EXPLORING PERCEPTIONS OF THE ABILITY OF STUDENT NURSES TO ACHIEVE LEARNING OUTCOMES IN COMMUNITY-BASED PSYCHIATRIC MENTAL HEALTH CLINICAL SETTINGS

BY

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Submitted to the graduate degree program in Nursing
and the Graduate Faculty of the University of Kansas
in partial fulfillment of the requirements for the degree of
Doctor of Philosophy

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Date Defended: May 30, 2012

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ABSTRACT

The purpose of this qualitative descriptive study was to investigate how traditional undergraduate baccalaureate (BSN) student nurses and their faculty perceive students' ability to achieve learning outcomes in community-based psychiatric mental health (PMH) clinical settings. Studies have shown that 25% of American adults experience a diagnosable PMH problem each year, and that acute care medical-surgical nurses carry an average patient load of five to six persons. Traditionally, PMH clinical experiences occurred on inpatient units located in acute care hospitals or within psychiatric hospital settings. However, many schools are downsizing and even eliminating PMH clinical experiences in favor of those clinical sites providing more technically based skills. The National Council of State Boards of Nursing also has decreased the psychosocial content on state boards to as little as 6% (2010). Additionally, many schools are moving much of the PMH clinical experience to community-based settings.

This move to the community mirrors that of present and future employment opportunities for nurses, and statistics provide evidence that all nurses need PMH skills in order to meet the complex needs of their patients. However, there is no evidence as to what students are learning in these more diverse community-based settings. The research questions for the study included: 1) What are student nurses' perceptions of their ability to achieve learning outcomes in community-based PMH clinical settings? 2) What are faculty's perceptions' of the students' ability to achieve

learning outcomes in community-based PMH clinical settings? 3) What are student nurses' perceptions of their ability to transfer knowledge gained in their community-based PMH clinical experiences to other healthcare settings?

The sample consisted of 42 students and four faculty members from two Midwestern universities, with one faculty member from each school serving as a key informant, assisting the researcher with identification of possible participants and providing additional information useful in understanding the phenomenon. Students were given the option of completing questionnaires online or per paper/pencil. Faculty was encouraged to complete interviews, while given the option of completing an online questionnaire in lieu of the interview. Four self-selecting participants from the student group also participated in an online focus group as a means of member checking, as well as three faculty members participating in individual member checking.

Content analysis was completed with responses by students and faculty to the open-ended questionnaire and interview items, as well as their responses during the online focus groups and/or individual member checking. Simple demographics were used to describe the sample. Corroboration of data from campus visits and artifacts was also included and used to provide a richer, thicker description of the phenomenon. The findings from this study showed that student nurses and their faculty perceived that students were able to achieve learning outcomes in the majority of PMH nursing skills through experiences provided in community-based PMH

clinical settings. Three student themes emerged from the data: *meeting the challenges of developing PMH nursing skills, sharing multiple experiences of feeling competent and empowering all nurses through PMH nursing skills*. Three themes also emerged from the faculty data: *seizing the day(s), sharing the road to competency, and empowering students in all areas of nursing.* Two surprising, yet important findings were that even though most students felt competent with most PMH skills, the few students who did not perceive themselves as achieving the majority of PMH learning outcomes, felt that the experience was worthwhile and valuable. Most students also strongly felt that the PMH experience was important and that it they could and did apply the PMH skills they learned in all nursing practice areas.

ACKNOWLEDGEMENTS

I owe so much, to so many, that it is difficult to write these acknowledgments. Words cannot express the heart-felt gratitude I feel for the support, knowledge, advice, guidance, understanding, and patience that has been provided to me, while on this journey. First, and foremost, I wish to thank my Chairperson, Dr. Wanda Bonnel, for her unwavering confidence and belief in me; whether it was emotional or intellectual in nature, she always provided exactly what I needed, when I needed it. I also wish to thank Dr. Domian for sharing her expertise, insights, and support into the qualitative research process, which were invaluable in completing this study. Thank you to Dr. Connors, Dr. Fopma-Loy, and Dr. Billinger, for so graciously serving on my committee and providing truly great feedback and food for thought on the phenomenon.

Thank you also the faculty and students who participated in the study. Without your willingness to share, this study would not have been possible.

Thank you most of all to my wonderful husband, Kim, who encouraged me when I was down, supported me when I was faltering, and cheered with me when I was successful. Without your support, none of this would have occurred. The time spent on this journey, impacted your life tremendously, and yet you were always there with words of encouragement and love.

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Chapter One: Background

Today, depression ranks as the leading cause of disability worldwide including Americans ages 15-44 (National Institute of Mental Health [NIMH], 2009; World Health Organization [WHO], 2009). Additionally, it is well documented that the presence of a mental disorder increases one's risk to develop communicable, as well as non-communicable illnesses, and over 25% of American adults suffer from a diagnosable mental health disorder in a given year (NIMH, 2009; WHO, 2009). However, despite these facts and the critical role performed by nursing schools in educating student nurses regarding this issue, the identification and acquisition of clinical settings for undergraduate psychiatric mental health (PMH) nursing students remains a difficult process, with nursing education in this area steadily losing ground to more technically based curricula. Additionally, the National Council of State Boards of Nursing has decreased the psychosocial content on state boards to as low as 6% (2010).

The prevalence and problems associated with mental disorders have been long recognized. Almost 50 years ago, President Kennedy addressed Congress concerning this issue

> We as a Nation have long neglected the mentally ill…[and] the shortage of professional manpower seriously compromises both research and service efforts. The insufficient numbers of medical and nursing training centers now available too often lack a clinical focus on the problems of

> mental retardation and…psychiatric teaching [related to] the care of the mentally ill (1963, p. 6).

Additionally, statistics garnered in a study conducted by the WHO, Harvard University and the World Bank from 1990 show that the disease burden for all mental health disorders was second only to cardiovascular disease (Murray & Lopez, 1996). Almost half a century after President Kennedy's speech to Congress, the WHO reiterated his mandate, calling for mental health to be incorporated into all basic nursing education, with "mental health concepts introduced early, reinforced often and expanded throughout the curricula" (2007, p. 2).The significance of this problem escalates dramatically when considering President Kennedy's additional testimony just months before his assassination:

> Mental illness and mental retardation are among our most critical health problems. They occur more frequently, affect more people, require more prolonged treatment, cause more suffering by the families of the afflicted, waste more of our human resources, and constitute more financial drain upon both the public treasury and the personal finances of the individual families involved than any other single condition (1963, p. 1).

Despite this historic call to action, the facts remain that state hospital use is down, many institutions are located a great distance from the university, and most PMH nurses are now working in community settings. This situation raises questions not only about how best to prepare nursing students to work in the field of PMH nursing,

but also how to best prepare them for employment in all areas of nursing – as knowledge and experience with PMH concepts is vital in providing the holistic care that the entire nursing profession, as well as the patients and families, expect and deserve.

Financial Considerations

In President Kennedy's speech in 1963, he outlined his vision for programs intended to combat mental retardation and mental health disorders, marking one of the first times that the two entities were linked. At the time, approximately 1.8 billion dollars was provided annually for services for those with mental health disorders, with an additional 600 million dollars for those diagnosed with mental retardation (Kennedy, 1963). Today, mental disorders (including mental retardation) account for more than 60 billion dollars in medical expenditures in the United States (Agency for Healthcare Research and Quality [AHRQ], 2007) with almost 25 billion dollars spent on out-patient/home visits. In addition, mental disorders rank fourth in total dollars spent, ahead of diabetes, hypertension, and chronic lung disease.

Struggle to Define the Field

Despite nearly half a century of widespread awareness of the problem of providing well-equipped nursing professionals to care for those with mental health disorders—not to mention the insight that mental and physical health are incapable of separation—nursing and other PMH professionals' remain thwarted in their struggle to define the field. This turmoil, which undermines clinical and theoretical discussions concerning what to teach and where to teach it, begins with the tangled

web of terminology. Vocabulary and inclusion criteria in this area are fluid and complicated. What is a mental disorder? Is it different from a mental illness, mental health, behavioral health, and psychiatry? Is substance abuse part of the conversation? Do mental illness and mental retardation belong in the same discussion?

This mystifying maze has been recognized by no less than the World Health Organization (WHO, 2010), who attempted to address this issue with its *International Classification of Diseases, Tenth Edition, Clinical Modification* (ICD-10-CM) (2009). This edition ultimately included nine categories under the umbrella of 'mental disorders': organic/dementia, substance use/abuse, schizophrenia/psychosis, mood/affective, neurosis/stress/somatoform, physiological/physical including eating disorders, personality disorders, mental retardation, and psychological development (childhood disorders). "In the course of preparation of the ICD-10 chapter on mental disorder, certain categories attracted considerable interest and debate before a reasonable level of consensus could be achieved among all concerned" (p. 13), with information regarding the debate included in the final document.

> These descriptions and guidelines carry no theoretical implications, and they do not pretend to be comprehensive statements about the current state of knowledge of the disorders. They are simply a set of symptoms and comments that have been agreed, by a large number of advisors and consultants in many different countries, to be a reasonable basis for defining the limits of categories in the classification of mental disorders (WHO, 2009, p. 9).

Nursing organizations' attempts to define the field. Does the WHO's publication indicate that consensus was reached regarding terminology and content inclusion issues? Who uses which terminology to describe themselves and/or their field of study/expertise? Although their decisions differ, professional organizations such as the International Society of Psychiatric-Mental Health Nurses (ISPN) and the American Psychiatric Nurses Association (APNA) have made obvious choices. Additionally, the American Nurses Association (ANA) developed Standards of Psychiatric Mental Health Nursing Practice. The American Association of Colleges of Nursing (AACN) identified P-MH nurse practitioner competencies, but does that mean an individual with these competencies can apply for a position entitled "Nurse Practitioner – Behavioral Health" posted by Provena Health on Careerbuilders.com (2010)? Furthermore, who is qualified for employment in the Behavioral Health Department of the Cleveland Clinic, which includes various combinations of in-patient and out-patient services for those with substance abuse issues, chronic pain, child/adolescent psychiatry, eating disorders, and mental retardation (2010)? The APNA recognized this difficulty when they identified "Psychiatric nursing workplace, workforce and practice definition issues" as a priority in 2010 grant funding (p. 1).

Government and private agency attempts to define the field. The situation is further complicated by the number of organizations involved in this field. The US Department of Health and Human Services (HHS) includes various sections and

divisions, including the National Institute of Mental Health (NIMH), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Committee for People with Intellectual Disabilities—housed not in the NIMH or SAMHSA, but in the Administration of Children and Families (2010). The National Alliance on Mental Illness (NAMI) is a well-known organization focusing on improvement in the day-to-day lives of those affected by "severe mental illness," including patients and their families/significant others (2010). However, NAMI does not include mental retardation or any type of organicity or dementia in its list of what it terms "illnesses," nor does it include substance abuse in the absence of a dual diagnosis of a more traditional psychiatric nature.

State-level organizations are also involved in the field. For example, the state of Ohio has designated the Ohio Department of Mental Health (ODMH) as separate from the Ohio Department of Developmental Disabilities (DODD) (2010). Another existing agency is the Ohio Department of Alcohol and Drug Addiction Services (ODADAS), which does not include any mention of mental health, illness, or disorder in its mission or vision. Furthermore, Ohio operates a system in which some counties have separate mental health boards (MHB) and alcohol and drug addiction (ADA) boards that serve as local authorities and distribute state monies to agencies within their jurisdictions, while other counties have boards that combine these areas; however, no counties include developmental disabilities in this integration.

Educators' attempts to define the field. So what does this complex lexicon have to do with education for nursing students? Not only how best to teach appropriate

content (integrated versus entire course debates) but also what clinical sites for pre-licensure nursing students are best? It represents the difficulty associated with determining which experiences undergraduate programs should provide, as well as how to determine the effectiveness of these experiences. What do we intend for students to learn? Are they learning it? Which sites provide the best experience for the student? As it is important to remember that, "mental health problems do not affect three or four out of every five persons, but one out of one" (Dr. William Menninger, n.d.).

Waite (2005) studied the educational needs and experiences of new registered nurses [RNs] employed in PMH settings. Although nursing programs reportedly graduate generalist nurses who can work in any area, Waite discovered that students had not been adequately prepared for interpersonal therapeutic relationships with complex mental health clients with co-occurring medical and substance abuse diagnoses. She further pointed out that the Institute of Medicine (IOM) recommended that PMH topics have an increased profile in medical schools, yet nursing schools were de-emphasizing this same content. Waite concluded that there is little evidence that PMH content is being integrated into nursing curricula and that the topic needs further research to document what type of educational preparation is needed to truly prepare beginning nurses for this area of practice.

In addition, Isaac and Rief (2009) addressed behavioral and social sciences in medical education worldwide, stating that experts such as those at IOM in 2002 had widely recognized that psychosocial and mental health issues are essential to good medical care; however, this education is infrequently provided. Although evidence indicates those interventions are medically and cost-effective, few doctors implement

behavioral interventions. The authors stated that students take their 'lead' in determining interest and importance of the content from educational institutions; consequently, medical schools need to identify professors who are interested in this area and develop materials that can be used for this purpose. The authors further asserted that individual committees responsible for reviewing and revising medical education need to address this issue aggressively, rather than allowing the lack of focus in this area to continue. However, specifics ideas on how to integrate this information were not provided.

The American Association of Colleges of Nursing (AACN) suggested that sample content for student nurse clinical experiences include "management of acute and chronic physical and psychosocial conditions across the lifespan, psychobiological interventions, milieu therapy, and depression screening" (2008, pp. 33-34). In addition, it argued that it is essential for clinical experiences to help students apply professional communication strategies to client interactions.

Many nursing schools are combining the clinical component of community health (Lasater, Luce, Volpin, Terwilliger, & Wild, 2007) or adult health (Haas & Hermann, 2003) with PMH courses. Others are integrating PMH content across the curriculum (Perese, 2002) while excluding traditional PMH clinical experiences. As many nursing schools are deemphasizing PMH, the IOM (2009) recommends that PMH topics have an increased profile in medical schools, identifying nine PMH topics among its priority research areas.

Problem Statement

How can undergraduate nursing education ultimately respond to the need for graduate nurses to be well equipped to care for the PMH needs of their clients? The National League for Nurses (NLN) affirmed that nursing education needs to move "away from a focus on content coverage" and on to "evidence-based decision making in nursing education" (2005, p. 3). Given the paucity of traditional PMH clinical sites and the confusion regarding what constitutes the area of PMH nursing, how can educators' best use their available resources to provide the experiences needed for students to apply the theoretical to the practical? The purpose of student clinical experiences focuses on the application of theoretical knowledge, skill building, and to gain a comfort level with content. Yet what does the evidence tell us about what students are learning in various PMH clinical sites?

Purpose of the Study/Research Questions

The specific purpose of this qualitative descriptive study is to explore how undergraduate student nurses and faculty perceive the students' ability to achieve learning outcomes in community-based PMH clinical settings. The results of this study will provide faculty with preliminary insight regarding how students learn and practice in these settings. This understanding is crucial for faculty in planning clinical experiences that meet the immediate needs of their students and empower future nurses with the confidence and skills required to meet complex patient needs. The specific research questions to be addressed are:

1) What are student nurses' perceptions of their ability to achieve learning outcomes in community-based PMH clinical settings?

2) What are faculty's perceptions' of the students' ability to achieve learning outcomes in community-based PMH clinical settings?
3) What are student nurses' perceptions of their ability to transfer knowledge gained in their community-based PMH clinical experiences to other healthcare settings?

Significance of the Study

The importance of mental health and PMH nursing is well documented. However, despite the recognition of that importance, this content and its resultant clinical experiences are being squeezed out in favor of a more acute care or technology-focused curriculum. In addition, the difficulty of accurately defining PMH nursing threatens its inclusion; if we do not know what it is, how do we know if we have included it? It is imperative for educators to determine what students are learning in various clinical settings so that curricular decisions can be driven by evidence, rather than by tradition or misconception.

Definition of Terms

Investigatory definitions are provided here to explain concepts and promote ease of understanding, while placing the reader and researcher on equal footing regarding terminology. These definitions are employed throughout the study. This section was difficult to write, as it became clear that language was fluid in this area. Some may argue that 'everyone knows what a 'psych' nurse does', however,

> language is a powerful tool in defining our reality. The language that we use and are familiar with influences the way we think about the world around us

> and the people we interact with. The use of language is frequently raised as an important influence in nursing practice (Happell, 2007, p. 223).

Therefore, extreme care was used in developing these working definitions, which were only identified following a concept analysis of psychiatric mental health nursing. Specific information obtained in this analysis is shared throughout this proposal.

Behavioral healthcare - “Continuum of services for individuals at risk of, or suffering from, mental, addictive, or other behavioral health disorders” (SAMHSA, 2010, p. “B”).

Community-based PMH setting - Includes community settings in which patients with mental disorder diagnoses, per the ICD-10-CM, are treated. These may include—but are not limited to—group homes, community residential settings including independent apartments and family homes (where the identified patient is living with parents or other relatives), substance abuse out-patient centers, substance abuse residential settings, battered women’s shelters, jails, prisons, drop-in centers, and homeless shelters.

Learning outcomes - Clinical competencies for generalist BSN graduates identified by the APNA.

Mental health - “How a person thinks, feels, and acts when faced with life's situations. Mental health is how people look at themselves, their lives, and the other people in their lives; evaluate their challenges and problems; and explore choices.

This includes handling stress, relating to other people, and making decisions" (SAMHSA, 2010, p. "M").

