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MAXIMISING, OPTIMISING, EMPOWERING: THE WORK OF THE PUBLIC HEALTH NURSE IN A COLLEGE SETTING

A thesis presented in partial fulfilment of the requirements
for the degree of
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ABSTRACT

This qualitative study focuses on the work of one Public Health Nurse delivering primary health care to potentially 950 students during her regular weekly visits to their suburban college. The interesting interface of health and education is captured by a single-case study design. In its ninety years of existence, public health nursing has seen very little research into practice, least of all practice in a secondary school or college. Data was collected from one primary participant in the form of two reflective monologues, six interviews taped at weekly intervals and five participant-observation sessions, and three taped interviews with senior school staff. The use of Yin's (1984) framework for data analysis generated support for the proposition that adolescent health was a great need in the nurse's area. Current literature shows that adolescence is one of the fastest growing areas of need in health today, particularly because of concern with New Zealand's high rate of youth suicide and poor mental health services for this age group. In keeping with the philosophy of primary health care, health promotion and self-responsibility, three key themes and associated subthemes were generated from the data. These were maximising ('working with' and 'working without'), optimising ('building' and 'breaking') and empowering ('using the critical moment' and 'sustaining the self'). These concepts encapsulate the substantial contribution that the Public Health Nurse participant made to adolescent health in a college. In 'working with' the student, the college staff, the nurse's colleagues, as well as the community, the nurse made a difference by 'maximising' or making the most of the moments she spent with the students in making decisions about their health. Issues, including sexuality, drug and alcohol abuse, are further articulated in the optimising and empowering themes which look at the need for young people to hope by empowering themselves to cope with the future. The nurse was seen by the staff at the college as a vital part of the community. It was this connection that was most valued for the balanced perspective that the Public Health Nurse brought to the college in her weekly visits.

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INTRODUCTION

Introduction

This study is about the work of a Public Health Nurse with adolescents and adults in a college setting. The introduction will provide an overview of the study, how it evolved and what was involved in the process of carrying it out. This will then be followed by an explanation about the layout of the thesis. The content and sequence of chapters will be described in relation to one another, as well as to the study as a whole. Its relevance to nursing and nurturing the needs of adolescents will also be discussed.

Background to the study

The focus for this thesis is on a single Public Health Nurse working with adolescent students during her regular weekly visits to their college. Taking a single case study approach, it examines in depth the complex processes involved in the delivery of primary health care to these young people in the naturalistic environment of their college.

This study evolved from an earlier one which surveyed sixteen Public Health Nurses for the work they did in primary schools (O'Sullivan, 1993). When I thanked the nurses on that occasion for their rich contextual data, one of them happened to remark,

> *Oh! But you should see what I do in my college - I do much more work there with the young people than I do with those in my primary schools.*

I was naturally inquisitive to know more. This first experience in research had taught me the value of indepth interviews when exploring human responses to actual or potential health problems encountered in the field of public health nursing. Therefore, I decided to study the work of one Public Health Nurse in a way which would allow issues to emerge as they do in the course of the nurse's daily work. It would also allow me to identify where Public Health Nurses made

a difference to the health and wellbeing of their clients. Much of this work is taken for granted, and yet it emanates from a nursing expertise that has tended to remain silent and invisible for too long.

Another reason why I carried out this study was to learn about an area reputed to be one of the fastest growing in New Zealand today. Although I was an experienced Public Health Nurse, I had to admit to having limited experience with adolescence, and much more familiarity with the younger age group in primary and intermediate schools. Hence, the thesis has given me a rare insight into adolescence which I have already put to good use in my everyday practice. It has also taught me the importance of recognising and affirming the skills of others, and valuing the way in which their collegiality and expertise can complement my own work for the benefit of clients.

Overview of the study

The study began in May 1994 and data collection was completed in September that same year. For personal as well as professional reasons (see p. 138-141), analysis and writing has taken longer than anticipated. The goodwill of the participants was exemplary and I hope this study does justice to the major contribution they made in the form of interviews and participant observation sessions.

There was one key participant in this study. The Public Health Nurse began by recording her reflections about her work on two monologue tapes. Then I commenced weekly taped interviews with the nurse after each of her clinics over the course of six weeks. I also interviewed the Deputy Principal, the School Guidance Counsellor and a teacher to obtain their views on the work of the Public Health Nurse in adolescent health care at their college. These interviews were purposely left open and unstructured in order to allow the emergence of issues which might not have been captured if a more structured framework had been imposed.

There were also five participant observation sessions that opportunistically arose within the course of the study. These allowed me to observe the nurse in a workshop setting with students and/or parents, when she delivered important messages about prevention, health promotion and self responsibility. As happened in her clinic work, many health issues arose during these sessions,

requiring a wide range of nursing skills. Topics covered included sexuality, drugs and alcohol, child abuse, anorexia, truancy, depression, behaviour, menstruation, hygiene, vision, orthodontics, tuberculosis, cardiac and cultural needs.

The study provides an answer to the exploratory question: "What sort of work is the Public Health Nurse doing with adolescents in a college?". The explanatory question, "How does the Public Health Nurse deliver primary health care to students in a college?" was answered by the theoretical development of three themes: MAXIMISING, OPTIMISING and EMPOWERING. They identify the essence of the work of the nurse as she connected with the students, and helped them to make decisions in the "here and now" that would potentially make a positive impact on their future.

Young people need to be nurtured in ways that are safe and culturally acceptable. This nurturance has never been more urgently needed than at the present time when there are real concerns for young people in New Zealand.

Overview of the thesis

The thesis is presented in six chapters. Chapter 1 reviews the literature related to public health nursing's involvement with adolescent health over its ninety years of existence. Only a small amount of research has ever been carried out in the general area of public health nursing, with only the occasional indirect reference to the role of the Public Health Nurse in a college. This deficiency is evident despite the current plethora of adolescent literature, particularly with its emphasis on youth suicide, depression and the mental health of New Zealand young people.

Chapter 2 presents the research methodology along with the aims and objectives for this study. It reviews the general case study method and the single-case study design used for this research. Details concerning participant selection are given along with a description of the college setting in which the research takes place. The method for data collection and analysis is outlined. Issues for ethical consideration are raised and these include acknowledging the ongoing need for informed consent as distinct from a one time signing event before the study commences. Rigorous steps were taken to ensure the anonymity of the participants, the college and any third party who became

involved in the course of data collection. Students were not interviewed at any time in the course of the research.

Chapter 3 gives a brief overview of the research outcome including an explanation of the three major themes and their associated subthemes. Collectively, these support the proposition that adolescents have many health needs and Public Health Nurses have much to offer in this area. In Chapters 4, 5, and 6, each of the major themes is identified, defined and discussed, supported by stories from the data. Verbatim quotes are recorded in italics and are preceded with a brief introduction explaining how they illustrate the meaning of the theme. Some key points are underlined for emphasis.

Chapter 4 presents the theme, MAXIMISING, with its associated subthemes, Working with and Working without. The former relates to those paradigmatic moments in the "here and now", when the nurse is working with the student, working with the college staff and working with the community health staff. Here, the emphasis is on partnerships of various kinds. Working without refers to the nurse working in the community, "without" the walls of an institution which could affect her accessibility. This subtheme is about community connection, and illustrates the way the nurse uses practical knowledge and networking skills in the community.

Chapter 5 focuses on hope as embodied in the theme entitled, OPTIMISING, with its accompanying subthemes of Building and Breaking. These imply the building up of strengths, the breaking down of barriers and the breaking through from resistance to success. Young people are given the opportunity to look at all the possibilities within each given situation they face. The nurse can be seen working in a variety of scenarios that focus on the future for young people.

The third theme, EMPOWERING is described in Chapter 6. It follows on from the two previous themes, and presents the premise that "maximising" and "optimising" are not effective if people are not empowered to make the changes necessary for their health and wellbeing. It also maintains that only people can empower themselves, but that they can be supported and inspired by others to seek health through their own self-determination. Different aspects of empowering are explored under the two subthemes. One is dedicated to the client (Using the critical moment) and the other to the nurse (Sustaining the self).

Chapter 7 is the final chapter in which the findings from the study are discussed in an overview of the three themes. They are related to the literature, and the implications for adolescent health and public health nursing are also discussed with several recommendations being made for this particular area of practice. Limitations of the study are then explored along with suggestions for further study. The thesis concludes with a brief discussion on what I have learned from this study, as a Public Health Nurse, researcher and person, and this is recounted as a journey.

Chapter 1

PUBLIC HEALTH NURSING AND ADOLESCENCE: A LITERATURE REVIEW

Introduction

Following extensive searches in both library and on computer (INNZ, ERIC, INR & HEAPS), as well as in consultation with public health and nursing colleagues, it would appear that there is very little research directly related to the topic of the Public Health Nurse, or Health Visitor, in a secondary school or college. From the few studies there are on public health nursing, a picture emerges of the work of the Public Health Nurse as very complex, context determined and *not* understood *or acknowledged by those outside* (Public Health Nursing Review Committee, 1986, p. 11).

It is the intention of this chapter to investigate the origins of public health nursing, particularly in relation to the work that Public Health Nurses currently do in the area of adolescent health. New Zealand, like the rest of the world, has major concerns about the health of its young people, and schools are seen as a setting that can influence adolescents in a variety of ways, both positive and negative. One positive way is the invisible yet often pivotal work that Public Health Nurses do. Its relevance will be explored in the context of 'new' public health philosophies, namely those of primary health care, health promotion, community development and empowerment. But first, it is pertinent to look back to the early beginnings of public health nursing, and relate its development to today's youth and the work of meeting their needs in the school environment.

Early beginnings

Public health nursing history goes back nearly ninety years. The first New Zealand Public Health Nurses were appointed in 1911, "against a background

of rapid political, social, cultural and economic change and reform" (Barham, 1984, p.15). Their goal was to improve the health of the community and this has never changed. But, the primary focus in 1911 was for Public Health Nurses to "work with the Maori people in all aspects of health as primary health care givers" (Ibid, p.16). Consequently, during these early beginnings, Public Health Nurses were identified as the only nursing service delivering total health care to Maori. This involved "curative and preventative care, working with all ages and ailments in all situations, whether it be the home, school, or workplace" (Ibid, p.15).

Initially, Public Health Nurses worked directly under the auspices of the Health Department and the government of the day. Over time, this has changed, as have the role and function of the nurse, and the needs of the overall community have both remained and multiplied. During its eighty-six year history, New Zealand public health nursing has expanded into other areas such as disease control (immunisation, personal hygiene, health education), school work (sickness detection and health surveillance), occupational health, and primary health care (to people living in both isolated and urban areas).

The worldwide expansion of public health nursing services was recognised in 1961 by a series of WHO Public Health Papers which described public health nursing as being "much wider in scope than nursing in its traditional acceptation as the care of the sick" (p.7). Around that time, the WHO Expert Committee on Nursing (1959) submitted this definition:

> *Public health nursing is a special field of nursing that combines the skills of nursing, public health and some phases of social assistance, and functions as part of the total public health programme for the promotion of health, the improvement of conditions in the social and physical environment, rehabilitation, the prevention of illness and disability. It is concerned for the most part with care of well families and with non-hospitalized sick persons and their families, with particular groups of people, and with health problems that affect the community as a whole. Because of the traditionally close relationship between nurses and the families they tend, public health nursing frequently serves as the channel by which many other public health and community services are brought to the public* (p. 4).

Over time, New Zealand public health nursing has become a client-centred, community-focused institution, espousing the principles of primary health care, namely, accessibility, acceptability, affordability and participation by individuals, families and communities. As articulated by the 1978 Alma Ata Conference, primary health care is:

> *Essential health care based on practical, scientifically sound and socially acceptable methods, and technology, made universally accessible to individuals and families in the community, through their participation, and at a cost that the community and country can afford, to maintain their development in the spirit of self reliance and self determination* (quoted in Appendix III, Swanson & Albrecht, 1993, p.691).

Roorda (1988) attributes this emphasis by Public Health Nurses on primary health care and prevention to having both a "tradition of trust and care", as well as being seen as the "first contact for families in need of care" (p.7). A similar acknowledgement was made to the Minister of Health by the Public Health Commission in its 1995 report on School Health:

> *Schools value and trust Public Health Nurses...they tend to have good rapport and be trusted by "high risk" families, and by many Maori...their on-site, "drop-in", and free nursing service improves the chances of early detection and intervention, and tends to appeal to young people* (Public Health Commission, 1995, p.24).

Both rural and urban Public Health Nurses have played a significant role in helping many Maori, Pakeha and Pacific Island families cope with their socio-economic circumstances and unmet health needs. They also work with immigrants from Asia and beyond, including refugees from the war zones of Africa, Europe and the Middle East (Buckland, 1996).

Public Health Nurses encounter challenging situations on a daily basis. Pybus (1993) gives insight into the work that Public Health Nurses do when trying to promote health amongst "at risk" children living in complex and often volatile family situations. Zerwekh (1991) offers parallels in her study of thirty Washington West Public Health Nurses whose competencies she described in

the "exquisitely delicate" work they carried out with families from similar high-risk situations (p.213).

Through the analysis of ninety public health nursing stories, Finalyson, Anderson, Blahitka, Gray, Langdon, Marin-Link, Sommer, Benoit, Hopkinson, Orleski & Etoroma (1993) identified ten core themes, conceptually describing the "breadth, scope and all-encompassing health approach" of their Alberta public health nursing colleagues (p.5). The ten core concepts were: "Upstream Thinking", "Facilitating Change in Populations", "Reaching Out", "Being There", "Being a Constant in the Community Over Time", "Looking Ahead and Beyond", "Providing Options", "Advocating for the Client", and "Linking Up" (Ibid, p.6).

It was a hundred years ago that the American nurse, Lillian Wald, first invented the term, *Public Health Nurse*, choosing that particular title to place emphasis on the "community value of the nurse" (Buhler-Wilkerson, 1993, p.1778). She saw Public Health Nurses as the "guardians of the Public Health", their work "going beyond" caring for families during illness, to "encompass an agenda of reform in health, industry, education, recreation and housing" (Keith, 1996, p.4). The Public Health Nurse was therefore seen as a link between families' social, economic and health needs, and the services they needed to become or to stay healthy. This networking nature of public health nursing is a common theme and appears in Craig's (1983) observation of New Zealand's own Public Health Nurses:

> *I have found that public health nurses particularly, have their fingers in several pies at once, and you should never overlook them as potential allies* (p.54).

Public health nursing is but one component of the contemporary New Zealand health system. The challenges facing that system are many and varied. They include the changing patterns of disease, the changing health care structures, and the changing philosophies of public health which will now be discussed.

The New Public Health

It is the view of the New Public Health that the traditionally organised health structures are not always the most appropriate avenue for addressing those

health problems "rooted in the social, economic and cultural environments" (Blue, 1994, p.8). Most current manifestations of ill-health are chronic conditions that may not be effectively treatable, but are, nevertheless, often preventable. Improvements in health are most likely to result from changes in social and individual behaviour rather than from new, and often expensive treatments. Solutions are therefore likely to be found within the domain of health promotion which WHO (1988) defined as the process of

> *...enabling people to increase control over the determinants of health and thereby improve their health* (p. 7).

The primary avenues to health are now considered to be through education, economic progress and other socially created health promoting contexts such as the Healthy Cities and Healthy Schools Projects (Pears, 1994). Central to the philosophy of the New Public Health is the concept of empowerment, which the 1986 Ottawa charter defines as the ability of

> *...individuals and communities to identify their health problems, and take self-directed action towards solving them, "developing personal skills", "creating supportive environments", "strengthening community action"* (cited in Blue, 1994, p. 8).

Empowerment requires both a shift in power *and* a shift in thinking (Gibson, 1991, p. 357). Rather than imposing their expertise on clients, Public Health Nurses now use it as a tool for empowerment within the context of equal partnership. The Onepoto Awhina Community Development Project is but one example of this, where the Public Health Nurse, over a five year period, promoted health at the macro-social level in a high need multicultural community (O'Sullivan, 1988). The nurse was able to work with the community to address many of the conditions that controlled, influenced and produced health (and illness) amongst the large numbers of poor, solo-parent, Maori and Polynesian families in the Onepoto-Northcote state housing area. Through the energy evident within this and many other similar projects, social networks and support systems have been strengthened, self-care efforts of the community have been enhanced, and nursing interventions have been more effective than had they been introduced without such backing from the community.

As many health professionals have discovered, imposed solutions do not work. If people do not perceive a health problem is important, or the suggested solutions as appropriate, then they will be less likely to change their behaviour. If, however, health programmes are initiated and owned by the community then their chances for success will be that much greater. This was the case with the Dargaville youth health project whose primary aim was

> *...to involve a community in developing strategies to enhance the health and well-being of young people aged 15-24 years* (Disley, Coggan, Peters, Patterson, Schick & Tau, 1995, p.1).

It achieved this in the course of one year through the collaborative efforts of the key players, namely Dargaville High School, health and other service providers (one of whom was the Public Health Nurse), and those community members who "gave their time, thought and opinions on how to improve the health of young people in Dargaville" (Ibid, [i]). Working closely with this community were the Mental Health Foundation and the Auckland School of Medicine's Injury Prevention Research Centre who conducted the project using a process of consultation, collection of survey data and community feedback on

> *...the health status and level of risk-taking behaviour among the target group, current service provision to young people, and ways in which young people and service providers consider the health and well-being of the target groups can be improved* (Ibid, p.1).

This data has since been used for professional development and training workshops. It has also been the catalyst for the current trial of a positive mental health teaching module at Dargaville High School. Perhaps these outcomes will generate further community led initiatives which promote the health and well-being of young people. This is important given that Dargaville, as is the case in the rest of Northland, has one of the highest pregnancy rates for adolescents in New Zealand.

A prerequisite for effective health promotion is full community involvement (Child Health Committee, 1986). This calls for the reorientation of services to the new philosophies in Public Health, as outlined by De Lacey (1989):

> *Within the health context, community development would be reflected by people in communities identifying their own health issues and fully participating in the planning, implementing and reviewing of health services set up to meet the needs as identified. Community development in health would also be demonstrated by health professionals working in a way that enables consumers individually or in groups to empower themselves; and by those health workers acquiring relevant skills and self-development to do this* (p. 4).

Lungley & Barnett (1991) had found this was in the main happening when Public Health Nurses worked in schools and communities. While Public Health Nurses had always taken a child-centred approach, their focus still remained on the child but more as a resource-consultant operating from within a "health promotion-community development framework" (Blue, 1994, p. 9).

This new way of working had in part been pre-empted by the 1985-7 Priority Areas Programme (PAP) which used a team approach to address areas of high public health needs, one of which happened to be in a secondary school:

> *The work diary of one school PAP nurse showed evidence of such troubles as anorexia, suicide, incest and pregnancy, coming to light while the nurse was in close personal contact with the students. School staff often see the role of the nurse as dealing with minor health problems and accidents. In the holistic view taken by this PAP nurse it was both more effective and humane to address these larger issues as they emerged. Time is needed for both the students and staff to understand what the nurse can offer the school* (Stapley, 1988, p. 34).

The nurse in this context got to know both staff and students. Surveys were taken to assess the students' levels of health knowledge and these opened up areas of further concern, namely

> *The students' lack of knowledge about sexuality, sexually transmitted disease, pregnancy, diet, exercise, contraception, parenting and relationships. Low self esteem and high stress*

> *levels were found to be a common factor among many of the students* (Ibid, p. 35).

Examples of some of the care that the nurse delivered to this school were:

* *relaxation classes to help raise self esteem*
* *facilitating peer counselling*
* *self-referral or drop-in clinics*
* *help for school staff in learning about and gaining confidence in the health related issues*
* *giving classes about the subjects mentioned above*

(Ibid, p. 35).

In time the PAP workers became providers of resources in response to school's requests for health-related information. Often they were able to empower the schools to discover these resources amongst their own staff, students, and parents, for example, peer counselling for students.

This innovative way of working was then integrated into the primary health care sector of the newly established Area Health Boards (Stapley, 1988). Public Health Nurses worked within these structures until in time they were replaced with provider institutions which the Green and White Paper referred to as CHEs, or Crown Health Enterprises (Upton, 1991).

Public Health Nursing Philosophy

Despite the upheavals over the last decade or so, the philosophy of the public health nursing service in New Zealand is just as relevant today as when it was first published twelve years ago.

> *We believe that the public health nursing service provides a specialised field of nursing practised within the wide area of health services. It focuses on health promotion and disease prevention and is attuned to the needs of the society in which we live. It recognises that effective community health programmes depend on the coordination and liaison of the members of all health and*

> *social agencies. It is responsible for ongoing evaluation and research into its own approach to community health care...*
> (Department of Health, Wellington, 1985, p.2).

One of the central tenets of nursing is to attempt to maintain a holistic perspective, whilst "viewing its clients within their own social context" (Allen & Whatley, 1986, p.11). To this end, recent research has shown that Public Health Nurses are vitally concerned in the delivery of contextualised, holistic care to all individuals and groups. As the following position outline shows, this frequently involves adolescents in both school and other community-type settings:

> *PHNS have responsibilities in many areas of* ***School Health*** *e.g. primaries, intermediates, colleges, correspondence school children, health camp, as well as intellectually and physically disabled children. Additional areas of responsibility include* ***Child and Family Health*** *e.g. infant & preschool welfare, early childhood centres (creches, kindergartens, daycares, playcentres, etc), children in at risk situations (abuse, neglect, poor access to help of any sort), families living in at risk situations (poor housing, poor access to health care, alcohol/substance abuse, women's refuge), mental health issues;* ***Health Promotion & Education****: access groups, clinics (women's health, adolescent health, etc), special programmes (ear health, smoking cessation, cervical screening), the mobile wellness unit (campervan);* ***Community Development****: networking & linking, community advocacy, healthy cities;* ***Other Obligations****: practice nurses (statutory); overseas nurses (seeking registration), students (seeking experience), staff development/upskilling, quality assurance;* ***Immigrant-Refugee Health****;* ***Infectious Disease Control****: immunisation programmes, Tuberculosis follow-up, STDS, Rheumatic Fever, epidemic response & disease prevention e.g. Meningococcal Meningitis/Septicemia* (O'Sullivan, 1993, p. 67).

Research showing Public Health Nurses in schools

In a survey of home visits by Dunedin Public Health Nurses, Blakey & Bradley (1980) found the topics most frequently discussed by nurse and client were housing, financial hardship, household management, employment, specific illness or disability in adults, and marital or family disharmony. The most frequently discussed topic was "the general health of family members" (52% of the visits, N=346) (p.18). This was followed closely by "school-related problems" (43%, N=285). When "discussion plus some positive advice or teaching was given", the most frequently occurring topic was "specific illness or disability in the school aged child" (p.19). Other notable referrals included "behavioural problem" and "mental and emotional development" in the school-aged child (p.18). As this last reference was made to children going to "health camp", it is assumed that these home visits were mainly for primary school children.

In a study of 1036 primary school referrals made to 16 Public Health Nurses over the course of one year, O'Sullivan (1993) found that out of a total of 77 broad category concerns, *ears* (242) scored highest, followed by *hardship* (226), then *behaviour* (175). The effect that socio-economic hardship has on health, and that health has on learning was universally evident.

The impact that other issues can have on the overall delivery of 'health' nursing in a school was seen in the 1982-83 trial integration of the Public Health Nurse's role with that of the District Nurse in Palmerston North. Here it was found that the immediacy of domiciliary needs took precedence over "very important public health work" which was not done, much to the despair of the project nurse:

> *I just don't know how long I can go on in this job, I am so far behind in all my office work, so far behind with families, schools. The harder I try, the worse it becomes* (Kinross, Nevatt, Boddy, North, Pybus, Takarangi & White, 1987, p. 138).

Public Health Nurses visit all schools in New Zealand. Therefore, any appraisal of a school health nursing service must take into account not only the philosophy and goals of the service, but also the interactional influence of such variables as social structures, resources, workloads, environment and "user

care process" (Ibid, p. 17). User pay care systems can be an incentive for clients taking advantage of the free services offered by Public Health Nurses, particularly during times of economic, health and educational reform. But as a study in Northland revealed:

> *The total amount of work done in schools in any area depends on the Public Health Nurses staffing level...the amount of other work presenting in that area and on the relative importance given to school work by different Public Health Nurses* (Flight, 1984, p.5).

Public Health Nurses working in adolescent health

While there may be a dearth of research on Public Health Nurses working in colleges, nevertheless there are many Public Health Nurses involved in adolescent health, not only in schools or communities but also in specific work with teenage parents and their infants (Austin, 1993; Cheer & McKay, 1995).

Some Public Health Nurses have helped set up Youth Health Centres in response to the needs of the young people in their local area. For example, the Beachhaven/Birkdale primary health care initiative offers young people access to information, support and consultation on a range of health issues and concerns. The Centre also has an outreach to the local college, intermediate school and access group, and has a close working relationship with Family Planning (Messer, 1993).

Other Public Health Nurses hold weekly clinics in their colleges, taking student, teacher, counsellor and parent referrals. They run health programmes with pre-employment and other classes, dealing with such issues as sexuality, safer sex, contraception, alcohol and drug use, mental health, nutrition (including anorexia), and hygiene (Hathaway, 1993; Cheer & McKay, 1995).

In reporting the needs of the children and young people in Waitakere City, Wildermoth and Blaiklock (1996) acknowledged the contribution Waitemata Health Public Health Nurses made to their schools in running drop-in/self-referral clinics. One of these was located in a community health venue and this allowed access to both primary and secondary school students. Over an eight

month period these nurses took a total of 739 consultations in nine clinics from students in ten schools. Some of the issues identified by the students were:

* *relationships - family, friends, family break-up*
* *sexuality and related issues of contraception, sexually transmitted diseases and pregnancy*
* *mental health issues*
* *skin care*
* *anger management*
* *alcohol related issues* (Wildermoth & Blaiklock, 1996, p. 75).

