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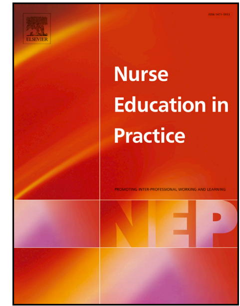

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UNDERSTANDING THE IMPACT OF MENTAL HEALTH PLACEMENTS ON STUDENT NURSES' ATTITUDES TOWARDS MENTAL ILLNESS

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Understanding the impact of mental health placements on student nurses' and attitudes towards mental illness

Abstract

Student nurses maintain unfavorable views of people with mental health issues. Many continue to perpetuate common stereotypes, are fearful and believe people with mental health problems are in some way dangerous. The impact of placements greatly affects these views. A pre-post survey of 85 student nurses was conducted to establish the opinions and attitudes of student nurses regarding mental health. Groups were allocated to either community or hospital placements. Each group received the same educational preparation prior to placement. Both community and hospital placed students had improved clinical confidence when working with people experiencing mental health problems. Community placed students demonstrated greater positive attitudes towards people experiencing mental health issues across a number of domains. Students in hospital settings demonstrated more confidence when working with people with mental health issues yet had less attitudinal change about mental health. The approach taken by clinical facilitators also influenced student attitudes. It is suggested that offering community opportunities along with exposure to positive instructor beliefs about mental illness will both improve student attitudes prior to the completion of their nursing studies and may encourage entry into mental health as a nursing option post-education.

1. Introduction

Newly qualified nurses continue to choose areas of nursing other than mental health. The reasons given vary from negative stereotyping (Happell et al., 2014; Linden and Kavanagh, 2012; Stevens et al., 2013; Stuhlmiller, 2005a) or believing a consolidation period in medical and surgical nursing is necessary (Nadler–Moodie and Loucks 2011), to having little

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encouragement while completing their tertiary degrees to consider mental health as a reasonable option (Auerbach et al., 2011).

Stigma and discrimination remain a serious problem for people experiencing mental health problems (Link and Stuart, 2017; Stuart, 2016). Corrigan (2000) has argued that there is a link between discriminatory cues such as labeling and symptoms that may lead people to act negatively towards people with mental health problems. These actions are considered stigmatizing to the individual and if not adequately addressed in health professional education such as nursing, can lead to poor outcomes and lower take-up of mental health practice (de Jacq et al., 2016).

Student nurses, naturally, bring with them a set of pre-conceived attitudes and beliefs about mental health prior to embarking on their mental health placements. These beliefs may be unfavorable toward people experiencing mental health problems (Barrett and Jackson, 2013). Such views include: perpetuating stigma, negative stereotyping, fear, and that people with mental health issues are dangerous (Hunter et al., 2015). Having a personal experience of mental illness through family or friends offers more accepting views by student nurses (Alexander and Link, 2003). Within their education as nurses, and in particular their clinical preparedness for working with people experiencing mental health problems, educators need to modify the link between discriminatory cues held, and the stereotypes they may develop of people with mental health problems. In doing so, the student nurse will be better able to avoid falling into stigmatizing behaviors. Three key stereotyping attitudes have been identified and are authoritarianism, benevolence and social restrictiveness (Cohen and Struening, 1962; Dear et al., 1980)

Authoritarianism refers to a person with mental health problems being viewed as inferior to others or requiring constant supervision. Benevolence is paternalistic related to humanistic and sympathetic view of people experiencing mental health problems. Social restrictiveness

is specific to the attitude that people with mental health problems are somehow dangerous or a threat to society and therefore need to be avoided (Bedaso et al., 2016; Cohen and Struening, 1962; Granello and Gibbs, 2016).

Attempts to tackle these pejorative attitudes held by students have included: 1. length of exposure in didactic and clinical mental health practice, 2. pre-clinical preparation, 3. placement settings, and 4. clinical facilitator/educator support and, to a lesser extent, their beliefs and attitudes.

