Learning to Respond to Thought-Disordered Speech – Nursing Students' Experiences: A Mixed Method Study

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Certificate of Original Authorship

I, Denise Elizabeth McGarry, declare that this thesis is submitted in fulfilment of the requirements for the award of Doctor of Philosophy (Nursing) in the Faculty of Health at the University of Technology Sydney.

This thesis is wholly my own work unless otherwise referenced or acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

This document has not been submitted for qualifications at any other academic institution.

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Thanks

My engagement with a doctoral study program to understand how nursing students can be better supported to learn how to respond therapeutically to people whose speech exhibits thought-disorder, owes thanks to many.

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Abstract

Introduction

Nursing students experience challenges in responding to people who exhibit thought-disorder. Learning how to respond in a manner supportive of consumers' recovery goals is important to beginning nursing practice across many clinical fields.

Aims

The aim of this research study was to explore how pre-registration nursing students were prepared to respond to people experiencing thought-disorder according to students, recent graduates and mental health nursing academics.

Methods

A sequential, two-phase mixed methods project was undertaken to explore the learning and teaching experiences of nursing students and recent graduates. Quantitative and qualitative data were collected from 148 nursing students by online survey, followed by semi-structured interviews with 11 nursing students and 12 mental health nursing academics.

Results

Analysis of the results found that little direct learning and teaching supporting skills development in responding to thought-disorder was reported. Learning of mental health nursing skills was described as having little focus in pre-registration nursing programs but all participants confirmed the importance of learning to respond to thought-disorder as a pre-registration beginning nursing skill. Clinical placement was suggested by all participants as the context for learning how to respond to people exhibiting thought-disorder in their speech.

Discussion and conclusion

Strategies to prepare nursing students with therapeutic communication skills needs further exploration. Determination of effective learning strategies is warranted to prepare nursing students for beginning practice across many clinical environments in responding to people exhibiting thought-disordered speech. The development of these learning strategies should employ the insights of Experts by Experience to

help ensure all nurses are equipped to support consumers to achieve their recovery goals in health care.

Chapter 1: Introduction - Learning to respond to thought-disordered speech

Personal motivation to undertake this research project

Having worked in mental health nursing in clinical and education capacities for over forty years, I have observed the impact of first encounters with people exhibiting thought-disordered speech. A particular man who experienced enduring and severe mental health problems that had resulted in long term residential mental health treatment comes to mind. He was someone I met frequently in my role as the manager for education. He had a great interest in the many students who passed through his life whilst on clinical placement and he often asked me about them and their study. He was interested in helping them to have a constructive learning experience when on placement and would take the initiative to approach students to welcome them to his residence – a locked ward. His attempts at friendly overtures frequently fell flat. This was apparently as a result of his communication style that was marked by significant thought-disordered content and form. The structure of his speech was highly disorganised obscuring meaning and leaving little shared meaning. He was visibly upset by this repeated inability to communicate with and welcome students, especially when students appeared fearful or laughed in discomfort.

Responding to thought-disordered speech presents challenges for nursing students as it does for many registered nurses and indeed, many health professionals. Nursing students can be fundamentally bewildered when they first encounter this type of communication. (Kameg et al. 2009) and Kameg et al. (2014) report that students experience anxiety and fear that their responses may be misunderstood or even damaging to the person's wellbeing in communicating with people experiencing mental health problems. Students retreat from interacting at all or on some occasions respond inappropriately with laughter. The difficulty in empathising with thought-disordered speech has been noted in the published literature (Elvevåg et al. 2017). The constancy of these observations over time in my professional experiences and similar commentary in the research literature motivated my interest in exploring this topic (Fisher 2002; Galvin et al. 2015).

What is thought-disordered speech?

> *That's wish-bell double vision. Like walking across a person's eye and reflecting personality. It works on you like dying and going into the spiritual world but landing in the vella world.*

This quote, from a personal clinical practice interaction, captures features of thought-disordered speech. It is an example of a range of differences to ordinary expression that may be labelled as thought-disorder. The woman who made this statement was a long-term resident of a mental health service who had been diagnosed with a range of psychotic diagnoses, including schizophrenia and schizo-affective disorder. She had lived the majority of her adult life as an inpatient in a locked ward for longer than ten years.

Thought-disorder is a concept associated with medical models of mental health problems. Alternate explanations or descriptors of this phenomenon are difficult to locate in the literature both from those with a Lived Experience of mental health disorders or other theorists and scholars in this field. Unlike the established literature challenging the medical model explanations of auditory hallucinations by reconfiguring understandings to 'Hearing Voices' (Corstens et al. 2014; Romme & Morris 2007), thought–disorder has not yet been critiqued by a body of Lived-experience scholarship. I recognise this current limitation may impact this dissertation by privileging a medical lens of the phenomenon of thought-disorder, no alternative could be established in the literature. The phenomenon is an established and observable experience and as the focus of this dissertation is learning to respond rather than positing alternative framework of explanation or understanding, further explanation or challenge to the traditional view of thought-disorder has not been attempted.

Thought-disorder can be evident in the speech of people experiencing a range of mental health problems (for example substance use disorders) but is frequently encountered by those experiencing or diagnosed with psychotic disorders (Sass & Parnas 2017). Thought-disordered speech has some key features – disordered content (delusions), disordered form (unusual linkages of ideas, invented terms for

example) and disordered process (volume, speed or absence of speech for example) (Elvevåg et al. 2017; Procter et al. 2017). The focus of this dissertation is on nursing students learning to respond to the phenomenon of disorders in thought form, rather than disordered thought content (delusions) or disordered process.

The term thought-disorder is used in this dissertation, although the content, form and processes of thinking are only ever discernible to an outsider observer through the individual's speech. The assumption being that the speech has a direct correlation with the thought processes and this being so privileges the observer with a window to the speaker's inner world. The assumption of a shared reality between speaker and listener is unstated but underpins comments of this type (Elvevåg et al. 2017; Hart & Lewine 2017).

As such, thought-disorder is regarded as a cardinal feature of serious mental health problems and a marker for the difficulties people with this experience encounter in day-to-day living (de Sousa et al. 2016; de Sousa et al. 2015). Expressions such as 'out-of-touch-with-reality' may have their genesis in observations arising from such speech. Expressions (form), responses (content) or the very structure of utterances may be so entirely foreign to ordinary discourse as to be readily identified as out of the ordinary.

There are multiple explanations for the genesis of such differences in thinking and in speech and range from biological observations of neurochemical changes through interpretations of human response to past trauma. Essentially such deliberations are as yet inconclusive but do not point toward a uniform theory. Rather each contributes a part to a whole and as yet far from complete understanding of thought-disorder (Bentall et al. 2014; Tan & Rossell 2014; Yalincetin et al. 2017).

For the purposes of nursing practice, in immediate encounters, these understandings may be less important than the effort of finding a response. However, clarity regarding the best form of response to thought-disordered speech is lacking and researched evidence to guide the instruction and learning of nursing students hard to identify (Bowers et al. 2009).

The frequent approach in nursing education is to assist nursing students to master communication skills for a comprehensive range of people whom they may encounter in practice (patient, consumer, co-worker) and also for the dominant techniques of communication, such as written, electronic, verbal and non-verbal. In comprehensive nurse education programs, any special skill sets required for people experiencing thought-disorder are often deferred to specialist graduate education.
Material deleted in response to Examination 1
In the instance of thought–disorder, learning for nursing students may involve as little as an introduction to the labels for different types of thought-disorder and the diagnostic groupings where these may be commonly witnessed (Evans, Nizette & O'Brien 2017). It is less usual for nursing students to explore potential responses within their classroom preparation beyond encouragement to identify and respond to underlying emotional cues.

Learning to respond to thought–disorder is commonly assumed to occur on clinical placement. However, explicit monitoring of this achievement is rarely communicated and is likely difficult to ensure. More readily identified skills such as assessment is ordinarily pursued (Levett-Jones et al. 2011). The Australian Nursing Standards Assessment Tool (ANSAT) has been widely adopted and also applied to mental health clinical placements (www.ansat.com.au). The variability of mental health nursing clinical placements makes mastery of communication skills relevant to thought-disorder an uncertain assumption (Forber et al. 2016; Hazleton et al. 2011; Ironside, McNelis & Ebright 2014).

Importance of this learning

Heading re-phrased

Having, asserted the difficulty in ensuring that nursing students learn skills to respond to people experiencing thought-disorder, it is relevant to consider whether this learning is important and should be an essential component of nursing student preparatory education. Learning to respond therapeutically to people experiencing thought-disorder has a minor part in the undergraduate curricula that does not seem proportional to the prevalence of mental health problems reported for the Australian population (Morgan et al. 2011a; Productivity Commission 2020).

In Australia, as in many western countries the prevalence of mental health problems in the population in any one year is recognised to be one in five of the population (Australian Bureau of Statistics (ABS) 2008). In addition, estimates assert that around 45% of the population will experience a mental health problem at some point in their lives (Morgan et al. 2011b; Productivity Commission 2019, 2020). It is important to recognise that these prevalence figures refer to mental health problems that meet the threshold for medical diagnosis. Not all people diagnosed with – or experiencing – mental health problems will ever seek or receive health care or interventions. Not all these mental health problems will involve experiences of thought-disorder.

However, given the high prevalence of mental health problems in the Australian community and the observation that the people who experience these problems may also experience physical health problems, the likelihood of nurses encountering people exhibiting thought-disorder in health services is high. There is evidence originating from New Zealand that mental health problems are present among people with chronic physical ill-health at a higher rate than those without. Estimates put this prevalence of mental health problems for people experiencing chronic physical ill-health at a rate between 25 – 29% compared with around 15.1% prevalence for people not experiencing any physical ill-health (Oakley Browne, Wells & Scott 2006). Not only does this establish the importance that nurses are prepared to respond to people experiencing mental health problems, but there are also a range of other circumstances in 'ordinary' nursing practice that support such preparation. People with pre-existing thought-disorder may develop physical health problems requiring nursing care. A range of health problems and procedures are known to trigger mental health problems, including those that feature thought-disorder. Post-anaesthetic psychosis (Vijayakumar et al. 2018) and puerperal psychosis (VanderKruik et al. 2017) are two examples where thought-disorder is a possible outcome other than as a pre-existing known mental health problem (Productivity Commission 2019, 2020).

An additional and more generic concern is the frequency by which breakdown in communication is identified as a root cause of health system errors and

dissatisfaction with care (Alert: Sentinel Event 2017; McKechnie 2015; Perry et al. 2013; Pincock 2004; Wheeler 2015). The nurse-consumer relationship is accepted as central to good mental health nursing practice (Peplau 1997); however, there are many reports of low levels of actual nurse-consumer interaction in practice settings (Altschul 1972; Hurst, Wistow & Higgins 2004; Martin 1992; Sandford, Elzinga & Iversen 1990; Sanson-Fisher, Poole & Thompson 1979; Tyson, Lambert & Beattie 1995; Whittington & McLaughlin 2000).

Altschul (1972) reported that as little as eight percent of nursing time was spent in interaction with a consumer in acute psychiatric services. This finding was replicated by other researchers, albeit with variable but low figures (Sandford, Elzinga & Iversen 1990; Sanson-Fisher, Poole & Thompson 1979; Tyson, Lambert & Beattie 1995; Whittington & McLaughlin 2000). Other studies have reported from the consumer perspective, finding that as little as four percent (Hurst, Wistow & Higgins 2004) or six percent (Martin 1992) of their time is accounted by communication with nurses. Sandford, Elzinga and Iversen (1990) found that as staffing numbers increased, staff-consumer interaction did not increase, although interactions between staff did so. Stenhouse (2011) observed that although consumers expected nurses to actively initiate supportive and therapeutic interactions, this was not experienced. Consumers therefore turn to each other for this support, often feeling emotionally burdened and perceiving nurses to be too busy with what was characterised as 'non-nursing' activities (Stenhouse 2011).

These observations and critiques have cemented communication studies in undergraduate nursing curricula world-wide. Indeed in the United Kingdom (UK), centralised audits were introduced to query nurse-consumer interactions mandating a documented minimum of 15 minutes one-to-one nurse consumer interaction for every consumer during the course of a nursing shift (Healthcare Commission 2008). MacLean, Kelly, Geddes and Della (2017) in an integrative review of simulated (standardised) patients used to develop communication skills with nursing students, report that this approach has been applied across a range of mental health diagnoses including depression (Becker et al. 2006), bipolar affective disorder, anxiety disorders (Kameg et al. 2014), schizophrenia disorder (Doolen et al. 2014) and suicidal ideation (Luebbert & Popkess 2015). However, nursing communication

curricula emphasise skills for working with people who are interested in communicating and able to do so. Those who experience thought-disorder may not be so positioned.

Further, a range of inquiries into the mental health theoretical content and clinical placement components within the Australian comprehensive pre-registration nursing programs have found these to be inadequate in their implementation into teaching programs (Happell 2010, 2011; Happell & Cutcliffe 2011; Mental Health Workforce Australia Advisory Committee 2010). In spite of these repeated findings and the recommendations for increased mental health content, there has been little change since the adoption of a single register of comprehensively prepared nurses (Barry & Ward 2017; Happell 2010; Happell & McAllister 2014a, 2014c; McCann et al. 2009; Wynaden 2010, 2011b).

Regulatory context of nursing

As a regulated health profession, nursing is subject to the requirements of centralised governmental bodies as regards registering to practice, standards of practice and the content of nursing curriculum. The Australian Health Practitioner Regulation Agency (Ahpra) has overarching authority that includes identifying approved programs of study which can lead to registration in association with the National Boards (Australian Health Practitioner Regulation Authority (Ahpra) 2019; Australian Nursing and Midwifery Accreditation Council (ANMAC) 2017).

In Australia, mental health nursing is not recognised as a separate program of study or form of registration as a nurse. Mental health placements are not mandated, although many pre-registration programs do include these. Mental health nursing content is obligatory in pre-registration programs, but its specific content or mode of delivery is not set. Rather, the practice outcomes are specified for beginning nurses as including some unspecified capability to recognise and to deliver health care for people who are experiencing mental health problems (Australian Nursing and Midwifery Accreditation Council (ANMAC) 2012).

This regulatory imprecision in the mental health preparation of nurses in their per-registration programs in Australia has enhanced the role for the relevant professional associations. In this case, the Australian College of Mental Health Nursing Inc. (ACMHN) has addressed what some regard as a regulatory shortcoming by developing a voluntary scope of practice, standards for practice, and curriculum documents (Australian College of Mental Health Nurses Inc (ACMHN) 2013, 2015, 2018, 2019). They have a consultative, rather than a regulative role.

Further, the ACMHN has developed a program for recognition of Credentialed Mental Health Nurses (CMHN) by meeting a set of criteria for advanced practice. This has been recognised by the Australian Government for eligibility for various schemes, such as the Mental Health Nurses Incentive Program (Buus et al. 2020; Happell & Platania-Phung 2017) and has acted as a blue-print for a range of other nursing specialties to develop schemes for recognition of specialist status (Dunshea & Morphet 2015).

The Federal government has also been concerned to set practice standards for the broader mental health workforce and services (Australian Government Department of Health 2010, 2013). However, these regulations do not address specifics of preparation of the workforce.

Mental health nursing preparation

In Australia, mental health nursing has a contested status as shown in the previous discussion of nursing regulation (Lakeman & Hurley 2021). Until the significant changes of the late twentieth century in beginning nurse preparation and nursing registration, mental health nursing was a separate nursing registration in all Australian states and territories and had an independent educational preparation. Progressively, all states and territories standardised beginning nursing preparation. This resulted in a single comprehensive award that subsumed mental health nursing within a generalist (comprehensive) preparation. This preparation transferred to a University Bachelor's degree during this period and by July 2010 there was a single Australian registration for Registered Nurses (Daly, Speedy & Jackson 2010). The Report of the Productivity Commission into Mental Health (Productivity Commission

2019, 2020) has suggested that consideration is given to the reintroduction of a pre-registration mental health nursing degree and a specialist registration system (Productivity Commission 2019, 2020).

This history has meant that identification of a mental health nurse by virtue of preparation or registration is no longer possible. Some nurses remain in the workforce who initially attained mental health (psychiatric) nursing registration and who completed a dedicated independent program of educational preparation. Otherwise, claims to the status of mental health nurse rest upon practice experience and possible postgraduate qualification (Buus et al. 2020). Postgraduate mental health qualifications are not required for employment as a Registered Nurse (RN) in mental health nursing.

The Professional Association, the Australian College of Mental Health Nursing, Inc. (ACMHN), has addressed this limitation through the award of a Credential for Mental Health Nursing (CMHN), discussed above. This recognises advanced preparation and practice and involves a register requiring renewal every three years to monitor maintenance of advanced preparation and practice (http://www.acmhn.org/credentialing/what-is-credentialing). The ACMHN has also led a broader implementation of Credentialing programs to recognise other areas of specialist advanced nursing practice, such as Children and Young People's Nursing (https://www.c4n.com.au/).

The presence of a credential award from the ACMHN would represent an additional method above and beyond practice or postgraduate studies to claim status as a mental health nurse. However, in the absence of explicit demand by employers, adoption has not been wide-spread. The Nursing and Midwifery Office Queensland from 2013 supported acquisition of the award of Credentialed Mental Health Nurse for nursing staff working in Hospital and Health Services (HHSs) mental health services (http://www.acmhn.org/career-resources/recruitment/82-credentialing/376-qld-cmhn-project). Credentialing has been recognised by the Australian Government for funding arrangements directed to programs requiring a mental health nurse. Participation in the Federal Government funded Mental Health Nursing Incentive Program (MHNIP) required participants to have this award (Happell & Platania-

Phung 2017; Meehan & Robertson 2013). However, the change in funding models by the Federal government to Primary Health Networks has seen this program's independent funding removed and the program markedly diminished except for isolated individual arrangements (Buus et al. 2020).

In the case of mental health nursing, within many undergraduate curricula, risk avoidance and maintenance of professional boundaries over-rides an emphasis on establishing therapeutic relationships in learning outcomes for mental health curriculum (Rio et al. 2020). Learning therapeutic nursing skills applicable to those experiencing mental distress is seen as secondary to maintaining safety or at times, referring to other professions for this support (Happell, Wilson & McNamara 2014).

Some misconception of the relevance of mental health nursing skills plays out in a number of ways during pre-registration education (Happell & Cutcliffe 2011; Happell & Gaskin 2013). There is common advice reported that a newly graduated RN risks losing important basic nursing skills by choosing to work immediately after graduation in mental health nursing (Flaskerud 2018; Nadler–Moodie & Loucks 2011). These misconceptions mimic commonly held social misunderstandings and stigmatising beliefs about the nature of working in services for people experiencing mental health problems, and the effect of this on the professional standing of mental health nursing (Corrigan, Druss & Perlick 2014). Although programs to counter these beliefs have been pursued for several decades in Australia, there is emerging evidence that they have not been fully successful (Buus et al. 2020; Cleary, Horsfall & Happell 2009; Hooper, Browne & O'Brien 2016).

The position of mental health nursing study in the BN curriculum may also be arguably an expression of stigma and reinforce any stigmatising prior held beliefs of students. Its minor profile for example, may reflect this in terms of curriculum resources of time and materials when compared with subjects supported by simulation learning (such as dedicated laboratories and equipment) (Bogossian et al. 2018).

In spite of decades of health promotion schemes in Australia, inclusive of mandatory classes in secondary schools (Kelly, Jorm & Wright 2007), nursing students are

experienced as or chose to adopt a position of tabula rasa (McCann, Lu & Berryman 2009). These prior learnings may be 'siloed' and unavailable as a scaffolding device to students for their further learning. This is particularly evident also in subjects studied prior to the mental health subjects within the undergraduate nursing program that are not seen as linking to mental health nursing studies. This may be a reflection of pre-existing stigmatising attitudes held by students and academics (Wynaden et al. 2014) in which they regard mental health as 'the other' that does not share common features with all nursing. Communication subjects, ethics and legal subjects can be cases in point.

Thought-disorder and reduced communication

Given the prevalence of mental health problems which will be encountered by nurses across a broad range of clinical practice areas and the absence of clear regulatory direction regarding mental health content for nursing preparation, communication preparation for students in responding to thought-disorder is important. This section will examine common guidance and approaches and consider their usefulness for beginning registered nurses.

As previously mentioned in the context of common advice regarding responses, thought-disorder may communicate emotional content. Over the past 30 years, through the development of the Hearing Voices Movement led by people who hear voices (Corstens et al. 2014; Styron, Utter & Davidson 2017) are increasing their exploration of the meaning of their perceptual experiences involving processes such as the Maastricht approach to interviewing (http://www.dirkcorstens.com/maastrichtapproach; http://www.intervoiceonline.org/). None of these however directly address responding to thought-disorder in the context of beginning nursing practice. Rather these are techniques and approaches that are used by people with lived experiences and delivered by clinicians who may include nurses, following specialist education in the context of a longer term and focussed therapeutic context.

Given that communication is recognised as exchange, thought-disorder can be established as reducing communication in the absence of knowledge, skills and strategies on the part of nurses to respond to such speech when encountered.

Learning in nursing

In this dissertation, learning is viewed as an active process involving the learner in the creation of knowledge but also involving a social dimension – the relative contributions and importance of each dimension is unsettled. Individuals have a range of characteristics that affect acquisition of knowledge, but the context of the learning experience also has significance (Andrew, Tolson & Ferguson 2008; Lave & Wenger 1998, 2002; Wenger 2004) The emphasis of this section is not how students are taught, rather how the nursing students participate in a process that equips them as a beginning practitioner of the art and science of nursing. This is conceptualised as a process separate from, but closely related and often parallel to, the activities of teaching. Teaching will aim to support students to learn but will not and arguably cannot ensure that learning occurs. Nevertheless, it is by engagement with a formal teaching program that nurses commonly participate in learning. It is conceivable that this learning may occur in a manner separate from teaching; however, because of the regulated nature of nursing, requiring successful participation in a program of nursing instruction, such learning is poorly recognised.

This section addresses the theoretical frameworks that have relevance to understanding the process of learning as a nurse in the context of learning to respond to people experiencing thought-disorder. All these ideas and understandings about learning are referred to loosely as Practice Theory: a term that refers to associated thinking about learning in groups. These include Ericsson's insights into the role of sustained practice (Ericsson 2008), Bruner's ideas around the scaffolding of learning (Bruner 1983), and the work of Vygotsky addressing the notion of the 'zone of proximal development' (Vygotsky 1978b). The work of Lave and Wenger (1998) in emphasising the social context of learning is recognised as of critical significance in learning for nurses. Finally, the strengths and limitations of

these approaches will be recognised in relationship to learning how to respond to thought-disordered speech.

The conceptualisation of knowledge and learning

The nature of learning and of knowledge is contested (Bruni, Gherardi & Parolin 2007). Ideas range from knowledge as a discrete body of agreed information ("facts") to knowledge as relative and emergent (DeYoung & DeYoung 2009). Learning is also an activity that does not have accepted agreement. Ideas range from those termed a "banking model" that characterises learning as a process of accumulation to concepts of learning as an act of creation. The so-called "banking model" may be conceptualised as a passive process and is frequently regarded as a gift of teachers. The alternate view of learning as an active process involves the learner in the creation of knowledge (Bahn 2001; Bandura, Adams & Beyer 1977; Rutherford-Hemming 2012). Ideas about learning also recognise both an individual and a social dimension and debate the relative contributions and importance of each dimension (Brown et al. 2009; Lave 1996; Lave & Wenger 1991). Individuals have been recognised to have a range of characteristics that affect acquisition of knowledge, but the context of the learning experience also has significance (Lave & Wenger 1998). In addition, the manner in which learning is 'pitched' in relation to prior understanding and learning has also been recognised to be critical for successful learning (Lave & Wenger 2002; Vygotsky 1978b).

Importance of action

The diverse collection of writings known as Practice Theory is concerned with the manner which groups use knowledge to alter their environment. Groups are recognised as varied and social. The focus of these writings incorporates the effects of the group on forming the world. In this way knowledge and learning are seen as social and as action based (Corradi, Gherardi & Verzelloni 2010).

The existence of knowledge independent of action cannot be separately conceptualised. Learning is altered by interaction in its social context. This proposes

that the nature of knowledge is relative – its expression and formation in action will vary according to the social environment in which it was formed (Brown & Duguid 2001).

Knowledge in nursing practice has many of these characteristics. Although some may observe that there are fundamental unalterable (perhaps physiological) processes, nursing is a profession that translates such knowledge to the individual circumstance of health and well-being. As such, this foundational knowledge will be transformed by its social context, part of which is the person's characteristics of ill-health expression and part of which is the social context in which it is encountered. The nurse has an active role in developing the knowledge relevant for the person in their care.

Insights from theoretical frameworks of learning

Further theorists of Practice Theory have augmented the understanding of learning utilised in nursing education. Ericsson's understandings of the importance of sustained practice for developing expertise is one such theory (Ericsson, Krampe & Tesch-Römer 1993). His work in examining expertise across a great range of endeavors supports the importance of deliberate practice rather than innate ability and capacity. In summary, expert practice is mediated by developing complex skills of perceptual, cognitive and motor nature underpinned by physiological adaption. The relevance to psycho-motor skills employed in procedural nursing competencies is readily evident, however learning complex therapeutic communication skills is also argued to benefit (Lok & Foster 2019). Nursing students cannot rely only upon a theoretical understanding of the development and appearance of thought-disorder to guide their therapeutic response. Sustained practice has an important contribution to make. This could be within a simulation context as it allows for repetition and error and the opportunity for reflection either individually or as part of a group on that practice. However, clinical practice placement also plays a role in providing an opportunity to practice in vivo with varying amounts of support and feedback. Its ethical limitations and practical guarantee of exposure make it less tenable as a guaranteed context for learning.

Situated within the constructivist tradition of knowledge, the Scaffolding theories of Bruner (1966, 1983, 1990) arise from understandings drawn from the study of cognition, particularly child development theory originating from Piaget's work. Bruner (1966, 1983, 1990) proposes that learning is an active process in which the learner engages in the construction of new concepts mediated by past and current knowledge. The ease of learning is supported by structured learning that allows building on prior knowledge, so called "Scaffolding".

Preparing students to respond to those exhibiting thought-disorders may be usefully approached as a series of smaller steps requiring mastery. The identification of these steps may not be definitively achievable, or indeed may be infinitely variable; however, breaking down a complex skill to smaller elements has merit. This is the value of Bruner's Scaffolding theory. The steps may be subject to differing ideas but identifying integrated steps to learn therapeutic communication with those who experience thought-disordered speech would be conceivable and beneficial.

A school of thought that closely addresses the notion of learning in the context in which it is used is known as Situated Learning. Seminal work in this field was that of Vygotsky (1978a). His work was further developed by cognitive psychologists including Brown, Collins and Duguid (1989) and Lave and Wenger (1991). The critical feature stressed is that learning is a contextualised activity often characterised by co-construction of knowledge by the participants in the learning environment. These fellow participants and their co-operation in knowledge construction is termed a Community of Practice (Wenger 1998). This social process is embedded in a context of particular physical and social characteristics. The relevance to nursing student clinical placement and its replication in simulation is readily apparent. It suggests that employing simulation may be more effective if it allows for co-construction of knowledge by students as a Community of Practice. This involves a shift from teacher-centred pedagogy to a student-centred approach. Although congruent with andragogy (Malin 2000), this emphasis may represent a significant change to usual teaching patterns that feature the direction being determined by the teacher, and is consistent with the type of learning students will experience when they graduate and join the workforce.

Haigh (2007) argued simulation teaching and learning experiences (for midwives) should not be regarded as 'second best' to clinical placement. The capacity in simulation for deliberation and deep-learning (Eraut 2000) draw on human activity theory (Engestrom 2001) and can be greater than that possible during clinical placements. This could redress identified shortcomings of situated learning theory and the concept of legitimate peripheral participation conceptualised by Lave and Wenger (1991) as regards the expression of tacit knowledge (Eraut 2000) in the clinical learning context.

The extensive emphasis on learning drawn from reflection in the health professions including nursing and the work of Schön (1983) is predicated on an individual's engagement in the reflective activity. Eraut's (2000) observations that others are part of both the experience and the learning, suggests that the group reflective process of debriefing following a simulated or clinical placement learning experience may be more effective for learning than the individual reflective exercises.

In the context of this project of learning to respond to thought–disordered speech, the observations made by Haigh (2007) drawn from simulation have relevance. They indicate the linkages between learning in simulated environments and deep learning that may facilitate better use of insight from reflection on action, by incorporating others in the manner of a Community of Practice. This suggests that active approaches to learning may be more effective at times in a simulation context than during clinical placement.

Simulation and clinical placement learning both emphasise application of knowledge in a context and active construction of knowledge through a discursive process during debriefing and other reflective processes. Of particular pertinence to this is the insights from the theory of 'Transformational Learning' (Mezirow 1991). The recognition of learning as '…becoming critically aware of one's own tacit assumptions and expectations and those of others and assessing their relevance for making an interpretation' (Mezirow 2000 p4), is central to the practice of mental health nursing and hence relevant to the learning of beginning communication skills.

Bandura's model of social learning incorporates the understanding that learning is a continuous process motivated by interactions with others not only in the classroom or work life but also in personal life. How an individual works is influenced by the work practices observed among the people with whom they work or study. Bandura (1977a) postulates that there are four successive processes in such learning: attention, retention, reproduction and reinforcement. Reinforcement may provide motivation for future learning (Bandura 1977b). The overall experience of learning in this social model of behavioural modelling leads to a sense of 'self-efficacy'. Self-efficacy is described as the judgement of one's capability to accomplish a certain level of performance (Bandura 1977a, 2012).

It is apparent that having theoretical knowledge and skills is insufficient for learning a specific skill such as responding to thought-disordered speech. Consideration of the effectiveness of clinical placement for learning is also necessary. If simulation pedagogies are considered as a method to offer the best replication of the clinical placement experience, it is worthwhile to question whether clinical placement is a good pedagogical method itself.

Levett-Jones, et al (2006a) describe an Australian quality improvement project that spanned the university and clinical sectors seeking to enhance student experience of clinical placements. They identified five factors that influenced learning on clinical placement: communication breakdown between the university and clinicians; mentorship; preparation for clinical placements; clinical competence; and graduates' readiness for practice. These findings highlight the complexity of achieving consistent learning outcomes from clinical placement for all students. This is in addition to achieving sufficient placements across a full range of clinical experiences.

A study of clinical stakeholders' views of challenges to quality learning outcomes and student satisfaction during mental health clinical placements identified the importance of collaboration, resources, student personal attributes, creative clinical teaching, the roles of preceptors and clinical facilitators, and nursing curricula (Cleary, Horsfall & De Carlo 2006). The parallels to the findings of Levett-Jones et al (2006a) are telling. These studies (Cleary, Horsfall & De Carlo 2006; Levett-Jones et

al. 2006b) establish that clinical placement learning outcomes are difficult to guarantee due to the number of factors that influence the quality of the experience.

The importance of the context and community of practice

Lave and Wenger (1991) have explored the contribution of groups to learning within different practice environments. They named these groups communities of practice and described different roles within a variety of occupationally based groups[1]. Primary functions of communities of practice are to transmit knowledge and coordinate practice activities. Theorists (Andrew, Tolson & Ferguson 2008; Brown, Collins & Duguid 1989; Brown & Duguid 1991, 2001) have extended the ideas of Lave and Wenger (1991) to apply to a broad range of learning environments in order to better understand social dimensions of learning. Communities of practice are organised by a particular activity (occupational or other) and the sharing of a range of skill sets and experience levels. The communities of practice group acts as a way of transmitting knowledge from more experienced members, of applying knowledge to a task, and of creating or modifying knowledge (via applying established knowledge to a fresh task).

The application of communities of practice to nursing and the experience of learning in nursing has been recognised (Andrew, Tolson & Ferguson 2008). However, this model has many tensions including that individuals belong to different communities of practice simultaneously. For students of pre-registration nursing, these may include communities of practice within their individual subjects and also communities of practice emerging during different clinical placements. These communities of practice will change over time in their education program as students are grouped differently in subjects or change their colleagues by individual choice. Between clinical placements, change is experienced throughout the curriculum. It is unclear that learning in one context or community of practice will be readily transferred to subsequent communities of practice and contexts of nursing, in part due to the influence of the uniqueness of the cultures experienced (Sole & Huysman 2002).

[1] Midwives, tailors, quartermasters, meat cutters and members of Alcoholics Anonymous were studied.

The composition of communities of practice experienced by nursing students may also vary. Perhaps within the education provider context, the group will encompass fellow students who all share a fairly uniform level of knowledge. It would be expected that most communities of practice members, as fellow students, may be roughly homogenous in terms both of prior knowledge of the subject and in terms of their experience as students. The teacher, as a member of the communities of practice, assumes a role of expert. A teacher could be seen as external to these communities of practice, as analogous to management in clinical practice. Then the student communities of practice do not include a dominant expert.

The communities of practice experienced by students in clinical practice placements are highly varied. Students may have (transitory) membership of an established community of practice while on clinical practice placement. These groups may be fairly fluid, grouping and regrouping, around the challenges of practice and across time due to the structure of working life in nursing practice. Shift work and differing acuity levels among patients can necessitate change in communities of practice in these contexts.

By contrast, the communities of practice that nursing students experience during their education are relatively homogenous. The range of experiences among student members of communities of practice is much narrower than those encountered in clinical practice. There, in clinical practice, archetypical membership is dominated by experienced members, and novices are in the minority (Gherardi & Nicolini 2000). This has implications for the use of simulations as a pedagogy technique when attempting replication of the practice environment. Absence of experienced members, to contribute to the formation of knowledge, changes the process of learning. Although it may be possible to argue that what is in fact learnt is how to learn in a manner that will be applicable in later practice.

Role models

In the context of communities of practice when enacted on clinical practice and within classroom learning, role models have been observed to be a feature (Passi et

al. 2013). Role models are like experts within a community of practice. They also share certain features of mentors in that the student selects a more senior or experienced person to emulate. It differs from both experts or mentors in that there is not an agreement, explicit or tacit, to support this student as a role model. The selection of a role model may be unknown by the person selected. The features that students value in selection of a role model are poorly understood or described (Illingworth 2009)

The health care literature suggests that role models may be either positive – displaying admirable professional practice - or negative (Passi et al. 2013). Positive role modelling is defined by high standards of clinical competence, high clinical teaching skills and 'humanistic' personal qualities (Passi et al. 2013, p. e1422). Either role model may influence student learning, consciously or unconsciously. A student may recognise a poor role model and avow to ensure a better standard of practice (Jack, Hamshire & Chambers 2017). However, poor models may not be clearly recognised and still be emulated (Illingworth 2009, p. 815).

The nursing literature recognises the existence and importance of role models for nursing student learning (Del Prato 2013; Jack, Hamshire & Chambers 2017). However little research is evident that explores and explains how role modelling functions in detail. There is agreement that role modelling represents a significant influence on the formation of practice (Passi et al. 2013). Role modelling has been commonly understood as occurring during clinical placement (Jack, Hamshire & Chambers 2017), however the influence of nursing academics may well be more significant due to the greater exposure of students to these role models (Baldwin et al. 2014). This phenomenon has had limited exploration (Baldwin et al. 2014).

Illingworth (2009) in a small phenomenological study of third year nursing students' perceptions of role models in mental health education concluded that the predominance of late adolescent or early adult aged nursing students represents a particular challenge around role modelling. He suggests that nursing students may be more susceptible to influence due to their developmental stage. This underscores the importance of conscious preparation of educators both within clinical practice and academic practice for the importance of role modelling in learning.

In the context of student learning to respond to people with thought-disorder, role models on clinical placement may have great significance. Although students may not meet people experiencing thought-disorder, more general learning from role models in mental health nursing may be influential. Empathy, respect and person-centred practice are characteristics which when displayed by a role model may be emulated. Such practice skills will have utility across a range of problems and challenges encountered in mental health nursing, including learning to respond to people with thought-disorder.

Embodied learning

Learning being expressed in action has been explored by some theorists working within practice theory (Fenwick, Nerland & Jensen 2012; Hopwood 2014). This work has drawn on some aspects of the ideas of Pierre Bourdieu (1977, 1985, 1990, 1998). The focus of this work encompasses learning as embodied action: that is being manifest in the body, in time, in material elements and in spatial location (Gherardi & Nicolini 2002). Bourdieu drew attention to the role of the bodily disposition in practice and learning through the notion of habitus – a concept analogous to 'learning to play the game'. Prior internalised understandings and habitus (bodily disposition) mediate between social structures and activity. Mediation involves the actions taken in regard to the material artefacts, the timing of actions and the location in space that these take place.

In nursing learning, this is evident in the relationship of simulation learning and other student members of the communities of practice, the timing of interventions and the employment of other material artefacts of practice, including uniforms and ordinary items of practice including pens and stethoscopes. Nursing practice, even as replicated in a simulation environment, is replete with elements other than a procedure, intervention or person-to-person encounter.

Dilemmas of practice theory

Practice theory as an overarching conceptual framework to understand knowledge generation presents identifiable challenges in undergraduate nursing. Application to learning activity within a simulation framework such as role play seems well aligned. However, as noted the composition of the communities of practice may contain particular features that demand consideration. The previous discussion noted that in practice, the composition of communities of practice may be more heterogeneous than that of student communities of practice in learning environments. This changed composition may affect both the capacity to generate knowledge within the communities of practice and the type of knowledge generated between different students' communities of practice.

So, the contention is that students may develop differing bodies of knowledge in action from their membership of different communities of practice. It may be argued that such heterogeneity is not an issue because the task of the educator is to enable the student to learn how to learn, rather than to transmit a definable, absolute body of knowledge. Accrediting bodies such as ANMAC do not require checklists of information and skills to be demonstrated. However, a further stakeholder in the education of undergraduate nurses – their eventual employers – may be at variance with this. This suspicion is supported by concerns that graduates are 'work ready' and the increasing interest in 'capabilities' for practice which tend toward this requirement (Bromley 2017; Mirza et al. 2019). The view of health care consumers, the fourth stakeholder in nursing education, is not known in this context.

This is in addition to the tension from conceptualising of homogenous groups of student learners as the source of learning generation. The original conceptualisations (Lave & Wenger 1991), was of a quasi-apprentice: master relationship. The communities of practice that included variations in experience, skills and knowledge brought to bear on a shared problem, task or challenge in practice. Knowledge generated was shared through its mutual creation and this included those who did not actively participate but took a role described as

‘legitimate peripheral participation’ (Lave & Wenger 1991). The question arises – how will the generation of knowledge occur in these circumstances, especially due to the time limits that circumscribe learning sessions? If the experience and knowledge is at a beginner level, there is a reduction of resources for and in the communities of practice.

A final issue arises in nursing preparation for practice utilising communities of practice. As Lave and Wenger (1991) have observed, there is a legitimate role in communities of practice for members whose participation is minimal or non-existent. However, within the confines of the education provider for preparation of undergraduate nurses, there is an expectation that each student will have equivalence in demonstrating skill and knowledge acquisition. If the model of communities of practice recognises ‘legitimate peripheral participation’, there is a tension that exists with other conventions of learning. Reconciliation may prove problematic, especially as the notion of ‘legitimate peripheral participation’ draws on ideas arising from the work of Vygotsky (1978b), particularly that of the ‘zone of proximal development’ (ZPD).

The ‘zone of proximal development’ (ZPD) describes the observation that on an individual level, people learn when the task to master extends them from their current level of knowledge and skills. Such ZPDs can be variable, although influenced broadly by developmental stage in children, the ZPD are not uniform in any given population (by age or educational stage). This lack of uniformity of student participation further confounds the experience of communities of practice within nursing education as the manner of generating knowledge. Individuals may have varying capacity to engage in the learning experience, influenced by their personal ZPD.

The challenge in the preparation of nursing students is to take them from a position of relative unknowing in relation to thought-disorder to confident and competent mental health nursing practice.

The view of Experts by Experience

Personal accounts of the experience of thought-disorder specifically are scarce and difficult to locate. These accounts often fall outside the academic peer-reviewed literature and draw on personal experience and consensus understandings. Material may be situated within a broader framework and not reflect the medically influenced lens of thought-disorder.

Accounts of the experience of psychotic disorders predominately recount a personal story situating psychosis in the person's life history (Happell & Bennetts 2016; Happell, Byrne, et al. 2014b). This commentary often explores system characteristics rather than exploring helpful approaches to respond to the experience of thought-disordered speech (Happell, Bennetts, Platania-Phung, et al. 2015).

The literature that has examined the role of Experts by Experience as academics is more widely available (Happell, Bennetts, Harris, et al. 2015; Happell, Byrne, et al. 2014b; Happell et al. 2018; Happell, Platania-Phung, et al. 2019; Happell, Wynaden, et al. 2015). Findings from Australia describe a range of informal academic arrangements in spite of the policies that emphasise the inclusion of Experts by Experience in all aspects of policy, services and education (Happell, Bennetts, Harris, et al. 2015; Happell et al. 2016; Happell, Bocking, et al. 2019). The type of involvement in nursing student preparation is influenced by financial and curriculum limitations, faculty attitudes and lacks clear guidelines (Happell, Bennetts, et al. 2019; Happell, Wynaden, et al. 2015). Involvement in the delivery of nursing preparation by Experts by Experience has been shown to increase interest in mental health nursing careers and reduce stigmatising attitudes (Happell, Byrne, Platania-Phung, et al. 2014).

Mental health nursing clinical skills

Mental health nursing competencies are expected in the preparation of Australian Division 1 (Registered) comprehensive nurses. There has been concern from the Australian mental health nursing profession regarding the adequacy of preparation

for mental health nursing practice (Happell & Cutcliffe 2011; Happell & McAllister 2014c; Happell & McAllister 2015; Stuhlmiller 2005). The concern has been present since the introduction of comprehensive preparation and the implementation of a single register in the 1980s (Morrissey 2003). This concern continues largely unabated (Happell & McAllister 2014b; Mental Health Workforce Advisory Committee 2008; Productivity Commission 2019, 2020; Wynaden 2011a) to some degree because implementation of integrated mental health studies has demonstrated considerable variability in form (Happell & McAllister 2014a; McCann et al. 2009; Mental Health Workforce Advisory Committee 2010).

Originality of research or contribution of the research

The contribution of this research project is to explore the learning that occurs in relation to responding to thought-disorder. Little is known about how this learning occurs within the context of the undergraduate nursing program. The presence of the topic of thought-disorder in the curricula is interrogated and the opinion of nursing students and of mental health academics regarding its importance for beginning comprehensively prepared nurses investigated. The understanding of how learning is experienced by nursing students is explored with both nursing students and with mental health academics. The opinions of both groups were sought regarding the value of different types of learning pedagogies in order to examine the relative merits.

Chapter summary

The personal observations from my clinical practice identified that nursing students experience anxiety and difficulties in responding to people who exhibit thought-disorder, and this challenges their ability to adopt person-centred, strengths-based models of practice.

There are several learning models that may be effective in supporting students' learning about thought-disorder. These models draw on recognising active learning. They incorporate situated learning and practice theory insights of the social and

contextual features of learning to be a nurse. Communities of Practice are also relevant, as they often form during clinical placements or within simulation-based learning models used to develop these communication skills.

Organisation of the thesis

This chapter outlines some features of thought-disorder and learning to respond therapeutically as a nursing student. The topic and the rationale for the research study is presented, and the key terms are defined. The chapters in the thesis are presented as outlined below.

Chapter 2 explores the reviewed published literature that addresses the research question: 'How to support pre-registration nurses learning to respond to thought-disorder'. An integrative literature review and its findings are reported.

Chapter 3 reports the selection of methodology and methods for this research study. A mixed methods approach to this study is supported by explanation of its 'fit' for the research question. The aims and design of the study are identified, and details of the participant recruitment and data collection, including the survey instrument and the interviews, are presented. The methods used to analyse the quantitative and qualitative data are outlined, and the ethical considerations of the study are presented.

Chapter 4 reports on Phase One results from a survey of student and newly registered nurses. The quantitative data are descriptively analysed, and the qualitative data explored with thematic analysis.

Chapter 5 addresses Phase One findings from semi-structured interviews with student and newly graduated nurses. The thematic analysis of the interview data is presented.

Chapter 6 describes the findings of Phase Two of the research study. The thematic analysis of interviews with mental health nursing academics who work in pre-registration nursing programs is reported.

Chapter 7 is the final section of the dissertation. This chapter provides a discussion of the findings from the two phases of the research study and proposes a set of conclusions. This includes delineating the limitations of the research study and suggestions for further research to better understand the recommendations for the research question: 'Preparing nursing students to respond to thought-disorder'.

Following the discussion chapter are the appendices. All of the in-text references are situated in a Bibliography that adheres to the HARVARD (UTS) format.

Glossary/ key terms

Consumer

refers to a person who is currently using or has used a mental health service in the past. This does not include all people who experience mental health problems as many people do not seek or receive these services. A consumer is the term adopted by mental health services and policy makers and ordinarily indicates that the person has a diagnosis of mental illness. Not all people in these categories accept this terminology.

Carer

is a term used to refer to people who support those with mental health problems. This is often family, including partners and children, but can also include unrelated people like friends. Those who receive payment are not included. In some Australian jurisdictions, under the relevant Mental Health Legislation such as the NSW Mental Health Act (2009), carers must be nominated by the person receiving treatment. A carer does not default to be the person's next-of-kin.

Experts by Experience

refers to people who have experienced or continue to experience mental health problems and is a term with increasing currency. It has gained use especially as a means of contrasting with those deemed experts by learning – clinicians and other professionals of various disciplines.

Lived experience

(of mental health) is an expression used to identify people who have experienced mental health phenomenon, with or without seeking help, care or assistance from mental health services and who may not identify these experiences as problematic**.**

Psychiatric survivors

is a term with origins in the USA and is primarily used as a self-description by people who have experienced mental health treatment and services.

Service users

is primarily a term used in the UK and refers to people who have been treated within mental health services.

Thought-disorders
are manifested in speech that is associated with several mental health problems but primarily psychotic diagnoses. It shows cognitive organisation that is apparently illogical, lacking in usual sequencing of words and/or concepts, and may exhibit delusions or bizarre features.

Chapter 2: Literature review: Pre-registration learning to respond to thought-disorder

Introduction

Pre-registration nursing students undertake learning in mental health, but report that mental health clinical placements are stressful, especially when communicating with people diagnosed with mental illness (Kameg et al. 2009). Therapeutic communication is a foundational topic across nursing curricula and provides learning that could prepare students to respond to thought-disordered speech. The features of thought-disordered speech, detailed in Chapter 1, may contribute to the stress experienced by students when communicating with people diagnosed with mental illness. This chapter examines the literature in the form of an integrative review (Torraco 2005; Whittemore & Knafl 2005). It presents a critique and synthesis of the representative literature on the topic of this research study, with the aim of generating fresh perspectives and frameworks (Torraco 2005).

The literature reviewed produced disappointing results, as few studies directly addressed the question: "*In pre-registration nursing students, what educational or learning strategies teach students to respond to a person exhibiting thought-disorder speech?"* The literature reviewed established that learning to respond to thought-disordered speech was not identified as a discrete skill; it was subsumed into broader communication skills employed with people experiencing mental health problems and simulation and clinical placement were prominent in teaching approaches. This review demonstrated some definitional obscurity between the terms, therapeutic communication, and interpersonal skills, and identified peripheral issues such as the use of standardised patients, addressing pre-clinical placement anxiety, achieving person-centred care and therapeutic communication, and the place of mental health nursing skills in pre-registration nursing programs.

It was determined not to include the literature that examined responding to those hearing voices or who have delusional ideas during psychotic experiences as it is

argued that these represent sufficiently separate and distinct psychotic phenomena. Delusions are commonly referred to as thought content. Although it is clear that the experience of each psychotic phenomenon is rarely discrete and can often be intertwined, with one phenomenon supporting another (Jones & Shattell 2016), the focus of this research study is the phenomena of thought-disordered speech form. The largely perceptual (mis)interpretation of hearing voices and the differing cognitive interpretation represented by delusional ideas is distinct from the confusion of ordering thoughts as evident in thought-disordered speech form. Hearing voices, experiencing delusions and exhibiting thought-disorder may have shared features such as the suggested importance of prior trauma for example in their genesis. The challenges for students learning to respond and support people with thought-disorder have distinct differences from responding to delusional beliefs or hearing voices. Thought-disordered speech form is characterised by incomprehensible structure that from initial engagement entails different communication responses and skills from those that may be helpful for people who are hearing voices or who hold delusional beliefs. The relative coherence in the presentation of these phenomena (hearing voices and delusional beliefs) – even if not a commonly shared experience or belief – distinguishes them from the phenomenon of thought-disordered form.

Method

The aim of the literature review is to establish the existing research base on learning to respond to people exhibiting thought-disordered speech. An integrative literature review was the selected method as these are recommended in emerging fields or those with limited publications (Whittemore & Knafl 2005). Their method supports the combination of papers of diverse methodologies and can include both empirical and theoretical papers in the development of comprehensive understanding of particular health care phenomenon (Whittemore & Knafl 2005, p. 546). The outcomes of an integrative literature review are claimed to be useful for the development of theory, practice and policy and to identify the current state of knowledge (Torraco 2005; Whittemore & Knafl 2005). This integrative literature review sought to establish a foundation of current knowledge to which the experience of participants in the research study could be compared. The exploration of current research would identify any gaps in knowledge and areas that need further investigation.

The process of examining pre-existing knowledge for the topic of this research study required a rigorous and systematic approach. Establishing pre-existing knowledge follows a process that has evolved over the past three decades, and is also witnessed in nursing practice in the application and development of Evidence Based Practice (EBP) (Grant & Booth 2009). This problem-solving approach incorporates a 'spirit of inquiry' that encourages curiosity and routine questioning of usual clinical practice (DiCenso, Cullum & Ciliska 1998; Melnyk et al. 2011). It acts as a model and provides a guide for a thorough search for relevant quality evidence about the topic of this research study.