Mental health disorder, mental health problem, mental illness or psychiatric disorder/illness - Real problems that "affect one's thoughts, body, feelings, and behavior. Mental health problems are not just a passing phase. They can be severe, seriously interfere with a person's life, and even cause a person to become disabled. Mental health problems include depression, bipolar disorder (manic-depressive illness), attention-deficit/ hyperactivity disorder, anxiety disorders, eating disorders, schizophrenia, and conduct disorder" (SAMHSA, 2010, p. "M"), as defined by *International Classification of Diseases, Tenth Edition, Clinical Modification* (ICD-10-CM) (2009).

Severe mental illness and chronic mental illness - A psychiatric illness with a resultant medical diagnosis that seriously impedes an individual's ability to lead a 'normal' life on a long-term (i.e., more than six months) basis. Examples of medical diagnoses that fall into this category are various types of schizophrenia and bipolar disease.

Student nurse - Any individual attending a pre-licensure undergraduate baccalaureate program leading to a traditional bachelor of science in nursing degree (BSN). These students are not enrolled in BSN programs specifically intended for students seeking a second degree. These students do not have previous professional nursing experience, although they may be a licensed practical nurse (LPN) or certified nursing assistant (CNA).

Substance abuse - “misuse of medications, alcohol or other illegal substances” (SAMHSA, 2010, p. “S”).

Traditional mental health clinical setting - An acute care psychiatric inpatient unit or an in-patient unit in a state psychiatric hospital. These sites are not inclusive of out-patient settings.

Summary

Chapter one of this proposal has provided an introduction to the problem leading to this investigation, as well as the purpose of the study, specific research questions guiding the study, and the significance of the investigation. Additional information is included to elucidate study terminology. Chapter two will include a review of the relevant literature.

Chapter Two: Review of the Literature

A paucity of scholarly literature exists related to learning outcomes in community-based PMH clinical settings. Therefore, this chapter begins with a historical perspective, followed by evidence related to clinical nursing experiences in general (not only specific to PMH), as well as, a discussion of the link between physical health and mental health and specifics on PMH clinical experiences.

Historical Perspective

Significance. Many have espoused the importance of studying history. In fact, Winston Churchill, one of the great statesmen of the 20th century, is reported to have responded to a question regarding his ability to anticipate future problems as being due to his study of history. Indeed, respect for the history of PMH nursing education will enable nurses to embrace change and find solutions to current problems within the profession (McAllister et al., 2006). Clearly, if we want to understand where we are and where we are going, it is vital to cultivate a thorough understanding of where we have been. In other words, our past shapes our future.

Early years. Despite recognition of the obvious need for nursing care for those with PMH issues, content related to psychiatric nursing was not always an element of nursing curricula. In 1882, Linda Richards—who is generally identified as the founder of psychiatric nursing in the United States and the first nurse to graduate from a formal nursing program in this country—collaborated with Florence Nightingale (a robust advocate for equal/quality treatment for persons with mental disorders) to open the first nursing program specifically aimed at educating nurses to

care for persons with psychiatric illnesses. The program was housed in the Boston City Hospital Training School for Nurses (St. Lawrence County, New York Branch of the American Association of University Women, n.d.) and marked the first time in history that formal education was available for psychiatric nurses.

During the first half of the 20th century, psychiatric nursing became more recognized as a legitimate specialty in the field of nursing. In 1913, under the direction of Euphemia (Effie) Jane Taylor, Johns Hopkins became the first school to include psychiatric nursing as core component of its general nursing curriculum.

Several years later, in 1920, Harriet Bailey published the first textbook on psychiatric nursing, entitled *Nursing Mental Diseases.* During the 1930s, the National League for Nursing Education recommended that theory and clinical be included in all nurse education curricula. Schools quickly added psychiatric content and, by the mid-1950s, nursing schools were required to include psychiatric nursing in their curricula or face decertification by the National League for Nursing (NLN) (Videbeck, 2008).

More recently. The expansion of the role of the psychiatric mental health nurse was followed by Congressional passage of the Community Mental Health Act of 1963. Deinstitutionalization, along with the positive effects of modern psychiatric medications, allowed many patients to leave state hospitals and return to or remain in their communities, creating a need for PMH nurses outside the traditional hospital setting. Thus, the field of PMH nursing grew significantly in the first half of the 20th century, supported by educational institutions, professional organizations, and legal

mandates. Hildegard Peplau—often referred to as the mother of modern psychiatric nursing—developed the first graduate program for psychiatric nursing at Rutgers University in 1954 (Peplau, 1992).

During the 1990s, expansion of evidence-based practices (EBPs) was forcefully encouraged by the United States Surgeon General (United States Department of Health and Human Services, 1999), the Institute of Medicine (2001), and The President's New Freedom Commission on Transforming Mental Health Care (2003). Such changes served as the backdrop for the development of specific clinical competencies developed by the International Society of Psychiatric-Mental Health Nursing (ISPN) and the American Psychiatric Nurses Association (APNA), published in a document entitled *Essentials of Psychiatric Mental Health Nursing in the BSN Curriculum* (2008), which identified 13 areas of core nursing content, including pharmacotherapeutics, therapeutic communication, disease prevention and health promotion.

Each category in the document includes key Psychiatric Mental Health Nurse (PMHN) content as well as clinical competencies. As varying educational approaches and learning outcomes at schools of nursing have caused some confusion regarding how to assess or evaluate student learning on a larger scale, *Essentials of Psychiatric Mental Health Nursing in the BSN Curriculum* (2008) provides the expert basis for the data collected in the current study. Moreover, the document was used as a guide for developing the online questionnaire, inclusive of open- and closed-ended items,

for the current study. More information regarding the specifics involved is provided in chapter 3.

The Connection between Physical and Mental Health

It has long been believed that mental health is related to physical health. In fact, in 1684 a noted English physician, Thomas Willis, who first used the term *diabetes mellitus,* is quoted by Lustman and Clouse (2005) as stating that diabetes was the result of "sadness, or long sorrow" (p.1). Almost two centuries later, English physician Henry Maudsley (1835-1913), superintendent of the Manchester Royal Lunatic Asylum, was quoted as saying, "the sorrow that has no vent in tears may make other organs weep" (Finest Quotes: keyword tears, n.d.). Several more recent studies have demonstrated a clear link between mental and physical health. Indeed, for more than 25 years, it has been estimated that as many as 10 to 13% of patients seen by primary care health providers (PCP) suffer from major depressive disorder (MDD) (O'Connor, Whitlock, Beil, & Gaynes, 2009).

In 2002, a task force of learned experts from the private sector, organized by the United States Department of Health and Human Services, reviewed current research and provided recommendations for the best use of clinical preventative services. This task force, called the United States Preventative Services Task Force (USPSTF), "found good evidence that screening improves the accurate identification of depressed patients in primary care settings and that treatment of depressed adults identified in primary care settings decreases clinical morbidity" (Agency for Healthcare Research & Quality (AHRQ), p. 1). In that same year, the American

College of Obstetricians and Gynecologists (2002) asserted that their members should be vigilant in assessing their patients for symptoms of depression. More recently, the United States Preventative Services Task Force (USPSTF) amended its recommendations in 2009 to include mental health screenings in primary care settings only when staff-assisted supports (such as case management) are available within the practice, as without these supports the benefit of depression screenings was small.

Such conclusions further underscore the need for nurses to be well versed in PMH issues and treatment. However, given the extensive information that must be taught during a traditional four-year undergraduate nursing program, do all nurses—including those going entering the traditional non-psychiatric areas of nursing—need to be fluent in this area? An initial answer to this question would seem to be in the affirmative. After all, mental disorders are prevalent in our society, and mental health is valued (NIMH, 2009; WHO, 2009). As such, knowledge in this area would likely be deemed relevant.

This conclusion is also supported by medical-surgical nurses, who have identified that they are caring for patients with PMH issues and that these patients provide a unique challenge. The Academy of Medical-Surgical Nurses (2012), states medical-surgical nurses "manage the care of patients with multiple medical, surgical and/or psychiatric diagnoses" (p.1). To underscore the importance of this issue, this organization is providing education for their nurses in this area. They provide a text that includes their core curriculum, with 27 chapters that can be used for review and/or continuing education credits. One chapter within this text is entitled,

"Behavioral Health." The key objectives of this chapter are to enable medical-surgical nurses to identify risks and behavioral cues that can complicate nursing care on medical-surgical units and to develop care plans for patients that take into consideration the unique issues involved with individuals experiencing a PMH disorder. Additionally, the American Association of Critical Care Nurses (2012) includes identifying and caring for critically ill patients with psychiatric problems/complications as a current area of concern. They are, therefore, providing access to experts who are able to address these issues for their membership.

Several recent studies support this conclusion as well. For example, Chafetz et al. (2005) found that the physical functioning of persons with a severe mental health disorder was comparable to a person up to 20 years older, but without the psychiatric diagnosis. The phenomenon was so striking that they eventually referred to it as premature aging. This connection can also affect mortality. After matching 1,920 persons with a diagnosis of schizophrenia for age, sex, date and healthcare plan, Enger, Weatherby, Reynolds, and Walker (2004) found that mortality rate—due to all causes—was four times higher in clients with a diagnosis of schizophrenia treated with typical or atypical anti-psychotics than for the general population. These same clients had an additional risk of developing new onset Type II diabetes.

Though this mortality issue was recognized and is being addressed, there continues to be a gap in life expectancy. A study published in 2011 included over 31,000 persons and found that individuals with a PMH illness had an eight to seventeen year lower life expectancy than those without such a diagnosis (Chang, et

al.). Similar results were identified by Dossa, Glickman, and Berlowitz (2011) in their study that looked at outcomes for stroke patients with and without pre-existing PMH disorders. Their database included 2162 patients who had experienced a stroke and participated in inpatient rehabilitation. They found that patients with two or more PMH disorders had a higher incidence of being readmitted or dying within six months following this experience, as compared with patients without a PMH disorder. A secondary analysis of data collected for a longitudinal study examined Americans by stratifying individuals with diabetes per depression scores. Zhang et al. (2005) demonstrated a 54% increased mortality for those with moderate-severe depression (Center for Epidemiologic Studies Depression Scale [CES-D] scores >= 16), with particular mortality increases among those with a medical diagnosis of hypertension, myocardial infarction, or stroke. The authors came to the same conclusion as Williams et al. (2004): "depression should probably be considered a target for diabetes management interventions" (Zhang et al., 2005, p. 658). Moreover, it has been found that not only depression affects the outcomes for persons with diabetes, but also having less education. This was demonstrated by Carthenon, Kinder, Fair, Stafford and Fortmann (2003), who found an increase in the incidence of Type II diabetes in persons with depression who did not graduate from high school.

Meanwhile, a positive relationship between depression and mortality was found for persons with specific medical diagnoses, including cerebral vascular accident (House, Knapp, & Bamford, 2001), congestive heart failure (Jiang et al., 2001), coronary artery disease (Sheps, McMahon, & Becker, 2002), hip fracture

(Iolascon, Cervone, Gimigliano, Di Pietro, & Gimigliano, 2011), and myocardial infarction (Lesperance, Frasure-Smith, Talajic, & Bourassa, 2002). In fact, Frasure-Smith, Lesperance & Talajic (1993) found that—in the first six months after the cardiac event, persons with depression had a mortality rate four times higher than those without depression. In addition, Strommel, Given, & Given (2002) asserted that individuals with a history of depression are two and a half times more likely to die from cancer than persons without this history. Pinquart and Duberstein (2010) completed a meta-analysis addressing the association between cancer mortality and depression. They found that a diagnosis of depression "predicted elevated mortality. This was true in studies that assessed depression before cancer diagnosis as well as in studies that assessed depression following cancer diagnosis. Associations between depression and mortality persisted after controlling for confounding medical variables." (p. 1797). Helwick (2007) quoted Dr. Patrick Lustman, an oft-published researcher in the diabetes-depression connection, as stating that, "Depression somehow causes a susceptibility to dying" (p. 2).

The studies connecting increased incidence of medical illness and mortality rates to persons with mental health disorders highlight the importance of bringing psychiatric mental health education to all nurses. All nurses require—and should demand—the knowledge and confidence to care for these clients with the same competence employed with more traditional non-psychiatric clients. Thus, it is vital to examine the evidence in regard to nursing students' clinical experiences generally

as well as specifically look at the evidence in regard to clinical experience in PMH nursing.

The Holistic Nature of Nursing and Clinical Experiences

> Nurses are educated to be attuned to the whole person, not just the unique presenting health problem…Nurses' broad-based education and holistic focus positions them as the logical network of providers on which to build a true health care system for the future. (American Nurses Association [ANA], 2010, p. 1).

In its "Essentials of Baccalaureate Education for Professional Nursing Practice," the American Association of Colleges of Nursing (AACN) states that, "The [baccalaureate] generalist nurse practices from a holistic, caring framework. Holistic nursing care is comprehensive and focuses on the *mind, body, and spirit, as well as emotions*" (p. 10, emphasis added). AACN further asserts that, "The baccalaureate program prepares the graduate to…implement holistic, patient-centered care that reflects an understanding of human growth and development, pathophysiology, pharmacology, medical management, and nursing management across the health-illness continuum, across the lifespan and in *all* healthcare settings" (p. 32, emphasis added).

To prepare students to provide this holistic care, it is imperative that they be taught basic concepts introduced in a typical PMH nursing course (such as therapeutic communication and use of psychotropic medications). Such concepts must be learned, practiced, and incorporated into care so as to better prepare students for caring for all

patients in all healthcare settings. This learning process requires exposure to the content, awareness of one's communication patterns, practice with therapeutic communication techniques and how they impact the information gained from patients, and practice with a variety of persons who present with different communication challenges. In other words, students need time, exposure to a clinical instructor who is an expert in this content, and on-the-spot encouragement and problem solving in "real time".

Each person expects and deserves this focus of care. Yet students or nurses are frequently unaware that the patient or family member for whom they are caring in a non-psychiatric setting is actually experiencing a mental health disorder. However, as one in four American adults suffers from a diagnosable mental health disorder in a given year, one in every four to five patients and/or family members is likely experiencing a mental disorder (NIMH, 2009; WHO, 2009). Therefore, the typical nurse working on an acute care medical-surgical unit with an average patient load of five (Hershbein, 2005), must remember that at least one of these patients is likely experiencing a mental health disorder.

Clinical experiences. In describing how they learned to become a nurse or "think like a nurse," students invariably pointed to clinical situations. Chan (2001) asserted that student nurses perceive the clinical setting as the most significant context contributing to their ability to attain nursing skills and related knowledge.

> Clinical education is a vital component in the curricula of pre-[licensure] nursing courses and provides student nurses with the opportunity to combine

> cognitive, psychomotor, and affective skills. Various studies have suggested that not all practice settings are able to provide nursing students with a positive learning environment. In order to maximize nursing students' clinical learning outcomes, there is a need to examine the clinical learning environment (Chan, 2004, p. 2).

Despite the importance of these clinical experiences, many students are not satisfied with the experiences provided in their undergraduate education (Sharif & Masoumi, 2005). When the clinical and classroom instruction were not integrated, meaning provided together or completed in a similar time frame, students reported a fragmented experience (Gilliss, 2010). Students also reported anxiety related to feelings of incompetence due to their perceived lack of the knowledge and skills to care for patients appropriately.

Psychiatric mental health clinical experiences. Clinical experiences are an integral part of nursing education, yet student nurses are frequently fearful at the beginning of their psychiatric mental health clinical rotation. This fear is generally attributed to concern that a patient may harm them or that the students will say the wrong thing or be unable to help (Charleston & Happell, 2005; Melrose & Shapiro, 1999). Such fear often peaks when patient behavior is erratic and unpredictable, as is frequently the case on in-patient units.

Traditionally, the PMH nursing clinical occurred in large state hospitals where length of stay (LOS) was measured in years, rather than days, or in acute care in-patient units in general hospitals, where LOS was measured in weeks. However, state

hospitals have experienced a steady trend of closing and/or downsizing since the passage of The Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (Public Law 88–164). Acute care in-patients units now have a high patient turnover rate, with most staying only a few days while experiencing a high level of acuity with their illness. Moreover—largely in response to the demands of third-party payers—admission to these units rarely occurs without evidence that the patient is an immediate danger to him-/herself or others.

Challenges related to clinical experiences. Between 2008 and 2018, employment in ambulatory healthcare settings is expected to increase by more than 44% (United States Department of Labor, Bureau of Labor Statistics, 2009). Indeed, in 2009, fewer than 58% of nurses were employed in hospitals, with more than 1 million registered nurses (RNs) currently working within alternate employment sites, including home care and ambulatory clinics/offices. This is down from a peak of more than 68% being employed by hospitals in 1984. Thus, student nurses need access to diverse locations for clinical sites.

The Carnegie Foundation for Advancement of Teaching concurred in its recent report (Benner, Sutphen, Leonard, & Day, 2009), strongly advising that pre-licensure nursing education be limited to the baccalaureate or master's levels that provide diverse clinical sites for nursing students. According to the findings of this report, most clinical experiences occur in the acute care setting, yet other agencies and situations are needed to truly round out a student's educational experience and provide access to one's own clinical reasoning. This study and ensuing report are

meant to serve as a "catalyst for conversation and debate, self-assessment, and above all change" (Gilliss, 2009, n.p.). The Carnegie Foundation for Advancement of Teaching's model for nursing education stresses self-assessment as a necessary precursor to outcome evaluation/achievement; without knowing which outcomes are being met/unmet through clinical placements, it is impossible to make evidence-based changes that will bring about the more desired outcome.

