APPRECIATIVE INQUIRY TO TRANSFORM NURSING PRACTICE FOR MENTORING CHILDREN OF PROMISE

By

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Abstract

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A Nurse-Mentoring Program based on Peplau's Interpersonal Relationship Theory (1952) and Erickson, Tomlin and Swain Modeling and Role Modeling Theory (1983) was implemented to promote optimum health and educational outcomes among children at high risk for intergenerational incarceration. The aim of this study was to reflect on the existing strength and effectiveness in the nurse-mentoring program for children with incarcerated parents, to lead the nurse-mentors in discovering what is important, and build a collective vision of the preferred future for mentoring this population. Through the appreciative inquiry (AI) process, a type of action research, nurses transformed their practice in assisting children toward healthy behaviors. Participants were RNs who enrolled in a Baccalaureate program and worked for at least 60 hours in the role of nurse-mentor. Data were collected through individual interviews and focus groups that resulted in consensus for an action plan. A dialectic-hermeneutic approach was employed to interpret the texts of participants who experienced working with Children of Promise and construct personal meaning from them. An action plan was implemented and evaluated after three months. Based on the evaluation, conclusions were drawn and a collective view emerged regarding best nurse-mentoring practices for this program and implications for other programs for children with incarcerated parents. The nursing theories were effective in helping participants to establish relationships with children in the context of mentoring.

Keywords: Children of incarcerated parents, nursing, mentoring, mental health, appreciative inquiry.

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"Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has." -Margaret Mead

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Dedication

This dissertation is dedicated to my parents, Ernest and Christine Falk, who gave me unconditional love and devotion, which made me feel lovable and loved. In turn, I have been able to reciprocate that love to the Children of Promise. My parents prepared me for this study by setting an example of having a strong work ethic, advocating for compassionate care for all members of society, and social justice. I imagine them looking down at me from heaven saying, "Great job Kathy!"

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Chapter One

The Research Objective

The children of incarcerated parents are among society's most vulnerable populations who experience disparities in health care (Center on Addiction and Substance Abuse (CASA), 2008; Edelman, 2007, 2010; Parke & Clarke-Stewart, 2003). Each day 2.7 million children in the United States encounter many negative consequences of parental incarceration (Glaze & Maruschak, 2008; Pew Charitable Trusts, 2010). Parental imprisonment can cause instability in families and have direct and long-term negative implications on children's health and education (Murray, Farrington, Sekol, & Olsen, 2009; Parke & Clark-Stewart, 2003; Phillips, Erkanli, Keeler, Costello, et al., 2006). These include inadequate healthcare, loss of family income, difficulties with childcare, educational underachievement, lack of contact with the imprisoned parent, social stigma, discrimination, unstable housing, and numerous school relocations (Krupat, Gaynes, & Lincroft, 2011; Murray, et al., 2009). Since 1991, the number of children who have imprisoned parents increased 79% with a staggering 122% increase of incarcerated mothers (Glaze & Maruschak, 2008). This rise partly reflects the "get tough on crime" social policies implemented in the 1980s and the early 1990s, which contributed to doubling the United States prison population between 1991 and 2007 (Mauer & King, 2007). Mandatory, lengthy sentencing guidelines and stricter penalties for those convicted of minor illegal drug offenses and non-violent crimes contributed to the tremendous growth in prison populations. In 2010, nearly two-thirds of prisoners had been convicted of nonviolent offenses (Pew Charitable Trusts, 2010).

With the structural racism and injustices in our judicial system, African American and Latino children are disproportionately affected (Mauer & King, 2007). African American and Latino children experience the effects of poor prenatal care, substance abuse of their mothers and

overall deprivation. After birth, these children generally live in areas with environmental hazards and impoverished circumstances that compound their deficient prenatal care (Johnson, 2009). Family instability, not having positive role models and overwhelming stress prior to and after parents are incarcerated contribute to high rates of mental health problems in African American and Latino children. Depressive symptoms manifested by physical aggression or becoming withdrawn and anxious are 2.5 times higher in this population of children (Murray et al., 2009). Incarcerated parents are alive but are inaccessible, creating uncertainty, anxiety and ambiguity. The unpredictable nature of living in such turmoil compounds the families' fragility and breeds feelings of helplessness, hopelessness and desperation (Boss, 2006).

The culmination of exposure to numerous risk factors among these children has led to a variety of social and emotional afflictions (Murray et al., 2009). For example, truancy, and substance abuse, which can stem from childhood depression, presents the highest risk factors for entering the juvenile justice system (Parke & Clark-Stewart, 2001, 2003; Phillips et al., 2006). These elements coupled with extreme poverty and living in crime filled environments create the "perfect storm" for children to be swept into the criminal justice system (Edelman, 2007). Children and young adults who are initiated into juvenile detention have a strong probability of future incarceration as adults (CASA, 2008). The Children's Defense Fund (2007) has named this phenomenon, the "Cradle to Prison Pipeline crisis®." Lack of adequate healthcare was cited as the most prominent predictor for incarceration and was also highly correlated with poverty (Edelman, 2007, 2010).

Children with incarcerated parents experience chronic stress and episodes of crisis that span many years (Murray et al., 2009; Phillips et al, 2006). Over time, they may have decreased emotional resilience and become susceptible to mental health problems, antisocial behaviors and

substance abuse (Parke & Clarke-Stewart, 2001; Phillips et al., 2006). However, despite the many stressors and problems that can occur, these children can improve their resilience. Resilience is defined as the capacity to thrive and fulfill their potential in the face of adversity (American Psychological Association, 2012). Based on this potential, these children are often referred to as Children of Promise (Goode & Smith, 2006).

Successful adaptation to adverse childhood events (ACE) such as parental incarceration is influenced by the type and frequency of risks as well as the amount of protective or resilience factors (National Institutes of Health, 2009). Social resources that occur outside the family such as schools, peer groups, positive role models, and faith-based organizations that support children's and caregiver's coping efforts through mentoring can help to protect children who face adversity by promoting resilience (DuBois, Holloway, Valentine, & Cooper, 2002; Grossman & Tierney, 1998; Tierney, Grossman
& Resch, 1995).

Resilience theorists (Luthar, Ciccheti, & Becker, 2000b; Ruter & Sroufe) have postulated that there are three sets of protective factors that help children make good adjustments, i.e., personal attributes, caregiver support, and positive relationships. Examples of personal attributes that promote resilience are temperament, high self-esteem, intelligence, and independence. A parent or central caregiver can offer support that buffers adverse events. Connecting children with positive relationships outside the family can help them to learn behaviors that decrease the risk of developing responses that reduce resilience (Bandura, 1998; Goode & Smith, 2006; Luther, Cicchetti, & Becker, 2000a, 2000b; Rutter & Sroufe, 2000).

Mentoring relationships promote such resilience (DuBois, Holloway, Valentine, & Cooper, 2002; Grossman & Tierney, 1998; Tierney, Grossman, & Resch, 1995). Mentors can help children through modeling and helping them to learn social and emotional skills such as: (a)

awareness of how their behavior affects themselves and others; (b) development of positive attitudes; (c) responsible decision making; and (d) development of positive social interactions (Payton et al., 2000). With the chronic nature of ACE in this population, interventions that improve resilience and health are as important as those that prevent loss of health. Mentoring and modeling interventions have successfully been used to achieve these objectives (Davidson, Redner, Blakely, Mitchell, & Emshoff, 1987).

Given the tremendous needs of this growing population and the existing research highlighting the problem of inadequate healthcare and the value of mentoring, Falk established a program for children in New York City based on the Amachi national model. Amachi is a West African phrase meaning "who knows but what God has brought us through this child." The name Amachi refers to one-to-one mentoring programs specifically for children of incarcerated parents and is used interchangeably with the term *Children of Promise* Programs. However, it is a unique aspect of this New York City program that the mentors are registered nurses who focus on promoting healthy behaviors (Appendix A). In this Children of Promise Program, the expectations of healthy behaviors in children are based on six priority areas that prevent chronic illnesses (Centers for Disease Control, 2012). The six areas are: (a) refraining from tobacco use; (b) eating a healthy diet; (c) having adequate physical activities; (d) abstaining from drug or alcohol use; (e) avoiding sexual behavior that has risks for Human Immune Virus (HIV) infection and Sexually Transmitted Diseases (STD) and unplanned pregnancy and (f) not engaging in behaviors that result in injury and violence. The latter two areas focus on teaching critical skills in adaptation, decision-making and emotional regulation when confronted with self-destructive situations. These expectations for healthy behaviors were consistent with the national and global goals of Healthy People 2020, National Institutes of Health (2009) Health

Promotion to Prevent Mental, Emotional and Behavioral Disorders in Young People, and the United Nations Millennium Development Goals. They aimed to reduce the disparities in health care and educational outcomes. They also strived to decrease the rate of teenage pregnancy, infant mortality, HIV infection in youth and mental health disorders.

The nurse-mentors were registered nurses who returned to school to complete a Bachelor of Science degree (RN to BS). The RN to BS students had an opportunity to choose the nurse-mentoring program as clinical placement in the courses Community Health Nursing, Urban Health Issues, and/or Independent Study. In this program, all nurse-mentors were expected to complete 60 hours of mentoring in an academic year. This time period was supported by research on mentoring and consistent with policies of national mentoring programs, *Amachi, Big Brothers, and Big Sisters of America* (DuBois, et al., 2002; Grossman & Tierney, 1998; Tierney, Grossman, & Resch, 1995). Falk became a certified program director by the Amachi National training program and an AmeriCorps VISTA supervisor for programs designated to mentor children who have incarcerated parents. The clinical faculty instructed nurses on the application of Peplau's (1952) as well as Erikson, Tomlin, and Swain's (1983) theories. They also received mentor training provided through the New York Mission Society Amachi program.

Based on the theoretical proposition that children can heal in the shared experience of therapeutic interpersonal relationships (Peplau, 1952) and can learn healthy behaviors by modeling and role modeling (Erickson, Tomlin, & Swain, 1983), the *Mentoring Program for Children of Promise* was developed and implemented. It was partially funded by the W.K. Kellogg Foundation and the U.S. Department of Health and Human Services (HHS). The RN students provided mentoring services to the children at a public elementary school, kindergarten through eighth grade.

Nurse-mentors worked with the children, their caregivers and the school based support team to achieve the goals for each child's health and education. The objectives were to (a) improve academic performance comprised of homework, organizing class work, developing positive attitudes about school, and setting targets for better grades on report cards; (b) change their behavior, which included improving impulse control, avoiding physical aggression and making decisions that had positive outcomes and (c) develop appropriate social interactions that involved sharing, respect for others, and having positive peer relationships (Appendix A).

The nurses made connections with Brooklyn neighborhoods that had the highest concentrations of children with incarcerated parents to the nurse-mentoring program. The families had kept their units together and participated in this program geared to strengthen their coping skills. Despite the hurdles of delivering care to children living in areas with extreme poverty and high rates of violent crime, the nurses created synergistic relationships with both the children and their families.

In this region, so deplete of resources, the nurse-mentors galvanized the larger community in order to help the children reach their goals for healthy behaviors. This entailed reaching outside their traditional comfort zone of practicing within institutional settings, such as hospitals. They sought partnerships that supported the goal of community health nursing, which is both health promotion and protection (Lind & Smith, 2008). Examples of productive community partnerships that the nurses have forged thus far are: (a) NYC District Attorney's prevention programs; (b) Superintendents of NYC Department of Education; (c) school-based psychologists, school nurses, social workers, and guidance counselors; (d) faith-based organizations; (e) community health clinics; and (f) the Girl Scouts and Boy Scouts of America.

Aims and Research Questions

The aim of this qualitative study, using appreciative inquiry (AI) was to reflect on the existing strengths and effectiveness in nurse-mentoring, to lead the nurse-mentors in discovering what is important to transform the future practice of nurses who work with Children of Promise (Chenail, George, Wulff, & Cooper, 2012; Cooperrider & Whitney, 2005; Ludema & Fry, 2011). The AI process identifies the appreciative topic, then goes through the AI 4D Cycle: "(a) Discovering the best of what is; (b) Dreaming to imagine what could be; (c) Designing what will be; and (d) Destiny-learning from the enacted change; to become what we most hope for" (Ludema & Fry, 2011, p. 283). Through the AI 4 Stage Cycle, nurses will transform their practice in assisting children towards healthy behaviors. Based on the perspectives of the nurse mentors, a specific plan was designed with concrete steps to be carried out by action teams for the purpose of building on the positive components of the nurse-mentoring program (Appendix B).

As the program entered the second year, an appreciative inquiry made it possible for the nurse-mentors to take collective action toward reaching a shared ideal of working with Children of Promise (Barrett & Fry, 2005; Cooperrider & Whitney, 2005; Zandee & Cooperrider, 2011). The children and caregivers experienced a host of circumstances that they neither created nor controlled and thus, were at risk for learned helplessness and hopelessness (Peterson, Maier, & Seligman, 1995; Peterson & Park, 1998). Similar to the AI research by Bonham (2011) and Lind (2005), the nurse-mentors were in a position to counter learned helplessness and hopelessness in the children by focusing on positive, strength-based possibilities. Resilience was not measured in this qualitative study. Through the steps of appreciative inquiry, an amalgamation of the individual nurse's experiences of mentoring children in this specialized program brought forth a

collective view regarding best mentoring practices for this and other Children of Promise Programs.

Research Question

What changes occurred in the shared visions and collective actions of nurses as a result of working with Children of Promise?

Specific questions to guide discussion with the nurse mentors were based on the specific steps of appreciative inquiry, the purposes of the steps, and the recommended techniques. These are delineated in Chapters Three and Four.

Theoretical Framework

The theoretical framework of this appreciative inquiry study consisted of Peplau's *Theory of Interpersonal Relations in Nursing*, (1952) and Erickson, Tomlin and Swain's *Modeling and Role Modeling Theory* (1983; Schultz, 2013).

Theory of Interpersonal Relationships in Nursing

Peplau's grand theory of Therapeutic Nurse-Patient Relationships is the seminal theoretical framework for learning psychiatric and mental health nursing and is fundamental to the curriculum of professional registered nursing programs (American Psychiatric Nurses Association, 2012). Peplau's concept of therapeutic nurse-client relationship includes three distinct phases: (a) orientation; (b) working; and (c) resolution (Peplau, 1952). In the Children of Promise Program, within the therapeutic nurse–client relationship, nurses adopted one or more of six helping roles when working with the children: (a) stranger; (b) resource person; (c) teacher; (d) leader; (e) surrogate; and (f) counselor. The RN to BS students had already learned Peplau's theory from their previous educational experiences. With this knowledge, they were able to identify nursing interventions based on the helping roles that they assumed

and the phase of the interpersonal relationship (See Appendix A).

The stranger role occurs when nurses and clients meet and become acquainted (Peplau, 1952). They begin the relationship as strangers, each with preconceived expectations for the first encounter. The goal of the nurse is to establish the relationship and build trust with the child. Peplau (1952) believed that compassionate verbal and nonverbal communication, a respectful approach, and nonjudgmental behavior were essential to this role. Successful implementation of the stranger role is the underpinning for development of a therapeutic relationship and a necessary condition for the establishment of the other roles. This role is carried out during the orientation phase.

The working phase is divided into two subphases; the identification of the problem, and exploitation. Nurses' helping roles of resource person, teacher, surrogate, and counselor are functions of the working phase. In the resource person role, nurses provide specific factual health information in response to questions and interpret the clinical plan of care. Important to this role are expert professional knowledge, ability to convey client centered information in a thoughtful manner, and critical thinking skills needed to sort out children's questions and offer therapeutic responses. The primary goal of the teacher role is to assist clients to attain knowledge to improve health. This process may be formal, such as providing detailed instructions for individuals or conducting training sessions for groups to teach a health-related behavior, or the process may be informal, such as nurses' role modeling patterns of health and wellness in therapeutic relationships. It is within modeling patterns that nurses promote development of social and emotional skills.

In the surrogate role, nurses functioned as advocates or substitutes for another human being who was well known to the client, such as a parent, sibling, other relative, friend, or

teacher. Through this process, children may unconsciously transfer behaviors or emotions that are connected to incarcerated parents onto nurses. Nurses addressed this reaction and assisted children to recognize the differences as well as similarities between themselves and others. In the counselor role, nurses encouraged children to explore their current situation or presenting problem. Nurses must be aware that such considerations often generate anxiety and, therefore, nurses must facilitate environments that are favorable for children to safely express their concerns. To successfully perform the counseling role, nurses exhibited active listening skills, applied therapeutic communication techniques, provided guidance and support in the process of learning about one's self, and retained professional boundaries and self-awareness.

During the exploitation subphase, nurses assisted clients using all possible modalities and support to reach their goals (Peplau, 1952). Nurses provided the leadership role in this phase of the therapeutic relationship. The leadership role involved collaboration between nurses and clients to meet desired treatment goals. Nurses offered guidance, direction, and support to promote clients' active participation in maintaining their health. In this phase, the goal of nurses was to help children accept increased responsibility for plans of care.

The last phase is the resolution phase, which occurs when clients reach goals that were set in the identification of problems. It is the period of time when the nurses and clients work toward termination of relationships. Nurses delineate the skills that clients acquired during therapeutic interpersonal relationships and encourage clients to transfer those skills to other situations and relationships.

Modeling and Role Modeling Theory

Modeling and Role Modeling (M & RM) is a mid-range nursing theory that embraces

the philosophical premise that human beings are holistic in nature, alike in some ways and unique in others (Erickson et al., 1983; Schultz, 2013). Children of incarcerated parents have the same developmental goals and needs as other children to become self-actualized people, but have very unique and different internal and external environments than that of their childhood counterparts. The definitions of health and holism in Erikson's et al. theory (1983) address the care needs of this special group of youth. Holism is described as the incorporation of multiple subsystems, joined by spiritual energy that pervades all aspects of each person. The consciousness and unconsciousness are amalgamated (Schultz, 2013, p. 178). Health is a "state of physical, mental and social well-being not merely the absence of disease or infirmity." Additionally, it connotes a state of equilibrium within each of the various subsystems of a holistic person, (Erikson, Tomlin, & Swain, 1983, p. 253). Erikson et al. (1983) describe the "give and take" process between nurses and clients as facilitation, in which clients' learn to identify and develop their strengths. In the M & RM, nurses do not affect outcomes for the client but facilitate movement toward holistic health.

The core concept of M & RM asserts that nurses must understand the clients' world. Nurses model the clients' world, as it exists for them. It is the process used by nurses to collect and analyze data in order to reach an understanding of the clients' perspectives and contexts in which these are formed. Areas that nurses assess include how clients interpret their situations, their current and future expectations, their strengths and support systems, and their goals. When the process of modeling is complete, then nursing actions (role-modeling) occurs.

The foundation for nursing interventions is based on interpersonal relationships with clients. Within interpersonal relationships, trust is built upon unconditional acceptance, in

which clients are kept in positive regard, and where facilitation, and nurturing takes place. A basic premise of the M & RM is the belief that people have an intrinsic need to grow and self-actualize. In the Children of Promise Program, nurses-mentors were working with the children by "nurturing their humanity, helping them to learn how to help themselves" (Walsh, Vanden, Bosch, & Boehm, 1989). The nursing process in which nurses facilitate self-potential is delineated by Erikson et al. (1983) as the relationship among five interventional goals, including their principles and the aims (objectives).

Developing a trusting relationship is the first aim and the building block for other interventional goals. The second principle of affiliated-individuation is the balance between "I and we" in the nurse-client relationship. It is derived from the belief that in order for humans to have equilibrium in relationships, clients need to have accomplished positive orientation of themselves. Using this theory, nurses facilitate self-projected views of being futuristic and positive in clients by conveying that clients are "acceptable, respectable, and worthwhile human beings" (Erikson et al, 1983).

The third principle is regarding human beings' development and is contingent on the perception that they can have some sense of control over life (individuation) while still maintaining connectedness (affiliation). The aim is that clients will have the ability to sustain affiliated-individualism with minimal ambivalence. Through nursing interventions that address clients' need for affiliation, as well as their need to embrace individuation, clients will maintain a state of equilibrium.

The fourth principle describes an intrinsic drive towards holistic health that can be facilitated by what Erikson and colleagues (1983) call "consistent and systematic nurturance" (p. 47). Through the affirmation of clients' strengths, nurses promote a holistic state of health

that is adaptive and flexible. In this way, clients are able to be in holistic states of equilibrium because they are better equipped to cope with stress.

The final principle is that human growth and development is dependent on fulfillment of basic needs and is promoted by "growth-need-satisfaction" (Schultz, 2013, p. 182). Using this theory, nurses set mutual goals that are health directed to promote coping mechanisms that satisfy basic needs and foster growth-need-satisfaction. Based on clients' functional and chronological developmental stages, nurses facilitate successful consummation of the growth-needs.

In summary, Erikson's (1983) M & RM Theory postulates that human beings need to successfully satisfy basic needs before self-actualization can progress to the optimal level. The model is linear in nature, which guides nursing practice to meet the clients' most basic needs for survival before moving toward goals of maximum potential. Modeling allows for clients' worldview, currently classified in nursing as "patient-centered care," to be the foundation of the nursing process. It facilitates the blending of two concepts; that human beings have common health responses, and that each person has unique internal and external environments that shape their experiences of health. Role modeling is defined as "the facilitation of the individual in attaining, maintaining or promoting health through purposeful interventions" (Erikson et al., 1983, p. 95). Role modeling involves the art of nursing, reflected in planning client care based on the model of their world. It is also a science established by planning theory-based interventions. Through this model and these interventions the nurses in this program aimed to promote resilience in children with incarcerated parents.

Need for Study

This study was needed to: (a) address disparate healthcare in children at risk; (b) elicit the strengths of Falk's Nurse-Mentoring Model©; (c) create a plan for change to improve nursing practice; and (d) advance the body of knowledge in nursing practice for promoting resilience in children at risk of health disparities, particularly in mental health.

The children in this nurse-mentoring program are similar to other children of prisoners, because they are living in poverty and are among African-American and Latino minorities (Glaze & Maruschak, 2008; Pew Charitable Trusts, 2010; Mauer & King, 2007). Therefore, children with incarcerated parents are particularly vulnerable to disparities in treatment for depression (Olfson, et al., 2002; Olfson, Gameroff, Marcus, & Waslick, 2003). The development of nursing knowledge in the use of non-pharmacologic approaches such as the nurse-mentor program has the potential to reduce the risk for depression and protect vulnerable children from disparities in health care (Center on Addiction and Substance Abuse, 2008; Luther et al., 2000b; Rutter and Sroufe, 2000).

This study generated the perspectives of the nurse-mentors on the strength of the nursing model. Data on the perceived strengths and what changes are necessary to enhance nursing practice were used to develop an action plan. The healthcare demands for this population of children are great, and the aggregate continues to grow. The nurse-mentors were using a new model of nursing care for children who face adversity. In order to effectively deliver services, it was necessary to evaluate what processes promoted healthy behaviors as well as the obstacles to achieving those goals. The nurses who were actually implementing this model were the experts for evaluating what transpired and formed consensus-validation about how to move forward with the nursing model of care.

The study generated a plan for change, which in this type of study was referred to as an action plan for improving how nurse-mentors deliver care to Children of Promise in a specialized program. The condition of ownership of an action plan that is created by all the nurse-mentors increases the likelihood of successful outcomes (Stringer, 2007). The outcomes of the action plan were evaluated at the end of one cycle of appreciative inquiry (AI) and formed the question of the next AI. This information led to additional research that involved rigorous testing of nursing interventions.

Advancing nursing knowledge provided nurses with information on how to promote resiliency by helping children to develop healthy behaviors. Loss of resiliency in these children leads to depression and behavioral responses that increase their risk for entering the juvenile justice system (Parke & Clark-Stewart, 2001, 2003; Phillips et al., 2006).

Assumptions and Biases

It was my bias that children with incarcerated parents are victims of adverse childhood events. I assumed that children who experienced adverse events could be helped to maintain and restore resiliency with the assistance of supportive adult relationships that provided positive role models. It was also my bias that children who have a delay in developing emotional and social skills can learn these through the interpersonal nurse-client relationship and modeling and role modeling in the nurse-mentoring program. In assessing the policies that resulted in doubling the prison population over the past thirty years, this researcher did not believe that it improved the safety of society, but rather that it had a deleterious effect on tens of millions of children and their families.

Chapter Two

Review of Literature

This chapter is a review of previous research on mentoring children with incarcerated parents. Despite recent interest in helping this population through mentoring programs (Goode & Smith, 2006; Phillips et al., 2006; Phillips & Gleeson, 2007; Murray et al., 2009), there is a paucity of research on the topic for a number of reasons. In this chapter, I explain the reasons there have been difficulties in studying the effects of programs to help this population and describe the design and findings of previous studies.

Difficulties in Conducting Studies of Children with Incarcerated Parents

There is an overall paucity of research on mentoring programs for children with incarcerated parents for four major reasons (Murray et al., 2009; Parke & Clarke-Stewart, 2001). First, it is difficult to keep participants in a study long enough to evaluate the effects of mentoring based on the population's lack of permanency of caregivers, family configuration and housing (Johnson, 2009). Second, it is difficult to identify children of incarcerated parents and caregivers because their families choose to not to disclose this information in order to avoid the social stigma and the risk of becoming victims of prejudice (Goode & Smith, 2006). Third, identifying the population is further complicated by the lack of mechanisms in the public health system or child welfare services to identify those children with incarcerated parents. Fourth, there are ethical reasons why experimental designs with control groups are inappropriate for studying children who experience adverse events and are in need of interventions to promote resilience (Bauldry, 2006).