The formulation of a research question can make finding high quality evidence more efficient and effective, overcoming key barriers to ensuring thorough examination of existing knowledge (Stillwell et al. 2010b). Without a systematic approach, results can be frustrating, irrelevant or unreliable. A well formulated question systematically identifies the key components of an issue, leading to the most relevant literature, thereby providing the best evidence of relevant pre-existing knowledge (Stillwell et al. 2010b). Better specificity and conceptual clarity in the question should achieve relevant results of higher precision (Agoritsas et al. 2012).

Formulation of research question

A recommended method for formulating a clear question that will facilitate a comprehensive search of the literature incorporates the following elements that are referred to as the acronym PICOT (Stillwell et al. 2010a):
Population or Problem (P) – A clear identification enables improved focus in searches and the identification of key words and synonyms. In this research study the population is pre-registration nursing students.
Intervention (I) – The education or learning and teaching strategies.
Comparison (C) – In this research study, there is no population or alternative learning or educational program to act as a comparison.
Outcome (O) – For this research study the desired outcome is communication skills for responding to a person exhibiting thought-disorder speech.

Timeframe (T) – The relevant timeframe is by graduation that is within the undergraduate or pre-registration nursing program. It is redundant to repeat this as it is indicated in the population that has been identified.

Using the PICOT method, this question has been structured as follows: ***In pre-registration nursing students (P), what educational or learning strategies (I), teach students to respond to a person exhibiting thought-disordered speech (O)?***

Literature search strategy.

Discussion will now turn to explain the search strategy undertaken (informed by Stillwell et al. 2010). As shown in Table 2.1 keywords for searching were taken directly from the PI(C)OT question, synonyms were identified, and United States of America (USA) and United Kingdom (UK) spelling were identified. Truncations were used for keyword searches, and exact phrases expressed using inverted commas.

Table 2.1: First search terms

PICOT	Keywords	Synonyms	CINAHL heading
Pre-registration nursing students (P)	"Nurs* Students"	Undergraduate Nurses College Nurses University Nurs* Students	Students, Nursing
Education or learning strategies (I)	Education Training Teaching Program*	Train* Stud*	Education Nursing, Baccalaureate
Comparison (C)	Not applicable		
Teach students to respond to a person exhibiting thought-disorder (O)?	"respond to thought-disorder"	Communic* Therap* mental illness OR mental disorder	Psychotic disorders

Different databases were searched, as databases index different studies. CINAHL (Complete) and PubMed (Medline) were searched for primary studies, as well as systematic reviews and meta-analyses. When using CINAHL (Complete) and PubMed, the language of the databases was adopted in addition to the keyword searches, to cover the literature indexed under the 'controlled vocabulary' of Medical Subject Headings (MeSH) and Subject Headings (SH) (Stillwell et al. 2010). Additionally, other databases were searched for evidence. These included PsycINFO, ERIC, Scopus, and Google Scholar. PsycINFO is a database of the American Psychological Association, and chiefly addresses the international research literature in mental health, and potentially includes education in the field. ERIC is supported by the US Department of Education and focuses on the educational research literature. Google Scholar is a web-based search engine that focuses on indexing the scholarly literature drawn from a broad range of publishers. Scopus was launched in 2004 by Elsevier for disciplines inclusive of health sciences and indexes peer-reviewed journals from more than 11,000 publishers.

Searches were conducted individually, and then combined using Boolean operators. "OR" was used to combine synonyms to broaden the articles for each component of the PI(C)O(T). Then to find articles that narrow to the PI(C)O(T) question, the search terms were combined using "AND"/"OR". Different combinations of terms were adjusted to increase or reduce the number of results. Limiters were applied to identify the most relevant and useful articles: English, since 1998 (21 years), peer-reviewed, from an academic journal.

The titles and abstracts of the results were scanned for relevance, using inclusion and exclusion criteria (Stillwell et al. 2010a), as shown in Table 2.2. References of papers were also scanned (so-called 'ancestry method') (Fineout-Overholt et al. 2010). Finally, full text versions of the papers were rapidly appraised for relevance. The limiters and exclusion and inclusion criteria used enabled a selection process that supported the research question and allowed a focused search of the literature (see Table 2.2). The search did not require that all the inclusion criteria were met for article selection.

Table 2.2: Limiters, and inclusion criteria

Limiters	English language Academic Journal Peer reviewed Last 21 years 1998-2019
Inclusion Criteria	Nursing students AND health students Formal learning experiences Informal learning experiences such as clinical placement Communication training Mental Health/psychiatric nursing

This integrative review was informed by PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines (Moher et al. 2009). These guidelines assist in reporting findings from systematic searches of the health research literature, especially meta-analyses and systematic reviews by outlining a process to report the selection of relevant articles. This supports transparency for this aspect of the research process. It does not however, provide a process that critically assesses the quality of the resultant articles. This is a separate process. Although the PRISMA guidelines were primarily developed to guide authors in selection of meta-analyses and systematic reviews, it is useful in guiding systematic identification of a range of other research including observational studies, for example.

The literature search for this research project was expanded to include other undergraduate health professional students and was up-dated to include the literature published until 2019. This was carried out as there was a limited number and quality of literature initially identified. Expanding the search terms aimed to ensure all available sources of information for this research project were identified. The newly formulated search terms are summarised in Table 2.3:

Table 2.3 Second search terms.

PICOT	Keywords	Synonyms	CINAHL heading	Boolean operator
Pre-registration Nursing Students (P)	Health Students" Nurs* nurses Nursing Student nurse Health care professionals	Undergraduate College University Nurs* Students	Students,	AND/OR
Education or Learning Strategies (I)	Education Training Teaching Program*	Train* Stud*	Education, Baccalaureate	AND
Comparison (C)	Not applicable			
Teach Students to Respond to a Person Exhibiting Thought-disorder (O)	"respond to thought-disorder"	Communic* Therap* treatment intervention Communication skills mental illness OR mental disorder	Psychotic disorders	AND
Before Graduation (T)?	Graduat*	Regist*		AND

This strategy of a second search increased the original 36 articles identified and identified an additional 933 articles. When all of these were reviewed by abstract and title, 26 articles remained. These were then reviewed in full text for relevance to the research question. This resulted in seven additional articles that were selected as meeting the search criteria. These were included in the review, expanding the number of articles from five to 12.

A final further search was undertaken to focus on the views and any relevant observations from the emerging literature of the consumer or carer communities who increasingly have input into undergraduate nursing educational preparation. The search terms are summarised in Table 2.4.

Table 2.4 Third search Terms

PICOT	Keywords	Synonyms	CINAHL heading	Boolean operator
Consumer and/or Carer (P)	Consumer Carer	Patient "Expert by Experience" Service user		And/or
Education or Learning Strategies for Health professionals(I)	Education Training Teaching Program* Health Students"	Train* Stud* Undergraduate College University Nurs* Students	Education, Baccalaureate Students,	AND
Comparison (C)	Not applicable			
Teach Students to Respond to a Person Exhibiting Thought-disorder (O)	"respond to thought-disorder"	Communic* Therap* mental illness OR mental disorder	Psychotic disorders	AND
Before Graduation (T)?	Graduat*	Regist*		AND

This search expanded the 969 identified articles identified from the first two search strategies by a further 309 articles. A review of titles and abstracts of these 1278 articles reduced this number to 366 that were potentially relevant. Articles that were excluded at this stage included those that explored the attitudes of professionals towards service user involvement, strategies for supporting self-management, or motivation for self-advocacy, for example. Review of the full text of these articles added a further two articles that met inclusion and exclusion criteria for this research study.

The complete literature review examined 368 articles for full text review. This full text review found 42 articles that fully or partially met the inclusion and exclusion criteria. This process is reported on the PRISMA flow diagram (Moher et al. 2009) in Figure 2.1

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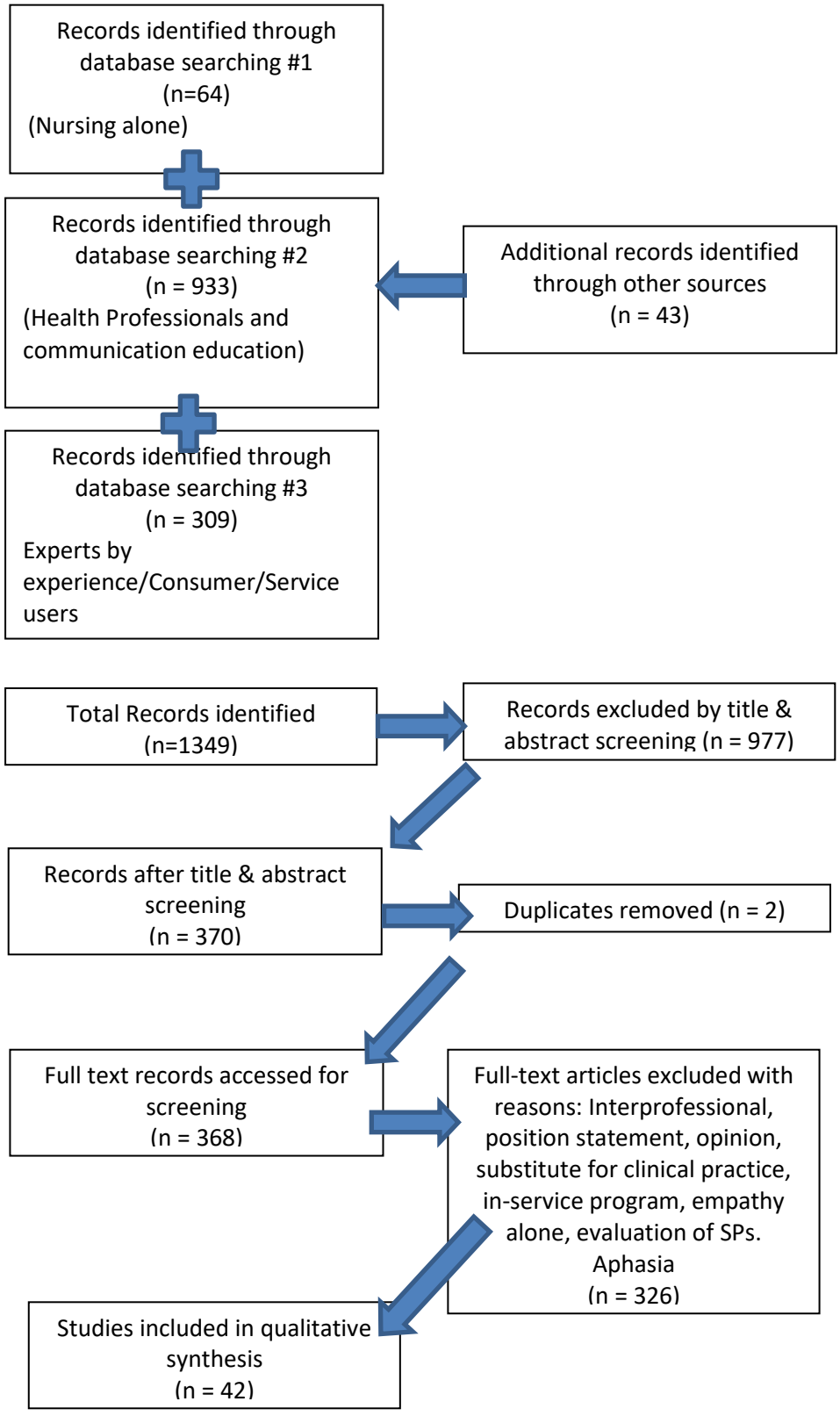

Figure 2.1 Literature review strategy (PRISMA flow diagram)

Analysis

The papers identified were further examined using CASP (Critical Assessment Skills Programme) checklist for use when reading Qualitative research (Critical Appraisal Skills Programme 2017). This is one of eight checklists developed by the Oxford Centre for Triple Value Healthcare (https://casp-uk.net/). This appraisal system addresses three broad issues about the research articles under consideration - validity of results, the nature of the results, and the local applicability of the results. These issues are addressed systematically by a ten-question checklist (See Appendix 1 for completed example of checklist.). The review process found all 42 articles met the criteria for retention of qualitative research.

The selected articles are listed in Appendix 2. This table summarises factors about each of the articles to facilitate comparison. The country of research is noted as features of health and education systems are known to vary between countries in ways that may impact the relevance of the findings to this research project. For example, not each country has a comprehensive undergraduate nursing preparation. In the UK there are four distinct and independent undergraduate nursing programs that lead to separate nursing qualification and registration – Adult, Child, Learning Disability and Mental Health.

Each study was also categorised by year of publication, study design and sample, purpose of the study, and main findings. The table clearly illustrates the diversity of the selected articles.

Findings

Forty-two research study papers were identified that focussed on the development of skills within a mental health nursing framework. These were conducted in a range of countries. Six papers (Bee et al. 2008; Bowers et al. 2009; Chant et al. 2002; Currid & Pennington 2010; McCann & Bowers 2005; Proctor & Welbourn 2002) were from the UK and 17 from USA (Dearing & Steadman 2008, 2009; Doolen et al. 2014; Ellis et al. 2015; Grant & Jenkins 2014; Jones & Shattell 2016; Jones et al. 2016; Kameg et al. 2013; Kameg et al. 2010; Kameg et al. 2009; Martin & Chanda 2016; Miles et

al. 2015; Reeves 2015; Sleeper & Thompson 2008; Swan & Eggenberger 2020; Webster 2013, 2014), one from Hong Kong (Chan 2014) and two papers from an international collaboration from six countries (Finland, Australia, The Netherlands, Norway, Ireland, Iceland) (Bocking et al. 2019; Horgan et al. 2018). Three papers were from Denmark (Ammentorp & Kofoed 2010; Ammentorp et al. 2007; Nørgaard et al. 2012), four from Australia (Cleary 2003, 2004; McCann, Lu & Berryman 2009; Stomski & Morrison 2017), one from New Zealand (Beavan 2007), one from Greece (Fenekou & Georgaca 2010), one from Ireland (Roche et al. 2015), one from Northern Ireland (Whittington & McLaughlin 2000) and one from Norway (Kalhovde, Elstad & Talseth 2013). A further collaboration was from Australia and Northern Ireland (Grant et al. 2016), one from The Netherlands, USA and UK (Guloksuz & Van Os 2018); one from The Netherlands, UK and Norway (Romme & Morris 2007) and one from Australia, Canada, Northern Ireland and Norway (Foster et al. 2016).

Thematic analysis of these 42 articles was undertaken. Repeated reading suggested themes of relevance to this research study. Each article was assessed for the presence of these relevant themes and the results are reported in Table 2.5 The processes of analysis were checked by and discussed with supervisors for relevance.

The six themes identified and applied to the articles were:

1. Undergraduate nurse preparation for responding to thought-disordered speech.
2. Trauma-informed and Recovery orientated approaches.
3. Addressing anxiety to improve communication.
4. Experts by Experience.
5. Therapeutic communication and interpersonal training.
6. Simulation as an educational approach

Not all papers addressed each theme and this review identified only two papers (Bowers et al. 2009; Jones & Shattell 2016) that directly addressed the topic of the research project (thought-disorder) specifically. The other papers had a focus on undergraduate nursing students' education in mental health skills. They had variable

direct relevance to the research topic but were of interest in reflecting more peripheral views and issues of concern to the topic of this research study: supporting nursing students to learn how to respond to people exhibiting thought-disorder (see Table 2.5).

Therapeutic communication featured as a theme common to many papers and nine papers were particularly concerned with simulation use in the teaching and learning experience. Five of the papers raised the issue of anxiety experienced by students before mental health clinical placement. Five papers explicitly raised person-centred care, but it is also arguably implied by therapeutic communication. There was only one paper that also investigated the role of Expert by Experience involvement in supporting student preparation.

The six themes also subsume several subthemes that are discussed in turn.

Table 2.5 Themes within the reviewed papers

Paper	U/G Nurse preparation for responding to Thought-Disorder	Trauma-Informed and Recovery Orientated Approaches	Addressing Anxiety to Improve Communication	Experts by Experience	Therapeutic Communication and Interpersonal Training	Simulation as an educational approach
Ammentorp and Kofoed (2010)					✓	✓
Ammentorp et al. (2007)					✓	✓
Beavan (2007)				✓		✓
Bee et al. (2008)				✓	✓	✓
Bocking et al. (2019)				✓		**Corrected**
Bowers et al. (2009)	✓	✓			✓	
Chan (2014)		✓			✓	
Chant et al. (2002)		✓			✓	
Cleary (2003)						✓
Cleary (2004)						✓
Currid and Pennington (2010)					✓	✓
Dearing and Steadman (2008)					✓	✓
Dearing & Steadman (2009)					✓	✓
Doolen et al. (2014)		✓	✓		✓	

Paper	U/G Nurse preparation for responding to Thought-Disorder	Trauma-Informed and Recovery Orientated Approaches	Addressing Anxiety to Improve Communication	Experts by Experience	Therapeutic Communication and Interpersonal Training	Simulation as an educational approach
Ellis et al. (2015)		✓			✓	
Fenekou and Georgaca (2010)		✓				✓
Foster et al. (2016)		✓				✓
Grant and Jenkins (2014)		✓			✓	
Grant et al. (2016)		✓				✓
Guloksuz and Van Os (2018)		✓				
Horgan et al. (2018)		✓	✓	✓	✓	
Jones and Shattell (2016)	✓	✓		✓	✓	✓
Jones et al. (2016)		✓		✓		
Kalhovde, Elstad and Talseth (2013)						✓
Kameg et al. (2009)			✓		✓	✓
Kameg et al. (2010)		✓	✓		✓	
Kameg et al. (2013)						✓
Martin and Chanda (2016)		✓	✓		✓	
McCann, Lu and Berryman (2009)						✓
McCann and Bowers (2005)					✓	✓

Paper	U/G Nurse preparation for responding to Thought-Disorder	Trauma-Informed and Recovery Orientated Approaches	Addressing Anxiety to Improve Communication	Experts by Experience	Therapeutic Communication and Interpersonal Training	Simulation as an educational approach
Miles et al. (2015)		✓			✓	
Nørgaard et al. (2012)					✓	✓
Proctor and Welbourn (2002)		✓			✓	
Reeves (2015)		✓			✓	✓
Roche et al. (2015)						✓
Romme and Morris (2007)		✓		✓	✓	✓
Sleeper and Thompson (2008)		✓	✓		✓	
Stomski & Morrison (2017)				✓		✓
Swan and Eggenberger (2020)						✓
Webster (2013)		✓			✓	
Webster (2014)		✓			✓	
Whittington and McLaughlin (2000)					✓	✓

1. Undergraduate nurse preparation for responding to thought-disorder

Interacting therapeutically with people experiencing acute psychosis characterised by thought-disorder, stresses the benefits drawn from principles for therapeutic interactions. The guidelines developed by Bowers et al. (2009) employed this approach.

Bowers et al. (2009) used a snowball technique to recruit participants initially identified by Nurse Managers of three UK Health Trusts as expert nurses from inpatient acute mental health services. Twenty-eight participants were recruited however the rationale for the sample size was not stated and the reasons that expert nurses may have declined to participate not included. The technique of analysis of the semi-structured interviews was partially reported but some aspects – the point of saturation for example – was unstated.

The research by Bowers et al. (2009) has a clear focus on therapeutic skills useful for working with acutely unwell people in inpatient mental health care settings. This research also includes a range of other experiences people may be exhibiting including apathy, withdrawal, agitation, over-activity, aggression, hallucinations and delusions. Thought-disordered speech had a minor place in the range of experiences discussed in this monograph. The aim of this research paper was to uncover tacit knowledge held by recognised expert nurses about how to work with acutely psychotic people. This was knowledge not otherwise reported in other sources informing standard texts.

Based on thematically analysed interviews with 28 nurses designated ‘expert’, the research reported suggests that clear transferable skills for responding to thought-disordered speech specifically are still to be established (Bowers et al. 2009). A universally accepted, detailed format of skills useful for nurses working with people experiencing thought-disorder are not identified. Indeed this research found confusion amongst its participants (the experts) of what constituted thought-disorder, with the phenomena of thought insertion and thought broadcasting reported as included by some participants at times in support of this observation of confusion

(Bowers et al. 2009, p. 53). However, psychiatry is observed to include thought insertion and thought broadcasting as forms of thought-disorder. These varied views of the phenomena of thought-disorder explain that agreed upon skills or approaches were not forthcoming. Additionally, the expert participants did not view thought-disorder as the target of therapeutic intervention, rather as a context in which other therapeutic goals were addressed. But the techniques recommended as a skill base do apply across more than one experience of people who are diagnosed as psychotic, with recommendations such as nonverbal language, voice tone, vocabulary and timing of interactions having relevance in responding therapeutically when people communicate in a thought-disordered manner. Self-control of nurses' responses such as anxiety, irritation or frustration were identified as universally important in therapeutic responses (Bowers et al. 2009, p. 60).

- **Relationship of thought-disorder and mental-health problems**

People experiencing thought-disorder rarely experience this psychotic phenomenon in isolation (Bowers et al. 2009). It is more usual that a range of other psychotic phenomena will co-exist and that the different phenomena are dynamic and changeable in short periods of time (Guloksuz & Van Os 2018; Jones & Shattell 2016; Jones et al. 2016; Romme & Morris 2007). This may mean an individual experiencing delusional beliefs and thought-disorder may also experience hallucinations whose intensity varies throughout the day. Consequently, the responses to an individual will be guided by the current concerns, and these will vary between encounters.

- **Therapeutic engagement with thought-disorder**

The nature of thought-disorder and its changeable and individual nature emphasise the importance of person-centred nursing approaches. Although a clear indication for a particular psychotherapeutic approach is unclear (Roche et al. 2015), trauma-informed care and recovery principles provide guidelines. These guidelines stress a rights-based approach that values hope, safety, respect and belief that the person has skills to evolve a solution to their distress and develop a recovery that builds on connectedness and achieves a contributing life.

The challenge for students learning how to respond often includes mastering anxiety (Kameg et al. 2009), the development of self-knowledge and use of self as a therapeutic tool (Chant et al. 2002; Currid & Pennington 2010).

2. Trauma-informed and recovery orientated approaches

Trauma informed care approaches have developed from work with adult survivors of childhood complex trauma (Reeves 2015). These approaches emphasise the criticality of trust and authenticity (Miles et al. 2015).

Recovery orientated approaches to mental health care share some of these features with trauma-informed care and emphasise the importance of respect and hope. These approaches to responding to mental health problems take a fresh, perhaps revolutionary approach vis-à-vis the biomedical approach with a greater recognition of meaning, strengths and person-centred paradigms (Fenekou & Georgaca 2010; Jones & Shattell 2016). The degree of agency is challenged by recovery-orientated approaches, suggesting the passive medical model paradigm may impede some aspects of establishing a therapeutic relationship if mistakenly based on a view of people experiencing thought-disorder as majorly a victim (Jones et al. 2016).

It is noted that the continued influence of medical conceptualisation of psychoses as evidenced in the classification and diagnostic systems, acts as a brake on full implementation of recovery-orientation in mental health services (Guloksuz & Van Os 2018). The tension in practice may restrain nursing practice from fully adopting recovery-orientation especially as it refers to establishing therapeutic goals in collaboration with those diagnosed with mental health problems. Definitional difficulties for schizophrenia in the Diagnostic and Statistical Manual, 5th edition (DSM5) (American Psychiatric Association 2013) are suggested to limit the possibilities of recovery approaches due in part to its emphasis on establishing definitive experiences and on prognosis (Guloksuz & Van Os 2018; Jones & Shattell 2016).

Co-production of nursing curricula between Experts by Experience and mental health academics addresses this conundrum, by better communicating the person-centred human-rights foundation of Recovery-orientated and Trauma-informed care (Horgan et al. 2018).

- **Families**

Recovery-orientated governmental policies in Australia emphasise the need to collaborate with the families of those experiencing mental health problems. This is recommended both in recognition of the continuing concern and knowledge of the person's experiences and their preferences, strengths and desired outcomes often known by families. It is also recognised that children whose parents experience mental health problems may experience a range of difficulties as a result. The health service is able to include response to these needs when identified (Foster et al. 2016; Grant et al. 2016; McCann & Bowers 2005).

The recognition of the importance of families to a person experiencing mental health problems indicates a further area of response needed for people experiencing thought-disorder. Nursing students need to develop skills to include these responses in practice (Swan & Eggenberger 2020).

Families have often been overlooked in the provision of support for the person experiencing thought-disorder as with many psychotic experiences such as voice hearing (Beavan 2007; Fenekou & Georgaca 2010). Inclusion of people's families and the broader general community in approaches to care assisted in improving the acceptance of these experiences and conferred other benefits (Fenekou & Georgaca 2010; Kalhovde, Elstad & Talseth 2013). It is likely that this would also hold for those experiencing thought-disorder.

- **Mental health nursing approaches to thought-disorder**

Studies of mental health nursing in inpatient environments have reported for some time, that the amount of time that mental health nurses spend with those experiencing mental health problems is troubling little and competing demands are often numerous (Cleary 2003, 2004). Whittington and McLaughlin (2000) found as little as 6.75% of a nurse's time was spent in potentially therapeutic communication.

Bowers et al. (2009) reported that the recommendations from expert nurses were few as regards skills to interact with those experiencing thought-disorder. Compared with other behaviour associated with diagnoses of acute psychoses, Bowers et al. (2009) reported that thought-disorder was not clearly understood and "advice on how to deal with it and respond to it were rather scant" (p. 53). The participants' suggestions were fairly generic, emphasising providing time, acceptance and listening to the person's attempt to communicate. A suggestion to explore how thought-disordered expression impacted the affected person was reported as tentative and given only by a small number of the expert nurse participants (Bowers et al. 2009, p. 54).

- **Nurses' knowledge of mental health**

Nursing students during their initial learning in mental health may be affected by stereotypes of those experiencing mental ill-health. This can also limit their ability to develop therapeutic relationships when participating in clinical placements (Kameg et al. 2010). Provision of care may be affected by insufficient knowledge to challenge stereotypes and result in anxiety and uncertainty. This may impede their willingness to engage in conversation with any one judged as behaving unusually, including exhibiting thought-disorder or auditory hallucinations (Dearing & Steadman 2008).

McCann, Lu and Berryman (2009) found that although nursing students' knowledge of and attitudes toward the helpfulness of a range of mental health therapies improved over the course of the undergraduate program, they started their comprehensive nursing programs with attitudes and knowledge similar to that of the general public. It was unclear whether the improvement seen was due to the curricula or the response to life experiences and university life (McCann, Lu & Berryman 2009). The preponderance of the placement of mental health subjects later in the program was suggested to pose a risk that students may not incorporate mental health nursing into their conceptualisation of nursing and limit their provision of holistic care (McCann & Bowers 2005).

These findings regarding nursing student mental health literacy have application to learning to respond to thought-disorder. Improving the standard of mental health literacy would need to precede learning therapeutic communication and interaction skills. The structure of the comprehensive undergraduate nursing program may impact the success of moving students from commonly held stereotypes in order to be effectively supported to learn therapeutic responses to thought-disorder.

3. Addressing anxiety to improve communication

The aim of some studies refers to students' experience of anxiety prior to mental health clinical placement (Doolen et al. 2014; Kameg et al. 2009). These papers reported that a range of educational interventions reduced student reports of anxiety or improved their confidence prior to placement (Martin & Chanda 2016). None of the studies followed up students either during clinical placement or after clinical placement. Such follow-up could have ascertained the impact at these times to check whether there were differences, for example from the student reports prior to clinical placement or from other students who had not experienced the interventions (Sleeper & Thompson 2008). However, the impediment to effective learning that anxiety represents was clearly recognised (Ellis et al. 2015).

Bowers et al. (2009) report that their expert nurse participants continue to experience anxiety when interacting with people exhibiting a range of behaviours associated with a diagnosis of psychosis. These experienced participants speak of actively recognising and controlling their own responses including anxiety, but also frustration, in order to achieve better therapeutic communication (Bowers et al. 2009, p. 60).

It should be cautioned, however, that improved self-efficacy and confidence that results from concerted training in communication skills does not necessarily translate into improved communication in clinical practice. The study of the effect on doctors' and nurses' self-efficacy following participation in a week's training, showed improvements in self-efficacy that were still evident after six months. (Ammentorp & Kofoed 2010; Ammentorp et al. 2007). Evidence also shows that the parents of child

- patients, found communication with clinicians who had undertaken communication training, improved their ratings of their satisfaction (Nørgaard et al. 2012). These improvements may not be transferable to responding to thought-disorder. Jones and Shattell (2016) caution, indeed, that a shared vocabulary for describing experiences may not exist (p. 769).

4. Experts by Experience

A search of the literature did not readily identify how Experts by Experience could inform students about how to respond to thought-disorder. Consequently, views relevant to this project were drawn from the literature with a range of different primary foci but included valuable insights into the Expert by Experience observations of mental health nursing.

The input of Experts by Experience (patients, consumers or service users) was recognised as helpful. Experts by Experience identified their unique capacity to challenge stereotypes and personalise the experiences of mental health problems (Horgan et al. 2018). These inputs were recognised to also help embed a recovery orientation to students' approaches to mental health nursing. However, specific information was not provided of the inclusion of the experience of psychosis or thought-disorder.

Bee et al. (2008) reported the suggestion from a systematic review of 92 qualitative and 40 quantitative studies that people with a lived experience of mental health problems regarded mental health nursing having a multi-faceted role with three key features. These were practical, social and formal psychologically skilled interventions. The capacity to respond effectively to deteriorations in mental health, skills and training for diagnosis of problems and a prioritisation of mental health problems were attributed by people with a lived experience of mental health problems to effective mental health nurses.

However, those people who had experienced inpatient services reported that mental health nurses spent insufficient time with them. They felt that collaboration skills to

work with the person experiencing mental health problems were poorly developed. Positive personal qualities of the nurses were reported as empathy, respect, and compassion. Negative qualities included being dismissive or judgemental or adopting coercive techniques (Bee et al. 2008).

A qualitative synthesis of the literature performed by Stomski and Morrison (2017) of 19 studies published between 2000-2015 concluded that 'service user participation in mental healthcare remains a policy aspiration, which has generally not been translated into clinical practice' (p. 9). The persistence of difficulties in adopting collaboration into practice suggests that the input of Experts by Experience into pre-registration programs, may help redress this shortcoming.

- **Changing mental health nursing practice**

The input into education programs by Experts by Experience may assist students to learn about help-seeking behaviours. It potentially strengthens students' recognition of the importance of empathetic responses to thought-disorder and developing a therapeutic relationship as a caring strategy (Dearing & Steadman 2009; Fenekou & Georgaca 2010; Kameg et al. 2013).

Bocking et al. (2019) confirmed the value of contributions of Experts by Experience to student preparation through their capacity to humanise the experience of mental health problems by showing the person behind the story, and this also improved the relationships between them and the students. This global study of a co-produced learning module suggests the possibility of redressing stigma when using this approach to preparation, a suggestion with implications for anxiety reduction prior to clinical placement and broadening learning outcomes to endorse "…a more socio-political humanistic focus in mental health nursing, congruent with rights-based reform agendas" (Bocking et al. 2019, p. 2).

5. Therapeutic communication and interpersonal training

In expanding the search terms to include therapeutic communication and interpersonal skills training, the published articles on this topic made it apparent that

this was an important, necessary and frequently mandated skill for graduating nurses (Bowers et al. 2009). But the amount of published research remained limited (Chant et al. 2002; Grant & Jenkins 2014; Miles et al. 2015; Proctor & Welbourn 2002). Definitional clarity was an issue with terms such as therapeutic communication and interpersonal skills at times used interchangeably (Chant et al. 2002; Miles et al. 2015). The identification of agreed micro-skills that comprised therapeutic communication or interpersonal skills were missing, and concepts were often broad and ill-defined. These terms included concepts of person-centred care (Chan 2014; Chant et al. 2002), communication clarity (Chant et al. 2002), and emotional and cultural sensitivity (Proctor & Welbourn 2002).

Some of the definitional confusion identified by Chant et al. (2002) in their integrative literature review in 2000 in the UK might be improved by their suggested refined grouping of communication skills. Distinguishing between the process, the mode of communication, communication skills and communication strategies addresses this. In considering responses to thought-disorder, recognition of these components usefully provides a chained model relevant for scaffolded learning strategies. This aligns with the observation that the challenges of sequencing communication studies throughout the curriculum at times results in communication studies being relegated to mental health subjects alone that often occur later in the curriculum (Miles et al. 2015, p. 35). Earlier introduction of these building blocks of communication may enhance development of therapeutic communication and relationships.

6. Simulation as an educational approach

The mental health nursing specific literature featured small reports and studies of an exploratory or descriptive design about the use of simulation in classes, including high fidelity mannequin simulation (Kameg et al. 2013; Kameg et al. 2010), standardised patients (Chan 2014; Doolen et al. 2014; Martin & Chanda 2016) and role play (Miles et al. 2015). These studies had small sample size, limited time-frames or limited sites/venues (Doolen et al. 2014; Ellis et al. 2015; Martin & Chanda 2016; Miles et al. 2015; Webster 2014), and used unvalidated survey instruments that were based on student self-reports of satisfaction and self-efficacy (Martin &

Chanda 2016) or staff assessment of student performance on a range of arbitrary parameters (Chan 2014; Doolen et al. 2014).

These studies reported positive reception for the use of this form of instruction but did not establish clear advantages to later nursing practice that were sustained or resulted in improved consumer outcomes (Doolen et al. 2014; Miles et al. 2015). There is suggestion that high fidelity mannequin simulation that blend medical and mental health care are less successful due to the limited possible communication styles of mannequins and may result in students preferentially responding to medical cues alone (Kameg et al. 2013). However, these simulation modalities offer the opportunity for repeated practice in a safe environment that did not endanger consumer safety (Doolen et al. 2014; Miles et al. 2015) and is an important point of distinction from clinical placement alone, especially in the possibility for feedback and critique. There is reported improvements in student self-efficacy when simulation is used before clinical placement which may enhance learning that is possible from that environment (Kameg et al. 2010).

Some of the selected literature reports standardised patients depicting specific psychiatric diagnoses that are often associated with thought-disorder. But these reports did not expand on the exact nature of the problems simulated to replicate the diagnosis (Doolen et al. 2014; Miles et al. 2015). It is possibly worth considering how such problems would be determined for these depictions and the potential for misinformation or reinforcement of stigmatising attitudes when problems are paired with a psychiatric diagnosis rather than as an understandable response to the challenges some people experience. However, whether thought-disorder was demonstrated and, if so, how this was shown, is not clear. Furthermore, use of senior students (Miles et al. 2015) as an integrated component of these simulations in response to fiscal constraints may compound the risk for inaccurate or stereotyped portrayals.

Four of the papers (Chan 2014; Doolen et al. 2014; Ellis et al. 2015; Martin & Chanda 2016) examined standardised patients use in simulation, but the foci of these studies were different. All studies recruited convenience samples for

participants from their existing student bodies and used variations of satisfaction self-report from these participants.

Chan (2014) reported a study of pre-registration nursing students' responses to cues delivered by actors as simulated patients in simulated routine nursing care. Although this study did not focus on thought-disorder, it uncovered that social distancing was employed by students to 53% of 110 cues included in the simulation. The 12% of cues that were explored or 47% acknowledged, were characterised by task-completion, use of predominately closed-ended questions and provision of information and explanations based on unchecked assumptions. The debriefing with video-taped recordings increased student reflexivity and increased awareness of the tension between task focus and person-centred care. This may have relevance as an approach in supporting students learning in responding to thought-disorder in reinforcing similar learning.

In the study by Doolen et al. (2014) a tool was used that measured student satisfaction but had no reported information about its psychometric validity. Students elected to allow the use of their evaluation of a simulation session for the research. Participants were recruited over three semesters and so potentially had different learning experiences. There was no follow-up evaluation of learning resultant from participation in the simulation session.

The focus of the study by Ellis et al. (2015) did not examine student learning outcomes either. Rather it sought to establish whether use of faculty (staff) was a viable (and cheaper) alternative to the use of standardised patients drawn from acting communities. This study incorporated a description of the experience of faculty taking the role of standardised patients in the simulation. The value of this study was that it described elements for consideration when implementing mental health simulation, inclusive of therapeutic communication responses to people experiencing thought-disorder, in a mental health nursing subject. However, specific detail of how thought-disorder was portrayed, or what responses to thought-disorder were supported, was not detailed.

Martin and Chanda (2016) examined use of simulation to support undergraduate nursing students to develop therapeutic communication skills from another perspective. Their study involved a pre- and post-study design, enabling measures of both improved confidence in therapeutic communication skills and knowledge following participation in an education session before mental health nursing clinical placement. This did not include anything specific to people experiencing thought-disorder. While these measures provide more rigorous evaluation of student change as a learning outcome, this does not measure practice but rather confidence in capacity to practice which is not identical. The tool developed for testing the change in knowledge was developed by the researchers from question banks drawn from the subject text. The psychometric properties of the tool were not reported.

Studies selected for their focus on achieving therapeutic nursing practice also explored this practice from a regulatory compliance perspective. They made reference to regulatory obligation to prepare nurses with therapeutic communication skills (Miles et al. 2015) and an orientation to nursing practice characterised as person-centred (Horgan et al. 2018). The methods employed to achieve this compliance evaluated broad parameters of communication and person-centred practice and did not comment on the micro-skill training required or on the specific skills entailed in responding to a person exhibiting thought-disorder.

Chapter summary

The selected literature for this integrative literature review was broad. This approach allowed for the use of diverse methodologies (Whittemore & Knafl 2005) which assisted combining the insights from a broad range of sources into the topic of this research study. The review identified 42 articles with relevance to the topic of how nursing students are supported to learn to respond to thought-disordered speech. These articles when analysed displayed six themes: undergraduate nursing preparation, trauma-informed and recovery-orientated approaches, addressing student anxiety to improve communication, the input from Experts by Experience,

therapeutic communication and interpersonal training and simulation as an educational approach.

The investigation of published peer reviewed research studies revealed that a focus was not evident establishing how nursing students learn to respond to people exhibiting thought-disorder. Rather, studies that examined learning therapeutic communication skills emphasised techniques to reduce student anxiety, improve confidence and examine the feasibility of standardised patient simulation. Examination of approaches that achieved effective learning, that established practice approaches, or that examined the perspective of the recipients of the therapeutic communication interventions – those exhibiting thought-disorder - were absent.

This review of published peer-reviewed research literature addressing pre-registration nurses learning to respond to thought-disorder identified a gap. This finding supported the modification of the initial formulation of my research study. The underlying pragmatism that guided this research study was driven by an urgency arising from clinical practice to prepare undergraduate nursing students more thoroughly to communicate with people experiencing mental health problems – especially those exhibiting thought-disorder. In contra-distinction from those research projects that aim to uncover new knowledge, this research study sought answers to inform ways of improving clinical preparation. As investigation progressed, improved preparation for students demonstrated in altered and improved practice outcomes was revealed to be an overly ambitious objective. The focus of the current study contracted to a need to establish how students experienced preparation to respond to thought-disorder and how academics attempted to support this preparation in pre-registration nursing programs.

The focus was therefore refined to identifying those approaches to learning how to respond to thought-disordered speech experienced by nursing students and recent graduates in their undergraduate nursing programs and identification of learning methods that were viewed as helpful by students and recent graduates. The views of academics in mental health nursing programs were included to complement these findings.

Chapter 3: Methodology

Introduction

The literature review outlined in Chapter 2 established the limited amount of research about preparing pre-registration nursing students to respond to thought-disorder. In this chapter the methodology and conduct of the research study are presented/discussed. The aim of the research study is clearly discussed followed by an explanation of the theoretical framing selected. An overview of the selected research methods to conduct this research study follows including the rationale for the chosen methods. The chapter then addresses the research design, and the selection of participants is outlined, including discussion of the recruitment methods selected. The data collection process is outlined for each of the study phases, including details of the instrument design and the demographic data collected. Analysis of the data collected, both quantitative and qualitative is explained, and a discussion of the ethical issues involved including the storage of data, is presented.

Aims of the research

The purpose of this research study was to explore how pre-registration nursing students are taught and prepared to respond to thought-disorder. To establish this, several aims contributed to this understanding. These are listed below:

1. To determine whether learning to respond to thought-disorder is regarded as an important skill for newly graduated nurses.
2. To establish if this learning is routinely incorporated into pre-registration nursing curricula.
3. To discover the teaching approaches used to support learning to respond to thought-disorder.
4. To uncover those approaches to learning how to respond to thought-disorder regarded as important for or potentially offering improvement in learning outcomes.
5. To find what methods are used to assess this learning.

6. To determine the opinions of different stakeholders to this process – nursing students, newly graduated RNs and mental health academics.

Theoretical framing.

Outlining a guiding theoretical framework for this research study required a set of principles that included:

- individual readiness to learn.
- knowledge development within a social context
- learning that resulted in action.

These were observed to be relevant to nursing preparation for practice and applicable to the existing approaches including clinical placement, simulation and theoretical input.

Design

Research studies that feature a variety of approaches within the same study framework are ordinarily referred to as mixed methods designs (Creswell 2009, 2015; Creswell & Clark 2007). Such research may incorporate a design that has both qualitative and quantitative methods that facilitates both establishing the number of certain features of a research question and also the meaning attributed to them. However, as there are many ways in which qualitative and quantitative elements may relate, this means there is no single 'recipe' that comprises mixed methods. Critical factors that may vary include the timing of the different methods employed and the relationship between these. The different methods used in separate phases informed the direction of the following phase of the research design – an iterative approach where findings of the previous phase informed the next (Teddlie & Tashakkori 2006). Methods in this research study were used sequentially. Decisions determined research design and influenced the way in which knowledge was uncovered. However, the critical element that distinguishes mixed methods and elevates it to more than a compilation of quantitative and qualitative studies alone, is

that the qualitative and quantitative studies combine to create greater understandings than each study might contribute alone (Teddlie & Tashakkori 2006).

It is not feasible to exhaustively delineate mixed methods typologies because components are recognised to be partially determined in the process of research and partially by the findings of the research (Teddlie & Tashakkori 2006). At least two factors are recognised as contributing to this feature of mixed methods. Firstly, the qualitative methods components draw from a developing and evolving field where designs are not finally determined. Additionally there is a feature of mixed methods recognised as opportunistic (Teddlie & Tashakkori 2006). As a research program proceeds, unexpected or unanticipated findings and opportunities emerge. These suggest approaches that may not have been pre-determined in the planning process. Their significance or existence may have become apparent in the process of the research activity itself.

Irrespective of the agreement that definitive typographies are not applicable to mixed methods research, seven criteria are recognised as central to a descriptive definition (Teddlie & Tashakkori 2006). These criteria will be present in these methods of research. Firstly, the type of methods that predominate in the mixed method research study can vary, in type, order or combination. The typography can also differ by the number of phases that are included and incorporate mono- or multiphase designs. These phases may be implemented at different points of time, either sequentially or concurrently and in different phases in different ways. Sequential implementation supports subsequent phases benefiting from the findings of prior phases. Integration of findings of different phases of the research design is a fourth criterion that defines mixed method designs. Variations exist on the amount of integration of findings from different phases. The relative dominance of the methods utilised within the overall research design is another variable characteristic of mixed methods designs. The intent of different phases and different methods in the research design is a further variable. A phase may employ a different method as a means of confirming or adding detail to the findings of another phase. Finally, the theoretical framework of mixed methods research designs is another point of variation. The characteristic pragmatism and opportunism of this design can be misunderstood as atheoretical but, as argued by Creswell (2009), can signal an

unexamined theoretical perspective. Transformational frameworks are a commonly acknowledged framework.

Mixed methods, by embracing different approaches for data collection within its research design, calls for clarity about the beliefs that guide these selections – Creswell's 'worldview' (Creswell 2009, p. 6). Often the theoretical perspective of mixed methods research is characterised by advocacy and/or participatory concepts. Engagement in a political agenda that seeks inclusion of marginalised groups supports research that involves a reform action plan for participants, researchers and for organisations. Elements of this theoretical perspective have informed this research study. The aim to improve preparation of nursing students to work with people experiencing mental health problems involves an action plan to alter existing curriculum and a manifestly political agenda seeking to change the inclusion for a marginalised group. This draws on philosophical traditions espoused by Marx (Mayo 2012; Rikowski 2004), and Habermas (1974), and given educational application by theorists such as Freire (1970), and Kemmis and Smith (2008).

However, the dominant theoretical perspective that has guided this research study's development is essentially pragmatic - operating from the perspective that knowledge is moulded by actions, situations and consequences. The importance of solutions and applications of knowledge is central to this research study. There is emphasis on the research problem and utilising all approaches to provide solutions. Peirce, Mead, Dewey (2009), Teddie and Tashakkori (2006), and Creswell (2009) were significant influences for this perspective.

The combinations of qualitative and quantitative approaches to research design in a mixed methods research study are multiple. The ontological and epistemological underpinnings of mixed methods have a good fit with the underlying theoretical framework of this research study.

This research study utilised a mixed methods approach that aligns most closely with an explanatory sequential design. It adopted a sequential, two-phase data collection design that supported an iterative process (Figure 3.1). Both qualitative and quantitative data were collected in Phase One. The findings from the qualitative

survey data informed the focus of the interviews in Phase One. Phase Two drew on the findings from the previous phase to inform its focus. This explanatory sequential design was chosen as it addressed development of knowledge (Leech & Onwuegbuzie 2009; Onwuegbuzie & Collins 2007).

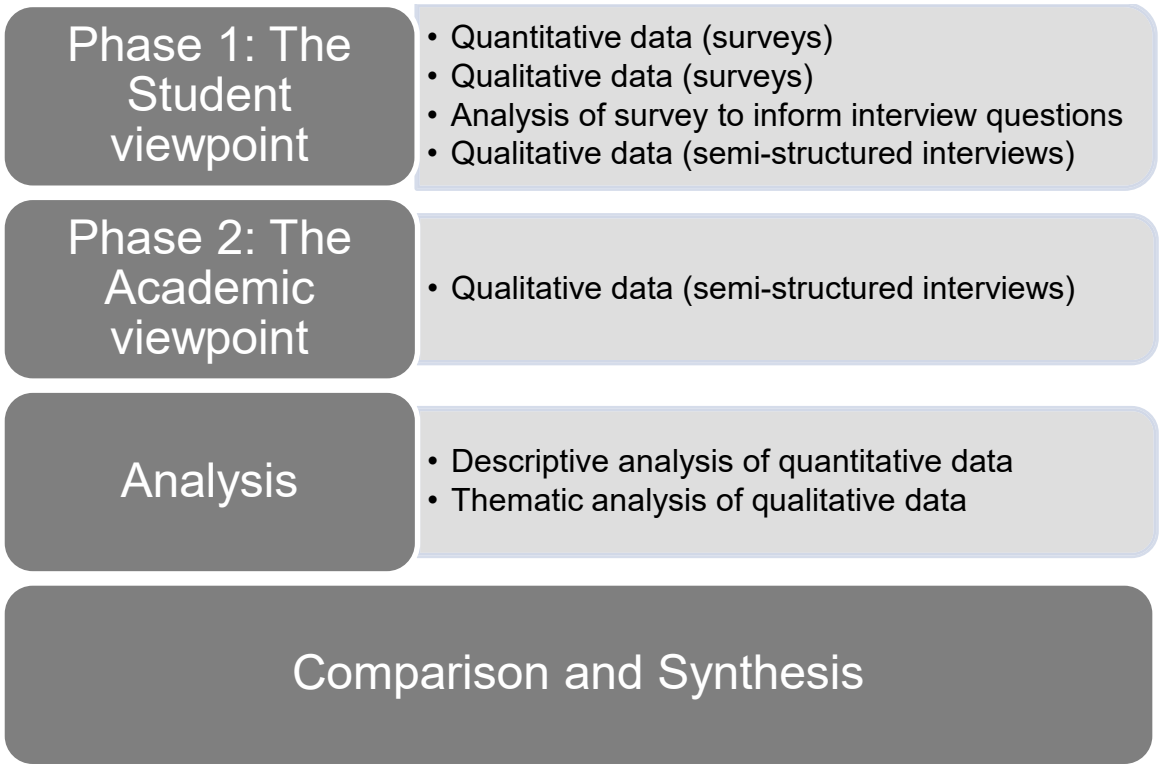

Figure 3.1 Model of the Research Study Design

Application of mixed methods to this research study

In this research study, the findings from the literature search suggested little was known about the amount and type of preparation nursing students received to respond therapeutically to thought-disorder. For Phase one therefore a survey method was selected to uncover how frequently students were receiving preparation in their undergraduate programs, what preparation was used, where the preparation took place, who guided this aspect of learning and why this learning was addressed in their programs. The major component of this survey used data collection by open-field answer sections providing opportunity for qualitative responses.

The findings from this phase of the research study suggested that learning to respond therapeutically to people exhibiting thought-disorder was a minor

component of curricula. This survey finding supported the use of semi-structured interviews with student and academic participants and informed the questions and prompts to add depth to the data provided by the survey. The questions were crafted to allow participants maximum freedom to report the factors of their learning which they had found useful in preparation for practice. The questions were used to prompt responses to all factors indicated by the survey and the ensure some uniformity in breadth addressed in the interviews.

Examination of the results from the student participants' data indicated that further information was required. Increased data about the design and delivery of pre-registration nursing programs would complement the data from students based on their experience. Mental health academics offered a source for these data for the second phase of the study. They provided another source of data about learning to respond therapeutically to thought-disorder. Semi-structured interviews gave these participants freedom to make contributions to the topic they believed were important, and the semi-structured method allowed each interview to respond to a uniform set of issues.

Setting

This study was undertaken from July 2017 until January 2018 with undergraduate students, newly graduated nurses, and mental health nursing academics. Phase One surveys were accessed via the on-line platform Survey Monkey© allowing global participation. In Phase One, nursing students and newly graduated RNs recruited by the survey were interviewed via phone using a Cisco© conference system and recorded. This too allowed global participation. A second recruitment of student participants occurred in July and August 2020 as the first recruitment had a poor response rate (n=3). The additional eight participants were interviewed from June until August 2020 and recorded online via the Zoom© platform. For Phase Two, mental health nursing academics were interviewed and recorded individually face-to-face or via Cisco© conference system. This also allowed for global participation.

Participants: Recruitment

Recruitment of participants for this research study was multi-faceted, reflecting the two phases of the study. Each used differing approaches that are described discretely in the following sections.

