurse should not succumb or surrender to fear and anxiety, nor to other mental health and addictions conditions. Instead, they should understand that the biblical admonition “Do not be afraid” (King James Bible, 2002, Mk. 5:36) is both a statement of fact and a statement of faith. They should seek professional help in time of mental health and addiction crises, and should complement professional help with healthy spirituality and healthy religious beliefs.

Despite the ways in which faith can complement and augment therapeutic treatment, the Christian nurse should be aware that some health care professionals are ambivalent about and resistance to the inclusion of spirituality and religious beliefs in their patients’ care. The Christian nurse should, therefore, continue to explore the issue and ask the questions that could lead to answers that address this fundamental flaw.

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Nursing Role Ambiguity in Alberta: Impact and Institutional Influences

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Abstract
Increasing health system demands and costs in an economically strained environment places extraordinary challenges on Alberta's workforce planners who continue to address critical gaps. In addition to routine operational planning, unpredictable and often-reactive market demands continuously influence workforce needs. The role and scope of health care providers, particularly nurses, is constantly evolving, which leads to difficulty interpreting their differences. To achieve successful shifts toward team-based collaborative care, it is essential that providers, with their specific skill sets, be appropriately aligned with patient groups and settings. This is challenging when skill sets and scope are confusing to administrators. Changes to health care providers' scope of practice impact academic programming and regulatory processes, and can create confusion and ambiguity for many providers, especially nurses. Role ambiguity among nurses, unabated by key institutions, contributes to inefficiencies and can be potentially harmful to patients. Role ambiguity in nursing therefore creates challenges for employers, educators, regulators, and nurses themselves. Role ambiguity is not entirely new: historical reports of role ambiguity pertaining to Alberta nurses do exist. This ambiguity persists today among Alberta nurses. Moreover, the strategies used to mitigate this ambiguity are themselves ambiguous. The purpose of this paper is to critically examine the literature that defines role ambiguity and its impact, to highlight antecedents, and to explore the role of the key stakeholder institutions that are best positioned to address the issue in Alberta.

Keywords: nursing, role ambiguity, role differentiation, role confusion, antecedents.

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Nursing Role Ambiguity in Alberta

Role ambiguity (RA) has significant impacts across all levels of the health care system and affects patients, employers, system planners, and nurses themselves (Butcher et al., 2018; Fraser et al., 2019; Nelson et al., 2014). With variation in regulatory approaches and interpretation, the lack of clarity of the scope and role of the existing regulated nursing categories creates challenges for employers, health care providers, and leaders (PNATF, 2020). When employers and workforce planners are unsure of nurses' scope of practice, inefficient utilization is likely to occur, leading to increased costs or poor patient care. Although not explicitly studied in Alberta, RA among nursing designations in Canada has been entrenched in the profession for decades (Almost, 2021). Jurisdictions such as Alberta have unique laws and policies that create specific conditions for all health care providers, including nurses. In Alberta, legislation for nursing practice imparts both flexibility and ambiguity, contributing to RA as evidenced through prior research (Besner et al., 2006; Clark & Hunsberger, 2009; Fraser et al., 2019). Legislation, namely, the Health Professions Act—does not stipulate how to describe nursing roles. As a result, each of the three nursing colleges in Alberta elaborate on their nurse members' scope of practice in ways that impede clear differentiation (Clark & Hunsberger, 2009). The provincial institutions best suited to understand and respond to the impact of RA are regulators, educators, employers, and policy makers (Government of Alberta, 2012; Besner et al., 2006; Martin & Weeres, 2016). Antecedent conditions for RA are complex, requiring a coordinated and collaborative approach among these institutions. There are national-level regulatory, association, and education institutions that influence the professional development of Canadian nurses. Although these institutions may influence the prevalence of RA over time, Alberta can begin to address this issue through its existing provincial stakeholders. RA creates challenges for

employers, educators, regulators, and nurses themselves, yet it is not readily apparent how institutions should address this issue in Alberta, nor which institutions should take on this role. An analysis of institutional roles that influence nurse RA in Alberta offers the potential to address the issue with a collaborative and system-focused approach. A review of the literature showed a better understanding of contributing factors is fundamental in considering potential mitigating strategies to reduce RA.

Literature Review Procedure

A general narrative literature review was conducted to gain an understanding of how RA exists among nurses, as well as its impact and the potential strategies that have been and can be used to mitigate its prevalence in the Alberta context. A narrative literature review (i.e., one that is skewed toward a qualitative interpretation of prior knowledge) is the traditional way of reviewing the extant literature in an attempt to summarize or synthesize a particular topic (Paré & Kitsiou, 2017). The central question in this review is, Whose role is it to address RA in Alberta from an institutional or strategic perspective? The goal is to explore the relevant background in order to understand the current issue, highlight any new research, and ideally present options to address RA in Alberta. The issue of RA is diverse and relates to various structures, stakeholders, and constructs, requiring combinations of search terms to capture relevant research. The initial search strategy was to identify articles related to nursing role clarity and its related constructs such as role conflict, role tensions, role ambiguity, role differentiation, and intraprofessional conflict. Search parameters included peer-reviewed, English-language, and full-text availability. A concentrated search through Google Scholar and Google focused on nursing frameworks, guidelines, standards, and policies relative to the scope and role of nursing

and collaborative practice. This approach helped the author further understand how legislation shapes nursing practice through the interpretation of various institutions that regulate and educate nurses. Grey literature from government documents related to legislation, national nursing organizations, and regulatory websites for resources related to RA assisted with further framing the institutional roles. A focused review of Alberta-specific research on RA through the Athabasca University Discovery Database produced limited results. A review of Canada-wide literature relevant to RA in nursing was also conducted. Because standardized institutional processes exist nationally despite variance in provincial legislation, findings from this review are also appropriate for provincial jurisdictions, including Alberta. The search was performed using several terms and free text words combined with Boolean operators. Key search terms included:

> nursing AND role ambiguity; role differentiation AND nursing; role confusion AND nursing; role clarity in nursing; role differentiation AND nursing; role overlap OR role conflict AND nursing; intraprofessional tensions AND nursing; collaborative practice barriers OR facilitators.

Originally, the search parameters aimed at research from 2015 onward, but this yielded limited results, prompting a more targeted review of historical papers to ascertain if Alberta previously experienced issues related to RA. Overall, this literature review intends to explore institutional influences of RA in an effort to align potential strategies to address the issue and report any new insights. After reviewing a combined 103 reports, articles, websites, research papers, and other documents, several key themes surfaced as a guiding conceptual framework for this review. The themes were (1) the evidence and (2) the impact of RA in Alberta, (3) the antecedents of RA, and

(4) potential strategies to address RA through appropriate institutions. This review lays out key contributing factors (i.e., institutional influences) to RA and summarizes potential ways to address these issues based on the role of each Alberta stakeholder institution.

Literature Review

RA can be defined as a lack of clarity concerning employees' roles, responsibilities, and/or the procedures to achieve what is expected of them (Allen, 2020; Kalkman, 2018). Role confusion and role overlap lead to decreased role clarity, which contributes to RA (Macleod et al., 2019). In team settings, if members do not know each other's roles well, or if their own roles are not clearly described, role conflict and RA can ensue (Allen, 2020). This is counterintuitive as we strive for improved patient and system outcomes by utilizing effective collaborative practice models to support team-based care. Nearly a decade ago, the Alberta government developed a collaborative practice framework that presented an opportunity to reduce demand for, and on, the health workforce by improving workforce utilization through collaborative models of care (Government of Alberta, 2012).

