Quality Mental Health Clinical Placements: Perspectives of nursing students and their mentors

by

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Dedication

This work is dedicated to all the students who despite all the challenges decided to enrol in a nursing programme and invest in a nursing career. This would not be possible without the constant support of academics and mentors who are crucial in the formation years of these students.

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Abstract

Background: Mentoring facilitates the learning experience during the clinical placement. This learning experience is at the core of nursing education and is essential in the development of competent and capable nurses. Effective mentorship contributes to the reduction of the theory-practice gap and facilitates the transition from a student to practitioners whilst improving competence and reducing anxiety.

Objectives: This study aims to develop a handbook, the Acute Mental Health Nursing Student Handbook as a guiding framework for nursing students during their acute mental health nursing placements. This study also tries to determine whether this handbook can ameliorate clinical mentoring, learning outcomes, competency development and overall experience for nursing student during the acute mental health placement.

Design: This study employed a mixed method QUAN(qual) embedded design.

Settings: This study was conducted at the local psychiatric hospital, recruiting both students following an undergraduate course offered by the University of Malta and mentors servicing the same institution.

Participants: 35 mentors working within the Mental Health Services and 36 students enrolled undergraduate nursing courses offered by the University of Malta were recruited using purposive sampling.

Methods: This study employed a three-phase approach. The first phase focused on investigating the current mentorship system and feedback from mentors to identify clinical learning objectives and ways to improve the present system. During phase 2 the Acute Mental Health Nursing student handbook was developed, which was then given to students in the experimental group following randomisation. Phase 3 involved two parts, namely 3A which focused on the evaluation of students' perceptions and attitudes towards mental illness base on the Mental Health Education Survey (Happell, 2008b,c) (part 1 at pre-placement and part 2 at post placement) and the Attitudes to Mental Illness Questionnaire (Luty et al., 2008). Phase 3B consisted of the evaluation of the student and mentor's comments reported in the Acute Mental Health Nursing Student Handbook.

Results: 8 domains of practice were identified with specific learning outcomes pertinent to each of the domains. Results indicate that those students who were provided with the handbook experienced more favourable attitudes post-placement on

the following domains: (i) preparedness to care for individuals with mental health issues; (ii) a reduced anxiety surrounding mental health and (iii) a feeling that their course prepared them adequately to the mental health field. Learning using reflective practice is very indicative however students need to be educated in how to carry out reflective practice.

Conclusions: This study contributes to previous literature by highlighting the importance of clinical mentorship in the formation of student nurses. The Acute Mental Health Nursing Student Handbook addressing gaps within the local mental health clinical placements, by providing a guiding framework to both the mentor and mentee.

Keywords: QUALITY MENTORING, UNDERGRADUATE, NURSING STUDENTS, MENTAL HEALTH, CLINICAL PLACEMENT, COMPETENCIES.

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List of Abbreviation

AMIQ	The Attitudes to Mental illness questionnaire
ASMI	Anxiety Surrounding Mental Illness
BSc	Bachelor of Science
BSN	Bachelor of Science in Nursing
CALDs	Cultural and Linguistic Diversity
CE	Course Effectiveness
CEBM	Centre for Evidence-Based Management critical appraisal tool respectively
CLES+T	Clinical Learning Environment, Supervision and Nurse Teacher
CMs	Clinical mentors
DDA	Dangerous Drug Administration
DSM	Diagnostic and Statistical Manual
ECT	Electroconvulsive Therapy
FC	Future Career
FESS	Empowerment Supervision Scale
HCP	Health Care Provider
HEI	Higher Education Institution
KMI	Knowledge of Mental Illness
MCSS	Manchester Clinical Supervision Scale
MeSH	The Medical Subject Headings
MHNCCS	Mental Health Nursing Clinical Confidence Scale
MMAT	Mixed Methods Appraisal Tool
MNSc	Master of Science in Nursing
NMS	Neuroleptic Malignant Syndrome
NS	Negative Stereotypes
NSR	Nurse Self Report questionnaires
PCA	Principal Components Analysis
PMHF	Preparedness for Mental Health
PRISMA	Preferred Reporting Items Systematic Reviews and Meta-Analysis
PsychNPAI	Psychiatric Nursing Performance Appraisal Instrument
RMN	Registered Mental Health Nurse
RN	Registered nurse

RS	Readiness for students
SD	Standard deviation
SpO2	Oxygen Saturation
SPSS	Statistical Package for the Social Sciences
TMS	Transcranial Magnetic Stimulation
UK	United Kingdom
USA	United States of America
VC	Valuable Contributions

Chapter 1: Introduction

1.1 Introduction

The clinical learning experience of student nurses is an important and integral part of all pre-registration preparation, training and education programmes (Brown, 2000). McCabe (1985) describes clinical learning as the 'heart' of professional practice. However, the learning outcomes and the assessment of clinical skills during clinical placement has been ambiguous, questionable and a controversial area in nursing education (Wooley, 1977), which continues even to this date.

1.2 Background

The World Health Organization (2020), reports that the nursing profession accounts for close to 50% of the global health workforce within the health care delivery systems. This poses a high demand on pre-registration education in order to educate and prepare future nurses both theoretically and practically so as to be able to providing the highest quality of care possible based on the integration of theory and practice. This highlights the importance of having a learning tool that includes clear, in-depth and attainable learning outcomes that facilitates the mentor's role as a clinical educator and supports student learning. Clinical learning in the form of clinical placements are an integral part of any undergraduate nursing programme. Levett-Jones et al. (2007) suggest, that clinical placements are one of the pillars of nursing education, as they allow for the actual observation and practice of skills whilst exposing students to the realities of the working life (Hartigan-Rogers et al., 2007). Levett-Jones et al. (2007), argue that the clinical experience may impact the student's personal and professional growth both positively or negatively, further highlighting the importance of improving mentorship if a positive experience is desired.

In fact, clinical placements are an essential part of undergraduate nursing preparation and constitute 50% of the overall undergraduate programme hours in the United Kingdom (UK) (Nursing and Midwifery Council, 2010). This clinical preparation is similar to that found in Europe, United States of America (USA) and Australia (Saarikoski et al., 2007). In Malta, as in many other countries, a system of mentoring is in place, in which students are allocated with a mentor during their various clinical placements. Jerlock et al. (2003) highlight that at undergraduate level, mentoring of students plays a pivotal role in the facilitation and integration of theory and evidence based research in order to attain evidence based nursing practice. Mentoring and

clinical placements provide experiences, skill and knowledge together with exposing students to the realities of the working life (Hartigan-Rogers et al., 2007). Patient care is a complex activity and skill development is necessary, highlighting the importance of a comprehensive pedagogical tool that encompasses relevant learning objectives.

1.3 Personal Perspective

Several reasons motivated me to select this research topic. Primarily, my main interest stems from the fact that I myself am a mentor and have clinical learning at heart. I have been working as a mental health nurse within the acute mental health setting for the past 8 years. I started my nursing career by completing a diploma in nursing studies. During the mental health placement within this course, I was allocated with a mentor in an acute female ward. My initial reaction was that of fear and avoidance, however with the help of my mentor I overcame this, and inspired me to further my career in mental health nursing. After successfully completing my Bachelors of Science in Mental Health Nursing with the Department of Mental Health, University of Malta, I started to mentor students. Although this degree has expanding my skills, critical thinking and overall comprehension of mental health nursing, I still found it challenging to adapt clinical education with the ongoing developments in mental health nursing. This has inspired to investigate the perceptions of mentors towards learning outcomes, compile a contemporary handbook that reflects the learning outcomes that students are expected to master within an acute mental health setting and investigate if this handbook did in fact contribute to an improved student clinical experience. Like myself during my student years, many students that I have mentored reported a great deal of anxiety and fear prior to their mental health placement. Most often this is fuelled by reports of incidents in the media or negative experiences shared by fellow students including the lack of learning objective and skill practice within the mental health scenario. General nursing students in particular associate the clinical placement environment as a learning and practice opportunity for a more generic aspect of clinical skill application such as changing of a dressing or setting up of intravenous infusions. Although these skills are also important within any mental health setting, the skills employed within an acute mental health setting extend further. This highlighted the need for a handbook that facilitates the student learning process of these specific learning outcomes, through the support of their mentor and self-reflection.

1.4 Local Situation

Two distinct pathways exist in Malta that lead a nursing student to work within a mental health field. The direct approach is by following the mental health nursing undergraduate course offered by the Department of Mental Health, Faculty of Health Sciences, University of Malta. The alternative pathway is by following a general nursing course offered either by the University of Malta or another higher institution. Mental health nursing students, upon successfully completion of their course are recruited and deployed to the Maltese Mental Health services. Conversely, general nursing students, although not specialised in mental health might also be deployed in the same national mental health services. Although these student nurses might end up within the same clinical environment, their clinical preparation varies significantly. The mental health nursing students follow the "Pre-registration practice portfolio for mental health nursing students" during their clinical placements whilst the general nursing students have no guiding document. Clinical teaching is expected to be carried out by mentors without any framework. This translates into a cacophony of learning outcomes based on the mentor's own perceptions of what constitute mental health learning outcomes. Also clinical mentoring in Malta has been undergoing revisions for the last 5 years, with the implementation of a formal mentoring system which replaced the informal mentoring structure used decades ago. Formal mentoring introduced specific criteria, such as the number of years that a nurse must have in a particular work setting in order to be eligible to serve as mentor. During the informal years of mentoring, mentors used to discuss the performance of the student with an academic member of staff appointed as the student's clinical link lecture, and this link lecturer graded the student. With the introduction of formal mentoring, mentors now grade the students. Also the introduction of formal mentoring introduced a remuneration package for the mentors. Nurses used to mentor on a voluntary basis before the introduction of the formal mentoring structure. There is a lacuna in research relating to the perceptions of both mentors and students towards the acute mental health nursing clinical placements that is targeted in this study.

1.5 Significance of the Study

The literature review described in Chapter 2, highlights a lack of assessment tools and rating scales, including clinical learning standardised guides for mental health clinical

mentoring (Andrews & Chilton, 2000; Dobrowolska et al., 2015). Chambers (1998) in her review of the literature focusing on issues related to clinical assessments identifies that reflection and reflective practice has great value in the development of clinical competence. Clinical competence is achieved by satisfying specific learning outcomes which include an amalgamation of skills, knowledge, attitudes and performance of nursing practice. Measuring competence based on a series of learning outcomes is essential to determine the ability and readiness of students to provide quality client centred care. Learning outcomes also serve as a much-needed teaching strategy and may be the strongest contributor to evidence based reform in undergraduate nursing curricula (Armstrong & Pieranunzi, 2000; Rushworth & Happell, 1998; Taymore, 1999; Utley-Smith, 2004). Girot (1993) adds that student nursing evaluation/assessment has posed problems of objectivity, validity and reliability to the educators. Bourbonnais et al. (2008), suggests that evaluation must be an ongoing and continuous process. The role of the mentor is to bridge the gap between theory and practice to facilitate student's clinical competence. A challenge identified in literature is that no universal framework exists, but rather each country or institution develop their own learning objectives. Within the local setting this is either limited or non-existing such as in the undergraduate general nursing courses. Thus, limiting the potential benefits of mentoring which are central to quality clinical learning outcomes for students. This study aims to address these limitations by introducing a guiding handbook for both mentors and students aimed as a pedagogical tool for the acute mental health nursing clinical placement.

1.6 Research Aim and Objectives

The proposed research study entitled, "Quality Mental Health Clinical Placements: Perspectives of nursing students and their mentors" aims to develop a mental health nursing student handbook for the acute setting that can be used as a pedagogical tool by mentors and nursing students within an acute setting and to determine whether the use of this handbook has an impact on the nursing students' attitudes towards mental health nursing and stigmatising attitudes towards mental illness, thus improving the quality of mental health mentoring for future students' cohorts.

Thus, the research question pertaining to this study reads, what is the impact of a mental health nursing student handbook on nursing student attitudes during the acute

mental health placements?

The objectives in the study are to:

1. Explore mentors' views regarding what they consider as relevant mental health nursing learning objectives for students on their mental health placement.

2. Identify the barriers towards the provision of quality mentoring according to mentors and students and develop ways to improve them.

3. Develop a standardised handbook that addresses the limitations outlined by clinical mentors and in the relevant literature.

4. Determine if the handbook contributed to any changes in nursing student's attitudes, and mental health education from pre-placement to post-placement.

5. Explore the student's reflections whilst being mentored and making use of the handbook.

1.7 Method

A mixed method QUAN(qual) embedded design was used in this study, which includes three distinct phases. The first phase collected quantitative data from mentors working within the Mental Health Services. Mentors were asked to identify and rate clinical objectives they deemed relevant to the acute mental health nursing student placement. Data was collected using open-ended questions to enable the mentors to comment about their perspectives and experiences as well as provide an outlet for suggesting improvements. Content analyses was used to analyse the data and generate frequencies. Following data analysis of phase 1 and review of concurrent literature, the Acute Mental Health Nursing Student Handbook was developed (Appendix A). This handbook supports the mentor's teaching role by servicing as a pedagogical tool that lists specific learning outcomes for students and also serves as a potential guide for the assessment of students during their mental health clinical placement. The

handbook facilitates student learning through reflective practice, enabling the students to actively involve themselves during the placements. It also lists and provides links to resources which are commonly used within the acute mental health setting and also provides a comprehensive glossary of terms aimed to support the students with understanding of clinical terminology encountered during the placement. In order to investigate the effectiveness of this handbook, a third phase was included in this study. This third phase consisted of two phases occurring concurrently, namely the experimental phase (phase 3A) and the reflective phase (phase 3B). Phase 3A, involved the administration of two questionnaires. Two brief self-report questionnaires were used prior to the commencement of the placement and again after completion of the placement to assess the students' attitudes towards mental health nursing, recent clinical experience, preparedness for mental health field; knowledge of mental illness; negative stereotypes; future career; course effectiveness; anxiety surrounding mental illness and their contribution to the mental health service. Recruitment was carried out from students currently enrolled in the undergraduate nursing and mental health nursing courses offered by the University of Malta who were commencing their acute mental health clinical placement between October 2019 and January 20202. Participants were randomised in two groups, namely an experimental group and a control group. Both groups were allocated with mentors, however the experimental group were also provided with a copy of the Acute Mental Health Nursing Student Handbook. This was done in order to evaluate any changes in attitudes between pre-placement and post-placement of the nursing student cohort for the experimental group and the control group. The questionnaire package included the Psychiatric / Mental Health Nursing part 1(Happell, 2008b), Psychiatric, Mental Health Nursing part 2 (Happell, 2008c) and The attitudes to Mental Health Illness Questionnaire (Luty et al., 2006). Data emerging from phase 3A was analysed using Statistical Package for the Social Sciences (SPSS). Phase 3B, consisted of analysing the students' evaluation of their perceived progress in relation to the domain of practice based on their own reflections and mentor's comments reported in the Acute Mental Health Nursing Student Handbook which were conducted throughout the intervention. A thematic analysis of the student's written reflections for each of the 8 domains of competence and mid-placement meeting between the mentor and the mentee was conducted.

1.8 Overview of the dissertation

This chapter has provided an introduction of the study, including the aims and objectives and a brief description of the methodology. Chapter two presents a critique of relevant literature whilst an in-depth report on the methods, tools and ethical considerations pertaining to this study are reported in chapter three. The emerging findings are reported in chapter four, whilst chapter five attempts to critique the findings in light of available literature. The last chapter provides an overall conclusion, strengths and limitations of the study and also presents recommendations for future practice, education policy and research.

1.9 Conclusion

The study presented here focused on understanding mentors' expectations as well as their own experiences of mentorship. The aim of the study was to develop a handbook, the Acute Mental Health Nursing Student Handbook and determine whether the use of this handbook has an impact on the quality of clinical mentorship and improve the nursing student experience during mental health placements. A three phase mixed method QUAN(qual) embedded design was best indicated for this study. Furthermore, this study provided an insight into the students' preparedness and attitudes towards acute mental health clinical placements. The following chapter provides a review and critique of relevant literature.

Chapter 2: Literature Review

2.1 Introduction

This chapter provides an outline of the search strategy undertaken. An evaluation and critique of the pertaining literature related to quality mentorship, provision of mentorship and clinical competencies targeted for undergraduate nursing students in the mental health clinical placement follows. Finally, a summary of the main points of the literature review and the limitations in the existing body of knowledge are presented, which highlight the relevance of conducting this study.

2.2 Search Strategy

A well-constructed search strategy is the foundation of any review, as the search strategy determines the accessibility, eligibility and inclusion of the studies reflecting the question being investigated (Polit & Beck, 2014). In order to conduct an in-depth critical appraisal of the literature, relevant research based articles on quality mentorship, provision of mentorship and clinical competencies targeted for undergraduate nursing students in the mental health clinical placement were searched and retrieved using the HyDi platform. The HyDi platform is an online search system which includes several search databases including PubMed, Embase, CINAHL, Medline, BioMed Central, PsychInfo and ProQuest. The HyDi was accessed through the University of Malta library online facilities. To supplement the HyDi search Google Scholar was also accessed. Relevo (2012) outlines the importance of using all known vocabulary variations of a word when conducting a search. Keywords used to guide the present search included '*undergraduate nursing students*', '*psychiatric nursing'*, '*mentorship*', *'clinical competencies'*, '*clinical educator'*, '*clinical supervision'*, '*mental health clinical placement'*, '*pre-registration education*' '*placement*', '*practice environments'* and *'psychiatric clinical placement'*. The Medical Subject Headings (MeSH) Browser, dictionary and thesaurus were used to identify synonyms and alternative terms for the keywords relevant to the research question, making the search more comprehensive and inclusive. In order to obtain relevant archival and contemporary literature the search covered the period between 1980 to 2020. The decision to include articles falling within this time frame was influenced by the fact that relevant literature related to the focus of the study were

published during this time frame.

The Hydi and Google searches for peer reviewed articles yielded a total of 231 potential articles (Fig 2.1). These articles were screened and non-related (n=81) and/or duplicate articles (n=67) were removed, leaving a total of 83 potentially relevant articles. These were further screened by reading through the abstract, leaving a pool of 31 articles relevant to the focus of the study. The excluded articles (n=52) were discarded as they mainly focused on post-qualification supervision. The below inclusion and exclusion criteria guided the screening of the articles.

Inclusion Criteria

- Studies in English Language
- Year 1980- present
- Studies targeting mental health nursing clinical competencies
- Studies not restricted by geographical area
- Studies investigating the attitudes and experiences towards mentorship by undergraduate nursing students
- Studies investigating clinical teaching within a mental health nursing placement

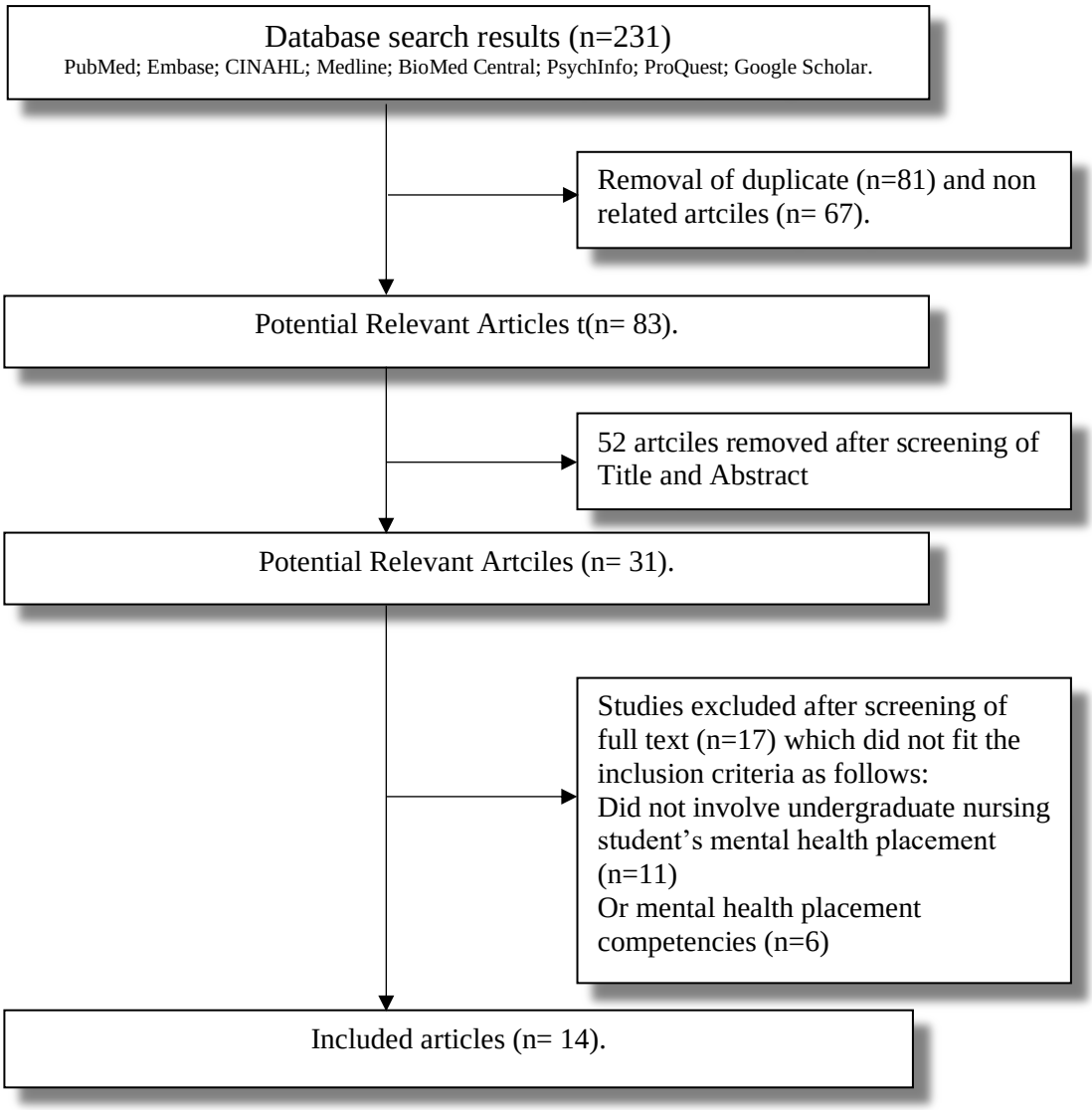
Exclusion Criteria

- Studies in non-English language
- Studies not involving undergraduate nursing students
- Studies not including competencies within a mental health clinical placement

After screening of the remaining 31 articles on full text, 17 articles were discarded, leaving a total of 14 articles pertinent to the current research. Out of these 17 discarded articles, 11 did not involve undergraduate nursing student's mental health placement, whilst a further 6 did not focus on mental health placement competencies.

The Preferred Reporting Items Systematic Reviews and Meta-Analysis (PRISMA) was used to ensure a systematic description of every step of this process. The flowchart (figure 2.1) highlights the article selection process.

Figure 2. 1. Prisma Flowchart



After full text screening, all retrieved studies were in English and originated mainly from the United Kingdom (4), Australia (3), USA (2), Canada (1), Spain (1), Norway (1), Scotland (1) and Poland (1). The distribution according to the research design of the articles extracted from the literature search are outlined in Table 2.1.

Table 2. 1 Article distribution according to their Research Design

Research Design	Total Number of articles
Mixed Method design	3
Quantitative	3
Reviews	1
Qualitative	5
Tool Development (quantitative study)	2

The majority of articles (n=5) extracted used a qualitative design. Creswell (2014), states that the qualitative studies can be utilised to explore the views of participants which then can be used to build an instrument that is further investigated quantitatively. The retrieved articles, including their authors, date of publication, country where the study was conducted, the aims, methodological design, sample and main findings are summarised in table 2.2 below

Table 2. 2 Article distribution according to their Research Design

Author/s Year Country	Purpose	Methodology	Sample	Main Findings
Bondy et al. (1997) USA	Development and validation of a mental health nursing clinical tool	Tool Development with Quantitative validation	51 nursing students	6 domains of Practice Identified: knowledge base/critical thinking; nursing process; nursing interventions; communications skills; professional socialization behaviors; self-evaluation,
Bourbonnais, Langford & Giannantonio (2008) Canada	To develop a tool to identify nursing student learning outcomes.	Tool Development	Feedback from course coordinators (3); clinical teachers (17) and students (126).	5 learning outcomes identified that allow a student nurse to become a self-directed learner, an effective communicator, a critical thinker, an evolving professional and a knowledgeable worker.
Chambers (1998) UK	Assessing clinical practice	Literature Review	No research protocol listed in the review.	This literature review identifies reflection and reflective practice as great contributors to clinical competency development.
Charleston & Happell (2005) Australia	Investigate the perceptions of undergraduate nursing students and psychiatric nurses towards preceptorship in the Mental Health setting	Qualitative study	Semi-structured individual interviews were conducted with 9 psychiatric nurse mentors and focus groups with 16 nursing students	Mentoring is central to quality clinical learning and it has a direct effect on the positive learning outcomes of student nurses
Dobrowolska et al. (2015) Poland	Comparison of undergraduate nursing clinical mentorship in European and non-European countries	Case Study	Expert panel from 11 countries recruited using purposeful convenience sampling.	A non-uniform mentoring system exists within the EU, with different countries having specific requirements according to either the educational institutional or health care provide.
Duffy et al. (2000) Scotland	Investigate the effectiveness of the current mentoring system towards the preparation and ongoing support for mentors.	Survey Design	71 mentors recruited using convenience sampling	• Attending study days increased the mentor's level of confidence in providing constructive feedback, teaching and assessing the level of competence of the student. • Mentors strongly suggested more frequent visits by lecturers in the practice areas. • Mentorship support was inadequate, lacked feedback and failed to address their individual needs. • Mentors require further support regarding assessment documents
Fuentes-Pumarola et al. (2016) Spain	An evaluation of the experience of undergraduate nursing students following their practicum.	Mixed method approach	163 nursing students completed the questionnaire. Followed by qualitative analysis of data derived from a focus group of 5 students and 5 professors.	This study highlights the importance of reflective practice and the crucial role of the nursing mentor/instructor in student learning.

Gilje, Klose & Birger (2007) USA	Explore nurses' perceptions of undergraduate students' critical clinical competencies.	Exploratory descriptive study	18 nurses recruited using purposive sampling	Clinical competencies are a vital component of nursing practice and student learning. More research is required on what constitutes mental health clinical competency.
Grav, Juul & Hellzén (2010) Norway	Investigate the experience of undergraduate nursing students towards their mental health nursing placement.	Mixed method design	15 students, 21 mentors and 7 teachers responded recruited using purposive sampling.	• Student's participation, involvement and integration into the day to day activities of the ward lead to a positive mental health placement outcome. • Mentors also felt positive in the way they could support and guide the students. • An environment of recognition, respect and openness offers a safe space for the students to learn under supervision.
Henderson, Happell & Martin (2007) Australia	Explore the influence of the mental health component of a Bachelor of Nursing course on second-year undergraduate nursing students' self-reported knowledge, skills, and attitudes in relation to mental health nursing	Times-series quasi-experimental design	192 nursing students using convenience sampling	Students find both the theoretical and clinical aspects of the mental health component to increase their learning outcomes. A positive clinical placement had the greatest influence on nursing students' self-reported knowledge, skills, and attitudes and interest in nursing people experiencing mental health problems.
Jack, Harris & Barrett (2017) UK	explored the perceived unfairness experienced by student nurses during the undergraduate clinical placements	Mixed method design using a descriptive narrative approach	1425 student nurses from adult and mental health nursing undergraduate degree programmes, followed by an unstructured interview of 22 students recruited via stratified sampling method from nine different UK institutions.	The majority of students felt respected and enjoyed their placements, whilst some reported that they felt ignored and unsupported. Understaffing was also identified as detriment to quality mentoring. Adopting a tiered mentorship model helps to improve quality mentorship.
Mullen & Murray (2002) Australia	Evaluate the quality of mental health clinical placements for undergraduate nursing students	Qualitative study	10 undergraduate nursing students recruited using purposive sampling	• 90% of the participants rated their mental health clinical placement as positive, with staff being friendly and able to address the students learning needs. • Half of the participants suggested that the clinical placement needs no improvements, whilst 20% suggested that the placement should be longer. • All the participants reported positive perceptions of the clinicians.
Myall, Levett-Jones & Lathlean, (2008) UK	Investigate students and mentors' experiences towards clinical mentorship	Quantitative online survey design	161 nursing students and 156 practice mentors	• The mentor's role was seen as rewarding and instilled a great sense of job satisfaction. • Students considered the mentor's role as key in maximising their learning opportunities as well as role models.
Watson (1999) UK	Investigate students' experiences and perceptions towards mentorship	Qualitative design using case study approach	35 nursing students and 15 mentors	• The mentor's role was seen as rewarding and instilled a great sense of job satisfaction. • Students considered the mentor's role as key in maximising their learning opportunities as well as role models.

Katrak et al. (2004) stress the importance of using critical appraisal tools in evidence-based healthcare training to assist in clinical decision-making. The authors add that critical appraisal tools are extensively being used in evidence-based social and health sciences (Katrak et al., 2004). Burls (2014) highlights that the use of critical appraisal tools for the systematic analysis of retrieved studies enables the researcher to evaluate whether the research question is addressed, if adequate methodologies are employed and whether such studies are valid and trustworthy. In addition, such tools help to evaluate internal validity, generalizability and conclusions. In this study, the Critical Appraisal Skills Programme tools (2014) were used to critique qualitative and observational studies and systematic reviews. Studies employing a mixed method design or a quantitative research design were critically appraised using the Mixed Methods Appraisal Tool (MMAT), the Centre for Evidence-Based Management critical appraisal tool respectively (CEBM) (LoBiondo-Wood & Haber, 2017).

The following section provides an in-depth review of what constitutes clinical mentoring with particular focus on the challenges that arise from such a system.

2.3 Clinical Mentoring

Jordan (2005) defines mentoring as the provision of support, guidance and assistance in the learning of new skills, acquisition of new attitudes and adaptation of new behaviours. Higgins and McCarthy (2005) add that the ability to stimulate reflection, which in turn promotes learning, should be part of this definition. There is a general consensus that mentorship in nursing was introduced in order to support students to develop competencies, self-awareness and self-confidence (Barkun, 2006; Koskinen & Tossavainen, 2003). Huybrecht et al. (2011) stress that mentorship can lead to the reduction of the theory-practice gap, better ease the transition from student to practitioner thus reducing the initial anxiety and reality shock. The authors add that enthusiasm, positive attitude, willingness to spend time with students and experience are the most important characteristics of mentorship (Huybrecht et al., 2011). Mentorship has been developed alongside preceptorship (Koskinen & Tossavainen, 2003) and although both have their own specific aims, these terms may create confusion. Huybrecht et al. (2011), highlight the inconsistences when referring to mentoring and preceptorship as an interchangeable term. In many countries mentorship is considered a long-term relationship with a mentee, not involving any

form of assessment or evaluation (Andrews & Wallis, 1999). This is due to the fact that assessment may be inappropriate or biased in an environment that fosters friendship and guidance. Conversely, preceptorship is usually referred to as a short-term relation that could include assessment and evaluation. In certain situations, the same clinician is expected to act as a mentor and as a preceptor, meaning that they are faced with the task of supporting and providing guidance and assistance to the student, whilst also acting as an assessor to the same student. Bray and Nettleton (2007) suggest that this dual role gives rise to conflict. Watson (2000) argues that these two roles should be clearly defined and separate, as otherwise failing a student, if necessary, becomes a very stressful situation for mentors, especially if the adequate support is not offered. Neary (2000) suggests that the overlap between the role of supporting and guidance and that of assessing is becoming more and more the norm. This is also reflective in the local mentorship system, highlighting the need for an adequate assessment system for mentors that is transparent and does not place the mentor in a stressful situation.

In Malta, mentorship has been in existence since the late 1990's however this was not a formal system. The introduction of a formal system which involved the assessment of students has only been introduced in 2017 which is very recent. Thus, the present system is still in flux as it is undergoing several changes and improvements. To date, the present system operates by allocating a nursing student to a qualified mentor. The mentor is responsible to guide and support the student in learning and achieve clinical competency, followed by evaluation and assessment of that same student. This is not just limited to the mental health clinical placement, however due to the nature of the present study, only mental health clinical placements are discussed. The mentoring process facilitates a learning experience that occurs during the clinical placement. This learning experience is described by Levett-Jones et al. (2006) as the core of nursing education and essential to the development of capable and competent nurses.