2. Background

2.1 Length of exposure

A literature review found students who had received more hours of theoretical preparation in mental health nursing and undertaken longer clinical placements had more favourable attitudes towards mental health (Happell and Gaskin 2013). While baccalaureate leading nursing schools in the UK and European Union have a two year specialty focus of mental health nursing with 2,400 supervised practice hours within a three year program (Nursing & Midwifery Council, 2010; World Health Organization, 2009), students in Australia, Canada and the United States for example, may only receive one course or a few lectures/learning modules in an integrated curriculum with little or no practice hours over the course of a three year Australian or four year North American programs (Happell et al., 2015). Mental Health Nursing is thus considered a specialty to be pursued in post graduate education (Robinson and Griffiths, 2007). Although a comparison study of UK, US, and Australian nursing student attitudes toward mental health has not been undertaken, unsurprisingly undergraduate student nurses from USA often feel they are lacking the educational background or basic skills needed to work with people with mental health problems (Thongpriwan et al., 2015). Schools' of nursing, in trying to address this problem, are introducing alternative methods of clinical preparedness education for their students in mental health practice. Such educational

practices are largely designed to alter the stereotypes, seen as a significant step towards the student feeling better prepared and less anxious of people with mental health problems.

2.2 Pre-clinical education

A range of didactic, non-traditional, and experiential approaches have been used to prepare students for mental health clinical. Traditionally role play and simulation has been used to help student nurses in their clinical understanding of people experiencing mental health problems. The benefits of role play in preparing students for their clinical placement has been demonstrated and includes increased confidence and improved communication skills (Curtis, 2007; Lewis et al., 2012). However, criticisms have accompanied the use of role play including students not viewing it as realistic, academics embracing it at different levels, and poor translation into actual practice (Northcott, 2002).

In order to enhance the effects of role play, many nursing schools have included standardized patients as simulation (Brown, 2008). Simulation, either solely as a mental health exercise, or within a broader physical care context provides opportunities for students to consider how they may respond in situations where they are confronted with the issues people face with mental health problems. The use of standardized patients with simulation has been found to be an effective method of educating student nurses in mental health (Alexander and Link, 2003; Doolen et al., 2014; Webster, 2014). Simulation has also been shown to reduce anxiety in student nurses regarding working with people who have mental health problems (Brown, 2015; Lehr and Kaplan, 2013; Szpak and Kameg, 2013) and better prepares students for practice especially in communication and clinical understanding (Brown, 2015; Kirkbakk-Fjær et al., 2015). In some programs this approach to clinical education has been used to replace formal placements in mental health settings. While students report improvements in their communication and clinical reasoning, this was never tested in a clinical setting (Rossetti et al., 2013). The overall benefits of role play over simulation or vice versa have not

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been shown, with both approaches demonstrating positive attitudes, increased confidence and better communication skills in students (Alfes, 2015; Fossen and Stoeckel, 2016).

The addition of media with role-play and simulation has also be shown to be effective. One study noted class discussions of examples of mental health in movies along with an opportunity for self-reflection, significantly reduced the student nurses' anxiety (Ganzer and Zauderer, 2013). Three dimensional computer software such as Second Life have been extensively used to educate student nurses with mixed results (Ghanbarzadeh et al., 2014; Kidd et al., 2012). A systematic review of Second Life in undergraduate education demonstrated that although participation promotes student engagement and positive learning outcomes, further research is needed to validate learning effectiveness (Irwin and Coutts 2015). Common problems associated with such methods remain the quality of the technology and the level of reality experienced by students. Current advances in three dimensional goggles may help improve such experiences further (Ott and Laura, 2015)(Ott and Laura, 2015). Despite this, Linden Labs (2013) creator of Second Life, reports more than 35 million people have registered as members since its launch in 2003, and approximately 1 million people actively use it every month including health professionals and nursing students (Benham-Hutchins and Lall 2015).

Formalized drama has been used to enhance role-play and simulation (Wasylko and Stickley, 2003). However, without experiencing a person with mental health issues, the student nurse may not adequately address their potential negative stereotypes.

Other approaches to mental health clinical education include co-production with people experiencing mental health problems. These approaches often encourage the student nurse to work with the person outside of the traditional clinical setting. Several programs have provided immersive camps in which student nurses, their educators and consumers of mental health services all come together and participate in a common set of activities (Cowley et al.,

2016; Moxham et al., 2016; Mullen and Murray, 2002; Patterson, Moxham et al. 2017; Stuhlmiller, 2003, 2005b). In most all cases, the attendance at an immersive camp significantly improved student nurses' clinical confidence and reduce stigma and fear (Cowley et al., 2016; Stuhlmiller, 2005b). The use of consumers at all levels of mental health education have begun to show promise (Byrne et al., 2014; Forrest et al., 2000; Schneebeli et al., 2010). Learning with and alongside people with mental health problems provides more direct challenging of negative stereotypes.