While employers and workforce planners have trouble differentiating between nurse provider types, the current state of RA in Alberta is largely undocumented, and the research is limited. In 2006, Besner et al. examined nurses' perceptions of their ability to work to their full scope of practice (SOP) and to identify perceived barriers to and facilitators of role optimization. The Alberta-based study centred on the three main nursing provider types at that time: licensed practical nurses (LPNs), registered nurses (RNs), and registered psychiatric nurses (RPNs). The authors concluded that substantial role confusion was evident among these three nursing designations. They also recommended stakeholders work together to better understand role

overlap and begin to clarify roles for more effective health care human resource planning. Specifically, the authors aimed at key institutions (employers, regulatory bodies, educators, practitioners, unions, and policy makers) whose role it is to improve the utilization of all health care professionals. Later, in 2009, Alberta stakeholders convened in a comprehensive research activity (the Knowledge and Education Project) to compare these same nursing groups, acknowledging that appropriate utilization of nurses was still of interest to employers and administrators (Clark & Hunsberger, 2009). The researchers assumed that within each type of nurse, there ought to be a "chain of congruence" leading from the legislation to SOP and competency statements, then to the curriculum documents that guide academic programs and finally integrated into student nurse's knowledge (Clark & Hunsberger, 2009, p. iii). As SOP is fundamental for standards of practice, educational preparation, and job descriptions, comparing these across the three nurse types would be advantageous for administrators, supervisors, and nurses themselves (Clark & Hunsberger, 2009). The authors indicated that without a common overarching framework for the SOP and competency statements, comparison is infeasible. The research further inferred that nursing role confusion is reinforced by three different types of credentials, backed by different knowledge bases with significantly overlapping and significantly different responsibilities (Clark & Hunsberger, 2009). A key principle of the recently published pan-Canadian nursing vision centres on clarified roles and responsibilities of the regulated nursing groups to increase awareness and knowledge among employers, health care professionals, and the public (PNATF, 2020). Ultimately, the way to improve the deployment of nurses requires a better understanding of the education, roles, scopes, and regulation of the nursing designations (Almost, 2021).

Sharma et al. (2016) studied staffing levels and the mix of RNs, LPNs, and health care aids (HCA) across Alberta acute care units, which revealed substantial variations. More recently, Fraser et al. (2019) concluded that LPN role variation is influenced by site-, zone-, and provincial-level factors. They examined the role and scope of LPNs in home care and recommended operational and human resource policies be revised with clear role expectations to better support new role adoption (Fraser et al., 2019). Thus, it appears that Alberta has experienced nursing RA to some degree previously, with some research exposing tensions and ambiguity specifically between LPNs and RNs (Kusi-Appiah et al., 2019; Macleod et al., 2019; Martin & Weeres, 2016). Ultimately, high variability in staffing levels and mix has major implications for human resources planning as well as overall staffing costs (Sharma et al., 2016). Nurse practitioners (NPs) also continue to clarify their role to employers and colleagues in Canada (Brault et al., 2014). This may be equally problematic here in Alberta and become more challenging as physician assistants enter the primary care sphere heightening role overlap and ambiguity (Almost, 2021). Provincial job descriptions for NPs may lend clarity to their role for the health authority and eventually to other sectors such as primary care, although this is beyond the scope of this review. Job descriptions that outline key differences between LPNs and RNs are also potentially helpful for workforce planning. Alberta currently has four regulated nurse types (RNs, LPNs, RPNs, and NPs) with HCAs soon to be regulated. This furthers the potential for role confusion for patients, providers, and employers as HCAs often work side-by-side with nurses.

In Alberta, the three regulatory bodies for the nursing professions jointly published a document that promotes collaboration among health professionals to achieve client- and system-level benefits (CARNA et al., 2019). A key principle within the document is “role clarity,”

which can be understood as nurses knowing the capabilities and roles of all team members while respecting and acknowledging their team member's contributions. Similarly, a position statement on intraprofessional collaboration by the Canadian Nurses Association (CNA) indicates role clarification is needed to ensure all regulated nurses understand their own and their nurse colleagues' roles (CNA, 2020). The CNA acknowledges that intraprofessional conflict, role tensions, and ambiguity hinder effective team-based care. Elsewhere in Canada, Baumann et al. (2019) note that in high-functioning teams, LPNs and RNs have agreement on roles, awareness of each other's SOP, and the knowledge of the skill level of each team member. Macleod et al. (2019) state that LPN roles and SOP remain underresearched in the Canadian context. To date, RNs, LPNs, and HCAs have little understanding about the roles of their fellow nursing team members (Kusi-Appiah, 2019). Although limited Alberta-specific research on nursing RA exists, these recent studies indicate RA is an issue to some degree. Examining the numerous system-level impacts of RA may encourage stakeholders to consider assessing the current state of this issue in Alberta.

Impacts of Role Ambiguity

The literature reveals numerous publications regarding the impacts of RA. Overall, the key themes that resonate are (1) the impacts on collaborative practice (impaired), (2) challenges to workforce planning (ineffective), and (3) challenges to nursing professionalism (diminished).

Impaired Collaborative Practice

Collaborative practice requires team members to know and respect each other's capacities and contributions (Mackinnon et al., 2018). This knowledge and attitude is

fundamental to working effectively where work is shared to the most appropriate provider. RA contributes to intraprofessional tension and conflict, interfering with collaborative practice and decreasing the potential for high-functioning teams (Macleod et al., 2019). Key benefits of collaborative practice are lower patient mortality rates, reduction in errors of omission, improved patient safety, and enhanced job satisfaction (Allen, 2020; Government of Alberta, 2012; Limoges et al., 2018). Work by Prentice et al. (2020) indicates that much of the research base on nursing collaboration and its outcomes needs strengthening. When the authors reviewed 10 Canadian collaborative practice guidelines, they found many of these were not informed by evidence. They also described concern regarding the lack of conflict resolution processes within the guidelines. These critical gaps may allow the tensions and conflict derived from RA to perpetuate, leading to dysfunctional teams. Role conflict, often stemming from RA, diminishes the quality of care delivery in the context of team-based care (CNO, 2018).

Ineffective Workforce Planning

RA often challenges effective health care workforce planning through misallocation or underutilization of nurses (Government of Alberta, 2012; Kalkman, 2018; Lankshear & Limoges, 2019; Macleod et al., 2019). Underutilization of nurses can occur if employers, administrators, and nurses themselves are unsure of the role of each nursing designation . This perpetuates gaps in care and contributes further to role conflict and employee dissatisfaction (Butcher et al., 2018: Martin & Weeres, 2016). Employers may hire more costly nurses when they are unsure of the respective roles and competencies. When organizations generate task-based lists for nurses as a method to manage this ambiguity, nurses become frustrated (Macleod et al., 2019; Martin & Weeres, 2016). Improper utilization also leads to burnout and a host of

other factors such as intraprofessional conflict, decreasing the safety and efficacy of nursing care (Kalkman, 2018; Macleod et al., 2019). Ensuring nurses are able to work to their full SOP is an important retention strategy that can address system gaps (Besner et al., 2006). The ultimate goal of enabling full SOP is to create better-resourced teams and accessible, patient-oriented care (Nelson et al., 2014).

The cyclical nature of poorly understood role differentiation among planners and nurses prompts the need for interventions at appropriate junctures. Changes in roles can lead to power struggles among and between nursing groups (Brault et al., 2014). Therefore, employers must carefully consider how to support these transitions (Besner et al., 2006). This was evidenced in Fraser et al. (2019), where role expectations for LPNs in homecare were not clearly outlined.

Additionally, if nurses feel they have artificial restrictions preventing them from working to their full scope, they tend to migrate to other positions, organizations, and even other jurisdictions (Harris et al., 2013). As an example of these artificial restrictions, consider LPNs who are unable to work to full scope due to misunderstandings on the part of their managers and leadership who are unfamiliar with the evolution of LPN SOP.

Diminished Professionalism

Kalkman et al. (2018) offer the condemning yet poignant remark that “the consequences of role ambiguity may be devastating to a profession that continues to define itself and that has been charged to lead healthcare reform and advance health for all people” (p. 238). They add that RA is a potential threat to the successful assumption of a professional role. Limoges et al. (2018) state that, as part of the process to create a distinct body of knowledge and differentiate between nursing roles, professional demarcation was introduced that involved boundary work and

credentialism. This, Limoges et al. say, continues today, and with ever-shifting nursing roles, there are inherent unintended consequences such as RA. The traditional divisions in nursing education, regulation, SOP, and organizations continue to propagate this ambiguity (Almost, 2021).

Documents such as codes of ethics and standards of practice are developed by regulators to establish fundamental expectations of members' behaviours and attitudes, which contribute to the overall professional culture and image of nursing (Wilkie & Tzountzouris, 2017). Historically, power differentials exist between health care providers (HCPs) and the public. A regulator's position is to foster power balance between HCPs and the public. Hence, regulators create conditions for their members such that the public can trust that HCPs are competent through appropriate accountability measures (Wilkie & Tzountzouris, 2017). Although tribalism and role tensions are not explicitly identified as improper, these behaviours may negatively influence nursing culture. When HCPs are indoctrinated into stereotypical "tribes" their behaviours can erode the effective communication and shared care approaches that high-functioning teams require (Braithwaite et al., 2016).