Henderson et al. (2007) conducted a times-series quasi-experimental design to explore the influence of the mental health component of a Bachelor of Nursing course on second-year undergraduate nursing students' self-reported knowledge, skills, and attitudes in relation to mental health nursing in the state of Victoria, Australia. Two hundred and twenty-nine (n=229) enrolled students were invited to participate, with

192 agreeing to participate, giving a high response rate of 84%. Since this study employed three stages of data collection, the response rate decreased to 71% after the second stage and to 65% after the third stage. The demographic distribution of students highlights that 54.6% had previous clinical experience but 78.2% reported no experience in mental health. 88.2% studied full time and 90.7% of the sample were females. The questionnaire package included the "About You" and the Nurse Self Report (NSR) questionnaires. The NSR demonstrated good internal reliability with a Cronbach's alpha of 0.86. Data analysis was carried out using SPSS ver. 11.5 and all ethical approvals were sought and obtained by the relevant ethics committee prior to the commencement of the study. Results show that those students with previous mental health experience, at the pre-stage of the study scored statistically higher in skills of assessing suicide risk ($p<0.01$), carrying out a mental status examination ($p<0.01$), triaging a mental health problem ($p<0.05$), assessing psychotic symptoms ($p<0.001$), communicating effectively with paranoid or suspicious individuals ($p<0.05$). Other statistically significant results emerging from this study include greater knowledge about drug side effects ($p<0.001$), in the use of psychiatric terminology ($p<0.01$), legal aspects within mental health ($p<0.001$) and knowledge about services ($p<0.05$) and referrals to a psychiatrist ($p<0.001$). The inference of gender on the results could not be calculated as the number of male students was too low to enable reliable analysis. At the post stage of the study, which included 25 hours of theoretical education for the students enrolled with a metropolitan campus and 35 hours for those enrolled within a regional campus, results highlight that those students receiving more theoretical education reported higher confidence in knowledge, skills and attitudes. Overall results indicate that students find both the theoretical and clinical aspects of the mental health component as positively increase their learning outcomes, which includes effective communication; dealing with self-harm and substance misuse, understanding the therapeutic actions of psychoactive drugs; use appropriate psychiatric terminology; identifying the legal parameters; detecting side-effects of psychoactive drugs; performing a mental status assessment and differentiating substance intoxication and psychosis (Henderson et al., 2007). An interesting finding is that a positive clinical placement had the greatest influence on nursing students' self-reported knowledge, skills, and attitudes and interest in nursing people experiencing mental health problems however, the quantity of theoretical education also emerged as an influencing variable. This is supported by concurrent literature

which also states that clinical experience is fundamental to the acquisition of students' knowledge, skills and attitudes (Arnold et al., 2004; Martin & Happell, 2001; Mullen & Murray, 2002). The results reported by Henderson et al. (2007) must be viewed with caution due to the limited generalizability attributed to a low sample size and the application of convenience sampling.

The following section discusses clinical competence and provides a critique of studies examining the various domains of clinical competence.

2.4 Clinical Competence

The definition of competence in nursing has long been debated (Eraut, 1998; Runciman, 1990). Benner (1984) defines competence as the ability to operate in the real world whatever the conditions. Conversely, Girot (1993), defines competence as:

> "the ability to perform tasks and as a psychological construct – the nurse's ability to integrate cognitive, affective and psychomotor skills when delivering care – has credibility even though as a psychological construct it has to be inferred through competent performance rather than observed directly". (Girot, 1993, p. 83)

whilst Worth-Butler et al. (1994), defines competence as involving:

> "mastery of requirements for effective functioning, in the varied circumstances of the real world, and in a range of contexts and organisations. It involves not only observable behavior which can be measured, but also unobservable attributes including attitudes, values, judgmental ability and personal dispositions: that is – not only performance but capability". (Worth-Butler et al., 1994, p. 226–227).

Coates and Chambers (1992) define competence as an objective concept that can be measured, standardized and validated with examinations, assessment tools and rating scales. Literature highlights a lack of assessment tools and rating scales, including standardised guide for mentors (Andrews & Chilton, 2000; Dobrowolska et al., 2015). Most guidelines are specific to particular nursing programs, Universities or Higher Education Institutions. Utley-Smith (2004) stresses the importance of clinical competencies and that such competencies contribute to evidence based practice.

Clinical competencies also serve as a much-needed teaching strategy and may be the strongest contributor to evidence based reform in undergraduate nursing curricula (Armstrong & Pieranunzi, 2000; Rushworth & Happell, 1998; Taymore, 1999; Utley-Smith, 2004). Gilje et al. (2007) conducted an exploratory descriptive study, to investigate critical clinical competencies in undergraduate psychiatric mental health nursing students. After initial review of the literature including guidelines for nursing programs, psychiatric and mental health nursing text-books, the authors developed 8 undergraduate psychiatric nursing critical clinical competencies. Gilje et al. (2007) report that these 8 competencies were mainly influenced by the work of Chinn (1999) criterion-based approach to clinical teaching and Watson (1999) carative factors. These 8 competencies, or more adequately defined as competency domains include, *Therapeutic Communication*, *Therapeutic Use of Self*, *Nursing Process*, *Safety*, *Clinical Learning*, *Dialogue*, *Faculty Guidance* and *Professional Conduct*. Competency domains is a more adequate term as each competency domain contains a series of criterion-related items. The authors acknowledge that these 8 clinical competencies might not be representative of the entire undergraduate mental health clinical competencies, however these are the competencies identified in their review. In their study Gilje et al. (2007), recruited 18 nurses using purposive sampling. The participants were aged between 29 to 55 years and with a range of 3 up to 30 years of experience in psychiatric nursing practice and a mean of 8 years psychiatric nursing education. All participants successfully completed a baccalaureate degree, with 4 enrolled on a master's program. The study was conducted in USA and participants were recruited from various Universities and hospitals in either Montana, North or South Dakota which the authors do not list. Participates voluntarily agreed to participate and no information identifying the participants was requested in the study.

Participants were asked to evaluate the identified 8 critical clinical mental health competencies. The survey instrument consisted of 2 main sections, namely a demographic section and the 8 Psychiatric Mental Health Nursing Critical Clinical Competencies. Each of the 8 Psychiatric Mental Health Nursing Critical Clinical Competencies included categories of knowledge, skill and attitude, outlined to demonstrate a level of performance in the effective application of knowledge, skill and judgment. Each category included 2 to 11 items, for a total of 190 items. Respondents rated all the 190 items together with the 8 Nursing Critical Clinical Competencies, for a total of 198 instrument items on a 5 point Likert scale (1 strongly disagree and 5 strongly agree). Initially 19 surveys were distributed between 2003 and 2004 either by mail or distributed by hand. All surveys were returned to the authors by mail. One response was found to be incomplete and was eliminated leaving the total of returned questionnaires to 18. Data were analysed using descriptive statistics. Results illustrate that 80% of the items were rated by participants as strongly agree or agree, indicating favorable attitudes to the domains, such as the importance of engaging in a therapeutic relationship with patients. Gilje et al. (2007) report that the analysis of the 8 critical clinical domains and the 190 items were analysed independently. Overall results show that 50% (n=9) of respondents endorsed all the items that compose the 8 domains by rating them as strongly agree, whilst 17% (n=3) endorsed these items by rating their perception to all the items as agree on the Likert scale. A striking comment arising from the findings is that respondents suggested that documents such as the Diagnostic and Statistical Manual (DSM) should be listed as a resource. This highlights the need to include resources in competency frameworks. Another emerging comment reported in the results suggest that a Likert scale (No opportunity to demonstrate; Demonstrates consistently; Demonstrates inconsistently; Does not demonstrate) should be used to evaluate and assess the actual performance of the student. Gilje et al. (2007) report similar findings with those of Bondy et al. (1997). Bondy et al. (1997) developed and validated a clinical mental health nursing tool named the Psychiatric Nursing Performance Appraisal Instrument (PsychNPAI). The PsychNPAI is a 73 item tool that measures the students' performance on 6 domains of practice. These domains are "knowledge base/critical thinking", "nursing process", "nursing interventions", "communications skills", "professional socialization behaviors" and "self-evaluation". The instrument was distributed to 51 general nursing students opting to choose the mental health module in their semester.

Results report very high coefficient values which indicate that the PsychNPAI is a valid and reliable instrument. A limitation of this study is that no sampling techniques are mentioned in the recruitment process of the students. Also the study does not indicate if the 51 students participating in the study are the entire student cohort or the number that accepted to participate out of an unspecified number of students currently enrolled in the nursing course. Although Bondy et al. (1997) lists only 6 domains, Gilje et al. (2007) report that their 8 competencies domains are similar in focus to the six domains outlined by Bondy et al. (1997), and both are used as a pedagogical tool. Pedagogical tools can provide a measure of assessment and evaluation for skills and competencies related to practice in undergraduate nursing courses (Watson et al., 2002). Gilje et al. (2007) acknowledge that their results, due to their small purposive sample may not be representative and may also be biased because the participants were selected by the authors themselves, potentially introducing selection bias. Creswell (2014) defines selection bias as an error that occurs when the researcher decides who is going to be studied, rather than the random selection of participants.

2.5 Clinical Evaluation

Clinical evaluation of students is one of the many challenges in nursing education (Bourbonnais et al. 2008; Squiers, 1981; Wood, 1982). This is mainly due to the fact that clinical evaluation or assessment is predominately based upon the observation of performance of a student by a qualified mentor/clinical teacher, which inevitably is subjective in nature. Girot (1993) adds that student nursing evaluation/assessment has posed problems of objectivity, validity and reliability to the educators. Mahara (1998) recommends that clinical evaluation should be a discovery and verification of the teachings and understanding of nursing practice.

Within a locally context, two learning frameworks have been identified, namely, “The Pre-Registration Practice Portfolio for Mental Health Nursing Students” and the “Mental Health Placement Workbook for Students”, both introduced in 2009 (Grech et al., 2017). Both these documents served different purposes. The Pre-Registration Practice Portfolio for Mental Health Nursing Students is used by students following an undergraduate mental health nursing degree, whilst the Mental Health Placement Workbook for Students was used by nursing students during their mental health

placements following an undergraduate general nursing course. This workbook provides a step-by-step approach that guides students during their mental health placement, with examples of activities that can be carried out, such as carrying out a cooking session with the clients. The workbook is divided into 12 sections, namely the placement, the hospital building, the hospital system, the ward, the clients, nursing care, psychiatric treatment, recovery approach, being a care receiver and what they think as well as activities and session documents. The workbook was in use till 2017, when formal mentoring was introduced, bringing with it changes in the assessment system adopted by the Department of Nursing, University of Malta. The revised clinical placement system devised by academic members of staff within the Department of Nursing, University of Malta, makes use of an online assessment based on 6 domains of practice with each domain having a range of 3 to 9 items. The domains are personal and professional development; communication, teamwork and cooperation; organization and delivery of nursing care; knowledge and clinical application; ethical and legal aspects of care and last but not least teaching and promoting a healthy lifestyle. Mentors are asked to complete the assessment at the end of the placement on an online assessment form by selecting from a 5 point Likert scale comprising from 'consistently', 'often', 'sometimes', 'rarely' and 'never' demonstrated in order to rate the student's clinical performance on the items and domains outlined. With the setting up of the Department of Mental Health in 2016, programmes relating to mental health nursing courses were now provided by this department. The previous "Pre-Registration Practice Portfolio for Mental Health Nursing Students" was retained by the Department of Mental Health for students following the undergraduate mental health nursing course. This document is divided in 5 domains, namely professional and personal development; interpersonal relationships and communication; management of care; integration of knowledge into practice and ethical and legal issues related to professional practice. Each domain includes a number of competencies described as performance indicators that outline the capacities and capabilities which student must demonstrate to achieve competence. The structure of this portfolio follows the progression of the undergraduate course, with different placements over the course of 3 years.

Bourbonnais et al. (2008) identified 5 learning outcomes when they developed a clinical evaluation tool for baccalaureate nursing students in Canada. They report that

these five learning outcomes should enable a student nurse to become a self-directed learner, an effective communicator, a critical thinker, an evolving professional and a knowledgeable worker. Whilst acknowledging that traditionally evaluation of students used a pass/fail system or a five-category rating system, namely excellent, good, satisfactory, marginal and unsatisfactory, Bourbonnais et al. (2008) proposed a two-category rating system of Satisfactory or Unsatisfactory. Satisfactory is defined as a student who demonstrates competence in the learning outcome without the need of assistance or direction, whilst an unsatisfactory student performance refers to the inability of the student to demonstration clinical learning outcomes without the need of repeated support and assistance by a supervisor.

Bourbonnais et al. (2008) stress that safe, ethical, and accountable behavior by students must be demonstrated at all time. Results emerging from the work of Bourbonnais et al. (2008), highlight that evaluation must be an ongoing and continuous process. A strength of this study is that course coordinators (n=3), clinical educators (n=17) and students (n=126) were recruited in the validation of the learning outcomes of the clinical evaluation tool. This enabled the inclusion of the perspectives of all the partners involved in clinical learning. Emerging recommendations report that clinical educators need to be provided with the adequate knowledge and education of how to make use of an evaluation tool and that introducing clinical conferences help students discover how they were meeting the clinical outcomes as well as provided an opportunity for regular reflection on their performance (Bourbonnais et al., 2008). This highlights a lacuna in the training of mentors to specific frameworks used in specific undergraduate nursing programs.

Chambers (1998) in her review of the literature focusing on issues related to clinical assessments identifies that reflection and reflective practice has great value in the development of clinical competence. Chambers (1998) highlights that the mentor/clinical nurse should demonstrate credibility in both theoretical knowledge and practical skills. Chambers (1998) stresses that clinical educators/mentors should understand the importance of their role and must be aware of their accountability in assessing clinical competencies, because if they fail to fail incompetent practitioners they are allowing such individuals entre in the professional. In a similar vein, Fuentes-Pumarola et al. (2016) key finding in their mixed method study of 163 fourth year

nursing students investigating the nursing student and professor perceptions and assessments of the achievement of practicum competencies reports the importance of reflective practice and that nurse mentor/instructor have a crucial role in student learning and reflective practice process. The following section provides a critique of the attributes of a mentor.

2.6 The Role of Mentor

Up until the 1970s, the mentor's role was to shadow a novice nurse, provide guidance and support reflection to familiarize the lesser experienced nurse acclimate within the new clinical environment (Rowland, 2016). Kanter (1979) adds that the mentor was considered as an experienced guide and sponsor. In a survey carried out by Duffy et al. (2000) a total of 150 mentors from the Greater Glasgow area were recruited using convenience sampling, out of which 71 accepted to participate. The authors aimed to investigate the effectiveness of the current system towards the preparation and ongoing support for mentors. A questionnaire was developed and pilot tested with 5 registered nurses having experience in teaching and research. Ethical approval was obtained by the Glasgow Caledonian University. No demographics data of participants were collated and the questionnaire was completed anonymously. Overall results highlight that mentors found that attending study days increased their level of confidence in providing constructive feedback, teaching students and assessing the level of competence of the student. Another interesting finding is that mentors strongly suggested more frequent visits by lecturers in the practice areas. Close to half of the respondents felt that mentorship support was inadequate, lacked feedback and that it failed to address their individual needs. Mentors also reported that they require further support regarding assessment documents. This further highlights a gap in the current assessment tools available for mentors. Duffy et al. (2000) suggests more input from the university on assessment methods and frameworks was required. Although insightful, the results outlined by Duffy et al. (2000) must be viewed with caution due to the poor sample size and low response rate (47%). As the study recruited participants using convenience sampling as opposed to randomized sampling limited the extent to which results could be generalized.

Dobrowolska et al. (2015) study demonstrated that there are no formal rules, qualifications or requirements to practice as a mentor. Most requirements are set by

the specific Universities or Higher Education Institutions, ranging from undergraduate degrees, postgraduate degrees up to specialized mentoring courses (Dobrowolska et al., 2015). Table 2.3 below illustrates the requirements to act as a mentor in different countries around the world.

Table 2. 3 Mentorship qualifications in different countries

County	Experience and Qualification	Additional course, by whom	Mentor engagement	Benefits received by mentor
Australia	Practicing registered nurse (number of years of practice not specified) Bachelor Degree in nursing studies	Higher Educational Institute.	Higher Educational Institute.	Continuing education credits and course discounts.
Croatia	5 years Master of Science in nursing and mentorship course	None	Higher Educational Institute	Remuneration from Higher Educational Institute
Czech Republic	2 years' experience. Generic nursing qualification.	Higher Educational Institute offer specialised mentorship training	Health Care Provider	Higher salary category
England	Practicing nurse registered as a mentor. Mentor needs to be mentor at least 1 student in a period of 3 years to remain eligible to mentor.	Higher Educational Institute.	Health Care Provider	No remuneration
Iceland	1year experience and qualified at Masters, degree or diploma level	Higher Educational Institute offer specialised mentorship training	Health Care Provider	Extra remuneration or Educational credits
Ireland	No preceptorship course	Higher Educational Institute offer specialised mentorship training	Health Care Provider	No remuneration
Italy	2 years of clinical experience and clinical supervisors training course	Higher Educational Institute & Health Care Provider	Health Care Provider	Extra remuneration or Educational credits
Malta	2 years of work experience. Or Registered Mental Health Nurse Clinical Education in Practice (Mentorship) course by University of Malta	Yearly training organised by the Higher Educational Institute	Higher Educational Institute	Extra remuneration
New Zealand	Registered nurse with minimum Bachelor Degree in nursing studies	Higher Educational Institute offer specialised mentorship training	Higher Educational Institute	Educational credits
Poland	Registered nurse with 1 year of clinical experience. Ideally has a Master's degree	Higher Educational Institute as part of an MSc programme	Higher Educational Institute & Health Care Provider	Extra remuneration
Serbia	5 years' clinical experience. Qualified as a nurse specialist	Higher Educational Institute offer a specialised mentorship training every 5 years	Higher Educational Institute & Health Care Provider	Extra remuneration
Slovenia	Registered nurse with 5 year of clinical experience. General nursing degree	Yearly training organised by the Higher Educational Institute	Health Care Provider	No remuneration
Spain	Registered nurse with 5 year of clinical experience. General nursing degree	Higher Educational Institute offer specialised mentorship training	Higher Educational Institute	Extra remuneration
USA	Registered nurse with minimum Bachelor Degree in nursing studies	Higher Educational Institute offer specialised mentorship training as part of National accreditation.	Higher Educational Institute	Extra remuneration

RN – Registered Nurse; HCP – Health Care provider; HEI – Higher Educational Institution; MNSc – Masters of Nursing Science

As outlined in the table above the requirements or qualifications to act as a mentor vary. It is essential to give a little background of the local situation in order to fully understand how the Maltese mentoring and mental health clinical placements operate. In Malta, the Department of Mental Health within the Faculty of Health Sciences, University of Malta offers a Bachelor's degree in Mental health nursing whilst The Department of Nursing within the same institution offer two undergraduate courses, namely a Higher Diploma in Nursing and a Bachelor's degree in Nursing. Since the mental health placements in these courses are different in nature the requirements to act as mentor for the Department of Mental Health are slightly different than those of the Department of Nursing. Although both share the same clinical mentorship training course, individuals who wish to serve as a mentor with the Department of Mental Health must either be a registered mental health/psychiatric nurse or a general nurse with 4 years active employment within the Mental health field in the last 5 years. The Department of nursing request that their mentors have 2 years of working experience in the field. Although one might argue that this already poses a challenge towards providing quality mentorship due to the inconsistencies between the requirements, one must note that over 95% of mentors that serve the Department of Nursing are also recruited by Department of Mental Health so they fulfil both Department's requirements. As from 2021 nurses can only serve as mentors if they have successfully completed the Clinical Education in Practice (Mentorship) study unit offered by the Faculty of Health Sciences, University of Malta. This study unit is a 6 ECTS credit module specifically aimed to support the development of mentors and equip them with the required teaching and assessing skills for clinical teaching. Clinical education can be done in a simulated environment or in the actual clinical setting. In clinical placement students are allocated a mentor in a particular clinical environment. The following section aims to critically highlight the importance of the mental health clinical placement.

2.7 The Mental Health Clinical Placement

Mullen and Murray (2002), identify that the clinical placement is one of the very few opportunities within an undergraduate nursing program that students have to observe and practice close to individuals who have a mental illness. Dearman et al. (2018) reports that clients enjoy the contact and interactions with students. Several authors highlight that in order for this to be effective, the role of the clinical teacher/mentor is

central if quality clinical placements are to be ensured (Campbell et al., 1994; Edwards et al., 2004; MacLeod & Farrell, 1994; Mullen & Murry, 2002; Packer, 1994). Extant literature identifies that the clinician's role in nurse education should not only increase but also reflect the learning needs of the students (Clinton & Hazelton, 2000; MacLeod & Farell, 1994; Mullen & Murray, 2002; Packer, 1994). Conversely, Halpern (2014) describes that in reality the mental health placement contrasts to that of a general placement. The mental health environment is less structured, with a higher level of professional autonomy and a greater reliance on a multidisciplinary team approach to care (Cowman et al., 2001; Moir & Abraham, 1996). This prompts the investigation of the quality of mentoring and constant monitoring of what is being taught as this may have a potential impact on the learning experience of the student within the mental health placement.

Mullen & Murray (2002) conducted a qualitative study to evaluate the quality of mental health clinical placements for undergraduate nursing students. The study was carried out in the Rockdale Community Mental Health centre in Australia. Ten students (7 females; 3 males), in their second year of studies were recruited using purposive sampling. These participants had a mean age of 23.1 years and had a mean placement duration of 12.8 days. The participants were subjected to a series of open ended questions developed specifically for the study to provide feedback at the completion of the mental health placement, asking the students to report the benefits and the negatives aspects of their placement, and their impressions about the clinicians/mentors. The authors report that the questions were reviewed by a panel of academic experts in the field of clinical teaching in order to establish validity and reliability. Mullen & Murray (2002) report that the questions achieved an acceptable face validity and reliability. The authors presented a series of excerpts related to the five themes identified, namely "Overall Impressions"; "Improving the Placement"; "Perceptions of Clinicians"; 'Beneficial Learning Experience" and "Mental Health nursing". Overall results outlined that 90% of the participants rated their mental health clinical placement as positive, with staff being friendly and able to address the students learning needs. Students felt part of the team as they were involved in everything and not treated as students. Interesting to note that 50% of respondents attributed the positive impression of the clinical placement to the positive attitudes of their clinicians/mentors. Further analysis of the participant's responses identifies that 50%

suggested that the clinical placement needs no improvements, whilst 20% suggested that the placement should be longer. All the participants (100%) reported positive perceptions of the clinicians with comments such as "excellent, very positive, supportive and proactive", "they made the placement totally enjoyable' and they would always consult with us (students) after every meeting with a client, often asking our point of view". This led to a 100% positive beneficial response to the question asking about their learning experience. Excerpts from the student responses include, "this placement basically pulled all the theory information together and made it more understandable" and "mental health involves a wide range of issues, needs to be looked at individually for each client'. A split result was observed when participants were asked if they see a career in mental health nursing. 50% stated that they definitely see themselves working in this field, 30% reported that they consider it as an option for the future, whilst 20% preferred other areas. Although the sample included both male and female students no comparison of results are provided by demographic variables. The authors acknowledge that this sample size does not allow for generalisability. Also as the study lacked a control group it is difficult to attribute the positive results obtained to the interaction of clinicians within the mental health placement or if any other placement would have had similar results. Mullen & Murray (2002) highlight the need for conducting further research with a larger sample size, adopting a pre- and post- clinical placement assessment would provide more valuable data. Adding a control group would also further strengthen this study.

Grav et al. (2010) conducted a mixed method study to investigate the experience of undergraduate nursing students towards their mental health nursing placement. Although 22 students, 22 mentors and 7 teachers were recruited using purposive sampling, however after data collection 15 students, 21 mentors and 7 teachers responded. Students age ranged between 20 to 39 years of age and with mentors having between 1 and 23 years of experience in psychiatric care (mean 10.8). All the seven teachers had formal training in competency supervision and mental health clinical experience. Participation was on a voluntary basis, confidentially was ensured as no data identifying the respondents was requested. Permission to conduct the study was obtained from the relevant authorities in Norway. Grav et al. (2010) self-developed questionnaire included a demographic section as well as a section with activities pre- and post- student placement. The tool included both open and close

ended questions. A pilot study was carried out on 15 formal students to determine if the questions are manageable. This is the only step the authors took to ensure validity and reliability of their tool. Data was analysed using descriptive statistics and the SPSS ver. 14 software package. The textual data was analysed using content analysis inspired by Graneheim & Lundman (2004). Results corroborate those reported by Mullen & Murray (2002) where student's participation, involvement and integration into the day to day activities of the ward lead to a positive mental health placement outcome. A student reported "*my mentor met me when I came to the ward…. spent time…. a very good reception*". Mentors also felt positive in the way they could support and guide the students. A general emerging comment from the mentors was "*the student is like one of the staff*". Teachers reported that an environment of recognition, respect and openness offers a safe space for the students to learn under supervision. Conversely the study highlighted negative aspects within the mental health clinical placement. These include mentors not turning up for the University feedback. Another important result highlighted by Grav et al. (2010), is that students reported a lack of information about the placement and what is expected from them in terms of clinical competency and skill. The authors emphasise the need for further research on what may make a mental health clinical experience positive and most importantly what information or guidelines should be available for both mentors and students in order to address needs of the students within a particular undergraduate course. Although this study provides more insight on the challenges of the mental health clinical placements, the results cannot be generalised due to the limited number of participants. Also, the courses in Norway may differ significantly to those offered in other countries. The negative findings highlighted by Grav et al. (2010), are also corroborated by the work by Jack et al. (2017) who in their descriptive narrative study explored the perceived unfairness experienced by student nurses during the undergraduate clinical placements. A mixed method deign was used recruiting the entire cohort of 1425 student nurses from adult and mental health nursing undergraduate degrees in the north west of England. This was followed by an unstructured interview of 22 students recruited via stratified sampling from nine different institutions. All ethical approval was obtained from the Manchester Metropolitan University Research Ethics Committee. Overall results showcase that 69% of students felt respected and 61% enjoyed their placements. 59% reported that their mentors did not have time to teach them and 59% said that they were treated as

just an extra pair of hands. Other comments reported by students included “I felt ignored and very unsupported” and “it is important to have a strong mentor”. Understaffing was also identified as detrimental to quality mentoring. A finding of great concern emerging from this work revolves around the negative cultural practices and attitudes. A student commented,

> “the one thing that lacks in placements! I find I learn more actually in university than placements. They all seem to contain dark, gloomy, unsatisfied, worn out, tired, snappy, over worked, sad, skint staff. And I’m really worried as a student, about ending up like this”. (Jack et al., 2017, p.934)

Jack et al. (2017) suggests adopting a tiered mentorship model in order to address the issues identified in their study and in similar studies. Central to this model are 4 key qualities of the mentor, namely a role model, advocate, respect and legitimiser. The second tier include leadership and educational philosophy which are complemented by a national policy, strategic support, local environment and professional guidelines as the third tier. The authors cite that none of these qualities in their model has higher or lower importance, but all work at different levels in order to provide the highest level of mentoring possible. Truly understanding what makes a mental health clinical placement a negative experience can support the necessary changes required to improve mentoring (Jack et al., 2017). Employing a total population survey for the quantitative part of the mixed method design provides strength to the study and allows for the generalisability of the results. Also, unstructured interviews allow more flexibility and comfort than structured interviews, resulting in a better understanding of the participant’s perspectives. Conducting the interviews in 9 different institutions strengthens this study as data is not limited to just one setting. Stratified sampling was used to recruit participants for the qualitative component of this mixed method study. Stratified sampling ensures adequate representation of students recruited from the different institutions whilst reducing sampling errors.

Myall et al. (2008) researched the experiences of 161 nursing students and 156 practice mentors in UK, using a 27-item and a 31-item online questionnaire respectively. Both

questionnaires were specific to this study, derived from the literature and included both open and close ended questions. Quantitative data was analysed using SPSS ver.14, whilst qualitative data was analysed using inductive and thematic analysis. Ethical approvals were granted by the local research ethics committee and from the internal ethics committee of the nursing schools participating in the study. Anonymity and confidentiality of data was ensured. Results highlight that the role of a Mentor was seen as rewarding and instilled a great sense of job satisfaction. A mentor's response states that, "Having enthusiastic students, you can watch and develop as the placement progresses, seeing those students go on to become staff nurses is the biggest perk of mentoring". (Myall et al., 2008, p. 1839).

Corroborating with existing literature (Fuentes-Pumarola et al., 2016; Grav et al., 2010; Jack et al., 2017) students viewed mentors as role models and having a key role in maximising their learning opportunities. A student commented that,

> "A good mentor is someone who gives you the opportunity to undertake a wide variety of skills, observing and participating, observing a variety of procedures, tests, interactions and then being supported in having a go at them, if possible". (Myall et al., 2008, p. 1838)

In agreement with the findings described by Myall et al. (2008), Jack et al. (2017) also report that students sometimes felt as just a pair of hands and that nursing staff are either too busy or understaffed to give student enough attention. Corroborating the student's views, mentors also recounted challenges whilst mentoring. These include staff shortages, under-resources and time constraints. Mentors stated, "sometimes there are too many students and not enough mentors or trained nurses…." (p.1839) and "sometimes when you are busy having a student can be difficult, you can't just get on with it, but have to explain everything, especially with first year students" (p.1839). Myall et al. (2008), recommend that students should spend as much time as possible with their mentors, as this was found to have a direct correlation with the perceived experience of the placement. Similarly, Charleston & Happell (2005) conducted a qualitative study in Melbourne, Australia to investigate the perceptions

of undergraduate nursing students and psychiatric nurses towards preceptorship in the Mental Health setting. The term preceptorship in this study replaced the term mentorship. Nine psychiatric nurses aged between 31 to 43, and 16 students participated in this study. Ethical approval was obtained by the relevant authorities. Semi-structured individual interviews were conducted with the psychiatric nurse mentors and focus groups with the nursing students. Findings reported by Charleston & Happell (2005) are in agreement with the existing body of knowledge (Happell & Rushworth, 2000; Myall et al. 2008; Fisher, 2002; Stevens & Dulhunty, 1997) which argue that mentoring is central to quality clinical learning and it has a direct effect on the positive learning outcomes of student nurses. The results reported by Charleston & Happell (2005) must be viewed with caution and due to the nature of the study design, the findings cannot be generalised to the entire population, highlighting the need for a follow-up study employing a quantitative design. Watson (1999) in his ethnographic study investigated the experiences of diploma and degree UK nursing students towards and perceptions of mentoring, recruited 35 students and 15 mentors using purposive sampling who were interviewed using a semi-structured interview guide. The study received all the necessary ethical approvals. Following content analysis, results outline that lack of uniformity in mentoring causes a lot of anxiety in students, further highlighting the need for a uniform mentoring approach. Watson (1999) also reports that the first year of an undergraduate nurse course is fundamental for the student, as it will directly impact their practice and also retention in nursing. Employing an ethnography research design, recruiting 35 students and 15 mentors, strengthens the findings of this study as such design and participant numbers allow for a rich and in-depth investigation of experiences, which the authors sought to identify.

2.8 Conclusion

The studies identified in this review together with other articles used to extend the knowledge identify the perceptions of nursing students and their mentors towards quality mentoring. Literature clearly identifies that mentorship is core to clinical learning and that mentors are in a position to influence the experience and outcome of a clinical practice. Challenges do exist and revolve around the staffing capacity and lack of competency frameworks. Therefore, in order to provide quality mentorship, mentors should be knowledgeable, able to support and guide students and most of all have a positive attitude towards the nursing student during their formation as a nurse.

However, in order to accomplish this, mentors need adequate resources and support, which as outlined in the literature review is not always available, further highlighting the need for guiding frameworks. On the other hand, students must be eager to learn and involve themselves in their clinical activities. Literature outlines that students' worst experience is when they are considered just a pair of hands. In order to avoid this both mentors and students must work together within a structured framework provided by the University or Institution running the nursing course. The challenges encountered in mentorship and the need for updating local frameworks suggested the need to investigate the quality of nursing mentorship in Malta.

Chapter 3: Method

3.1 Introduction

This chapter outlines the design and methods used to investigate the perspective of nursing students and their mentors relating to the current mentorship system. The aim and objectives together with the theoretical perspectives, sampling methods and data collection procedures are discussed. Details relating to the research instruments, ethical considerations, issues of reliability and validity, as well as methodological rigor are outlined in this chapter.

3.2 Theoretical framework

After an in-depth scrutiny of international literature, the theoretical framework that guided this study included the model of "Novice to Expert" by Benner (1984) and Bloom's Taxonomy (1956/2001).

The model "From Novice to Expert" was articulated by nursing theorist Dr. Patricia Benner in her book titled *"From Novice to Expert: Excellence and Power in Clinical Nursing Practice"* published in 1984 (Benner, 1996). An adaption of the skill acquisition model cited in Benner's work (1984) was used to grade the expected student level of development. The model proposed by Benner (1984) focusing on the development of practice from a novice level to an expert level, identifies five stages in which a practitioner transitions, develops and grows. These five stages include the "novice" stage, the "advanced beginner", "competent" stage, "proficient" and the highest stage is referred to as the "expert" stage. The transition from one stage to another is incremental and depends on the exposure of the nurse to experiences and to the accumulation of knowledge gained over time. Alligood (2017) highlights that Benner's model (1984) is one of the most practical frameworks to assess nurses' exigencies at different stages of professional evolution. Darbyshire (1994), adds that Benner's work is one of the utmost challenging, deliberative, influential, empirical and research-based bodies of nursing research that has been composed in the last 20 years'. The clinical experience is fundamental in nursing as it supports the nurse in their expansion of knowledge in order to provide the most competent and holistic care possible (Benner (1984). Benner's (1984) research investigated the difference in description between the various stages of expertise, namely novice to expert when faced with the same clinical incident. Benner's model may also be applied in

undergraduate nursing education where students transition as they progress in their course of studies in their formation as nurses. Benner's theory was applied in this study as this theory supports the acquisition of knowledge, skill competence and provision of care derived from exposure and experience. Thus, following Benner's classification mentors are considered the experts in clinical learning, who support junior nurses or students in their development.