Review of Existing Studies

Support for the present study is evident in the findings of previous studies to: (a) evaluate the effects of mentoring programs for high risk children; (b) implement a Nurse Family Partnership model for long-term home visitation of high risk young first time mothers to reduce the rate of incarceration and improve the health of mothers and their children; and (c) identify the perspectives of children with incarcerated parents, their caregivers, incarcerated parents, and formerly incarcerated parents related to mentoring services.

Studies to Evaluate the Effects of Mentoring Programs for High Risk Children

In this section, five studies of mentoring programs for high-risk children are reviewed. The first three were conducted by Public/ Private Ventures (P/PV), a national nonprofit research organization whose mission is to improve the effectiveness of social policies, programs and community initiatives, especially as they affect children and young adults. The first two studies are viewed as landmark studies in evaluating the effects of mentoring (Tierney, Grossman, & Resch, 1995).

In an experimental study with random assignment to intervention and control groups, Tierney et al. (1995) tested the hypothesis that mentoring interventions would reduce unhealthy behaviors such as underage alcohol, illegal drug use and delinquency. The sample consisted of 1,138 applicants to Big Brothers and Big Sisters (BB/BS) programs in 1992-1993 from eight large cities in the United States, ages 10-to 16-years-old. Sample characteristics that contributed to the risk status of these children were: (a) 90 percent lived in a single parent home; (b) 6 percent lived with a grandparent; (c) 20 percent of parents did not finish high school; (d) two- thirds of the children lived below the federal poverty level; (e) 40 percent received public assistance; (f) over 25 percent lived in homes with domestic violence; and (g)

40 percent resided in homes with substance abuse. Over 60 percent were boys and more than 55 percent were African-American and Hispanic. Approximately half of the participants (N= 571) were randomly assigned to a treatment group for which BB/BS made mentor-mentee matches; and (N= 567) were assigned to mentor waiting lists. It is standard procedure for BB/BS to have waiting lists for mentors, as there are always more children who need mentors than there are mentors. During the recruitment period for this study, BB/BS maintained their organizational goals for mentor recruitment. Fifteen instruments were used to measure study variables such as internal consistency reliabilities were reevaluated using coefficient alpha and were found to be acceptable, ranging from .61-.86 at baseline and .61-.90 at follow-up. The results were that at follow-up assessment, participants in the treatment group demonstrated statistically significant decreases from baseline measurements in the following anti-social behaviors compared to the control group: (a) 45.8% less initiation of drug use ($p = .05$); (b) 27.4 % less initiation of alcohol use ($p = .10$); (c) 31.7% fewer episodes of using physical aggression to resolve conflict ($p = 0.05$); (d) 36.7 % fewer skipped classes ($p = .05$); (e) 52.2 % fewer days of skipped school ($p = .01$); and (f) 36.6 % less episodes of lying to parents ($p = .05$).

In the second study, a secondary data analysis, Grossman and Rhodes (2002) used data from the Tierney et al. (1995) study to investigate the effects of mentor relationship duration on mentoring outcomes. The goal of the study was to test the hypotheses that the positive effects of mentoring relationships improve over time, and that relatively short mentor-mentee matches can lead to negative outcomes. They divided the mentored youth into four categories depending on the length of the mentor-mentee relationships: (a) less than three months (6%); (b) three to just under six months (13%); (c) six to just under twelve months (36%); and

twelve months or more (45%). The results were that children who were in matches that lasted more than twelve months reported significant increases in self-worth, perceived social acceptance, perceived scholastic competence, quality of parental relationships, school value, and decreases in both alcohol and drug use. The hypothesis related to short mentoring relationships was also supported in that children whose mentor-mentee relationships were terminated within three months experienced significant declines in their global self-worth, and their perceived scholastic competence. Mentor-mentee relationships were more likely to end prematurely if there were adolescent variables, such as referral for psychological or educational programs or sustained emotional, sexual, or physical abuse. Additionally, relationships that involved 13-16 year olds were 65% more likely to discontinue than matches with 10-12 year olds. The findings signify the importance of considering the duration of relationships in determining the effects of mentoring programs. The most positive effects emerged in relationships that persisted for a year or longer which were consistent with previous research regarding the complexities of mentoring relationships (Rhodes et al., 1999).

In the third PPV study, the PPV research team partnered with the Office of Juvenile Justice and Delinquency Prevention (OJJDP) to test the hypothesis that mentoring high risk children would decrease depression, therefore reduce risk of school truancy, substance abuse, and delinquency (Bauldry, 2006). This was a descriptive correlational study with a convenience sample of 209 boys and girls 62% of whom had been arrested and of this group, nearly half (48%) were repeat offenders and 38% had been identified as exhibiting behaviors that could lead to arrest. The setting was the mentoring component of the National Faith Based Initiative (NFBI), in five major cities in the United States. The

NFBI's mission is to connect all children seeking services to supportive adult relationships, thereby striving not to have children on waiting lists. Therefore, for this study, there was no possibility of a comparison group. Eighty-six percent of the participants were between the ages of 12-19, 10% between 8-11 years-old, and 4% were between 20-22-years- old. Two instruments were completed at baseline and at follow-up, 6-9 months later; these were the Center for Epidemiological Studies Depression Scale for Children (CES-DC) and Adult Support (Walker & Arbeton, 2004). A high percentage of participants (77%) completed the follow-up assessment (N =160). In follow-up assessment, the success among this population was attributed to the mentoring program and outreach by the mentors. Holding constant whether participants showed signs of depression when they enrolled, as well as other youth characteristics, those who were mentored at least six months were 69 percent more likely to remain resilient and not show signs of depression ($p = 0.01$). Mentoring seemed to have acted as a protective agent against depression. This, in turn, had an effect on how the youth negotiated conflicts, avoided substance abuse and reduced recidivism. This demonstration project showed promise in improving mental health.

A fourth study, funded by the National Institute for Mental Health, was an experimental, longitudinal study focused on the efficacy of using mentor volunteers for juvenile offenders in reducing recidivism rates (N = 213), (Davidson et al., 1987). There were four intervention groups that involved mentor volunteers for juvenile offenders and a control group that was the treatment-as-usual group who referred the youth back to the court for processing. The mentor intervention groups that received intensive training and supervision were contrasted to the treatment-as-usual control group and an attention-placebo group. The sample consisted of youth offenders in a mid-western juvenile justice system

that was referred to the study by the court. The caregivers and the youth who agreed to participate were randomly assigned to one of four treatment groups or the control group. The four intervention groups involved the mentors spending six to eight hours per week for 18 weeks with the youth offender conducting specific interventions and receiving two hours of clinical supervision with a senior psychology doctoral student. The *Action condition (AC)* intervention used techniques of behavioral contracting and child advocacy. The *Action condition-family focus (ACFF)* intervention was similar to the AC techniques with the difference of setting contracts and advocacy interventions that also included the youth's family. The *Action condition-court setting condition (ACCS) intervention* was used to examine the contribution of court supervised setting interventions. The *Relationship condition (RC)* intervention was based on the interpersonal human behavior theory (Rogers, 1957; Sullivan, 1953) that focused on the development of empathy, unconditional positive regard, communication skills, and genuineness. In the control group, an *Attention placebo condition (APC)* was implemented to control for the effects of non-specific attention. It offered the student mentors minimal training and supervision instead emphasizing the mentors' natural skills.

The intervention models were implemented in four phases: (a) assessment of desired behavior change and providing needed community resources; (b) beginning of implementation of behavioral contracts and advocacy efforts; (c) evaluation and revisions of interventions; and (d) preparation for end of service. The results were that intervention groups with specific treatment models (AC, RC and ACFF) had lower recidivism rates than the control group. The AC and RC interventions were each individually superior to the control group. The results provided no evidence of differential effectiveness between the

specific contents of the interventions. The researchers concluded that the complete diversion from the justice system that took place in the AC, ACFF, RC and APC conditions contributed to reducing the risk of officially recorded recidivism and that the specific interventions in the AD, ACFF and RC groups added to the decrease in youth recidivism.

The fifth study was a meta-analysis focusing on the effectiveness of mentoring programs for youth (DuBois, et al., 2002). The evaluations of 55 mentor programs were analyzed. Overall findings provided evidence of a small to moderate effect size in the benefit of mentoring programs. The average unweighted effect size, d-index was d = .23 and the median effect size was d = .18. It was concluded that the effectiveness of programs increased significantly when two variables were present: (a) the construction of the program was theory- based and empirical practices were used and (b) strong relationships were formed between the mentor and mentee. The disadvantaged youth who had the greatest environmental risk benefited most from mentoring.

The authors noted four limitations that could explain the less than robust findings for effectiveness of mentoring programs and recommendations for future studies. The first was that positive effects of programs were evident in studies using well-controlled designs and in those where mentoring was provided alone as an intervention rather than in combination with other types of treatments.

The second consideration was that the responses of youth, parents, and other informants such as teachers could introduce bias into the outcome measures. Dubois et al. (2002) state: “There is a related need for evaluation to more consistently assess characteristics of the relationships that are actually developed between mentors and youth” (p. 191). To address these concerns, it was recommended that future evaluations of

mentoring programs include more objective measures into youth outcomes, such as, archival records of arrests, educational accomplishments, and school dropout rates.

The third factor is that it may not be possible to have a true control group. Whenever possible, the preferred modality for treating children with delinquency related to mental health problems and substance abuse is settings outside the juvenile justice system. The children at high-risk are often referred to an array of community-based services, therefore children who are randomly assigned to a control group may actually be receiving informal supportive adult relationships through another agency, such as faith-based organizations and in school.

The fourth consideration was that mentoring programs were heterogeneous in that they vary in both the mentors and the populations to whom they provided services. Categorizing the context of mentoring programs in a national registry would facilitate future meta-analysis of program effectiveness by specialty, hence developing more homogeneous methods of studying the effects of mentoring.

Nurse Home Visitation Model: Long Term Effects in Reducing Criminal Behavior in High Risk Mothers and Their Children

The Nurse-Family Partnership (NFP) is a Home Visitation Program that has been rigorously evaluated in a longitudinal, randomized controlled trial, for effectiveness in reducing criminal behavior in high-risk mothers and their children (Kitzman, et al., 1997; Olds, 2008; Olds, Henderson, & Kitzman, 1994; Olds et al, 1998). The program was proposed as a nursing care model but was based on two borrowed theories, human attachment (Bowlby, 1969) and self- efficacy (Bandura, 1977). The nursing care model involved pairing a professional, registered nurse with a low income, first time mother who

was considered to have low psychological support. The nurse-client relationship began before the 25th week of pregnancy and continued throughout the first two years of her offspring's life. Pregnancy and early childhood offer an opportunity to prevent adverse maternal and child outcomes but also have significant implications for the development of criminal behavior (Clark & Cornelius, 2004; Hawkins, Catalano, & Miller, 1992; Olds, 2008; Olds, et al., 1997; Olds, Sadler & Kitzman, 2007). The nurses' interventions were focused on the following three goals: (a) improve the outcomes of pregnancy by assisting women improve their prenatal health; (b) improve the child's subsequent health and development by helping parents to provide more competent care; and (c) improve parents' life-course by helping them develop visions for their future and then make smart choices about planning future pregnancies, completing their education, and finding employment. The latter, a function of modeling and role modeling is described as; "Life coaching for the mother and her family, enabling economic self-sufficiency among mothers by encouraging them to develop a vision for their own futures, stay in school, find employment, and plan future pregnancies" (Olds et al., 2007).

A fifteen year, follow-up study was conducted with the NFP participants (Olds et al., 1998). The investigators examined the long-term effects of nurse home visitation on child abuse, child neglect, substance abuse, and criminal behavior in both the mothers and the children. Of the 400 pregnant women enrolled in the study, 324 participated when their children were 15 years old. Among the women who were unmarried, and from households of low socioeconomic status at enrollment, in comparison to the control group, the nurse-visited women had 1.3 compared with 1.6 subsequent births ($p = .02$), 65 instead of 37 months between births, ($p = .001$), 60 compared to 90 months receiving welfare ($p = .005$), 0.41 instead of 0.73 behavioral problems related to alcohol and substance abuse ($p = .001$),

and 0.16 compared to 0.90 arrests disclosed by New York State records (p = .001), (Olds et al., 1998).

When children in the study were 15 years old, those born to women who received nurse visits during pregnancy and postnatal (*N* = 315), in contrast to the comparison group (*N*= 324) had fewer episodes of running away (0.24 and 0.60; p = .003), fewer arrests (0.20 and 0.45; p =.03), fewer convictions and violations of probation (0.09 and 0.45; p = <.001), fewer lifetime sex partners (0.92 and 2.49; p =.003), fewer cigarettes smoked per day (1.50 and 2.5; p = .10) and fewer days of consuming alcohol in the last six months (1.09 and 2.49; p = .03). The mothers of the nurse-visited children reported that their children had fewer behavioral problems related to use of alcohol and other drugs (0.15 and 0.34; p = .08), (Olds, et al., 1998). The researchers concluded that these were long-term positive effects of the mothers and children of nurse home visitation and interventions.

Perspectives of Children

This section describes four studies that sought to capture the perspectives of children with incarcerated parents, caregivers, incarcerated mothers, and formerly incarcerated parents. The designs of four studies relating to programs that support children with incarcerated parents and their families were based on the premise that studies benefit children when children participate in the process. The first study used mixed methodology; the second study used case study methods; and the latter two embraced youth as co-researchers in action research processes. The four studies were constructed from a strengths-based perspective, acknowledging the strengths, wisdom, and skill of youth and their parents who are impacted by parental incarceration.

The goal of the mixed method two-phase study, conducted by The Council of

Children and Families, was to better understand how the children of incarcerated parents, their caregivers, and formerly incarcerated parents dealt with the challenges related to incarceration (De Masi & Bohn, 2010). This information was intended to inform policy-makers and advocates of interventions and policies that could support children and families during this experience. The research sought to capture data on the journey from the time of the parent's arrest, throughout incarceration and re-entry from prison. The participants were from the NYC region and a large upstate region of New York. Due to the difficulties in identifying these families, a convenience sample was obtained by seeking participants from ten agencies that provided services to families affected by incarceration.

The youth and young adults were divided into two age groups: 12-16 year-olds, and 17- 24 year-olds. The first phase used qualitative methods by conducting 32 focus groups with 262 participants (*N*= 262). The participants were assigned to the focus groups of children, caregivers, or formerly incarcerated parents' focus group. The group interview protocol included the following topics: (a) parents' arrest and/or disclosure of parent's incarceration; (b) issues related to maintaining a parent-child relationship during incarceration; (c) the impact of this experience on children's social and emotional well-being; and (d) changes, challenges and supports encountered as a result of this adverse event (e.g., custody, housing, mentoring, finances). The data were analyzed for schematic themes. The themes that emerged from all participant groups regarding the children's experiences were: (a) profound sense of loss that triggered feelings of abandonment, insecurity, and confusion; (b) shame and guilt; (c) decline of quality of life; (d) role stress from assuming new roles in a recently reconfigured family; and (e) issues of conflicted fidelity with the incarcerated parent.

The second phase used quantitative administration of two standardized instruments.

The caregivers completed the Strengths and Difficulties Survey about their child and the youth completed the Coping Skills Survey. In analyzing the results, combining the responses "a great deal" and "quite a lot" in the Strengths and Difficulties Survey resulted in caregiver ratings of: 41.6% of their children were rated as being upset; 35% of the children's behavior interfered with the home; and 52% had problems that interfered with classroom learning. In the Coping Skills Survey more than 70% of the participants exercised self-control by substituting positive thoughts, solutions and strategies for impulsive self-destructive ruminations. Additionally, other internalized maladaptive responses were reduced by at least 30%, mitigating such familiar response tendencies such as isolation, denial and aggression.

Coping skills used by older youth varied somewhat from their younger peers. For example, older youth (ages 16-24) were more likely to seek counseling or ask adults who may know more about their parent's situation. However, older youth were also more likely to report they self-medicated to deal with adverse experiences. Overarching themes from the focus groups were that children and families affected by incarceration benefitted from advocacy, social support, and outreach inside and outside of prison. All three categories of participants identified mentoring to be a highly desired service and helpful in developing critical skills. The qualitative and quantitative data illustrated the difficulties that children experience with parental incarceration and the need for positive role models to foster effective coping and to assist in reversing unhealthy responses.

The research using case study method was a dissertation, *Children of Promise* (Boudin, 2007). The author started the study while serving a 22-year prison sentence and completed it upon her release. This action research method study used interviews and focus

groups to involve eight youth, 4 boys and 4 girls, ages 14-18-years-old whose mothers' were incarcerated in a maximum-security prison. The author helped to develop a parenting program for mothers in prison called *Teen Time* and worked with the children and teens of those mothers.

The teens had monthly visits with their mothers as well as mentoring adult relationships outside the prison and debriefing "rap" sessions after the visits. The mothers received assistance in parenting adolescent children while in prison and in seeking legal help for custody issues. Provisions were made for the mothers and their children to create family traditions such as celebrating achievements and milestones. The teens developed a support system among themselves, their own mothers, and the other mothers. Their reflections during interviews, when they were between 18 to 21 years of age, focused on the challenges and the positive effects of the three sets of relationships. The results revealed that adolescents felt positive about the support that they received during this usually difficult period of development, which was compounded by parental incarceration.

In the first of the action research studies, six adolescents aged 15-18, and the investigator met for a year and a half, engaging in developing an action plan (Boudin & Zeller-Berkman, 2010). They met 40 times for at least three hours to develop the research questions, and the research protocols. Then they conducted focus groups with 36 youth from non-profit agencies in NYC who were impacted by parental incarceration. The outcome of the focus groups was the basis for developing a policy titled *Bill of Rights for Children with Incarcerated Parents*. Unfortunately, a grassroots effort to reveal a national policy proposal was thwarted when the anticipated federal legislation HR 618 and S. 938, calling for a White House Conference on Children and Youth in 2010 did not come to fruition (HR 618 and S.

938, 111th Congress, 2009 Library of Congress).

The second action research study involved a research collective that built on the previous study (Boudin & Zeller-Berkman, 2010). Eight focus groups were conducted with over 50 participants ages 8-21, from the NYC area that had incarcerated parents. The study aimed to develop a series of policy recommendations by youngsters impacted by parental incarceration. Under the auspices of the Osborne Society policy initiative, guidelines for health professionals were developed. The Osborne Society also used the information in this study to develop their Youth Advisory Board (YAB). Similar to the youth participatory activities in Boudin & Zeller- Berkman (2010), the YAB "encourages youth with incarcerated parents to become leaders and advocates in the movement to transform their rights into their realities" (Krupat, et al., 2011, p. 1).

Conclusions and Summary

I concluded from this literature review that there was sufficient research-based evidence to support development of programs that provide mentoring for children of incarcerated parents and for additional studies on this topic. The findings of previous studies are not conclusive because of various weaknesses in study designs and implementation. Because it is difficult to conduct studies with rigorous designs with this population, in a majority of studies, sample sizes have been small, and no studies have been replicated. This review involved two groups of participants with ACE, high-risk children in general and the specific group of high-risk children, children of incarcerated parents. Both groups experience adverse childhood events (ACE).

Evidence indicates that providing positive role models to children with ACE may promote resilience and healthy behaviors. In the meta-analytic review of mentoring high-

risk youth, programs that had the most favorable outcomes for reducing the antisocial, antecedent behaviors of juvenile crime were those that were theory-based and used best practices. In the studies by Bauldry (2006) and Davidson et al. (1987), children who were referred for mentoring already had been arrested for juvenile offenses. By mentoring them in community- based programs, unrelated to the juvenile justice system, children benefited from social support without being stigmatized and labeled as criminals. In Bauldry's (2006) study, the lack of a control/comparison group and follow-up at 6 to 9 months rather than 1 year was a weakness. In the Davidson et al. (1987) study, the small cell sizes led to the results being less convincing than a randomized experimental research.

The Nurse Family Partnership (NFP) study was a well-designed, longitudinal, experimental study in which high-risk children with young, pregnant mothers of low income and low social support were mentored by professional registered nurses. The nurse-client therapeutic relationship had an enduring benefit to both the mothers and their offspring as they entered their teen years. The NFP has not conducted research to replicate this 15-year follow- up on their other two studies (Kitzman, et al., 1997; Olds, et al., 1998; Olds, 2008).

The studies that examined the effectiveness of mentoring high-risk youth did not distinguish the children who were prone to social and personal maladaptation due to parental imprisonment from those who were more generally at risk due to poverty and systemic deprivation. Epidemiology studies of the U.S. prison population show that the rate of parental incarceration among African American children is 7 times higher than that of Caucasians and 2.6 times higher in Hispanic children (Glaze & Maruschak, 2008; Mauer & King, 2007). Consistent with these data, the African American and Hispanic youth who participated in the reviewed studies had parents who were imprisoned at a significantly

higher rate, but they were not distinguished as such and therefore not studied for predisposition to ACE.

One mixed method study and three qualitative studies sought to capture the perspectives of children with incarcerated parents. They recruited participants from organizations that offered mentoring services to those afflicted by extreme poverty and family dysfunction. It should be noted that based on the difficulty to identify those affected by parental incarceration, the participants in these studies were not representative of the majority of families suffering from the unique stresses related to parental imprisonment. The vast majority of families with members who are imprisoned do not get these services. For that reason the quantitative outcomes of De Masi and Bohn (2010) cannot be generalized. Furthermore, transferability among the qualitative studies is limited for the same reason.

In each of four studies, the children revealed through self-reporting that they suffered from numerous ACE. However, the emotions and behaviors related to grief, shame, guilt, poor quality of life, and conflicted fidelity were subjectively and objectively decreased in a significant number of participants through supportive interventions that had mentoring components. A limitation to the applicability of these results is that the studies have not been replicated with the general population of families with incarcerated members. Such families report that mentoring was very helpful in developing critical skills needed to cope in healthier, more socially acceptable ways (De Masi and Bohn, 2010).

The youth who were co-researchers in the two action research studies participated in adult supportive relationships. Through the process of role modeling, they were empowered to create a *Bill of Rights for Children of Promise.* In turn, they engaged additional Children

of Promise to take leadership roles in making their own lives better as well as the lives of other children with incarcerated parents. Thus, a self-reinforcing cycle of positive social behaviors and resilient perspectives appeared to have been established with mentoring interventions. These studies should be repeated with larger sample sizes.

A neglected area of research is to identify nursing interventions within a nursing theoretical framework that target this population. This researcher's aim is to fill this void by: (a) delineating the nursing interventions that work well when caring for this special population; (b) determining the obstacles experienced by nurses in delivering health care to the children; and (c) defining the nursing knowledge that has been created through the shared vision and collective actions of the nurse-mentors.

The knowledge created in this study is necessary to help the growing numbers of children who experience ACE related to parental incarceration. While this need is significant, the numbers of professionally trained caregivers from the nursing field is sufficient to meet these needs. Of the 2.9 million RNs in the U.S., high percentages are already working with children and families. Additionally, the 646 RN to BS programs nation-wide have experienced an increase in enrollment for nine consecutive years (American Association of College of Nurses (AACN, 2012). These groups of nurses that have contact with children and are enrolled in RN to BS programs represent the largest health professional work force, and therefore could make dramatic changes in breaking the cycle of intergenerational incarceration. Both the problem and the solution can be delineated and implemented through appreciative inquiry research as represented by this study.

Chapter Three

Method

This chapter describes the appreciative inquiry (AI) qualitative method used for this action research study. Action research (AR) is broadly described as: "A systematic approach to investigation that enables people to find effective solutions to problems they confront in their everyday lives with focus on specific situations and localized solutions" (Stringer, 2007, p.1). AR focuses on the pragmatic use of knowledge developed by community participants, which is a dynamic process and is re-evaluated in the routine of observation, reflection and action (Israel, et al., 2008; Stringer, 2007). In the following sections I detailed: (a) the evolution of AR with contributions of Lewin (1946) and Freire (1970), two of the sixteen AR philosophers/theorists; current day use of AR; (c) AI, a branch of AR; (d) the appreciative topic and the 4 stage cycle of AI; (e) values of AI; (f) the role of the researcher in AI; and (g) strategies to attain rigor with AI.

Evolution of Action Research with Contributions of Lewin and Freire

The impetus for AR stems from societal needs to solve problems by placing inquiry in a local context instead of trying to discover generalizable truths (Stringer, 2007). Action research methods were developed as a way of decentralizing efforts to find solutions to social problems by developing knowledge that is specific to a community rather than imposing generic solutions. The methodological process of AR involves three basic routines of observation, reflection, and action (Reason & Bradbury, 2011; Minkler & Wallerstein, 2008; Stringer, 2007). Implicit in the process of solving problems and taking actions are change and liberation (Reason & Bradbury, 2011; Stringer, 2007). The changes that were brought about by two of the major theoretical contributors, Lewin (1946) and Freire (1970), were seen as

radically threatening to the existing powers, so attempts were made to silence their works.

Lewin's Contributions

The first AR model is credited to Lewin (1946), who sought to develop a research method that would close the gap between theories and practice (Minker & Wallerstein, 2008). Lewin's *Action Research and Group Dynamics* (1948) model and *Field Theory in Social Science* (1951) were based on the following tenets: (a) the values, objectives, and powers of the parties involved are crucial for understanding the issues and therefore, in constructing an effective resolution; (b) peoples' participation is needed to define their situations; and (c) collaborative approaches must be used to choose new options, and to evaluate results. This was the period just after World War II when the focus was on national recovery (Bradbury, Mirvis, Neilsen & Pasmore, 2011). During this time, a philosophical shift began to emerge that countered the positivist research stance whereby "knowledge equals science equals reality" (Watson, 1999). This philosophical approach differed from that of previous scientists by seeking the meanings understood by research participants as they act in their world, as opposed to studying them separately and apart from the context of issues (Bradbury et al., 2011).