To date, there is no consensus in the discourse around the role stakeholder institutions should play in addressing emerging health care trends and issues related to RA. Some suggest regulators and their immediate stakeholders must collaborate and respond to nursing-related system issues, while others feel regulators are not appropriate for solving broader policy issues (Wilkie & Tzountzouris, 2017). One agreement is that employers, educational institutions, and professional associations all have an important role to play and can succeed if they focus on patients' outcomes versus their own mandates (Wilkie & Tzountzouris, 2017). Regulators do not want to be viewed as either advocating for the profession or being self-serving; however, this

may allow issues such as RA to flourish, potentially diminishing professionalism. When nurses become indoctrinated by "turf wars" in which one professional group competes against another, intraprofessional collaboration is challenged (Nelson et al., 2014; Wilkie & Tzountzouris, 2017). Protecting institutional mandates may perpetuate continued disharmony among nurses and contribute to the erosion of professionalism and ultimately unsafe conditions for patients. Professionalism among nursing is more than competency-based alignment. It evokes a certain public attitude toward the profession. Tribalism and conflict are not features of the profession that promote public trust.

Antecedents of Role Ambiguity in Nursing

RA among nursing types results from numerous factors related to different institutions. Kalkman (2018) identified 11 antecedents of RA: lack of information related to job or task; role conflict; poor leadership; role incompatibility; managerial issues; unclear objectives; lack of emotional support; inconsistent job descriptions; multiple accountabilities; lack of education; and inconsistent role socialization and role teaching. While many of these antecedents are associated with employers and educators more directly, other institutions such as regulators and policy makers also have influencing roles. Five prevalent themes of contributing factors, or antecedents, to RA arose from the research accompanied by potential institutional influences: (1) legislative and education, (2) challenges in articulating role and scope of practice, (3) hierarchies and silos, (4) research and data groups, and (5) intraprofessional versus interprofessional collaboration.

Legislative and Educational Shifts

When governments respond to market forces, they make legislative changes for HCP roles. Regulators are then required to adapt to the new standards. This in turn leads education systems to align their curriculum and programs with the standards to ensure competencies are met. This cascading effect of responding to market demands for nurses has contributed to ambiguous roles, overlapping SOP, and hierarchies that subdue collaborative practice (Butcher, 2017; Butcher et al., 2018; Limoges et al., 2018). Therefore, while a number of factors such as legislation, regulatory frameworks, and health care system structures impact the optimization of nursing roles (Nelson et al., 2014), they equally create misconceptions of what nurses should and can do. Additionally, differentiation of nursing knowledge among nurse types is unclear for many (Martin & Weeres, 2016).

In 2020, the Government of Alberta introduced an omnibus bill requiring HCAs to adhere to the same regulatory standards as other health professionals. With another regulated provider entering Alberta's health care system that may be perceived by the public as a nurse (i.e., HCAs), RA may become more of an issue. This creates an opportunity for the HCA regulatory body to proactively address role confusion with their members and the public. To combat confusion between nursing groups, regulators respond with guidelines that outline the legislation that is relevant to different HCPs (CNO, 2018). Nurses' SOP is governed by legislation and regulations and is further defined by employer-based job descriptions, employer policies, and individual competencies (Macleod et al., 2019). Rapid legislative changes take considerable time and effort to culminate into aligned job descriptions and organizational policies. This challenges employers to stay abreast of nursing SOP changes in all sectors and settings where nursing care occurs. Ensuring that we effectively prepare the right number and type of health professionals to meet

emerging population health needs requires proactive, rather than responsive, planning (Besner et al., 2006).

Challenges in Articulating Role and Scope of Practice

When nurses are able to articulate their SOP, they can aim to "optimize" their scope by working toward the outside boundaries of their practice. When health system planners are familiar with nurses' SOP, they can effectively utilize human resources to improve patient outcomes and increase staff retention (Besner et al., 2006; Fraser et al., 2019). It is important for regulated nurses to be aware of the limits of their own individual competence and practice as well as other regulated nurses' roles and levels of competence (Almost, 2021). This way, nurses know when and with whom they can consult for practice support outside of their scope or role. From a planning perspective, employers may hire more costly providers when they are unsure of the scope of each nursing type. When polled, RNs expressed that their role is not always understood by colleagues, employers, and in some instances by the RNs themselves. They also indicated they are not being utilized to their full potential in many practice settings (CARNA, 2014). It is possible that some nurses are even working beyond their scope, presenting safety issues. A clear understanding of the RN role supports the best possible patient outcomes and most effective use of RN knowledge and skills (CARNA, 2014). With over 54,000 regulated nurses in Alberta (CIHI, 2020) the potential for increased costs related to underutilization of human resources due to nursing RA is conceivable. Administrators should know each nursing designation SOP well enough to minimize improper utilization of this workforce.

Lankshear & Limoges (2019) urge the development of education for nurses on the SOP of each designation, their distinct contributions, and where there is overlap. Increasingly, the

skills and practice settings once specific to RNs overlap with LPN SOP as curricula are revised to optimize roles (Limoges et al., 2018). In one Ontario study, registered practical nurse SOP (equivalent to LPN, and referred to as such here) was found to be widely misunderstood and unclear to managers, directors, clinical educators, RNs, and LPNs themselves (Martin & Weeres, 2016). Researchers also found lowest agreement on LPN role clarity among faculty members and LPNs were more familiar with the RN role than RNs were with the LPN role. The overlap in SOP, role expansion, and changing roles creates confusion for faculty. This creates challenges in delivering education to support collaborative practice when faculty are unsure of the role differences between the nurse designations themselves (Limoges et al., 2018). Macleod et al. (2019) indicate the practical nurse role has evolved over the past decades and more recent graduates received education and expectations of a greater SOP than their predecessors. Many employers have potentially not updated their understanding of the LPN role and scope as it has evolved (Martin & Weeres, 2016*).* Health care systems continue to transform with a focus on team-based care where members are working to their full SOP in collaborative models (Prentice et al., 2019), making the reduction of RA tantamount to effective work force planning. This cannot take place without addressing the historical and persistent cultural factors that foster hierarchies and silos.

Hierarchies and Silos

A lack of theorizing and research on the activation of hierarchies, siloed education, and boundary work allows RA to continue to impact intraprofessional collaboration (Almost, 2021; Limoges et al., 2018). In a study, Limoges et al., 2018, found that activation of hierarchies positioned university programs with more “status and legitimacy” over college programs (p.

116). They describe these established power relations as impeding nursing education around role clarity. Another finding was the fact that faculty members found it challenging to articulate the actual differences between the roles and contributions of LPNs and RNs. Historically, the significant changes for these two nurse groups occurred in "already established hierarchies" between community colleges and universities, which influenced how they were educated (Limoges et al., 2018, p. 114). LPNs and RNs are prepared with different educational backgrounds yet work side-by-side while establishing their professional boundaries resulting in encroachment and confusion (Limoges et al, 2018). Almost (2021) indicates that to move forward and create effective changes, these traditional hierarchies need to be challenged with a clearer understanding of each of the regulated designations of nurses. Almost also suggests a more intraprofessional approach that diminishes the traditional hierarchy, which leads to better patient and system outcomes. Nursing students also express the detriments of segregated and hierarchical educational experiences and prefer a more integrated approach to learning (Butcher, 2017). This is noted in earlier Alberta-based research, where students described their learning experiences as hierarchical and segregated (Clark & Hunsberger, 2009). Education silos that keep nursing students apart reinforce unnecessary boundaries and power relations that impair collaborative practice and perpetuate myths and misconceptions about each designation of nurse (Limoges et al., 2018). Kalkman (2018) studied RA in senior nursing students and proposed "inconsistent role socialization" and "role teaching" as the most important antecedents in this area of research (p. 7). This means educators should consider what is taught about RA, the consequences of that teaching, and how to prepare students to know their roles more specifically and clearly in real-world scenarios.