Among different New Zealand communities today, there are many similarities in the issues about adolescent health need. Each community has endeavoured to develop its own resources in response to that need. It is germane to now study what the Public Health Nurse's role has been in two of these. The models of care chosen are set in two provincial towns with their college students coming from a mix of both urban and rural backgrounds. Eyre (1983) found there were no significant differences amongst rural and urban college fourth form students in their knowledge and attitudes towards health.

The Wanganui YAC (Youth Advice Centre) model was first proposed back in 1989 by a group of health-related professionals -

> *...people such as Public Health Nurses, School Counsellors, the Occupational Health Nurse (Wanganui Regional Community Polytech), Asthma Educator, Social Workers, General Practitioner and other interested parties* (Colonna & Portland, 1994, p.1).

YAC is a good example of how needs can be identified but not met because of a lack of resources. It was not until 1991, when the local polytechnic opportunistically began looking for extra student health services, that this proposal was then reconsidered. First, YAC carried out a needs survey in the polytechnic and local secondary schools. The results revealed that students did indeed want a health care facility but one with a wide focus that included such services as budgeting and legal advice. This was agreed to and, in 1992, YAC commenced operations in the revamped premises owned by, but essentially separate from, the polytechnic one block away. It was highly accessible as well as acceptable to the young people in the city of Wanganui.

The first person to move in was the STD Educator who was employed by Good Health Wanganui. She was followed by the Men Against Violence Group, whose presence met the students' specific request that the centre be comfortable for both males and females. This apparently was not the case at the local Family Planning Clinic located in the women's unit of the Wanganui Women's Resource Centre.

Two months after its opening, the Adolescent Public Health Nurse became the third person to move into the new YAC premises. Her appointment by Good Health Wanganui to this position and this location, was aptly captured in the comment:

> *...this is the best possible site to work from, to have maximum accessibility and acceptability for her many young clients* (Ibid, p.2).

The Public Health Nurse's role at YAC was comprehensive and included counselling, providing Family Planning services as well as running courses for baby sitters and peer support trainees. The nurse also played a leadership role, chairing YAC's membership committee in the management of administering YAC's daily affairs.

Because of an increase in both clients and services, a coordinator was appointed in 1994. By then YAC services had grown to include a Drug and Alcohol Counsellor and as well, a Drug and Alcohol Educator, a Guidance Counsellor, a Child and Adolescent Social Worker, a Plunket Nurse, an Asthma Educator, an Adolescent Health Specialist, a Medical Officer, a member of the HIV/AIDS network, a local lawyer, a budget adviser, and graduates of the peer support training programme. With the establishment of a free youth advice phone, YAC's services became accessible to a wider group of young people, in particular to the rural youth in the Wanganui region. This was a classic case study in youth health community development and the Public Health Nurse played a major role in its evolution.

A neighbouring rural community was brought together when two Public Health Nurses initiated a health promotion project aimed at the needs of youth in the Tararua district. Using a multidisciplinary approach involving health workers

from Physiotherapy, Mental Health, Alcohol and Drug Services, Maternity, Iwi, Dental Therapy, and Asthma Education, the two nurses consulted with teachers and students from their nearby secondary schools as well as Training Opportunities Programmes. Their objective was to identify what activities were most relevant to the needs of their adolescents.

> *It was decided to base the promotion around the concept of 'Choice', and so it was named 'Tararua Youth are Choice'* (Cheer & McKay, 1994, p.1).

The project was particularly timely, given that the target group and their families had been under considerable stress following multiple fatalities from two separate car accidents. In the words of the nurses, "the project grew like Topsy" due to general public sympathy and because many members of the public saw the promotion as "a timely response from health workers" (Ibid, p.1).

With this wave of public support, and coverage by the media, donations from a number of organisations were received including promotional give-aways from local businesses. This enabled the development of an Adolescent Health Kit which was given out to over 700 young people with the key messages contained in a letter:

> *Dear Student,*
>
> *WE CARE ABOUT YOUR HEALTH AND HAPPINESS!*
> *The teenage years are a time when you will be making some really important decisions, decisions that will affect your future. We want you to know that you have 'CHOICES' and we hope you will use the information in this bag for many years. The bag will wear, the biro will run out and the stickers and pamphlets will fade but the knowledge you gain from learning about your health and wellbeing will be with you forever. Good luck for your future. AROHANUI* (Ibid, p.7).

Other activities included a seminar for parents, teachers and those "living or working with young people", on *'The Signs of Stress, Depression and Suicide in Teenagers'* (Ibid, p.2). The guest speaker was Dr Barbara Disley, Director of the Mental Health Foundation of New Zealand, who addressed the audience on

what they could do to help their children and also what could be done to provide a supportive environment for young people in the community following a major trauma such as recent road fatalities. Dr Disley also ran a lunchtime workshop for the students at Tararua College which helped the young people identify and deal with the stresses and pressure in their lives.

A series of lunchtime workshops by several key community workers encouraged young people to make healthy choices:

1. *Sports Fitness (Physiotherapist)*
2. *Coping with Pressure/Stress (Mental Health Team)*
3. *Maori Health (Iwi Health Worker)*
4. *Dental Awareness (Dental Therapists)*
5. *Body Image (Mental Health Educators)*
6. *Asthma/Keeping Safe (Asthma Educator/Police)*
7. *Healthy W.O.F. (Public Health Nurses)* (Ibid, p. 6).

A short story competition entitled, *The Choices you make now will affect your future health and wellbeing,* enabled students to create their own consciousness about self-responsibility, empowerment and prevention (Rosetto, 1997).

For those adolescents who had left school and were now young parents, the Public Health Nurse and the local Karitane Nurse facilitated the formation of a *Teenage Mother's Support Group. O*ne young mother said

> *Teenage mothers' support is badly needed in Dannevirke as there are now so many teenage mums who need the support and courage of others. A group like ours provides a friendly, caring environment, which enables young mums to meet new people and learn new skills for our children as well as ourselves such as natural home remedies, budgeting, cooking and many more others we are hoping to organise* (Cheer & McKay, p. 9).

One of the successful outcomes from the promotion was the permanent appointment of an Adolescent Health Nurse to the Tararua District. Not only had the health of young people and their community been promoted, but so had the role of Public Health Nurses in adolescent health.

Understanding adolescents:The need for specialist skills

The health reforms brought reorganisation to the health care system in New Zealand. In Community Health Services, some Child & Family units split their Public Health Nurses into teams, dedicating one to Adolescent Health (Williams, 1994). This allowed for the intensification of specialised skills which were not always present among people working with adolescents.

In 1986, the New Zealand Board of Health had reported that health services for young people were either "non-existent or woefully inadequate and often inappropriate" (Rampton, 1991, p. 44). Some of the concerns at that time were as follows:

> *Few Area Health Boards can identify a person, or unit as having responsibility for youth health service development...there is a failure to recognise and respond to the 'special needs' of young people...almost all Area Health Boards have failed to take steps to improve accessibility to services for young people, and their staff receive little or no training in recognising or meeting the needs of their young clients* (Ibid, p. 45).

The following criticism was of particular note:

> *There is dissatisfaction with the quality of treatment received from health professionals, especially Doctors and Public Health Nurses. They were seen as unable to communicate with their younger clients, especially young clients from ethnic minorities...as judgemental, or patronising, to their young clients, and often failed to provide appropriately, if at all, the information and skill young people need to take control of their health; Public Health Nurses have been viewed as 'mothering' young people...Health professionals need to see their young clients as the dominant participant in achieving good health* (Ibid, p. 45-46).

The failure to recognise the needs of young people was still a major theme five years later when Rampton conducted interviews with a range of informants from local City Councils (Youth Development Officers), Family Planning, Maori Women's Welfare League, Iwi, Area Health Boards, Ministry of Women's

Affairs, Youth Affairs, Transition Teachers, School Counsellors and Nurses. In relation to the needs of young people in schools, Rampton (1991) reported:

> *With Tomorrow's Schools and the changes that have come in, health education is just slipping out of the curriculum...A number commented on the ineffectiveness of past/current health promotion. They pointed to the absence of youth culture and values in these programmes. These programmes relied on centralised mass media 'hit or miss'...or 'mug or jug', that is drilling holes in young peoples heads and pouring the information in, or ...'spray and pray' where you do a massive campaign and pray it has hit somewhere it is needed* (Ibid, p. 47 & 49).

Part of the challenge with health promotion is that:

> *Every health promotion plan and project stems from human values, and there are few objective truths when it comes to health...whenever you make a judgment about what's good for someone else, you enter the world of values* (Seedhouse, 1997, p.13-14).

Seedhouse went on to suggest that:

> *...health promotion must make itself explicit (and) expose itself to wide and informed debate. If you are going to practise health promotion you should commit to a position which can be examined for coherency and contradictions...in a society where openness and accountability are considered to be central social values, the public is entitled to know what is going on* (Ibid, p.14).

A good place to begin is with the adolescents themselves. When Rampton (1991) asked her young informants what they saw as the priorities for youth health, she found

> *...almost all identified the following issues: unemployment, self-esteem, sexualities and sexual health, including HIV/AIDS, cultural identities, confidentiality, communication between young people and health professionals, alcohol and drug abuse,*

> *housing, life skills, appropriate health promotion, depression and suicide, smoking, accidents, diet/eating disorders, cervical cancer* (p. 49-50).

In a study on 15 to 19 year olds, Morris (1985) found it was imperative to focus on what was relevant according to adolescents' beliefs and concerns. Equally important was the need to present programmes that stressed the positive as opposed to the negative, when helping adolescents achieve their ideals. As one young person said:

> *Yeah, I know all the things you shouldn't do. Don't smoke. Don't eat fat. Don't eat salt. Not too much sugar. Coffee's bad for you. Coke's bad too I read somewhere. Not too much starchy stuff, not too many hamburgers. It's all bad for you. It's like at school, you're always wrong. Why doesn't someone say what's good for you* (Morris, 1985, p.11).

Disley (1992) claims that young people are asking for three things. Firstly, straightforward information, free from value judgements, on matters like drugs, alcohol, contraception, stress, peer pressure, sexuality and as well as physical health.

> *They see health as holistic, and that sound physical health leads to good emotional and mental health, and vice versa* (p. 28).

Secondly, young people want easier, cheaper, better access to health care, and they want these services to be holistic, that is comprehensive and capable of catering for individual need.

Finally, young people are concerned that their point of view is often ignored or misunderstood. Hence they want a louder voice in decision making.

Involving young people in adolescent health promotion

Experience both within New Zealand and overseas has indicated that, in order to reach a population for health education purposes, it is necessary to involve the representatives of the target group in both project development and design.

> *Projects have to be creative and appealing for young people even to be involved and the best way to do that is to find out what young people like and have them involved in organisation and delivery* (Rampton, 1991, p. 49).

To this end, adolescents have already played a part in the development of such educational resources as the Department of Health's (1990) *Break Free* and *Together as Friends* resource kits which deal respectively with addictive habits, and relationships and self-esteem. More recent productions have included *Welcome To My Smokefree Room* (Public Health Commission, 1995) and *Sisters* (YWCA & Public Health Commission, 1995). In launching their sexuality education programme entitled *Challenges and Change*, Mackay & Cleland (1994) paid tribute to

> *...the courage and honesty of our young contributors who willingly shared their personal pain and triumphs in order to facilitate the journeys of many other young people who will be touched by these stories* (p. iii).

The process of encouraging young people to make healthy choices through informed decision-making is complex, and requires energy and understanding from both the nurse and the client. De Maio-Esteves (1990) found that among 159 adolescent females, the more effective mediators of daily stress and perceived health status, were introspection and problem-focused coping, as opposed to the more self-defeating, emotion-focused coping. Other studies have shown that adolescents are willing and able to look after their health, providing they feel supported, as they move through a number of discrete transitions, during this important yet sensitive developmental period (Lauer, 1990).

The developmental stage of adolescence

Adolescence has been described as that developmental stage which occurs between childhood and adulthood during which young people strive to develop their own identity, as well as a healthy self-image of competency and strength (Maskill, 1991). It has been divided arbitrarily into the substages of preadolescence (9 - 11 years), early adolescence (12 - 14 years), middle

adolescence (15 - 19 years) and late adolescence (20 - 25 years) (Nolan, Murray, Grohar, Leonard, Smith & Zentner, 1979). It is considered to be:

> *The period of life which begins with puberty and extends for 8 or 10 years, or longer, until the person is physically and psychologically mature, ready to assume adult responsibilities and be self-sufficient because of changes in intellect, attitudes, and interests* (Nolan et al, 1979, p. 206).

There, however, needs to be caution in the way such definitions are applied as

> *...there are individual variations in the rate and extent of maturity and psychological growth. Thus some persons will be adolescents longer than others, while a few individuals may never achieve psychological maturity* (Wold, 1981, p 96).

Derived from the Latin word, adolescere (*to grow towards maturity)*, adolescence has not always been recognised as a developmental stage in preparation for adulthood (Simpson, 1959, p. 18). In many traditional societies

> *...one is either a child or an adult, although the expectations and tasks assigned to young people between 10-19 years of age differ according to age and level of maturity* (Potential For Action, p. 9).

Indeed, it is only in the last one hundred years that Western societies have come to culturally and intellectually identify adolescence as a "critical period in development with a distinct cultural function" (Tolan & Cohler, 1993, p. 1). While the advent of adolescence is heralded by the appearance of puberty, the end of adolescence is less clearly defined. And not only is there individual variation but also there are differences between generations, cultures, subcultures, and societies.

In New Zealand, as in most Western cultures, maturity is associated with the achievement of an appropriate degree of independence from one's family or whanau, sexual identification, a 'suitable' vocation, a secure identity, and a place in society (Hill, 1983). But in the face of long term youth/adult unemployment, such societal expectations are not always achievable. Modern

adolescents can be seen to have concerns that are different from past generations.

> *They are concerned about social and environmental issues such as unemployment, rapid social change, pollution and lack of money within their families and communities.* (Nye & Wilson, 1993, p. 19-20).

These concerns in turn affect their emotional and mental health, and are complicated by the context in which they are occurring, namely the mixed messages within a rapidly changing social, economic and technological world (Maskill, 1991). Given the extensive biological, psychological, and social changes that are already happening within the young person, the potential for turmoil can be great. As one student stated,

> *Contrary to many of the older generations' beliefs, teenagers do have serious problems and pressures. Peer pressure is strong and only a small minority can claim they have not been either influenced or affected by it. Parental advice on this subject, although well meaning, is often unhelpful and outdated."Just say no" or "they're really not your friends" just don't seem to work in a generation where individuality is achieved through cloning and keeping up with the Joneses, or 'Cosmopolitan' is often more important than being yourself* (Brightmore, 1997, p.13).

The interplay between the adolescent and his or her peers versus his or her parents is more subtle and complex than subculture theories have previously assumed (Muuss, 1988). A recent example is the time honoured pressure of doing well at school.

> *Being a scholar used to bring you respect and praise from your peers, now it is used to insult people who actually want to graduate before they turn 20. Some teenagers seem to think that it is cooler to fail than to pass for reasons that I, other teenagers and other generations, cannot understand* (Brightmore, 1997, p.13).

Based on adolescents' perceptions, Brown, Lohr & McClenahan (1986) identified eleven types of peer groups whose values and behaviours were binding on different college group associations. These were built around stereotypical catchwords such as

> *..."brains"', "druggies". "jocks", "loners", "normals", "outcasts", "populars", "toughs", special-interest groups (e.g. "farmers", "band buddies"), and "hybrids" (e.g. "party Jocks", "preppy brains")...*(Brown et al, cited in Muuss, 1988, p. 315-6).

While college students themselves seemed aware of these peer group types, their unique characteristics, and what was required to become a member, professionals and parents did not. Depicting peer pressure as "a repressive, monolithic force", parents and professionals failed to examine the subtle but highly relevant differences in value orientation that adolescents held towards their peer group (Ibid, p. 316). Labels, the pressure to wear the 'right gear', listen to the 'right music' and talk the 'right language' is all part of what Taylor (1994) has described as

> *...belonging to the collective cult. A system of values and beliefs which enables members to interpret and make sense of the world (both natural and supernatural) around them. It was no longer 'what I think' but rather 'what the group thinks'* (p. 3).

Operating within the collective aroha is an important social process for adolescents. It helps the young person to undertake the egocentric yet vital developmental task of asking, 'Who am I?'. Taylor (1994) urged that those working with adolescents needed to understand adolescents, their language, their economic systems, and the processes they used in negotiation with others.

> *In arguing with the teacher or parent it was irrelevant whether they won or lost. The important thing for them was to have the argument. The process was more important than the content* (Ibid, p. 4).

It was also important to understand the adolescents' love of noise. Listening to loud stereo was identified as a time for ritual, reflection and healing. An adult

asking for the sound to go down was seen as both invasion and violation of the adolescent sanctuary. Taylor (1994) saw problems like this could easily happen in health and the health care arena.

> *Adolescence is now one of the fastest growing dynamic areas in health. Often those working in the area are not equipped to deal with those needs. If you're going to deliver good, safe cultural care, you're going to have to understand the cult of the group - how they operate, and why they operate in that way* (Ibid, p. 4).

Many clinical descriptions present a picture of adolescence as a normally tumultuous time of alienation, symptomatology, and rebellion. However, in their survey data, Elmen & Offer (1993) showed a different picture to the negatively skewed vision health workers often held about the self-image of the normal adolescent.

> *The findings suggested that mental health professionals had not caught up in their conceptual perspectives with what behavioural scientists have empirically discovered. The mental health professionals studied believed that normal adolescents have a particularly hard time in dealing with their moods, with interpersonal and family relationships, and with confusion about future vocational and educational goals, whereas the study's data, collected from 407 normal, mentally healthy adolescents, indicated that this was not the way normal adolescents feel about themselves* (Ibid, p. 11).

Elman & Offer concluded that the ebb and flow of adolescent concerns were indicators of the emotional lability that was heightened during adolescence, but that these were not exclusive to only that developmental stage. Turmoil, however, was unusual and merited concern in the form of urgent followup.

Potential for turmoil: Current adolescent health concerns

For several years there has been a growing recognition of the need to develop specific adolescent health services. A worldwide body of documented evidence shows that young people experience a variety of serious health concerns largely related to risk-taking. While experimentation is a normal part of growing

up, it can lead to health-compromising behaviour such as substance abuse and unsafe sexual practices. And this can set the scene for their health status in adulthood and for future generations (Maskill, 1991).

This is reflected in the literature on the health profile of New Zealand adolescents (Maskill, 1991), their sexual practices (Brander, 1991) and their mental health (Taylor, 1988). More recently there has been public concern expressed by New Zealanders about the health and well being of their young people (Calder, 1997; Calder & Horwood, 1997; Corbett, 1997). And these concerns have been echoed by the young people themselves, particularly with reference to New Zealand's high rate in youth suicide compared to the rest of the world (Ministry of Youth Affairs, 1994).

Similar trends have been seen in other developed countries including New Zealand's nearest neighbours. Recently, the Medical Journal of Australia reported that their nation's 15 to 24 year olds are suffering more psychological disorders, have less trust, are more cynical and more pessimistic than their baby boomer parents and Second World War-vintage grandparents (Eckersley, 1997). The term Aces, coined from earlier world surveys of other adolescents, was used to encapsulate this mood. Standing for alienated, cynical, experimental and savvy, Aces is largely reflective of adolescent dismay towards

> *...baby boomer parents who have failed to grow up and who have been betrayed by their own rules and values; pessimism, even fear, about their own future; cynicism at a society they believe is unlikely to fulfil their ambitions or possibly even their needs* (Ansley,1997, p. 11).

This same uncertainty is captured in the writings of one young New Zealander.

> *Girls...guys...music...alcohol...drugs...money...cars - the youth of today have all the traditional teenage worries, with a few more added on. Our future, for one. For young people in the 1990s the future seems more uncertain with each passing year. The world is moving so fast who can say where we will be in five years' time? Schooling through primary and secondary is not a problem. It is tertiary education that worries teenagers today. The main cause of anxiety is money. If young people want to further their*

> *education in these times they must first pay for it. We see older siblings struggling with the pressure of a huge student loan that they may have for years to come...the other cause for concern is employment...it is still perfectly possible for young people to emerge from university with a degree only to discover that there is no job for them* (Lester, 1997, p. 13).

Parenting

Adolescence can also be a challenging and confusing time for parents as they reflect not only on their own performance but also that of their generation.

> *We have to wonder whether baby boomers are the worst parents that time has known. It is not just that this generation has left children fatherless in greater numbers than any war did, though that is the worst of it. We do not seem to understand adolescence. That is understandable, perhaps, since we have never outgrown it. We still think we were the first generation to discover sex, drugs and teenage rebellion...*(Rougham, 1997, p.15).

There could be no greater indictment on society than Warwick Pudney's (1994) diatribe on *Absent Fathers Angry Sons*:

> *...because society has accepted absent fathers as normal and failed to recognise what the presence of fathers can do, the planetary ecology suffers from the lack of male inner life...the affirmation by the same gender parent is critical for a solid male identity to develop...our sons want the pain of 'no meaning' to stop. Alcoholism for our sons and unfathered men is four times that of women* (p.6).

Certain social indicators reflect changing family structures and their impact is felt by all adolescents growing up in New Zealand, and in neighbouring Australia.

> *Our children are inheriting a different world. There is no single, or even simple definition of a 'normal' Australian family any more, and the units that now cross the new family spectrum are subject*

> *to strains and breakdowns at levels unknown to preceding generations. While most children still live with adult couples, there are more step-parents, and de facto, sole-parent and homosexual households. In more than 40 per cent of households, both parents work, and almost half the nation's children under 12 are in some form of child care. The divorce rate is rising - 40 per cent of marriages fail over a 30 year period - the number of children born out of marriage has risen from fewer than one in 10 in the 1960s to a quarter of births, and parents are spending less time with their children - an average six minutes' play a day, compared with an hour and a half of television. Reported cases of child abuse and neglect have been rising at an average rate of about 15 per cent a year for the past decade, and more children are born into struggling families...Australia's child poverty rate is second only to the United States in the developed world* (Ansley, 1997, p.11).

Where once there was a time when young New Zealanders could leave their family and cross the Tasman in search for better prospects, it would seem there is now little to be gained by doing this, as indicated by the following Australian comment:

> *More students are now staying on to complete high school than ever before. Higher and technical education have increased, but employment prospects are bleak. One quarter of all job seekers are aged 15 to 19; the unemployment rate for teenagers ranges from 20 to 30 per cent (*Ibid).

Smoking, sex, drugs and alcohol

On a number of other issues, similar patterns have emerged between young New Zealanders and their trans-Tasman peers. Teenage smoking is on the rise. A recent survey carried out by the New Zealand Cancer Society on 1500 Wellington fourth formers shows the smoking rate in boys has almost doubled from 7 to 13 per cent while in girls it has risen from 12.5 to 14.3 per cent. The latter smoke about six cigarettes a day, while the average for boys is eight. These findings are all the more significant given that the 1996 census shows overall numbers of smokers aged over 15 has dropped from 721,116 in 1981 to 609,297 in 1996 (Alexander, 1997, p.5).

More adolescents than 20 years ago are reportedly having sexual intercourse before they turn 18. One New Zealand study showed that 67.9 per cent of girls and 57.6 per cent of boys as having sex before that age (Silva, 1990). With girls, behaviour patterns were linked closely to sexual maturity. Those who menstruated early before the age of 12, were much more likely to get into fights, steal, and use alcohol and illicit drugs. It was found that single-sex schools helped to protect early maturers from delinquency while girls who did not menstruate until 15 tended to bypass delinquency altogether (Ibid).

In Australia pre- and early teen participation in sexual activity is increasing with the mean age loss of virginity standing at about 16, and most teenagers engaging in sex by 19. However, participation in sport, and even moderate physical activity, falls significantly after primary school, while TV, video and computer time has soared to levels that are even higher than the United States. Over the last 20 years, there has also been a steady rise in the rate of juvenile offending.

> *Teenagers who leave home early are leaving younger with disturbing numbers turning to drugs, prostitution and crime. By the time they are 20, more than half will have used cannabis, one in five amphetamines, and 3 to 6 percent heroin or cocaine* (Ansley, 1977, p. 11).

Adolescents are exposed to a hierarchy of drugs with intravenous drugs at the top and solvents at the bottom. Despite preconceptions, young people who fall into substance abuse cross all barriers of gender, class and race. Middleton (1997), manager of New Zealand's Odyssey House which offers rehabilitation services for under 18 year old drug and alcohol abusers, suggests:

> *...these are just normal and good kids. But their drug use is a symptom of something else that is going on. Abusers are often the "quiet sensitive kid" that picks up all the problems in the family* (Middleton, cited in Barber, 1997, p.14).

While schools and the Government are clear in the message that drugs will not be tolerated, the School Trustees' Association feel that adolescents should be offered help to kick the habit rather than *kicking them out of school* (Kelly, 1997,

p.3). Fisher (1997) quotes one Principal as saying that drugs are now commonplace in schools.

> *I don't think the average Mum and Dad out there comprehends how common marijuana is in society. In the eastern Bay of Plenty you can swap a reefer for a meat pie - if you have to pay at all. One of the real problems in a place like this is marijuana is the cottage industry keeping areas afloat* (p.2).

Nurturing the nation's children

Popular belief holds adolescents to be a relatively healthy population but the world's most powerful country has found that this may not be the case.

> *Although adolescence is usually considered a healthy time of life, it is the only age group in the United States not to have experienced an improved health status during the past 30 years* (Blum, 1987, cited in Carpenter & Givens, 1993, p. 218).

Ongoing improvement in the health status of children in the industrialised world can no longer be taken as a given. There are now children in economically advanced nations whose quality of life is poorer than that of children in the developing world (Hewlett, 1993). In her salutary address on behalf of American children and their families, Edelman (1994) acknowledged that

> *...at bottom, the fault lies in the kind of values and the kind of progress we have been pursuing. We have oversold ourselves on one dominant aspect of our culture - its material success. We have communicated to our young people that to be admired and respected they must have particular and ever-changing possessions and lifestyles. Yet at the same time as parading these material definitions of success, we have denied to too many the legitimate means of achieving them - the education, the skills, the jobs and the opportunities. As a result, many young people feel that they have no economic and social place in our society, that they have little to respect in themselves or to be respected for by others. And from this point of alienation and frustration, the path to drugs, alcohol abuse, crime, violence and prison is ever*

> *open. What we are now seeing is the result of years of neglect and lack of investment in our children* (cited in UNICEF, 1994, p.41).