Addressing the Inherent Challenges in Clinical Settings

Based on the discussion thus far, clinical sites for PMH nursing need to include community settings that provide the opportunity for students to learn, apply and assimilate new information while meeting the course, departmental, and professional outcomes of providing safe care to a variety of patients in a variety of healthcare settings. Although this is the ideal situation, many who teach PMH nursing are experiencing difficulty identifying agencies that meet these criteria (Cleary & Walter, 2006; Happell, 2005). Though the Baccalaureate Essentials direct clinical experiences to assist the graduate in developing psychomotor and communication proficiencies, most community agencies are smaller in size and do not provide the resources a clinical instructor with 8 to 10 students requires (AACN, 2008; Happell, 2005). One area that is especially problematic is providing an experience that is other than observational in nature (Utah Board of Nursing Education, 2007). Therefore, many times students in the same clinical group are placed in a variety of agencies, with one or two at each and a clinical instructor left to make the rounds among the agencies, providing as much guidance and support as can be garnered in the short

period of time they have to spend with each student. These instructors are burdened not only by the needs of the students and the needs of the patients, but also by the agency needs and the limited number of sites from which to choose.

It is obvious that providing the best clinical experience for each student is imperative. The need exists for a generalist graduate nurse who can: (a) safely practice in a variety of settings; (b) perform mental status exams and initiate appropriate plans of care; (c) remain calm and non-judgmental when caring for persons with unusual mannerisms (e.g., uncontrolled tongue or leg movements); (d) confidently assess patients' physical, mental, spiritual, and emotional health; (e) provide educational interventions as appropriate for a variety of psychiatric medications, including side effects; and (f) use therapeutic communication techniques to elicit vital information while providing a safe haven for persons experiencing a variety of disorders/illnesses (AACN, 2008; APNA, 2008). Such a combination is a tall order. However, little evidence exists as to what nursing students are learning in the various sites chosen by clinical instructors.

Time dedicated to relevant topics. A fundamental question to be asked is how much time and attention are provided for PMH topics in nursing education today? To begin this discussion, five traditional BSN programs in the Midwest were surveyed, as they are the target of this study. School A integrates all PMH content into other nursing courses, and they are not aware of the total number of theory hours dedicated to this content. Additionally, they have no clinical hours specifically

identified for PMH experiences. The number of hours of theory and clinical for each are outlined in Table 1.

Table 1.

Number of Hours of Theory and Clinical for 5 Midwestern BSN Programs

School	*Theory Hours*	*Clinical Hours*
School A	?	0
School B	30	80
School C	60	80
School D	30	60
School E	30	90

These results are consistent with those of Patzel, Ellinger and Hamera (2007), who found the average number of hours of clinical for PMH nursing was 80.26, and point out the vital nature of making every hour of PMH clinical experiences count.

Course objectives from PMH nursing courses. The objectives for PMH courses in schools B through E followed two themes. First, they were predicated on a framework of patient-centered, caring, holistic practice. Second, they included various objectives that were more generic in nature and applied to the PMH setting (i.e., applying nursing research to a variety of practice settings within the mental health system).

Clinical objectives from PMH nursing courses. The objectives for the PMH courses in these schools also followed two themes. First, many were somewhat

generic in nature (i.e., applying the nursing process to a variety of patient problems in varying PMH settings). Second, additional objectives were related specifically to PMH content, including completing a mental status exam/assessment, assisting in creating and maintaining a therapeutic milieu, clarifying one's own values/beliefs about mental health disorders and persons' diagnoses (including bias/stigma issues), and an increased focus on the use of self- and therapeutic communication techniques. As a result of the movement of PMH nurses into the community, these standard course objectives are now met using a greater variety of community-based clinical settings, rather than the traditional inpatient sites traditionally employed.

Assignments common to PMH clinical courses. Two themes were again identified. First, traditional course assignments were applied to the PMH setting (e.g., completion of a nursing care plan [NCP]). Second, assignments more specific to PMH nursing were assigned, such as interpersonal process recordings and required attendance at self-help group meetings such as Alcoholic Anonymous (AA), to enable students to meet objectives related to self-awareness, values clarification, and improved therapeutic communication.

Ongoing Needs

It is evident from the literature review and specific requirements of five selected pre-licensure nursing programs that a variety of theoretical and clinical experience is provided for PMH content. It is also evident that it is incumbent upon these programs to provide experiences for students in the community in light of the fewer long-term or acute-care in-patient units/facilities, patterns of post-graduation

nursing employment, and future projections of further movement of care to the ambulatory setting. However, little is known regarding (a) how students perceive their experiences, (b) how faculty perceive student experiences, and (c) whether course/departmental/professional learning outcomes/clinical competencies are effectively being met, particularly in these various sites. Therefore, it is incumbent upon nurse educators to study this phenomenon so that clinical placement decisions are based upon evidence rather than expediency or tradition—which is precisely the intent of the current study.

Chapter Three: Methods

Chapter three begins with a review of the specific purpose and research questions identified in chapter one. It also provides an overview of the study's methods, discusses the literature related to the methodological decisions, and concludes with descriptions of the specific procedures used in this study.

Purpose and Research Questions

The specific purpose of this qualitative descriptive study was to explore how undergraduate student nurses and their faculty perceive the students' ability to achieve learning outcomes in community-based PMH clinical settings and to transfer this knowledge to other health care settings. The specific research questions addressed are:

1) What are student nurses' perceptions of their ability to achieve learning outcomes in community-based PMH clinical settings?
2) What are faculty's perceptions of the students' ability to achieve learning outcomes in community-based PMH clinical settings?
3) What are student nurses' perceptions of their ability to transfer knowledge gained in their community-based PMH clinical experiences to other healthcare settings?

Overview of Methods

The sample consisted of 42 students and four faculty members from two Midwestern universities, with one faculty member from each school serving as a key informant, assisting the researcher with identification of possible participants and

additional information useful in understanding the phenomenon. Students were given the option of completing questionnaires online or per paper/pencil. Thirty-three students completed the paper/pencil questionnaire, while nine completed it online. Faculty was encouraged to complete in-person interviews, while given the option of completing an online questionnaire in lieu of the interview (two faculty members completed the questionnaire online and two completed interviews). Four self-selecting participants from the student group also participated in an online focus group and three faculty members participated in individual member checking.

The researcher personally transcribed each of the paper/pencil responses and each interview, saving them as Word documents. All transcripts were de-identified; thus no names, initials, or locations were listed on the documents. Data from online questionnaires was automatically transferred to a secured network database at the University of Kansas, School of Nursing (KUSON) and eventually sent in a Microsoft Excel file to the researcher through Kansas University Medical Center (KUMC) Secure Files© for review.

Content analysis was completed with responses by students and faculty to the open-ended questionnaire and interview items, as well as their responses during the online focus groups and/or individual member checking. Simple demographics were used to describe the sample. Corroboration of data from campus visits and artifacts was also included and used to provide a richer, thicker description of the phenomenon.

Choice of Methods - Review of Literature

Study Design

The current study used a qualitative descriptive approach. Qualitative methods "provide results that are usually rich and detailed, offering many ideas and concepts to inform [nursing] programs. Qualitative methods can tell you how people feel and what they think" (Oak Ridge Associated Universities, n.d., p. 1). Qualitative research is broadly defined as "any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification" (Strauss & Corbin, 1990, p. 17) and that allows for understanding and illumination, rather than quantification. This study focused primarily on gathering information about the thoughts and feelings of undergraduate student nurses as well as faculty in regard to their experiences in community-based PMH clinical settings, which makes the qualitative approach appropriate.

In particular, the study investigated educational experiences of baccalaureate nursing students in community-based PMH clinical settings. According to Sandelowski (2000, p. 334),

> qualitative descriptive studies have as their goal a comprehensive summary of events in the everyday terms of those events. Researchers conducting qualitative descriptive studies stay close to their data and to the surface of words and events. Qualitative descriptive designs typically are an eclectic but reasonable combination of sampling, and data collection, analysis, and re-

presentation techniques. Qualitative descriptive study is the method of choice when straight descriptions of phenomena are desired.

Qualitative descriptive methodology allows for an emergent process rather than one that is completely predetermined. Although this study includes specific research questions to be explored and data collection strategies, it is understood that some flexibility is necessary to ensure optimal understanding of the experiences of the students and clinical faculty (Patton, 2002).

Students' perceptions regarding learning experiences in community-based PMH settings, especially related to the ability to achieve clinical competence, were unknown as no previous study of this type exists. Therefore, schools were solicited for BSN students whose PMH clinical experiences occurred exclusively in the community.

Questionnaires

Questionnaire research, as such, does not belong to a particular field and can be used by a myriad of disciplines. More than 50 years ago, Campbell and Katona (1953) wrote that, "It is this capacity for wide application and broad coverage which gives the survey technique its great usefulness" (p. 16). Data for the study was collected in several ways, including via an online semi-structured questionnaire developed for this purpose. Kiesler and Sproull published the results from the first online questionnaire in 1986 in the *Public Opinion Quarterly.* Since then, the growth of computer use and the internet has catapulted the use of online questionnaires in research studies.

Online questionnaires. The research is mixed on response rates and the quality of responses when using online questionnaires. One review of the literature on this topic revealed that online questionnaire response rates from 1986 to 2000 ranged between 19 and 72% (Sheehan, 2000). The mean number of questions in these questionnaires was 42.3, with a mean response rate of almost 37% and a mean salience score of 4.09 out of 5. A study at Stanford in 2002, using alumni as participants, resulted in a response rate of 50%, with those under 30 providing the highest rate at almost 55% (Pearson & Levine, 2003). Ballantyne (2003), Cody (1999, as cited in Collings and Ballantyne, 2004), and Hmieleski (2000) found lower response rates for online questionnaires than for paper-and-pencil versions. Furthermore, Johnson (2003) found little response bias with online questionnaires; response rates also increased over time among college students.

According to Ballantyne (2004), comments provided in online questionnaires are more detailed—albeit less frequent—than those provided in traditionally administered questionnaires. Hardy (2003), Muffo, Sinclair, and Robson (2003, as cited in Collings & Balantyne, 2004), and Schaefer and Dilman (1998) found exceptionally rich comments provided by college students completing course evaluations when open-ended items were used with online questionnaires; Schaefer and Dilman (1998) described four times as many comments when online questionnaires were used compared to paper-and-pencil versions.

Qualitative online questionnaires. Although use of online qualitative questionnaires is relatively new, several studies have been conducted using this

method of data collection. Curtis, Robertson, Forst, and Bradford (2007) included 252 women in their study focused on identifying symptoms experienced and strategies helpful for women with postpartum mood disorders. Jowett and Peel (2009) surveyed 190 persons regarding non-HIV chronic illness in a qualitative online format, while future research topics regarding healthcare experiences of parents of children with congenital limb differences was also explored in this manner (Andrews, Williams, Vandecreek, & Allen, 2009).

Strengths and weaknesses of online questionnaires. These electronic relatives of the pen-and-paper questionnaire have many strengths and weaknesses. Strengths of electronic questionnaires are numerous in nature and include cost; automaticity of responses—usually directly entered into a secure database; fast distribution; quick feedback; potential enhanced honesty among participants (Bachman, Elfrink & Venzana, 1999); ease of response; convenience of completing the questionnaire at a time chosen by respondents; time limits are not incurred, enabling respondents to take as much or as little time as personally necessary to complete the questionnaire ; and more detailed answers to questions may be provided by respondents (Paolo, Bonaminio, Gibson, Patridge, & Kallail, 2000). However, online questionnaires also have inherent weaknesses, including a respondent pool limited to those with access to a computer with online capability, thereby affecting sample demographics; the fact that it may be hard to ensure anonymity and confidentiality due to hackers; the potential for additional participant instruction to explain how to complete the questionnaire; the potential for computer “hiccoughs”;

further clarification of responses is impossible; and respondents may stop the questionnaire when it is only partially completed and exit the questionnaire site (Colorado State University, 2010). Weighing the pros and cons as listed, the advantages to online questionnaires appear to outweigh the disadvantages for the current study. Cost and time are important variables for any researcher; given that respondents may provide more detailed and honest responses to this type of questionnaire, these positives weighed heavily against negatives such as computer access (which is virtually assured with college students and faculty) and computer problems (the University of Kansas has numerous backup and spyware systems).

Questionnaire/interview guide development. The researcher conducted an extensive literature review to determine guidelines for developing the questionnaires/interview guide used in this study. This search and development of items, allowed for use of the questionnaire, as an interview guide for faculty participants (as discussed later in this chapter), as well as for online (faculty and student) or paper/pencil (student) questionnaire data collection. Qualitative online questionnaires are relatively new to research, with traditional qualitative semi-structured interviews used to collect much of the information gathered for qualitative descriptive studies. The purpose of the study, research questions, type of data desired, and how the data would be used and analyzed were all considerations in questionnaire/interview guide development (Munhall, 2007).

In the current study, questionnaire/interview guide items were directed toward learning outcomes defined as clinical competencies for generalist BSN graduates by

the APNA (2008). Before making this decision, the researcher also considered using the guidelines put forward by both the AACN in its document "The Essentials of Baccalaureate Education for Professional Nursing Practice" (2008) and the American Nurses Association (2007) in its ANA Standards for Psychiatric Nursing Standards. Although the items in the questionnaire/interview guide were wholly consistent with these guidelines, the integration of content and the use of more general methods of describing what "the baccalaureate program prepares the graduate" (AACN, 2008, p. 13) to do raised concerns regarding interpretation of these guidelines by the students and casual faculty. Therefore, as the APNA guidelines are specific in nature and philosophically consistent with those of the AACN and ANA, they were chosen for this study. Further discussion of the final instruments (see Appendices D and H) is provided later in this chapter.

Focus Groups

A focus group is a "carefully planned series of discussions designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment" (Krueger & Casey, 2000, p. 5). Focus groups can be used for many purposes; in this study they were used for member checking.

Online focus groups. Although the use of online focus groups is relatively new, several exploratory studies have been conducted. King et al. (2006) used a synchronous online focus group to explore experiences of adolescents using online counseling resources. Meanwhile Aguilar, Boerema and Harrison (2010) used two asynchronous groups over a 10 day period to explore the meaning attributed to

computer use by persons aged 65 and older. In Ortman and Arsenault's (2010) study, 15 preceptors of dietetic interns took part in an asynchronous online focus group over a period of three weeks. Their study aimed to identify the perceptions of the roles, benefits, and supports available to preceptors while working with student dieticians as well as which skills are most important for students to have prior to the internship. Meanwhile, Turney and Pocknee (2005) ran three online asynchronous focus groups; while also including nine groups meeting face-to-face, to follow up on earlier survey results related to public perceptions of stem cell research and the use of DNA testing for determining paternity. The researchers determined that "not only was the method theoretically sound, it actually enhanced their ability to connect with difficult-to-access populations that were disparately spread" (p. 1).

Online focus groups offer several benefits over their traditional counterparts. Two of these benefits are particularly cogent to this study: persons who are physically located in various geographical areas can be included and an asynchronous format allows for participants to enter the discussion when it is convenient for them (Im & Chee, 2006; Tates et al., 2009). As this study included students living across a large section of north-eastern Ohio, with schedules varying tremendously throughout each week, these benefits were paramount.

Several limitations to these groups have also been considered, the largest of which is that the moderator and other participants are unable to "see" verbal cues provided by those entering their responses (Moloney, Dietrich, Strickland, & Myerburg, 2003; Stewart & Williams, 2005). Research provides several ways to

offset this issue. Many scholars are now commonly using these techniques in their online communication with family, friends, and professional contacts. These methods include the encouragement of participants' use of emoticons (e.g. "smiley" faces and "sad" or "angry" faces), words or sentences entered with capital letters, exclamations or questions marks (often the use of several when one would traditionally be used), and spacing or font changes (Kenny, 2005; Stewart & Williams, 2005).

Sample size. Extensive consideration was given to the sample size needed for this study as much debate exists concerning this topic (Morse, 1991; RWJF, 2008; Sandelowski, 1995, 2000). However, most agree with Sandelowski's (1995) assertion that,

> determining adequate sample size in qualitative research is ultimately a matter of judgment and experience in evaluating the quality of the information collected against the uses to which it will be put, the particular research method and purposeful sampling strategy employed, and the research product intended (p. 179).

Morse (2000) further concluded that, when semi-structured (interviews) questionnaires are used—garnering data with less depth than open-ended interviews—30 to 60 participants are needed. However, when the data are richer in nature, fewer participants are necessary for credible results. Sample size should not be so large as to either unnecessarily preclude or confuse deep, unit-oriented analysis (Sandelowski, 1995). It was hoped that a minimum of 30 student participants would

provide saturation of the qualitative data obtained via the open-ended questionnaire items. However, this number was not meant to preclude additional students from responding to the questionnaire items, although it was used to help guide the researcher toward appropriate schools to solicit for study participation. Thus, schools with larger student populations scheduled exclusively in community-based PMH clinical experiences were sought for this study. All students meeting the study criteria at the two participating universities were invited to participate in the study, making a larger sample possible. Four PMH nurse faculty members were expected to participate as well. Indeed, the inclusion of 30 faculty members is not practical given the preliminary numbers provided by the participating schools.

Current Study Procedures

Sample and Setting

A purposive sample of 42 BSN nursing students as well as four PMH nursing faculty from two large Midwestern universities participated in this study. One faculty member from each school served as a key informant, assisting the researcher with the identification of and contact with possible participants and additional information useful for understanding the phenomenon. The key informants provided rich descriptions about specific experiences at each school. They were also asked to participate in other aspects of the study, including the faculty focus group and/or individual member checking.