Research and Data Gaps

Often talked about yet minimally researched is the influence of nursing hierarchies on RA in Alberta's workforce. More research is needed to better understand how to support nursing teams in learning about one another and about the benefits of knowing each other's roles (Kusi-Appiah, 2019). Significant gaps in research remain in how RNs and LPNs experience changes in care provision, and how changes in their roles influence nursing education (Butcher, 2017; Macleod et al., 2019). Minimal research exists to guide nursing faculty in adjusting their approach to educating when changes to entry to practice occur (Limoges et al., 2018). The Registered Practical Nurses Association of Ontario (RPNAO) published a comprehensive report on nursing role clarity with a focus on the overlapping practice between registered practical nurses (LPN equivalent) and RNs (RPNAO, 2014). The report recommended more research and noted that program evaluation studies could increase understanding of the enablers and barriers to optimal SOP, characteristics of high-functioning nursing teams, nursing models of care delivery, and the impact on outcomes at the patient, nurse, organization, profession, and system levels. Many institutions describe intraprofessional collaboration between nurses as essential for the provision of quality patient care, yet evidence for collaboration among nurses and the outcomes to support these claims are insufficient (Prentice et al., 2020). Research is needed to further understand how shifting care teams have an impact on health outcomes (CNA, 2020). Braithwaite et al. (2016) indicate that there are historical, cultural, behavioural, and attitudinal reasons for the continuation of profession- and gender-based silos affecting both interprofessional and intraprofessional collaboration. They suggest the need to understand the underpinnings of poor teamwork based on professional differences and power imbalances in order to improve collaborative practice.

Intraprofessional Versus Interprofessional Collaboration

A major focus on *inter*professional collaboration may overshadow *intra*professional issues. Historically entrenched conflict and tribalism among the regulated nursing designations is apparent (Almost, 2021). Without acknowledging the need to reduce intraprofessional conflict, we may hinder the benefits of interprofessional collaborative practice. Professional associations, nurse scholars, and practicing nurses agree that intraprofessional collaboration between nurses is essential for the provision of quality patient care (Limoges et al., 2018). Effective intraprofessional collaboration among nurses is fostered through education, leadership, and structures such as policy and models of care (Almost, 2021). It is important that nurses are educated toward a strong intraprofessional collaboration and understanding of role differences as this allows all nurses to optimize their practice (Limoges et al., 2018). Addressing RA in these contexts requires a network of institutions that each have some degree of influence to assess and address the issue.

Addressing Role Ambiguity

To reduce gaps in care, ensure patient safety, and adopt fiscally responsible mechanisms in workforce planning, it is necessary to understand the roles of institutions that influence RA (Besner et al., 2006; Clark & Hunsberger, 2009; Martin & Weeres, 2016). There is a need to explore the roles of employers, regulatory bodies, educators, practitioners, unions, and policy makers for improving the utilization of nurses (Besner et al., 2006; Clark & Hunsberger, 2009; Kalkman et al., 2018; Lankshear & Limoges, 2019). In Alberta, the Nursing Leadership Network (NLN) consists of key provincial institutions whose collective role may serve as an important mechanism to review the current state of RA. This collaborative network of nurse leaders

engages in strategic dialogue relating to transforming nursing practice, leadership, education, and the advancement of nursing science (Alberta Health, 2018). The current stakeholder membership of the Alberta NLN aligns well with the literature on institutional roles related to RA (see Appendix A), with the exception of unions and primary care networks (PCNs). The literature includes these actors among the institutions that can play a role, but they are currently absent from Alberta's NLN. Allen (2020) explains that appropriate conditions, processes, and actions can mitigate role uncertainty that impairs teamwork and collaborative coordination of care. Thus far, it appears that institutions that educate, employ, regulate, and legislate nurses may be well suited to apply mitigating strategies. The literature offers numerous potential strategies for reducing RA, which could be used by relevant Alberta institutions. Possible strategies are listed by institution in Appendix B. While not exhaustive, these strategies may serve as a basis for discussion to assess the current state of nursing RA in Alberta and consider updating the membership of the NLN to include unions and PCNs.

Conclusion

This review outlines the discourse regarding RA in Alberta and offers an opportunity for stakeholders to consider current mechanisms to assess and address the issue. Additionally, this review serves as a path forward for provincial data gap analysis for approaches to addressing RA. A critical starting point should be reconvening the NLN with a focus on stakeholder analysis to ensure all appropriate institutions are included. Based on the review findings, an initial consideration is to discuss the inclusion of additional members such as PCNs and nursing unions. This may also take the form of consultation with these potential future members. More importantly, a timely dialogue around nursing tribalism and a call to action to address the culture

that perpetuates hierarchies and silos should be part of the NLN future agenda. Other provinces and territories may benefit from this review by considering the implementation of mechanisms like the NLN within their own jurisdictions. RA is complex and a collaborative institutional approach is required to effectively interrupt the long-standing culture sustaining the silos and role tensions.

Almost (2021) poignantly states that other concerns such as "rigidly segregated education, jealously guarded delineation of scopes of practice, [and] a lack of understanding of each other's roles…may all be limiting nurses' ability to give the quality of care patients need and deserve, and adding to the strain on our health-care systems" (p. 89). The issue of RA appears largely unknown today in Alberta and therefore the amount of strain is not determined. It is possible that many strategies to reduce RA are already in motion within Alberta's postsecondary institutions, the health authority, and other Alberta institutions. It is equally possible that underutilization is costing the system in numerous ways and/or that RA is creating poor patient conditions. Nurses and policy decision-makers must determine which conditions support optimized scope, productivity, safety, and satisfaction in nursing practice for effective workforce planning (Almost, 2021). Alberta can begin to explore its current state regarding the prevalence and impact of RA through existing mechanisms and appropriate stakeholders within the NLN. Policy makers can begin to apply effective policies that look at market demand cycles and determine how to proactively engage with key stakeholders for all HCP role changes, including those of nurses. Finally, the sustainability and governance of Alberta's NLN is important to ensuring that nursing RA is assessed and mitigated over the longer term.

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Appendix A

Institutional Roles Related to Role Ambiguity

Alberta-Specific Institutions Influencing Role Ambiguity						
	Education	**Regulation**	**Association**	**Union**	**Employer**	**Government**
College of Registered Psychiatric Nurses of Alberta		X				
College of Licensed Practical Nurses of Alberta		X				
College and Association of Registered Nurses of Alberta (CARNA)		X				
Nurse Practitioner Association of Alberta (NPAA)			X			
AHS / Covenant Health / Primary Care Networks (PCNs)					X	
Alberta Health (AH)						X
Ministry of Advanced Education (AE)						X
UNA/ AUPE (Unions)				X		
Postsecondary Institutions	X					
Gaps in Institutional Representation in Alberta's Nursing Leadership Network (NLN)						
NLN Membership	Present	Present	Present	Absent	Partially absent (PCNs)	Present (AH & AE)

Appendix B

Provincial Institutions' Potential Role in Addressing Role Ambiguity

Alberta Health (AH; Ministry of Health)

- Besner et al. (2006) state that policy makers should address the role ambiguity (RA) that currently exists across the health professions. A clear understanding of professional roles and contributions is essential to appropriate health care human resources planning, including planning for the right number and type of education seats.
- Alberta Health (AH)[1] can convene with health care workforce planning stakeholders to discuss data availability to measure workforce trends and issues (such as RA) and the effects they have on patient, provider, and system outcomes.
- Policy makers and administrators should explore the push-pull forces that influence the internal mobility of nurses and determine if RA plays a role (Harris et al., 2013).
- The Nursing Leadership Network (NLN) should recommence stakeholder engagement and achieve consensus from members on new terms of reference and on adding additional members relevant to RA issues.

Ministry of Advanced Education (AE)

[1] More information about Alberta Health's role can be found at https://www.alberta.ca/health.aspx.

- The *Roles and Mandates Policy Framework for Alberta's Publicly Funded Advanced Education System* (Government of Alberta, 2007) is a foundation that can ensure the best program and institutional mix to meet the needs of learners, the economy, and society. This framework also serves as a foundation for ongoing evolution of Alberta's advanced education system. Ultimately, an effective system will be one that meets the needs of learners, promotes access, leverages capacity, and allows resources to be effectively allocated to provide outcomes with the greatest value.
- AE can be consulted for their role in reviewing the design of nursing bridging programs for the potential for collaborative education.