2.3 Placement settings

Outcomes of student learning in mental health placements continue to have mixed reviews (Happell et al., 2015). Student nurses gain more positive outcomes and attitudes while in community settings compared with traditional hospital settings (McAllister, 2007; Perese, 1996). Feeney and colleagues (2013) found that students in recovery-focussed community placements developed more positive attitudes towards people with mental illness. However, it is claimed that placements in hospitals enable students to acquire important skills in the areas of communication and de-escalation (Henderson et al., 2007). There is further evidence to suggest there are no learning differences linked to clinical sites (Bjørk et al., 2014; Ross et al., 2013). In an attempt to address the shortage of clinical placements, there is evidence of faculty (Clifton and Roberts, 2016) and student-led clinics (Dieckmann et al., 2013; Lloyd et al., 2015; Stuhlmiller and Tolchard, 2015) which enhance mental health placement outcomes.

2.4 Instructor support and attitudes

The degree and level of support received while on clinical placement is important. A sound level of clinician mentorship and supervision with direct support from the Academe have been shown to enhance the student experience (Papastavrou et al., 2016; Reid et al., 2013). Several models of faculty interaction with students have been utilized from traditional faculty

attending clinical placement with students, specific clinical faculty, experts in an area, providing on-site support (Reid et al., 2013) and virtual in-practice support (Hardy et al., 2016). It has also been suggested such mentorship should be with a person who is experiencing mental health problems (Fokuo et al., 2016; Speers and Lathlean, 2015; Turnbull and Weeley, 2013) or in the form of peer-mentorship among students themselves (Terry et al., 2016).

The beliefs held by clinical instructors also have a powerful influence over student views and attitudes (Baldwin et al., 2014; Brown et al., 2012; de Swardt et al., 2017; Gibbs and Kulig, 2017. Students internalize the values and norms that they are exposed to (Burbank et al., 2006; Cozort, 2008; Holroyd et al., 2009; Sheffler, 1998. Educator beliefs and attitudes are therefore an important factor for consideration.

This study is an offshoot of a larger project that evaluated student pre-clinical learning outcomes from participating in a mental health nursing education camp with consumers (Stuhlmiller, 2003, 2005). The study reported here aimed to specifically evaluate changes of opinions of mental illness in nursing students placed after the education camp in either a community or hospital mental health setting using standardized measures. While students in community settings had more positive attitudes toward mental illness, discovered was the additive influence of the instructor's attitude toward mental illness conveyed to the students. With the ongoing challenge to find quality learning environments that support the development of positive attitudes towards mental illness among students, understanding more about strengths and shortcomings of specific settings and educators can better inform and craft student experiences.

3. A pre-post evaluation

Students about to embark on their undergraduate mental health placement were chosen to participate in this pre-post evaluative project.

3.1. Ethical considerations

University ethics approval was obtained to gather data on all nursing students enrolled in the required BSN undergraduate mental health nursing course of a four year nursing program in the United States. All students were exposed to the same classroom instruction on mental health nursing and camp? Students were randomly assigned to a hospital (n =40) or community (n=45) mental health placement.

3.2. Educational preparation

All nursing students received didactic teaching in their coursework, followed by an immersive education focused mental health camp. The camp consisted two days of working with a group of consumers from the local mental health service with educators from the university. The program included trust and confidence building exercises as well as socialization through joint preparation of meals and leisure activities. Following the camp, students then attended either a community or hospital based 15 week mental health placement, supported by an onsite faculty clinical instructor as well as clinicians working at each setting.