Four faculty members completed a semi-structured interview or completed the online questionnaire, which included open-ended questions. While an intended

faculty focus group was not completed due to low faculty volunteer rate, three faculty participants agreed to participate in individual member checking. Faculty inclusion criteria for interview or online questionnaire completion were that (a) they have university designation as adjunct, tenured, non-tenure track, tenure-track, visiting, clinical, or instructor nursing faculty in a traditional baccalaureate nursing program at a Midwestern university, (b) they facilitated at least one PMH clinical group in the preceding 24 months, and (c) at least one of their PMH clinical groups had spent an entire semester in a community-based PMH setting.

Specific inclusion criteria were used for student participants—namely, (a) they were junior- and/or senior-level nursing students enrolled in a traditional baccalaureate nursing program at a Midwestern university (from the identified schools discussed later in this section); (b) they had completed one semester of clinical experiences in PMH nursing; and (c) all of these clinical experiences occurred in community-based PMH settings.

Following final IRB approvals for this study at the University of Kansas, IRB approval was granted by three universities: Cleveland State University (CSU), Kent State University (KSU), and the University of Toledo. Ultimately, data was collected from two schools, CSU and KSU, as the third site (University of Toledo) did not respond. All PMH clinical experiences for CSU students occurred in community-based settings, with the key informant at KSU assisting in determining which clinical groups to include in the study. Students at both schools were typically assigned to one or two community-based PMH settings during the course of the semester and all

students were concurrently enrolled in another nursing course with a clinical component.

- Kent State University
  - located on their main campus
  - campus enrollment of 23,834
  - two faculty met study criteria
  - eight students met study criteria
  - community based settings included outpatient substance abuse treatment programs, crisis residential settings purposed to prevent inpatient hospitalizations, group homes, day programming and community mental health centers
- Cleveland State University
  - located on a single campus
  - campus enrollment of 15,000
  - five faculty meeting study criteria
  - 76 students enrolled in PMH in fall 2011, all meeting study criteria
  - community based settings include group homes, outpatient mental health centers, independent housing/apartments, hospice, 24-hour crisis setting, day programming and addictions outpatient

Data Collection Procedures

Key informants. Each of the deans of the participating schools were asked to name a key informant, whom the researcher contacted immediately following IRB

approval in order to schedule an interview (Appendix A) to gather needed data about the school, including (a) specific courses or sections of courses in which students meeting study criteria were enrolled, (b) number of faculty members teaching these courses, (c) number of faculty members who met study criteria (as key informants could identify additional persons, such as adjunct faculty members, not initially identified by deans), (d) community-based PMH clinical settings used in their programs, (e) number of weeks students spend in each setting during their clinical rotation, (f) number of hours students spend in clinical on a clinical day, (g) how faculty determine which settings to use, (h) how to best navigate their school for this study, and (i) assistance they may be able to provide in contacting possible faculty participants. These audio-taped interviews were approximately one hour in length and occurred at the convenience of the key informants. Confidentiality of shared information was maintained, and the researcher de-identified and transcribed each interview as soon as possible after its completion, saving it as a Microsoft Word document. In addition, contacts with the key informant occurred later in the study to gain additional descriptions of the phenomenon. Multiple data collection points per phone, email, and/or in-person occurred with the key informants from each school to gather additional specific, thick descriptions of the community-based PMH clinical experiences, student population, and other aspects that emerged from student and faculty responses.

Participants

Students. Faculty identified by key informants and/or key informants sent out initial emails (Appendix B) to students meeting study criteria after the students completed all scheduled on-site clinical experiences during the fall 2010 and/or fall 2011 semesters (Appendix C). This email explained the purpose of the study, invited students to participate, and provided a link to study materials, including the student questionnaire (Appendix D). Follow up emails were sent, inviting those who did not originally respond to do so.

Additionally, paper/pencil copies of the questionnaire were distributed in person to students who met study criteria at CSU, in December 2011. This distribution occurred immediately following a scheduled class in which all of the qualifying students were enrolled. Students were also offered the opportunity to self-select an online focus group if they chose to participate. The distribution of paper/pencil copies of the questionnaire was also planned for students at KSU, but was not accomplished due to multiple issues beyond the control of the researcher, including student enrollment in hybrid courses that met irregularly.

Faculty. During the initial interviews with the key informants, the researcher asked them to contact faculty members meeting the study criteria. During this contact with potential faculty participants, the key informants asked if the individuals were willing to participate in the study. If the potential faculty participants were willing, the key informant either provided the researcher's contact information (email and phone number) so that faculty could contact the researcher directly, or sent an introductory email to the individual to explain the purpose of the study, invite them to

participate (Appendix G), and provide a link to the study materials including the faculty questionnaire (Appendix H). Follow up emails were sent, inviting those who did not originally respond, to do so. Two faculty members chose to participate in the interview and two chose to complete the online questionnaire. Two of the four participating faculty were also key informants. The researcher was contacted directly by one faculty member, to whom the purpose of the study was explained and an interview was set up at the faculty member's convenience. Prior to the interview itself, written consent was obtained (Appendix F). One key informant also chose to participate in the interview and this same process was followed. The confidentiality of shared information was maintained, and interviews were de-identified and transcribed within 72 hours of their completion, saving them as Microsoft Word documents.

Study Questionnaires and Item Development

Items were designed to gain answers to the research questions. As previously discussed, questionnaire/interview guide items were directed toward learning outcomes defined as clinical competencies for generalist BSN graduates by the APNA (2008). Other guidelines were considered, but since the APNA guidelines are specific in nature and philosophically consistent with guidelines of the other nursing organizations, they were chosen for this study.

The questionnaires/interview guides went through multiple revisions based on feedback from current PMH nurse faculty (3), nurse faculty in other areas (2), nursing students (6), persons outside of nursing, and members of the dissertation committee.

Ultimately, two questionnaires/interview guides were developed, one for students and one for faculty. The interview guides, though not identical, were similar in nature.

Final questionnaires for both students and faculty included five demographic and 13 open-ended items, for a total of 18 items each. Both questionnaires began with an open-ended experiential question, and ended by asking for any additional information the respondent wished to share on this topic. Student and faculty questionnaires also included an item directed toward identifying perceptions of the students' ability to transfer knowledge gained in these clinicals, to other healthcare settings.

As previously discussed, eight of the open-ended items were based upon specific learning outcomes defined as clinical competencies for generalist BSN graduates by the APNA (2008). Students were asked to describe a time they used specific PMH nursing skills such as performing a mental status exam and using therapeutic communication techniques, while faculty were asked to describe their students' opportunities to learn and practice these same PMH nursing skills, during the students' community-based PMH clinical experiences.

Online Student and Faculty Focus Groups

In addition to the questionnaire and/or interview, students and faculty were invited to participate in separate asynchronous online focus groups and/or individual member checking conducted after all questionnaires and interviews were completed, thus resulting in two data collection points for some participants.

One online focus group was held for the four student volunteers, with questions introduced over five days. The mechanism for convening this focus group was to send an informational email to those agreeing to participate, including when the focus group would meet and rules for the focus group seven days prior to its being held. The student focus group occurred in March 2012.

Focus group interview questions were developed to provide respondents an opportunity to review and reflect upon preliminary themes and provide feedback as to whether or not these themes made sense to them and accurately reflected their perceptions of the phenomenon being discussed. An interview outline for the focus group discussions (Appendix I) included questions focused toward the opening/introduction, transition to the area of focus, key questions to this research study and ending or wrap-up questions (Kruegar & Casey, 2000). The discussion occurred over six days, with introductory/opening questions posted on day one, transitional/key questions posted on day three, and wrap-up questions on day five (Appendix I).

Opening questions were meant to highlight commonalities among participants, along with being factual in nature and quickly answered. Opening questions were posted on day one of the focus group and included (a) How would you like to be addressed within the group? (b) In what type of nursing clinicals are you currently enrolled? and (c) When will you graduate?

Meanwhile, key questions were meant to serve as the true focus of the study. They were developed first and posted on day three. Major themes and categories were

outlined, and students were asked to answer four questions: (a) Does/how does this theme ring true for you? (b) Does it make sense? (c) If it does not accurately portray your perceptions, how does it differ? and (d) How is it similar? Finally, ending questions were reflective and provided closure. They were posted on day five along with a summary of the previous responses and included (a) Is that an adequate summary? (b) Did I miss anything? and (c) Suppose you had one minute to talk to nurse educators across the country on use of community-based PMH clinical settings; what would you tell them?

Additional Methods of Data Collection

Campus visits. During the initial school visit, the researcher toured each campus, including any buildings in which nursing was taught, as well as several community-based PMH clinical settings used by the participating schools. The researcher recorded field notes of these experiences, de-identified them, and saved them as Microsoft Word documents for later reflection, comparison, and contrast of participants' responses to further the researcher's understanding of the phenomenon. No specific information included in the field notes was shared.

Artifacts. In addition, artifacts were collected during the campus visit(s) and/or via online/email contact with the key informants. Examples of artifacts collected included curricula, lists of PMH clinical settings used, student clinical and course assignments theory, handouts, course syllabi, prerequisite psychology courses, brochures explaining the programs to potential future students and concurrent nursing courses. Any assignments inclusive of a student name were immediately de-identified

and kept without record of any identifying information. These were used in to support findings from other study sources and provide historical and cultural background of the phenomenon. They were also assembled for further researcher reflexivity.

Data Analysis

Demographic Analysis

Demographic data was obtained from student and faculty questionnaires, interviews, and focus groups in order to include descriptive data purposed to quantitatively depict each data set. Descriptive data is provided in frequencies (e.g., the number of participants within a particular age group), the percentage of participants in each age group, and the number and percentage of participants with clinical experiences in each setting.

Six Steps of Content Analysis

For this study, the six-step process for content analysis identified by Elo and Kyngas (2008) was used for all qualitative data collection (informant and faculty participant interviews, student and faculty questionnaires, the online student focus group, and individual member checking). Elo and Kyngas (2008) identified six steps for content analysis that are logical, inclusive of others' published methods, well explained, and supported by the literature. The six steps followed were (a) preparation, (b) open coding, (c) development of coding sheets or book, (d) grouping, (e) categorization, and (f) abstraction process.

Preparation. This initial step involved the researcher: (a) downloading the data collected online into Microsoft Excel (b) transcribing all student questionnaires

that were completed via paper/pencil (c) transcribing all information collected via phone and/or in-person interviews, and campus visits/observations. The researcher personally transcribed and de-identified the thirty-three paper/pencil questionnaires completed by students and the two faculty interviews, with data from online questionnaires automatically transferred to a secured network database at the University of Kansas, School of Nursing (KUSON) and eventually sent in a Microsoft Excel file to the researcher through Kansas University Medical Center (KUMC) Secure Files© for review and content analysis.

As questionnaires and interviews were completed, initial data analysis began, with immersion in the questionnaire (paper/pencil and online) and interview responses, as well as field notes and artifacts. Following completion of data collection via questionnaires and interviews, all responses continued to be reviewed. Graneheim and Lundman (2004) suggested that entire interviews or entire questionnaires be used as units of analysis as they are large enough to be regarded as a whole while remaining small enough to be repeatedly considered as the context for meaning. This practice was followed in the current study. It was understood that these were the students' perceptions of competency in each of the skills identified; no definition of competency was provided.

Open coding. Next, notes and headings were added to the transcripts as they were repeatedly reviewed. This process was followed again and again until all aspects of the content were described in the headings (Elo & Kyngas, 2008; Hsieh & Shannon, 2005).

Development of coding sheets. Next, the codes that were written into the margins of the transcripts were transferred to coding sheets. Individual codes were defined by the data (i.e., what the respondents were saying – called meaning units on the coding sheets). The coding sheets were eventually used to develop categories, and their content was discussed with a peer de-briefer, the dissertation committee chair, and another committee member, as appropriate.

Grouping and categorization. Data headings from the coding sheets were grouped under broader, higher-order categories to allow for the description of the phenomenon as well as enhanced understanding and generation of knowledge. This was accomplished through constant comparisons, to identify headings that belonged and those that did not belong in the same category. This process enabled the researcher to move closer to describing the phenomenon related to student learning in community-based PMH clinical settings.

Abstraction. Finally, categories were named with content-characteristic words as the researcher moved from smaller, more specific subcategories to larger, more inclusive categories and eventually to main categories, as abstraction involves generating a general description of the phenomenon by generating categories. This process was repeated until all data was categorized under three main themes for students and three main themes for faculty, with no further delineation reasonable.

This mix of abstraction and "concrete realities" was indispensible for eliciting a practical and usable interpretation of research findings (Thorne, Kirkham, & MacDonald-Emes, 1997). These methods allowed for testing of emerging themes

while exploring alternative explanations (Marshall & Rossman, 2006), resulting in data integration and conclusions without forcing the data into predetermined or otherwise inappropriate categories.

Trustworthiness/Authenticity/Methodological Rigor

The four aspects of trustworthiness identified by Lincoln and Guba (1985) for all qualitative research studies—namely, credibility, dependability, confirmability, and transferability—were used to evaluate the trustworthiness of this study's findings. "Research findings should be as trustworthy as possible and every research study must be evaluated in relation to the procedures used to generate the findings" (Graneheim, & Lundman, 2004, p. 109).

Credibility. Credibility is defined as the "quality or power of inspiring belief" (Merriam-Webster, 2010, n.p.). Credibility was established in several ways, including multiple methods of collecting data, prolonged engagement, and peer debriefing. Prolonged engagement occurred, as the researcher was immersed in the relevant literature for several months and continued with this immersion throughout the study. In addition, the researcher is an experienced pre-licensure nursing student who has been employed as nursing faculty member for more than 20 years and who has more than 21 years of experience in the PMH field, in both community-based and non-community-based settings. Furthermore, peer debriefing was conducted with several fellow University of Kansas Ph.D. candidates experienced in qualitative methodology.

In addition, multiple ways of looking at the phenomenon examined were incorporated into this study's design, including the participation of student and faculty groups from two separate universities, questionnaires inclusive of open-ended items and/or faculty interviews, perspectives of the key informants, a collection of artifacts, a student focus group (March, 2012) and individual faculty member checking (April/May, 2012).. Those participating in member checking stated that the themes and categories made sense to them and accurately reflected their perceptions of the phenomenon.

Dependability. Dependability for this study was established based on the establishment of credibility and the use of an audit trail. Dependability in this methodology refers to "the degree to which data change over time and alterations in the researcher's decisions during the analysis process" (Graneheim & Lundman, 2004, p. 110). The difficulty in determining dependability in a qualitative study was best exemplified by Lincoln and Guba (1985): "Since there can be no validity without reliability (and thus no credibility without dependability), a demonstration of the former is sufficient to establish the latter" (p. 316). Thus, dependability was established by establishing credibility, as previously indicated. However, these authors did suggest one method for increasing the ability of others to depend upon the results of a study: the use of an inquiry audit. Therefore, an inquiry audit was included in the study to address both the process and product of the study.

Confirmability. Confirmability was provided in this study through the use of an audit trail. Confirmability refers to the extent to which the investigator's findings

are shaped by the participants' responses and not by the researcher's bias or ulterior motives (e.g., financial gain or notoriety) (Lincoln & Guba, 1985). Confirmability is usually provided through an audit, which includes virtually all aspects of the study and has a slightly altered focus from that of the inquiry audit, although in practice these are usually carried out simultaneously, as was the case in this study. Reflexive journaling and peer debriefing assisted the researcher with awareness of personal biases, allowing the researcher to concentrate on the experiences of the participants, rather than those of the researcher.

Transferability. Thick descriptions of the study data were provided to enable others to determine transferability of the findings. Transferability is generally described as the ability to apply the findings from one study to other contexts. However, this ability is dependent upon the degree of similarity between the contexts. Within the naturalist paradigm, an individual investigator is neither able to nor responsible for determining the transferability of findings to other contexts, although the investigator is able to and responsible for providing thick descriptions of the phenomena, thereby enabling others to decide if the findings are applicable to their own situation (Lincoln & Guba, 1985). Therefore, thick descriptions of the findings were provided to include a comprehensive summary of the data using uncomplicated, straightforward descriptions of students' and faculty members' perceptions of learning in diverse PMH clinical sites in everyday terms for practice and research dissemination (Sandelowski, 2000).

Authenticity

Authenticity criteria were also identified by Guba and Lincoln (1989), as essential when conducting a naturalistic study. Authenticity is concerned with the consequences of the study for the participants in regard to fairness, knowing (ontological and educative) and action (catalytic and tactical).

Fairness. Fairness is concerned with presenting a balanced look at all viewpoints presented in the study. Fairness was ensured in this study by presenting viewpoints of all participants, including contradictory information, in a balanced and fair manner and as close to the actual words of the participants as possible; a student focus group and individual member checking with faculty were also used to clarify the findings. Furthermore, peer debriefing was used to assess the fairness of the findings.

Knowing—Ontological and educative authenticity. Ontological authenticity refers to the impact that participation in the study has on participants' level of awareness of the phenomenon being studied, whereas educative authenticity is concerned with the participants' understanding of—although not necessarily agreement with—the viewpoints of others. Such authenticity was provided for in this study by assessing individual responses to the interview/questionnaire and focus group items for evidence of growth in understanding as well as respect for the viewpoints of others regarding the phenomenon being studied.

Action—Catalytic and tactical. Catalytic authenticity refers to the degree to which participation in the study results in the willingness, by those involved, to take some sort of action regarding the phenomenon; tactical authenticity is concerned with

their feelings of empowerment to act. These actions were provided for in this study via the focus group and individual member checking.