New Zealand has been at these same crossroads for some time. Seven years ago, in her book entitled *Children: Endangered Species?,* Max (1990) shocked New Zealanders with her revelations about the "poor, nasty, brutish and short lives" of too many New Zealand children (p. 263). Four years later, at the Mental Health Child Protection Conference entitled, *Promoting Healthy Children and Young People,* things were still no different.

> *We have all been shocked by the tragedies of Delcelia Witika, Jordan Ashby, Craig Manukau and so many other children. These children suffered intensely and they died, but most abused children survive, damaged physically, emotionally and morally. These children generate considerable cost. There is a proven much higher likelihood in a person abused or neglected as a child, of school failure, of mental illness, unemployment and violent crime. Again all are major cost generators* (Max, 1994, p.7-8).

Even though very little appears to have changed, Max (1997) is starting to see hope.

> *...the deadly epidemic of non-nurturing still rages. It still destroys children's bodies through sins of omission and commission - health neglect, avoidable injuries, abuse and murder. It stunts children's minds through lack of appropriate stimulation and interaction. And it destroys children's souls through neglect of, or violence to, their emotional needs* (p.17).

Conservatively estimating 10 to 15 per cent of the child population to be at risk, Max (1997) has based her evidence on

> *The health statistics that put us near the bottom of the OECD countries; the developed world's worst youth suicide rates; educational failure; disturbing levels of youth offending; and of*

> *young, unsupported child-bearing* - ***the cycle of disadvantage*** (p.17).

Described as the "lost generation", these young people need to be balanced against the 85 per cent who are

> *...well-fed, well-clothed, well-educated, as well-balanced as they can be in such a fast-changing milieu - but we rarely hear about them* (George, 1997, p.2).

Exceptions are the two major New Zealand longitudinal studies conducted in Dunedin and Christchurch. The Dunedin 21 year Multidisciplinary Health and Development Study has found that out of an original cohort of 1661 children, most were adept at dealing with adversity, and that separation was not always the end of their world. As the study's founder, Dr Phil Silva, explained to a journalist:

> *Broken homes can play a part. It does come up as a factor affecting mental health outcomes...but we've found kids are incredibly resilient. Unfortunately, we can't predict which ones are and which ones aren't...We will be able to, probably within another two decades* (Reid, 1990, p 13-14).

Adversity, depression and suicide

Silva (1990) and his Dunedin team found that the damage comes when adversity adds up - when low incomes, parental conflict, depression and a lack of security combine over time. These factors then lead to behaviour problems, boys being more vulnerable in their early years while girls are less resilient nearer puberty. A most reassuring result was that quality child-rearing overcomes adversity. Wealth means little when even the most poverty-stricken household can raise children with no disadvantages as long as the basics are looked after, namely, that early experience is rich, care is consistent and children are loved. Different cultures have known and shown this for centuries, not least the Jewish community whose people have answered adversity for over 40,000 years with the gift of literacy backed by education, religion, tradition and the family. Reflecting on the increasing secular society, the senior Rabbi of Auckland's Hebrew community said to a journalist:

> *We answer problems by giving material things to our children, rather than by helping them develop an inner sense of meaning and value. We live in such a value-free environment - don't impose any absolutes...But if you don't give values and structure, people flounder and that explains the hopelessness and helplessness around...if you stand for nothing, you fall for anything* (du Chateau, p. 1).

The Dunedin Study has confirmed it is very difficult to shake off the effects of a poor start. It found that antisocial three-year-olds are more likely to become antisocial teenagers. Overall, one-third of 15 year olds in the study engaged in delinquent acts like shoplifting or vandalism and by 18, 90 per cent of the boys reported some degree of delinquent behaviour. But only 5 per cent of all adolescents actually became hardened in their delinquency. The rest appeared to be simply acting out a rite of passage.

This finding provided relief for parents by suggesting that most teenage rebellion was normal. However, the study urged parents to become concerned about teenage depression, particularly as New Zealand and Australia share one of the highest teenage suicide rates in the developed world. Those who do badly in the development race all their lives are among the most depressed (Reid, 1990). Preventive work in adolescence is therefore well worth the effort.

In the Dunedin study, more than one third of the teenagers (aged between 15 and 19) were found to be suffering from some sort of mental disorder. Two thirds of those disturbed at 15 remained so at 18. These tended to be the adolescents with more serious disorders, the most prevalent of which was depression. In addition, it was found that the daily lives of 36% of all 18 year olds were impaired by mental disorders, including alcohol and drug addiction. Principal investigator, Dr Rob McGee described this to a journalist as

> *...pretty worrying because there's been a tendency to think of it as adolescent moping but teenagers do suffer quite debilitating depression* (quoted in Reid, 1990, p.15).

Depression was found to largely stem from poor quality relationships with peers and parents. Conversely, well adjusted 15 year olds were described as having

a close attachment to their parents. The importance of parents taking time to listen to their children's point of view and problems was therefore heavily emphasised by Silva in the same article.

> *It's salutary to know that teenagers don't really want to reject their parents. In fact, it's the last thing they want. They prefer to be close to them, even though they might not admit it* (Ibid).

The main causes of death for young people in New Zealand are from both non-intentional and intentional injury, with fatal motor vehicle crashes and suicide cited as the leading causes (Ministry of Youth Affairs, 1994). In the last decade there has been heightened interest in the prevalence, predictors and correlates of adolescent suicide and suicide attempts (Drummond, 1996). The past 40 years have seen a fourfold increase in the rate of adolescent suicide in most Western countries.

Using annually collected data from the 18 year longitudinal Christchurch Health and Development Study of 954 children born mid 1977, Fergusson & Lynskey (1994) studied the prevalence of, and the relationships between, adolescent problems of adjustment, psychopathology, childhood circumstances and the risks of adolescent suicide attempts. They found 3 per cent of the cohort (4.2 per cent of females and 1.9 per cent of males) had made a suicide attempt by the time they were 16. All 29 young people shared a common pathway beginning life with

> *...(a) early disadvantageous childhood and family circumstances which lead to (b) increased risks of adolescent psychopathology and problems of adjustment which lead to (c) increased risks and vulnerability to adolescent suicidal behaviours* (Fergusson & Lynskey, 1994, p.2).

While much has been made about teenage suicide, Emeritus Professor of Psychiatry, Dr John Werry (1997) points out that, in 15-19 year olds, it accounts for only 15 per cent of deaths whereas accidents account for 80 per cent. Motor vehicle accidents cause both death and enormous non-fatal disability. Most suicide occurs from age 18 on and among those who have left school. It was important to put these needs into context.

> *We know the causes of accidents, we do not know the causes of suicide (beyond alcohol and major psychiatric illness in some cases), nor do we know how to predict or prevent it. In this context the national obsession with teenage suicide is an obscenity...mental health problems are the problem of adolescence and behind all of them, the pervasive cancer of alcohol* (Werry, 1997, p.19).

Dealing effectively with these problems demands a range of services, most of which should be lay - community, religious or culturally based.

> *But we also need a coordinated, tiered set of professional services culminating in specialist adolescent mental health services* (Ibid).

Many such services exist but are poorly resourced and coordinated. Allocation of resources often favours adults.

> *For central Auckland, adult community mental health services have 12 psychiatrists, child and adolescent services have 0.8; adult services have a budget of about $30 million, child and adolescent, about $1 million* (Ibid).

Advocacy

Advocacy involves championing a cause and applying pressure on those in power, as illustrated by the words of the Executive Director of the Pacific Foundation for Health, Education and Parent Support:

> *I think we should ensure that politicians are 100 per cent aware that we cannot call ourselves a civilised society while children are being burned, raped, beaten and starved and that we demand two things - services that provide for the critical needs of children now; and services that will prevent misery and failure in the mid-term* (Max, 1997, p.1).

Equating human rights exclusively with adult rights is changing, albeit slowly. Glimmers of hope emerged in 1996 when a group of professionals formed

themselves into the Child Protection Trust and launched New Zealand's first ever Children's Agenda. This is a charter designed to ensure children's needs and interests are protected in all areas of public policy making (Corbett, 1997). Those advocating the change include a former Commissioner of Children. Their objective is to prevent thousands more young people growing up alienated, violent and suicidal. The strategy is simple - to ensure that state and government attach the same importance to children's needs as they do to the economy. In their seven-point manifesto the Children's Agenda called for

> *...a stand-alone policy for children including a requirement that cabinet papers and legislative proposals include a statement on how they will impact on children; a children's advocate appointed to all local and central Government planning agencies; a review of existing legislation to assess whether our laws are compatible with children's best interests; an independent review system on child deaths; a coordinated system to deliver health and education services to children; a commitment to collecting data on children and researching the effect of public policy on them* (Masters, 1997, p.11).

Treaty of Waitangi

Compared to other countries like Norway with its ministry for children or Germany with its parliamentary commission on children's affairs, New Zealand still has some way to go towards integrating the child's perspective into the political process. In this country there are many calls for the Treaty of Waitangi to be honoured. Tahana Waipouri-Voykovic (1997), an experienced teacher, states:

> *The breakdown of the fabric of Maori society has had a major impact on our people. Those who have suffered most have been our taonga (children)...History shows that a number of factors contributed to the destabilising of a once balanced Maori social structure. The Treaty of Waitangi not being honoured, the confiscation of land, the banning of speaking our language, the loss of almost entire generations in some tribes through illegal imported cargoes of diseases.The need to move into cities for employment and housing and the enlistment of many of our*

> *people into the two world wars further weakening the iwi, hapu and whanau base* (p.15).

The drift from rural areas to the cities has been a physical, spiritual and emotional marathon for many Maori families. They needed work, and the cities provided it but government housing policies gave primacy to the small nuclear family and did not provide an opportunity to maintain family stability as did the more traditional country lifestyle. Recalling her own dislocated childhood, Waipouri-Voykovic (1997) said:

> *On reflection our large family of 18 children came through those turbulent times with deep scars. Our impoverished childhood with its lack of an adequate diet, warmth and poor provision for educational needs was not the stuff that provided "the tools" to make it in the big city...what a picture we must have presented to the schools we attended. Many of my peers including myself struggled to operate within a system that was foreign to us not only in language but also in its physical structure. Coping with the constant put downs we experienced from many of our teachers...*(p. 15).

In some areas, second generation city based parents see their own children faring no better than they did. Many schools are stepping in to provide basic nurturing and parent care before they can even get on with their first responsibility of teaching. While there is frustration, anger and disillusion on all sides, Waipouri-Voykovic emphasises the need for balance.

> *It seems that adults do what they do because that is all they know, and many children play out those models. We cannot repair the past but we can make the future better. The poverty of our present situation is brought about by society failing to honour the basic human rights of our taonga as stated in the United Nations Charter on the rights of the child, to which New Zealand is a signatory* (Ibid).

The United Nations convention has placed the responsibility on each signatory to render appropriate assistance to parents and legal guardians of the child, and to ensure standards of living are adequate for the child's physical, mental,

moral, spiritual and social development. It therefore behoves not just schools but every member of society to ensure there is no abdication of this responsibility. The rights of children, for instance, are more important than the feelings and beliefs of the parents.

> *Too often culture is used as an excuse for behaviour. The rights of children must override any cultural ways, practices and habits. Building a better future requires commitment and investment. Paying lip service to children's needs must no longer be accepted* (Ibid).

Has child welfare been abandoned?

Statistics on the health status of New Zealand children are now low by world standards. Carol Stott (1997), Manager of Auckland Healthcare's Child and Family Services, believes this

> *...is an indication of a society which either cannot afford to provide for these needs or which just does not care enough to do so* (p.19).

During the International Year of the Family, Fulcher (1994) asked the critical question, *Has child welfare been abandoned?* (p.3). Taking the affirmative, he replied:

> *...it is timely for reflection on a decade of economic deregulation and state sector reform...for the past twenty years or more, social policy in all Western economies has been dominated by a handful of practice ideologies, including normalisation, de-institutionalisation, mainstreaming, minimal intervention, diversion and use of the least restrictive environment...combined with an economic ideology of free market trade, these practice ideologies have had an even greater impact on the health, education and welfare services of all Western countries* (p.1-3).

New Zealand is therefore at the crossroads, trying to find effective ways to address the complex needs of its young people. Its performance will be monitored by the rest of the world and measured against its record for human

rights, as well as its image for being "a great little country in which to grow up" (Corkery, 1997, p.18). The outcome for future generations will be important, as outlined by the following United Nations forecast.

> *The day will come when the progress of nations will be judged not by their military or economic strength, nor by the splendour of their capital cities and public buildings, but by the well-being of their peoples: by their levels of health, nutrition and education...by their ability to participate in the decisions that affect their lives...by the provision that is made for those who are vulnerable and disadvantaged; and by the protection that is afforded to the growing minds and bodies of their children* (Unicef, 1994, p. i).

Public Health Nurse in a college

On a visit to America as president of the NZ School Principals' Association, Pat Lynch reportedly found adolescent health centres in schools not only improved the health and mental attitude of students, but they also proved to be "the basis of higher academic achievement" (quoted in Carroll, 1993, p.7). He claimed that,

> *Schools are the ideal vehicle for delivering adolescent health care* (Ibid).

Given that there are over 2,800 schools in New Zealand educating approximately 666,560 students and employing 40,000 teachers, schools are uniquely placed as

> *..."settings" or locations for improving and protecting the public health* (Public Health Commission, 1995, p. 6).

Schools are also important occupational and environmental settings. What they do can have a significant impact on the health and wellbeing of students, staff, non-teaching staff as well as parents, caregivers and family/whanau. Population and personal health care services can be provided by the Public Health Nurse:

** providing support for the teachers who are delivering programmes based on the health education syllabus (this includes assisting with the provision of health education resources)*

** influencing school boards of trustees to develop health promoting policies*

** providing well child care, for example immunisation and hearing and vision screening*

** providing health and disability support services for children and young people with disabilities either in special schools or who are mainstreamed*

** providing personal health care, for example, clinical services and health care checks*

** providing and monitoring of environmental health protection services*

** providing information on health promotion programmes, for example, melanoma prevention and smokefree*

(Public Health Commission, 1995, p.6).

This is not new. Since the turn of the century, school nurses have played a key role in keeping children healthy in order that they may "realize their learning potential" (Edwards, 1987, p.157). The incorporation of school nursing into the general community health programme with a single nurse serving the school and the community at large, was seen as having certain advantages (Freeman, 1970). These included unifying in-school and out-of-school care, economies in nursing time, and allocating nursing time in the school in accordance with community-wide nursing priority. Disadvantages occurred when demands outstripped the resources of the nurse as the full extent of community need became known.

Each school is a microcosm of the community it serves (Waugh, 1986). Hence school-based nursing services are shaped according to the needs emerging from the whole community. As each community is unique, so are its school-

based clinical services in terms of the staff makeup, range of services and funding. Whatever their differences, all communities share the common belief that healthy students make better students (Moll, 1991). Or, as Nutbeam (1996) has stated,

> *You can't educate young people if they're unhealthy and you can't keep young people healthy if they're uneducated* (cited in Gwyn, 1996, conference notes).

The interface of health and education

Health and education are basic human rights for everyone, especially children. *"Health for All"* and *"Education for All"* are expressions which reflect the United Nations' commitment to health and education. Because these goals are closely linked, they must be achieved concurrently (Jones, Kickbusch, & O'Byrne, 1995). This requires strong alliances between health and education agencies such as those exemplified in the global school initiative, *Health Promoting Schools* (Gwyn, 1997) which emerged out of the earlier programme, *Healthy Schools* whose objective is still relevant and remains operative, namely

> *...to improve and protect the public health by developing strategies to maximise the positive effects of* ***schools*** *on health* (Public Health Commission, 1995, p. 6).

Strengthening the school as a setting for the development of adolescents recognises and values the resources within the school setting. Trickett & Schmid (1993) identified teachers as powerful resources for the development of "energy, ideas, structures and occasions" in the development and continuity of interventions (p.181). "Other school personnel" were also recognised for the "valuable role" they play in the formal and informal support of different school members:

> *In addition to resources that evolve from formal roles, there are resources inherent in individuals who, because of personal style, serve latent organizational roles in dealing with the varied problems of adolescents. For example, it is not uncommon for adolescents defined as deviant by the dominant school culture to*

> *find subtle though real support from adults who are also not in the mainstream of school life* (Trickett & Schmid, 1993, p. 182).

As part of the formal and informal resource network operating within schools, Public Health Nurses help to create an environment for the many indigenous and empowering interventions happening within their colleges eg. health programmes and helping students on a one-to-one basis. There are very few studies focusing on this area in public health nursing, and this is regrettable given the valuable insights to be gained by studying the nurse's work in depth. In particular, the Public Health Nurse's ability to work collaboratively with members of the school and the wider community is critical, as one nurse acknowledged in her report to a Board of Trustees:

> *My involvement with Dannevirke High School as a visiting Public Health Nurse began in February 1988. The past year has been one of building a good working relationship with staff so that the health needs of all students can be reached and satisfied...I feel 1988 has laid the foundations for a future successful relationship with the school, which will in turn benefit the health and welfare of students* (Cheer, 1989, p. 41).

In a climate where children are exposed to the health-threatening trends of a mixed message environment, While & Barriball (1993) view

> *...the point of contact with an informative but neutral source in the school setting as increasingly important* (p. 1206).

The sensitive nature of factors influencing the health status of school children would indicate there are potential benefits to be drawn from regular counselling or contact with the nurse, either on a one-to-one basis or in the classroom. The issue of access to health care is important as barriers will only reduce access to additional care such as quality health promotion. Inaccessibility also interferes with educational attainment and associated wellbeing. The following barriers can be, and have been, encountered in the implementation of school health clinics.

> *Inappropriate room at school ie. out of bounds area; 'sick bay' provided for 'Health Clinic'; inadequate privacy; lack of*

> *support/liaison staff; school forgetting to advertise times and dates; Health given low priority in school; poor appointment system; clinics too infrequent; staff uninformed as to Health Clinic system; Public Health Nurse denied access to classroom therefore has decreased profile amongst students* (Gage, 1994, p.1).

Conversely, Gage (1994) found the best response came when the Public Health Nurse had prior access to the classrooms. Teaching about health gave the nurse the chance to establish trust with the flow-on effect of students then coming to see the nurse in the clinic.

Taking a holistic health approach

Seedhouse (1986) believes health work essentially involves encouraging people's normative and positive potentials, which has the effect of opening up possibilities for individuals to achieve further growth and development. When health workers focused on only the negative such as the misdemeanors of risk-taking youth, the effect was to reduce the potential for growth and development, thereby throwing doubt on the ability of individuals to seek their own solutions for self empowerment. For the nurse, this meant having...

> *...to stand back and..relinquish the traditional power base of the medical model and to develop one's own personal effectiveness* (Clarke, 1991, p. 1181).

Nye and Wilson (1993) write of one college in Porirua where this had to happen.

> *...the health issues facing Porirua College are more diverse than they were previously. The college needs to recognise that the medical model is no longer appropriate and that a holistic, multi-faceted approach to health is required* (p.33).

A holistic, all encompassing model of health inevitably places more responsibility on informed communities, groups and individuals. Although student health needs often present as personal health issues, in reality these

emanate from broader socio-environmental issues such as those already discussed in this literature review.

Like many colleges in New Zealand, Porirua is acknowledging the challenges and facing the future with confidence. Its strengths lie in its school culture which emphasises positivity and embraces cultural diversity with

> *...commitment and pride within the college and a potential to develop an approach to health that is unique and specific to their community* (p. 5).

Using a healthy schools approach, most post-primary schools are currently endeavouring to integrate health education, policy, counselling and clinical services for the benefit of their school and the wider community. One of the contributors is the Public Health Nurse whose scope and domain of practice is the subject of this thesis. As there appear to be very few studies focusing on work carried out in this area, this study is both timely and relevant not only to nursing, but also to the broad area of adolescent health.

Summary

This chapter has explored the role of the New Zealand Public Health Nurse in relation to adolescent health. The goal of public health nursing is to improve the health of the community in which the nurse works. The literature shows that, for nearly ninety years, this has been achieved by the delivery of primary health care and primary prevention to different client groups such as Maori, European, Pacific Islander, immigrant and refugees; by working with individuals and families as well as in multidisciplinary teams and programmes on the identified needs of any emergent subgroup eg. adolescents; and by taking a holistic approach in empowering people to take responsibility for their own health eg. adolescents in a college. There has been much written nationally and globally about the current concerns about adolescent health ie. suicide and depression. But there has been little written on the specific preventative practice of a Public Health Nurse working with young people in a college. Given that schools are ideally placed to promote the health as well as learning of their young people, any research into this topic will only be of benefit to those working in the areas of adolescents, education and nursing.

The next chapter presents the research methodology and design. The single case study is described along with the reasons for its use. Issues to do with ethical concerns are also discussed.

Chapter 2

THE RESEARCH PROCESS

Introduction

As indicated in the literature review, there has been very little research into the work that Public Health Nurses have done for nearly ninety years. This first became evident when I began researching one specific area, namely that of Public Health Nurses working in primary schools (O'Sullivan, 1993). It was the findings from that study that led to the interest in the current topic which focuses on the work of a Public Health Nurse in a secondary school.

It was this earlier experience of research that influenced my choice of method to explore the work of a Public Health Nurse in a college. In the 1993 study, I had surveyed 16 Public Health Nurses working in 60 primary schools. This yielded a vast amount of quantitative data that demonstrated the breadth but not the depth of public health nursing. That is, it did not show the complexity of care that Public Health Nurses gave to children and their families when multifaceted health needs emerged within the school environment.

Hence, I needed a method that would allow me to explore the depth of public health nursing in the context of a nurse visiting a school. After consultation, and consideration of alternative methods, I decided that the most appropriate method would be that of the single case study. This would allow me to gather the qualitative data I needed to explore individual human responses to actual or potential health problems in one setting. The single case study method would also allow me to gain an indepth understanding of the complex processes involved in the Public Health Nurse's delivery of primary health care and primary prevention to students within the naturalistic environment of their college.

This chapter describes how I used the case study method to gather and analyse data from one key and three other participants, namely, the Public Health Nurse, the Deputy Principal, the Guidance Counsellor and the teacher.

This is preceded by the aim and objectives for the study, followed by an overview of the general case study method. The chapter concludes with a discussion on ethical issues.

Aims and objectives

The aim of the study was to describe the work of one Public Health Nurse with adolescents in a college. This involved two objectives. The first was to identify the issues on which the Public Health Nurse was consulted within the college setting; the second was to describe the nursing approach taken in order to meet the adolescent health needs identified within the college setting.

Case study method

The case study method has been used widely by many different disciplines and practising professions including education, sociology, anthropology, medicine, law and social work. Its purpose as a research design is to describe in-depth the characteristics or attributes of a single unit such as an individual, group, community, culture, situation, problem, or process (Burns & Grove, 1987).

In this thesis, the Public Health Nurse in a college was defined as the primary unit of analysis which was being studied in depth. In nursing, single cases are a common research design and eminently suitable given the complex nature of the social phenomena that make up the essence of nursing practice (Hutchinson, 1990).

While the case study may be seen as a reaction to the reductionist approach of positivism (Stenhouse, 1988), in practice, many nursing problems involve a complex interaction of variables that cannot easily be assessed using only quantitative strategies. A case study uses a naturalistic paradigm to get close to the everyday world of the people in the study.

Seaman & Verhonick (1982) have identified several advantages of a descriptive case study.

> *The case study is often a source of stimulating insights. At times, the researcher is able to create a Gestalt - a whole - from diverse*

> *bits of information. The exhaustive approach of the case study brings the individual or group to life as human beings rather than study objects* (p. 152).

Yin (1984) believed the single-case design was 'eminently justifiable' under certain conditions ie. where the case represented a critical test of existing theory, where the case was a rare or unique event, or where the case served a revelatory purpose (p. 47). The Public Health Nurse in a college is not a rare or unique event given that every college in New Zealand at some time or another is visited by a Public Health Nurse. But, the case study does serve a revelatory purpose in that there have so far been no studies on this subject to date.

Case studies typically focus on 'how' and 'why'

> *...the subject of the investigation thinks, behaves, or develops in a particular manner, rather than what his or her status, progress, actions or thought are* (Polit & Hungler, 1989, p.155).

Yin (1984) has claimed the case study to be the preferred strategy for when 'how' and 'why' questions are being posed, when the investigator has little control over events, and when the focus is on a contemporary phenomenon within some real-life context (p.13). The 'how' or 'why' question is typical in an explanatory case study whereas asking a 'what' question usually determines an exploratory approach to the case study.

In Public Health Nurse in a college, either approach could be used eg. by asking, "What sort of work is the Public Health Nurse doing with adolescents in a college?" or "How does the Public Health Nurse deliver primary health care to students in a college?". The former assumes very little is known about the work the nurse does. The latter rewords this question by asking how primary health care is actually operationalised within the college setting ie. accessibility, acceptability, etc. From that point of view this study could be described as both exploratory and explanatory.

Yin (1984) further clarified the case study method by defining it as

> *...an empirical inquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries*

> *between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used* (p.23).

Seaman & Verhonick (1982) have identified the case study as a basic type of descriptive exploratory design used to conduct intensive and lengthy investigations such as Leininger's 1978 study of health from a cross-cultural perspective (p.152). When one examines the complexity of a phenomenon developing over time, the case study can begin to take on a longitudinal perspective. Increased understanding of human response phenomena in the case study can lead to reflection on nursing practice related to those phenomena. This, Barnard, Magyary, Booth & Eyres (1987) claim, is one of the goals of nursing science.