Alberta Primary Care Networks (PCNs)

- PCN[2] leadership could work with Alberta Health Services (AHS) to develop competencies and job descriptions for all nurses in primary care. This ensures the potential for provincial standardization and less RA.
- Role clarity issues among PCN nursing types can also be discussed among key stakeholders. Clarifying professional roles among members of a primary care team can be an effective approach to mitigating power struggles, facilitating the integration of new roles in teams, and fostering interprofessional collaboration (Brault et al., 2014).

[2] More information about PCNs can be found at https://pcnpmo.ca/alberta-pcns/Pages/default.aspx.

Alberta Health Services (AHS; Provincial Health Authority) and Covenant Health (Major Health Care Organization)

- Besner et al. (2006) recommend conducting a current state review of job descriptions for RNs and LPNs to determine if optimized scope of practice (SOP) is evident and strategies for improved clarity between roles is understood by managers and workforce system planners. Employers and managers must engage health professionals in discussion of distinct and shared responsibilities among team members to promote effective collaborative practice, improve role clarity, and enhance quality of care.
- AHS and Covenant Health may consider developing resources to help nurses, managers, and health human resource planners improve their awareness of role differentiation. Other strategies to support intraprofessional collaboration are providing resources to assist nurses in understanding their unique contribution and roles (Brault et al., 2014; Lankshear & Limoges, 2019) and providing education and support to assist all regulated nurses to optimize their full SOP (Almost, 2021).
- Kusi-Appiah (2019) suggests working with regulators to create clear job descriptions for nurses, starting in areas where there is considerable overlap and confusion. Nurse managers could facilitate clarification about nursing roles and support effective role deployment. Changes made to RNs' or LPNs' SOP will be implemented with the collaboration of nursing team members, legislative bodies and employers.
- A review of organization-level policies regarding change management to support the adoption of new staffing models at the program and unit level is recommended

for AHS and Covenant Health. Nursing employers and managers must use effective change-management strategies when introducing new staff-mix models (Besner et al., 2006) and ensure that ongoing education and clarification regarding SOP is embedded into orientation (RPNAO, 2014).

- AHS and Covenant Health can provide adequate, formal safe staffing education around the SOPs of different nursing designations for leadership and staff to ensure that nursing resources are matched to individual care needs (Almost, 2021).
- Administrators should explore the degree of nursing RA in their respective organizations.

College and Association of Registered Nurses of Alberta (CARNA), College of Licensed Practical Nurses of Alberta (CLPNA), and College of Registered Psychiatric Nurses of Alberta (CRPNA)

- Nursing colleges collaborate to augment the collaborative practice guidelines to include evidence-informed strategies to address RA. Collaboration between regulators and other stakeholders is a key to responding to emerging health trends (Wilkie & Tzountzouris, 2017).
- Regulatory bodies could work together in harmonizing existing competency frameworks and consult with each other in the future development of their respective regulatory documents (Besner et al., 2006).
- Nursing colleges and ensure that updates from the regulatory body about legislative changes are outlined in practical language (RPNAO, 2014).

- Nursing colleges are allowed by Bill 46 amendments (Government of Alberta, 2020) to amalgamate, creating more solidarity for nursing voices in the health system. This could improve the ability to address cultural issues, including role tensions from ambiguity and overlap. The role of regulatory bodies should be to advocate for quality within the profession (as a whole) as part of its broader goal of public protection (Wilkie & Tzountzouris, 2017).
- Nelson et al. (2014) recommend bringing together all the professional associations to discuss how best to meet patient, community, and population needs. This means addressing issues that influence patient care and workforce planning such as RA.

Alberta Union of Provincial Employees (AUPE) and United Nurses of Alberta (UNA)

- Unions have information regarding the front-line perspective of nurses, whose work is impacted by RA. Unions are currently absent within the NLN and may serve as key consultants for new approaches to managing RA.
- Regulatory bodies and unions representing the different categories of nurses must work together to help their respective members become more informed about their own and their colleagues' roles in the health system (Besner et al., 2006).
- Nelson et al. (2014) identify unions as key actors for increasing flexibility around SOP and are also viewed as a barrier to the evolution of SOPs based on their inherent profession-protective nature.
- Despite concerns about bias, the need to bring unions into discussions around how best to meet patient, community, and population needs is warranted (Nelson et al., 2014).

Postsecondary Nursing Institutions (PSIs)

- PSIs should consider offering collaborative practice (CP) education in sites where colocation of LPN/RN programs exist. PSIs should create modules specific to intraprofessional nursing issues around role clarification, differentiation, culture, and benefits of CP.
- Educators have an important role to play in preparing future health professionals for CP. That role will require that educators are able to transmit, accurate knowledge to their students about the roles and responsibilities of nurses and other providers in the health system (Besner et al., 2006).
- Supporting faculty to recognize the distinct and overlapping contributions of each type of nurse can support educational reform that promotes competencies in collaborative care (Limoges et al., 2018). PNIs can enable faculty to engage with and challenge the discourses, social processes, critical analysis, and reflexive practices necessary to better understand how hierarchies between colleges and universities influence faculty work (Limoges et al., 2018).
- To reduce RA, PNIs should help faculty recognize the distinct and overlapping contributions of each type of nurse and embed strategies in curricula to support the development of intraprofessional collaboration in all programs (Lankshear & Limoges, 2019; Limoges et al., 2018).
- Limoges et al. (2018) recommend that nursing education (faculty) aim to understand the discourses that influence their teaching practices and course content. They state, “addressing the social processes activated by faculty that are linked to

the confusion and tension between nurses could strengthen nursing education and intraprofessional collaboration" (p. 116).

- PNATF (2020) articulates the need to reconsider the historical silos in which nursing categories are educated and evaluated separately, limiting their ability to understand each other's roles and scope, and thus delaying effective collaboration.
- Numerous issues can be traced to the traditional divisions in nursing education, regulation, SOP, and organizations (Almost, 2021). To this end, all institutions should work together in assessing the extent of the issue and consider collaborative approaches to addressing RA.
- Almost (2021) suggests education strategies embedded in the curricula of all nursing programs to support the development of intraprofessional collaboration and education for regulated nurses regarding SOP, including shared and unique competencies of each nursing designation.

Nursing Leadership Network (NLN)

The following excerpt is taken from the NLN terms of reference (Alberta Health, 2018) to inform the reader of existing provincial mechanisms in Alberta available to address system-level nursing issues and provides an opportunity to assess for stakeholder gaps, based on this review.

- The Alberta NLN is a collaborative network of nurse leaders—coming from a variety of capacities and entities—established for the purpose of engaging in strategic dialogue, focused on improving the health of Albertans across the care continuum and influencing health system improvement.

- Focused on improving the health of Albertans, positively impacting patient experiences, and establishing the NLN as a trusted advisor on issues impacting Alberta's health care system, specific tactics and initiatives of this collective leadership group include:
  - Strengthening relationships and collaboration across the nursing professions, with other professionals involved with or impacting the performance of Alberta's health care system, and with stakeholders;
  - Identifying policy issues—impacting nursing and/or Alberta's health system—barriers, and risks affecting the nursing professions and/or the quality of patient/family-centred care being delivered by Alberta's health care system;
  - Making strategic and evidence-informed recommendations to address policies and otherwise advising on issues that impact the performance of Alberta's health care system;
  - Evaluating and communicating to decision-makers and stakeholders the cost, benefits and other implications associated with decisions or directions impacting Alberta's health care system;
  - Establishing a shared vision and identifying key priorities to advance Alberta's health care system;
  - Consulting with key stakeholders including the public; and
  - Bringing forward each individual organization's unique perspective, experience and insights to the benefit of the NLN and Albertans.

The literature identifies the following strategies for addressing RA:

- Given the changes in nursing education, credentials, SOP, and the paucity of Canadian evidence of outcomes, regulated nurses require guidance and support to navigate the distinct and overlapping SOPs and new professional relationships (Almost, 2021). The NLN can serve as a mechanism to better understand institutional mandates and orient these toward system-level thinking to address nursing-related issues.
- The NLN can discuss and develop consensus on how to address RA through each institution for a collaborative approach. Employers, regulatory bodies, educators,

practitioners, unions, and policy makers must engage in dialogue about strategies for improving the utilization of all health professionals (Besner et al., 2006). There is an opportunity for legislative bodies, policy makers, nursing leaders, educators, researchers, and employers to identify pragmatic strategies for improving team members' understandings of the roles of their colleagues and enhancing their collaboration in practice (Kusi-Appiah, 2019).