Implementing Lewin's theories (1946 and 1951) placed the emphasis on practitioners acting as co-equals to the researchers in the research process (Wallerstein & Duran, 2008). At that time, action science researchers in the fields of organizational development and social psychology worked to create a consensus model, assuming that in organizations, the management and workers have equal power to influence quality improvement (Brown & Tandon, 1983; Argyris & Shon, 1996). This was an erroneous assumption, however, as decisions in consensus models can be vetoed by those in power positions and are therefore

vulnerable to manipulation. To address the disequilibrium of power in organizational-decision making, humanistic researchers have added an element wherein strength-based, collaborative approach produced a cooperative inquiry strand within the consensus model (Brown & Tandon, 1983; Argyris & Schon, 1996). This element ensured that none of the participant groups could sufficiently influence decisions regarding the research process (Rowan, 2006).

Lewin's theories proposed that behavior is influenced by the environment, and the context in which it occurs (Lewin, 1951). This was in stark contrast to the dominant paradigm at the time, Freudian psychology, and posed a threat to those in power positions within academic research (Bradbury et al., 2011). The thrust of action research was also thwarted in the U.S. by influences of the Cold War such as McCarthyism, and positivist science conservatism of U.S. psychology. Lewin's vision was a radical challenge to how science was practiced and therefore was "reduced to a set of techniques and axioms" (Fine, et al. 2003). However, AR methods were commonly applied to research in the developing countries of Latin America.

Freire's Contributions

In the slums of Brazil, Paulo Freire's experience with teaching literacy to the powerless and marginalized poor influenced his seminal work (1970). Freire believed that the purpose of education was to liberate humans, "which means that people are the subjects of their own learning, not empty vessels filled by the knowledge of experts" (Minkler and Wallerstien, 2008, p.37). By using emotionally charged words and pictures initiating feelings of social dissatisfaction, Freire increased awareness, articulated grievances and facilitated the social movement to *conscientization,* or critical consciousness, and *praxis,* or (action based on

conscientization) that promotes social change. Freire proposed that the first step in empowering the oppressed is listening to the general themes that community members have enunciated, so that a structured dialogue can ensue, enabling community members to participate and become co-learners (1970). This is an analytic process, the goal of which is to create a shared social reality among community members that can be used for stakeholder engagement toward solving problems. The purpose of going through processes of dialogue, conscientization, and praxis is to facilitate the repetitive cycles of reflection and action that people take in order to construct social change (Park, 2006). Eventually, exiled from Brazil in a military coup, Freire resided in Chile from where he was also exiled.

Evolution to Current Day Use of AR

In the 1970's, the AR studies conducted in Latin America, Asia, and Africa arose out of structural crises of underdevelopment (Wallerstein & Duran, 2008). These crises were characterized by inequality of wealth distribution between the overwhelming majority of poorer, less industrialized countries and the smaller number of vastly richer western nations. Economic crises in Latin America propelled AR from the theoretical, to the practical value of applying science to community life, so as to address social inequities and create radical but beneficial changes.

Since the 1970's, AR was used in the fields of business and community development, education, and more recently, in health care research (Kemmis & McTaggart 1999; Reason & Bradbury, 2011; Stringer 2007; Waterman, Webb, &Williams, 1995). Today, AR is accepted as appropriate when research questions can best be answered by the people who are experiencing the problem and where qualitative research methodologies have made it possible to validate peoples' pragmatic experiences as "a way of knowing." The practical use of

information arising from AR reflects the dynamic process referred to by Freire (1982) and results in standard systems of evaluation that include observation, reflection and action.

Appreciative Inquiry, a Branch of Action Research

Appreciative Inquiry (AI) is a generative form of AR (Ludema & Fry, 2011). The theorists who conceptualized AI, David Cooperrider and Suresh Srivastva (1987), categorize AI as a philosophy and method in which inquiry and anticipatory learning take place. Cooperrider, (1990) described AI as a "strength-based approach to transforming human systems toward a shared image of their most positive potential by discovering the very best in their shared experience" (Ludema & Fry 2011, p. 281). As a branch of AR, AI seeks to create a positive revolution toward transformative changes (Barrett and Fry, 2005; Fry et al., 2001; Whitney & Trosten-Bloom, 2003). AI was further developed after Seligman proposed that the dominant psychological model was focused on disease, psychopathology and illness (Seligman, 1999). Seligman and Csikszentminhalyi (2000) suggested an alternative approach that emphasized strengths. The AI methods evolved from psychologists proposing that meaningful and essential changes occur through identifying and valuing strengths, assets, vision, and ideals of individuals. By appreciating core strengths and values, individuals understand those aspects that give meaning to their daily lives (Seligman et al., 2005). This, in turn, enables them to arrive at a shared vision of the preferred future and participants are energized and inspired to take collective action.

Assumptions of Appreciative Inquiry

The primary assumption of AI is that every living system has a concealed and underutilized core of strengths, which is referred to as the positive core. When the positive

core is freed, it provides a maintainable source of positive energy for both individual and organizational transformation (Bushe, 1995; Cooperrider & Srivastva, 1987). Cooperrider and Sekerka (2003) explain the sustainable source of energy by the concept of fusion energy. Fusion is the power source of the sun and the stars. It results when two positively charged elements combine into one, "…when joy touches joy, strength touches strength, health touches health, people are empowered and liberated to create ascending spirals of co-operation" (Ludema & Fry, 2011, p. 282). The ascending spiral in AI involves the process of identifying the appreciative topic and going through the AI four stage cycles (Appendix B).

The Appreciative Topic and the Four-Stage Cycle

The AI method begins with choosing a topic of common interest (Carter et al., 2007; Ludema & Fry, 2011). An intentional reframing of the presenting issue attracts interest and generates hope and positive anticipation. Reframing words focuses inquiry in a way that attracts participants to engage in discourse about the primary matter and what they envision as the desired outcome of working together (Ludema & Fry, 2011, p. 285). The AI topic is then put into a question. For example, "How can we develop a system of_that best meets the needs of clients and promotes autonomy of nurses in the practice setting?" After the topic has been chosen, AI moves into the four stage cycle, referred to as the 4D Cycle: "(a) discovering the best of what is; (b) dream to imagine what could be; (c) design what will be; and (d) destiny- learn from the enacted change, to become what we most hope for" (Ludema & Fry, 2011, p. 283). The 4D Cycle is typically pursued during one or two-day retreats or AI sessions organized in a series of meetings (Appendix B).

The discovery stage elicits sources of meaning and purpose among individuals in

the organization. Participants are paired with another member and interviews take place regarding their perceptions of the following: (a) recollections of a peak experience related to the appreciative topic and focus on when the individual and/or organization was at its best and the individual found their work the most rewarding; (b) reflections on the scenario that identify the role that participants played, what systems were in place that allowed this peak experience to occur; and (c) group sharing inquiry into these stories that draws out individual strengths, cooperative capacity and positive images. This process creates positive energy that fuels the next stage for participants to imagine (dream) what their practice might look like if the peak experiences were daily occurrences (Carter et al., 2007; Ludema & Fry, 2011).

The goal of the dream stage is to create a collective vision of the ideal practice. Participants are asked to visualize what their practice might look and feel like in the future if the strengths and meaningful experiences emphasized in Discovery occurred more often. To facilitate visioning a transformed practice, small groups work on portraying their image of the ideal practice to the larger group. Creative modalities such as drawings, skits, songs, poems and stories are used to reveal the shared vision of the ideal and identify common themes. Once the shared visions of opportunities to create the ideal practice have been discerned, they are transferred to the design stage (Carter, et al., 2007; Zandee & Cooperrider, 2011).

The mission of the design stage is to move from the vision to a more specific plan with concrete steps that participants can take to make their ideals come to fruition. The groups are asked to explore the first step needed or "the smallest change with the biggest impact in moving toward its ideal practice" (Carter et al., 2007, p. 196). Common themes

can be posted, and then, if necessary, the project choices can be narrowed on the basis of priorities, pragmatic assessment of existing resources, and participants' interests. Concept mapping can be used in this stage to help participants clarify and reconceptualize the issues by presenting a visual diagram of how the categories and themes are inter-linked. Participants vote on the project that they have the most interest in and would be willing to commit their work and energy towards. Action teams are formed based on the participant's interests in specific group projects. Each action team(s) is asked to designate a coordinator who will organize meetings and focus the group on the chosen task. These work groups will use the "Plan," "Do," "Study," "Act" (PDSA) cycle to work on a project. They plan activities, try out early steps, evaluate the results and report back at regular intervals to the larger groups (Carter, et al, 2007; Ludema & Fry, 2011).

The last stage, Destiny, is an invitation to build the future through innovation and taking action that brings about change. After a pre-determined amount of time, (the Destiny deadline), the participants reconvene to review, communicate and celebrate the outcomes and learning that has transpired. This gives the members of the larger organization opportunities to acknowledge the action team(s) efforts, have input into the next steps, and revisit how the work fits with the vision of the future practice. This stage also encompasses plans to continue generative, appreciative learning by asking questions for the next AI ascending cycle (Carter, et al, 2007; Ludema & Fry, 2011; Stringer, 2007).

Values of Appreciative Inquiry as an Action Research Method

The social values of AI, like that of AR are: (a) democratic; (b) equitable; (c) liberating; and (d) life enhancing (Israel, et al., 2008; Minkler and Wallerstein, 2008;

Stringer 2007). AI is democratic because it provides opportunities for community members to participate and offer their ideas. Community members are considered to be both co-creators and co-learners. Second, AI is equitable because it acknowledges that each participant's worth and expertise is considered equally valuable. It is cooperative in nature, by engaging community members and researchers in a joint process in which both equally contribute. This equitable process achieves a balance between research and action. Third, the act of becoming co-creators and problem solvers is liberating, thereby removing barriers to free expression. Liberation in AI involves decreasing dependency on systems that oppress particular groups of people. This is achieved by planning for systems development and in improving the capacity of the community to utilize this system. Finally, AI is "life enhancing," as it enables the expression of the stakeholders' full human potential (Stringer, 2007, p.11).

Role of Researcher in Appreciative Inquiry

The role of researcher in AI is one of facilitator, to assist participants rather than direct them. The researcher invites participants to the process; makes arrangements for meetings, conducts interviews and reports to all stakeholders the contributions of participant groups during the research process. This methodology allows researchers to formulate and test hypotheses as they continue to gain knowledge of the dominant topics and refine actions. The researcher can facilitate the basic action research routine cycle envisaged by Kemmis and McTaggart (1999) as the "look, think, act" procedure. The researcher guides the participants to engage in a spiral of activity that builds on the previous cycle of examining a problem, thinking about how the problem can be changed, and then making an action plan.

Strategies to Attain Rigor with Appreciative Inquiry, a Qualitative Method

Rigor in qualitative methods such as AI is based on stringent monitoring to ensure that the results of studies are trustworthy, credible, transferable, dependable, and confirmable (Hupcey, 2005; Lincoln & Guba, 1985; Munhall, 2012). Trustworthiness ensures the results of studies reflect the perspectives, biases, and worldview of the participants and that they are based on substantial analyses of the issues investigated. In AI, it is essential that participants trust that the researcher is accurately portraying their perspectives and contributions.

Credibility is accomplished through repeated monitoring by means of: (a) prolonged engagement (b) persistent observation and (c) triangulation. Prolonged engagement is necessary to enable participants to develop thorough understanding of the issues of investigation and to explore and express their experiences and perspectives. Extending the length of engagement in a study promotes full exploration of the issues and develops consensus. This can be accomplished by providing the participants with opportunities to increase the number of focus groups and forums for discourse (Mackey, 2012).

The researcher conducts continuing observations that are in the natural setting of the phenomena of interest. The credibility of research is enhanced when participants make a conscious effort to observe meetings and activities in the context in which these occur. Recording field notes of what is actually transpiring is superior to describing it from memory or from an interpretation of participants' verbal recollections (Stringer, 2007; Wolf, 2012).

Triangulation is a term that describes the use of multiple data sources to capture a more thorough understanding of a phenomenon. The four types of data triangulation that are used to enhance the quality of a study are; time, space, person, and method (Denzin & Lincoln,

2005). Time triangulation involves collecting data about the same people and the same thing at different points of time. Space triangulation entails collecting the same data at different sites. Person triangulation is accomplished by collecting data about the same phenomenon from various groups of stakeholders. Method triangulation refers to the use of multiple methods of data sources such as, focus groups, individual interviews and observations (Hentz, 2012).

Transferability refers to the capacity of a study to present a detailed description of the contexts, activities and events that are reported as part of the outcomes. Although outcomes of qualitative research are not generalizable, as in quantitative research, qualitative outcomes can be applicable to others in similar settings. It is possible for someone not involved in the study to make judgments about whether or not the situation is sufficiently similar to their own for the outcomes to be applied (Munhall, 2012; Stringer, 2007).

The dependability of an AI study refers to the degree to which others can be ensured that the researcher and participants adhered to all procedures required of a systematic research study. An inquiry audit can be used to provide a detailed explanation of the procedures that have been followed and provide the basis for evaluating the degree to which they are dependable (Stringer, 2007). Researchers confirm, through audit review, that the procedures described actually occurred. An audit trail creates an environment of transparency in which an observer can view the collected data, field notes, tapes, journals or other objects related to the research (Munhall, 2011, Stringer, 2007). Dependability can also be enhanced by using member- checking that involves participants reviewing data, analyses, and reports derived from the data (Munhall, 2012; Hupcey, 2005). At these junctures, the participants have opportunities to clarify and extend information related to

their experiences. In addition, all participant groups are kept informed of the contributions made by individual groups; consequently all participants are kept apprised of the process.

In AI, confirmability is achieved during the process of referential adequacy. This process involves data interpretations that keep the perspectives and experiences of the participants in their own words as much as possible. Analyzed and interpreted data must be understood and recognizable to the participants by clearly depicting their perspectives. The researcher makes efforts not to "interpret data according to schema from a theoretical or professional body of knowledge" (Stringer, 2007, p. 59).

Chapter 4

Methodology

Applied

The application of appreciative inquiry (AI) in this study included: (a) protection of human subjects; (b) sample; (c) role of the researcher; (d) implementation of qualitative rigor; (e) identification of the AI topic; and (f) the AI process of generating nursing knowledge for Children of Promise.

Protection of Human Subjects

After CUNY Institutional Review Board (IRB) application was submitted and approved, this researcher recruited study participants from nurse-mentors who had completed a minimum of 60 hours of mentoring in the Children of Promise Mentoring Program. To eliminate the risk of coercion and bias, the nurse-mentors had already received their grades for the clinical course- work involved in mentoring and were no longer in the role of RN to BS students with this researcher. The purpose of the study and the manner of collecting data were explained to potential participants, including that they were to sign consent and could withdraw from the study at any time without penalty. The researcher and nurse-mentors completed the Citi Collaborative IRB Training Initiative: modules designated for Social Behavioral Research prior to enrollment in the study.

To maintain confidentiality, each participant was assigned a code rather than using identifying information such as names. No identifying data were published and anonymity was maintained. When the nurse-mentors who agreed to participate related their stories and journal entries in the Dream stage of AI, the children that were mentored were not referred to by their real names; fictitious initials were used. All hard copy research materials were stored

in a locked cabinet and any electronic files were held on an encrypted secure server at the CUNY Graduate Center.

It was anticipated that there would be no risks related to this study, including stress or adverse responses. In the unlikely event that a nurse-mentor experienced stress related to describing their recollections of mentoring children who face adversity, the participant was to be referred to the college's Student Counseling Services or other private counseling services.

Sample

The participants were a convenience sample comprised of nurse-mentors who had previously participated in the Children of Promise Mentoring Program. It was anticipated that at least 10-12 nurse-mentors (out of 26 who are eligible) would agree to participate in the study. The nurse-mentors were invited to share their experiences, perspectives and opinions on how best to help the children develop healthy behaviors. The RN to BS students who most recently completed mentoring for at least 60 hours were notified of the study by college e-mail and those who had graduated were notified through the Alumni e-mail system. Participants signed the consent form prior to individual interviews. When I received additional funding for this study, an addendum to IRB was submitted and approval given for each participant a to receive $150.00 honorarium (see Appenices E & F). After the first stage of analyzing and interpreting the data from the process of determining the AI topic, the researcher arranged for a one or two day retreat and asked for participants' input regarding convenient times, dates and location in order to facilitate attendance.

Role of the Researcher in This AI Study

The researcher facilitated the AI process and assisted the participants rather than directed them. The researcher invited the nurse-mentors to the process as delineated in the

section on Protection of Human Subjects. The researcher arranged the place and times for meetings and retreats that were convenient for as many nurse-mentors as possible. The participants were guided by the researcher through the AI process of topic identification as well as the 4D Cycle by informing them of the: (a) purpose of each stage; (b) activities that were to take place; and (c) questions that would prompt goal attainment for each step (Table 4.1).

Table 4.1
Procedures for the Study

Category	Procedures	Time
Recruitment	**The researcher will:** • Send recruitment letter to nurses who meet the criteria for participation (Appendix C)	
One to one interviews	• Explain study to potential participants. • Obtain written consent. • Conduct one-to-one, audio taped interviews at the researcher's college office.	30-60 minutes per individual interview.
8 hour retreat **A. Identify the Appreciative Topic**	**In collaboration with participants, the researcher will:** • Welcome and Introductions • Review study procedures • Obtain written consents Use interview questions for reflection on experiences, and hopes for future practice of nurse mentoring • Review content of interviews through an interpretive dialectic process. Create a grid and input data. Synthesize data by identifying key themes. • Ask groups to present key themes depicted in a concept map format. • Verify that key themes represent content of interviews. • Engage in audio taped group consensus validation to arrive at a decision for the Appreciative Topic. • Frame or reframe the topic in generative and positive terms.	1-2 hours in the beginning of the retreat

B. Discovery	□ Assign participants to dyad groups for reflection: a time during mentoring that was most meaningful. □ Reconvene dyads to the larger group to share reflections in stories. □ Transfer positive energy by immediate engagement in the Dream step.	1-2 hours to take place in the retreat
C. Dream	□ Form small groups of 3-4 people. □ Envision what the practice would look like if those peak moments happened more often. □ Imagine nursing practice 3-5 years in the future where those most meaningful experiences are happening with increased frequency. □ Create representation of that future nursing practice, i.e. pictures, skit, poems, or songs. □ Record representations with photographs, video, and audio taping.	1-2 hours to take place in retreat
		Lunch Break-1 Hr.
D. Design	□ Present visions for changed practice to the larger group. □ Engage in consensus-validation dialog to prioritize the actions that should be addressed first. □ Consult with others, if necessary, regarding pragmatic considerations for mentoring in a NYC, DOE elementary school. □ Establish ownership of actions in the "Plan, do, assess cycles." □ Select team leaders. □ Conduct additional meetings if needed with the action teams.	2-3 hours to take place in retreat End of retreat
E. Destiny	□ Select "Destiny Deadline" for 1-3 months to evaluate the effects of the changes that were put in place. □ Plan additional meetings with the action teams if needed to crystallize the plan of action. □ Plan monthly meetings with teams.	5-20 hours over the course of 1-3 months. Take place in various settings.

	□ Communicate team activities and results to larger group of participants. □ Link the participants to instrumental resources and partners. □ Meet with teams for Destiny Deadline Evaluation. □ Identify what has been learned and make recommendations for the future of the nurse-mentoring model of care. This will start to identify questions for the next AI cycle.	

The AI method of action research is a dialectic-hermeneutic approach that interprets the texts (stories and journals) of those who experience a phenomenon and constructs personal meaning from them (Stringer, 2007). This researcher ensured that an atmosphere was promoted in which all participants felt free to express their perspectives based on their personal experiences. Opposing views were valued as much as consenting views and the larger group of nurse-mentors were asked to consider each contribution equally as they proceeded through the AI process.

The researcher was available for consultation regarding the administrative limitations and resources provided in this school-based mentoring program. In the stage of identifying the AI topic, this researcher facilitated the process of concept mapping as delineated in Chapter 3. Meetings with the action teams and conferences with the designated coordinators was the responsibility of the researcher. The researcher disseminated progress reports to the larger group of nurse-mentors. There are many forms of engagement of AI; each is designed to meet the unique needs and goals of the people, community and organization involved. This researcher has chosen the AI Learning Team format, which is described by Whitney and

Trosten-Bloom (2003) as: “A small group of people with a specific project-an evaluation team, a process improvement team, a benchmarking team, or a group of students who conduct an AI 4D-process.”

Rigor of Study

Rigor in AI is based on a system of checks to ensure that the outcome of the research is trustworthy (Hupcey, 2005; Lincoln & Guba, 1985; Munhall, 2012). Trustworthiness is achieved through procedures that assess the credibility, transferability, dependability and confirmability of a study.

In this AI, the credibility was supported by prolonged engagement; (a) persistent observation/triangulation; (b) member checking; and (c) referential adequacy. Extending the length of engagement in this study was accomplished, in part, by setting the sample criteria that the principals had participated in at least 60 hours in the mentor or mentee role prior to the study. The participants also had the opportunity to increase the number of meetings to decide on the AI topic. A retreat for the 4D Cycle was set for an eight hour time period that could be extended for additional days if needed to develop a consensus (Stringer, 2007; Wolf, 2012). The nurse mentors based their perspectives on having persistent observations of the children during the course of a school year in various settings in their neighborhood, such as escorting them on public transportation to community-based activities, trips to the college and field trips.

The credibility of this study was strengthened through person triangulation. This was achieved by using multiple data sources, which captured a more thorough understanding of mentoring Children of Promise. Multiple data sources were comprised of nurse mentors from three different classes or years of study. Since the inception of the program, there have been

three sets of nurse-mentors and children. Each semester of RN to BS students has its own dynamic and the children who were mentored also changed, reflecting this dynamic. The three groups of nurse-mentors and mentees each had unique and synergistic interactions. By increasing the perspectives from nurse-mentors representing each cohort, the data became richer and more reflective of genuine effects (Hentz, 2012).

Encouraging the participants to use stories and journals reinforced credibility. In this way, they effectively created meaning as defined in the dialectic-hermeneutic process. As the participants talked about their experiences and perspectives, their descriptions were composed of a wide array of interconnected ideas, activities, and events.

The next phase was to identify distinct ideas, concepts, events and experiences that were incorporated into their text in order to separate and delineate each specific experiential element. This is referred to unitizing the data (Stringer, 2007). The units of meaning were categorized again when concept mapping was completed, and finally when the action plan was evaluated (Springer, 2007). At these junctures, the participants had opportunities to clarify and extend information related to their experiences. In addition, all groups were kept informed of the contributions made by the other groups. This allowed all participants to be kept apprised of the process.

Credibility of this study was further increased by the use of referential adequacy. The researcher reported the perspectives and experiences of the participants in their own words, as much as possible, when interpreting the data (Springer, 2007). Analyzed and interpreted data were recognizable and thoroughly understood by the participants, clearly depicting their perspectives. The researcher avoided using phrases when interpreting the data that stemmed from theoretical and professional jargon.

Transferability was supported by the ability to apply the outcomes of this study to others in similar settings (Munhall, 2012; Stringer, 2007). The capacity to present a detailed description of the contexts, activities, and events that were reported as part of the outcome made it transferable. The descriptive details made it possible for someone not involved in the study to produce judgments about whether the situation was sufficiently similar to their own for the outcomes to be applied. The models in Appendix A were disseminated in reports of this research. These depict the curriculum, context, and nursing care model in which the nurse- mentor program was implemented. The purpose was to assist readers in determining the applicability of these results to their own settings.

Dependability was achieved by the researcher's adherence to all procedures required of a systematic research study. This researcher was able to confirm, through corroboration that the procedures described actually occurred. The researcher created an audit trail that enabled an observer to view the data (field notes, tapes, journals etc.) related to the research. These confirm the accuracy of the study, therefore support that the research process was trustworthy (Munhall, 2012; Stringer, 2007). An inquiry audit provided a detailed explanation of the procedures that were utilized and supplies the basis for evaluating the degree to which they are dependable (Stringer, 2007).

The AI Process of Generating Nursing Knowledge for Children of Promise

This section delineated the process of AI, which involved the AI topic and the 4D AI cycle of discovery, dream, design and destiny (Appendix B). Each step of the AI cycle was defined in terms of its purpose. Examples of techniques that were used to facilitate the AI process, and work activities by the participants that lead to the goal of the preferred future were supplied. Samples of interview questions for each step of the AI process were explained

in terms of how they facilitated the goal of generating change and new knowledge (Carter, et al., 2007; Ludema & Fry, 2011; Zandee & Cooperrider, 2011). Procedures for carrying out the process of AI in this study are delineated in Table 4.1

The AI Topic

The AI topic, a component at the center of AI was discerned from discussions of problems and opportunities among the stakeholders, who in this study were the nurse-mentors. Based on the positive aspects of promoting healthy behaviors in children with incarcerated parents, the nurse-mentors were asked to discuss what facilitated the mentoring process and what challenges they experienced that hindered the process. During one-to-one interviews with the researcher, the nurses were asked to reflect on their experiences, and their hopes for the future practice of nurses working with Children of Promise in similar mentoring programs. The units of meaning in the reflections were placed in a grid. At the completion of the interviews and compiling data into the grid, key themes were synthesized. Concept mapping was used to help the participants understand the complexity of concepts involving a particular aspect of parental incarceration. Mapping provided a visual display of how various concepts were interwoven. It serves to clarify how the nurse-mentoring program can promote resiliency through developing healthy behaviors.

The researcher intentionally framed or re-framed the AI topic from a strength-based perspective. For example, during an excursion with the children to a science center, it was observed that other groups of school children were more adventurous with hands-on experiential tasks compared to our children. The mentees were able to venture forward after their mentor tried the activity first and then encouraged the children to try the activity with them. Instead of categorizing the behavior from a perspective of a problem or deficit “lack of

confidence" the researcher reframed this to a strength-based position that the children "showed curiosity that was enhanced by supportive relationships."