The design for a case study is flexible and this allows the researcher to structure it in terms of the time and material available. However, Yin (1984) recommends that the following five components are included in the data analysis: the study's questions; its propositions ('if any'); its unit(s) of analysis; the logic linking the data to the propositions; and the criteria for interpreting the findings (p.29). With regard to the latter two Yin (1984) admits there is no precise way of doing this. Each case study has to determine its own configuration of the criteria and the logic for linking the data to the propositions. This could be seen as a weakness in reliability and in the subjectivity of the researcher.

The case study's greatest disadvantage is its inability to be representative of the larger population. Replication is not possible, nor are its results generalisable. But, as Polit & Hungler (1989) have identified,

> *The information obtained in case studies, however, can be extremely useful in the production of hypotheses to be tested more rigorously in subsequent research* (p.156).

Furthermore, the intensive probing that characterises case studies often leads to insights about previously unsuspected relationships. In this way, existing theories can be strengthened or weakened through case studies of deviant cases. Yin (1984) refers to this strength as 'analytic generalisability', when theories and/or conceptual frameworks generated in case study research, are then used for examining and explaining other situations. With theory, meaning

is made of the numerous experiences, behaviours and events encountered in nursing (Hutchinson, 1990). Case studies can be one method for starting that journey which ultimately leads to a better understanding of practice.

The next section discusses how the data in this study was collected. This will be followed by consideration of data analysis using Yin's (1984) framework as part of the explanation.

The Setting

The study took place in a college, a state co-educational secondary school situated on the edge of a suburban area, with a catchment of approximately 950 rural and urban students. Amongst the student population there was a mixed ethnicity and this included a small number of Maori. There was an increasing number of students who were from overseas. Of these 100 were ESOL (English as a second language) and 45 were fee-paying. The specific area within the college utilised for this study was a discrete counselling unit comprising one classroom and several offices. One of these was used as a clinic by the Public Health Nurse on her weekly visits and was often referred to in the study as the Bean Bag room. The other offices belonged to counsellors and office staff. There was no school nurse on staff.

The Participants

The data was collected from one key participant, the Public Health Nurse, and three others, the Deputy Principal, the Guidance Counsellor and a teacher. They were selected as participants for the study on the following basis:

1. During her participation in the 1993 research on "Public Health Nurses in Primary Schools", the participant-Public Health Nurse made the recommendation that any *future research in public health nursing should be carried out on the work that the Public Health Nurse did in a college.*

2. The participant-Public Health Nurse had, at that stage, a four year history of high level involvement in the college chosen as a setting for this study.

3. The participant-Public Health Nurse expressed her willingness and availability to participate, and the Child and Family Coordinator gave official managerial support for the Public Health Nurse to take part in this study.

4. The School staff i.e. Deputy Principal, Guidance Counsellor and a teacher were included in the study because they had played a major role in working with the Public Health Nurse, promoting the wellbeing of adolescents at their college as well as being members of their pastoral school network. The staff also indicated, by formal letter, their support for and their willingness to participate in the study.

Data collection

Data collection took place during the second term. Four forms of data were collected:

a. *Preliminary reflective monologues on current work and practice.*

The Public Health Nurse recorded, on self-operated audio-tape, two preliminary reflective monologues on her work during the first two weeks of the study. These were transcribed, analysed for meaning and consensually validated with the Public Health Nurse.

b. *Weekly interviews*

Following the initial analysis of the monologue tape transcripts, the Public Health Nurse was interviewed six times, at weekly intervals immediately following her Wednesday afternoon college clinic. The interviews were audio-taped and took approximately thirty minutes or longer. The purpose of the interviews was to gain further insight and understanding into the issues emerging from the clinic, and any other work that had been recently carried out at the college. The data obtained at each interview was firstly transcribed, analysed for meaning, then consensually validated with the Public Health Nurse for further validation. During subsequent interviews, the Public Health Nurse was sometimes asked to comment on the analysis of any previous interview.

IT IS IMPORTANT TO NOTE THAT STUDENTS WERE NOT INTERVIEWED NOR OBSERVED DURING THE PUBLIC HEALTH NURSE'S CLINIC SESSION.

c. *Participant observation.*

Five participant-observation sessions took place in the course of the study period. These were:

* two classroom teaching sessions with a pre-employment group of students

* one 'safe sex' teaching session with a small group of Form Five female students carried out discretely in the 'bean bag' room of the school's counselling unit

* one 'drugs and alcohol' evening session spent with students and parents on the Gain programme

* one evening session with members of the Parent Teacher Association spent presenting the role of the Public Health Nurse as part of a multidisciplinary panel whose resources the school and community could call upon at any time

The researcher was introduced as an observer, studying the work of the Public Health Nurse. The data therefore focused on the Public Health Nurse and not on the individual students. There was no tape recording during any of the participant observation sessions. Data were collected by either unobtrusive notetaking during the session, and/or fieldnotes written soon after. These were analysed then validated with the Public Health Nurse.

d. *Interviews with college staff*

The Deputy Principal, Guidance Counsellor and one Teacher were interviewed separately and on a one-to-one basis. Interviews were open-ended and focused on the staff's perception of the work the Public Health Nurse did in their college. The interviews took approximately thirty minutes and were audiotaped. Information collected during the first interview was transcribed, analysed and

validated with the individual staff members. Each of the three school staff was interviewed a minimum of two times. During the second interview, each staff member was invited to comment on the analysis of their first interview. The data were gathered during the second half of the school term and consensual validation was obtained within this same time frame, one teacher making herself available during the September school holidays.

Data analysis

As stated above, Yin (1984) suggests five steps to be followed in case study data analysis. They are the study questions; its propositions, if any; its unit(s) of analysis; the logic linking the data to the propositions; and the criteria for interpreting the findings (p.29). Data analysis is discussed under these five headings.

The study questions were formulated as both exploratory, "What sort of work is the Public Health Nurse doing with adolescents in a college?", as well as explanatory, "How does the Public Health Nurse deliver primary health care to students in a college?". The former assumes very little is known about the work the nurse does. The latter assumes that primary health care is delivered to the college, and that asking how that is operationalised will reveal further knowledge about the work of the Public Health Nurse.

The study's explanatory proposition was thus formulated as follows, "The Public Health Nurse believes that adolescent health is an area of need and that the Public Health Nurse can contribute to the health of adolescents through working in a college setting". According to Yin (1984), if the case study's topic is exploratory, it should state a purpose instead of a proposition. The purpose of the case study therefore was to explore

(i) the way in which the Public Health Nurse worked within the college

(ii) the issues on which the Public Health Nurse was consulted

(iii) the Public Health Nurse's response to the situations she encountered at the college.

The unit of analysis was one individual Public Health Nurse in one individual college. Other people included in that analysis were the Deputy Principal, Guidance Counsellor and the Teacher with whom the Public Health Nurse worked closely on health matters arising at the college.

The data did indeed verify the proposition that adolescents were a major need in the nurse's area. This finding came from analysis of the four hundred pages of data that were transcribed from the tapes and field notes. These were then edited to two hundred pages and coded for concepts that best described the rich contextual nature of the narratives, in particular, their meaning for the work of public health nursing. The technique of mindmapping was used to further fine-tune and highlight scenarios and associated concepts. An example of this formation would be the concept of affirmation, emerging from the Public Health Nurse's statement:

> *We meet some neat kids...some very damaged kids, but some really neat kids in this line of work*

This statement was embedded in the narrative in which the nurse described the care she gave to a student with anorexia:

> *She lives with an older brother who has been in and out of institutional care over many, many years. Disruptive, difficult - he's back home at the moment. And we talked about the fact that maybe the exercise and the food were the only areas of control she had. The rest were mainly around her brother. And her parents, working - trying to look after her brother. They had not time for this young lady to be naughty! They did not have the energy to cope with that. Hence she was always good and always did what was expected of her.*

Concepts concerning primary health care in a college were identified, described and classified alphabetically with full referencing to their original source and subsequent memos. The latter took the form of a full and reflective critique each time the particular emergent concept was illustrated in the data. Through this process many different concepts were identified. Patterns emerged and these were eventually subsumed under three themes that seemed to reflect the essence of the nursing time and effort focused on meeting adolescent health

needs. It was in this way that the data came to be linked to the proposition. A fuller analysis of this reasoning and outcome is found in Chapter 3.

The multiple concepts generated from the data became subsumed into three overall themes (MAXIMISING, OPTIMISING, EMPOWERING). In essence, these reflected the fact that the nurse had minimal time and opportunity to assist adolescents with their health-related needs, not just for their 'here and now' but also for their future. The dynamic and challenging nature of adolescent health-related needs was apparent in this study as in the literature. The term, 'Aces', standing for "alienated, cynical, experimental and savvy" is reflective of this need, particularly, adolescent

> *...pessimism, even fear, about their own future; cynicism at a society they believe is unlikely to fulfil their ambitions or possibly even their needs* (Eckersely, 1997, p.24).

The proposition that 'Adolescent health is an area of major need' would therefore seem to be supported by patterns emerging not only in this study but also regionally, nationally (NZ Herald, June, 1997) as well as globally (Edelman in UNICEF, 1994). An extension of this proposition could well be that adolescent health is one of the greatest needs in society today. It is unlikely that evidence could be produced to the contrary.

Ethical issues

Ethical Approval was obtained from the Department of Nursing and Midwifery, Massey University and from the Human Ethics Committee, Massey University. Then ethical approval was formally sought from North Health Ethics Committee. However, the committee advised that ethical approval was not necessary if the researcher was interviewing only the nurse and school staff, and not the students. During the participant-observation part of the study students were observed but at no time were they interviewed, and the focus was on the work of the nurse.

Three potential areas of ethical concern were as follows:

Informed consent: Support for the study was given by the Public Health Nurse's employer and the school. Each of the four participants were given the

details of the study both verbally and in writing (see information sheet, Appendix A and B). Their questions were answered to their satisfaction. Each participant signed the consent form (see Appendix C). Informed consent was not seen as a one time event but as a negotiated and ongoing process. As a courtesy, the researcher also informed the respective managements of both the Public Health Nurse and College participants, prior to each visit. An undertaking was given that both participants and management would be informed of the study findings.

Anonymity: Every effort has been taken to remove any identifying characteristics pertaining to any of the participants, other parties including students, or study setting. It was acknowledged that the participants needed to feel free to describe experiences that would include details of individuals and places. They, therefore, needed to be reassured of their anonymity and that their safety, and the safety of any third party or institution, would not be jeopardised as a consequence of their participation in the study. First names only were used during the course of the interviews. When transcribed, only pseudonyms for participants, other persons or institutions were used. The thesis was then screened to ensure that confidentiality pertaining to the informants and the information they gave was maintained. Some factual data has been amended to preserve the anonymity of those involved

Confidentiality: Interview tapes and transcriptions were kept separately and in a locked metal filing cabinet. The fieldnotes of participant-observation were kept in a further separate and locked metal filing cabinet. This prevented access to the data by anyone other than the researcher or supervisor. The researcher transcribed all her own tapes and fieldnotes on her own word processor to which no one else had access. At the beginning of the study, agreement was reached about the shredding of all fieldnotes and the erasing of all tapes, at the completion of the study. Finally, the researcher, in consultation with the participants, agreed to delete any part of the script which might threaten the privacy or anonymity of any third parties.

Summary

This chapter has given an account of the research process for this study. The case study method has been discussed with particular emphasis on the single-case design which was selected for this study. Details concerning data

collection were outlined, including an explanation of how participants were chosen for this study. Yin's (1984) framework was used to guide the process. The chapter concluded with a discussion concerning ethical issues associated with the study.

The next chapter gives a brief overview of the research outcome prior to indepth discussion of the three key themes in chapters 4, 5 and 6.

Chapter 3

THE RESEARCH OUTCOME

Introduction

This chapter will introduce the outcome of the research and give an overview of the themes and subthemes that emerged from data analysis. These will then be described more fully in the chapters that follow.

As indicated in Chapter 2, the proposition that adolescents were a major need in the nurse's area was supported by data analysis. This finding was also supported by the current literature that identifies adolescent health to be one of the top priorities in health today. Hence there is an urgency about adolescence that will not wait.

During the data analysis, the researcher interacted with the data and found recurring issues and concepts. These included the experience of grief, the need for parent support and education, the invisibility of the Public Health Nurse, the investment of nursing time in meeting client need, the building of working relationships, the investment of trust over time, the nurse's connection with the community, and so on. There was an increasing awareness of time as

> *...the continuous passage of existence in which events pass from a state of potentiality in the future, through the present, to a state of finality in the past* (Collins, 1993, p 1213).

Adolescence came to be seen as a short but meaningful period of time in a person's life. The time a young person spends in college will be even shorter. The three key themes which emerged have elements of time and power, as well as opportunities for learning and growth as a result of nursing work with adolescents in the college setting.

The following overview defines each of these themes along with their associated subthemes. A fuller definition is given at the commencement of each theme chapter.

Overview of the themes

Three themes emerged from the data:

MAXIMISING
OPTIMISING
EMPOWERING

Each of these will now be defined.

Maximising

Subthemes:

Working with - the student
- the college staff
- the community health staff

Working without

MAXIMISING became the first of three major themes describing the specific primary health care that the Public Health Nurse delivered to her clients in their college community setting. *Cape diem,* capturing the moment or making the most of every opportunity, emerged as the essence and art of working with young people and their multifarious needs. The term, MAXIMISING, was coined to encapsulate this concept, focusing on the need to make the most of the given moment in order to be effective in dealing with the dynamic health-related issues of adolescents. MAXIMISING has two subthemes: Working with the student, the school staff, colleagues and the community where partnerships play a valuable role in delivering effective health care. Working without explores the issue of the Public Health Nurse being in the community as opposed to being institutionally-based, and the effect this has on the nurse having a more holistic approach to community health care.

Optimising

Subthemes:

Building
Breaking

The Public Health Nurse spent an appreciable amount of time assisting students to think about their future, with particular reference on preventative aspects of their health and wellbeing. OPTIMISING, with its two subthemes entitled, Building and Breaking, describes the specific work that the Public Health Nurse did in order to optimise the young person's situation. Building included "building" on her clients' existing knowledge base, "rebuilding" beneficial relationships with significant others and "building up" stamina to resist peer pressure. Breaking included "breaking down" individual patterns of resistance as well as "making breakthroughs" in various areas of adolescent health need.

Empowering

Subthemes:

Using the critical moment
Sustaining the self

Adolescence is often seen as a time of building for the future, when young people focus on their own abilities, and harness these for their own self-improvement. Health promotion is a vital part of that process, especially because of the imminence of adulthood. For many if not all, this can be a daunting time as one is challenged to assume responsibility for one's own growth and learning. Hence the third and final theme for nurses' work is entitled, EMPOWERING. The Public Health Nurse can be seen supporting her clients as they face this task full on in the subtheme entitled, Using the critical moment. She can also be seen addressing her own needs as both a person and a professional. This is reflected in the final subtheme entitled, Sustaining the self.

The three themes of MAXIMISING, OPTIMISING and EMPOWERING, collectively reflect the key elements of nursing work in a college from a public health nursing perspective. Much of the nurse's time went into encouraging young people so that they have the knowledge and confidence to make wise decisions that will stand them in good stead now and in the future. The nature of the nursing resource invested in the health and wellbeing of youth while visiting a college is described in the three chapters which follow. While each theme is presented in a separate chapter, all three should be regarded as interrelated aspects of nursing practice in a college.

In each chapter, the findings for one theme will be presented beginning with a description of each theme. Excerpts from the nurse's and teachers' stories will then be used to illustrate the meanings of the themes and subthemes. Verbatim quotes are recorded in italics. Some key points are underlined by the researcher for further emphasis. Throughout the script, the term, "nurse" will be used interchangeably with the longer title, "Public Health Nurse". Where reference is made to nurses in general, both male and female gender will apply. Where reference is made to the nurse in this study, the female gender will be used.

Summary

This chapter has outlined the outcome of the research, namely the development of three key themes with their associate subthemes and a brief description of how they came to emerge from the data.

Chapter 4

MAXIMISING

Introduction

This chapter introduces MAXIMISING, the first of three themes which are the outcome of this case study. MAXIMISING will be defined along with its subthemes entitled, Working with and Working without. The results will then be discussed using the nurse's and teacher's stories to illustrate the moments where the Public Health Nurse made a difference for her client.

Maximising defined

MAXIMISING refers to the nurse's ongoing critical work of working with people at an individual level in a work environment where the potential is unlimited but where there are increasing work pressures. Often, in association with work redesign, people are advised to "work smarter, not harder". Increasingly, the nurse finds that she has only moments of time to spend with people in crisis or potential crisis; only moments to work with young people with life changing decisions to make; only moments to work with adolescents as they seek to come to terms with the pressures of everyday life.

Years of working alongside people in such circumstances has given the Public Health Nurse the ability to maximise the care she provides in the minimum amount of available time.

This theme tries to capture the essence and quality of the caring moments in which the nurse counselled and educated clients in the college classroom or clinic situation. Given that the nurse visited other schools and preschools, as well as families and other significant groups in the community, it was imperative that she manage her time effectively. Two subthemes, Working with and Working without, provide the specific dimensions in which this nurse maximises her contribution to adolescent health care.

Working with

This subtheme focuses on the partnerships that the Public Health Nurse develops whilst working with clients and colleagues towards the goals of health restoration, health maintenance and health promotion. This subtheme recognises that cooperative partnership is integral to the outcome of maximising the moment and moving the client to where they want to be. The three main areas of partnership were identified and these were:

Working with the student
Working with the college staff
Working with the community health staff

Working with the student

Examination of 43 nurse/student contacts revealed a wide range of issues that could be grouped as sexuality (10), drugs & alcohol (8), abuse (4), anorexia (3), vision (3), truancy (3), depression (3), menstruation (2), cultural needs (2), behaviour (1), TB contact followup (1), hygiene (1), orthodontics (1), and cardiac problems (1).

Such a wide range of presenting needs requires the Public Health Nurse to be open and flexible, as well as knowledgeable and intuitive in her approach to her clients. Her initial assessment was critical as she sought an understanding of where the student was at in his or her individual circumstances. As the Deputy Principal was able to testify:

> *She understands teenagers so that anything to do with issues affecting their daily lives, particularly as it relates to their performance at school, will be her focus.*

There was a heavy emphasis on psycho-social aspects of wellbeing, particularly as these related to the developmental needs and socio-economic circumstances of the adolescents. Since the school leaving age was raised in 1993 to 16 years of age, the numbers of students staying on at school had

increased dramatically, as verified by the Deputy Principal:

> *Very few leave at 16...retention rates for Form 6 & 7 are way, way up...there are more solo parents, more socio-economic stress and more user-pays deterrents...their financial circumstances being such that they do not rush to a GP.*

Whereas previously the "at risk" student might have left school at 14 and found meaningful support in the workplace, this is no longer possible in the current climate of today's post-industrial society. The nurse visiting the college therefore had to take all these factors into consideration, and adapt her care according to the current context.

The Public Health Nurse was involved with students at both a classroom as well as clinic level. A significant number of referrals were made by the School Guidance Counsellor in consultation with the student. However, most referrals were made by the students themselves. The nurse believed this was because they had either seen the nurse teaching in the classroom, talking at assembly or had heard from a peer that she was 'safe', that is:

> *Somebody who will care, who is not going to put them down, or pull them to bits, where they can say things they're not going to be held accountable for.*

Working in partnership with the student required that the nurse first establish trust. She did this within the nurturative setting of the Bean Bag Room, the place where the nurse held her regular weekly clinics. Creating trust was very important because all too frequently the Public Health Nurse was working with students whose needs were very complex, as her comments here would indicate:

> *We meet some very damaged kids, but some really neat kids in this line of work. I don't think kids would drink and drive and have sex if everything else in their lives was rosy.*

Over the last year the nurse had noticed that student self-referrals from the third and fourth form had increased quite markedly. She attributed this to a talk she had given at assembly about viral meningitis, and the associated dangers of

spitting, and failing to wash hands after using the toilet. At the time there had been two students from one class who had developed symptoms and the school was anxious to prevent any further cases. As it happened, they did not. But as a result of the Public Health Nurse being introduced at assembly, the more junior students began consulting her, usually in pairs. Such scenarios illustrate the importance of being visible, of being seen to be safe, and being able to answer questions. As the Public Health Nurse explained:

> *You don't have to be the best nurse in the world, you don't have to know everything. You just have to be prepared to find out. If you're trusted, then they'll come back.*

In this study several students did come back for the ongoing monitoring of their health. Of one anorexic young woman, the nurse said:

> *She comes to see me regularly. She tells me she is doing extremely well. She looks tired but her skin is glowing and she looks much healthier than when I first saw her.*

In her ongoing assessment, the nurse intuited the need to sensitively confront this young woman with her doubts. Months of poor nutritional habits do not just suddenly disappear. So,

> *I reminded her that if things were not as she was saying, she was then only fooling herself.*

There was evidence of a number of instances of young people responding to the nurse's message about self-responsibility. In one situation, the nurse believed she needed to go further and challenge the entrenched behaviours of another anorexic who did not want to work on her problems. Instead she preferred to hide in the Bean Bag Room.

> *I was brutally honest...brutally frank. I told her that the only person who could get herself out of this was her. No! I don't want you staying unless you actually start to eat and drink! Otherwise I'm just condoning your behaviour.*

In challenging situations like this, reflective thinking often assisted both nurse and student to work on the solution as opposed to focusing only on the problem. Establishing the boundaries was often the first step in an effective relationship. This was clearly illustrated in another scenario when the nurse went to meet the new Pre-Employment class. She found it was not only the largest but also the most demanding Pre-Employment class she had ever had to work with. As she explained:

> *These are not your bright, academic, well-adjusted kids - these are the kids who are failing the system and in need of special help - a whole term of help - to get them to a stage where they can go for a job interview. I was telling them about the Health Day we would be having, and it was interesting that one young man continued to talk. So without raising my voice I said, I ACTUALLY SET THE GROUND RULES. Look! One thing I cannot tolerate is somebody else talking. The only way I can deal with that is - because I am a nurse, not a teacher - is to actually ask you to leave the class and I've never had to do that yet! So don't be the first class that starts me off!*

The outcome was dramatic, the silence was immediate and suddenly they were hanging on every word:

> *I say it with a very straight face, and afterwards, something really positive and smile! It was great! They listened and I said, Right-oh! We'll make a time together!*

By confronting issues head on, the nurse was getting the students to own the process as opposed to sabotaging it, and then the real work could begin on helping the students to address their own health needs. They often began this by telling the nurse their stories. She in turn took the time to listen:

> *I would rather spend time on the kids than on bits of paper...I'm not good at bits of paper (pointing to her head) its up here, I'm afraid! I'd rather write little and listen big.*

Being there and listening was often therapeutic for one young person in crisis:

> *She was still suffering from the shock of being told that she had an STD. Because it was some months since she'd had a sexual relationship, there were lots of issues that she had to work through.*

The Public Health Nurse's preferred way of working was consistent with an approach common to many Public health Nurses:

> *Walking her through by talking it through.*

While there was initial pressure to get the young woman to a clinic, the nurse recognised that there were other concerns. Through this young person's sexuality there was now a new vulnerability:

> *She was concerned that maybe she wouldn't have children in the future...we talked about that.*

The nurse found that students often urgently needed support and understanding from someone who was both knowledgeable and nonjudgemental. In particular they wanted practical advice on the steps they should be taking to resolve their dilemma:

> *We talked about her being able to go down and get the prescription from Family Planning, and that seemed to be a difficulty for her, but the main problem was that she really wanted to start on those antibiotics straightaway.*

The imperative of caring for students in a college setting often involved the Public Health Nurse negotiating with school authorities and sometimes acting as loco parentis:

> *As the school didn't have any other children for me to see, I suggested that I took her down to Family Planning, and the school covered me for that. We went and got the prescription filled, and I paid for it. I said, Please leave the money with the Guidance*

Counsellor. Then I took her back to school, just in time to get her on the school bus.

Observation of the nurse at work, and speaking with colleagues, led to an impression that the nurse was frequently called on to deal with challenging, and at times, "difficult" adolescents because she was perceived to be both effective and efficient. When working with the young clients she sought to create a supportive, learning environment. She seemed relaxed and reached out to the clients, affirming them with her own wit of wise comfort and humour:

A young man...was sent to me because his teachers all complained that he smells! Oh! Poor kids! I always feel sorry for them! But I have found that most of them appear to do better if I come straight out with it and say, "Hey! Listen! This is what I'm hearing! Hey! It happens a lot for kids of your age - but what can we do about it?!" And they're usually pretty upfront and will even find a reason for why they are smelly or what they haven't changed. When you're upfront, then the kids are upfront. And if you use a bit of humour, and are quite OK about it, the kids are! The kids are great!

This discussion has focused on the way in which the nurse works with young people, as individuals and in groups. Her professional and personal attributes combine to create an environment which facilitates a climate of trust, safety and comfort in the time she has available.

Working with the college staff

The professional working relationship between Public Health Nurse and college staff revealed a commitment to care not only for the students, but also for all members of the school community. While most referrals revolved around the students, the Public Health Nurse's perspective was that the staff were also entitled to, and at times in need of, her support:

They really do work hard...that's what I really appreciate about them. The fact that they don't hide their problems...they actually recognise it. They have some pretty tough kids up there. And they

all work their butt off for those kids, and they don't get a lot of recognition for it.

This sharing and mutual concern helped the college staff and Public Health Nurse to recognise what problems were emerging within the school community. Often these were a reflection of the wider community as the Guidance Counsellor indicates:

More and more adolescents are being left to bring themselves up, and I see that is where there are cracks in the system, because they don't know how to look after their own health...they simply don't know.

The Guidance Counsellor diagnosed the following needs in the student population, and most of these emerged in the course of this study: grief, group acceptance, acceptance by parents, parental expectations, family dysfunction, everything left to parents, 'Am I really being listened to?', language, moving to a new place, loneliness, labels, putdowns, repression of individuals, pressure having/not having a boy/girlfriend, relationships, sexuality, self-expectations, identity, 'I have my own personal goals', decisionmaking, power, quality of time, and time management. In this context, the Guidance Counsellor and Public Health Nurse shared similar philosophies about their work and what caring in a college should be. In order to meet the needs of young people the work needed to focus on the young people's total circumstances:

Its holistic - its caring, and that's what teachers are increasingly involved in - being everything to the kids...its very hard - that's why teachers are so stressed.