Bloom's taxonomy (1956) derives its name from its creator Benjamin Bloom who developed 'The Taxonomy of Educational Objectives: The classification of Educational Goals'. The taxonomy is subcategorised into a set of three hierarchical models that cover the learning objectives in cognitive (i.e. knowledge), affective (i.e. attitude) and sensory (i.e. procedural skills) domains. Focusing on the cognitive learning objective, Bloom (1956) describes six levels of thinking, ranked from a low to a high level of thinking. Several authors (Barak et al., 2007; Russell, 2011; Wang & Farmer, 2008) report that "knowledge", "comprehension", and "application" are classified as lower ranked level of thinking whereas, analysis, synthesis, and evaluation comprise the higher order thinking levels. A revised version of the taxonomy for the cognitive domain was created in 2001. As outlined the original bloom's taxonomy the Cognitive domain encompasses six categories along a continuum, which similar to Benner's (1984) theory, one transitions as they grow and develop. In 2001, Anderson & Krathwohl revised the taxonomy, to not only include the six categories within the cognitive domain, but also expand on the types of knowledge. Anderson & Krathwohl (2001) report four types of knowledge, namely factual, conceptual, procedural, and metacognitive. A major difference between the original Bloom's taxonomy (1956) and the revised one by Anderson & Krathwohl (2001) is that rather than focusing on developing tests to assess student performance, the focus has shifted on facilitating student learning (Beer, 2017). Anderson & Krathwohl (2001) emphasise that this framework allows for planning of intended learning objectives, promote instructional activities and allow assessment so that these 3 elements work in synchronisation with each other. As highlighted the main focus of the revised taxonomy focuses mainly on knowledge transfer, which is fundamental in higher education (Wagner et al., 2013) especially in nursing (Benner et al., 2010). Bloom's taxonomy (1956) model guided the development of the Acute Mental Health Nursing Student Handbook, as it guided the classification of competencies and skills.

Knowledge and development of intellectual skills are at the core of the cognitive domain of Bloom's taxonomy. The six key categories of Bloom's taxonomy, namely "knowledge", "comprehension", "application", "analysis", "synthesis", and "evaluation" guide the student to recall or recognize patterns, facts and concepts that instil a foundation for in-depth learning. Following analysis of results pertaining to student reflections, Bloom's taxonomy model will now be used to guide students in conducting an in-depth analysis. Several nomenclatures have been identified that define mentor and mentee, thus for the purpose of this study the operational definitions of mentors and mentees are explained in the following section.

3.3 Operational Definitions

Literature identifies several nomenclatures to define both mentor and mentees (Cohen et al., 2007). It has also been identified that each country has its own mentoring system (Myall Levett-Jones & Lathlean, 2008), thus it is important to define operational words within this study. For the purpose of this study mentors are defined as nurses working within the mental health field who are currently enrolled, or have successfully completed a mentorship training course offered by the University of Malta and satisfy the mentoring criteria set by the Department of Mental Health, Faculty of Health Sciences, University of Malta. Conversely a mentee refers to a student nurse in any of the undergraduate nursing courses offered by the Faculty of Health Sciences, University of Malta who is mentored during their mental health placement. The following section highlights the research aim and the objectives of the study.

3.4 Research Aim and Objectives

Research Aim:

The aim of this study was to develop a mental health nursing student handbook for the acute setting that can be used as a pedagogical tool by mentors and nursing students within an acute mental health setting and to determine whether the use of this handbook has an impact on the nursing students' attitudes towards mental health nursing and stigmatising attitudes towards mental illness. Thus, the research question pertaining to this study reads, how can the provision of a mental health student handbook improve the nursing student attitudes during mental health placements?

To achieve this aim, the objectives of this study include:

1. To explore mentors' views regarding what they consider as relevant mental health nursing learning objectives for students on their mental health placement.

2. To identify the barriers towards the provision of quality mentoring according to mentors and students, and develop ways to improve them.

3. To develop a standardised handbook which addresses the limitations outlined by clinical mentors and in the relevant literature.

4. To determine if the handbook contributed to any changes in nursing student's attitudes, and mental health education from pre-placement to post-placement.

5. Explore the student's reflections whilst being mentored and making use of the handbook.

The following section highlights the methodology best suited to address the study aim and objectives.

3.5 The Research Methodology

This section provides in-depth detail on the various steps that make up the research methodology. These steps include sampling and data collection, identifying the appropriate research instruments, and adopting the most relevant research designs in order to conduct this research effectively.

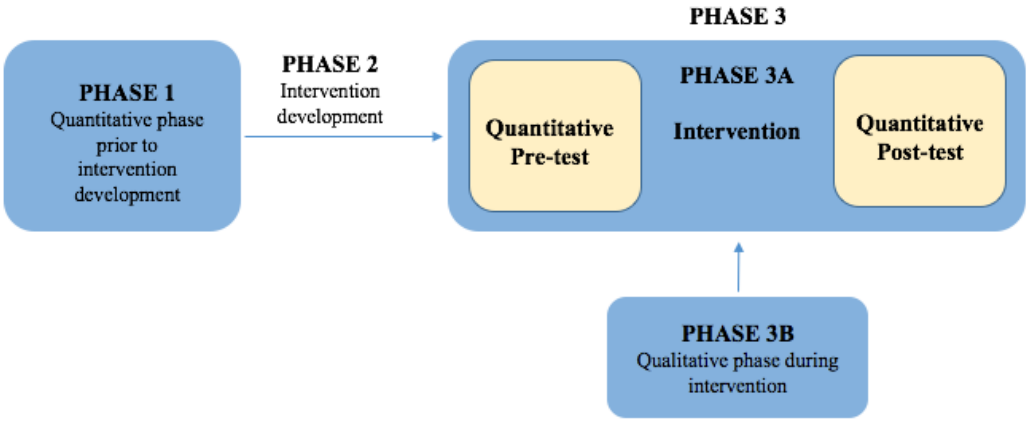
In order to explore and understand the effectiveness of mentorship in the mental health clinical placement a mixed method QUAN(qual) embedded design was best indicated for this study. A mixed method design attempts to understand research problems thoroughly by collecting and analysing both quantitative and qualitative data within one study (Creswell, 2015).

Qualitative research is indicated when data from specific cultures such as values, behaviours, opinions, practices and qualities of a particular population is required, as it focuses on the human experience of perception of that issue (Polit & Beck, 2010). Therefore, the primary aim of qualitative studies is to provide a rich contextualised understanding of the problem being investigated from the lived experience of individuals. This type of research allows for expression of theories and higher-level concepts which are not individual to one particular setting or individual (Glaser, 2002; Misco, 2007). Creswell (2014) highlights that in qualitative research the researcher generates themes emerging from the data collection process, being a focus group, interviews or documents.

Conversely, quantitative research tends to prove theories by investigating the association and link between variables (Choy, 2014; Creswell, 2014). Researchers employ a deductive approach in order to test theories and generate hypotheses. The measurement of variables can be conducted using several instruments which in turn generate numeric data. The generated data in the forms of numbers is analysed using statistical tests. For results to be accurate and generalizable to the entire population large samples are required (Creswell, 2014; Polit & Beck, 2014).

Mixed method research design incorporates the strengths of both quantitative and qualitative research approaches (Johnson & Onwuegbuzie, 2004). A greater combined utilisation of the data is achieved in a mixed method design as opposed to the individual collection and analysis of data in separate qualitative and quantitative studies. A mixed method design allows for the participants to voice themselves, ensuring that the findings emerge from the experience of the participants (Polit & Beck, 2010). A mixed method QUAN(qual) embedded design was identified to best address this studies' research question. In this kind of design one data set supports the primary data obtained in the study (Creswell, 2014). In this study, the qualitative data supports the quantitative data retrieved in the initial phase of the study.

Figure 3. 1. QUAN(qual) embedded Mixed method design employed in this study



This mixed method QUAN(qual) embedded design consisted of three phases as outlined in figure 3.1 above. Phase 1, consisted of data collection using a self-devised questionnaire to investigate the mentor's views of clinical competency and what can hinder or improve the current mentoring system. The analysis of emerging data from phase 1 guided the second phase (Phase 2) which consisted of the development and compilation of the Acute Mental Health Nursing Student Handbook (Appendix A) by the researcher. The aim of this handbook is to guide mentors and support students during their acute mental health clinical placement. In order to investigate the effectiveness of the handbook, a third phase was included in this study. Phase 3 consisted of two parts, Phase 3A consisted of a randomised control trial to evaluate any changes between pre-placement and post-placement of the nursing student cohort between the experimental group (i.e., students who were provided with the handbook and their mentors) and the control group which consisted of students who were not provided with the handbook (and their mentors). Phase 3B of the study consisted of an evaluation of the reflections conducted by students as part of the learning process within the handbook and an evaluation of the comments by students and mentors at mid-placement. The following section describes the sampling and data collection procedures.

3.6 Sampling and Data Collection

The target population in this study includes all mentors working in the acute mental health nursing field and all nursing students who have a mentored mental health clinical placement starting October 2019 and ending January 2020. This study

employed purposive sampling to recruit the largest sample possible and reduce the variance of statistical estimates. Purposive sampling allows the researcher to select participants who are knowledgeable about the area being studied. Polit & Beck (2010) state that such sampling method is indicative when the researcher wants a sample of experts, which was the case for data collection from mentors, which are considered as experts.

It has to be acknowledged that although every effort to recruit the entire target population of nursing students was made, the numbers are still low as compared to research generated from other countries. This is mainly due to the limited time available for sampling and data collection whilst conducting a postgraduate degree, in addition to the fact that the present study unlike others, incorporated a series of phases in the development of the handbook. The timeline of planning and carrying out of the other phases of the study such as formulation the handbook, dictated the collection of data from the students. Data collection from students commenced at the start of the mental health placement in October 2019 and at the end of the same placement in January 2020, limiting the total number of potential participants.

A letter to both mentors and nursing students was distributed by the intermediaries asking if they wished to participate in this study. Different sampling and data collection techniques were utilised in the various phases of this study, which are discussed in more detail in the separate subsections below.

3.6.1 Phase 1

During Phase 1 of the study, quantitative data was collected using both closed and opened ended questions in a self-devised instrument (Appendix B). Open ended questions were analysed using quantitative content analysis. Quantitative content analysis allows for the interpretation of the content of text data which is systematically categorised and recorded, generating frequencies and provides information about themes or patterns (Hsieh & Shannon, 2005). The sample included all the mentors servicing the Department of Mental Health, thus since the total population of mentors were included (i.e., 50 mentors), the sampling can be referred to as a total population survey. These mentors were administered this questionnaire aimed to collect information about improving the current mentorship system, what hinders quality

mentoring and also what competencies and skills mentors perceived should be part of the learning outcomes. Distribution and collection of the questionnaire was carried out via an intermediary. This ensured both anonymity and confidentiality. This was of particular importance as the researcher is a registered psychiatric nurse working in the same institution were data was collected. Completed questionnaires were returned in an envelope and placed within a labelled and sealed box located at the intermediary's office.

3.6.2 Phase 2

Phase 2 consisted of the development and compilation of the Acute Mental Health Nursing Student Handbook. The formulation of this handbook was guided by the results generated from the first phase of the study, following the feedback from mentors about the competency domains, learning outcomes and skills and documents identified in the literature review. In order to formulate the handbook comments and responses from mentors were analysed using quantitative content analysis. The handbook highlighted 8 domains, namely, "Therapeutic Relationship", "Assessment", "Care Planning and Coordination", "Nursing Intervention", "Managing Crisis and Psychiatric Emergencies", "Ethical Issues", "Education and Research" and "Legal Implications". The handbook was reviewed by the coordinator for the clinical placements within the Department of Mental health and by the research supervisor for face validity.

3.6.3 Phase 3A

During this phase, an investigation on the effectiveness of the handbook as a guide for clinical learning was conducted. Students currently enrolled in either the Higher Diploma in Health Sciences, BSc Nursing and BSc Mental Health Nursing offered by the University of Malta who had their placement between October 2019 and January of 2020 were asked to participate. A total of 43 students were eligible to participate. All 43 students were randomly assigned using a computer-generated software (random.org) to an experimental group or control group. The experimental group consisted of nursing students and their mentors who were provided with the 'Acute Mental Health Nursing Student handbook' (that provided a formal structure or guide) to the placement and a control group that consisted of students and mentors who were not provided with a copy of the handbook.

The randomisation was carried out by the placement co-ordinator to safeguard anonymity and confidentiality. Randomisation prevents selection bias and protects against accidental bias. Randomisation also produces comparable groups whilst eliminating bias in group assignments (Creswell & Creswell, 2018). The control and experimental group consisted of both general and mental health nursing students, ensuring comparable groups. It was essential that the randomisation process was carried out by the placement co-ordinator to ensure that student names and data would not be disclosed to the researcher. Twenty-two students were randomly allocated to the experimental group whilst 21 students were randomly assigned to the control group.

All 43 students completed the pre-placement questionnaire package, whilst 36 students completed the post-placement questionnaire, giving a total attrition rate of 16.3% (n=7). One respondent in the experimental group did not complete the post-placement questionnaire, resulting in an attrition rate of 4.5%(n=1) whilst 6 students in the control group did not complete the post-placement questionnaire resulting in an attrition rate of 27.2% (n=6). The distribution and collection of the questionnaires was also carried out by a second intermediary (Appendix C) to once again safeguard anonymity and confidentiality, whilst allowing the students to freely express their views. It is important to note that during this phase, the nursing students were having their mental health theoretical module, whilst the mental health students were having their acute mental health theoretical module.

3.6.4 Phase 3B

Phase 3B consisted of an evaluation of the student comments written as part of their reflective learning process as instructed in the handbook. The aim of this phase of the study was to evaluate the effectiveness of the handbook as a pedagogical tool and if it truly addresses the learning objectives emerging from the first phase of this study. A thematic analysis of the student's reflections of the evaluation of their progress in attaining competency to the learning outcomes within the mental health nursing student handbook was carried out. This was followed by another thematic analysis of the comments on the progress of the student within the clinical placement at mid-placement by both the mentor and the mentee. Thematic analysis allows for the

analyses of qualitative data such as interviews and transcripts. Data was analysed and examined in order to identify common theme and patterns of meaning that come up repeatedly.

Results emanating from the thematic analysis are presented in the following chapter in the form of excerpts.

3.7 Research Instruments

Having valid and reliable research instruments are essential in providing strong evidence to investigate the experiences of students about their mental health placement together with the mentor's views on mentoring and competencies/learning outcomes in order to improve quality mentoring. An analysis of the various tools identified in literature was conducted. Specific searches were carried out in order to identify learning outcomes and clinical handbooks used in the first and second phase of the study. For the third phase of the study, tools measuring the student's knowledge, competence, attitudes and experience during the mental health placement were retrieved. Development of tools or identification of validated tools had to be identified that best addressed the scope of each phase of the study. Hence the research instruments used in each phase of the study is presented in the following sections.

3.7.1 Phase 1

As previously outlined this phase focused on the collection of quantitative data from mentors. A self-devised instrument was compiled based on the different competency based frameworks identified in literature including the Psychiatric Mental Health Nursing standards (Maltese Association of Psychiatric Nurses, 2017), Pre-registration practice portfolio for Mental Health Nursing Students (Department of Mental Health, 2009), Guidance and health and character (NMC, 2019), The NMC Competency Framework Mental Health Nursing (NMC, 2019), Mental Health Nursing: Field Specific Competencies and Standards for competence for registered nurses (NMC, 2019). The Psychiatric Mental Health Nursing standards (Maltese Association of Psychiatric Nurses, 2017) is a reliable document which has been endorsed by the European Psychiatric Nursing Association HORATIO, the Director of Nursing Services in Malta and the Department of Mental Health, Faculty of Health Science,

University of Malta. The NMC Competency Framework Mental Health Nursing (NMC, 2019), is the UK's official recognised competency framework which needs to be successfully completed in order to register as a Psychiatric Nurse in UK, whilst the Pre-registration practice portfolio for Mental Health Nursing Students (Department of Mental Health, 2009) is the official competency framework that mental health nursing students must complete in order to qualify and register as psychiatric nurses. Thus, all three consulted documents are considered highly reliable and valid.

A tool was compiled to address the objectives outlined in the present study. It consisted of 3 sections, namely sections A, B and C. Section A included demographic data and open-ended questions about the current mentorship system and ways to improve such a system. Section B was subdivided into 9 domains of competency in which participants were asked to rate the importance of each competency within that domain on a 5 point Likert scale (1= not important; 5= extremely important), as well as providing respondents with the opportunity to further expand on their previous answer. The final section of this tool, Section C, included a list of 64 core and auxiliary skills which were once again rated on a 5 point Likert scale.

3.7.2 Phase 2

During the second phase of the study, the Acute Mental Health Nursing Student Handbook was compiled. The handbook consists of several sections, including an introduction to explain in more detail how to make maximum use of the handbook and a "Placement Regulations" section which illustrates to the students the placement rules, policies and expected behaviour during the mental health placement, such as the use of mobile phones, absenteeism, conflict of interest, boundaries and professional appearance. This is followed by the Domains of Competence section which includes 8 Domains, namely Therapeutic Relationship", "Assessment", "Care Planning and Coordination", "Nursing Intervention", "Managing Crisis and Psychiatric Emergencies", "Ethical Issues", "Education and Research" and "Legal Implications", with each domain containing a list of learning outcomes that students must strive to attain. This is followed by the Competence Evaluation section which requires students to reflect and document their progress during their clinical experience and also discuss such progress with their mentors during a mid-placement meeting. A skills checklist

highlights 15 practical skills, such as “administer and record an intramuscular and a depot medication” and “recognise signs of neuroleptic malignant syndrome (NMS) and lithium toxicity”, which mentors had to rate (Appendix E). The penultimate section includes a student resource section, linking important documentation and information such as the Maltese Mental Health Act (2012) and the Data Protection Act (2018). Finally, the handbook concludes with a glossary of terms that serves as a quick reference for students when they come across new terms.

Following data analysis of the student reflections and mentor’s comments in phase 3B and verbal feedback provided at the end of the clinical placement by mentors to the Mental Health Placement coordinator, it was decided to revise the handbook (Appendix A) in order to address the arsing issues. The revisions include the removal of the skills checklist. The skills listed in this checklist were distributed under their respective domain of competency and duplicate skills eliminated entirely. An evaluation based on the criteria, “Satisfactory”, “Not Demonstrated” or “Unsatisfactory” has been added so that mentors can gauge the students’ attainment of the learning outcomes pertaining to each domain of competency.

3.7.3 Phase 3A

In order to examine the attitudes of undergraduate nursing students and quality mentoring in mental health clinical placement, the researcher conducted a thorough literature search on various tools available and used in the extant literature. During the planning stage of the study in depth literature search was conducted and several research instruments were retrieved. After consultation with the supervisor three self-administered questionnaires were identified that were perceived to best address the research question. These tools were chosen in favour of others previously cited in research such, as the “Mental Health Nursing Clinical Confidence Scale” (MHNCCS) (Patterson et al., 2017); “Cultural and Linguistic Diversity” (CALDs) (Mikkonen et al., 2017); “Clinical Learning Environment” (Mikkonen et al., 2017); “Supervision and Nurse Teacher (CLES + T)” (Mikkonen et al., 2017); “The Nurses Self Report (NSR) questionnaire” (Henderson et al., 2007); “The Manchester Clinical Supervision Scale” (MCSS) (Severinsson & Sand, 2010) and the “Empowerment Supervision Scale” (FESS) (Severinsson & Sand, 2010). The Psychiatric / Mental Health Clinical Placement Survey (Pre/Post Placement Survey) (Happell, 2008b,c) utilised in the

present study allowed the collection of data related to the perceived level of preparedness for mental health nursing, degree of satisfaction with clinical experience and quality mental health clinical placements and mentoring. No other instrument could be found that targeted all the aspects cited previously.

The questionnaires used in the present study were self-administered. This provided numerous advantages which include more time available for the participant to complete the tool and also that one can control the pace at which it is done. Being a self-administered questionnaire also allows for the participants to freely express themselves and feel less apprehensive.

The research instruments used in the Phase 3A (Appendix D) of the study were:

- The Psychiatric / Mental Health Clinical Placement Survey for the First Day of Placement (Pre-Placement Survey), (Happell, 2008b)
- The Psychiatric / Mental Health Clinical Placement Survey for the Last Day of Placement (Post-Placement Survey), (Happell, 2008c)
- The Attitudes to Mental Health Illness Questionnaire (Luty et al., 2006).

In addition to completing these three questionnaires students were asked to complete a demographic section indicating their gender, age, placement setting and course being followed (i.e., Bachelor of Science in either Mental Health Nursing, Nursing or Diploma in Nursing).

(i) The Psychiatric / Mental Health Clinical Placement Survey (Pre/Post Placement Survey)

The Psychiatric/ Mental Health Clinical Placement Survey is a brief self-report survey used to examine the preparedness of nursing students for mental health clinical placements. It also examines attitudes towards persons experiencing a mental illness and towards mental health nursing. This tool is an extended modified version of the tool developed by Wynaden et al. (2000) after consultation with groups of experts in the field of mental health nursing including clinical specialists, academics and managers. Since both tools have a good psychometric property with samples of nursing students and are easy to be administered, various researchers have used this

tool for their studies (Happell, 2005; Happell, 2008a; Happell, Robins & Gough, 2007, Happell, Robins & Gough, 2008, Happell & Gough 2009; Happell et al., 2011, Hayman-White & Happell, 2005; Thongpriwan et al., 2015). Both the pre-and post-placement survey take between 10 to 15 minutes to complete.

a. The Psychiatric / Mental Health Clinical Placement Survey for the First Day of Placement (Pre-Placement Survey)

The first part of the pre-placement survey is composed a demographic section, which was replaced by the researcher's own demographic section, which removed if the placement was either elective or compulsory; the university that the student was registered with and year of course. These have been removed as they do not apply within the local setting, however this study demographic section did ask participants their age and which course they were following, i.e., mental health or general nursing at a degree or diploma level. The second part of the questionnaire consists of 24 statements which appraise the attitudes and experiences of students. Responses are based on a 7-point Likert scale, namely strongly disagree, quite strongly disagree, disagree, neither agree or disagree, agree, quite strongly agrees and strongly agree.

Responses to the 24 statements were used to calculate the seven subscale scores. The subscales have been extracted through principal component analysis conducted by Happell (2005) to examine the psychometric properties of the clinical evaluation component of the survey. The 7 subscales include:

Preparedness for Mental Health Field (PMHF) – The Preparedness for mental health field comprises 4 items, namely questions 1, 4, 7 and 10. Higher scores represent a greater sense of preparedness by the respondent to care for individuals with a mental health condition)

Knowledge of Mental illness (KMI) – This subscale is made up of 4 items, namely questions 9, 18, 19 and 23. Higher scores on this subscale indicate more informed knowledge and attitude towards mental illness.

Negative stereotypes (NS) – The negative stereotypes subscale is made up of 4 items, namely questions 8, 13, 21 and 24. The lower the scores obtained on this subscale represent less stereotypical beliefs.

Future career (FC) – Two questions make up this subscale, namely questions 6 and 12. Higher scores on this subscale report a greater desire to pursue a career in psychiatric/mental health nursing.

Course effectiveness (CE) – This subscale is made up of 4 items, questions 14 through 17. Higher scores represent the degree to which students' university courses had prepared them for various areas of nursing.

Anxiety Surrounding Mental Illness (ASMI) – The anxiety surrounding mental illness represents the respondent's levels of anxiety when dealing with mental illness. This subscale is made up of 3 items, namely 3 and 5 which are reversed scored and question 22. Higher scores represent lower levels of anxiety.

Valuable contributions' (VC) – This subscale reports the belief that psychiatric nurses provide a valuable service to consumers, the community, and students' nursing careers. Three items make up this subscale, namely question 2, 11 and 20. Higher scores on this subscale represent a stronger belief that that psychiatric nurses provide a valuable service to consumers, the community, and students' nursing careers.

Item loadings and commonalities obtained following principal components extraction revealed that the seven subscales are made up of relatively homogenous items, and most of these items were found to be a good or excellent measure of each subscale. Validity and reliability of this instrument are reported in section 3.8.

b. The Psychiatric/Mental Health Clinical Placement Survey for the Last Day

The post-placement questionnaire consists of a self-report survey with the same number of questions in the pre-placement questions and an additional 15 questions, targeting the students' perceived level of the mentor clinical competence and readiness and preparedness to mentor. This survey is used to assess students' preparedness, attitudes and beliefs relevant to mental health nursing, as well as information relevant to their recent clinical experiences (Happell et al., 2008). The pre-placement survey statements were repeated in the post-placement survey to allow for the identification of changes in the attitudes and beliefs of nursing students towards mental health nursing after the completion of their mental health clinical placement. This tool

however consisted of an additional 15 statements aimed to highlight the mentor's effort to support the student. In total nine subscales make up the post-placement survey. These subscales were identified following principle component analysis (Hayman-White & Happell 2005). The two additional subscales comprise:

'Clinical skills' (CS) – This subscale is made up of items 25 and 36–39. High scores in this subscale reflect a higher perceived level of clinical skill in staff involved with student placements.

'Readiness for students' (RS) – The readiness for students' subscale is composed of items 26, 27, 29, 31, 33–35. High scores represent a greater readiness or preparedness of staff for students.

Since this study sought to investigate any statistical significant changes in the student's responses on the subscales at pre-and post-placement for the experimental and control group, the two additional subscales were not reported in the study findings for two main reasons. The first reason is that these two additional subscales focus on the students view of their mentor's level of preparedness and skill competency. Secondly, no pre-placement data is available for these two subscales, so no pre-and post-analyses could be conducted.

(ii) The Attitudes to Mental Health Illness Questionnaire

The AMIQ (Luty et al., 2006) is a 5 item, questionnaire based on the work of Cunningham et al. (1993). Respondents are asked to read a short vignette, then answer five questions. Each of the 5 individual questions for each vignette is scored on a 5-point Likert scale, namely Strongly Agree, Agree, Neutral, Disagree and Strongly Disagree. Questions 1, 4 and 5 are weighted -2 for Strongly Agree, -1 for Agree, 0 for Neutral or Don't' know, +1 for Disagree and +2 for Strongly disagree, whilst Questions 2 and 3 are reversed scored, that is, +2 for Strongly Agree, +1 for Agree, 0 for Neutral or Don't' know, -1 for Disagree and -2 for Strongly disagree. The summation of the individual scores for the five questions for each vignette are added giving a theoretical minimum score of -10 and a theoretical maximum score of +10 for each vignette. The 7 vignettes presented in the AMIQ scale are quoted below;

A. John has been injecting heroin daily for 1 year.
B. Tim is depressed and took a paracetamol overdose last month to try and hurt himself.
C. Steve has been drinking heavily for 5 years. He is now going for treatment and has started attending Alcoholics Anonymous meetings.
D. Robert is a convicted criminal. He has spent time in prison for several convictions for theft and shoplifting and is currently on bail for fraud and burglary.
E. Peter has diabetes. He needs to inject insulin every day and has a special diet.
F. Steve is a practising Christian. He attends church every Sunday and attempts to lead a Christian life.
G. Michael has schizophrenia. He needs an injection of medication every 2 weeks. He was detained in hospital for several weeks 2 years ago because he was hearing voices from the Devil and thought that he had the power to cause earthquakes. He has been detained under the Mental Health Act in the past. (Luty et al., 2006, p.258)

3.7.4 Phase 3B

Phase 3B of this study involved the thematic analysis of the student competence evaluation and reflection. This phase aims to generate in depth data about the value of the clinical handbook as a tool to improve mentoring and the student's experience during mental health clinical placements. Data concerning the student's evaluation of their perceived progress in relation to the domains of practice together with data emerging from the mid-placement meeting held between the mentees and the mentors was analysed.

3.8 Reliability and Validity of the Research Instruments

Reliability and validity are crucial aspects when identifying the most suitable survey instrument. Reliability deals with how the instrument is able of producing similar results over multiple trials (Creswell, 2013), whilst the ability of the instrument to measuring what it was designed to measure is referred to as validity (Creswell, 2013). The following section discuss the measures undertaken at each phase to achieve validity and reliability.

3.8.1 Phase 1

As a self-devised questionnaire to measure the mentor's views on mentoring including which clinical competencies are relevant to the acute mental health placement as well as ways to improve mentoring was developed and adapted from the relevant literature. No validity and reliability testing was previously ascertained. Therefore, the finalised tool was reviewed and vetted by the study supervisor as well as the coordinator of clinical placements and mentorship allocation within the Department of Mental Health for face validity. Although face validity is one of the weakest forms of validity, it ensures that the measuring tool being used, in this case the self-devised questionnaire measures what it is supposed to measure.

3.8.2 Phase 2

The same form of validity and reliability testing used in phase 1 was also applied in phase 2. The Acute Mental Health Nursing Student Handbook was reviewed for face validity and consistency by the study supervisor, the coordinator of clinical placements and mentorship allocation within the Department of Mental Health, the President of the Maltese Association of Psychiatric Nurses and the Practice Development Nurse with the Maltese Mental Health services. Furthermore, the handbook was piloted in phase 3 of the present study.

3.8.3 Phase 3A

During phase 3 of the study standardised validated instruments, namely the Psychiatric/Mental Health Clinical Placement Survey for the First/Last Day of placement by Happell (2008) and The Attitudes to Mental Health Illness by Luty et al. (2006) were utilised. The validity and reliability of each tool are discussed in the following section.

3.8.3.1 The Psychiatric / Mental Health Clinical Placement Survey for the First/Last Day of Placement (Pre/Post-Placement Survey)

To determine validity of this tool the author (Happell, 2008b,c) conducted several tests including content validity, construct validity and criterion validity. The survey was first piloted on a representative group of 47 nursing students to ensure no adverse

reactions to questions composing the survey or comprehension difficulties. This analysis was carried out amongst 802 Australian nursing students before their mental health clinical placement was carried out. Construct validity was established by using principal components analysis (PCA). The seven comparatively homogenous statements were: preparedness for mental health field, knowledge of mental illness, negative stereotypes, future career, course effectiveness, anxiety surrounding mental illness and valuable contributions. Additionally, these seven subscales accounted for a substantial proportion of variance in the data (57%). Concurrent validity was established by comparing "The Psychiatric / Mental Health Clinical Placement Survey for the First/Last Day of Placement (Pre/Post-Placement Survey)" to another established tool developed by Bell et al. (1998), namely "The Mental Health Nursing Clinical Confidence Scale". In addition, the 24 item survey was reviewed by a board of experts in academia, psychiatric nursing practice and management. These experts concluded that the survey has a good content validity. During this review a mental health consumer was also actively involved. Known group validity was assessed by comparing two cohorts of nursing students, without any clinical experience (n=748) and the other after completing their clinical placements (n=688). Statistically significant differences were reported in the group who completed the clinical placements. They scored higher on five of the subscales, namely "Preparedness for Mental health field" ($t=20.00$, $p<0.005$); "Future Career" ($t=9.64$, $p<0.005$), "Valuable Contributions" ($t=7.10$, $p<0.005$); "Course Effectiveness" ($t=10.06$, $p<0.005$) and Anxiety Surrounding Mental Illness ($t=31.93$, $p<0.005$). Reliability of the instrument was measured using internal consistency. Cronbach alpha scores for each subscale, namely "Preparedness for Mental health field" ($\alpha=0.78$); "Knowledge of Mental illness" ($\alpha= 0.61$); "Negative Stereotypes" ($\alpha=0.47$); "Future Career" ($\alpha=0.89$), "Valuable Contributions" ($\alpha=0.68$); "Course Effectiveness" ($\alpha=0.51$) and Anxiety Surrounding Mental Illness ($\alpha=0.74$), indicate that the tool is reliable as five out of the seven subscales achieved statistically significant internal consistency as the Cronbach alpha score is higher than 0.6.

3.8.3.2 The Attitudes to Mental Health Illness Questionnaire

Luty et al. (2006) suggest that the Attitudes to Mental Health Illness Questionnaire has been validated on a sample of 1079 adults residing in the UK randomly selected

using newspaper adverts and randomly picking addresses using the wildcard function of the British Telecom online directory.

Factor analysis using principal component analysis with varimax rotation identified one component accounting for 80.2% of the variance that involved significant contributions from all five questions. Luty et al. (2006) labelled this factor as 'stigmatisation'. The authors conclude that the results indicate excellent construct validity. After 2 to 4 weeks a questionnaire was sent to a sample of respondents. Reliability testing was conducted on 256 participants and a reasonable test-retest result (r=.70) was obtained.

3.8.4 Phase 3B

During phase 3B the researcher explored models that ensured rigor whilst preserving the relevance of qualitative research. Rigour and trustworthiness were ensured by applying the 4 criteria suggested by Guba (1981) namely credibility, transferability, dependability and confirmability. Credibility refers to providing a detailed description of how interpretations of the data were made. This was enabled by providing excerpts from the student's reflections to support each theme, enabling the reader to recognize how interpretations were made from the data collected. Sandelowski (1986) suggested that a study is credible when the accurate interpretation or description of the lived experiences are immediately recognizable to those who share them. A strength of the qualitative phase is that it was conducted in its naturalistic settings, that is, mental health clinical placements, with few controlling variables. Transferability was ensured by providing a description of the context in which the study took place, i.e., acute mental health clinical placements, thus enabling the reader to decide whether the data could be transferred. Dependability incorporated the provision of a detailed description of the methodological process, in order to allow for replicability. Confirmability describes the extent to which the findings were shaped by the respondents and not researcher biased. This was ensured through the inclusion of the reflective accounts allowing the students and mentors to voice their own experiences. Sandelowski (1986) highlights that reliability in quantitative research is of utmost importance as it ensures consistency, equivalence and stability in a study. The following section presents details regarding the data analytic procedures.