The AI topic and the cycle were pursued during a one-day retreat. At the beginning of the retreat, the nurse-mentors were requested to decide on a topic that addressed one or more opportunities for constructive change that built upon what is positive and aligned with the goals of the mentoring program. Throughout the 4D cycle, the participants used the appreciative topic to frame the needs of the nurse-mentoring program and the possibilities for change. Once the topic(s) was chosen, the participants moved into the 4D cycle.

The 4D Cycle of AI: Discovery, Dream, Design and Destiny

In the discovery phase, the researcher used techniques to assist the nurse mentors to bring meaning to the surface. The nurse-mentors worked in pairs and interviewed each other to identify shared peak experiences through stories. They were encouraged to ask each other open ended questions such as: "Reflecting on your entire experience with mentoring, what was a time that was most meaningful to you; when you felt the most alive and inspired?" "Can you talk about what you value deeply; things about yourself, your life experiences that led you to become a nurse-mentor?" The pairs of nurses also shared selections from their coursework, journaling on the experiences and insights of mentoring children in this specialized program. The pairs were reunited with the entire group of participants and related what meanings had been illuminated in the process. Inquiry into their recollections helped to define the individual strengths, cooperative abilities, and positive images that created energy in the room. The positive dialectic interchanges set the stage for participants to Dream or imagine what nursing practice might look like if the peak experiences happened more often.

The purpose of the Dream stage was to have the nurse-mentors envision a transformed practice for this Children of Promise Mentoring Program and other programs two to three years in the future. The participants tapped into the positive energy that was created in Discovery to imagine what nursing practice would look like if the meaningful experiences elucidated in the Discovery stage occurred more often (Carter, 2007; Ludema & Fry, 2011; Zandee & Cooperrider, 2011).

Activities that facilitated this process took place in group work (3 people), involving fun and creative modalities that "portrayed" their ideal practices to the larger group. Participants could draw pictures; create songs, poems, stories or skits. In order to engender inquiry and facilitate discussion, the participants were asked to talk about the future as if they were already in it and as if they were already successful. The groups of three people revealed their visions of the preferred future to the whole group of participants. Next, the nurse-mentors looked for common topics and themes to reach a shared vision of ideal practice. Once the shared vision of the preferred future of the nurse-mentoring program was achieved, it was time to move a vision into a plan.

The task of the design stage was to discuss concrete steps that individuals and groups could take to realize the vision of their practice of the future (Carter, 2007; Ludema & Fry, 2011; Zandee & Cooperrider, 2011). Participants were asked to join small groups and brainstorm about necessary actions in order to reach the preferred future. The small groups shared their ideas with the entire group of participants and the researcher facilitated writing common themes and posting these on the walls. Often, diverse concepts were combined under larger themes. It was helpful to ask the group to explore the first step needed or the "smallest change with the biggest impact in moving toward the ideal practice" (Carter et al., 2007, p.

197). Then the areas for taking action were rated according to the degree of difficulty in implementation. It was often beneficial to begin with activities that were likely to be successful (Stringer, 2007, p. 127). This strategy created a momentum of "getting things off the ground" and stimulated the energy needed to accomplish the more difficult tasks.

After choosing the first action plan to be implemented, the remaining areas were ranked in order of priority. At this juncture, participants were asked to commit to an action of interest to them and join that particular action team. Each of the action teams (working groups) designated a coordinator who organized meetings and focused the group on the chosen task. The working groups used the "Plan, Do, Study, Act" cycle (PDSA) to work on the specific project (Carter, 2007; Stringer, 2007). Each action team decided whom it needed to include for completing the task, such as community partners, the children and/or their caregivers. They planned initial activities, tried out early steps and evaluated results. The work groups regularly reported back to the larger group of participants to report progress.

In the third destiny stage, referred to as the destiny deadline, the nurse-mentors, after an agreed amount of time, reconvened to review, communicate and celebrate achievements and learning (Barrett & Fry, 2005; Carter, 2007; Ludema & Fry, 2011). There were two important purposes to the Destiny stage. The first was that it ensured that Dreams were realized through planned actions and outcome assessments. Secondly, it included plans to continue generative, appreciative learning.

During this stage, it is essential to reflect on the newly created nursing knowledge for best practice with Children of Promise. The participants were asked questions to prompt reflections such as, "What happened?" "How did it work out?" "What were the hurdles and successes?" "What did you learn that could help sustain change?" At this stage, participants

identified what changes occurred in the shared vision and collective actions as a result of their experiences with Children of Promise through the AI process.

In conclusion, appreciative inquiry was used as the primary method to analyze the data gathered in this study. After IRB approval this researcher recruited participants and fully informed them as to the purpose of the study and the process of data collection. The researcher's role was to facilitate the AI process and assist but not direct the participants. These participants were recruited from the total pool of nurse-mentors previously involved with the Children of Promise Mentoring Program. Each step of the AI cycle was defined in terms of its purpose. Based on the positive aspects of promoting healthy behaviors in the children through mentoring, the nurse-mentors were asked to discuss what facilitated the mentoring process as well as the challenges they encountered. The 4D cycle of AI was then employed to complete the research process. Lastly, each step of Discovery, Dream, Design, and Destiny was completed to assure the integrity, validity and reliability of the research methodology and the accuracy of the results.

Chapter 5

Results

This Appreciative Inquiry (AI) Action Research was conducted in four distinct phases. Phase I involved sampling, collecting data from individual face-to-face interviews, analyses of data, development of conceptual themes from the data, grouping concepts with common characteristics, building constructs, and construct mapping. Phase II was conducted during group retreats in which the AI topic was determined by RN to BS students, and included the steps of Discovery, Dream, and Design, the 4-D Cycle took place, revealing a shared vision and plan for collective action. In Phase III the plan for collective action was implemented. In the final step, Phase IV, I led the Destiny phase with RN to BS students, in which the action plan was evaluated, the knowledge generated was identified, and the stage was set for the next AI study. Throughout the research procedures, the researcher and participants referred to the children with fictitious names.

Phase I

This section describes results of the first phase of conducting this study: (a) obtaining the sample; (b) collecting interview data; analyses of data; identification of concepts; grouping common concepts together; building constructs; and mapping constructs as a basis for conducting the AI process. Phase I was initiated after the Institutional Review Board (IRB) of City University of New York approved conduct of the study (Appendix F).

The Sample

This was a convenience sample comprised of 12 nurse-mentor volunteers who had previously participated in the Children of Promise Mentoring Program. The nurse-mentors shared their experiences, perspectives and opinions on how best to help the children develop healthy behaviors. To obtain volunteers, the 26 RN to BS students from three cohorts who completed mentoring for at least 60 hours were notified of the study by invitation letter and flyer

(Appendices C & D) through the college e-mail and those who have graduated were notified through the alumni e-mail system. Four nurse-mentors in the alumni group could not be notified due to obsolete e-mail addresses. Three of the potential participants declined, citing that they were engaged in graduate studies and working full time. Five of the nurse mentors replied, and could not participate because they geographically relocated. Two of the most recent graduates from the RN to BS program declined because they were seeking full time employment and had per diem jobs that required them to be on-call if needed to work a shift on short notice. The sample of 12 volunteers represented all three classes who participated in the Children of Promise Program: (a) two from cohort 1; (b) two from cohort 2; and (c) eight from cohort 3, which was the most recent cohort.

The participants were given a demographic questionnaire to complete with the following categories; (a) age (b) gender; (c) religion (d) marital status; (e) parental status; (f) racial identification; (g) year of RN licensure; and (h) areas of practice since RN licensure. The participants' ages ranged from 21-49 years, with a mean age of 27 years. Gender identification was 8 females and 4 males. Religious affiliations among the sample were 6 Catholics, 5 Christians, and 1 Jewish. Eight described themselves as single and 4 as married. Five participants were parents. Participants' identified their race as being African American (n=7), Caucasian (n=3), Afro-Caribbean (1), and Latina (n=1). The range of years since RN licensure was between 2-6 years, with a mean of 3 years. Areas of nursing practice since RN licensure were identified as long-term care (n=5), sub-acute care (n=3), community health nursing (n=3), pediatric (n=2), per diem school nursing (n=2), adolescent (n=1), psychiatry (n=1), pediatric psychiatry (n=1), obstetrics/newborn (n=1), and pulmonary-thoracic (n=1).

The demographic data of participants reflects the college nursing department's RN to BS population with the exception of the ratio of female to male students. In this study, men represent 33.3% of the participants, while the college's RN to BS male students are 14% of the student population. The discrepancy can be explained in part by encouragement of male students to join the Program because so many boys with incarcerated fathers are referred to the program and are in desperate need of positive role models. The majority of participants (66.7%) were relatively young, between 21-32 years old and graduated with an Associate's degree within the last few years. Their nursing practice experiences vary and represent the region's hiring trends of Associate degree nurses employed in long term care, sub-acute care, home care/community health nursing, and per diem school nursing.

Multiple data sources of the three cohorts in the sample made it possible to capture a more thorough understanding of mentoring Children of Promise. This is an example of person triangulation, which strengthened the credibility of this study. Each cohort of students differed in demographic characteristics and the children who are mentored also changed. The three groups of nurse-mentors and mentees each had unique and synergistic interactions. Inclusion of nurse- mentors representing each cohort contributed to richer data and reflected genuine effects (Hentz, 2012).

Data Collection: Interviews

Data were collected from face-to-face individual interviews with the nurses, which began on June 21, 2012 and ended on July 23, 2012. Participants were given an appointment to meet with me for the purpose of explaining the research study as delineated in the consent form (Appendix E). After participants signed the consent, a coding number was assigned to

each participant. Identifying information such as name and e-mail address was kept separately from the interview data. An audio taped semi-structured one-to-one interview, which took about 45 minutes, was conducted in my college office immediately after the consent was signed. The interview environment was conducive to private communication in a comfortable setting. The following questions were posed to each interviewee: (a) "Tell me about your reflections of what strengths in the program helped to facilitate the mentoring process?" (b) "What were the challenges you faced that hindered the mentoring process?" and (c) "What are your hopes for the future practice of nurses working with Children of Promise in similar mentoring programs?"

Audio taped interviews were transcribed by a service and I checked the transcriptions for verbatim accuracy. Three interviews were audited by the Chair of this dissertation committee for accuracy of transcription and content analysis of concepts and constructs. Encouraging participants to use stories and describe personal experiences reinforced credibility. In this way, they effectively created meaning as defined in the dialectic-hermeneutic interpretive process (Stringer, 2007). As participants talked about their experiences and perspectives, their descriptions were composed of a wide array of interconnected ideas, activities, and events.

The transcribed interviews were analyzed for concepts, and then for common characteristics. Based on common themes, constructs were formed and interconnectedness among constructs was mapped. Using the participants' stories and personal experiences and keeping verbatim accounts of their contributions enhanced credibility of data.

Data Analysis of Interviews

The next step was to identify distinct ideas, concepts, events and experiences of the

participants' text. In action research, this is referred to as unitizing the data to identify concepts (Stringer, 2007, pp. 98-103). All units of data were included. Both opposing and consenting views were presented and the larger group of nurse-mentors was asked to equally consider each contribution as they proceeded through the AI process. I listened two times to audio-recorded interviews, and then read each transcription to elicit the concepts (Tables 5.1, 5.2, & 5.3). A separate Excel sheet was used to enter units of data for strengths of the program, challenges, and hopes for the future of nursing practice for Children of Promise. When these units were repeated, I noted the number of subjects who identified the same concepts. Those that had similar themes were grouped together, forming constructs. The following is a narrative description of the concepts that formed the constructs and how they were derived.

Data Analysis of Interviews: Strengths of Nurse-Mentoring Program

Thirty-one concepts were derived from the interview data about the strengths of nurse- mentoring program. Concepts with common characteristics were grouped together and the following seven constructs were formed: (a) Leadership and Training; (b) School Based Support Team; (c) Nurse-Mentoring Curriculum; (d) Modeling and Role Modeling; (e) Therapeutic Relationship; (f) Guide Toward Positivism, Optimism, and Hope; (g) Decisions for Positive Outcomes (Table 5.1). The first construct identified that the preparation BS nursing students received prior to embarking on the role of nurse-mentors was an important strength of the program. The preparation was mentioned as strength in: (a) formal training (n=9) and (b) having leadership and guidance throughout the mentoring experience (n=9). Formal training was identified as the Amachi National Guidelines for Mentoring, provided by The New York Mission Society's Amachi Program (n=6), and NYC Department of Health

Table 5.1

Data Analysis of Interviews: Concepts and Constructs Strengths of Nurse-Mentoring

Concepts	N=12	Constructs
Δ Made aware of problems that parental incarceration have on children.	n=7	
Δ Leadership and Guidance.	n=9	
Δ Over-all preparation and training.	n=9	
Δ NARAL (DOH sponsored education for health care providers on how to communicate about reproductive health with adolescents).	n=5	**Leadership and Training**
Δ Amachi Guidelines	n=6	
Δ School Based Support Team (SBST) identified children and referred to mentoring program.	n=10	
Δ SBST Coordination and obtained parental consents for children to join the program.	n=6	
Δ SBST assisted with scheduling.	n=5	**School Based Support Team Coordination**
Δ SBST assisted with trips.	n=2	
Δ Opportunity for nurses to work in DOE system and interface with SBST	n=1	
Δ Health Education.		
Δ Pregnancy and sexually transmitted disease prevention.	n=5	
Δ Nutrition, food is very important to the children.	n=7	
Δ Amachi Guidelines.		**Nurse-Mentoring Curriculum**
Δ Developing structures are important for mentoring activities.	n=4	
	n=6	
Δ Set an example for the children.	n=7	
Δ Make a difference in the children's lives.		
Δ Mentors are of similar culture, ethnicity and race as the children.	n=8	**Modeling and Role Modeling**
	n=5	
Δ Modeling	n=3	
Δ Make a difference in the children's lives.		
Δ Opportunity for nurse's to learn the use of therapeutic groups as a healing modality.	n=8	**Therapeutic Relationship**
Δ Children want help and agree to participate.	n=5	
Δ Opportunity for nurses to learn how therapeutic relationships as a single modality can assist children in developing healthy behaviors.	n=5	
	n=4	
Δ Can overcome adversity with support.	n=6	
Δ Connection to the college; able to show the path to higher education.	n=5	
Δ Help children to plan for the future.	n=4	**Guide Toward Positivism, Optimism, and Hope**
Δ Amachi philosophy.	n=7	
Δ Promotes positivism, optimism and hope.	n=6	
	n=7	
Δ Experience alternative ways of making decisions that result in positive outcomes.	n=3	**Decisions for Positive Outcomes**
Δ Provide guidance toward healthy behaviors	n=6	
Δ Consistent support and guidance.	n=5	

sponsored training to improve health care providers' communication with adolescents on sexual activity and reproductive health (n=5). In addition to over-all leadership and guidance, the participants noted that it was leadership that brought them to the decision to mentor Children of Promise. Without making them aware of the adversity those children with incarcerated parents face, they would not have chosen this clinical experience (n=7).

The second area of strength identified was the school based support team (SBST) coordination. The SBST's role in identifying Children of Promise, making determinations which children who would benefit from mentoring, and referring children were viewed as essential to program's existence (n=10). The SBST efforts in getting children and caregiver consent to participate in the program (n=6) and assistance with scheduling mentoring sessions was important to the care providers' communication with adolescents on sexual activity and reproductive health (n=5). In addition to over-all leadership and guidance, the participants noted that it was leadership that brought them to the decision to mentor Children of Promise. Without making them aware of the adversity those children with incarcerated parents face, they would not have chosen this clinical experience (n=7).

The nurse-mentoring curriculum depicted in Appendix A was the third construct mentioned as strength. The curriculum was described as providing a structure in which mentors planned nursing interventions. Health education was an area of the curriculum that the mentors viewed as a strength (n=5), specifically prevention of pregnancy and sexually transmitted diseases (n=7). The curriculum included nutritional education, cooking classes, and sharing meals together like a family. Four of the participants noted that food is very important to the children and that preparing nutritious meals together were strong points and should be part of nurse-mentoring programs. The Amachi Mentoring Guidelines were helpful

to mentors in reinforcing their role and the process of mentoring (n=6). In the context of where the mentoring takes place, seven participants stated it was important to develop structures in which mentoring activities in the curriculum can happen. For example, planning for the future involved activities of career exploration. Having designated times when the mentee and mentor could use the computer lab to investigate preparation for careers of interests to the mentee was important to the strength of the program.

The fourth strength that nurse-mentors identified was Modeling and Role Modeling, which was accomplished by setting an example for the children (n=8) and doing so could make a difference in their lives (n=5). Mentors who said they were of similar culture, race and ethnicity as the children indicated this enhanced the modeling and role modeling process (n=3).

The participants identified a strength of the program was opportunities for them to learn transformational, non-pharmacological approaches to nursing care, such as the use of therapeutic relationships as tools to promote health and healing (n=6). The opportunity to co-lead therapeutic groups was viewed as a strength in preparing RN to BS students to work with community aggregates (n=5). Five nurse-mentors expressed their conviction that the children could overcome adversity with adequate support of strong community based programs such as this model. Participants also identified the children as being a strength, as this is a voluntary program and they wanted help and agreed to become members (n=4.)

The sixth strength centered on the program being protective to children who face chronic and acute stress by providing a consistent message of positivism, optimism and hope (n=7). The Amachi philosophy was viewed as solidifying the message of hope and optimism by espousing the belief that all things are possible and there is infinite potential within each

child (n=6). Helping children to plan for their academic, vocational, and social future was also seen as a protective factor that anchored children during times of crisis and fostered hope (n=7). The program's connection to the college and being able to give children opportunities to learn about the path to higher education was seen as promoting positivism, optimism and hope.

The final strength was helping children learn how to make decisions with positive outcomes. Participants identified that it is essential to teach children that the power lies within them to make decisions that have positive outcomes leading to healthy behaviors (n=6). Outlining the steps to help children determine the consequences of behaviors and to carefully consider the decisions that have significant consequences was an important feature to the program (n=3). Nurse-mentors indicated that the children require consistent support and guidance in developing decision making skills (n=5).

Data Analysis of Interviews: Challenges of Nurse-Mentoring Program

Twenty-two concepts resulted from interview data about the challenges of the nurse-mentoring program. Concepts with common characteristics were grouped together and the following six constructs were formed: (a) Need More Time with Children and Flexible Schedules; (b) Time to Develop Trusting Relationship. Use of Nursing Intervention *Caring Presence* Unrecognized by Nurses; (c) Truancy/Poor Educational Outcomes; (d) Crises and Disruptive Family Life and Families Living with Chronic Poverty; (e) Narrow View of Potential; Need Structures that will Offer Continued Positive Relationships and Support Children's Progress (Table 5.2).

Table 5.2

Data Analysis of Interviews: Concepts and Constructs; Challenges of Nurse-mentoring

Concepts	N=12	Constructs
Δ Nurse-mentors need more flexible schedule to be with children.	n=10	**Need More Time with Children and Flexible Schedule**
Δ Need more private space.	n=4	
Δ Don't schedule mentoring sessions when children have fun time with friends.	n=5	
Δ Need a way of communicating with children during the week to foster decision making skills.	n=3	
Δ Program is evolving; children adjusting to the changes.	n=1	
Δ Extensive time that is needed to develop a therapeutic relationship.	n=9	**Time to Develop Trusting Relationship. Use of Nursing Intervention of *Caring Presence* Unrecognized by Nurses**
Δ Nurses did not recognize their use of *Caring Presence* in developing relationships.	n=9	
Δ Need more training in adolescent communication.	n=1	
Δ Nurses need contact with caregivers. Truancy reflects what is happening in the family.	n=5	**Truancy/poor Educational Outcomes**
Δ Caregivers are secretive about family life.	n=6	
Δ Overwhelming needs of the children.	n=4	**Crises and Disruptive Family Life. Families Living with Chronic Poverty**
Δ Basic clothing and hygiene needs are not met.	n=4	
Δ Impoverished environment/lack of community resources.	n=8	
Δ Patterns of crises and disruptions to family life.	n=5	
Δ Stigma; society judges these children and have low expectations for them.	n=3	
Δ Living in chronic poverty.	n=8	
Δ Safety of nurses is a concern.	n=1	
Δ Cultural influences reflected in media messages.	n=7	**Children had Narrow View of Their Potential**
Δ Children do not realize their potential.	n=7	
Δ Need organizations and programs to transition children to so that they can continue to experience positive relationships when nurse-mentoring relationship ends.	n=8	**Need Structures that will Offer Continued Positive Relationships and Support Children's Progress**
Δ Need to develop more community partnerships.	n=8	
Δ Outreach to larger community/ government agencies because immediate neighborhood is impoverished.	n=8	

Table 5.3

Data Analysis of Interviews: Concepts and Constructs; Future of Nursing Practice

Concepts	N=12	Constructs
Δ Community based healthcare.	n=10	**Community Health Nursing**
Δ Funding included in Affordable Health Act; home visitation program.	n=6	
Δ Important to go where the families live. Shows that nurses accept them for who they are.	n=1	
Δ Publish the stories of nurses & children.	n=1	
Δ A model similar to the Nurse Family Partnership; home visitation program.	n=10	**Family Approach to Care**
Δ Support caregiver through Peplau's helping roles.	n=10	
Δ Advocate for long-term caring relationship with family.	n=8	
Δ Advocate for building partnerships and creating structures.	n=6	
Δ Interventions that reduce chronic stress.	n=5	
Δ Reward caregivers.	n=1	
Δ Reduce the number of family disruptions by intervening early in the process.	n=3	**Prevention: Intervene Before Crises, Such as Homelessness and Abuse**
Δ Assess and identify mental health and substance abuse problems and refer for care.	n=6	
Δ Advance practice and doctoral prepared nurses to develop practice through research.	n=6	**Development of Nursing**
Δ Develop a reimbursement source for a standardized model.	n=8	
Δ Advocate for policies that strengthen families.	n=6	
Advocate for creation of cost effective alternatives to prison.	n=1	
Δ Advocate for Creation of prison transition programs for parents.	n=1	
Δ Expand to other BS Nursing programs.	n=2	

The first challenge was that nurses needed more time with the children and were willing to be more flexible with mentoring schedules in order to meet that goal (n=10). Mentors felt it was counterproductive to schedule mentoring sessions when children have fun time with friends, such as recess and gym classes (n=5). The fact that mentors were not authorized to receive mentees' phone numbers, they had no way of communicating with the children during the week, which impeded their ability to foster decision-making skills (n=3). Limitations on the amount of private space made it difficult for children to focus on the mentoring session (n=4). One participant noted that the program was evolving and children were adjusting to the changes.

The second challenge was that it took an extended amount of time for the children to develop a trusting relationship (n=9). Participants did not recognize that they were providing Caring Presence during the formative period of the interpersonal relationship (n=9). Although the topic of taking time to establish relationships with children who experienced disappointing relationships in the past is taught during orientation, nurses experienced this to be challenging. One participant thought that there was a need for more training in communication with adolescents.

The third major challenge was the high rate of truancy and poor educational outcomes. The participants felt that truancy in elementary school age children reflects what is happening in the family (n=6). By not having contact with the caregivers, nurses were unable to help discern the source of truancy, offer support, or make interventions such as referrals and collaboration with the multi-professional team (n=5).

The fourth challenge identified was the task of delivering consistent support to families who have patterns of crises, which disrupt children's sense of security and continuity

of education. In addition to the disruptions that parental incarceration causes, these children are also living in chronic, extreme poverty (n=8). The community environment is equally impoverished of resources, making it difficult for children to develop healthy social behaviors (n=8). Participants experienced feelings of being overwhelmed by the children's basic clothing and hygiene needs not being met (n=4). Participants found it challenging to deal with the stigma associated with parental incarceration and that society judges the children, setting low expectations for them (n=3). One nurse expressed concern about the safety of nurses in the immediate community.

The fifth challenge focused on modeling and role modeling. In the modeling component of Erickson et al. (1983) theory, the nurses embraced the world-view of children. In doing so, the participants found that their mentees had an extremely narrow views of their potential (n=7). For example, when the boys were asked what they wanted to be when they grew up, the answers were an athletic super-star, a rapper or a gangster. When they asked the girls the same question there was a total void in responses. The girls were asked to think about it and were posed the same question a week later. This time two out of twelve girls said they would like to be a teacher. The remaining 10 girls still did not express ideas about the possibilities for their future roles. Nurse-mentors believed that cultural influences reflected in media messages perpetuate this narrow view of potential (n=7).

The final challenge that mentors identified was a need to develop more community partnerships and outreach to larger community/government agencies for resources (n=8). The mentors knew that prior to the termination process (Peplau, 1952), the nurse mobilizes resources to support the transition of positive nurse-client relationships to opportunities for other positive relationships (n=8). Participants found it challenging to access any resources

because organizational partnerships and community resources did not exist (n=8). For example, a girl in the program enjoys and excels at track and field sports. The nurse has been working on a plan with the girl to join the track team when she goes to high school next year. The mentor and mentee agreed that part of their sessions would be spent practicing sprinting together. The mentor believed this would help transition the girl to healthy activities in high school and provide opportunities to develop positive relationships when their relationship ended. However, lack of resources for this activity to happen safely in the school or the surrounding neighborhood thwarted this plan.

Future Practice of Nurse-Mentoring

Eighteen concepts were derived from interview data about future nursing practice with Children of Promise. Concepts with common characteristics were grouped together, forming the following four constructs: (a) Community Health Nursing; (b) Family Approach to Care; (c) Prevention of Crises such as Homelessness and Abuse by Intervening Early; (d) Development of Nursing Practice (Table 5.3).