Clearly, the Guidance Counsellor saw the Public Health Nurse as not only part of the school community but also as a valued member of the school's pastoral care network:

Our pastoral network cares for the kids in a holistic way...and to be holistic, we really need the Public Health Nurse's input to deal with all the range of ages and people.

The school pastoral network comprised all the support systems within the school, which included the school subject areas, members' personal areas, as well as problem areas. Each area then locked into the guidance network which extended, like an umbrella, from the Deputy Principal, Deans, Form Class Teachers, to the actual Guidance Department. As one member explained:

> *The pastoral network is not just a Guidance Counsellor working out of an office. Its the classroom responsibilities you as a teacher show towards your colleagues and students. Under this umbrella, if a referral needs to be made to the Public Health Nurse, it would be taken from here.*

The pastoral care network was the human response by a committed school to meeting its perceived areas of need. Its composition reflected both teamwork and professionalism, which was also evident the night the network presented itself to the Parent Teachers Association. On this occasion eight panellists informed the small audience of parents (apparently the notice had inadvertently not gone out in time) about their particular role in the school. Amongst the representatives were: the School Guidance Counsellor, the Police, the Gain Programme, Income Support, Community Alcohol and Drug Services, the Counselling Service from a nearby Community House, the Visiting Teacher from NZ Education Psychological Service and last but not least, the Public Health Nurse herself, from the local Crown Health Enterprise, Child & Family Service.

In this setting, the nurse expanded on the role she played in prevention and early detection of illness, informing parents of the primary health care service she delivered in the form of her weekly school-based clinic. She also described the health promotion activities she carried out on Health Days such as the Pre-Employment Programme each term, and the Form 6 Day after the end-of-year exams. The current programme development for Form 5 exemplified both the commitment and working relationship the nurse had with the college. As the Deputy Principal observed:

> *I think the critical thing is the nurse's commitment to come every week...that's the difference...that's been the turning point - her regular attendance. And the Deans know she's there, so when*

they're seeing students, they think of her as another resource, or another avenue who can help.

By being physically present in the school on a regular basis, the Public Health Nurse was thereby being preventive. Her presence encouraged the teacher to make an early referral which often led to early intervention, as the Deputy Principal explained:

We can rely on her being here, being available, and not simply someone at the end of the phone. The fact that she actually comes is deeply appreciated. Then people will tend to use her as a resource rather than wait for something really serious that they then have to phone up someone else about.

As a consequence of cost saving educational (and other) reforms, many services to schools have been cut to the point where there is little or no confidence that the system will respond, for example, in the case of abuse. The Deputy Principal provided insight into the likely scenario that can and often does happen in these situations:

You tend to need that reliability of that resource person there, otherwise you find 'other ways'. And most often, you don't address the issues. If the person isn't available, then you won't make it something that you can actually attend to. And you'll think, 'Well, no, that's not really our job'...and you'll just hope that it goes away.

The nurse's regular attendance therefore generated more than just referrals. It restored faith amongst those working at the interface of both health and education. In particular, it helped to develop an effective working relationship between two key workers. As the Deputy Principal noted:

That working together between Guidance Counsellor and Public Health Nurse - that's made it so effective as well...there is a very strong professional relationship there. They seem to be on the same wavelength, and get on very, very well.

The critical elements of this relationship were most notably rapport and trust which the Guidance Counsellor acknowledged in the following statement:

> *I consider myself very, very lucky when I talk to other counsellors who perhaps don't have the same rapport with their health nurses as I do. The Public Health Nurse has excellent rapport and excellent people skills, and is totally confidential and trustworthy...if she was not like that, I would be hesitant in using her as much as I do....*

Trust was seen as having a ripple effect on the rest of the college. This was evident in how the staff would make referrals to the Public Health Nurse. The Deputy Principal again:

> *The earning of trust - she's in the staff room often...a lot of individual staff will say to the Guidance Counsellor, "I've got a worry or a concern in one of my classes...is the Public Health Nurse coming Wednesday?"*

From the Public Health Nurse's perspective, being trusted by the rest of the college largely emanated from the working relationship she had with the key liaison personnel within the college:

> *You've got to be trusted in a certain relationship. It has to develop between the Public Health Nurse and the primary person that the young people see in the colleges, like the Counsellor or Deputy Principal.*

Throughout the study there were many examples of how this partnership worked. Each case demonstrated different levels of Public Health Nursing involvement. The following scenarios illustrate the different strategies the nurse would use in order to deliver the best outcome for students and staff. Throughout this process the Public Health Nurse maintained a two-way communication with the college, fine-tuning her response according to each

situation. The first scenario illustrates Public Health Nursing support that was appropriated at a lower level of involvement:

> *A teacher came flying in, wanting one of us to do something about this fourth form group who were not her normal group, who were going on about 'blow jobs'...and something had to be done there and then...*

Asking the right questions was critical for assessing the need and the Public Health Nurse's response. Hence the nurse's reply to both teacher and Guidance Counsellor was:

> *I want to do something about the blow jobs if we know what we're actually talking about here...are we talking about kids actually doing it? Or, are we talking about kids talking about it? Are we talking about somebody being sexually harassed..?*

The nurse clarified the issue according to the following rationale:

> *There was just no way I was going to rush in and get the wrong end of the stick, and have the kids all laughing at you...you just make things worse!*

Deciding on a course of action in this and any other situation was reached through a consultative process:

> *We went over to the classroom and we watched the teacher through the room, and she seemed to be getting them all under control...things seemed to be settling down...it was some of the boys...*

Knowing when to step back is just as important as knowing when to become involved:

> *Then the Guidance Counsellor got the teacher out of the classroom, and I just left her with her. They seemed to be sorting it out. She had a male teacher who she was going to get to talk to a couple of the boys about sex...*

Most referrals required greater involvement from the Public Health Nurse. One abuse case, in particular, placed extraordinary demands on the nurse. After several abortive attempts to urgently communicate with the child protection social worker, the nurse began to question her own integrity and ability to continue working at the school. This was because the nurse was not able to give the school the vital feedback they needed on the youth who was too old for CYPS (Children & Young Person Service), too young for the Police and had ESL (English as a second language) needs. Reflecting on all of these issues, the nurse said:

> *Had I not had a good relationship with that school, I think it would have blown it away completely. Sometimes Public Health Nurses' relationships with schools are very tenuous - they remember the last thing you have done, and if you have done it well, fine! But if you've not done it well, then they actually don't want to know you again. We're very much at the mercy of forces. Our reputation takes years to build and minutes to knock down. I'm very lucky that I'm trusted in that school, and that when I said, "I'm sorry, I've done this, this and this, but I can't tell you what's happening", it was accepted. Nobody at school put pressure on me. I was very lucky.*

Certainly this experience showed that at the centre of this working relationship was trust, including mutual respect and concern. For example, in trying to make the most of her short lunch hour, the nurse attempted to teach, without interruption, five young women about safe sex. She paid tribute to the Guidance Counsellor's thoughtfulness:

> *Guidance Counsellor was really neat...actually put a (do not disturb) sign up on the door... booking the room for me for the whole lunch hour, which was really nice.*

During a rare opportunity for observation, I was able to witness an affirmation paid, concerning the Public Health Nurse by one staff member :

> *She can put across the messages that perhaps they haven't accepted eg. alcohol, drugs, nutrition, or (in this case) unsafe sex.*

The way in which the Public Health Nurse and college staff work together perhaps could be best summed up by the Guidance Counsellor's statement:

> *Why I need a Public Health Nurse: because I'm a firm believer in using the specialties where specialties are necessary. For some of the specifics I don't have. In particular, the basic needs of vision and hearing, and other specific problems that only a nurse has specific knowledge for really - the specifics that I don't have time for (I had ten kids in each room today!!). I see it as a specialised role, that is, not as just anybody could do it. Because its the body of knowledge that the nurse has - the body of specific knowledge. I update myself. I presume nurses do. I don't do both. I can't do both!*

The focus for this particular section has been the Public Health Nursing-College partnership which emerged out of shared concern for students and staff in a college. Both health and education were brought together within the framework of the college's pastoral care network. In this context the Public Health Nurse's contribution was seen as a vital part of the college's wellbeing.

Working with the Community Health staff

In the course of caring within a college, the Public Health Nurse had the need, on several occasions, to call on the expertise of her colleagues from Community Health. This section focuses on who these colleagues were and what the role was they played in maximising the quality of care that the nurse was endeavouring to deliver to the school.

On one occasion the Public Health Nurse phoned the Manager of the Dental Service about:

> *A young man with two sets of teeth! Recently arrived at the college. Living with his Dad. Having difficulties coping in a busy suburban school. Manager of the Dental Service suggested having two sets of teeth at Form 3 level was extremely unusual.*

> *Presumed overcrowding - correct!. With that in mind, Manager of Dental Service faxed me up the dentists who are contracted to give free care for secondary students.*

Every consultation brought new learning for the nurse, like the time when she requested help from the Health Promotion Public Health Nurse:

> *The Health Promotion Public Health Nurse then got us some printouts off the computer, related to Asian Health Youth workers, and all that came back was from Australia - nothing about here, New Zealand! So that's really interesting!*

An established good rapport with an agency like Community Alcohol & Drugs Service, was often an entree for the next time the nurse or school requested intervention. Asked what she would do if a student with a drug habit requested help, the nurse replied:

> *Well, I would probably give them some options, but I would use Community Alcohol & Drugs Service. I've used them before, and supported people to get what they need - just by the telephone. But I've always had a good rapport with CADS, as has the Guidance Counsellor. We find they've always been very, very good. I know. I've used them quite a lot.*

The skills of the Medical Officer were also drawn upon when a student had problems gaining access to a General Practitioner because of cost, caregiver or other complications in the young person's life.

> *...and then we also saw the young lady who I had seen the week prior with ulcers in her mouth. My Medical Officer came up with some ideas for her, but I had the feeling she wasn't actually going to follow them through! As yet I have not been able to contact Dad (with whom she is staying for the moment) to say what we did and what went on...*

Because Medical Officer time was very restricted, the Public Health Nurse had to make the most of the moments she did have with the Child & Family Doctor.

Hence other referrals were organised to fit around his busy schedule. This included:

> *A young immigrant gentleman who had inadvertently missed (through lack of communication) having a BCG at the BCG Clinic.*

The young man had been under the care of the nurse's colleague, who had sent him to the BCG Clinic without all his necessary TB contact documentation. The BCG Clinic nurse was therefore unable to give him the BCG because she lacked the essential information with which to make an informed and safe decision. About this mix-up, and eventual fix-up, the Public Health Nurse philosophically said:

> *You do get there in the end, and without blaming, because these things happen constantly in our job, because there are so many people, and so many arms of things...things that inadvertently get missed, but longterm, we usually get picked up.*

It was this 'give and take' attitude that allowed the Public Health Nurse to cope with other exigencies eg. when a colleague failed to give vital feedback on an abuse case. The following excerpt demonstrates the possibilities of not only working together, but also doing so with renewed hope:

> *I've had a call from the Child Protection Social Worker who's now back at work, to apologise for her not following the abuse of just over a week ago, and to let me know she had gone to the new immigrant community, and a gentleman is following it up with that particular family who he does know. And from that the Child Protection Social Worker is now asking if I would like to be involved with some extra abuse training with new immigrant communities. And that's really exciting! I feel really good about that! I feel things are really starting to come together...*

The Public Health Nurse's relationship with the rest of the growing social work team reflected a willingness to find new ways of working. Management had decided that the Public Health Nurses should now work with the new social workers who were wanting to come and work in the nurses' schools. Rather than taking this challenge defensively, the nurse saw it as an opportunity to

capitalise on each others' strengths. After discussions with colleagues including the Public Health Nurse Clinician Specialist, the nurse invited the new area social worker to be part of the next Pre-Employment Health Day:

> *How do I feel about that? In some ways, a bit guarded because it's something that my off-sider and I have been doing now for some years...and it feels good! But we both talked, and we said, Well, the objective of doing it is the kids - not us. It's the kids...it's what they need to know. So it's time to try something out, and bring in another viewpoint.*

Thus, collegiality was extended to the newcomer from another field. She was made to feel welcome, important and affirmed:

> *The new Social Worker was delighted. And she is going to talk with the students on depression & suicide. And I said, It's the best thing she could do! It's wonderful!. We've also put her in after the noisy bit - she's been warned about the noisy bit! And she's comfortable about that.*

Collegiality featured many times in discussions amongst the team of Public Health Nurses. It was an integral part of sharing and caring eg.:

> *At the end of last year, after Form 6 had finished their exams, WE HAD A DAY. I did contraception. The Guidance Counsellor did relationships and not hurting each other. And my Public Health Nursing colleague (from another office) did STDs...*

Of considerable value was the support that one nurse could give to another, particularly when they shared the same office and saw each other every day:

> *If there's anything major that's ever happened, I come back and discuss that with my off-sider. She does the same with me...and we've always done that. We've always talked through any problems so we don't carry it home in our heads.*

This sharing was instrumental in creating a unique form of collaborative practice, the duo often going off together to teach in tandem at each other's colleges:

> *I'm doing drugs & alcohol up at my offsider's college - that's a whole new thing...we've never had it before...we've tried for years to get in there! And now we've suddenly got that [with the kids] PLUS we've got to talk to parents about drugs & alcohol there next week as well!*

Celebrating nursing's achievements was an important source of sustenance for the nurse's ongoing enthusiasm for her work. The nurse reflected on the role that expertise plays in the generation of practice-based knowledge:

> *You can be a very bright lady, but if you don't have that knowledge that comes with experience...the two are very different. You need both: You need that kind of theoretical knowledge. But you also need the feet-on-the-ground, the people-who-have-been-there-for-some-time. You actually need that experience knowledge as well.*

It was in this context that the nurse made the following reference:

> *A know-it novice can be very dangerous, and very difficult to deal with.*

Even the experienced Public Health Nurse still has to consult widely. As the nurse said:

> *No one person can know everything.*

Given the variety of questions in her daily work, this situation was constant. Fortunately, the nurse found many of the answers by conferring with her colleagues from the Community Health Service. Using the expertise available in her own organisation was a saving in both time and money. The resulting teamwork was positive for overall team building and service development.

Working without

This subtheme refers to the Working without walls which is present in Public Health Nursing. It happens within the community, as opposed to the structural constraints of a building. The Public Health Nurse's client therefore is not a patient in a hospital but rather is an individual or a group in the community. Sometimes the community itself is the client, as was the college in the study. Also, the nurse's office is not situated within the confines of an institution. Instead, the Public Health Nurse was community-based and thereby practised care from a community health perspective. She is on the move. Working without walls has a number of positive consequences for client care, namely, acceptability, accessibility, availability, and adaptability to need. As one teacher saw it:

> *It's advantageous that the Public Health Nurse is right there in the community and can work flexibly and creatively to meet that specific need.*

This was demonstrated in a number of ways. Firstly, the routine of visiting the college weekly was often augmented with extra visits and phone calls. There were also times when it was appropriate to see clients off the college campus. On one specific occasion the nurse had received:

> *...another urgent call from the Guidance Counsellor to ask if I could stay at base and wait for a young lady (who I had seen before), who had been hit by her Dad the day before. The young girl had chosen to see me, so the school had allowed her to do that. So she arrived about 4, and with my offsider, we documented her injuries...*

In this situation, as with many others, the nurse used a holistic approach in her follow up of the socio-emotional as well as physical needs of the case:

> *I saw the young girl again at school the next day. She was very clear that it was never going to happen to her again. She wasn't going to be a victim anymore! She told Mum who wasn't very impressed - talking it outside the family!! How DARE she do that!...But also, that particular young lady has caused a lot of strife*

in the family before and to a degree, she believes that some of it is of her own making. Perhaps it is...who knows...its all very well to say...

Having worked with many different groups and individuals out in the community, the Public Health Nurse had a fairly comprehensive overview as to what she saw were the needs "out there". When asked if working with adolescents was her first love, she quickly replied:

No! They're not - they're the greatest need in our area.

When it came to complicated cases, such as child abuse, there were certain benefits in using the Public Health Nurse. Her personal knowledge in this area was extensive as well as her geographical knowledge pertaining to families, schools and preschools. It was for this reason that she was approached by three Form 3 students and asked to intervene in a suspect multiple abuse case involving another student and a preschooler:

I had to tell the kids that on some of those things there's nothing I can do (for example, the hygiene issues). But that on others, I would be going to the schools and talking with the teachers in one school, talking with the counsellors in another school, talking with the community creche, and if necessary, going to Care & Protection Team.

If the school or preschool was not "in her patch", she could link in with the Public Health Nurse whose patch it was. Being able to tap into these resources was seen by the Guidance Counsellor to be of great strategic value:

The other thing that the Public Health Nurse would have that we do not is...she has an overall focus of the whole family. She's got great access to primary, intermediate & secondary schools. Also, she can use her network of nurses to deal with issues of child protection. I know that I can tell her and that she'll find a way of getting that information to the right person. She's sort of within the school but the Public Health Nurse is coming from outside, therefore she has a huge amount of networks, and her boundaries

go much wider. Her network is parallel to mine. Because it's not the same, it's good!

The Guidance Counsellor also identified the Public Health Nurse as being a *good and reliable local resource person* that the school could call on in the event of a sudden death at the school:

As you know, suicide is a big, big thing in our school, and other schools right throughout New Zealand. If I've got them on contracts, and it's going to be over a long period of time, I almost always get hold of the Public Health Nurse if it's going to be over a long period of time, and she takes over from me during the holidays. Picking up for other people at crisis time - that's what the Public Health Nurse does for me when I'm on holidays.

Another teacher emulated her confidence in this service:

I know that the Public Health Nurse will follow through and keep an eye on them if it's an ongoing problem.

The school pastoral care network appreciated that sometimes there was greater acceptability by the student of talking to someone from outside the school, as opposed to somebody from within:

If there is an area of concern to me and they're not going to talk to somebody in the school environment, I suggest, There might be other things you want to talk about...the Public Health Nurse is here, if you would like me to make an appointment. If you want to make an appointment, that's fine! That's your decision. And usually I find they take that up.

'Being there' for people included visiting them at home and meeting them as a family in their own community. This was especially important for Maori families, as one teacher explained:

A lot of people deserve the consideration of their being seen on their ground, rather than an artificial one. They may feel more in control. They've lost something in an office. I can think of one

example of a student who felt it was so important that the student and his Mother were seen by the Public Health Nurse. And that was a family situation. That was very much a team effort. Could be addressed in the school, and addressed at home.

In these days of uncertainty and financial attacks, it was reassuring for teachers to know that, if the need was there, the Public Health Nurse was available to do a home visit. As one of them said:

We can get the Public Health Nurse to go and do a home visit if that's obviously a thing that has to be done. That's again a good part of knowing it can be done, and has been done in the past.

There were several instances in which the Public Health Nurse either saw or met up with some of her college clients when they, like her, were out in the community during their off-duty time. One particular young lady had been of immense concern to both school and nurse, the Public Health Nurse describing her as:

Fragile...she's exceedingly fragile and exceedingly demotivated. I think she's switched off...'in there', and maybe it's become a behaviour. She's actually talked it over about how she's always hated her parents. And she hates being at school. Her objective is to leave school...that's where she's moving towards which is a huge disappointment to her family.

But here, in a different place and a different space, the nurse saw somebody different, somebody whose self esteem had been lifted and was walking high:

I saw her in the holidays, and instead of looking like this (head down), she was beautifully dressed. And it was the way this young woman was walking. And she just looked lovely. And I just looked at this young lady as I was going past in the car, and then suddenly she 'up & waved'! And suddenly I realised it was her! So it was her! She just looked so together. And so neat! So different! So happy to what she was looking at school. That was really neat to see her like this - spontaneous and welcoming in spite of all

we've been through. It's still good to see it, but her potential won't ever be fully utilised if we're not very careful.

This prediction proved correct the next time they met. The accompaniment of a sibling shedding significant light on that occasion:

I saw her on Saturday when I was shopping. She bounced up to me. She was with her brother. He was the most abnoxious, self-centred, self-conceited pratt you could imagine! Everytime she tried to talk, he said, 'Oh! You're just dumb! And you can't even get a job! And I'm only 13 and I've got a job!' I really just wanted to hit him! It knocked all the bounce out of her. And I realised even more it's not just her. There's a whole family problem there - an enormous family problem. And this boy is going to be a monster when he hits high school.

The nurse then viewed this young woman for a last time, this time going past her office window:

I saw her yesterday go past the office - but I didn't see her until she had gone past. I don't know whether she saw me or not. But she was with another young girl. And I was on the phone at the time, talking to Department of Social Welfare. And it crossed my mind, 'What's she doing here and not at school?'

As a community based health worker the Public Health Nurse has an existence beyond the school. This can be advantageous in making meaningful connections:

Well! The reason she was not at school was because the two of them, at some stage yesterday made three second phone calls to the college saying, 'Bomb alert! There's a bomb in the school!' The school immediately got onto the Police who got onto the Hamilton (phone call tracing) Centre, who very quickly traced it...And within half-an-hour was able to tell them where the phone call had come from, and who had made it.

Being community based, as opposed to being fulltime in a particular school, provided the nurse with a unique opportunity to be better informed on some issues. The following scenario provides a good illustration of how community observation can lead to a better understanding of a problem that had emerged in an earlier classroom session:

> *Yes! They're regularly bombed out. That we know is true, because after we had finished that session up at the school, my offsider and I were sitting in our tearoom, back down at the office, and one of those young men walked past with another one, and they were both smoking joints.*

The Deputy Principal was, also, quick to acknowledge the contribution the Public Health Nurse's community knowledge brought to the daily operations of the school:

> *I don't think the Public Health Nurse should be fulltime at a school, because I think they need that wider perspective to be valuable to us...because otherwise they would become like another medically trained counsellor within the school. And we need, the Public Health Nurse needs to be able to give us that sense of perspective, a sense of balance, and a sense of, 'Oh! But that's a problem all over the region at the moment!'*

While the Deputy Principal admitted she could easily find work for a fulltime Public Health Nurse (*no trouble!)*, there were several political considerations for her preference for the Public Health Nurse to be part-time:

> *That business of them coming from outside is important because schools are getting more and more independent in the sense that they're stand alone institutions. You haven't got the Ministry making all your policy decisions, or giving you advice. They're not on the end of the phone with advice anymore. You've got to really make your own way. So it's really important to have people who have an outside perspective all the time as well.*

The Public Health Nurse was therefore seen by teachers as someone who brought stability at a time when schools, and their communities, were

experiencing the turbulence of change brought about by economic development and governmental reform. As the Deputy Principal explained:

> *You need someone from outside who may have new ideas, who can put things in perspective, who can suggest, 'Oh! But there's a counsellor at a school down the road who's developing an excellent programme to do with that - get in touch with her!' So I wouldn't like to see the Public Health Nurse seeing just a school. Because otherwise you become very internal. I think they should be community-based still. I think that's important.*

Being based in the community was seen as enriching for both the nurse and the college. In the following themes this issue will be explored further as the nurse worked to capture not just the moments, but also the hopes of young people for their future.

Summary

This chapter has presented the first theme entitled, MAXIMISING. Making the most of the given moment was the broad definition given to the holistic nature of this theme. It was then described under its two subthemes entitled, Working with and Working without which looked at the issue of primary health care and its role in prevention. The nurse's and teachers' stories added further meaning to the messages behind MAXIMISING. Chapter 5 will discuss the second theme: OPTIMISING.

Chapter 5

OPTIMISING

Introduction

OPTIMISING is the second theme with two subthemes entitled, Building and Breaking. Both explore the work that the nurse did with young people in relation to their health and future. Once more the nurse's and teacher's stories will be used to illustrate aspects of nursing practice pertaining to this particular theme.

Optimising defined

OPTIMISING is a future-oriented term about expectation and hope. This term incorporates the belief that any health work carried out with young people today, will benefit them as the adults of tomorrow. Adolescence is therefore seen by the nurse as a hopeful time when young people are "starting out" in life, hopeful that it will provide them with opportunities for beneficial growth and development. Hence there is a certain sense of "optimism" within the young person which, if fostered, will support the development of a firm sense of identity and a wide range of effective coping skills. It is argued that young people who have these resources will have then what is needed to deal with the challenges and changes that characterise adolescence and young adulthood. The nurse's attention, not unnaturally, focused heavily in this domain and this was evident in her preventative and health promotive work, carried out on a one-to-one basis or in groups. Her optimising work is described under two subthemes entitled, Building and Breaking, both of which connote the building up of strengths, the breaking down of barriers, and the breaking through from resistance to success.

Building

A major part of a Public Health Nurse's work is education and, in particular, building on what is already there. That is, building on the knowledge that the student already has. This role was identified early in the study by the Deputy Principal who said of the Public Health Nurse:

> *She's like a staff member, she's part of the Guidance Team, she's very widely respected by the students and staff, and parents. She is a very wonderful resource to us, both from a medical point of view, and from a teenage-educative counselling point of view.*

In relation to teaching, adolescence today was seen as a time of turbulence that could not be compared to the past. As one teacher said:

> *There is much more awareness of the needs of adolescents. I mean, you only have to look at the Herald in the last couple of weeks...and the Listener...and the radio. It brought up a whole lot of issues. The fact that there is far more pressures...people keep on saying that sort of platitude every generation, but there are far more pressures on young people now than there were ten years ago. And because of those pressures, there's a much more widening range of adolescent health problems.*

The issues for Public Health Nurses, as this teacher saw it, were therefore:

> *Education - education of needs, education of families, education of parents, but also, education of kids.*

There were many instances in which the Public Health Nurse participated in teaching related issues and played the role of educator. For example, at the beginning of the term, the Public Health Nurse spent considerable time with college staff planning the future development of the school's health education programme. These discussions were part of an ongoing process, as outlined by the nurse when she talked about the proposed Fifth Form programme:

> *They've actually got something going this year because we've been pushing for a couple of years now. We'll probably do*

something on relationships and self esteem at the Form 5 level so that we can actually build on it next year when we do our 6th Form Day.