3.9 Data analysis

In the first phase, all data retrieved from questionnaires sent to mentors was analysed using content analysis. Content analysis is the systematic examination of communication materials. As Creswell (2013) suggests, content analysis enables researchers to easily analyse and filter large volumes of data in a systematic way. Content analysis is very indicative in examining patterns or trends (Creswell, 2013). This involved selecting the content to be analysed, followed by defining the categories of analysis. A set of coding rules were then developed and the text was coded according to these defined rules. This allowed the results to be analysed and conclusions drawn. The aim of the phase was to examine trends and patterns from mentors to then form phase 2 of this study which is the formulation of the handbook "Acute Mental Health Nursing Student Handbook".

In the phase 3A data collection from student attending mental health clinical placement was analysed using statistical software, IBM SPSS version 26. Students completed "The attitudes to Mental Health Illness Questionnaire" (Luty et al., 2006) both at pre- and post-placement, whilst "The Psychiatric / Mental Health Clinical Placement Survey for the First Day of Placement (Pre-Placement Survey)" by Happell, (2008b) at pre-placement and "The Psychiatric / Mental Health Clinical Placement Survey for the Last Day of Placement (Post-Placement Survey)" by Happell, (2008c) at post-placement. A 95% confidence interval was used in order to allow for a comfortable degree of uncertainty. Significance value was considered at p equal or less than 0.05. An independent student t-test was used to analyse pre and post data for the experimental and control group. An independent t-test was chosen to determine whether there was a significant change in scores between the pre and post placement. The questionnaires were filled in anonymously, one could not link the responses for each student at pre-placement with those at post placement. This decision was necessary as the present researcher worked in the same setting as study participants and is also a mentor, hence this could have an impact on the beracity of their replies on the questionnaire. The significance value reported was dependent on the results obtained from the Levene's Test of equality of error variances. If the Levene's test was significant, then variances were considered to be different and the corresponding p value on the test was reported. If the Levene's test was non-

significant, then the assumption of equal variances was met and the corresponding value is reported.

During phase 3B the researcher evaluated the "Acute Mental Health Nursing Student Handbook". The students reflected on how the 8 domains were achieved in their clinical placement. To analyse this phase of this research, the researcher decided to examine the data through thematic analysis. Thematic Analysis was used to examine this data as it is an accessible and flexible method of qualitative data analysis (Creswell, 2013). Thematic analysis is based on the identification of recurrent themes or patterns in data (Creswell, 2013), which involves six steps, namely, the preparation and organisation of data as the first step. The second step involved reviewing the data, whilst in the third step the data was coded. During the fourth step, themes were generated, followed by the representation of the themes in the qualitative narrative. The interpretation of the findings was carried out in the last step. Thus, the researcher first familiarised herself with the data collected, then preliminary colour codes were assigned to the data in order to identify similar content. The different coloured coded data were reviewed in order to identify themes. The themes were reviewed, defined and named. A final report was generated and is presented in section 4.5.2 of the Results Chapter.

3.10 Pilot study

A pilot study was conducted prior to the full-scale research project in order to evaluate time, feasibility, cost, and improve upon the study design. Only phase 1 could be piloted. In order to preserve the target population for the actual study, the pilot study recruited those nurses who are currently undergoing training to become mentors, and not yet serving as mentors. Recruitment and distribution of the questionnaire was carried out by the intermediary. A total of four questionnaires were distributed to nurses currently undertaking mentorship training. Data protection and ethical considerations were all adhered to as outlined in section 3.11 of this chapter.

Overall no difficulties were reported regarding the understanding and meaning of the questions. The respondents reported that 15 minutes is an adequate time to complete the questionnaire. One participant suggested that the Likert-scale in section C could

be clarified further, thus following this suggestion, the scale was amended to read "1= not important", "2 = slightly important", "3 = moderately important", "4 = very important" and "5 = extremely important".

3.11 Ethical Considerations

Ethical approval was sought from the Faculty Research Ethics (FREC) and all the entities governing data collection at the research sites (Appendix F). Permissions to use the tools from their respective authors was also granted (Appendix G). Data collection was commenced only after all necessary ethical approvals were given. Participation in this study was strictly voluntarily and participants were free to withdraw at any time without the need to give reason or notice. Participants were instructed not to write their name or identify themselves in any way on the questionnaires. Confidentiality was ensured as all the information was provided anonymously. Each questionnaire included an information letter highlighting the aim of the study and information about participation, confidentiality and anonymity, consent and participants right to refuse participation. Distribution and collection of the questionnaires was carried out by two intermediaries, one intermediary distributed and collected the questionnaires to nurses working within the mental health field who render mentoring services to the University of Malta. The other intermediary distributed and collected the provided questionnaires to all undergraduate students enrolled in the BSc Mental Health Nursing and 2nd year undergraduate nursing students enrolled in the Higher Diploma in Health Sciences (Nursing Studies) (Full-Time) and Bachelor of Science (Honours) Nursing (Full-Time) within the University of Malta.

This ensured that the researcher did not have any contact with the participants. Only the researcher had access to the completed questionnaires. Participants were free to decline participation in the study and no pressure was made on mentors and students to fill the questionnaire. No harm was intended nor was done to the participants. Incomplete questionnaires or those including data that could identify the respondent were considered invalid. Participants were assured that the gathered data would only be used for the research purposes of this study and handled only by the researcher and the researcher's supervisor. Informed consent is implied if the participant completes

and returns the questionnaire as indicated in the information letter handed out to the participants.

3.12 Conclusion

Chapter 3 described in detail the design and data collection methods adopted to investigate quality mentoring. A mixed method design was the most indicative as it allowed the researcher to collect data in both forms with minimization of the limitations of both approaches (Creswell, 2013). After an extensive literature search, it has been identified that a mixed method QUAN(qual) embedded design is the most indicative measure for this study. The target population included mentors serving the department of mental health in the first phase of the study, which amounted to a total of 50 eligible participants. For the third phase of the study, students doing their mental health placement between October 2019 and January 2020 were eligible to participant. A total of 43 students enrolled in this research. Following all ethical clearance, the two intermediaries distributed the questionnaires. Participation was strictly voluntarily. Once data was collection it was analysed and emerging results are presented in the following chapter.

Chapter 4: Results

4.1 Introduction

Chapter four presents the findings collated throughout this study. These findings were analysed using IBM SPSS ver. 26. As the study consisted of three main phases it was decided to present the findings in a manner that reflects this sequence. The first phase explored the perceptions of mentors servicing the Department of Mental Health, University of Malta regarding their views about the current mentorship system and ways of improving it. The second phase of the study involved the compilation of the Acute Mental Health Nursing Student handbook, that was guided by a review of the literature and findings emerging from the first phase of the study. In the third phase of the study, nursing students (both mental health and general) were divided randomly into two groups. The first group (experimental group) was provided with the Mental Health Nursing Student handbook (compiled during phase 2) whilst the other group (control group) were not provided with a handbook. The perceptions of both groups of students regarding their clinical learning experience and their attitudes towards mental illness were evaluated using two questionnaires that were administered at pre- and post-placement respectively (phase 3A of the study). Concurrent with this phase, students in the experimental group were asked to document on their handbook their reflections on the attainment level of the competencies outlined in the domains of practice (phase 3B of the study).

The following section provides details regarding the sociodemographic characteristics of both the mentor and nursing student samples.

4.2 Socio-demographic data of Study Participants: Mentors and Students

This study employed multiple phases and two distinct groups of participants, namely mentors and nursing students. In this section, the socio-demographic characteristics of the two participant groups are outlined. The socio-demographic characteristics of the Mentors servicing the Department of Mental Health, University of Malta are illustrated in section 4.2.1, whilst those pertaining to the nursing students are described in section 4.2.2.

4.2.1 Socio-Demographic characteristics of Mentors

The entire cohort of mentors servicing the Department of Mental health were invited to participate in Phase 1 of the present study. A total of 50 questionnaires were distributed and 35 questionnaires were returned, giving a response rate of 70%. Table 4.1 illustrates the socio-demographic distribution of the mentor's cohort. The variable Work Setting was divided into Acute In-patient and Acute-community. Acute inpatient incorporated the Acute Adult Admission Wards, Substance Misuse and Child and Adolescent Acute Wards, whilst the Acute Community work setting, incorporates the Rehabilitation and Community/Outreach Settings which students were allocated to during the period of data collection.

Table 4. 1Socio-demographic characteristics of Mentors.

Socio-demographic characteristics (Mentors)	N (%)
Gender	
Male	10 (28.6%)
Female	25 (71.4%)
Age (years)	
20-30	15 (42.9%)
31-40	11 (31.4%)
41-50	3 (8.6%)
51-65	6 (17.1%)
Work Experience (years)	
Less than 5	5 (14.3%)
6 to 15	16 (45.7%)
16 to 25	8 (22.9%)
26+	6 (17.1%)
Work Setting	
Acute In-patient	**27 (77.1%)**
Acute Adult Admission	22 (62.9%)
Substance Misuse	4 (11.4%)
Child and Adolescent	1 (2.8%)
Acute Community	**8 (22.9%)**
Community/Outreach	5 (14.3%)
Rehabilitation	3 (8.6%)
Years in Mentoring	
<2	17 (48.6%)
3-5	5 (14.4%)
6-10	5 (14.4%)
11+	8 (22.6%)
Highest Qualification achieved	
Masters in Health Service Management	1 (2.8%)
Masters in Mental Health Nursing	10 (28.6%)
BSc in Mental Health Nursing	15 (42.9%)
BSc in Nursing	6 (17.1%)
Diploma in Mental Health Nursing	1 (2.8%)
Diploma in Nursing	1 (2.8%)
Traditional Nursing Course	1 (2.8%)
Total Sample	35

As illustrated in Table 4.1 the majority of mentors participating in this study were females (n=25, 71.4%), aged between 20 to 30 years old (n=15, 42.9%), working within the Acute In-patient setting (n=27, 77.1%), having mentored for 2 years or less (n=17; 48.6%) and holding a Bachelor of Science in Mental Health Nursing qualification (n=15,42.9%).

The following section provides the sociodemographic characteristics of the student sample. This information is required for interpreting findings for Phase 3 of the study.

4.2.2 – Socio-Demographic Data of Nursing Students

Phase Three of the study involved the recruitment of nursing students who had their clinical mental health nursing placement between October and January 2020. This amounted to a total sample of 43 students, of which 36 students completed the post placement questionnaire, giving a response rate of 83.7%. There was a total attrition rate of 16.3% (n=7) between pre-and post-placement, with the highest attrition rate observed in the control group (n=6, 14%). The entire eligible student cohort from three different nursing programmes offered by the University of Malta were invited to participate in this study. The three nursing programmes incorporate the Mental Health Nursing programme and both general nursing programmes, namely those leading to a Diploma or a Degree in Nursing.

The socio-demographic characteristics of the sample are outlined in Table 4.2. Details included in the table relate to students completing the questionnaires provided at pre- and post-mental health nursing placement.

Table 4. 2 Socio-demographic distribution of student cohort.

Student Demographics (Nursing students)	Pre- Placement n (%)	Post Placement	
		With Handbook n (%)	Without Handbook n (%)
Gender			
Male	15 (34.9%)	9 (42.9%)	5 (33.3%)
Female	28 (65.1%)	12 (57.1%)	10 (66.6%)
Age			
18-29	33 (76.8%)	18 (85.7%)	12 (80%)
30+	10 (23.2%)	3 (14.3%)	3 (20%)
Placement			
Acute In-patient	28 (65.1%)		
Acute Adult Admission	24 (55.8%)	12 (57.1%)	8 (53.3%)
Substance Misuse	3 (7.0%)	1 (4.8%)	1 (6.7%)
Child and Adolescent	1 (2.3%)	0	0
Acute Community			
Community/Outreach	12 (27.9%)	7 (33.3%)	6 (40.0%)
Rehabilitation	3 (7.0%)	1 (4.8%)	0
Course attended			
BSc Mental Health Nursing	14 (32.6%)	8 (38.1%)	5 (33.3%)
BSc Nursing	20 (46.5%)	11 (52.4%)	4 (26.7%)
Diploma Nursing	9 (20.9%)	2 (9.5%)	6 (40.0%)
Total Sample	43	21	15

As demonstrated in Table 4.2, the student cohort consisted of 14 Mental Health nursing students and 29 general nursing students, of whom 20 were reading for a degree and 9 for a diploma in nursing. The majority of the students were females (n=28, 65.1%), aged between 18 to 29 years (n=33, 76.8%) and with the majority following an acute in-patient placement (n=28, 65.1%). The following section provides the findings for each phase of the present study.

4.3 Phase 1 – Mentors Feedback

Phase one of the study collected data from the mentors currently servicing the Department of Mental Health, University of Malta. In order to carry out such data collection, mentors were provided with a self-designed questionnaire (Appendix B) divided into 3 sections. The first section of the questionnaire (section A) focused on the respondent's socio-demographic data which has been reported in section 4.2.1 of this chapter and four general open ended questions relating to the current mentorship framework, key learning objectives, a typical day of mentoring students and the worst experience encountered by mentors whilst mentoring students. Responses of mentors to these questions were subjected to content analysis to identify themes and frequencies of corresponding responses. The second section of the questionnaire (section B), asked the mentors to rate the importance/relevance of a series of

competencies as learning objectives for students, listed under 9 main domains namely: Therapeutic Relationship; Assessment; Care planning & Coordination; Nursing Interventions; Managing Psychiatric Emergencies; Ethical Issues; Education & Research; and Legal Implications. Mentors were asked to rate the importance of each statement relating to a competency as a learning objective for students on a 5 point Likert scale, namely 1= Not Important; 2= Slightly Important; 3= Fairly Important; 4= Important and 5= Extremely Important. The list of competencies is provided under each domain as demonstrated in the questionnaire for Mentors (Appendix B). The results collated for section B are reported in section 4.3.2. Section C of the questionnaire required the mentors to rate additional ancillary clinical skills on a 5 point Likert scale, namely a score of 1= Not Important; 2= Slightly Important; 3= Moderately Important; 4= Very Important and 5= Extremely Important. Results for this section are presented in section 4.3.3.

4.3.1 Mentors views on current mentoring system

Section A collected socio-demographic data from the respondents together with feedback on the current mentorship system with a series of open ended questions addressing ways to potentially improve the mentorship system, and identification of hindering factors amongst others. This feedback is discussed in more detail in this section.

When mentors were asked if the current mentorship framework should be amended or revised, responses were almost equally divided with 51.4% (n=18) in agreement, while 48.6% (n=17) replied that no changes were required. Those mentors who endorsed that changes were required highlighted the following aspects for improvement: more goal oriented (n=11, 61%); more supervision and meetings from supervisors/lecturers with mentors and students including visits at the workplace (n=13, 72%); higher frequency of placement days in which students meet their mentor, ideally working the same shift as their mentor (n=15, 83%); framework of tasks/ guidelines depending on student's year of studies. (n=16, 89 %) and mental health specific skills, interventions and competencies rather than generic nursing competencies (n=17, 94%).

Mentors were then asked to identify the key learning outcomes for students' during their mental health nursing placements. Thirty-three (n=33, 94%) respondents reported key learning outcomes, whilst two (6%) participants did not comment. The key learning outcomes identified by mentors were: learning about the Maltese Mental Health Act (n=22, 67%); pharmacological issues including administration of medications (n=26, 79%); working in a multidisciplinary team (n=29, 88%); building a therapeutic relationship (n=31, 94%) and skill competency (n=32, 97%).

When asked to describe a typical day of a mental health clinical placement for their students, thirty-four mentors (n=34, 97%) replied, whilst 1 (3%) participant did not comment. Mentors highlighted the preparation and administration of treatment in the presence of their mentor or a qualified nurse (n=26, 76%); preparation of group sessions (n=16, 47%); assisting with parameters (n=26, 76%); writing nursing reports under supervision (n=33, 97%); attending to ward routines and learning about the patient's diagnosis and mental illnesses (n=30, 88%) and engaging with patients as much as possible (n=29, 85%).

Thirty-one (n=31, 89%) respondents reported their worst experience with students during a mental health placement, whilst 4 (11%) participants did not comment. Mentors responding to this question highlighted aspects such as no concept of boundaries or ethics (n=22, 71%); lack of respect towards nursing staff (n=26, 84%); reluctant and not interested in mental health nursing (n=29, 94%) and students feeling overwhelmed when encountering patients with severe mental health problems (n=24, 77%). Further analysis of the responses given by mentors are discussed in the following section.

4.3.2 Mentors responses regarding Core Mentorship Skills

This section reports the results emerging from Section B of the mentor's questionnaire. The questionnaire reported 9 domains with specific competencies related to each domain. Results are presented in two tables. Table 4.3. reports the frequency responses for competencies falling under each of the main 9 domains. Participant responses were on a 5 point Likert scale and the mean score and standard deviation (SD) for each competency are listed in the final column.

Table 4. 3 Mean (SD) and Frequency responses of Mentors for competencies falling under the 9 domains
N.B. Scores for Likert responses: 1= Not Important; 2= Slightly Important; 3=Moderately Important; 4 =Very Important; 5=Extremely Important; SD=standard deviation

Domains	Not Imp. n (%)	Slightly Imp. n (%)	Moderately Imp. n (%)	Very Imp. n (%)	Ext Imp. n (%)	Mean (SD)
Domain 1: Therapeutic Relationship						
Communicate effectively with clients with a mental health problem	0	0	0	4 11.4%	31 (88.6%)	4.89 (.32)
Using engagement techniques and appropriate verbal and non-verbal communication skills to establish the therapeutic alliance	0	0	0	10 (28.6%)	25 (71.4%)	4.71 (.46)
The needs of the client are identified and explored	0	0	2 (5.7%)	8 (22.9%)	25 (71.4%)	4.66 (.59)
Domain 2: Assessment						
Gathering information and assessing the patient for changes in mood, thought content, affect, behavior, communication…	0	0	1 (2.9%)	6 (17.1%)	28 (80.0%)	4.77 (.49)
Carry out a comprehensive psychosocial assessment of clients	2 (5.7%)	1 (2.9%)	5 (14.3%)	11 (31.4%)	16 (45.7%)	4.09 (1.12)
Conduct a mental state examination	2 (5.7%)	0	3 (8.6%)	11 (31.4%)	19 (54.3%)	4.29 (1.05)
The utilization of psychiatric rating scales in which the clinician measures psychiatric symptoms such as depression, anxiety, hallucinations, aggressive behavior…	1 (2.9%)	2 (5.7%)	7 (20.0%)	16 (45.7%)	9 (25.7%)	3.86 (.97)
Domain 3: Care planning and Coordination						
Utilize the information gathered through the assessment, observation and monitoring to formulate the patient's problem/s and nursing diagnosis	0	1 (2.9%)	1 (2.9%)	13 (37.1%)	20 (57.1%)	4.49 (.70)
Collaborate with the patient, careers and other professionals involved, to determine mental health needs and plan interventions required	0	2 (5.7%)	0	9 (25.7%)	24 (68.6%)	4.57 (.78)
Develop a nursing care plan on the basis of the assessment	0	0	1 (2.9%)	13 (37.1%)	19 (54.3%)	4.40 (.81)
Domain 4: Nursing Interventions						
Assist clients with Mental illness to clarify treatment goals	4 (11.4%)	1 (2.9%)	1 (2.9%)	15 (42.9%)	14 (40.0%)	3.97 (1.27)
Assist clients to develop living skills	0	2 (5.7%)	4 (11.4%)	14 (40.0%)	15 (42.9%)	4.20 (.87)
Provide client with knowledge and education regarding medications and their side-effects	0	1 (2.9%)	2 (5.7%)	12 (34.3%)	20 (57.1%)	4.46 (.74)
Conduct group therapy sessions	1 (2.9%)	3 (8.6%)	4 (11.4%)	15 (42.9%)	12 (34.3%)	3.97 (1.04)
Provide one to one sessions towards clients	0	0	6 (17.1%)	12 (34.3%)	17 (48.6%)	4.31 (.76)
Participate in case reviews and liaising with other professionals to ensure safety and effective care plan	1 (2.9%)	1 (2.9%)	0	13 (37.1%)	20 (57.1%)	4.46 (.82)
Domain 5: Managing Crisis and Psychiatric Emergencies						
Complete risk assessment and use de-escalation techniques to lessen aggressive behavior before considering use of restraints	0	0	5 (14.3%)	9 (25.7%)	21 (60.0%)	4.46 (.74)
Assess and recognize psychiatric emergencies and provide safe environment for the patient to express his/her feelings	0	0	1 (2.9%)	12 (34.3%)	22 (69.2%)	4.60 (.55)
Can handle clients who are verbally and/or physically aggressive	0	0	5 (14.3%)	10 (28.6%)	20 (57.1%)	4.43 (.74)
Domain 6: Mental Health Promotion & Relapse Prevention						
Act as role model and promote mental health wellbeing	0	1 (2.9%)	2 (5.7%)	14 (40.0%)	18 (51.4%)	4.40 (.73)
Engage in activities that promote education, break myths surrounding mental illness and reduce stigma	1 (2.9%)	0	3 (8.6%)	13 (37.1%)	18 (51.4%)	4.34 (.87)
Assist patients to take active part in their community	2 (5.7%)	0	4 (11.4%)	15 (42.9%)	14 (40.0%)	4.11 (1.02)
Domain 7: Ethical Issues						
Provide interventions that respect that patients an individual and as an autonomous human being with his/her own rights and dignity; irrelevant of his or her diagnosis, gender, sexual orientation, ethnicity, religion, social status and cultural background	0	1 (2.9%)	0	7 (20.0%)	27 (77.1%)	4.71 (.62)
Provide ethical and moral behavior all times	0	1 (2.9%)	1 (2.9%)	7 (20.0%)	26 (74.3%)	4.66 (.68)
Maintain professional boundaries and refrain from engaging in social, intimate, sexual or business relationship with patients	0	0	0	5 (14.3%)	30 (85.7%)	4.86 (.36)
Domain 8: Research						

Keep up to date with the latest research, new developments within mental health by reading related articles in journals and online resources	0	1 (2.9%)	4 (11.4%)	13 (37.1%)	17 (48.6%)	4.31 (.77)
Domain 9: Legal Implications						
Be aware of current Mental Health act (2012), Maltese and EU legal implication in relation to mental health nurse functioning within the Maltese mental health services	0	0	1 (2.9%)	10 (28.6%)	24 (68.6%)	4.66 (.54)
Be informed about the legal rights and obligations of the patients which fall under his/her care	1 (2.9%)	0	2 (5.7%)	11 (31.4%)	21 (60.0%)	4.46 (.85)
Demonstrate awareness of data protection legislation	0	0	2 (5.7%)	9 (25.7%)	24 (68.6%)	4.63 (.60)

Results presented in table 4.3 indicate that the majority of respondents consider the competencies listed, as either important or extremely important. This is further corroborated by the mean scores which are all above 4, except for three competencies. These competencies are "the utilization of psychiatric rating scales in which the clinician measures psychiatric symptoms such as depression, anxiety, hallucinations, aggressive behaviour…" with a mean score of 3.86; "assist clients with Mental illness to clarify treatment goals" with a mean score of 3.97 and "conduct group therapy sessions" with a mean score also of 3.97. Although these are the lowest scoring competencies, the modal category for participant responses all fell under the participant endorsement of very important.

The highest rated competency is "communicate effectively with clients with a mental health problem" which has a mean score of 4.89. This is followed by the competency "maintain professional boundaries and refrain from engaging in social, intimate, sexual or business relationship with patients" with a mean score of 4.86, also indicating the great importance given to this competency by the mentors. Both these competencies relate to the interactions between the professionals and patients, which is perceived to be of extreme importance by mentors.

Mentors who endorsed competencies (outlined in Table 4.3) as either slightly important or higher were then invited to further describe learning outcomes relating to each competency. Content analysis of these responses was then conducted to interpret the meaning of participant responses. The learning outcomes identified for each domain are reported together with the corresponding frequency of responses in Table 4.4.

Table 4. 4 Content analysis of comments pertaining to the competencies within the 9 Domains.

Domain 1 - Therapeutic Relationship	**Further Learning Outcomes**
Communicate effectively with clients with a mental health problem	Differentiate between verbal and non-verbal communication skills (n=28, 80%) Demonstrates - Active listening; Boundaries; Empathy; Trust; Patience and Understanding (n=30, 86%) Articulating appropriate clinical terminology (n=31, 89%)
Using engagement techniques and appropriate verbal and non-verbal communication skills to establish the therapeutic alliance	Demonstrates the ability to conduct a conversation with the client. (n=30, 86%) Shows an ability to identify barriers limiting effective communication, trust and therapeutic engagement (ex. paranoid ideation). (n=31, 89%)
The needs of the client are identified and explored	Ability to identify priorities and categorise clients' needs. (n=31, 89%)
Domain 2 - Assessment	**Further Learning Outcomes**
Gathering information and assessing the patient for changes in mood, thought content, affect, behavior, communication, speech, substance use, risk assessment, history of abuse or trauma and difficulties in coping with activities of daily living	Demonstrate the ability to take proper history from clients and relatives and be able to identify what aspects needs prioritization. (n=33, 94%) Understanding the relevance and importance of conducting an exhaustive assessment as this forms the foundation of patient centered care delivery. (n=32, 91%) Be able to gather information: Medical, social and psychological. (n=28, 80%)
Carry out a comprehensive psychosocial assessment of clients	Co-ordinate and liaise with other Mental health professionals so that a complete and thorough assessment is carried out. (n=27, 77%)
Conduct a mental state examination	Understand what constitutes a Mental State Examination. (n=26, 74%) Be aware of the need to carry out such an examination, e.g.: suicidal ideations, thoughts of self-harm, depressive / anxiety state. (n=28, 80%)
The utilization of psychiatric rating scales in which the clinician measures psychiatric symptoms such as depression, anxiety, hallucinations, aggressive behavior. Such as……	Ability to identify which tool can be used to measure specific symptoms. (n=28, 80 %) Be aware of the limitations of using rating scale and psychometric tools in practice. (n=27, 77%)
Domain 3 - Care planning and Coordination	**Further Learning Outcomes**
Utilize the information gathered through the assessment, observation and monitoring to formulate the patient's problem/s and nursing diagnosis	Understanding the nurse 's role in constructing a nursing diagnosis. (n=33, 94%) Understand the principles of care planning. (n=32, 91%) Be able to address the specific needs of the patient. (n=33, 94%)
Collaborate with the patient, careers and other professionals involved, to determine mental health needs and plan interventions required	Understanding the importance of including the patient and their relatives in the care plan whilst working with other professionals of the multidisciplinary team. (n=31, 89%) The role of relatives and primary careers within a mental health setting. (n=29, 83%) Be able to demonstrate appropriate collaboration and interaction with careers and other professionals. (n=29, 83%)
Develop a nursing care plan on the basis of the assessment	Be able to identify client needs, on which students should be able to development a care plan based on short and long-term goals. (n=31, 89%) Understand what a care plan is and how its function within the clinical setting. (n=29, 83%) Monitoring and evaluate the clients' progress or regression. (n=30, 86%)
Domain 4 - Nursing Interventions.	**Further Learning Outcomes**
Assist clients with Mental illness to clarify treatment goals	Demonstrate knowledge about the different mental health conditions. (n=27, 77%) Aware of the barriers in reaching treatment goals, (e.g., lack of insight). (n=27, 77%) Educate clients about their condition and services available. (n=25, 71%)
Assist clients to develop living skills	Perform a SWOT analysis with the client. (n=28, 80%) Encourage clients to maintain their Activities of Daily Living. (n=29, 83%) Develop different ways to help clients develop their skills according to their abilities. (n=28, 80%)
Provide client with knowledge and education regarding medications and their side-effects	Demonstrate knowledge of medications, their side-effects and indications/consideration of use, especially: anti-depressant, antipsychotics, anxiolytics, mood-stabilizers. (n=34, 97%) Provide education and adequate information that the client can understand. (n=28, 80%)
Conduct group therapy sessions	Show an understanding of group dynamics. (n=29, 83%) Able to manage a group effectively. (n=29, 83%) Be aware of conflict and hindering factors to conducting a group therapy session. (n=28, 80%)
Provide one to one sessions towards clients	Be able to plan and carry out a one to one session effectively with a therapeutic aim. (n=31, 89%)

Participate in case reviews and liaising with other professionals to ensure safety and effective care plan	Give effective and relevant feedback about the presenting case to the multidisciplinary team. (n=31, 89%) Demonstrate the ability to work within the multidisciplinary team. (n=30, 86%)
Domain 5 - Managing Crisis and Psychiatric Emergencies.	**Further Learning Outcomes**
Complete risk assessment and use de-escalation techniques to lessen aggressive behavior before considering use of restraints	Identify escalating behaviors and contributing factors leading to client escalation (n=30, 86%) Demonstrate knowledge of de-escalating techniques and engagement. (n=30, 86%) Differentiate between chemical and psychical restraints measures. (n=29, 83%)
Assess and recognize psychiatric emergencies and provide safe environment for the patient to express his/her feelings	Be able to combine theoretical concepts to the clinical setting, using clinical judgement. (n=33, 94%) Never be in danger or place someone else in danger when addressing an emergency. (n=33, 94%)
Can handle clients who are verbally and/or physically aggressive	Be able to discuss with mentor other possible resolutions to any emergency management. (n=32, 91%) Be able to trigger an emergency response if in difficulty. (n=33, 94%) Understand the legal implications of abuse within a mental health setting both for the client and for the nurse. (n=30, 86%)
Domain 6 - Mental Health Promotion and Relapse Prevention	**Further Learning Outcomes**
Act as role model and promote mental health wellbeing	Act professional within the clinical setting. (n=29, X%) Clients relate to you even as students, thus it is important to portray a positive attitude. (n=30, 86%)
Engage in activities that promote education, break myths surrounding mental illness and reduce stigma	Identify and recognize common misconceptions in mental health, and provide adequate education to counter them. (n=28, 80%) Conduct activities to support those with mental health issues in the clinical setting and beyond. (n=31, 89%)
Assist patients to take active part in their community	Promote client independency and decision making. (n=30, 86%) Relate theory to the recovery process of clients in care. (n=30, 86%) Empower patients to pursue realistic life goals such as employment, hobbies etc. rather than taking on the 'sick role' and depending on others. (n=28, 80%)
Domain 7 - Ethical Issues	**Further Learning Outcomes**
Provide interventions that respect that patients an individual and as an autonomous human being with his/her own rights and dignity; irrelevant of his or her diagnosis, gender, sexual orientation, ethnicity, religion, social status and cultural background	Demonstrate moral and ethical behavior with clients. (n=32, 91%) Be familiar with the Code of Ethics and Patient Charter. (n=30, 86%) Be aware of the different needs of the clients being religious, sexual or cultural and be able to adapt to such needs in a moral and non-conflicting way. (n=29, 83%)
Provide ethical and moral behavior all times	Demonstrate the ability to respect clients and treat them with dignity. (n=30, 86%) Have a non-judgmental and non-discriminatory behavior. (n=29, 83%)
Maintain professional boundaries and refrain from engaging in social, intimate, sexual or business relationship with patients	Never give personal information outside the remit of the clinical environment. (n=31, 89%) Demonstrates assertiveness and ability to maintain professional Boundaries. (n=30, 86%)
Domain 8 - Research	**Further Learning Outcomes**
Keep up to date with the latest research, new developments within mental health by reading related articles in journals and online resources	Demonstrates self-directed learning. (n=30, 86%) Be able to question and discuss with the mentor. (n=32, 91%) Shows additional reading on areas highlighted by the mentor. (n=31, 89%)
Domain 9 - Legal Implications	**Further Learning Outcomes**
Be aware of current Mental Health act (2012), Maltese and EU legal implication in relation to mental health nurse functioning within the Maltese mental health services	Have an understanding of the Mental Health Act (2012). (n=31, 89%) Be aware of the rights and responsibilities of both clients and staff as outlined in the Mental Health Act. (n=30, 86%)
Be informed about the legal rights and obligations of the patients which fall under his/her care	Be able to demonstrate an awareness of client's legal rights, obligations and responsibilities. (n=29, 83%)
Demonstrate awareness of data protection legislation	Shows appropriate handling of data. (n=30, 86%) Aware of the data protection act, confidentiality breech, and appropriate ways to discuss cases with other mental health professionals or relatives/careers. (n=31, 89%)

Results presented in table 4.4 highlight learning outcomes which mentors consider relevant to the domains of competency. These learning outcomes are all highly endorsed by mentors with the ability to demonstrate knowledge of medications, their side-effects and indications/consideration of use, especially: anti-depressant, antipsychotics, anxiolytics, mood-stabilizers, receiving the highest endorsement by 97% of the mentors. This illustrates the importance that mentors placed on the knowledge of pharmacological interventions and monitoring. Other highly endorsed learning outcomes include the concepts of care planning and delivery, use of adequate clinical terminology and safety measures. Conversely, only 71% of the mentors reported that clients should be educated about their condition and services available, making this the least reported competency.