3.3. Questionnaires

Students completed pre and post measures using the *Mental Health Nursing Clinical Confidence Scale* (MHNCCS) (Bell et al., 1998) - which is a recognized tool with well-established validity - and *Opinions about Mental Illness Scale* (OMI) (Cohen and Struening, 1962; Hampton and Sharp, 2014; Pankhurst, 2009; Rabkin, 1972) - which continues to be the most widely used scale to determine specific attitudinal changes following exposure to people with a mental illness (Evans-Lacko et al., 2013; O'Connell and Stein, 2011). The scale has been translated to other languages (Kopera et al., 2015; Mora-Rios et al., 2013). The MHNCCS is a 20-question Likert scale which asks specific questions pertaining to confidence on a range of skills such communication, teamwork, assessment, medications and handling verbal and physical aggression. The OMI scale includes 51 questions to draw out

opinions related to five factors. The first factor is A: authoritarianism, which represents opinions of the mentally ill as a class of people inferior to other individuals. The second factor is B: benevolence, which represents attitudes that are encouraging to mentally ill persons. The next factor is C: mental hygiene ideology, which represents a professional view of treatment and mental illness being seen as an illness like any other. The fourth factor is D: social restrictiveness, which sees the mentally ill as a danger to society, and suggests mentally ill clients should be restricted both during and after hospitalization. The final factor is E: interpersonal etiology, which represents the belief that mental illness results from bad interpersonal experiences such as the lack of parental love and attention.

3.4. Data analysis

SPSS (Version 24) was used to conduct within group paired sample t tests (*t*) and between group one-way ANOVA s (*F*) with list wise deletion. Statistical significance at the 95 percent confidence level was established with a *p* value of <0.05. In order to manage some missing data, multiple imputation was used to provide greater power to the data analysis. Where multiple imputed data is being reported, numbers will appear larger than the population size.

4. Findings

On pre-testing there were no within or between group differences on the MHNCCS and OMI. On post placement, not surprisingly both hospital and community students had higher levels of confidence on the MHNCCS (hospital: $t(30) = 10.28$, $p < .001$; community: $t(35) = 9.38$, $p < .001$).

No significant differences were found on the OMI pre and post placement within hospital students. However, community students reported significant within group differences in three of the five OMI factors on paired sample t-tests. They were factor A: authoritarianism ($t(35) = 2.83$, $p < .01$), factor B: benevolence ($t(35) = 2.39$, $p < .05$), and factor D: social

restrictiveness ($t(35) = 3.91$, $p < .001$). These were for three substantive negative stereotyping factors discussed.

On closer examination, while students in both hospital and community did not show significant change in Factor C (ideology), based on a bootstrap paired sample t-test of individual items within this factor, community students perceived people with a mental illness to be more competent than hospital students. While both sets of students reduced their negative opinions regarding dangerousness (item 8), community students were more aware of the ability of people with a mental illness to work (item 13: $t(38) = 2.92$, $p < .05$) and also the need to provide higher privacy to ensure a level of dignity is maintained (item 33: $t(38) = -2.8$, $p < .01$). Conversely, compared to their community counterparts, hospital students reported that better education and training of all staff would significantly improve the outcomes of clients (item 23: $t(39) = 3.09$, $p < .01$).

Between group differences on a one-way ANOVA with the OMI revealed significance for factor B: benevolence ($F(1, 87) = 6.48$, $p < .05$) and factor D: social restrictiveness ($F(1, 87) = 4.10$, $p < .05$) for community students. These findings confirm the differences found in the t tests. However, the significant differences for authoritarianism were not present.

A separate analysis of OMI using a repeat measures general linear model revealed some information to consider with caution. This analysis uses all five OMI subscales. There was a significant link between instructors and student post-OMIs (as determined by Wilks' Lambda = .68, $F(12, 177.56) = 2.35$, $p < .05$). Instructors known for their liberal views and flexible approaches to clinical education yielded students with significantly improved opinions about people suffering from mental illness, while instructors who facilitated learning in a more cautious and structured style yielded students with little change to their opinions pre and post clinical experience. However, the Mauchly's test of sphericity ($W = .32$, $\chi^2(9) = 77.18$, $p < .001$) was less than the normal distribution of .05, so sphericity was violated. Similarly, there

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were no differences between placement type at pre-OMI, however there was a significant difference post-OMI with community settings showing greater improvement in student scores (Wilks' Lambda = .81, $F(4, 69) = 4.10$, $p < .01$). Again, the Mauchly's test of sphericity (W = .32, $\chi^2(9) = 79.81$, $p < .001$) was less than the normal distribution of .05, so sphericity was violated. These potential connections warrant further study.