Phase One: Recruitment for survey participants

Participants were either students or recent graduates of preparatory programs for the highest tier of the nursing workforce (Registered or 1st Division nurses in Australia). Participants were required to have undertaken a mental health nursing subject in their program, including their clinical placement if offered. Recent graduates were limited to those within two years of graduation or completion of their preparatory program in order to maximise recall of the approaches to learning and teaching of this topic and associated skills and allow reflection on practice if relevant.

Background recruitment considerations

Accessing participants for nursing research studies can prove difficult. Response rates for surveys are often low putting the validity of findings at risk (Cooper & Brown 2017). Further, accessing nursing participants is subject traditionally to a range of gatekeepers who can restrict contact between researcher and groups of potential nurse participants (Tuckett 2004). Although nursing education transition to tertiary education is close to thirty years old in Australia, there are still elements in the culture of nursing that question this approach to nursing preparation and also are antithetical to nursing research (Clark & Thompson 2019; Myers et al. 2016; Pringle 2016).

Recruiting participants for any research presents many challenges. This antipathy is one such challenge in managing to access nurse participants for research (Akerjordet, Lode & Severinsson 2012; Roxburgh 2006). These challenges also include ensuring that the sample is representative of the population of study and

contacting potential participants in a timely manner. Satisfying those who act as gatekeepers for contact to these populations can be time consuming and also subject to capricious conditions (Lee 2005; McFadyen & Rankin 2016, p. 83).

This suggested that Facebook© may represent a means to reach hitherto difficult to recruit groups of nurses, including millennial and those nurses not holding senior positions. It is reasonable to suspect that Facebook© use by nurses reflects general population uses of social media. However, research of the nursing demographics of social media use is largely unreported (Green 2017).

Social media acts as a disruptive innovation to these prior patterns of nursing relationships (Christensen, Bohmer & Kenagy 2000; Weeks 2015). In nursing, social media has been adopted avidly (Green 2017). Social media offers the researcher access to nurses in ways not previously available. Traditional gatekeepers have been disempowered. The flow of information (about research participation) responds to fresh gatekeeping imperatives (Christensen, Bohmer & Kenagy 2000; Weeks 2015).

Closer consideration of the usage profile indicates that although close to two thirds of Facebook© users are not millennial, it still provides an entrée to access younger demographics when combined with a snowballing technique. Other social media preferences, however, do not readily perform all the Facebook© functions that are helpful for snowball recruitment. Hosting a site for access to research with a stable temporal feature and capacity for multi-media, distinguishes Facebook© from many other social media platforms that may have short life, or limited size, or preference images over text.

Whilst Facebook© would appear to expand the possible methods to recruit nurses to participate in research, there may have simply been an expansion of number and type of gatekeepers. The values that guide the gatekeeping of these sites are not uniform and are often opaque. Similar imperatives of time and pre-judgement of the interest of members of closed Facebook© groups may not be more empowering of these marginalised research subjects. This is in contradiction to other arguments that Facebook© is the method of choice to access marginalised groups for research

(Cohen & Arieli 2011; Sadler et al. 2010). It may be, in relation to nursing populations, that there has been development of a new category of nursing gatekeepers in addition to those who traditionally have fulfilled this role.

Snowballing method for recruitment

Snowballing was recognised as an appropriate method to use in this context, where recruitment could proceed by identifying an appropriate participant and using their contacts to recruit further participants (Sadler et al. 2010). Purposive sampling was utilised in this way as there was a definite plan of who was the desired participant. This was a student or newly graduated nurse as they would be able to answer the research question. This is an example of selection bias in recruitment but reflects the flexibility of non-probability sampling strategies (Sadler et al. 2010).

Sample validity of recruiting online does not result in less representative samples than traditional recruitment methods (Denissen, Neumann & van Zalk 2010). It was therefore decided to address recruitment by seeking participants via snowballing methods that did not require formal access via traditional gatekeepers and to utilise the popularity of Facebook©.

Identification of appropriate Facebook© sites to approach employed a snowballing technique where the sites were examined for additional pages that were 'liked' for potential recruitment sites. Twenty-eight Facebook© pages were identified that met the search criteria as having relevance to students or recently graduated nurses including those with expressed interest in education, or mental health nursing (Appendix 3 Facebook© sites). Once a page of interest was identified, then a further search was conducted of pages that the Facebook pages identified liked. This was carried out until a saturation point was reached, and no new pages were identified as relevant. (Appendix 3 Facebook© sites)

Those Facebook© sites that were closed, that is requiring membership to be approved to use, had their administrators identified. These administrators were then contacted with a request for membership or to host an invitation for members to

participate in the research study. This request provided a suggested posting for their use. The posting included information about the research study and a link to the dedicated Facebook© research page. An invitation to pass on this request and to 'like' the dedicated research Facebook© page was also included. When a Facebook© page was not 'closed' the identical posting was placed on the site (Appendix 4 Facebook Invitation Posting).

The dedicated research study Facebook© page was specifically established to support this research study. It included participant information about the research and a link to the survey. The survey ensured participant consent was collated and informed.

Several administrators of selected closed Facebook© sites did not respond to request to post an invitation or to allow membership. A follow-up was sent, but if this did not result in a response, further approaches were not undertaken. No closed Facebook© sites refused the request for membership or posting the invitation to recruit participation. Two professional association sites (Australian College of Nurses and Australian College of Mental Health Nurses, Inc.) initiated additional postings on their associated websites. One professional association commissioned a small piece describing the research topic in greater detail and posted this with the invitation in their electronic quarterly member publication (Appendix 5 Australian College of Nursing Recruitment article Nurse Click, Appendix 6 Australian College of Nursing eBulletin Recruitment Posting).

Inclusion and exclusion criteria

The survey participants were nursing students or recent graduates from pre-registration nursing programs, in Australia and globally. On-line recruitment did not limit participants to Australian students, believing the topic of learning to communicate with people exhibiting thought-disorder would be enriched by multiple inputs from a range of national backgrounds. Student participants were excluded from recruitment if they had not yet studied mental health nursing or if they had not

participated in an associated mental health clinical placement if offered in their program of study.

Recruitment of nursing student and newly graduated RN participants for semi-structured interviews

The first participants were recruited by invitation at the end of the on-line survey. All these interview participants had completed the on-line survey and self-selected for further involvement. As participants they required access to telephone or to reside in Sydney Australia if they were to elect a face-to-face interview. All participants were interviewed by telephone.

Participants could be recent graduates or students who had completed their mental health subject and clinical placement. This was verified prior to the interview when participants were supplied with a further information sheet, detailing the rational for this phase (Appendix 7: Participant Information Sheet). Participants also provided consent for participation in this phase of the research study by completing and returning a Consent Form (Appendix 8 Student Informed Consent Form)

A second round of recruitment for student participants was undertaken in June 2020 with identical requirements of completion of a mental health subject and clinical placement. These participants had not completed the on-line survey but were recruited via a broadcast email to third year BN students at the University of Technology, Sydney (Appendix 9 Student recruitment email UTS). An application for amendment of the Ethics Consent had been successfully submitted (Appendix 10).

Phase Two: Recruitment of mental health academics

Academics were recruited via an electronic snowballing technique. Contacts were approached with an invitation to participate and request to forward the invitation to other suitable academics to participate (Appendix 11: Mental Health Academics Consent form). Professional on-line Facebook sites were also approached to advertise the invitation. Both the Australian College of Mental Health Nurses, Inc and

the Australian College of Nursing carried recruitment notices in their member on-line newsletters.

Academics were deemed suitable to be included if they had recent experience teaching in a pre-registration nursing program in the mental health component. This involvement could be in a full-time, part-time, sessional or casual capacity based in theoretical (lecture or tutorial formats for example), clinical laboratory (experiential, simulation classes) or clinical placement experiences. Participants were not restricted to Australia.

Participants were ineligible if they did not teach mental health nursing in pre-registration programs. For example, academics who worked only within graduate programs were not eligible. Academics who addressed mental health problems within subjects that were focussed on other skills were assessed on an individual basis. An example being those academics who prepared students with communication skills generally, but also addressed communication in mental health contexts, or medical simulations that incorporated a significant mental health component in the simulated presentation. No academics were recruited who were in this category.

Data collection

Phase One: Survey

Recruitment of participants for the on-line survey was undertaken between April and July 2017, with a single request sent to participating Facebook© sites for re-posting. The participants met the inclusion criteria of being nursing students who had undertaken their mental health studies or were nurses within two years of graduation.
Figure 3.2 displays the volume and timing of responses in the four months that the survey was open. The increase in responses during July 2017 reflects a renewed recruitment effort via social media.

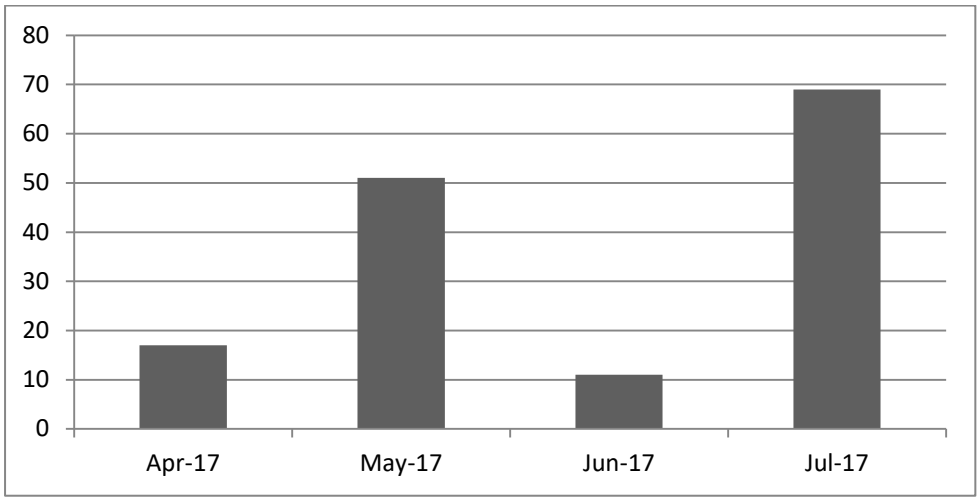

Figure 3.2: Volume and timing of responses

Instrument

Initial data were collected by using a survey. This is a method that could be administered online and potentially distributed to a global audience (Evans & Mathur 2018). A survey offered a method to collect and analyse data using both qualitative and quantitative methods (Ponto 2015). This was attractive to add depth to the data collected. Further, this method could be undertaken at a time that was convenient for participants (Kongsved et al. 2007). Difficult to reach populations can be accessed more readily using an online survey (McInroy 2016; Regmi et al. 2016).

The survey was designed by the researcher with support from her supervisors (Appendix 12: Survey Instrument). The questions were designed to reflect the gaps identified from the literature review and personal observations as a clinician and academic including those arising from extensive discussions with clinical and academic colleagues about short-comings in mental health preparation in pre-registration nursing curricula. A mixture of question types was used, question wording was reviewed for clarity and jargon avoided when possible or meaning provided when it could not be avoided (McInroy 2016). Questions were sequenced in an order that was reviewed for logical flow. Ranges were used for answers to some questions where logical, for example for ages (Evans & Mathur 2018). The survey

was constructed to maximise attractiveness and reviewed for length, with a view to improve the completion rate. Information was provided to participants of the anticipated time required. A progression bar was placed on each page to enable participants to monitor their progress. Navigation between pages was standardised and pages were labelled to guide participants (Evans & Mathur 2018). Pre-testing was not performed. The survey employed the online survey platform Survey Monkey© (https://www.surveymonkey.com/).

The survey comprises 25 items and explored the experience of learning to respond to thought-disorder in pre-registration nursing mental health curriculum. The first 16 questions collected demographic data from participants. These data included age, gender, country of residence, first language, additional languages, ethnic or cultural identity, schooling, current study program, country of study, year of study, employment status, employment type, work that includes interacting with those exhibiting thought-disorder, prior personal knowledge of thought-disorder as a person with the Lived Experience, carer or clinician, other relevant educational background and attitude to working with people experiencing mental health problems. These were important questions that could allow exploration between different groups of participants to better understand their responses. Questions were presented as a range of fixed choice responses or open fields for personal commentary. The following nine questions collected data about features of the participants' experience of learning to respond to thought-disorder. These included fixed choice questions, Likert-type scales, and open-fields.

Phase One: Nursing student and new graduate interviews

Participants in Phase One engaged in a semi-structured interview of between 30 and 45 minutes with the researcher. Each participant from the first recruitment was interviewed individually, by phone and had their interview recorded via Cisco© teleconference host. These audio recordings were transcribed verbatim for later analysis of findings. Participants from the second recruitment were interviewed individually via Zoom© on-line. Their interviews were audio-visually recorded for transcription and later analysis.

Interview participants were asked their age, identified gender, and place of residence. Their status as a student or newly graduated RN was confirmed, and learning experiences identified as regards formal class-based instruction and mental health nursing clinical placement. The interview participants were asked if they identified as a carer for a person experiencing mental health problems or a consumer of mental health services. Their employment history was established.

The experience of learning to respond to thought-disorder was explored in a semi-structured manner that allowed the participant to lead the discussion, identifying experiences and features that they had found important. The researcher followed their lead, seeking clarification at times, or encouraging elaboration. Issues were raised if they had not been covered toward the end of the interview by reference to a guide (See Appendix 14: Phase 1 Interview Schedule second recruitment). The guide used for students recruited in 2020 was expanded to include questions about role models, critical incidents and approaches they learnt for responding to people experiencing thought-disorder during university class or on clinical placement.

The participants were very generous with their willingness to reflect on their experiences regarding learning to respond to thought-disordered speech. The responses were detailed and descriptive and included their personal interpretation and understanding from their learning experiences. Clarifications were made by the interviewer when responses were a little unclear. Similarly, participants clarified the interviewer's questions when these were not clear. Participants were thanked verbally at the conclusion of the interview. They were also sent a written (email) thanks following interview which reiterated the invitation to contact the researcher if there were any issues that arose from the interview later. Three participants returned email expressing their appreciation in participating in the research study.

Phase Two: Mental health nursing academics

Mental health nursing academics were recruited as participants in Phase Two. They each engaged in a semi-structured interview of between 30 and 60 minutes with the researcher that was audio-recorded and professionally transcribed. Interviews were

conducted either individually, face-to-face in the researcher's office, or individually via the Cisco© teleconference platform. All interviews were transcribed verbatim.

Interviews were semi-structured to capture the issues that participants regarded as important. The researcher initiated the interview by establishing some common demographic features, and toward the end of the interview raised any issues that had not been discussed (See Appendix 15 Phase 2 Interview Schedule). Otherwise, the researcher sort clarification or elaboration from the participants of issues that they raised.

In Phase Two, all participants were asked to identify their backgrounds both in mental health nursing and in education. They were invited to describe current approaches in their undergraduate programs used to prepare nurses to respond to people experiencing thought-disorder, what assessment was employed and what constraints impacted on these efforts. Finally, participants were asked to identify what approaches would be ideal in an endeavour to prepare undergraduate nursing students in this skill.

All mental health nursing academic participants except one were known professionally to the researcher. All were interested in the topic of the study and generous in providing considered responses about how nursing students were supported to learn how to respond therapeutically to thought-disordered speech. At completion of the interview each mental health nursing academic participant was thanked for their generosity. A further emailed thanks was sent in addition.

Data analysis

Quantitative data

Quantitative data obtained from Phase One survey responses was analysed using statistical analysis software. The proprietary program Stata (14) common to social research, was used (https://www.stata.com/). The data were descriptive based on

fixed choice responses; some open-ended answers were interpreted by descriptive thematic analysis.

Descriptive analysis provided a summary of the information collected. This included the demographic characteristics reported. Measures for the central tendency (mean, mode and median) were examined for data such as age. Measures of dispersion (standard deviation) were also reviewed when relevant. The data were examined for evidence of any multi-variate relationships to describe the relationship between any independent variables.

Data were examined to test whether variables were associated in a causative manner. Pearson's chi-square test was selected in order to examine if such theories should be accepted or rejected (Curtis, Comiskey & Dempsey 2015). Both experience of working with people experiencing thought-disorder and experience of thought-disorder as a major learning objective were examined with (Pearson's) chi-square test for a range of assessed variables. These characteristics were hypothesised to be possible causes of different patterns of responses. Consultation with two experienced bio-statisticians at two points of time informed the quantitative data analysis regarding both descriptive and causal analysis.

Qualitative data

The thematic analysis approach taken to uncovering patterns and themes from qualitative data of Phases One, and Two, in this research study is recognised as a method of wide application (Braun & Clarke 2006). It offers flexibility in relation to data that can be advantageous if adopted in a systematic and rigorous manner that explicitly outlines decision making, assumptions and possible ambiguity (Appendix 18 Steps of Thematic analysis in this study).

In accord with the argument presented by Braun and Clarke (2006), thematic analysis is regarded as an independent method of analysis, not a technique within another method of analysis. Rather than a process undertaken with a larger analytic tradition, such as grounded theory, thematic analysis is conceptualised and argued

by Braun and Clarke (2006) to be a flexible method, that is 'essentially independent of theory and epistemology and can be applied across a range of theoretical and epistemological approaches' (Braun & Clarke 2006, p. 78).

The criticism of thematic analysis as a method is common to criticism of other qualitative research methods – that of being 'an anything goes' technique (Antaki et al. 2003, p. 2). However, thematic analysis can be applied rigorously as a method for identifying analysing and reporting patterns within data (Braun & Clarke 2006). The rigorous application of thematic analysis was ensured in this study by examining decisions made in analysing the data and being explicit about these (Appendix 19 Collating subthemes in Student participant transcript).

An 'essentialist' or 'realist' method of assigning themes was adopted which reports the experiences, meanings and realities of the participants. That is, it was not themes assigned to reflect society's meaning (so called 'constructivist' analysis) or other types of thematic analysis like discourse analysis or grounded theory. Themes were selected to represent a pattern in the responses that captured an aspect of importance for the research topic. The prevalence of the issue required to make it a theme is not set. Rather it needed to occur across the data. It is an attribution assigned by the researcher's judgement of significance (Braun & Clarke 2006) (Appendix 20 Example of identifying themes from student transcript).

Thematic analysis was used to examine data collected by open-field responses in the survey (Phase One), the student and recent graduate interviews (Phase One) and in the academic interviews (Phase Two). N-Vivo 12© organised the process for examination of these responses using thematic analysis (DeCuir-Gunby, Marshall & McCulloch 2011; Sinkovics & Alfoldi 2012). As argued by Green and Thorogood (2009), thematic analysis provides an account of descriptions from these data sets that is coherent, logical and concise.

The process undertaken involved reading the data and assigning preliminary themes that were checked and revised by re-reading and discussion with doctoral supervisors. The themes allocated were broad, in order to enable inclusion of data and to support credibility. The themes were developed to support explanation for the

data examined against the research study focus and topic. The final themes offered represent a distillation of the consistently appearing patterns in the responses in the qualitative data examined. Differences were discussed and concordance reached (Braun & Clarke 2006). For example, peer support was recognised in the transcripts of three participants who commented a total of four times. This did not develop as an independent theme as it was not identified across the data set.

Saturation was attained in analysis of the Phase One data as no new themes were discerned. The themes identified in the open field of the survey reached saturation and the first student and new graduate nurse interviews added limited fresh information to this. The data from the Phase Two interviews with mental health nursing academics were found to have reached saturation and not require further data collection. The 12 interviews contributed information that repeated themes and added new information that informed the semi-structured interview questions for the second recruitment of Phase One student interviews.

Research trustworthiness

The trustworthiness of the research is synonymous with the rigour of the study. It refers to the degree of confidence in the data, interpretation and methods used in this study to ensure its quality (Polit & Beck 2014). The trustworthiness of this project has been demonstrated by careful reporting of each stage: preparation, organisation, and reporting (Elo et al. 2014). Trustworthiness is understood to be demonstrated by four features: credibility, transferability, dependability, and confirmability (Elo et al. 2014; Polit & Beck 2014; Shenton 2004). Of these, it is argued that credibility may be most critical as it addresses confidence in the truthfulness of the study and hence its findings (Polit & Beck 2014).

- **Credibility**

The credibility of this project is demonstrated by its clear links with the reality of undergraduate preparation to respond to thought-disordered speech whether occurring in clinical placement or theoretical classes within universities. This project

used a form of triangulation of sources in that it collected data from different populations (students and mental health nursing academics) at different points in time. It also used triangulation of methods by using survey data and semi-structured interviews to collect data. Member-checking, another way to establish credibility was used informally. A formal information to share data, interpretations and conclusions was not taken up by participants. However, I informally consulted a small number of participants and clarified their meaning and confirmed interpretations.

The method of analysing data is a well-established and credible method for analysing qualitative health research data. The careful demographic description of participants also addresses credibility (Elo et al. 2014). As I had worked in the field of mental health nursing education, my credibility as a researcher in this field was confidently accepted by participants (Shenton 2004). A commentary about reflexivity is expanded below, as this also contributes to the credibility of the research project.

- **Transferability**

The detail provided about the context of the research project allows the reader to make judgements regarding the applicability or relatability of the findings to contexts that the reader is familiar with (Elo et al. 2014). The research study environment includes the number of participants, the types of people who contributed, the data collection methods and the organisations where participants worked or studied and drew their data from. In this study it included nursing students from a range of pre-registration programs, newly graduated RNs and mental health nursing academics of a range of backgrounds, organisations, positions and years in academic positions. Readers familiar with undergraduate nursing curricula may determine the findings have applicability to similar studies of preparation of undergraduate nurses. Analysis and re-analysis of the data, from general to specific, developed familiarity.

- **Dependability**

The third feature of trustworthiness, dependability, addresses the replicability possibility of the work by future researchers (Shenton 2004). The detailed description

of the methodology of this research project determines the ability of future researchers to repeat this study. The use of a survey instrument and semi-structured interviews could be replicated by future researchers in different settings at different times. The detail of the survey tool and interview guides were provided, along with commentary of their limitations should facilitate replication.

Consistency in analysis was managed by my undertaking the role of coder and moderator that improves equivalence and hence reliability. Dependability needs stability in data under different conditions and over time (Elo et al. 2014). However, these findings are a 'snapshot' being specific to the time and context of the study. Changes in nurse education policy, provision of clinical placement, admission policies for students and academic employment practice could change findings of any future studies.

- **Confirmability**

It is a feature of all qualitative research that it has the potential to be biased by the background and experiences of the researcher. My recording of personal background information that influenced selection of research method used and decisions made provides reassurance that the data was drawn from findings of the data (Shenton 2014). I acknowledged my experience with nursing students, mental health nursing academics, Experts by Experience and with people experiencing thought-disorder at all times with my academic supervisors. My experiences in forming nursing pre-registration curricula were recognised and part of all stages of collaboration with my academic supervisors.

Using a reflective journal as a part of the process of the project helped to affirm that findings were drawn from the data. Routine meetings with my academic supervisors throughout my candidature and the research study provided a forum to test ideas, correct misunderstandings and ensure that methods employed were critiqued. This aspect of the project allowed me to examine power differentials at play in data collection between myself and research participants, especially the student participants. These processes highlighted the possibility of privileging my previously

developed beliefs within the analysis and acted as a foil that supported an ethical account of the data.

Reflexivity

Reflexivity is a crucial process to ensure that the influence of the researcher on their findings is examined and incorporated into elements of a research study such as its design and analysis of findings (Sandelowski 2000). As the researcher I did not enter the research process as a tabula rasa and my prior understandings, opinions, and attitudes toward the topic of my research needed a process of continuous critical reflection. This was approached in several ways for this research study. Regular meetings with my supervisors involved challenging assumptions uncovered in the design and reporting of the research. Individual field notes allowed personal reflection of influence and issues to be raised during supervision sessions.

Ethical considerations

This research was guided by the overarching framework of respect for people, study merit and integrity and justice and beneficence as outlined by the National Health and Medical Research Council, the Australian Research Council and Universities Australia (2007) in the National Statement on Ethical Conduct in Human Research. These emphasise the importance of the study adhering to principles that ensure the outcome of the research is justified and that any risks to participants are recognised and if they cannot be eliminated are minimised. No conflict of interest was identified.

Ethical Permissions

Phase One

The study was approved by UTS Human Research Ethics Committee (UTS HREC REF NO. ETH16-0911). The survey included an information sheet as an introduction describing the purpose of the survey and consent was implied by continuing and completing the survey (Appendix 14: HREC Permission Phase 1). A second recruitment for student participants followed in June 2020. This amendment was

approved by UTS Human Research Ethics Committee (UTS HREC REF NO. ETH20-4954) (Appendix 10 HREC Permission Ethics Amendment). Interested participants were sent an information sheet and consent form when arranging a time for interview (Appendix 7: Information and Consent sheet 2020). These signed consent forms were returned prior to the commencement of the interview.

Phase Two

Due to the iterative process responding to data from Phase One of this research study in 2017, an amendment was made to the recruitment strategy. Mental health academics were recruited to provide an understanding of approaches employed to support students learning to respond to people experiencing thought-disorder. The requisite application was made to the UTS Human Research Ethics Committee in October 2017 and an amendment was granted to the original approval (ETH 17-1780) that authorised this adjusted recruitment strategy (Appendix 17: HREC Permission Phase 2).

Consent

Risk and its management

There were several risks associated with participation in this research study. Strategies were put in place to minimise or eliminate these risks.

Physical risks were highly unlikely but may have included fatigue. In the survey this risk was minimised as the survey was limited, requiring less than 20 minutes to complete and participants were made aware of this. Participants could discontinue the survey at any time with no ensuing consequences. Participants for Phase One and Phase Two (interviews) were informed that the interviews were expected to last between 30-45 minutes and the timing of the interviews was scheduled for mutual convenience.

Psychological harms may have included embarrassment at the process of being interviewed, or distress at being questioned about uncomfortable topics or disclosing sensitive information. Phase One survey participants could choose to not answer

survey questions or could discontinue the survey entirely. Phase One and Two interview participants were always treated respectfully and were able to refuse to discuss distressing topics. As the interviewer, I am an experienced mental health nurse with considerable clinical experience. I was prepared to facilitate referral to University Counselling Services if this was necessary. This did not eventuate.

The remote risks of social harm to participants due to their student status or employment status were minimised as student participants in the Phase One survey were anonymous and their data were only handled in an aggregated manner, making identification of individuals extremely difficult. The data from participants' interviews in Phase One and Two were de-identified. Their identities were known only to me as the researcher. Participants in Phase One and Phase Two were given the opportunity to view their data if they wished to do so. No participants chose to do so.

All participants in Phase One, and Phase Two consented to participate and were given information about the research study to assist their decision making and help to minimise any risk to which participation may inadvertently expose them.

Data management

As noted in the previous section, provision was made to ensure participant identity remained confidential. All survey data were anonymous and reported only in aggregated form. Data from the qualitative open field sections of the survey reported only the source for these data – whether from the survey of Phase One or the interviews of Phases One or Two. The survey data were downloaded from the on-line platform and stored electronically in a password secured computer file by the researcher.

Consent forms from the interviews of Phase One and Two were the only documents that included participant names. Phase One on-line consent did not require participant identification. The interview consent forms from Phases One and Two were electronically stored in a computer file requiring password access on the researcher's computer.

Participant's names were not included in the audio recordings or transcriptions of their interviews. These electronic files were also stored in a password protected file on the researcher's computer. In compliance with National data management rules, the data will be kept in secure storage for seven years after publication of the results. It will then be archived for further use.

Chapter summary

This study used an explanatory sequential mixed methods research design of two phases that were informed iteratively. This design selection supported the integration of findings from the qualitative and quantitative survey data with findings from the interview data. Participants were nursing students who had undertaken their mental health nursing study, newly graduated registered nurses, and mental health nursing academics.

During Phase One, data collection was undertaken by an on-line survey instrument, designed by the researcher. This collected demographic data about the participants and data about their experience of learning to respond to thought-disorder in pre-registration nursing programs. It included both quantitative data and open-field qualitative data. Phase One and Phase Two comprised individual semi-structured interviews that were recorded and transcribed verbatim.

Statistical analysis of the quantitative data and thematic analysis of the qualitative data from semi-structured interviews and open-field survey responses were undertaken and synthesised. Participation in the research study was voluntary. Consent was obtained from all participants.

The participants' identities were protected either by anonymous participation in the case of the survey, or through de-identification of the interview participants. All risks identified for the study were managed and the research study was supervised by experienced academics.

Chapter 4: Phase one survey results

Introduction

Phase one of this study consisted of a survey and semi-structured interviews of students to determine the 'state of play' in student and new graduate learning about responding to people experiencing thought-disorder. This was undertaken as the literature review (reported in Chapter 2) found that little had been written about this topic. Specifically, knowledge of how the skills of responding to thought-disorder were developed and which learning approaches were most useful in existing pre-registration nursing programs was sought. Quantitative and qualitative data were collected, along with demographic items. This chapter reports the demographic characteristics of participants and relationships between characteristics are noted. This is followed by the results of the analysis of the quantitative and qualitative data. The final section of this chapter highlights the contributions of this phase to the research study[2].

There were 148 responses to the survey. Not all participants responded to each question of the survey. Results have therefore been presented to accommodate this circumstance. Results presented in the table reflect the entire participant sample (N=148). The results are reported as it relates to the proportion of responses to that question. For example, if 48 participant responses are missing this is reported in the table, but the characteristics of the responses will be reported in relationship to the responses given (n=100).

1. Survey participants

The gender distribution of participants was roughly reflective of the distribution in the nursing workforce and nursing student populations. Participant ages ranged from 18 to 65 years. Most participants were 18 to 24 years of age (41.1%) followed by those 25 to 34 years old (27.1%). These age groups are when most people undertake their

[2] My thanks for assistance in the analysis of the descriptive data of the survey go to Dr Denis Visentin, Senior Lecturer, School of Health Sciences, College of Health and Medicine, University of Tasmania

education and join the workforce. Other age groups, account for almost one third of participants (Table 4.1).

Participants were drawn from a global audience, however, Australian and United Kingdom (UK) residents accounted for the place of residence for 75.5% (n=68) of participants. Other participants were from New Zealand 8.8% (n=8), United States of America (USA) 2.2% (n=2) and Canada 1.1% (n=1). All these areas are predominantly English-speaking countries and could reflect the accessibility of a survey written in English.

English was the usual language of 99% (n=106) of participants. Participants indicated knowledge of a range of other languages including Afrikaans, Dutch, Dari, Farsi, French, German, Greek, Indonesian, Japanese, Mandarin, Polish, Punjabi, Serbian, Shona, Spanish and Welsh. There were 21 ethnic backgrounds nominated, dominated by the countries of residence – Australian and British ethnicities. Additional ethnicities included Maori, Afghani, Caribbean, Irish, Sikh, Russian, Scottish, Sri Lankan, and Ukrainian.

Table 4.1: Demographic characteristics of participants

Variable	Level	n (%)
Gender	Female	97 (65.53)
	Male	9 (6.1)
	Other	1 (0.67)
	Missing	41 (27.7)
Age (years)	18-24	44 (29.73)
	25-34	29 (19.59)
	35- 44	20 (13.51)
	45-54	12 (8.11)
	55-64	2 (1.35)
	Missing	41 (27.71)
Usual language	English	106 (71.62)
	Other than English	1 (0.68)
	Missing	41 (27.70)
Language	English only	64 (43.24)
	Additional	26 (17.57)

	Language	
	Missing	58 (39.19)
Ethnicity	British	39 (26.34)
	Australian	29 (19.59)
	New Zealander	8 (5.41)
	European	4 (2.70)
	Indian Subcontinent	3 (2.03)
	African	2 (1.35)
	Chinese	2 (1.35)
	Afro-Caribbean	1 (0.68)
	Russian	1 (0.68)
	Latin-American	1 (0.68)
	Missing	58 (39.19)
Total		**148**

The educational background of participants was dominated by baccalaureate levels 50% (n= 52). High school or equivalent was nominated by 14% (n=15) as their highest level of (completed) education. There were 18.3% (n=19) of participants who had some college participation but had not completed a degree, and 4.8% (n= 5) who had an associate degree. A previous graduate degree was reported by 12.5% (n=13) of participants. Two participants preferred to not respond. The number of participants who reported a prior completed degree was unexpected at almost 46.8% (n=70) an undergraduate or graduate degree, although only 23% (n=34) of respondents were in the age range 35-64. This result may reflect misunderstanding of the question that was interpreted as ambiguous and encouraged participants to nominate the current enrolment, rather than only completed educational awards. It may also reflect the number of older participants who are undertaking a Bachelor of Nursing as a career change (Table 4.2).

Table 4.2: Prior education

Variable	Level	n (%)
Highest qualification	Less than high school	0
	High School	15 (10.3)
	Tertiary incomplete	19 (12.9)
	Associate degree	5 (3.6)
	Bachelor's degree	52 (34.3)
	Graduate degree	13 (8.9)
	Prefer not to answer	2 (1.5)
	Missing	42 (28.5)

There were a range of responses to the question about current program of study. This reflected the range of titles for undergraduate pre-registration programs, including the UK division into Adult, Children, Mental Health and Learning Disability programs.

Participation was limited to those who had finished a mental health theory subject and a mental health clinical placement. Most participants reported to be currently studying in their 3rd year 52% (n=50). Reflecting the variety in curriculum design, 31.25% (n=30) of participants were in their first or second year of study (Table 4.3).

Table 4.3: Current degree characteristics

Variable	Level	n (%)
Current degree	Undergraduate	93 (62.83)
	Graduate	8 (5.41)
	Unclear	1 (0.68)
	Diploma	1 (0.68)
	Missing	45 (30.4)
Year of study	First year u/g	15 (10.14)
	Second year u/g	15 (10.14)
	Third year u/g	50 (33.77)
	Fourth year u/g	0
	Fifth year u/g	1 (0.68)
	First year p/g	10 (6.76)
	Second year p/g	5 (3.38)
	Missing	52 (35.13)

u/g=undergraduate p/g=postgraduate

The country where participants were undertaking their programs mirrors prior responses about ethnicity and language. Most participants were studying in Australia 51.92% (n=54) or UK 38.46% (n=40). Seven participants were studying in New Zealand 6.7% (n=7), two in the USA and one in Canada (Table 4.4).

Table 4.4: Country of residence for study

Variable	Level	n (%)
Country of residence	Australia	54 (36.49)
	UK	40 (27.03)
	NZ	7 (4.73)
	USA	2 (1.35)
	Canada	1 (0.68)
	Missing	44 (29.72)

Most study participants (80.18%) reported being in paid employment, and all of these participants were employed within health or human services. This figure reflects the sample that included newly graduated nurses. A majority of those who are employed reported that they worked with people experiencing thought-disordered speech (75.78%) (Table 4.5).

Table 4.5: Employment characteristics

Variable	Level	n (%)
Paid employment	Yes	85 (57.43)
	No	21 (14.19)
	Missing	42 (28.38)
Health or human services employment	Yes	85 (57.43)
	No	20 (13.51)
	Missing	43 (29.06)
Working with people with thought-disorder	Yes	72 (48.64)
	No	23 (15.54)
	Prefer to not answer	1 (0.68)
	Missing	52 (35.14)

2. Personal experience of mental health problems

Study participants were asked whether they identified as a consumer or person with a lived experience of mental health problems, referred to as a service user in the UK

context. They were also asked whether they identified as a carer of someone who experiences mental health problems or as a health practitioner who worked with people experiencing mental health problems. Participants were invited to mark as many options as possible which described their experiences or participants could nominate that they had no prior experience of people who experience mental health problems.

Almost two thirds of participants identified as consumer or carer (63.51%, n= 94) and 27.70% (n=41) nominated experience as a health practitioner to people experiencing mental health problems. No participants missed this question and only one indicated a preference to not respond. There were 8.11% (n=12) participants who indicated that they had no prior personal experience of people experiencing mental health problems in the role of a consumer, a carer, or as a health practitioner (Table 4.6). Tests of association were not possible between this demographic variable and any other responses due to insufficient numbers of participants responding to this question.

Table 4.6: Personal experience of mental health problems

Variable	Level	n (%)
Personal mental health experience	Consumer	52 (35.14)
	Carer	42 (28.37)
	Health practitioner	41 (27.70)
	No prior experience	12 (8.11)
	Prefer not to answer	1 (0.68)
	Missing	0

3. Context of learning to respond to thought-disordered speech

Survey participants were asked whether they learnt about thought-disordered speech within their course. There were four alternatives given: learning within the BN, learning other than in the BN course, not learning or other with a free field to provide details. The response rate was poor, 77 participants did not answer this question meaning that answers were from 47.97% (n=71) of participants only. No participants indicated that their experience was other than the three alternatives presented. More participants indicated that they learnt about thought-disorder

outside of their BN course 25.35% (n=18) or did not learn at all 28.16% (n=20) than nominated the BN course as the source of their learning (46.48% n=33) (Table 4.7).

Table 4.7: Context of learning

Variable	Level	n (%)
Learning about thought-disordered speech	BN	33 (22.30)
	Outside BN	18 (12.16)
	No learning	20 (13.51)
	Other	0
	Missing	77 (52.03)

The following question asked participants to nominate the type of teaching experience they had encountered when learning to respond to thought-disordered speech. This question gave participants five alternatives and an open field to record all approaches they had experienced. The instructions invited multiple responses if this captured the learning experience most accurately, or an open field encouraged the addition of alternative experiences. This question was not answered by 37.83% (n=56) of participants Table 4.8).

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Table 4.8: Learning to respond to thought-disordered speech

Variable	Level	n (%)
How learning to respond to thought-disordered speech occurred	Lectures	23 (15.54)
	Tutorials	22 (14.86)
	Clinical practice; Role play	5 (3.38)
	Clinical practice	7 (4.73)
	Demonstration	
	Clinical placement	35 (23.65)
	Other	0
	Missing	56 (37.84)

The distribution of numbers of learning types experienced is reported in Figure 4.1.
It was most common for participants to report a single experience of learning/teaching about this topic and this was on clinical placement 38.04% (n=35). The next most common learning/teaching experiences were either in a formal lecture 25% (n=23) or a tutorial 23.91%(n=22). Role play or demonstration within a clinical

skills laboratory was infrequently reported at 5.4% (n=5) and 7.6% (n=7) respectively.

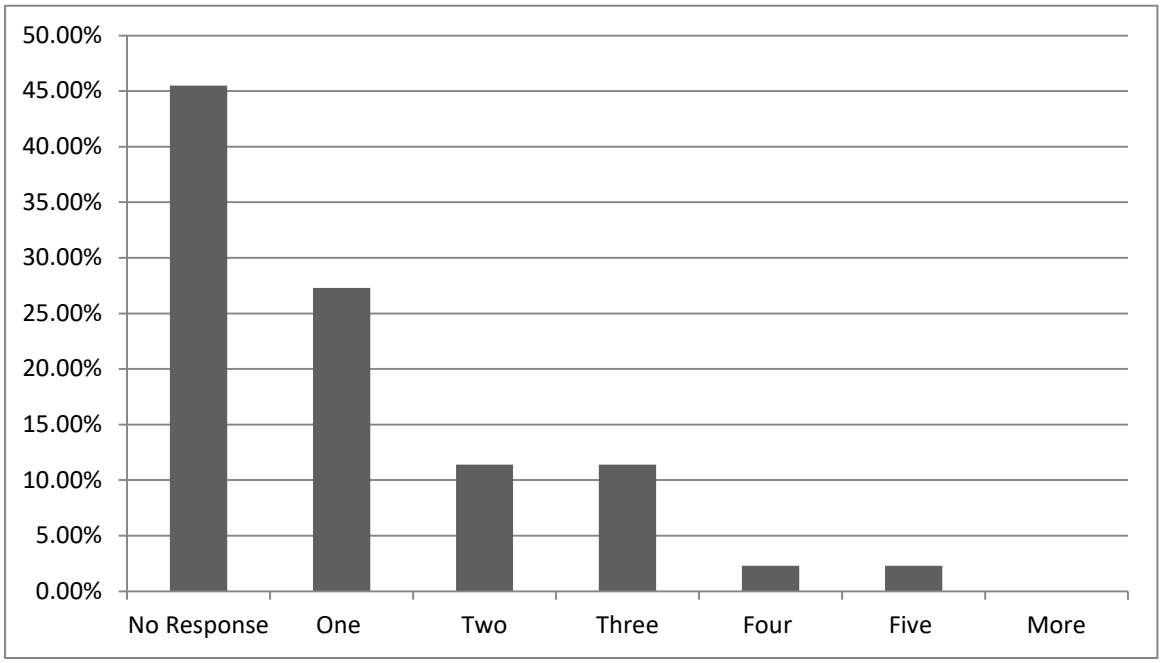

Figure 4.1: Number of learning types

4. Where most learning occurred: Class or placement

Participants were asked to indicate on a sliding scale from Theory Classes only to Clinical Placement only where most of their learning occurred about responding to people with thought-disorder. Results were collated by taking the scale to represent 100 points and reporting on three intervals: below 35 (where 0 = Theory classes only), 36-70, and above 70 (where 100 = Clinical placement only). This question was not answered by 27% (n=40) of participants. Participants recorded learning experiences favouring clinical placement as the main source of learning. Details are reported in Figure 4.2.

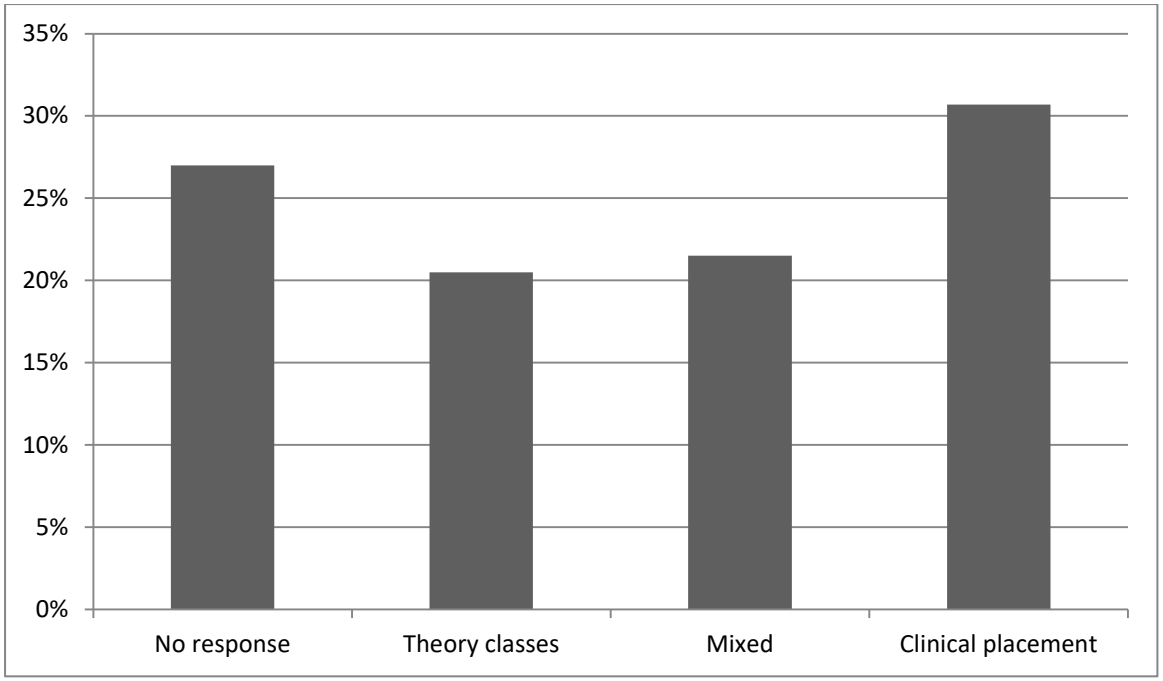

Figure 4.2: Source of learning

Participants' responses had a mean and standard deviation as indicated in Table 4.9. This indicates that it was most common for participants to have had a mixture of sources for their learning – both within the classroom and on clinical placement. However, the standard deviation suggests that participants' experiences were diverse, and that participants reported either theory or clinical placement experiences alone at similar frequency, as shown in Figure 4.2 to those having more than a single source of learning. When considering that theory classes encompass a range of learning modes – lectures, tutorials, clinical skills laboratory – the dominance of clinical placements as the sole source of learning is clear. This reinforces the findings from question 20 which asked participants the source of their learning about responding to thought-disordered speech (Table 4.8).

Table 4.9: Analysis of variance of main source of learning

Variable	Mean (SD)
Main learning source:	
Theory or clinical (n=64)	55.58 **(**36.66)

5. Assessment of learning about responding to thought-disordered speech

Participants were asked to nominate as many of the five methods that were used to assess their learning about responding to thought-disordered speech or to provide additional methods in an open field. The choices were three types of formal examination – by multiple choice questions, short answer questions or case study, assessment by simulation (for example Objective Structured Clinical Examinations (OSCE)) or assessment on clinical placement.

These questions were answered by 45% (n=58) of participants. Table 4.10 reports the participants' responses. Clinical placement was the most commonly used and reported assessment method 46.15% (n=24) followed by multiple choice question examination 24.14% (n=14). Simulation, while utilised, was the method of assessment least reported 6.89% (n=4). Participants did not nominate any other methods of assessment. The survey did not ask participants to indicate if they had not been assessed about thought-disorder, so it is not possible to report any data reflecting this. It cannot be assumed that those who did not respond to this question were people who had not had learning to respond to thought-disordered speech assessed in their nursing programs.

Table 4.10: Assessment of learning

Variable	Level	n (%)
Assessment of learning	MCQ Exam	14 (9.46)
	Short answer exam	7 (4.73)
	Case study exam	9 (6.08)
	Simulation	4 (2.70)
	Clinical placement	24 (16.22)
	Other	0
	Missing	90 (60.81)

6. Learning to respond to thought-disordered speech as a learning objective

The participants were asked to rate the importance that learning to respond to thought-disordered speech was given in their program of study using a five-point Likert scale from very important, somewhat important, neither important nor unimportant to not very important and not important at all. Forty percent of participants provided a response. These responses favour learning to respond to thought-disorder as being an important learning objective. The choices of 'very important' or 'somewhat important' were chosen by 62.07% (n=36) of participants compared with 20.69% (n=12) of participants who reported that it was 'not very important' or 'not important at all' (Table 4.11).

Table 4.11: Importance as learning objective

Variable	Level	n (%)
Importance as learning objective	Very Important	20 (13.51)
	Somewhat important	16 (10.81)
	Neither	10 (6.76)
	Not very	6 (4.05)
	Not at all	6 (4.05)
	Missing	90 (60.82)

Relationships between survey variables

Statistical analyses of variables measured by this survey were carried out to test whether there were any relationships that were not determined by chance. Pearson's chi-squared test was performed to test demographic characteristics for these possibilities against two variables:

1. experience of working with people experiencing thought-disorder (Appendix 21)
2. experience of thought-disorder as a major learning objective in the undergraduate/pre-registration program (Appendix 22).

These tests were performed to investigate if differences in these experiences were associated with the demographic characteristics of participants.

Four groups were identified as more likely to have experience working with people who have experiences of thought-disorder.

1. Those who identified their ethnicity as New Zealander.
2. Those who were studying in New Zealand.
3. Those in paid employment.
4. Those working in health or human services.

The second variable tested was experience of thought-disorder as a major learning objective in the undergraduate/pre-registration program against demographic variables reported by participants. Participants were asked whether their study program featured learning to respond to thought-disorder as a major learning objective. There were no significant associations evident for any demographic variables. The survey did not ask if participants considered learning to respond to thought-disorder should be a major learning objective in undergraduate nursing programs. So, these findings do not reflect whether participants consider that learning to respond to thought-disorder should be a major learning objective, only whether it was an important learning objective in the program in which they had studied.

Age, employment or self-dentification as a consumer of mental health service, carer for someone with the experience of mental health problems, or worker with those experiencing thought-disorder was not associated with greater recognition of those aspects of learning experiences which address preparing to respond to thought-disorder (see Appendix 19).

Open field responses in survey

The open-field questions were included within the survey to give participants an opportunity to expand on their responses, to raise issues of concern, and to express these in their own words. The survey contained five open-field questions. These questions asked participants to use their own words to express their responses to a range of questions about aspects of the topic. The questions and the numbers of participants who provided a response are reported in Table 4.12.

Table 4.12: Open field survey questions and participant numbers

Question	n (%)
17: How do you feel about working with people experiencing mental health problems?	97 (65.5%)
18: What do you understand thought-disordered speech to be?	61 (41%)
21: Were you taught about how to talk with people experiencing thought-disordered speech?	62 (41.9%)
25: What way did you find most useful to help you learn about thought-disordered speech?	64 (43.2%)
26: Please add your suggestions for learning and teaching about thought-disordered speech. Add as many approaches as you wish that may help to learn about thought-disordered speech and how to respond to people exhibiting this type of speech.	44 (29.7%)

The responses to the five open-ended fields provided a platform for participants to express a range of issues, if they desired. Three themes were identified, and these are detailed in Table 4.13.

Table 4.13: Themes from open field responses

Theme	Explanation
It's a silo	Learning in mental health generally and about responding to thought-disorder is not seen to relate to other parts of the curriculum or subjects of study within the pre-registration program. It is also about the value of learning from people with the experience of thought-disorder, particularly in a clinical setting.
It is our responsibility	Participants expressed the belief that the requisite skills for responding to thought-disorder are their responsibility to master because it is largely unaddressed in their learning programs.
Advocacy	Students who embrace this work and regard their participation as a crucial component for people's recovery. Some elements of collaboration are evident, but some conceptualisations are paternalistic.

Responses within the open fields confirmed a paucity of formal explicit teaching and learning about how to respond to thought-disorder that has been reported elsewhere in the survey questions. The approaches taken or lessons learnt were about definitional categories useful in assessment and report writing. The meaning for

people experiencing thought-disorder, or suggested ways to respond, were largely absent or represented by generic communication principles.

It's a silo

Mental Health Nursing is regarded as a unique and separate domain of nursing by participants in the survey. The skills, attitudes and knowledge seen as pertinent to caring for people with mental health problems reflect an understanding that sees these as unique and of a different nature than those utilised and learnt for nursing practice more generally.