Mentors were also invited to identify any other additional learning outcomes not listed which they feel are important when mentoring students. Sixteen respondents (n=16, 46%) answered this question, out of which 9 (26%) reported additional comments, whilst 7 (20%) mentors reported that no other domains are important. 19 (54%) participants did not comment. The additional learning outcomes identified by these 9 mentors include the ability to delegate effectively to junior staff (n=5, 56%); recognize own competence or lack of (n=6, 67%); ensure safe practice (n=8, 89%), transfer of skills used in a mental health setting (general nursing students) to general hospital setting (n=4, 44%) and Provision of holistic care (n=8, 89%). These comments provided more insight on what the mentors consider as additional areas of competency for clinical learning and were integrated as part of the competencies relevant to the domains once the Acute Mental Health Nursing Student Handbook was compiled.

When mentors were asked to “comment or suggest ways to Improve the quality of Mental Health Placements?” twelve participants did not comment, whilst twenty-three respondents (n=23, 66%) answered this question. Within these 23 replies, a mentor commented that no improvements are required. Twenty-two (n=22) mentors outlined ways to improve the quality of mental health placements including having a clear understanding of what theoretical aspects were covered at University (n=20, 91%); having the placement concurrent with the theoretical module (n=21, 95%); greater availability of mentors present during placements (n=14, 64%); not allocating students

with mentors who during the placement will be aboard for more than 1 week (n=7, 32%) and greater involvement of students as much as possible (n=20, 91%).

When asked "what do you think is the greatest measure of support given by the mentor and that is most appreciated by the student?", six participants (n=6, 17%) did not comment, whilst the remaining twenty-nine (n=29, 83%) suggested reassurance (n=25, 86%); providing a learning experience (n=24, 83%); communication (n=25, 86%); reflection and feedback (n=19, 66%) and appraising and encouraging students so that they feel capable to do the placement (n=17, 59%).

Finally, mentors were asked "what one piece of advice would you give to another mentor having a student on a mental health nursing placement?" Six mentors (n=6, 17%) did not comment, whilst twenty-nine (n=29, 83%) outlined that, the student has to learn to be part of the ward compliment (n=16, 55%); the need to dedicate effective time to the student (n=20, 69%); to act as a role model (n=24, 83%); and to ensure their knowledge is adequate, evidence based and up to date (n=28, 97%); to provide a learning environment for the student (n=26, 90%) and to make the student feel welcome (n=23, 79%).

In addition to the domains of competencies and further learning outcomes outlined in table 4.4 above, a set of ancillary clinical competencies have also been included in the questionnaire given to the mentors. These were grouped under "Other Skills" in the questionnaire given to the mentors. The mentor's ratings of these ancillary skills are outlined in section 4.3.3.

4.3.3 Mentors responses regarding Ancillary Skills

This section presents the frequency distribution and mean scores for mentor's responses relating to additional auxiliary clinical skills. Originally the mentors were asked to rate these auxiliary skills on a 5 point Likert scale. The results including the frequency distribution and mean scores are presented in Table 4.5.

Table 4. 5 Frequency and Mean distribution for ancillary skills.

N.B. Scores for Likert responses: 1= Not Important; 2= Slightly Important; 3=Moderately Important; 4 =Very Important; 5=Extremely Important

	Not Imp. n (%)	Slightly Imp. n (%)	Moderately Imp. n (%)	Very Imp. n (%)	Extremely Imp. n (%)	Mean (SD)
Assist patient with comfort and sleep	0	2 (5.7)	6 (17.1)	12 (34.3)	15 (42.9)	4.14 (.91)
Provide emotional support to patients	0	0	2 (5.7)	8 (22.9)	25 (71.4)	4.66 (.59)
Provide dignity	0	0	1 (2.9)	4 (11.4)	30 (85.7)	4.83 (.45)
Recognize when an individuals' condition is deteriorating	0	0	1 (2.9)	8 (22.9)	26 (74.3)	4.71 (.52)
Demonstrate knowledge of drug therapeutic uses, normal dosage, action, side effects, precautions, contraindications	0	0	2 (5.7)	9 (25.7)	24 (68.6)	4.63 (.59)
Participate in preparing individuals for discharge or transfer	0	0	3 (8.6)	15 (42.9)	17 (48.6)	4.40 (.65)
Recognize and value the role and responsibilities of other members of the caring team	0	0	2 (5.7)	12 (34.3)	21 (60.0)	4.54 (.61)
Adhere to risk assessment policy and protocol	0	0	2 (5.7)	9 (25.7)	24 (68.6)	4.63 (.59)
Dealing with a patient's hallucinations and delusions	0	0	2 (5.7)	11 (31.4)	22 (62.9)	4.57 (.61)
Demonstrating empathy	0	0	0	10 (28.6)	25 (71.4)	4.71 (.46)
Dealing with a psychiatric emergency	0	0	4 (11.4)	6 (17.1)	25 (71.4)	4.60 (.69)
Prepare a patient for ECT	1 (2.9)	1 (2.9)	5 (14.3)	12 (34.3)	16 (45.7)	4.17 (.99)
Monitoring a patient during ECT	1 (2.9)	0	5 (14.3)	15 (42.9)	14 (40.0)	4.17 (.89)
Caring for a patient after ECT	1 (2.9)	0	4 (11.4)	15 (42.9)	15 (42.9)	4.23 (.88)
Teaching relatives about mental illness	0	0	6 (17.1)	15 (42.9)	14 (40.0)	4.23 (.73)
Teaching a patient about budgeting	0	1 (2.9)	10 (28.6)	16 (45.7)	8 (22.9)	3.89 (.80)
Be aware of Admission process	0	0	1 (2.9)	14 (40.0)	20 (57.1)	4.54 (.56)
Write a nursing report	0	0	1 (2.9)	5 (14.3)	29 (82.9)	4.80 (.47)
Conduct hand-over	0	0	1 (2.9)	11 (31.4)	23 (65.7)	4.60 (.65)
Assessing patient risk for vulnerability and neglect	0	0	2 (5.7)	15 (42.9)	18 (51.4)	4.46 (.61)
Monitoring a patient during seclusion	1 (2.9)	0	2 (5.7)	9 (25.7)	23 (65.7)	4.51 (.85)
Administer Depot injections	0	0	1 (2.9)	13 (37.1)	21 (60.0)	4.57 (.56)
Awareness of Non-pharmacological treatment.	0	1 (2.9)	4 (11.4)	12 (34.3)	18 (51.4)	4.34 (.80)
Efficient use of resources: - Time - Financial - Human (e.g. ability to delegate).	0	2 (5.7)	3 (8.6)	16 (45.7)	14 (40.0)	4.20 (.83)
Managing untoward incidents.	0	1 (2.9)	6 (17.1)	11 (31.4)	17 (48.6)	4.26 (.85)
Be aware of community Mental Health services	0	1 (2.9)	2 (5.7)	13 (37.1)	19 (54.3)	4.43 (.74)
Medical emergencies.	0	1 (2.9)	1 (2.9)	9 (25.7)	24 (68.6)	4.60 (.70)
Risk Management & Elevated level of supervision.	0	0	0	9 (25.7)	26 (74.3)	4.74 (.44)
Awareness of Standard operation procedures	0	1 (2.9)	5 (14.3)	15 (42.9)	14 (40.0)	4.20 (.80)
Mental Health disorders and management	0	0	1 (2.9)	10 (28.6)	24 (68.6)	4.66 (.54)
Recognize signs of neuroleptic malignant syndrome (NMS)	1 (2.9)	0	1 (2.9)	4 (11.4)	29 (82.9)	4.71 (.79)
Recognize signs of lithium toxicity	0	1 (2.9)	2 (5.7)	6 (17.1)	26 (74.3)	4.63 (.73)
Recognize the necessary blood investigations related to the drug medication prescribed	0	0	2 (5.7)	9 (25.7)	24 (68.6)	4.63 (.60)
Assessing and recording a blood pressure, pulse, respiratory rate, temperature and glucose monitoring	0	0	1 (2.9)	13 (37.1)	21 (60.0)	4.57 (.55)
Making an unoccupied bed	2 (5.7)	5 (14.3)	10 (28.6)	11 (31.4)	7 (20.0)	3.46(1.15)
Assisting a semi-dependent patient in bathing (e.g., eye and ear care)	2 (5.7)	0	8 (22.9)	17 (48.6)	8 (22.9)	3.83 (.99)
Assisting a fully dependent patient in bathing (e.g., eye and ear care)	2 (5.7)	1 (2.9)	5 (14.3)	19 (54.3)	8 (22.9)	3.86(1.00)
Mouth Care	1 (2.9)	2 (5.7)	11 (31.4)	12 (34.3)	9 (25.7)	3.74(1.01)
Moving a patient from bed to armchair	2 (5.7)	2 (5.7)	10 (28.6)	14 (40.0)	7 (20.0)	3.63(1.06)
Assisting patients with walking	2 (5.7)	2 (5.7)	6 (17.1)	18 (51.4)	7 (20.0)	3.74(1.04)
Assisting patients with eating and drinking	1 (2.9)	2 (5.7)	6 (17.1)	17 (48.6)	9 (25.7)	3.89 (.96)
Assisting patients with elimination	1 (2.9)	2 (5.7)	7 (20.0)	17 (48.6)	8 (22.9)	3.83 (.95)
Specimen collection	0	3 (8.6)	12 (34.3)	11 (31.4)	9 (25.7)	3.74 (.95)
Oxygen therapy	3 (8.6)	2 (5.7)	4 (11.4)	15 (42.9)	11 (31.4)	3.83(1.20)
Aseptic technique and change of dressing	2 (5.7)	2 (5.7)	6 (17.1)	12 (34.3)	13 (37.1)	3.91(1.15)
Neurological observations	0	2 (5.7)	2 (5.7)	13 (37.1)	18 (51.4)	4.34 (.84)
Administering and recording oral medication	0	0	2 (5.7)	9 (25.7)	24 (68.6)	4.63 (.60)

Administering and recording sub-cutaneous medication (exc insulin)	0	0	0	11 (31.4)	24 (68.6)	4.69 (.47)
Administering and recording intramuscular medication	0	0	0	11 (31.4)	24 (68.6)	4.69 (.47)
Administering and recording a DDA drug	0	0	0	8 (22.9)	27 (77.1)	4.77 (.43)
Administering and recording of medications via the rectal route	1 (2.9)	0	1 (2.9)	13 (37.1)	20 (57.1)	4.46 (.82)
Administering and recording of ear medications	1 (2.9)	2 (5.7)	2 (5.7)	15 (42.9)	15 (42.9)	4.17 (.99)
Administering and recording of eye medications	1 (2.9)	2 (5.7)	3 (8.6)	15 (42.9)	14 (40.0)	4.11 (.99)
Teaching a patient how to make an unoccupied bed	2 (5.7)	2 (5.7)	10 (28.6)	11 (31.4)	10 (28.6)	3.71 (1.12)
Making an occupied bed	2 (5.7)	5 (14.3)	12 (34.3)	10 (28.6)	6 (7.1)	3.37(1.11)
Care after death	1 (2.9)	1 (2.9)	6 (17.1)	19 (54.3)	8 (22.9)	3.91 (.89)
Inserting a naso-gastric tube and providing care.	2 (5.7)	2 (5.7)	5 (14.3)	17 (48.6)	9 (25.7)	3.83 (1.07)
Inserting a urinary catheter and proving care.	2 (5.7)	1 (2.9)	8 (22.9)	15 (42.9)	9 (25.7)	3.80(1.05)
Removal of sutures	2 (5.7)	1 (2.9)	8 (22.9)	16 (45.7)	8 (22.9)	3.77(1.03)
Measure and record height and weight	0	3 (8.6)	10 (28.6)	13 (37.1)	9 (25.7)	3.80 (.93)
Cleanse hands at appropriate times and use alcohol gel appropriately	0	0	4 (11.4)	10 (28.6)	21 (60.0)	4.49 (.70)
Assisting patient with CPR	0	1 (2.9)	2 (5.7)	8 (22.9)	24 (68.6)	4.57 (.74)
Handle, segregate and dispose of clinical waste safely including soiled and/or infected linen	0	0	5 (14.3)	11 (31.4)	19 (54.3)	4.40 (.74)
Handle and dispose of sharps to reduce risk of injury (including needles and razors)	0	0	2 (5.7)	9 (25.7)	24 (68.6)	4.63 (.60)

The results presented in Table 4.5 indicate that those auxiliary skills reporting a mean score of 4 and higher, have been rated by mentors within the very important (4) or extremely important (5) range. Mentors strongly endorsed skills related to safety and prevention of harm, medication related skills such as administration, monitoring of side effects and appropriate documentation together with professional attitude and knowledge. Conversely, skills such as bed making, ambulation and other activities of daily living including assisting the patient with eating, mobility and elimination although scoring lower (with a mean score between 3.0 and 4.0) still had modal categories relating to endorsement of the skill as 'very important' by mentors.

4.3.4 Summary of feedback received by mentors

The analysis carried out in Phase 1 corroborated the importance of identifying domains of competency, further learning objectives and skills which mentors highlighted should be included in a clinical teaching framework. Specific details regarding the changes following the feedback given by mentors has contributed to the development of the Acute Mental Health Nursing Student Handbook, which will be discussed in section 4.4.

4.4 Phase 2 – Compilation of the Acute Mental Health Nursing Student Handbook

Phase 2 of this study involved the compilation of the Acute Mental Health Nursing Student Handbook. The results emerging from Mentor's feedback (section 4.3.1), Mentors responses regarding core mentorship skills (section 4.3.2) and Mentors responses regarding ancillary skills obtained during the first phase of this study (section 4.3.3), together with documents retrieved during the literature review guided the formulation of the Acute Mental Health Nursing Handbook.

All competencies pertaining to the 9 domains were highly endorsed by the mentors. The analysis of the additional comments from mentors (outlined in sections 4.3.1 and 4.3.2) led to the reorganisation of competencies and a further addition of competencies by the researcher which are highlighted in bold in Table 4.6. This compilation led to the restructuring of the 9 domains outlined in section 4.3.2 to 8 domains. The domains *Mental Health Promotion and Relapse Prevention*, *Research* and *Legal Implications* were restructured into two domains namely, *Education & Research* and *Legal Implications*. The restructuring of these three domains into two was carried out due to an overlap and repetitiveness of competencies being listed under these different domains. This allowed for a more cohesive set of competencies with minimal overlap.

The 8 domains represented within the acute mental health nursing student handbook are, **Therapeutic Relationship**, **Assessment**, **Care planning & Coordination**, **Nursing Interventions**, **Managing Psychiatric Emergencies**, **Ethical Issues**, **Education** & **Research** and **Legal Implications**.

These domains and their relevant learning outcomes are reported in table 4.6. The learning outcomes denoted in bold highlight additional learning outcomes emerging from the analysis of data from phase 1 of the study.

Table 4. 6. Learning outcomes within each reworked domain.

Domain 1 **Therapeutic Relationship**	**Domain 2** **Assessment**	**Domain 3** **Care Planning & Coordination**	**Domain 4** **Nursing Interventions**
Communicating effectively and **demonstrating the ability to conduct a therapeutic conversation** with clients having a mental health condition. Understanding the difference between verbal and non-verbal communication skills and be able to demonstrate both types of communication skills effectively, including active listening, use of open-ended questions and paraphrasing, eye contact, facial expressions, tone of voice, body language and posture. Articulating appropriate clinical terminology **(example: Inebriated instead of the term 'drunk').** **Demonstrating a non-threatening, empathic and non-judgmental attitude and approach.** Having a clear understanding of boundaries **and their implications within a clinical setting.** Showing an ability to identify barriers limiting effective communication, trust and therapeutic engagement (example: paranoid ideation). **Understanding Transference and Countertransference and their implications within a clinical setting.** **Being aware of student's own non-verbal's and understand the implications of such to the service users.** **Understanding and adopting a Person-Centred Care Approach in practice.**	Understanding the relevance and importance of conducting an in-depth client assessment as the foundation of person-centred care delivery. Demonstrating the ability to take a history from the client and their relatives/primary carers, then identify which aspects needs prioritisation. A**ssessing for client's changes in mood, thought content, affect, behaviour, communication and speech.** Gathering information related to a client's medical history and presenting parameters **including but not limited to Blood Pressure, Pulse, Respiration, Blood Investigations, Drug and Pregnancy Screening.** Gathering information related to a client's social and psychological **history including but not limited to substance misuse, abuse or trauma, difficulties with activities of daily living, housing, employment, financial situation, thoughts of self-harm and suicide ideations.** **Recognising client progression or regression and differentiate between sociological problems and psychological needs.** **Understanding the importance of co-ordinating and collaborating with other Mental health professionals for a complete and thorough assessment.** Understanding what constitutes a Mental State Examination **and the ability to conduct under supervision appropriate documentation and relevant nursing action**. Demonstrating the ability to identify and measure specific psychiatric symptoms using psychometric rating scales including but not limited to Beck's Depression Inventory, Broset Violence Checklist, GAD-7, Mood Disorder Questionnaire, Brief Psychiatric Rating Scale, Drug Use Questionnaire, SQUARE, Edinburgh Postnatal Depression.	Utilising the information gathered through the assessment, observation and monitoring to identify the client's presenting needs and formulate a nursing diagnosis. Understanding the nurse's role in constructing a nursing diagnosis and the principles of care planning. **Differentiating between the medical diagnosis and the psychiatric diagnosis however address them holistically.** Understanding the scope and function of a care plan. **Developing a care plan in collaboration with the client, based on short and long-term goals reflective on the client's own needs and concerns.** Monitoring and evaluate for progress or regress of the patient **according to the care plan milestones.** Understanding the importance of including the client and his/her caregivers (if client consents) in the care plan whilst collaborating with other professionals of the multidisciplinary team. **Demonstrating handover skills between the parties (members of the MDT).** **Showing the ability to think critically and use evidence-based research to generate alternatives interventions based on the information gathered.** **Understanding the admission process.** **Being able to demonstrate appropriate collaboration and interaction with both formal and informal carers and other professionals.** **Discussing the impact of a client's social situation on their mental state (example: unemployment).**	Demonstrating knowledge about the different mental health conditions and **understand the principles of concordance, compliance and treatment alliance.** **Assisting clients with a mental illness to clarify treatment goals, develop living skills reflective of their abilities and according to their level of understanding.** **Understanding the concept of institutionalisation and deinstitutionalisation.** Being aware of the barriers in reaching treatment goals (example: lack of insight). Educating clients about their condition, medications, side-effects, relapse prevention, relative support and available services in a language and at a level that the client can understand. Demonstrating knowledge of medications, their side-effects and indications/consideration of use, especially but not limited to anti-depressants, antipsychotics, anxiolytics and mood-stabilizers. Performing a SWOT analysis with the client. Showing an understanding of group dynamics **including conflict and hindering factors.** Planning and conducting effectively under the supervision of the mentor a Group therapy session and a One to One session with a therapeutic aim. Participating in case reviews, give relevant feedback to the multidisciplinary team and liaise with other professionals to ensure an effective care plan.

Domain 5 Managing Psychiatric Emergencies	Domain 6 Ethical Issues	Domain 7 Education and Research	Domain 8 Legal Implications
Differentiating between a medical emergency, crises and a psychiatric emergency. Identifying escalating behaviours and contributing factors leading to client escalation, whilst allowing the patient to express themselves in a safe environment. Demonstrating awareness of different risk assessment tools, such as, "SQUARE" and be able to identify and conduct the most appropriate in the presenting situation, including client risk assessment and environmental risk assessment. Demonstrating knowledge of de-escalating techniques and engagement, chemical and physical restraints measures. Being able to combine theoretical concepts related to safety and risk management to the clinical setting, using clinical judgement. Being knowledgeable about safety issues when dealing with any kind of emergency. Avoiding being in danger or place someone else in danger when addressing an emergency. Observing how qualified staff manage verbal or physical aggressive patients. Being able to discuss with mentor other possible resolutions to any emergency management. Being able to trigger an emergency response if in difficulty whilst always aware of own limits, boundaries and emotions. Demonstrating knowledge of the Zero Tolerance policy. Using appropriate documentation to report the incident.	Providing interventions that respect the client as an individual and as an autonomous human being with their own rights and dignity, irrelevant with their diagnosis, gender, sexual orientation, ethnicity, religion, social status and cultural background. Demonstrating moral and ethical behaviour with clients Familiarising with the Maltese Code of Ethics and Patient Charter. Demonstrating awareness of the different needs of the clients being religious, sexual or cultural and be able to adapt to such needs in a moral and non-conflicting way with a non-judgmental and non-discriminatory attitude. Respecting client confidentiality. Understanding the ethical implications of conducting nursing interventions such as, one to one and group sessions. Refraining from giving personal information outside the remit of the clinical environment, whilst being assertive and able to maintain professional boundaries. Discussing ethical dilemmas encountered within the clinical setting. Refrain from using offensive, degrading or discriminatory comments.	Keeping up to date with the latest research and developments within mental health field by reading related articles in journals and/or online resources. Demonstrating self-directed learning Showing interest in the clinical setting by doing additional reading on areas highlighted by the mentor, and discuss any difficulties or queries that may arise. Keeping a portfolio of work highlighting clinical cases, experiences, activities and difficulties encountered during the clinical setting. Acting as a role model and promoting mental health wellbeing by being professional, portray a positive attitude, lead a healthy lifestyle and be conscious of self-care practices. Engaging in activities that promote education, break myths surrounding mental illness, reduce stigma and support those with mental health issues in the clinical setting and beyond. Demonstrating the ability to identify and recognise common misconceptions in mental health, and provide adequate education to counter them. Empowering clients to pursue realistic life goals, independency and decision making. Assisting clients to take an active part in their community as well as be involved in mental health awareness and promotion events.	Demonstrating awareness of the current Mental Health act (2012), Maltese and EU legal implication in relation to mental health nurse functioning within the Maltese mental health services. Having an understanding of the Mental Health Act (2012) including the legal rights and responsibilities of both clients and staff and Mental Health Schedules with particular attention to schedules 1, 2, 3, 4, 5, 7 and 9. Being able to differentiate between voluntary and non-voluntary admission and the legal implications of each type of admission. Demonstrating awareness of related forms and documents such as the appointment of responsible carer, consent to treatment, client complaint or suggestion forms. Demonstrate awareness of data protection legislation and show appropriate handling of data. Demonstrates adequate documentation techniques. Being knowledgeable of the data protection act, confidentiality breech, and appropriate ways to discuss cases with other mental health professionals or relatives/careers. Understanding the legal implications of abuse within a mental health setting both for the client and for the nurse. Understanding the Legal implications of conducting nursing interventions such as, one to one and group sessions.

Similarly, an analysis of the findings of the Ancillary Skills reported in section 4.3.3 (Table 4.5) gave rise to additional clinical skills and learning outcomes. The initially 64 ancillary skills were reviewed using cross analysis. Those skills pertaining to one of the 8 domains of practice outlined in table 4.6 were removed. The remaining skills were collapsed, such as "*administer and record oral medication*" and "*administer and record topical medical*" and similar learning outcomes were collapsed into one outcome to read to "*administer and record oral, ear, eye, topical, rectal and vaginal route medication*". This resulted in a total of 15 ancillary skills that made up the Skills Checklist. These 15 ancillary skills have and are reported in Table 4.7.

Table 4. 7. Skill Checklist.

Skill Checklist
Administer and record oral, ear, eye, topical, rectal and vaginal route medication.
Administer and record sub-cutaneous medication including insulin indications, dosage, documentation, storage, hypoglycaemia and hyperglycaemia episodes.
Administer and record an intramuscular and a depot medication
Administer and record a DDA drug, including knowledge about the DDA protocol and the drugs listed under the dangerous drug act (including dosages).
Recognise signs of neuroleptic malignant syndrome (NMS) and lithium toxicity.
Recognise the necessary blood investigations related to the prescribed drug.
Adequate use of documents related to drug administration including treatment charts, depot chart and blood investigation results.
Demonstrates proper handling and disposal of sharps.
Engage in a meaningful and appropriate therapeutic relationship.
Carry out an admission including all the necessary documentation pertaining to the admission process according to the ward policy.
Prepare, monitor and care for a client prior to, during and after an ECT including the necessary documentation and consent.
Measure and record height, weight, Blood Pressure, Pulse, Temperature, SpO2, Respirations including appropriate documentation, charts and awareness of normal and abnormal ranges.
Monitor clients during seclusion and/or raised level of supervision including an understanding of related documents.
Conduct a risk assessment as well as shows aware of risk management techniques in a variety of situations including preventive and during a psychiatric emergency.
Perform a neurological observation and specimen collection including but not limited to urine and faeces.

During the revision of the Acute Mental Health Nursing Student handbook following recommendations by the Mental Health Placement coordinator, based on face to face feedback from mentors, it was decided to remove the skills checklist (Table 4.7) completely and rework the remaining 15 skills as part of the domains of competency

outlined in the handbook. The final version of the handbook is presented in appendix A. Table 4.8 presents the domains and the updated learning outcomes.

Table 4. 8. Domain of Competency and Revised Learning Outcomes.

Domain 1 **Therapeutic Relationship**	**Domain 2** **Assessment**	**Domain 3** **Care Planning & Coordination**	**Domain 4** **Nursing Interventions**
Communicate effectively and demonstrate the ability to conduct a therapeutic conversation with clients having a mental health condition. Differentiate between verbal and non-verbal communication skills and be able to demonstrate both types of communication skills effectively, including active listening, use of open-ended questions and paraphrasing, eye contact, facial expressions, tone of voice, body language and posture. Articulate appropriate clinical terminology (example: inebriated instead of the term 'drunk'). Demonstrate a non-threatening, empathic and non-judgmental attitude and approach. Define boundaries and articulate their implications within a clinical setting. Demonstrate an ability to identify barriers limiting effective communication, trust and therapeutic engagement (example: paranoid ideation). Define Transference and Countertransference and their implications within a clinical setting. Evaluate student's own non-verbal's and understand the implications of such to the service users.	Discuss the relevance and importance of conducting an in-depth client assessment as the foundation of person-centred care delivery. Demonstrate the ability to take a history from the client and their relatives/primary carers, then identify which aspects needs prioritisation. Assess for client's changes in mood, thought content, affect, behaviour, communication and speech. Analyse information related to a client's medical history and presenting parameters including but not limited to Blood Pressure, Pulse, Respiration, Blood Investigations, Drug and Pregnancy Screening. Analyse information related to a client's social and psychological history including but not limited to substance misuse, abuse or trauma, difficulties with activities of daily living, housing, employment, financial situation, thoughts of self-harm and suicide ideations. Recognise client progression or regression and differentiate between sociological problems and psychological needs. Co-ordinate and collaborate with other Mental health professionals for a complete and thorough assessment. Define and demonstrate under supervision a Mental State Examination including appropriate documentation and relevant nursing action. Identify and measure specific psychiatric symptoms using psychometric rating scales including but not limited to Beck's Depression Inventory, Broset Violence Checklist, GAD-7, Mood Disorder Questionnaire,	Analyse the information gathered through the assessment, observation and monitoring to identify the client's presenting needs and formulate a nursing diagnosis. Discuss the nurse's role in constructing a nursing diagnosis and the principles of care planning. Differentiate between the medical diagnosis and the psychiatric diagnosis however address them holistically. Discuss the scope and function of a care plan. Formulate a care plan in collaboration with the client, based on short and long-term goals reflective on the client's own needs and concerns. Monitor and evaluate for progress or regress of the patient according to the care plan milestones. Evaluate the importance of including the client and his/her caregivers (if client consents) in the care plan whilst collaborating with other professionals of the multidisciplinary team. Demonstrate handover skills between the parties (members of the MDT). Critically think and use evidence-based research to generate alternatives interventions based on the information gathered. Describe the admission process. Demonstrate appropriate collaboration and interaction with both formal and informal carers and other professionals.	Demonstrate knowledge about the different mental health conditions and understand the principles or concordance, compliance and treatment alliance. Assist clients with a mental illness to clarify treatment goals, develop living skills reflective of their abilities and according to their level of understanding. Differentiate between institutionalisation and deinstitutionalisation. Name the barriers in reaching treatment goals (example: lack of insight). Educate clients about their condition, medications, side-effects, relapse prevention, relative support and available services in a language and at a level that the client can understand. Demonstrate knowledge of medications, their side-effects and indications/consideration of use, especially but not limited to anti-depressants, antipsychotics, anxiolytics and mood-stabilizers. Administer and record medications including but not limited to oral, ear, eye, topical, rectal vaginal, sub-cutaneous and intramuscular medication. Demonstrate knowledge about the dangerous drug act, the psychotropic drugs listed under this Act (including dosages) and the DDA protocol. Describe insulin indications, documentation, dosage, storage, hypoglycaemia and hyperglycaemia episodes. Formulate a SWOT analysis with the client. Showing an understanding of group dynamics including conflict and hindering factors. Plan and conduct effectively under the supervision of the mentor a Group therapy session and a One to One session with a therapeutic aim. Participate in case reviews, give relevant feedback to the multidisciplinary team and liaise with other professionals to ensure an effective care plan. Perform a neurological observation and specimen collection including but not limited to urine.

Describe and apply a Person-Centered Care Approach in practice.	Brief Psychiatric Rating Scale, Drug Use Questionnaire, SQUARE, Edinburgh Postnatal Depression. Recognise signs of neuroleptic malignant syndrome (NMS) and lithium toxicity	Discuss the impact of a client's social situation on their mental state (e.g. unemployment).	Measure and record height, weight, Blood Pressure, Pulse, Temperature, SpO2, Respirations including appropriate documentation, charts and awareness of normal and abnormal ranges. Monitor of clients during seclusion and/or raised level of supervision including an understanding of related documents. Prepare, monitor and care for a client prior to, during and after an ECT/TMS including the necessary documentation and consent. Demonstrate Infection Control practices including but not limited to handling and disposing of sharps.

Domain 5 Managing Psychiatric Emergencies	**Domain 6 Ethical Issues**	**Domain 7 Education and Research**	**Domain 8 Legal Implications**
Differentiate between a medical emergency, crises and a psychiatric emergency. Identify escalating behaviours and contributing factors leading to client escalation, whilst allowing the patient to express themselves in a safe environment. Demonstrate awareness of different risk assessment tools, such as, "SQUARE" and be able to identify and conduct the most appropriate in the presenting situation, including client risk assessment and environmental risk assessment. Demonstrate knowledge of de-escalating techniques and engagement, chemical and physical restraints measures. Discuss theoretical concepts related to safety and risk management to the clinical setting, using clinical judgement. Identify safety issues when dealing with any kind of emergency. Avoid being in danger or place someone else in danger when addressing an emergency.	Provide interventions that respect the client as an individual and as an autonomous human being with his/her own rights and dignity, irrelevant of his or her diagnosis, gender, sexual orientation, ethnicity, religion, social status and cultural background. Demonstrate moral and ethical behaviour with clients Differentiate between the Maltese Code of Ethics and Patient Charter. Demonstrate awareness of the different needs of the clients being religious, sexual or cultural and be able to adapt to such needs in a moral and non-conflicting way with a non-judgmental and non-discriminatory attitude. Respect client confidentiality. Identify the ethical implications of conducting nursing interventions such as, one to one and group sessions. Refrain from giving personal information outside the remit of the clinical environment, whilst being assertive and able to maintain professional boundaries. Discuss ethical dilemmas encountered within the clinical setting. Refrain from using offensive,	Demonstrate the latest research and developments within the mental health field by reading related articles in journals and/or online resources. Demonstrate self-directed learning Question and discuss any difficulty or query with the mentor. Conduct additional reading on areas highlighted by the mentor, and discuss any difficulties or queries that may arise. Compile a portfolio of work highlighting clinical cases, experiences, activities and difficulties encountered during the clinical setting. Act as a role model and promoting mental health wellbeing by being professional, portray a positive attitude, lead a healthy lifestyle and be conscious of self-care practices. Engage in activities that promote education, break myths surrounding mental illness, reduce stigma and support those with mental health issues in the clinical setting and beyond. Demonstrate the ability to identify and recognise common misconceptions	Demonstrate awareness of the current Mental Health act (2012), Maltese and EU legal implication in relation to mental health nurse functioning within the Maltese mental health services. Discuss the Mental Health Act (2012) including the legal rights and responsibilities of both clients and staff and Mental Health Schedules with particular attention to schedules 1, 2, 3, 4, 5, 7 and 9. Differentiate between voluntary and non-voluntary admission and the legal implications of each type of admission. Demonstrate awareness of related forms and documents such as the appointment of responsible carer, consent to treatment, client complaint or suggestion forms. Demonstrate awareness of data protection legislation and show appropriate handling of data. Demonstrate adequate documentation techniques. Define the Data Protection Act, confidentiality breech, and appropriate ways to discuss cases with other mental health professionals or relatives/careers. Discuss the legal implications of abuse within a mental health setting both for the client and for the nurse. Evaluate the legal implications of conducting nursing interventions such as, one to one and group sessions.

Observe how qualified staff manage verbal or physical aggressive patients. Discuss with your mentor other possible resolutions to any emergency management. Trigger an emergency response if in difficulty whilst always aware of own limits, boundaries and emotions. Demonstrate knowledge of the Zero Tolerance policy. Identify appropriate documentation to report the incident.	degrading or discriminatory comments.	in mental health, and provide adequate education to counter them. Empower clients to pursue realistic life goals, independency and decision making. Assist clients to take an active part in their community as well as be involved in mental health awareness and promotion events.	