5. Discussion

This study aimed to understand more about the impact of mental health placements on student nurses' clinical confidence and attitudes towards mental illness. The literature points to factors of length of student exposure to a mental health setting, preclinical preparation, placement setting types, and instructor influences. While our study did not compare mental health exposure length or pre-clinical preparation, our findings support what others have found pertaining to placement settings. In addition, this study reveals the additive factor of instructor views when combined with the placement setting, influence student attitudes.
Each student in this study was prepared in the same way with a combination of didactic knowledge attainment and immersive educational camp experience. Therefore, the only differences were in which setting they attended clinical placement and the views and pedagogical approach of the facilitator. Using the MHNCCS, students had improved confidence post placement regardless of where they went and whom their facilitator was. This reflects the commonly reported finding regarding student confidence after placement in most clinical settings and supports the established validity of the MHNCCS.
Changing negative stereotypes among student nurses regarding people's experiences of mental health is essential if they are to have positive placement outcomes and provide the best possible care. This study confirms the usefulness of the OMI scale in providing valuable information about the specific areas of attitudinal change that occurred and under what educational circumstances. Three dominant attitudes were identified as students' level of

authoritarianism, benevolence, and social restrictiveness towards people with mental health problems. Students attending a community setting had significant changes in their views toward authoritarianism, benevolence, and social restrictiveness. These changes were both significant with and between groups at post-OMI. This makes sense because they are working with individuals who are less unwell and living within the broader social context. As (Schrank and Slade 2007) claim, community treatment is more recovery oriented and focuses on fulfilling meaningful life, promoting a positive sense of identity, and having control over one's life. Thus community based students have more quality time communicating and interacting with people attending the service. However, the degree to which hospital students can achieve similar changes in attitude appears limited. Hospital settings tend to focus on symptom relief, medication, and stabilization (Torgalsbøen 1999; Wykes, Csipke et al. 2018). So persons confined to hospital are generally acutely or severely ill and thus require more direction and greater restrictive measures to ensure safety and comfort (Stuhlmiller, 2005). While community students showed a difference over time in Authoritarianism while hospital students did not, there was no difference between both groups post-OMI. This may indicate any exposure to working with people experiencing mental health issues will bring about attitudinal change in this domain. However, the responses of students being mentored by more traditional facilitators was clearly a factor of the facilitator, not the setting. There were fewer positive attitudinal changes with the more traditionalist facilitators. This was further supported by hospital based students whom also believed the regular clinical nurses were not best placed to offer them or the clients a full experience.

The question as to whether students respond better to community placements over traditional hospital settings and develop positive attitudinal changes depending on the beliefs and attitudes of their clinical instructor have provided some new insights.

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If indeed the instructors' opinions are taken up by students, it might be provocative but useful to administer the OMI to potential facilitators to test out and determine their potential impact. It may be that the factor of faculty opinions and attitudes exerts more influence than previously realized. When determining mental health curricula including pre-clinical and clinical education, it may be more important to consider who is delivering the materials and guiding the learning over the actual content.

6. Conclusion

While this study does offer some compelling support for student nurses gaining experience of mental health in community settings, we recommend that further research is needed in this area. Similarly, identifying and working to a common pedagogical approach with consideration for instructor views would appear to be relevant in terms of attitudinal change achieved by students. For this study, it would have also been useful to tease out the effect of the pre-clinical preparation of the camp. While our previous pre and post study of the camp indicated significantly reduced student anxiety and stigma, what remains unknown is if the camp had an additional effect in student confidence or mental health attitudes.

This study would also have benefitted from consumer feedback both from clinicians in the field and the people with whom the students came into contact while on placement. While the student may have perceived themselves as having changed their attitudes this may or may not be confirmed, especially by people with mental health problems. Finally, the results of this study need to be considered within the context of the limitations relating to the relatively small sample size and the use of convenience sampling.

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Highlights:

Clinical placements in mental health nursing impact students' attitudes toward mental illness.
Community placed students demonstrate greater positive attitudes towards mental illness.
Clinical facilitator views about mental illness impact on student attitudes.

Key words: mental illness, attitudes, clinical placements, nursing students

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