Participants reported conflicting messages about the responses that might be helpful for people experiencing thought-disorder. Different contributors in their learning gave inconsistent guidance:

> *Mixed responses from staff! Some say not to engage with individual's psychosis others say that the individual's thoughts are very real to them at that time* (Participant 56).

As this response indicates, there is not an agreed consensus in approaches for responding to thought-disorder. This is also reflected in the absence of a clear body of evidence to support clinical guidelines. At times participants' comments indicate that the siloing of mental health skills and knowledge are manifest by the absence of formal learning curriculum during the theoretical component of their programs. Participants turn to their clinical placement experience as a place of authentic learning – especially when the range of mental health challenges is not addressed in class or responding to these is not part of the curriculum. Participants commented that their learning to respond to thought-disorder did not occur until:

> *… I went on placement* (Participant 31).

Participants went further and suggested that such a skill cannot be learnt in a classroom:

> *Hands on is the only real way to learn about these things and everyone is different so can't really be taught* (Participant 84).

Participant 84 expanded the idea of "hands on" being necessary by identifying that there were individual differences in learning styles.

Experts by Experience, that is people who have experienced mental health problems, are nominated as appropriate sources for learning:

> *…I believe you gain the knowledge working with these people* (Participant 25).
>
> *Service users talking about best way to speak to them when thought-disordered* (Participant 60).

This observation, however, did not reflect a position that the skill was irrelevant or unimportant in preparation for practice. Rather, it asserted that the nature of such learning was not suited to learning outside of clinical practice settings:

> [Learning occurs by] *being exposed to patients in clinical setting and learning from supervisors* (Participant 80).

Participant 80 creates the impression that interacting with consumers and support from their supervisors were the major sources of learning about interacting with consumers who had thought-disorder. This strengthens the importance of including clinical placement within mental health facilities.

It is our responsibility

Student responses indicate a belief it is their responsibility to develop the requisite skills for responding to thought-disorder. Their responses characterised the learning that they had experienced as:

> *…There is miniscule information…at uni. It's all about you should know how to document and do the obs (*Participant 44).

Participant 44 highlights that much of the curriculum she experienced emphasised skills, procedures or tasks rather than engagement or other therapeutic communication skills development. Whilst not dismissing the legitimacy of learning to

assess and to document, comments such as this suggest that learning other communication skills appropriate to responding to those experiencing thought-disorder in pre-registration nursing programs is minimal. This contrasts to the expressed conviction by many participants that such skills have importance in the curriculum for nursing:

> *Greater emphasis placed on teaching about thought-disordered speech* (Participant 32).

> *I believe it should be compulsory in my course (*Participant 7).

Another participant extended this by advocating for a:

> *…compulsory subject in all disciplines* (Participant 24).

These three quotes reinforce participants' willingness to be exposed to consumers experiencing thought-disorder as an endorsed component of the undergraduate nursing curriculum. This exposure has strengthened their recognition and understanding of the importance of being knowledgeable about the subject of thought-disorder and skilled to interact with people experiencing thought-disorder – skills derived from theoretical input in class.

Advocacy

The third theme evident across the range of open field responses is advocacy. Some participants avowed an attitude toward working in mental health settings and services that was effusive:

> *I love working as a mental health nurse* (Participant 48).

This was tempered by some participants with an acknowledgement that the work could be difficult at times:

> *Very fulfilling can be challenging at times, but 100% worth it* (Participant 58).

Other participants volunteered more mixed responses, indicating some ambivalence:

> *I'm open to working in mental health services, but I don't think it's my calling* (Participant 35).

> *May be a bit of a shock at the start, but I believe I could do it* (Participant 43).

Such responses did however credit mental health work as a legitimate form of nursing practice. While these responses could be characterised as ambivalent there was also an element of reflection and a willingness to consider the possibility of working in a mental health environment. A key feature of this work was conceptualised as countering the social disadvantage experienced by many people often as a result from stigmatising attitudes:

> *I believe they need strong advocates due to the stigma society places on them* (Participant 6).

This was conceptualised in terms of social justice:

> *They deserve the same care as people with other physical problems* (Participant 73).

The ways of working referred to by participants emphasised approaches common across other areas of nursing practice. These collaborative working patterns, however, were also inclusive of those with the lived experience of mental health problems. The objective of the collaborative therapeutic relationship was not conceptualised as the biomedical notion of recovery and cure or elimination of symptoms: this notion of clinical recovery is opposed to personal recovery and a life worth living or a meaningful life. Rather it (recovery) was conceived in terms of the Recovery Principles drawn from the Consumer Movement as personal recovery ensuring hope and meaning are retained despite the challenges faced by people experiencing mental health problems. However, an individual's personal recovery goal may be to eliminate symptoms. Adopting therapeutic pessimism is rejected:

> *It's all about collaborating with team and client to depict hope and in meaning to life (*Participant 44).

This theme included comments that reflected self-confidence of participants that they had skills to make a positive difference:

> ... [I feel] *confident and competent* (Participant 135).
>
> *I have no issues or difficulties* [interacting with people experiencing thought-disorder] (Participant 142).

This confidence was surprising in a context where most participants (52%) reported that they had not had any instruction about responding to those experiencing thought-disorders. Furthermore, several participants went so far as to report feeling under-skilled and apprehensive – responses more understandable against a background of reported lack of instruction. These feelings are reflected in comments such as feeling:

> *Scared at times* (Participant 27).
> *Apprehensive* (Participant 121).

Participant 34 took this further and considered the reason for her uncertainty and apprehension may be because of awareness of her own limited skills and concern about the effect on consumers:

> *I struggle working with clients with mental health issues due to myself not knowing what to say. I do not want to hurt people, so I get very awkward* (Participant 34).

These comments, however, may also reflect unfounded stigmatising attitudes or realistic self-assessment. The tenor of the findings about participants' assessment of readiness to practice with people experiencing thought-disorder is reflected in this final comment:

> *Underprepared, lack of experience (*Participant 59).

This final comment supports that people with thought-disorder represent a challenge for nurses' skills of interpersonal relatedness and therapeutic communication. This requires inclusion within the curriculum to enable the provision of appropriate and safe recovery-focussed nursing practice.

Chapter summary

The survey of nursing students and newly graduated nurses clearly confirmed they recognised the importance of therapeutic communication and other interpersonal skills in responding to people experiencing thought-disorder and that this learning was poorly addressed in pre-registration programs. Most participants nominated that they had only learnt about thought-disorder in single learning environments – primarily on clinical placement. Few recognised assessments of this learning beyond a minor part of formal examination. This contrasts with the type of learning and assessment participants nominated as valuable, which focussed on in-vivo modes such as Objective Structured Clinical Examinations (OSCEs).

Participants nominated a range of teaching and learning approaches having potential to support this learning but stressed the importance of clinical placement as an integral component of the learning experience. There was also recognition among some participants that people with a lived experience of mental health problems were equipped with unique expertise to support learning these therapeutic communication skills.

When participants responded to the open-field question about their suggestions for learning, responses emphasised that these skills required practice and perseverance. This recognises the significance of theoretical input as a scaffolding device to provide the guidance and opportunity for graduated practice prior to clinical practice. The development of personal style from knowledge of one's own strengths and abilities (like the Recovery model approach) was raised and signals the importance of reflection in this aspect of nursing practice.

The survey results identified that pre-registration nursing students were challenged by responding to people exhibiting thought-disorder. It uncovered that the teaching and learning of the requisite therapeutic communication skills which are argued to

have relevance and application beyond mental health nursing practice alone, were inconsistent.

Much of chapter 4 revised and sections removed.

Chapter 5: Phase one – Findings from student interviews

Word cloud removed

> *I don't think we were taught how to respond to thought-disordered speech at all. We were taught about thought form and about thought content and about what those – how they're represented, what they look like. But then that next step as to how would you respond to that just wasn't there (Alex).*

Introduction

The preparation of nursing students to respond to people expressing thought-disorder is rarely mentioned or explored within the research literature. As Alex (study participant quoted above) reflected, her learning experience addressed recognition of thought-disorder, but not developing responses. This phase of the study explored the learning experiences of nursing students and one newly graduated nurse. These interviews aimed to develop an understanding of the experiences of learning to respond to people exhibiting thought-disorder in undergraduate nursing programs, through semi-structured interviews. The interview questions were informed by the literature and also by the responses to the survey and the questions of the research study. Participants responded to semi-structured interview questions that explored whether learning this skill was important for new graduates, if they had experienced this learning, how this skill was taught, and what assessment was included to test mastery. After exploring the participants' learning experiences, they were asked to nominate those educational approaches that they considered would have helped them to master clinical communication skills when working with people who had thought-disorder.

This chapter will present the results of thematic analysis of the interview data. These findings build on the results from the previous chapter of quantitative and qualitative responses to the survey. In building on these responses, greater depth and understanding is achieved. First, the characteristics and demographics of the participants are reported.

Demographic details of interview participants

There were 11 participants who were asked their age, identified gender, and place of residence. Their status as a student or newly graduated Registered Nurse (RN) was confirmed, and learning experiences identified as regards formal class-based instruction and mental health nursing clinical placement. The interview participants were asked if they identified as carer for a person experiencing mental health problems or consumer of mental health services. Their employment history was established.

All participants were Australian residents, and women, but drawn from four different states, as detailed in Table 5.1.

Table 5.1: Residence of participants

Current residence	Number of interview participants	Pseudonym for interview participant
Victoria, Australia	1 x 3rd year student	Kim
Perth, Western Australia	1 x RN1	Chris
Hobart, Tasmania	1 x 3rd year student	Alex
Sydney, NSW	8 x 3rd year students	Darcy, Bobbi, Andi, Bernie, Casey, Gabby, Jo, Morgan

Three participants (Bernie, Kim and Gabby) identify as past or current consumers of mental health services. Others, Morgan, Andi, Chris and Darcy, identified that relatives had experience as consumers, but did not have this experience themselves or identify as their carer. Jo identified as a carer for a relative with mental health problems, but not as a consumer herself. The other participants did not identify with either experience (Darcy, Bobbi, Casey) (Table 5.2).

Table 5.2: Prior personal mental health experiences

Participant	Consumer of mental-health services	Carer of a person with mental ill-health	Relative with mental ill-health	Works or worked in mental health services
Kim	✓			AIN Aged Services
Chris			✓	✓RN 1 MH Transition placement
Alex				EN, not MH
Darcy				Student admin. officer
Bobbi				None reported
Andi			✓	✓AIN Children's MH services
Bernie	✓			✓AOD[3] casual
Casey				✓AIN MH
Gabby	✓			✓EN 4 yrs MH
Jo		✓		Dental assistant
Morgan			✓	✓Community worker NDIS

All participants were employed at the time of the interview. In total, six of the participants reported employment in fields associated with mental health or drug and alcohol services. Assistant in Nursing (AIN) employment is offered to nursing students from their 2nd year in Australia, without any additional training required.

[3] Alcohol and Other Drugs (AOD) services are not considered part of Mental Health Services but do share a number of qualities including a Recovery, strengths-based approach and use of a peer workforce. In addition, AOD is a common co-occurring problem for people diagnosed with mental ill-health.

Thematic analysis

The interviews provided fresh information from the earlier survey and open field data. A thematic analysis of the interview data identified two major themes in addressing the topic of this project: *learning to respond to thought-disorder* and *learning during clinical placement*. Both themes will be reported on in terms of the meaning assigned to them and their subthemes (Table 5.3).

Table 5.3: Themes and subthemes

Theme	Subtheme	Meaning
Learning to respond to thought-disorder	What was learnt	Explanation of the components of the learning.
	Understandings of the rationale for learning about thought-disorder	Participants explanations of why this learning was a part of their curricula.
	How learning was supported	The techniques and approaches employed to sustain this learning. Who introduced and reinforced learning regarding responding to thought-disorder.
	Suggestions for approaches to learning	Those approaches participants suggested should be adopted.
Learning during clinical placement	Difference between learning settings	Participants noted differences between their learning in class and in a clinical environment, between mental health placement and clinical placements in other components of their BN program, and between different mental health services experienced.
	Support	Support was explored in the formal provision of debriefing, as experienced from peers and from facilitators and staff. Strategies for self-care were also related to this subtheme.
	Emotional response	The description of gaining confidence during clinical placement and pre-clinical emotional trepidation about mental health clinical placement was clear in participants' discussion. Empathy was frequently noted. Participants who witnessed critical incidents reviewed these as an essential component of mental health clinical placement.
	Authentic Experiences	A range of experiences during clinical placement were described as authentic and contrasted in this domain with theory classes. Person-centred care and reflective practice were also commented on as hallmarks of clinical placement.

Learning to respond to thought-disorder

Participant responses to the central question of this project addressed a number of features of their experience of learning that have been grouped within the four subthemes. These subthemes are: what was learnt; understandings of the rationale for learning about thought-disorder; how learning was supported; and suggestions for approaches to learning.

Subtheme 1: What was learnt

Participants spoke of the topic being approached in a descriptive manner that provided information to help recognise and categorise thought-disorders – usually for the purposes of assessment and documentation. Morgan's discussion indicated this when she commented:

> *…they tell you about it. They just say these are the things that if you do a mental health, say a mental health assessment, these are the things you might find. People might you know, struggle to communicate* (Morgan).

She situates the thought-disorder as a deficit or problem with communication, not initially as something with meaning that may be unclear.

Kim reported that:

> *they talked about how it affected the person's life and what – how they couldn't get across things that they wanted to say, or they were getting, … frustrated and how it affected their entire life* (Kim).

Again, this identifies thought-disorder as a deficit, that fails to communicate meaning and acts as an impediment to shared meaning.

Jo stated that she had learnt the following:

> *Yes, we were always taught never to fight it. It's not something you can really justify or explain what someone else, what's in someone else's head, it's not something you could fight against or to argue against and to never do that. Yeah. It's a very, it was very different for different patients that I had, so it was very dependent on the patients that I had*…(Jo).

Jo's comments reflect an understanding of the individualised features of thought-disorder and that a non-judgemental attitude is recommended. She also commented on the physical positioning and body-language that was helpful when responding to people exhibiting thought-disorder. She said:

> *I was quite open and … I sat very comfortably, and I made sure that I wasn't closing my body … or being really rigid and I was maintaining eye contact … you need to seem friendly* (Jo).

These factors of positioning in communication were understood as a basis in the response to those with an experience of thought-disorder.

Chris commented on the extent of learning about thought-disorder by saying:

> *…it's more like an introduction rather than a comprehensive learning experience* (Chris).

She is recognising the limits of the experiences offered for learning how to respond to thought-disorder. Further, Chris reflected on her learning by saying:

> *I feel like looking back on my learning it was two things – it was, one, this happened, and two, just kind of go along with it or don't buy into it. It's kind of a bit dismissed* (Chris).

Chris recalls limits to her learning that she characterises as …a bit dismissed, although she has placed this comment in the context of characterising the learning as "an introduction".

These limits were also how Gabby described what was learnt:

> *… I felt that it's not super … practical when it comes to, well if I'm confronted with somebody who's thought disordered and I have to engage with them, what tools am I taught?... I found that you're not really taught any* (Gabby).

Gabby critiques her learning as not "practical", she reports not having learnt how to respond when interacting with people experiencing thought-disorder and infers that she had learnt nothing.

Andi notes:

> *I don't really feel like we were taught like how to recognise or how to respond to it* (Andi).

In Andi's comment, she raises doubt as to whether the learning she experienced was successful in helping her to recognise thought-disorder. Alex's experience of her learning is different, and she makes the distinction between recognising thought-disorder and learning how to respond to it:

> *I don't think we were taught how to respond to thought-disordered speech at all. We were taught about thought form and about thought content and about what those – how they're represented, what they look like. But then that next step as to how would you respond to that just wasn't there* (Alex).

Bobbi recalls learning to respond to distress generally and that which may be associated with thought-disorder. She said:

> *they teach us how to deal with distressed people, just like – as far as I remember, I think they said you just need to … you can take them into a – like a quiet place and then talk to them about the incident and then I think most of the people realises their mistakes, even though they are – there was a split-second decision and then even the mental health patients can – do realises their mistakes, like why did they do it. And sometimes they have a good insight about their health, like mental health, and then they know that they do this because of their illness … So, you could … take them to a quiet place, talk to them about it and … if you need to educate them, you can educate them. And then there's some techniques like deep breathing techniques you can use to calm people down* (Bobbi).

In this recollection, Bobbi suggests that those experiencing thought-disorder may respond to a calm and an educative approach with "realising their mistake". She suggests the value of supporting relaxation techniques in helping people who are distressed.

Casey had difficulty nominating learning how to respond to thought-disorder before clinical placement. She said:

> *So, it was by chance that I'd learnt about how to have sort of discussions and a lot of the advice that was given was really vague* (Casey).

Casey described her learning in class as not addressing learning to respond to thought-disorder:

> *In university we kind of learnt things that were, not really to do with thought-disorders, more to do with like how you'd respond to someone that's suicidal or wants to kill themselves or has anxiety or has depression and some methodologies that you could use in terms of motivational interview and all that sort of stuff but in terms of thought-disorders: no* (Casey).

This was also reflected in Darcy's comment about her learning. She nominated learning:

> *…examination status, mental examination status* (Darcy).

Darcy could not recall any further learning about thought-disorder beyond the recognition and categorisation necessitated by the mental state examination.

Subtheme 2: Understandings of the rationale for learning about thought-disorder

Participants identified a range of different rationales for learning to respond to thought-disorder. The explanation for the inclusion of this topic was the prevalence of the experience of mental ill-health. Casey commented this way:

> *… it's very important because it's such a prevalent thing, I know from my hospital it's a daily thing we're going to get people with thought-disorders* (Casey).

Gabby, a participant with a personal lived experience suggested the rationale for learning to respond to people experiencing thought-disorder relates to developing understanding:

> *I'm very aware that even though someone may present as being disorganised in thought and behaviour, it doesn't mean that they don't know what's going on, they're just kind of responding to things in a way that seems deregulated to the outside observer. But there's often like a rich meaning to the individual that we can't often see and that's, I know that that's true for myself so I don't obviously assume that my experience is the same and everybody else's but it's helped me develop empathy and more patience I suppose* (Gabby).

She recognises that thought-disorder may be meaningful for the individual and this meaning demands understanding. Gabby suggests thought-disorder may be an attempt at communication and that this calls for "empathy and …patience".

Andi suggested that fear of the person exhibiting thought-disorder and concern of causing harm by ill-considered comments was common:

> *sometimes when people have quite severe mental illness it's hard not to be like afraid of them. Not afraid, but you feel scared about what you are going to say to them because you don't want to make them feel worse and you don't really know what to say* (Andi).

Andi confirms that she regards knowledge of how to respond would be helpful as she reports she "[doesn't] really know what to say", perhaps suggesting she lacks confidence about what to say.

Alex also summed up the rationale for learning to respond to thought-disordered expressing similar concerns:

> *…we learn about thought-disordered speech, but I still don't know how to respond to it. That's really concerning to me, that really troubles me. Obviously, I've been in situations where I have responded to thought-disordered speech, but have I done that correctly?* (Alex).

Alex reports her feelings of concern of not knowing how to respond as troubling her.

Casey also reports urgency in learning how to respond:

> *Because that's something that students need strategies on because that's something that you're going to struggle with especially on placements when you know, you're so nervous because you're like oh my God, you know mental health unit, you know, and especially like me, I haven't had any exposure to mental health units, a lot of my friends–my friends and family are well so going on, going into those units, or going even on that placement I was like "oh my God". So, you really do need strategies because [it is] your first interactions* (Casey).

Casey comments on her lack of personal experience of mental distress as contributing to her anxiety in interacting while on clinical placement. She emphasised that learning some strategies prior to this suggesting how to respond to thought-disorder, would be helpful for initial interactions when anxious.

Subtheme 3: How learning was supported

The techniques and approaches employed to sustain learning to respond to thought-disorder were raised by participants and included the processes of assessing learning. These were comments about the pedagogical approaches within the classes at university. Participants reported that a clear focus on this learning was not evident. For example:

> *We did one lesson on it which was, like I didn't even really know that people had thought-disorders until I went to university. So, we had one lesson on it, and I didn't really understand it* (Casey).

Casey was focussed on learning what thought-disorder was and how it was evidenced rather than commenting on learning to respond to this.

Many students spoke of videos being used in university settings:

> *We watched quite a lot of videos though. They did show us quite a lot of different scenarios and different cases and my tutor was great* (Jo).

In this comment Jo acknowledges the importance of the role of her tutor in relation to the set videos. There is a suggestion that this learning approach was used commonly, indeed perhaps even over – used, by the phrase "…a lot of videos though".

This observation was made by other participants:

> …*we watched videos of like interviews, but there was never anyone who came in* (Andi).
>
> *We watched a lot of videos about people talking about their experiences* (Alex).

Participants' remembered a number of different people, including lecturers, tutors and staff on clinical placement, who introduced and reinforced learning regarding responses to thought-disorder. However, there was minimal mention of formal instruction by Experts by Experience as either staff or guest-lecturers. Gabby reported her exposure to learning from Experts by Experience in this way:

> *I guess the culmination of the theory was we had, I think, six Experts by Experience enter the room and we each kind of had a really informal …the exercise was to engage in therapeutic conversation and just to learn about their recovery journey, so there was that component to our study* (Gabby).

She has identified this as a culmination to her learning in theory, rather than an integrated pedagogical approach. However, Gabby tempered this judgement by noting the experience was limited by the size of the class.

> *it was about a 30-person class and we did groups, so you just kind of rotate so you'd only get the opportunity to have one chat* (Gabby).

She reported a single opportunity to participate in interactions as an outcome of a class of 30 students.

A large class size reduced the full potential of learning from a role play with Experts by Experience and was also reported by Bernie. Not only did the large numbers of fellow students reduce the chance to interact with an Experts by Experience and receive their feedback, if one had that opportunity, but additional feedback from the tutor was also not always available:

> *…the class was pretty big so not everyone was able to get feedback, and not everyone was able to interact in the role play with the tutor observing* (Bernie).

Bernie's comment focuses on the deficit of large classes in engaging in learning with Experts by Experience. She remembers the learning experience but did not comment on its positive effect on her learning.

Another approach reported as supporting learning about interaction with people experiencing thought-disorder was the use of role play and occasional other forms of

simulation:

> *…during that subject, the mental health subject we did some role plays and we had examples, video examples* (Bernie).

This use of role play did not specify that it focussed on mastering techniques for interacting with people who experienced thought-disorder or whether it was more generalised.

Comments about the assessment experiences of the participants and its emphasis on thought-disorder reported that this focused mostly on recognising, labelling and documenting usually in the context of Mental State Examination. Objective Structured Clinical Examination (OSCE) forms of assessment were not reported, rather written forms of assessment were reported:

> *…we did have an assessment which was like a video of someone having an interview with a doctor and we essentially had to sort of diagnose them. But I think the, in the test that I did the person had addiction* (Andi).

This report did not focus on responding to people experiencing thought-disorder, rather labelling and reporting the observations of complex behaviour that may or may not include thought-disorder.

Although Alex reports assessment inclusive of thought-disorder, it emphasised recognition of thought-disorder rather than mastery of responding to people with this experience:

> *we had an exam which didn't present … any cases within the exam. It was just a lot of questions around if … a patient said this, what would you think? Is this …relating to thought form or thought content?* (Alex).

Darcy recollected her assessment in this way:

> …[we were] *assessed by online quiz and also, we did watch a video of consumer – like the short video and we did write an essay*.. (Darcy).

She did not report that her learning assessed mastery of the ways to respond to people who experience thought-disorder.

Darcy felt her learning was well supported by traditional learning and teaching approaches:

> *I did learn those thought-disorders – the idea of thought-disorders from this subject, especially from the tutor – tutorials and then also the lectures that, that*

> *they had. I didn't know anything about it, so, I – it was a very, very interesting concept for me from the subject* (Darcy).

Darcy suggests that it was her tutor who particularly made her learning effective.

Jo also acknowledged support for her learning from her tutor:

> *He* [the tutor] *went through, he went through what he would do or how he would assess these patients. So, he was really great at showing us and telling us different strategies to use but we never actually spoke directly with someone with a lived experience* (Jo).

Jo's comments did not specifically identify responses to people experiencing thought-disorder, but she appreciated the approach from her tutor that expanded the response beyond assessment to provide his individualised approach when working with a consumer.

Subtheme 4: Suggestions for an ideal model for learning

Participants suggested teaching and learning approaches that could be adopted to develop their interactions with people experiencing thought-disorder. Morgan made these suggestions for learning in class:

> *…maybe a bit more role play at uni you know, that'll be a good help. Like one person trying to act that out and then the other one trying to communicate. I think that would – you could see – because I know in the mental health classes we did have some activities that we did and that when we – when you do an activity you really get a sense of it* (Morgan).

Morgan had found active learning experienced in role play valuable and suggested it would be useful if employed more commonly. She considered the process of participating in activity achieved learning through experiential processes. Morgan did not elaborate further to explain how or what in role play engendered a "sense of it".

This is also suggested by Alex:

> …*some role play in some kind of virtual environment where you're able to select appropriate responses to certain situations. That might help* (Alex).

Alex proposes that role plays could include simulated environments that support selecting alternative responses to thought-disordered interactions.

The use of role plays is strongly supported as a means of addressing short-comings was identified in learning to respond to thought-disorder:

> *I think a role play is much more effective than writing about it. Role play gives you the opportunity to actually be in a group and like have a discussion in a group as to how you would respond to that and then re-enact it and that way when you go on placement or you work in a hospital you're like oh I can have ... that conversation with them and have a discussion with them because ... that's not really kind of taught in university* (Casey).

Casey noted that working in a group as part of the role plays contributed to this learning, through discussion and practice of alternative ways to respond. She suggests this adds to learning outcomes.

Conversely, Jo proposed that a role play was not entirely sufficient for the best learning outcomes:

> *I think it would have been great to do more, if not role playing, maybe getting in someone with a lived experience to just talk to and discuss what their strategies were or what nurses they really enjoyed talking to or enjoyed being cared by* (Jo).

Jo is suggesting that the learning opportunities need to be increased by additional learning approaches. She says, "if not role playing", she would value input from Experts by Experience. She suggests that this would be beneficial if they expanded their narratives beyond the personal strategies they used and included reflection of their nursing care experiences.

Chris also suggests that learning could be supported by input from Experts by Experience:

> *…if we had a greater understanding of why this certain individual maybe is continuing to experience thought-disordered speech or what – or evidence of what has worked for them in the past in communicating with them would probably have helped* (Chris).

She suggests that the factors that perpetuate the individual's experience of thought-disorder and the strategies they identify to enhance communications would be valuable learning.

Caution was expressed by Andi about the use Experts by Experience in class in this way:

> *…having someone come in and talk to us who was experiencing it might have been useful and being able to ask questions about that sort of stuff might've been useful. But I don't know, it's hard to say because like I would love to just know what is the right thing to do and know like what people want to hear, but it's very situational* (Andi).

The critical importance of the individual was stressed, reflecting the imperative of person-centred care in mental health. By stating “it’s very situational”, Andi points out the variation that is reflected in individual experiences and contexts.

A request for teaching in mental health by specialists was made by Alex. She said:

> *I just think that if you’re going to be teaching something, you need to have a lot of experience in that area because it’s, especially with mental health, there are so many subtleties that occur and learning to manage behaviours is really important. If you don’t have experience in doing that, then you can’t teach your students how to do that* (Alex).

The quote is ended with Alex making a direct connection between a teacher’s clinical experience and their capacity to teach and the standard of teaching.

Gabby addressed the type of videos employed in class:

> *I suppose really tasteful or professionally done recreations of what it could be might be helpful just to kind of get into, yeah get into the feel of what it really is* (Gabby).

This reflection acknowledges the potential for videos to be enhanced by ensuring ‘professional’ standards in their production or selection.

Bernie commented that learning to respond would be better supported by videos that had more examples of interactions:

> *some of the videos did show actual people with mental health disorders, but I don’t think we saw any examples of back and forth with a person experiencing psychosis or the disorganised thought and speech, and how somebody was responding, like a professional responding, which I think would be helpful to see actually different conversations, different scenarios and how someone with experience deals with it, how they interact with that person* (Bernie).

A recommendation that the content of videos might be expanded to include examples of a range of conversations with and responses to people experiencing thought-disorder.

Clinical placement

Participants talked extensively about their experience and consideration of clinical placement as a way to learn how to respond to people experiencing thought-disorder. Their comments formed a further five subthemes: Differences between

learning settings, support, emotional response, authentic experiences, and ideal clinical placement learning.

Subtheme 1: Difference

The difference between clinical placements in mental health environments included comments contrasting it to other clinical placement areas:

> *So, when you go on clinical placement and you go to a normal [sic] hospital ward, the person comes in unwell, you fix them up generally and they go home. Where mental health was very different, we had to get our heads around that. People, you – it's not a quick fix and you need to really – their healthy might not..., be what we think is healthy. Or as long as they can live a functioning life where they can you know, look after themselves and be the best that they want to be, it's not necessarily your healthy* (Morgan).

Morgan reflects on a difference in mental health clinical placement that is challenging for students to learn. The norm of a procedural role with a fairly limited and predictable time frame resulting in resumption of the person's previous life is not her experience while on mental health clinical placement. Resumption of a lifestyle that may challenge her personal judgement of "healthy" is confronting to accept but recognised as part of the learning during her mental health clinical placement.

Jo commented on the different time frames encountered in mental health services as follows:

> *I found the pace of the ward a lot slower than a clinical setting which took me a couple of days to adjust …, I enjoyed it* (Jo).

This comment picks up on the change in pace of nursing practice. It is slower than the activity levels experienced previously on clinical practice.

Morgan also reflected on the differences between the theoretical classes and the clinical placement experience:

> *they try to teach you, but I felt like you learn more on clinical, at clinical placements* (Morgan).

Her comment highlights a gap between classroom and clinical placement learning. Morgan's understanding developed in the classroom with the major component of her learning occurring from the exposure to clinical placement experiences.

Another example commented on by participants was the contrast between practice-

based learning experienced on placement and the theory learnt in class. Casey commented on this difference as follows:

> *it wasn't until I was confronted with it in the hospital that's when I learnt. In university we kind of learnt things that were, not really to do with thought-disorders, more to do with like how you'd respond to someone that's suicidal or wants to kill themselves or has anxiety or has depression and some methodologies that you could use in terms of motivational interview and all that sort of stuff but in terms of thought-disorders no* (Casey).

In this quote Casey notes that learning had a different focus in University than the immediate challenge experienced on clinical placement. She did not feel prepared to communicate and respond to those whose speech was thought-disordered. Casey continues by highlighting her self-directed approach to gain support from the facilitator and staff to assist her learn to respond to people experiencing thought-disorder:

> *I approached my facilitators and I approached my RN's and just said that this kind of came up and we had a discussion about it* (Casey).

A further type of difference that was noted was between inpatient and community mental health services. For example, Bobbi expressed this type of difference as follows:

> *I really liked how the mental health unit had outpatient community ward organised like that. … – but that was quite surprising, and it was quite interesting as well. … I feel like I like the outpatient ward better than the inpatient because, I don't know, I feel like the independence they get …it's like I am a mental health patient and staying at my own place, I'm doing my own stuff, no one's going to come and put a tag on me and say this is – this patient has this …. No one's going to know about my stuff. So, I feel like that was more – that connected, that clicked on me. And then the inpatient ward, it was okay but I understand* (Bobbi).

She distinguished between inpatient and out-patient services noting that outpatient services decreased the labelling of people and supported retention of independence.

Subtheme 2: Support

In exploration of clinical placements, support for learning was raised both in a general sense and also in terms of responding to thought-disorder. Gaining this support was often an outcome of the students identifying a need for increased knowledge or skills development and approaching their facilitator or staff. Three

sources of support were identified – the university appointed facilitator, the staff of the clinical placement and peers. Participants also explored the way they employed self-care.

Bernie described the self-confidence she had to approach staff on an "as-needs" basis:

> *I usually go and speak to somebody about it and say I'm not comfortable at the moment, could you either stay with me while I do it or show me how to do it and sort of explain it to me again, I just ask for some support* (Bernie).

Andi commented on support being a more formalised model in this way:

> *They [facilitators] usually will come around a couple of times a day just to have a chat to you and then you'll have a big debrief with all the other students a couple of times a week. But there's definitely support there it's just depending on who it is* (Andi).

These comments from Bernie and Andi identify the confidence they have in the unit staff and facilitators appointed by the university to guide and support their learning and address challenges during clinical placement.

Staff during clinical placement and university facilitators were nominated as being helpful resources for learning when on clinical placement:

> *I approached my facilitators and I approached my RN's and just said that this kind of came up and we had a discussion about it but I really, yeah, I really didn't, I didn't really know too much of what to say, I didn't know whether or not to agree and I remember having that discussion with one of the RN's and they said yeah just listening can be the best tip* (Casey).

Casey describes a recommendation from clinical staff to listen to people who are experiencing thought-disorder as the critical response in providing support.

The unit staff supported the students' learning through sharing their clinical practice experiences, which was highly valued:

> *a couple of people who were really good as mentors, they would talk about a lot of different things they would do* (Jo).

> *I would say the nurses explaining it to me was quite helpful because they were speaking on the basis of their experience … I think that was good* (Bobbi).

The views informed from experience in practice were highlighted in these comments. Both Jo and Bobbi were appreciative of staff sharing their understandings from clinical practice.

Gabby did place a caveat on the support received from staff and facilitators while on clinical placement. She noted:

> *I find generally the facilitators are quite good, but it's just you never know what kind of workplace culture you're going to stumble into and what their kind of values are and the way that they've been practicing or agreeing to I guess – yeah how they're going to approach care, and how they approach students as well. It's always a bit of a mixed bag* (Gabby).

The impact of culture – an intangible larger than the individual staff or facilitator – was recognised as influential by Gabby who reported that her experiences on clinical placement had been "a mixed bag". The practice modelled, the values enacted in this, and their interactions with students were variable and not predictable prior to placement.

Some participants commented on their personal ways to ensure self-care - their means of managing challenging experiences and making sense of these. Morgan identified reading as a way that she does this:

> *I try to do a bit of reading about it and think you know, is this normal? What do you – what do other people do? Because there's always other people who are in the same situation who deals with it. And there's some great resources on how to – especially in mental health if you feel a bit overwhelmed you know, what to do and how to* (Morgan).

Morgan is suggesting that increased knowledge is helpful, as it reinforces the understanding that your challenges have been shared.

While Jo reports value in the more formal accessing of the support from staff:

> *I de-brief with my RN, it wasn't any major de-briefing, but she was just talking to me about what they did and what techniques you can use for next time and how they document that sort of stuff* (Jo).

Jo suggests she routinely de-briefs with the RN she is working with, as a preventative measure, not merely in response to particular issues or incidents.

Having a duress alarm equipment routinely issued was identified as supportive. Bobbi summed this up as follows:

> *First, I knew that there were – there were RN's with me, I was under supervision and I'm always safe because there's an RN looking after me and I also had a … alarm on me so I just pressed it and someone would come and help me and I knew the exit doors where they are and I could just jump out somewhere if anything like happened. So, I assured myself that I'm safe, it doesn't happen that often, it was just – during my 2-week placement it just happened once* (Bobbi).

Darcy also nominated that carrying a duress alarm helped her confidence:

> *I didn't feel scared … because we were always – carrying the duress alarm* (Darcy).

Bobbi also found the presence of other staff and capacity to leave the area helped her feel safe and supported when challenged by a situation on the ward. She expanded this by saying:

> *I feel like the way I manage is literally just by thinking that at any time I can go and I can go back into the nurses office or I can go back into the station or I can just have kind of a conversation that's just quite like closed and I can disengage from it and that definitely took some time because I think at the beginning I was so like overwhelmed by it that I almost had to take a step back* (Bobbi).

Bobbi finishes by identifying learning to be able to disengage when feeling discomfort as a means of feeling supported on clinical placement.

Subtheme 3: Emotional response

The discussion of clinical placement highlighted the personal emotional experiences arising often in the context of feeling supported. Participants spoke of anticipating their mental health clinical placement with some concern:

> *like it's hard – sometimes when people have quite severe mental illness it's hard not to be like afraid of them. Not afraid, but you feel scared about what you are going to say to them because you don't want to make them feel worse and you don't really know what to say* (Andi).

Andi identifies mixed emotions at the beginning of her placement that she explained as fear tempered with concern that she did not inadvertently disturb the wellbeing of consumers she meets and feeling inadequate.

Bobbi's comment speaks of a personal fear of those experiencing mental ill-health, rather than fear of responding in a damaging manner:

> *Yeah, because I was really scared to be very honest in – at the beginning of the placement because I had never approached a person with mental illness or anything like that* (Bobbi).

Her fear is attribute as possibly arising from lack of previously knowing anyone with a lived experience of mental ill-health.

Morgan discussed the empathy she felt when considering the experiences of consumers:

> *Yes, well very much so and I think especially because some of them had such traumatic, they had such, so much trauma in their lives and that was obviously the coping skill they used for the mental health issues ... you know, the drugs and alcohol that they used. So, you just - and sometimes you feel like, am I really going to win this battle? And then, but you can't yeah, just have to keep going, so.* (Morgan).

Although the personal circumstances were at times overwhelming for her, Morgan recognised a commitment to continue to offer support.

Participants who witnessed critical incidents reviewed these as an essential component of mental health clinical placement. Person-centred care and reflective practice were also commented on as hallmarks of clinical placement. Gabby reported witnessing the death of a member of staff associated with an altercation with a client but attributed to underlying medical conditions that resulted in a cardiac arrest. Bernie reported witnessing a woman who was seeking admission self-harming when admission was declined by threatening to "jump in front of a freight train". Admission was achieved after police and ambulance intervention at the train tracks. Both Bernie and Gabby acknowledged support was available and offered in the context of these incidents. Routine debriefing while on clinical placement was described by many participants, at times with other students who were on clinical placement at the same facility.

Andi raised the difficulty she found in caring for a man who had jumped off a building whom she met while on placement on a surgical ward. She reported:

> *…it was very uncomfortable, for me at least. And I guess I just sort of like would go into the bathroom … I sort of just avoided him to be honest* (Andi).

Further concerns were expressed as she observed:

> *he wasn't getting the mental health support that I felt that he needed and also none of the nurses really knew how to deal with it either* (Andi).

This experience was not supported in Andi's account as a learning opportunity either with the ward staff or her facilitator:

> *I don't really feel like I was given any pointers* (Andi).

However, in the context of critical mental health incidents in surgical contexts, Andi spoke of panic attacks being well supported, and having an opportunity to learn breathing techniques:

> *patients are often very anxious especially pre-surgery and so, I feel like sometimes I'm able to just talk people through, mainly with breathing techniques because that's what I find the most useful* (Andi).

Darcy reported an altercation between inpatients with a hot drink being thrown and the person yelling:

> *I think it just scared me because ... you know how she was just playing happy … a second before and then she just changed into something … and I feel like I felt like that environment was quite risky for me because I don't know what the next thing is when it happened, like what the next thing would be … I was not sure that I'm in a very safe environment at that moment. That … quite scary* (Darcy).

The personal threat was not reported as being debriefed or processed into a more sophisticated understanding of the nature of conflict and her personal response to this. But Darcy reported that she responded in the following way:

> *I thought it, it is best to just leave the situation and then refer … or sometimes I, I would talk to them and then I, I could ask like, what is concerning? Like, what, what is bothering you?* (Darcy).

Subtheme 4: Authentic learning opportunities on clinical placement

Participants nominated clinical placement as the opportunity to learn how to respond to people exhibiting thought-disorder. At times this was contrasted with the learning opportunities in class, which was typified as less authentic. Casey described her experience of the authenticity of clinical placement as follows:

> *They went through a few things like schizophrenia [in class] and then like to do with all of these kind of complex disorders and I really didn't understand it, it wasn't until I went to the hospital that I learnt more about it and I asked questions* (Casey).

Casey's comment attributes learning on clinical placement as improving her

understanding of thought-disorder but does not nominate responding being part of this learning.

Morgan emphasised that there were limits on what could be learnt in a class setting as compared to clinical placement:

> *I feel like they try to teach you about it and talk about it, but it's a whole another story when you actually have to deal with someone, work with someone who does have yeah, some thought you know, disturbances, things like that. I find that's a, it's very different when you're sitting there face-to-face with someone and you need to get information, or you try to help them but it's very hard to communicate in a way* (Morgan).

She identified the need to have a repertoire of responses available when on clinical placement, and that these are different from those outlined in class – perhaps in the moment rather than hypothetically. The comments emphasised that interacting with people experiencing thought-disorder was not always experienced while on clinical placement:

> *I guess just through placements and talking to people who weren't, I don't know, a lot of the time it's mainly just people who were on lots and lots of drugs therapeutically, can sometimes be a bit confused* (Andi).

Andi's suggestion that clinical placement was the context of learning support for responding to thought-disorder, was equivocal. She said she "guessed" this learning was supported on clinical placement. However, her recollection was that the people she met were taking medications that may have treated this experience and that she understood their experience was one of "confusion" rather than thought-disorder. Perhaps this was a sedative side-effect.

A specific example was reported by Bobbi from her clinical placement that supported her learning about thought-disorder:

> *When I did my clinical placement at XXX, there were – the nurses there are using a lot of thought-disorder when they were doing the mental state examination, the MSE's. … I asked one of the nurses about it and she explained it to me as well. I also looked it up myself … and that is how I learnt about it* (Bobbi).

She took initiative to ask and read further about thought-disorder. It is not clear or reported that this learning extended to how to respond to people experiencing thought-disorder.

Clinical Placement was credited as the learning environment where the needs of

people experiencing thought-disorder were recognised.

> *that was really really hard because I went into the hospital and I was confronted will all of these conversations with patients where I had no idea how to respond and I was like do I agree? Do I disagree? Do I go with it? Do I say that's not true? That was something that you have to learn with experience and I never got taught properly. I'm sure if I asked or I'm sure if the question was raised of how would you respond, then you, you know what I mean but it never just really kind of came to my understanding, I didn't really understand the severity and a lot of patients do have that sort of thing* (Casey).

Casey reports feeling under-prepared and concerned that she may respond in a way that is unhelpful and believes that learning to respond is developed with experience of interacting with people who express thought-disorder.

Chris cautioned that the role modelling by staff was critical to the learning occurring on clinical placement. She suggested that her experience might show practice standards that are not to be recommended:

> *I guess maybe better role modelling, if I think about my current experiences. A lot of the time, if a patient is presenting with thought-disordered presentation, the staff don't really, I mean, if they're seeming distressed by it, then I guess medication will be used, but that's not the only option available, and other times the staff sort of just – just glaze over it, like, yeah, yeah, yeah, okay, okay, yep, cool, kind of – not really. And I know that you can't sit down and get involved with all types of these conversations, but I think there's some perhaps benefit in doing so in a – in some small way* (Chris).

Chris is suggesting the example set by staff as role models is important for learning and should demonstrate a range of interventions that are not limited to the use of medication, such as therapeutic communication. Chris recognises that not every instance of thought-disorder lends itself to conversational interaction, and that there may be a place for medication as a therapeutic response, but she expresses concern that the decision may reflect staff convenience or limited therapeutic communication skills rather than clinical need.

A participant reported that their clinical placement was on a recreational camp (the Recovery Camp http://recoverycamp.com.au/). Their learning occurred in an environment where those who had an experience of mental ill-health were in recovery. However, learning about responding to thought-disorder still occurred as Casey described:

> *I think the first person I engaged with had type 2 bipolar and I was really scared but he was really really open and really enjoyed having conversations about his mental health and opened up a lot and he told us his whole story and from that moment on I sort of settled into the experience and we were kind of given tips on to just ask people and just to have open kind of conversations, really therapeutic conversations* (Casey).

This experience was reported by Casey as developmental and supportive of establishing "therapeutic conversations".

Subtheme 5: Ideal clinical placement learning

Kim argued that mental health clinical placement should be guaranteed to have minimum duration:

> *Four weeks … – well, it could be eight weeks but see, if you do four weeks you can have an understanding enough and see different variances of mental health* (Kim).

Kim stresses that the duration of the clinical placement was important, and, in her view, a minimum placement of four weeks was needed in order to experience and master some of the learning opportunities. This point was also made by Darcy:

> *…one week and one week was just really short to experience and … just see what's happening. So, I would like to have a little bit longer – placement* (Darcy).

The two-week placement that incorporated a change between units after one week was characterised by Darcy as "really short". She did not nominate an ideal length for the clinical placement but said she would "…like to have a little longer".

Bobbi also nominated clinical placements as an ideal context for learning how to respond to thought-disorder. However, the type of service for placement affects the opportunities. She said:

> *As far [for] the learning the opportunities I would say inpatient was better because you would see the patient in the ward all the time and then you could go and talk to them and have a long chat, know about them more* (Bobbi).

She was commenting that the learning experience in community mental health services was less likely to provide on-going opportunities to talk with people experiencing thought-disorder.

Alex also strongly emphasised the importance of the skills and standards of staff-those who are role models on clinical placement as well as academic staff. She put it in this way:

> …*mental health is about communicating with human beings. Like, you cannot work in mental health without communicating with your patients … you can learn all about stroke and you can learn all about the cardio-vascular system but unless you have direct experience with somebody who is delusional or psychotic or so depressed they can't talk properly, you can't, yeah. So, having more experienced staff would really have helped* (Alex).

She speaks of communication skills as fundamental to mental health nursing practice, especially to respond to thought-disorder. "Experienced staff" are important for this learning.

Chapter summary

The analysis of the semi-structured interviews of eleven participants was reported in this chapter. The participants were Australian residents, from four states, all participants except one were undergraduate students, and the exception was in her first year following graduation.

Participants reported minimal preparation to respond to people experiencing thought disorder beyond an ability to recognise it and document it. They identified clinical placement as offering a significant opportunity to augment learning that occurs in formal classes. Incorporation of increased input into learning by those who are Expert by Experience was endorsed, especially extending beyond accounts of personal experiences. Participants reported feeling poorly prepared and some expressed concern that this may be harmful to those for whom they provide nursing care.

Chapter 6: Phase two – Findings from mental health nursing academics' interviews

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Introduction

Having established an understanding from nursing students and newly graduated RNs of their experience of learning how to respond to thought-disordered communication in pre-registration nursing programs, it was clear that academics working in mental health nursing education could provide another source of understanding. Consequently, a further phase was developed for this research study. It explored what academics consider important in nursing preparation for supporting those with mental health problems and sought to establish whether this included responding to thought-disordered speech. If so, academics were asked how this was being incorporated in their teaching and curricula, and about the factors that facilitated and challenged students' learning. Finally, the factors identified by the mental health nursing academics were checked for their alignment with those identified by nursing students and newly graduated RNs.

Demographic details of interview participants

The characteristics of the participants reported varied regarding their employment, educational preparation and teaching experience. There were 12 participants who were interviewed, representing five universities. Four universities were in Australia, one in each Victoria, South Australia and NSW and one national (although all participants were from the NSW campus). One participant was from Japan, albeit with previous lengthy experience as an academic in Australia.

The participants represented four employment modes within tertiary education. Six (50%) were employed full time as academics by tertiary education institutions and they had worked in nurse education for the longest period ranging from five to more than 30 years. There was one (8%) part-time, four (33%) casual academics and one (8%) sessional academic. The amount of experience in education for those employed in casual or sessional capacities was markedly lower than those employed

full or part-time. It ranged from two to five years (Table 6.1). The casual and sessional academic proportion was representative of the overall staffing arrangements in tertiary education both in Australia and world-wide (Australian Government Department of Education & Training 2017; Universities Australia 2018).

All academics had qualifications in mental health nursing. Those who had worked longer as academics had initial hospital-based training in mental health and those who were younger had postgraduate mental health nursing qualifications. Not all participants had qualifications relevant to teaching in the tertiary education sector in addition to these clinical specialist qualifications and experience. Opinion was divided about the need for a specific teaching qualification, experience and positive and enthusiastic attitude being raised as equivalent or exceeding this formal qualification.

Most (n=8) of the participants, taught only in the university environment. One participant worked with students only within the clinical environment as a clinical facilitator employed by several universities. The single sessional participant worked with students as both a university-based lecturer and as a clinical placement facilitator. There was a long-term full time academic who also provided seminars in the clinical environment during the period of clinical placement for undergraduate nursing students. All other programs did not support the involvement of full time or part time tenured academics to teach in the clinical environment. Many of those with long periods as academics did refer to a time when this was routine, especially early during the transition of nursing preparation to tertiary education in Australia. Table 6.1 provides an overview of the participants' work characteristics.

Table 6.1: Participant profiles

Employment type	Pseudonym	Gender	Type of teaching	Years teaching	Co-existing clinical practice
Full-time (tenured)	Casey	F	University	30+	No
	Dale	M	University	20+	Yes
	Daryl	F	University	5	No
	Dylan	M	University	6	No
	Jamie	F	University	10	No
	Jesse	F	University	28+	No
Part-time	Jordan	F	University	12	Yes P/T
Casual	Lou	F	University	5	Yes
	Pat	F	University	3	Yes
	Riley	M	Clinical placement	5	No
	Taylor	F	University	3	Yes P/T
Sessional	Sam P/T	F	University+ clinical placement	2	No

The participants' qualifications are summarised in Table 6.2. This was explored only in relation to their qualifications for teaching in the tertiary sector and their qualifications in mental health nursing. There were four ways in which the academics received a mental health nursing qualification. These refer to the highest mental health nursing qualification reported by participants. Firstly, there were those who had qualifications arising from hospital-based training alone (n=5) and those who had a BN as their sole mental health nursing qualification combined with current or predominant clinical experience working in mental health services (n=2). The remainder (n=5) had postgraduate mental health nursing degrees.

This finding represents a snapshot of the current point in time where those filling an academic role are aging (hence the high number of hospital-based qualifications). It also represents the varied nature of the mental health nursing qualification.