In the eyes of the nurse, the Sixth Form day had been a particular achievement:

We're going to try and make the 6th Form Day an annual event if we can, because it was so successful. We did a lot of small group work...a very lovely low key approach, and very safe, too. It was exciting! We're hoping that we can start doing the same from now on because some of the young people said, 'Why couldn't we have had this information earlier?'. The staff and I both recognise that a lot of the information is not available anywhere. So that's why we wanted to start Fifth Form this year.

By building on what had been successful, the nurse was steadily working towards her dream. Even though it was some way off, she spoke about her vision for the future with regards to health programmes in all colleges:

As you know, I'd rather have a programme that would run from third form and that you just added to every year in the 4th, 5th, 6th and 7th. That's my dream...that all schools do it, so that they've all had information to that level. Instead of the present 'plugging the gaps' that we do so well all the time. Not always the best plan, but perhaps the most useful at the time, and in most instances, the best for all.

Seeking out opportunities whilst working with what resources one had, were the strategic steps the nurse took in attaining her goal. For instance, when during the previous year she was offered the sixth form, the nurse said:

I thought it was too late for some of them, but I was offered the 6th, so I grabbed it. A couple of girls said, 'Oh! I wish I had this information a year ago'. But for some, it was exactly the right time. And for some, it was still too early...

From the Public Health Nurse's point of view, learning was never too late, nor too early, but rather, it was linked to the opportunities available at the time:

> *That's why I want to start and build it up - so that the kids actually know that if they've got any questions, they can still come and see you, one-to-one. So those who actually need their needs met, will get them met earlier than the norm.*

One classic example was a young woman who came to the clinic with a friend, ostensibly wanting family planning. But the discussion began to centre on other, if not more equally pressing issues:

> *Two student were new today, two I had never seen before. They didn't offer their surnames...they were feeling uncomfortable. But they were wanting to come and talk together. So I didn't ask their surnames. They needed that for their perceived anonymity today, to be able to feel as though they could talk. Both 4th Formers, and both wanting to go on to Family Planning, but didn't know where it was, what to expect, what would happen, who the people there would be, and were concerned that, being 15, the police would be told!*

In these circumstances, the students were trying to help themselves, but did not know how to go about this. The nurse moved first to reassure them by explaining their rights to confidentiality:

> *I told them it's the same as GPs - it's confidential information. What happens with me, what happens with Family Planning - is confidential in those places. They can't tell parents. We talked about that, and from there we talked about contraception...the different kinds of contraception.*

The nurse then assessed their current levels of knowledge in order to find the right starting point:

> *They really knew very little. I talked about the need to use condoms as well as the Pill if they were having serial-sexual*

> *partners. I talked to them about STDs, which they knew nothing about. I talked to them for their views on HIV.*

As this discussion progressed another issue began to emerge. It happened, as with other clients, because the nurse seized the opportunity for lifestyle education:

> *I don't know what brought it up, but I talked about alcohol. If I can bring alcohol in, I do because its a real problem with 14 and 15 yr olds. And it was interesting that for one of the girls alcohol was a problem. As we talked, she explored and asked questions. And it was interesting, because she then realised that she was drinking a lot of rum. Rum's the drink of teenagers at the moment...and alcohol is very high in calories!*

Making this connection was beneficial to this young woman's future wellbeing. The nurse then illustrated the interrelationships between the different issues in her current lifestyle:

> *She was talking about how she couldn't lose weight. She exercised, but she still couldn't lose weight. So I talked about nutrition and brought in alcohol, and calories in alcohol, and related that to unprotected sexual intercourse, and STDs and pregnancy, which was really neat because she made the connections very quickly.*

With sensitivity and sensibility, the nurse and the student sought out the solution:

> *It was really neat that she was able to talk about it, and how she could suddenly see that if she wanted to lose weight...so we talked about nutrition, and made an eating pattern for her. And we verbally agreed on an eating pattern. And then we talked about alcohol - about her either filling up with water or orange juice first before she picked up the Coruba, and then she could sit on one or two for the evening. And she actually felt comfortable with that.*

Life is a journey along which one learns by exploring the possibilities:

> *We talked about within a year or two, there probably wouldn't be the same peer pressure. And she talked about how all of her mates only drank to get drunk. And we know that from research. And so I related that to its deadening effect which stops you from thinking about, and taking in the pain, of whatever it is that is so painful.*

The students then demonstrated their insight into the problem for themselves:

> *But the problems were still there the next day. And it was she who said, 'Yes! But you've also got the effect of alcohol'. And the other one said, 'Yes! You're vomiting and you're feeling really unwell! And you're not thinking straight'.*

Success could be measured by the students' response which signalled to the nurse that the energy that had gone into this health education session had been well worth it:

> *I probably spent an hour with them, and when they left, they said, 'We have learnt so much!'...and they'll go and talk to their friends in 4th form level, and that's great, too!*

Health does not happen in a parentless vacuum. Throughout the study, there were several reminders of this, one notable example being the Gain Programme. Here parents and adolescents came together in a conscious effort to focus on issues that affected their daily lives eg. relationships, communication, drugs and alcohol, to name but a few. As the nurse observed, these were:

> *...parents who, on the surface, looked as if they are coping very well.*

Many parents were coping well. But the nurse recalled parents in previous programmes who had spoken openly about their own addictions and/or areas of abuse, and their attitudes to education, teachers and life in general. Their frankness helped the nurse to understand the context for some of the problematic lifestyle choices being made for their sons and daughters.

Most parents need support in raising their children, especially in adolescence. On the issue of parenting skills, one teacher said:

> *Parents don't know what they need to know.*

With regard to drugs and alcohol, the teacher then added:

> *Parents don't know what they need to know to help them protect their children.*

In one instance, the nurse spoke of a mother who came to her asking for help with

> *...a daughter who had given extreme problems to the family for some years and had now come to Mum with a positive pregnancy test, but on scanning no baby, but a cyst in the ovary, and a history of very high levels of cortisone and antibiotics. Lots of issues that had to be discussed and talked through. And information that Mum needed to help her make decisions...or to help her to help her daughter make decisions for the future. We spent quite a bit of time talking through the issues...and how Mum felt, and what choices there really were for her, and where to go from here.*

As with the student, time was the key requirement for giving the parent quality support. Such interactions have implications for the future of the whole family. In communicating with the group of parents on the night of the Parents Teachers Association meeting, the nurse delivered this important message:

> *I just make that plea from the kids - eat with your kids...that you actually know that your kids are eating, and that you find time to share meals together...every day. And likewise, touch your kid every day (hug if you can, but if you can't then just touch them). And finally, know where your kids are, and they you.*

The Public Health Nurse was a parent herself but she did not assume the role of parenting these students.

> *That would only replace one lot of problems with another. And that would assume that I was actually sometimes a better parent than their own parents, and that's not right. I can't solve all their problems, and I don't pretend to. And there are also other sides to all these stories. I can't be their parent.*

The theme of Building has been described, with illustrations from the nurse's and teachers' own words. This nurse was consistently working with adolescents and their families, whenever and wherever the opportunity arose, to give relevant support at the same time ensuring that they always retained power over their own decisionmaking and actions.

Breaking

In building her clients up, the Public Health Nurse was encouraging them to take full responsibility for their own health. While doing this, the nurse occasionally ran into resistance. By steadily working through each problem as it arose, the nurse gradually broke down barriers as she sought to help her clients find the best pathways for their own circumstances. Often the nurse was called upon for her expertise in expediting a breakthrough that had, up till then, eluded others:

> *I had been introduced to her perhaps 6 weeks ago in the counsellor's room - a [_ _] yr old whose great failing is that she is getting further & further behind each year. She has been doing extensive counselling with the counsellor but a stalemate seems to have been reached...maybe she would relate to somebody else a little easier.*

At first there was no movement:

> *Her answer to every question is, 'I don't know' or 'No, I don't remember anything of my earlier years'. Very hard to get through to...lots of rolling of her eyes, and sighing. Quite happy to be here, but not very forthcoming. I kept thinking, Look! I wonder*

> *if it's about [_ _] but that didn't come up...and drugs didn't come up [either]...*

The nurse tried several avenues, including story telling:

> *We went round & round...different sorts of things, until I started telling her a story about [_ _] and I could see that some of that actually fitted for her. And suddenly she's attentive and listening, and saying, Yes, some of that might actually be talking about her as well, but she doesn't know why...*

By drawing on the young woman's past, the nurse created possibilities for their future meetings:

> *I've given her some homework to do seeing there's such gaps in her early memory of her childhood. She doesn't seem to remember anything before 3 years ago. She's going to look out family albums & have a look at pictures of herself, and see what she used to do when she was young. See if it sets off any good memories for her. And we will go from there next week.*

Then came the breakthrough:

> *When I arrived about 10 past 1, which was very early for me, the young lady was waiting for me! She looked somewhat brighter. She was actually looking a whole lot brighter, and it was interesting, when I fed back and talked to [the Guidance Counsellor] afterwards (and this young lady has given us permission to do that) - it was interesting to discover that the Guidance Counsellor had felt she had made a breakthrough.*

All situations encountered by the Public Health Nurse, require sensitivity. Of particular note was one young woman who by-passed the Guidance Counsellor and other significant people in her life, to refer herself directly to the nurse.

Even then she felt the need to sound the nurse out first:

> *'You probably don't know but I had [_ _ _] back in [_ _ _], and now I'm on the Pill, but I'm having some difficulties with that'. She was on [contraceptive] and was having some bleeding in the middle of periods, and her thought was to just stop taking the Pill. She thought it was mucking up her system. So that was one issue that we talked about. And I said, 'Right! I'll get you some information on [contraceptive] and bring it back for you on Friday'.*

Perceiving the nurse to be safe, the student then told the nurse what was really worrying her:

> *The other thing was, she had had anal sex the night before, and she couldn't discuss that with her Mum, although she's got a close relationship. Couldn't discuss it with any of the other kids at school because, as she said, 'I just don't know what they'll think of me'. And that was worrying her. But she couldn't sit down either, and she was bleeding, and she was feeling really uncomfortable, and she was feeling really revolting.*

The nurse affirmed this young woman's courage for coming and talking about this experience. Her next step was to give her the reassurance she needed:

> *I just laughed it off really in many ways, and then I normalised the behaviour. I talked about how it was actually a common thing, and how it happens in just about everyone's relationships at some stage or another. It's not just the homosexual activity. It's actually a heterosexual activity as well. But for the reasons that she found out, most people try it once and don't continue with that because of the pain. So that made her feel really good, and she had a good laugh about it, and hopefully, didn't blow me away.*

The nurse then advised the young woman on the various comfort measures she could take:

> *We talked about why it wasn't such a good idea - because the mucous membrane being so easily damaged. We also talked*

> *about the sphincter, and the damage that could occur there, and I actually sent her home to sit on some ice packs. And we talked about how to make those up. And no, she didn't want to discuss it with Mum.*

She re-emphasised that she did not want to discuss these problems with anyone else:

> *She is really close to the Mum. But there are some things you can discuss, and there are some things you can't. Its not something that they usually discuss ie. they don't discuss it openly, and this girl is a real open person. She discussed the [_ _ _], and things with other people, but she couldn't discuss that one. So she went away quite happily.*

There were also the breakthroughs that eluded the nurse, as this account of an anorexic young woman shows:

> *She has weighed as little as 35 kilos a few months ago. She's a little heavier than that at the moment. She's got loss of energy, is on iron & multivite, vitamin B & garlic, and uses complan if she misses a meal, or to add after a meal. Her [school] friends are concerned. Her circumstances of living aren't very great. There's a lot of power control. This young lady is responsible for her own cooking. She accepts that eating and nutrition are a problem at times but she says categorically she's not anorexic or bulimic, and doesn't believe that she has a problem.*

But the nurse persisted and tried to keep the door open while recognising the difficulties in working with people with anorexia:

> *I don't know quite where to go with her. I have said I'm here. She's welcome to come back anytime. I'd love to see her. We talked about the consequences. We talked about other places she could go. But she really wasn't interested because she doesn't believe that she has a problem.*

When all avenues have been explored, and all offers of help declined, the nurse has no alternative but to reflect on the situation, and, albeit reluctantly, move on:

> *Its just that she 'forgets' to eat sometimes, and she 'isn't always good' at producing her own meals. On that I have to accept that at least those tablets must be keeping her in slightly better condition. I hope she will move on from there. An attractive young lady who has goals in life. Not the normal kind of anorexic or bulimic. She definitely sees a future for herself and is planning and working towards that.*

In working with one young woman, the nurse, acknowledging the limitation of her role in many human situations, took care not to promise the impossible:

> *Mother knows this girl has bulimia. The girl has in fact been seen by the local GP...has no intention of stopping the behaviour...doesn't see it as a problem...doesn't want to do anything about it. She accepts it as perfectly normal behaviour because she wants to be a model like Kate Moss - the skinniest, most anorexic, pale-looking model I've ever seen! Her chance of looking like Kate Moss really are just not possible! She's an entirely different figure - big-boned...not a small girl.*

The nurse recognised that the care required for this young woman was beyond the expertise of one Public Health Nurse:

> *It became obvious that there were many problems with this young lady - one of which was that her Dad had died suddenly when she was 8 or 9 and she had come out into the room - in the middle of the night - and found all these people weeping in the house. And it wasn't explained to her, and she was sent back to her room. So there are an awful lot of issues relating to her Father's death which at this stage, she doesn't really want to think about.*

When the nurse proposed that the young woman see someone who could work

with her, she met with resistance:

> *I asked that she would go back and see a Counsellor. I suggested some counsellors. But, No! They weren't what she wanted to do. And, No, she wouldn't go back and see the Guidance Counsellor. So in the end, I asked if she would come back and see me. And she said, Yes she would - after her exams, and only if I sent out for her.*

Given these circumstances, the nurse had no choice but to resign herself to continuing contact on this level:

> *That's really not where I think she should be. I think this young lady requires some very specialised counselling. And I guess all I can do is to support her, and try and move her to that place. I'm feeling a little bit out of my depth, but I guess its better that she come and sees me than she doesn't see anybody.*

Such behaviour in a client often comes at a cost to the nurse:

> *I actually feel pretty overwhelmed by this one. I could see the potential for it going badly wrong because of her entrenchment in this bulimic behaviour, and her belief that it's perfectly normal to do so...and I have these great concerns because of these other issues relating to it...we'll see how we go.*

The Public Health Nurse was not unaccustomed to working with persistent and difficult problems, an experience she described aptly as:

> *Like hitting your head against a brick wall. It's great when you stop!*

The Guidance Counsellor recognised how difficult this work could be, particularly when the problems are associated with prevalent social problems:

> *The types of kids you see right through are from alcoholic families. Alcohol is the bad one. I've heard it all a hundred times before. They present as problems in the past, and it's still going*

on. The kids are worse affected by violence. Dysfunctional families - they're the hardest thing to move.

The impact of previous and current social circumstances on adolescent behaviour is well illustrated in the Public Health Nurses' first encounter with the students from a Pre-Employment class. Challenged all the way, the Public Health Nurse and her colleague had this comment to make:

Oh! They were a tough crew! Both of us afterwards said, Did we actually want to go back and try with this lot?! We actually wondered if it was worth our while! We were just very frustrated and also really sad that somebody had screwed these kids up so much that they were their own worst enemies. These kids had the chance of having a really neat morning, and they blew it. They stopped themselves in valuing the morning...

Drug abuse is also a major problem among many 'at risk' students. The nurse saw a link between their presenting behaviour, addiction and the world of drugs:

That's part of the denial process of addiction. When they talked about their addictions and their families, how could they not be screwed up, dysfunctional kids. The [young man] who talked a lot about depression but didn't want to know anything about how to remedy it - he actually spoke a lot about the addictions in his family. They've got the role models of the older ones. That [young man] spoke about his family who had [harmed] somebody over drug issues. He said it hadn't stopped him. He had only continued - it wasn't your crisis. It might have affected you, but it wasn't your crisis. All in denial...

The Public Health Nurse was philosophical in her appraisal of these events:

I felt despondent because it became very evident what a huge problem it was for that group of kids. But I didn't feel I was wasting my time. Even if some 'little scrap' gives them some protection in the future. I won't have anybody saying later on they didn't know the consequences of their behaviour. Denial - we're not going

change that. The only thing that may make a difference is that before today, one of them has come and approached me - not from this lot, but, yes, in the past kids have actually approached me afterwards, and said, Hey! I have got a problem, and Yes! I do want to do something about it...

The antidote to despair is to never give up. Integrity requires an inner strength to persist, time after time, to help young people to resist the pressures that peers and role models bring to bear on them. The nurse in the college was in a good position to help break down these pressures, and in their place, work with the young person to build up their reserves in order to attain future high level wellness and functioning.

Summary

This chapter has discussed the work that the Public Health Nurse did with young people and their parents in helping them focus on significant issues that had a bearing on their future eg. sexuality, nutrition, alcohol and drugs. There was a strong emphasis on both self-responsibility and optimism. Hence the title for this results chapter was called OPTIMISING, with support and hope expressed in the two subthemes, Building and Breaking. The next chapter presents the third key theme entitled, EMPOWERING.

Chapter 6

EMPOWERING

Introduction

This chapter follows on from the last two chapters which focused on the nurse and client making the most of the moment (MAXIMISING) and the future (OPTIMISING). But none of that is possible if people are not empowered to make the necessary changes for health and wellbeing. Hence this last chapter is about empowering the self. The theme will be defined and discussed using examples from the nurse's and teacher's narratives.

Empowering defined

This theme assumes that people have the ability to empower themselves. That is to say, people have the ability to meet their own needs, solve their own problems and mobilise those resources necessary for them to feel in control of their own lives. One of the premises behind this concept is the belief that only people can empower themselves. That is, they cannot be empowered by others, but they can, however, be supported and inspired by others to seek health and self determination over all that health entails. The nurse's role in health promotion seeks to enhance the person's capacity to make decisions that are best for them. Success can only be defined by the people concerned. Different aspects of empowering emerged within the study, and these were explored under the following subthemes, Using the critical moment and Sustaining the self.

Using the critical moment

Crises are a normal part of life, particularly in adolescence. Occasionally situations get out of control, and can have a domino effect. For example, drug and alcohol abuse, pregnancy and STDs, depression and attempted suicide may coexist. The empowering principle views all these events as critical in their

potential to be cataclysmic for the person as well as triggers for life-changing turning points. This subtheme therefore focuses on the personal growth that can come out of crisis. The following scenarios illustrate this phenomenon. Young people came to the nurse with their individual dilemmas and, with her help, some went on to seek out solutions that were right for them.

In some cultures, the word crisis includes the concept of opportunity. This was particularly relevant in the following scenario:

> *I was talking to a group of new [adult women] immigrants, and as part of that time I actually talked about the needs of the [country of origin] students as I see them...and their reaction was really interesting - No! They couldn't talk to their young people about sex, drugs & alcohol. But they did accept that that could be a real problem for their teenagers, and they are really looking at how they could actually alter that for their young people.*

As the nurse explained, these people already assumed the power to solve their own problems.

> *[Country of origin] people are unlikely to present their problems for discussion - more likely to keep them quiet, especially within the family. Parents don't talk about sex with their kids. They don't talk about drugs or alcohol. They have this sort of 'toeing the family line' - especially women. My guess is that most of them are very intelligent, professional in their own right, do a lot of reading, but they do not talk about it with other people, their friends, with their husbands, or with their children. They just don't talk about it. It's cultural.*

The women went on to define the ways in which they wanted to achieve their goal. Considering the adjustments they were already making in their new environment, their ready assumption of personal power was seen by the nurse as both innovative and unique.

> *I was really impressed with how proactive they [the women] became as that was so contrary to their culture. One of them has asked me to please come to her house when all her four*

> *teenagers are home during the [school] holidays. And if she can get some of the other [country of origin] kids as well, so that we can actually talk about some of these issues together. She felt that they might listen to me talking about sexuality, and safer sex, and drug & alcohol use, much more than they would listen within their family, because culturally, it's not just done.*

This inability to discuss problems within the family was common among both New Immigrant and New Zealand families. The nurse recalled one New Zealand Mother had recently phoned the school and asked, what had "they" done to her son. It transpired that the preceding day, the young man had attended one of the nurse's workshop sessions on drug and alcohol abuse. He had gone home

> *...and had discussed it with the parent. It was about alcohol for him, and said he thought he had a problem, and, well, he knew he had a problem. And they discussed it, and they had never discussed it before. And the parent always knew there was something wrong, and they never knew what it was. And they rang the teacher and said, Look! I don't know what you did with the kids yesterday. It set up a whole series of things here which we are now able to address. And they said, Look, thank you! And the teacher said, Oh! Well, the Public Health Nurse comes in and does that. And the Mother said, Oh! Please don't ever stop it!*

In essence, the nurse had been the catalyst who had presented the student with the opportunity to reflect and to change, and he had taken this up. Such a response is not always so immediate, as the nurse found following her first session with a Pre-Employment group.

> *I was dreading what it was going to be like! After the previous week of feeling so bad...But I came out of yesterday's [session] feeling, Hey! They actually...listened!! It was participative listening. It was active listening...and they were actually learning. Although it was noisy, it was actually learning noise, and there was a real difference...a real difference, and I actually think everyone of them went out with something.*

The important message learnt here was to never give up. Even when resistance is at its greatest, adolescents shouldn't stop trying to interpret their world. As their teacher was able to confirm,

> *The makeup of that [pre-employment] group is based on the same needs initially [school leaver, slow achiever, job seeker], but the group turns itself into something different every term! It's like being on a stage! And the Public Health Nurse has to go with it, adapt and respond to it!!*

This the nurse clearly did in her efforts to capture the group's interest. It came during the sexuality component and, as the nurse explained, this was unexpected.

> *They were not a closeknit group to start off with, but something like this actually does bring them together, no doubt about it! I was fascinated when I asked them to get out a pen and fill in the first questionnaire. I thought, God! The way they've been, none of them are going to do this...*

By remaining open to the possibilities, the nurse enables the critical teaching moment to occur. This can be both rewarding and empowering for nurse and student.

> *They all searched for their pens immediately!! One couldn't find his and said, Quick! Anybody got a pen?! Some of them, really quickly, started asking each other, What do you think the answer to this is? They all did!*

Had the nurse not been reflective and patient, the positive outcome may never have been achieved.

> *I don't think they were going to say, 'Sorry we were so awful'. I don't think they were going to say that at all! I actually think they were saying, Hey! We are interested after all! We actually are interested. We are actually learning something here. And they actually got onto it! And my guess is that they hadn't done that for a long time.*

There were many surprises with this group of students. Suddenly their behaviour changed and they became

> *...willing to talk about the ones that they'd got wrong or got different answers for. But a lot of them got them right! They also wanted to do the sexuality questionnaire which was meant for them to take home because it was so personal. But I was so amazed! They all immediately wanted to get onto that, but I didn't think they would as it was really personal.*

The group can be a powerful learning environment.

> *...one of the guys wanted to know what 'outercourse' was, and he was the one that had been so awful that first day. But he wanted to learn, and he was the one who actually said, 'It's not worth doing this'. He really wanted to think about this...'Why weren't we told all this earlier?!! Why didn't we get this information earlier?!' So he actually learned a lot.*

'At risk' young people face greater challenges than their peers who come from what seem to be more secure backgrounds. For them the personal empowering process is critical, as the class teacher explained,

> *I think one of the things that is hard for kids is that peer pressure. They're still doing it...far too many of them...getting drunk at a party, at age 15, and having sex...*

But the teacher had noticed welcome changes.

> *There seems to be a swing now starting in certain areas that kids around you be more of an individual rather than part of a pack. A lot of these health problems come out of that. The fact that some kids are saying, 'No!' to alcohol, 'I never do drugs' or 'Get drunk at a party or get in a car that is being driven by a drunk'. Now it's not cool to do. But rather it's a bit cooler to say, 'I'm me! I want to be worth it'*

One young woman made a decision to take action with regard to her partner's nonuse of condoms. Initially she thought this was because he had never used one before. She did not know how to use them herself. There were other young women in this group taking similar risks with unprotected intercourse. In discussing these issues, the Public Health Nurse said,

> *I'm not there to teach my moral stance...it's not my place to put my morals on those kids. It's to* ***give them the information they need to make choices for themselves****. So we discussed the issues, and what we are going to do...I'm going to pop up to the school in my lunchtime....and her and this other young lady, and probably a couple of their friends are going to come. And I'll show them how to use a condom.*

Following a teaching/learning session attended by the researcher, the nurse commented on a mature and responsible attitude amongst these young women despite their tender years.

> *Did you notice that if we actually treat kids with respect and treat them as equals, they actually give it back? Did you notice that they actually gave back the condoms? None of them wanted to take them off, and blow them up, and do the silly things that 14 year olds often do. It was more important that they actually practised it but the most important thing was that they learnt and felt comfortable about using condoms, because they've all had unprotected sexual intercourse.*

The value of group teaching was evident in that they learned by listening to others.

> *They've got their bit of paper so that they can think it through. They were asking the right questions. Often they don't need an adult to tell them those things if it's been raised by somebody else. They actually worked that process through very well. And they'll talk, because those five have actually shared that time. And they'll actually keep talking about those things...guarantee it.*

The nurturative nature of an informal teaching/learning environment, furnished with bean bags, facilitated this process. From her position on the floor, the nurse figuratively gave them the power.

> *You can all just sprawl out, and sit on your bean bags, and there's no barriers...or they can build barriers with the bean bag or the cushions if they want to...and a couple of them were. And they were higher than us, too. But they don't need to, do they? Because it's very non-threatening. And they're open and honest if we treat them that way. Those girls are going to be assertive enough that if they feel uncomfortable, they're going to say.*

Leaving the safety of the nurse's clinic the young women went out into the world. One of them demonstrated her new found knowledge and skills by reportedly, and assertively, saying to her young man,

> *Culturally to you condoms may not be acceptable, but culturally they are very acceptable to me*

She returned one week later with further insights and a new awareness of herself.