Moreover, most of the mentors (n=31, 89%) expressed the need for students to articulate and familiarise themselves with the appropriate clinical terminology used within the clinical setting and this led to the inclusion of a Resources and a Glossary of Terms section in the acute mental health student nursing handbook. The handbook also contains a reflective section which attempts to address the mentor's feedback arising from phase 1 of this study. Mentors reported that in order to improve the quality of the mental placements, students should be able to have a clear understanding of what theoretical aspects were covered at University (n=20, 91%) and also be proactive and participate in clinical learning as much as possible (n=20, 91%). Mentors add that one of the greatest supportive measures which is highly appreciated by students is reflection and feedback. Thus, the reflection section enables the student to reflect on the learning process, on the application of theory to a practice as well as identify strengths and areas of improvement. In turn, this will be discussed with the mentor in the mid-stage meeting so that any difficulties, limitations or queries can be discussed and addressed in order to provide the best clinical learning experience possible.

A copy of the final version of the Acute Mental Health Student Nursing Handbook can be found in appendix A. The first version of the Acute Mental Health Student Handbook consisted of 38 pages including 8 sections, namely, *Introduction; Placement Regulations; Domains of Competence; Competence Evaluation; Skills Checklist; Resources; Glossary of Terms* and *References*. The final version presented

in appendix A is the amended version following feedback from mentors and mental health placement coordinator. Once the handbook was compiled, the present author could move to phase 3 of the study, that is, the implementation of the handbook within the clinical practice scenario. The aim of this section of the study was to determine whether the acute mental health nursing student handbook has a significant influence on the learning outcomes, experiences and attitudes of student nurses in their mental health placement. The results of the third phase are presented in section 4.5.

4.5 Phase 3

The third phase of the study consisted in two parts occurring concurrently, namely the experimental phase (phase 3A) and the reflective phase (phase 3B). Phase 3A, involved the administration of two questionnaires namely the Mental Health Education Survey (Happell, 2008b) (part 1 at pre-placement and part 2 at post placement) and the Attitudes to Mental Illness Questionnaire (Luty et al., 2006), at two different intervals, namely at pre-placement and at post-placement, for students having their acute mental health nursing placement. Phase 3B, consisted of evaluating the student's reflections and mentor's comments reported in the Acute Mental Health Nursing Student Handbook and which were conducted throughout the intervention.

4.5.1 Phase 3A – The Quantitative Experimental Phase

The Mental Health Education Survey (Happell, 2008b), measured seven domains, namely Preparedness for Mental Health (PMHF); Knowledge of Mental Illness (KMI); Negative Stereotypes (NS); Future Career (FC); Course Effectiveness (CE); Anxiety Surrounding Mental Illness (ASMI) and Valuable Contributions (VC). Conversely, the Attitudes to Mental Illness Questionnaire (AMIQ) (Luty et al., 2006) provided measures of the stigmatising attitudes towards mental illness based on seven different scenarios. By administering this questionnaire at pre-and post-placement, any potential attitudinal changes could be identified.

The students were randomly assigned into one of two groups namely those who were provided with the acute mental health nursing student handbook (experimental group) and those who were not (control group) as outlined in section 3.6.3 in the methods chapter. The randomisation process was conducted to ensure that there would be no

confounder differences between the groups that could impact on the final outcomes obtained. The sample consisted of all nursing students (n=43) who in Semester 1 (year 2019/2020) had a mental health nursing placement. At the end of the placement a total of 36 questionnaires were completed, resulting in a response rate of 83.7% with an attrition rate of 16.3% (n=7). The highest attrition was observed in those who did not have a handbook.

4.5.1.1 Findings for the Mental Health Education Survey Questionnaire

Section 4.5.1.1 reports the finings emerging from the comparison at pre-and post-placements of student responses to the Mental Health Education Survey Questionnaire (Happell, 2008b,c). Students were administered Part 1 of the questionnaire before the start of the placement and Part 2 at the end of the placement.

Table 4.9 reports the mean scores and standard deviations for each clinical experience domain obtained for the experimental group (i.e., those having the handbook available) at both pre- and post-placement. This enabled the identification of whether the use of the handbook had any significant impact on any of the domains from the pre-to the post stage.

Table 4. 9. Mean (SD) scores for the Experimental Group at Pre-and Post-Testing.

MHE Survey Questionnaire	Pre-Placement	Post Placement Experimental Group	t (df)	p
	Mean (SD)	Mean (SD)		
Preparedness for Mental Health (PMHF)	4.30 (1.13)	4.91 (0.90)	-2.38 (48.82)	**0.02**
Knowledge of Mental Illness (KMI)	5.76 (1.04)	5.68 (0.82)	0.35 (49.23)	0.73
Negative Stereotypes (NS)	4.08 (0.91)	3.82 (0.75)	1.21 (47.43)	0.23
Future Career (FC)	3.67 (1.80)	3.79 (2.07)	-0.21 (35.19)	0.83
Course Effectiveness (CE)	4.04 (0.89)	4.54 (0.99)	-1.95 (36.47)	**0.05**
Anxiety Surrounding Mental Illness (ASMI)	4.22 (0.79)	5.50 (0.86)	-6.68 (29.51)	**<0.001**
Valuable Contributions (VC)	5.95 (0.79)	5.78 (0.89)	0.73 (35.94)	0.47

As presented in Table 4.9, statistically significant differences were identified between the pre and post placement for the **experimental group** in the following subscales: Preparedness for Mental Health (PMHF) [t(48.82)= -2.38, p=0.02], Course Effectiveness (CE) [t(36.47)=-1.95, p=0.05], and Anxiety Surrounding Mental Illness (ASMI) [t(29.51)=-6.68, p=<0.001]. This implies that students in the experimental group demonstrated an increase in the preparedness to tackle mental health issues, higher integration of their theoretical teachings and a decreased level of anxiety regarding mental illness. No statistically significant differences were noted for the

experimental group at pre- and post-placement on the subscales Knowledge of Mental Illness (KMI), Negative Stereotypes (NS), Future Career (CS) and Valuable Contributions (VC).

Contrastingly, table 4.10 reports the difference between the Mean and Standard Deviation between the pre-placement and the post-placement for the various educational subscales (2008) for the control group (i.e., students not provided with a handbook).

Table 4. 10. Mean results of Control Group at Pre-and Post-Testing.

MHE Survey Questionnaire	Pre-Placement	Post Placement Control Group	t (df)	p
	Mean (SD)	Mean (SD)		
Preparedness for Mental Health (PMHF)	4.30 (1.13)	4.40 (0.91)	1.69 (30.19)	0.10
Knowledge of Mental Illness (KMI)	5.76 (1.04)	5.40 (1.04)	0.87 (25.64)	0.40
Negative Stereotypes (NS)	4.08 (0.91)	3.75 (1.15)	0.21 (22.37)	0.84
Future Career (FC)	3.67 (1.80)	4.10 (1.71)	-0.50 (33.17)	0.62
Course Effectiveness (CE)	4.04 (0.89)	4.25 (0.70)	1.02 (34.00)	0.31
Anxiety Surrounding Mental Illness (ASMI)	4.22 (0.79)	4.80 (1.15)	2.01 (24.62)	0.06
Valuable Contributions (VC)	5.95 (0.79)	5.53 (0.81)	0.85 (31.85)	0.40

No statistically significant differences were noted between the pre-placement and post-placement for the control group on any of the subscales.

On comparing the findings of the experimental group versus the control group, it was demonstrated that the experimental group performed significantly better on three subscales, namely “Preparedness for Mental Health” (PMHF); “Course effectiveness” (CE) and “Anxiety surrounding Mental Illness” (ASMI). Hence, it was decided to conduct an inter-correlational analysis to determine the association of these three subscales with the various subscales of the Mental Health Education Survey Questionnaire. This computation would further assist in our understanding of student attitudes on mental health. However, Table 4.11 describes the strength and direction of the monotonic relationship between the subscales of the Mental Health Education Survey (Happell, 2008a) for the experimental group.

Table 4. 11. Correlation of the significant subscales for the Experimental Group at Post Test

Pearson Correlation at Post Test (Experimental Group)								
Subscales		PMHF	KMI	NS	FC	CE	ASMI	VC
Preparedness for Mental Health (PMHF)	Correlation P-value	1	0.178 0.117	-0.166 0.144	0.604 <0.001	0.297 0.008	0.520 <0.001	0.374 0.001
Course Effectiveness (CE)	Correlation P-value	0.297 0.008	0.460 0.684	-0.123 0.280	0.049 0.667	1	0.343 0.002	0.280 0.012
Anxiety Surrounding Mental Illness (ASMI)	Correlation P-value	0.520 <0.001	0.186 0.102	-0.214 0.058	0.314 0.005	0.343 0.002	1	0.165 0.147

Results indicate a significant positive correlation between the subscale Preparedness for Mental Health and the following subscales Future Career (r=0.604, n=21, p=<0.001); Course Effectiveness (r=0.297, n=21, p=0.008); Anxiety Surrounding Mental Illness (r=0.520, n=21, p=<0.001) and Valuable Contributions (r=0.374, n=21, p=0.001). Hence, higher student perceptions for preparedness for Mental Health indicates a greater desire to pursue a career in psychiatric/mental health nursing as well as a lower level of anxiety surrounding mental illness, as higher scores for anxiety surrounding mental illness represent lower levels of anxiety. Results also indicate that the more prepared students feel, the more valuable contribution and service they can provide and the more effective is their course. Results also highlight a significant positive correlation between the subscale Anxiety Surrounding Mental Illness and Future Career (r=0.550, n=21, p=0.01) and Course Effectiveness (r=0.343, n=21, p=0.002). This illustrates that students with low anxiety levels (as higher scores represent lower levels of anxiety), are more inclined to pursue a career in psychiatric/mental health nursing and a higher course effectiveness outcome. Results also highlight a significant positive correlation between the Course Effectiveness (r=0.343, n=21, p=0.002) and Valuable Contributions (r=0.280, n=21, p=0.012). This illustrates that the higher the course effectiveness results, the higher the contribution and service provided by the student.

4.5.1.2 Findings for the Attitudes to Mental Illness Questionnaire

Section 4.5.1.2. reports the findings emerging from the comparison at pre-and post-placements of student responses to the Attitudes to Mental Illness Questionnaire (Luty et al., 2006). The Attitudes towards Mental Illness Questionnaire (AMIQ) presents 7 scenarios namely Scenario A relates to heroin addiction; Scenario B relates to depression and overdosing on paracetamol; Scenario C relates to alcoholism; Scenario

D relates to criminality and being a convict; Scenario E relates to diabetes and the use of insulin; Scenario F relates to religious practice whilst Scenario G presents a case related schizophrenia and hallucinations. Students were administered the AMIQ before the start of the placement and again at the end of the placement post randomisation into the experimental and control group.

Table 4.12 reports the difference between the Mean and Standard Deviation at the Pre-placement and post-placement for the experimental group on the Attitudes towards Mental Illness Questionnaire.

Table 4. 12. Means and Standard deviations for responses of the experimental group on the AMIQ: for Pre-and Post-placement

Attitudes to Mental Illness Questionnaire (AMIQ)	Pre-Placement	Post Placement Experimental Group	t (df)	P
Equal Variance Not Assumed	Mean (SD)	Mean (SD)		
Scenario A	-4.44 (2.49)	5.32 (1.06)	-21.96 (61.23)	<0.01
Scenario B	2.95 (3.16)	4.94 (0.82)	-3.86 (52.36)	<0.01
Scenario C	-0.12 (3.43)	-4.00 (2.65)	4.98 (50.21)	<0.01
Scenario D	-6.67 (3.00)	3.86 (3.14)	-12.80 (38.22)	<0.01
Scenario E	8.23 (2.25)	0.14 (3.85)	8.92 (26.84)	<0.01
Scenario F	6.65 (3.39)	-7.52 (2.60)	18.38 (50.18)	<0.01
Scenario G	-0.23 (2.81)	9.24 (1.18)	-18.95 (61.07)	<0.01

For the experimental group, statistically significant differences were recorded on all 7 scenarios from pre-to post placement.

Results report a statistically significant change for Scenario A from pre to post placement [t(61.23)=-21.96, p=<0.001]. The mean score of -4.44 at pre-placement indicates a negative attitudinal score, which changes to 5.32 at post placement reporting a positive change in attitudes for this scenario in the experimental cohort.

Results for Scenario B also illustrate a statistically significant change for pre to post placement [t(52.36)=-3.86, p=<0.001]. The mean score from pre-placement (M=2.95, SD 2.49) reports a positive attitudinal score which is further increased at post placement (4.94, SD 0.82). This indicates that the experimental group viewed the scenario representing a depressed individual who overdosed on paracetamol to try and hurt himself even more sympathetically at the end of the placement.

Statistically significant results were also reported for Scenario C [t (50.21) =4.98, p=<0.001]. The mean at pre-placement (M=-0.12, SD 3.43) reports a neutral attitudinal view than increases in negativity at post placement (M=-4.00, SD 2.65), implying that students reported a negative attitudinal view towards this case at post placement.

A statistically significant result was reported for Scenario D [t (38.22) =-12.80, p=<0.001] which presented a convicted criminal who was in prison for fraud and burglary and is currently on bail. At pre-placement a negative mean score (M=-6.67, SD 3.00) reports a negative attitudinal score, which shift to a positive attitudinal score (M=3.86) at post placement, indicating an attitudinal shift from negative to positive in the experimental cohort for such a scenario.

Scenario E also reports statistically significant change from pre-to post placement [t (26.84) =8.92, p=<0.001]. Students in the experimental cohort reported a sympathetic view (M=8.23, SD 2.25) towards the case representing an individual who self-injects insulin and in on a special diet due to his diabetes. At post placement the mean score deceased (M=014, SD 3.85) indicating a neutral view.

Scenario F reports a case of a practicing Christian who attends church every Sunday and leads a Christian life. A statistically significant change in attitudes was reported between pre-and post-placement in the experimental group [t (50.18) =18.38, p=<0.001]. Mean score at pre-placement report a positive attitudinal view towards this scenario (M=6.65, SD 3.39) which changes to a negative attitudinal view towards such scenario at post placement (M=-7.52, SD 2.60).

Scenario G presents the case of an individual who has schizophrenia, is on depot medication, currently detained under the mental health act due to auditory hallucination. Once again, a statistically significant result was obtained between the pre-and post-placement comparison [t (61.07)=-18.95, p=<0.001]. The mean score at pre-placement (m=-0.23, SD 2.81) indicates a neutral view, whilst the mean score at post placement (M=9.24, SD 1.18) indicates a positive attitudinal towards such a scenario.

Conversely, Table 4.13 reports the difference between the Mean and Standard Deviation at the Pre-placement and post-placement for the control group on the Attitudes towards Mental Illness Questionnaire.

Table 4. 13. Means and Standard deviations for responses of the control group on the AMIQ: for Pre and Post placement

Attitudes to Mental Illness Questionnaire (AMIQ)	Pre-Placement	Post Placement Control Group	t (df)	p
Equal Variance Not Assumed	Mean (SD)	Mean (SD)		
Scenario A	-4.44 (2.49)	5.05 (0.94)	-21.09 (55.57)	<**0.001**
Scenario B	2.95 (3.16)	4.73 (0.73)	-3.44 (52.24)	<**0.001**
Scenario C	-0.12 (3.43)	-2.47 (5.10)	1.66 (18.62)	0.11
Scenario D	-6.67 (3.00)	3.27 (4.43)	-8.07 (18.67)	<**0.001**
Scenario E	8.23 (2.25)	-0.40 (3.52)	8.87 (18.13)	<**0.001**
Scenario F	6.65 (3.39)	-4.93 (3.86)	10.31 (22.02)	<**0.001**
Scenario G	-0.23 (2.81)	7.73 (2.60)	-9.99 (26.24)	<**0.001**

As outlined in table 4.13, when data was analysed from pre placement to post placement without Handbook, statistically significant results were reported for 6 of the 7 scenarios, namely, Scenario A [t(55.57)=-21.09, p=<0.001], Scenario B [t(52.24)=-3.44, p=<0.001], Scenario D [t(18.67)=-8.07, p=<0.001], Scenario E [t(18.13)=8.87, p=<0.001], Scenario F [t(22.02)=10.31, p=<0.001], Scenario G [t(26.24)=-9.99, p=<0.001].

The Control group report the same attitudinal views as those in the experimental group for each scenario achieving statistically significance between pre-and post-placement analysis. Of note is that no statically significant difference between pre-and post-test findings were reported for Scenario C. This finding differs from that obtained in the experimental group where a statistical significant increase in negative attitudes from pre-to post placement was reported.

4.5.1.3 Summary of Findings of Phase 3A

The overall findings emerging from phase 3A indicate that the experimental group reported statistically significant improvements in the following educational subscales, Preparedness for Mental, Course Effectiveness and Anxiety Surrounding Mental Illness when compared to the control group. The only difference in attitudes between the experimental and control was reported for only one scenario, namely scenario C, which is based on an individual who after 5 years is seeking treatment for his alcohol

addiction (section 4.5.1.2). This highlights that the Acute Mental Health Nursing handbook contributed to changes between the experimental and control group.

Students provided with the handbook were further requested to conduct self-reflections whilst concurrently doing their clinical placement (i.e., during phase 3A). They were thus requested to write their reflective account on the handbook provided (Appendix A, page 24). These reflections targeted the competencies relevant to the 8 domains of practice found within the Acute mental health nursing student handbook. Their reflective accounts were then analysed using thematic analysis and are reported in section 4.6. this phase of the study is discussed within phase 3b of the study.

4.5.2 Phase 3B – The Reflection Phase

The reflection phase consisted of evaluating the student's reflections and mentors' comments found in the Acute Mental Health Nursing Student Handbook. This phase occurred concurrently with phase 3A outlined above. The analysis of these comments provided an insight on the clinical application of the handbook as an adequate clinical learning tool for the acute mental health nursing placements. A thematic analysis of students written reflections under each of the 8 domains of competence within the acute mental health nursing student handbook, as well as the written mid-placement reflection by the mentor and mentee, coded for each response, will be presented in this section. In many instances, the mid-placement meeting occurred towards the second part of the placement rather than at mid-placement. Table 4.14 outlines the themes extracted and excerpts from the student reflections for each of the 8 domains of competence, whilst table 4.15 outlines the student and mentor comments following the mid-placement meeting, which was scheduled between the student and the mentor close to the end of the placement.

Table 4. 14. Thematic analysis arising from the reflection process

Domain	Themes Extracted and Excerpts from students and mentors	
Domain 1 Therapeutic Relationship	**Theme 1 Facilitate Communication** "*the main focus of the relationship is based on the patient's experiences, idea and feelings. Both the nurse and the patient should identify areas that need to be focused and evaluated in order to see the change in the patient gradually".* **Student G** *"once mutual trust and respect was developed I was able to overcome communication barriers and be more influential in the patient's road to rehabilitation"* **Student F** *"effective nursing practice is dependent on an effective therapeutic relationship between the nurse and the client to reach desired goals"* **Student H**	**Theme 2 Gaining Client's Trust** *"at first, I found it a bit challenging as I had to set boundaries and let the patient know I cared at the same time"* **Student L** *"building therapeutic relationships has become the bread and butter to our placement routine, one cannot carry out successful, therapeutic nursing interventions without building trust and without showing unconditional positive regard towards the patient"* **Student P**
Domain 2 Assessment	**Theme 1 Identifying Specific needs of the client** *"through holistic assessment, therapeutic assessment and the ongoing collection of objective and subjective data, I was able to provide improved person-centered care to the patient"* **Student A** *"you see the patient as a whole, not only the patient's history but also the background and the needs of the patient"* **Student E** *"I understand the relevance and importance of getting an in-depth client assessment. I now know how to assess patient's mood, thought content, affect, behavior and speech. I understand how to gather patient's history, including childhood and past medical history and recognition when a patient's progressing and regressing"* **Student O** *"observing appearance, behavior, cognition, speech, mood, insight and judgement are all factors which can show whether a patient is improving"* **Student F**	**Theme 2 Effective use of Psychometric tools** *"assessments are based on scales, varying on admission. Some examples of scales used are Brief Psychiatric Rating Scale (BPRS), Health of The Nation Outcome Scales (HONOS), Broset Violence Checklist, and the Mini-mental scale exam (MMSE)"* **Student G** "*…taking a patient history was quite challenging due to lack of experience. Day to day changes in mood were successfully observed whilst also being able to identify patient progression or regression. I have also been able to successfully complete on alcohol withdrawal scales in the ward"* **Student J**

Domain 3 **Care Planning and Coordination**	**Theme 1** **Providing a Person Centred Care approach** *"a successful care-plan was always patient centered and the patient was involved as much as possible".* **Student J** *"this same care plan is also discussed with the patient himself/herself"* **Student C** *"I was able to understand and evaluate the progress of how a care plan is managed from the beginning of a patient's admission"* **Student E** "*…I have observed how each member of the team contributed in order to achieve the most therapeutic outcome… although I did not participate in a care plan, during ward rounds, I have observed how each member of the team contributed in order to achieve the most therapeutic outcome"* **Student H** *"I understand the importance of forming a care plan as I had the chance to write one along with my mentor"* **Student O**
Domain 4 **Nursing Interventions**	**Theme 1** **Application of core psychiatric skills in practice** *"…with the help of my mentor, I have learned about psychiatric medications and how essential they are for the mental health patients to function normally"* **Student F** *"my mentor helped me understand more about the different mental health conditions and the different treatment actions"* **Student J** "*…developing coping skills, develop distraction techniques, conduct and manage a group therapy or one to one sessions and conducting patient education*" **Student N** *"I have gained a good knowledge of medication and their side effects and managed to take part in group therapy session"* **Student O**
Domain 5 **Managing Psychiatric Emergencies**	**Theme 1** **Observing Crisis Mitigation in Action** *"I experienced several instances of escalated behavior such as anxious, frightened, angry or even fighting patients. These instances were handled best with direct patient communication and offering a safe environment for the patients to express themselves"* **Student C** "*the patient become upset and aggressive as the doctor had cancelled her permission for main garden. She had to be chemically restraint and transferred to a time-out room after all verbal de-escalation techniques were exhausted"* and *"a reflected session with the mentor was carried out, as I had been upset upon seeing the patient being chemically and physically restrained and secluded"* **Student E**

	"…although I have not witnessed psychiatric emergencies, I have learned what it entails and how it should be properly managed. De-escalation techniques and restraint was also discussed in depth with my mentor. I have observed how to write an incident report". **Student J** *"…the patient had no insight and was uncompliant. The nurse managed the potential psychiatric emergency by staying calm, using effective de-escalation techniques and appropriate non-verbal. The situation did not escalate as the nurse handled the case well"* **Student O**	
Domain 6 **Ethical Issues**	**Theme 1** **Working within the context of the Maltese Code of Ethics** "*all nursing interventions observed during my time at the placement were always in the interest of the patient. The patients are always respected as individuals with their own rights, irrelevant of race, religion, ethnicity, sexual orientation or background"* **Student C** *"I maintained confidentiality with the patient, I had respected every patient about their dignity and saw the patient as a whole. I familiarized myself with the Maltese code of ethics and patient's charter".* **Student E** *"during my placement, I have observed the nurses advocate for their patients, respect them and their decisions, requirements (upon weighing the benefits within the setting) which is very important as mental illness does not degrade an individual"* **Student H** *"I have observed my mentor show non-judgmental and non-discriminatory ethical and refrain from giving personal information outside the remit of the clinical environment"* **Student O** *"…patients should be aware of their rights eg. renewal of a community treatment order, the patient should be briefed and should have the opportunity to voice this opposition, if there is the case*" **Student P**	
Domain 7 **Education & Research**	**Theme 1** **Bridging the Theory Practice Gap** *"I have observed my mentor empowering patients to pursue realistic life goals and independency".* **Student E** *"my mentor has been very helpful in teaching me how to address psychiatric episodes and how to roughly diagnose a patient just by observing language, behavior and attitudes and their way of thinking"* **Student F**	**Theme 2** **Mentor's Supporting Role** *"I did not get the chance to discuss all my queries with my mentor as she is very busy and has little time on her hands"* **Student E** *"when I was in doubt, I always consulted my mentor for clarification"* **Student J**

	"from the first day of my placement, my mentor had provided me with a lot of information guided me thoroughly. She encouraged me to read more and reflect on my knowledge by observing and communicating with the patients during my ward days" **Student H** *"I discussed difficulties with the mentor and how to overcome such obstacles"* **Student I**	
Domain 8 **Legal Implications**	**Theme 1** **Working within the Maltese Legal Framework** *"I observed several legal implications of nursing practices such as handling DDAs, maintaining confidentiality of the patient as well as documentation"* and *"it is important to document properly as the patient's data is handled and abuse of documentation can have legal implications. I learnt the proper ways to document and handle DDA from my mentor and the other nurses"* **Student D** "*by the end of the placement, I was able to have an understanding of the Metal Health Act (2012) with particular emphasis on Schedule 1,2,3,4,5,7,9. I was able to demonstrate awareness of the legal rights and responsibilities of both clients and staff as outlined in the Mental Health Act (2012)"* **Student B** *"the mentors guided us very well on the Mental Health Act and how patient's admissions are on a voluntary and non-voluntary basis"* **Student L**	**Theme 2** **Policies, Documents and Procedures** *I have seen and understood multiple forms and documents that have to be adhered to and completed, which protect both the nurse and the right of the patient"* **Student C** *"I have become familiar with the Mental Health Act and the Mental Health Act's schedule in my time on the ward. I have also been thought about the different procedures between a voluntary and non-voluntary (sectioned) patient which bought about a different variety of legal forms and documentation"* **Student J**

Table 4. 15. Thematic analysis arising from the Students and Mentors comments at the Mid-placement meeting

Mid-Placement Student Comments	**Theme 1** **Placement Experience** *"this placement made me think about mental health illnesses and the importance of reducing the stigma associated with it"* **Student B** *"I feel I have grown doing my placement however I am ready to keep on improving on these skills to offer the best nursing care possible"* **Student C** *"I found it a bit hard as a placement as I did not have any experience and background about mental health, the staff helped a lot. I hope to learn more as it is an interesting area of nursing"* **Student G** *"welcoming staff helped to enhance the placement experience"* **Student K** *"I felt that sometimes the mentor was too busy with the clinic for me to be her shadow"* **Student N**	**Theme 2** **Learning Objectives** *"I learned a lot from talking therapy techniques used by my mentor"* **Student N** **"***…in this placement, I performed well with daily assignments, with my mentor, I worked excellent, … discussed my weaknesses and he advised me on how to prepare the treatment well. I felt good working with the proactive staff. I found new challenges and new experience in a different environment"* **Student A** *"…with the help of my mentor, I was supported and educated on the purpose of psychiatric nursing and how to care/ or help patients with mental health illness"* **Student E** *"…this placement has also strengthened my knowledge and clinical thinking"* **Student F** *"the mentor did not notice that I was struggling to understand the system and her methods"* **Student O**
Mid-Placement Mentor Comments	**Theme 1** **Placement Experience** *"has shown great interest and commitment whilst acting professionally and without prejudice…he was emphatic and readily accepted feedback. He also improved his knowledge of psychiatric conditions and their management. He integrated well with the staff in the ward and with the multidisciplinary team, it was a pleasure having him as my student"* **Mentor M**	**Theme 2** **Learning Objectives** *"…the student was able to demonstrate her knowledge of which she herself seemed to attain by research. She was able to follow care plans, monitored progress and regression through scales and score sheet. She took the opportunity to communicate with other healthcare professionals during ward rounds and participated in the construction of care plans. Identified the long and short-term goals in this care plan. She was also able to identify the side effects of the antipsychotics and monitored the elevation of the same side effects whilst the dose was being tailored off or an antidote was given. Participated in a group therapy session whilst she identified the effectiveness of the same therapy session. She was also able to discuss with me (mentor) the possible resolution and the de-escalation techniques to dissolve a psychiatric emergency".* **Mentor F** *the student acted professionally throughout the placement. She identified her own learning needs and demonstrated an attitude to learn and improve. She integrated herself with the nursing staff, patients and relatives and was able to discuss issues related to nursing care plan as needed".* **Mentor B** *"needed some more confidence in the domains especially in building a therapeutic relationship and the legal and ethical issues relate to patient with mental illness".* **Mentor F**

Results highlight that the excerpts provided by participants bordered on the descriptive rather than providing an in-depth reflection on their experience during the placement. In order to address such issue, the original "*Reflection and Evaluation*" section was revised to include the categories highlighted by Bloom (1956/2001) in the cognitive domain in order to better support the students in their reflection. The final "*Reflection and Evaluation*" section can be viewed Appendix A (page 24).

4.5.2.1 Summary of Findings of Phase 3B

Overall students seem to not only be able to carry out the competencies outlined in the handbook, but to also reflect on the importance of such competencies within the clinical setting. It must also be noted that at times the excerpts bordered on the descriptive rather than a deep reflection on the shortcomings or rather highlighted their achievements. It is also clear that students found the mental health placement challenging, however with the support of their mentors guided by the acute mental health nursing student handbook, most reported improvement in their skill competence and overall understanding of mental health care. Conversely, mentors praised the students on their diligence and although some might still lack confidence, mentors were pleased with the overall performance of the students.

4.6 Conclusion

Results presented in this chapter highlight the findings from the three phases of the study investigating the perspectives of nursing students and their mentors in order to provide quality mental health clinical placements. The first phase guided the researcher to identify the domains of practice with the core competencies relevant to each of these 8 domains. Also, the relevance of ancillary clinical skills outside the 8 domains was also investigated. The analysis of this data lead to the second phase of the study, which involved the compilation of the Acute Mental Health Nursing Student handbook. During phase 3A of the study the students were asked to complete two questionnaires, one at pre-placement and one at post-placement. Results outline that the group with the handbook reported significant differences on 3 out of the 7 of the subscales for the Mental Health Nursing Education Survey, whilst those without the handbook reported no significant difference on the same subscales. Both groups

reported significant differences between pre-and post-placement on the AMIQ scale. Phase 3B of the study reported the reflection of the mentees and mentors having a copy of the handbook at the mid stage point of the placement. Overall the comments are very positive and showcase a level of engagement by both the mentees and the mentors during the placement period. An attempt to interpret, compare and critically analyse these results in relation to previous literature and the implications within the Maltese mentoring context will follow in the Discussion chapter.

Chapter 5: Discussion of the Findings

5.1 Introduction

In this chapter, the researcher discusses the findings reported in chapter 4 in light of existing literature and theoretical models. The discussion focuses on providing quality mentoring which is discussed in section 5.2 and the evaluation of the Acute Mental Health Nursing Student Handbook which is discussed in section 5.3. Finally, a concluding section provides a salient summary.

5.2 Providing Quality Mentorship

Mentoring is very complex and has ramifications in both the academic and clinical domains (Stephenson, 2014). Without quality mentoring, there is a high risk of having unskilled and inadequately trained future nurses, thus Stephenson (2014) stresses the importance of prioritising mentoring as a means to ensure quality nursing education and the provision of quality care. As outlined in chapter 2, quality mentoring does not come without its challenges in the field relating to the clinical learning environment, the mentor as a role model, attitudes towards mental illness together with variations in guiding frameworks. The mental health clinical learning environment is known to be less structured, thus a higher level of professional autonomy is required (Cowman, et al., 2001; Moir & Abraham, 1996). Whilst the mentor should act as a role model, their role gives rise to conflict as they are faced with the task of supporting and providing guidance and assistance to the student, whilst also acting as an assessor to the same student. Furthermore, as highlighted by Dobrowolska et al. (2015) there are no international standardised formal rules, qualifications or requirements to practice as a mentor. Yet several authors highlight that the clinical mentor is central if quality clinical placements are to be ensured (Campbell et al., 1994; Edwards et al., 2004; MacLeod & Farrell, 1994; Mullen & Murray, 2002; Packer, 1994). This further highlights the need of guiding frameworks in order to support the mentors in such a crucial role. Although guiding frameworks vary between institutions and countries, the core aim of these guiding frameworks is to provide the highest level of education possible to equip student nurses with competencies and skills necessary to deliver person centred care. Thus, the acute mental health nursing student handbook focuses particularly on providing a person centred care approach.

5.2.1 Person Centred Care

Person-centred care model has increasingly become the norm in healthcare delivery. Rosewilliam et al. (2019) report that students identified that their student status, placement pressures, placement characteristics especially mentoring influenced their development of patient-centred attributes. Person-centred care refers to a model of care that incorporates and respects the person's values, needs, experiences and preferences in the planning, coordination and delivery of care (Gluyas, 2015). McCormack, Dewing and McCance (2011) add that person-centred care is underpinned by values of respect for persons, an individual right to self-determination, mutual respect, and understanding. Building a therapeutic relationship between the person and the healthcare professional is fundamental for such a model to work (Gluyas, 2015; McCormack et al., 2010). McCormack et al. (2011) further refine the definition of person-centred care as an approach to practice that is established through the formation and fostering of therapeutic relationships between all care providers, patients, and others significant to them.

McCormack & McCance (2006, 2010) developed a person-centred nursing framework based on empirical research based on the experience of caring in nursing. The person-centred nursing framework incorporates fours constructs, namely prerequisites, the care environment, person-centred process and outcomes. Focusing on the prerequisites construct, which specifically focuses on the attributes of the nurse, in this case, the formation training of a student to a nurse, which includes professional competence, having developed interpersonal skills, job commitment and the ability to demonstrate clarity of beliefs and values whilst having self-awareness (McCance, McCormack & Dewing, 2011). This is further corroborated by Sharghi et al. (2015) who state that high quality nursing care depends on the nurses' level of competency.