The first plan for the future was to bring care of children with incarcerated parents into the community where they went to school and lived (n=10). Participants cited future funding allotted to Home Visitation Programs in the Affordable Health Act would make it possible to reach this silent population of children and families (n=6). One participant said, “It is important to go where the families live. It shows that nurses accept them for who they are.” Another nurse pointed out that if there is going to be a future in caring for Children of Promise, “We have to get the information about the children out there to the mainstream of nurses by publishing our stories…our community health nursing experiences with the children.”

The second plan for the future of nursing practice was a paradigm shift from the Amachi Model, which is child-centered, to a family approach to care, which is still child-centered, but includes focus on the family. The genesis of the Amachi National Model was to address one of the essential and neglected components of mass incarceration, the collateral damage to children left behind. While agreeing with the need to help children who are experiencing adversity from parental incarceration, the participants identified instituting a model that would be more effective and efficient and includes the family system, similar to the Nurse Family Partnership home visitation program (n=10). In order to break the cycle of inter-generational incarceration, Peplau's (1952) helping roles of teacher, advocate, surrogate, role model and leader were identified as nursing care that should be offered to caregivers as well as the children (n=10). One of the nurses reflected this view, "In my country (Nigeria) we have a saying, 'When you teach a mother health promotion, you have taught the community. When you have taught a community, you have taught a nation'." The nurses' role of advocate was cited as necessary in order to implement long-term caring relationships with families (n=8), and to address the need for building partnerships and creating structures (n=6). Teaching coping skills to children and families for stress reduction was viewed as an important nursing intervention (n=5). One participant felt that rewarding caregivers for their participation in the program would give incentive toward further engagement in care.

The third construct participants identified for the future practice of nurses with this population was to focus on prevention of crises. They suggested that nursing practice conducted in the community and in home visitation should include early intervention to reduce the number of crises, such as the prodromal events to homelessness, as well as substance abuse and mental illness (n=6).

Finally, in responding to what their vision for future nursing with Children of Promise, participants described the construct of development of nursing knowledge. Acknowledging their pioneering efforts in nurse-mentoring, they identified that advanced practice and doctorally- prepared nurses are needed to develop knowledge through research (n=8). They cited that a standardized model is needed prior to seeking a reimbursement source (n=8). An example given was the Medical Model Adult Day Health Care (ADHC). In that program, there is one standardized model regulated under the New York State Department of Health and Hygiene, in which Medicaid and the Veteran's Administration provide reimbursement for services.

Advocacy by nurses for policies that will strengthen families will provide opportunities for nurses to develop nursing practice (n=1). One participant identified the need to advocate for prison reform and that imprisoned parents have access to evidence-based prison transition programs. Two participants stated that for nursing practice to progress, the nurse-mentoring model needs to be expanded to other BS nursing programs.

Construct Mapping

Separate construct mapping charts were created to summarize information obtained from participants' answers to three questions of the interview process, i.e., strengths of the program; challenges; and hope for the future practice of nurse-mentors (Appendices G, H & I). I reorganized constructs and drew lines between those that were interconnected. This provided a visual depiction of how the various constructs were interconnected. The nurse-mentors were able to understand how addressing one construct could affect several areas. Two weeks before the scheduled retreats, the participants received emails with Tables 5.1, 5.2, 5.3 and Appendices G-I in order to give them opportunities to clarify and extend

information related to their experiences.

Phase II Appreciative Topic and the 4-D Process

The AI topic and 4-D Cycle process was conducted during one day group retreats. In order to accommodate the nurse-mentors work schedules, two groups for retreats were necessary. I gave the nurse-mentors a list of possible dates for the retreats and two dates were selected based on their responses. The first group (Group A) attended August 11, 2012 and the second group took place on August 18, 2012 (Group B). Twelve nurse-mentors, who participated in the interviews, also attended one of the two retreats. Six participants attended each retreat. I chose the college campus for the retreats because of its familiarity to participants' for traveling. Breakfast, lunch and a snack were provided during the retreats. Group A retreat was professionally video-recorded for the purpose of auditing the researcher's adherence with the AI methodology. The Chair of this dissertation audited the video recorded retreat for adherence with AI methodology. Both Groups A and B retreats were audio-recorded and transcribed.

I did not share retreat data with either group until completion of the second retreat. This was done to eliminate undue influence of one group over the other. Consistent with the democratic and equitable values of action research methods, it acknowledged that each participant's worth and expertise was considered equally valuable.

Appreciative Inquiry Topic

At the beginning of the retreat, I displayed the three construct maps (Appendices G-I) on large poster boards for the participants to review. Participants were given another opportunity to clarify, edit or add to the construct maps. Nurse-mentors were requested to decide on an AI topic that addressed one or more opportunities for constructive change that

builds upon what is positive and aligns with goals of the mentoring program. The participants from Group A and B reached consensus that the AI topic chosen was "Children of Promise Have a Narrow View of Their Potential." Consistent with the AI methodology, I intentionally re-framed the AI topic from a strength-based perspective as, "In the Context of the Nurse-Mentoring Program, How Can Nurses Help Children of Promise Reach Their Potential?" Throughout the 4D cycle, the participants used the appreciative topic to build upon strengths of the nurse-mentoring program, as well as to address the challenges and possibilities for change. After establishing the AI topic, I directed the groups through the research procedures of the 4-D Cycle.

4-D Cycle of Appreciative Inquiry

The procedures carried out in the retreats are delineated in Table 4.1. Questions posed to the participants to prompt goal acquisition of the 4-D Cycle stages of Discovery, Dream, Design and Destiny are listed in Table 5.4. Participants reflected about their most meaningful experiences as nurse-mentors in story format. Content of reflections fell into three main categories: (a) the gift of self; (b) the gift of facilitating change; and (c) being made aware of the scope of adversity and injustices that the children faced was the first step in helping the children. When reflection stories were finished the researcher moved immediately into the Dream step to transfer the positive energy.

Discovery Stage. At the onset of the Discovery stage, participants were assigned to dyad groups to reflect on times when mentoring was most meaningful. When the dyads reconvened in the larger group, they shared their reflections in story format. For some nurse-mentors, the most meaningful mentoring times occurred when they described a "break-through with a child." This is delineated in Peplau's (1952) theory as moving from the stranger phase

Table 5.4

Sample Questions for One to One Interviews and Retreat Group Interviews

Category	Questions
One to One Interviews	Δ "Tell me about your reflections of what facilitated the mentoring process and what challenges you faced that that hindered the process?" Δ "What are your hopes for the future practice of nurses working with Children of Promise in similar mentoring programs?"
Retreat-Group Interviews 1) Discovery Stage	Δ "Reflecting on your entire experience with mentoring, what was a time that was most meaningful to you; when you felt the most alive and inspired?" Δ "Can you talk about what you value deeply; things about yourself, your life experiences that led you to become a nurse-mentor?"
Retreat Group Interviews 2) Dream Stage	Δ "What would the nursing practice look like if the meaningful experiences elucidated in the Discovery stage occurred more often?" Δ "Based on your portrayal of the ideal future practice, what are your images of the practice as if you are already working in it and as if it is already successful?" Δ "What are the common topics and themes that will help you reach a shared vision of ideal practice?"
Retreat Group Interviews 3) Design Stage	Δ "What are the necessary actions in order to reach the preferred future?" Δ "What is the first step needed to achieve the smallest change with the biggest impact in moving toward the ideal practice?"
Retreat Group Interviews 4) Destiny Phase	Δ "What happened?" Δ "How did it work out?" Δ "What were the hurdles and successes?" Δ "What did you learn that will help sustain change?" Δ "What changes occurred in the shared vision and collective actions as a result of their experiences with Children of Promise through the AI process?"

to the working phase of the therapeutic interpersonal relationship. One participant described that she had been scrapbooking with her mentee and on one of the pages the child made a diagram of her trusted circle of adults. The mentor's name was included among the people in her life that she could trust. The mentor experienced the true joy of the gift of self. The mentor expressed how honored she felt to be a nurse, saying, "This reminded me why I became a nurse in the first place."

Other mentors talked about the changes they witnessed in the children from the time that they began mentoring to the time that they ended. These mentors experienced facilitating the gift of change. One of the mentees was able to use the teaching and role modeling from her mentor to learn ways to effectively and constructively communicate with her incarcerated mother. For some participants, the realization of the breadth of the adversity that the children faced was the most meaningful. A participant said, "The need is so great for these children. I don't want to see their faces on America's Most Wanted Posters. When I say needs, I'm not talking about trips to Disney World or the X-Box video system. I'm talking about basic parenting, learning to do the right thing, help with social skills, hygiene, and grooming."

Dream Stage. At the onset of the Dream stage, I directed participants to resume two groups of 3 and asked them to envision how nursing practice would change if peak moments happened more often. Furthermore, they were asked to imagine nursing practice 3-5 years in the future when these most meaningful experiences are happening with increased frequency. After reflection in small groups, they were asked to create a representation of the future of nursing practice, i.e., pictures, skits, poems or songs.

Retreat A Group chose to create representations of future nursing practice in drawings. The first group (A_1) drew an analogy of a child before and after mentoring using an

illustration of a tree in an urban setting. Before mentoring, the tree's foliage was sparse, but after mentoring the tree grew tall and wide, bore fruit and provided for a healthy future generation of trees. The second group (A_2) drew a large house called, "Amachi Nurses' House" and within the house were several rooms that portrayed their vision of future practice. Each room had an unique theme: (a) a universal curriculum for all nursing programs to use when implementing the nurse- mentor model; (b) primary care clinic for children inside the school; (c) safe community dwellings with permanency for Children of Promise and their families, so nurses can gain access to these families; (d) mental health and substance abuse clinics with advanced practice nurses so that nurse-mentors could make referrals; and (e) a family room, where incarcerated parents could move freely about to visit often with their children and share in their lives.

Retreat B Group chose to create a poem and a skit. The group that wrote the poem (B_1) also used a comparison of a single barren tree in the harsh urban "projects" trying to survive, but not weathering the storm very well. With mentoring, the tree became strong, grew into adulthood and flourished. The second group (B_2) performed a skit with 3 participants playing different roles of a 15-year-old girl whose parents are incarcerated, the uncle who became the child's caregiver, and the girl's teacher. In the opening scene, the girl was displaying anti-social behaviors of stealing from students, truancy, and being disrespectful to her teachers. Her behavior showed two types of response mechanisms; first she was aggressive as a defense to perceived threats and then she was rejecting as a way of offensively protecting herself from future threats. The uncle, a single man who worked two jobs was overwhelmed. The teacher called for a conference with the uncle and the girl. The teacher offered the girl an alternative to expulsion from school if she did two things. First, she had to make restitution for her offenses, which she could do by providing community

service activities at the school. Secondly, she had to agree to join an Amachi nurse-mentoring program. After the uncle's emotional appeals, she agreed to the teacher's terms for avoiding expulsion. A six-month follow up found that the girl had no subsequent suspensions from school, and she enjoyed the time that she spent with her mentor. The girl was beginning to explore her academic and vocational future.

Creative representations of the ideal future practice had similar characteristics. They ended with a depiction of Children of Promise being helped by relationships with nurse-mentors. Children were described from strength-based capacities as being able to achieve their potential with support, which is the AI Topic. In the illustration of the "Amachi Nurses' House," the nurses-mentors' visions also included the structure of future nursing practice. Their view was a comprehensive nursing collaborative effort involving APN, primary care, academia, community residences, and the prison system. This concluded the Dream step and the retreat convened for a lunch break.

Retreats reconvened after lunch. At this step of the 4-D Cycle, I informed the participants that the objective of the Design step was to set goals for creating the ideal nursing practice and determine what actions would be necessary to achieve those goals. Then the group was asked to engage in a consensus-validation dialog to prioritize the actions that should be addressed. I provided consultation regarding pragmatic consideration for mentoring in a NYC DOE elementary school. Table 5.5 depicts data from the Design step for Group A.

Design Stage. Retreat Group A engaged in dialog and shared their ideas about creating an ideal nursing practice. A large list of suggestions was formulated that would make it possible for ideal nursing practice to occur. The large list of ideas was posted and

Table 5.5

Report of Retreat Group A: *Appreciative Topic*: *In the Context of the Nurse-mentoring Program, How Can Nurses Help Children of Promise Realize Their Potential?*

Goal	Action Plan
Establish relationships with care-givers as a first step toward a family approach to nurse-mentoring.	Δ *Plan* a "Meet and Greet" event for care-givers, community leaders, and point persons from potential partnerships. Δ *Conduct* "Meet and Greet" event. Δ *Provide* positive reinforcement for care-givers, such as basket of fruit and vegetables from the Farmer's Market. Δ *Introduce* nurse-mentors to caregivers and establish role of nurse-mentor to caregiver. Δ *Request* college culinary arts department and other departments of interest to the children to set up displays and demonstrations at the "Meet and Greet" event.
Develop a more formal way of implementing the nursing process: Set objectives with children's input that are driven by nursing assessment.	Δ *Implement* use of a nurse assessment screening tool Δ *Evaluate* the effectiveness of the tool in capturing data that can be used as a basis for interventions, e.g., Referral. Δ *Communicate* objectives for each child to teachers, SBST, and caregivers.
Improve the effectiveness of mentoring time with children.	Δ *Provide* flexible schedules for Nurse-mentors to carry out nurse-mentoring activities. Δ *Develop* a scheduling system that disseminates the nurse-mentor and child meeting times to teachers, caregivers and children.
Increase communication among nurse-mentor, child and caregiver.	Δ *Change* the consents for children's participation in the mentoring program to include agreement that: mentors can telephone children at home between mentoring sessions; Δ Nurse-mentors can contact caregivers by telephone.
Promote development of therapeutic relationships by reducing environmental distractions.	Δ *Work* with the school principal and assistant principal to get cubicle dividers and alternate spaces in the school to have more private spaces for nurse-mentors and children to meet.

then participants grouped common categories together. Eventually they narrowed down the categories to five goals that would facilitate the ideal practice of nursing with Children of Promise. I asked the group to prioritize the goals from ascending to descending order. Next, I charged the participants with creating an action plan for each goal that could be implemented and evaluated in three months.

The first goal reflected the construct of creating a program that was both child-centered and family focused. The objective was to e*stablish relationships with caregivers as a first step toward a family approach to nurse-mentoring.* The following five actions were planned: (a) organize a "Meet and Greet" event for caregivers, community leaders, and the point persons from potential partnerships; (b) conduct "Meet and Greet Event;" (c) provide positive reinforcement for care-givers, such as baskets of fruit and vegetables from the Farmer's market; (d) introduce nurse-mentors to caregivers and establish the role of nurse-mentor to caregiver; (e) request college departments of interest to the children to set up displays and demonstrations at the "Meet and Greet" event.

The second goal was to *develop a more formal way of implementing the nursing process: Set objectives for children that are driven by nursing assessment.* Nurse-mentors set three actions plans to achieve this goal. First they wanted to implement the use of a nurse assessment- screening tool. The next objective was to evaluate the effectiveness of the tool in capturing data to make interventions, such as referrals. Lastly, the plan included communicating objectives for each child to their teachers, SBST and caregivers. The construct in the Challenges section of data analysis; *Need More Time with Children & Flexible Schedule* (Table 5.2) was reflected in the third choice for goals, i.e., *Improve the effectiveness of mentoring time with children.* The first action planned was to provide flexible schedules for

nurse-mentors to carry out mentoring activities, and then develop a scheduling system that disseminates the nurse-mentor and child meeting times to teachers, caregivers and children.

In the fourth category of goals, in addition to the objective of taking the first step toward a family approach to nurse-mentoring, the participants proposed to *increase communication among nurse-mentor, child and caregiver.* In order to accomplish this, the participation consent forms had to give the nurse-mentors permission to telephone the caregivers.

The final goal was to *promote development of therapeutic relationships by reducing environmental distractions.* The actions necessary to accomplish this goal were to work with the school principal and assistant principal to get cubicle dividers and alternate spaces thereby providing more privacy for mentoring sessions.

I asked the group to select a team-leader who would be willing to attend additional meetings, take part in coordinating consensus activities with Group B if necessary, and participate in the assessment cycle. A team leader was selected. The participants were told that after the Retreat Group B Goals and Action Plan were formulated, that they will be compared and opportunities for consensus will be made available as necessary. The Retreat Group A was ended.

Retreat Group B was conducted one week after Group A and followed the stated procedures in Table 4.1. As noted, both groups chose the same AI topic. Group B had narrowed their AI topic to two choices: (a) children with a narrow view of their potential; and (b) nurses needing to establish relationships with caregivers. The participants were asked to continue the dialog to determine if the topics could be incorporated into one AI topic. The group then decided that by adopting the reframed topic of, “In the context of the nurse-

mentoring program, how can nurses help children reach their potential?**”** an action plan addressing the need to establish relationships with caregivers would be a prioritized goal to help children reach their potential.

Results of the AI topic selection and 4-D Cycle processes in Retreat Group B had more areas of consensus than differences with Group A. The areas of differences from Group A are highlighted in Table 5.6. Group B added an action plan; that during the *Open House, samples of the children's accomplishments and participation in the program could be on display.* For the second goal, participants stated that there was a need to have a measurable criterion to assess change. Suggestions included collaborating with teachers to track children's attendance, as well as completion of classwork, and homework. In the third goal, another action plan was generated, inviting caregivers to share in celebrations of their children's accomplishments. It was believed that this would promote strength-based interventions and increase communication among nurse- mentors, children and caregivers.

Two new goals were developed by Group B that differed from Group A. The first was; *assist children in developing academic and vocational plans.* Action plans were formulated according to age category. For elementary school children, progress in use of coping skills was suggested to help children develop healthy ways of reducing stress and promoting academic performance (Table 5.6). The action plan for middle school children included development of a portfolio modality for children to plan their academic and vocational futures.

Table 5.6

Report of Retreat Group B: Appreciative Topic: In the Context of the Nurse-mentoring Program, How Can Nurses Help Children of Promise Realize Their Potential?

Goal	Action Plan
Establish relationships with care-givers as a first step toward a family approach to nurse-mentoring.	Δ *Plan* an "Open House" event for care-givers, community leaders, and point persons from potential partnerships. Δ *Conduct* "Open House" event. Δ *Provide* positive reinforcement for care-givers, such as basket of fruit and vegetables from the Farmer's Market. Δ *Introduce* nurse-mentors to caregivers and establish role of nurse-mentor to caregiver. Δ *Request* college culinary arts department and other departments of interest to the children to set up displays and demonstrations at the "Open House" event. Δ *Display* the children's accomplishments and participation in the program.
Develop a more formal way of implementing the nursing process: Set objectives for children that are driven by nursing assessment.	Δ *Implement* use of a nurse assessment screening tool. Δ *Evaluate* the effectiveness of the tool in capturing data that can be used as a basis for interventions, e.g., Referral. Δ *Communicate* objectives for each child to teachers, SBST, and caregivers. Δ *Collaborate* with teachers to track children's attendance, completion of classwork, and completion of homework.
Increase communication among nurse-mentor, child and caregiver.	Δ *Change* the consents for children's participation in the mentoring program to include agreement that: mentors can telephone between sessions. Δ Nurse-mentors can contact caregivers by telephone. Δ *Invite* caregivers to share in celebrations of their children's accomplishments and participation in the program.
Assist children in developing academic/vocational plans.	Δ Elementary school age children: *Develop* coping skills progress boards that includes adaptations to reduce stress and promote academic performance. Δ Middle school age children: *Develop* a portfolio modality for children to plan their academic/vocational future.
Decrease children's identification with negative models.	Δ *Collaborate* with school administrators on the use of positive behavioral approaches. Δ *Teach* nurse-mentors how to implement the positive rewards approach.

The second goal of *Increasing children's identification with positive models* was in addition to Group A's contributions. Group B specified that ways of accomplishing this goal was to collaborate with school administrators on the positive behavioral approaches used within the NYC DOE and teach mentors how to implement the positive rewards approach.

At the end of the Design step, I asked participants in Group B to select a team leader participant who was willing to attend additional meetings, take part in coordinating consensus activities with Group A, and participate in the assessment cycle. A team leader was selected. I told participants that the goals and action plans of both groups will be compared and opportunities for consensus will be made available as necessary. The Retreat Group B was ended.

I assigned team leaders to review the differences between Group A and Group B. They were then requested to evaluate the merits of including these based on the AI topic and for opportunities to construct change building upon what is positive and aligning with the goals of the mentoring program. The team leaders decided to include the contributions of participants in both groups and Table 5.7 *Consensus of Goals and Action Plan through Appreciative Inquiry Process* was created.

Differences between the groups were determined to be synergistic in nature because interconnected goals and actions actually enhanced each other. For example, in Group B; *assisting children in developing academic and vocational plans by using coping skills tracking boards and portfolios* will actually enhance the goal of Group A which was, *Improve the effectiveness of mentoring time with children.* Similarly, a goal of Group A; *Promote development of therapeutic relationships by reducing environmental distractions,* will facilitate a goal of Group B; *Children should have increased identification with positive*

models. Tables 5.5 and 5.6 were sent electronically to all participants and they were asked to examine the highlighted areas (areas of differences between the two groups). Then Table 5.7 (a synthesis of both groups) was sent. Participants were asked to review the synthesized report and respond by e-mail if they have descending views. I offered to arrange for participants to meet with the team leaders and me if they want to edit or clarify their contributions to the AI process. Participants approved of the goals and action plan delineated in Table 5.7.

Phase III Implementing the Action Plan

Implementation of the AI Action Plan began on September 05, 2012 and was evaluated on December 13, 2012 (Destiny Date). The location for carrying out the action plan was the elementary school in NYC where the nurse-mentoring program takes place. The Fall 2012 RN to BS students enrolled in Community Health Nursing at this clinical site were instructed by their clinical professors on the mentoring activities that incorporated the goals of this AI cycle. The team leaders provided assistance with planning and scheduling activities and meeting with the principal of the school to negotiate those parts of the action plan that required administrative attention. This section includes a delineation of how seven goals with corresponding action plans were implemented and a description of contextual changes that occurred in this AI cycle.

Action research takes place in the context in which the phenomenon is occurring, and by the individuals, families and communities that it affects. As such, it is impossible to control how changes in the context will impact a research study. Two major changes occurred in the setting of nurse-mentoring during this AI cycle. Both reflect the economic downturn and how it affects the most vulnerable. The first and most surprising change was that, over the summer, the rate of children in the program who became homeless rose from 2 out of 15

Table 5.7

Consensus of Goals and Action Plans. Appreciative Topic: In the Context of the Nurse- mentoring Program, How Can Nurses Help Children of Promise Realize Their Potential?

Goal	Action Plan
Establish relationships with care-givers as a first step toward a family approach to nurse-mentoring.	Δ *Plan* an "Open House" event for care-givers, community leaders, and point persons from potential partnerships. Δ *Conduct* "Open House" event. Δ *Provide* positive reinforcement for care-givers, such as basket of fruit and vegetables from the Farmer's Market. Δ *Introduce* nurse-mentors to caregivers and establish role of nurse-mentor to caregiver. Δ *Request* college departments to set up displays and demonstrations. Δ *Display* the children's accomplishments in the program.
Develop a more formal way of implementing the nursing process: Set objectives for children that are driven by nursing assessment.	Δ *Implement* use of a nurse assessment screening tool. Δ *Evaluate* the effectiveness of the tool in capturing data that can be used as a basis for interventions, e.g., Referral. Δ *Communicate* objectives for each child to teachers, SBST, and caregivers. Δ *Collaborate* with teachers to track children's attendance, completion of classwork, and homework.
Increase communication among nurse-mentor, child and caregiver.	Δ Revise the consent to include agreement that mentors can telephone children at home between mentoring sessions; Δ Nurse-mentors can contact caregivers by telephone. Δ *Invite* caregivers to share in celebrations of their children's accomplishments and participation in the program.
Assist children in developing academic/vocational plans.	Δ Elementary school: *Develop* coping skills progress boards that includes adaptations to reduce stress and promote academic performance. Δ Middle school: *Develop* a portfolio modality for children to plan their academic/vocational future.
Increase children's identification with positive models.	Δ *Collaborate* with school administrators on the use of positive behavioral approaches that are approved by the NYC Department of Education. Δ *Explore* the possibility of implementing a positive rewards approach.
Improve the effectiveness of mentoring time with children.	Δ *Provide* flexible schedules for Nurse-mentors to carry out nurse-mentoring activities. Δ *Develop* a scheduling system that disseminates the nurse-mentor and child meeting times to teachers, caregivers and children.
Promote development of therapeutic relationships by reducing environmental	Δ *Work* with the school principal and assistant principal alternate spaces in the school to have more private areas for nurse-mentors and children to meet.

children (13%) to 9 out of 18 (50%). Based on the overall 18% increase of homeless families with children in NYC, three new homeless shelters were opened in the Bronx (NYC Department of Homeless Services (DHS), 2012). Consequently nine homeless children were commuting from the Bronx by train for 2 ½ hours each way in order to remain in their original school. As of September 2012, the average length of stay for a homeless family in the shelter system was nine months, but for some it was extended (DHS, 2012).

The second change was that the partnership with the New York Mission Society ended when their Amachi Mentoring Program was discontinued because of decreases in federal funding. Previously the Mission Society paid for the background checks of students, fingerprinting, and provided mentor training for nurse-mentors. Now the DOE background check fee was paid by the RN to BS students. For RN to BS students who could not afford the fee, the principal at the school got the fee waived. I provided leadership in training the nurse- mentors and the clinical faculty participated under my supervision. The impact that these developments had on the action plan will be explored fully in the Destiny Phase.

Goal # 1: *Establishing relationships with caregivers as a first step toward a family approach to nurse-mentoring*, entailed planning and carrying out an event to meet the caregivers and orient them to the Amachi Nurse-Mentoring Program. The team leaders and I met with the guidance counselor and principal to discuss a date, time and format for the meeting. A breakfast event was agreed upon that involved the children, their caregivers and nurse-mentors. The date was scheduled as the first clinical day after the nurse-mentees completed their mentor training and would be introduced to their Child of Promise. Written invitations were sent home with the children and followed up with a phone call from the parent-teacher coordinator at the school. The room for the “Meet and Greet Breakfast” was

arranged to facilitate the theme of infinite possibilities for their futures. Posters from the various departments at the college were displayed, along with mentoring posters. The college's culinary arts department provided food demonstrations because several children had voiced interest in restaurant-hospitality industry.

On the day of the meeting, there was a strong sense of anticipation among nurse-mentors and children. The nurses were embarking on new roles and said they experienced anxious feelings, similar to those when they were novice nurses. The children were looking forward to something unique and special. As the children came down the steps and entered the room, the faculty and mentors stated that they were reminded of their childhood recollections of Christmas morning. The children's eyes were wide with wonderment, faces smiling at the prospect of good things happening. After a brief introduction, the nurse-mentors accompanied children to the breakfast buffet. During breakfast, the children and nurses got acquainted and talked about the nurse-mentoring activities scheduled for upcoming months.

The table that was reserved for caregivers was set with baskets of fruits and vegetables, as welcoming gifts. This was an empty table; only one caregiver attended the event. That caregiver met with the nurse-mentor and child and talked about hopes for the future and how the nurse might facilitate the child and family's goals. Despite the nurses' disappointment of not meeting more caregivers, the children and nurses had positive experiences, talked about the upcoming year together, and set times for their next mentoring session. As stated in this section, half the families are in the crisis of homelessness, and temporary relocation in the shelter system far from the school. In post conference, the nurse-mentors expressed their commitment to "go back to the drawing board" and figure out a way to extend the nurse-mentoring program to families. They had an opportunity to see the empty

table and chairs as a symbolic representation of missing parents who are incarcerated and the over-burdened caregivers who are doing the best they can to keep families together. The clinical faculty instructed nurses to use the theoretical framework of Peplau (1952) to explore nurses' role of surrogacy. Considering the rise in homelessness, the clinical faculty prepared nurse-mentors for the likelihood of being called upon to more often assume the role of surrogates.

In reviewing the low caregiver turnout at the event, the guidance counselor described "needing to dig deep" by making numerous attempts and being flexible about the circumstances of meeting the Children of Promise families. She explained that for some children, there were as many as ten attempts to get the permission slips signed so that the children could participate in the Amachi program. The other factor was that a few days prior to the event, the teacher-parent coordinator was absent; therefore preplanned follow-up phone calls with caregivers did not happen. The guidance counselor acknowledged that there was a lack of communication between the school and the nursing faculty about the issue.

Goal # 2: *Develop a more formal way of implementing the nursing process: Set objectives for children that are driven by nursing assessment.* The first step in assisting the RN to BS students with making a comprehensive health assessment was my decision to use the Functional Health Patterns Assessment Screening Tool (FHPAST) by Foster & Jones, 1997- 2008©. The FHPAST, a valid and reliable tool (Jones & Foster, 1999; Jones, Duffy, & Flanagan, 2012), was developed based on an adaptation of Gordon's Functional Health Patterns (1994). One of the most widely used pediatric nursing textbook, (Wong, 2009, p 16) recommends use of Functional Health Patterns Assessment stating, it "provides an excellent format for data collection before nursing diagnoses." I examined the screening tool items that

represented the eleven functional patterns, and determined that the tool would provide a comprehensive health assessment and appropriate to assess for stress, anxiety and depression. The FHPAST is a concise tool that can be completed by children and nurse-mentors during one session.

Although the FHPAST was designed for use with adults, it was written for third grade literacy. The questions that relate to mature subjects such as sexuality, alcohol and drug use are appropriate for this population of 13-16 year olds because this is an area with one of the highest teen pregnancy, infant mortality, and HIV infection rates in NYC (NYS Department of Health Perinatal Data Profile, 2012; NYC Annual HIV/Aids Surveillance Statistics, 2012). I contacted Dr. Dorothy Jones, requesting possible use of the FHPAST for this study. Dr. Jones gave permission to use the tool. The nurse mentors received training by the clinical faculty on how to use the tool, ask follow-up questions and document responses in the "Comments" section. Fifteen nurse-mentors met with their mentees age's 13-16 years-old to complete the FHPAST. Children were given a copy of the tool and the nurse used a separate copy to make comments and score the responses. They read the questions together and the nurse asked the frequency in which the items occurred. The data were used to set objectives for the nurse-mentoring relationship and to form the basis of communication with the SBST and caregivers.

Goal # 3: *Increase communication among nurse-mentor, child and caregiver.* I met with the school's principal to request that the consent to participate in the program be changed to include permission for mentors to telephone caregivers and the children. The principal agreed to discuss this with administrative superiors because the bureaucratic system of the NYC DOE does not allow principals to independently make decisions such as these. During

this action cycle, the principal gave monthly updates and at the end of this AI cycle, Children of Promise was given permission to ask caregivers for their phone contact information and caregivers had the option of agreeing or disagreeing to receive phone contact from mentors. The guidance counselor, who is responsible for getting consent forms signed by caregivers, drafted a revised consent that included a section for caregivers to check off whether or not they want mentors to have their telephone numbers.

Goal # 4: *Assist children in developing academic/vocational plans by implementing a coping skills progress board.* In preparation for implementing this goal, I provided nurse mentors with information from the De Masi & Bohn (2010) use of the Coping Skills Survey. In the Coping Skills Survey more than 70% of the participants exercised self-control by substituting positive thoughts, solutions and strategies for impulsive self-destructive ruminations. Additionally, the study results were that other internalized maladaptive responses were reduced by at least 30%, mitigating such familiar response tendencies as isolation, denial and aggression.

The nurse-mentors accessed the publication (De Masi & Bohn, 2010) and used it as a reference list of adaptive coping skills that were helpful to Children of Promise. The nurse-mentors received clinical supervision from faculty members in analyzing responses to the FHPAST. Responses were identified that would indicate if a child would benefit from learning self- regulating behaviors. The children were taught how to chart their use of coping skills and monitor progress. For example, a child indicated on the FHPAST that he does not seek assistance from his family when he feels angry or upset and engages in self-isolative behaviors, sometimes for more than several days at a time. During these periods the child described his responses as: “Just doing nothing, no homework or reading. I stay by myself,

sleep and stay in bed until the anger goes away." The nurse-mentor and child explored how these behaviors interfere with his goals of passing fifth grade, and how his peers and teachers perceive him as being unapproachable during those times. The nurse-mentor encouraged the child to record what made him angry in a journal, and then try to do something active, such as doing homework or exercising. During their mentoring sessions, journal entries were used as a safe way for the child to express anger and learn how to constructively use anger to create positive changes. As a result of this, the child was able to plot his progress in developing self-awareness and making decisions that had positive outcomes.

Middle school age children were introduced to the concept of developing a portfolio to help them plan for their academic and vocational futures. Mentors asked children to write down the characteristics a potential employer or college would be looking for in candidates. They were then instructed to write down an example of the type of behavior that demonstrates that characteristic. For example, children identified that it is important to be respectful of others. They wrote about a behavior that demonstrates their competency in this area. When they demonstrated acquisition of this characteristic, they received a certificate that was added to their portfolio. At the end of the academic year, children plan to write a summary of their accomplishments. This summary will be the basis for introducing the concept of writing a resume and a personal statement.

Goal # 5: *Increase children's identification with positive models.* This goal was formulated to counter children's narrow view of their potential and identification with negative models. I identified a positive behavioral program implemented by the NYC DOE, entitled *Positive Interventions and Supports: Effective Schoolwide Intervention.* It was developed by the Office of Special Education Programs, US Department of Education for the

purpose of supporting positive behaviors of all students. It provides a curriculum of instruction for professionals based on research-driven practices that change the culture of behavior in schools. I met with the principal and guidance counselor to discuss the possibility of implementing these strategies with Children of Promise. The principal indicated that the school district will have *Positive Interventions and Supports: Effective Schoolwide Intervention* workshop training programs scheduled later in the school year. He explored sending an Amachi faculty member with the district superintendent. The principal got permission to send a faculty member to the training workshop next semester along with key personnel from the school. Based on their experience with the method, some or all of the components will be implemented when working with children to develop coping skills as well as helping them to plan for their academic and vocational futures (Goal # 4).

Goal # 6: *Improve the effectiveness of mentoring time with children.* It was difficult to schedule mentoring sessions during the regular school day because there were conflicts with children's core curriculum classes. As noted in the data analyses of challenges, the children did not want to miss fun activities in order to attend mentoring sessions and nurse-mentors stated this practice was counter-productive. This created a dilemma regarding the best time to schedule mentoring sessions and activities. Participants in the study believed some nurse-mentors would opt for a more flexible schedule in order to facilitate having more time with the children. In the Spring 2013 semester, nurse-mentors, who completed Community Health Nursing and are continuing as nurse-mentors in the course, Urban Health Issues, were given the option of traditional clinical hours or a flexible schedule. Those who opted for a flexible schedule were scheduled to meet for group supervision with faculty at scheduled intervals and will send weekly reports to clinical faculty.

The issue of making a weekly and monthly schedule for mentoring sessions continued to be a challenge because the public school was and always will be a setting of dynamic processes. The public school clinical sites needed to make ongoing adjustments in scheduling in order to meet the needs of an ever-changing environment. Initially there was a plan for a designated school aide to make a weekly mentoring schedule based on any changes in the over-all school schedule from the previous week. With budgetary cuts, the school lost two aide positions, so the plan was no longer viable.

I introduced an innovative type of program scheduling this semester that involved clustering mentor sessions to a specific class of children. We 'adopted' a special education class with a high rate (83%) of parental incarceration and provided nurse-mentoring activities to the entire class of 12 children. The teacher knew that every Wednesday 3rd and 4th periods were devoted to mentoring activities and 5th period was health promotion education for the entire class. This allowed the teacher to make weekly teaching plans accordingly and the children did not lose core curriculum instruction time. Feedback from the teacher, children and SBST on the change in delivering care was positive and clustering mentor activities was renewed for next semester.

Goal # 7: *Promote development of therapeutic relationships by reducing environmental distractions.* I met with the principal to discuss the lack of private space and multiple environmental disruptions that impeded development of nurse-child therapeutic relationships. The classroom that was previously reserved for Amachi was needed for additional classes, so the Fall semester was particularly challenging. We were given library space as well as a spare classroom that was empty on clinical days. The auditorium was also an area that we could access when not in use. Staff members who perceived encroachment on their territory did not always meet administrative decisions on the use of space favorably.

This type of response occurred with the librarian who clearly did not want Amachi mentoring in her domain. The nurse-mentors were confronted with a hostile environment and at times the librarian prohibited them from using the space. Additional meetings with the principal and assistant principal eventually resulted in the problem being resolved.

Summary. Implementing the action plan involved seven goals with corresponding interventions that centered on the AI topic (Table 5.7). The action plan cycle in the Design stage was initiated for the three months of September through December. During this period, contextual changes occurred in the increased rate of homelessness among the children and lose of the partnership with New York Mission Society. Accomplishments during this period were implementing action plans that: (a) took the first steps toward a family approach to nurse- mentoring; (b) developed a more formal way of implementing the nursing process with Functional Health Patterns Assessment Scale Tool (Foster & Jones, 1997-2008 ©); (c) increased communication among nurse-mentors, children, and caregivers; (d) assisted children to develop academic and vocational plans by using a coping skill progress board and portfolios; (e) identified the use of *Positive Interventions and Supports: Effective Schoolwide Intervention* program to increase children's identification with positive models; (f) improved the effectiveness of mentoring time with children; and (g) promoted development of therapeutic relationships by reducing environmental distractions. Detailed evaluation of the goals, action plan, and influence of contextual changes will be discussed in the Destiny Phase.

Phase IV: Destiny Step of the 4-D Cycle

The Destiny step included evaluation of the results of the AI process and answer to the research question; "**What changes occurred in the shared visions and collective actions of nurses as a result of working with Children of Promise?"** The Table 5.8 depicts the goals

and knowledge generated during the AI process. The evaluation process involved feedback from clinical faculty, data from RN to BS nurse-mentors derived from a focus group and a questionnaire on the changes that occurred as a result of the action plan. In evaluating the influence of the contextual changes that occurred during this AI Cycle, I asked the questions of the Destiny Phase in Table 5.4. "What happened?" "How did it work out?" "What were the hurdles and successes?" The areas of the action plan that were most affected by the crisis of homelessness were establishing relationships with caregivers and children, and planning for the academic and vocational futures of children. These goals were affected because children's survival needs surpassed these goals. As stated earlier, 50% of the children in the program became homeless and had to travel long distances to attend their original school. Erickson, et al. (1983) state that Modeling and Role Modeling must first address meeting the client's basic needs, before advancing to hierarchy of developmental needs. The children's risk for insults to health, wellbeing and safety rose significantly during their homelessness, therefore nursing interventions centered on providing protection. The clinical faculty provided leadership in teaching the RN to BS students to adjust their mentoring goals and objectives according to the crises that children were facing. The nurses' assessment of the children's' areas of risk were based on data from nurses' observations and completion of the FHPAST. Common areas of risk were inadequate hydration, poor nutrition; sleep deprivation, anxiety, and lack of preventative healthcare. Sleep deprivation was more pronounced in the middle school age children, because their caring responsibilities toward younger siblings prevented opportunities to relax and revive. The younger children were able to sleep on the train; therefore they were less sleep deprived. The RN to BS students, under the supervision of clinical faculty, developed the following protective interventions: (a) worked with the school nurse in

Table 5.8

Destiny Phase: Evaluation of the AI Process

Goal	Knowledge Generated and Activities
1: **Establish relationships with caregivers as a first step toward a family approach to care.**	Enhanced family approach to care: Δ Obtained caregivers permission for telephone contact Δ Established partnerships to facilitate access to caregivers, e.g., comprehensive supportive housing programs. Δ Contacted caregivers often Δ Conducted home visits to establish relationships.
2: Develop formal ways of implementing the nursing process: Set objectives for children that are driven by nursing assessment.	Δ Nurses assessed Children of Promise, ages 13-16, using a valid and reliable screening tool, i.e., the Functional Health Patterns Assessment Screening Tool (FHPAST): Δ Provided a catalyst for development of nurse-child relationships. Δ Collected comprehensive assessment data Δ Identified areas of risk, particularly related to stress, anxiety, and coping mechanisms. Δ Identified high-risk responses. Δ Collaborated with peers, faculty and other to learn about high-risk responses.
3. Increase nurse-mentors' communication with children and caregivers.	Nurse-mentor program planning included: Δ Consent forms that give caregivers the option of releasing phone contact information and agreement to have mentor contact. Δ Avoided mandatory caregiver participation.
4. Help children develop academic and vocational plans by using health promotion activities.	Initiate health promotion activities such as teaching children coping skills, promoted children's development of academic and vocation plans: Δ Used coping skills progress boards for elementary school children. Δ Assisted with portfolio development by middle school children.
5. Increase children's identification with positive role models.	Perform as change agents in the public school setting: Δ Advocated for evidence based programs that support positive behavior in all children. Δ Received training in *Positive Interventions and*

	Supports: Effective School wide Intervention. Δ Disseminated information to intra-professionals about alternatives to traditional suspension and expulsion.
6. Improve effectiveness of mentoring time.	Nurses used mentoring time more effectively: Δ Developed innovative scheduling strategies of clustering care and giving mentors options for flexible schedules Δ Responded positively to off-site group supervision.
7. Promote development of therapeutic relationships by decreasing environmental distractions.	Nurses obtained private space for mentoring: Δ Used inclusionary communication with all those involved and avoided hierarchal "top-down approach." Δ Developed flexible and innovative schedules that Decreased demand on resources.

contacting caregivers to make sure children got the Flu vaccination and provided a list of clinic locations close to the shelter; (b) contributed weekly hygiene kits in addition to bottles of water, cartons of milk that did not require refrigeration and fresh citrus fruit for children to take with them at the end of the school day; (c) provided large stuffed animals for the children to use as pillows at the school, so that older children could put their heads down on the desk and sleep during free periods; (d) used positive imagery and relaxation techniques to teach children to cope with anxious feelings; (e) offered extra love and encouragement; and (f) coordinated these efforts with teachers and the SBST.

The areas of the action plan that were most affected by the crisis of homelessness were establishing relationships with caregivers, and the children planning for their academic and vocational future. The children's survival needs were a priority. Despite the hurdles in establishing relationships with the caregivers, there were successes. Four nurse-mentors were able to make home visits. Those visits were productive in establishing relationships, setting objectives for the nurse-mentoring sessions and opened telephone communication on a regular basis. A homebound mother that was visited had a progressive neurological disorder. The nurse-mentor approached the mother about her child continuing with mentoring services (Big Brothers and Big Sisters of America) after the nurse- mentor graduates, and the mother was receptive to the idea.

One of the participants, during the individual interviews showed leadership and wisdom by saying, "It is important to go where the families live. It shows that nurses accept them for who they are." Future caregiver interventions will include efforts to accompany the Family Worker on home visits and establish partnerships with comprehensive housing programs. These types of programs provide greater access to caregivers. Another success

was getting authorization to include caregiver contact information on the consent forms. This improved communication between caregivers and nurse-mentors.

As reflected in participant interview data, leadership was identified as one of the major strengths of the nurse-mentor program. During partnership with the New York Mission Society, we learned from their leadership how to provide services to families affected by parental incarceration. Although I would have preferred the relationship to continue, what the Mission Society provided for us will help sustain the nurse-mentor program. As described in Chapter 1, I became a certified Amachi Trainer and most recently I developed a NJSNA 8 hour Continuing Education Program to educate nurses on the nurse-mentor model of care for Children of Promise. I provided leadership in assuming the nurse-mentor training for the incoming nurse-mentors, and also began training the clinical faculty so that they will eventually conduct the training.

Goal #1: *Take the first steps toward establishing a program that is both child-centered and family focused.* We learned was that establishing relationships with caregivers were attainable if administrative processes were in place and nurse-mentors had opportunities to make home visits. Nurses need to be tenacious with efforts to engage families by "digging deep" and drawing on their personal strengths of patience, perseverance, courage, acceptance, humility and gratitude. Unanimously, nurse-mentors rated as high the need for caregivers to participate in the program but cautioned that making it mandatory would exclude the most vulnerable children who are living in isolated family systems, therefore at highest risk.

Goal #2: *Develop a formal way of implementing the nursing process: Set objectives with children based on their input and driven by nursing assessment.* The Functional Health Patterns Assessment Screening Tool (FHPAST) was implemented for children ages 13-16

(Jones & Foster, 1999; Jones, et al., 2012). Nurse-mentors who rated this tool as highly effective in identifying areas of risk, enhancing the development of nurse-child relationships, establishing objectives for the nurse-mentor sessions, making recommendations for referrals, and establishing a basis for communication with the SBST and caregivers, assessed validity. Children found the items easy to understand and respond to. Reliability of FHPAST was not assessed in this qualitative study. Nurse-mentors recommended that the FHPAST be done during the first month of mentoring and then every three months after that to assess changes and response to mentor interventions. The nurses found that they were able to collect much more data with use of the FHPAST, than they were without it. This was most likely related to the clandestine nature of families with parental incarceration because the children are told not to tell others about their personal affairs.

The clinical faculty found that use of the FHPAST helped nurse-mentors to focus on areas of risk and identify appropriate objectives and interventions. Faculty members also reported that with FHPAST generated data, students were able to benefit from a group clinical supervision format. In group supervision, nurses worked collaboratively in developing objectives and interventions. The nurses favored working in groups because they feel more supported and less alone in the challenges of caring for Children of Promise.

Goal # 3: *Increase communication among nurse-mentor, child, and caregiver.* The nurse-mentors believed that in order to help children decrease truancy; they needed to have communication with caregivers. They felt that nurse-mentors are in excellent positions to help families with parental incarceration to improve school attendance by identifying the reasons for absences and making referrals for health care. NYC DOE was not authorized to release the caregivers' private information such as phone numbers, so the mentors had no way

of contacting the family when a child was truant. There was a meeting with the principal about changing the consents to include caregiver contact information. The principal had a series of communiqués with DOE administration, and a decision was made to give caregivers the option of releasing their contact information to nurse-mentors. The consent forms were revised to reflect the change.

Goal # 4: *Assist children in developing academic/vocational plans.* Mental health promotion modalities, such as the coping skill progress boards and portfolios were introduced to help children achieve age-appropriate tasks, positive sense of self-esteem, mastery of self-control, and social acceptance. These are consistent with recommendations of the National Institutes of Health Report (NIH), 2009. The RN to BS students rated as highly effective use of coping skills progress boards and portfolios in helping children develop age appropriate behaviors, but also strengthening children's abilities to cope with adversity. In the focus group, nurse-mentors recommended that progress with coping skills and acquisition of positive behaviors should be connected to a rewards system.

Goal #5: *Increase children's identification with positive models*. The genesis for this goal was participants' observations that suspending children from school for infractions did not result in children making positive changes. In fact, the suspensions had just the opposite effect, as manifested by continuance of anti-social behavior and identification with negative role models. Deviant behaviors that continue into adolescence increase the risk of dropping out of high school (Parke & Clarke-Stewart, 2001; Phillips et al., 2006). Johnson (2009) found that black males who were high school drop outs and had a history of school suspension, expulsion or charged with a crime had an alarmingly high (67%) cumulative risk of death or incarceration by the age of forty.

In the Dream step, the group who performed the skit portrayed a high school girl who made restitution for her offenses by doing community service and that she was offered support of positive role models instead of expulsion. During this AI cycle, I explored behavioral programs that the NYC DOE endorsed for changing the culture of negative behaviors and that most closely resembled the intervention depicted in the skit. *Positive Interventions and Supports: Effective Schoolwide Intervention* was the program that incorporated positive reinforcement for desired behaviors and mechanisms for children to engage in restitution, rather than punishment, detention and suspension. Nursing faculty, teachers and SBST personnel need to be trained in this technique before instituting program. Plans are underway for at least one nursing faculty, teachers and other key personnel to be trained this year.

Goal # 6: *Improve the effectiveness of mentoring time with children.* As described in the Design phase there were many hurdles to scheduling and carrying out nurse mentoring during the course of the public school day. Public schools are the most efficient way for nurse-mentors to reach high-risk children because legislation and child protection agencies mandate that children attend school. Public schools also offer safe environments for nursing students to learn. Faculty and nurse-mentors have learned the delicate art of being flexible while also being firm regarding the educational needs of RN to BS students. The clinical faculty evaluated the program from a strength-based perspective regarding "What worked best" and expanded on those types of scheduling.

Goal # 7: *Promote development of therapeutic relationships by reducing environmental distractions.* Nurse-mentors experienced a lack of private space to meet with their mentees as something that impeded development of nurse-child relationships. In my thirty years in nursing, adequate space has been a problem everywhere within institutions.

Professionals who work at the school were clamoring for space, so there was resistance for allocating space to college nurse-mentors who were viewed as "outsiders." Upon reflection, program planning was done primarily with the guidance counselor and principal, therefore teachers and other school personnel were not fully aware of the mission and how the program was being carried out. Although I sent a letter of introduction electronically to the teachers' e-mail addresses, many teachers said they never got the letter and did not know anything about Amachi. During the Fall semester, my corrective measures to disseminate information consisted of communicating to the teachers in face-to-face meetings the programs goals and objectives and asking for their feedback. This promoted a sense of unity and decreased resentment.

In addition to administrative support for the program, innovative scheduling techniques discussed in Goal # 6, put less stress on the school's resources and facilitated private space for mentoring. Portrayal of the "Amachi Nurses' House," as mentioned in the Dream Stage was visionary and I hope to one day cross the threshold of that house. Until then, the nurse-mentors and I are grateful for the opportunity to reach society's most vulnerable children in public school settings.

Chapter 6

Conclusions, Implications, and Recommendations

This chapter presents conclusions, implications, and recommendations from data generated in this AI study. Conclusions, drawn from the Destiny phase of the AI process (Table 5.8), are only related to nurse-mentors in this study and the children with whom they interacted. Implications were delineated for nursing practice, research, and education. Recommendations are related to future nurse-mentor programs for Children of Promise and future research.

Conclusions

This section provides conclusions related to (a) use of nursing theoretical frameworks to teach nurses how to mentor Children of Promise and (b) evaluation of goals in the Destiny phase of the AI process. Consistent with AI action research methodology, conclusions are delineated at the end of the AI cycle. Those conclusions set the stage for future AI studies (Ludema & Fry, 2011; Stringer, 2007). After conclusions related to the theoretical frameworks, the remaining conclusions are listed in the order of goals presented in Table 5.8. Examples of qualitative data from the AI Process are provided to support each conclusion.

Theoretical Conclusions

The theoretical frameworks of Peplau (1952) and Erikson, et al. (1983) effectively guided the pedagogy of faculty and the practice of nurse-mentors in this AI study. Clinical faculty provided nurse-mentor training that included the tenets of Interpersonal Therapeutic Relationships (Peplau) and Modeling and Role Modeling (Erickson, et al.). Throughout the RN to BS students' clinical experiences, these two theories were used to explain current interchanges between nurses and children.

Peplau's Interpersonal Relations in Nursing theory (1952). Peplau's theoretical framework was widely used in clinical settings such as (a) developing assignments for students;

and (b) explaining events between nurses and children that were discussed during clinical pre and post conferences. I devised a form based on Peplau's theory for nurse-mentors to complete each time they had a mentoring encounter. The students were asked to assess which of Peplau's four stages they were using and which helping roles they assumed during encounters with their mentees. Identifying a specific stage was important because there are particular interventions for each stage.

Encouraging self-awareness by nurses is an integral part of Peplau's theory. When nurse-mentors identified the particular helping roles they assumed, it provided them with opportunities to explore their own feelings about performing in those roles. Peers further enhanced self-awareness as they compared and contrasted emotional experiences.

Modeling and Role Modeling theory. This middle range theory of Erickson, et al. (1983) provided the framework for two salient features of nurse-mentoring. The first was to avoid judging incarcerated parents, parents that have neglected and abused their children, situations of current caregivers, and children's infractions of school rules. The second was it helped nurse-mentors to work with Children of Promise who presented with complex needs, ranging from acquiring basic biological sustenance to achieving self-actualization. Initially, nurse-mentors found that prioritizing objectives for these interpersonal relationships to be daunting tasks. Applying this theory helped them to make useful choices. The nurse-mentors realized that sometimes nurses must face the challenge of establishing trusting relationships with human beings whose acts are repugnant and counter nurses' worldviews. The nurse-mentors came to understand that if they pass judgment on parents, caregivers, or children, trusting relationships will not occur and children's perceptions of themselves as acceptable, respectable and worthwhile human beings would be impeded. During modeling, nurses assessed how

children interpreted their situations, their current and future expectations, their strengths and support systems, and their goals. By embracing children's worldviews, nurses developed clearer understandings of children's perceptions and the context in which they occur. Modeling aided nurse-mentors to be non-judgmental and thereby facilitated development of interpersonal therapeutic relationships.

Conclusion related to Goal # 1. Establish relationships with caregivers as a first step toward a family approach to care. The nurse-mentors who were able to assess family support systems facilitated the hopes and aspirations of those families for the health and wellbeing of their children. Because the majority of caregivers do not come to the school for meetings, the nurse-mentors tried to obtain permission from the caregivers for home visits; only four nurse mentors were successful. The purpose of the home visits was to assess families' health seeking behaviors, and to learn the hopes and aspirations that caregivers had for the children. For example, a nurse- mentor made a home visit to a mother who kept her 13 year-old daughter, Linda, from attending school when the mother did not feel physically able to escort her. Truancy compromised the school's ability to continue providing Linda with additional educational resources to help her stay in a regular eighth grade class. During the home visit, the mother confided to the nurse- mentor that she had an inoperable tumor pressing on her spinal column and that her functional capacity had declined in the past year. The mother admitted that from the time her former husband went to prison, she had been overprotective of Linda. She stated that there was a high concentration of violent crimes in the neighborhood and she was fearful for Linda's safety. The nurse ascertained that the mother's hopes and aspirations for her daughter's health and wellbeing were that Linda would graduate from high school, get vocational training, become an independent adult, and be healthy.

During previous nurse-mentoring sessions with Linda, the nurse learned that she occasionally stayed home because her mother was feeling sick and she felt guilty leaving her mother alone. The nurse-mentor identified that the family needed support to assist the mother with her chronic illness issues and promote Linda's school attendance. The nurse educated the mother about home care possibilities that would enhance her ability to live in the community and also provide grief counseling. Counseling was indicated because the mother was experiencing loss of her health and her daughter would eventually leave home as she achieved her goals. The mother was receptive to a referral for home care services and explored alternative ways for Linda to walk safely to school. The nurse-mentor continued her role in delivering child-centered care, while maintaining focus on the family.

Conclusion related to Goal # 2. Develop a more formal way of implementing the nursing process: Set objectives for children that are driven by nursing assessment. The Functional Health Pattern Assessment Scale Tool (FHPAST), a valid and reliable screening tool for adults (Barrett & Jones, 2011), provided an appropriate assessment guide for 13-16 year old Children of Promise. In the process of determining possible validity for use with 8-12 year old children, four pediatric nurse specialists determined that it was not appropriate for children of younger than 13years. The following case scenario is an example of a nurse-mentor's ability to collect useful data with the FHPAST.

A 14 year-old girl, Briana, with an incarcerated mother and an uninvolved father, was in a house fire. Firefighters found Briana in the burning home under her bed. She suffered only minor smoke inhalation and was released from the emergency room. After the fire, the family, a maternal aunt, her four children and Briana and her three siblings were relocated to temporary housing in the shelter system. The School Based Support Team (SBST) and teachers noticed

that she didn't consistently respond to the class lessons and activities. She also seemed detached. Using the FHPAST, when the nurse asked Briana about anxiety and worry, Briana responded that she routinely worried "about mommy and daddy." The nurse's follow-up questions revealed that when Briana was in the fire, she feared dying and never seeing her parents again. Subsequently, she suffered flashbacks of the experience, which were overwhelming and immobilized her with panic. The nurse-mentor communicated the findings to the teacher and support team, initiating a referral. Data collected using the FHPAST, provided essential information about Briana's experience, which led to her receiving diagnostic evaluation.

Conclusion related to Goal # 3. Increase nurse-mentors' communication with children and caregivers. Seventy-eight percent of caregivers (n=14) agreed to be contacted by the nurse-mentors. Telephone contact increased nurse-mentors' communication with caregivers and children, making it possible for mentors to reinforce and support their efforts toward positive change. For example, a nurse-mentor noticed that his mentee, Ernesto, a 15-year-old boy, was having rapid changes in activity and sleep. He was described as "being up and alert, interacting with peers one minute and in the next minute, his head was on the desk sound asleep." When the nurse talked to the boy about his concerns, Ernesto explained in detail what his life was like when he left school. The boy was suffering from hunger and sleep deprivation. Both his parents were paroled from prison with court remanded substance abuse rehabilitation. Because of past domestic violence between the parents, they were mandated to live separately. They were having adjustment problems with living in the community and being in rehabilitation. There lacked a consistent schedule for the boy to do homework, eat and go to bed. Ernesto went to his father's single occupancy room after school, but was never

sure what time his mother would pick him up at take him home.

The nurse-mentor developed a plan of care that included: (a) arrangements for school staff to send Ernesto home with extra take home meals that could be microwaved; (b) supplied a backpack to help Ernesto take his homework books from one home to the other; and (c) reminders to Ernesto by telephone when to eat, when to begin homework and when to go to bed. Ernesto's mother also spoke with the mentor by telephone, expressing gratitude for helping her son. Ernesto responded favorably to the interventions and was able to complete the required schoolwork for passing his core classes. The nurse-mentor's ability to telephone the boy with reminders, support and positive reinforcement made a substantial difference in the outcome for this child.

Conclusion related to Goal # 4. Help children develop academic and vocational plans by using health promotion activities. With nurse-mentors' use of Coping Skills Progress Boards, children learned and applied new coping skills that contributed to children's development of academic and vocational plans. For example, Tonya, a 10 year-old girl, lived in a family of six children with a prevalent history of school phobia. The nurse-mentor noticed that Tonya was beginning to display some of the signs of anxiety and school avoidance. The nurse- mentor reviewed the antecedent behaviors of truancy and tardiness. One of the things that prompted truancy was a lack of preparation the evening before school, which resulted in anxiety about class performance. She did not do her homework; get her clothes ready, or complete routine hygiene tasks. The nurse constructed a coping skills board to help Tonya finish these tasks and she was given points by her teacher when she arrived at school on time, dressed and groomed appropriately, and with completed homework. Positive reinforcement was in the form of being able to join a girls' leadership group, which rewarded

her with enrichment field trips and relationships with children who were academically successful. Constructing plans to teach Tonya coping skills made it possible for her to change from a pattern of truancy to full engagement in the educational process.

Conclusion related to Goal #5. Increase children's identification with positive role models. Children identified with positive, instead of negative, role models. For example, the following case scenario occurred after a public school instituted a positive oriented restitution program for infractions of school rules instead of traditional prolonged suspension.

A thirteen year-old girl, Marlene, was found engaging in sexual activity with a boy as classes were changing. The usual suspension for this type of behavior was one week. Marlene had poor self-esteem and a chaotic family life related to parental incarceration. It appeared that she engaged in sex to get attention and affection. The consequences of her behavior included being ridiculed and labeled by her peers as a "slut," thereby further lowering her self-image. The nurse-mentor advocated for reduction of Marlene's suspension to one day and for Marlene to help the school nurse as a form of community service. During the girl's free periods, she went to the nurse's office and assisted her with various tasks, such as preparing handouts for health education activities. These were opportunities for the nurse to discuss the consequences of high- risk behaviors and explore alternative ways that Marlene could get attention and feel affection. This experience seemed to raise Marlene's self- esteem and increase her identification with a positive role model (the nurse). Marlene went on to complete the semester without behavioral infractions and, after completing community service, she continued to stop by the nurse's office to help out and talk.

Conclusions related to Goal #6. Improve effectiveness of mentoring time. Nurse-mentors developed innovative scheduling strategies to effectively use mentoring time with

children. Nurse-mentors created more flexible schedules to adjust to bureaucratic routines that previously had limited their ability to productively deliver services to their mentees.

A nurse-mentor of Tommy, a 12 year-old boy, found the time constraints of mentoring to be frustrating. On the traditional clinical day, 8:30 am-12:30 pm on Wednesday, his mentee only had 40 minutes to meet. The boy stuttered, thereby needing more time for mentoring sessions. The nurse-mentor believed that the brevity of their meeting put undue stress on Tommy, and was an ineffective way to carry out a therapeutic relationship. Therefore, the nurse mentor opted for a more flexible schedule, in which he mentored the child on Fridays, when Tommy's school schedule permitted more time together. These types of arrangements also required clinical faculty's willingness to provide supervision for students who had chosen flexible schedules. Mentors, who opted for alternative schedules, were supervised by clinical faculty off site, in group format. Innovations like this one stemmed from nurse-mentors and faculty seeking solutions to problems themselves, as opposed to expecting administration to make changes. As written by Henry David Thoreau, "things do not change, we do."

Conclusions related to Goal #7. Promote development of therapeutic relationships by decreasing environmental distractions. Nurse-child relationships improved when faculty taught nurse-mentors to include use of the nursing interventions of Presence and Active Listening interventions with children (Bulechek, Butcher, Dochterman, & Wagner 2013) and Advocacy, especially for additional private spaces. An example is Karen, a 12-year old girl, who experienced several childhood adverse events, including sexual abuse by her mother's boyfriend, yet she showed incredible strength and spirit. Karen was referred to the program because she had been suspended several times for physical aggression. When the sessions began, Karen was guarded and defensive. In the early phase of the interpersonal

relationship, Karen could not tolerate close physical contact with her mentor, but despite this, came to every session, sitting several feet from the nurse. The clinical instructor taught the nurse-mentor that she was providing the nursing intervention of Presence and about the process of change within the therapeutic relationship. It was pointed out that during a field trip; Karen preferred that the mentor sit on the bus seat directly across from Karen, instead of in the same seat. Gradually, Karen's demeanor changed and she eventually formed a trusting relationship with the mentor.

One of the objectives for the mentoring relationship was to teach Karen to confide in only those she believed she could trust. She had a tendency to blurt out personal information to the entire class, thereby becoming the brunt of ridicule and scapegoating. The nurse-mentor used cognitive-behavioral approaches, including role-playing, to teach Karen how to develop a filter and to restrain the impulse to say whatever came to mind. The nurse-mentor was able to secure private space for Karen to learn the skills and role-play. Karen practiced what the nurse taught and the negative interactions with her peers diminished over time.

Implications for Nursing Practice, Education, and Research

This section delineates implications derived from this AI action research. The implications for practice, education and research are consistent with the Future of Nursing (IOM, 2010) recommendations to strengthen nurses' roles and remove barriers to nursing practice.

Nursing practice. Data from this study implies that nurse mentoring can be used: (a) with other vulnerable populations; (b) in public health initiatives for high-risk behaviors; and (c) to promote access to silent populations. For example, similar nurse-mentoring programs can be used for pre-school, high-risk children and parents. Nurse leaders can establish

additional settings for nurse-mentoring programs by affiliating with organizations that share Amachi's mission and philosophy. For example, the Educare model of school readiness would be a compatible program for collaboration because the goal is to teach emotional and social skills in early development (Frank Porter Graham Child Development Institute at University of North Carolina at Chapel Hill, 2012).

The second implication, use a nurse-mentoring model in public health initiatives, suggests possibilities to target populations with high occurrences of teen pregnancy, infant mortality, or HIV/AIDS. In using a mentoring model with high-risk populations, nurses can also use the FHPAST with older children and adults to identify high-risk behaviors and provide interventions that facilitate health protection. In this study, health promotion and protection was used to increase children's coping skills, thereby reducing chances of school dropouts and engagement in high-risk behaviors. Baccalaureate nursing programs can partner with public health departments to increase children's exposure to health promotion through nurse-mentoring. The shared goal would be to reduce the incidence of morbidity related to high-risk behaviors.

The third implication, promote access to silent populations, indicates that nurses can expand their roles in non-traditional settings. The researcher, clinical faculty, and baccalaureate-nursing students of this study were able to integrate the highly structured bureaucracy of the New York City Department of Education (NYC DOE) to create a new role for nurses.

Nursing education. Implications for nursing education drawn from these study data are: (a) the theoretical frameworks of Peplau (1952) and Erickson, Tomlin, and Slain (1983) can be effectively used to help RN to BS nurses learn how to work with vulnerable populations,

especially in community settings; (b) Nurse educators should use a mentoring model to prepare nurses for helping high risk populations; and (c) doctorate programs in nursing should educate their students to design innovative studies for evidence-based practice with high risk and vulnerable populations.

The first implication, that educators should use the theoretical frameworks of Peplau (1952) and Erickson, et al. (1983), is supported by the successes of these RN to BS nurses in developing therapeutic relationships and performing as nurse-mentors. Prior to using these theories, these RN students did not have the same skills. Students' understanding of Erikson, et al.'s theory enabled them to embrace unfamiliar client worldviews and to more effectively execute role-modeling interventions.

The second implication, that nurse educators should use the nurse-mentor model to prepare baccalaureate nurses to work with high-risk populations, is supported by the Affordable Care Act (ACA, 2010). This new health care design includes the Home Visitation Program (HVP), which targets early intervention for high-risk infants, children and families. Under the ACA, the foci for community-based programs are to provide interventions for mental health, substance abuse, neglect, physical abuse, crime, and unemployment. Students who work with high risk populations during baccalaureate nursing programs become more comfortable in difficult social situations and are more likely to consider employment in community-based programs similar to those supported in the ACA (2010).

The third implication, increase the numbers of doctoral-prepared nurses to study programs for high-risk populations, provides the evidence needed for practice. The first phase of home visiting programs in the ACA involves cultivating the programs and the second phase sets benchmarking criteria to measure results to create evidence-based practice. This

implication is also supported by the Robert Wood Johnson Foundation Initiative at the Institute of Medicine (IOM), 2010 report on *The Future of Nursing*.

Nursing research. The implication for nursing research is that AI action research should be used to facilitate nursing's leadership role in healthcare redesign (IOM 2010). Nurse leaders, innovators and researchers can use the AI process and methodology to redesign healthcare, particularly in situations with seemingly intransigent solutions. As facilitator, researcher, and leader of this AI action research study, I refined a strength-based model that faculty and registered nurses used to reshape the care of vulnerable children. The AI process generated an endless supply of positive energy, resulting in nursing knowledge to redesign the program. The productive dimensions of AI spurred the creation and perpetuation of an optimistic perspective that nursing care for children who face adversity can be effective in countering the forces that impede progress (Zanee & Cooperrider, 2011; Whitney, Trosten-Bloom, & Radar, 2010).

Recommendations

The results of this study have generated two primary recommendations (a) to expand use of nurse-mentor models to other baccalaureate nursing programs, and (b) to continue research with the nurse-mentor model. Future scientific inquiry is dependent on developing additional programs, so that larger numbers of nurse-mentors and children can be studied.

Expand the nurse-mentor model to other baccalaureate nursing programs. When I approached other nursing programs about developing Children of Promise nurse-mentoring programs, initial reactions were that of intrigue, quickly followed by hesitant and avoidant behaviors. Avoidant behaviors may stem from fear of the unknown and emotional responses associated with the concept of criminals and people in prison. My own

involvement in developing a nurse-mentor program occurred after reading *Amachi Model Building from the Ground Up* (Goode & Smith, 2006). By reading this resource, I became cognizant of the magnitude of children affected and the plight of Children of Promise. Most importantly, practical strategies were provided to develop a mentoring program. This helped me feel confident enough to start the process. The manual also taught me how to access federal resources to create and operationalize a nurse-mentor program.

I propose several ways to educate and motivate others to develop programs for Children of Promise. First, I will disseminate information about Amachi and the nurse-mentoring model through presentations and publications. I will write a training manual that provides leadership instructions about how to construct and operationalize nurse mentoring, and pedagogical strategies to develop nurse-mentors.

Second, I will formulate strategies to free children and their families from the stigma of incarceration. This could be accomplished by educating nurses on the effects of poor health care and poverty in perpetuating the cycle of incarceration. As a recipient of 2012-2014 Jonas Nurse Leader Scholarship, I plan to post the Children of Promise video produced for television on the website of the Future of Nursing Campaign for Action and to initiate a dialogue among nurses. I will also become a member of the NYS Regional Action Coalition's committee that addresses the Future of Nursing initiatives in NYS. The Association of Community Health Educators *Mentoring Program for Leaders* will provide a venue for promoting the nurse-mentor model. By developing a network of interested baccalaureate programs, an organization can be formed to support the mission of expanding the nurse-mentor model. Creating training webinars would make the training more accessible and convenient.

Finally, I will generate the support and mentoring of other nurse innovators, nurse

researchers, administrators, and funding sources so that more nurse leaders will be motivated to assume the responsibility of developing nurse-mentoring programs. I credit my success in operationalizing the program and conducting research to the mentoring that I received from Rev. Dr. Wilson Goode, Executive Director of Amachi. During the past five years he has helped me navigate the many rough spots encountered along this journey. Now is the time for me to share the nursing knowledge developed in this study and what I have learned from Rev. Goode with other nurses who are interested in helping children realize their potential and develop prospects for healthy futures.

Continue research with the nurse mentor model. The participants in this study identified that future interventions with Children of Promise will require leadership and doctoral level nurse researchers and innovators to conduct scientific inquiry. I recommend that both qualitative and quantitative research be conducted to further advance nursing practice.

***Qualitative research*.** Qualitative research can be continued through the next cycle of AI, grounded theory development, and phenomenology. I suggest that the next AI cycle study address the goals and action plans that need further development from the previous cycle and include the contextual changes that occurred during this study such as homelessness and loss of the partnership with the New York Mission Society. The advantage of the AI methodology is that it releases an endless source of energy that fuels perpetual cycles for developing progressive and preventative nursing care. As discussed in the conclusions, FHPAST was helpful in teaching nursing students how to identify high-risk areas in older children and in developing objectives and nursing activities that have protective factors.

With grounded theory studies, it may be possible to develop nursing care that is

tailored to the phenomenon of parental incarceration. Because Children of Promise live with unique situational challenges, they would benefit from the generation of middle range nursing theories that apply to these specific contextual circumstances (Wuest, 2012).

Phenomenological studies would illuminate the meaning of the lived experience of parental incarceration originating from the "knowers" themselves (Munhall, 2012, p.25). It would be helpful for nurses working with Children of Promise to understand how children experience various occurrences, both negative and positive. These understandings can become foundational for development of objectives and interventions that are centered on children's unique needs.

Quantitative research. Quantitative research can build on the knowledge that was generated in this study. It is important to establish nursing practice based on measurable outcomes that have been rigorously tested. For example, nurses can study: (a) changes in the FHPAST, psychometric evaluation for use with younger children, and testing with larger numbers of older children; (b) measurement of the impact that nurse-mentoring has on children's development of social and emotional skills; and (c) measurement of children's resilience in relation to adaptive coping skills and health promotion activities.

Currently, there are no comprehensive health assessment tools that specifically evaluate the responses unique to Children of Promise. In this study, children's data on the FHPAST revealed role incongruence within families, anxiety, poor concentration, lack of routine preventive health care, and sleep disturbances. These findings warrant further investigation with larger samples to develop data on common high-risk responses among Children of Promise.

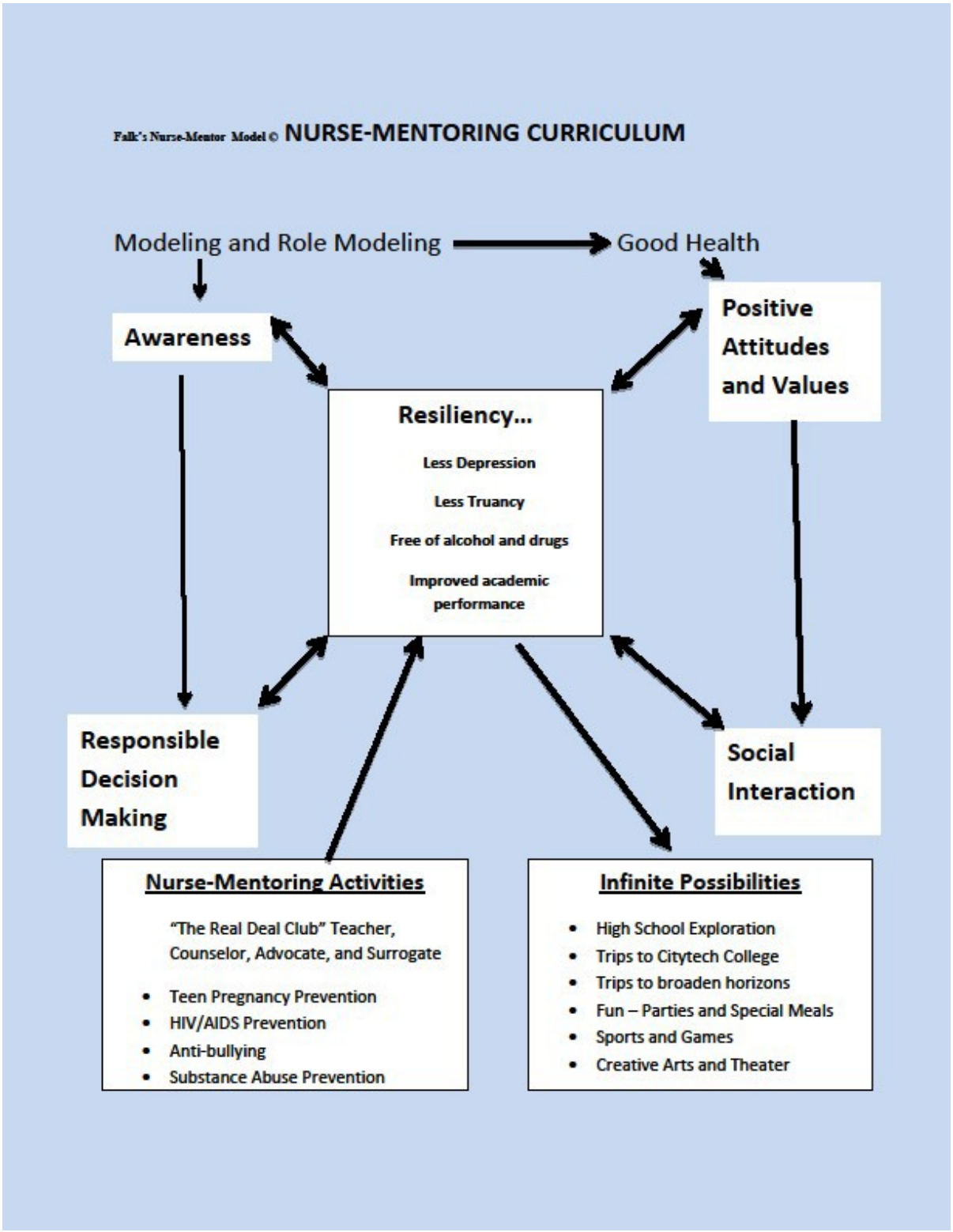
Children need to learn social and emotional skills, such as self-awareness, effective

decision-making, appropriate attitudes, and positive social relationships, as foundations of healthy behaviors (Payton, 2000). Children with incarcerated parents do not have the same opportunities to learn these critical skills as other children. Nurse-mentors in the role of surrogate parents can teach social and emotional skills to children. It is vital to gauge the significance of nurse-mentor interventions on children's attainment of social and emotional skills by comparing pre and post nurse-mentor interventions.

Children who experience parental incarceration endure acute and chronic stressors that span childhood years. Nurses who work with these children are in excellent positions to teach them coping skills for prevention of emotional and behavioral disorders, and improvement of resilience to adversity (Evans, 2009).