- Once reconvened, the NLN members can review the topic of RA as a future agenda item. NLN should conduct a comprehensive stakeholder analysis and consider additional members as appropriate, such as PCN leadership and union consultation or participation.

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"We Thought We Would Just Be Following the District Nurse Around": Innovation in Australian Student Nursing Placements in Rural Primary Health Care

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Abstract
To understand primary health care practice, student nurse education requires opportunities to engage in authentic, person-in-environment interaction. This paper reviews an innovative student nurse placement model developed in rural Australia through a multidisciplinary partnership between a rural health service, a university, and the state governmental Department of Education and Training. Semi-structured interviews were conducted with a purposive sample of 12 student nurses at placement completion. Themes drawn out of the data collected were grounded in the participants' opinions and experiences. The interview findings were grouped into six themes surrounding: (1) placement model, (2) identity, (3) autonomy, (4) interpersonal skills, (5) primary care, and (6) young people. Overall, student nurses gave positive feedback about the placement model and felt the experience contributed to their professional identity and autonomy as they transition to graduate roles. They self-reported strong indications that learning about the nuances and complexity of primary health care contributed to their practice skills. Investing in placement models such as the one presented in this paper is important to build capacity in the nursing workforce. Enabling an adaptable, responsive nursing profession is a critical area for further nurse education research and evaluation.

Keywords: student placement, primary care, nurse education, school nurse, rural nursing.

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Introduction

In a complex health and social care system, the nursing profession has an ever-expanding role in influencing individual, community and population health across the continuum of promotion, prevention, early intervention, treatment, and management (Holmes & Warelow, 2000; Mazhindu et al., 2016; Mitchell, 1996; Zardosht, 2020). The training of student nurses has therefore become an intense academic undertaking enhanced by provision of real-world learning experiences, a challenge in this world of increasing virtual teaching and learning (Atakro et al., 2019; Copley et al., 2007). In Australia, student nurse experiential learning is undertaken as multiple industry placements involving core skill areas such as medical, surgical, pediatrics, and—the focus of this paper—primary health care (Carrigan, 2012; Nolan, 1998; Taylor et al., 2015). During placement, students are exposed to important aspects of clinical practice along with an opportunity to develop their professional identity and interpersonal skills (Armitage & McMaster, 2000; Killam & Carter, 2010; Mazhindu et al., 2016; Wei et al., 2021).

Our study focused on student nurse experiential learning in rural primary health care in Australia. The study involved a review of an innovative student nurse placement model that provided an upstream experience for student nurses through a research project and interactive activities with children and youth in a rural community. This paper presents the short-term outcomes of this placement model, exploring student nurses' experiences and opinions and providing ideas for improvement and model replication.

Literature Review

Conventional placement approaches are often health service based, where the focus is on treatment and management rather than contextually relevant promotion and early intervention as recognized in primary health care (Lewis & Kelly, 2018; McInnes et al.,

2015; Ndateba et al., 2015). A comprehensive primary health care approach is a whole-of-society strategy that seeks to equitably maximize the level and distribution of people's health and wellbeing needs and preferences (Irwin & Scali, 2005; Wilkinson & Marmot, 2003). It occurs at the community level and considers the effects of structural and institutional barriers and the impacts of inequality (Bennett et al., 2013; Golden et al., 2015). Previous research indicates there is confusion with the teaching and learning of primary health care in nurse education, indicating a need to further explore this critical area (Bennett et al., 2013; Brommelsiek & Peterson, 2020; Orsborn, 2009).

A challenge for experiential learning within primary health care is in distinguishing between primary health care as a philosophy and system on the one hand, and, on the other, the *how* of operationalizing it into practice through implementation strategies and actions, such as health promotion activities to influence health behaviour and improve health literacy in the community (Keleher, 2001; Kidd et al., 2008). To support realistic learning in primary health care, the experience must provide active participation for the student nurse that engages with the social determinants of health of where people live, grow, work, and age (Golden et al., 2015).

In the rural context, primary care health workforce preparedness requires an understanding of the health inequalities facing rural communities and the ability to make connections to primary care practices (Cosgrave et al., 2019; Mortimer et al., 2019). Rural services face challenges attracting and retaining health professionals, and thus experience chronic workforce shortages (Cosgrave et al., 2018; Killam & Carter, 2010; WHO, 2010). This results in critical gaps in health care provision that adversely impact health outcomes. As such, rural communities have poorer health compared to their metropolitan counterparts (Cosgrave et al., 2019; Reid et al., 2019), reinforcing the need to promote primary care nursing in rural regions.

Rural health professionals face physical, social, and professional isolation (Malatzky et al., 2020; Redford, 2019). This impacts services' abilities to attract and retain skilled workers. Rural health workforce recruitment is plagued by negative connotations; for example, the rural space is seen as "less skilled" and the workforce's perceived scope of practice is often limited to treatment of the elderly (O'Sullivan et al., 2021; Redford, 2019). Remuneration and career advancement is another factor as rural communities have limited resources in terms of political power and economic stimulation. This causes economic disparities for the rural workforce (Humphreys & Wakerman, 2018; Martiniuk et al., 2019). Applicants may also be deterred by their peers' perception of rural health practice as less valuable than other areas of health practice. Further, retention of health professionals is affected by high workload due to the maldistribution of health services and workers relative to rural population health needs (Bourke et al., 2014; Wakerman et al., 2019). This has impacts on rosters and on-call requirements, which in turn affects workers' wellbeing, family, and social life (Cosgrave et al., 2019; Malatzky et al., 2020).

Methods

This paper is based on original qualitative research that examined student perceptions of a primary health care placement model. Semistructured, audio-recorded interviews were undertaken with a purposive sample of 12 student nurses (the total cohort) who took part in the placement model. Participation was voluntary with signed consent and was independent of placement assessment (undertaken by the site educator). The interview questions sought student nurses' views about the placement experience generally, as well as their perspectives and understanding of primary health care specifically related to the placement activities, the degree to which they found it useful to apply the activities to practice, and their feedback the

placement to identify areas for improvement. Effectiveness was measured through analysis of student nurses' subjective experiences and opinions on the primary health care specialization.

The placements occurred in a rural area of Victoria, Australia, in 2018. The area faces significant disadvantage as evidenced by low income, high unemployment, and low educational attainment (ABS, 2020). There is also high prevalence of multiple health risks factors such as obesity, high rates of smoking, and poor vegetable intake. The area has additionally been adversely affected by climatic events including floods and drought.

The 12 student nurses, one male and 11 females ranging in age from 23 years to 52 years, were all undertaking the final placement component of their bachelor of nursing degree. The student nurses completed a two-week block in three rotation groups of four students per block. Students' placement project activities were coordinated and supervised by two of the authors, Carol Reid from the University Department of Rural Health (UDRH) and Leigh Stanbrook from the regional Department of Education and Training (DET). Supervision at the health service placement site was undertaken by the allied health and nurse clinical educators.

The placement model was developed through a partnership between the local rural health service (placement site), the UDRH, the School Nurse Program within the regional DET, and five rural primary and secondary schools. Previous relationships existed between the schools and the health service through an ongoing health promotion initiative. The aim of the placement model was as an innovative approach for experiential student nurse learning in rural primary health care skills and practice. The study had ethics approval from the University of Melbourne's Human Ethics Advisory Group (ID: 1852383.1).

The model involved internal experiences within the health service primary care department and external experiences through a student-nurse-led research project with local schools. Internal health service activities included student nurse involvement in the Meals on

Wheels service whereby hot meals are delivered to socially isolated and mobility-limited people living in the local community. Student nurses additionally attended and supported health promotion events including days to raise awareness about heart and mental health and to encourage early years reading.. The health services' community connections enabled interactive activities to enhance student nurse understanding of people and place. For example, each student nurse group was invited to a tour and training evening with the local state emergency service (SES) to understand the work the SES volunteers do when responding to local emergencies. In another example, a representative from the local historical society gave each student nurse group a walking tour of the township.