Table 6. 2: Summary of mental health and teaching qualifications

Highest mental health nursing qualification	**Number**
Hospital certificate only	5
Bachelor of nursing + clinical experience only	2
Postgraduate qualifications in mental health nursing	5
Total	12
Highest teaching qualification	**Number**
Postgraduate higher education qualification	3
Postgraduate education (not higher education) eg Graduate diploma community education	5
Undergraduate education qualification	0
Non-university qualification (Certificate IV workplace learning)	1
No identified or incomplete teaching qualification.	3
Total	12

Themes

Four themes were identified in the analysis of academics' responses. The themes and subthemes are presented in Table 6.3.

Table 6.3: Themes and subthemes

Theme	**Subthemes**	**Meaning**
1. The fight has been lost	a. Lack of clear focus b. Adequacy of learning opportunities.	Academic participant commented on the overall status of mental health nursing within the comprehensive curricula. This comprised two subthemes that worked in concert to result in an attitude of defeat regarding preparation in mental health skills, attitudes and knowledge.
2. There are no guarantees	a. Absence of close ties with health facilities b. Difficulties with practice and staffing standards c. Students will pick up this skill from Experts by Experience d. Students' beliefs and pre-conceptions	Learning and the experiences of mental health clinical placement were regarded as variable. The deficiencies of these experiences were held to be able to be overcome by Experts by Experience, however student beliefs and pre-conceptions influences their readiness to learn.

Theme	Subthemes	Meaning
3. It's a silo	a. Different pedagogy in mental health nursing preparation b. Student siloing of personal knowledge and experience	Teaching mental health skills and knowledge often employed different techniques and valued different qualities. Students were limited in their willingness or ability to draw on knowledge from other subjects or their personal life experiences.
4. Sharing in transformation	No subthemes identified	Academic participants spoke warmly of witnessing students' 'getting-it'. They felt privileged to be part of this.

Theme 1: The fight has been lost

All participants acknowledged that the context for learning and teaching mental health nursing was sub-optimal. This was largely accepted wisdom and formed an apologetic background to many discussions. The need for preparation of beginning nurses was undisputed. This was regardless of eventual clinical destination and addressed a broad range of skills for working with people experiencing mental health problems either as the primary cause of clinical care or not. However, participants reported that universal support for this preparation in the academy and general nursing profession was largely absent. Participants identified ideal models or reflected on models that were more generous to mental health in past curricula. This theme was labelled as 'The fight has been lost'.

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Two subthemes were recognised within this broader theme in participants' responses: lack of clear focus, and adequacy of learning opportunities. 'Lack of clear focus' highlights multiple instances of absence of clarity of factors such as adequacy of learning objectives for mental health in curricula, and the understanding of academics of the nature of mental health care and needs. 'Limited opportunities' reflects a wide range of resources including budgets to cover educational materials and experiences, as well as non-material resources such as time or weighting within the program of study. Each of these subthemes will be discussed in turn.

a. Lack of clear focus

This subtheme reflected changes to curriculum design that emphasised integration of mental health nursing skills and concepts within other subjects. For example, under an umbrella unit of assessment, mental health assessments would be included. There was often no requirement for mental health nursing clinical expertise by the academic delivering this material. The potential outcome of this lack of clinical expertise in mental health nursing was identified by Casey:

> *the curriculum sort of talks about knotting and threading mental health throughout the whole three years and from my experience and from other people that I've spoken to over a period of time that tends to get lost* (Casey).

Casey's comment reflects a concern of the loss of a clear focus on mental health nursing and a diminishing of importance within the curriculum and subjects. When topics specific to development of mental health nursing skills are delivered by academics without mental health experience, this risks trivialisation or marginalisation. The lack of familiarity can be expressed as poor confidence and capacity to transmit its context within nursing practice. The nuances can be lost.

Casey had spoken of an approach that integrated mental health perspectives, knowledge and skills as "threaded and knotted" in the broader curriculum. She indicated that this approach was vulnerable to the phenomenon of 'curriculum drift', where the resource was lost over time.

Academics when employed specifically to teach mental health components that do exist in curricula are not required to meet the professional standard of specialist practice – credentialing. Rather, the resume, verified by selection panel interview and check, is regarded as adequate evidence of specialist skills and knowledge. This may be clinical experience of variable quantity and quality with little mental health nursing specific education beyond initial nursing qualification. When the issue of qualification to teach mental health nursing in the Bachelor of Nursing was discussed, assurances such as that of Dale were usual:

> *all of our staff who teach the mental health - undergrad mental health - have a mental health background* (Dale).

Jordan explained this phenomenon of not employing staff with mental health experience or qualification as arising in circumstances of exceptions – when suitably qualified or experienced mental health clinical facilitators were not available:

> *…there will be facilitators out there on the clinical, who are employed specifically for that, and they can be mental health nurses, most of the time, … but if there's a shortage, and there can be, you can get a nurse who's not mental health* (Jordan).

Jordan's observation underscores that it is no longer an absolute that clinical facilitator staff will be distinguished by any form of mental health nursing expertise. The professional standard of specialist practice and evidence of clinical practice in mental health services is not always met.

Use of non-mental health services for clinical placement was also reported. It reflects the competition to secure any clinical placement in mental health services especially as best practice models for mental health services are increasingly community based and in primary care and non-government organisations. Sam's comment speaks to this:

> *they may get sent to an aged care or something that may not be – may not always be a mental health placement* (Sam).

It is another example of a lack of clear focus on mental health nursing within the broader comprehensive pre-registration nursing curricula. Material deleted

The influence of stigma or stereotypes continues beyond the classroom and clinical placements. Participants noted a common experience during career planning for nursing students. Students are advised to avoid immediate job applications to mental health services at graduation. This is seen to restrict future job prospects by limiting their skill repertoire:

> *sometimes students kind of think, oh, well, if I – if I go into mental health nursing, I'm going to lose all my real nursing skills and therefore kind of – do they question whether or not they're a real nurse* (Daryl).

This was referred to more robustly by another participant, Dylan, as follows:

> *… we have to really challenge our students to actually say, if you really want to do mental health don't follow this myth about consolidating your year postgraduate, because that's all crap* (Dylan).

Clinical placement had prominence in the data supplied from academic interviews as a potent learning environment. It was repeatedly referred to as a safety net for skills not covered in the formal curriculum or as a panacea for shortcomings more generally. When challenged, the assumptions of the outcomes from mental health clinical placement experiences regarding learning to respond to thought-disordered speech often crumpled. Participants conceded an inability to ensure uniform student learning outcomes across clinical placement experiences. This is a further example of 'lack of clear focus' being afforded to mental health nursing within the curriculum.

Taylor reflected this in the following comment. She was uncertain when or if the topic of learning to respond to thought-disordered speech was addressed and speculated about its best fit:

> *I think the way we're teaching currently, it's happening in clinical placement, but I think there is potential that it could happen in the classroom, and the way for that to happen would be through more intelligent use of … simulation* (Taylor).

All participants spoke of the critical importance of clinical placement as a safety net for addressing this learning, as Taylor did above. Although she expresses recognition that learning to respond to thought-disordered speech could occur in other ways, and suggests simulation as a possibility, she conceded that this skill is probably being addressed on clinical placement. However, she is unsure that this is the case, saying that this is what she "thinks".

Assessment of successful learning of skills was mostly limited to demonstrating a capacity to identify, name and document thought-disordered speech. Discussion revealed that such assessment, if present at all, was haphazard. Most participants were hesitant to confirm that this was routinely examined. If it was so, both informal and formal assessments were nominated. Casey's comment exemplifies this:

> *...there's a traditional sort of formal examination theory type of thing and potentially something from clinical practice on how to address it and then the informal exercises* (Casey).

Casey reflects a hesitancy but assumption that this is addressed 'somewhere' within the assessment schedule. Dale is more specific and locates knowledge of responding to thought-disordered speech as falling within the Mental State Examination (MSE) assessment tool tested:

part of the assignment requires them to do an MSE – a screening MSE (Dale).

This falls short of assessing how to respond to thought-disordered speech. It reflects a capacity to recognise, name and document. Those few participants who discussed using role plays (from the same university) suggested that discussion and demonstration were employed to attain the desired skill – an example of direct instruction. This was an isolated example. Most common however, were formal assessment in the context of mastery of the MSE tested as part of examination or as a required skill acquisition and demonstration on clinical placement.

Focus on demonstrated attainment of skill around responding to thought-disordered speech did not use approaches such as OSCE. On-line interactive assessment was not used.

b. Adequacy of learning opportunities

Several elements were explicitly raised that reflected on the adequacy of learning opportunities available for nursing students regarding learning to respond to people's thought-disordered speech. There was common agreement of resource reduction. Resources were conceived broadly and included an emphasis on the disproportionate time allocated to learning about mental health nursing in BN curricula. This impacts the time available to address mastering skills of responding to people experiencing thought-disordered speech. Casey's comment directly identifies a reduction within the curriculum of the nursing program she teaches:

In the past we had three semesters of mental health and now we only have one (Casey).

This represents a reduction to one third of previous curriculum iterations. Material deleted

Another significant area that was identified as being adversely affected by resource reduction was clinical placement opportunities:

> *We have problems with the number of placements available…there's not a lot of diversity…The thing about placements is it's kind of like worksites have placement fatigue* (Dale).

Dale's comment highlights that this issue is multifaceted: not only the absolute availability of mental health service placements, but also the quality of these placements. In this comment, Dale attributes the difficulties of quality to what he terms "placement fatigue" whereby a limited number of mental health service placements being used, perhaps excessively.

These short-comings in overall number of available mental health clinical placements, restricts the capacity of the universities to exercise selectiveness in facilities utilised. There was consensus among participants' comments that the experience and consequential learning for students was beyond control of the academics or university due to the pressure on quantity and quality of available mental health placements. This was reported as another example of the way the theme, 'The fight has been lost', is manifest. But these placements, with recognised short-comings, continue in use. Jamie addresses this as follows:

> *The other thing too with students, and this is outside my ability to control is just what the students learn by going on clinical placement… can't guarantee they would have that experience* [learning to respond to thought-disordered speech] *and if they had it, what learning took place and supported that….there's quite a diversity of experiences there and some are good and some are not so good* (Jamie).

Jamie directly reports that the matter of quality and learning outcomes for students on clinical placement is "outside my ability to control". This is a significant undermining of academic responsibility that focuses on learning – its outcome and its quality. It was reported in a matter-of-fact manner redolent of 'the fight/cause being lost'.

The quality of the clinical placement is also a factor in the maximising of learning as Jesse explains:

> *clinical is becoming less and less and a lot of students don't get the opportunity to have a very good clinical experience where they could see different types of clients in different settings* (Jesse).

This comment from Jesse highlights another concession that has become normalised in the teaching and learning context for mental health nursing. The clinical focus of the facility used for clinical placement can no longer be selected.

Further, participants raised the issue of the length of clinical placement offered in mental health services as another manifestation of lack of resources. This was affected both by the shortage of available placements and changes in curriculum as some universities responded by reducing the amount of mental health specific clinical placement within the undergraduate programs:

> *we used to get like 4 weeks of preparation, 4 weeks of clinical placement, now they're getting 3. … you know it just continues to get diluted as time goes on* (Dylan).

Dylan's comment reflects the theme of loss poignantly in the expression "it just continues to get diluted as time goes on". There is a resignation to the inevitable diminution of this component and of learning in pre-registration nursing preparation.

There was a strong suggestion that the length of placement affected the opportunity to learn:

> *…within that three weeks I think the first week is just getting an idea of that you can actually go and talk to people and not to be afraid and just dispelling the myths and stigmas and understanding the processes and we don't encourage students enough to get out and explore other specialty areas in mental health, because they don't have that time I think, that they used to* (Jesse).

Jesse's comment also raises another loss in "the fight [that] has been lost". She mentions that students cannot explore the rich diversity of mental health nursing through multiple clinical placements. She hints that previous models or curricula supported pre-registration nursing students experiencing clinical placements in more than one specialty area of mental health nursing. Reminiscent of general pre-registration nursing clinical placements that cover multiple areas of clinical speciality, she reports the loss of this experience for current nursing students on their mental health nursing clinical placements.

Whether the clinical placement is contiguous with the theoretical classes was recognised by many academic participants as being important to effective student learning. Increasingly students' clinical placement does not always fall within formal study periods, and this may mean it occurs before mental health nursing has been studied. This is another manifestation of the 'fight/cause being lost' by a lack of resources. The restricted number of clinical placement possibilities has resulted in asynchronous learning experiences for students. Dylan described this as an unsuccessful approach:

> *this year what we've been doing is we've been sending them out to clinical before they've actually received their clinical subject. And with some of them, we've actually had more problems this year* (Dylan).

The situation reported by Dylan disallows preparation for this clinical placement and preparation for learning possibilities expected from it. The relational nature of mental health nursing that works through therapeutic alliance to address collaboratively identified recovery objectives is in stark contrast to other clinical placement experiences where procedural or task focused nursing practice is more dominant. It calls for preparation so students can recognise and use learning opportunities when on clinical placement.

Alternatively, the clinical placement may occur after the study period. This means students do not discuss their experiences within class following their clinical placement. Daryl reports this as a lost learning opportunity as follows:

> *students aren't going out on clinical placement until after the theory – there's no real time for them to come back and say, hey, I spoke to someone with thought-disordered speech and this is what I found really useful, this is not what I found useful* (Daryl).

Daryl's concern may be dismissed as facilitators or health facilities would be expected to address this gap and to help students achieve their integration of theoretical and clinical learning. But the interviews with participants established that both the lack of surety about facilitator's engagement in student learning, and that some students may not have reliable support for their learning on clinical placement at all, occurs. Indeed, staff allocated as facilitators for students on their mental health clinical placement may not have preparation in this type of nursing practice either.

Essentially, the placement was seen as most effective when occurring at a time integrated with the formal theory subject. Sam put this forcefully:

> *… look I think it's really, really important for them to have a mental health placement during the mental health course* (Sam).

Sense-making for students is identified by Sam as occurring when clinical placement and theoretical classes occur concurrently

Participants also reported that assessment of learning on clinical placement is based on an increasingly standardised national model used across all clinical placement specialties. The Australian Nursing Standards Assessment Tool (ANSAT) (www.ansat.com.au) has been widely adopted and also applied to mental health clinical placements:

> *…it's competency-based learning* (Dale).

This model is arguably less suited to mental health nursing where skills are relational and less readily demonstrated or observed for the purposes of assessment. However, some elements of establishing rapport and a therapeutic relationship are observable and their recognition within this assessment framework is credible.

There is consistency between the different Australian universities regarding the mental health nursing skills or competencies addressed on clinical placement. The predominant skills assessed by Australian universities from mental health nursing clinical placements are establishing a therapeutic relationship, developing skills in assessment, particularly the Mental State Examination (MSE) and documenting and reporting both.

> *…one of the challenges is to build therapeutic relationships, but you obviously can't build them for everybody. But you know we talk about what's a therapeutic relationship, how do you, thinking about how you build it, you can't do it instantaneously, it takes a bit of time* (Riley).

Riley questions the capacity for students to master establishing a therapeutic relationship (a pre-requisite for an assessment) during a mental health clinical placement. This will also impact the opportunity of learning to respond to thought-

disordered speech while on clinical placement. She notes two factors that reduce students' learning as being the inability to achieve a therapeutic relationship with every person and the time required to establish a therapeutic relationship.

Taylor accepts that it may be unnecessary or indeed unreasonable to expect a significant therapeutic relationship to be achieved and lowers the bar for expectations of learning outcomes:

> *The main thing I get them to do is just to repeatedly, they can do MSE's* [Mental State Examination] *and then just to see and assess their recognition of what they're seeing and their ability, describe it* (Taylor).

The reductionist approach to achievable learning outcomes thus becomes almost procedural – what do you see, and how is this communicated? It cannot be guaranteed that students observe thought-disordered speech or learn to respond to it while on their allocated mental health nursing clinical placement. This reflects the pressure experienced in securing placements and their variable quality. As Daryl reported:

> *Students will go to a wide variety of clinical placements and may or may not experience someone or be on the same unit as someone who was admitted because of a particular illness that is experiencing thought-disordered speech … you can't guarantee it* (Daryl).

The range of clinical placements used to achieve a mental health clinical placement are noted by Daryl as limiting the capacity of universities guaranteeing certain experiences and consequential learning outcomes for students. This includes meeting people experiencing thought-disordered speech.

Taylor reports that when students do meet people experiencing thought-disordered speech, the approach emphasises assessment skills:

> [When] *the person we're going to meet will often be very disorganised in the way they'll put their sentence together, … when we come out, I'll say, ask them to try and describe what they were hearing and what the person is saying and then try and put some labels against what they're giving. So that they can actually know the name of what they've just experienced* (Taylor).

The approach described by Taylor also reflects a reductionist approach to preparing students with mental health nursing skills. Students who are placed with people who experience thought-disordered speech are not supported in learning to respond to

such people. Rather, it is learning to assess what is exhibited and to report this – not the inter-related aspect of forming a therapeutic relationship in such circumstances and perhaps exploring the meaning of such experiences for the person affected.

Participants raised other issues that reduced students' chances to learn, such as their approaches to learning on clinical placement. Taylor commented on a degree of passivity that triggered her to develop an exercise to ensure that learning occurs:

> *I find them to be just a little passive, and they'll sit there and drink up what I'm saying, but I want to see them thinking as well, and so I find if I get them to write, when they get stuck, they have to ask a question. They start asking questions then* (Taylor).

This "passivity" is a phenomenon that is the antithesis of an active learning paradigm recognised as a cornerstone for successful learning. Taylor responds to this by developing an approach in response. She challenges students to action – but in a way familiar to students and aligned with required learning outcomes and clinical communication capabilities: writing.

Lou notes the impact of technology on student approaches to their learning that seems to encourage a virtual experience even when in the authentic environment:

> *…people* [that] *have more of a focus on technology … and that will tell me the answers for x,y,z or I will just Google this … and tell you great theories, but you get lost in the theory and forget that the person actually is right in front of you and it's actually around utilising your interpersonal skills. That's probably one of the big shifts I've seen* (Lou).

Lou and Taylor have identified concerns about student attitudes to learning that can reduce their clinical placement outcomes. Lou commented on the change over time in student approaches that reflects greater digital literacy and access. However, she expresses concern that paradoxically this may represent a further hurdle to benefiting from the immediate learning opportunities of clinical placement. Specifically, she identifies these as the development of skills in direct person-to-person communication.

Casey comments that engagement with people experiencing mental health problems is the critical experience of clinical placement and that this starts to address the integration of theory and clinical skills:

> *… once they get into actually sitting and talking to people and then I think that is the best way taking all the information from the classroom out into the clinical area* (Casey).

Riley's observation in regard to learning to respond to people experiencing thought-disordered speech is particularly pertinent for this research study. She notes that students are often challenged to know how to respond and categorise the person's communication as meaningless. Further, she notes the emotional discomfort this engenders in students:

> [A person diagnosed as] *psychotic will often just come up to students on the first day and start, … as far as the students are concerned, you know babbling on about stuff they don't actually understand, the students … can feel quite uncomfortable about it, but also they, … they don't know how to respond* (Riley).

The power of clinical placement for student learning is encapsulated in the following comment from Sam:

> *we teach them in the class but until you see them* [people experiencing thought-disordered speech] *in practice it can be a very difficult thing to fully understand* (Sam).

Sam speculated that when students had a clinical placement integrated with their classroom theory, there was a clearly discernible difference in understanding apparent in the classroom:

> *people who have been out on placement really get it in class and really understand the whole concept of it* [thought-disordered speech] *because they've seen it whereas people who haven't I think got a great disadvantage* (Sam).

Sam's comment suggests that clinical placement may ensure that students understand "the whole concept". However, Sam did not expand on what this concept was – whether it was specifically how to respond to those experiencing thought-disordered speech or to recognise and develop an understanding of it.

Pat expressed caution regarding the value of clinical placement. She noted the importance of the individual's attitude to their learning in the following terms:

> *the more enthusiastic the person, then the more they'll get out of the clinical* (Pat).

However, the major point stressed by participants regarding integrating theory and clinical practice learning was the critical nature of the temporal positioning of clinical placement and classroom theory. When these were separated compromised learning was observed. This was frequently the case as an outcome of the high demand for available mental health nursing clinical placements. Students were reported as not having the clinical placement associated with the mental health nursing theory for anything up to a year following:

> *when people have been out on clinical placement later, and you've done the subject the year before, the connection of theory and experience, I don't find it's good, and I noticed that when they're out on clinical* (Jordan).

Jordan's observation was communicated in a despondent tone and raises the resignation inherent in this theme – the fight to have clinical placements integrated with theoretical learning experiences appears to have been conceded.

Jamie observed a further barrier to learning as the ability in a tightly scheduled curriculum to engage students in sense-making of their clinical placement experiences:

> *will the students get a chance to sort of talk about and hear responses from the teacher and others in the group about talking to someone who's got thought-disordered speech, maybe, maybe not…you might get – hear some feedback from them, I mean, … it would be very ad hoc, if anything* (Jamie).

The numbers of students enrolled also increases the difficulty in providing this individualised student-centred learning:

> *some won't be doing it until the next scheduled one, … a month or two later because they just don't all get out at the same time, and even if they did all have it and came back to class, will they all speak about those experiences? No. Will 33 or 35 students get a chance doing a two-hour class with other activities? No* (Jamie).

Jamie identifies another element in which the capacity to support student learning about how to respond to people exhibiting thought-disordered speech is limited. The number of students reduces the ability to engage each student about their individual clinical placement experience and learning when they return to class.

Theme 2: There are no guarantees

Participants' discussion of learning to respond to thought-disordered speech shared a second common theme. This was labelled 'There are no guarantees'. This theme was expressed through a strongly held conviction that learning cannot be assured, however it nonetheless is likely to happen. There were four subthemes that made-up this theme. These were identified as:

a. Absence of close ties with health facilities
b. Difficulties with practice and staffing standards
c. Students will pick up this skill from Experts by Experience
d. Students' beliefs and pre-conceptions

Material deleted

a. Absence of close ties with health facilities

The participants were questioned about the staff who supported student learning on clinical placement. Jamie reported a dual arrangement during her interview:

> *everything's not equal, no…they are facilitated by facilitators the university employ, although in – sometimes in some of the private settings, it's someone that's provided by the service…The facilitator won't always be there* (Jamie).

This comment also raises an issue that may arise from the divided loyalties of facilitators in private health facilities. The staff nominated by the private health facility and although paid for by the university may not always be available to students.

Another model of clinical placement supervision used is allocation by the clinical facility of their own staff to assume responsibility for students – a role commonly referred to as a preceptor or sometimes a buddy. This responsibility is assumed alongside routine clinical practice activities, ordinarily for a single student. It may at times work in parallel with a facilitator appointed by the university. Unfortunately, this arrangement was described as having a range of problems, as Lou reports, operational priorities can mean that preceptors are not appointed at times:

> *people are supposed to be buddied up and have a preceptor … that doesn't always happen because of time and shortness of staff* (Lou).

Lou's observation can also be explained in other ways. Clinical staff change, predictably via shift allocation or unpredictably in response to short-term contingencies in the clinical placement services. It is conceivable that an assumption is made that others are taking up the student responsibility, when it is being over-looked or poorly coordinated. However, this is a disappointing shortcoming when it is acknowledged that universities are paying these facilities for preceptors to support student learning.

Dale noted that there were responsibilities on the part of universities to prepare and support all types of staff used on clinical placements. Whether this is adequately met is questionable:

> *they're* [clinical facilitators] *normally not an academic person – so normally a clinician. So there is a role I think that we don't do very well, I think we could do better around having that person do more focused discussion, reflective practice* (Dale).

He raises the suggestion that the preparation and support for clinical facilitators and preceptors would usefully take the form of deepening their skills in discussing reflective practice and communicating this to students. This may have direct relevance for supporting students to learn about responding to thought-disordered speech using therapeutic relationship skills.

Jamie notes however, this expectation of support and preparation from the universities may be unreasonable given the current scale of clinical placements that are occurring routinely:

> *We would employ hundreds of clinical facilitators across every mental health setting in Sydney* (Jamie).

Self-evidently there are logistical and financial implications referred to in Jamie's observation.

Lou reports variability in staffing for clinical placement has outcomes for student learning:

> *you can see the difference in a student who has come off … another unit who has had a solid preceptor that (1) want it to be their preceptor and (2) had some skill and enjoyment in doing that and the confidence and the amount that they* [the student] *gain are very different from someone who is allocated someone who is always on nights or is disinterested or disengaged* (Lou).

Lou addresses the rationale that justifies identifying staff of clinical placement being the critical factor for student learning to respond to thought-disordered speech. If this clinical communication skill is defaulting to being learnt while on clinical placement, then the way in which this occurs is relevant. Lou however identifies that staff in the role of supporting and facilitating student learning on clinical placement may or may not be skilled but further may lack interest or engagement with this responsibility. Indeed, Lou reports being aware that students emerge from the experience of clinical placement with different learning outcomes that reflect these factors.

Staff assigned by health facilities to support student learning during clinical placements are an important group within these facilities. However, these staff are often unknown or not identified to the university. They were not recognised as having clear communication or briefing avenues to collaborate consistently in the support of undergraduate nursing students' learning.

Daryl acknowledged her ignorance of what and how communication occurs with these players in students' learning in the following way:

> *I believe that the clinical coordinators do meet with staff who supervise students out on clinical but again, I'm not sure …there's no regular training on mental health component and about how to support the students in that* (Daryl).

These observations from Daryl highlight the absence of close ties with the health facilities being used for clinical placement experiences. There is no reference made in the responses of mental health academic participants to routine flow of communication between the staff of the universities and the health facilities around learning and teaching during student clinical placements. Those ties that exist are serendipitous or forged around the administrative functions of securing clinical placements.

The capacity of mental health nursing academics, and those of other specialties, to have a presence in both the classroom and in clinical placement is no longer routine. Jesse notes that a range of factors have led to this situation, and suggests that the separation of university and clinical services could create a further difficulty for students to integrate the classroom theory with the clinical placement experiences:

> *the more clinical exposure and quality clinical exposure, obviously, the better. But I just feel that we've lost that ability to go out into these areas with the students and, because of the different drivers and the different resources that are available to academics now* (Jesse).

Jesse's comment also includes acknowledgement of a lack of resources, as an explanation for the diminished ties between education providers and clinical facilities.

b. Difficulties with practice and staffing standards

A disinterest or even cultural resistance to supporting student learning on clinical placement was mentioned by some of the academic participants. This was at an individual staff level as reported by Riley:

> *…how do you counter someone's worked … here for 30 years and is very unhappy and is disinterested, do you know what I mean, and they're not actually abusing the students, they're just showing no particular interest … some people don't accept students, the majority do but some don't* (Riley).

Riley is commenting on the cultural elements of some mental health clinical placements. She observes that the elements contributing to suboptimal learning environments are the consequence of inaction of staff, reminiscent of burnout.

This problem can be more extreme as reported by Dylan, in that students are completely unsupported by the health facility while on clinical placement:

> *…my first issue when I took on clinical facilitating was simply the fact that they never saw educators. I changed that* (Dylan).

Dylan's comment reflects that for some health facilities, the support of students on clinical placement is of low priority. Although this may in some circumstances as

discussed earlier reflect the vagaries of clinical demands, the circumstances he is discussing highlight that the staff charged with an educative role does not see that as extending to support of nursing students on clinical placement. Whether this is an individual clinician's stance, or that of the health facility, is unclear. Unfortunately, it would be students who experience this as a suboptimal practice standard.

Participants also expressed concern about clinical practice standards in some health facilities that would necessarily impact student learning and potentially establish dissonance between the university and the clinical placement for students. Dale raised this in relation to practice that was not person-centred. He reported that:

> *there are some examples of workplace practices that are not geared towards student learning …so there are some workplace practices that essentially the practice is marked by trying to shut down the consumer through … medication or use of other…forms of restrictive practice that do take away an aspiration – so the aspiration of what the student was hoping to do, … where the guided learning has been up until that point - seems to be in sharp contrast to the practices on the unit* (Dale).

Dale refers to the witnessing of restrictive measures in clinical practice such as medication use, although this can also refer to physical restraint and seclusion. Such practices remain legal but are contentious and public policy and professional practice actively encourage and support use of alternative approaches prior to resorting to these measures. He reports the existence of health services that are "marked by trying to shut down the consumer*",* a description that does not acknowledge attempts to intervene by less restrictive or coercive means. It suggests practice that is not working in partnership nor collaborative. Exposure to practice standards falling outside professional and practice guidelines are highly problematic for student learning. They raise the issue of witnessing unethical conduct and may reinforce a 'practice-theory' gap for students, creating dissonance between the universities and the clinical partners in student placements.

The issue of standards also applies to standards of preparation for teaching nursing students how to respond to thought-disordered speech. Participants when questioned did not identify specific qualifications or awards as being pre-requisites for teaching generally, mental health nursing specifically, or preparing students to respond to thought-disordered speech particularly. Beyond clinical experience –

unspecified in focus, role or duration – capacity to teach was not raised in terms of formal preparation. Rather, it was personal qualities that were stressed by Jordan:

> *it does come down to how passionate and interested the teachers are, and whether they can really have some, some say in experiential learning for the students* (Jordan).

No additional or specific qualifications or awards were raised in the interview regarding those employed as casual academics to prepare pre-registration nurses in mental health nursing. Jordan is dismissing other pre-requisites by reporting that "it does come down to how passionate and interested the teachers are" and not predicating that on capacity to structure teaching and learning experiences or the possession of clearly recognised knowledge and qualifications in mental health nursing.

Daryl asserts the possession of clinical experience in mental health nursing as being a standard held to for teaching staff, as in the following statement:

> *all the staff that teach in mental health nursing unit are either practicing mental health in a kind of clinical environment or have a past experience of practicing in a clinical environment* (Daryl).

This does not however guarantee recent or current clinical experience or clinical practice that exemplifies professional standards. However, his prior comments demonstrated, even current clinical practice does not guarantee or exemplify professional standards.

Jesse's comments on her take on desirable characteristics for the teachers of mental health echoes those of Jordan as follows:

> *…it does come down to how passionate and interested the teachers are*…(Jesse).

Jesse does not stress formal qualification but rather conviction of the value and significance of the learning that is communicated by teachers.

However, the participants suggest that enthusiasm alone is insufficient. Those who teach should be current and this is asserted to be a factor of recency of clinical placement. Jesse addresses this in the following manner:

> *they've been in the tertiary education sector probably too long and some of them probably don't know what's actually occurring out in the real clinical area* (Jesse).

This assertion by Jesse runs the risk of lacking adequate nuance. This assertion is made without critical analysis of the quality of the clinical practice, or the possibility that such practice may be limited in its clinical focus and as such do not reflect the requirements of pre-registration preparation which it is presumed to improve. For example, recency of practice in child mental health services may have limited utility in ensuring contemporary practice-based knowledge relevant to informing the preparation of beginning nurses. Additionally, it does not address the capacity of the academic to translate this practice knowledge effectively for student learning.

Discussion by participants routinely assumed that the communication of teaching requirements could fall short of desirable. Lou indicated this when reporting the following in relation to casual academic teaching staff:

> *you've got to do for your casual academic – is great like meeting with them – actually talking about the correct curriculum and … all that was really great* (Lou).

Lou sets a very low standard that suggests that even routine preparatory discussion would improve current practice standards. Although electronic briefing and provision of materials would be routine, Lou is highlighting that preparation for teaching involves more than provision of information. There is a welcoming function (induction or 'on-boarding') parallel to that which facilitates success for students on clinical placement.

It is sobering to suggest that the preparation of those in the casual workforce might be haphazard, and that this characteristic extends to those employed by universities to support students in clinical practice (preceptors). Dale identifies the 'hit or miss' nature of support and preparation provided for clinical facilitators or preceptors by the universities in the following comments:

> *they're normally not an academic person – so normally a clinician. So, there is a role I think that we don't do very well, I think we could do better around having that person …there's a facilitators' workshop and a facilitator preparation. It's really interesting because … when I talk to my colleagues in other places, it seems that there's a lot of investment at our end* (Dale).

Dale's comment shows concern that the efforts of his university fall short of adequately preparing clinical facilitators to support students' learning on clinical placement. However, he recognises that the efforts that his university makes exceed the norm: "it seems that there's a lot of investment at our end". There is recognition that despite his university exceeding others' contributions to the preparation of facilitators and preceptors, it is still falling short.

Confirmation of Dale's concern is evident from Dylan's interview. He was specifically pressed about the preparation of facilitators and preceptors by the university to support student learning to respond to thought-disordered speech and confirmed that at his university it simply did not happen. There is a resignation reflecting the first theme: 'The fight has been lost'. Dylan had no hesitation in confirming that there was no preparation provided and offered no explanation of the failure to support and prepare these casual staff for their teaching role. Dylan also confirmed the widespread failure of universities to prioritise and ensure that this occurs:

> *we don't support the preceptors and the facilitators enough* (Dylan).

It may be unclear what constitutes "enough" support, but the recognition that whatever level of support that is in place is wanting is clear from Dylan's remark.

Worryingly, the interviews with participants revealed further that there is ignorance about how or what student learning is addressed by university facilitators while on clinical placement. The failure to support preparation for these staff extends to an ignorance of their teaching and learning activity with students on clinical placement. Daryl reports this specifically in regard to preparing students to respond to thought-disordered speech in the following manner:

> *It's an unknown in the sense that I'm not sure … how … educators would talk to students or educate students around responding to a thought-disordered – or a person with thought-disordered speech – I'm not sure … what they would be saying to the student* (Daryl).

Not only is there no clear process for preparing facilitators and preceptors, there is no mechanism for feedback or debriefing following students' clinical placements. There is a comprehensive lack of knowledge of how mental health nursing clinical skills are addressed.

When commenting more specifically about university sponsored preparation of facilitators for student clinical placements, participants spoke of a generic briefing that needed to address large numbers of facilitators supporting students across all clinical placements. Jordan spoke of these arrangements as follows:

> *there is* [a briefing] *… They should come to a day here, at the university, but they don't specifically look at mental health, and so, they'll be more looking at the processes of being a facilitator, what you do if something goes wrong, basically* (Jordan).

These briefing sessions were not run by the subject specialists but other university staff, further reducing the specific preparation of the facilitators for specific student learning. Jamie confirms this situation also applies to her university setting. Her comment reflects that this is a change from previous practice that incorporated specific subject or unit preparation, including that for mental health specific clinical placement. The increased student enrolments were instrumental in changing these past practices as she details in the following comment:

> *So, they get briefings through a different part of the faculty now but not specifically from the co-ordinator as it was in the past when student numbers were smaller, and the numbers of facilitators were much smaller and you might just have had a handful of key people doing mental health facilitation. They're huge now. Huge. Three mental health subjects and potentially – let me add up – 11-1200 students, so no* (Jamie).

Although the absolute numbers of students in Jamie's experience may not be that of all universities, clinical placements predominately occur across a shared number of clinical facilities amongst all Australian universities. Consequently, elements of this are common for many universities, namely larger student numbers resulting in less capacity for personalised responses. When a standardised approach is taken to preparing casual staff, a generic approach is more likely to be taken. Specific preparation for detailed learning is not addressed as it is precluded by the large numbers of facilities and clinical specialties sharing the preparation session. This

may revert to an emphasis on procedure and compliance issues or even risk mitigation (vis a vis vaccination and security checks).

c. Students will pick up this skill from Experts by Experience

Working with people with a Lived Experience of Mental Ill-Health was nominated as either an aspiration, or badge of honour for the programs discussed. It was implied that this was a means by which students could develop skills without direct or explicit instruction. Dale was proud to report his university had a member of academic staff specifically employed to use their lived experience of mental health problems:

> *our school has a lived experienced lecturer (Dale).*

The principle of collaborative development and delivery of curriculum was reported in ways that suggested a model of Lived Experience contribution being directed by mental health (non-Lived Experience) academics.

Lou emphasises that Experts by Experience (consumers) provide a contribution to student learning that is not readily reproduced by people without their particular background and presents a range of experiences of recovery and recovering:

> *it's always incredibly valuable when you can have consumers come and spend time with you, and so they can actually have that experience of somebody with a lived experience, and a range of … consumers as well – like consumers actually maybe from a locked facility or a long long long term recovery facility; maybe some people from a group home and then maybe people that are actually are working – peer workers and then we've got our many highly successful consumers, so if you can see the whole range because I think people also … get tunnel vision around what a mental health consumer looks like and that's hugely varied* (Lou).

Comments such as this by Lou, hint at a practice that is controlled by academics. Jamie's comment contrasts with this and approaches a co-production model more closely:

> [what] *I've tried to do is develop relationships and collaborations with people who are Experts by Experience, who have lived experience of being diagnosed with mental illness including psychotic conditions and conditions in which, yeah, they certainly have had experiences of thought-disorder, and have worked collaborating in terms of developing teaching and learning resources, so interactive modules, live simulations, a number of things* (Jamie).

Jordan summarised the value of involving students with learning with and from those with the Lived Experience of mental health problems – a guaranteed experience of being with a person who has experienced mental health problems:

> *the power of sitting with someone is number one, and that would be my magic wand that the students had that experience where someone sits with them. And not a big classroom. It might be a small group of students just sitting with the person for ten minutes while the rest of the class is doing something else, and they move around the classroom* (Jordan).

These observations reflect the nature of incorporation of Lived Experience expertise into curricula. Meeting learning outcomes such as preparing students to respond to those experiencing thought-disordered speech is advanced to be supported by learning with and from such teachers. It is not established by the data whether these teachers give direct instruction to students about specific skills.

c. Student beliefs and pre-conceptions

This subtheme recognises elements that students bring to learning about responding to thought-disordered speech. These beliefs and pre-conceptions can act as a significant challenge to successful learning and may be unrecognised or very difficult to address. It is not uncommon to witness fear amongst students that is particularly pervasive on clinical placement. Clinical placement has been identified as the safety net for learning, yet this fear may cause significant interference with learning in that context.

Riley reports that she directly acknowledges the commonplace experience of anxiety as a technique to support students:

> *I prepare them by telling them that I understand that they're anxious when they first come in, … they're terrified actually, generally, on the first day they start before they go in* (Riley).

Such fears and concerns may have origins in commonly held and unexamined understandings of mental health problems across cultures. Sam reports that students may experience emotions stronger than anxiety that would indisputably

affect their capacity to learn. The fear she describes witnessing could reflect the common misapprehension that violent and unpredictable behaviours are an inevitable manifestation of mental health problems:

> *it's daunting for students to go into the clinical field and I have students who have been quivering, absolutely quivering* (Sam).

Sam notes that apprehension is common across all clinical areas at the beginning of clinical placement and contrasts this with observations about mental health clinical placements.

Of course, anxiety at the beginning of any clinical placement is not unusual. Clearly any placement experience can involve confronting experience of tragedy, trauma and death. However, the challenge of those triggered by mental health clinical placements should be acknowledged for the potential impediment it represents for learning, even if this also exists for other clinical placements:

> *there's stigma for most people. And I think that that takes time to work through, to figure out that they're not scary, they're not there to harm you, that they're actually just humans who are having an incredibly difficult experience and are describing it in a manner that you don't fully understand* (Taylor).

Whilst the dominant emotional response of fear is experienced by students regardless of cultural background, apprehension for mental health clinical placement can be especially challenging for some students. Pat suggests that their concerns may be unrecognised or not well understood by the students. This can result in avoidant behaviours that limit the students' opportunities to challenge their initial beliefs and attitudes:

> *it's the cultures where mental health is hidden still and not talked about. So it's fearful. It's not a relaxing experience for them. They took themselves away and read notes, and unless there's somebody who's got a special interest in students* (Pat).

Student fear of mental health nursing clinical placement is recognised by these academics however, there is no mention from the participants of the development of approaches that are systematically applied to address this recognised phenomenon. These participants recognise and informally address student fear, but a consistent and explicit approach was not reported. The much-vaunted capacity of clinical

placements to redress reduced learning opportunities elsewhere in the curriculum has unaddressed challenges to realisation.

Theme 3: It's a silo

This theme identified and labelled 'It's a silo', reflects commentary that situates learning to respond to thought-disordered speech as something separate and distinct within the concerns of the overall curriculum. It stands in contradistinction to the generic communication or assessment subjects, siloed within the separate subject of mental health nursing. This contrasts with the observation made in the first theme 'The fight has been lost', that in some curricula mental health nursing skills are integrated throughout their subjects. This approach was observed as risking loss of these skills through their devaluation and marginalisation.

'It's a silo' contains two subthemes.

a. Differing pedagogy in mental health preparation.

b. Student siloing of personal knowledge and experience

There was a direct correspondence with the theme evident in the survey responses reported earlier and partially to the theme labelled as 'Fear and concern' from the interviews of students.

a. Differing pedagogy in mental health preparation

All the participants confirmed that developing skills in responding to those experiencing thought-disordered speech is important for beginning nurses. When this is present, participants reported that responding to thought-disordered speech was not often framed as a therapeutic clinical skill, rather in terms of identifying, naming/classifying and documenting:

> *I guess it's more around theory… how you identify thought-disordered speech when speaking to someone…then how you then document that* (Daryl).

This limits learning to respond to thought-disordered speech to a descriptive assessment skill rather than extending such learning to being treatment focussed.

Although the participants nominated approaches to teaching and learning that were traditional – formal lectures, tutorials and clinical skills laboratories, some emphasised a range of techniques inclusive of video and role plays that had a strong emphasis on experiential approaches. The latter approaches could emphasise mastery of a clinical skill more than the approach reported by Daryl. Jesse summed up approaches as follows:

> *…small sort of group work, through to large lectures, tutorial sessions, seminars*…(Jesse).

Jesse's typification of pedagogy was given different emphasis by Jamie who chose to emphasise the centrality of role plays as follows:

> *…role plays … class teacher might actually demonstrate that with a couple of volunteer students, being the person who has a concern and then you respond, try and demonstrate some empathy (Jamie).*

Some of the different pedagogy refers to learning approaches common to mental health nursing preparation. Simulation involving role plays or discussion resembling group work methods prevalent in clinical mental health nursing are common but can present difficulties. Pat speculates that shifting focus from self-mastery of skills to group creation of knowledge via community of practice approaches can be confounding for students:

> *They hold back because … I don't know if we've taught them that it's all about the client, not about them. And so, it's that concept stops them joining in group work* (Pat).

Pat's comment highlights one aspect of pedagogy that has a different emphasis in learning mental health nursing skills. The relational takes precedence over the procedural. The capacity of students to engage in both the subject matter and style of teaching and learning is observed to improve during the learning session. Riley reports this the following way:

> *…it is that kind of, almost a bit tabloid in a way you know, and that, but that changes, that'll change but that's how they start out* (Riley).

Riley discounts the transformational nature of the change observed in students' approaches to learning. She asserts "that'll change" and minimises the contribution that teaching itself makes to this change.

b. Student siloing of personal knowledge and experience

Another element recurrent in the comments of participants that contributes to this theme addressed difficulties that come from student preparation for learning. This also incorporates other concerns such as cultural differences, ignorance and myths and stigma but is distinguished by a focus on immediate preparation for class.

> *I think sometimes students aren't prepared when they come to class* (Daryl).

The commonly heard complaint of some academics and teachers – failure of students to prepare for class – has importance when considering the other factors highlighted as contributing to challenging successful learning outcomes for mental health nursing skills. However, those students who are deemed mature – not school leavers – have life experiences that often give advantages in preparation for learning, in class or on clinical placement. Lou reports some of these characteristics that act as a foil to the lack of preparation reported by Daryl, as follows:

> *…really clear pattern I guess is that students who had some life experience – like they might be older students – they might be students that are already enrolled nurses or AINs and in the care industry already – like when I have seen them clinically on the actual unit then interacting … tend to do it incredibly well and incredibly comfortably and have more confidence however in the classroom I've noticed that they will generally tend to struggle* (Lou).

Lou suggests however that the advantages conferred by life experiences for mature aged students may be limited to the relational approaches required on clinical placement. Within the more formal and traditional university learning environment, mature aged students experience challenges reported by Lou. It may be speculated that prior pedagogical model exposure such as raised by Pat in the subtheme 'Differing Pedagogy in mental health' as a partial explanation but also a failure in preparation for class may compound this difficulty.

Participants spoke of students disavowing prior knowledge of the nature of mental health. Students are often reticent in recognising that they have met people with experiences of mental health problems. This could be within prior clinical contexts or even in their own lives; however, this can reflect the highly stigmatised nature of mental health problems:

> *some of the students that come into our second year where we have our mental health teaching have never … perhaps met anyone with a mental health problem* (Casey).

The consequence of this lack of prior recognised experience can have emotional repercussions for students:

> *many students wouldn't have experienced someone with an experience like that before it creates a lot of anxiety for students and they immediately kind of go, well, I don't know how I'd respond, become a bit giggly and see it as maybe not as important as what it should be* (Daryl).

Of course, this also interacts with the cultural backgrounds of students. This might be seen among students who are converting overseas registration after undertaking undergraduate nursing programs that did not have a comprehensive curriculum:

> *recently I did teach … mental health in China, and I went into a psychiatric ward with the students, and it was very interesting to see that they had very limited clinical experience in mental health in China* (Jesse).

The academics note that the ignorance of mental health problems among International students may exceed simple unawareness of this domain of health need. Some students are noted to take an absolutist position, occasionally in a combative position. Riley's experience was duplicated among other academic's experiences including that of the author:

> *There's no depression in our country, people are too busy trying to get food* (Riley).

The study of mental health nursing is affected by a range of myths and stereotypes, often verging on stigmatisation. Dale commented on this current constraint for teaching and learning about responding to thought-disordered speech as follows:

> …[a] *blend of trying to focus on stigma reduction but simultaneously building the skills of people to be able to respond to people experiencing thought-disordered speech* (Dale).

Considerations arising from pre-existing understanding of mental health extend beyond that occurring on clinical placements. As they are so prevalent, they require express strategies to enable learning to be optimised.

Learning outcomes are challenged by a need to examine the pre-existing attitudes of students by incorporating a wider range of personal experiences and learning from outside the mental health nursing 'silo'. As Casey observed:

> *we often don't start with going straight into looking at how we're going to talk to people…they actually come into mental health at this stage they are not able to bring with them the things that they've learnt and to consolidate* (Casey).

Casey explicitly recognises the need to help students to access prior learning experiences and to recognise their significance for scaffolding their learning in mental health nursing.

Some students challenge the legitimacy of mental health in the curriculum and often verbalise that they did not enrol in a Bachelor of Nursing in order to learn mental health nursing skills. The perniciousness of these stigmatising attitudes among nursing students can be profound. Riley's observation recognises that this directly affects the students' experiences when they commence on their clinical placement component of learning:

> *one of the myths in the community, cos students tell me this, some do, you know that mental illness is kind of, you know it's all, it's bullshit basically, people just make it up…they're terrified actually, generally, on the first day they start before they go in* (Riley).

Jamie identifies a de-valuing of mental health nursing skills arising from students' pre-existing and unexamined understanding of mental health problems as follows:

> *it's something that might be very devalued, some – their background, it's devalued here, so it's devalued everywhere, and so you've got a bit to overcome that and stigma and so forth before you even begin* (Jamie).

Jamie expands this observation of devaluation arising from students' stigmatising attitudes by observing the ramifications for their learning as follows:

> *when you get students to try and do that in a role play between themselves, …you'll see the stereotypes, or you'll see the lack of experiential knowledge…then you've got a range of cultural and – or linguistically diverse students too … it's not something they want to know much about…* (Jamie).

Jamie comments that "it is not something they want to know much about", representing a hurdle for adequately supporting students to learn mental health nursing skills within a comprehensive pre-registration nursing program. Jamie suggests that students have an apriori set of beliefs of what represents nursing knowledge. This does not always include those skills that would inform responding to people experiencing thought-disordered speech.

Theme 4: Sharing in transformation

Most of the academics in this study made comments in their discussion of teaching mental health of various incidents that had a tenor of vindication. The affirmation of their values, concerns, and professional work was reported with delight and a sense of validation. These reports were frequent enough to represent a final theme in the interviews of participants. This was termed 'Sharing in Transformation': the transformative nature of the real-life learning experience and the shared enjoyment of the students and the academics when this occurs.

The participants irrespective of their academic role, spoke enthusiastically of the transformative nature of mental health nursing teaching and learning especially from clinical placement. These reports included those of students who were initially antithetical to a mental health placement and grudgingly discovered something of value was experienced:

> *The students enjoy it much more, they're expecting something that they don't want to do and they're not going to like, and a lot of them actually like it, … it's very powerful actually* (Riley).

Frequently this is expressed in terms of enjoyment as by Riley and indeed, on occasion this may result in students reviewing their nursing career ambitions as noted by Daryl:

> *I have spoken to students who did say, I had no interest in mental health and then they go out on clinical and they actually go, hey, I had a really great time and I'm now considering this as a future pathway* (Daryl).

Participants do not report these experiences as though it fulfils an agenda on their part of recruiting to the future mental health workforce. Rather, it is student-centred and celebrates the individual student's development of understanding. Pat captures this point-of-view in her comment reported below:

> *not wanting to go out …, not really – and we see that sometimes and what's really quite lovely is, I see that sometimes and then by the placements finished, the student will tell you this is nothing like I thought it was going to be* (Pat).

She shares the student's excitement in transformation of their pre-existing understanding of the nature of mental health problems and nursing.

Essentially, this transformative experience is commonly witnessed, but true to its nature as an individual liminal experience, it was unable to be orchestrated. It was also understood by the academics to fulfil an advocacy role for people experiencing mental health problems. This is suggested by achieving understanding in future health professionals for the travails of people experiencing mental health problems. This transformative experience witnessed in some students also nurtured the academics themselves, giving them emotional sustenance to continue their work despite their experience of marginalisation.

Chapter summary

The interviews with twelve participants involved in teaching mental health to pre-registration nursing students, revealed four themes. These themes subsumed a range of concerns about preparing nurses with communication skills in responding to people exhibiting thought-disordered speech. There is surprising uniformity between these academics drawn from five universities and representing between two to more than 30 years teaching experience.

The primary concern identified was a concern for a loss of a clear focus on mental health nursing and a diminishing of its importance within the undergraduate nursing curriculum and its subjects. This concern extended across a range of elements within the existing approaches to the preparation of nursing students.