Ethical Considerations/Protection of Human Subjects

Prior to conducting this study, approval through the University of Kansas Medical Center Human Subjects Committee was acquired. Following IRB approval at KUMC and prior to implementing any research activities on the campuses of Kent State University and Cleveland State University, letters of permission from each school as well as their IRB approval were obtained, and these documents were submitted to the Human Subjects Committee at KUMC. These documents indicated that the particular institution allowed for recruitment of their faculty members and students for study participation. Student nurse and faculty participants were informed of the study objectives prior to making their decision to participate in the study. The researcher's email address, phone number, and postal address were included in the invitation to participate so that participants could contact the researcher with any questions. The invitation to participate also encouraged possible participants to ask any questions they had regarding the study. Participants were assured that their participation or nonparticipation in the study would not affect their student or faculty status in any way.

Participants were free to stop the questionnaire or interview at any time. All questionnaires were completed anonymously; information such as names and addresses were not collected, although demographic data was obtained. Every reasonable precaution was taken to ensure anonymity, including carefully crafting the

report of the data so as not to enable anyone outside of the dissertation committee to identify the response of a particular participant.

Participant confidentiality was maintained. The confidentiality of the data collected (including interview responses) was maintained by limiting knowledge of particular responses to members of the dissertation committee and only on a need-to-know basis. All transcripts were de-identified; thus no names, initials, or locations were listed on the documents. Tape recordings were destroyed following verbatim transcription. Password protected computers were used for all data storage.

Data from online questionnaires was automatically transferred to a secured network database at the University of Kansas, School of Nursing (KUSON) and eventually sent in a Microsoft Excel file to the researcher through Kansas University Medical Center (KUMC) Secure Files© for content analysis. Questionnaires were coded with consecutive numbers, one to forty-two for students and one to four for faculty. The researcher did not know any of the participants prior to the study and has had no contact with participants outside of the study. Completed paper/pencil questionnaires were maintained in a secure, locked location by the researcher. Following successful completion of the study, one hard copy of the data and one electronic version on a flash drive will be maintained in a locked, secure location, all other forms of the data will be destroyed. After fifteen years, all data will be destroyed.

Assumptions and Limitations

The collection of qualitative data via interviews, questionnaires and online focus groups requires and assumes participant honesty, introspection, and self-disclosure. In addition, the use of online questionnaires and online focus groups requires a preliminary level of electronic literacy and comfort with the process as well as a willingness to spend the time necessary to complete the questionnaire or discuss the phenomenon during an interview or online focus group in a thoughtful manner. However, the use of an online data collection process also provides the ability to access informants who would not be available using only an individual interview format.

Participants may be unwilling to share negative information regarding a clinical placement experience; thus, reliance on self-reporting must be considered as a limitation of this study. In addition, self-reporting is limited by participants' current level of insight. Indeed, students may not be aware of the impact of particular situations on their learning whereas faculty members' perceptions may be clouded by "tradition". In addition, the number of faculty members available to participate in the study is limited by the relatively low numbers of faculty teaching in this area at the participating schools. However, considering the scarcity of research on student nurses' and faculty members' perceptions of their learning in community-based PMH clinical settings, the current movement of nursing education into community settings, the international focus on the importance of PMH nursing, and the lack of traditional PMH clinical sites, self-reporting offered a valid method for collecting data in this qualitative, descriptive study.

Summary

This chapter has discussed the study's methodology, including both broad review of the literature on methodological choices and specific information regarding design, sample, and setting. The questionnaire/interview guide was discussed, with specific items identified to assist the researcher to answer specific study questions. Qualitative content analysis was discussed as the method for analyzing the data obtained. Chapter four will discuss the results gained from this study.

Chapter Four: Results

The purpose of this qualitative descriptive study was to explore how undergraduate student nurses and their faculty members perceive students' ability to achieve learning outcomes in community-based PMH clinical settings (group homes, independent apartments, forensic units, out-patient/day programs and a 24 hour crisis unit) and to transfer this knowledge to other health care settings. Chapter four presents the findings for the data collected during the study. This chapter includes a description of the sample and discussion of the process followed for the study. A thick description of the phenomenon is provided, including the discussion of subcategories, categories and themes.

Sample and Setting

The study sample included 42 traditional BSN students and 4 PMH clinical faculty members from 2 separate, large Mid-western universities: Kent State University and Cleveland State University. Students were able to participate by either completing an online questionnaire or responding to the same items using a paper/pencil format. Faculty participated in interviews or online.

Student participants. A total of 42 students completed the questionnaire, with 9 students participating in the online option, and 33 responding using the paper/pencil version. Student participants largely fell in the 18- to 24-year-old age range (81%). Eighty-six percent of the students were female, 84% were Caucasian, and 76% were in their junior year of the BSN program. Further information about student demographics can be found in Table 2.

Sites in which students practiced. Students participated in clinical experiences in a variety of settings, with most students going to two separate sites. Fifty percent of the students completed at least some of their PMH clinical experiences in group home settings, while 24% participated through out-patient/day programs. This day programming usually involved persons with chronic mental health disorders, though all experiences did not fall into this category. Seventeen percent of students learned and practiced their PMH nursing skills on a 24 hour crisis unit, with 14% working with patients living in independent apartments. Additionally, some students also went to locked units in extended care facilities or forensic units (7%) with one student (2%) going on home visits (Table 2).

Table 2

Student Demographic Characteristics

	Frequency	*Percent*
Age		
18-24	34	81
25-34	7	17
34-44	1	2
45+	0	0
Gender		
Male	6	14
Female	36	86
Ethnicity		
African-American	2	5
Asian	2	5

Caucasian	36	85
Hispanic	0	0
Other	2	5
Program Year		
Junior	32	76
Senior	10	24
Settings used		
24 hour crisis unit	7	17
Out-pt/day programming	10	24
Locked ECF unit/forensics	3	7
Group homes	21	50
Independent apartments	6	14
Home visits	1	2
	48*	*114

*Number does not total 42 or 100 as some students went to more than one setting

Focus group participants. Four students agreed to participate in the online focus group; their demographics are provided in Table 3. Three were female and one male; three students were in the 18- to 24-year-old age group, while one was in the 25- to 34-year-old group. Three self-identified as Caucasian and one as African-American; two were juniors and two were seniors. Running the focus group proved to be somewhat challenging as students were very busy personally and academically; however, following several reminders, responses were obtained.

Table 3

Student Focus Group Demographic Characteristics

	Frequency	*Percent*

Age		
18-24	3	75
25-34	1	25
34-44	0	0
45+	0	0
Gender		
Male	1	25
Female	3	75
Ethnicity		
African-American	1	25
Asian	0	0
Caucasian	3	75
Hispanic	0	0
Other	0	0
Program Year		
Junior	2	50
Senior	2	50

Faculty participants. All four faculty participants were female, in the 50+ age range, and Caucasian (see Table 4). They had between 12 and 30 semesters of experience teaching PMH clinical in community-based settings with pre-licensure undergraduate nursing students. Two faculty participants were also key informants, while two were not. Two faculty members completed the online option, and two provided their initial responses via in-person/phone interviews. Individual member checking was completed with two of the four faculty respondents.

Table 4

Faculty Demographic Characteristics

	Frequency	*Percent*
Age		
50+	4	100
Gender		
Female	4	100
Ethnicity		
Caucasian	4	100
Semesters Teaching PMH clinical		
10-20	2	50
21-30	2	50

Overview of themes. Three themes were identified by students and three by faculty. The themes, although not contradictory in nature, were not identical. Student responses will be discussed first. Appendix J provides a table of the themes and categories identified by students with Appendix K providing this information for faculty members.

Student themes. The first theme identified by the students, M*eeting the challenges of developing PMH nursing skills*, captures the students' thoughts and feelings on the crucial and fundamental components needed to develop PMH nursing skills. As one student stated, "It's a lot different than what you expect and almost

overwhelming at first. However, this setting helps you gain a lot of communication skills and confidence." Two categories were identified within this theme: (a) transforming attitudes and (b) therapeutic communication.

The first category, transforming attitudes, was distinctive in that the students reported how their overall view of mental health disorders and individuals with mental health disorders had changed. Regarding how their awareness regarding individuals with mental health disorders were altered, students stated, "It was life changing because it's my first time being exposed to it" and "[It's] completely eye opening. I had no idea these places existed and I was truly amazed and touched by the people in these locations." A third student reported,

> I would say it's a real eye opener. You get to see both sides to a mental disease. You will look at some of these residents and [you] wouldn't be able to pick them out of a group of people on the street and others you'll just want to help and find any way you can to help them just normally function in society.

Other students focused on their initial fear of patients developing into a feeling of comfort, thereby allowing learning to occur. While one student stated, "We found out one of the clients was accused of murder years ago and I realized that having that information scared me; however, it was a good learning experience and I would not have some of the skills I have without it"; another said, "You get a 'feel' for the population and realize they are not 'crazy or scary people." Still a third student

reported, "[in the beginning] you are working with a group of people you are not used to, it's uncomfortable at first, but by the end they have a place in your heart."

Furthermore, other students described how their preconceptions regarding persons with mental health disorders changed over the semester. According to one student, "I was able to confirm my own biases and know how to handle them." Another said that, without this clinical experience, "I would have been opinionated, judgmental and biased." A third student focused further in this area when she reported, "While working with these patients, it's important to have an understanding of self. You must listen and truly use [your] therapeutic self." Only two students reported that this clinical experience was not beneficial to them, thus providing additional confirmation of this theme and this category.

The second category, therapeutic communication, emerged from students' descriptions of their deepening understanding of the vital nature of this skill with regards to all other PMH nursing skills and their multiple dimensions. Two subcategories were identified within this category: (a) developing a one-on-one relationship and (b) developing group activities as meaningful interventions. Students' descriptions of a time when they used therapeutic communication techniques effectively were many and varied, with this area being the one most frequently referenced throughout all responses, including the skill most frequently used in other nursing situations (those outside of PMH) and a skill upon which others were built. Regarding the crucial nature of therapeutic communication, numerous

students emphasized the frequency of using these skills, using phrases such as, “every patient encounter,” “everyday,” and “I use my therapeutic communications skills with every patient.”

The first subcategory emerged as students described their experiences with patients in one-to-one situations. Some students emphasized specific skills they were practicing in this area. As one student described, “I am always reflecting and empathizing with clients’ experiences. I use silence a lot and I use active listening; just having someone to talk to can be very therapeutic.” A second stated, “Self-reflection is most important in TC.” A third simply said, “Silence is hard”. Other students focused on characteristics of patients with whom they developed a one-to-one relationship, such as “I spoke with a delusional pt who thought she was pregnant” and “I used therapeutic communication numerous times in this setting, especially with suicidal and depressed patients to get them to open up.” One student described using these skills with “a guy being diagnosed with alcoholism—I listened and supported, empathized.” Another student seemed to summarize the thoughts and feelings of several when she stated that nurses can “never fully prepare [themselves] for what the patients may say.”

The second subcategory, developing group activities as meaningful interventions, included students’ descriptions related to using their therapeutic communication skills in a variety of group settings. One student stated,

> Several times I got the opportunity to go to the children's center and organize activities for the children to participate in. I felt that therapeutic

> communication was established when each child voluntarily brainstormed methods to reduce anger, wrote each on construction paper and formed a group chain.

One area widely reported by students related to using these skills was in leading psycho-educational groups. One student described her experience as such:

> We did a group activity where everyone drew a memory that they had during which they experienced a particular feeling: fear, anger, happiness, and sadness. It was to help them identify what situations cause different emotions, and how to put words to their emotions so they would not necessarily have to use potentially inappropriate actions to express the feelings.

Another large group of students discussed using these skills in health fairs provided for residents of different agencies. Topics covered in the health fairs and psycho-educational groups were similar in nature and included stress, nutrition, distraction techniques, and hygiene. One student summed up the thoughts of many on therapeutic communication when she stated, "It really works."

Students participating in the focus group stated that this theme rang true for them and accurately portrayed their perceptions. Comments included, "I pushed past my own biases to help others, and now my perception is forever changed. My first thought was, "What have I gotten myself into? My end thought was, 'Wow. I'm really glad I got to have this experience!'"; "I used skills from therapeutic communication to probe, clarify, and empathize with clients. I found them to be fully functioning individuals with an issue that they were currently trying to resolve"; and

"I developed such respect for the individuals after this experience because I actually got to know them on a level that made them just another that I knew rather than a person with a mental illness." One student explained:

> I learned that mental illness is nothing like I thought. It changed my outlook on people with mental illness. Since it was my first experience with people who have a mental illness, I had pictured them to be violent, mean, unstable and uninterested in what I had to say. From now on I will take this into consideration when I interact with people.

The second theme, *Sharing multiple experiences of feeling competent*, captures students' perceptions of their competence in a variety of PMH nursing skills. According to one student, "Although I am still learning, I feel like I had an invaluable opportunity to practice nursing in a different way. The skills that I have gained in this branch of nursing are mainly the product of this clinical." Two categories emerged from within this theme: (a) various levels of competency and (b) still seeking competency.

The majority of students reported that they felt competent with most PMH nursing skills. When asked about how they would describe their overall competence with specific skills, students chose a variety of ways to portray their perceptions. Some students described feeling competent very succinctly: "I'd give myself an 'A,'" "good," "very good," "very competent," "competent," "OK," "satisfactory," "adequate," "proficient," "uncomfortable, but competent," and "satisfied in my competence." Other students described their feelings further: "I think it is safe to say

that I have become confident and comfortable with therapeutic communication," "I think I definitely improved my therapeutic communication skills because I was able to focus on this skill in clinical," and "I feel that therapeutic communication is a strength of mine and I am confident in my abilities."

When asked about how they felt their overall competence had been affected by the clinical experience students provided additional insights. Most attributed their improvement/competence directly to the clinical experience. Students stated that, without this experience, "I would have no idea what I'm doing," "I wouldn't know how important it is to speak to patients therapeutically," "I would be much less competent," "It would be difficult; it was a needed experience," "I learned so much; I would not be as competent," and "I would be greatly less skilled."

However, three students did not feel that the clinical experience was helpful in their skill development, although they believed that they were, nonetheless, competent. This included students who worked as patient care/nursing assistants in the PMH field. One student reported that the clinical experience "did not affect [my skills] much because I work in a psych nursing home."

The second category, still seeking competency, emerged as students described feelings of ambivalent competence and/or not feeling competent. Ambivalent competence captured the feelings expressed by nine students, with most reporting this ambivalence in regard to only one or two skills, and no skill identified more than another in this manner. Concerning feelings of competence with therapeutic communications skills, one student described herself as "confident, although unsure a

little"; another stated that "[these skills] are probably not as good as they could be. I find it hard to phrase my questions so they are open-ended." Still another said that, in regards to clarifying her values in working with individuals with mental health disorders, "It takes time; I have to remind myself not to react." When addressing competence in evaluating the effects of psychiatric medication, one student explained that "The more I learned in lecture, the more side effects I spotted at clinical"; another described her competence as "Good?"

Still other students (most, but not all of whom, also reported ambivalence with a skill as previously described) identified not feeling competent with one or more PMH nursing skills. While most of these students identified not feeling competent with particular skills (performing a mental status exam, evaluating the effects of psychiatric medications, and/or assessing a patient's potential for suicide), six students attributed these feelings to all/most PMH nursing skills.

One student seemed to sum up the feelings of several others regarding performing a mental status exam, when she stated that she felt "not very good. I need more practice to feel more confident." Other students described their feelings by evaluating the effects of psychiatric medications as "Probably not that great unless it's an obvious symptom" and "We only put what we thought they were on; [we had] no access to charts."

Although not feeling competent with PMH nursing skills in general was not identified by a large number of students, the six students who described these feelings were clear. One student explained: "I feel the residential setting did not fully allow us

to develop competency in all aspects of psychiatric care. I feel like we missed out on learning new experiences." Several other students simply responded "never" when describing a time when they performed a specific skill and "N/A" as their perception of their competence in that particular skill. The students participating in the focus group stated that this theme did ring true for them and accurately portrayed their perceptions.

The third theme identified was *Empowering all nurses through PMH nursing skills*. This theme captures students' use of PMH skills "across the board" and their increased feeling of confidence in their nursing practice. As one student stated,

> I am always interacting with clients, so therapeutic communication skills are very important to all areas of nursing. My psych teacher said it best: "To be a good nurse, you have to be a good psych nurse." I strongly believe it!

Two categories were identified within this theme: (a) the complex/holistic focus of the PMH nursing skill set and (b) using this skill set with individuals outside of the PMH clinical setting. The first category, the complex/holistic focus of the PMH nursing skill set, was distinctive in that the students reported how their overall view of the nature of these skills and of nursing care had changed. Two subcategories were identified within this category: (a) more holistic view of patients and (b) the complex nature of these skills.

The first subcategory emerged from students' descriptions of how their outlook for all patients had changed and become more holistic in nature. One student

stated, “I learned to focus on the person more so than the illness”; another said, “I now look at [all] my patients holistically—body, mind, spirit.” Some students focused more upon a change in their view of nursing care for individuals with mental health disorders:

> Without this experience I would not look at patients as holistically; I think it is good to not allow student nurses to see charts on mental health clients. This forced me to treat each client appropriately for the current state they were in and view them as a whole person, not just a diagnosis.

Other students focused on the complex nature of these skills, although the overlap with a holistic view was evident. For example, one student stated, “Working with mentally ill people can be very rewarding and it requires a unique set of skills” whereas another expanded further upon this ‘unique set of skills’:

> Application of nursing skills in this setting/field is much different than in a regular hospital. While all fields of nursing focus on specific patient needs, mental health nursing more specifically involves environmental, social, familial and behavioral aspects of care.

The second category—using this skill set with individuals outside of the PMH clinical setting—emerged from students’ descriptions of situations other than those identified as PMH situations in which they had used their developing PMH skills. Therapeutic communication was the major focus. This category includes two

subcategories: (a) using this skill set with patients in other school clinicals and (b) using this skill set in other areas.