> *[She] came back in...the young man's broken it up with her, and she hasn't talked to anyone about it, but she's actually very aware. She's able to talk about her feelings at really, a very deep level. As we got talking, she was able to realise that, Hey! It wasn't her not being good enough! That was when she really looked at his behaviour, and put her life forward - she said, 'Oh! I couldn't make a life with him'. The obvious longterm scenario for her: 'He probably would end up in prison'. And I said, 'Well, how would that fit if you were his partner?' And she said, 'I couldn't bear it...I couldn't bear to have children and to have a partner in prison...I'd go mad'.*

She discovered within herself the power to make important decisions about her future.

> *She acknowledged that it still hurt because she was very fond of him in spite of all the other things about him...so we started talking about perhaps 'lucky escapes'...and it took a lot longer than that, and it came out better than that, because she actually did the whole process herself. She was looking forward to planning what she was going to do next weekend, and realising that perhaps she* ***had*** *had a lucky escape.*

The desire to have control over her life was also shared with the nurse by another young woman.

> *It was the hole-in-the-heart that was worrying her. It was affecting her whole lifestyle. But she felt so powerless where the medical profession were concerned. She wants to know why he won't do surgery. She didn't understand. He'd told her that her brain wouldn't function properly. And something about a pacemaker. It just didn't make sense to her.*

This young woman took exception to the restrictions necessitated by her illness.

> *She was sick of taking these tablets that she has to take twice a day for her heart. Plus she has to take extra vitamins. Plus whenever she runs, she gets short of breath. And she has to use a puffer for that, and she's just sick of the whole thing really!*

While the nurse could not provide any medical answer, she could however encourage the student to

> *...verbalise all this very, very coherently. I said, 'You know, you'll need to go back and ask'. It was her life, and she felt she didn't have any power with it. So we talked about the places where Mum could go [and] make waves. I felt quite sorry for her because she had obviously moved. She hadn't seen this doctor for over a year. So I explained that he had probably thought of her and talked to her like a child.*

With the nurse's help, this young woman formulated her plan for empowerment.

> *She was going to go home and talk it through with Mum...and she decided she would go back to her GP, once she had made a list of all the ways that it affected her life, and then all the questions that she needed answered. She was going to take that with her, and tick them off, and put the answers down. At this stage she was thinking she would go to her GP. That might change after she has talked it through with Mum.*

When young people presented with non-accidental injury, the nurse's focus was directed on their becoming self-determining survivors as opposed to remaining powerless victims. For some, documentation of their situation was seen as important.

> *She talked about the hurt. What she wanted was, she wanted to make sure she had the documentation. That was very important to her. And it is becoming increasingly important to young people. That is, they are asking that it become documented, and deciding not to do anything about it, which is fascinating. But they want to know that someone has documented it and verified it...*

This was not a new phenomenon. The nurse was able to recall,

> *I had a young man last year who also [wanted this]. I said to him, Why am I documenting this if you don't want to do anything with it? And he said, I want it - I want a record of it now. And I said, What for? And he said, I really don't know what for, but I want it recorded.*

The nurse's documentation seemed to help these young people to formulate their options for the future.

> *I think it is a form of power because if anything happens in the future, they know that someone has recorded that [injury]. And if they need to in the future, they know that it can be recalled. That particular girl...I gave her all her notes to read. She made a minor*

adjustment and felt really good about it...she wanted to know that she had an option in the future.

The ability of the client to grow from crisis captures the essence of this subtheme.

Sustaining the Self

Feeling good about oneself boosts a person's self esteem and consequently the community in which one works. This is important for Public Health Nurses who face many challenges and changes in the course of their daily work. In order to be able to do this work day after day, year after year, nurses need to work at sustaining their own personal resources, ie. their self esteem, their sense of wellbeing, their knowledge and their skills. Thus, the nurse's internal and external environments need to be self-sustaining. This includes the self-sustaining activities of the nurse herself as well as the need for colleagues and employers to create a work environment which facilitates the nurse's personal and professional effectiveness. Finding the right balance between self and others can be a compromise. How you are feeling impacts on how you are caring, as seen here by the nurse's reflections about the changes happening in her work place

I don't know that I'll actually want to be part of this in another couple of years... I'm not talking about the client stuff - I love the client stuff. I'm talking about [those meetings]...instead of, 'Hey! Haven't we done a good job!' And, 'Aren't we doing well!' And, 'Oh! I really enjoyed hearing about so-in-so saying about this, this and this', and, 'We could build on that'. Instead it seems to me to be a very destructive process. For me it does harm. And if I was really feeling down, then I just didn't go to those meetings. All I found was myself very frustrated by the end of them. I often don't feel that they are very productive. I found a way of not going because for me, personally, it wasn't worth it...it really zaps my energy. And I would come out of there feeling so negative when normally, I am very positive.

And again

> *I keep feeling...for many of us as Public Health Nurses - and we've got lots of integrity among us. I feel that that keeps getting squashed, and that it's dollars all the time. And I feel that the service we are giving is decreasing and being destroyed...constantly, and I don't respect the people at the top...What I really resent is the losing the possessiveness and coming out feeling really dragged down...my personal integrity is reaching a stage where I want to say, 'Shove it!'*

This nurse is not feeling sustained as person and nurse within the context of her work and employment.

> *I'm the sort of person who would rather be doing what I did today [Safe Sex Session with sexually active, underaged young women], and thinking about the ripples that come off that [ie. their empowerment]. I would much rather be doing that, than attending a meeting like the meeting we had yesterday afternoon.*

This nurse readily acknowledged the contribution that Public Health Nurses make to their field. An upcoming Youth Summit in which the Minister of Youth Affairs was going to be in attendance would provide a unique opportunity to tell the government directly about the problems young people were facing. In preparing the school's address, the School Guidance Counsellor called upon the Public Health Nurse for her input.

> *These case studies for the Ministry...the fact that the School Guidance Counsellor had already rung me and said, 'Hey! Can we do this?!', I think shows the value that Public Health Nurses are held in. That when schools have to give some feedback via the Principal, the Public Health Nurse is asked to look at that with the Counsellor. It's recognition! It is! We are very much affected by political decisions made in Wellington. We are affected in our work for our young people. We have some understanding of it. So we spent probably about half an hour to three quarters of an hour looking at what we want to do in relation to the Ministry's Youth Summit.*

It is important for morale that any work done well, is recognised and acknowledged. In an uncertain world where cutbacks seem to be the only constant, it is imperative that nurses recognise the value of their own work. This begins with being visible and valuing the self. Whilst planning her leave and the necessary cover, this nurse clearly acknowledged the significance of the nurse's presence in the school to the young people.

> *It can so easily happen! People get use to you not being there, and that might say, 'Hey! Are we valued?' . But, no! It's not that at all. It's if you're around, and you're visible, and they see you, then they will use you. They'll have a cover. They'll have my offsider every second week. It's just so important, because if the kids see you (are there), they'll zip in and see you.*

Working with adolescents requires energy and time. This applies equally to nurses as well as teachers.

> I *was actually glad that I had only one young lady to see today, although she did take me well over one hour...I think my batteries are wearing down. I hear the teachers saying the kids are really stroppy today in class!* [laughs]. *They've all had enough of them, so one was probably all I could handle today.*

The School Guidance Counsellor had recognised the nurse's fatigue and gave support.

> *...[she] said that I was looking really tired and exhausted, and I said, 'Well, yes, actually I am!' I reassured her that I have taken some time off next week to actually, hopefully deal with that. Just to give me some space & some time out.*

The nurse acknowledged the physical toll her work made on her.

> *I came back here because I was really feeling cold. I often come back really very low, because I've given out so much or just listening. Quite often at the end of the day, my circulation packs up anyway. And sometimes by 4.30, I get the shakes. But that's*

> *from my metabolism. I often eat something at this time of day, and that will actually see me through.*

Teaching adolescents, particularly when the theme is sexuality, can be unusually demanding.

> *I was aware that working with adolescents actually takes quite a bit of your energy. It actually takes a lot of energy to appear very comfortable teaching sexuality. It's quite an exhausting process to get to that state - to appear really comfortable, and to be able to talk about anything that came up...OK it looks really easy now, and it is, relatively now, but it didn't use to be...*

She went on to say

> *It's actually harder to talk to your own [children]! However, I'm really comfortable with my own sexuality these days, but probably have only been so for really the last ten years. But that's a process thing...and a learning thing.*

Learning to do this work, as the nurse pointed out, is not achieved overnight. It happens over time, and is not without difficulty.

> *I came from a very private family where I had never seen [nakedness] or anything like that. So the process has been quite painful at times. To reach that stage where you can talk about anything, and it doesn't actually affect you, it took years, it really did.*

Blending formal, theoretical learning with practical, hands-on experience helped the nurse to feel confident and competent with this topic.

> *I did a lot on sexuality when I did my ADN [Advanced Diploma of Nursing]. We had to. That was a big focus in our advanced diploma, and I really learnt a lot at that time. And then I did some work at the [_ _] women's prison, with women who were in for drugs. And always there would be lesbian activity in the room when I came in. And it was done to shock. After I addressed it, it*

disappeared. But I would always address it and talk about the need for affection. Even when in prison, that need didn't stop.

The nurse had developed her specialist nursing knowledge from the experience of working with different people and groups. Of these learning opportunities, including those which occurred during the study, she said,

Every time I have a group, that's a whole new thing. As a Public Health Nurse in my first year, I was sent up to [_ _ _], to go through the [Alcohol & Drug Rehab] programme with the programme participants...and that was the most amazing learning experience. Living it. Absolutely! Undilutedly. I just loved it. The 'not judging', because there were people there from right across the strata. And it made you very aware that it could have just have easily been you, or somebody in your family, or somebody who you loved, because it was right across. So I guess that's where the interest started.

The nurse displayed an ability that many community workers develop over time, namely, the affinity to work with the marginalised. This can be seen here in her affirmation of an at risk youth.

And then I saw a young man who is causing great strife in the school, who has the most devastating smile. And I can't help really liking that young man. Oh! He's madly charming! I mean he can't manipulate me with his charm, but he's easier to work with because of his charm. I had a chat with him about his future, and how good - or bad - he had been. Grins all over his face! And he says, 'No! I haven't been all that good!' He's been everything! You name it, this young man's been it! He uses the words, 'Good' and 'Bad'. He knows when he's been bad. I believe violence could be part of his personality, but not something I've ever seen. I've just seen a delightful, frank, open young man, who puts on this bravado and is very proud of his misdemeanours. But I get the feeling that it's not really how he wants to be. But I've got a real soft spot for him.

Despite the enthusiasm there were also pitfalls about which the nurse needed to be aware. Taking care of the self takes on a whole new meaning as nurses confront situations in today's world.

> *It's the traps. The thing that will catch me some day is hugging kids or touching kids...won't be a kid! It'll be a parent. I know that when I hug kids, I know there is nothing sexual in it. I mean, I'm very clear about why I do this. And why I touch kids. But we are living in a society where there are all these policies being made in schools now that say you do not instigate touching a child.*

The advent of health reforms has seen many extra demands being placed on staff, some of which seem quite unrealistic given existing workloads. This nurse's insight into her practice and the realities of her own resources allowed her to survive. She took a stand.

> *You can't do it. You can't do all these extra things. I don't even feel guilty. I just don't! I think it would be harder to maintain our integrity. Here, we just say, 'Yes' or 'No', and take no guilt with us. We try very hard, if we can do something, to do it. But if we can't, then that's OK. And there's no excuses. Because when you try to do everything, you can end up actually pleasing nobody, yourself included.*

Often the nurse had to make a stand to assert her own professional accountability - she could go so far, but no further.

> *I had to go in and talk with a parent. The school had arranged for the girl to go on the Spirit of Adventure, and they needed a medical filled in. I had done them before when they'd needed them in a hurry. But I said, 'That's fine. Where is the young lady? Could we send her down to the office?' They said, 'No. She's in [another city]. We don't know how to get hold of her'...I just said, 'Well, I won't fill in this form'. And the Guidance Counsellor said, 'Would you get into trouble?' and I said, 'Yes! I could be struck off! I'm not prepared to do that without actually seeing the person'...So we talked through what we could do...'*

The world of Public Health Nursing has changed radically over the last few years. Whatever the field, or the future, Public Health Nursing will always be challenging. None less so than in adolescent health as illustrated in this study. This final theme acknowledges the importance of being empowered as both nurse and client respond creatively to the changing world around them.

Summary

This chapter on EMPOWERING is the last of the key themes. It has discussed the need for people - both client and nurse - to have control over their own lives in order to operationalise the ideals of self care and health determination. Support of the themes comes from the nurse and teachers' stories. Personal empowerment is critical in the face of peer pressure, forms of victimisation and the realities of today's changing world. The ability to grow from challenge and crisis has been captured by the two subthemes entitled, Using the Critical Moment and Sustaining the self. The final chapter summarises the study and explores its implications.

Chapter 7

DISCUSSION

Introduction

This study, using a single case study approach, has described the work of one Public Health Nurse in a college setting. This chapter will now summarise the findings and relate them to the literature. Implications for adolescents as well as nursing will be discussed. Recommendations will be made in relation to public health nursing practice. Limitations of the study will then be explored followed by suggestions for further study. What I learnt from the experience as both a Public Health Nurse and a researcher will be considered before the conclusion.

Summary of the findings

In this study the school and the local community emerged as ideal venues in which the Public Health Nurse can creatively respond to the health needs of adolescent students. Lynch (1993) also described schools as being the *ideal vehicles for delivering adolescent health care* (cited in Carol, 1993, p. 7). Trickett & Schmid (1993) recognised the resourcefulness of the school as a social context in which empowering indigenous interventions could take place. The Public Health Commission (1995) acknowledged the contribution Public Health Nurses made to primary and intermediate schools, but they made no mention of the work these nurses did and could do in colleges. There could be several reasons for this.

Coming into the college from the outside to deliver essential primary health care to high risk adolescents demands a certain degree of discretion in order to get vulnerable students to the point where they trust someone like the Public Health Nurse. But, in doing so, the nurse's work often remains hidden, unheard of and to all intent and purpose, nonexistent. This invisibility can be to the

Public Health Nurse's disadvantage. Hopefully, this thesis will help to expose the nature and value of the work of the Public Health Nurse.

MAXIMISING, OPTIMISING and EMPOWERING reflect the essence of the nurse's work with students, teachers, parents and colleagues on issues well recognised in current adolescent health literature. These include emotional, spiritual, socio-cultural, mental and physical health concerns covering a wide range of areas involving sexuality, STDs, pregnancy, contraception, relationships (with both peers and parents), self esteem, identity, grief, depression, drugs, alcohol, anorexia, child abuse, hygiene, and truancy (Stapley, 1988). There was also a large educative-counselling role dealing with these and other matters of a more medical nature such as cardiac, orthodontic and tuberculosis contact followup.

Time was finite as most referrals to the Public Health Nurse had to be dealt with in a minimum of time. While this working style sometimes suited the attention span of the adolescents as well as the immediacy of their needs, it was also largely born out of organisational necessity. More than a decade of economic deregulation and state sector reform has taken its toll on the health, education and welfare services in New Zealand (Fulcher, 1994). This was evident in those instances where the Public Health Nurse "working at the coalface" felt the lack of backup from management and other services, for example, in the followup of child abuse and the support of field workers in general.

> *I keep feeling for many of us as Public Health Nurses - and we've got lots of integrity among us - I feel that that keeps getting squashed, and that it's dollars all the time. And I feel that the service we are giving is decreasing and being destroyed...constantly, and I don't respect the people at the top.*

It was under these circumstances that the nurse tried to make a difference for her client by delivering the maximum care in the minimum of time. Hence, her focus was on the quality of the given moment of care and it is a credit to the professionalism of this nurse that she, and her colleagues, are able to provide care under constraints such as these.

Under the theme of MAXIMISING, there was a classic example when the Public Health Nurse arrived at the school to run her usual weekly clinic, only to be

confronted by a highly anxious student who had just received positive results on an earlier STD test. The nurse described herself as "dancing on a moving carpet", as she quickly rearranged her clinic to take this young woman back to Family Planning, onto the chemist for her prescription, then back to the college "just in time to get her on the school bus".

The nurse's response to this and many other urgent issues is frequently unseen by outsiders. But this study has allowed it to be revealed, demonstrating nursing's ability to be adaptable, accepting, culturally appropriate and confidential in helping clients to meet their needs in an effective and timely manner. It is in this context that health teaching is lived as life's lessons are being learned.

Underpinning primary health care, are the hands-on principles of prevention and health promotion. Nowhere were these more evident than in a Pre-employment class session where some of the students began talking openly about their illicit drug and alcohol use. Maskill (1991) suggests experimentation is a normal part of growing up. But, it can lead to health-compromising behaviour such as substance abuse which can then set the scene for health problems in adulthood and future generations beyond.

When bravado led to behaviour designed to shock the Public Health Nurse, she creatively used it as an opportunity to explore with the students where they saw their responsibilities in relation to health and, in particular, what choices they felt they had for their future. With well publicised concerns about the health status of New Zealand young people, including their mental health and suicide rates (Taylor, 1988), it was appropriate for the Public Health Nurse to guide her young clients into thinking about these issues, not just for today but as my Mother often said, for the "tomorrow of life" (O'Sullivan, 1996). This was particularly pertinent for risk-taking behaviours that potentially could affect future health potentials, such as the effects of marijuana and other drugs on the unborn child.

Encouraging young people to make healthy choices through informed decision-making is not easy, and requires energy and understanding from both nurse and client (De Maio-Esteves, 1990). The Public Health Nurse in this study intricately wove introspection and problem-focused coping into her OPTIMISING work with young people in the "here and now". This was deemed

to have benefits for their quality of life in the future, particularly in the areas of safe sun, safe sex, and safe alcohol. This was particularly salient in the paradigmatic case of the student who disclosed his alcohol problem to his parents following the Public Health Nurse's workshop on alcohol and drug abuse.

In a world of negative role models, the Public Health Nurse appreciated that some students had considerable difficulty in their daily lives when making lifestyle choices that were different from those of their addictive or violent parent, caregiver, older sibling or dominant family member. Students, who Eckersley (1997) might describe as ACES (alienated, cynical, experimental and savvy), often found solace in the nonjudgemental but knowledgeable support of the Public Health Nurse in the community, classroom or within the nurturative nature of the clinic, affectionately known as the Bean Bag Room.

Often the Public Health Nurse played the role of catalyst, helping her clients to face their challenges full on by figuratively picking them up with both hands and journeying with them from a state of crisis to one of personal growth and empowerment. This finding was supported by Lauer (1990) who found adolescents were willing and able to look after their health, providing they felt supported as they moved from one discrete transition to another during this important yet sensitive time of adolescence. The third theme, EMPOWERING, illustrated this in the second Pre-Employment group session where both nurse and client mutually worked on areas which were previously in denial eg. drug and alcohol abuse and cavalier attitudes towards unsafe sex.

Implications for adolescents

Adolescent health is now recognised as one of the fastest growing, dynamic areas of need in health today (Hathaway, 1993; Taylor, 1994). It is an area that requires special training with ongoing skill and knowledge updates. As the only age group not to have experienced an improvement in health status over the past 30 years, adolescence requires those working in the field to be both skilled and empathetic in their understanding of young people (Blum, 1987, cited in Carpenter & Givens, 1993). This includes policy makers as well as "people on the ground" such as caregivers and field workers.

Studies like this shed light and insight onto the diverse issues facing many confused young people today. The study showed that students were indeed affected by an environment which frequently gives mixed messages. The interplay between the media, peers, expectations of caregivers and the example of some role models led one teacher to emphatically testify that the pressures on young people today were far greater than they were ten years ago.

Even though the onset of puberty is earlier overall, adolescence is still essentially the same process of transitional growth from childhood to adulthood that it has been for some time. But it is the world that one enters as an adolescent that is different. The turbulence of social and economic reform in this past decade has increased the impact. Gambel (1997, p.3) cites this as one of the reasons why some young people have opted out, stating that members of the new "younger, Generation X" believe it better to cope this way and survive, than go the other way and suicide.

On a one-to-one basis, the Public Health Nurse performed much preventive work, covering for others during the school holidays, and attempting to fill gaps and needs whether students were in school or out in the community. This area of work had increased as the school leaving age had also increased. Where once it was possible to leave school early and find meaningful support in the work place, this was no longer a viable option in the present post-industrial society. High unemployment has made jobs scarce with employers demanding higher school leaving qualifications from young people. This is a very different world from that of their parents, many of whom are themselves solo and struggling under socio-economic stress.

In visiting the college, the Public Health Nurse therefore brought a certain amount of solace and stability in relation to health and lifestyle issues to students, teachers and parents. Teachers found themselves being increasingly involved with the needs of adolescents who had been left by busy or absent, stressed parents to "bring themselves up", with many young people not knowing "how to look after their own health" needs (Guidance Counsellor). This was an area in which teachers needed support.

The nurse's work of being there for young people was captured in the MAXIMISING subtheme entitled Working With the Student. It took time and

patience to be the nurse and to listen. But it resulted in rewarding partnerships illustrated in the discussion on OPTIMISING and the subthemes of Building and Breaking. The nurse made the observation that "a lot of information is not available elsewhere". While this sometimes is the case, there were also times when information was available but was not getting through, particularly in the area of adult-adolescent and peer communication. The Dunedin study found high rates of adolescent depression were often associated with poor quality relationships with peers and parents (Silva, 1990). Taking time to just be with their children, hear their points of view and discuss any problems they may have, was part of the nurse's message to parents at the PTA (Parent Teacher Association) evening and Gain Programme. In reaching out to them, she said

> *...find time to share meals together every day...touch your kid every day...and know where your kids are, and they you.*

Today, most if not all parents need support when their children are in adolescence. Although only 15 per cent of them actually turn out to be "at risk", one cannot safely assume that those who are well-fed, well-clothed and well-educated will not be amongst them (Max, 1997; George, 1997). As one teacher sagely said,

> *Parents don't know what they need to know to help them protect their children.*

Schools are microcosms of community need. At the same time, they are the ideal vehicle for delivering adolescent health care to their students. The Public Health Nurse is well placed to do that work, a knowledgeable and skilled person coming from outside to deliver needed service to the school, one that is based on the principles of primary health care, health promotion and prevention. The implications of this for nursing will now be discussed.

Implications for nursing

We live in a real human world - not an unreal, ideal, abstract one. Public Health Nurses deliver care to the people of this world whether it is in their home, a camping ground, a city street, a community house, a clinic or a college. As reflected in the study, it is nursing that is community-based and client-centred; it is primary health care at the cutting edge of what some would say is "the

coalface", others "the cliff face" and in this study, "the interface" between health and education. Health promotion and prevention are integral parts of that care. The environmental domain in nursing is seen as central to the development of public health nursing knowledge (Kleffel, 1991). Wherever the venue, Public Health Nurses are always guests bringing their unique perspective and "internalized knowledge base" to their working relationships with clients, colleagues and communities (Clarke & Cody, 1994, p. 43). The college community saw it was particularly important that the Public Health Nurse came to their school not just to be with their students but also to bring fresh ideas and perspectives, as the Deputy Principal explained:

> *...they need that wider perspective to be valuable to us...we need, the Public Health Nurse needs to be able to give us that sense of perspective, a sense of balance, and a sense of, 'Oh! But that's a problem all over the region at the moment!'*

Since the introduction of Tomorrow's Schools (1989), the Ministry of Education is no longer directly involved in the daily running of schools. This means schools are like stand alone institutions and are largely cut off from each other both regionally and nationally. Schools found they needed support as they came to terms with the consequences of this new configuration.

> *You haven't got the Ministry making all your policy decisions, or giving you advice. They're not on the end of the phone with advice anymore. You've got to really make your own way. So its really important to have people who have an outside perspective...* (Deputy Principal).

Having the nurse "coming from outside" had several distinct advantages for the college. One of these was the 'linking up' that happened because of the nurse's local knowledge and networking in the area. Identified by Finalyson et al (1993) as one of the ten core themes in public health nursing, 'linking up' was acknowledged to be of great strategic value by the Guidance Counsellor.

> *The other thing that the Public Health Nurse would have that we do not is...she has an overall focus of the whole family. She's got great access to primary, intermediate & secondary schools. Also, she can use her network of nurses to deal with issues of child*

> *protection. I know that I can tell her and that she'll find a way of getting that information to the right person. She's sort of within the school but the Public Health Nurse is coming from outside, therefore she has a huge amount of networks, and her boundaries go much wider. Her network is parallel to mine. Because it's not the same, it's good!*

The Public Health Nurse was perceived to be like a bridge for their students, as the teacher explained,

> *If there is an area of concern to me and they're not going to talk to somebody in the school environment, I suggest, There might be other things you want to talk about...the Public Health Nurse is here, if you would like me to make an appointment...and usually I find they take that up.*

Some students will not listen to their teachers, or their parents. But they might listen to somebody perceived as neutral and nonthreatening, and knowledgeable. These perceptions were summed up by the teacher as follows,

> *She can put across the messages that perhaps they haven't accepted eg. alcohol, drugs, nutrition, or (in this case) unsafe sex.*

This was evident in the breakthrough the nurse made with two young women who came to the nurse about contraception and ended up with additional insights into obesity and alcohol, including knowledge on how to have a good time without getting hurt. Like other first time visitors, they had come on the recommendation of their friends, and they came together for peer support. Other students came because they had seen the nurse talking at assembly or in the classroom, and on that basis had made the decision that she was safe. It was this visibility that enabled the Public Health Nurse to connect with so many, either on the campus or out in the community, in their own homes, or in her office. Sometimes it was just the happenstance of meeting in the street. All these connections support Gage's (1994) finding that access improves communication and hence the working relationship that nurses then have with their communities.