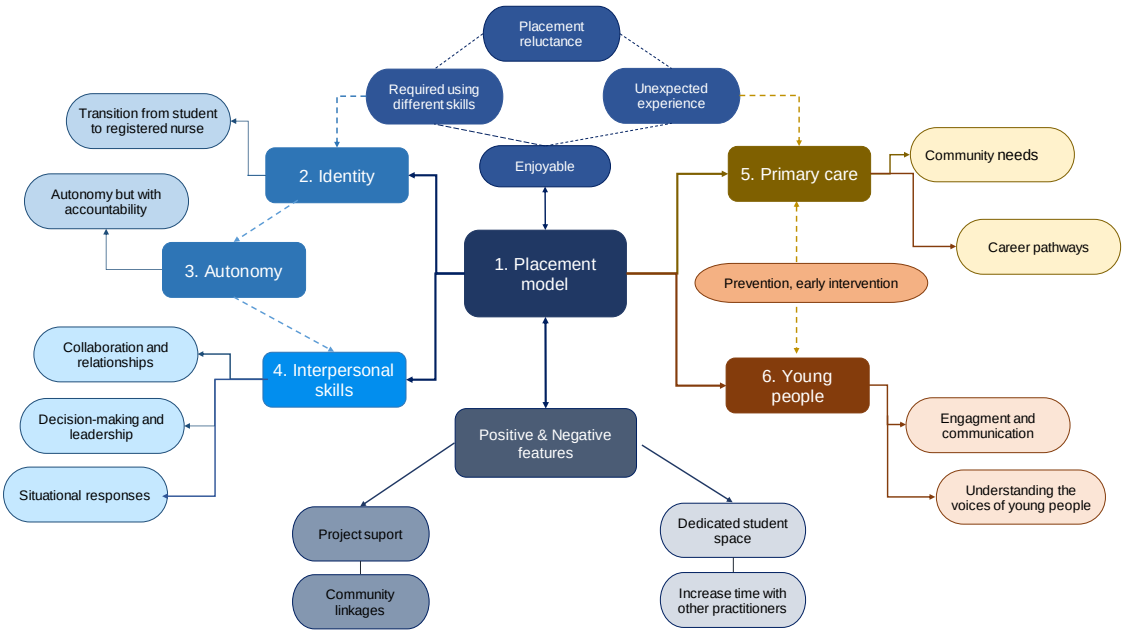
The external activity was to research and develop an interactive activity for school students around the topic "What is health?" The student nurses were provided with a project brief and scheduled (supervised) opportunities to interact with three classes of Grade 5 students and three classes of Grade 9 students. In total, student nurses interacted 92 rural school students. The student nurses were supported to develop and facilitate the classroom activity themselves.

Findings

Interview transcripts were analyzed using the stepped thematic analysis method outlined by Clarke and Braun (2015). This involved two authors (Carol Reid, Leigh Stanbrook) independently reading and rereading transcripts, looking for patterns, and generating basic codes to then compare and agree on the emerging categories (Maguire & Delahunt, 2017). Categories were then organized through discussion between these two authors into significant themes (see Figure 1). Six major themes (the placement model, identity, autonomy, interpersonal skills, primary care, and young people) and associated subthemes were identified from the analysis of the interview data. The themes are explored

below with quotes from the student nurse interviews. The interviews are coded with student nurse numbers (SN#) to maintain confidentiality.

Figure 1. Concept map of themes and subthemes



The Placement Model

The student nurses' views on the placement model were important. As demonstrated in the quote used in the title of this paper—"We thought we would just be following the district nurse around" (SN08)—they had preconceived expectations on what a primary care placement could involve. The interviews indicated student nurses were hesitant about the placement prior to commencement. For example, one student nurse said, "I wasn't particularly looking forward to this placement" (SN07). They acknowledged it was unlike other placement experiences as "it was so different to just being on the wards" (SN011). In terms of their overall assessment of the placement, the student nurses' opinions ranged from acceptance ("It was good, it was a different placement than anything I have ever done" [SN04]) to full embracement ("I enjoyed it thoroughly" [SN06]; "Loved it, loved it, it was great" [SN01]).

When discussing strengths and weaknesses of the placement, student nurses suggested that it would have been helpful if their university had prepared them more; specifically, they felt underequipped in their understanding of what primary care entails. They raised the point that the health service had limited space to accommodate students and was consistently noisy and busy, highlighting the need to provide student nurses with a quiet space for project work. However, they felt the placement model was well planned and designed to help them get the most out of the placement. In the interviews, the student nurses mentioned that the written project brief, regular weekly project meetings, and cultural competency training were useful.

Identity

The student nurses commented on the importance of their last practice placement and noted that this phase helped consolidate their identity as an emerging professional:

> Definitely a placement like this, involvement in project research, it's been really beneficial. I actually would have liked to put it on my application for my [postgraduate appointment] but I have already done it. (SN08)

The idea of being an emerging practitioner was captured by one student nurse, who highlighted that this placement—their last—was a transitional phase between the completion of core training and becoming a qualified nurse:

> Well, it's my last placement so, having that transition from student to registered nurse. So that's been great. (SN04)

Autonomy

The placement model encouraged autonomy as a key part of becoming an effective, self-sufficient, and responsible practitioner. As one student nurse said, "We appreciated it was our own directed learning" (SN09). Placement can be demanding for student nurses but independence was increased through this innovative model as opportunities were provided for students to take responsibility for their own placement outcomes:

> I always feel quite stressed on placement. This way we have put the responsibility on ourselves and we have done quite well. I am pretty proud of our efforts. I think that's shown us, as a group, that we can [succeed] without someone pressuring us and pushing us along. So it's been good to see that we have been able to do it by ourselves. (SN01)

The notion of autonomy with accountability was a strong subtheme. The quote below demonstrates the reflective process a student nurse undertook toward becoming a responsible practitioner:

> Definitely a lot of responsibility in this project. I think we found that even today when we came to you and asked permission to go to lunch and that next step to not having to be told every step, learning you are reliable for yourself…it's that next step-up into being responsible and yes you are still accountable but yes take that next step. (SN04)

A particular highlight of the placement model from the student nurses' perspective was the focus on developing their autonomy as emergent health professionals. They stated that they enjoyed and learned from the opportunity to take ownership of the "What is

health?" research project. They specifically noted the professional development they accrued by working through the challenges of collaborating to develop and facilitate the school classroom session and learning from the children and young people's responses and discussion.

Interpersonal Growth

The student nurses all noted that the placement helped enhance their teamwork and relationship-building skills. Practice placements seek to increase skills in both areas to contribute to interprofessional collaboration, which is essential for health care teams to deliver high-quality care. As one student nurse said:

> It was good working in a group. Being such a big nursing class I didn't even know these girls so we had free time together. (SN12)

The students acknowledged that working as a team is critical in professional settings and this placement provided another way to experience collaboration and develop their interpersonal skills, particularly through organization and facilitation of the "What is health?" student-nurse-led research project. In the words of one student, "It gives you that real experience, another experience of working in a team" (SN07).

It was also an avenue for recognizing a multidisciplinary approach where different knowledge and skills are brought together:

> I really enjoyed the most working as a team and collaborating on our different ideas. As we said [our research project involved]

> acknowledging our different skills and bringing them to the group. (SN05)

Although teamwork was seen as challenging at times—for instance, if a group member was "bossy" (SN10)—this was tempered through the acknowledgement that "someone had to make decisions" (SN08). Exposure to low-level conflict around group decision-making offered additional opportunities to practice interpersonal skills.

The student nurses identified that placement opportunities that allowed them to interact with nursing professionals and other stakeholders in the community were particularly beneficial for supporting interpersonal growth. They highlighted the value of working closely with community members and volunteer organizations as a helpful way of getting to understand local contexts. Responding to their interaction with local SES, one student nurse explained the value of

> thinking and learning about what they do in the community, and then linking all that back into a community placement and care needs of the community. (SN06)

Despite identifying positives around engaging with the community and receiving support from staff in the health service, one student nurse felt that some of the health service staff were judging them for not being in the wards "working" (SN09). Another commented:

> We felt like a burden sometimes to staff when we asked for stuff. There was a lot of rude reactions. (SN11)

The student nurses were interested in spending more time with professional staff who worked within the partner organizations (i.e., the regional DET and local schools) who helped develop the placement model and they highlighted the learnings they gained from interactions with these professionals. In particular, they suggested it would be useful to spend more time with the school nurses, the unit manager from the School Nurse Program, and the health service health promotion officer.