Students described a myriad of experiences on many different hospital units (including medical-surgical, oncology, trauma, and intensive care (ICU), with one student identifying use of these skills in community clinical) in which they used their PMH skills. As one student described,

> I had a new admission on a med-surg floor. The patient was hearing voices and everyone was calling him crazy, and nervous about talking to the patient. With the background information I learned from my psych clinical, I was able to enter the room, explain the procedure to the patient, confidently state that I didn't hear the voices but I did believe he could hear them, and assist the nurse in performing the assessment and admission information.

Several students discussed using these skills with depressed patients. One student described assessing multiple patients on medical-surgical floors for suicide potential while another student stated, "On several occasions, I cared for patients on the medical surgical unit who had cancer and subsequent depression. I was able to use methods of therapeutic communication (learned in mental health clinical) with these patients."

Still other students identified using these skills to decrease patients' anxiety. One student described such a situation in which she was working with a patient who "was experiencing serious anxiety due to the injuries she suffered from a bad car

accident." Another said, "I had a very anxious patient on a med-surg floor and we talked over her issues. She stopped crying and discussed things rationally and she said she felt much better after our discussion."

The second subcategory, using this skill set in other areas, includes students' experiences using these skills outside of school clinical settings. Students reported using these skills in many areas of their lives, including work-related healthcare settings and with family, friends, and others.

Several students described using skills developed in their PMH clinical in their roles as patient care/nursing assistants. These students stressed the importance of newly acquired non-verbal communication skills, including the ability to "read body language" as a way of improving care. One student mentioned using "calm language" in upsetting situations. Students also acknowledged the use of these skills with family members, such as: "I have a cousin with schizophrenia that I was able to communicate with" and "My cousin—he's bipolar; we deal with his issues as a family. I'm better able to help with this now." Students also reported using these skills with friends/others. According to one student, "There's a mentally disabled grocer that I am comfortable talking to [now]"; another said that he had used these skills "at home with my girlfriend—she was having an anxiety attack."

It is evident that students found PMH nursing skills useful and empowering in their lives as nurses and as "people." Indeed, one student explained:

> This clinical has been an eye opener. I think that if I did not have this clinical I would not be as prepared going into nursing. You have

> psychiatric patients enter into every other division of nursing and knowing how to communicate with patients (mentally ill or not) is a crucial part of nursing. Also dealing with patients with mental illness is really important in maintaining patient and self safety.

The students in the focus group also stated that this theme rang true for them and accurately portrayed their perceptions. For example:

> I learned from this experience that people are people first. I think as nurses we focus on what the "problem" is and not the patient themselves. This has changed for me. My goal is to use this thought process with all my other patients in all my other clinicals and eventually when I graduate and get a job in a hospital.

Message to PMH faculty regarding these experiences. When students in the focus group were asked what they wanted PMH nursing faculty to know about these experiences, they provided additional responses that were helpful in understanding the phenomenon under study while further confirming the study's results. One student explained that,

> I think it helps nursing students to see what interventions are needed for successful community living and what needs to be put in place to help prevent relapse. Though during our clinical experience I was frustrated at times, it turned out to be a really great experience. We really got to put the nursing process to use and learned how to work better in the community.

Others stated that, “I was glad I had the community health experience because I felt the community was a laid back setting where I got to learn about mental illness and talking to people. I feel better prepared for other nursing experiences after going through this clinical” and “It was relaxed and almost informal, so it took my anxiety level down a lot. I was so comfortable. It was easier to learn.”

> This setting plays a significant role in teaching students the right and wrong way to therapeutically communicate. It reinforces what we have learned in the classroom. Talking about how we communicated helps us to see what was therapeutic and what was not. Also, a nursing student can see examples of how pharmacologic and non-pharmacologic therapies are either helping or not helping community members. One can also see the different levels of compliance with therapy as well as observe socialization skills.

Faculty themes. “For the things we have to learn before we can do them, we learn by doing them” (Aristotle, n.d.). One faculty member summed up the feelings of the others regarding student learning in community-based PMH clinical sites when she stated, “It’s experiential, active learning; students gain familiarity and develop skills with clients with various mental illnesses.”

The first theme, *Seizing the day(s)*, captures the faculty’s thoughts and feelings on the importance and finite nature of this clinical experience and includes one category: maximizing the opportunity. Faculty felt that maximizing the opportunity was particularly important in that “[students] don’t get this emphasis in

any other class or clinical experience." One way learning was maximized was that students became comfortable with PMH clients more quickly, thereby allowing for more practice of these skills.

> Community psych is such a wonderful learning experience for students…so many [students] take so long to get over the fear in acute psych settings that they miss out on so much. The fear decreases much more rapidly in a community psych setting.

Another faculty member focused on comparing these community-based settings favorably to inpatient experiences, thereby providing for better use of student clinical time:

> Whatever they miss by not going to an in-patient unit, they make up in other areas…one of the things that they get is the overlap between disciplines. The continuum of psychiatric care and treatment of chronically ill people… [these clients] are homeless, jobless, no money, no ride to an appointment, spent their money on cigarettes…they [the students] get all the economic overlap—it's invaluable.

Another reported,

> It's OK that they're not getting restraint care—they get that on med-surg units. Missed opportunities on in-pt units are not as useful to students as opportunities available in out-patient settings. An example

> of this is short-term stays on inpatient would limit [the] "long-term" work they do with clients.

However, faculty agreed that students need to move out of their comfort zones to make the best use of their clinical time at these sites. As one faculty member expressed,

> [the students] can get it [the experiences], but they have to take the initiative. They have to put themselves out there. Some hold back…the potential is there, but I can't be there with each of them as they interact with everyone.

Another reported, "They have to take some of the initiative there…choose who to talk to, to interact with."

Faculty also acknowledged their vital role in providing opportunities to be seized. "I do all kinds of things…giving the different experiences, different settings, patients with different needs…I rotate them to different sites." Another said, "I role model to the students how to interact and communicate therapeutically with this population. I demonstrate and assist with running therapeutic and psycho-educational groups."

Faculty felt strongly that these community settings provided a plethora of situations in which students could learn and practice their PMH nursing skills. As one faculty member stated, "These settings afford the student an opportunity to establish a therapeutic relationship, work on their communication skills, and learn about using therapeutic self as a tool." Seizing the day(s) in regards to maximizing learning is a

combination of providing the right experiences with the appropriate mix of guidance and encouragement, thereby allowing each student to reach his/her potential during this limited clinical experience.

The second faculty theme, *Sharing the road to competency*, captures the faculty's perceptions of how students moved from inexperienced novices to competent practitioners. Two categories emerged within this theme: (a) natural opportunities for learning and practicing and (b) additional opportunities for learning and practicing. Overall, faculty believed that students gained competence in most—if not all—PMH skills through their clinical experiences in community-based PMH clinical sites.

The first category, natural opportunities for learning and practicing, was distinctive in that faculty identified specific skills that students had an increased or decreased likelihood of using with clients in their PMH clinical setting. Faculty members indicated that students had the best opportunities to learn and practice therapeutic communication, including teaching aspects of managing psychiatric symptoms, participating in MH promotion activities, clarifying their own values in working with persons with psychiatric disorders, and maintaining a therapeutic relationship with someone with chronic mental health disorder. Students had "unlimited opportunities to learn and practice therapeutic communication in groups and one-on-one." One area in which faculty noted that students showed particular growth was clarifying their values. As one faculty member stated,

> They come in with stigma, fear and ignorance. The most common thing I hear after is, "I found out they're just like us." One requirement is to go to an AA meeting. Many go with a buddy; then they write it up. Again they say, "They look like you and me" and you realize how biased they were going in.

Faculty also identified skills that students had fewer opportunities to learn and practice during their PMH clinical, including performing mental status exams, evaluating the effects of psychiatric medications, and assessing the potential for suicide. However, some community-based settings did allow for extensive student practice with these skills. In addition, faculty believed that students gained at least a beginning level of competence in all PMH nursing skills and that students improved in all skills over the semester.

The second category, additional opportunities for learning and practicing, was distinctive in that it included complementary ways of facilitating PMH nursing skill development when "natural" experiences were not as readily available. Faculty facilitated student learning by having students practice mental status exams and assessing for suicide potential with each other, using a variety of assessment forms/outlines, and by having weekly discussions on medications. Students also taught clients about their medications, how to cope with problems such as hallucinations, what to do if they were considering hurting themselves or someone else, and how to recognize early warning signals of problems in these areas. Students ran groups on these topics and discussed these issues one-on-one with clients, thereby

providing additional learning opportunities. As one faculty member reported, "If you want to really learn something, teach it to someone else." Another stated, "Groups are an opportunity for meaningful learning for students and patients." In fact faculty members believed that students' competence in PMH nursing skills would be "terribly compromised" without these experiences.

The third faculty theme, *Empowering students in all areas of nursing*, captures their belief that "increased confidence, comfort and understanding with individuals with mental illness, allows students to provide the best nursing care for these persons in other healthcare settings." This theme includes one category: using PMH skills with individuals outside of the PMH setting. As one faculty member stated,

> There is no point in teaching psych in a vacuum…medical problems are compromising [patients'] mental health…patients deal with these [issues] all the time, so nurses do, too. So many nurses in medical areas don't pay attention to these issues; they [the students] learn how to listen better, focus—"I'm not just there to start an IV."

A second reported,

> We need to redefine it [psychiatric nursing]. Take it outside the specialty and link it to all of nursing practice. I had a student whose patient was threatening her with a full urinal. I asked her "what does he want? What does he need? You've got to go to the window—tell

> him when you will do what—it will probably take several tries." On the third try, he put down his urinal; she never forgot it.

Faculty had numerous students who reported using these skills outside of their PMH clinical.

> I have a lot of students who work as aides, techs. I have many students who were asked to be a sitter for a patient who was suicidal and on a med-surg unit. In ER [student was in a student role]—a patient came in and had cut themselves. I emphasize using it in other settings—most of my students don't like psych and don't plan to go into it. I'm constantly linking it to other settings—SSRIs [Selective Serotonin Reuptake Inhibitors]—those are so widely prescribed—serotonin syndrome—these are psych topics. I'm constantly making these links.

According to one faculty member,

> They have found that they are treating individuals with mental illnesses in all areas of the health field. Having worked closely and comfortably with these clients in the community, they feel less afraid and more confident to give these patients the attention and care they deserve. They say they have a better understanding of them and are more comfortable with them.

Another said that "[the students] describe it every day as they are in med-surg or OB/Peds along with psych; some also describe experiences in these areas as they work as techs."

Faculty also identified the stable nature of clients in these community-based settings and how that stability enhances students' ability to use these skills in other areas. "Most nurse generalists will work with patients who are stable MH-wise [like these patients]"; "[the] stability of patients allows students more opportunity to transfer skills to other healthcare settings." Another faculty reported, "Physical [health] and MH affect each other and cannot be addressed independently." In these settings, "Students learn to listen and focus on the patient, not on the task."

Summary

This chapter has summarized of the results of the study, exploring students' and faculty members' perceptions of student learning in community-based PMH clinical settings. Data were collected using interviews, online questionnaires, campus visits, and artifacts. Forty-two students participated, along with four PMH clinical faculty members. A qualitative descriptive approach was used. The sample included pre-licensure traditional BSN students from two large, Midwestern universities. The student participant sample was largely (more than 80%), Caucasian females in their early twenties. All four faculty members were age 50 or older, Caucasian, and female.

Chapter Five: Discussion, Conclusions, and Recommendations

This study explored how undergraduate student nurses and their faculty perceive the students' ability to achieve learning outcomes in community-based PMH clinical settings (group homes, independent apartments, forensic units, out-patient/day programs and a 24 hour crisis unit) and to transfer this knowledge to other health care settings. This chapter provides a discussion and implications, as well as specific strengths and limitations of the study. In addition, recommendations for future research are provided.

Discussion

It is crucial for clinical experiences to provide opportunities for students to meet objectives that are important for all graduate nurses. Nursing faculty is constantly concerned with affording students these best opportunities for learning which frequently includes community-based PMH clinical settings; however, little is known of what students are learning in these sites. The following discussion will be guided by the research questions:

1) What are student nurses' perceptions of their ability to achieve learning outcomes in community-based PMH clinical settings?
2) What are faculty's perceptions of the students' ability to achieve learning outcomes in community-based PMH clinical settings?
3) What are student nurses' perceptions of their ability to transfer knowledge gained in their community-based PMH clinical experiences to other healthcare settings?

Research Question One

The first research question asked "What are student nurses' perceptions of their ability to achieve learning outcomes in community-based PMH clinical setting?" This question was answered through student themes one and two.

Regarding student theme one, *Meeting the challenges of developing PMH nursing skills,* students identified many different experiences which helped them to transform their attitudes (clarifying their values) about mental health disorders and persons with mental health disorders, moving from fear and misunderstanding to comfort and understanding. They also identified a myriad of examples in which they learned and practiced therapeutic communication in both group situations and one-on-one with clients.

Although there is little evidence of what students are learning in these non-traditional community-based PMH settings, this theme and categories are well supported by previous studies involving student nurses in more traditional PMH clinical settings (Proctor & Hafner, 1991; Melrose & Shapiro, 1999; Hung, Huang & Lin, 2009; & Ketola & Stein, 2012). Proctor and Hafner (1991), asked 51 second-year students to complete a questionnaire prior to and following their five day, traditional in-patient, PMH clinical experiences. Almost half of these students reported that their interactions with patients on these units helped dispel stereotypical attitudes that they had prior to the experience, with the second most frequent response to their questionnaire that they were "surprised to find that psychiatric patients are

normal people with illnesses" (p. 847). Melrose and Shapiro (1999) conducted a qualitative study of six BSN students on a traditional PMH in-patient unit. They found that previous to their clinical experience all six students were "afraid of patients on the unit who might hurt them and anxious about their own ability to help" (p. 1454). However, following their clinical experiences, none of the students described feeling fearful of these individuals; in fact they demonstrated respect and admiration for them.

Themes identified in a recent phenomenological study, are completely consistent with the findings of the study, as Hung, Huang, & Lin (2009) identified the theme of "breaking the stigma of mental illness" (p. 3129), which included removing the stigma attached to mental health disorders and persons with mental health disorders and developing a relationship with individuals with a mental health disorder. A second theme emerging from their study was "developing a trusting relationship" (p. 3130), which supports this study's second category, inclusive of developing one-on-one relationships with persons experiencing PMH illnesses. Additionally, Ketola and Stein (2012) conducted a study with 67 baccalaureate nursing students, pre/post their PMH clinical experiences. They reported that nursing students had 'life changing experiences', during which they changed their attitudes about mental health disorders and those with mental health disorders, as well as increasing their listening and communication skills and developing empathy.

Furthermore, in a recent study using a non-traditional community

setting for approximately one-third of students' PMH clinical hours, Hampton (2012) found that many students reported an increase in their listening skills, as well as a change in their personal beliefs about mental health disorders and persons with mental health disorders, that they attributed to their experience in the non-traditional setting, thus providing additional support for this study's findings.

In, perhaps, the most noteworthy study in regards to findings as applicable to this study, Happell (2008) found that "The mean scores [regarding stereotypical beliefs] for students who undertook their clinical placement in a community-based [PMH] service were significantly lower than those of students' whose placement was in either an acute or rehabilitative bed-based service" ($p=.001$), thus indicating that their community-based clinical was effective in helping students to see individuals with mental health disorders in a new light (p. 30).

Student theme two, S*haring multiple experiences of feeling competent,* also helped answer this research question. Students described their feelings of competence with eight different PMH nursing skills. Students described feelings of competency, not feeling competent and feeling ambivalently competent in various skills. Considering the diversity of learners, learning styles, and clinical settings, it is not surprising that students reported differing levels of feeling competent and that six students reported not feeling competent with the majority of skills. However, generally, students in this study described their ability to achieve learning outcomes

in the majority of PMH nursing skills during their clinical rotation in community-based settings. Students provided many examples of their experiences practicing specific skills, and their overall descriptions were of competence and improvement in these skills during their clinical time in a variety of community sites.

This second student theme is also supported by previous research involving students in more traditional PMH clinical settings (Happell, Robins, & Gough, 2008; Hung, Huang, & Lin, 2009). Based upon the responses of 148 undergraduate nursing students, Happell, Robins and Gough (2008) found that most students felt prepared to care for persons with mental health disorders following their PMH clinical experiences. A third theme identified by Hung, Huang, and Lin (2009), "gaining professional knowledge and skills" – which was inclusive of "practicing skills and applying the knowledge of PMH nursing" - was also very consistent with the second theme of this study, as they reported student nurses' feelings of "success" and "achievement" (p. 3131) when they were able to reach their goals or objectives and practice specific PMH nursing skills. However, these findings are contrary to those of Melrose and Shapiro (1999), who found that students on a traditional, in-patient PMH unit did not feel competent to work with patients experiencing mental health disorders at the end of their rotation.

After approximately 150 students (65% of a possible 229 students) completed their PMH clinical experiences, some of whom were in non-traditional community-based settings, while others were in traditional in-patient settings (the numbers in each setting are unclear), Henderson, Happell and Martin (2007) asked students their

perceptions of their competency in a number of PMH nursing skills. They reported that generally, students felt more confident in their skills following their clinical experiences. They also found no statistically significant difference in student perceptions ($p < .05$) of their competency based upon placement in a traditional or non-traditional setting.