The client cannot be separated from the natural, sociocultural and symbolic worlds that he/she shares with family, friends and the community. In the study, many young people lived in the suburbs surrounding the college; some bussed in daily from rural areas; some had only recently immigrated to New Zealand. Sensitivity to, and understanding of, the context of the human experience by the nurse, allowed critical issues to emerge and be addressed. These included social responsibility, access to care, cultural diversity, and human health experiences. Many recorded scenarios illustrated this concept, eg. the parents, immigrant and New Zealand born, who found it difficult to talk to their children about drugs, alcohol and sex. Then there was the young man just fresh from the country...

> *...with two sets of teeth! Recently arrived at the college. Living with his Dad. Having difficulties coping in a busy suburban school.*

When one has the opportunity to work closely with individuals or groups in their own settings, such as teachers or students in a college, or parents and families in the community, public health nursing can be at its most rewarding. The boundaries of partnership are very broad, with individual differences being respected, possibilities being explored, choices being made, and goals arising from the people themselves, in mutual process with the nurse (Clarke & Cody, 1994).

Sine qua non, the preparation for working in such a field requires an expertise emanating from a broad nursing background as well as an affinity for understanding young people (Taylor, 1994). As an autonomous, theory-based practice, public health nursing is grounded in a specific body of nursing knowledge (Siddle, 1992). The Guidance Counsellor was cognizant of this quality in her statement of belief.

> *Why I need a Public Health Nurse: because I'm a firm believer in using the specialties where specialties are necessary. For some of the specifics I don't have. In particular, the basic needs of vision and hearing, and other specific problems that only a nurse has specific knowledge for - the specifics that I don't have time for (I had ten kids in each room today!!). I see it as a specialised role, that is, not as just anybody could do it. Because it's the body of knowledge that the nurse has - the body of specific knowledge. I*

update myself. I presume nurses do. I don't do both. I can't do both!

In the course of the study, the Public Health Nurse was seen to be constantly updating her knowledge, for example of drugs including antibiotics, the contraceptive pill and recreational chemicals currently being used by adolescents; of diseases including viral meningitis and of programmes such as the Australian Programme for Asian Youth Workers. With rapidly changing trends in health, she remarked,

No one person can know everything.

Hence her wise warning about the "know-it novice" and the need for there to be a balance between theory and practice.

You need both: You need that kind of theoretical knowledge. But you also need the feet-on-the-ground, the people-who-have-been-there-for-some-time. You actually need that experience knowledge as well...A know-it novice can be very dangerous, and very difficult to deal with.

According to Meleis (1985), the 19th century philosopher, Kant, once maintained that "while knowledge begins with experience, this does not mean all knowledge evolves from experience" (p. 35). Kant also stated that

Experience without theory is blind, but theory without experience is mere intellectual play (Kant, in Smythe, 1992, p.1).

The nurse's expertise in the following two scenarios reflects the complexity of the nurse's decision making in determining what level of involvement should be appropriate in the following challenging situation.

A teacher came flying in, wanting one of us to do something about this fourth form group who were not her normal group, who were going on about 'blow jobs'...and something had to be done there & then...

The cues intuited by the nurse and grounded in her past experience, told her to wait and observe first before rushing in and becoming involved with this class. This hands off approach allowed the teachers the opportunity to discover they actually had the resources within their own ranks to solve this problem. Hence, the nurse's actions led to the teachers becoming empowered to manage this and any similar situation should it ever arise again. This, however, was not her decision in another scenario.

> *...she had had anal sex the night before, and she couldn't discuss that with her Mum, although she's got a close relationship. Couldn't discuss it with any of the other kids at school because, as she said, 'I just don't know what they'll think of me'. And that was worrying her. But she couldn't sit down either, and she was bleeding, and she was feeling really uncomfortable, and she was feeling really revolting.*

In this matter, no one else except the Public Health Nurse was acceptable. The student perceived her to be safe and nonjudgemental, neutral as well as knowledgeable, with the added bonus of being able to reassure her with wise comfort and humour. Clarke & Cody (1994) state that

> *Nursing theory-based practice requires knowledge of complex human-to-human and human-environment relationships, which unfold in the context of one's whole life - family, home, social networks, community, and patterns of daily living in all kinds of health experiences* (p.50).

The dynamic data from this study clearly demonstrates this. Public health nursing is a knowledgeable practice based on mutual trust and respect. A key aspect of this is the relationship the Public Health Nurse has with the school.

> *You've got to be trusted in a certain relationship. It has to develop between the Public Health Nurse and the primary person that the young people see in the colleges, like the Counsellor or Deputy Principal.*

This mutual trust system was evident in the nurse's safe sex session hurriedly put on during one lunch hour for a group of risk-taking, sexually active young

women. The Guidance Counsellor had even booked out the room and thoughtfully put a 'Do Not Disturb' notice on the door.

The nurse's longterm relationship with anorexic young women was further testimony to this chain of trust. The nurse had a gift also for accepting the 'kids' who were different or marginalised, and for presencing herself with those who were 'difficult'. Helping these students to own their own process for self-empowerment, as opposed to ritually sabotaging it, required a fine blend of respect, firmness, fairness, patience and positiveness. This was clearly identified in the participant observation sessions of the Pre-Employment classes where the students were in denial to certain messages about drug misuse. Rather than admonishing them for what they did not want to know, the nurse gave them credit for what they did know.

> *You've got the knowledge there, but it's not in the right place...and some looked startled! They actually felt great that they had some knowledge.*

Affirmation comes in many forms. Being there at the critical moment when a student first revealed abuse or suicidal thoughts was a poignant moment. It began with the nurse intuiting that the individual students were wanting to tell her something but first needed assurance that they would have the protection they needed before doing so. Then, by the nurse asking the right question, the student would begin to slowly unfold. Having affirmed her young clients for their courage, she immediately followed this up with repeated reassurances that their confidentiality would be maintained, and only broken with their knowledge and/or permission. Never promising the impossible is a lesson an expert nurse learns in the course of following up abuse. Being honest is an essential art.

In one particular abuse case, the nurse found her own integrity was challenged as she tried unsuccessfully to get other agencies to urgently followup the case. It was ten days before she would hear back from one of them. The nurse's dilemma clearly demonstrated the high level of trust operating between her and the school at the time. As her comments indicate, this is not achieved without previous investment of nursing commitment and "going the extra mile" in terms of time, energy and nursing input:

> *Had I not had a good relationship with that school, I think it would have blown it away completely. Sometimes Public Health Nurses' relationships with schools are very tenuous - they remember the last thing you have done, and if you have done it well, fine! But if you've not done it well, then they actually don't want to know you again. We're very much at the mercy of forces. Our reputation takes years to build and minutes to knock down. I'm very lucky that I'm trusted in that school...*

Not long after this incident, the then Minister of Youth Affairs visited the local region to discuss issues of youth concerns in the area (McClintock, 1994). Fragmentation of care and lack of coordination were top of the list. Three years later they are still there as different youth agencies struggle to serve the increasingly complex needs of adolescent health (NZ Herald, 1997).

It was not without significance therefore that the Deputy Principal paid a profound tribute to the nurse's commitment to come every week to the college

> *...that's the difference...that's been the turning point - her regular attendance...we can rely on her being here, being available, and not simply someone at the end of the phone.*

Being there and being available to do school, and even home visits if necessary, can be a simple but powerful act of prevention.

> *Then people will tend to use her as a resource rather than wait for something really serious that they then have to phone up someone else about.*

In the true spirit of the Ottawa Charter, the nurse created supportive learning environments for the students in which they themselves made many meaningful connections between health and illness. These were then shared by learning and listening to others in the group, and in this way the net of knowledge and competencies was spread.

In a world where the only constancy is cuts, it was reassuring for teachers to know that the Public Health Nursing service is still operating. While there are not the same numbers today, at least its philosophy of *health promotion and*

disease prevention is still intact and relevant for the needs of today's young people.

Recommendations

In the light of the study's findings, several recommendations have been made with reference to public health nursing practice within a college or community setting. These are:

1. *That the uniqueness of public health nursing be reflected in a framework for practice that reflects the reality of work carried out in the specific area of primary health care with adolescents.*

Using the themes developed in this study, the emerging model would include a portable, dynamic knowledge base that could then be used when working with adolescents in any other area of public health today eg. communicable disease and immigrant health.

2. *That Public Health Nurses use evidence-based practice to provide the best possible care to their clients.*

This is to ensure that practice remains relevant now and into the 21st century. It involves the synthesis of practice, education and research which in turn helps the nurse to make complex professional decisions in the course of delivering daily competent care.

3. *That Public Health Nurses establish processes, including peer review and supervision, to monitor and mentor their work.*

Public health nursing is demanding work and as such, Public Health Nurses need to be able to access the support and coaching necessary for facing the daily challenges in this field of nursing adolescents.

4. *That Public Health Nurses show their commitment to adolescent health promotion by participating in projects like the Health Promoting Schools Programme currently being carried out in colleges.*

Linking up and effectively networking with other agencies such as Family Planning, Peer Educators, School Nurses, GP Practice Nurses, Child Protection, Social Workers, Iwi, Youth Health NZ et al, provides a common focus for adolescent health and a firm basis for collaborative practice. Potential partnership models would see the sharing of knowledge and skills, and facilitate coordination between services with reduced fragmentation of care. They would also encourage fully informed consumer participation with maximun self-determination.

5. *That public health nursing's agenda for adolescent health include advocating for the kind and level of support needed on the basis of goals identified by adolescents themselves.*

This requires both a unique form of partnership with young people, and a professional nursing perspective that accurately reflects these matters to planners, policy makers and politicians with integrity, dialogue and debate.

6. *That, during periods of economic or health reform, nurses encourage governments to consider the true costs and benefits of health care in human terms, rather than merely financial and bureaucratic ones.*

Public Health Nurses have a responsibility to continually monitor health consequences and outcomes associated with health status and reforms. Concerns surrounding these issues should be reported to the Childrens and Young Persons Commissioner.

Adolescents also need support to seek empowerment to have a political voice on their rights as laid down by the New Zealand Children's Agenda and United Nations Convention on the Rights of the Child. This is an essential part of this recommendation.

7. *That every college in New Zealand make provision for an adequately resourced adolescent health care centre on-site in their school, including the part-time involvement of at least one Public Health Nurse if a designated school nurse is not present.*

Schools are important occupational and environmental settings. As such, models of care within these settings should also include support for teachers

and parents whose role is often pivotal in the daily health and wellbeing of adolescents.

8. *That the work carried out by Public Health Nurses become visible and recognised for its contribution to nursing, adolescent and public health.*

The invisibility of public health nursing is evident in nursing language and literature. This state needs to be reversed by research carried out, published and presented at conference.

9. Last but not least, *That Public Health Nurses role model the importance of self awareness, self care and self empowerment*, particularly in the actualisation of the above recommendations.

Limitations

Few researchers if any, had previously investigated the work of the Public Health Nurse in a college, despite there being over 300 Public Health Nurses visiting more than 2,000 schools in New Zealand (Coalition for Public Health, 1997). This study therefore had legitimate reasons for taking a single case study approach and asking exploratory and explanatory questions that needed to be answered.

The study yielded much relevant information associated with the contribution of the Public Health Nurse to adolescent health and wellbeing within one college. However, like all qualitative methods, the case study approach does have certain limitations with regard to the generalizability and reliability of its findings. It is simply not possible to say that one Public Health Nurse working in one college is representative of all her other 300 colleagues. Indeed, as the Deputy Principal said, how one community would look upon the Public Health Nurse could be very different to that of another (Deputy Principal). But Rissmiller (1991) points out

> *...there are fewer threats to external validity in qualitative research (than there are in quantitative research) because it emphasises the study of phenomena in their natural setting with few controls* (p. 1).

Hence, while qualitative research samples may be small, and in this case only one, the nature of the contact with participants such as the Public Health Nurse, Deputy Principal, School Guidance Counsellor and Teacher is likely to reveal many issues common to others working with adolescents, but this can only be tentative. This is acceptable because there is a commitment to the uniqueness of human situations. However, if the study were to be repeated, the steps in the research process could be followed using the decision trail as outlined in Chapter 2.

Finally, while the subjectivity of the researcher is acknowledged, because she was directly involved in collecting the data, is a Public Health Nurse herself and knew the participant-Public Health Nurse in the study, there is always the possibility of human bias in wanting to present the results in the best light possible. However, there was a continuing effort to seek data support for the interpretation which generated the research outcome. Throughout, grounding in the data is used to minimise this potential problem.

In their current state of tentative development, the three themes may be criticised for being of only limited application in examining and explaining other situations. This can only be eliminated by further study.

Suggestions for further study

It would be of immense value to develop a framework for public health nursing practice that would explore the impact of the application of the three themes, MAXIMISING, OPTIMISING and EMPOWERING, to the different settings within public health nursing today eg. a college, a communicable disease follow-up, and perhaps with younger children.

> *Nursing concepts must be nurtured in nurses in ways that empower nurses to practice nursing autonomously and thereby enable full, caring participation with and accountability to those they serve* (Clarke & Cody, 1994, p 48)

Likewise, it would generate further knowledge to do a repeat study of the Public Health Nurse In A College either with the same or different design, altering such

variables as setting (rural or central city), gender (same or co-ed), management (private or state school), and number of participants.

A separate study on the attitudes of teaching and non-teaching staff towards Public Health Nurses would shed light on the positive ways in which to establish and build a working relationship between the visiting Public Health Nurse and the college staff.

Another area well worth investigating could be the current concerns schools have about communicating with outside agencies regarding the coordination of health-related care for young people in the community.

Studying students' perceptions of the Public Health Nurse in their college and of their own health-related needs would enhance the insights and understanding which result from the present study. Such a study would seek to improve nursing's delivery of services by directing resources to areas of student-identified need.

The role of the Student Peer Educator in a college working alongside the Public Health Nurse would be an interesting area for exploration, particularly in relation to the role peers play in supporting and learning positively from one another during their time at school.

Comparing the work of the School Nurse with that of the Public Health Nurse would be a valuable study given their differences eg. the former is employed by the school and working on campus while the latter is employed by the local CHE and visits the school as part of her (or his) geographical area. Both nurses focus on the health and wellbeing of students. What differences, if any, are present in their care?

Researching the health needs of adolescents and the nursing response within a multidisciplinary/interdisciplinary environment, would help to identify the overall contribution that nurses make in the area of adolescent health.

A history of public health nursing would be an appropriate project given the upcoming millennium as well as the first centenary in this particular field of nursing. This would celebrate the transformation which has taken place from pioneer nursing to practice as it is today.

What I learned as Public Health Nurse, researcher and person

As one of my clients once said, *It has been a learning for me*. Not just in pursuing the research process over four years, but also in learning how to cope with the demands of fulltime work, and commitments to family as well as to this thesis.

As a Public Health Nurse, I learned I was a sensitive human being discovering these same qualities in other people such as colleagues, clients and managers.

The idea for 'Public Health Nurse in a College' was first mooted while I was a Public Health Nurse in Child and Family. Looking back, I can see it was all a process of negotiation, consultation and consideration. Time was always the factor particularly with working fulltime. And the fear of running out of time to complete the research was real, particularly, when there was crisis or change.

In the study the nurse eloquently expressed her disenchantment with the health system. For many this was and still is true. One year after commencing the study, I changed fields of practice (or fields of fire!), going from Child and Family to Communicable Disease Control and Immigrant Health. While I was happy at the time, there were a number of issues that concerned me as I continued with the study.

Firstly, I was concerned that I might 'grow away' from the study, now that I had left the field in which I had collected the data. Thankfully, this never happened. Just because I was no longer in the field did not mean I no longer cared about its concerns. There is not a day that has gone by in which I do not think about my Child and Family colleagues and clients, and I hope this is reflected in my writing.

Secondly, nobody knew that meningococcal disease, hepatitis A, measles, pertussis and tuberculosis would all become epidemics in the nineties! Working up to ninety hours a week did not leave much time for thesis writing. But it did not stop me 'thesis-thinking'. The gift of data that my participants had given me, has kept me faithful to the cause of articulating adolescent health concerns, within a public health nursing-college caring framework.

One of the greatest learning experiences for me was discovering adolescence. I have nothing but admiration for those who work in this challenging field. I know that long after this study is over, I will still be collecting articles on this significant subject. This is because it has many implications for nursing and New Zealanders. I think it was a strength that I never saw myself in the role as the expert nurse in this field. I left that to others but I was grateful that they allowed me to study their expertise from a distance. Kia Kaha, you can stand tall, my colleagues.

In my present role as a communicable disease control and immigrant health Public Health Nurse, I have frequently applied my new learning. I have been to many young adolescent parents of meningococcal disease babies. I have gone into colleges for students affected by this and other notifiable diseases. I have given BCG vaccinations to babies held by their adolescent mothers and fathers. And, I have found my new learning invaluable when working with adolescents from refugee-immigrant families. In this context, the dichotomy between personal and public health appears false as care transcends all boundaries.

An added bonus in this study has been tracing the history of public health nursing, seeing where the present is made meaningful by the past and anticipated future. Becoming a Public Health Nurse-researcher has enriched me both personally and professionally. It has also at times confused me! But being one and not the other was a challenge and actually impossible to achieve.

It was a challenge to carry this life on when my Mother became ill with cancer in the middle of 1995, when the thesis was in its second year, and the epidemics were in their first. It was both a privilege and a pleasure to be the daughter who dared to care, and I would unhesitatingly do it all again. Two years after diagnosis and at times much suffering, my Mother died peacefully at home. That was a few months ago. Throughout this journey, I have persevered with the thesis and have found the meaning of caring and commitment. As a nurse and a person, I can categorically say I value people.

As a researcher, I learned that adolescents are forever searching for meaning in their lives. What the Rabbi said (p.36) was true - we answer problems by giving material things to our children, rather than by helping them develop an

inner sense of meaning and value. In my researcher role I became aware that the students in the study just wanted to talk to someone who was neutral enough to listen and knowledgeable enough to advise them about their health issues. This was what the Public Health Nurse did by being there for them.

This was the second time I had done qualitative research on the general subject of Public Health Nurses in schools. I have no regrets on my decision to study just one Public Health Nurse. As predicted from my 1993 study of sixteen Public Health Nurses in sixty primary schools, I generated enough indepth data to answer the research question, "How does a Public Health Nurse deliver primary health care to students in a college?". It has been rewarding seeing the study through to its conclusion, and the development of its three themes. I have already applied them to different nursing situations in my current area of practice, communicable disease control and immigrant health public health nursing. Perhaps this is the start of theory generation for that field too!

There were many people who were there for me as a beginning researcher and these included members of the Department of Nursing and Midwifery at Massey University and, in particular, my supervisor who guided me through the process. I was grateful for the letters of support I received from my then manager of Child and Family, as well as the college Deputy Principal in the early stage of the research; and also to my colleague who came out at night to support me during the hearing of the Regional Health Authority Ethics Committee. This study could not have been possible without the courage and integrity of the Public Health Nurse and College staff who allowed me to collect the vital data that then developed into this thesis.

In the last ten years I have received a total of eighteen days of study leave from my fulltime work place, and that was from a Public Health Medical Specialist during my third year of the thesis. I was moved that this medical colleague believed in the value of nursing studies not just for the self but also for team, service and client.

The same nurse who came out at night to support me in my ethics committee hearing covered me while I took all my annual leave to look after my Mother and at the same time, try and complete the thesis. Some of this annual leave I converted to sick leave when I, not surprisingly, became ill with colds and flu. It

would be an understatement to say it has been uphill all the way. Now, I certainly understand the rigours of research.

Researching and writing the thesis have been a learning experience. I have learned that public health nursing is a special field and that its specific contribution needs to be articulated. I have endeavoured to do this through the medium of research. I hope others will continue this challenge. And I would like to be there with and for them when they do.

Conclusion

You do get there in the end, with calmness
(Public Health Nurse in a College)

This chapter has discussed the findings from the research. Implications for adolescent health as well nursing were explored as were the recommendations and limitations of the study. Suggestions for further study were then made, followed by a personal reflection on what I have learned as both Public Health Nurse and as researcher from this experience.

I began this journey by asking a question, "What sort of work does the Public Health Nurse do with adolescents in a college?". This then led to the more definitive question of, "How does the Public Health Nurse deliver primary health care to students in a college?".

This study has endeavoured to address those answers by developing an all-purpose, all-inclusive framework describing the diverse aspects of preventative and health promotive care in public health nursing in a particular context today. The three themes of MAXIMISING, OPTIMISING and EMPOWERING capture the paradigmatic moments when the Public Health Nurse connected with clients, colleagues and the community in order to work more collaboratively on issues concerning adolescent health.

Like adolescence itself, time is finite for getting across the important messages considered essential if students are to make the right decisions about their present and future health. It is also essential that students become empowered to make these decisions on their own once they are out in the world, and no longer within the protective confines of the school.

This specialised area of care has received considerable media attention over the last few years, particularly in relation to New Zealand's high rate of youth suicide. Adolescent health is a constantly challenging and changing field of work. It demands ongoing upskilling as well as high levels of trust and integrity if one is to work effectively with young people and their caregivers. It is with regret that only rarely does the work of the Public Health Nurse get recognised as a worthwhile contribution to this and any other area of high need. It is hoped that this work goes some way to putting that deficit right.

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APPENDIX A

CASE STUDY OF THE PUBLIC HEALTH NURSE IN A COLLEGE

INFORMATION SHEET

(for the Public Health Nurse)

My name is MARGARET O'SULLIVAN. I am a graduate student of the Department of Nursing & Midwifery at Massey University. I am currently enrolled in my Masters thesis. Information gathered during this study is for this purpose only. I am a Registered General & Obstetric Nurse, as well as Midwife. I have spent the last fifteen years of my professional life working as a Public Health Nurse.

This study has grown out of research carried out last year on what Public Health Nurses do in Primary Schools. This year I would like to look at what the Public Health Nurse does in a College. Nursing literature contains little information about this subject. Given the Public Health Nurse's commitment to meet the needs of adolescent health, I would like to do an indepth study of this facet with special focus on prevention and health promotion work delivered within the college setting.

As a participant, you are asked to consent to:

a. *Recording on audio-tape, a preliminary reflective monologue on your work and practice as a public health nurse with adolescents in a college setting.* You are then asked to maintain a chronicle monologue as outlined in (c) below.

b. *Allowing me, as researcher, to carry out participant observation of you, as a public health nurse, delivering a health teaching session to a classroom of students.*

Following your introduction of me, the researcher, as 'being present today to observe one of our health lessons', participant observation will then be carried out as the opportunity presents, up to six times, over the course of one term.

Data will be collected by either unobtrusive notetaking during the session, or fieldnotes written soon after. It will then be initially validated with you, analysed, then taken back to you for further validation.

c. Maintaining an ongoing reflective monologue, whereby you record on audio-tape all insights and reflections concerning your work with adolescents in a college setting.

These recordings will be made approximately six times, at weekly intervals, with each entry being prefixed with respective date and time.

The data from these recordings will be initially validated with you, analysed, then taken back to you for further validation.

d. *Being interviewed* approximately six times, at weekly intervals, following the initial analysis of both participant observation field notes, and the accompanying monologue tape transcripts for the preceding period. The interviews will be audio-taped and will take approximately thirty minutes or longer. The purpose of the interviews is to gain further insight and understanding into the issues that have emerged from the data to date.

The data obtained at each interview will firstly be validated with you, analysed, then taken back to you for further validation. During subsequent interviews, you may be asked to comment on the analysis of any preceding interview.

If you take part in the study, you have the right to:

* refuse to answer any particular question, and to withdraw from the study at any time,

* ask any further questions about the study that occur to you during your participation

* provide information on the understanding that it is completely confidential to the researcher, my supervisor and transcribing typist. All information transcribed from the tapes will only include pseudonyms of any names of people or institutions, and it will not be possible to identify you or any third party eg. students, in the study's final report.

Upon completion of the study, you will be given a copy of the results. These will be used to develop and write a thesis, in accordance with the requirements for completing the degree of Master of Arts in Nursing, and may be used in papers/presentations arising from the thesis.

I can be contacted at work:

and at home:

APPENDIX B

CASE STUDY OF THE PUBLIC HEALTH NURSE IN A COLLEGE

INFORMATION SHEET

(for College staff)

My name is MARGARET O'SULLIVAN. I am a graduate student of the Department of Nursing & Midwifery at Massey University. I am currently enrolled in my Masters thesis. Information gathered during this study is for this purpose only. I am a Registered General & Obstetric Nurse, as well as a Midwife. I have spent the last fifteen years of my professional life working as a Public Health Nurse.

This study has grown out of research carried out last year on what Public Health Nurses do in Primary Schools. This year I would like to look at what the Public Health Nurse does in a College. Nursing literature contains little information about this subject. Given the Public Health Nurse's commitment to meet the needs of adolescent health, I would like to do an indepth study of this facet with special focus on prevention and health promotion work delivered within the college setting.

Participants are asked to consent to being interviewed two or three times. Interviews will be audio taped. They will take approximately thirty minutes. Information collected during the first interview will be analysed before the subsequent interviews. You may be asked to comment on that initial analysis during a subsequent interview.

If you take part in the study, you have the right to:

* refuse to answer any particular question, and to withdraw from the study at any time

* ask any further questions about the study that occur to you during your participation

* provide information on the understanding that it is completely confidential to the researcher, my supervisor and transcribing typist. All information transcribed from the tapes will only include pseudonyms of any names of people or institutions, and it will not be possible to identify you or any third party eg. students, in the study's final report.

Upon completion of the study, you will be given a copy of the results. These will be used to develop and write a thesis as part of requirements for Masters in Nursing, and may be used in papers/presentations arising from the thesis.

I can be contacted at work:

and at home:

APPENDIX C

CASE STUDY OF THE PUBLIC HEALTH NURSE IN A COLLEGE

CONSENT FORM

I have read the Information Sheet for this study and have had the details of the study explained to me. My questions about the study have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I also understand that I am free to withdraw from the study at any time, or to decline to answer any particular questions in the study. I agree to provide information, on audiotape, to the researcher, with the understanding that it is kept completely confidential.

I agree to participate in this study under the conditions set out on the Information Sheet, of which I have a copy.

Signed:

Name:

Date: