

**Establishing Guidelines for the Development of Quality
Clinical Experience in Mental Health within Bachelor
of Nursing Programs offered in Victoria**

Dr. Anthony Welch
A/Prof Lina Shahwan-Akl
Kana Intherarasa

ACKNOWLEDGEMENTS

We thank the Department of Human Services for the grant supporting this project. We also extend our appreciation to nursing academics, mental health nurses, clinicians, mentors and preceptors in Victorian mental health agencies, HACSU, and ANF who gave so generously of their time and participated in data collection. Without your support this project would not have been possible.

Copyright 2007 Material may not be reproduced without permission.

TABLE OF CONTENTS

1.0 BACKGROUND TO THE PROJECT	1
1.1 Introduction.....	1
1.2 Context of the Project	2
2.0 REVIEW OF LITERATURE	4
2.1 Mentoring as a Model for Teaching and Learning in the Clinical Practice Setting .	5
2.2 Preceptorship as a Model for Teaching and Learning in the Clinical Practice Setting	
2.3 Clinical Reflection and Journaling as a Model for Teaching and Learning in the Clinical Practice Setting.....	11
3.0 THEORETICAL FRAMEWORK INFORMING THIS PROJECT.....	13
3.1 Philosophic Perspectives of the Exploratory Methodology.....	13
3.2 The Exploratory-Descriptive Design for this Project	14
4.0 METHOD	14
4.1 Aim of the Project.....	14
4.2 Objectives	14
4.3 Key Stakeholders Involved in this Project.....	15
4.3.1 Mental Health Nurse Clinicians.....	15
4.3.2 Education Institutions and Professional Organisations	15
5.0 RECRUITMENT METHOD AND SAMPLE SIZE	16
5.1 Recruitment method.....	16
5.2 Sample size	16
6.0 DATA GATHERING	17
6.1 Information Analysis	18
6.2 Storage of Information	19
6.3 Ethical Considerations for this Project	19
6.3.1 Informed Consent.....	19
6.3.2 Confidentiality	19
6.3.3 Anonymity	19
7.0 PRESENTATION OF FINDINGS	20
7.1 Preamble	20
7.2 Current Mental Health Nursing Culture in Relation to the Provision of Quality Clinical Mental Health Placements for Students.	20
7.2.1 Discussion of findings.....	21
7.3 Facilitators and Barriers to Achieving Quality Mental Health Clinical placements for Students	23
7.3.1 Facilitators to achieving quality student clinical placements	23
7.3.2 Discussion of Findings.....	23
7.4 Barriers to achieving quality student clinical placements.....	24
7.4.1 Student attitudes.....	25
7.4.1.1 Discussion of Findings.....	25
7.4.2 Student cognition	25
7.4.2.1 Discussion of Findings.....	26
7.4.3 Student knowledge/skills development.....	26
7.4.3.1 Discussion of Findings.....	27

7.5 Ensuring Sustainability of Quality Clinical Student Placements.....	29
7.5.1 Organisational Structures.....	29
7.5.1.1 Contractual Arrangements Between Facilities.....	30
7.5.1.2 Centralised Statewide Approach to Clinical Allocation	30
7.5.1.3 Standardized Assessment Tools.....	31
7.5.1.4 Length of Clinical Placement.....	31
7.5.1.5 Education Qualifications and Preparation of Staff Involved in the Clinical Education of Students	31
7.5.1.6. Formal Acknowledgment by the Education Providers of the Crucial Role Played by Clinicians in the Provision of Quality Clinical Education of Students.....	32
7.5.1.7 Education processes to ensure sustainability of quality clinical mental health placements for students.....	32
7.5.1.8. Teaching and learning activities and resources for students to enhance their learning	34
8.0 RECOMMENDATIONS	35
8.1 Recommendations from the Literature	35
8.1.1 Clinicians engaged in providing educational support for students	36
8.1.2 Clinical facilities	37
8.1.3 Students on clinical placement.....	37
9.0 GUIDELINES FOR THE DEVELOPMENT OF QUALITY CLINICAL MENTAL HEALTH PLACEMENTS FOR STUDENTS UNDERTAKING A BACHELOR OF NURSING PROGRAM IN VICTORIA.....	38
10 CONCLUDING REMARKS.....	41
REFERENCES	42
APPENDICES	47
Appendix 1 Application for Ethics Approval of a Project Involving Human Participants.....	48
Appendix 2 Invitation to Participate in a Research Project	61
Appendix 3 Prescribed Consent Form For Persons Participating In Research Projects Involving Interviews, Questionnaires or Disclosure of Personal Information	65
Appendix 4 Participant Statements.....	67

LIST OF TABLES

Table 1: Number and employment location of participants invited to participate in the project.	16
Table 2: Participants invited to participate and the actual number of participants who actually took part in the project.	17

1.0 BACKGROUND TO THE PROJECT

1.1 Introduction

The aim of this exploratory-descriptive project was to develop guidelines for the effective delivery of mental health theory and practice within Bachelor of Nursing programs offered in Victoria. In recent times concerns have been raised by universities, the health care industry and, the Health and Community Services Union, Victoria (HACSU) concerning what is perceived to be inadequate preparation of graduate nurses to take on role as a beginning practitioner in mental health nursing. In addition, concern has been expressed with regard to the small number of nurses entering the mental health field after graduation. Furthermore, there is a growing dissatisfaction at the level of exposure in undergraduate student preparation to mental health nursing (theoretical content and quality clinical experience). This limited mental health exposure impacts on the decision of nurse graduates to pursue a career in this important area of professional nursing practice.

To be an effective mental health nurse clinician, requires both breadth and in-depth understanding of psychiatric nursing studies and contemporary practice which is consistent with the multi-faceted nature of contemporary psychiatric nursing delivery. Social, economic, political, and cultural influences impact on the health care system and the context in which mental health nursing is practiced. Therefore, if nurses are to make a substantive contribution to the provision of quality care within mental health speciality, their preparation must provide them with opportunities to develop their ability to analyse-synthesise new knowledge, and engage in critical self-reflection. This will assist graduate nurses to professionally improve and enhance their delivery of mental health services to all communities, and acquire a beginning ability to engage in scholarly debate with other health professionals.

To this end, the quality of student nurse education within the area of mental health (theory and practice) emerges as pivotal in the way students perceive and value the contributions of mental health nursing in the provision of care and treatment for people

with a mental illness. Research suggests that a positive clinical experience has the propensity to influence a student's decision about choice of a career pathway. In light of the diminishing numbers of graduates entering the field of mental health nursing, concern has been expressed about the type and quality of mental health education within nursing programs in Victoria.

In consideration of the abovementioned issues this project was undertaken with the financial support from the Department of Human Services, Victoria.

1.2 Context of the Project

In 2002 the Nurses Board of Victoria (Nurses Board of Victoria, 2002) released a discussion paper on the review of the mental health/psychiatric nursing component of the undergraduate nursing program. The paper agreed that current content and clinical experience specified in the undergraduate programs was not sufficient for beginning practice in this important area of nursing. The review panel identified a broad variation in the quantity and quality of both theory and clinical experience in mental health/psychiatric nursing in undergraduate Bachelor of Nursing programs offered in Victoria. The review panel made a number of recommendations to enhance the mental health content of undergraduate programs. Recommendations included the following:

1. Mental health/psychiatric nursing content be evident in each of the three years of undergraduate programs
2. A minimum of four weeks (20 days) clinical experience was to be specified for mental health/psychiatric nursing.
3. That all or part of the final clinical experience block be offered in the area of mental health/psychiatric nursing to facilitate consolidation of learning.

The discussion paper generated by the Nurses Board of Victoria (NBV) in 2002 put forward a number of recommendations which included the following:

1. That the Deans of Nursing undertake an extensive review of the clinical facilities available in Victoria for mental health/psychiatric nursing with the aim of

- developing a plan of action to ensure that all students receive quality clinical placements consistent with their theoretical preparation .
2. That each university has access to a well-developed educational program for clinical teachers/preceptors that focus on mental health/psychiatric nursing.
 3. That academics teaching in the clinical area have competency and recency of practice and, that processes are in place to ensure continuing competency and recency of practice.

Despite changes by education providers in addressing concerns of the NBV review panel, the problem of providing a specialist psychiatric/mental health nursing workforce remains. Post-graduate programs have been introduced as a measure to redress the deficiencies in undergraduate preparation. However, postgraduate programs were preparing graduates for beginning level practice in psychiatric/mental health nursing by default, rather than the desired specialist preparation. The content of undergraduate programs does not reflect the prevalence and complexity of mental health issues within the general population and the healthcare setting. Consistent with the apparent lack of theoretical content in undergraduate programs is the concern expressed by student nurses about their lack of preparation and subsequent inability to provide appropriate mental health care while on clinical placement resulting in negative attitudes toward the mentally ill reinforcing negative stereotyping. The literature has identified that existing 'comprehensive' nursing education programs continue to adhere to a central focus on medical-surgical nursing to the detriment of mental health nursing.

Since the introduction of 'comprehensive nursing programs' there has been a notable decline in the number of students choosing mental health nursing as a professional career. The reduction of numbers is not limited to Victoria but evident Australia wide. Therefore, creating a teaching and learning environment in which students are exposed to quality educational clinical experiences that facilitates the consolidation of theoretical knowledge through the application of such knowledge to the practice setting in personally meaningful ways is fundamental to attracting students into the field of mental health nursing.

2. REVIEW OF LITERATURE

Since the shift of nursing education from hospitals to universities the selection and availability of appropriate clinical placements has been the main focus of discussion and competition among Australian universities.

Accessing appropriate clinical placements is a challenge to all practice-based disciplines particularly nursing because of the sheer number of students who enroll in nursing programs. All university nursing students are required to undertake a set number of clinical hours within their Bachelor of Nursing program. At the end of each clinical placement students are expected to have reached a minimum level of clinical competence based on the Australian Nursing Council (ANCI) competency standards.

Clinical placements provide nursing students with opportunities to apply theory to practice. To date, student supervision has utilized a range of clinical education models including clinical teacher, preceptor, and mentor. Student supervision is undertaken by university academics, clinicians of the clinical facility, contracted registered nurses and nursing agencies. In light of the range of clinical models in current use and the apparent lack of clarity as to each model's effectiveness in facilitating student learning, a review of literature was undertaken to ascertain what is contemporary thought about what constitutes a best practice model for student supervision. The review targeted three models that are purported to be used in contemporary student clinical education – mentorship, preceptorship, and clinical journaling.

2.1 Mentoring as a Model for Teaching and Learning in the Clinical Practice Setting

In recent times the practice of mentoring as a vehicle for student learning within the clinical setting has received increasing attention from both academics and nurse clinicians working with undergraduate students.

There has, in the past, been some confusion over the definition of the term mentoring, primarily due to the United Kingdom using the term for what Australians refer to as preceptoring (Mills et al, 2005). Many authors have endeavored to define and discriminate between preceptoring and mentoring (Morle, 1990; Armitage and Burnard, 1991; Anforth, 1992; Madison, 1994; Lloyd Jones et al, 2001; Hayes, 2005; Mills et al, 2005). Some believe the two roles to be incompatible (Anforth, 1992), while others believe the two terms can be used interchangeably (Cope et al, 2000) as some ‘mentors’ also have the roles of preceptor (Earnshaw, 1995). There appears to be a raft of definitions of what constitutes the activity of mentoring without an agreed definition to reflect a common understanding (Earnshaw, 1995). In light of the level of disagreement about the term it has been suggested the preceptor model is more appropriate for student supervision and assessment because of clarity in definition and understanding of the term (Morle, 1990).

Concern has also been expressed regarding the increased push to use a mentoring model without consideration of its actual purpose (Morle, 1990). The role of mentor has been described as a transitional one – looking after students on clinical placement and providing guidance to new graduates as registered nurse (Madison, 1994; Armitage and Burnard, 1991). A number of authors have agreed that the role of mentor should involve providing counseling, guidance, advice, and socializing the student to clinical reality however, the mentor should have no involvement in the formal assessment of the student (Anforth, 1992; Lo and Brown, 2000; Chow and Suen, 2001; Lloyd Jones et al, 2001). The last point is a contentious one with considerable debate continuing about whether the role of mentor should be involved in student assessment (Morle, 1990).

However defined, the practice of mentoring is seen as a beneficial relationship with positive results for both the student and the mentor (Earnshaw, 1995). A study by Lloyd Jones et al (2001) explored the impact of time spent between mentor and student on effective learning. They examined diaries kept by both students and their mentors during clinical placement to ascertain how much contact occurred between student and mentor, and the type of student activities. The study highlighted the need for regular contact with the mentor as a lack of partnership has the potential to lead to poor learning experiences as a consequence of the student feeling 'in the way'. Hayes (2005) suggests the mentorship program can be more effective when students are given the opportunity to choose their own mentor.

Lloyd Jones et al (2001) found that students require regular contact with their named mentor for effective learning. Hayes (2005) suggests that as well as regular contact between student and mentor, continuity of supervision for an extended period of time enhanced student learning. Anforth (1992) suggests mentoring should be over a long period of time to enable the development of rapport between mentor and student. Cope et al (2000) supports the findings of Anforth (1992) in positing that students need time to become familiar with the ward environment and to develop a sense of professional confidence. He suggests further short clinical placements make it difficult for students to learn as they are limited to the role of observer with restricted opportunities to be actively involved in patient care.

Successful mentoring depends on appropriate preparation of both mentors and students (Lo, 2002). It has been recognized that support for mentors in the form of preparation for the role is essential (Chow and Suen, 2001). This may include making available a mentor guidebook which contains details of the student's prior learning, protocols governing clinical experience, synopsis of skills required and advice on planning their day (Lo and Brown, 2000). Students who have previously undergone the mentoring process have also suggested that mentors should have completed a formal mentoring course prior to undertaking the role which gives them details of the program the student is undertaking

which allows the mentor to engage in constructive questioning of clinical knowledge, promote reflection, and improve clinical competence (Cude and Edwards, 1998).

Lo (2002) evaluated the process of mentoring for second year nursing students. The placement did not include formal assessments, although general evaluation of clinical skills was undertaken at the end of the clinical experience. Mentors volunteered for the role and completed a formal workshop on the role of mentor prior to the placement. Students were allocated mentors and given flexibility in when to undertake the placement. A questionnaire on the mentoring experience was distributed to students for completion and return. The findings of the study indicated that mentors need support, guidance and educational incentives - workshops on research, stress management, conflict resolution and communication to continue in such a role (Lo, 2002; Lo and Brown, 2000). Cude and Edwards (1998) supports the findings of Lo (2002) and Lo and Brown (2000) in suggesting there is a need for mentors to make time during the first week of the program to discuss the purpose of the placement and the competencies the student wishes to complete. Defining the parameters and expectations of the clinical placement from both mentor and student perspectives suggests Chow and Suen (2001) is essential for student learning.

Bruce (2002) explored issues confronting students and mentors in clinical practice. The study was conducted in the United Kingdom. Findings of the study indicated that clinicians involved in clinical education of students had limited knowledge of current approaches to student education and emerging new terminology (e.g. evidence-based practice). Students were found to have unrealistic expectations of what nurses do. The students also felt that rather than being an observer they were at times used as 'cheap labour'. The findings of Bruce's (2002) study also indicated that students wanted mentors to be involved in setting realistic learning objectives, facilitate developing a strong relationship between mentor and student, and assisting the student to develop a realistic view of nursing through hands-on practice. Lo and Brown (2000) suggest the mentored student is more likely to be self-confident, independent, and willing to discuss their shortfalls and how to improve.

Wright (1990) traced the processes used to facilitate the implementation of a mentored elective placement for final year nursing students. The mentors were selected by nursing administration of each facility and inducted into the role through a formal program (a five-day workshop) conducted by the Nursing Faculty. Students were allocated to mentors whom they met prior to placement. Learning contracts were negotiated between the mentor and the student. A Faculty representative also visited the organisation weekly to support the mentors. Wright (1990) found that mentoring of final year nursing students was seen as positive by both mentor and student.

Lloyd Jones et al (2001) found that the quality of mentorship fell when staffing levels were low, as mentors felt they had insufficient time to provide appropriate mentoring due to time constraints. Clinicians engaged in mentoring students have also indicated that they required additional time and reduced workloads in order to mentor students in the appropriate manner (Lo and Brown, 2000). Cude and Edwards (1998) suggest that to alleviate time constraints and workload concerns students should be shared equally among mentors.

2.2 Preceptorship as a Model for Teaching and Learning in the Clinical Practice Setting

Preceptorship as a model for clinical teaching and learning has, in recent years emerged as one of the preferred approaches to facilitating student learning. The general consensus is that preceptoring greatly benefits student clinical learning (Ferguson, 1996). Preceptors generally find the experience intrinsically rewarding and remain educationally and professionally stimulated enhancing student clinical performance (Bain, 1996; Ellerton, 2003). Freiburger (2001) who conducted a study on preceptor education found that the preceptors viewed their experience as personally and professionally fulfilling. The students' response to the preceptoring program was encouraging, as demonstrated by positive feedback in their journaling. Following on from his initial study, Freiburger (2002) conducted a second study in which he monitored students who were preceptored

over a period of 90 hours. The findings of the study indicated that the preceptoring program achieved the stated outcome which was to promote increased self-confidence and improved clinical competency (Freiburger, 2002). Lillibridge (2006) explored levels of satisfaction and commitment of five nurses in a Baccalaureate Program in North Carolina (USA). The findings of the study identified common themes; making a difference, engaging in the process, accepting the role and taking responsibility. Each of the participants had a positive experience of preceptoring which outweighed the difficulties and frustrations of the position.

Conrick et al (2001) conducted a comparative study of three different models that facilitate learning in the clinical setting – external facilitator, internal facilitator and preceptored placement – based on feedback from the Senior Nurse Academic Forum in 1998. The findings of the study suggest that the use of the preceptorship model enhances student learning. However, research explicating the positive outcomes of the preceptorship model is limited. The vast majority of research on preceptorship is concerned with the negative impact on the preceptor and, to some extent, the student (Kaviani and Stillwell, 2000).

Bain (1996) suggests that preceptoring can be demanding especially in the face of high workloads, changing rosters, time constraints, and lack of peer support. A number of authors suggest that preceptors need to take precautions to avoid the risk of burnout because of the nature of the role and unrelenting demands of the clinical setting (Bain, 1996; Ellerton, 2003; Ballard and Trowbridge, 2004; Lillibridge, 2006). Ballard's and Trowbridge's (2004) study of undergraduate nursing students in a critical care rotation in their first semester of clinical experience utilizing the preceptorship model and drawing on the principles of adult learning and a learner-centred environment, found that preceptor burnout was an emerging problem due to insufficient numbers of preceptors, the intensive nature of the role and competing clinical demands.

A recurring theme in the findings of a number of studies was the need for preceptor support. What constitutes support was varied. Support from the education provider was

identified as a major issue for preceptors. Abdication of responsibility for student learning by the education provider and therefore, lack of support for the preceptor was raised as a significant impediment to preceptors continuing in their position (Ferguson, 1996). Kaviani and Stillwell (2000) suggest strongly that preceptors require ongoing support from the education provider. Support in the form of appropriate initial educational induction of the preceptor, Faculty accessibility, Faculty mentoring of the preceptor, and preceptor debriefing have been identified as fundamental to effective preceptoring (Ferguson, 1996). Collaboration between preceptors and the education provider in identifying student learning objectives and teaching and learning strategies to achieve student outcomes was identified as important in determining the quality of student learning and the level of preceptor support (Lillibridge, 2006). Collaboration between education providers, clinicians, and managers of the clinical facility provides a strong support base in reducing “reality shock” and bridging the gap between education and clinical practice, which in turn, promotes successful preceptoring (Bain, 1996; Kaviani and Stillwell, 2000; Conrick et al, 2001). Successful preceptoring also requires the clinician to be knowledgeable, clinically competent and willing to assume a preceptoring role (Bain, 1996) along with skill acquisition in teaching, identification of student learning needs, time management and ability to network (Kaviani and Stillwell, 2000)

An Australian grounded theory study conducted by Charleston and Happell (2005) explored the experience of preceptorship for undergraduate nursing students in mental health. Twenty undergraduate second year nursing students were recruited from a mental health service and divided into two groups of 10. Interviews were audio-taped and transcribed. The analysis of findings revealed the major core category as “coping with uncertainty”. Limitations to the study were that only one university and one mental health service were involved. The study did however provide some initial insight into the experience of preceptoring within mental health. The study concluded that preceptors are vital to student learning and the development of student clinical confidence. Overall, the literature is far from conclusive in determining the value of preceptorship as an effective model for student clinical teaching and learning.

2.3 Clinical Reflection and Journaling as a Model for Teaching and Learning in the Clinical Practice Setting

In the past three decades the process of clinical reflection as a potentially potent technique for enhancing personal insight and clinical competency has been widely discussed in the literature. Over-time the process of critical reflection has been increasingly advocated as a pedagogical activity through which “theory and practice are meaningfully integrated and thoughtful, intelligent, and careful practice is achieved” (Jensen and Joy, 2005, p. 139). Critical reflection involves cognitive, affective, cultural and socio-political reasoning directed toward change, self-awareness, personal growth, continuous professional improvement, and lifelong learning. Blake (2005) posits that clinical reflection aids the individual in discovering meaning, instilling values of the profession, making connections between the classroom and experience, and development of clinical thinking skills.

The ability to think critically, engage in self-examination and develop personal pathways to professional development can be achieved through the process of reflective practice. Chaves et al (2006) suggests that if reflection informs practice, the end result is that reflective learning, and ultimately health care, will be improved. The importance of critical reflection on practice is posted by the American Association of Colleges of Nursing (1998) in recommending that: coursework of clinical experiences should provide the graduate with the knowledge and skills to engage in self reflection and collegial dialogue about professional practice.

With increasing emphasis on learner-centered approaches to teaching and learning, the practice of critical reflection has emerged as an important pedagogy especially in an age of increasing complexity within the teaching-learning environment (Chaves et al, 2006). Making the shift from teacher-centered to learner-centered-learning has required that long held assumptions about the centrality of the teacher in the teaching and learning process is interrogated and new pedagogies examined for relevance and potential benefit to

contemporary education - in this instance, nursing and health care education (Diekelmann and Lampe, 2004).

Tanner (2006) suggests that clinical judgment is an essential skill for all health care professionals and further suggests that reflection on practice is critical for making sound clinical judgments. Sound clinical judgments involve the process of clinical reasoning - a deliberate process of generating alternative solutions to often diverse and complex client and family health care needs. The complexity of making a clinical judgment through engaging in a process of critical reflection enhances learning from experience - expanding and enhancing clinical knowledge (Tanner, 2006). To engage in critical reflection Tanner (2006) believes that it requires a responsible attitude, and a willingness to critically analyse and understand one's actions in relation to outcomes. Critical reflection on practice can be enhanced through the process of journaling which provides a way to reflect on what has been learned (Jensen and Joy, 2005).

According to Dymont and O'Connell (2003) journaling is an educational tool used to reflect on clinical-educational experiences in a concrete way, assisting the student to give structure to what has transpired in practice. Through the application of journaling to the teaching-learning experience (classroom education and clinical practice) enhancement of critical thinking, development of observational skills, integration of observations with theoretical knowledge, and improvement of students' writing skills can be enhanced. Journaling is particularly relevant for experiential teaching and learning situations in which students are required to engage in clinical problem-solving and decision-making. Reflective journaling therefore, when applied to the clinical setting has the potential to provide a strong nexus for clinical praxis - theory-practice-synthesis, and enhanced clinical competency.

3. THEORETICAL FRAMEWORK INFORMING THIS PROJECT

3.1 Philosophic Perspectives of the Exploratory Methodology

The method chosen for this consultancy was situated within the qualitative research paradigm, a form of naturalistic inquiry. Naturalistic inquiry is concerned with and reflects such values as subjectivity, uniqueness of the person, holism and interpretation as a means of explicating understanding. Naturalistic inquiry is a discovery-oriented approach to inquiry, the aim of which is to explore issues of concern in their 'natural' surroundings (Patton 2002). Within the context of naturalistic inquiry, the world and reality are seen as human constructs which cannot be considered and appreciated in isolation from their context (Patton 2002). From this perspective, reality is essentially constructed in the mind of individuals.

The epistemological goal within naturalistic inquiry is to explore and depict the 'truth' by asserting that peoples' perceptions shape their reality and give meaning to their world, their truth. The value of this process is about developing and presenting rich depictions of peoples' stories, coupled with the researcher's ability to facilitate the exploration and description of peoples' perceptions and expectations of an issue of concern. Therefore, a naturalistic methodology was considered by this consultancy team as the most suitable mode of inquiry for this project.

The selection of the most appropriate naturalistic methodology was informed by the aim of the project and the nature of the area for investigation. The correct choice of methodology for a particular study determines the credibility of that study and therefore, the value of the study's contribution to extant knowledge on the topic. In consideration of the aims of the project, an Exploratory-Descriptive Design (EDD) approach was chosen.

3.2 The Exploratory-Descriptive Design for this Project

The selection of an Exploratory-Descriptive Design (EED) for this project provides a ‘practical blend’ of techniques which draws on personal accounts, semi-structured interviews and focused groups in order to gain understanding of informants’ perspectives and expectations of a particular situation, in this instance, the provision of quality clinical experience for students undertaking a mental health clinical placement.

The EED approach relies on “rich, detailed, and concrete descriptions” [of the issue of concern] (Patton 2002, p. 438) and therefore, presents descriptions in a comprehensive summary in everyday language without rendering data in a highly abstract manner.

4. METHOD

4.1 Aim of the Project

To develop guidelines for the delivery of quality mental health clinical placements within Bachelor of Nursing programs offered in Victoria.

4.2 Objectives

1. To explore current workplace culture in relation to the provision of quality clinical mental health placements for students
2. Determine barriers and facilitators to realising quality clinical mental health placements for students
3. Identify resources (human and material) for sustainable quality clinical mental health placements.

4.3 Key Stakeholders Involved in this Project

Key stakeholders were drawn from industry, education and professional organizations representing mental health nursing.

4.3.1 Mental Health Nurse Clinicians

Mental Health Nurse Clinicians who were registered with the Nurse Board of Victoria (NBV) as a Division 3 or Division 1 nurse with endorsement as a mental health nurse and, who have been involved directly or indirectly in the clinical education of student nurses were invited to participate in the project. Respondents were drawn from Metropolitan and Rural Victoria. Nurse from the following categories of professional mental health nursing participated:

- RPN 2 (registered psychiatric nurse level 2)
- RPN 3 (registered psychiatric nurse level 3)
- RPN 4 (registered psychiatric nurse level 4)
- Clinical teachers/student mentors/student preceptors

4.3.2 Education Institutions and Professional Organisations

Education Institutions and Professional Organizations who participated in this project were:

- The Australian and New Zealand College of Mental Health Nurses
- Hospital and Community Services Union (HACSU)
- The Hospital Employees Federation (HEF)
- Mental Health Nurse Academics from Victorian Universities

5.0 RECRUITMENT METHOD AND SAMPLE SIZE

5.1 Recruitment method

The process of purposive sampling was utilized in this project for recruitment of participants. The intention in choosing to use this selection technique was to ensure persons who could provide substantive information about providing quality clinical placements took part in the project. As mentioned above participants were drawn from a range of facilities and different levels of service delivery.

5.2 Sample size

Table 1: Number and employment location of participants invited to participate in the project.

Registered Nurses working in the community	5
Registered Nurses working in the hospital setting	87
Nurse Academics	13
Total invited to participate	105

Table 1, provides a breakdown of the number of participants and their employment location who were invited to participate in this project. The majority of nurses were from the hospital sector - 83 % with University e 12% from Universities and 5% working in the community.

Table 2: Participants invited to participate and the actual number of participants who actually took part in the project.

Attended focus groups or interview	Opted to complete questionnaire in preference to attending focus groups	Completed and returned questionnaires	Total participants	% of participants from those invited
40	65	9	49	47%

Table 2, shows there were a total of 49 participants

(47% from a potential 105 invited to be part of the project. Of the questionnaires distributed to participants who indicated they were unable to participate in either individual or focus group workshops, 13.8 % were returned to the project team. Overall, the response rate was low despite being invited on three occasions. The reasons for the low response rate could be attributed to

1. Timing of the study
2. Competing priorities in terms of staff work loads and competing priorities
3. A National study on a similar topic
4. The Christmas period – a number of potential participants indicated that they were not available over this period of time.

6 DATA GATHERING

Participants were invited to attend either a focus group workshop, individual interviews or alternatively, to complete a questionnaire. Both the focus group workshops and individual interviews were taped-recorded and later transcribed in preparation for analysis. The questions generated for this project which gave focus to the data gathering process were:

1. How would you describe the current workplace culture in relation to providing quality clinical placements for students?
2. In relation to workplace culture what are the barriers and facilitators to realising quality clinical placements for students?

3. What needs to be in place to ensure sustainable quality clinical placements for students in relation to the following?

Structure

- University-clinical agency links and contractual affiliations
- Honouree appointments
- Clinical teaching arrangements within the facility
- Qualifications of staff
- Support infrastructure

Processes

- Timing of placements
- Teacher-student mix
- Lines of responsibility and role clarification
- Preparation for clinical teachers/preceptors/mentors/Buddy
- Student preparation for clinical practice by universities
- Appropriateness of clinical venues for knowledge acquisition and skill enhancement
- Evaluation – student, clinical teacher/preceptor/mentor/buddy, clinical venue, and education provider
- Teaching-Learning Activities for Students – clinical journaling and reflective practice
- Resources – physical, human, teaching-learning?

6.1 Information Analysis

Data was analyzed according to each of the questions which informed the interview process and framed the questionnaire. Data pertaining to each question was analyzed for common responses or themes. The process of explicating themes involved:

1. Multiple readings of each transcript by each member of the project team.
2. Each member of the project team documenting their individual findings
3. Convening a meeting of the project team to review each member's findings and to identify common themes across the project team.
4. Identifying quotes/responses from the focus groups, interviews, and questionnaires to include in the report as evidence of the presented findings.

6.2 Storage of Information

Throughout this project all information shared by participants was stored in a locked filing cabinet within a locked office of the principal project person. In accordance with the policy and procedures of RMIT University Human Research Ethics Committee, on completion of this project all information obtained from participants in the form of audio-transcriptions and questionnaire will be retained for storage for a period of five years. After which time, and in accordance with RMIT University policy for destruction of confidential information, the data will be destroyed.

6.3 Ethical Considerations for this Project

Ethics approval was sought and received from the Human Research Ethics Subcommittee of the School of Health Sciences, Science, Engineering, and Technology Portfolio, RMIT University.

6.3.1 Informed Consent

Participants were provided with a Plain Language Statement related to the project. Once participants agreed to be a part of this project formal written consent was obtained. The participants were advised that they could withdraw from the project at any time without prejudice.

6.3.2 Confidentiality

Participants were informed that all data pertaining to the project would only be available to the project team for the purpose of analysis and subsequent writing up of the report for the Department of Human Services, Victoria.

6.3.3 Anonymity

Participants were informed that no identifying information would be used in the final report of the project. As the majority of participants attended focus group workshops they

were informed that absolute anonymity could not be assured. Participants were asked to maintain confidentiality and not to disclose the identity of those attending the focus group workshops.

7 PRESENTATION OF FINDINGS

7.1 Preamble

The following is a presentation of findings explicated from this Descriptive-Exploratory investigation. Participant responses are discussed in relation to the list of questions which informed this Project. The findings are presented first in table format followed by discussion.

7.2 Current Mental Health Nursing Culture in Relation to the Provision of Quality Clinical Mental Health Placements for Students.

- The majority of clinicians enjoy and value having students on placement
- The need for students to have a positive clinical experience is acknowledged by clinicians as fundamental to the recruitment process
- Clinicians are generally prepared to invest time and energy to ensure student experiences are positive
- Mental Health facilities generally strive to provide a broad range of clinical experiences for students
- A minority of clinicians do not see the value of students who are preparing to work in mainstream nursing having a clinical placement in mental health
- Differing values, expectations, and level of commitment by clinicians results in tension between staff
- Being involved in the clinical education of students has the propensity to compromise patient care

- Being involved in the clinical education of students is a workload issue that needs to be addressed by management
- If you have positive leaders/senior staff the more positive the experience for students
- Staff attitudes determine the clinical culture
- A positive culture toward student learning is linked to staff who have undertaken post-graduate qualifications
- Reciprocity between clinical agencies and education institutions enhances clinician commitment to student learning.

7.2.1 Discussion of findings

The majority of mental health nurse clinicians enjoy and value being involved in creating an educational environment that facilitates student learning. Clinicians are cognizant of the importance of providing positive teaching and learning experiences for students in acquiring essential knowledge and skills for safe competent mental health practice. To this end, nurse clinicians generally are dedicated to the provision of quality clinical placements and therefore, invest significant time and effort to ensure that such a climate of teaching and learning is realized. Particular attention is given to providing students with a broad range of experiences within the constraints of the facility that reflects the diversity and complexity of contemporary mental health nursing practice.

Although the vast majority of nurse clinicians have taken a positive stance in providing quality clinical placements for student nurses, there is a minority of nurse clinicians who are reticent to take an active role in student learning which they purport removes them from what they believe is their primary responsibility – providing quality client management. Differences in values, expectations and level commitment to student teaching and learning has the propensity to create varying levels of tension and workload inequities within the facility. A number of mental health facilities faced with the challenge of creating a workplace culture in which all staff are committed to promoting student clinical learning have introduced a number of initiatives in the areas of staff

development, skill enhancement in working with students and, strengthening links with education providers. Each of these initiatives are expanded on later in the discussion of findings.

7.3 Facilitators and Barriers to Achieving Quality Mental Health Clinical placements for Students

7.3.1 Facilitators to achieving quality student clinical placements

- The need to further develop and maintain strong co-operative links between education providers and industry
- Commitment on the part of universities and clinical agencies to the provision of quality teaching and learning experiences for students
- Collaboration between education providers and clinical agencies in defining the teaching and learning experiences for students
- Appropriate and timely sequencing of theoretical content prior to clinical experience
- The delivery of specific content for safe practice prior to clinical experience
- Appropriate length of clinical placement to ensure application of theory to the practice setting
- Appropriate educational preparation of clinicians in working effectively with students
- Clinicians committed to student teaching and learning
- The use of appropriate models of teaching and learning for each clinical setting

7.3.2 Discussion of Findings

The need to develop and maintain strong co-operative and committed links between education providers and industry affiliations was considered fundamental to facilitating quality clinical mental health placements. A collaborative approach by education providers and industry in articulating clearly educational requirements for student learning, and the associated organizational structures and processes to achieve mutually agreed educational outcomes, was seen as essential in maximizing student learning opportunities. Appropriate sequencing of theory and practice was strongly supported.

Adequate theoretical preparation prior to exposure to the clinical setting was considered imperative for safe and meaningful clinical practice. Particular attention to symptomatology, mental health assessment, mental status examination, pharmacology – knowledge of drug use, contra-indications, and side effects, - the mental health act, risk assessment, interpersonal communication and parameters of professional conduct were considered essential for optimizing student learning and enhancing the delivery of quality client care.

The length of the clinical placement was identified as a crucial factor in facilitating student learning. Four to six weeks was deemed an appropriate length of time for the students to gain an appreciation of the work of the clinical agency, become familiar with organizational processes and protocols for the delivery of safe clinical practice, develop rapport with clients, become an active member of the team, and develop foundational skills in working with people with a mental illness.

Appropriate educational preparation of clinicians involved in student learning was highlighted as key to the provision of quality clinical experience. Clinicians with a strong theoretical background coupled with knowledge of curriculum content and assessment requirements by the respective education providers was viewed as imperative to creating an environment in which student learning is valued and actively supported.

The use of appropriate models of student teaching and learning within the clinical setting was also viewed as important in facilitating the learning experience of students. Careful consideration to the appropriate use of such models has the potential to enhance student learning and contribute to the quality of the clinical experience.

7.4 Barriers to achieving quality student clinical placements

Education preparation of students for exposure to the mental health clinical setting surfaced as a major area of concern for nurse clinicians. The overall lack of adequate preparation by universities in the educational domains of attitude, cognition and,

knowledge/skills development was raised as a fundamental flaw in the education process for undergraduate students.

7.4.1 Student attitudes

- Students view mental health clinical experience as unimportant to their program of learning
- Mental health clinical placements viewed as ‘a break from real nursing’
- Limited opportunities to learn
- Lack of motivation to learn
- Negative reaction of staff to negative attitudes of students

7.4.1.1 Discussion of Findings

In the domain of student attitudes a significant number of students undertaking a clinical placement in the area of mental health nursing viewed such experiences as unimportant to their learning and future career prospects and therefore, perceived such an experience an encumbrance to their clinical experience in medical and surgical nursing, the central focus of their studies. For some students undertaking a clinical placement in mental health was viewed as nothing more than ‘a break from real nursing’. Harboring such views gave rise to negative attitudes by students about the value of educational opportunities in the area of mental health as part of their undergraduate preparation for professional practice. Low levels of motivation by students to acquire knowledge and skills in working with people who have a mental illness were the subsequent results. Negative attitudes displayed by students during their clinical placement engendered feelings ranging from frustration through to disinterest in those clinicians involved in their clinical education resulting in non-motivational behaviors (lack of encouragement) to assist students in appreciating the need to learn about the importance of caring for people experiencing mental health concerns and/or living with mental illness.

7.4.2 Student cognition

- Clinical experience viewed by students as a hurdle rather than an opportunity for learning
- Students fear and apprehension about undertaking a mental health placement

- Negative attitudes by nurse academics to mental health nursing
- Negative attitudes by dissatisfied or disillusioned mental health clinicians

7.4.2.1 Discussion of Findings

For many students a placement in mental health engenders feelings of uncertainty, apprehension and/or, fear. Students who hold such feelings view their mental health clinical placement as a hurdle rather than an opportunity to learn. Their major objective is simply to ‘survive’ the experience with little consideration to enhancing their knowledge about mental illness and mental health nursing practice. Age and level of maturity/self-awareness were presented as important factors in how students viewed their clinical experience (in a positive or negative light). The more mature the student the less intimidating the clinical experience. Of interest to note was that the majority of students who had a background in mainstream nursing as a Certificate 1V nurse were open to new possibilities for career prospects in contradistinction to students who had direct entry to the program through VCE. Only a small number of VCE prepared students expressed interest in mental health issues and/or pursuing a career in mental health nursing. Student beliefs about mental health and mental health nursing appeared to emanate primarily from attitudes held by academic staff teaching into Bachelor of Nursing programs and reinforced by dissatisfied or disillusioned mental health clinicians.

7.4.3 Student knowledge/skills development

- Inadequate theoretical and skill acquisition preparation by the education providers
- Marginalised mental health content within the curriculum
- Emphasis on medical/surgical content to the exclusion of mental health content
- Lack of recognition by academics of the relevance of knowledge and skill acquisition in mental health nursing
- Timing of clinical placements in relation to theoretical preparation
- Limited access to appropriate clinical venues for quality experience
- Fluctuating staff workloads

- Rostering patterns
- Length of clinical placement
- Lack of appropriate preparation of clinicians to act as Mentors/Preceptors/Clinical Teachers
- Lack of theoretical knowledge by clinicians

7.4.3.1 Discussion of Findings

There was a general consensus that mental health content in Bachelor of Nursing programs offered by the various education providers was inadequate in preparing students for a positive, quality clinical placement. Mental health content was viewed as ‘squeezed in’ or marginalized rather than an important core component of curriculae. Emphasis on medical/surgical/high dependency nursing to the exclusion of mental health content was evident in the majority of undergraduate programs. Lack of recognition by academic staff (not holding qualifications in the area of mental health nursing) of the importance of mental health content for holistic nursing practice was considered to be a major factor in how students perceived the relevance of such content to professional practice.

Student preparation for mental health clinical placement was an issue of considerable concern. There was a general consensus that students were not adequately prepared for a mental health placement in terms of level of knowledge and skill acquisition for safe practice. Two areas of particular concern were the timing of clinical placements in relation to theoretical preparation and, the type of knowledge students require for safe practice. In respect of the timing of clinical placements, on many occasions students undertake clinical practicum with minimal theoretical preparation as a direct result of clinical venue availability.

Increasing competition for clinical access and limited capacity of clinical venues to accommodate student numbers have forced education providers to utilize available clinical times at either end of the academic semester/year. Utilization of these times

results in students either undertaking clinical experience with little theoretical preparation or, having a significant time lapse between theoretical delivery and clinical experience. In either situation students are deemed to be at a significant disadvantage to maximize learning opportunities and to consolidate theory with practice.

In relation to the type of knowledge required for safe clinical practice, students generally lacked specific knowledge of symptomatology and mental health assessment including mental status examination. Lack of skill in communicating effectively with staff and clients was also an issue of concern. In situations where students lack essential knowledge and skills for safe practice, clinicians felt the need to protect students by limiting access to unwell clients and/or protecting clients from over-exposure to student contact. In each circumstance student learning opportunities were restricted.

Fluctuating workloads, rostering patterns and, length of student clinical placement also impact on student learning and clinical skill acquisition. Fluctuating workloads of clinicians often dictated their availability in facilitating student learning and therefore, the quality of student clinical experience. Rostering patterns including annual leave of clinical staff involved in student supervision made it difficult to maintain continuity in student-staff allocation and therefore, consistency in clinical supervision. The length of clinical placements varied with universities. Clinical placements generally ranged from two to four weeks. There was general agreement that two weeks of clinical experience is essentially a token gesture which tendered to create confusion and negativity in the student and frustration in the clinician. Within a two week period the student is only beginning to feel sufficiently comfortable to take an active part in their own learning when the placement ends.

Lack of adequate preparation of clinicians to assume the role of clinical teacher/mentor/buddy/preceptor was sighted as a significant area of concern. Difficulty in providing appropriate preparation for clinicians to take an active role in student teaching and learning within the clinical setting was attributed to shortages of permanent staff, staff turn-over and, employment of agency nurses. Lack of knowledge of the theoretical

content of undergraduate programs, differing university clinical requirements and a range of student assessment processes/protocols/tools for clinical assessment were identified as additional barriers to effective student learning. Lack of knowledge by clinicians concerning theoretical/philosophical underpinnings of teaching and learning processes and their application to clinical practice was a noticeable deficit in preparing clinicians to assume a teaching role.

Rural Victoria has its unique raft of barriers to the provision of quality mental health clinical experiences for students. Apart from those mentioned above a recurring theme was the 'tyranny of distance' faced by students in order to access appropriate clinical venues. Traveling time was a major concern for students who felt significantly disadvantaged in respect of their teaching and learning because of the distance from home to the clinical facility and consequent level of tiredness. Because of the limited availability of clinical venues and competition between education providers from within Victoria and interstate students are often required to undertake clinical experience outside the academic year and outside their region - having to travel to Melbourne for clinical practicum.

7.5 Ensuring Sustainability of Quality Clinical Student Placements

7.5.1 Organisational Structures

Structures deemed necessary by clinicians for sustainability of quality clinical placements were the establishment of strong links between the health care industry and education providers. The term 'strong' was used by participants to emphasize the need for committed and enduring affiliations through which long-term planning and review processes can be achieved. A number of key points were raised by the clinicians in conceptualizing such a structure. Key points raised included:

- Contractual arrangements between facilities
- A centralized statewide approach to clinical allocation

- The introduction of standardized student assessment tools
- Appropriate length of clinical placement
- Education qualifications for clinicians involved in student clinical education
- Formal acknowledgment by the education providers of the crucial role played by clinicians in the provision of quality clinical education of students.
- Education processes for informing clinicians of curriculum content
- Supervision for staff involved in clinical education of students

7.5.1.1 Contractual Arrangements Between Facilities

The need to have continuing contractual arrangements between facilities was raised as pivotal for sustainable quality clinical placements. Such arrangements would be open to periodic review by each facility with the aim of addressing issues of concern and/or evolving anomalies. Timely negotiations for change to in-place arrangements was identified by clinicians as essential for continuity of clinical placements. Disruption to student learning occurs when existing contractual arrangements cease and new arrangements have yet to be finalized. In such circumstances student clinical practicums may be deferred or cancelled.

7.5.1.2 Centralised Statewide Approach to Clinical Allocation

With increasing competition between education providers for access to clinical venues, there is a growing need for a coordinated centralized approach to clinical placement allocation for undergraduate programs. The level of need by education providers to secure appropriate clinical placements coupled with increasing limitations on clinical access has resulted in some education providers negotiating exclusive rights to clinical venues. Such arrangements significantly impede access by other education providers. Competition between healthcare professional groups – medical students, physiotherapy students, and occupational therapy students etc – further reduce clinical access for student learning. A coordinated centralized approach to clinical allocation has the potential to

maximize clinical capacity while ensuring the provision of quality clinical placements is not compromised.

7.5.1.3 Standardized Assessment Tools

The need to set in place standardized clinical assessment tools was emphasized by clinicians. In view of the number of education providers accessing a clinical facility at any given time, each with their own aims, objectives, and assessment procedures for student clinical evaluation, clinicians expressed concern about the inherent difficulty in assessing student learning and level of clinical competency. Clinicians supported the development of a generic assessment tool for mental health clinical experience which they believe would strengthen the evaluation of student clinical competency – knowledge and skills – and significantly contribute to ensuring sustainability of quality clinical teaching and learning experiences for students.

7.5.1.4 Length of Clinical Placement

A minimum of two (2) weeks in acute settings or four (4) weeks in non-acute areas is required for students to acquire beginning knowledge and skills in working with clients experiencing mental illness. Furthermore, students should not be allocated a mental health placement until the second semester of year two of Bachelor of Nursing programs by which time the students have developed a level of maturity to benefit from such a clinical experience. A clinical placement in years two and three would provide opportunities for consolidation of theory to practice while providing students with a broader range of experiences in mental health nursing.

7.5.1.5 Education Qualifications and Preparation of Staff Involved in the Clinical Education of Students

Level of education and/or education preparation to undertake the role of clinical teacher/mentor/preceptor/buddy was considered by clinicians to be fundamental to

providing sustainable quality clinical experience for students. In terms of qualifications, staff should be required to hold either a Bachelor of Nursing or a Bachelor of Psychiatric Nursing with evidence of post-graduate qualifications or attendance at professional development opportunities provided either by the education providers and/or the health care facility. In addition, staff should have the opportunity to complete formal studies in teaching and learning whether provided by the education providers or the clinical facilities.

7.5.1.6. Formal Acknowledgment by the Education Providers of the Crucial Role Played by Clinicians in the Provision of Quality Clinical Education of Students

Formal recognition by education providers of the central role played by clinical staff involved in student clinical education is a significant motivator for attracting clinicians to take on education role and to encourage those committed to student education to continue in such a role. The lack of recognition of those working at the clinical coalface of student education appears to reinforce a sense of ‘them and us’ rather than promoting a collaborative collegial approach to advancing the profession through quality education of students. Establishing a formal structure for recognising the contributions of clinicians has the potential to enhance a collaborative approach to undergraduate nurse preparation, particularly in the area of mental health nursing. Such a structure could involve formal appointments at an Adjunct or honorary level for example. A number of the education providers have established such a structure. However, a universal approach to acknowledging the contributions of clinical staff should be considered.

7.5.1.7 Education processes to ensure sustainability of quality clinical mental health placements for students

Establishing education processes that facilitate sustainable quality mental health clinical placements was viewed by clinicians as both essential for student learning and in

promoting the profession of psychiatric nursing as a potential career pathway. Education processes cited by clinicians as central to achieving such outcomes include:

- Establishing and maintaining clear lines of communication between key personnel of the education provider and the clinical facility
- Opportunities for the clinical facility to have input into the appropriate level of theoretical preparation and skill acquisition prior to exposure to the clinical setting
- Ensure all clinicians involved in the education of students are provided with a working knowledge of curriculum content.
- Appropriate use of models for supervision of students
- Articulating teaching and learning processes required by both student and clinician to achieve designated student clinical learning outcomes.
- Educate students to act within the parameters professional conduct
- Collaboration in the evaluation of students - clinicians involved in student education, the clinical facility and preparation of students by the education provider

Establishment of clear lines of communication between key personnel of the education provider and the clinical facility will facilitate collaboration in planning and evaluating the quality of student clinical experiences. Implicit is the involvement of key clinician of the clinical facilities in determining student clinical objectives, processes for achieving the objectives and evaluating whether the student has achieved stated required outcomes. Evaluation of student clinical competence is essentially a tripartite process involving the clinical facility, the education provider and, the student. Therefore, all parties should have the opportunity to contribute to the development of the evaluation process to measure student learning outcomes.

A process for orienting clinical staff to undergraduate curriculae was deemed to be imperative in order to provide a framework for clinicians in assisting students in the application of theory to clinical practice in a meaningful manner. The program could either be delivered at the education facility or at the clinical venue. The orientation program should include an overview of the aims and objectives of the clinical placement, expectations of the clinical facility in facilitating student learning, theoretical content and

skill acquisition delivered by the education provider, process/es for student evaluation, procedures for unsatisfactory student performance and, lines of communication between facilities if and when required.

In view of the number of current models used to facilitate student teaching and learning within the clinical setting – clinical teacher, mentor, preceptor and, buddy – and the level of apparent confusion about what each model entails, education of clinical staff in the appropriate use of each approach needs to be undertaken. A collaborative approach between the education provider and industry partners was recommended by participants. If the appropriate use of such approaches to student clinical teaching and learning are to be sustainable in light of staff turnover, processes for on-going staff development in preparing new staff to be involved in the education of students needs to be set in place.

Involvement of clinicians in the theoretical preparation of students was raised as an important initiative in enhancing student learning and strengthening collaboration between education providers and industry. Involvement of clinicians in the delivery of theoretical content has the potential of bringing clinical reality into the classroom while providing students with currency of clinical practice issues and modes of intervention.

The need for students to act within the designated parameters of professional conduct was deemed by participants as essential for safe, student-competent practice. In view of the diversity and complexity of mental health practice settings, the appropriateness of clinical venues for student learning requires careful consideration by both the education providers and the clinical facilities.

7.5.1.8. Teaching and learning activities and resources for students to enhance their learning

A number of teaching and learning processes were identified by participants to assist students in achieving designated learning outcomes. Of particular note was the process of reflective practice. The use of reflective practice was considered by participants as an

effective means of encouraging students to develop skills in critical reflection which can then be utilized in evaluating their level of clinical competence – level of knowledge and skill acquisition - in relation to the established aims and objectives of the placement. The process of reflective practice could form the basis of the daily debriefing/tutorial session during which students are encouraged to discuss their experiences and insights of the day's clinical activities. However, inclusion of such an approach to debriefing and clinical review would require those involved in the supervision of students to have a sound working knowledge of such practices.

In addition to achieving the stipulated aims and objectives of the curriculum, students should be encouraged to set their own clinical objectives for each day. Such a practice assists students to focus on their own specific learning needs in combination with curriculum requirements.

Regular review of student performance and constructive feedback throughout the clinical placement was seen by participants as critical to student learning.

8.0 RECOMMENDATIONS

In order to propose appropriate guidelines for establishing quality clinical for students undertaking a mental health placement a review of recommendations from the literature was undertaken. The final recommended guidelines are a synthesis of literature findings and key suggestions from the participants of this project.

8.1 Recommendations from the Literature

The recommendations from the literature are divided into three categories:

- Clinicians engaged in providing educational support for students
- Clinical facilities providing clinical experiences for students
- Students undertaking clinical experience

8.1.1 Clinicians engaged in providing educational support for students

- Clinicians engaged in clinical educations of students to undertake a formal mentoring program prior to working with students. The program should include curriculum content, role and function of clinical teachers, skills in teaching, time management, and networking (Kaviani and Stillwell, 2000; Lo and Brown, 2000 ; Bruce , 2000, Kaviani and Stillwell, 2000).
- Mentoring should be over a long period of time to enable the development of rapport between the mentor and the student (Cope *et al*, 2000).
- Mentor guidebooks which contain details of students' prior learning, protocols governing clinical experience, synopsis of skills required and advice on planning daily clinical activities would enhance communication between mentor and student while facilitating quality teaching and learning student clinical experiences (Lo and Brown, 2000).
- Students to be included as a member of the treatment team as a means of providing a realistic view of nursing, improve student confidence, independence and time management skills (Lo and Brown, 2000).
- Set in place a liaison person who maintains strong links between the education provider and the clinical facility (Kaviani and Stillwell, 2000).
- Preceptors/mentors/clinical teachers/buddies to have ongoing support from both the education provider and the clinical facility (Kaviani and Stillwell, 2000).
- Provide preceptors/mentors/clinical teachers/buddies with incentives, to continue in their respective roles (Bain, 1996; Ellerton, 2003; Ballard and Trowbridge, 2004; Lillibridge, 2006).
- Take precautions to prevent burnout of clinicians involved in student clinical education (Bain, 1996; Ellerton, 2003; Ballard and Trowbridge, 2004; Lillibridge, 2006).

- Preceptor/mentor/clinical teacher/buddy selection to be based on level of professional knowledge, clinical competence, willingness to participate, skills in teaching, ability to prioritise/time management, and networking (Kaviani and Stillwell, 2000).

8.1.2 Clinical facilities

- Monitor clinicians in respect of high workloads, rostering, availability of time for student education and level of peer support to prevent professional burnout (Kaviani and Stillwell, 2000).

8.1.3 Students on clinical placement

- Students to be treated as partners in providing patient care (Cude and Edwards, 1998; Hayes, 2005).
- Students to have regular contact with their named preceptor/mentor/clinical teacher/buddy for effective learning opportunities (Lloyd Jones *et al*, 2001).
- Where possible students to remain with the same preceptor/mentor/clinical teacher/buddy to enhance learning, develop high levels of professional conduct and social confidence (Hayes 2005).
- Students to be given appropriate time to become comfortable and familiar with the clinical environment as a prelude to learning (Anforth, 1992).
- Rationalisation of clinical objectives, required clinical skills, assessment tools or instruments across education providers as a means of facilitating consistency of assessment in determining student learning outcomes (Anforth, 1992).

9.0 GUIDELINES FOR THE DEVELOPMENT OF QUALITY CLINICAL MENTAL HEALTH PLACEMENTS FOR STUDENTS UNDERTAKING A BACHELOR OF NURSING PROGRAM IN VICTORIA.

The following guidelines which emanated from a review of literature and the findings of this project have been developed. The guidelines are formatted in the following sequence: presented in this section of the project will be divided into two sections:

1. Guideline Statement
2. Guideline Details

GUIDELINE STATEMENT	GUIDELINE DETAILS
<p>Guideline 1 Commitment by the respective organizations to work collaboratively in providing quality student learning experiences.</p>	<p>Mutually agreed contractual arrangements that stipulate the following:</p> <ol style="list-style-type: none"> a). Lines of communication between key personnel. b). Clear delineation of roles and responsibilities between facilities c). Mutually agreed structures and processes for student teaching and learning; <ol style="list-style-type: none"> i. staff-student ratio ii. model/s of teaching and learning to be used iii. selection process of clinicians iv. educational preparation of clinicians v. student assessment protocols vi. protocols for evaluating student preparation by the education provider, quality of student clinical teaching-learning and, the suitability of the clinical venue for student learning vii. Processes for conflict resolution

<p>Guideline 2 Commitment by the respective organizations to a continuing relationship in the provision of quality clinical placements for students.</p>	<p>Contractual arrangements need to be on-going with minimal change from year to year to facilitate projected planning and reduce peaks and troughs in accessing clinical venues.</p>
<p>Guideline 3 A centralized approach to the coordination of clinical placement allocation to reduce the possibility of exclusivity and to maximize clinical capacity.</p>	<p>A centralized approach to clinical venue access has the potential to reduce/eliminate the possibility of exclusivity clinical access while maximizing clinical capacity. If such an approach is beyond the realms of possibility because of the complex nature of clinical coordination Statewide, an alternative is a regional approach to clinical placement allocation.</p>
<p>Guideline 4 Standardisation of clinical assessment tools to determine student clinical competency.</p>	<p>A common assessment tool would address the following:</p> <ol style="list-style-type: none"> 1. Aims and objectives to be achieved 2. Assessment format identifying key areas to be evaluated 3. Strategies for formative and summative assessment. 4. Processes for learning remediation if required.
<p>Guideline 5 Stipulated level of education qualifications and assessment of knowledge and skill competency.</p>	<p>Clinicians involved in clinical teaching and learning of students should demonstrate:</p> <ol style="list-style-type: none"> 1. Registration as a Division 3 nurse with the Nurses Board of Victoria or 2. Registration as a Division 1 nurse with endorsement as a mental health nurse with the Nurses Board of Victoria. 3. Hold a degree in nursing or mental health nursing and/or 4. Hold post-graduate qualifications in mental health nursing. 5. Demonstrated commitment to ongoing professional development.
<p>Guideline 6</p>	<p>Clinicians need to have a working knowledge of the</p>

<p>Education providers and/or clinical facilities to provide formal educational opportunities for clinicians to develop a sound working knowledge of what constitutes student clinical education.</p>	<p>following:</p> <ol style="list-style-type: none"> 1. Philosophical underpinnings of the curriculum. 2. Aims and Objectives of the clinical placement 3. Mental health content specific to the clinical placement. 4. Mode/s of assessment and assessment requirements 5. The specific role and the associated responsibilities which the clinician will be undertaking – clinical/teacher/preceptor/mentor/buddy. 6. Theory of teaching and learning relevant to the clinical setting. 7. Critical incident and conflict management procedures.
<p>Guideline 7 Establish strong links between the education provider and the respective clinical facilities/s through shared input into theoretical delivery of program content.</p>	<p>A collaborative approach to the delivery of theoretical content offered by the education provider has the potential to enhance the quality of education for students by bringing clinical reality into the classroom. Education/Industry collaboration in this respect can be achieved by:</p> <ol style="list-style-type: none"> 1. Joint appointments 2. Sessional lecturing by clinicians 3. Education providers involved in in-service education within the clinical facilities for staff and students. 4. Reconfiguring existing patterns of theory/clinical delivery to incorporate theory delivery in the clinical setting.
<p>Guideline 8 Have in place a process by which clinicians engaged in clinical education of students receive formal recognition for their contributions.</p>	<p>Clinicians could be recognized by one of the following:</p> <ol style="list-style-type: none"> 1. Certificate of Recognition 2. Honouree position 3. Access to resources of the education provider – the library, research and education consultation etc. 4. Opportunities to attend classes on an informal basis without cost.
<p>Guideline 9 A comprehensive evaluation</p>	<p>Evaluation of the clinical experience of students need</p>

<p>of students' clinical experience needs to be undertaken at the completion of each clinical rotation or at the end of each academic semester.</p>	<p>to be a tripartite process involving the following:</p> <ol style="list-style-type: none"> 1. Evaluation of the quality and appropriateness of student preparation. 2. Evaluation of the clinician/s working with students in an educative role. 3. Evaluation of the clinical venue as a suitable clinical experience placement. <p>The evaluation process must involve students, clinicians, key organizational personnel from both the education provider and the clinical facility/s involved in the planning and implementation of student teaching and learning clinical experiences.</p>
<p>Guideline 10 Appropriate theoretical preparation of students prior to exposure to the clinical setting.</p>	<p>Theoretical content prior to clinical placement should include;</p> <ol style="list-style-type: none"> 1. Symptomatology 2. Health Assessment 3. Mental Status Examination 4. Pharmacology

10. CONCLUDING REMARKS

The findings of this project clearly indicated that there is still considerable confusion about what constitutes the most appropriate means of providing quality mental health clinical placements for students undertaking Bachelor of Nursing programs in Victoria. The above guidelines have been extrapolated from a review of contemporary literature and the contributions of participants in this project. It is the belief of the project team that the developed guidelines will provide a much needed framework for both education providers and clinical facilities in the provision of quality clinical experiences for students. In view of the continuing lack of clarity in this area further research is required.

REFERENCES

- ABS. (2002). *Australian Trends- Australian Bureau of Statistics*: Australian Government.
- Anforth, P. (1992). Mentors, Not Assessors. *Nurse Education Today*; 12, pp 299-302.
- Armitage, P. and Burnard, P. (1991). Mentors or Preceptors? Narrowing the Theory-Practice Gap. *Nurse Education Today*; 11, pp 225-229.
- Bain, L. (1996). Preceptorship: A Review of the Literature. *Journal of Advanced Nursing*; 24(1), pp 104-107.
- Ballard, P. and Trowbridge, C. (2004). Critical Care Clinical Experience for Novice Students: Reinforcing Basic Nursing Skills. *Nurse Educator*; 29(3), pp 103-106.
- Barnard, A. G., & Dunn, S. V. (1994). Issues in the organization and structure of clinical education for undergraduate nursing programs. *Journal of Nursing Education*, 33(9), 420-422.
- Blake, T.K. (2005) Journaling: An Active Technique. *International Journal of Nursing Education Scholarship*. 2(1 Article 7.
- Bruce, C. (2002). Placement Blues. *Nursing Times*; 98(17), pp 24-26.
- Charleston, R. and Happell, B. (2005). Coping With Uncertainty Within the Preceptorship Experience: The Preceptorship of Nursing Students. *Journal of Psychiatric and Mental Health Nursing*; 12, pp 303-309.
- Chaves, J.F., Baker, C. M., Chaves, J. A., Fisher, M.L. (2006) New Pedagogies and New Possibilities. *Journal of Nursing Education*. 45 (1) Health Module pp 25-31.
- Chow, F. L. W. and Suen, L. K. P. (2001). Clinical Staffs as Mentors in Pre-Registration Undergraduate Nursing Education: Students' Perceptions of the Mentors' Roles and Responsibilities. *Nurse Education Today*; 21, pp 350-358.
- Conrick, M., Lucas, N. and Anderson, A. (2001). Undergraduate Clinical Education in the "Real World". *The Australian Electronic Journal of Nursing Education*; 7, pp 2.
- Cope, P., Cuthbertson, P. and Stoddart, B. (2000). Situated Learning in the Practice Placement. *Nursing*; 31(4), pp 850-856.

- Clinton, M., & Hazelton, M. (2000). *Scoping study of the Australian mental health nursing workforce. Final report. Report of the Australian and New Zealand College of mental Health nurses Incorporated to the Mental Health Branch of the Commonwealth Department of Health and Aged Care.* Australia.
- Cude, S. and Edwards, J. (1998). The Nature of Nurture. *Nursing Times*; 94(40), pp 66-67.
- Dickson, C., Walker, J., & Bourgeois, S. (2006). Facilitating Undergraduate Nurses Clinical Practicum: The Lived Experience of Clinical Facilitators. *Nurse Education Today*, 26, 416-422.
- Diekelmann, N. (2004). Experienced Practitioners as New Faculty: new Pedagogies and New possibilities. *Journal of Nursing Education*. 43 (3), Health Module, pp 101-1-3.
- Diekelmann, N., and Lampe, s. (2004). Student-centered Pedagogies: Co-creating Compelling Experiences Using the New Pedagogies. *Journal of Nursing Education*. 43(6) , Health Module, pp 245-247.
- Dyment, J.E., and O'Connell, T.S. (2003) . Journal Writing in Experiential Education: Possibilities, Problems and Recommendations. *ERIC Digest. ERIC Clearinghouse on Rural Education and Small Schools*. <http://www.ericdigests.org/2005-2/journal.html>
- Earnshaw, G. J. (1995). Mentorship: The Students' View. *Nurse Education Today*; 15, pp 274-279.
- Ellerton, M. (2003). Preceptorship: The Changing Face of Clinical Teaching. *Nurse Educator*; 28(5), pp 200-201.
- Er4klenz-Watts, M., Westbay, T., and Lynd-Balta, E. (2006). An Alternative Professional Development Porgram: Lessons Learned. *College Teaching*; 54 (3) pp.275-279.
- Farrell, G., Pearson, A., & Roberts, K. (2002). The Challenges in Providing Quality Clinical Education for Undergraduate Nursing. *Collegian*, 9(2), 6-7 & 9.
- Ferguson, L. (1996). Preceptors' Need for Faculty Support. *Journal of Staff Development*; 12(2), pp 73-80.

- Freiburger, O. (2001). A tribute to Clinical Preceptors. Developing a Preceptor Program for Nursing Students. *Journal for Nurses in Staff Development*; 17(6), pp 320-327.
- Freiburger, O. (2002). Preceptor Programs. Increasing Student Self-Confidence and Competency. *Nurse Educator*; 27(2), pp 58-60.
- Grealish, L. and Carroll, G. (1998). Beyond Preceptorship and Supervision: A Third Clinical Teaching Model Emerges for Australian Nursing Education. *Australian Journal of Advanced Nursing* ; 15(2), pp 3-11.
- Guba, E., & Lincoln, Y. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.
- Hall, L. (1997) Mentoring Relationships of New Zealand Nurses: An Empirical Study (Part 1). *Collegian*; 4(4), pp 28-31.
- Happell, B. (2006 a). Psychiatric/Mental Health Nursing Education in Victoria, Australia: Barriers to Specialization. *Archives of Psychiatric Nursing*, 20(2), 76-81.
- Happell, B. (2006 b). Nursing Clinical Development Units - A Strategy to Promote the Relationship Between Practice and Academia. *The International Journal of Psychiatric Nursing Research*, 11(3), 1322-1330.
- Hayes, E. (2005). Approaches to Mentoring: How to Mentor and Be Mentored. *Journal of the American Academy of Nurse Practitioners*; 17(11), pp 442-445.
- Heidegger, M. (1962). *The Basic Problems of Phenomenology*. Bloomington: Indiana University Press.
- Heims, M. L., & Boyd, S., T. (1990). Concept-based learning activities in clinical nursing education. *Journal of Nursing Education*, 29(6), 249-254.
- Henderson, A. J., Forrester, K., & Heel, A. (2006). The establishment of structures and processes for the safe and effective clinical placement of nursing students. *Nurse Education in Practice*, 6, 275-280.
- Henderson, A., Twentymann, M., Heel, A. and Lloyd, B. (2006). Students' Perception of the Psycho-Social Clinical Learning Environment: An Evaluation of Placement Models. *Nurse Education Today*.
- Husserl, E. (1965). *Phenomenology and the Crisis of Philosophy*. New York:: Harper and Row.

- Jensen, S.K., and Joy, C. (2005). Exploring a Model to Evaluate Levels of Reflection in Baccalaureate Nursing Students' Journals. *Journal of Nursing Education*; 44(3); Health Module, pp 139-142.
- Kaviani, N. and Stillwell, Y. (2000). An Evaluative Study of Clinical Preceptorship. *Nurse Education Today*; 20, pp 218-226.
- Lillibridge, J. (2006). Using Clinical Nurses as Preceptors to Teach Leadership and Management to Senior Nursing Students: A Qualitative Descriptive Study. *Nurse Education Today*.
- Lloyd Jones, M., Walter, S. and Akenhust, R. (2001). The Implications of Contact with the Mentor for Preregistration Nursing and Midwifery Students. *Journal of Advanced Nursing*; 35(2), pp 151-160.
- Lo, R. (2002). Evaluation of a Mentor-Arranged Clinical Practice Placement for Students. *Collegian*; 9(2), pp 27-32.
- Lo, R. and Brown, R. (2000). A Clinical Teaching Project – Evaluation of the Mentor-Arranged Clinical Practice by RN Mentors. *Collegian*; 7(4), pp 8-13.
- Madison, J. (1994). Mentors and Preceptors in the Nursing Profession. *Contemporary Nurse*; 3(3) pp 123-126.
- McErlane, K. (2006). Managing Conflict in the Clinical Setting: A Case Scenario. *Journal of Nursing Education*. 45(40), Health Module, p .142.
- McKenna, L., & Wellard, S. J. (2004). Discursive Influences on Clinical Teaching in Australian Undergraduate Nursing Programs. *Nurse Education Today*, 24, 229-236.
- Merleau-Ponty, M. (1956). What is phenomenology? *Cross Currents*, 6, 59-70.
- NBV. (2002). *Nurses Board of Victoria ; Review Of Mental Health/Psychiatric Nursing Component Of The Undergraduate Nursing Program: Discussion Paper*. Melbourne, Victoria.
- Mills, J. E., Francis, K. L. and Bonner, A. (2005). Mentoring, Clinical Supervision and Preceptorship: Clarifying the Conceptual Definitions for Australian Rural Nurses. A Review of the Literature. *Rural and Remote Health*; 410, pp 1-10.
- Morle, K. M. F. (1990) Mentorship – Is It a Case of the Emperors New Clothes or A Rose By Any Other Name? *Nurse Education Today*; 10, pp 66-69.

- O'Donovan, M. (2006). Reflecting during clinical placement - Discovering Factors that Influence Pre-registration Psychiatric Nursing Students. *Nurse Education in Practice*, 6, 134-140.
- Patton, M.Q. (2002). *Qualitative Research and Evaluation Methods*. 3rd ed. California: Sage Publications, Inc.
- Reimer Kirkham, S., Hoe Harwood, C., & Van Hofwegen, L. (2005). Capturing a Vision for Nursing. Undergraduate Nursing Students in Alternative Clinical Settings. *Nurse Educator*, 30(6), 263-270.
- Rice, P. L., & Ezzy, D. (1999). *Qualitative Research Methods - A Health Focus*. South Melbourne, Australia: Oxford University Press.
- Royal College of Nursing Australia (2004). Mentor Registration Package – Australian Government Rural and Remote Scholarship Program; Undergraduate Scheme.
- Solomon, R. C. (2001). *Phenomenology and Existentialism*. New York: Rowman and Littlefield.
- Stuhlmiller, C. (2005). Re-thinking Mental Health Nursing Education in Australia: A Case for Direct Entry. *International Journal of Mental Health Nursing*. 14, 156-160.
- Tanner, C.A. (2006) Thinking Like A Nurse: A Research-Based Model of Clinical Judgment in Nursing. *Journal of Nursing Education*. 45(60), pp204-212.
- Taylor, S. J., & Bogdan, R. (1989). *Introduction to Qualitative Research Methods: The Search for Meanings*. New York: John Wiley & Sons.
- Van Kaam, A. (1966). *Existential Foundations of Psychology*. Pittsburgh: Duquesne University Press.
- Van Manen, M. (1990). *Research Lived Experience: Human Science for an Action Sensitive Pedagogy*. Ontario: University of Western Ontario.
- Van Rhyn, W. J., & Gontsana, M. R. (2004). Experiences by Student Nurses During Clinical Placement in Psychiatric Units in a Hospital. *Curationis*, 27(4), 18-27.
- Warelow, P., & Edward, K. (2007). Evidence-Based Mental Health Nursing in Australia: Our History and our Future. *International Journal of Mental Health Nursing*, 16, 57-61.
- Wright, C. M. (1990). An Innovation in a Diploma Program: The Future Potential of Mentorship in Nursing. *Nursing Education Today*; 10, pp 355-359.

APPENDICES

Appendix 1: Application for Ethics Approval

Appendix 2: Invitation to Participate in a Research Project

Appendix 3: Consent Form

Appendix 1

Application for Ethics Approval of a Project Involving Human Participants

No handwritten applications can be accepted. This form is available from:
<http://www.rmit.edu.au/rd/hrec>

Section A: Approvals and Declarations

Project No:

Project Title: Establishing guidelines for the effective delivery of mental health theory and practice within Bachelor of Nursing programs offered in Victoria.

Research Degree	Staff Research Project
Complete this column if you are undertaking research for a research degree at RMIT or another university (Masters by Research/PhD)	Complete this column if your research is not for any degree.
Investigator	Principal investigator
Name: <i>(family name to be underlined)</i> Student No: Qualifications School: Address: Phone: Email Degree for which Research is being undertaken:	Name: Dr Anthony Welch Qualifications: PhD; M. Ed; Grad Dip, Counselling; Grad Dip Appld Sc (N. Ed); B. Ed; RN; RPN. School: Nursing Queensland University of Technology Phone: 07-31383878 Email: anthony.welch@qut.edu.au
Senior Supervisor	Other investigator/s
Name: Qualifications: School: Phone: Email:	Name/s: Associate Professor Lina Shahwan-Akl Qualifications: RN; B.N; M.N; PhD School: Health Sciences Phone: 99257443 Email: lina.shahwan-akl@rmit.edu.au Name/s: Ms Kana Intherarasa

	Qualifications: M. Ed; B. A;BN. School: Health Sciences Phone: 99257606 Email: kana.intharasa@rmit.edu.au
--	--

Add additional rows as required for additional co-investigators.

Declaration by the Investigator/s:

I/We have read the current NH&MRC National Statement on Ethical Conduct in Research Involving Humans 1999, and accept responsibility for the conduct of the research detailed in this application in accordance with the principles contained in the National Statement and any other conditions laid down by the RMIT Human Research Ethics Committee.

Name: _____ Date: 14/01/2007

 (Signature of Principal Investigator)

Name: _____ Date: 14/01/2007

 (Signature of Co-Investigator)

Name: _____ Date: 14/01/2007

 (Signature of Co-Investigator)

Name: _____ Date: _____

 (Signature of senior supervisor if applicable)

Copy, paste and complete additional signature boxes to enable all co-investigators to sign.

Declaration by the Head of School:

The project set out in the attached application, including the adequacy of its research design and compliance with recognised ethical standards, has the approval of the School. I certify that I am prepared to have this project undertaken in my School/Centre/Unit.

Name: _____ Date: 14/11/2006

 (Signature of Head of School or approved delegate)

School/Centre: Division of Nursing and Midwifery, School of Health Sciences Extn: 57744

Section A: Approvals and Declarations

Project No:

Project Title: Establishing guidelines for the effective delivery of mental health theory and practice within Bachelor of Nursing programs offered in Victoria.

Research Degree	Staff Research Project
Complete this column if you are undertaking research for a research degree at RMIT or another university (Masters by Research/PhD)	Complete this column if your research is not for any degree.
Investigator	Principal investigator
Name: <i>(family name to be underlined)</i> Student No: Qualifications School: Address: Phone:	Name: Dr Anthony Welch Qualifications: PhD; M. Ed; Grad Dip, Counselling; Grad Dip Appld Sc (N. Ed); B. Ed; RN; RPN. School: Nursing Queensland University of Technology Phone: 07-31383878 Email: anthony.welch@qut.edu.au

Add additional rows as required for additional co-investigators.

Declaration by the Investigator/s:

I/We have read the current NH&MRC National Statement on Ethical Conduct in Research Involving Humans 1999, and accept responsibility for the conduct of the research detailed in this application in accordance with the principles contained in the National Statement and any other conditions laid down by the RMIT Human Research Ethics Committee.

Name: _____ Date: 14/01/2007
(Signature of Principal Investigator)

Name: _____ Date: 14/01/2007
(Signature of Co-Investigator)

Name: _____ Date: 14/01/2007
(Signature of Co-Investigator)

Name: _____ Date: _____
(Signature of senior supervisor if applicable)

Copy, paste and complete additional signature boxes to enable all co-investigators to sign.

Declaration by the Head of School:

The project set out in the attached application, including the adequacy of its research design and compliance with recognised ethical standards, has the approval of the School. I certify that I am prepared to have this project undertaken in my School/Centre/Unit.

Name: _____ Date: 14/11/2006
(Signature of Head of School or approved delegate)

School/Centre: Division of Nursing and Midwifery, School of Health Sciences Extn: 57744

Please set out the details of your proposed project according to the headings given below

Investigators are advised to include with their application sufficient detail about the project (including discussion of the expected benefits relative to the risk to participants), recruitment method and procedures for obtaining informed consent, to enable the Committee to evaluate the proposal for conformity with the principles set out in the NHMRC *National Statement*.

Refer to *Notes to assist in completing the HREC Form 1* for further details on completing these Sections.

Section B: Project particulars

- B1. Title of Project: : Establishing guidelines for the effective delivery of mental health theory and practice within Bachelor of Nursing programs offered in Victoria.
- B2. Project description: for HREC assessment of ethical issues. (Research aim/s, Background, Research Method, End points, Statistical aspects)

Psycho-social and mental health problems can surface in individuals receiving treatment for a range of general health care concerns, requiring medical and/or surgical intervention. The psycho-social and mental health problems can either be of a pre-existing nature or occur as a direct result of the health status of the individual. The context in which individuals and their families experience such mental health concerns is not limited to one area of service provision (general hospitals) but involves every aspect of service delivery – across the human life-span and at all stages of the health-illness continuum. Such diversity and complexity in the occurrence of psycho-social and mental health problems requires nurses in all healthcare settings to have a competent working understanding of mental health issues. According to the National Survey of Health and Well-Being (ABS 1999), 17% of Australians will experience a mental health problem at some stage of their life and 4% will experience a severe mental disorder.

Concerns have been raised by some sectors of industry that current nurse graduates are inadequately prepared to take on roles as beginner practitioners in the specialist area of mental health nursing (Clearly, M., Horsfall, J., and De Carlo, P. 2005). In addition, concern has been expressed with regard to the low number of nurses entering the mental health field (Happell, B. 1999). There is growing concern that the level of exposure in undergraduate student preparation to mental health nursing (theoretical content and quality clinical exposure) may influence students' decisions on whether to pursue a career in this area of profession practice (Happell, B., and Rushworth, L. 2000).

The government established the “Victorian Taskforce on Nurses’ Preparation for Mental Health Work” to examine options to ensure adequate education and preparation of undergraduate nurses for mental health nursing. A theme from the taskforce is the establishment of stronger links between universities and Area Mental Health Services, in particular, identification of resources to ensure effective coordination, liaison and education regarding clinical placements.

To practice in the discipline of psychiatric nursing students require both breadth and in-depth understanding of psychiatric nursing studies and practice. The need to provide both in-depth and breadth in content and practice is consistent with the multi-faceted nature of contemporary psychiatric nursing delivery. Social, economic, political, and cultural influences impacting on the health care system are constantly changing the way in which health care is delivered and the contexts in which mental health nursing is practiced. Therefore, if nurses are to make a substantive contribution to the provision of quality care within the field of mental health, the preparation process for nurses must be concerned with providing students with opportunities to

develop their ability to analyse-synthesise new knowledge, engage in critical self-reflection and reflection-in-action, adopt a disposition of inquiry directed toward professional improvement and enhancement of service delivery, and acquire a beginning ability to engage in scholarly debate with other health professionals.

The purpose of this study therefore, is to develop guidelines for the effective delivery of mental health theory and practice within Bachelor of Nursing programs offered in Victoria. The study will employ a qualitative approach to inquiry.

Participant Selection.

Potential participants will be recruited from each of the Mental Health Services throughout Victoria. An invitation will be sent to all registered nurses holding the following positions – clinical teacher, mentor, preceptor, unit manager, and clinical co-ordinator.

Accessing Participants

The names of persons occupying the above positions have been provided by the Area Co-ordinators of each region. The invitation will include a brief description of the project, time commitment required, and methods of information gathering. Potential participants interested in being part of the project will be asked to inform the project team of their interest by email.

Information Gathering

Information will be gathered by two processes – individual interviews and focused group workshops. Individual interviews will be conducted with key stakeholders in the Department of Human Services, Australian Nursing Federation, Australian and New Zealand College of Mental Health Nurses and, Hospital and Community Services Union. Focused group workshops will be conducted with clinical teachers, mentors, preceptors, unit managers, and clinical co-ordinators. The venues for the focused groups will be either at RMIT University or in the clinical field. Both interviews and focus group workshops will be audio-taped. Each interview will last approximately 30-60 minutes. The focus group workshops will be conducted over a two-hour period. Participants will be asked to share their knowledge and expertise in responding to the following questions.

1. How would you describe the current workplace culture in relation to providing quality clinical placements for students?
2. In relation to workplace culture what are the barriers and facilitators to realising quality clinical placements for students?
3. What needs to be in place to ensure sustainable quality clinical placements for students in relation to the following?
 - Structure
 - i. University-clinical agency links and contractual affiliations
 - ii. Honoree appointments
 - iii. Clinical teaching arrangements within the facility
 - iv. Qualifications of staff
 - v. Support infrastructure
 - Processes
 - vi. Timing of placements
 - vii. Teacher-student mix
 - viii. Lines of responsibility and role clarification
 - ix. Preparation for clinical teachers/preceptors/mentors/buddies
 - x. Student preparation for clinical practice by universities
 - xi. Appropriateness of clinical venues for knowledge acquisition and skill enhancement
 - xii. Evaluation – student, clinical teacher/preceptor/mentor/buddy, and clinical venue,

- Teaching-Learning Activities for Students – clinical journaling and reflective practice
- Resources – physical, human, teaching-learning?

Information Analysis

Information will be analysed thematically using the headings as set out above. An Exploratory-Descriptive approach to inquiry was used as the methodological framework for this project.

B3. Proposed commencement of project

October, 2006

B4. Proposed duration of project; proposed finish date. April, 2007

B5. Source of funding (internal and/or external)

Department of Human Services, Victoria (\$42,000.00)

B6. Project grant title; proposed duration of grant (where applicable)

Establishing guidelines for the effective delivery of mental health theory and practice within Bachelor of Nursing programs offered in Victoria.

Section C: Details of participants

C1. Number, type, age range, any special characteristics of participants and inclusion/exclusion criteria.

It is anticipated that 80-100 participants will form the cohort for this study. Potential participants who meet the following inclusion criteria will be invited to participate:

- Mental health nurses who either hold registration as a Division 3 nurse or hold registration as a Division 1 nurse with endorsement as a mental health nurse and
- Currently working in the clinical field as one of the following:
 - RPN 2 (registered psychiatric nurse level 2)
 - RPN 3 (registered psychiatric nurse level 3)
 - RPN 4 (registered psychiatric nurse level 4)
 - Clinical teacher/student mentor/student preceptor/buddy
- The Australian and New Zealand College of Mental Health Nurses
- The Hospital and Community Services Union
- The Hospital Employees Federation
- Mental Health Nurse Academics from Victorian Universities

C2. Source of participants (attach written permission where appropriate)

Potential participants who meet the following inclusion criteria will be invited to participate:

- Mental health nurses who either hold registration as a Division 3 nurse or hold registration as a Division 1 nurse with endorsement as a mental health nurse and
- Currently working in the clinical field as one of the following:
 - RPN 2 (registered psychiatric nurse level 2)
 - RPN 3 (registered psychiatric nurse level 3)
 - RPN 4 (registered psychiatric nurse level 4)
 - Clinical teacher/student mentor/student preceptor/buddy
- The Australian and New Zealand College of Mental Health Nurses
- The Hospital and Community Services Union
- The Hospital Employees Federation

- Mental Health Nurse Academics from Victorian Universities

C3. Means by which participants are to be recruited

Each Area-coordinator of Mental health Services throughout Victoria will be contacted by phone to request access to the names and work contact details of staff members involved in the clinical education of students. On receipt of the requested information a letter of invitation will be sent out (see Project Information Sheet). Potential participants interested in being part of the project will be asked to inform the project team of their interest by email. In relation to the recruitment process for the organisations listed above, each organisation will be contacted by phone to initially ascertain who would be the key stakeholder with whom to talk about involvement in the study. On receipt of the required information the person/s will be send a letter outlining the purpose of the study (see project Information Sheet) and inviting them to participate. Those who express interest in being part of the study will be invited will be given the opportunity to either be interviewed individually or as part of the focus group.

C4. Are any of the participants "vulnerable" or in a dependent relationship with any of the investigators, particularly those involved in recruiting for or conducting the project?

No

C5 Are you seeking to recruit Aboriginal and Torres Straits Islanders to this investigation?

No

C6 If "Yes", have you taken account of the requirements in NH&MRC, *Values and Ethics - Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research*, June 2003, when designing your research? Describe how:

Section D: Risk classification and estimation of potential risk to participants

D1. Please identify the risk classification for your project by assessing the level of risk to participants or (if any) to the researcher.

The risk classification for this project is Level 2

D2. If you believe the project should be classified level 2 or level 1 please explain why you believe there are minimal risks to the participants.

OR

If you believe the project is classified level 3 please identify all potential risks to participants associated with the proposed research. Please explain how you intend to protect participants against or minimize these risks.

It is the considered opinion of the research team that the study is a level 2 risk. The participants will be asked questions that form part of everyday professional practice for those supervising or engaged in the education of students in undergraduate nursing programs. However, if at anytime a participant expresses discomfort about being part of the study the focus group or the interview will be temporarily interrupted and the participant will be given an opportunity to discuss their feelings or concerns. They will be reacquainted with their right to withdraw from the study without prejudice. If they decide to discontinue their involvement in the study their decision will be respected. As a member of a Focus Group Workshop ascertaining the person's contribution for removal

will be virtually impossibility however, every attempt will be made to remove the person's contributions from the transcripts if requested.

D3. Please explain how the potential benefits to the participant or contributions to the general body of knowledge outweigh the risks.

There is no direct benefit to those participating in this study however, the development of guidelines for quality clinical experience has the potential to benefit those engaged in student supervision and education.

D4. Contingency planning: first aid / debriefing

None required

D5 Adverse Events: Are procedures in place to manage, monitor and report adverse and/or unforeseen events that may be associated with your research? Give details:

D6. Please complete this checklist by placing Y (Yes) or N (No) and give details of any other ethical issues that may be associated with this project.

	Yes	No
a Is deception to be used?		X
b Does the data collection process involve access to personal or sensitive data without the prior consent of participants?		X
c Will participants have pictures taken of them eg, photographs, video recording, radiography?		X
d Will participants come into contact with any equipment which uses an electrical supply in any form e.g, audiometer, biofeedback, electrical stimulation, etc?		X
e If interviews are to be conducted will they be tape-recorded?	X	
f Do you plan to use an interpreter?		X
g Will participants be asked to commit any acts which might diminish self-esteem or cause them to experience embarrassment or regret?		X
h Are any items to be taken internally (orally or intravenously)?		X
i Will any treatment be used with potentially unpleasant or harmful side effects?		X
j Does the research involve a fertilised human ovum?		X
k Does the research involve any stimuli, tasks, investigations or procedures which may be experienced by participants as stressful, noxious, aversive or unpleasant during or after the research procedures?		X

l	Will the research involve the use of no-treatment or placebo control conditions?		X
m	Will any samples of body fluid or body tissue be required specifically for the research, which would not be required in the case of ordinary treatment?		X
n	Will participants be fingerprinted or DNA "fingerprinted"?		X
	Are the participants in any sort of dependent relationship with the investigator/s?		X
p	Are participants asked to disclose information that may leave them feeling vulnerable or embarrassed?		X
q	Are there in your opinion any other ethical issues involved in the research?	X	

Where you have answered Yes to any of the questions on the checklist, please give details and state what action you intend to take to ensure that no difficulties arise for your participants.

e. Interviews will be audio-taped for the purpose of information gathering and analysis.

- Anonymity

Assurances of anonymity will be maintained for those participants who are interviewed. Participants of the focus group workshops cannot be guaranteed anonymity within the context of the group. However, participants will be required not to disclose the identity of participants to any outside agent.

- Confidentiality

Confidentiality of information will be required between members of the focus group workshop. All information shared by participants within the workshops or interviews will remain confidential and only made available in the final report. No information that may lead to the disclosure of any participant will be used in the final document.

- Storage of Information

All information shared during the course of this study will be kept under lock and key in the office of the Principle Investigator. On completion of the study all information will be retained by RMIT University for a period of 5 years and then destroyed in accordance with RMIT University policy for the destruction of confidential information. Such a process meets the Department of Human Services, Victoria requirements for storage and destruction of confidential information.

Section E: Informed consent

E1. Attach to the application your plain language statement & consent form.

See attached

E2. Dissemination of results

Results will be published in a final report for the Department of Human Services, Victoria. Additional publications may be through conference presentations and refereed journals.

E3. Participants under 18 years

No

E4 Persons subject to the Guardianship Act (Vic) (If applicable)

N/A

Section F: Research Involving Collection, Use or Disclosure of Information

We wish to acknowledge permission from the Department of Human Services, Vic on whose Common Application Form the questions in this section have been based.

Please note that if you propose to **collect** information about an individual from a **source other than the individual**, or to **use or disclose** information **without the consent of the individual** whose information it is, you will **also** have to complete the Special Privacy Module (Form No 5 – see also the related explanatory document, *Special Privacy Module*) in addition to questions below. Under statutory guidelines a HREC may approve some research where the public interest outweighs considerations of privacy, however a researcher must make a special case for such approval. The Special Privacy Module is the starting point for preparing such a case.

For a more detailed guidance and definitions for each of the question below, see *Notes to assist in completing HREC Form 1, Section F*.

F1 Does this Section have to be completed?

Does the project involve the collection, use or disclosure of personal information (includes names & contact details), health information including genetic information, or sensitive information,? (see *Notes to assist in completing the form, Section F*)

No – you do not have to answer any questions in this section. Go to Section G.

X Yes – you must answer questions in this section. Go to Question F2.

F2 Type of Activity Proposed

Are you seeking approval from this HREC for:

(a) collection of information?

X Yes – start at Question F3

No – start at Question F4

(b) use of information?

Yes– start at Question F4 No

(c) disclosure of information to some other party?

Yes– start at Question F4 No

F3 Collection of Information

(a) Does the project involve collection of information directly from individuals about themselves?

No – (If collected from a third party/existing records) You must fill out the Special Privacy Form (Form 5) as well as this form.

X Yes – answer the following questions:

(b) What type of information will be collected? (Tick as many as apply)

- personal information
- sensitive information
- health information

(c) Does the plain language statement explain the following:

- | | |
|--|---|
| The identity of the organisation collecting the information and how to contact it? | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| The purposes for which the information is being collected? | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| The period for which the records relating to the participant will be kept? | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| The steps taken to ensure confidentiality and secure storage of data? | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| How privacy will be protected in any publication of the information? | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| The fact that the individual may access that information? | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| Any law that requires the particular information to be collected/disclosed?
(eg notifiable diseases or mandatory reporting obligations re child abuse) | Yes <input type="checkbox"/> No <input type="checkbox"/>
Not Applicable <input checked="" type="checkbox"/> |
| The consequences (if any) for the individual if all or part of the information is not provided? (eg any additional risks if a participant does not fully disclose his/her medical history) | Yes <input type="checkbox"/> No <input type="checkbox"/>
Not Applicable <input checked="" type="checkbox"/> |

If you answered "No" to any of these questions, give the reasons why this information has not been included in the plain language statement.

F4 Use or Disclosure of Information about Individuals

(a) Does the project involve the use or disclosure of identified or potentially identifiable information?

- No – go to Question F5.
- Yes, answer the following questions.

(b) Does the project involve use or disclosure of information without the consent of the individual whose information it is?

- No - go to Question F5.
- Yes, You must fill out the Special Privacy Form, as well as this form.

Projects involving the access, use or disclosure of information, without the consent of the person whose information it is, are classified as risk level 3 and must be reviewed by the RMIT Human Research Ethics Committee.

F5 General Issues

- (a) How many records will be collected, used or disclosed? Specify the information that will be collected, used or disclosed (e.g. *date of birth, medical history, number of convictions, etc*).

Information from focus group workshops (10 participants x approximately 7 groups), individual interviews (approximately 12 persons) and questionnaires. The type of information will include, current position and level of involvement in teaching students in the clinical area.

- (b) For what period of time will the information be retained? How will the information be disposed of at the end of this period?

On completion of the study all information will be retained by RMIT University for a period of 5 years and then destroyed in accordance with RMIT University policy for the destruction of confidential information. Such a process meets the Department of Human Services, Victoria requirements for storage and destruction of confidential information.

- (c) Describe the security arrangements for storage of the information. Where will the information be stored? Who will have access to the information?

All information shared during the course of this study will be kept under lock and key in the office of the Principle Investigator. On completion of the study all information will be retained by RMIT University for a period of 5 years and then destroyed in accordance with RMIT University policy for the destruction of confidential information. Such a process meets the Department of Human Services, Victoria requirements for storage and destruction of confidential information.

- (d) How will the privacy of individuals be respected in any publication arising from this project?

In any publications from the findings of this project no identifying material will be included.

- (e) Does the project involve trans-border (i.e. interstate or overseas) data flow?

Yes **No**

If Yes, give details of how this will be carried out in accordance with relevant Privacy Principles (e.g. HPP 9, VIPP 9 or NPP 9).

- (f) Does the project involve using unique identifiers assigned to individuals by other agencies or organisations?

Yes **No**

If yes, give details of how this will be carried out in accordance with relevant Privacy Principles (e.g. HPP 7, VIPP 7 or NPP 7).

F6 Adverse Events – re Data Security

Are procedures in place to manage, monitor and report adverse and/or unforeseen events relating to the collection, use or disclosure of information?

Yes No

Give details.

All information collected during the course of this project will be kept under lock and key at the university. Only the researchers involved in this project will have access to the material.

F7 Other Ethical Issues Relating to Privacy

Discuss any other ethical issues relevant to the collection, use or disclosure of information proposed in this project. Explain how these issues have been addressed.

No

Section G: Other issues

G1. Do you propose to pay participants? If so, how much and for what purpose?

No

G2. Where will the project be conducted?

In Victoria

G3. Is this project being submitted to another Human Research Ethics Committee, or has it been previously submitted to a Human Research Ethics Committee?

No

G4. Are there any other issues of relevance?

No

If you answered "No" to question F1, please answer G5 and G6:

(Applicants who have completed all of section F will already have answered questions).

G5. For what period of time will the research data be retained? How will the information be disposed of at the end of this period?

On completion of the study all information will be retained by RMIT University for a period of 5 years and then destroyed in accordance with RMIT University policy for the destruction of confidential information. Such a process meets the Department of Human Services, Victoria requirements for storage and destruction of confidential information.

G6. Describe the security arrangements for storage of the information. Where will the information be stored? Who will have access to the information?

All information shared during the course of this study will be kept under lock and key in the office of the Principle Investigator at RMIT University.

For any further detail about completion of the application form, or for additional information, please contact the Secretary of your Portfolio HRE Sub Committee, or the Executive Officer of the RMIT Human Research Ethics Committee, c/- Research & Innovation, (03) 9925 2251.
--

Please check that the plain language statement, consent form and other documents as applicable (eg. evidence of required external approvals, recruitment advertisement, questionnaire and/or list of questions, clinical trial protocol) are attached to your application.

Appendix 2

Invitation to Participate in a Research Project

Project Information Statement

Project Title:

Establishing guidelines for the effective delivery of mental health theory and practice within Bachelor of Nursing programs offered in Victoria

Investigators:

Dr. Anthony Welch, Principal Investigator, the Division of Nursing and Midwifery, RMIT University.

Email: anthony.welch@qut.edu.au Phone 07-31383878; Fax 07-31383814

Associate Professor Lina Shahwan-Akl, co-investigator, the Division of Nursing and Midwifery, RMIT University.

Email: lina.shahwan-akl@rmit.edu.au Phone 99257443; Fax 9467 – 1629

Ms Kana Intherarasa, co-investigator, the Division of Nursing and Midwifery, RMIT University.

Email: kana.intherarasa@rmit.edu.au Phone 99257453

Dear

Our names are Dr Anthony Welch, Associate Professor Lina Shahwan-Akl and Ms Kana Intherarasa. We are academic staff of the Division of Nursing and Midwifery, RMIT University. You are invited to participate in a Department of Human Services Victoria project, the aim of which is to establish guidelines for the effective delivery of mental health theory and practice within Bachelor of Nursing programs offered in Victoria

Invitation

You are invited to be a participant in this research project. Before deciding whether or not to participate, it is important that you understand the purpose of the project, how it may affect you, any risks to you, and what is expected of you. This information sheet describes the project in

everyday language. Please read this sheet carefully and be confident that you understand its contents before deciding whether to participate. If you have any questions about the project, please ask either of the investigators listed above.

- Your participation is entirely voluntary;
- You may withdraw from the study at any time without prejudice
- If the study is changed in any way which could affect your willingness to continue in the study, you will be informed about the changes and may be asked to sign a new consent form.

Who is involved in this research project? Why is it being conducted?

The person leading this research project is Dr Anthony Welch. The aim of this project is to establish guidelines for the effective delivery of mental health theory and practice within Bachelor of Nursing programs offered in Victoria. The project is funded by the Department of Human Services Victoria and conducted by academic staff within the Division of Nursing and midwifery, RMIT University

Why have you been approached?

You have been approached and specifically invited to participate in this research project because of your experience, expertise, and knowledge of supervising nursing students in the clinical practice setting.

What is the project about? What are the questions being addressed?

As previously stated, the focus of this project is to Establish guidelines for the effective delivery of mental health theory and practice within Bachelor of Nursing programs offered in Victoria.

The questions that you will be asked follows:

4. How would you describe the current workplace culture in relation to providing quality clinical placements for students?
5. In relation to workplace culture what are the barriers and facilitators to realising quality clinical placements for students?
6. What needs to be in place to ensure sustainable quality clinical placements for students.

If I agree to participate, what will I be required to do?

If you agree to participate in this study you will be required to be either interviewed by a member of the project team or be a participant in a focus group workshop. Both the interviews and the focus groups will be audio-taped for the purpose of later transcription in preparation for analysis. The interviews will last between 30-60 minutes dependent on each participant. The focus groups workshops will last for approximately two hours. The questions that you will be asked are listed above. At the end of the research project all of the audio recordings, and typed transcripts will be destroyed. Your name will not appear on the audio recording, or transcript. Instead, the audio recording and transcript will be given a number and a false name.

What are the risks or disadvantages associated with participation?

There are no perceived risks outside your normal day-to-day activities. There are no known risks to discussing with the researchers your thoughts and experiences on the topic. If at any time during your involvement in the project you feel that you would like to end the discussion or withdraw from the research project, you may do so without explanation or penalty.

What are the benefits associated with participation?

There is no direct benefit to you as a result of your participation in this study. However, you may feel satisfied that you helped to create new knowledge about what constituted quality clinical placements for student nurses undertaking a mental health clinical placement.

What will happen to the information I provide?

- The interviews and the focus group discussions will be tape-recorded for the purpose of transcribing the discussion in preparation for analysing the information.
- Your participation with this research project is both anonymous and confidential. Anonymous means that you will be known only to the research team. Your name or any identifying information will not be used on the tape or transcript.
- Confidential means that any information shared by you during either the interviews or focus group workshops will not be disclosed unless you give permission to do so.
- The transcribed interviews and focus group workshops will be kept under lock and key in the principal researcher's office at RMIT University.
- As required by RMIT University, the data will be held and kept secure by RMIT for a period of five years after completion of the project and then destroyed.
- Quotations obtained during the data-gathering may be used anonymously in research reports and publications.
- Any information that you provide can be disclosed only if (1) it is to protect you or others from harm, (2) a court order is produced, or (3) you provide the researchers with written permission.
- It is a requirement to obtain a signed consent form after you have read this information sheet and have had all of your questions answered. The consent form must be signed before the research team can begin the study.

What are my rights as a participant?

- The following are your rights as a research participant, which include:
 - The right to withdraw your participation at any time, without penalty or prejudice.
 - The right to have any unprocessed data (data that is not used) withdrawn and destroyed, provided it can be reliably identified, and provided that in so doing does not increase the risk for the participant.
 - The right to have any questions answered at any time.

Whom should I contact if I have any questions?

- If you should have any questions at any time please contact Dr Anthony Welch on 03 99257465

What other issues should I be aware of before deciding whether to participate?

Nil

Thank you for taking time to read this information and for your interest.

Sincerely yours,

Dr. Anthony Welch
School of Nursing
Midwifery
Queensland University
of Health Science
of Technology
University
Kelvin Grove Campus
Melbourne, Vic, 3865
Brisbane, QLD, 4001

Associate Professor Lina Shahwan-Akl
Division of Nursing and Midwifery

School of Health Science

RMIT University

Bundoora, Melbourne, Vic, 3864

Ms Kana Intherarasa
Division of Nursing and

School

RMIT

Bundoora,

Any complaints about your participation in this project may be directed to the Secretary, Portfolio Human research Ethics Sub Committee, Business Portfolio, RMIT, GPO Box 2476V, Melbourne, 3001. The telephone number is (03) 9925-5598 or email address rdu@rmit.edu.au. Details of the complaints procedure are available from the above address or <http://www.rmit.edu.au/council/hrec>.

Appendix 3

Prescribed Consent Form For Persons Participating In Research Projects Involving Interviews, Questionnaires or Disclosure of Personal Information

Portfolio	Science, Engineering and Technology Portfolio
School of	Health Sciences, RMIT University
Name of participant:	
Project Title:	Establishing guidelines for the effective delivery of mental health theory and practice within Bachelor of Nursing programs offered in Victoria.
Name(s) of investigators:	(1) <u>Dr Anthony Welch</u> Phone: <u>07-31383878</u>
	(2) <u>Associate Professor Lina Shahwan-Akl</u> Phone: <u>03-99257443</u>
	(3) <u>Ms Kana Intherarasa</u> <u>03-99257606</u>

1. I have received a statement explaining the interview/questionnaire involved in this project.
2. I consent to participate in the above project, the particulars of which - including details of the interviews or questionnaires - have been explained to me.
3. I authorise the investigator or his or her assistant to interview me or administer a questionnaire.
4. I acknowledge that:
 - (a) Having read Plain Language Statement, I agree to the general purpose, methods and demands of the study.
 - (b) I have been informed that I am free to withdraw from the project at any time and to withdraw any unprocessed data previously supplied.
 - (c) The project is for the purpose of research and/or teaching. It may not be of direct benefit to me.
 - (d) The privacy of the personal information I provide will be safeguarded and only disclosed where I have consented to the disclosure or as required by law.
 - (e) The security of the research data is assured during and after completion of the study. The data collected during the study may be published, and a report of the project outcomes will be provided to _____ (researcher to specify). Any information which will identify me will not be used.

Participant's Consent

Participant:	_____	Date:	_____
	(Signature)		
Witness:	_____	Date:	_____
	(Signature)		

Appendix 4

Participant Statements

1. A more realistic expectation of professional behaviour should be emphasised by both the clinical agency and the university.
2. A lot of students have the attitude their mental health placement is a break from 'real nursing'.
3. Stronger links between the organisations and the universities such as visiting academics, fellowship programs and teaching in the clinical setting. However there are competing demands – workforce demands and university demands are increasing. Having the course co-ordinator attend facility meetings.
4. Greater contact with clinical teachers during placements or a central co-ordinator for each clinical area to improve communication lines between the university and the facility during clinical placements. This includes e-copies or online availability of lecture outline and programs for staff.
5. Placements to be planned at least a month in advance for the purpose of allocating staff/preceptors for students – this is not always the case. Placements to be longer- 2 weeks is inadequate.
6. Set placements could be negotiated between universities and hospitals and vacancies could appear as a second round offer.
7. Ongoing holiday periods put pressure on the facilities – that is, filling in for clinical educators.
8. Consistency with staff organising placements. Clinical placements to be structured whereby student numbers could be doubled – e.g. 8 students that are usually spread 4 to inpatient and 4 to community to be doubled – however work the students one day clinical setting and one day intensive workshop. When the first group is in workshop the other group is in the clinical area. The Nurses Board requirement for 1 clinical teacher for 8 students is limiting.
9. Set debriefing times for students [2-3 pm] to avoid interruption to daily clinical activities.
10. It remains difficult to get staff qualified in preceptorship due to rostering, shortages of staff, and staff turn-over. Debriefing for students tends not to happen in a preceptored placement.
11. University academics to provide in-service education – such as what to expect, assessment tools and so on. Lecturers to visit the agency at least once during their placement.
12. The assessment tool needs to be standardised and placement specific – mental health is different to generalist areas.

13. Students with an interest in mental health should be selected for placement and some education related to mental health should occur before the clinical placement. Students knowledge base of mental health is inadequate thus little can be imparted to them in a few weeks.
14. Student evaluations on the first day and then on the last day of clinical – a standardized form.
15. Staff at clinical locations may be considered for honouree appointments at universities to enhance the links between the university and the clinical setting. These positions need to be advertised. There is little benefit to the clinical area or the clinician in terms of honouree appointments.
16. Staff qualifications should have a minimum undergraduate psychiatric nursing degree/certificate or a Bachelor of Nursing with psychiatric nursing qualification and a minimum of 5 years post registration experience. Preceptorship may be multidisciplinary – Dual preceptorship. The staff should have demonstrated teaching skills and extensive experience in mental health.
17. Current supports in infrastructure are there, however it is inadequate due to the high numbers of students and the student's poor knowledge base in relation to mental health.
18. Supervision and professional development to be regular and available.
19. Placement length should be for a minimum of 2 weeks in acute or 4 weeks in non-acute areas. Inclusion of shift work (ie: night duty). Some theoretical learning needs to take place prior to placement.
20. Students need to be sent out to clinical placement prepared – matching theory to placement and involving the clinical team in induction at the university level. Students in 1st and 2nd year gain little from the mental health clinical placement. Students to have their mental health placement in their 3rd year – students are generally more mature and have better knowledge of mental health.
21. A teacher student mix of 1:6 or 1:8 maximum.
22. For preceptors the ration ought to be 1:1. In addition, a 'buddy' system as per current practice on the clinical unit. Consider geographic location of students – teachers need to spend more time with students and less time travelling between sites.
23. Need to contain in the orientation folder what students can and cannot do. Students need to understand the different roles within the multi-disciplinary team. Students need to have an opportunity for multi-disciplinary preceptorship due to mental health clinical practice being situated in the multi-disciplinary context.
24. Clinical teachers to be part of the unit staffing in a super-nummary position. Preceptors to oversee the clinical placement rather than a

- clinical educator coming in new to a facility. Need to create a culture of discussion between placements and the university.
25. Some formal education/training for clinical teachers/preceptors/mentors – i.e.: certificate IV training and assessment, preceptorship training.
 26. All clinical nurse educators should have education qualification and a graduate diploma or be working towards one.
 27. Additional training to relate to educative skills e.g.: principles of self directed learning and homework setting.
 28. Preceptors could be mentored by the clinical educators.
 29. Student preparation is inadequate – this varies much between the different universities. Student preparation to be grounded in nursing process including foundational understanding of Mental Health Act, mental state examination, common psychiatric conditions, pharmacology, communication skills, group skills, reflective practice and supervision [what is it], risk assessment skills and nursing theories underpinning mental health nursing. Lectures need to be compulsory for students.
 30. More subjects within the curriculum to be spent on mental health – currently this varies across different universities from 0% - 17% of total curriculum focussed on mental health.
 31. Simulation may offer some avenue for skills mastery but cannot replace hands on experience.
 32. Clinical venues need to be able to provide for knowledge acquisition and synthesis. Some venues are not good for the under prepared student and can cause trauma to the student.
 33. Additionally, clinicians can be exposed to risks due to student behaviours.
 34. More flexibility in the placement where the student is given a choice where they go and could include areas currently not utilised widely- such as consultation liaison, neuro-psychiatry, eating disorders.
 35. Universities should liaise between each other to ensure their requests for placements are evenly spread over the year to maximise opportunities for placements.
 36. There need to be a balance between theory and practice opportunities for nursing students.
 37. Evaluation should be conducted between clinical teacher, organisation and student. Evaluations/feedback currently goes back to the university. Evaluation has to be meaningful – such as pre and post evaluations – to measure knowledge gained and theory to practice synthesis.
 38. Universities should run sessions in the clinical agency on competency assessment and tools – free of charge.

39. The assessment tool is often not user friendly – the Australian Nursing & Midwifery (ANMCI) competencies do not readily apply to the mental health area.
40. Agencies should encourage their staff to take up clinical teaching at the university.
41. Agencies should be assessed yearly against an agreed criteria and feedback provided to the agency.
42. Reflective practice sessions and opportunities would be useful for the student in terms of making their experience meaningful.
43. Inclusion of a tool that can reflect the undergraduate's journey while on placement – especially longer placements.
44. Learning objectives set by the university, the facility and the students own objectives.
45. Learning hurdles to include the student to undertake an ISP.
46. Increase face-to-face opportunities for reflective practice which may replace clinical journaling which students do not enjoy and rarely understand its purpose. Otherwise to have students journaling regularly (daily).
47. Regular tutorials throughout the clinical placement focussing on a prescribed format including MSE, risk assessment, definitions, and questionnaires to test knowledge throughout the placement.
48. Assessment tool from the universities is confusing and needs to relate to mental health and be standard across universities.
49. The therapeutic use of self care knowledge to be integrated into the clinical placement teaching.
50. Education/teaching/debriefing area in clinical settings for students to utilise. These rooms need have whiteboard access. Most clinical agencies have limited space for this.
51. Well publicised processes and contacts for students.
52. Preceptorship training and refresher courses to be made available.
53. Formal networking between university and facilities.
54. Access for staff to computer program that provides support and appropriate information matching students objectives.
55. Students should be given an opportunity to feedback about their clinical experience to the clinical agency.
56. Some units are so small they cannot arrange a buddy for the students – such as rural areas.
57. Comprehensive nursing programs do not provide adequate time in the curriculum for mental health education. It is often 'squeezed in'. This is often reflected by the students on placement where some students come to placement thinking they know all there is to know about mental health, while others see mental health as unimportant to their career as nurses.
58. Some clinical educators are not always available. The role of the clinical nurse educator is unclear and the majority of the workplace contact with students falls to the preceptors on the ward. This can

be a positive thing since the students get a 'real sense' of what a psychiatric nurse does. However there is a lack of trained preceptors.

59. The barriers are associated with the structure of the education itself, the workloads and the clinical area rostering.
60. Sometimes there is a lack of interest on the student's part and with overburdening of clinicians with large numbers of students it becomes problematic.
61. Clinical placements are too short providing narrow exposure to mental health. Often there are more students than placements available considering placements are required in health for all disciplines. There is also a limited capacity to take students – does not include weekends.
62. Preparedness of students is an issue. The lectures and tutorial offered at university are not compulsory and theoretical learning related to mental health may have occurred long before placement or clinical may have taken place before theoretical learning. There is poor theoretical framework prior to placements.
63. Mental health clients/patients may not like students or consent to students being present to the therapeutic interaction.
64. There may be generational difference between nurses and the student nurse.
65. The 'Black humour' used by mental health clinicians is often not understood or appreciated by students. It may offend the student.
66. There is a lack of trained preceptors.
67. Some staff do not have a theoretical background to adequately explain concepts to students.
68. There are a lot of students in the facility (2 per unit per day of the week), staff tend to get very weary.
69. Two week placements have a very negative impact for both student and the staff- both the student and the nurse start to feel comfortable and the placement ends.
70. Disinterest from the student has a negative effect.
71. The students self awareness is very limited due to their age and when they do the clinical placement.
72. Staff protect students from unwell clients - or clients from being over exposed to student contact - further limiting exposure for the student to the aspects of mental health care.
73. The relationship with the university is important. It needs to be an open relationship. Often organisations are dealing with too many universities and this can be problematic. Having support, clear processes and guidelines including clear expectations and well prepared students would benefit clinical placement quality.
74. Students can accompany staff to home visits which means other staff are free to do other tasks.

75. The workloads vary and this can impact on the student's experience of the placement and what they learn.
76. There are a lot of hospital trained clinicians who do not understand the university system.
77. There are limited placement availabilities in rural so student have to travel long distances, often to Melbourne.
78. Staff are aware of the importance of providing positive clinical experiences for students.
79. There are a significant minority of staff who hold negative attitudes to student clinical placements.
80. Looking after students detracts from caring for patients.
81. The value of students is known and appreciated by staff. Staff take more time to make the clinical experience as positive as it can be since this may lead to recruitment to mental health.
82. There is an increased reliance on preceptors and the organisation 'take the money and run' - the units and staff do not get direct benefit of the funds.
83. There is a decreased availability of clinical teachers and an increased reliance on preceptors within organisations. This leads to more pressure on staff when using the preceptor model where there is no clinical teacher for support.
84. Student's attitude impacts on the clinical placement – a positive attitude will generally lead to a good placement experience and so on. The attitude of the staff in charge of the student on placement is also important – that is, one that is welcoming and encouraging.
85. Two week placements are considered a token placement by staff – not long enough.
86. There is available time to debrief which is helpful for students. Also, ongoing daily training opportunities within the organisation for students to attend provides a good learning environment.
87. The buddy system offers students support especially on the first day.
88. The challenge is for staff to keep up a sound knowledge base so they can impart their experience to students in a meaningful way.
89. Clinical experience varies from site to site. Due to receptivity of staff, structure of the site (community versus inpatient) and experience of staff.
90. What students actually learn is up to their level of motivation.
91. Some students cope to their mental health placement and say they are not interested in mental health at all.
92. Many students are afraid in the mental health area and this is very time consuming for staff.
93. Poor student motivation or attitude has a negative impact on the clinical placement.
94. Some areas of MH may not be appropriate for student level of knowledge and self awareness.

95. Two week placement is a token placement in mental health.
96. There is a decreased availability of clinical teachers and an increased reliance on preceptors.
97. The challenge is for staff to keep up a sound knowledge base so they can impart their experience to students in a meaningful way.
98. Over all staff are dedicated to providing quality clinical placements.
99. Staff protect students from unwell clients - or clients from being over exposed to student contact - further limiting exposure for the student to the aspects of mental health care.
100. The relationship with the university is important.
101. The students self awareness is very limited.
102. Disinterest from the student has a negative effect.
103. There is a lack of trained preceptors.
104. Clinical placements are too short providing narrow exposure.
105. The barriers are associated with the structure of the education itself, the workloads and the clinical area rostering.
106. Comprehensive nursing programs do not provide adequate time in the curriculum for mental health education.
107. Some clinical educators are not always available.
108. There are limited placement availabilities in rural so student have to travel long distances, often to Melbourne.
109. A more realistic expectation of professional behaviour should be emphasised for student behaviour.
110. Stronger links between the organisations and the universities.
111. Greater contact with clinical teachers during placements.
112. Consistency with staff organising placements.
113. Set placements could be negotiated between universities and hospitals and vacancies could appear as a second round offer.
114. Students with an interest in mental health should be selected for placement and some education related to mental health should occur before the clinical placement.
115. Staff at clinical locations may be considered for honouree appointments at universities to enhance the links between the university and the clinical setting.
116. Current supports in infrastructure are there, however it is inadequate due to the high numbers of students and the student's poor knowledge base in relation to mental health.
117. Supervision and professional development to be regular and available.
118. Placement length should be for a minimum of 2 weeks in acute or 4 weeks in non-acute areas.
119. Students to have their mental health placement in their 3rd year – students are generally more mature and have better knowledge of mental health.
120. A clinical teacher student mix of 1:6 or 1:8 maximum.

121. For preceptors the ration ought to be 1:1.
122. Need to contain in the orientation folder what students can and cannot do.
123. More subjects within the curriculum to be spent on mental health.
124. There need to be a balance between theory and practice opportunities for nursing students.
125. Universities should liaise between each other to ensure their requests for placements are evenly spread over the year to maximise opportunities for placements.
126. The ANMCI competencies do not readily apply to mental health.
127. Agencies should encourage their staff to take up clinical teaching at the university Agencies should be assessed yearly against an agreed criteria and feedback provided to the agency.
128. Reflective practice sessions and opportunities would be useful for the student in terms of making their experience meaningful.
129. Learning hurdles to include the student to undertake an ISP.
130. Regular tutorials throughout the clinical placement focusing on a prescribed format including MSE, risk assessment, definitions, and questionnaires to test knowledge throughout the placement.
131. Inclusion of a tool that can reflect the undergraduate's journey while on placement.
132. Inclusion of the therapeutic use of self in clinical placement teaching.
133. Availability of education/teaching/debriefing area in clinical settings for students to utilise.
134. Students should be given an opportunity to feedback about their clinical experience to the clinical agency.
135. Well publicised processes and contacts for students.
136. Inclusion of the therapeutic use of self in clinical placement teaching.
137. Teachers representing other areas in health and who have a negative view of mental health impose their view onto their students.
138. Mental healthcare is very specialized and requires excellent communication and engagement skills.
139. Developing a standard mental health assessment tool with objectives for students would help to focus the clinical placement.
140. Students from a non-English speaking background usually require more support in the mental health clinical setting due to communication difficulties.
141. Organizations have to develop infrastructure for student placements.