Research Question Two

Research question two—"What are faculty's perceptions of the student's ability to achieve learning outcomes in community-based PMH clinical settings?"—was answered using faculty themes one and two. Faculty theme one, *Seizing the day(s),* helped provide insights into faculty's thoughts and feelings on the unique nature of PMH clinical experiences. Faculty members expressed a desire and an ability to maximize the opportunity in these community-based sites as students are unable to focus on these skills in other nursing clinical settings. Thus, faculty members felt a responsibility to maximize each clinical day.

Virtually all studies in this area identify the importance of using student clinical time well, as it is limited in nature and typically students do not focus on these topics in any other course work (Henderson, Happell, & Martin, 2007; Happell, 2008; Happell, Robins, & Gough, 2008; Hampton, 2012; Ketola & Stein, 2012). Henderson, Happell and Martin (2007) discuss the problems of limited clinical time in PMH and state that this issue was discussed in a Senate committee meeting in Australia in 2002. Happell (2008) focuses on using preceptors for at least a portion of the limited clinical time, as she found that students who spent more time with a preceptor/mentor

felt more prepared to work with patients in PMH. Happell, Robins and Gough (2008) discuss the importance of theory in PMH and how it relates to successful clinical experiences, while Hampton (2012) looked at how to best use limited PMH clinical time in an accelerated pre-licensure program. Ketola and Stein (2012) focus on the importance of student nurses learning to help all patients handle emotional stress and how the limited PMH clinical time assists students in this area. Many different approaches are being used, including journaling, use of pre- and post-conferences for skill development, case studies, and role playing, but all are focused toward maximizing the students' limited clinical time in the best possible manner.

In faculty theme two, *Sharing the road to competency,* faculty indicated that students are generally able to learn and practice a variety of PMH nursing skills in the community-based settings available to them, and that the great majority of students improve and achieve competence in most PMH nursing skills during this clinical experience. Faculty members also identified several skills in which they create learning experiences via pre- and post- conferences, providing students with additional opportunities to learn and practice these skills as well as gain increased competence.

Faculty is very creative in the methods they employ to insure students' have the best opportunity for learning and practicing PMH nursing skills. Happell (2008) and Wood (2010) stress the importance of using preceptors or mentors to assist students individually with these skills, while Hampton (2012) focuses on students working

one-on-one with an individual with a mental health disorder in the community, and Kidd (2004) asks her students to write a poem about their PMH clinical experience. Most researchers have found that students do have multiple opportunities to learn and practice PMH nursing skills during their clinical experiences in traditional settings (Happell, Robins, & Gough, 2008; Huang, Hang, & Lin, 2009; Wood, 2010) though little is known of student experiences in non-traditional settings. However, Happell's (2008) findings, as previously discussed, do support this study's findings that students in non-traditional community-based settings are able to learn and practice most PMH nursing skills and become competent with them.

Research Question Three

Research question three—"What are student nurses' perceptions of their ability to transfer knowledge gained in their community-based PMH clinical experiences to other healthcare settings?"—was answered using the third theme for both students and faculty. This third student theme, *Empowering all nurses through PMH nursing skills*, specifically included students' examples of how they are using the skills learned in their community-based PMH clinical experiences in a variety of nursing and non-nursing settings. Students described the complex/holistic nature of these skills and how they now see patients as individuals, rather than as "tasks" to accomplish. They also provided many examples of how they used these skills in medical-surgical, ICU, ER, and community nursing settings. They described using PMH nursing skills with family, friends, and others, helping friends who were having anxiety attacks while feeling better equipped to interact with persons disabled in a

variety of ways within their communities. They see mental health in a different light and are ever-expanding their use of these skills. Furthermore, faculty theme three, *Empowering students in all areas of nursing,* describes faculty's perceptions of students' competence when using PMH skills in a variety of nursing settings, outside of PMH. Faculty discussed the many clinical situations in which their students have used these skills, including experiences in ICU, obstetrics (OB), pediatrics, community, and medical-surgical nursing, thus reinforcing students' perceptions by demonstrating that students are able to use the skills learned in this clinical experience in non-PMH settings. As most students do not plan to go into PMH nursing, the ability to transfer this knowledge into other healthcare settings is imperative. Faculty members expressed a need for students to use these skills outside of the "vacuum" of psychiatric nursing and provided many examples of how their students are indeed doing so.

Although there is little research in this area, the third student and faculty themes in this study, are also supported by previous studies (Happell, 2008; Happell, Robins, & Gough, 2008; Ketola & Stein, 2012). While Wood (2010) asserts the need for PMH nurses to be able to care for the physical needs of their patients as many have coronary and/or respiratory illnesses, as well as other medical issues such as diabetes, this assertion also points out the necessity of all nurses to be competent working with patients experiencing PMH illnesses. Though not the focus of their study, Happell, Robins, and Gough (2008) asked students if they felt their PMH nursing course had prepared them to work in medical-surgical nursing. Most students reported that they

felt that the class had helped them in this regard, though no specifics, as to how it had helped the students, were identified. Ketola and Stein (2012) explored if working with PMH patients would assist future nurses with helping 'all' patients with different emotional issues. The authors reported that many students planned to transfer these skills and use them throughout their nursing practice. Furthermore, in a study that looked at perceptions of 703 undergraduates following their PMH clinical experience, Happell (2008) found that most students felt mental health nursing provided a valuable contribution to their future nursing careers, with students in community-based settings perceiving this contribution as more significant than those in more traditional PMH settings ($p=.0005$) . These findings also support statements by the Academy of Medical-Surgical Nurses (2012) and the American Association of Critical Care Nurses (2012) in regards to the importance of, and need for, competence in PMH nursing skills, for all nurses.

Additional Findings

One surprising finding in this study was that most students who responded "never" or "N/A" in describing a time that they performed a majority of these skills and/or their competence with them still felt they had learned/changed from the clinical experience. One student who described herself has not having the opportunity to perform six of these skills stated that, without this experience, she "would not understand mental illness." Another student who identified that she was unable to perform/did not feel competent with five of the skills said that, "Overall it was a great

experience, I learned a lot. This course really helped me improve my performance and effectiveness as a future nurse."

Implications for Nursing Education

Student suggestions for improvement. Students' suggestions for improving the clinical experience tended to focus on three areas: having direct access to patient charts/medication records, performing more "formal evaluations" (especially regarding mental status exams, effects of psychiatric medications and assessing suicide potential) compared to informal assessments that were completed weekly, and spending some clinical time on traditional in-patient PMH units. The amount of time students identified as appropriate to spend on in-patient units ranged from one to eight weeks. Most who included this, stated a desire to "see what it's like on an in-patient unit", but no one stated a desire to spend an entire semester on such a unit. As one student explained, "It's good to see people stable and in the community, but I didn't get to see things like seclusion and restraint."

Additional implications. The many faculty examples of strategies used to assist students in maximizing their clinical experiences can be applied by future nurse educators. Focusing on providing additional planned opportunities for students to learn and practice performing mental status exams, assessments of patients' suicide potential, and evaluations of the effects of psychiatric medications would further enhance opportunities for students to achieve competency in these skills. These additional opportunities could include modeling while working with 'real' patients

and/or role playing with a group of students, as these strategies were identified by faculty and students, in this study, as helpful in student learning. Furthermore, based on faculty feedback, many students were performing mental status exams, though they did not recognize them as such, thus indicating a disconnect between faculty and students. Frequent use of this terminology by faculty, when discussing mood, thought content, etc., may help students better understand the concept of a mental status exam and that they are, indeed, performing at least a "mini-mental status exam" on their patients on a routine basis while in community-based PMH clinical settings.

Additionally, simulations may be considered that directly assist students to transfer the skills learned in PMH to a multitude of other settings. These settings may include (a) a patient who recently attempted suicide and is in an ICU, (b) a mother with bipolar disorder whose son is in the hospital with leukemia, and/or (c) a patient seen during a community health home visit for complications of diabetes who also has a diagnosis of schizophrenia. For those with clinical experiences in more traditional PMH settings, simulations could be specifically aimed at situations in which patients with a primary diagnosis of a mental health disorder are stable and functioning in the community, rather than experiencing psychosis on a traditional in-patient unit. Additionally, a patient could be 'followed' per an unfolding case study that moves students through a patient's experience with their illness on a traditional in-patient unit and out into the community where they encounter difficulties such as transportation to medical appointments, cost of medicines, and weighing the

advantages and disadvantages of staying on medications that have significant, permanent side effects.

Students and faculty both identified that working with stable patients in community-based settings, allowed students to become comfortable with patients experiencing a mental health disorder more quickly, thus 'increasing or extending' the clinical time available to students to learn and practice these skills. As these clinical experiences are limited, and may become more so in the future, the ability to increase the amount of useful clinical time is noteworthy. Faculty also reported that clinical experiences in the community allowed an easier transition for students in using these skills with persons outside a PMH setting. Additionally, students who perceived themselves as unable to learn and practice the majority of PMH nursing skills in these settings, still reported that they felt the experience helped them better understand mental health disorders and 'improve their performance and effectiveness as nurses'. As previously stated, all nurses work with patients experiencing mental health disorders, though most do not work in PMH. In this study, the majority of students not only perceived that they were able to transfer knowledge learned in these clinical experiences outside of PMH, but actually did transfer this knowledge and use these skills in other healthcare settings.

Strengths and Limitations of the Study

Use of a qualitative descriptive approach was extremely valuable in exploring students' and faculty members' perceptions of students' ability to achieve PMH

clinical competencies in community-based PMH clinical settings. Allowing students and faculty to express their thoughts, feelings and experiences in their own words, allowed for a thicker, richer description of the phenomenon, than would have been possible with many other approaches. As little or no research has been done in this area, this study contributes to greater understanding of student and faculty perceptions while the thick, rich descriptions allow others to determine if/which of the findings are transferrable to their particular situations.

An additional strength of this study is that data was collected from BSN students who participated exclusively in community-based PMH clinical experiences. Many students across the country split their clinical time between acute or chronic in-patient settings and community-based sites. Although students who participate in both experiences could be asked to separate their perceptions regarding their ability to achieve learning outcomes in one setting versus the other, this was not required of the students participating in this study. Furthermore, students and faculty were from the same schools, sharing their perceptions of some shared experiences.

A third strength of this study was that all four faculty members had extensive experience teaching PMH nursing clinicals in both traditional acute in-patient settings and community-based settings, thereby affording them the ability to see student progress through a varying lens, and provide additional perspectives on this phenomenon. Additional strengths include that students and faculty were from two separate universities, students were both juniors and seniors, and a variety of

community-based settings were used by the participating faculty and students. Moreover, responses from the student focus group further confirmed findings of the study.

Limitations to the study include that the faculty findings were based upon responses from four faculty members, two of whom were also key informants in the study. The limited number of faculty teaching these clinicals restricts the number of possible participants, even from larger schools, thus providing additional importance to thick, rich descriptions of the phenomenon from the perspective of those who do participate. An additional limitation was the small number of students agreeing to participate in the focus group. However, descriptions provided by these students truly informed the study and further confirmed its findings. Also, paper/pencil copies of the questionnaire were distributed at only one of the two study sites. Though this was due to multiple issues beyond the control of the researcher, it remains a limitation of the study.

Recommendations for Future Research

Additional research in this area is vital in further defining how to best help students achieve PMH learning outcomes. Though these skills are needed by all nurses, they are not emphasized in other clinical courses.

Looking at student and faculty perceptions of student competence in these outcomes, following clinical experiences in traditional in-patient settings, would further advance understanding. In addition, comparing student perceptions of their

competence in PMH nursing skills, when traditional, non-traditional community-based and a combination of these options is provided, would further inform nurse educators as to how to best help students attain these competencies in the situations in which they find themselves, as well as how choose the best clinical settings, from those available to them.

Focusing research on interprofessional teams and approaches to learning about mental health disorders is also an important avenue to pursue. If the goal of assisting each individual to achieve his/her highest level of wellness is to be achieved, nursing must collaborate with a variety of other disciplines. Persons with mental health disorders interact with social workers, 'medical doctors', psychiatrists, psychologists, dieticians, nurse practitioners, pharmacists, case managers, and clergy, to name only a few. It is important to learn from others' perspectives, so that those involved truly work as a healthcare 'team'.

Much of the previous research has been focused toward attitude change and therapeutic communications skills, which are very important. However, it is evident that most students do not enter the PMH nursing field, yet are in need of competency in many PMH nursing skills. Future focus on the ability of students to transfer knowledge gained in these clinical experiences to other healthcare settings is an area for additional study.

Conclusions

There has been little or no research conducted on the ability of student nurses to achieve competency in PMH learning outcomes, when clinical experiences are solely in non-traditional, community-based settings. However, more and more schools are using these sites and thus spending less time on traditional acute or chronic in-patient psychiatric units. This study has assisted in the acquisition of nursing knowledge by providing findings of student and faculty perceptions of student nurses' ability to achieve PMH learning outcomes in these settings. First and foremost, students generally perceived that they were able to achieve these outcomes when completing their PMH clinical rotation in non-traditional, community-based settings. The findings have also identified areas in which some students feel they need additional learning opportunities to best achieve these outcomes – performing mental status exams, assessing patients' potential for suicide and evaluating the effects of psychiatric medications. They have also identified areas in which students most identified personal growth in confidence and competence – therapeutic communication and clarifying their values related to working with patients with mental health disorders. Faculty perceptions supported student perceptions in this study. The qualitative, descriptive approach provided thick, rich descriptions of this phenomenon, which are truly imperative when little is known**.**

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Appendix A

Letter to Key Informants

Dear _____ (name of faculty),

As a faculty member at _____ (name of school), who was identified by _____ (name of dean) as having knowledge regarding undergraduate nursing student experiences in community-based psychiatric mental health clinical settings, you are being invited to participate in a research study that is purposed to provide valuable information to nurse educators in planning future clinical experiences of this type.

As you are probably aware, approximately 1 in 4 American adults has a medically diagnosable mental illness each year, with nurses providing the majority of care for these patients. Much of the clinical experience nursing students have in psychiatric mental health clinical is in community-based (rather than inpatient) settings, yet little is known of what students are doing and learning in these settings.

This study is being conducted through the University of Kansas Medical Center with Wanda Bonnel, PhD as the principal investigator and Suzanne Martin Stricklin, MSN as the student investigator.

Participation in the study is voluntary and choosing not to participate will have no affect on your employment at _____ (name of school).

If you choose to participate in this study, your participation would include a 30-60 minute interview with Ms. Stricklin, at your convenience to discuss the topic further, with possible follow-up emails. Any information you provide will be used to assist with understanding student and faculty perceptions regarding this phenomenon. Topics discussed may include faculty and student inclusion criteria, the number of faculty teaching PMH clinical, the number of students in a typical clinical group, community-based settings used and how to best navigate

your school for the study. You may also opt to participate in an on-line focus group with fellow psychiatric mental health nursing faculty that will take approximately 1-2 hours of your time, over a 6 day period of time in mid-late January, and involve 3 logins.

The only risk involved in participating in this study, is the possibility of a breach of confidentiality. However, in order to prevent this risk, no identifiable information will be shared with persons outside the research team. There is no direct benefit to you participating in this study. It is hoped information gained will help researchers learn more about what students are learning and how they are practicing in these community-based settings, and will assist nurse educators in planning these vital learning opportunities for students, so as to better prepare future nurses to meet the complex healthcare needs of their patients.

Please contact Dr. Wanda Bonnel (913-588-3363) and/or Ms. Suzanne Martin Stricklin (513-858-1527; sstrickl1020@aol.com; 5350 Bibury Road, Fairfield, OH, 45014) in case of any questions during or after the study.

If you are willing to help with the investigation, please contact Suzanne at sstrickl1020@aol.com or at 513-858-1527. We truly appreciate and thank you for your time and consideration.

Sincerely,

Wanda Bonnel, PhD, Principal Investigator

Suzanne Martin Stricklin, MSN, RN, CNE, Student Investigator

Appendix B

Letter to Students' Current Faculty

Dear _____ (name of faculty member),

I am a doctoral student at the University of Kansas, School of Nursing. I was given your name by _____ (key informant) as a faculty member with current contact with potential study participants and someone that may be willing to work with me.

I would like to approach students enrolled in _____ (name of course) and conduct an online questionnaire and focus group with consenting students. I am asking for your help in sending 2 emails to your students – one an introductory email and the other a reminder email. I would send the emails to you and ask that you then send them to students in your course. These emails would be sent 7 days apart.

If you are willing to assist me in this manner, please contact me. I am available to answer any questions you may have or to provide additional information.

Sincerely,

Suzanne Martin Stricklin

Suzanne Martin Stricklin, MSN, RN, CNE
513-858-1527
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Appendix C

Student Informational Letter, Online Questionnaire

Dear Undergraduate BSN student,

As a nursing student at _____ (name of school), you are being invited to participate in a research study looking at your experiences during your psychiatric mental health clinical rotation in community-based setting. This study is purposed to provide valuable information to nurse educators in planning future clinical experiences of this type

Approximately 1 in 4 American adults has a medically diagnosable mental illness each year, with nurses providing the majority of care for these patients. Much of the clinical experience nursing students have in psychiatric mental health clinical is in community-based (rather than inpatient) settings, yet little is known of what students are doing and learning in these settings.

This study is being conducted through the University of Kansas Medical Center with Wanda Bonnel, PhD as the principal investigator and Suzanne Martin Stricklin, MSN as the student investigator.

Participation in the study is voluntary and choosing not to participate will have no affect on your status as a student at _____ (name of school).

Your participation in this study involves completion of an online questionnaire taking approximately 25 minutes that will available for 14 days, through a link in this email. After completion of the questionnaire, you may also opt to participate in an on-line focus group with fellow nursing students that will take approximately 1-2 hours of your time, over a 6 day period of time in mid-late January, and involve 3 logins.