Appendix A

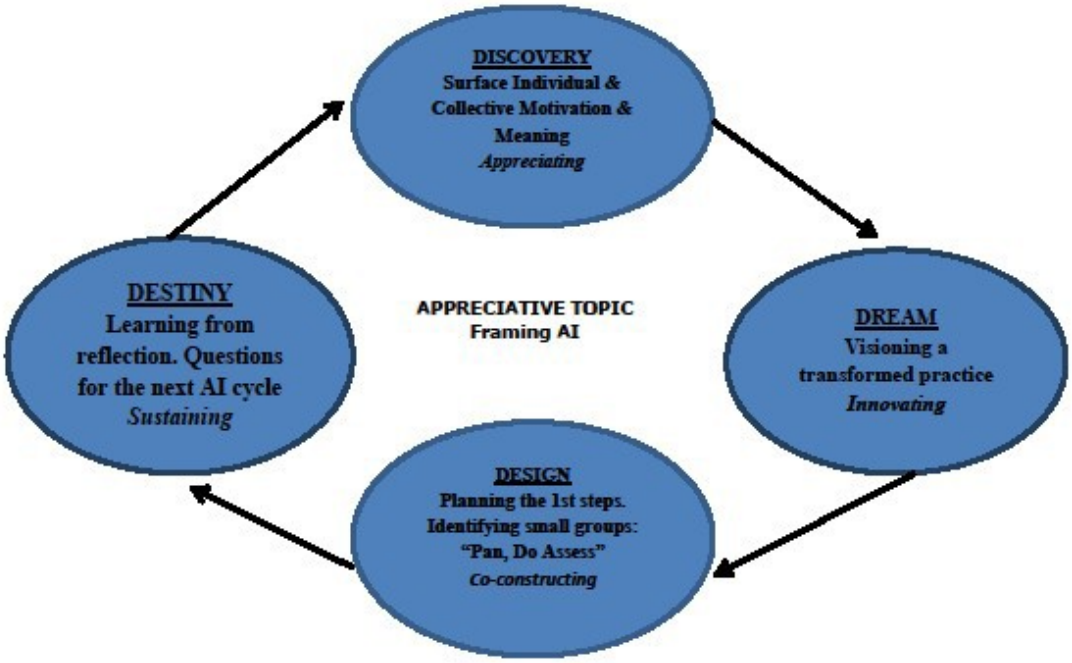
Nurse-Mentoring Program Model Curriculum


Falk's Nurse-Mentor Model © NURSE-MENTORING CURRICULUM
Modeling and Role Modeling
Good Health
Awareness
Positive Attitudes and Values
Resiliency...
Less Depression
Less Truancy
Free of alcohol and drugs
Improved academic performance
Responsible Decision Making
Social Interaction
Nurse-Mentoring Activities
"The Real Deal Club" Teacher, Counselor, Advocate, and Surrogate
Teen Pregnancy Prevention
HIV/AIDS Prevention
Anti-bullying
Substance Abuse Prevention
Infinite Possibilities
High School Exploration
Trips to Citytech College
Trips to broaden horizons
Fun – Parties and Special Meals
Sports and Games
Creative Arts and Theater

Appendix B

AI Process to Practice Change

Appreciative Inquiry to Practice Change



Appendix C

Letter of Invitation

The Graduate Center, City
University of New York
365 5th Avenue
New York, New York

June 03, 2012

Dear Nurse-Mentors,

This is a letter of invitation to participate in a research study. As a nurse-mentor, you touched the lives of children who were affected by parental incarceration. Now you have an opportunity to advance nursing practice for the future of nurse-mentoring. You have been selected to take part in a study because you completed 60 hours of nurse-mentoring activities in an academic year. The aim of this study is to reflect on the existing strengths and effectiveness in nurse-mentoring, and to build a preferred future for mentoring Children of Promise.

Participants will benefit professionally from the experience of engaging in qualitative research. The study is designed to develop nursing interventions that have the potential to prevent unhealthy behaviors in children. As healthcare reform rapidly approaches, your participation in this study will demonstrate to academic and clinical organizations that you have exceptional qualities in leading the profession towards a preventative model of care. At completion of your participation, you will receive a certificate of research participation.

As pioneers in nurse-mentoring, you have shown great fortitude and courage. It is my hope that you take the next step in developing nursing knowledge so that we can help society's most vulnerable children. Please contact me to arrange for an interview at the college by e-mail kfalk@citytech.cuny.edu or by phone, 718-916-0284.

Sincerely,

Kathleen Falk, Assistant Professor
Principal Investigator

Appendix D

Recruitment Brochure

Nurse-Mentoring Children of Promise Research Study

You touched the life of a child…Now you can share your expertise with other nurses

If you would like to participate in a research study in which your experiences of being a nurse-mentor will contribute to nursing knowledge, please contact the primary investigator:

Prof Kathleen Falk- kfalk@citytech.cuny.edu, 718-916-0284

Appendix E

Participants Informed Consents

Participant Informed Consent

You are requested to participate in this research study because you worked as a nurse-mentor in the Children of Promise Mentoring Program for at least 60 hours in an academic year. This appreciative inquiry research is being conducted to create knowledge on how to enhance the practice of nurse-mentors who work with Children of Promise. If you agree to be a participant in this study, you will be asked to take part in the following research activities:

1) An audio recorded one-to-one interview with the researcher (approximately 30-60 minutes) in which the researcher will ask you, a nurse-mentor, to reflect on your experiences, and hopes for the future practice of nurses working with Children of Promise.
2) All participants as a group will then participate in a one day (8 hour) retreat at a convenient location and at time that is conducive for the most nurse-mentors to attend. During the retreat, participants will be requested to join in small group work activities and focus group sessions that are audio recorded. The creative representation of your shared vision for enhanced practice will be recorded by photographs and video. Participants will engage in consensus-validation to develop goals to enhance the practice of nurse-mentoring as well as to decide on an action plan to achieve the goals.
3) Based on participants' areas of interest in enhancing nursing care in this specialized program, participants can volunteer to be team leaders or team members for implementing the action plan. It is estimated that this part of the research will take between 5 to 20 hours of participants' time. The setting for the action plan/s can vary depending on the action plan. It is anticipated that carrying out the action plan will take place at the Children of Promise mentoring site (public elementary school in NYC), community partnerships and/or capacity building organizations.

Participants will benefit professionally from the experience of engaging in qualitative research. Appreciative Inquiry is designed to promote liberation and empowerment to those who co-construct change. These experiences will foster leadership and independence in nurses who seek to promote civic engagement and advocacy for vulnerable populations.

It is anticipated that there will be no risks related to this study, including stress or adverse responses. In the unlikely event that a nurse-mentor experiences stress related to describing their recollections of mentoring children who face adversity, the participant will be referred to the college's Student Counseling Services- 718-260-5030 or the Brooklyn Center for Psychotherapy- 718-622-2000.

Participation in this study is voluntary, refusal to participate will involve no penalty or loss of benefits to which you are entitled and you may discontinue participation at any time

Participant Informed Consent

You are requested to participate in this research study because you worked as a nurse-mentor in the Children of Promise Mentoring Program for at least 60 hours in an academic year. This appreciative inquiry research is being conducted to create knowledge on how to enhance the practice of nurse-mentors who work with Children of Promise. If you agree to be a participant in this study, you will be asked to take part in the following research activities:

1) An audio recorded one-to-one interview with the researcher (approximately 30-60 minutes) in which the researcher will ask you, a nurse-mentor, to reflect on your experiences, and hopes for the future practice of nurses working with Children of Promise.
2) All participants as a group will then participate in a one day (8 hour) retreat at a convenient location and at time that is conducive for the most nurse-mentors to attend. During the retreat, participants will be requested to join in small group work activities and focus group sessions that are audio recorded. The creative representation of your shared vision for enhanced practice will be recorded by photographs and video. Participants will engage in consensus-validation to develop goals to enhance the practice of nurse-mentoring as well as to decide on an action plan to achieve the goals.
3) Based on participants' areas of interest in enhancing nursing care in this specialized program, participants can volunteer to be team leaders or team members for implementing the action plan. It is estimated that this part of the research will take between 5 to 20 hours of participants' time. The setting for the action plan/s can vary depending on the action plan. It is anticipated that carrying out the action plan will take place at the Children of Promise mentoring site (public elementary school in NYC), community partnerships and/or capacity building organizations.

Participants will benefit professionally from the experience of engaging in qualitative research. Appreciative Inquiry is designed to promote liberation and empowerment to those who co-construct change. These experiences will foster leadership and independence in nurses who seek to promote civic engagement and advocacy for vulnerable populations. Participants will receive an honorarium of $150.00 after completing the retreat.

It is anticipated that there will be no risks related to this study, including stress or adverse responses. In the unlikely event that a nurse-mentor experiences stress related to describing their recollections of mentoring children who face adversity, the participant will be referred to the college's Student Counseling Services- 718-260-5030 or the Brooklyn Center for Psychotherapy- 718-622-2000.

Participation in this study is voluntary, refusal to participate will involve no penalty or loss of benefits to which you are entitled and you may discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled. You are free to withdraw from the study at any time without prejudice.

Confidentiality will be maintained by assigning each participant a code and not using identifying information such as names. No identifying data will be published and anonymity will be maintained. When the nurse-mentors who agree to participate relate their stories in the Dream stage of AI, the children that are mentored will not be referred to by their real names; fictitious initials will be used. All hard copy research materials will be stored in a locked cabinet and any electronic files will be held on an encrypted secure server at the CUNY Graduate Center.

Call or e-mail Kathleen Falk if you have any inquiries concerning the goals of the research or the research procedures. She will also provide a summary of results upon request. For questions or concerns about research and research subjects' rights, call Angela Cartmell. In the event of a research-related injury to a subject, call or e-mail Angela Cartmell.

Kathleen Falk, Primary Investigator 718-916-0284; kfalk@citytech.cuny.edu

Angela Cartmell, College of Staten Island- Office of Research Protections 718-982-3867;

Angela.Cartmell@csi.cuny.edu

Your signature on this form indicates that you understood to your satisfaction the information about this research study and that you agree to participate in this research study.

_____ _____

Participant's Name Participant's Signature and Date

_____ _____

Primary Investigator Signature and Date

Appendix F

IRB Approval-CUNY Human Research Protection Program

The City University of New York

Human Research Protections Program

College of Staten Island (CUNY) HRPP Office

DATE:	June 19, 2012
TO:	Kathleen Falk, MS
FROM:	College of Staten Island (CUNY) HRPP Office
PROJECT TITLE:	[348077-1] Appreciative Inquiry to Transform Nursing Practice for Children of Promise
SUBMISSION TYPE:	New
Project ACTION:	
	APPROV
APPROVAL DATE:	June 19, 2012
EXPIRATION DATE:	June 18, 2013
RISK LEVEL:	Minimal Risk
REVIEW TYPE:	Expedited Review
REVIEW CATEGORY:	Expedited review category # *6&7*

Thank you for your submission of New Project materials for this project. The University Integrated IRB has APPROVED your research. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

Please remember that informed consent is a process beginning with a description of the project and assurance of the participant's understanding, followed by a signed consent form(s). Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require that each participant receives a copy of the consent document.

Please note that any modifications/changes to the approved materials must be **approved by this IRB prior to implementation.** Please use the appropriate modification submission form for this request.

All **UNANTICIPATED PROBLEMS (UPS)** involving risks to subjects or others, NON-COMPLIANCE issues, and SUBJECT COMPLAINTS must be reported promptly to this office. All sponsor reporting requirements must also be followed. Please use the appropriate submission form for this report.

This research **must receive continuing review and final IRB approval** before the expiration date of June 18, 2013. Your documentation for continuing review must be received with sufficient time for the IRB to conduct its review and obtain final IRB approval by that expiration date. Please use the appropriate continuation submission forms for this procedure. PLEASE NOTE: The regulations do **not** allow for any grace period or extension of approvals.

If you have any questions, please contact Angela Cartmell at 718-982-3867 or angela.cartmell@csi.cuny.edu. Please include your project title and reference number in all correspondence with this committee.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within the City University of New York's records.

The City University of New York

Human Research Protections Program

College of Staten Island (CUNY) HRPP Office

DATE:	August 7, 2012
TO:	Kathleen Falk, MS
FROM:	College of Staten Island (CUNY) HRPP Office
PROJECT TITLE:	[348077-2] Appreciative Inquiry to Transform Nursing Practice for Children of Promise
SUBMISSION TYPE:	
	Amendment/Modificatio
n ACTION:	APPROVED
APPROVAL DATE:	August 7, 2012
EXPIRATION DATE:	June 18, 2013
RISK LEVEL:	Minimal Risk
REVIEW TYPE:	Expedited Review
REVIEW CATEGORY:	Expedited review category #6 and #7

Thank you for your submission of Amendment/Modification materials for this project. The University Integrated IRB has APPROVED your research. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

Please remember that informed consent is a process beginning with a description of the project and assurance of the participant's understanding, followed by a signed consent form(s). Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require that each participant receives a copy of the consent document.

Please note that any modifications/changes to the approved materials must be **approved by this IRB prior to implementation.** Please use the appropriate modification submission form for this request.

All **UNANTICIPATED PROBLEMS (UPS)** involving risks to subjects or others, NON-COMPLIANCE issues, and SUBJECT COMPLAINTS must be reported promptly to this office. All sponsor reporting requirements must also be followed. Please use the appropriate submission form for this report.

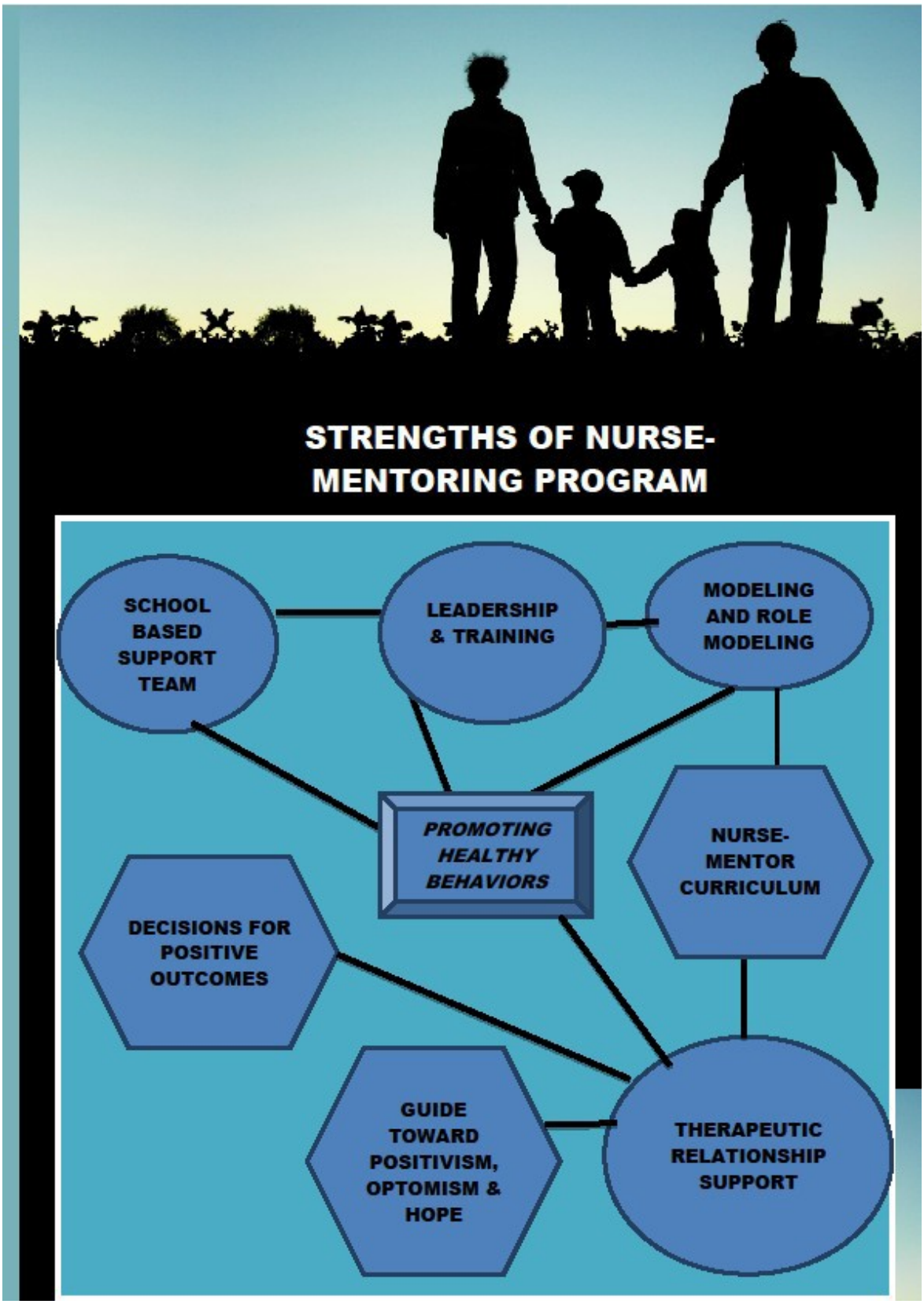
This research **must receive continuing review and final IRB approval** before the expiration date of June 18, 2013. Your documentation for continuing review must be received with sufficient time for the IRB to conduct its review and obtain final IRB approval by that expiration date. Please use the appropriate continuation submission forms for this procedure. PLEASE NOTE: The regulations do **not** allow for any grace period or extension of approvals.

If you have any questions, please contact Angela Cartmell at 718-982-3867 or Angela.Cartmell@csi.cuny.edu. Please include your project title and reference number in all correspondence with this committee.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within the City University of New York's records.

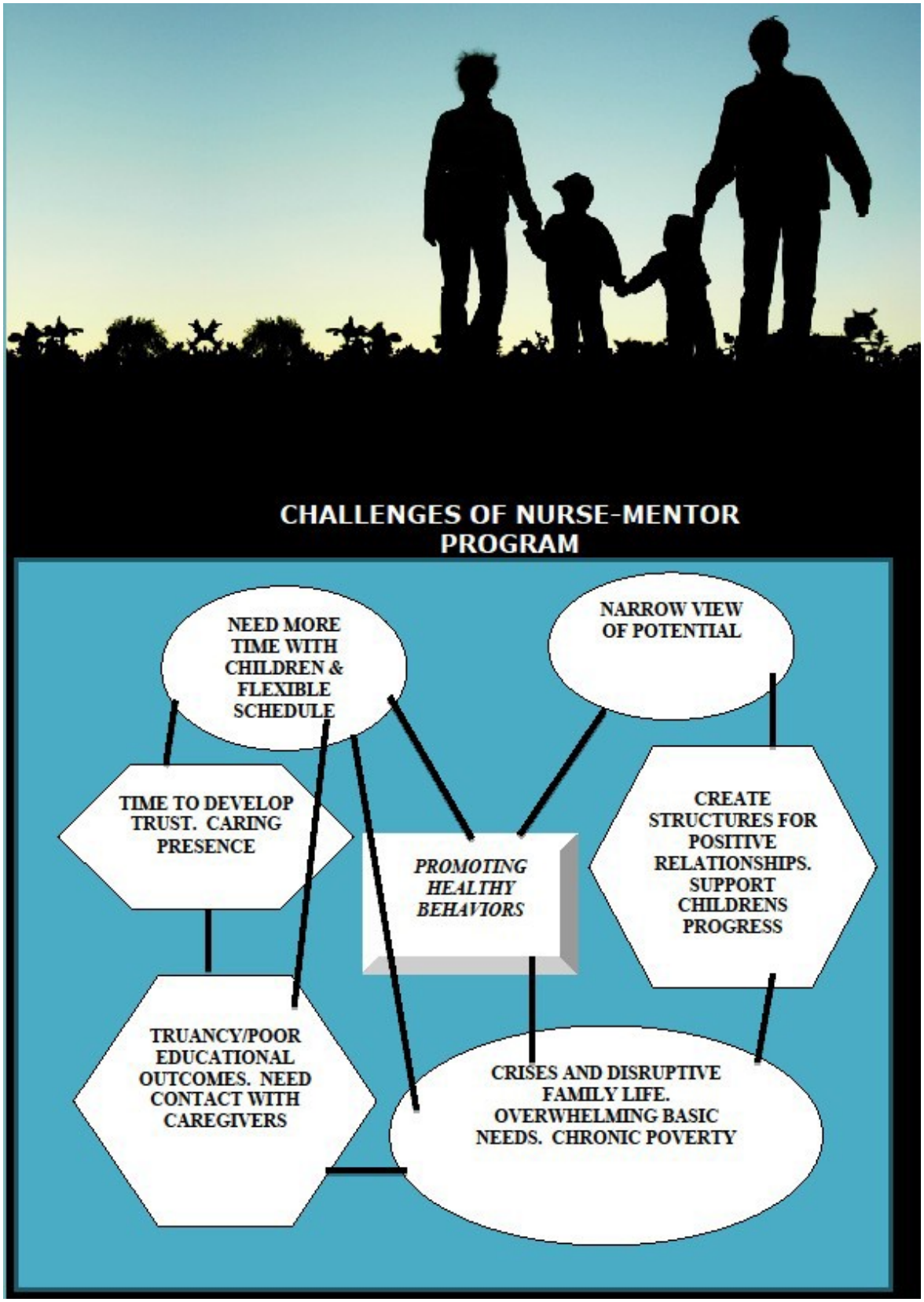
Appendix G

Strengths: Construct Mapping


STRENGTHS OF NURSE-MENTORING PROGRAM
SCHOOL BASED SUPPORT TEAM
LEADERSHIP & TRAINING
MODELING AND ROLE MODELING
PROMOTING HEALTHY BEHAVIORS
NURSE-MENTOR CURRICULUM
DECISIONS FOR POSITIVE OUTCOMES
GUIDE TOWARD POSITIVISM, OPTOMISM & HOPE
THERAPEUTIC RELATIONSHIP SUPPORT

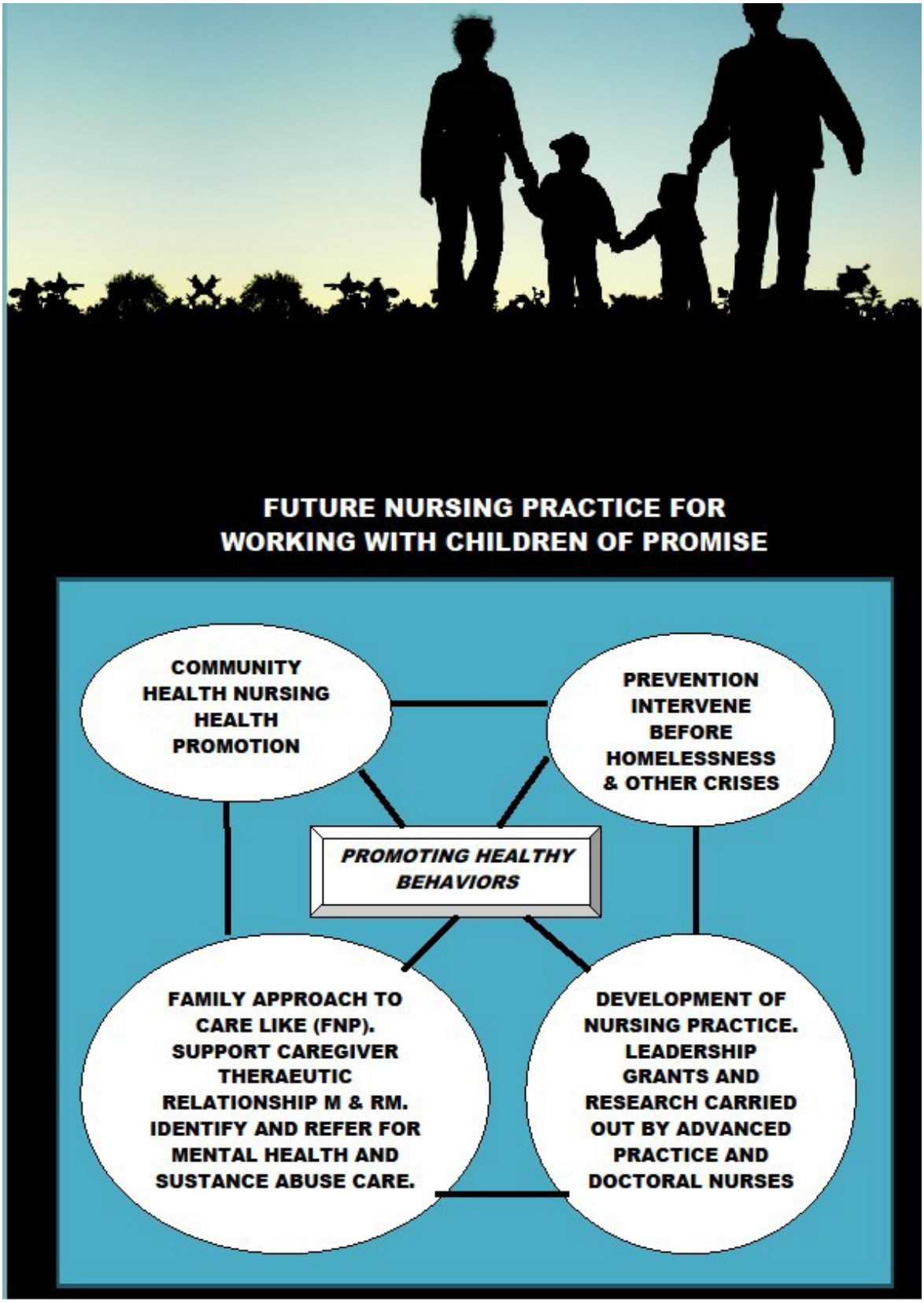
Appendix H

Challenges: Construct Mapping


CHALLENGES OF NURSE-MENTOR PROGRAM
NEED MORE TIME WITH CHILDREN & FLEXIBLE SCHEDULE
NARROW VIEW OF POTENTIAL
TIME TO DEVELOP TRUST. CARING PRESENCE
PROMOTING HEALTHY BEHAVIORS
CREATE STRUCTURES FOR POSITIVE RELATIONSHIPS. SUPPORT CHILDRENS PROGRESS
TRUANCY/POOR EDUCATIONAL OUTCOMES. NEED CONTACT WITH CAREGIVERS
CRISES AND DISRUPTIVE FAMILY LIFE. OVERWHELMING BASIC NEEDS. CHRONIC POVERTY

Appendix I

Future Practice of Nurses: Construct Mapping


FUTURE NURSING PRACTICE FOR
WORKING WITH CHILDREN OF PROMISE
COMMUNITY HEALTH NURSING HEALTH PROMOTION
PREVENTION INTERVENE BEFORE HOMELESSNESS & OTHER CRISES
PROMOTING HEALTHY BEHAVIORS
FAMILY APPROACH TO CARE LIKE (FNP). SUPPORT CAREGIVER THERAEUTIC RELATIONSHIP M & RM. IDENTIFY AND REFER FOR MENTAL HEALTH AND SUSTANCE ABUSE CARE.
DEVELOPMENT OF NURSING PRACTICE. LEADERSHIP GRANTS AND RESEARCH CARRIED OUT BY ADVANCED PRACTICE AND DOCTORAL NURSES

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