The development of competency is what clinical learning is all about and this study targets the quality of care delivery by improving the competency of students with the introduction of the acute mental health nursing student handbook to improve quality mentoring and skill acquisition. Learning outcomes such as "to communicate effectively and demonstrate the ability to conduct a therapeutic conversation with clients having a mental health condition", "discuss the relevance and importance of

conducting an in-depth client assessment as the foundation of person-centred care delivery" and "formulate a care plan in collaboration with the client, based on short and long-term goals reflective on the client's own needs and concerns", which were in fact amongst the highest endorsed competencies by mentors, relevant to the domains of practice "Therapeutic Relationship', "Assessment" and "Care Planning & Coordination" respectively are all examples of how the acute mental health nursing student handbook incorporates the person centred care approach model. This study reports findings which are in line with those reported by McCormack et al. (2011), who outline the importance of values of respect for persons, mutual respect and understanding. For example, study participants highlighted in their reflective accounts that *"once mutual trust and respect was developed I was able to overcome communication barriers and be more influential in the patient's road to rehabilitation"* (Student F). Also, Student H states that *"effective nursing practice is dependent on an effective therapeutic relationship between the nurse and the client to reach desired goals"*, that further emphasizes from a practical perspective, how building a therapeutic relationship between the person and the professional is fundamental to the person-centred care model as outlined by both McCormack et al. (2010) and Gluyas (2015).

Another core aspect to providing person centred care is the planning, coordination and delivery of care focused on the needs of the person (Gluyas, 2015; McCormack & McCance, 2006; McCormack & McCance, 2010). The Acute Mental Health Nursing Student Handbook also includes the domains of practice linked to care planning, coordination and delivery which are embedded in the domains "*Assessment"*, "*Care Planning and Coordination"* and "*Intervention"* domains. Student E commented that *"you see the patient as a whole, not only the patient's history but also the background and the needs of the patient"* reflecting the importance of these three domains and the competencies related to them. This is further corroborated by the comment of Student J who says that, *"a successful care-plan was always patient centred and the patient was involved as much as possible".* The handbook through its activities such as those incorporating reflection and learning outcomes presented such as "discuss the relevance and importance of conducting an in-depth client assessment as the foundation of person-centred care delivery" and "formulate a care plan in collaboration with the client, based on short and long-term goals reflective on the

client's own needs and concerns" encourage students to incorporate and respect the person's values, needs, experiences and preferences in the planning, coordination and delivery of care. It has also been identified that building a therapeutic relationship between the person and the healthcare professional is fundamental for the person-centred care model to work. Learning outcomes within the handbook such as "communicate effectively and demonstrate the ability to conduct a therapeutic conversation with clients having a mental health condition"; "demonstrate a non-threatening, empathic and non-judgmental attitude and approach"; "define boundaries and articulate their implications within a clinical setting"; "demonstrate an ability to identify barriers limiting effective communication, trust and therapeutic engagement (example: paranoid ideation)" aim to support and facilitate the formation of a therapeutic relationship. This tallies with the principles of person centred care which include personalised care, coordinated care, enabling care and treating the person with dignity, compassion and respect. Again these principles are reflected in the handbook in specific domains such as "Care Planning and Coordination", "Assessment" and "Ethical Issues" and in learning outcomes such as "provide interventions that respect the client as an individual and as an autonomous human being with his/her own rights and dignity, irrelevant of his or her diagnosis, gender, sexual orientation, ethnicity, religion, social status and cultural background"; "demonstrate awareness of the different needs of the clients being religious, sexual or cultural and be able to adapt to such needs in a moral and non-conflicting way with a non-judgmental and non-discriminatory attitude. These further alludes to the effectiveness of the acute mental health nursing student handbook as a guide to support the students in their mental health placements as well as guide them to attain competence. This ultimately leads to the practice of a person-centred model of care, which is now recognised as an important component of healthcare quality (Guastello & Jay, 2019). The following section discusses the importance of the clinical environment as an opportunity for learning.

5.2.2 The Clinical Learning Environment

The clinical placement is one of the very few opportunities within an undergraduate nursing program that students have to observe and practice close to individuals who

have a mental illness (Mullen & Murray, 2002). Concurrent literature states that clinical experience is fundamental to the acquisition of students' knowledge, skills and attitudes (Arnold et al., 2004; Martin & Happell 2001; Mullen & Murray, 2002). Ion et al. (2017) add that learning in the clinical practice setting, not only offers opportunities for skill development but is an important part of the socialisation process and can support decision-making about future career choices. Myall et al. (2008) stress that mentorship is not only integral to the students' clinical placement learning experiences but it also facilitates the development of clinical competence. However, this does not come without its challenges (Atkins & Williams, 1995). Literature identifies that students reported a lack of information about the placement and what is expected from them in terms of clinical competency and skill (Grav et al., 2010). Grav et al. (2010) have emphasised the need for further research on what may hinder or improve the clinical experience. The present study contributed by investigating the views of mentors towards the factors that improve or hinder the clinical experience. Results emerging from this present study highlight that mentors are split equally between the need for the current local mentorship framework to be amended or revised (n=18) or endorsing that no changes are required (n=17). Revisions suggested by mentors include that the clinical placement should be more goal oriented with more visits from supervisors/lectures on the clinical placement. Other suggestions include that students should work the same shift as their mentor, and have a framework with specific mental health competencies that guide the student depending on their year of study. These suggestions corroborate the extant literature which identifies that mentoring of students should not be generic but should approach the need of the individual student with learning objectives set accordingly (Hughes, 2011). In order to provide an individual learning experiences several factors should be in place to facilitate such a framework. These include, the mentor, the student and a guide that allows for the building of an individualised learning experience, whilst also covering the importance aspects of learning within a clinical context, which include observation and practice in order to acquire knowledge, skills and competence. This is hoped to be achieved with the use of the acute mental health nursing student handbook. Following the six categories of the Cognitive Domain in Bloom's taxonomy model (2001), students should be able to remember, understand, apply, analyse, evaluate and create. Mentors within this study have reported that common key learning outcomes should include learning of skills and achieving a level of competences in such skills and

highly endorsing skills related to medication. Mentors also endorsed the ability to function within a multidisciplinary environment, adequately communicate and build a therapeutic relationship with clients and show knowledge of the Maltese Mental Health legal framework. The resources and glossary sections within the acute mental health nursing student handbook also address the mentor's concern that students should use appropriate psychiatric terminology, as it provides students with a quick reference and understanding of terms encountered during their placement.

The aim of the mid-placement meeting as part of the Acute Mental Health Nursing Student Handbook, compiled as part of this study aims to allow exactly what literature refers to as a tailored, individualised placement. This meeting allows for the student to reflect on the progress attained so far and discuss with their mentor ways to support the student to further improve. The reflective process does not only provide documentation of the progress of the student but allows for the understanding of the learning outcomes which require higher level of cognitive skills of comprehension, application, analysis, synthesis and evaluation, leading to deeper learning and transfer of knowledge and skills (Adams, 2015). This further makes the placement experience individualised and target specific. This addresses the need highlighted by several authors (Clinton & Hazelton, 2000; MacLeod & Farell, 1994; Mullen & Murray, 2002; Packer, 1994), who suggest that the clinician's role in nurse education should reflect and be sensitive to the learning needs of the students. Students comments, such as, "…*in this placement, I performed well with daily assignments, with my mentor, I worked excellent, … discussed my weaknesses and he advised me on how to prepare the treatment well. I felt good working with the proactive staff. I found new challenges and new experiences in a different environment"* (Student A) and *""…with the help of my mentor, I was supported and educated on the purpose of psychiatric nursing and how to care/ or help patients with mental health illness"* (Student E), reflect that the clinical environment, indeed serves as a powerful learning environment. It must be acknowledged that the clinical environment would not be a powerful learning setting without the mentors that actually provide the education, knowledge and support based on a guiding framework, such as the acute mental health nursing student handbook. In the following section the mentor's role will be discussed.

5.2.3 The Mentor as a Role Model

Jack et al. (2017) highlight that the mentor's role can influence the student's clinical placements both positively as well as negatively. Mentors should present as positive role models, as this would support and further instil enthusiasm for the nursing role in nursing students (Jack et al., 2017).

They acknowledge that being positive is not always possible and many times it is beyond the mentor's control, however one must be vigilant when allocating students to mentors who have a lack of enthusiasm (Jack et al., 2017). This study reports that the support of mentors and other members of staff has proven invaluable for most of the students. Student G reported that, *"I found it a bit hard as a placement as I did not have any experience and background about mental health, the staff helped a lot. I hope to learn more as it is an interesting area of nursing"* whilst Student K commented that *"welcoming staff helped to enhance the placement experience"*. Student L reported that *"the mentors guided us very well on the Mental Health Act and how patient's admissions are on a voluntary and non-voluntary basis"* whilst Student F said that *"my mentor has been very helpful in teaching me how to address psychiatric episodes and how to roughly diagnose a patient just by observing language, behavior and attitudes and their way of thinking"*. This is congruent with statements reporting praise for the sterling support by mentors found in several studies (Almalkawi et al., 2018; Beskin, 2009; Foster et al., 2015; Fuentes-Pumarola et al., 2016; O'Brien, 2008). Conversely, various studies (Bradshaw et al., 2012; Jack et al., 2017; Ford et al., 2016) also report negative experiences of students whose mentors fail to adequately support them during their clinical learning experience due to lack of staff, limited time and mentors with little experience due to their young age. The issue of lack of experience does not seem to be a contributor towards limiting quality mentoring in the Maltese context, as the majority of the mentors within this study have more than 6 years of working experience. Conversely, lack of staff and limited time were also cited as contributors to a negative clinical experience, as Student N reported that *"I felt that sometimes the mentor was too busy with the clinic for me to be her shadow"* whilst Student O reported that *"the mentor did not notice that I was struggling to understand the system and her methods"*. The last comment also eludes to the concept of adequacy of the nurse to mentor and the resources available for mentors to cover the same

learning outcomes using an establish framework as presented in the handbook rather than their own methods. Also such issues can be identified at the mid-placement meeting as suggested in the handbook. Other obstacles that should be overcome in order to ensure quality mentoring include organisational issues and poor training (Rigby et al., 2012). This study also reports organisational issues highlighted by mentors that include learning outcomes should be more goal oriented; more meetings from supervisors/lecturers with mentors and students including visits at the workplace and a higher frequency of placement days in which students meet their mentor; ideally working the same shift as their mentor. The acute mental health nursing student handbook provides goal oriented leaning outcomes addressing the issue highlighted by mentors. Students reported time restrictions and intense workloads as factors that limited their interactions with their mentors. Student O reports that *"the mentor did not notice that I was struggling to understand the system and her methods"* indicating that although the mentor might be very proficient in nursing skills, their training in providing mentorship and teaching skills might be lacking. This highlights the need for further research on the mentor's ability to provide quality mentoring. The following section provides a discussion on the inclusion of a guiding framework to address the learning outcomes highlighted in literature and by the mentors in this study.

5.2.4 Guiding Framework

Several authors (Andrews & Chilton, 2000; Dobrowolska et al., 2015) highlight the lack of a standardized mental health guide for mentors, with most of the existing guidelines specific to particular nursing programs, universities or higher education institutions. Having a standardized guide for mentors would ensure that each mentor follows a set of guidelines, thus providing the same level of support and education to all students equally. This is further corroborated by the findings emerging from this study, which report the need of a framework or guidelines reflecting the student's year of studies. Mentors participating in this study add that such a framework or guide should include specific competencies directed at mental health topics. This finding echoes the work of Utley-Smith (2004) who stresses the importance of clinical competencies, which contribute to an evidence based reform within the nursing

curriculum. Although there is a consensus about the importance of clinical competencies, there seems to be discordance on the compilation of such competencies. Higgins & McCarthy (2005), report a dearth of empirical work investigating mentorship programmes from the perspective of student nurses to mental health. In the work carried out by Gilje et al. (2007), 8 mental health competency domains were identified namely, therapeutic communication, therapeutic use of self, nursing process, safety, clinical learning, dialogue, faculty guidance, professional conduct and survey description. Gilje et al. (2007), acknowledge that these 8 domains might not address all the learning outcomes within an undergraduate program. They add that the learning outcome of "*self-disclosure"* can be difficult for students as it involves tenuous professional boundary issues with legal and ethical implications, thus they suggest that this should be revised to read "*self-disclosure within professional boundaries".* Also in an effort to refine the tool, Gilje et al. (2007) report that competencies should be levelled, meaning that an evaluation approach for example *no opportunity to demonstrate, demonstrates consistently, demonstrates inconsistently,* and *does not demonstrate* should be introduced. Conversely, Bondy et al. (1997) identifies 6 domains of competency, namely knowledge base/critical thinking, nursing process, nursing interventions, communications skills, professional socialization behaviors and self-evaluation. Of particular note is that although both authors identified different competency domains, they are similar in focus and both are used as a pedagogical tool. The domains identified in literature, such as nursing interventions; nursing process; safety; communications skills; self-evaluation were all included in the acute mental health nursing student handbook, albeit under possibly different domains. This decision was based on the fact that these domains of competency are consistently mentioned in literature and in established frameworks used in other nursing courses, as they form the bases of what constitutes mental health nursing competency. As outlined a different domain structure was adopted. Initially, 9 domains related to mental health were presented in this study which all mentors acknowledged to be very important in the formation of nursing students. After an in-depth analysis of the comments provided by mentors on the 9 domains and their learning outcomes, these initial 9 domains were reworked into 8 domains, with each domain including several related learning outcomes. These domains include, *Therapeutic relationship, Assessmen*t, *Care planning & Coordination, Nursing Interventions, Managing Crisis and Psychiatric emergencies, Ethical issues,*

Education and Research and *Legal implications*. The impact and evaluation of the acute mental health nursing student handbook as an adequate guiding framework is discussed in more detail in section 5.3.

5.2.5 Nursing Student Attitudes Towards Mental Illness

Literature reports that Mental health nursing is the least desirable career choice amongst student nurses (Happell & Gaskin, 2013; Stevens et al., 2013). Although several factors have been outlined in literature that may be contributing to such a choice such as anxiety and stigma associated with mental health (McCann et al., 2010), various researchers (Happell et al., 2013; Hoekstra et al., 2010; Nadler-Moodie & Loucks, 2011) agree that clinical education, perception of the mental health profession and the exposure to mental health nursing are all significant positive contributors to selecting mental health nursing as a career. Results of this study further corroborate the importance of exposure to mental health nursing as highlighted by the comment of student G namely *"I found it a bit hard as a placement as I did not have any experience and background about mental health, the staff helped a lot. I hope to learn more as it is an interesting area of nursing"* Student G and *"this placement made me think about mental health illnesses and the importance of reducing the stigma associated with it"* (Student B).

Results emerging from this study are also in line with other studies (Thongpriwan et al., 2015) which report that students with no clinical exposure and clinical education expressed greater negative stereotypes and higher anxiety about mental illness. Findings from the present study concur with those by Thongpriwan et al. (2015) as at pre-placements students reported high perceived anxiety scores and higher mean score for the variable "negative stereotypes". Results from this study also highlight a significant difference in the perceptions of students who formed part of the experimental group, that is, made use of the acute mental health nursing student handbook from pre-to post placement. A significant difference from pre-to post-placement was observed in relation to preparedness for mental health field, course effectiveness and anxiety surrounding mental illness. Conversely, in the control group no statistical significant differences were reported. Of significant importance is that using a framework for clinical education contributed to significant changes in the

perceived preparedness for mental health field, course effectiveness and anxiety surrounding mental illness in the experimental cohort. With the use of the acute mental health nursing student handbook, the students felt better prepared about the mental health field, understood better the theoretical aspect and effectiveness of their course, reported more positive attitudes towards mental illness and felt less anxious about caring for individuals with a mental illness. Learning outcomes such as "define and demonstrate under supervision a Mental State Examination including appropriate documentation and relevant nursing action"; "recognise signs of neuroleptic malignant syndrome (NMS) and lithium toxicity"; "Differentiate between the medical diagnosis and the psychiatric diagnosis however address them holistically"; "demonstrate knowledge of medications, their side-effects and indications/consideration of use, especially but not limited to anti-depressants, antipsychotics, anxiolytics and mood-stabilizers"; "participate in case reviews, give relevant feedback to the multidisciplinary team and liaise with other professionals to ensure an effective care plan"; "demonstrate the latest research and developments within the mental health field by reading related articles in journals and/or online resources" and "demonstrate awareness of the current Mental Health Act (2012), Maltese and EU legal implication in relation to mental health nurse functioning within the Maltese mental health services" to name a few coupled with a comprehensive glossary of terms and reflective practice may have all contributed to the reduction of anxiety and the improvement of their attitudes towards mental health. As previously outlined the resource section provides additional links and resources which students would need to access in orde to further comprehend specific learning outcomes, such as patient's charter and the Maltese nursing code of ethics. The glossary of term on the other hand provides a quick reference to terms encountered in the clinical placement which students might not yet be familiar with. Further investigation on attitudinal changes following exposure to clinical mental health practice, measured by the Attitudes towards Mental Illness Questionnaire (AMIQ) (Luty et al., 2006), has identified that both cohorts (experimental and control) reported statistical significant improvement in their attitudes towards the scenarios presented. Clinical exposure may have led to better understanding of the difficulties surrounding mental health issues resulting in more understanding, compassion, empathy and overall reduction of prejudice and stereotypical assumptions. Existing literature (Atashzadeh-Shoorideh et al., 2019; Brown, 2000; Grav et al., 2010) also mentioned the duration of the clinical placement

as a contributor to the preparedness to the mental health field. This was not tested as all students had the same placement hours. This was also important as one of the objectives of the study was to investigate if the acute mental health nursing student handbook contributed to an improved clinical experience, provided more knowledge and better supported better the learning process within a clinical setting. However, in further research it is highly recommended that the time factor should also be investigated.

5.3 Evaluation of the Acute Mental Health Nursing Student Handbook

This section attempts to highlight the evaluation and impact of the acute mental health nursing student handbook as a teaching tool. This is of particular importance should this tool be eventually introduced and implemented during the acute mental health student nursing placements. A strength of the acute mental health nursing student handbook is that it aims to provide a tailored student learning experience. This is achieved by reflective practice.

5.3.1 Reflective Practice

Glen et al. (1995) describes reflection as an art-form, through which students learn from everyday experience. Saylor (1990) and later echoed by Huybrecht et al. (2011), agree that reflective learning brings together both the art and the science of nursing, which in turn reduces the theory practice gap (Boud et al., 1985; Jarvis, 1987; Powell, 1989; Mezirow, 1991; Murphy & Atkins, 1994). One of the aims of reflective practice, as highlighted by Powell (1989) is to advance the conceptual level of thinking of an individual, which empowers the individual to change and improve. Thus, within the clinical setting with effective reflective practice, nursing students should be able to advance their thinking and improve their practice. Atkins and Murphy (1993) highlight that in order for the reflective process to be conducted properly, one must follow the three key stages which involve being aware of the feelings and thoughts, be able to critically analyse the situation and finally be able to develop new perspectives. Graham (2000) states that reflective practice allows the student and the

mentor to build a strong professional relationship as it allows for the sharing of beliefs, values and questions, which in turn leads to a very powerful learning experience. This is corroborated by one of the students in the present study who reported that by reflecting on areas that also needed to be strengthened and through their ongoing discussion with the mentor, they were supported along their journey to improve their practice as explained, *"...I discussed my weaknesses and he (mentor) advised me on how to prepare the treatment well. I felt good working with the proactive staff"* (Student A). Conversely, Rigby et al. (2012) report that students are often unsupported during their clinical placement, with access to supervision being problematic, once again citing challenges such as busy time schedules, low staffing levels and overcrowded placements. These obstacles cannot limit the supervision of nursing students, as clinical supervision is crucial for mental health nurses working in the acute mental health setting as (Department of Health, 2006; UKCC, 1999). This study also presents the local challenges that mentors encounter whilst striving to provide quality mentorship. The most cited issue highlighted by mentors is that students should be aware of what has been covered within the theoretical component of their nursing programme, whilst it would be of great benefit if the placements are concurrent with the clinical placement. These suggestions by mentors need to be explored in more depth, as at face value they seem rather contradictory. In the mental health nursing programme, before the start of clinical placements, students first have a series of theoretical modules that give an overview of the fundamentals of mental health nursing including the role of a psychiatric nurse, the concepts of therapeutic engagement and therapeutic use of self and safety. This is followed by specific placements concurrent with the theoretical modules, for example acute mental health or community mental health. This is in line with what the mentors seem to be suggesting. Conversely, in general nursing programmes offered by the University of Malta, the theoretical mental health module accounts for only 1 study unit in the second year of studies, and 240 hours of clinical practice, which might occur in parallel to the theoretical study unit. This leads to the challenge of students actually doing their placement without any theoretical background. Such situation poses more difficulty on mentors as they have no points of reference that link to the clinical education. This study tried to address such a challenge by introducing the acute mental health nursing student handbook. This handbook provides a framework which students and mentors can utilise to bridge this gap. The handbook aims to be comprehensive by including

definitions, offers resources for further reading as well as provides a glossary of terms commonly encountered within the clinical field. These in addition to the clinical domains of practice and learning outcomes serve as a baseline teaching tool for mentors and a learning opportunity for the students. In turn, the clinical experience will further strengthen the students understanding of the theoretical component if this is not done concurrently with the placement.

Edwards (2017) proposes a four-dimensional approach to reflection, which includes reflection-before, reflection-in, reflection-on and reflection-beyond-action. The author reports that this four-dimensional approach enables nursing students to expand and deepen their understanding of professional practice, without any constraint. Reconstructing practice before and beyond it occurs enables a better exploration of practice, provides effective ways of expressing emotions and overcoming any difficulties that one might encounter. Edwards (2017) adds that such an approach enables a better understanding of one's professional development which is crucial to nursing students.

In this study mentors report that students should involve themselves as much as possible, including the preparation of group sessions, engaging with patients, preparation and administration of treatment under supervision and learning about the patient's diagnosis and mental illnesses. The clinical placement is a hands on setting and students are expected to perform tasks supervised, following which they develop enough competency to perform the same tasks unaided. Other skills and learning outcomes which have been highlighted by the mentors and part of the acute mental health nursing student handbook include knowledge about the Maltese Mental Health Act; pharmacological issues including administration of medications; be able to work in a multidisciplinary team; develop a therapeutic relationship and most of all be competent. The acute mental health nursing student handbook extends these learning outcomes outlined by the mentors by further expanding of the skills. The inclusion of related skill such as, "demonstrate awareness of data protection legislation and show appropriate handling of data"; "discuss the Mental Health Act (2012) including the legal rights and responsibilities of both clients and staff and Mental Health Schedules with particular attention to schedules 1, 2, 3, 4, 5, 7 and 9"; "demonstrate awareness of the current Mental Health act (2012), Maltese and EU legal implication in relation to mental health nurse functioning within the Maltese mental health services";

“demonstrate knowledge about the different mental health conditions and understand the principles or concordance, compliance and treatment alliance”; “assist clients with a mental illness to clarify treatment goals, develop living skills reflective of their abilities and according to their level of understanding”; “name the barriers in reaching treatment goals (example: lack of insight)”; “educate clients about their condition, medications, side-effects, relapse prevention, relative support and available services in a language and at a level that the client can understand”; “demonstrate knowledge of medications, their side-effects and indications/consideration of use, especially but not limited to anti-depressants, antipsychotics, anxiolytics and mood-stabilizers”; “administer and record medications including but not limited to oral, ear, eye, topical, rectal vaginal, sub-cutaneous and intramuscular medication”; “demonstrate knowledge about the dangerous drug act, the psychotropic drugs listed under this Act (including dosages) and the DDA protocol” and “describe insulin indications, documentation, dosage, storage, hypoglycaemia and hyperglycaemia episodes” are an example of how the handbook further expands and extends the learning outcomes and provides a more in-depth student application to practice. This is not simply an extension of the theoretical component, but rather a standalone learning opportunity which allows hands on experience to further solidify the knowledge gained in the theoretical component. The following section aims to highlight the impact of the acute mental health nursing student handbook complied as part of this study.

5.3.2 Impact of the acute mental health nursing student clinical handbook: student perspectives.

As outlined above the clinical placement is not simply an extension of the theoretical component, but rather a learning opportunity in its own merit. Various authors (Andrews & Chilton, 2000; Dobrowolska et al., 2015) have identified that standardised guides for mentors are lacking. This study tries to address such a gap in the literature by compiling a pedagogical tool for mentors and a clinical guide for students. However, this had to be evaluated in order to establish if indeed the proposed handbook does have an impact on the students learning outcomes. Unfortunately, the validation of the final version of the acute mental health nursing student handbook by the mentors was not possible due to time limitations. The clinical placement

coordinator did receive some verbal feedback including positive comments and also suggestions which were taken on-board, from the mentors following the student's end of placement meeting. This highlights the need for further research incorporating the validation of the handbook by mentors. Results emerging from this study illustrate that student anxiety surrounding mental illness has decreased from the start of the placement to the end of the placement in the experimental group. The experimental group also reported a significant change from pre-placement to post placement regarding their preparedness for mental health and their course effectiveness. Therefore, these significant results imply that the acute mental health nursing student handbook does indeed contribute to better preparedness for students working within a mental health setting and most importantly contributed to strengthen the effectiveness of the course and reduced anxiety.

5.3.2.1 Preparedness for Mental Health

Contrasting findings have been reported in literature (Happell & Rushworth 2000, Wynaden et al. 2000, Surgenor et al. 2005, Henderson et al., 2007, Happell 2008b, Happell et al. 2008a,b, O'Brien et al., 2008) on the influence of preparedness in caring for an individual with a mental health condition and mentoring. Participating students were following a general nursing course which included a mental health component. Students were completing their mental health theoretical module in conjunction with their clinical placement, however the authors do not specify the use of any clinical handbooks or the allocation of a mentor. These authors highlight slight changes in preparedness from pre-to post placement however, no statistical significant results were obtained. Conversely, results in the present study report a statistical significance between the pre-and post-placement ($p=0.04$) for preparedness. Literature acknowledges that a supportive environment (Charleston & Happell, 2005; Papp et al., 2003) coupled with quality time spent with mentors (Happell, 2008a; Happell & Gough, 2009) are all contributing factors for a good quality mental health placements. This is further corroborated by Student K who commented, *"welcoming staff helped to enhance the placement experience"*. Similarly, student E said that *"…with the help of my mentor, I was supported and educated on the purpose of psychiatric nursing and how to care/ or help patients with mental health illness"*. This study further

extends present literature, that whilst acknowledging the environment and time spent with mentors are both contributors to quality mentoring, the addition of a handbook as a guide for both the student and the mentor to facilitate knowledge transfer, learning and clinical practice may also contribute to students perceiving better preparedness. Since both experimental and control group were exposed to similar environments and mentorship practices and as students were randomly assigned to both groups, the significant difference in preparedness may be attributed to implementation of the acute mental health nursing student handbook. This handbook also addresses gaps reported in extant literature, such as the addition of a resources section, including amongst others a link to the Diagnostic and Statistical Manual (DSM). This finding emerged from the work carried out by Gilje et al. (2007) in which respondents highlight the need of including documents such as the DSM in a resources section. The need for such resources is further corroborated by the majority (89%) of the mentors participating in this present study who highly endorsed the necessity of students having an understanding of the Maltese Mental Health Act (2012). Therefore, this document is also listed as a resource to further facilitate learning which students commented favourably upon. Moreover, an understanding about the Mental Health Act (2012) seems to have been achieved by students using the handbook as demonstrated by the following excerpts: *"I have become familiar with the Mental Health Act and the Mental Health Act's schedule in my time on the ward. I have also been taught about the different procedures between a voluntary and non-voluntary (sectioned) patient which bought about a different variety of legal forms and documentation"* (Student J) and " *by the end of the placement, I was able to have an understanding of the Mental Health Act (2012) with particular emphasis on Schedule 1,2,3,4,5,7,9. I was able to demonstrate awareness of the legal rights and responsibilities of both clients and staff as outlined in the Mental Health Act (2012)"* (Student B) and *"the mentors guided us very well on the Mental Health Act and how patient's admissions are on a voluntary and non-voluntary basis"* (Student L). The above student comments further validate the importance of the resource section in the acute mental health nursing student handbook as it provides easy reference to documents and resources used with in the acute mental health placement.

5.3.2.2 Anxiety Surrounding Mental Illness

Several authors (Bell et al., 1997, Happell 2000, 2001, Happell & Rushworth 2000, Mullen & Murray 2002, Stevens & Dulhunty 1997) report that when faced with individuals with a mental illness, nursing students most often experience fear and apprehension, which contributes to a distorted perception towards the clinical environment. One student in the present study commented that *"I found it a bit hard as a placement as I did not have any experience and background about mental health"* (Student G). This is further corroborated by several authors who add that the clinical practice adds a high degree of stress and anxiety (Admi 1997; Beck et al., 1997; Timmins & Kaliszer 2002; Watson et al., 2008). Higgins and McCarthy (2005), in their study that explored the experiences of having a mentor during psychiatric nursing students practice placement, it was highlighted that mentors played a key role in helping students to integrate and adjust to the placements. Although the work of Higgins and McCarthy (2005) only reflects the Irish perspective, it is significant to the Maltese scenario, as Ireland and Malta share very similar mentorship systems and also undergraduate nursing programme structures. These include the successful completion of an undergraduate mental health nursing course followed by mentorship training. Mentors are also employed by the education institution or health care or provider. Several authors further extend this finding by stating that mentors support can decrease students' anxiety (Gray & Smith, 2000; Phillips et al., 1996; Spouse, 1998). Studies investigating the effects of mentoring among general nursing students during clinical practice are also rare (Becker & Neuwirth 2002; Sprengel & Job 2004). Li et al. (2011) conducted a randomised control trial that investigated the nursing students' perceived level of stress before and after the clinical practice in a medical and surgical setting and the effects of mentoring on such stress. Whilst the experimental group had previous medical and surgical experience the control group did not have any previous medical and surgical experience. In the present study, a statistical significant decrease in stress and anxiety was reported from pre to post placement in both the experimental and the control group. This indicates that such difference may be attributed to mentoring. Conversely, present results illustrate that only the experimental group reported any statistically significant change from pre-to post placement for anxiety surrounding mental illness. This finding contrasts with the findings of Li et al. (2011), which indicate that mentorship alone decreases anxiety and stress. Although in both

groups the mean scores did improve from pre-to post placement, no statistical significance results are observed in the control group. This indicates that clinical mentoring and exposure to the clinical environment alone did not have any effect on the anxiety surrounding mental illness. Conversely, a statistical significant increase in mean scores from pre (M=4.53, SD 1.24) to post (M=5.41, SD 0.96) placement in the experimental group implicates that the acute mental health nursing student handbook contributes to a decrease in students' anxiety levels when caring for individuals with a mental health condition as this change was not observed in the control group. Student C commented that *"I feel I have grown doing my placement however I am ready to keep on improving on these skills to offer the best nursing care possible".* Higgins and McCarthy (2004) identify that encountering individuals with a mental health condition for the first time often provokes anxiety and fear in students, and this fear of the unknown and apprehension about meeting mentally ill people seems to be the major source of student anxiety (Higgins & McCarthy, 2004). Apart from acknowledging the important role of the mentor in guiding and supporting the students in the initial orientation, they also allude to the importance of allowing students active participate in the client's care as a major contributor to the reduction of anxiety. One of the participants reported that the mentor would not allow the student to carry out a skill unless the mentor felt that the student was actually capable of. This faith in the student strengthens the student's moral and perceived competency level. Higgins and McCarthy (2004) add that in an attempt to create a quality experience, mentors use several teaching strategies ranging from role modelling, discussion, questioning, challenging students to get involved and assume responsibility to facilitating students to reflect upon their practice. The concept of reflective practice, together with an in-depth list of learning outcomes, which facilitate the mentor's role in educating the student and the student's own involvement in care, such as, "formulate a care plan in collaboration with the client, based on short and long-term goals reflective on the client's own needs and concerns"; "critically think and use evidence-based research to generate alternatives interventions based on the information gathered; demonstrate the ability to take a history from the client and their relatives/primary carers, then identify which aspects needs prioritisation"; "assess for client's changes in mood, thought content, affect, behaviour, communication and speech"; "analyse information related to a client's medical history and presenting parameters including but not limited to blood pressure, pulse, respiration, blood investigations, drug and pregnancy

Screening"; "analyse information related to a client's social and psychological history including but not limited to substance misuse, abuse or trauma, difficulties with activities of daily living, housing, employment, financial situation, thoughts of self-harm and suicide ideations" to name a few, may contribute to the reduction of anxiety in students. Thus, it may be assumed that the inclusion of the acute mental health nursing student handbook to the current mentorship system may be inductive to a decrease in anxiety of students and also provide an overall better quality clinical experience.

This is in line with other research (Richmond & Foster, 2003; Williams, 1999), which report that evidence based training and attitude education has a direct influence on the behaviour when applying knowledge and skills. These findings also sustain the findings presented by Mullen & Murray (2002) who highlight that students with more theoretical guidance adapt better to the clinical environment than those with less preparation, in turn making better use of the clinical learning environment. Mullen & Murray's (2002) observations are in line with the primary aim of this study, as it strives to provide a better clinical experience for the nursing students during their mental health placement.