Primary Care

Primary care included the subthemes of community needs and career pathways. The placement model sought to enhance students' understanding of primary care as a social model of health with a focus on prevention of ill health:

> With health promotion and prevention, they don't really teach a lot about primary health care nurses [as part of university course]. We get a tiny little snapshot of what it is. That's why when we saw we were coming here for primary health care placement we all thought, we don't even know what that means. [The university course does] focus a lot on skills in clinical settings and acute settings and illness but not prevention. We don't really talk about prevention in nursing. We were just talking about that as a group; it's blown our minds that it's something we were not fully aware of, we didn't know how big and important it is. I think that's something [that] as a group has surprised us. (SN03)

Similarly, to learn about primary care and prevention, the placement model intended to immerse the student nurses in the community and to engage them in nonclinical environments. In terms of the subtheme of "community needs," one student nurse highlighted:

> I liked that you were in the environment…even that first day when we had that meeting with everyone, hearing what a primary and secondary school nurse is and even the education department and learning about other things. Like, you do hear about other things in the community and to be able to relate that back. But this was like we are doing…research and health promotion in schools. (SN08)

Developing the placement in partnership with the regional DET was an opportunity to expose the students to future career pathways in the primary care setting. As one student nurse said, "I think it exposed us to other options we can go into with nursing, which are just different when you think about being a nurse rather than just being on the ward" (SN01). The experience also gave them an appreciation of the depth of primary care work:

> Have I thought any more about what a primary health care nurse is? Yes, 100%. I didn't even understand there was school nurses. I just thought they would be doing first aid, clinical skills. Don't get me wrong, I knew there were primary health care nurses out there, but there is way more than I anticipated. Like they are not on the floor but there is a lot of behind-the-scenes work. (SN03)

Young People

The partnership approach with the regional DET and local schools enabled the placement model to provide the student nurses with an avenue to engage and communicate with children and young people in a nonclinical setting. Additionally, the setting (schools) was the young people's "turf" where they felt more confident to engage with the student nurses. Importantly, and in contrast to their other placements, this approach gave the student nurses opportunities to interact with young people who were healthy. The student nurses felt it gave them more insight into how to speak to and engage with different age groups:

> This definitely gave me a lot of insight, in communicating with [young people] and learning what they think. If you are working in a hospital and somebody comes in and they are trying to explain to you what they need, you might have a bit more insight into what they might know. For example, to lower your big words but not to talk down to them. So it will help me for sure. (SN02)

> It did provide more insights, just around how children best engage as opposed to another method. Do you use paper-based or do you use online when thinking about engaging? I have got that insight from this placement and that little bit of extra information, in a sense. (SN10)

> It was good to see people, how people naturally are and in their environment and able to contribute. As opposed to, you might have a patient come in and they are unwell and children are unwell, you don't get a feel for what they are normally. (SN11)

The placement model also sought to give the student nurses an opportunity to listen to young people, which is essential in tailoring early intervention to the individual in primary care. The model used a no-wrong-answer approach. Student nurses were instructed not to lecture to rural school students, but to learn from their opinions and their understandings of what health entails:

> It was just interesting to see, initially, how they engaged with us, and secondly, seeing what their answers actually were. (SN07)

> Asking questions and listening more to them. And taking on board their opinion that they know everything about their situation and we don't know, but we can engage with them...find the gaps and fill them in. But not lecturing them but just asking questions around that so then we can fill in the gaps that way. (SN06)

When asked about working within schools during the placement, the student nurses offered some insights. They felt it was beneficial to work with children and young people of different age groups, some in primary school and some in secondary. They noted that they would have liked to work with a greater number of children. As already noted, this research project involved the student nurses working with 92 students over five rural schools—already quite a significant engagement. The fact that the student nurses asked for more suggests the student nurses found the interactions with schools and students to be valuable and enjoyable learning opportunities.

Discussion

The findings from this study highlighted the importance of providing student nurses with experiential learning in primary health care, promoting professional identity, and assisting emerging practitioners to develop autonomy and independence, as well as building interpersonal skills. The interviews with the 12 student nurses who participated in this innovative placement model provided evidence that these elements can be integrated into placement experiences through multidisciplinary group projects and research work, not only via clinical placement modalities.

The student nurses acknowledged that, in their transition from students to registered practitioners, this placement experience gave them an opportunity for professional independence, but with accountability. Professional identity is a process where profession-related knowledge, skills, norms, and values are learned and internalized, and then reflected in attitudes and behaviour (Mao et al., 2020; Stephens & Ormandy, 2018; Walker et al., 2014). There are correlations among professional identity, feelings of self-worth in work autonomy, and workforce retention in the nursing field (Jiang et al., 2020; Mao et al., 2020). This is important as health workforce retention is critical in rural areas.

The placement model sought to provide a learning experience of rural primary health care as a social model of health where service provision connects to the needs of the community (Ndateba et al., 2015). It was important for the placement to increase student nurses' understanding of the social determinants of health within everyday contexts (Golden et al., 2015). As clinical placements are limited in providing experiential learning and critical reflection on the broader impact of life circumstances on health (Parry et al., 2018), placements in primary care hold a special niche.

The placement model aimed to reduce the power imbalance inherent in clinical settings. It highlighted that primary care perceives people as the experts in their lives, noting that the way people view their world will impact their health understandings (Bennett et al.,

2013; Mitchell, 1996). The model provided opportunities for the student nurses to experience this through the research activities in an upstream situation where they could listen to young people. The student nurses reflected that this experience of talking to young people and asking them, "What is health?" would influence their future practice and how they will engage and communicate with young people. One student nurse commented that they "will talk to them rather than at them" (SN06).

Issues regarding health service staff attitude were noted by the student nurses, including feelings that some of the staff treated them as a burden and were rude. Students on placement may be seen as an additional burden for time-poor supervising staff; hence, they are expected to be an extra set of working hands and cannot be seen as idle (Cleak & Zuchowski, 2019; van de Mortel et al., 2020). This negative attitude toward placement students has been identified in previous nurse education research, where students were not treated respectfully, and staff culture was poor (Carrigan, 2012; Ryan et al., 2018). Lack of staff interest and poor role modelling adversely affect student learning experiences and can impact the development of professional identity and career planning (Walker et al., 2014; Wei et al., 2021). This contributes to the stress student nurses can feel on placement. As one student nurse identified, the expectation is "that you have to give 100%" (SN02). This highlights the need to work together to inform and include staff to ensure that student nurses are supported to learn and have positive placement experiences.

Seeking to ameliorate the impact of this, the placement model was designed around student-nurse-led group work to provide the student nurses with support from their fellow students and reduce the stress of placement. As suggested by the literature, being part of a group builds a sense of belonging and increases self-confidence (Walker et al., 2014). This further emphasizes the innovative nature of the placement model and highlights opportunities

to include existing staff who have developed their professional practice in the clinical context and have less experience in the community preventative space.

Despite the successes of the placement model in the study setting, several limitations must be acknowledged. The most obvious of these is the lack of longitudinal follow-up built into the study scope to consider student nurses' career trajectories and implementation of primary care skills learned on placement. Secondly, this study involved a small participant cohort and one rural health service site. It would be valuable to implement the placement model at several sites across a wider student nurse participant group. Lastly, to add to the evidence base and knowledge of nurse education and primary care practice, a comparison to urban health services sites may reveal other areas of professional identity and practice skills important to building capacity in the rural nurse workforce.

Conclusion

This study examined 12 student nurses' perceptions of the effectiveness of an innovative student nurse placement model. The placement model sought to unpack primary health care practice, showing it to be more than "just following the district nurse around" (SN08). The model emphasized experiences to support the student nurses in learning that improving individual, community, and population health through actions such as health promotion must be codesigned with the individuals, communities, and populations for whom they are intended. As well as contributing to student nurses' ability to reflect on community capacity and build awareness of context sensitivity, the placement model enhanced student nurses' confidence around entering the workforce as emerging practitioners by strengthening their professional identity, autonomy, and interpersonal skills.

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