Clinical placement learning was endorsed as central to the success of learning mental health nursing skills. Participants noted higher levels of student engagement in this form of learning. There is consensus that there is something about clinical placement that is different, more immediate and not easily simulated in other teaching and learning experiences. However, the participants' enthusiasm for learning on clinical placement was tempered by a range of factors.

A caveat was identified that the quality of the placement environment is a fundamental influence on the success of learning on clinical placement. Clinical practice must incorporate research evidence and best practice guidelines. Successful clinical placement outcomes rely on the collaborative efforts of both university support and support in the clinical arena, be that from facilitator or preceptor.

The timing of clinical placement was also regarded as important to maximise learning. It was argued that clinical placement experiences should be incorporated into classroom learning as well as explanation and exploration of experiences occurring during the clinical placement. There is a role of 'sense making' that can help students move from the observations from clinical placement to the more generalised or universal learning.

The use of simulation in the form of role play was also endorsed as an ideal way to support student preparation. The link of simulation as an adjunct to or even substitute for clinical placement experience was acknowledged. The value for students' learning of Experts by Experience was universally endorsed. However, more nuanced data about the detail of these contributions was not reported by academic participants.

All these approaches are predicated on provision of resources, both time and materials. Resources that ensure teacher to student ratios are supportive of students exploring what can be confronting topics in a manner that allows construction and testing of knowledge within a Community of Learning. This may necessitate additional resources to current arrangements.

The common view of the mental health academic participants was a clear desire to support nursing students to recognise that there is meaning in people's thought-disordered speech. All expressed delight in being a part of successful student learning and frustration for a loss of a clear focus on mental health nursing within the undergraduate nursing curriculum and its subjects.

Chapter 7: Discussion and conclusion

Introduction

The aim of this research study was to explore how pre-registration nursing students were prepared to respond to people experiencing thought-disorder according to students, recent graduates and mental health nursing academics.

. In this chapter the findings from the survey of student and newly graduated nurses and the structured interviews with student, newly graduated nurses and mental health nursing academics are integrated and discussed in relation to a range of published literature, enabling insights into how nursing students learn to respond to thought-disorder. The framework of Practice Theory, in particular the insight from the work of Lave and Wenger (Lave 1996; Lave & Wenger 1991, 1998, 2002) regarding learning in groups, informs this discussion. Limitations of this study are then recognised, final conclusions suggested, and further research and practice development identified.

Initially the project aimed to establish the learning and teaching experience of nursing students, new graduates, and mental health academics, and to determine whether this differed from the evidence-based approaches for responding to those exhibiting thought-disordered in the published research literature. If this was uncovered, the project was to suggest possible improvements of existing learning approaches. However, the investigation of published peer reviewed research studies revealed insufficient evidence establishing how nursing students learn to respond to people exhibiting thought-disorder. Rather, studies that examined learning therapeutic communication skills emphasised techniques to reduce student anxiety, improve confidence and examine the feasibility of standardised patient simulation to achieve this. An examination of approaches that achieved effective learning, established practice approaches, or that examined the perspectives of people exhibiting thought-disorder were absent. It was common to see mental health therapeutic communication skills (in papers that were not part of this review) confined to ‘communicating with the aggressive client’ (Moss 2015).

Diversion in responses from focus on learning to respond to thought-disorder

A major and intriguing feature of all the research findings was the difficulty in attaining focus on the topic of learning to respond to thought-disorder. The open-field parts of the survey and the semi-structured interviews provided participants an opportunity for commenting about the place of mental health nursing within the broader curriculum. It was striking that all participant groups used these opportunities to raise the place of mental health nursing in the comprehensive undergraduate nursing curricula as a significant issue, presumably because of its direct relevance to learning to respond to thought-disorder. If mental health nursing learning was marginalised overall as suggested, the capacity to develop and deliver learning opportunities about a specific mental health therapeutic communication skill would be limited. To seek to develop an understanding of the current state of this learning could seem misguided in such context. Any commentary about learning to respond to thought-disorder would necessarily be predicated on understanding the broader challenges and shortcomings of mental health nursing in pre-registration nursing curricula.

The major findings from the research project that did address learning to respond to thought-disorder were:

* To confirm the first aim of the project: To determine whether learning to respond to thought-disorder is regarded as an important skill for newly graduated nurses. Responding to thought-disorder was recognised as an important beginning skill for all nurses by all participants in all phases of the study.
* That the second aim of the study was determined: To establish if this learning is routinely incorporated into pre-registration nursing curricula. Students are not guaranteed learning about responding to thought-disorder in either theory classes or clinical practice.

- The third aim of the study: To discover the teaching approaches used to support learning to respond to thought-disorder uncovered a range of approaches which addressed responding to thought-disorder in limited ways. Recognition, labelling terminology and documentation were the primary objectives of learning about thought-disorder reported by all participants. Exploration of therapeutic interactions with people with the experience of thought-disorder was reported to be absent.

- The fourth aim: To find what methods are used to assess this learning, established that assessment of skills in responding to thought-disorder included examination via multiple choice questions and response to clinical scenarios or essay assessments. Clinical placements were assessed via knowledge of Mental State Examinations (MSEs). The learning outcome addressed by these reported assessments was recognition, naming and reporting of thought-disorder, not exploring how to respond therapeutically. In vivo approaches to assessment such as Objective Structured Clinical Examinations (OSCEs) were not reported by any participants.

- The fifth aim for the project: To uncover those approaches to learning how to respond to thought-disorder regarded as important or potentially offering improvement in learning outcomes discovered unanimity across participants for inclusion of or additional exposure to similar learning and teaching approaches.

    - Firstly, Experts by Experience are not fully engaged with in the preparation of nursing students learning to respond to thought-disorder. Their increased and routine engagement could enhance the authenticity of learning in this communication skill. Such involvement should invite an opportunity to meaningfully critique the curricula and contribute to its design, and delivery. Opportunity to reject the notion of thought-disorder should be available. Critically there are a diversity of contexts and experiences of mental health problems, so it is essential to ensure that a range of responses is acknowledged and supported.

- Second, clinical placement was regarded as a remedy to shortcomings in formal classes but is limited by availability, quality and guarantee of meeting people experiencing thought-disorder.
- Third, positive clinical and theoretical (classroom) experiences were both reported as being important for student learning. This is reflected in the existing literature (Happell & Gaskin 2013). Role models available to students who provide exemplary models of empathetic, person-centred practice that supports communication with people experiencing thought-disorder is reported by participants in this study as not always found either within classes or on clinical placement.

- The sixth and final aim for the study: To determine the opinions of different stakeholders to this process of learning to respond therapeutically to thought-disorder found a range of opinions and some differences between participants. Academics reported that for some students, theoretical and clinical learning was transformative – students change irrevocably in the process of learning.

  Insight from practice theory about successful approaches to learning, particularly the understanding of Lave and Wenger and Vygotsky, suggests that student readiness is important. In line with this, there was consensus among mental health academics that reduction of student anxiety must be addressed as well as stigmatising, pre-existing attitudes in any preparation program. This concern was not evident among student participants in interview or survey to the same extent.

Relevance of learning to respond to thought-disordered speech

All participants in this research study affirmed that learning to respond therapeutically to people whose speech exhibited thought-disorder was an important clinical skill for beginning nurses. This learning was not couched in terms of mastery of psychotherapy rather as communication capacity. This was despite the general

observation that students and academics often misconceive the rationale for mental health in BN curricula as being preparation for working as a specialist mental health nurse alone, rather than recognising the pervasiveness of mental health problems throughout nursing practice (Morgan et al. 2011b; Productivity Commission 2019, 2020; Schwartz 2019). This pervasiveness had been a rationale and driver for the development of current comprehensive pre-registration nursing preparation, but review of curricula since the advent of comprehensive preparation has documented that the presence, form and delivery of mental health nursing content in pre-registration programs is variable (Australian College of Mental Health Nurses Inc (ACMHN) 2015; Happell & Gaskin 2013; Mental Nurse Education Taskforce (MHNET) 2008; Stevens, Browne & Graham 2013).

The theme ‘It’s a silo’ identified in the mental health academic interviews and the student participant surveys and evident more broadly in pre-registration nursing programs, related to this issue of the presence of mental health nursing in the curricula. This theme extended the issue to include how differences in pedagogy or paradigm also marked mental health content as different. This difference could be typified as the difference between procedural and relational nursing. Students are challenged to engage in learning that has a different modus operandi when studying mental health topics (Horsfall, Cleary & Hunt 2012; Rieger et al. 2016).

Participants, however, did refer to the prevalence of mental health problems as a major factor supporting the relevance of this learning for beginning nurses. The prevalence findings indicate one in five people experience a mental health problem at any point of time and that 45% will have such experiences at some time in their lifetime (Australian Bureau of Statistics 2008; Morgan et al. 2011b; Productivity Commission 2019, 2020; World Health Organization 2013).

Mental health nursing placements and encountering those with mental health problems is reported as anxiety provoking amongst nursing students (Doolen et al. 2014; Kameg et al. 2010; Kameg et al. 2014; Ok, Kutlu & Ates 2020). Nursing students and those new to practice report that encounters with people exhibiting thought-disorder are experienced as stressful (Galvin et al. 2015; Garvey et al. 2021; Olasoji et al. 2020; Pryjmachuk & Richards 2007). Reports include that the speech is

experienced as mystifying, and concern is felt that the nursing students' responses are potentially harmful to the individual exhibiting such speech (Kameg et al. 2009). This project confirmed that students found thought-disorder to be mystifying. Not knowing how to respond and resultant anxiety were reported. Further, concern was expressed that inadequacy may result in inadvertently harming people.

It could be argued that nursing students and newly graduated nurses' communication is limited, and its capacity reduced by this lack in their preparation for practice, (Barry & Ward 2017) and as suggested by the findings from this study. This is further compounded by the common experience of anxiety (Kameg et al. 2009). Considering that successful nursing practice with people experiencing thought-disorder is built upon therapeutic communication that facilitates establishing a therapeutic alliance, such a finding is confronting. However, this may represent a beginning of the process of learning – the student discomfort acting as a trigger to learning as is consistent with Vygotsky's observations of the significance of the Zone of Proximal Development (ZPD) (Vygotsky 1978b). Vygotsky's theories recognise the importance of a student's 'readiness to learn', and nursing preparation for practice may be hindered by students' unpredictable readiness to learn how to respond to thought-disorder. Students may develop a readiness for this learning at different times dependent not only on curriculum but other experiences including life experiences, but importantly in this context the experience on clinical placement. Clinical placement has been identified as varying in clinical exposure and may not incorporate exposure to those mental health problems that demand a capacity to respond to thought-disorder (Australian College of Mental Health Nurses Inc (ACMHN) 2019; Hazleton et al. 2011; Jack et al. 2018). The literature has reported consistently since the inception of comprehensive preparation in Australia, that it is a minority of students who have an interest in mastering mental health nursing skills (Happell & Gaskin 2013; Stevens, Browne & Graham 2013; Wynaden 2011b). These factors combined, may partially explain why this aspect of preparation for nursing practice has been of lesser priority than others in what is a crowded pre-registration nursing curriculum.

Assessment of learning

All participant groups reported shortcomings in addressing or ensuring mastery of responding to thought-disorder as a clinical skill and a focus upon assessment and documentation of these variations of speech. Naming and recording the variations were the emphasis of existing undergraduate programs. Typically, this was in the context of a mastery of the MSE.

Examination of participant mental health assessment and communication skills when undertaken was in the context of traditional written examination or appraisal of performance on clinical placement employing standardised tools such as ANSAT (Ossenberg, Dalton & Henderson 2016). No participants reported use of OSCEs, although these are commonly used to assess other skill acquisition in pre-registration nursing programs, such as wound dressings and physical assessment skills (Mitchell et al. 2015). OSCEs have a long history in health education, but some argue that they are an expensive approach to assessment (Rushforth 2007). The uptake in mental health nursing skill assessment has been reported to be slower than in other clinical areas of nursing (Murcott & Clarke 2017). Moderation of markers to achieve inter-rater reliability in a range of simulation modalities employed in OSCEs (McGarry, Cashin & Fowler 2014a), the provision of simulation resources that may be consumable, and time and physical location resource allocation exceed those of more traditional assessment methods, such as written examinations. The restrictions of physical distancing imposed by the COVID-19 (Coronavirus) pandemic from 2020, add further expense and obstacles to this assessment approach.

The approach to assessing learning in the domain of thought-disorder has been found to be under-developed. As a beginning skill expected of all nurses (Bee et al. 2008; Blake & Blake 2019; Moyo et al. 2020), restricting this to recognition and naming types of thought-disorder in the context of mental state examination diminishes the need for all nurses to have a capacity to provide a response with greater therapeutic and supportive characteristics.

Experts by Experience

The benefit of collaboration with Experts by Experience in all domains of mental health – research, clinical services, governance and education – and all health disciplines, has been recognised in principle, but implementation has been uneven (Arblaster et al. 2019; Bell et al. 2006; Byrne et al. 2013; Byrne, Platania-Phung, Happell, Harris, Sci, et al. 2014; Dorozenko et al. 2016; Happell, Byrne, et al. 2014b). The unsettling of traditional power distributions has been one element slowing comprehensive adoption (Arblaster et al. 2019; Bennetts, Cross & Bloomer 2011; Byrne, Happell & Reid-Searl 2016; Happell et al. 2018; Happell, Wynaden, et al. 2015). Guidelines supporting involvement of Experts by Experience for best practice in mental health have been promoted for more than a decade (Australian Government Department of Health 2010; Australian Health Ministers' Advisory Council & National Mental Health Strategy 2013; Council of Australian Governments Health Council (COAG Health Council) 2018; Mental Health Commission of NSW 2018).

Co-design and co-production are principles of collaboration that are promoted to achieve authentic involvement of Experts by Experience. In response to global levels of unmet need for mental health services, the WHO has promoted collaboration as a means to fashion services (Sugiura et al. 2020). Collaboration is a means to meet need from the individual treatments, to the mental health services and organizational structures in meeting Recovery goals (Gheduzzi, Masella & Segato 2019; Ramon 2018). The range of benefits from these policies are reported to include empowerment, and draw upon interdisciplinary theories such as narrative theory, dialogical ethic, cooperative and empowerment theories (Goh et al. 2021; Palmer et al. 2019).

One of the four recommendations of the Mental Nurse Education Taskforce (MHNET) (2008) was working with Experts by Experience. The mental health academic participants reported working with Experts by Experience as either an aspiration, or a sign of exceptional merit in this study. The manner in which working with Experts by Experience of Mental Health in the pre-registration nursing program

was discussed suggested that this may remain an exception in staffing generally across universities (Happell, Byrne, et al. 2014a) and that the adoption of the recommendations from the Mental Nurse Education Taskforce (MHNET) (2008) remains patchy (Happell, Platania-Phung, et al. 2015). This is consistent with findings from research in Australian Schools of Nursing that have found variable and ad hoc involvement across programs (Happell, Byrne, et al. 2014a; Happell, Platania-Phung, et al. 2015; Happell, Wynaden, et al. 2015).

The mental health academic participants in Phase Two commented on their adoption of teaching practice with Experts by Experience. They noted a range of models used. Most commonly the contribution of Experts by Experience was limited to a guest within a previously determined curriculum. One university additionally described employment of an academic specifically selected to include expertise by experience (in addition to usual academic qualifications). There were also curricula that included co-produced on-line modules and simulations.

The student participants from Phase One commented favourably on learning involving Experts by Experience. However, students reported either none or few learning opportunities with Experts by Experience during university-based classes. Those experiences reported were as exceptions, a culmination to their mental health studies. Two of these reports commented on the limitations of large class sizes. The possibility of improvement in learning generally and of how to respond to thought-disorder specifically, recognised Experts by Experience as a desirable addition to curricula. Suggestions from Experts by Experience, in collaborative construction of learning opportunities was a suggested way forward to address learning to respond to thought-disorder. Similarly, to findings reported in the published literature (Happell, Platania-Phung, et al. 2019; Happell, Waks, et al. 2019;), the student participants in this study identified Experts by Experience as critical to authentic learning about responding to thought-disorder (Horgan et al. 2018). But these observations, did not clearly identify learning outside of clinical practice settings. More targeted learning, perhaps delivered by the Experts by Experience within classrooms, could achieve valuable learning. However, much student commentary ‘siloed’ potential learning to that occurring on clinical placement with in vivo encounters with people experiencing thought-disorder. This was inconsistent with recent studies that suggest that

classroom contributions by Experts by Experience are positively regarded by students (Happell, Platania-Phung, et al. 2019).

Incorporation of learning experiences with people who are Experts by Experience was suggested as a panacea for shortcomings by academics in a manner that did not evidence critical appraisal of the role of such people vis-à-vis the power distribution (Happell, Bennetts, Harris, et al. 2015). Discussion was not predicated on shared co-production of curricula (Horgan et al. 2018). This issue was not fully explored with participants in interview and represents an area for future research.

Material deleted (Clinical supervision)

Recognition as a mental health nursing academic

Teaching mental health nursing within the comprehensive pre-registration programs does not require demonstration of specialist mental health qualification and practice meeting any set standards. Within this study the academics identified this lack of requirement has the potential to impact on teaching and learning outcomes. The ACMHN's position statement on Nursing Education does argue that those teaching mental health nursing should be credentialed (Australian College of Mental Health Nurses Inc (ACMHN) 2015). The credential provides standards to address set requirements to meet the Professional Association's agreed definition of a mental health nurse and may underpin quality mental health nursing teaching and learning experiences.

Arrangements reported in data collected for this research study describe ad hoc systems, perhaps indicative of the marginalised nature of mental health nursing studies within the academy. Indeed, there is an argument that as the BN degree is comprehensive, not specialist, advanced qualifications and practice do not need to be demonstrated by those teaching mental health nursing. Rather any clinical nursing background and preparation has requisite knowledge to provide teaching in this field and this has been reported in the literature as a not-uncommon arrangement (Australian College of Mental Health Nurses Inc (ACMHN) 2019;

Mental Health Workforce Australia Advisory Committee 2010). It is unclear whether this argument is supported for similar specialist areas such as paediatric nursing skills at the beginning level being taught by academics without specialist preparation. Although all academic participants had mental health nursing qualifications and clinical experience, they commented on the employment of casual and sessional staff who did not, particularly as markers or facilitators in the clinical placement experiences.

Some students raised the issue of mental health experience of their lecturers at university as being important. This was a suggestion for improvement in learning experiences, with student participants proposing that mental health nursing clinical experience is a necessary pre-requisite for qualifying lecturers to teach in this field. Students appreciated that good will and enthusiasm were valuable characteristics but not substitutes for authentic clinical mental health nursing experience. This highlighted a risk that students may generate from these learning arrangements, interactions developed with lack of knowledge and experience from their teachers. The resultant interactions may be limited in their supportive value, or even perpetuate misunderstanding or stigma (Wada et al. 2019).

Mental health academic participants claimed that an individual's curriculum vitae at point of employment would provide the requisite evidence of mental health nursing expertise. However, there was no evidence that monitoring for currency of this mental health nursing qualification was undertaken or a current portfolio of mental health nursing-specific experience required throughout employment within universities. However, accreditation of nursing programs is provided by the Australian Nursing and Midwifery Accreditation Council (ANMAC). Part of the accreditation addresses the qualifications of Academic staff teaching into these programs. Evidence for experience, scholarship, research and professional development relevant to the subjects in which they teach is required. This includes any casual staff and provides guidance for required supervision for staff who do not fully meet these requirements. This means there is a standard to ensure that those teaching mental health subjects have preparation to do so (Australian Nursing and Midwifery Accreditation Council (ANMAC) 2015)

There is an observation of the importance of enthusiasm for teaching in mental health nursing subjects, reported in the research literature (Jack, Hamshire & Chambers 2017; Jack et al. 2018). It is argued to compensate for lack of formal qualification or relevant clinical experience and tertiary teaching preparation. This was a characteristic for successful mental health nursing academics raised by academic participants in Phase Two. This characteristic for teachers should not supersede the requirement of sound formal qualifications but is necessary when engaging with students in learning.

Demographic data revealed that there were no academic participants who held the Credentialing Award of the ACMHN. This is in sharp contradistinction to the Mental Nurse Education Taskforce (MHNET) (2008) statement that this should be a requirement of academics delivering undergraduate nursing programs. It should be underscored that several of the academic participants had been contributors in this work that was adopted by the Council of Deans of Nursing and Midwifery, Australia in 2009 (McCann et al. 2009; Mental Nurse Education Taskforce (MHNET) 2008; Moxham et al. 2011). It was not endorsed by the Australian Health Professionals' Registration Authority (Ahpra) although recommended by Mental Nurse Education Taskforce (MHNET) (2008) (Australian College of Mental Health Nurses Inc (ACMHN) 2015).

A clear definition of what is a mental health nursing academic has been recognised previously as contentious. The wide-spread adoption of comprehensive pre-registration nursing programs across many global jurisdictions, including Australia, over the past 30 years has made this difficult (Roberts 2016). This is a reflection of similar complexities recognised in the nursing workforce generally in identifying specialist mental health nurses (Barker 2001). Although professional credentialing schemes exist (as detailed earlier in this chapter), that attract some official governmental recognition (Happell & Platania-Phung 2017), these schemes are voluntary and do not command the authority to establish mental health nursing identity (Australian College of Mental Health Nurses Inc (ACMHN) 2015; Chin & McNichol 2000; Happell, Platania-Phung & Scott 2014). Consequently, some mental health academics were largely self-identified based on a mixture of past clinical

experience and current teaching and employment identity (Lakeman & Hurley 2021). Whether this is significant in the capacity to prepare nursing students to respond therapeutically to thought-disorder is not clear.

Clinical placement experience Words deleted

Many published studies propose that knowledge and confidence in caring for people diagnosed with mental health problems improves following clinical placement experiences (Cowley et al. 2016; Happell, Gaskin, et al. 2015; Moxham et al. 2016; O'Brien, Buxton & Gillies 2008). However, this evidence is not unequivocal. Some studies have suggested that clinical placement experience does not improve attitudes and skills in nursing with people who have mental health problems and that anxiety and lack of confidence as well as stigmatising attitudes persist (Happell & Gaskin 2013; Lim et al. 2020; Moxham et al. 2016; Tyerman, Patovirta & Celestini 2020).

Clinical practice experience was frequently proposed by participants in both phases of the study as the remedy for the recognised shortcomings of the formal curriculum to address learning to respond to people experiencing thought-disorder. However, the suggestion was not confidently developed in specific detail. The variable quality and difficulty in ensuring mental health nursing placements was raised as a limitation to achieving a robust clinical placement learning opportunity, and this is consistent with other studies (Happell, Gaskin, et al. 2015; Hazleton et al. 2011).

There were evident commonalities in themes identified in both the student interviews and in the survey responses. In the student interviews this was conceptualised as ‘It is our responsibility’. In the survey, the responses contained a theme characterised as ‘It’s some-one else’s responsibility’. These both encapsulate some notion that the responsibility for learning communication skills around thought-disordered speech and mental health more generally lies elsewhere and is not central to pre-registration nursing preparation. The Phase two mental health academic responses included a theme: ‘There are no guarantees’. This shares elements with the two previously

noted student participant and survey themes. Learning to respond therapeutically to those exhibiting thought-disordered speech could not be assured.

The data from the survey and from the student interviews identified additional related themes. In the survey, the theme identified as ‘It’s a silo’ embodied a notion that learning was not transparent and there was the ever-present possibility that learning about responding to people’s thought-disordered speech may be informed by a range of individualised, independent approaches. This could include poor practice or practice that is not informed by evidence or contemporary standards like trauma informed care. The theme with close alignment from the student interviews had been labelled as ‘It is our responsibility’. This also incorporated an element that the learning which was occurring may be irregular, even incorrect or not informed by evidence or best practice. This relates to elements of the subtheme:’ Difficulties with practice and staffing standards’.

The ‘hit or miss’ nature of learning about responding to thought-disordered speech is central to this theme identified from the mental health academic participants’ interviews: ‘There are no guarantees’. This arose in the context of frequent reference to staffing in mental health learning, both in the universities but frequently on clinical placement. The quality, accuracy and contemporary evidenced nature of support for student learning was often questioned.

The relevant staffing issues again stressed the casual and contractual nature of staffing employment arrangements, but also identified occasions when those teaching mental health nursing theory or skills did not have recognised mental health nursing qualifications or did not identify as mental health nurses (allowing for the contentious nature of mental health nurse identification). It also reflected the previously identified shortcomings in preparation and briefing of staff by universities – particularly facilitators and preceptors on clinical placements.

Clinical placement is a part of the curriculum required for all undergraduate nursing programs. In Australia, the Australian Nursing and Midwifery Accreditation Council (ANMAC) regulates this to recognise graduates of undergraduate nursing programs eligibility for practice as a registered nurse. However, this requirement does not

explicitly mandate that a mental health nursing placement form part of comprehensive nursing pre-registration programs. The clinical focus of any placement is not proscribed; rather the ANMAC proposes recommended learning outcomes of clinical placements. The minimum length of clinical placements is specified for the entire pre-registration nursing program at 800 hours (Australian Nursing & Midwifery Accreditation Council (ANMAC) 2019).

Consequently, in Australia the experience of mental health clinical placement is heterogenic both in clinical focus and length of placement. Individual universities determine the presence of a mental health nursing placement in their curricula (Happell, Gaskin, et al. 2015). Additionally, the temporal placement within the curriculum is not guaranteed due to shortage of availability and it may therefore occur in any year of the program, if at all.

Existing traditional clinical placements could possibly be strengthened by closer collaboration in partnerships with educational providers (Happell, Gaskin, et al. 2015). There has traditionally been a range of reservations about developing exclusive relationships as they are recognised as inequitable for all parties involved in nurse education and employment. A centralised clinical placement enhancement program could leverage the centralised public health services clinical allocation system. But mental health services are increasingly provided to people outside of traditional health services by volunteer or charitable, not for profit organisations. Their capacity and resources to support the magnitude of clinical placements required by nursing education, in addition to that requested by other health professionals, is limited.

The length of clinical placement is a related factor of clinical placement that is affected by the quantity of available clinical placements. It is apparent from research in the field that students' learning benefits from a longer placement, and this research project confirms findings from elsewhere that nursing students also see this as beneficial (Happell 2008a; Happell & Gaskin 2013).

Alternatives to clinical placement have been explored and include use of simulation and increased collaboration with Experts by Experience within the mental health

curriculum. Both approaches increase the exposure of students to mental health considerations in their curriculum, a consideration for what is often seen as an 'over-crowded' curriculum (Goh et al. 2021; Happell & McAllister 2014d; Happell, Platania-Phung, et al. 2019; Happell, Waks, et al. 2019).

Quality mental health clinical placements are in short supply in Australia (and globally) and explains the reluctance of AHPRA and ANMAC to mandate such clinical placement experiences as part of requirements for BN course accreditation. This is in contrast to the position formalised in 2008 by the Mental Health Nursing Education Taskforce (Mental Nurse Education Taskforce (MHNET) 2008) that such placements should be required. This position was adopted by the Australian and New Zealand Council of Deans of Nursing and Midwifery (McCann et al. 2009; Moxham et al. 2011). The widespread situation reported by participants of all phases of this research study was that securing a mental health nursing clinical placement was not a standard component of pre-registration programs.

Three reports into either mental health services (Productivity Commission 2019, 2020; State of Victoria Royal Commission into Victoria's Mental Health System 2019) or into nursing education (Schwartz 2019) in late 2019 made observations pertinent to mental health nursing education within comprehensive pre-registration preparation. All attest to the importance of inclusion of clinical placements in the pre-registration comprehensive nursing program. The Productivity Commission (2019) goes as far as to suggest that both separate registration and pre-registration be re-considered. Schwartz (2019) raises the need to address the short duration and perfunctory nature of many mental health nursing clinical placements.

The reduction of mental health nursing clinical placements reflects, in part, a global clinical change to service delivery in people's own communities. It also reflects increased competition from other student groups for access (Patterson et al. 2016). In addition, concern is expressed in the peer-reviewed literature regarding the quality of clinical practice that students are exposed to during these mental health nursing learning experiences (Hazleton et al. 2011) and other clinical placement learning experiences (O'Mara et al. 2014). Participants in this study reported that clinical

placements could be of variable quality in part due to individual practice standards, and because of the nature of the placement facilities in a manner similar to that reported by Happell, Gaskin, et al. (2015). Student participants and mental health academics both acknowledged that the quality of the learning experience on clinical placement was variable. Student reports of participation in the non-traditional clinical placement "Recovery Camp" were uniformly positive. Students acknowledged learning interactional communication skills in this informal setting that also increased their empathetic response to mental health problems in a manner reflected in the literature about this clinical placement experience (Patterson et al. 2017; Patterson et al. 2016; Patterson et al. 2018).

The findings of the data exposed the use of non-mental health clinical facilities as proxies for mental health nursing clinical placements. Aged care is an example, but even perioperative settings are reported to have been used with a rationale that this is relevant due to the prevalence of anxiety experienced by people in these situations. However, there is some evidence that placement in non-mental health environments does not support students to achieve relevant mental health nursing learning outcomes (Happell, Gaskin, et al. 2015; Happell & Platania-Phung 2012). A participant in Phase One elaborated on the lack of mental health response to need witnessed in a medical surgical nursing environment whilst on clinical placement, raising an additional dilemma. She reported that the staff in that environment resiled responding to mental health need and referred to it as being outside of their scope of practice.

The rationale for the designation of a placement in an aged care facility as meeting criteria for a mental health placement involve the (correct) observation of the pervasiveness of mental health problems across the Australian population. Although it is difficult to back this as an appropriate clinical placement for supporting students to learn mental health nursing skills, this is an example of a lack of clear focus on mental health nursing within the broader comprehensive pre-registration nursing curricula. Such widely held beliefs about learning mental health nursing skills can undermine student learning within undergraduate nursing curricula as these skills and knowledge have become increasingly marginalised and devalued (Wynaden 2010, 2011b; Wynaden et al. 2014).

The potential learning of a range of mental health skills in non-mental health clinical placements does not address learning to respond to thought-disorder. These mental health problems are less likely to be encountered in non-mental health clinical placements. Other communication difficulties cannot be proxies.

Role models

Student participants in Phase 1 nominated the impact of exceptional staff as role models for learning. This was primarily discussed in the context of staff in clinical placement settings, rather than elsewhere. The reports were polarised, recalling excellent role models or staff on clinical placement who fell short. This could be complicated by the observation by Cleary, Horsfall and Jackson (2013) that senior clinical role models may only provide partial learning opportunities to those less experienced than them which would include students on placement.

The mental health academic participants of Phase Two were questioned about the staffing who supported student learning on clinical placement and described two-pronged arrangements. One group of staff – usually referred to as facilitators – were employed by the university and had responsibility for up to eight students whose placements may occur over several clinical facilities and different shifts. These were usually not the permanent, tenured mental health academic staff, but staff employed on a casual basis for this role for the duration of the clinical placement. This includes responsibility for any assessment undertaken during clinical placement.

The exception to this model is more common in private (for profit) health facilities where the university appointed a paid facilitator, who was predominately a nominated member of the private health facility. Participants reported circumstances where the operational clinical need of the primary employer took precedence over those of the university and the learning needs of the student on placement. This was reported in the interviews of both academics and students.

A further and often complimentary model of clinical placement supervision staffing used is when the clinical facility allocated their own staff to assume responsibility for students – a role commonly referred to as a preceptor or sometimes a buddy. This

responsibility is assumed alongside routine clinical practice activities, ordinarily for a single student. Health facilities usually receive a payment for the services of such staff, but the arrangement is less formalised than that described previously as operating in private health facilities. It may at times work in parallel with a facilitator appointed by the university. This staff has responsibility, often on a volunteer basis, to support and orientate students and to access available learning opportunities in line with student clinical placement learning objectives (Boardman, Lawrence & Polacsek 2018; van de Mortel et al. 2017).

Unfortunately, the research participants reported instances that the choice of and commitment of preceptors was sub-par. Even if the attitude to individual nursing students was benign, the experience of neglect of their learning needs may impact both their mastery of clinical skills, but also their attitude toward these clinical fields (van de Mortel et al. 2017). This finding has been recognised by Australian researchers for a considerable time who have reported that the features of mental health placements were critical for student learning and attitudes toward mental health consumers and, nurses and experiences more generally (Foster et al. November 3, 2020; Happell 2008c). Such features include length of placement (Gaskin & Happell 2013), nature of support whilst on placement (Foster et al. November 3, 2020), number of hours per day, and type of mental health service where placed (community or inpatient, for example) (Happell 2008b, 2008c). A recent integrative literature review of work-integrated learning in nursing (Berndtsson, Lyckhage & Pennbrant 2019) noted the significance of clear learning objectives, supportive staff and collaboration between education providers and clinical facilities to achieve optimal integration of theoretical and clinical learning, similar to co-production models.

Although not a unique feature of mental health nursing clinical placements, the participants of this study did note the presence of registered nurses in mental health services who were of particularly long-standing and characterised as ‘burnt-out’. This is a feature that is supported by other researchers as having poor outcomes for nursing students’ learning (Hazleton et al. 2011; Johnson et al. 2018). The levels of ‘burnout’ among mental health services staff has been recognised (O’Connor, Muller Neff & Pitman 2018), but research of the effects of this for student learning on clinical

placement is not readily evident. This is a further factor that undermines clinical placement – as it currently stands – as a panacea for shortcomings in other parts of curriculum and may be reflected by student participant comments of a dichotomous experience of role models in clinical placement.

Loss of focus on mental health skills

The findings of this research study identified that there is a clear loss of focus on mental health nursing and that its importance within the curriculum has diminished. This was a position held by all mental health academic participants. Student participants were not positioned to comment on these historical curricula developments.

The presentation of skills and knowledge often regarded as the purview of mental health nursing within more generic subjects has been the source of concerned debate within mental health nursing professional circles (Happell, Wilson & McNamara 2014). The concern about short-comings in the pre-registration nursing programs by these academic participants regarding learning to respond to people with thought-disorder was consistently reported.

There were some links evident to themes identified in all phases of this research study. The theme identified from the open-field responses in the survey phase as ‘It’s our responsibility’ was partially related. It implied that responding to those experiencing thought-disordered speech was not the ‘core’ business of nursing practice and that it was more legitimately responded to by other disciplines within the multidisciplinary team. The theme identified in the students’ interviews, ‘Learning to Respond to Thought-disorder’, is also of relevance. This theme alleged that the undergraduate nursing curriculum offered few chances to master responses to people experiencing thought-disordered speech. Both themes relate to the experiences of students as a sequalae of the mental health academic participants’ theme of ‘The fight has been lost’. Because this was lost, learning opportunities were limited and students speculated that this was not the work of nursing practice but rather of some non-specified ‘other’ profession or discipline.

This has been a concern amongst Australian mental health nursing academics since the abolition of the separate register for mental health nursing and implementation of a single register (Happell 2009; Happell & Cutcliffe 2011). The resultant implementation of a comprehensive undergraduate curriculum for the preparation of registered nurses has worthy intent. It is hard to raise an argument against the aim of preparing all nurses with skills across the breadth of concerns that people may seek help with from nurses. It is, however, a clear limitation in implementation regarding mental health nursing skills illustrated by this research study in relationship to preparation to respond to people experiencing thought-disorder.

The combination of shortcomings reported in clinical placement availability, length and proportion of BN program curriculum, quality of pedagogy and the qualification or experience of those teaching into mental health nursing components are concerning. These problems have been known since the development of a comprehensive BN curriculum and abolition of independent register for mental health nursing and despite inquiry, reports, research and recommendations (Happell 2010; McCann et al. 2009; Wynaden 2006), the participants in this study reported the continuation of the same shortcomings. Although the sample is limited and the interview participants self-selected, likely on the grounds of passionate opinions about the field, this theme is gravely concerning especially against the background of mental health needs in Australian society.

It is no longer regarded as a reasonable, let alone achievable, expectation that theory and clinical placement are closely integrated or pedagogically sequenced in mental health subjects. Accessing mental health clinical placements when available is regarded as something to prioritise and other considerations of timing in curriculum or quality of placement are conceded.

The rationale for the designation of a placement in an aged care facility as meeting criteria for a mental health placement involves the observation of the pervasiveness of mental health problems across the Australian population. However, it is difficult to support this as an appropriate clinical placement for students to learn mental health nursing skills. Specifically responding to thought-disordered speech would be difficult to master in an environment that may also include examples of dysphasia resultant

from dementias.

The findings place the mental health nursing academics at odds with practice theory that suggest that some of these limitations could be addressed with alternate pedagogical approaches such as simulation. This group of participants expressed views found in the earlier survey of Australian mental health nursing academics about adoption of high-fidelity human (mannequin) simulation (McGarry, Cashin & Fowler 2014b). It may be that the persistence of a loss of focus on mental health skills in nursing curricula could be addressed in part by a renewed consideration of this simulation and other pedagogies. Careful scaffolding of steps in mastering and extending therapeutic communication would be of value. Simulation involving standardised patients (actors) and considered contribution of Experts by Experience may achieve better learning outcomes in a more guaranteed fashion than reliance on clinical placements alone.

A further confounding factor is that overall curriculum design and learning outcomes are not well known by all mental health nursing academics, perhaps reflecting casualisation of workforce (Wardale, Richardson & Suseno 2019). This may also reflect the 'novice to expert' developmental process for academics akin to that reported in clinical practice development (Benner 1984), given the modest experience of a proportion of mental health nursing academics. It also speaks to the 'siloing' phenomenon witnessed in the programs and reported in this study data.

The implementation of mental health learning has been subject to critical reservations and commentary since the inception of a single comprehensive undergraduate nursing degree as preparation for practice. This may reflect a broader problem of the stigmatisation of mental health both within health care and societally. Stigma is reported in the literature as being based upon such habits of 'othering' (Goffman 1963; Weiss, Gross & Moncrief 2016). Mental health nurses and academics could be subject to the phenomenon proposed by Halter (2008) of 'stigma by association' that serves to undermine the authority of argument for greater representation in pre-registration nursing curricula. Given that repeated studies of nursing students have ranked mental health nursing as least favoured career (Happell & Gaskin 2013; Hunter et al. 2015; Stevens, Browne & Graham 2013;

Thongpriwan et al. 2015), it is reasonable to expect such attitudes may be reflected among nursing academics and contribute to the longevity of the problems of mental health nursing in the curricula (Happell 2010).

An issue of concern in the preparation of future nurses to work with people experiencing mental health problems was the choice of language and expression in the open-field responses of the Phase One survey. The survey was constructed to reflect guidelines in the use of non-stigmatising language (Mental Health Coordinating Council (MHCC) 2013) reflecting Recovery Principles. The language used by some respondents reflected the dominant medical paradigm in the use, for example, of the contentious term: mental illness. Issues of control and of a procedurally dominated model in contradistinction to a relational, collaborative model seeking a therapeutic alliance were in evidence. This raises issues of great consequence for nursing practice of newly graduated nurses as it may indicate a lack of concordance with the Recovery Principles emphasising a consumer-led definition of recovery outcome (Australian Health Ministers' Advisory Council & National Mental Health Strategy 2013). Clinical and personal recovery appear poorly differentiated.

Further, there was some suggestion that embedding Recovery Principles in pre-registration nursing curricula is not yet fully achieved as the use of terminology included expressions regarded as potentially stigmatising and concepts of those experiencing mental health problems as ‘the other’ (Goffman 2018). Alternatively, such embedding is insufficient to counter student stigma. It may also relate to the qualifications of and use of non-mental health nursing academics and clinical placements including use of proxies for mental health and standards of clinical placements.

Readiness to learn

The work of Vygotsky and Lave and Wenger give some ideas about how to maximise the learning experienced by students. Vygotsky’s observation regarding the criticality of the ‘zone of proximal development’ (ZPD) (Daniels, Cole & Wertsch 2007; Karimi-Aghdam 2017) suggests that students may benefit by preparation for

learning in mental health before their formal classes. Although, rightly Mental Health First Aid should not be confused as an equivalent for mental health nursing learning (Happell, Wilson & McNamara 2014), it may have a role (Morrissey et al. 2017). As a pre-requisite for study, positioning this may serve to ensure students start with a common base level of knowledge. It may also give all students first-aid knowledge to recognise mental distress and need among consumers when on clinical placement, their fellow students and themselves and their families (Jorm et al. 2010; O'Reilly et al. 2011). This is analogous to the benefits of a pre-requisite physical first aid certification. This is particularly relevant in an educational environment that has been distinguished by its international features (pre-COVID-19 (Coronavirus) pandemic). Australian undergraduate nursing cohorts independently of international students, consists of students from cultural backgrounds that may hold divergent understandings of mental ill-health. Completion of Mental Health First Aid ensures that there may be some equivalence in students' ZPD.

Another approach to support nursing students' preparedness to learn by addressing their positioning with ZPD, could be mandating clinical placements in quality mental health services. It is a recognised issue that such placements are limited, so use of non-traditional clinical placements such as Recovery Camp (http://recoverycamp.com.au/) and the development of other non-traditional placements would need concerted effort (Moxham et al. 2016; Patterson et al. 2018; Perlman et al. 2017; Stuhlmiller & Tolchard 2019b; Taylor et al. 2017). The political will and financial means to do so is frequently limited, and the influence of 'champions' cannot be over-stated.

Lave and Wenger (1991, 1998, 2002) in commentary drawn from observation of practice theory, suggest that within communities of practice, peripheral participation in learning can be valuable. This suggests that students who are unable to directly take part in experiential learning opportunities for whatever reason, may still achieve learning through observation. The limitations reported by student participants and mental health academics in relation to role plays, clinical placements and interactions with Experts by Experience may be more nuanced. Observation of the learning exercises may have a desirable learning outcome. This suggests that

targeting the phenomenon of peripheral participation with adjunctive learning exercises with synergy to the learning objectives addressed by the primary activity.

This study's findings support this. Although some student participants reported learning experiences that were flawed, related to numbers of students and limited ability to directly participate, these learning experiences were described in ways that clearly suggested learning had occurred. This peripheral learning had value.

The significance of the students' readiness to learn or ZPD, was also apparent in students' responses. Some participants described a lack of knowledge about mental health prior to attendance at class. Their descriptions displayed a readiness to learn from traditional sources of information and less awareness of the responsibility to develop a capacity to respond therapeutically. One participant showed her lack of readiness by responding that questioning a person's motivation for thought-disorder or other problem behaviours directly could resolve communication problems.

This study demonstrates that effective pedagogy for responding to people experiencing thought-disorder has not been established and that current approaches are ad hoc. Further research should examine the most advantageous teaching approaches for student learning. There may be several (Happell 2008a) interim steps required to position students within their ZPD to accomplish this learning. An essential element of this research should be co-production with Experts by Experience.

Learning to respond to thought-disorder may not be achieved solely by knowledge of what to say and of communication skills. (Bandura 1977a, 2012; Bandura, Adams & Beyer 1977). Without a belief in one's capacity to respond in a manner to make a difference, low self-efficacy may increase avoidance of the anxiety-provoking situation. Increased confidence may result in increased decisions to participate. Studies examining the effect of self-efficacy to communicate with people experiencing thought-disorder specifically were not identified.

Cleary et al. (2012, p. 77) added further considerations to supporting student readiness to learn:

> Personal qualities that are conducive to effective interpersonal practice, which may be difficult to teach identified in our study include imagination, having a sense of humour, respecting patients' intrinsic humanity, being non-judgemental, patience and perseverance and internal calmness in the face of fire. Common-sense may tell us that personality and personal attributes that are part of a person before they become nurses underpin some communication and interpersonal skills potential.

This observation adds caution that any additional programs of study may be guaranteed as a remedy to supporting students acquiring therapeutic responses to thought-disorder.

Empathy

Empathy was a further element evident in the research literature that affects the capacity to respond to thought-disorder therapeutically. This identifies a required attitude to communicate akin to Rogers idea of 'being with the person' (Rogers 2012). Peplau identified this as a critical precondition for effective mental health nursing (Forchuk 1991) and Morse suggested that empathy may have four expressions – a cognitive empathy which understands the other person's experience, an emotional empathy that identifies the affective experience, a moral empathy that is related to a moral imperative to engage with the other and behavioural empathy which relates to communicating understanding (Morse, Anderson, et al. 1992; Morse, Bottorff, et al. 1992). This quality was evident in the responses of some student participants in Phase One. Comments identified as representing an Advocacy theme often commented on the lived experience of people with mental health problems. These comments described forms of empathy aligned with the descriptions of Morse, Anderson, et al. (1992) and Morse, Bottorff, et al. (1992).

The development of empathy toward people who exhibit thought-disordered speech may be supported by more extensive use of Experts by Experience throughout the curriculum. Research of the student outcomes from learning and teaching experiences suggests high levels of student acceptability for involvement of Experts by Experience (Byrne, Platania-Phung, Happell, Harris & Bradshaw 2014), as well as, improvements in attitudes supportive of empathy (Byrne et al. 2013). Simulation approaches are also effective in improving student empathy measures especially for

vulnerable populations (Levett-Jones, Cant & Lapkin 2019) and may involve role-plays and other approaches.

Limitations

The selection of a sequential exploratory mixed method for this research was selected as appropriate as very little was known of this topic. This method allowed application of an iterative method where each subsequent phase could be informed by the findings of the previous phase.

A range of shortcomings are recognised within this project that would benefit from modification. The survey instrument was found to have limitations that may have restricted participants' responses. The order of questions in the tool placed the topic of investigation towards the end of the survey. Participants may have stopped responding as their expectation of engaging with the central topic did not present immediately.

The definition provided for thought-disorder was not fully stated in both the survey and in the semi-structured interviews. The primary confusion was the restricted interpretation that this was equivalent to delusional beliefs alone. This was evident both in the open-field survey responses and the interviews, including those with mental health nursing academics. Establishing common meaning would improve confidence that the responses were entirely relevant to the topic of investigation.

Piloting of the survey instrument is required in any future use to overcome many shortcomings prior to these impeding the usefulness of the questionnaire. Prior to this process, opinion from an expert panel would strengthen the questionnaire.

Participants were predominantly Australian but included a number from other English-speaking countries, mainly New Zealand and the UK. This makes the findings most applicable to these settings. The application of the findings to other cultural backgrounds and health education systems is unclear. The surveys included

59 responses that were partial or incomplete and the overall response rate was small. This is noted in the results but reduced the generalisability possible.

Student participants recruited for Phase one interviews were from four Australian Universities. Three of these universities were urban and one regional. This supported some generalisability of results across both urban and regional circumstances.

Three of the 12 (25%) academic participants in Phase two were men. This was an over-representation of men compared to overall professional gender distribution in Australia that has been around 8-11% for some time (Nursing and Midwifery Board of Australia 2018). It does however represent the profile of men in the nursing profession who are frequently disproportionally represented in both senior 'line' positions (Brown 2009, p. 120; McMurry 2011, p. 23) and within tertiary education (Cleary et al. 2019; Redmond et al. 2017). The impact of this profile is unclear.

Implications for mental health nursing practice

The continued loss of focus on mental health nursing skills in the pre-registration curriculums of Australian Universities has been recognised previously (Happell 2010; McCann et al. 2009). This research study also found this was so when focussing on preparing nursing students with skills to respond to people experiencing thought-disorder. There was suggestion that this was also a global experience. Respondents from the UK, and New Zealand reported short-comings in regards preparation of nursing students to respond to people with these experiences in this study as it had been previously reported (Hemingway, Clifton & Edward 2016).

The findings from the Australian Productivity Commission on Mental Health (Productivity Commission 2019, 2020) commented on the educational preparation for nurses working with people experiencing mental health problems. It suggests renewed consideration for a separate pre-registration program for mental health nursing and the re-establishment of a separate registration (Productivity Commission 2019, 2020). Enthusiasm for adoption of this recommendation is difficult to gauge but

if the vote taken at the ACMHN Annual General Meeting in October 2019 is representative, opinion may be expected to be divided.

If a refreshed consideration of the way in which nurses are prepared for practice with people experiencing mental health problems, is to eventuate, in that context preparation for responding to thought-disorder may receive a discrete place in curriculum. However, there are many competing concerns, and in the absence of clear drivers or champions for this skill, it risks being subsumed into generic communication skills and a continued lack of focus.
Material deleted

Recommendations

Recommendations that arise from this study address different aspects of the preparations of undergraduate nursing students to respond to people experiencing thought-disorder. It is timely for Schools of Nursing to consider this given the two recent inquiries into mental health services that commented on nursing preparation (Productivity Commission 2019, 2020; State of Victoria Royal Commission into Victoria's Mental Health System 2019), and a Report into Nursing Education (Schwartz 2019).

The recommendations are as follows and will be discussed in turn:

1. Retention of mental health clinical placements.
2. Use of only educators with mental health nursing education and experience.
3. Greater use of Experts by Experience.
4. Explicit presence across the curriculum.

1. Retention of mental health clinical placements

This study identifies the continued valuing of clinical placement as a site for learning relevant skills, attitudes, and knowledge in nursing. Its role in mental health learning in a comprehensive curriculum is highly regarded by both student and mental health academics.

A range of short-comings were suggested. These supported previous studies reported in the literature including length and nature of placement (Happell 2008b; Happell, Gaskin, et al. 2015; Patterson et al. 2016; Stuhlmiller & Tolchard 2019a). The willingness and ability of clinical placement facility's staff to support student learning is an essential element of placements. It may be valuable to investigate ways that such staff themselves may be supported, including in deepening their understanding of student learning needs.

The recognition of limited numbers of clinical placements and of quality placements suggests that a systematic approach to developing and supporting alternative models might be appropriate. Recovery Camps are one model that has been successfully developed, increasing both numbers of placements available and their quality. Further developments of these approaches are important or risk the loss of mental health nursing placements within curricula or substitution with less appropriate approximations. This may require consultation with ANMAC to achieve this recommendation on more than a local level and in a sustained manner.

2. Qualifications of mental health educators

Employment policies for staff who deliver mental health units in the undergraduate nursing curriculum may also be influential in supporting the scope and focus of the mental health curricula. Recognition and formal endorsement of a scheme to ensure that mental health subjects and clinical placement education is delivered by educators with mental health qualification and experience is an important recommendation. This recommendation is to exceed the qualification required by ANMAC for academics teaching into mental health subjects and clinical placement (Australian Nursing and Midwifery Accreditation Council (ANMAC) 2015). Students recognise a depth of knowledge and experience enriches their learning. However, in the absence of a recognised mental health nursing qualification, this is difficult to achieve. The endorsement of a nurse as credentialled has much to recommend it but has not been adopted by universities.

It is recommended that University Schools of Nursing revisit recommendations previously developed by the ACMHN. The difficulty in identifying a mental health nurse (Happell 2014; Lakeman & Hurley 2021; Santangelo, Procter & Fassett 2018) could be addressed either by adoption of the professional credential as a necessary pre-requisite, or careful interrogation of criteria to assign staff responsibility for mental health preparation (Happell & McAllister 2014d). In conjunction to responding to recent Inquiries (Productivity Commission 2019, 2020), this matter may begin to remedy some challenges recognised by this study in the preparation to respond to thought-disorder. It may be that given the failure to adopt this long-standing professional recommendation, other champions may be needed. It is unclear who this may be as the affected staff have not successfully protected their relevance or critical contribution. Staff who are knowledgeable and qualified in the field of mental health has been found to be influential amongst nursing students in selection of career paths. This may also influence their preparedness to learn about an area of nursing practice that many find difficult or distressing.

3. Greater use of Experts by Experience

Greater use of Experts by Experience, another, long-standing recommendation by the mental health profession (Australian College of Mental Health Nursing Inc (ACMHN) 2018; Mental Nurse Education Taskforce (MHNET) 2008) and by Experts by Experience (Byrne, Platania-Phung, Happell, Harris & Bradshaw 2014; Happell, Bennetts, Harris, et al. 2015; Happell et al. 2016), also has a suggestion of tokenistic adoption. Difficulties in fully utilising such specialist educators (Goh et al. 2021) may be eased by designing positions that cross established organisational units. This would not be without challenges, including lack of clarity regarding accountability and a lack of ‘belonging’ possible for these academics. These issues are solvable and may address any reluctance that results from a concern about the amount of need for this staff.

4. Explicit mental health nursing presence across the curriculum

As clinical placement cannot be guaranteed to address shortcomings recognised in current curricula, the insights of practice theory combined with techniques developed in simulation pedagogy should be revisited. Scaffolding of discrete elements in a

chained fashion leveraging the features of communities of practice in active approaches to learning may offer students useful learning. Simulation is increasingly recognised in clinical specialties other than mental health nursing as not being 'second best' in a context where there are significant shortcomings in the availability and quality of clinical placement (Bogossian et al. 2018). However, to achieve sustainability of the greater use of simulation will require resources to address staff preparation, ensuring current evidence-informed practice and comprehensive evaluative mechanisms.

A concerted effort to incorporate examples and reference to mental health problems and nursing responses throughout the curriculum may reduce the tendency to 'silo' mental health that is observed (Happell 2010; Happell, Moxham & Clarke 2011; Happell, Robins & Gough 2008). Assessment, communication, ethics and law lend themselves to this function. Primary health, and First Nations Units of study may have mutually useful synergies. Understandings of social determinants of health are valuable across many fields in the BN. Risk exists that when taught by non-mental health specialists, these exemplars may be down-played at the cost of loss of identity. Inclusion in these fields of study would be beneficial for nursing students in underscoring the ubiquitous nature of mental health problems which may affect their ZPD and readiness to learn.

New Zealand has implemented curricula interventions aimed to reduce the stigmatising attitudes of undergraduate nurses toward people experiencing mental health problems and strengthening communication skills (Spence, Garrick & McKay 2012). This includes the positioning of mental health clinical placement from the first year of the program (Bingham & O'Brien 2018) and additional theoretical classes. The outcomes of these curricula adaptions have relevance for Australian nursing students and impact their readiness to learn therapeutic communication responses to support people experiencing thought-disorder.

Final word/conclusion.

In a context of unmet demand for mental health services, that is provided by nurses as the largest component of the mental health workforce, and by the integrated service model receiving widespread support that sees those experiencing mental health problems expected to have their needs met where-ever they access health services, the shortcomings in preparation of nurses requires a systematic and sustained remedy.

Future work in this field should include the voice of those who do or have experienced thought-disorder. These insights into what are helpful responses should be central to any preparation planned.

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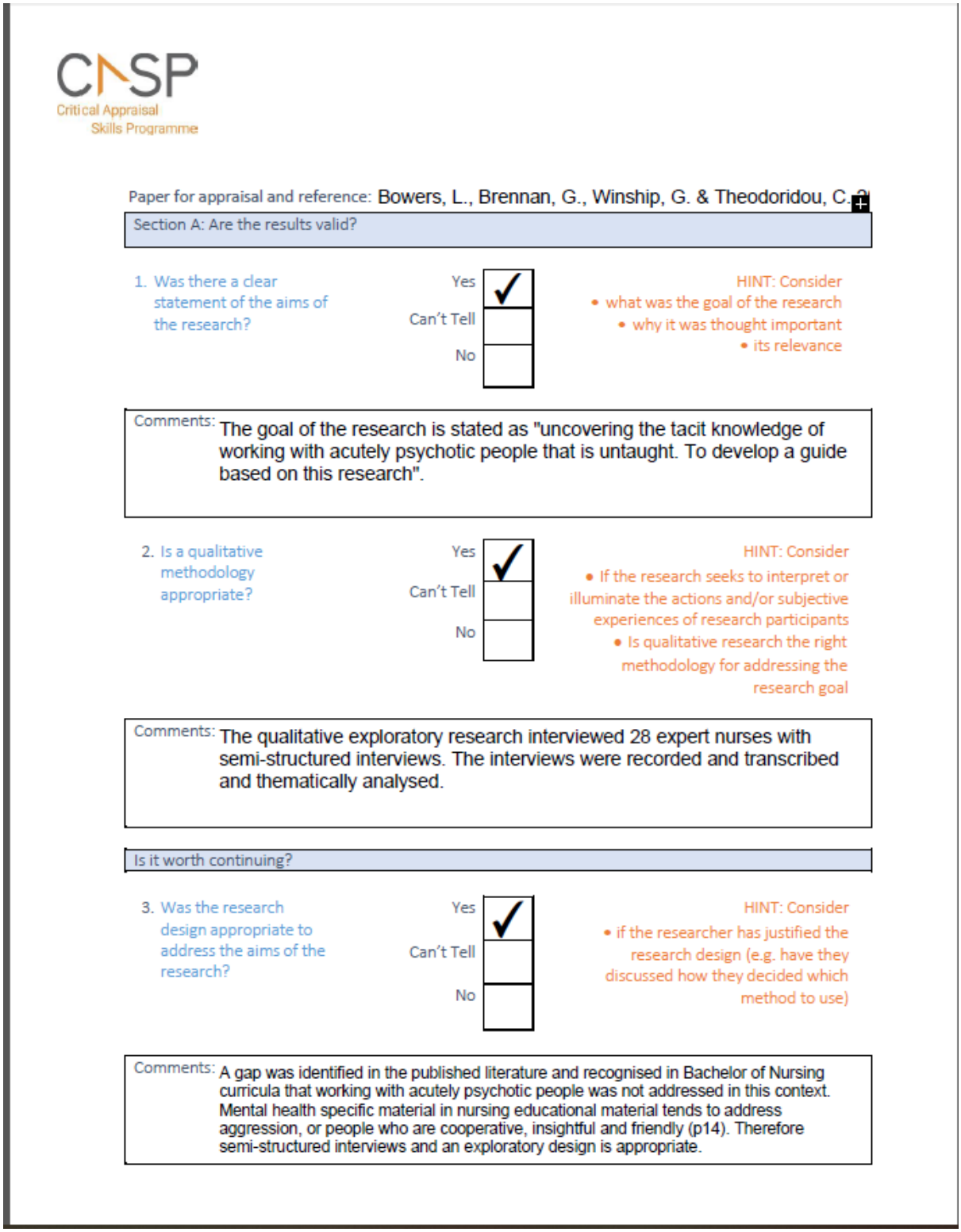
Appendix 1: CASP screening - Bowers et al (2009)



CASP
Critical Appraisal Skills Programme

Paper for appraisal and reference: Bowers, L., Brennan, G., Winship, G. & Theodoridou, C.

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes ✓
Can't Tell
No

HINT: Consider
- what was the goal of the research
- why it was thought important
- its relevance

Comments: The goal of the research is stated as "uncovering the tacit knowledge of working with acutely psychotic people that is untaught. To develop a guide based on this research".

2. Is a qualitative methodology appropriate?

Yes ✓
Can't Tell
No

HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal

Comments: The qualitative exploratory research interviewed 28 expert nurses with semi-structured interviews. The interviews were recorded and transcribed and thematically analysed.

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?

Yes ✓
Can't Tell
No

HINT: Consider
- if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments: A gap was identified in the published literature and recognised in Bachelor of Nursing curricula that working with acutely psychotic people was not addressed in this context. Mental health specific material in nursing educational material tends to address aggression, or people who are cooperative, insightful and friendly (p14). Therefore semi-structured interviews and an exploratory design is appropriate.

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4. Was the recruitment strategy appropriate to the aims of the research?

Yes	
Can't Tell	✓
No	

HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments: Initial identification of clinical nurse experts was by nursing management followed by a snowball recruitment(p3). The criteria for selection as an expert was not detailed. Recruitment was from 3 NHS Trusts and it is unclear whether this convenience sample was sufficient or representative. There was no discussion of those who may have refused to participate.

5. Was the data collected in a way that addressed the research issue?

Yes	✓
Can't Tell	
No	

HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments: However, the setting of data collection and issue of saturation of data not explicitly discussed.

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6. Has the relationship between researcher and participants been adequately considered?

Yes	
Can't Tell	✓
No	

HINT: Consider
- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments: This aspect poorly reported. No examination of possible researcher bias or reporting of changes during the study. The Principle Investigator (Len Bowers) is a prominent figure in the profession and any possible effect from this is not reported.

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes	
Can't Tell	
No	✓

HINT: Consider
- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments: These details were not reported.

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8. Was the data analysis sufficiently rigorous?

Yes	✓
Can't Tell	
No	

HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Comments: Contradictory or conflicting data was largely unexplored. Researcher bias in analysis not detailed explicitly.

9. Is there a clear statement of findings?

Yes	✓
Can't Tell	
No	

HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments: Additional researchers were used to verify findings. Exploratory design due to paucity of published research mitigates research findings from requirement to be explained against previous literature.

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Section C: Will the results help locally?	
10. How valuable is the research?	HINT: Consider • If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature • If they identify new areas where research is necessary • If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used
Comments:	The findings were formulated and presented as a structured practice guide. They address a broad range of experiences common to the diagnosis of psychosis, with clearly identified features addressed in a consistent manner when possible. The research has been clearly presented in a way to support educational preparation and questions arising from practice for nurses working with people experiencing acute psychosis. As this addresses a recognised "gap" the recommendation is for further investigation and research in the field. A limitation is its failure to involve experts by experience, but this may represent a discrete field for future research.

Return to:
- Chapter Two

Appendix 2: Evidence table of articles

Author (year) and country	Study design and sample	Purpose	Findings	Comments
Ammentorp et al. (2007) Denmark	5-day communication course compared with no participation in course.	RCT of effect of communication skills training on doctors' and nurses' self-efficacy.	Self-efficacy for communication skills improved and remained constant for 6 months. Did not influence prior efficacy.	Communication courses can improve confidence to communicate and may be so for thought-disorder too.
Ammentorp and Kofoed (2010) Denmark	Follow-up survey of parents' satisfaction for 3 years after training. Year 1 65%; Year 2 76%; Year 3 69%	Long term effects of training in communication for doctors and nurses.	Significant parental satisfaction after training that did not fall over time since training.	Not thought-disorder specific but relevance of effectiveness of training in communication may have bearing.
Beavan (2007) New Zealand	Mixed method survey (N=154) and interviews (N= 50)	PhD Thesis examining the phenomenon of hearing voices from consumers viewpoint.	Individual experience and meanings. Coping methods vary. Difficult voice content associated with more negative emotional responses to them	Importance of individual nature and understanding important for thought-disorder. Validation important to consumers.
Bee et al. (2008) UK	Systematic literature review of 132 articles from nursing literature. Data synthesised into narrative form.	Examination of service user views of UK mental health nurses, identification of source of review, assessment of rigour of article, evaluate extent of service-user involvement in article	Few studies involved collaboration. UK mental health nurses reported to provide inadequate information, poor inter-professional communication and lack of collaborative care. Inpatient nurses particularly inaccessible.	Recommendation for improvements in communication training, relationship building as well as therapeutic skills. Not thought-disorder specific but views of MHN skills and needs according to clinical context valuable.

Author (year) and country	Study design and sample	Purpose	Findings	Comments
Bocking et al. (2019) Australia, Ireland, Finland, Iceland, Norway, The Netherlands	Qualitative Explorative study. Thematically analysed and interpreted through Critical Social Theory	International project to implement and evaluate consumer co-produced mental health nursing module.	Two themes identified: 'made the human visible' and 'there wasn't a barrier' meaning how narratives supported development of relationships	Experts by experience may help address stigma and remediate status of mental health and address recruitment.
Bowers et al. (2009) UK	Qualitative Explorative research semi-structured interviews thematically analysed-28 expert nurses	Uncover tacit nursing knowledge of working with acutely psychotic people that is untaught and develop a guide based on this research	Language not the sole means of effective communication about untaught, traditional or self-developed skills among nurses	Thought-disorder a small component of communication considered. Acknowledge paucity of evidence for approaches
Chan (2014) Hong Kong	Mixed Methods	Investigate nursing students' communication styles regarding responding to cues	Task orientation dominant in patient interactions and use of closed questioning	Not a mental health focus, but relevant to person-centred care.
Chant et al. (2002) UK	Literature Review of 17 research reports of communication skills training in U/G nursing programs and difficulties in nursing practice	Highlight reasons for poor communication skills training and uptake	Poorly supported education, some definitional confusion, Practice settings do not value. Task vs person-centred care	Old literature review - possible change- see Grant and Jenkins (2014) for up-dated literature review. Not thought-disorder specific
Cleary (2003) Australia	Ethnographic investigation of acute inpatient mental health unit. 5-month observation in 22 bed unit, focussed interviews and discussion groups	How mental health practice is constructed in relation to changing policy	Patient-centred care is negotiated through relations with relationships, power, restriction and safety.	Relationships can be contradictory and challenging but respond to everyday approaches. Not thought-disorder specific.

Author (year) and country	Study design and sample	Purpose	Findings	Comments
Cleary (2004) Australia	Ethnographic investigation of acute inpatient mental health unit. 5-month observation in 22 bed unit, focussed interviews and discussion groups	How nurses construct their practice during service reform.	Difficulty to reconcile traditional practice values with changed service philosophy.	Deepens understanding of mental health nursing responses to change. Not thought-disorder specific.
Currid and Pennington (2010) UK	Amalgamation of approaches and understanding of the therapeutic use of self from different mental health disciplines	Comprehensive overview of approach and ways to develop skill	Self-assessment quizzes and exercises to support learning the therapeutic use of self.	Not thought-disorder specific, but extends relevant theory with exercises to develop a relevant skill
Dearing and Steadman(2008) USA	Results of pre/post test of nursing students (N=94) participating in a voice-hearing simulation (n=52) or not (n=42) during orientation on biases and development of therapeutic relationships.	To investigate effect of simulation on stigmatising attitudes to schizophrenia and development of therapeutic relationships.	Significant differences between groups in attitudes to those who hear voices.	Reduction of stigma and increase in empathy may also hold for thought-disorder with or without voice hearing.
Dearing and Steadman (2009) USA	Narrative investigation of reflective account of participation in hearing voices simulation. N=28	Study of impact of hearing voices simulation on the development of novice nurses' empathy and desire to form therapeutic relationship.	Participants reported greater understanding and empathising with hearing voices. Ability to attempt development of therapeutic relationship enhanced.	Development of intellectual empathy through simulation may be translatable to responding to thought-disorder at best, if not suggests simulation may be of value.

Author (year) and country	Study design and sample	Purpose	Findings	Comments
Doolen et al. (2014) USA	Qualitative Descriptive assessment of implementation 94 students Single School of Nursing	An evaluation of mental health simulation with standardized patients.	Standardised Patients contribute more meaningful learning for MH than manikins for therapeutic communication and interview skills.	No student or practice outcomes. Self-report tool not validated. Incorporates nuances of communication including nonverbal components. Not thought-disorder specific.
Ellis et al. (2015) USA	Descriptive Pilot study with eight nursing students	Psychiatric simulation of responding to and assessing different clinical presentations in four x 15-minute scenarios.	Success of simulation using faculty for mental health preparation in therapeutic communication and symptom recognition per student written reflection	Very small sample, 14-week study period, four staff involved. Generalised – no detail of thought-disorder learning.
Fenekou and Georgaca (2010) Greece	Qualitative study of voice-hearing. Semi-structured interviews. N=15. Thematically analysed (Modified grounded theory)	Exploration of hearing voices, highlighting complexity, meaning and experience for the person.	Voices perform a function for the person and have meaning for those who experience them	Complexity and individual responses may have parallels for thought-disorder. Sophisticated frameworks for each person's understanding or coping approaches. Not thought-disorder specific.
Foster et al. (2016) Australia, Canada, Northern Ireland, Norway	Integrative literature review, 1994-2014using PRISMA principles. 40 articles met inclusion criteria.	Clarify understanding of 'family-focussed' practice in adult, child and youth mental health services	Family-focussed practice conceptualisation by who comprised 'family', the family type, and context of practice.	Definition of family should be self-assigned and define unit of orientation for Family-Focussed Practice. Not thought-disorder specific.
Grant and Jenkins (2014) USA	Update of Chant et al. (2002), Literature review 2002-2013 of communication skills education in U/G nursing programs.	Assess quality or recent evidence for effectiveness of communication education in context of increases in active learning models including simulation.	Quality of research remains low making it unclear what approaches are effective, theoretical frameworks should be clearly identified and evaluation tools validated	Not mental health or thought-disorder specific.

Author (year) and country	Study design and sample	Purpose	Findings	Comments
Grant et al. (2016) Australia, Northern Ireland	Survey (Family focussed mental health questionnaire) N= 155 Mental health nurses in Victoria, Australia; N= 343 nurses in Northern Ireland.	Comparison of Australian and Northern Irish Family-focussed practice in adult mental health services	Differences found between family-focussed care between Australia & Northern Ireland. Australian mental health nurses engaged in greater family-focussed practice	Differences in nursing preparation, workplace support and policy may be responsible for the differences in practice found. Not thought-disorder specific but has ramifications for responses and support
Guloksuz and Van Os (2018) The Netherlands, USA & UK	Descriptive study of main issues of concept of Schizophrenia	Examine the case for framing psychosis as multidimensional syndrome	Concludes a case for introducing a psychosis-spectrum disorder in DSM5	Argument to alter psychiatric classification rather than examination of thought-disorder specifically.
Horgan et al (2018). Finland, Australia, The Netherlands, Norway, Ireland, Iceland.	Qualitative Descriptive design Eight focus groups of Expert by Experience participants, seven sites, 50 participants in total Thematically analysed	Explore the experience of co-produced nursing education from Expert by Experience perspective.	Two themes: 1. Seeing the strengths inherent in the 'human' behind the diagnostic label 2. Promoting self-reflection through two-way communication	Suggested to be more effective than other educational models in decreasing stigma. Expert by Experience contributions to U/G nurse education in classroom prior to placement. Not thought-disorder specific but included those that may exhibit thought-disorder
Jones and Shattell (2016) USA	Commentary about the representation of psychotic experiences	Challenge the biopsychosocial depictions of psychotic symptoms	Demonstrates the individual and heterogenous nature of experiences that do not align with ordinary (psychiatric) descriptions	Recognises impediments to in-depth exploration of experiences clinically but stresses the lack of understanding this means for people with these experiences Not thought-disorder specific.

Author (year) and country	Study design and sample	Purpose	Findings	Comments
Jones et al. (2016) USA	Qualitative design. 19 semi-structured interviews by service-user researchers	To investigate the subjective experience of agency in onset and early development of psychosis	A sub-group of people experience themselves as responsible for the onset and development of their psychotic experiences	This sense of agency could be further explored. Not thought-disorder specific.
Kalhovde, Elstad and Talseth (2013) Norway	Interview N=14 Hermeneutic phenomenological analysis	Increase understanding of experience of hearing voices.	The intentions of others can be intrusive and disrupt the lives of the voice hearers. Content, and tone of voices related to earlier experiences.	The importance of developing a knowledge of the person's understanding of their experiences could be helpful for thought-disorder. Not thought-disorder specific.
Kameg et al. (2009) USA	Overview of mental health nursing and communication learning	Use of simulation to become proficient in communication skills and reduce anxiety and lack of confidence in communication with people with mental health problems.	Use of mannequin-based simulation beneficial for repetition and lowering risk. But drawbacks in costs of method, clear link with achieving learning outcomes and transfer to clinical practice.	Not thought-disorder specific
Kameg et al (2010) USA	Quasi-experimental high-fidelity mental health patient simulation	Testing self-efficacy for communication (Bandura)	Improvements in self-efficacy measures alone. No other measures or differences.	Small sample (38). No focus on thought-disorder. Single study.
Kameg et al. (2013) USA	Quasi-experimental high-fidelity mental health patient simulation. 37 senior nursing students.	Assessing if simulation employing physical and mental health problems supported knowledge gain and retention.	Simulation did not improve knowledge gain but may help 'at risk' students. Students enjoy and regard as positive learning experience.	Definition of 'at risk' unclear. No focus on thought-disorder but caution regarding simulation germane. Small sample, single study

Author (year) and country	Study design and sample	Purpose	Findings	Comments
Martin and Chanda (2016) USA	Quasi-experimental one group, pre-post evaluation design. Convenience sample of 28 BN students, fourth semester of six semester program	Test intervention to prepare student therapeutic communication and reduce anxiety prior to MH clinical placement	Self-report of improvement	Rehearsal effects and reinforcing poor communication Self-report Single study Not thought-disorder specific but diagnoses portrayed included those that may exhibit TDS
McCann and Bowers (2005) UK	Seven acute inpatient units. Onsite training and follow-up	Training for inpatient mental health nurses and unqualified ward staff in psychosocial interventions, particularly cognitive behavioural techniques.	Leadership and staffing weaknesses affected training success	Not thought-disorder specific but techniques possibly included working with people with these problems
McCann, Lu and Berryman (2009) Australia	Longitudinal study of BN students' mental health literacy changes measured at 3 points in program	Understanding of students' knowledge of the effectiveness of interventions for people diagnosed with schizophrenia	Views positively changed about helpfulness of interventions through their program.	Suggestion evenly spread mental health units through nursing program to ensure literacy when graduate. Not thought-disorder specific but people with schizophrenia diagnoses often experience this.

Author (year) and country	Study design and sample	Purpose	Findings	Comments
Miles et al. (2015) USA	Descriptive Exploratory study of implementation of program. 76 participants (65% of those who undertook simulation)	Evaluate implementation of simulation communication module using videoed interaction with standardised patients in U/G mental health unit	Thematic analysis positively prepared for clinical placement (a) impact of seeing oneself, (b) significance of practicing, (c) opportunity for self-evaluation, (d) value of getting below the surface, and (e) power of transforming insight to goal setting.	The 2008 Essentials of Psychiatric Mental Health Nursing in the BSN Curriculum document (USA) identified therapeutic communication and interpersonal skills as core competencies for the baccalaureate-prepared nurse. Minimal research evidence on how to do this. Not thought-disorder specific
Nørgaard et al. (2012) Denmark	Pre-post questionnaire before course at end and 6 months after. N=181, all staff on orthopaedic ward.	Outcome study of 3-day program on respectful patient-centred communication and interdisciplinary collegiality	Self-efficacy improved and was maintained.	Not thought-disorder specific, but demonstrates possibility of specific communication training.
Proctor and Welbourn (2002) UK	Descriptive Exploratory study using routine student evaluations of module that includes lectures, experiential and reflective components including videoed micro-skills	Review of communication module in relation to regulatory authority requirement for communication preparation within Mental Health Nursing degree	Positive student evaluations. Need for further research. Need for further development of emotional intelligence and emotional labour components.	NB 2002 Not thought-disorder specific.
Reeves (2015) USA	Systematic Literature synthesis of articles addressing trauma-informed care until 2013 using PRISMA guidelines 26 articles met inclusion criteria	Examine research literature of trauma-informed physical health care for survivors of physical and sexual abuse to develop practice, research & policy to support implementation of trauma-informed practice.	Strong theoretical basis but little empirical research of effectiveness or from service-user view-points.	Not thought-disorder specific

Author (year) and country	Study design and sample	Purpose	Findings	Comments
Roche et al. (2015) Ireland	Systematic literature review of formal thought-disorder 1978-2013 using PRISMA guidelines 120 articles met criteria for inclusion.	Review Formal thought-disorder	Formal thought-disorder a common feature of psychoses diagnosis associated with clinical severity.	
Romme and Morris (2007) The Netherlands, UK, Norway	Critique about the representation of psychotic experiences	Analysis of diagnostic classification of schizophrenia	Construct flawed and stigmatising, label lacks scientific validity, ignores individual's experiences.	Appeals to staff to listen to the experiences and try to understand these. Not thought-disorder specific
Sleeper and Thompson (2008) USA	Descriptive study of the use of high fidelity (mannequin) simulation to learn therapeutic communication in mental health unit/course/subject	Describe use of algorithms to drive practice of therapeutic communication with the aim of reducing student anxiety prior to mental health clinical placement	Student evaluation positive. Further study indicated of effectiveness of algorithm versus other methods	Importance of addressing anxiety experientially prior to clinical placement. Not thought-disorder specific
Stomski & Morrison (2017) Australia	Systematic literature review 2000-2015, CASP checklist used to assess quality.	Meta synthesis of consumer participation in mental health care & articulates processes to ensure participation.	6 themes identified that facilitate participation in care: exercising influence, tokenism, sharing knowledge, lacking capacity, respect and empathy.	Participation not broadly implemented, remains aspirational. Fresh approach needed to achieve this. Not thought-disorder specific but identifies practice environment difficulties.
Swan and Eggenberger (2020) USA	Descriptive design of narrative data N=109 newly graduated nurses	Understand nursing student perceptions of implementing family-focussed practice in clinical settings.	Able to translate family-focussed practice to clinical practice.	Evaluation of implementation of family-focussed preregistration curricula. Not thought-disorder specific

Author (year) and country	Study design and sample	Purpose	Findings	Comments
Webster (2013) USA	Descriptive Evaluation of a BN student assignment of a videoed exchange with a standardised mental health patient. 15 BN students in Mental health course/unit/subject	Pilot study to determine the usefulness of the assignment in teaching and assessing therapeutic communication and person-centred care.	Positive responses from standardised patients and students. Inclusion of standardised patients in student debriefing a recommendation	Pilot, small numbers. Not thought-disorder specific but diagnoses portrayed included those that may exhibit thought-disorder.
Webster (2014) USA	Quasi-experimental, pre-post design one group design. BN students in psychiatric nursing course/subject/unit evaluated by staff (faculty). Convenience sample of 89 students	Test effectiveness of standardised patients to teach therapeutic communication skills with people with mental ill-health.	Showed improvement in 12 of 14 criteria of therapeutic communication. Non-validated tool.	Not thought-disorder specific but diagnoses portrayed included those that may exhibit thought-disorder.
Whittington and McLaughlin (2000) Northern Ireland	Observational study N=20 from 3 units	Explore nurses' time allocation in acute mental health inpatient units.	Less than half of day spent in patient contact, proportion of patient contact potentially psychotherapeutic very small (6.75%)	Relevance for policy and for education. Not thought-disorder specific

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Appendix 3: Survey Facebook© snowball contacts

Organisation	Type
Australian College of Mental Health Nurses	Mental Health Nursing peak organisation. Placed on Website ,Facebook site and Tuesday electronic newsletter. 2.9K likes of FB site
Student Nurse Advice and Support FB Page	UK student Facebook page posting 60k likes of FB page
Student Nursing Journeys and Beyond FB closed Group	A group for nursing students/professionals based in the UK. 10656 members September 2017
Health Education Doctoral FB page	Created to host survey 45 likes
Mental Health Nurses Facebook (closed) Group	International group 20 396 members September 2017
Australian College of Nursing	Peak Australian Nursing Professional Association. Published on student page of Facebook and emailed to members Article written for and published in 'Click'
NSWNMA Nurseuncut	NSWNMA Facebook page. 11855 likes September 2017.
Australian Nurse Diary	Closed FB page 8500 members September 2017.
Australian Nursing & Midwifery Federation	Union for all Australian categories of nurses. Request via Facebook page /administrator.
The Nurse Path	Australian Community Facebook group. 97k likes September 2017. Request via Facebook page /administrator.
Student Nurses Support and Advice	Closed Facebook group 3888 members September 2017 Request via Facebook page /administrator.
Royal College of Nursing	UK Trade union 122k likes September 2017. Request via Facebook page /administrator.
UC Nursing Society	University of Canberra Community Facebook Page Request via Facebook page /administrator. Posted 390 likes/followers September 2017.
I love nursing	Community Facebook group 621k likes September 2017 Request via Facebook page /administrator.
The Staff Nurse	Public Facebook group 259k likes September 2017 Request via Facebook page /administrator.
Nurses	Community Facebook group 738k likes September 2017 Request via Facebook page /administrator.
Macarthur Mental Health Nurses – New South Wales Nurses and Midwives Association (NSWNMA)	Community Facebook group 77 likes September 2017 Request via Facebook page /administrator.
Monash Uni nurses and midwives	Is there something missing here
QUT Society of undergraduate nurses -SUN	Charity Facebook group 4.1k likes September 2017 Request via Facebook page /administrator.
Asanna - Australian student and novice nurse association	Charity Facebook group 4.1k likes September 2017 Request via Facebook page /administrator.
Australian Nurse & Midwifery Federation South Australian Branch	State based site for ANMF with 21000 members.
Nurse in Australia	Health and Wellness Website/Facebook site. 5152 likes September 2017 Request via Facebook page /administrator.
National rural health student network	Charity Facebook group 4.4k likes September 2017 Request via Facebook page /administrator.
Mental health nursing course	Charity Facebook group 468 likes September 2017 Request via Facebook page /administrator

Organisation	**Type**
Congress of Aboriginal and Torres Strait Islanders	Facebook group 3.5k likes September 2017 Request via Facebook page /administrator
Kimberley nurses corner	Community Facebook group 81 likes September 2017 Request via Facebook page /administrator.
	Community Facebook group 692 likes September 2017 Request via Facebook page /administrator.
Drug and alcohol nurses Australiasia	Charity Facebook group 675 likes September 2017 Request via Facebook page /administrator
International journal of mental health nursing	Community Facebook group 1.5k likes September 2017 Request via Facebook page /administrator.
Individual	**Position**
Helen Hamer	New Zealand Mental Health Nurse and Academic (University of Auckland, New Zealand) in private clinical practice (Director, Helen Harmer & Associates Ltd, Auckland)
Fiona Orr	Mental health nurse and academic, UTS student facebook
Thomas Harding	Senior Lecturer, University of Canterbury, New Zealand
Rosanna McMaster	Professor of International Nursing, Yamaguchi University Japan
Anne Storey	Clinical Nurse Educator, Camperdown, Redfern, Marrickville Community Mental Health Service, Sydney LHD, NSW Health
Professor Nicholas Procter	Chair of Mental Health Nursing and leader of the Mental Health and Substance Use Research Group University of South Australia. Distributed through undergraduate students in School of Nursing.
Linda Soars , RN	Director Integration Partnerships and Enablers, Integrated & Community Health, Western Sydney Local Health District Responded to FB posting. Volunteered to distribute in The Shire health services, NSW
Meredith Kellahan	Responded via Australian Nurse Diary with invitation to distribute via Charles Darwin University, Northern Territory.
Jennifer Manning	Scholarly Teaching Fellow, School of Nursing, Midwifery and Indigenous Health, Charles Sturt University, Bathurst Campus
Dr Judith Anderson	Courses Director, School of Nursing, Midwifery and Indigenous Health, Charles Sturt University, Bathurst Campus.
James Hindman	Clinical *Nurse* Consultant, Rural and Remote Support, Mental Health Drug and Alcohol, Western LHD, NSW. Referred to Nurse Educator responsible for new grads.
Paul McNamara, Meta4RN	Nurse Educator and active online Mental Health Nurse blogger, twitter and facebook contributor. Request via Facebook page /administrator.
A/Prof Rhonda Wilson.	Associate Professor in E Mental Health at University of Southern Denmark - University of Southern Denmark. Distributed to European colleagues.
Karen Richards	A/ Mental Health Emergency Care Consultation Liaison CNC, Bathurst Base Hospital. Distributed.
Elizabeth Martin	Endorsed *Nurse Practitioner*, Clinical Nurse Consultant with Far west NSW LHD and as an academic lecturer with Sydney University at Broken Hill & Far West LHD. Distributed.
Alison Hansen	Lecturer (Mental Health) ACU and ex-forensicare (Victoria) – distributed via networks
Janet Green	Senior Lecturer at University of Technology Distributed via networks
Melanie White	Lecturer, ACU Distributed via networks.
Personal FB approaches X 58 via FB personal message	No Responses

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Appendix 4: Invitation for survey participation – Facebook© posting

Pre-registration nursing students: Learning to respond to thought disordered speech

Hi,

My name is Denise McGarry (RN) and I am a nursing academic and a PhD student at the University of Technology Sydney. I am researching "Pre-registration nursing students: Learning to respond to thought disordered speech". The purpose of this research/online survey is to find out how nursing students worldwide learn to respond to people experiencing thought-disordered speech during their undergraduate study. I'd like to hear the experiences of pre-registration/undergraduate nursing students and recently graduated/ registered nurses and their ideas of what would help this learning and teaching. You do not need to be working in mental health to participate – your experiences are important.

This study has ethics approval from the University of Technology Sydney UTS HREC REF NO. ETH16-0911.

If you use Facebook, you could fill out the survey via the link below. I am not seeking to access your Facebook site or private information. https://www.facebook.com/Health-Education-Doctoral-Research-1742559022723387/

You are most welcome to forward either the Facebook link, or the direct link to the survey: https://www.surveymonkey.com/r/FFPVJ5M to your professional nursing student and new grad friends and contacts.

Thanks, Denise

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Appendix 5: Australian College of Nursing NurseClick article June 2017 (https://www.acn.edu.au/?s=Nurse+Click+June+2017).

"Learning to Respond to Thought Disordered Speech ": Research Study.

The preparation of undergraduate[4] nursing students to provide collaborative care for people experiencing mental health problems is challenging. Both within Australia and in other Western countries; the preparation for undergraduate nursing students with mental health skills, knowledge and attitudes for practice has been a focus of concern. One concern has been supporting the development of students' therapeutic communication relevant for people experiencing serious mental illnesses[5].

The common focus of research about the preparation of pre-registration nurses for mental health has focussed primarily on career trajectories to mental health nursing, examining the

[4] In Australia and other countries, preparation to practice as a registered First Division Nurse is achieved via a three or 3.5 year Bachelor degree. The second Division or Enrolled Nurse whose practice is also regulated is prepared by a 12 month Vocational College program and practices under the supervision of a Registered Nurse. During preparation for practice terminology is ambiguous and makes differentiation between these two classes of nursing students difficult. Pre-service, pre-registration or nursing student are terms commonly used, but rejected in favour of the clearer term 'undergraduate nurse' that encompasses both the student and type of nurse examined.

[5] Serious mental illness is also referred to as significant or severe mental illness. SMI ordinarily refers to diagnoses of psychotic illness including schizophrenia and affective conditions, and may also include diagnoses of anxiety conditions and occasionally personality disorders.

significance of clinical placement experience and theory and practical classes in the tertiary educational sector (Happell & Gaskin 2013; Neville & Goetz 2014). It is reported that mental health clinical placements and the first clinical placements undertaken by nursing students are experienced as stressful (Galvin et al. 2015). It has been observed that nursing students in mental health environments experience more and different stressors than nursing students in other clinical areas (Pryjmachuk & Richards 2007). One of these concerns often expressed by nursing students prior to their mental health clinical placement is how to talk with people experiencing mental health concerns and the possibility of 'doing harm' inadvertently when doing so (Kameg et al. 2009).

In spite of the widespread agreement that therapeutic communication is pivotal to achieving recovery goals (Hewitt & Coffey 2005), studies from clinical practice record that nurses in mental health practice spend only small amounts of time in conversation with people in care. These reports of low levels of interaction have been reported for decades (Altschul 1972; Sanson-Fisher, Poole & Thompson 1979). Whittington and McLaughlin (2000) reported that 7% of nurses' time was spent in potentially therapeutic communication, and clients have been found to spend only 4% (Higgins, Hurst & Wistow 1999) or 6% (Martin 1992) of their time with nurses. Concern at these observations and recognition that therapeutic communication is seminal to Recovery goals has led to policy responses. In the UK, directives require 15 minutes one-to-one documented interaction with inpatients each nursing shift (Healthcare Commission 2008).

The motivation for my doctoral study of these issues was also partially personal. For many years I have worked with beginning nurses in a variety of roles as they first begin their formal tertiary mental health nursing education. These roles have been based both within the tertiary education and clinical education arenas. I have observed many nursing students struggle when attempting to talk with people who present with thought-disordered speech. Frequently they are visibly shocked at the difference from usual patterns of speech and/or concerned that they may inadvertently communicate in a way that damages or provokes the person. An opportunity to assist nursing students better prepare for this component of their future nursing practice and to relieve those experiencing thought-disordered speech from this reaction, was my motivation for my doctoral research. It is hoped that findings may support development of effective learning and teaching approaches. Furthermore, that a better prepared nursing workforce might afford people exhibiting thought-disordered speech more therapeutic responses: Responses that are therapeutic in content and duration.

Part of the data collection for this investigation is a survey of pre-registration/undergraduate and newly registered nurses. The survey, that is open until August 2017 is seeking the experiences and opinions about learning to respond to such speech during undergraduate

study. It also seeks to gather these participants opinions about what might help in this learning and teaching.

This survey has ethics approval from the University of Technology Sydney UTS HREC REF NO. ETH16-0911. It can be accessed via Facebook, (https://www.facebook.com/Health-Education-Doctoral-Research-1742559022723387/). I am not seeking to access anyone's Facebook site or private information.

It may also be accessed via a direct link to https://www.surveymonkey.com/r/FFPVJ5M

I would encourage participation in this research, so I can be best informed of the range of experiences and suggestions of pre-registration and newly registered nurses whether or not they work in mental health fields. One in five Australians can be expected to experience mental health problems in any 12 month period.

Denise McGarry MACN.

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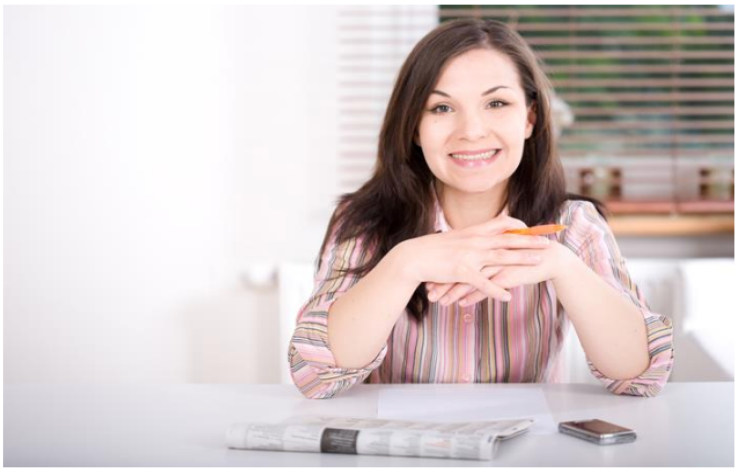
Appendix 6: Australian College of Nursing e-Bulletin 21 July 2017 survey recruitment

Survey open to clinical nurses to assist PhD research

Denise McGarry MACN, a nursing academic at the Australian Catholic University and PhD student at the University of Technology Sydney, is researching how nursing students and recent graduates (within two years) learn to respond to people experiencing thought-disordered speech. Nurses working in a broad range of clinical areas are invited to participate in the survey.



The survey is open until **25 August 2017** and should not take more than 20 minutes to complete. Denise would like to reach the goal of 100 survey participants.

Complete the **survey** to put your name down to be interviewed about this topic.

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Appendix 7: Participant information sheet

PARTICIPANT INFORMATION SHEET

Pre-registration nursing students: Learning to respond to thought-disordered speech

UTS HREC REF NO: ETH16-0911

WHO IS DOING THE RESEARCH?

My name is Denise McGarry and I am a PhD student at UTS. My supervisor is Professor Cathrine Fowler, Faculty of Health, University of Technology Sydney and co-supervisor is Dr Janet Green, Faculty of Health, University of Technology Sydney.

WHAT IS THIS RESEARCH ABOUT?

This research is to find out about learning about thought-disordered speech. The project seeks to:

1. Examine the place allocated to the topic of thought-disordered speech in the pre-registration nursing curricula,
2. Examine the learning and teaching approaches used to address the topic of thought-disordered speech,
3. Discover the methods of assessing & evaluating learning about thought-disordered speech
4. Consider suggested improvements for learning and teaching approaches in the area of thought-disordered speech.

IF I SAY YES, WHAT WILL IT INVOLVE?

I will invite you to participate in a 30-45 minute semi-structured interview/that will be audio/ video recorded and transcribed

ARE THERE ANY RISKS/INCONVENIENCE?

Yes, there are some risks/inconvenience. They are that you might be embarrassed, and you may be asked sensitive questions.

WHY HAVE I BEEN ASKED?

You have been approached because you are a current nursing student who has completed the mental health theory subject and clinical placement components of the pre-registration nursing programme, or a recent graduate of such a programme

DO I HAVE TO SAY YES?

Participation in this research is voluntary.

WHAT WILL HAPPEN IF I SAY NO?

You are free to withdraw from participating in this research at any time without consequences. I will thank you for your time so far and won't contact you about this research again.

IF I SAY YES, CAN I CHANGE MY MIND LATER?

You can change your mind at any time. However, changing your mind after data collection may affect analysis and research outcomes. Please advise as soon as possible of any intension to withdraw. I will thank you for your time so far.

WHAT IF I HAVE CONCERNS OR A COMPLAINT?

If you have concerns about the research that you think I or my supervisor can help you with, please feel free to contact us -

Professor Cathrine Fowler, E: Cathrine.Fowler@uts.edu.au or P: +61 2 9514 4847

Dr Janet Green, E: Janet.Green@uts.edu.au

Denise McGarry, E: Denise.E.McGarry@student.uts.edu.au

NOTE:

This study has been approved by the University of Technology Sydney Human Research Ethics Committee (UTS HREC). If you have any concerns or complaints about any aspect of the conduct of this research, please contact the Ethics Secretariat on ph.: +61 2 9514 2478 or email: Research.Ethics@uts.edu.au), and quote the UTS HREC reference number. Any matter raised will be treated confidentially, investigated and you will be informed of the outcome.

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Appendix 8: Student interview informed consent

INFORMED CONSENT FORM

Pre-registration nursing students: Learning to respond to thought-disordered speech
UTS HREC REF NO: ETH16-0911

I _____ *(participant's name)* agree to participate in the research project "Pre-registration nursing students: Learning to respond to thought-disordered speech" (UTS HREC REF NO. ETH16-0911) being conducted by:

Research Student: Denise McGarry (PhD Candidate)
Faculty of Health | University of Technology Sydney
E: Denise.E.McGarry@student.uts.edu.au

Chief Investigator: Professor Cathrine Fowler
Faculty of Health, University of Technology Sydney
E: Cathrine.Fowler@uts.edu.au
P: +61 407 942 916

Co-Supervisor: Dr Janet Green
Faculty of Health | University of Technology Sydney
E: Janet.Green@uts.edu.au

I understand that the purpose of this study is to investigate learning about thought-disordered speech in the pre-registration nursing curricula. This study has 4 objectives. To identify:

1. The place allocated to the topic of thought-disordered speech in the curricula
2. Learning and Teaching approaches used to address the topic of thought-disordered speech
3. Methods of assessing & evaluating learning about thought-disordered speech
4. Suggested improvements for learning and teaching approaches in the area of thought-disordered speech.

I understand that I have been asked to participate in this research because I am a current nursing student who has completed the mental health theory subject and clinical placement components of the pre-registration nursing programme, or a recent graduate of such a programme. I understand that my participation in this research will involve a 30-45 minute individual interview exploring my opinion about my learning experience of thought-disordered speech. This interview may be face-to-face (if in Sydney) or electronically if located elsewhere or I elect this. Interviews will be recorded and transcribed for analysis.
If I experience any discomfort, I understand I am encouraged to seek support from my education provider's counselling services or Lifeline (on 13 11 14 or online http://www. lifeline.org.au)

I agree to be:
☐ Audio recorded
☐ Video recorded
☐ Photographed

I agree that the research data gathered from this project may be published in a form that:
☐ Identifies me
☐ Does not identify me in any way
☐ May be used for future research purposes

I am aware that I can contact Professor Cathrine Fowler if I have any concerns about the research. I also understand that I am free to withdraw my participation from this research project at any time I wish, without consequences, and without giving a reason. Withdrawal from the research will not prejudice future academic progress or employment.

I agree that Denise McGarry has answered all my questions fully and clearly.

_____ ___/___/___
Name and Signature (participant) Date

_____ ___/___/___
Name and Signature (researcher or delegate) Date

NOTE:
This study has been approved by the University of Technology Sydney Human Research Ethics Committee (UTS HREC REF NO. ETH16-0911). If you have any concerns or complaints about any aspect of the conduct of this research, please contact the Ethics Secretariat on ph.: +61 2 9514 2478 or email: Research.Ethics@uts.edu.au, and quote the UTS HREC reference number. Any matter raised will be treated confidentially, investigated and you will be informed of the outcome.

Return to:
- Chapter Three

Appendix 9: Second invitation for student participants

Pre-registration nursing students: Learning to respond to thought-disordered speech

Hi,

My name is Denise McGarry (RN) and I am a nursing academic and a PhD student at the University of Technology Sydney. I am researching "Pre-registration nursing students: Learning to respond to thought-disordered speech". I want to understand how nursing students (you) learn to respond to people experiencing thought-disordered speech during your undergraduate study. I'd like to hear of your experiences and your ideas of what would help this learning.

This study has ethics approval from the University of Technology Sydney UTS HREC REF NO. ETH16-0911/ ETH20-4954.
If you are interested in participating you will be asked to take part in an interview, on-line or by phone. This will be audio recorded and transcribed, and de-identified.

Please contact me by emailing me on Denise.E.McGarry@student.uts.edu.au letting me know that you are interested and how to best contact you to arrange a time for interview. I will also provide more information and a consent form for you.

Kind regards,

Denise McGarry

Denise.E.McGarry@student.uts.edu.au

Return to:
- Chapter Three

Appendix 10: Ethics amendment approval

Thursday, June 11, 2020 at 15:04:04 Australian Eastern Standard Time
Page 1 of 1
Subject: Your ethics application has been approved as low risk - ETH20-4954
Date: Thursday, 11 June 2020 at 11:52:48 am Australian Eastern Standard Time
From: research.ethics@uts.edu.au
To: Research Ethics, Denise McGarry, Cathrine Fowler
CC: Karen Gomez, Priya Nair, Rebekah Ta/an, Lydia Feng
Attachments: Ethics Application.pdf

Dear Applicant
Re: UTS HREC Ref. No. ETH20-4954 - "Pre-registration nursing students: Learning to respond to thought disordered speech"

Your local research office has reviewed the amendment application for your above-named project and agreed that the amendments meet the requirements of the National Statement on Ethical Conduct In Human Research (2007). I am pleased to inform you that your amendment has been approved as follows:
Change of supervision team from Dr Janet Green who has now left UTS and she is replaced by Dr Fiona Orr who is a member of the School of Nursing and Midwifery.
Permission is being sort to recruit up to 12x3rd year students from the Bachelor of Nursing program at UTS. During the previous recruitment only 3 students (from other universities were recruited of an approved sample size of 5 to 15 students) so up to a further 12 students are needed to be recruited from UTS. I wish to confirm that the interviews will be conducted via a telephone call or a zoom link.
All 3rd year students will be sent an invitation to participate in this research study via an email that contains information about the research. They will be requested to reply via email if they are interested in participating. Interested students will be sent a consent form and information sheet and if they agree to participate they will be asked to return the signed consent form via email.
Prior to commencing the interview, the student will be asked if they are still willing to participate.
This amendment is subject to the standard conditions outlined in your original letter of approval.
You are reminded that this letter constitutes ethics approval only. This research project must also be undertaken in accordance with all UTS policies and guidelines including the Research Management Policy.
You should consider this your official letter of approval. If you require a hardcopy please contact your local research office.
To access this application, please click here. A copy of your application has also been attached to this email.
If you have any queries about this approval, or require any amendments to your approval in the future, please do not hesitate to contact your local research office or the Ethics Secretariat
(Research.Ethics@uts.edu.au).

Return to:
- Chapter Three
- Chapter Three – Ethical Permissions

Appendix 11: Mental health academics consent form

Faculty of Health
University of Technology Sydney
General inquiries
T: +61 9514 4879
Director of Research
T: +61 9514 4832
PO Box 123
Broadway NSW 2007
Australia
www.nmh.uts.edu.au/research
September 2017

INDIVIDUAL PARTICIPANT CONSENT FORM

Research Project: Pre-registration nursing students: Learning to respond to thought-disordered speech.

Chief Investigator: Professor Cathrine Fowler
Tresillian Chair in Child & Family Health
Faculty of Health
Centre for Midwifery, Child & Family Health
University of Technology Sydney

Co-Supervisor: Dr Janet Green
Senior Lecturer
Coordinator Graduate Certificate in Clinical Teaching
Coordinator Postgraduate Neonatal and Paediatric Nursing Courses
Faculty of Health | University of Technology Sydney

Research Student: Denise McGarry
PhD Candidate,
Faculty of Health | University of Technology Sydney
Lecturer in Nursing
School of Nursing, Midwifery and Paramedicine
Australian Catholic University

Research Organisation: Faculty of Health | University of Technology Sydney

Participation in this project involves:

- Reading and understanding the information sheet
- Participating in an audio taped interview for approximately 30-45 minutes
- Reading and signing the consent form

I, (Pl

…….....

have consented to participate in the above research project on the following basis:

- I understand that I am free to withdraw my participation in the research at any time, and that if I do I will not be subjected to any penalty or discriminatory treatment
- The purpose of the research has been explained to me and I have read and understood the information sheet given to me
- I have been given the opportunity to ask questions about the research and received satisfactory answers
- The purpose of the research has been explained to me, including the (potential) risks/discomforts associated with the research
- I understand that any information or personal details gathered in the course of this research about me are confidential and that neither my name nor any other identifying information will be used or published
- I understand that interviews will be audio taped
- I understand that University of Technology Sydney's Human Research Ethics Committee has approved this study
- I understand that if I have any complaints or concerns about this research I can contact:

Ethics Secretariat
University of Technology Sydney

T: +61 2 9514 2478
PO Box 123
Broadway, NSW, 2007

E: Research.Ethics@uts.edu.au
Quote the UTS HREC reference number (**ETH16-0911)**. Any matter raised will be treated confidentially, investigated and you will be informed of the outcome

Name: ……

Signature …… *Date* ……..

Investigator's signature: …… *Date* ……

Return to:Chapter Three

Appendix 12: Survey instrument

UNIVERSITY OF TECHNOLOGY SYDNEY

Pre-registration nursing students: Learning to respond to thought disordered speech

1. Invitation and Consent

Faculty of Health
University of Technology Sydney
General inquiries
T: +61 9514 4879
Ethics Secretariat
T: +61 9514 2478
PO Box 123
Broadway NSW 2007
Australia
www.nmh.uts.edu.au/research

Dear Participant,

Welcome to the survey : "Pre-registration nursing students: Learning to respond to thought disordered speech".

My name is Denise McGarry. I am a nursing academic and completing a Doctor of Philosophy (PhD) in the Faculty of Health, University of Technology Sydney. My supervisors are Professor Cathrine Fowler and Dr Janet Green. My study will involve an on-line survey of recently graduated nurses and nursing students world-wide and separate follow-up interviews about learning about thought disordered speech in the pre-registration curricula. This survey has 4 objectives. To identify:
1. The position allocated to the topic of thought-disordered speech in the curricula
2. Learning and Teaching approaches used to address the topic of thought disordered speech
3. Methods of assessing & evaluating learning about thought-disordered speech
4. Suggested improvements for learning and teaching approaches in the area of thought disordered speech.
You are invited to participate as a student of nursing in a Baccalaureate Nursing program or recent graduate. To be eligible to participate, you need to have completed the common compulsory mental health nursing subjects in your undergraduate Bachelor of Nursing or to have completed your program in the past year.
This research study has been approved through the Human Research Ethics Committee of the University of Technology Sydney. The approval number is XXX. Participation is entirely voluntary and you may withdraw at any time. Data will be aggregated after de-identification to maintain your anonymity and confidentiality. Your responses will not be able to be identified.
The survey takes approximately 20 minutes to complete and consists of 26 questions. If you change your mind at any time, you do not have to provide a reason.Thank you for your time. I won't contact you about this research again. If you have concerns about the research that you think we can help you with please feel free to contact Professor Cathrine Fowler on +612 9514 4847 or Cathrine.Fowler@uts.edu.au If you would like to talk to someone who is not connected with the

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research, you may contact the Research Ethics Officer on +612 95149772 or Research.Ethics@uts.edu.au and quote this number: [number of your research application]Please read the information thoroughly before completing the survey. You will only be able to move onto the survey itself if you complete the box at the bottom that indicates you have read this information and agree to participate.

Risks to you are minimal and benefits are expected to outweigh any risks of participation.If the topic of this research raises other concerns of a personal or mental health nature, Lifeline can be contacted on 13 11 14 or online http://www. lifeline.org.au You may wish to approach your educational institution's Student Counseling Services.Although there are not any direct or immediate benefits from participating in the study, you will be sharing your insights and experiences of learning to respond to thought disordered speech. Your comments will help to develop approaches to pre-registration nursing student learning.

If you agree to take part in this survey and to research data gathered from this survey to be published in a form that does not identify you, please continue with answering the survey questions.

* 1. Please answer the question below to indicate your agreement to participate in this doctoral research:

- ◯ I have read the information above and voluntarily agree to participate in this research
- ◯ I have read the information above and do not agree to participate in this research

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Appendix 12: Survey instrument

UNIVERSITY OF TECHNOLOGY SYDNEY

Pre-registration nursing students: Learning to respond to thought disordered speech

2. Additional Information: Glossary

Thought disorders are manifested in speech that is associated with a number of disorders but primarily psychotic diagnoses. It shows cognitive organisation that is apparently illogical, lacking in usual sequencing of words and/or concepts, and may exhibit delusions or bizarre features.

Consumer refers to a person who is currently using or has used a mental health service in the past. This does not include all people who experience mental health problems as many people do not seek or receive these services..

Carer is a term used to refer to people who support those with mental health problems. This is often family , including partners and children, but can also include unrelated people like friends. Those who receive payment are not included.

Lived Experience (of mental health) is an expression increasingly used to identify people who have mental health phenomenon, with or without seeking help, care or assistance from mental health services and who may not identify these experiences as problematic.

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UNIVERSITY OF TECHNOLOGY SYDNEY

Pre-registration nursing students: Learning to respond to thought disordered speech

3. About You

.

2. What is your gender?

- Female
- Male
- Other
- Prefer to not answer

3. What is your age?

- 18 to 24
- 25 to 34
- 35 to 44
- 45 to 54
- 55 to 64
- 65 to 74
- 75 or older
- Prefer to not answer

4. What country do you live in?

5. What language do you speak most fluently?

6. What languages do you speak other than English? If you do not speak other languages, please mark English only

4

Appendix 12: Survey instrument

7. How do you identify your ethnicity or culture?

8. What is the highest level of school you have completed or the highest degree you have received?

- ◯ Less than high school degree
- ◯ High school degree or equivalent
- ◯ Some college but no degree
- ◯ Associate degree
- ◯ Bachelor degree
- ◯ Graduate degree
- ◯ Prefer to not answer

9. In what degree are you enrolled or were you enrolled in, if graduated?

10. In what country are you studying?

11. What year are you in of your nursing program OR how long is it since you finished your program (Please specify which)

12. Are you currently in paid employment?

- ◯ Yes
- ◯ No
- ◯ Prefer to not answer

Other (please specify)

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Appendix 12: Survey instrument

13. Do you work in health or human services (personal care, nursing)?

- ◯ Yes
- ◯ No
- ◯ Prefer to not answer

14. If you work in health or human services does it include people who exhibit thought disordered speech?

- ◯ Yes
- ◯ No
- ◯ Prefer to not answer

Other (please describe)

15. Do you have prior personal knowledge of mental health issues? Prior knowledge (from personal experience) may influence your responses in a different way from that of people with no prior knowledge of mental health issues. Detail of your own personal experience is not required.
Please mark each answer choice that applies.

- ☐ Person (with the lived experience of mental health issues) or Consumer (of mental health services)
- ☐ Carer for a person experiencing mental health problems
- ☐ Health practitioner
- ☐ No prior experience of mental health issues
- ☐ Prefer not to answer

Other (please specify)

16. Please comment about other relevant work or educational experiences

6

Appendix 12: Survey instrument

17. How do you feel about working with people experiencing mental health problems?

7

Appendix 12: Survey instrument

UNIVERSITY OF TECHNOLOGY SYDNEY

Pre-registration nursing students: Learning to respond to thought disordered speech

4. Learning and Teaching about Thought – Disordered Speech

These questions aim to find out how you learned about thought-disordered speech. Please provide examples of the way thought disordered speech was taught to you and any other details you feel are relevant.

18. What do you understand thought-disordered speech to be?

19. Did you learn about thought-disordered speech within your course?

- ☐ Learned in Bachelor of Nursing Course
- ☐ Learned elsewhere/not in Bachelor of Nursing Course
- ☐ I have not learned about thought-disordered speech
- ☐ Other (please specify)

20. How did you learn about thought-disordered speech in your Bachelor of Nursing Course? Please mark all that apply.

- ☐ Lecture, formal instruction
- ☐ Tutorials, informal discussion and exploration
- ☐ Clinical practice sessions - role play
- ☐ Clinical practice session - demonstration
- ☐ Clinical Placement experience
- ☐ Other (please specify)

21. Were you taught about how to talk with people experiencing thought-disordered speech?

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Appendix 12: Survey instrument

22. Was learning about thought-disordered speech an important or major learning objective?

Very important	Somewhat important	Neither important or unimportant	Not very important	Not important at all
○	○	○	○	○

Other (please specify)

23. Did your learning about thought-disordered speech mainly happen in theory classes or while on clinical placement?
Please mark the mix which applies to your learning.

Theory Classes only	Equally in both theory classes and clinical placement	Clinical placement only

24. How was your learning about thought-disordered speech assessed?
Please mark all that apply.

- ☐ Formal examination by multiple choice question
- ☐ Formal examination by short answer questions
- ☐ Formal examination by case study
- ☐ Assessment by simulation (for example OSCE)
- ☐ Assessment on clinical placement
- ☐ Other (please specify)

25. What way did you find most useful to help you learn about thought-disordered speech?

26. Please add your suggestions for learning and teaching about thought-disordered speech. Add as many approaches as you wish that may help to learn about thought-disordered speech and how to respond to people exhibiting this type of speech.

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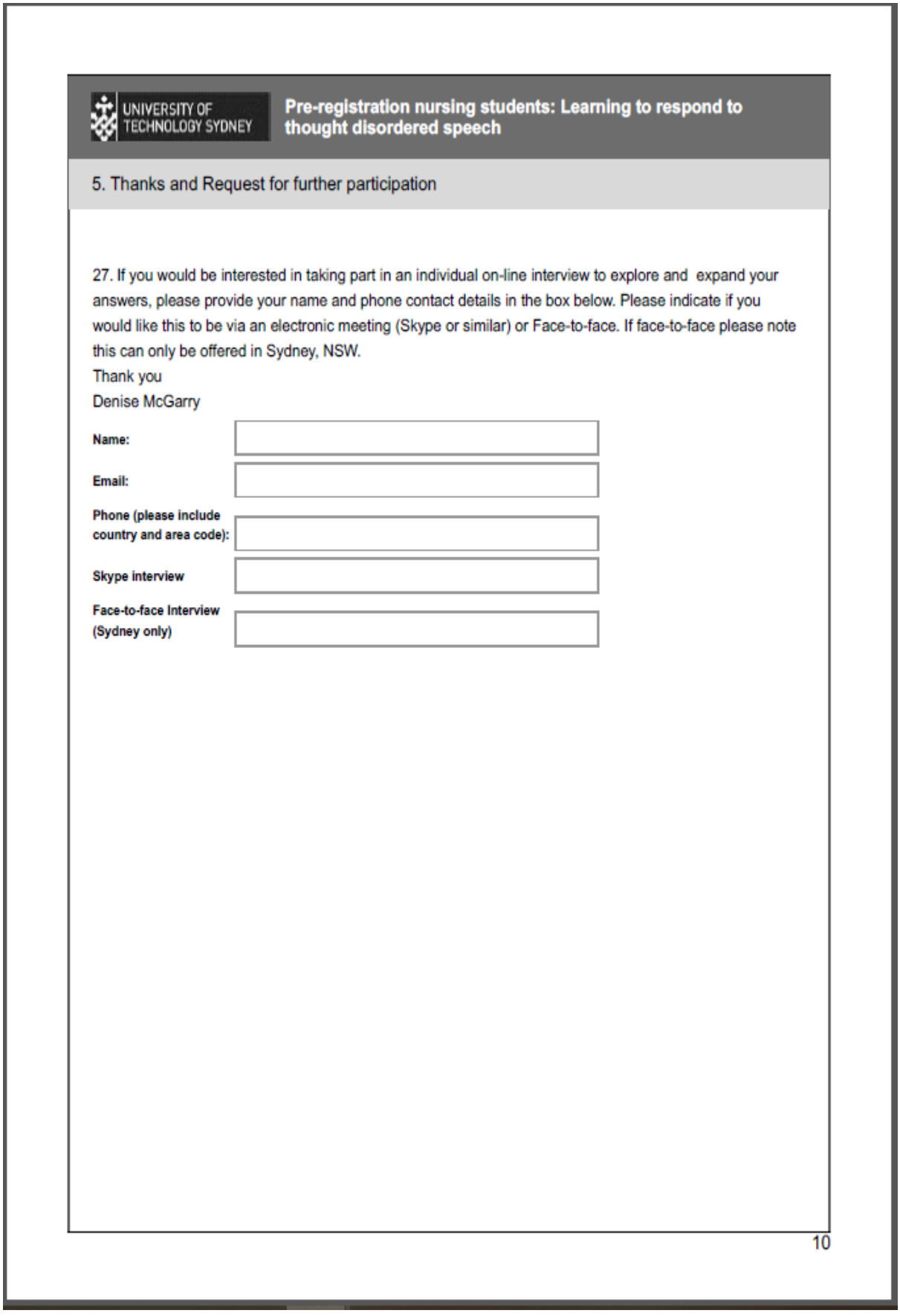
Appendix 12: Survey instrument



UNIVERSITY OF TECHNOLOGY SYDNEY

Pre-registration nursing students: Learning to respond to thought disordered speech

5. Thanks and Request for further participation

27. If you would be interested in taking part in an individual on-line interview to explore and expand your answers, please provide your name and phone contact details in the box below. Please indicate if you would like this to be via an electronic meeting (Skype or similar) or Face-to-face. If face-to-face please note this can only be offered in Sydney, NSW.

Thank you

Denise McGarry

Name:	
Email:	
Phone (please include country and area code):	
Skype interview	
Face-to-face Interview (Sydney only)	

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Appendix 13: Phase 1: Semi-structured interview guide first student recruitment

INTERVIEW GUIDE

Thank you for agreeing to participate in this study. Our purpose is to investigate the learning about thought-disordered speech in the pre-registration nursing curricula. This study has 4 objectives. To identify:-

1. The place allocated to the topic of thought-disordered speech in the curricula
2. Learning and Teaching approaches used to address the topic of thought-disordered speech
3. Methods of assessing & evaluating learning about thought-disordered speech
4. Suggested improvements for learning and teaching approaches in the area of thought-disordered speech.

My questions are designed to get a sense of how you learnt, what you found helpful, or less so and what you would like to see included in the future.

Firstly I would like you to provide me some details about yourself:

1. Are you a current pre-registration nursing student or recent graduate?
2. Have you completed an undergraduate mental health theory subject and clinical placement?
3. When did you complete your programme?
4. Are you employed – in what field?
5. Are you a consumer of mental health services, a carer or both?
6. What is the postcode of your home address if Australian, details of residence (state/province and country)?
7. How old are you?
8. What gender are you?

Your learning about thought-disordered speech

9. Can you tell me, in your own words, how you learned about thought-disordered speech??
10. What was effective in helping you to learn about thought-disordered speech??
11. Can you tell me, in your own words, how your knowledge was assessed?
12. What in your own words could improve your learning experience?
13. Is there anything else that you would like to add?

Thank you for participating, your opinion is valuable to us.

Appendix 14: Phase 1: Semi-structured interview guide 2nd student recruitment

INTERVIEW GUIDE

Thank you for agreeing to participate in this study. Our purpose is to investigate the learning about thought-disordered speech in the pre-registration nursing curricula. This study has 4 objectives. To identify:-

1. The place allocated to the topic of thought-disordered speech in the curricula
2. Learning and Teaching approaches used to address the topic of thought-disordered speech
3. Methods of assessing & evaluating learning about thought-disordered speech
4. Suggested improvements for learning and teaching approaches in the area of thought-disordered speech.

My questions are designed to get a sense of how you learnt, what you found helpful, or less so and what you would like to see included in the future.

Firstly I would like you to provide me some details about yourself:

1. Are you a current pre-registration nursing student?
2. Have you completed an undergraduate mental health theory subject and clinical placement?
3. Are you employed – in what field?
4. Are you a consumer of mental health services, a carer or both?
5. What is the postcode of your home address if Australian, details of residence (state/province and country)?
6. How old are you?
7. What gender are you?

This next part will look at your experience of learning about thought-disordered speech

8. Can you tell me, in your own words, how you learned about thought-disordered speech?
9. What was effective in helping you to learn about thought-disordered speech?
10. Can you tell me, in your own words, how your knowledge was assessed?
11. Can you tell me about your mental health clinical placement? Can you comment on its learning quality?
12. How does this (Mental health placement) compare with other clinical placements?
13. Were you encouraged by staff or your facilitator to talk with patients on the mental health placement?
14. Was this inpatient or community setting?

15. Were there any caveats about who you spoke with or suggestions regarding how to talk with particular people?
16. Did you witness or experience any challenging incidents during your placement – please describe. Why were they challenging?
17. Were you involved in de-briefing or discussion about the incident with other staff or your clinical facilitator?
18. What strategies did you use to manage your own feelings when concerned or distressed by a patient's communication style/ or confronting behaviour? Were these included in their lectures or preparation for clinical practice?
19. Was how to communicate with people who were different or appeared confronting in their communication style practiced or discussed in tour lectures or in simulation sessions?
20. What strategies did you use or find useful to support their learning during mental health placement or lectures?
21. During your clinical placement did you identify any staff you could use as role models of the behaviour to use when they were working with patients that were displaying different speech or behaviour that was not identified as 'normal'? What qualities did these role models display? (Empathy? Non-judgemental? Listening skills?)
22. During your clinical placement did you identify any person-centred approaches? Were you involved in planning interventions, identifying if interventions can be sustained when discharged etc
23. Were you involved with or introduced to people with lived experience of mental illness especially people with TDS– within the classroom setting as lived experience experts?
24. What in your own words could improve your learning experience? Is there something that that will demonstrate how learning about people with thought-disorders can be taught in a more appropriate way?
25. Is there anything else that you would like to add?

Thank you for participating, your opinion is valuable to us.

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- Chapter Three
- Chapter Three – Ethical Permissions

Appendix 15: Phase 2 Semi-structured interview guide mental health nursing academics

INTERVIEW GUIDE

Thank you for agreeing to participate in this study. Our purpose is to investigate the learning about thought-disordered speech in the pre-registration nursing curricula. This study has 4 objectives. To identify:-

1. The place allocated to the topic of thought-disordered speech in the curricula
2. Learning and Teaching approaches used to address the topic of thought-disordered speech
3. Methods of assessing & evaluating learning about thought-disordered speech
4. Suggested improvements for learning and teaching approaches in the area of thought-disordered speech.

My questions are designed to get a sense of how you taught and facilitated student learning, what you found helpful, or less so and what you would like to see included in the future.

Firstly I would like you to provide me some details about yourself:

1. Do you currently teach mental health nursing?
2. Is this an undergraduate mental health theory subject or clinical placement or other?
3. How long have you taught in this area?
4. What is your employment type?
5. Are you a consumer of mental health services, a carer or both?
6. Please describe your clinical experience in mental health nursing – recency, length, clinical type?
7. What are your educational qualifications?
8. What is the postcode of your home address if Australian, details of residence (state/province and country)?
9. How old are you?
10. What gender are you?

Your teaching about thought-disordered speech

11. Can you tell me, in your own words, how you teach about thought-disordered speech??
12. What seems effective in helping students to learn about thought-disordered speech??
13. Can you tell me, how student knowledge is assessed?
14. What could improve your teaching outcomes?

15. Is there anything else that you would like to add?

Thank you for participating, your opinion is valuable to us.

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Appendix 16: HREC Permission Phase 1

Dear Applicant

Thank you for your response to the Committee's comments for your project titled, "Pre-registration nursing students: Learning to respond to thought-disordered speech". Your response satisfactorily addresses the concerns and questions raised by the Committee who agreed that the application now meets the requirements of the NHMRC National Statement on Ethical Conduct in Human Research (2007). I am pleased to inform you that ethics approval is now granted.

Your approval number is UTS HREC REF NO. ETH16-0911.

Approval will be for a period of five (5) years from the date of this correspondence subject to the provision of annual reports.

Your approval number must be included in all participant material and advertisements. Any advertisements on the UTS Staff Connect without an approval number will be removed.

Please note that the ethical conduct of research is an on-going process. The National Statement on Ethical Conduct in Research Involving Humans requires us to obtain a report about the progress of the research, and in particular about any changes to the research which may have ethical implications. This report form must be completed at least annually from the date of approval, and at the end of the project (if it takes more than a year). The Ethics Secretariat will contact you when it is time to complete your first report.

I also refer you to the AVCC guidelines relating to the storage of data, which require that data be kept for a minimum of 5 years after publication of research. However, in NSW, longer retention requirements are required for research on human subjects with potential long-term effects, research with long-term environmental effects, or research considered of national or international significance, importance, or controversy. If the data from this research project falls into one of these categories, contact University Records for advice on long-term retention.

You should consider this your official letter of approval. If you require a hardcopy please contact Research.Ethics@uts.edu.au.

To access this application, please follow the URLs below:
* if accessing within the UTS network: https://rm.uts.edu.au
* if accessing outside of UTS network: https://vpn.uts.edu.au , and click on " RM6 – Production " after logging in.

We value your feedback on the online ethics process. If you would like to provide feedback please go to: http://surveys.uts.edu.au/surveys/onlineethics/index.cfm

If you have any queries about your ethics approval, or require any amendments to your research in the future, please do not hesitate to contact Research.Ethics@uts.edu.au.

Yours sincerely,

Associate Professor Beata Bajorek
Chairperson
UTS Human Research Ethics Committee
C/- Research & Innovation Office

University of Technology, Sydney
E: Research.Ethics@uts.edu.au

E11

Appendix 17: HREC Permission Phase 2

From: <Research.Ethics@uts.edu.au>
Date: 18 October 2017 at 10:49:51 am AEDT
To: <Denise.McGarry@uts.edu.au>, <Cathrine.Fowler@uts.edu.au>, <Research.Ethics@uts.edu.au>
Subject: HREC Approval Granted - ETH17-1780

Dear Applicant

UTS HREC REF NO. ETH17-1780

The UTS Human Research Ethics Expedited Review Committee reviewed your amendment application for your project titled, "Pre-registration nursing students: Learning to respond to thought-disordered speech", and agreed that the amendments meet the requirements of the NHMRC National Statement on Ethical Conduct In Human Research (2007). I am pleased to inform you that the Committee has approved your request to amend the protocol as follows:

"It is proposed to recruit academics who teach pre-registration mental health nursing to participate in semi-structured interviews. These interviews will explore their knowledge and experience of teaching pre-registration nursing students about responding to thought-disordered speech and their recommendations (if any) for any changes to current practice. These individual interviews of between 6-10 participants would compliment the findings from the survey of students already completed with insights from another group with interest in this learning.
The responses to these interviews will be transcribed and thematically analysed. These themes will provide information about the main ideas to support student learning about this required nursing practice skill."

You should consider this your official letter of approval. If you require a hardcopy please contact the Research Ethics Officer (Research.Ethics@uts.edu.au).

To access this application, please follow the URLs below:
* if accessing within the UTS network: https://rm.uts.edu.au
* if accessing outside of UTS network: https://vpn.uts.edu.au , and click on " RM6 – Production " after logging in.

We value your feedback on the online ethics process. If you would like to provide feedback please go to: http://surveys.uts.edu.au/surveys/onlineethics/index.cfm

If you wish to make any further changes to your research, please contact the Research Ethics Officer in the Research and Innovation Office, Ms Racheal Laugery on 02 9514 9772.

In the meantime I take this opportunity to wish you well with the remainder of your research.

Yours sincerely,

Associate Professor Beata Bajorek
Chairperson
UTS Human Research Ethics Committee
C/- Research & Innovation Office

University of Technology, Sydney
E: Research.Ethics@uts.edu.au
I:
https://staff.uts.edu.au/topichub/Pages/Researching/Research%20Ethics%20and%20Integrity/Human%20research%20ethics/human-research-ethics.aspx

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Appendix 18: Steps of thematic analysis

Braun & Clarke (2006)	Activity
1. Data familiarisation	I conducted all interviews. Following transcription of interviews, my supervisors and I read the transcriptions several times. I also collated the open field responses from the survey and my supervisors, and I read these several times.
2. Theme Generation	Eleven sample scripts were read with my academic supervisors. Each identified theme in the transcripts. These were discussed in depth for three of the scripts as related to the aims of the research project (Essentialist approach).
3. Theme collation	Following identification of these themes, they were able to be clustered by combining sub-themes into like groups. This process was performed independently for each qualitative data source: Open field survey responses, student participants and academic participants.
4. Defining themes	Each cluster was reviewed to clearly identify the themes
5. Naming themes	The name selected for the themes and sub-themes represents an interpretation of the data meaning which resulted in the following themes for the three data sets. Survey Open Field Themes: 1. 'It's a silo' 2. 'It is our responsibility' 3. 'Advocacy' Student Participant Themes: 1. 'Learning to respond to thought-disorder' 2. 'Clinical placements' Academic Participant Themes 1. 'The fight has been lost' 2. 'There are no guarantees' 3. 'It's a silo' 4. 'Sharing in transformation'
6. Reporting Themes	Findings are represented in this study

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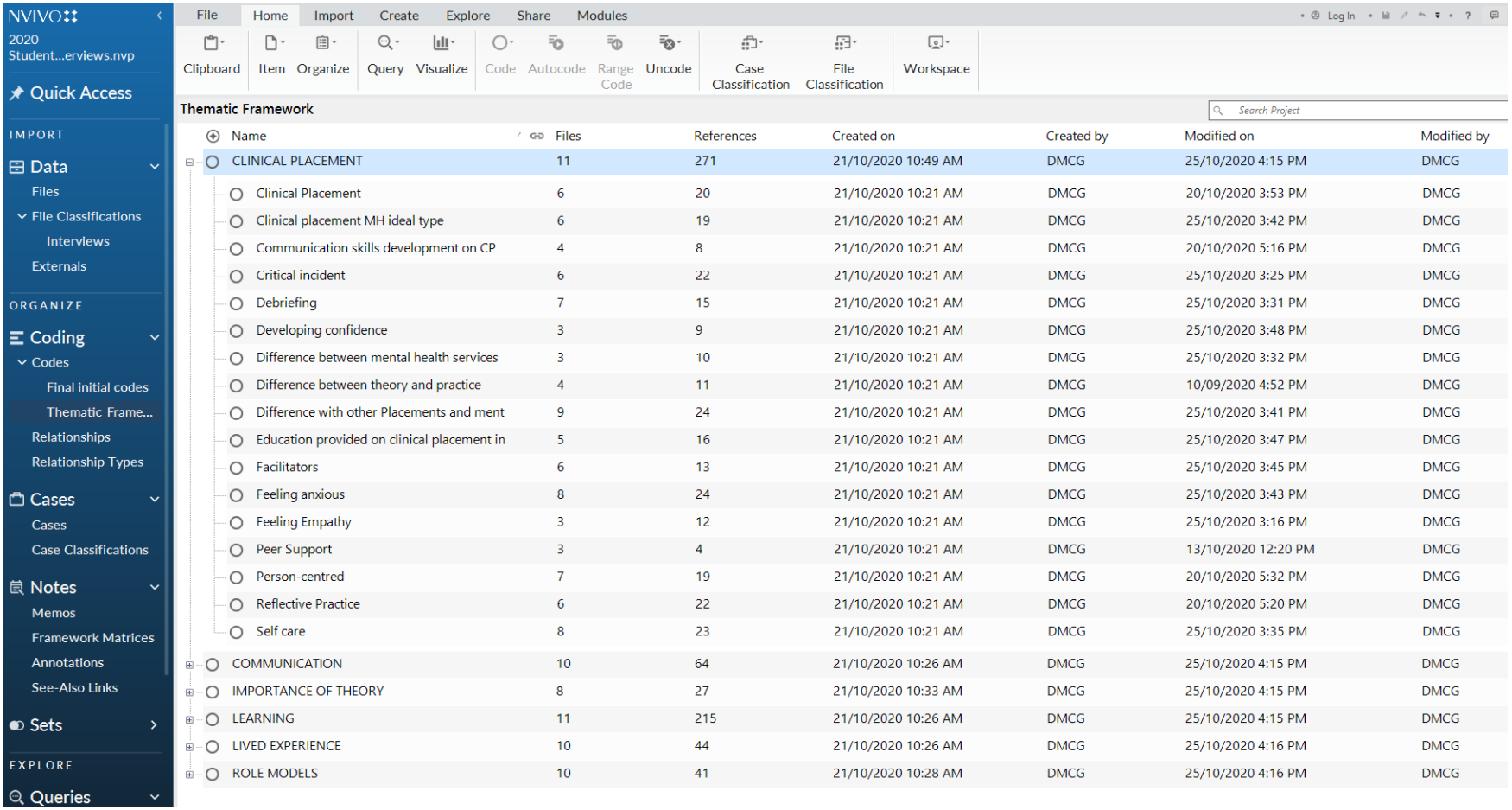
Appendix 19 Example of thematic analysis collating subthemes in student participant Interview (for theme: Clinical placement)



Name	Files	References	Created on	Created by	Modified on	Modified by
CLINICAL PLACEMENT	11	271	21/10/2020 10:49 AM	DMCG	25/10/2020 4:15 PM	DMCG
Clinical Placement	6	20	21/10/2020 10:21 AM	DMCG	20/10/2020 3:53 PM	DMCG
Clinical placement MH ideal type	6	19	21/10/2020 10:21 AM	DMCG	25/10/2020 3:42 PM	DMCG
Communication skills development on CP	4	8	21/10/2020 10:21 AM	DMCG	20/10/2020 5:16 PM	DMCG
Critical incident	6	22	21/10/2020 10:21 AM	DMCG	25/10/2020 3:25 PM	DMCG
Debriefing	7	15	21/10/2020 10:21 AM	DMCG	25/10/2020 3:31 PM	DMCG
Developing confidence	3	9	21/10/2020 10:21 AM	DMCG	25/10/2020 3:48 PM	DMCG
Difference between mental health services	3	10	21/10/2020 10:21 AM	DMCG	25/10/2020 3:32 PM	DMCG
Difference between theory and practice	4	11	21/10/2020 10:21 AM	DMCG	10/09/2020 4:52 PM	DMCG
Difference with other Placements and ment	9	24	21/10/2020 10:21 AM	DMCG	25/10/2020 3:41 PM	DMCG
Education provided on clinical placement in	5	16	21/10/2020 10:21 AM	DMCG	25/10/2020 3:47 PM	DMCG
Facilitators	6	13	21/10/2020 10:21 AM	DMCG	25/10/2020 3:45 PM	DMCG
Feeling anxious	8	24	21/10/2020 10:21 AM	DMCG	25/10/2020 3:43 PM	DMCG
Feeling Empathy	3	12	21/10/2020 10:21 AM	DMCG	25/10/2020 3:16 PM	DMCG
Peer Support	3	4	21/10/2020 10:21 AM	DMCG	13/10/2020 12:20 PM	DMCG
Person-centred	7	19	21/10/2020 10:21 AM	DMCG	20/10/2020 5:32 PM	DMCG
Reflective Practice	6	22	21/10/2020 10:21 AM	DMCG	20/10/2020 5:20 PM	DMCG
Self care	8	23	21/10/2020 10:21 AM	DMCG	25/10/2020 3:35 PM	DMCG
COMMUNICATION	10	64	21/10/2020 10:26 AM	DMCG	25/10/2020 4:15 PM	DMCG
IMPORTANCE OF THEORY	8	27	21/10/2020 10:33 AM	DMCG	25/10/2020 4:15 PM	DMCG
LEARNING	11	215	21/10/2020 10:26 AM	DMCG	25/10/2020 4:15 PM	DMCG
LIVED EXPERIENCE	10	44	21/10/2020 10:26 AM	DMCG	25/10/2020 4:16 PM	DMCG
ROLE MODELS	10	41	21/10/2020 10:28 AM	DMCG	25/10/2020 4:16 PM	DMCG

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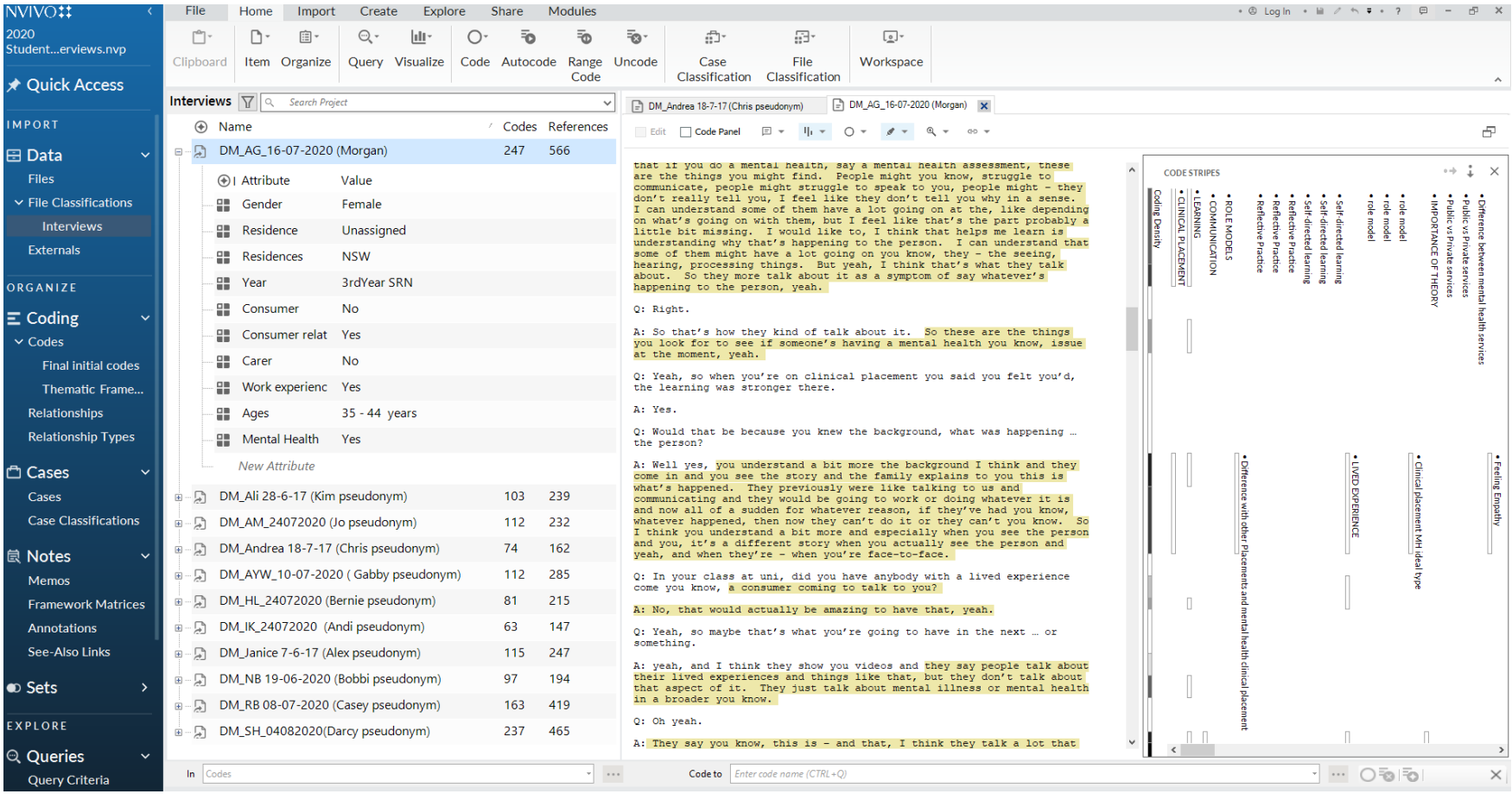
Appendix 20: Example of identifying themes from student transcript



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Appendix 21: Counts and experience of working with people experiencing thought-disorder for assessed variables with Pearson's chi-square test

	Total n (%)	Working n (%)	χ^2	p
Gender			0.8743	0.928
Female	97 (65.5)	65 (67.0)		
Male	9 (6.1)	6 (66.7%)		
Other	1 (0.7)	1 (100%)		
Missing	41 (27.7)	-		
Age			7.3726	0.497
18-24 years	44 (29.7)	29 (65.9%)		
25-34 years	29 (19.6)	21 (72.4%)		
35- 44 years	20 (13.5)	14 (70%)		
45-54 years	12 (8.1)	7 (58.3%)		
55-64 years	2 (1.4)	1 (50%)		
Missing	41 (27.7)			
Usual			3.2073	0.201
language	106 (43.2)	72 (67.9%)		
English	1 (0.7)	0		
Non-English	41 (27.7)			
Missing				
Language			2.0718	0.355
English only	64 (43.2)	44 (68.8%)		
Additional	26 (17.6)	16 (61.5%)		
Language				

	Total n (%)	Working n (%)	χ^2	p
Ethnicity			46.0947	0.000
Australian	29 (19.6)	24 (82.8%)		
British	39 (26.4)	28 (71.8%)		
New Zealander	8 (5.4)	2 (25%)		
Afro-Caribbean	1 (0.7)	0 (0)		
Indian	3 (2.0)	1 (33.3%)		
Subcontinent	4 (2.7)	3 (75%)		
European	2 (1.4)	1 (50%)		
African	2 (1.4)	0 (0)		
Chinese	1 (0.7)	0 (0)		
Russian	1 (0.7)	0 (0)		
Latin-American	58 (39)			
Missing				
Highest schooling			11.0894	0.351
High school	15 (10.3)	10 (66.7%)		
Tertiary	19 (12.9)	11 (57.9%)		
incomplete	5 (3.6)	1 (5%)		
Associate	52 (34.3)	38 (73.1%)		
degree	13 (8.9)	11 (84.6%)		
Bachelor degree	2 (1.5)	0 (0)		
Graduate	42 (28.5)			
degree				
Prefer not to				
answer				
Missing				
Current degree			3.8363	0.429
Undergraduate	93 (62.8)	63 (67.7%)		
Postgraduate	8 (5.4)	7 (87.5%)		
Unclear	1 (0.7)	0 (0)		
Missing	46 (31.1)			

Appendix 21: Counts and experience of working with people experiencing thought-disorder for assessed variables with Pearson's chi-square test

	Total n (%)	Working n (%)	χ^2	p
Study country			116.4187	0.000
Australia	54 (36.5)	41 (75.9%)		
UK	40 (27.0)	28 (70%)		
NZ	7 (4.7)	0 (0)		
Canada	1 (0.7)	0 (0)		
USA	2 (1.4)	2 (100%)		
Missing	44 (29.7)			
Study year			25.5957	0.012
First year u/g	15 (10.1)	11 (73.3%)		
Second year u/g	15 (10.1)	12 (80%)		
Third year u/g	50 (33.8)	28 (56%)		
Fifth year u/g	1 (0.7)	1 (100%)		
First year p/g	10 (6.8)	9 (90%)		
Second year p/g	5 (3.4)	3 (60%)		
Many years working	9 (6.1)	7 (77.8%)		
Missing	43 (29.1)			
Paid employment	85 (57.4)	68 (80%)	27.4783	0.000
Yes	21 (14.2)	4 (19%)		
No	42 (28.5)			
Missing				
Human or health services			45.5750	0.000
Yes	85 (57.4)	72 (84.7%)		
No	20 (13.5)	0 (0)		
Missing	43 (29.1)			

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Appendix 21: Counts and experience of working with people experiencing thought-disorder for assessed variables with Pearson's chi-square test

Appendix 22: Counts and experience of TDS as major learning objective for assessed variables with Pearson's chi-square test

	Total n (%)	Major learning objective n (%)	χ^2	p
Gender			6.7353	0.565
Female	97 (65.5)	19 (19.6%)		
Male	9 (6.1)	0 (0)		
Other	1 (0.7)	0 (0)		
Missing	41 (27.7)	1 (2.4%)		
Age			17.4502	0.133
18-24 years	44 (29.7)	6 (13.6%)		
25-34 years	29 (19.6)	6 (20.7%)		
35- 44 years	20 (13.5)	3 (15%)		
45-54 years	12 (8.1)	5 (41.7%)		
55-64 years	2 (1.4)			
Missing	41 (27.7)			
Usual language			2.6711	0.614
English	106 (43.2)	20 (18.9%)		
Non-English	1 (0.7)	0 (0)		
Missing	41 (27.7)			
Language			4.9550	0.292
English only	64 (43.2)	13 (20.3%)		
Additional language	26 (17.6)	2 (7.7%)		
Missing	58 (39.2)			

	Total n (%)	Major learning objective n (%)	χ^2	p
Ethnicity			20.6440	0.660
Australian	29 (19.6)	5 (17.2%)		
British	39 (26.4)	8 (20.5%)		
New Zealander	8 (5.4)	2 (25%)		
Afro-Caribbean	1 (0.7)	0 (0)		
Indian	3 (2.0)	0 (0)		
Subcontinent	4 (2.7)	1 (25%)		
European	2 (1.4)	1 (50%)		
African	2 (1.4)			
Chinese	1 (0.7)			
Russian	58 (39.2)			
Missing				
Highest			24.6083	0.217
schooling	15 (10.3)	1 (6.7%)		
High school	19 (12.9)	4 (21.1%)		
Tertiary	5 (3.6)	0 (0)		
incomplete	52 (34.3)	12 (23.1%)		
Associate	13 (8.9)	3 (23.1%)		
degree	2 (1.5)	0 (0)		
Bachelor degree	42 (28.5)			
Graduate				
degree				
Prefer not to				
answer				
Missing				
Current degree			2.2960	0.681
Undergraduate	93 (62.8)	18 (19.4%)		
Postgraduate	8 (5.4)	2 (25%)		
Unclear	1 (0.7)			
Missing	46 (31.1)			

Appendix 22: Counts and experience of TDS as major learning objective for assessed variables with Pearson's chi-square test

	Total n (%)	Major learning objective n (%)	χ^2	p
Study country			14.7832	0.541
Australia	54 (36.5)	9 (16.7%)		
UK	40 (27.0)	9 (22.5%)		
NZ	7 (4.7)	1 (14.3%)		
Canada	1 (0.7)	0 (0)		
USA	2 (1.4)	0 (0)		
Missing	44 (29.7)			
Study year			32.3569	0.118
First year u/g	15 (10.1)	1 (6.7%)		
Second year u/g	15 (10.1)	4 (26.7%)		
Third year u/g	50 (33.8)	8 (16%)		
First year p/g	10 (6.8)	1 (10%)		
Second year p/g	5 (3.4)	0 (0)		
Many years working	9 (6.1)	4 (44.4%)		
Fifth year u/g				
Missing	1 (0.7)	1 (100%)		
	52 (35.13)			
Paid employment			7.4002	0.116
	85 (57.4)	16 (18.8%)		
Yes	21 (14.2)	4 (19%)		
No	42 (28.5)			
Missing				
Human or health services			4.5714	0.334
Yes	85 (57.4)	18 (21.2%)		
No	20 (13.5)	2 (10%)		
Missing	43 (29.1)			

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Appendix 22: Counts and experience of TDS as major learning objective for assessed variables with Pearson's chi-square test

Appendix 23: Conference presentations related to and arising from research study

Hansen, AC, **McGarry, DE**, Johnson, A & Roche, M: "Students' Cultural Beliefs towards Mental Health: Implications for Learning and Teaching", Conference Paper, Nursing Education Research Conference 2018 (NERC18) NLN/STTI, Washington, DC, USA: 19-21 April 2018.

McGarry, DE, Green, JA & Fowler, CM: "Snowballing Facebook© : A novel way to recruit millennial nursing student research participants", Conference Paper, Nursing Education Research Conference 2018 (NERC18) NLN/STTI, Washington, DC,USA: 19-21 April 2018.

Anderson, JA; Kent, K & **McGarry, DE**: "Whose story is it? The relation between the Lived Experience of Carers and of Consumers" Conference Poster 42nd International Conference ACMHN Adelaide, South Australia: 25-27 October 2016.

Anderson, JA; Kent, K & **McGarry, DE**: "Perceptions of sharing the lived experience by people with mental health issues and their families" Conference Paper TheMHS 2016: "People: Authenticity starts in the heart" Conference, Auckland, New Zealand: 23-26 August 2016.

Anderson, JA; Kent, K & **McGarry, DE**: "Encountering the lived experience of mental health: undergraduate nursing/paramedic student responses" Peer-reviewed Conference Paper National Rural Health Conference 'People, Places, Possibilities', Darwin, NT, Australia: 24-27 May 2015.

Anderson, JA; Croxon, L & **McGarry, DE**: "The conceptual framework of the BN curriculum: Identifying student knowledge and perception of what is valuable to professional practice" Conference Paper CSUed2014: "Imagineering the future CSU Graduate" Conference, Albury, NSW Australia: 19-20 November 2014

McGarry, DE, Cashin, A & Fowler, C; "Practice Theory and Situated Learning: How could future educational approaches to mental health nursing preparation be informed?**"** Conference Paper 40th International Conference ACMHN Melbourne: October 2014.

McGarry, DE, Cashin, A & Fowler, C; "We need to talk about clinical" Conference Poster 39th International Conference ACMHN Perth: October 2013.

McGarry, DE, Cashin, A & Fowler, C: Is high fidelity human patient simulation: simulation of learning? Conference Paper NET2013 Conference, Cambridge University, United Kingdom: September 2013.

Fiona Orr, Michelle Kelly, Jane Stein-Parbury, Haidee White & **Denise McGarry** "'It was real': Use of actors in simulation to learn therapeutic communication" Conference Paper, Society in Europe for Simulation Applied to Medicine (SESAM), Stavanger, Norway 14-16 June 2012.

Fiona Orr, Michelle Kelly, Jane Stein-Parbury, Haidee White & **Denise McGarry** "'It was real': Use of actors in simulation to learn therapeutic communication" Conference Poster 4th International Nurse Education Conference (NET/NEP) Baltimore, Maryland, USA 17-20 June 2012.

Cashin, A, Fowler, C & **McGarry, D** “Marketing Mental Health Nursing on Australian Schools of Nursing Websites - Is Mental Health Nursing positioned 'Between the Flags?'”, Conference Paper 37th International Conference ACMHN Gold Coast October 2011.

Juelyn Ireland, & **Denise McGarry**. “Are Mental Health Drug & Alcohol Clinical Placements Still Transformative in 2010?” Conference Poster, 2nd Annual Nursing & Midwifery Clinical Innovations Conference, Northern Sydney and Central Coast Local Health Districts, Gosford, May 2011.

Denise McGarry & Dr Beverley Pegg. ‘The Past is another country…An Oral History of work in a psychiatric hospital in the 1960s and 1970s” Invited Paper, 7th Annual Conference GWS Branch ACMHN, Parramatta, March 2011.

Zara Habibzadeh, Juelyn Ireland, **Denise McGarry**, & Sandra O’Neil, Ten year retrospective analysis of nursing students’ evaluations of clinical placements in a psychiatric hospital., Conference Poster, 36th International Conference ACMHN, Hobart, September 2010.

Denise McGarry & Beverley Pegg. 'Those who cannot remember the past are condemned to repeat it' Santayana, George (1905) Conference Paper, 36th International Conference ACMHN, Hobart, September 2010.

Denise McGarry: ‘Collaboration and Adaption – How to maintain integrity. How to reap the benefits of a replication study’. Presentation to Professor Chris Tanner Research Forum, Faculty of Nursing Midwifery & Health, UTS , April 2010.

Marco Chan, Jan Plain, Mehmet Kasif, Anne Storey, **Denise McGarry** Managing risks of choking in a long stay psychiatric hospital - a multi-disciplinary approach. Conference Poster, Occupational Therapy Conference, 23 February 2010.

Harrison, E , Jeffrey, K, Kasif, M, McGarry, D, Mobbs, L, & Plain, J, Identifying and managing risks of dysphagia in a long stay psychiatric hospital Conference Paper 35th International Conference ACMHN Sydney October 2009.

Leigh Boivin, Stella Chung , Maree McDonald , **Denise McGarry**, Liz Newton Incontinence experienced by mentally ill clients in a large residential long term facility. Conference Paper 35th International Conference ACMHN Sydney October 2009.

Andrew Cashin, Kim Foster, Elizabeth Martin, **Denise McGarry,** & Claire Newman, Building Video Conferencing Communities of Professional Practice: Extending the exploration of success Conference Paper 35th International Conference ACMHN Sydney October 2009.

Cashin, A, Fowler, C & **McGarry, D** Can caring be simulated? An examination of the literature related to application of high fidelity simulation to mental health nursing preparation Conference Paper 35th International Conference ACMHN Sydney October 2009.

Tracy Davidson & **Denise McGarry** How would you feel wearing these labels? Conference Poster 35th International Conference ACMHN Sydney October 2009.

McGarry, D, Therapeutic Moments: Can Simulation Teaching Methods Capture this Art? Conference Paper 15th Annual Hunter Branch ACMHN Mental Health Conference Newcastle: April 2009.

Appendix 24: Publications related to and arising from research study

McGarry, D.E., Cashin, A. & Fowler, C. 2011, '"Coming ready or not" high fidelity human patient simulation in child and adolescent psychiatric nursing education: Diffusion of Innovation. ', *Nurse Education Today*, vol. 31, no. 7, pp. 655-9.

McGarry, D.E., Cashin, A. & Fowler, C. 2012, 'Child and adolescent psychiatric nursing and the 'plastic man': reflections on the implementation of change drawing insights from Lewin's theory of planned change.', *Contemporary Nurse*, vol. 41, no. 2, pp. 263-70.

McGarry, D.E., Cashin, A. & Fowler, C. 2014, 'Is High Fidelity Human Patient (Mannequin) Simulation, Simulation of Learning?', *Nurse Education Today*, vol. 34 pp. 1138-42.

McGarry, D.E., Cashin, A. & Fowler, C. 2014, 'Survey of Australian Schools of Nursing Use of Human Patient (Mannequin) Simulation', *Issues in Mental Health Nursing*, vol. 35, no. 11, pp. 815-23.