Questionnaire items are open-ended and focus on your learning experiences and use of newly acquired skills with the clients with whom you had contact during your community-based psychiatric mental health clinical rotation.

No item has a right or wrong answer and there is no predetermined length of response – this is totally determined by you, and as such may vary from question to question. Focus group topics will center upon clarification and expansion of questionnaire responses.

The only risk involved in participating in this study, is the possibility of a breach of confidentiality. However, in order to prevent this risk, we will not be collecting any identifiable information. There is no direct benefit to you participating in this study. It is hoped information gained will help researchers learn more about what students are learning and how you are practicing in these community-based settings, and will assist nurse educators in planning these vital learning opportunities for students, so as to better prepare your future colleagues to meet the complex healthcare needs of their patients.

Please contact Dr. Wanda Bonnel (913-588-3363) and/or Ms. Suzanne Martin Stricklin (513-858-1527; sstrickl1020@aol.com; 5350 Bibury Road, Fairfield, OH, 45014) in case of any questions during or after the study.

If you choose to participate in this study, please click on the "I agree to participate" link included in this email and you will be taken directly to the questionnaire. Simply ignore any reminder emails sent if you have completed the questionnaire. We truly appreciate and thank you for your time and consideration.

Sincerely,

Wanda Bonnel, PhD, Primary Investigator

Suzanne Martin Stricklin, MSN, RN, CNE, Student Investigator

Appendix D

Student Questionnaire

Your responses are invaluable. The questions focus on your psychiatric mental health clinical experiences this semester.

Your Personal Demographic Information

Age: 18-24 ____ 25-34____ 35-44_____ 45 or older_____

Gender: Male _____ Female_____

Race: African American_____ Asian_____ Caucasian_____ Hispanic _____ other_____

Year in Nursing Program: Junior _____ Senior_____

List the type of setting(s) where your psychiatric mental health experiences occurred (i.e. home visits, substance abuse residential, crisis residential setting, etc.).

1) What was your most satisfying experience?

2) How would you describe your learning experiences in this setting to students who have not yet taken this course?

3) Describe a time you used therapeutic communication techniques effectively in this setting.
    a. How would you describe your overall competence with this skill?

4) Describe a time you performed a mental status exam.
    a. How would you describe your overall competence with this skill?

5) Describe a time you taught a patient, some aspect of managing their psychiatric symptoms.
    a. How would you describe your overall competence with this skill?

6) Describe a time you evaluated the effects of psychiatric medications on a patient.
    a. How would you describe your overall competence with this skill?
7) Describe a time you assessed a patient's potential for suicide.

   a. How would you describe your overall competence with this skill?
8) Describe a time you participated in mental health promotion activities.
   a. How would you describe your overall competence with this skill?

9) Describe a time when you were able to clarify your own values regarding working with patients with psychiatric disorders.
   a. How would you describe your overall competence with this skill?

10) Describe a time you maintained a therapeutic relationship with someone experiencing a chronic psychiatric disorder.
   a. How would you describe your overall competence with this skill?

11) How do you think your current competence in these skills would be affected, if you had not had this clinical opportunity over the past several months?

12) Describe a time when you used skills developed in this psychiatric mental health setting in a clinical situation that occurred outside of these settings (i.e. in community health, OB, pediatrics, medical-surgical, etc.).

13) Add anything else you would like to say on this topic.

OPTIONAL: If you are willing to be involved in an online student focus group to discuss this topic further, please provide your contact information.

Email address _____Name_____

Thank you for your time, your willingness and your honesty. I believe the results of the questionnaire will truly benefit nursing education in the future, and thus the education of your future colleagues.

Appendix E

Student Informational Letter, Classroom Paper/Pencil Questionnaire

Dear Undergraduate BSN student,

As a nursing student at _____ (name of school), if you did not previously complete the online questionnaire for this study, you are being provided another opportunity to participate. This research study is looking at your experiences during your psychiatric mental health clinical rotation in community-based setting. This study is purposed to provide valuable information to nurse educators in planning future clinical experiences of this type

Approximately 1 in 4 American adults has a medically diagnosable mental illness each year, with nurses providing the majority of care for these patients. Much of the clinical experience nursing students have in psychiatric mental health clinical is in community-based (rather than inpatient) settings, yet little is known of what students are doing and learning in these settings.

This study is being conducted through the University of Kansas Medical Center with Wanda Bonnel, PhD as the principal investigator and Suzanne Martin Stricklin, MSN as the student investigator.

Participation in the study is voluntary and choosing not to participate will have no affect on your status as a student at _____ (name of school).

Your participation in this study involves completion of a questionnaire taking approximately 25 minutes and will be available following a regularly scheduled nursing class on your campus. Light refreshments will be served while you complete the paper/pencil version of the questionnaire. Written questionnaires will be collected by the study researcher immediately upon completion. After completion of the questionnaire, you may also opt to participate in an on-line focus group with fellow nursing students that will take approximately 1-2 hours of your time, over a 6 day period of time in mid-late March and involve 3 logins.

Questionnaire items are open-ended and focus on your learning experiences and use of newly acquired skills with the clients with whom you had contact during your community-based psychiatric mental health clinical rotation. No item has a right or wrong answer and there is no predetermined length of response – this is totally determined by you, and as such may vary from question to question. Focus group topics will center upon clarification and expansion of questionnaire responses.

The only risk involved in participating in this study, is the possibility of a breach of confidentiality. However, in order to prevent this risk, we will not be collecting any identifiable information. There is no direct benefit to you participating in this study. It is hoped information gained will help researchers learn more about what students are learning and how you are practicing in these community-based settings, and will assist nurse educators in planning these vital learning opportunities for students, so as to better prepare your future colleagues to meet the complex healthcare needs of their patients.

Please contact Dr. Wanda Bonnel (913-588-3363) and/or Ms. Suzanne Martin Stricklin (513-858-1527; sstrickl1020@aol.com; 5350 Bibury Road, Fairfield, OH, 45014) in case of any questions during or after the study.

If you choose to participate in this study, complete the paper/pencil copy of the questionnaire distributed by study researchers. Completion of the questionnaire implies your consent to participate in the study. We truly appreciate and thank you for your time and consideration.

Sincerely,

Wanda Bonnel, PhD, Primary Investigator

Suzanne Martin Stricklin, MSN, RN, CNE, Student Investigator

Appendix F

Interview Consent Form for Faculty

Dear Nursing Faculty Member,

As a faculty member at _____ (name of school), with recent experience teaching undergraduate nursing students in community-based psychiatric mental health clinical settings, you are being invited to participate in a research study that is purposed to provide valuable information to nurse educators in planning future clinical experiences of this type.

As you are probably aware, approximately 1 in 4 American adults has a medically diagnosable mental illness each year, with nurses providing the majority of care for these patients. Much of the clinical experience nursing students have in psychiatric mental health clinical is in community-based (rather than inpatient) settings, yet little is known of what students are doing and learning in these settings.

This study is being conducted through the University of Kansas Medical Center with Wanda Bonnel, PhD as the principal investigator and Suzanne Martin Stricklin, MSN as the student investigator.

Participation in the study is voluntary and choosing not to participate will have no affect on your employment at _____ (name of school).

Your participation in this study involves completion of an in-person or telephone semi-structured interview taking approximately 30-60 minutes. The interview will be scheduled at your convenience; it will be recorded and transcribed. After completion of the interview, you may opt to participate in an on-line focus group with fellow psychiatric mental health nursing faculty that will take approximately 1-2 hours of your time, over a 6 day period of time in mid-late January, and involve 3 logins and/or to be individually contacted later in the study to respond to additional questions that arise during the interviews or to

review a summary of all the findings to provide feedback on whether the researchers have accurately recorded your ideas and perceptions.

Interview items center on student learning experiences and their use of newly acquired skills with the clients with whom they had contact during their community-based psychiatric mental health clinical rotation. Focus group topics will center on clarification and expansion of questionnaire responses.

The researchers will protect your information, as required by law. The researchers may publish the results of the study. If they do, they will only discuss group results. Your name will not be used in any publication or presentation about the study. The only risk involved in participating in this study, as the possibility of a breach of confidentiality. However, in order to prevent this risk, no identifiable information will be shared with persons outside the research team. There is no direct benefit to you participating in this study. It is hoped information gained will help researchers learn more about what students are learning and how they are practicing in these community-based settings, and will assist nurse educators in planning these vital learning opportunities for students, so as to better prepare future nurses to meet the complex healthcare needs of their patients.

Please contact Dr. Wanda Bonnel (913-588-3363) and/or Ms. Suzanne Martin Stricklin (513-858-1527; sstrickl1020@aol.com; 5350 Bibury Road, Fairfield, OH, 45014) in case of any questions during or after the study.

A member of the research team has given you information about the research study. They have explained what will be done and how long it will take. They explained any inconvenience, discomfort or risks that may be experienced during this study.

By signing this form, you say that you freely and voluntarily consent to participate in this research study. You have read the information and had your questions answered.

You will be given a signed copy of the consent form to keep for your records.

_____

Print Participant's Name

_____ _____

Signature of Participant Time Date

_____

Print Name of Person Obtaining Consent

_____ _____

Signature of Person Obtaining Consent Time Date

Appendix G

Letter to Faculty

Dear Nursing Faculty Member,

As a faculty member at _____ (name of school), with recent experience teaching undergraduate nursing students in community-based psychiatric mental health clinical settings, you are being invited to participate in a research study that is purposed to provide valuable information to nurse educators in planning future clinical experiences of this type.

As you are probably aware, approximately 1 in 4 American adults has a medically diagnosable mental illness each year, with nurses providing the majority of care for these patients. Much of the clinical experience nursing students have in psychiatric mental health clinical is in community-based (rather than inpatient) settings, yet little is known of what students are doing and learning in these settings.

This study is being conducted through the University of Kansas Medical Center with Wanda Bonnel, PhD as the principal investigator and Suzanne Martin Stricklin, MSN as the student investigator.

Participation in the study is voluntary and choosing not to participate will have no affect on your employment at _____ (name of school).

Your participation in this study involves completion of an online questionnaire taking approximately 25 minutes that will available for 14 days, through a link in this email. After completion of the questionnaire, you may opt to participate in an on-line focus group with fellow psychiatric mental health nursing faculty that will take approximately 1-2 hours of your time, over a 6 day period of time in mid-late January, and involve 3 logins and/or to be individually contacted later in the study to respond to additional questions that arise during

the interviews or to review a summary of all the findings to provide feedback on whether the researchers have accurately recorded your ideas and perceptions.

Questionnaire items are open-ended and center on student learning experiences and their use of newly acquired skills with the clients with whom they had contact during their community-based psychiatric mental health clinical rotation. There is no predetermined length of response – this is totally determined by you, and as such may vary from question to question. Focus group topics will center on clarification and expansion of questionnaire responses.

The only risk involved in participating in this study, as the possibility of a breach of confidentiality. However, in order to prevent this risk, we will not be collecting any identifiable information. There is no direct benefit to you participating in this study. It is hoped information gained will help researchers learn more about what students are learning and how they are practicing in these community-based settings, and will assist nurse educators in planning these vital learning opportunities for students, so as to better prepare future nurses to meet the complex healthcare needs of their patients.

Please contact Dr. Wanda Bonnel (913-588-3363) and/or Ms. Suzanne Martin Stricklin (513-858-1527; sstrickl1020@aol.com; 5350 Bibury Road, Fairfield, OH, 45014) in case of any questions during or after the study.

If you choose to participate in this study, please click on the "I agree to participate" link included in this email and you will be taken directly to the questionnaire. Simply ignore any reminder emails sent if you have completed the questionnaire. We truly appreciate and thank you for your time and consideration.

Sincerely,

Wanda Bonnel, PhD, Principal Investigator

Suzanne Martin Stricklin, MSN, RN, CNE, Student Investigator

Appendix H

Faculty Questionnaire/Interview Guide

Your responses are invaluable. The questions focus on your students' community-based psychiatric mental health clinical experiences (those outside a state hospital or outside a traditional acute-care psychiatric mental health in-patient setting) that occurred anytime over the past 2 years.

Your Personal Demographic Information

Age: 22-29 ____ 30-39____ 40-49_____ 50 or older_____

Gender: Male _____ Female_____

Race: African American_____ Asian_____ Caucasian_____ Hispanic _____ other_____

How many semesters have you taught, using community-based psychiatric mental health clinical settings? ___

List the types of settings where these experiences occurred (i.e. home visits, substance abuse residential, crisis residential settings, etc.).

1) How would you describe student learning in these settings to a new faculty member with no experience in psychiatric mental health nursing?

2) What is one way you facilitate student learning in these settings?

3) Describe your students' opportunity to learn and practice using therapeutic communication techniques with patients in these settings.
    a. Describe their overall competence with this skill at the end of each semester.

4) Describe your students' opportunity to learn and practice performing a mental status exam.
    a. Describe their overall competence with this skill at the end of each semester.

5) Describe your students' opportunity to learn and practice teaching a patient with a psychiatric disorder, some aspect of managing their psychiatric symptoms.

   a. Describe their overall competence with this skill at the end of each semester.

6) Describe your students' opportunity to learn and practice evaluating the effects of psychiatric medications on patients.
   a. Describe their overall competence with this skill at the end of each semester.

7) Describe your students' opportunity to learn and practice assessing a patient's potential for suicide.
   a. Describe their overall competence with this skill at the end of each semester.

8) Describe your students' opportunity to learn and practice participating in mental health promotion activities.
   a. Describe overall competence with this skill at the end of each semester.

9) Describe your students' opportunity to learn and practice clarifying their values regarding working with patients with psychiatric disorders.
   a. Describe their overall competence with this skill at the end of each semester.

10) Describe your students' opportunity to learn and practice maintaining a therapeutic relationship with someone experiencing a chronic psychiatric disorder.
   a. Describe their overall competence with this skill at the end of each semester.

11) How do you think your students' overall competence with these skills would be affected, if they did not have this clinical opportunity?

12) How have your students described using the skills they developed in these psychiatric mental health settings in patient situations outside of these settings (i.e. in community health, OB, pediatrics, medical-surgical)?

13) Add anything else you would like to say on this topic.

OPTIONAL: If you are willing to be involved in an online faculty focus group to discuss this topic further or to be contacted later in the study to respond to additional questions that arise during the interviews or to review a summary of all the findings to provide feedback on whether the researchers have accurately recorded your ideas and perceptions, please provide your contact information.

Email address _____Name_____

Thank you for your time, your willingness and your honesty. I believe the results of the questionnaire will truly benefit nursing education in the future, and thus the education of your future colleagues.

Appendix I

Student Focus Group Interview Guide

Opening/Introductory Questions:

How would you like to be addressed within the group?

In what type of nursing clinicals are you currently enrolled?

When will you graduate?

Transitional/Key Questions:

We have now completed coding all of the student responses for the study on community-based PMH clinical skills. We would like for you to review our thoughts.

Theme One: Meeting the Challenges of Developing PMH Nursing Skills

This theme captures students' thoughts and feelings on the foundational components needed in developing PMH nursing skills, and includes: a) the change in student attitudes (from fear to comfort, misunderstanding to understanding) regarding mental illness/clients with mental illness and b) therapeutic communication – developing skills in 1:1 interactions as well as developing group activities as meaningful interactions.

Does/how does this theme ring true for you?

Does it make sense?

If it does not accurately portray your perceptions, how does it differ?

How is it similar?

Theme Two: Multiple Levels of Feeling Competent

This theme includes students' perceptions of their competence in the different skills and included: a) feeling competent, b) feeling ambivalently competent, and c) not feeling competent. Some described overall feelings in one of these categories, while others had different levels of competency dependent upon the specific skill.

Does/how does this theme ring true for you?

Does it make sense?

If it does not accurately portray your perceptions, how does it differ?

How is it similar?

Theme Three: PMH Nursing Skills are Essential Elements for Empowering All Nurses

This theme captures use of PMH skills "across the board" and increased feeling of confidence in one's nursing practice as a whole. Included here are descriptions of a) developing a more holistic view of clients, b) the complex nature of the skills, and c) how these skills were used outside of the PMH clinical setting (in other school clinical settings - ICU, ER, M/S, etc.), in work-related settings and with family/friends.

Does/how does this theme ring true for you?

Does it make sense?

If it does not accurately portray your perceptions, how does it differ?

How is it similar?

Summary/Closing Questions:

Provide a summary of students' responses and then ask:

Is that an adequate summary?

Did I miss anything?

Suppose you had one minute to talk to nurse educators across the country on use of community-based PMH clinical settings. What would you tell them?

Appendix J

Student Findings: Themes, and Categories

Theme I: Meeting the challenges of developing PMH nursing skills

A. Category - Transforming attitudes

B. Category- Therapeutic communication

a. Developing a one-on-one relationship

b. Developing group activities as meaningful interventions

Theme II: Sharing multiple experiences of feeling competent

A. Category - Various levels of competency

B. Category – Still seeking competency

Theme III: Empowering all nurses through PMH nursing skills

A. Category - The complex/holistic focus of the PMH nursing skill set

a. More holistic view of patients

b. Complex nature of these skills

B. Category - Using this skill set with individuals outside of the PMH clinical setting

a. Using this skill set with patients in other school clinicals

b. Using this skill set in other areas

Appendix K

Faculty Findings: Themes, and Categories

Theme I: Seizing the day(s)

A. Category - Maximizing the opportunity

Theme II: Sharing the road to competency

A. Category - Natural opportunities for learning and practicing

B. Category- Additional opportunities for learning and practicing

Theme III: Empowering students in all areas of nursing

A. Category – Using PMH nursing skills with individuals outside of the PMH setting