5.3.2.3 Course Effectiveness

In this study course effectiveness refers to the degree to which students have been prepared for the mental health area. Several authors report that the mental health component in nursing courses is limited and underrepresented, and increasing such component would result in a reduction of other modules (Clinton & Hazelton 2000, Bell et al., 1997, Farrell & Carr 1996, Happell 1998, 1999, 2000, 2001, Mullen & Murray 2002, Procter & Hafner 1991, Stevens & Dulhunty 1992, Stevens & Dulhunty 1997, Wynaden et al. 2000,). Happell (2008) recommend that undergraduate nursing courses must ensure that the quantity and quality of theory and clinical experience in mental health nurses is addressed. This is further corroborated by 91% of mentors participating in this present study who specifically outlined that students should have a clear understanding of what was covered in their undergraduate course at University. When course effectiveness was measured at pre-and post-placement a statistical

significant difference was reported only in the experimental group, that is, those having a copy of the acute mental health nursing student handbook. After randomisation, the distribution of both cohorts was still relatively homogenous, therefore such statistical result may be attributed to the only different variable, in this case, the use of the handbook. The handbook aims to bridge the clinical learning experience and allows for more guided and structured opportunity to practice and apply what has been learned in the theoretical component. This might be the reason why a significant result was observed only in the Course Effectiveness subscale in the experimental group. The control group although having the same theoretical knowledge as the experimental group did not have the handbook to guide them in a structural way to amplify what has been covered in their course and relate such knowledge into clinical experience and practice.

5.3.2.4 Negative Stereotypes

Lauber et al. (2006) defines stereotypes as false pairing of individuals and behaviours, and add that stereotypes may have devastating consequences due to false impressions being assumed. This study reports that in both the experimental and the control group there was a statistically significant reduction in negative stereotypes. Students B commented that *"this placement made me think about mental health illnesses and the importance of reducing the stigma associated with it"*. Further investigation of student's attitudes towards mental illness carried out by comparing the scores at pre-placement and post placement for the scenarios presented in the Attitudes towards Mental Illness Questionnaire (AMIQ) by Luty et al., (2006). The experimental group reported a statistically significant ($p<=0.001$) decreased attitudinal perception from a neutral stance towards the case scenario presenting a heavy drinker for over 5 years who is now going for treatment and has started attending Alcoholics Anonymous meetings when compared to the control group. Such findings may be attributed to the fact that relapse is very common in such cases and students might have encountered such situations during their clinical experience. Also, students might have encountered someone during detoxification and potentially aggressive due to the withdrawal symptoms. This might all potentially contribute to such a change in attitudinal view at post placement. This highlights that exposure to actual mental illness has an effect on the myths that surround it. This is further corroborated by Graham et al. (2020) who

add that registered psychiatric nurses are able to understand those with a mental health condition differently than those without the necessary skills and training, highlighting the importance of mentoring in the clinical area as a contributor to decrease stigma and lower anxiety. Mentors might have explained to the students the high relapse rates associated with such cases, and possibly the mentor's attitudes might not be positive towards such client groups, which might have also influenced the students. Baker et al. (2005) suggest that, self-destructive behaviour such as substance misuse, often gives rise to moralistic and stereotyping attitudes within health care professionals. Graham et al. (2020) report that comprehensive knowledge of mental health issues, and addictive behaviours influenced the values, beliefs, and attitudes that registered psychiatric nurses embody when they build therapeutic relationships and apply holistic care. Another possible reason might be the lack of preparation and skill to deal with such cases. The study programme for undergraduate nursing students following a Bachelor's Degree in Nursing lists a Mental Health Study unit, however it does not include topics on substance misuse nor stigma. Conversely, the undergraduate mental health nursing programme does include stigma and measure to reduce negative stereotypes, but does not include a module on substance misuse. Of note is that substance misuse module is in fact offered to those following the top up degree in mental health nursing. This highlights the need of including such modules/topics in both the mental health nursing and nursing undergraduate programmes. De Vargas (2012) outlines that lack of preparation to work with individuals with alcohol or other drugs issues will bring negative attitudes to the students when confronted with such clients. Present results corroborate with the emerging results from the studies conducted by De Vargas (2012), Rassool et al. (2006) and Rassool & Rawaf (2008), who report that students do not agree with the view that alcoholics are ill or weak, but rather as people without drinking limits, causing their own health problems and have no interest in taking care of themselves. These findings agree with another study carried out by Farnsworth & Bairan (1990) which also highlights evidence that nursing students have negative attitudes towards alcoholism, irrespective of such being considered as a disease or not. These views concur with further results outlined by De Vargas (2012) who report that students' rejection of alcoholic patients, also denotes a preference for not taking care of such client group. In an attempt to address these negative views, the acute mental health nursing student handbook specifically outlines skills effective for this specific client group, such as using alcohol withdrawal charts.

In fact, Student J reports that ... *I have also been able to successfully complete on alcohol withdrawal scales in the ward"*.

5.3.3 Assessing students

Literature outlines many challenges in evaluating and assessing nursing students (Bourbonnais, et al., 2008; Squiers, 1981; Wood, 1982). One of the main challenges is the subjective nature of the mentor's interpretation of the observed performance of the student Other challenges include objectivity, validity and reliability of an assessment method (Girot, 1993). Bray & Nettleton (2007) add that due to the dual role that many mentors normally assume, that is, as a mentor and as an assessor, conflict is inevitable. Although this study does not present any results arising from the assessment of students using the acute mental health nursing handbook, as this was not one of the aims of the present study, it can be a source which with minor changes can lead to a fair assessment of students, whilst overcoming the challenges outlined in the literature. Bourbonnais et al. (2008) suggests that rather than using either the traditional pass/fail system or a Likert scale system which rates the performance of each student, a two-category rating system is introduced, namely Satisfactory or Unsatisfactory. The Department of Nursing within the Faculty of Health Sciences, University of Malta already implements an online assessment system whereby the mentor rates the students' performance on a 5 point Likert scale based on 6 domains of practice. One of the strengths of the acute mental health nursing student handbook is that it enables reflective practice, which leads to the development of clinical competence and reduces the theory practice gap (Boud et al., 1985; Jarvis 1987; Powell, 1989; Mezirow, 1991; Murphy & Atkins, 1994). Hence, students have the opportunity at mid placement to reflect on their progress and identify any weaknesses or issues which can be further addresses or supported by the mentor for the rest of the placement duration. At the end of the placement the mentor can fill in an online form similar to the one used by the Department of Nursing, however marking the learning outcomes listed under the domains in the handbook and under the "Other Skills" section based on the two-category rating system suggested by Bourbonnais et al. (2008), that is, either satisfactory or unsatisfactory. In this study another category "not demonstrated" has been added as it must be acknowledged that certain learning outcomes might not be achievable during the currently placement. An example of this

is demonstrating effective de-escalation techniques or preparing a patient of an ECT, if none of these are situations occur whilst the students are on their placement. Each category will have a weight and when all the results have been computed a final score will be provided and a report automatically generated outlining the students' satisfactory/unsatisfactory performance on each competency/skill. If such a system would be incorporated, the students would know exactly which skills or competencies they would have not reached a satisfactory level, allowing them to revisit such skills in the following placements. This is in line with the argument brought forward by Bourbonnais et al. (2008), who stress that evaluation must be an ongoing and continuous process.

5.4 Conclusion

This study revealed that the acute mental health nursing student handbook is a contributor to clinical education and has proved influential on increasing the preparedness of students to work with individuals with mental health conditions. The handbook also serves to amplify better the theoretical teachings during the course as it has reported significant results for course effectiveness.

In conclusion, the acute mental health nursing student handbook seems to have also contributed to the reduction of perceived anxiety related to the acute mental health placement. Also, Maltese mentors report the need for such a framework that guides mentors but still provides individualized learning reflective to the needs of the students. Students did corroborate that the handbook was indeed useful in the attainment of competencies and skills as outlined by the various student comments. Recommendations for future education, research and practice together with the methodological issues, including the strengths and limitations of the study will be outlined in the following chapter.

Chapter 6: Conclusion and Recommendations

6.1 Introduction

The concluding chapter provides a comprehensive summary of the perspectives of nursing students and their mentors to quality mental health clinical placements, outlined in section 6.2. Section 6.3 provides realistic recommendations for clinical practice, education, management and future research to improve quality mentorship in Malta. Section 6.4 reports the methodological issues of the study, whilst Section 6.5 highlights the strengths and limitations of the study. In conclusion, Section 6.6 will present the concluding remarks.

6.2 Summary of the research study

It is acknowledged that mentorship supports students to develop competencies, self-awareness and self-confidence (Barkun, 2006; Koskinen & Tossavainen, 2003). Quality mentorship also contributes to the reduction of the theory-practice gap and facilitates the transition from a student to a practitioner, reducing anxiety and reality shock (Huybrecht et al., 2011). Extant literature corroborates that there are no formal rules, qualifications or requirements to practice as a mentor, with most requirements being set by the specific Universities or Higher Education Institutions (Dobrowolska et al., 2015). In Malta, those nurses who wish to serve as a mentor with the Department of Mental Health must either be a registered mental health/psychiatric nurse or a general nurse with 4 years' active employment within the Mental health field in the last 5 years. Findings from this study shed light on the importance of a clinical guide that supports and facilitates student learning and provides a standardised educational and evaluation platform for mentors.

The aim of this study was to develop a handbook, the acute mental health nursing student handbook and determine whether the use of this handbook has an impact on the quality of clinical mentorship and on an improved nursing student experience during the acute mental health placement. A mixed method QUAN(qual) embedded design was employed in this study, which included 3 phases.

Phase 1 of the study collected data from the mentors currently servicing the Department of Mental Health, University of Malta. In order to carry out such data collection, mentors were provided with a self-designed questionnaire divided into 3

sections, section A focused on the respondent's socio-demographic data and four general open ended questions relating to the current mentorship framework, key learning objectives, a typical day of mentoring students and the worst experience encountered by mentors whilst mentoring students. Section B of the questionnaire, asked the mentors to rate the importance/relevance of a series of competencies as learning objectives for students, listed under 9 domains. Section C of the questionnaire required the mentors to rate additional ancillary clinical skills on a 5-point scale. The results emerging from the mentor's feedback, mentors' responses regarding core mentorship skills and mentor's responses regarding ancillary skills, together with documents retrieved during the literature review guided the formulation of the Acute Mental Health Nursing Handbook in phase 2. The Acute Mental Health Student Handbook is a 46-page handbook consisting of 8 sections, namely, *Introduction; Placement Regulations; Domains of Competence; Competence Evaluation; Skills Checklist; Resources; Glossary of Terms* and *References*. Once the handbook was compiled, the third stage commenced which investigated the impact of the handbook within the clinical practice scenario. Phase 3 of this study consisted of two parts occurring concurrently, namely the experimental phase (phase 3A) and the reflective phase (phase 3B). Phase 3A, involved the administration of two questionnaires namely the Mental Health Education Survey (Happell, 2008b,c) (part 1 at pre-placement and part 2 at post placement) and the Attitudes to Mental Illness Questionnaire (Luty et al., 2008), also at pre-and post-placement, for students having their acute mental health nursing placement. Phase 3B, consisted of the evaluation of the student and mentor's reflections reported in the Acute Mental Health Nursing Student Handbook and which were conducted throughout the intervention.

Overall the Acute Mental Health Nursing Student Handbook tries to address the limitations outlined in literature and by mentors. Limitations outlined in literature are addressed by including resources available for students, such as links to the Maltese Mental Health Act (2012), Patient's Carter and the Data Protection Act (2018) to name a few. Also, the handbook includes a comprehensive glossary that allows the students to familiarise themselves with new terms. Such sections are not often found in similar documents. The handbook also tries to address the limitations expressed by mentors such as the importance of key learning outcomes and skill competency. These have been addressed in view of identified literature by developing the 8 domains of practice,

with specific learning outcomes pertinent to each of the domains. An example of such key learning outcomes developed to address the mentors concern that students do not have any concept of boundaries was addressed by including the learning outcome "define boundaries and articulate their implications within a clinical setting". The handbook also allows the students to reflect by conducting reflective evaluation. This is a unique aspect of the handbook, which promotes individualized learning. Reflecting writing aids students identify their tacit knowledge together with the gaps in that knowledge. The reflective process also allows for the evaluation of the student's skill competency level based on their own experiences, resulting in an improvement in skill acquisition and better future approach to similar experiences. It also highlights rhetorical and writing process decisions that can focus subsequent revision or learning, and most importantly encourages growth as a professional (Zubizarreta, 2009). Results also indicate that those students who were provided with the handbook experienced more favourable attitudes post-placement on the following domains: (i) preparedness to care for individuals with mental health issues; (ii) a reduced anxiety surrounding mental health and (iii) a feeling that their course prepared them adequately to the mental health field, thus bridging of the theory practice gap. Local mentors also report the need for such a framework, which this study attempts to address. Student and mentors' comments outline that the acute mental health nursing handbook together with the support and teaching of the mentors and other clinical staff has aided in the understanding of complex mental health issues, gaining competence is mental health skills and facilitated the relationship between the mentor and the student. The acute mental health nursing handbook includes competencies outlined in similar documents as used in countries such as UK, Ireland and Canada whilst reorganising them into 8 domains of competency which follow the academic components taught in the undergraduate mental health nursing students such as, Foundations of Mental Health Nursing 1 and 2 which focus primarily on assessment, care planning and building a therapeutic relationship, thus bridging the theory practice gap commonly reported in literature. The handbook also contributes learning outcomes which have not been previously identified in other similar documents. These include infection control practices; preparing and caring for a client underground electro convulsive therapy (ECT) or transcranial magnetic stimulation (TMS), whilst encouraging the students to familiarise themselves with the actual documentation used in practice. Also this handbook promotes learning by reflection which as previously

outlined, allows for the advancement in the conceptual level of thinking of an individual, which empowers the individual to change and improve. Thus, reflective practice incorporated within the acute mental health nursing student handbook, allows for nursing students to advance their thinking and improve their practice.

6.3 Recommendations for clinical practice

This section provides a series of recommendations based on the findings of this study. The recommendations presented are targeted to future research and clinical practice, education and policy.

6.3.1 Recommendations for clinical practice, education and policy

The following recommendations for clinical practice are being suggested:

It is being recommended that the Acute Mental Health Nursing Student Handbook is introduced as an official document in both Mental Health and Nursing undergraduate courses as a learning tool for students conducting the acute mental health placements.

Mentors must inform the allocating department of any planned absence beforehand so as to avoid allocation of students to mentors who will not be present, ensuring that students are never on a mental health placement unsupervised by a mentor.

Students should work with their mentors at all times, thus a change in the logistics of allocations is being put forward. Since students have both theoretical and practical session concurrently, and most mentors work on shift basis it is impossible to have students always mentored by the allocated mentor. A possible solution to this issue is that placements are carried out in bulk, thus the student would have a period in which the theoretical aspects are covered and then followed by a block of clinical placements. This also address the concern raised by mentors that students should be aware of the theoretical aspects before starting the placements. Similar block placements are used by Universities in Finland, UK and Germany.

It is also being recommended that an online assessment system is implemented based on the continuous learning approach, in which the mentor identifies the skills within the acute mental health nursing student handbook, that have been attained by the student and those that still require further development, in addition with a plan of

action that is negotiated between mentor and student.

In line with International standards, a mentorship license should be created certifying the competency of the particular individual to act as a mentor. This license should be renewed after a period of 3 years based on the successful completion of training workshops and seminars offered by the Department of Mental Health, student evaluation reviews, link lecturer's appraisal and an interview. Such an interview would determine the aptitude of the individual to mentor and assess the continuous development of the mentor.

It is recommended that all mentors receive training on the use of the acute mental health nursing student handbook, prior to the introduction of the handbook as an official document in both Mental Health and Nursing undergraduate courses.

Mentors should participate in biannual training workshops/seminars, as part of their continuous professional development and in order to renew their mentor's license if this is introduced.

It is recommended that mentors continue to contribute to further develop the handbook by identifying areas of development.

It is recommended that students receive in depth briefings of the mentorship system, the use of the Acute Mental Health Nursing Student Handbook and other general placement information well in advance of the commencement of the placement. This would serve to familiarise them with the upcoming placement, clarify any difficulties, reduce anxiety and make the best use of the placement experience.

Results indicate that students struggled in carrying out their reflections. Reflections at times did not demonstrate an in-depth exploration and examination and remained at a superficial level. Thus, it is being recommended reflective writing and reflective practice is included in the undergraduate nursing programmes and also prior to the commencement of the clinical placements students would have sessions on how to conduct a reflection discussing various categories within the cognitive domain such as application, synthesis, evaluation and recall.

A substance misuse module should be included in the undergraduate mental health nursing programme and the topic of substance misuse should be included as part of the mental health module in the nursing undergraduate programmes.

6.3.2 Recommendations for future research

Although results are promising, further research is needed to identify the benefits of the Acute Mental Health Nursing Student Handbook. It is being recommended that a longitudinal study, with a larger sample size possibly using a coded response system that would allow pair wise comparisons of student responses be introduced. Due to time limitations, this was not possible in the current study.

The researcher tried to make the Acute Mental Health Nursing Student Handbook as comprehensive as possible, however it must be acknowledged that further validation studies are required to further identify new areas of development to be included within the handbook.

A mixed method study is being recommended that investigates the mentor's preparedness and perceptions related to mentoring, perceived support required by mentors and where relevant and possible these can be targeted by the department of mental health.

An in-depth qualitative study is being recommended that investigates the perceptions of students before the start of the mental health placements and at the end of the placement. This would further shed light on the findings reported in this study, whilst identifying areas that need development.

6.4 Methodological Issues

Throughout the process of conducting this study, several methodological issues have been encountered. This study made use of a QUAN(qual) embedded design mixed-method design, which employed three phases. The methodological issues will be described in relation to the corresponding phase.

During Phase 1 of the study quantitative data was collected using both closed and opened ended questions in a self-devised instrument. This posed one of the major

methodological challenges, as although the questionnaire was based on existing literature, it was not previously validated. The questionnaire was intended to identify which competencies and clinical skills are deemed important by mentors whilst a student is on an acute mental health placement. The entire mental health mentor population was recruited which is a strength of the study, but when compared to the number of mentors cited in other studies the number of Maltese mentors working within acute psychiatry is relatively low. The mentor's level of experience, both as a clinician and as a mentor varied significantly, which might have influenced the results. Also, a potential methodological issue is that mentors might have answered more favourably in an attempt to showcase their proficiency, considering that mentorship of students is remunerated. A possible suggestion to overcome this issue is by having the students evaluate their satisfaction with the mentoring.

Phase 2 consisted of the compilation of the Acute Mental Health Nursing Student Handbook. This proved rather challenging mainly due to the fact that concepts within mental health are not isolated but link together. Thus, the main challenge was to analyse the data emerging from phase 1 and compile it in a manner that avoids repetition and is reflective of the domain of practice. Also, although the utmost care was employed to identify the terms highlighted in the glossary and the resources page for students, this might not be comprehensive. On hindsight, copies of the psychometric and evaluation tools such as the Beck's Depression Inventory (Suhr, 2015). (available within the public domain) mentioned in the learning outcomes could be included in the acute mental health nursing student handbook.

Phase 3 consisted of two parts, namely the quantitative phase (3A) and the reflection phase (3b). Both these phases occurred concurrently. One of the major methodological issues with the quantitative phase is that data was collected from one acute mental health placement due to time restrictions. Ideally data collection would be repeated during the course of a year or more. Acute Mental health placements are structured once per semester, giving a potential participation and data collection over the course of an academic year from 3 cohorts of students. The limited time for data collection might have influenced the study findings. Although a brief overview of the acute mental health nursing student handbook was given to the students in the experimental group after randomisation, this might not have been exhaustive for all the students.

Students in the control group might have seen or obtained a copy of the handbook from the students in the experimental group, although explicitly instructed not to do so.

Another methodological issue that needs to be highlighted is that all mentors had a copy of the handbook. Following a training session organised by the Department of Mental Health, the handbook was introduced and a copy given to all mentors, in view of the present study. Mentors were informed to only use the handbook with students who present for their placement with a copy of the handbook, i.e., the experimental group. This occurred as the randomisation process could not be carried out before the mentor's training session due to student allocation procedures. Therefore, although specifically informed not to make use of the handbook unless with students forming part of the experimental group, one cannot exclude the possibility that a mentor might have referenced the handbook during the placement.

The reflection phase (3b) provided the most relevant feedback on the application of the acute mental health nursing student handbook in practice. A major issue within this study is that the reflection failed to include a direct evaluation of the handbook as a learning tool by both the student and the mentor. The reflections of students focused on the progress in attainment of the learning outcomes by students, which is the primary aim of the handbook, however since this was the first time that the acute mental health nursing student handbook was tested, a separate evaluation form would have benefitted the study. Also, a reflection form to be completed by the control group would have also benefited this study as comparisons between the student's reflections in the experimental and control group would have been possible.

6.5 Strengths and Limitations

When interpreting findings, it is important to take into consideration its strengths and limitations which are further discussed in the following sections.

6.5.1 Strengths

The study has several strengths which should be acknowledged. The main strength of this study is that it is the first of its kind to investigate the mentoring system within the acute mental health setting from a local perspective. It is also the first to attempt to

develop a learning instrument which facilitates clinical learning within an acute mental health setting. Although it might not be conclusive, it provides a start for further research and development of such a document. The study also recruited all the mentors employed by the Department of Mental Health.

The use of a mixed method embedded study ensured a broader and in-depth perspective of the research question. In such a method, both quantitative and qualitative data are collected simultaneously, reducing time and resources, whilst taking advantage of the strengths of both quantitative and qualitative data. A mixed method embedded design also helps to offset possible weaknesses inherent to the predominant method, in this case the quantitative aspect.

This total population survey design coupled with a high response rate of participants strengthened the generalisability of the results in relation to the local situation. Another valuable aspect of this study is that having all the questionnaires employed in the various phases of the study, distributed and collected by intermediaries ensured anonymity and confidentiality, and allowed for participants to express their views freely. This was especially important as the researcher is a nurse working in a mental health hospital and also served as a mentor.

The study achieved a 100% response rate at pre-placement and achieved a very high response rate of 83.7% at post-placement.

This study contributes to the limited studies investigating the effects of mentoring among general nursing students during mental health clinical practice, by reporting findings from Malta. Studies available were mostly carried out in Australia, thus these finding extend the European perspective.

A strength of this study is the adoption of a randomised control trial to investigate the effect of the acute mental health nursing student handbook. An RCT is the only study design that is able to establish causation, and limit all sorts of bias, including selection bias. To the researcher's knowledge this is the first RCT being carried out locally that investigates ways to improve mentoring within the mental health nursing field.

A further study strength is that the randomisation ensured that the results were due to the intervention and not the presence of confounder variables between both groups. Also the randomisation process was not carried out by the research, once again safeguarding confidentiality and anonymity. The research never had any contact with either mentors of students recruited in the study. The research instruments used in the quantitative phase (i.e., phase 3A) were all previously validated on nursing students and have achieved good internal consistencies. Finally, this study has undergone ethical review and received all the necessary approvals.

This study further extends international literature by providing a clinical handbook for nursing students specifically related to their acute mental health clinical placements. It also provides an insight of the impact of this handbook on the perceptions and attitudes of students towards mental illness. This study also showcases the importance and need of reflective practice in mental health nursing.

Whilst acknowledging the strengths of this study, the study limitations must also be reported.

6.5.2 Limitations

It must be acknowledged that this study did not come without its limitations. A major limitation of the study was the limited time available to collected data. Due to the design of the study, data from students had to be collected before the start of the placement and at the end of the placement. This resulted in only one viable cohort, which may limit the findings.

The possibility of students within the control group of obtaining a copy of the handbook could have influenced the results. Similarly, mentors might have made use or referenced the handbook whilst mentoring student forming part of the control group.

An evaluation of the handbook as a learning instrument that facilitates clinical learning was not included, thus the outcomes of the handbook could only be measured from the reflective process on the attainment of competencies by students, and the changes from pre-and post-placements between the experimental and control group. A further

section directly asking for feedback on the handbook as a learning instrument would have benefitted the study. Another limitation of the study is that the mentor's level of experience, both as a clinician and as a mentor varied significantly, which might have influenced the results.

In the third phase (3A) of the study, which asked students to complete the questionnaire package at both pre-and post-placement, an attrition rate of 16.3% was reported. This might have influenced the results.

No reflection form was given to the control group, thus comparisons between the student's reflections between the experimental and control group were not possible.

6.6 Conclusion

This study contributes to previous literature by highlighting the importance of clinical mentorship in the formation of student nurses. The acute mental health nursing student handbook addressing gaps within the local mental health clinical placements, by providing a guiding framework to both the mentor and mentee. The use of the acute mental health nursing student handbook during the acute mental health placement has reported better student preparation to care for individuals with mental health issues, reduced the student's anxiety surrounding mental health and amplified the theoretical knowledge linking it to practice, thus bridging the theory practice gap. This study was the first of its kind locally which attempts to create a tool that can be implemented in practice, contributing to the development of more competent and skilled nursing professionals. The recommendations outlined above are being proposed to further strengthen and provide the best quality mentorship possible. Although the author acknowledges that logistical limitations do exist, such as the limited number of wards and qualified mentors, every effort should be adopted to continue and research mentoring and identify ways of improving it, as failing to do so might pose the high risk of having unskilled and inadequately trained future nurses.

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Appendixes

Appendix A

ACUTE MENTAL HEALTH NURSING STUDENT HANDBOOK

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The capacity to learn is a gift, the ability to learn is a skill, the willingness to learn is a choice.

BRIAN HERBERT

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ORIGINAL
Spirit
LAMAL

CONTENTS

INTRODUCTION

The Acute Mental Health Nursing Student handbook is being introduced to facilitate a better clinical experience and maximise the learning opportunities during the acute mental health nursing placement. Clinical placements are core components of any nursing programme, shaping the development and practice of knowledge and skills in preparation for the realities of the working life. This handbook specifically focuses on the acute mental health placement, which provides many learning opportunities potentially not available in other placements. Thus, in order to make this handbook as factual and relevant to the acute mental health placement, data was collected from the mentors in order to identify the core domain competencies which should be acquired during this specialised placement. This handbook provides a guide to the student and a structure for the mentor in order to attain the outcomes set for each domain in this handbook. It also sets a standard level of competency which must be achieved with the guidance and support of the mentors. The handbook is divided into 7 sections, namely Introduction, Placement Regulations, Domains of Competence, Competency Evaluation, Resources, Glossary of Terms and References. Please read thoroughly through each section and discuss with the mentor ways to showcase that the level of competency within each domain has been achieved. It is important to reflect and relate theory to practice, use critical thinking skills, reflective skills and observe attentively. When in doubt always seek assistance from the mentors.

Mentors have a vital part in the pre-registration nursing training as they help to establish a positive environment for learning and encourages personal and professional development. The role of the mentor focuses on 3 stages, that is, at the beginning of the placement where the mentor focuses on the integration of the student within the new environment, identify and discuss the core domains of competency and strategies to attain them. During the duration of the placement, the mentor acts as a role model by teaching the student skills, reflecting the core domain competencies outlined in this handbook. At the end of the placement the mentor should be able to discuss the experience, progress and skill achievements with the student in relation to the predetermined domain objectives.

On the other hand, the students must familiarise themselves with this handbook, recognise the importance of the clinical placements and ensure that they act professionally at all times, with an attitude to learn and improve but working under the guidance of their mentors to attain the goals outlined within this handbook. Last but not least students are encouraged to familiarise themselves with their central role in maximising their learning experience during the placement. This includes self-directed learning, discussion and integration within the clinical environment and interaction with their mentors, relevant members of staff, clients and their relatives.

PLACEMENT REGULATIONS

Professional Appearance

Students must present themselves in a neat and professional manner. Students are expected to wear their uniforms in most wards or units although there are some exceptions. Name badge must be worn at all times. Jewellery must be kept to a minimum i.e. wedding rings and one pair of stud earrings. Body piercing jewellery other than earrings must be removed (preferable) or covered at all times.

Students must secure their hair off the shoulder and away from the face. Facial hair such as beards and sideburns must be neat, clean and well-trimmed. Fingernails should be clean and in length that does not interfere with work. Nail polish, artificial/gellish nails are not acceptable in the clinical area. Moderate use of make-up, perfume, colognes and/or shaving lotions is allowed.

Any pens, scissors, torches should not be carried out in outside breast pockets, as they may cause injury or discomfort to patients during care activities. Such items should be carried inside clothing, in hip pockets or pencil cases.

Conflict of Interest

Students must declare any conflicts of interest such as working with family members / significant others or the admission of family or friends into the area or ward where s/he is working. If this occurs the student needs to notify the Nursing Officer and his/her University Placement Co-ordinator so that immediate steps can be taken for the student to complete the placement in another area.

Confidentiality & Boundaries

Privacy and the protection of health information for patients is a serious issue and one which students need to be aware of when undertaking clinical placements. Any form of photocopying or photographing of patient information is not permitted. Confidential information should not even be divulged at any time even during university based learning. When discussing or writing about cases or incidents with teaching staff or peers, students must not divulge any information that could identify the patient in any way. Students also need to be aware that confidentiality still applies after they have left the placement area and even after they have finished their University course. If there is any doubt whether a piece of information is confidential or not, it should be assumed to be confidential until it is otherwise defined. Professional boundaries should be respected at all times.

Therapeutic Relationship

The student must assume responsibility for ensuring that all relationships in a clinical area are therapeutic and professional and that professional boundaries are maintained at all times. It is inappropriate to share your telephone number, address etc., divulge other personal details or add patients on social networking sites.Patients must be treated with respect and should not be placed in situations which may cause them to feel embarrassed or offended. Patients are under no obligation to take part in teaching activities and their consent must be obtained before the student takes part in their care.

Absence

Sick days: If a student cannot attend the placement due to sickness, s/he needs to inform the Nurse in Charge of the ward and the University Placement Co-ordinator. A sick leave certificate covering sickness that lasts 1 day or more needs to be provided.

Planned absence: If the student has a valid reason for missing placement days, they need to inform the Nurse in Charge of the ward and the University Placement Co-ordinator, at least 2 days before the planned absence.

To change placement days: Permission needs to be sought from the Nurse in Charge of the ward and the University Placement Co-ordinator.

Please note that students cannot move to other areas other than to the one assigned to by the University Placement Co-ordinator. Night duties are only allowed when instructed by the University Placement Co-ordinator.

Mobile phones

Mobile phones must be kept on silent mode at all times during placements. Frequency and duration of personal calls should be kept to a minimum during placements. No calls should be made or received during patient interactions. At absolutely no time should a student allow a patient to use his/her mobile phone or any other device to take photographs within the hospital wards, areas or grounds (unless permission is obtained from the Hospital's Authorities and University Placement Co-ordinator). The use of social media such as Facebook and Twitter should not be accessed during placements.

Pregnancy

Students are to inform the university placement co-ordinator immediately once becoming aware that they are pregnant, to ensure their own safety while undertaking activities in a clinical setting.

Smoking

Students are not permitted to smoke at any time in the company of patients. Some wards / units may have designated smoking areas but generally students may only smoke outside. It is not acceptable to leave the ward to smoke unless it is in the official break time.

Gifts and favours from or to nursing students

Student nurses are not permitted to give or accept cash, gifts or 'favours' from or to patients or their relatives.

DOMAINS OF COMPETENCE

GUIDELINES

At the begining of the placement it is encouraged that a preliminary meeting between the student and the Mentor takes place. During this meeting it is recommended that the student discusses with their mentor the learning outcomes presented in the 8 domains of practice. A notes page is also included for students to wirte any diffiulties they wish to discuss with their mentor at a later stage.

A learning startegy is then formulated and overseen by the mentors. A formal evaluation of the progress of the student will be conducted at mid-placement based on the student's reflections and the mentor's overall observtions and feeback. Any issues hindering the learning process should be addressed at this stage and an action plan formulated.

At the end of the placement, the mentor will evaluate and mark on the degeee of attainment of each learning outcome based on the following criteria:

Satisfactory - ✓

Not Demonstrated - NA

Unsatisfactory - ×

THERAPEUTIC RELATIONSHIP

The therapeutic relationship (also known as therapeutic alliance, the helping alliance, or the working alliance) refers to the relationship between a healthcare professional and a client (or patient). It is the means by which a nurse and a client engage in order to effect beneficial change. This nurse–client relationship can be defined as an "ongoing, meaningful communication that fosters honesty, humility, and mutual respect and is based on a negotiated partnership between the patient and the practitioner" (Krauss, 2000, p. 49). The therapeutic relationship is a core component of all mental health care interactions that facilitate the development of positive nurse–client experience. This type of relationship is based on mutual trust and respect, the nurturing of faith and hope, being sensitive to self and others, and assisting with the gratification of the client's physical, emotional, and spiritual needs through knowledge and skill (Pullen & Mathias, 2010).

LEARNING OUTCOMES

- Communicate effectively and demonstrate the ability to conduct a therapeutic conversation with clients having a mental health condition.
- Differentiate between verbal and non-verbal communication skills and be able to demonstrate both types of communication skills effectively, including active listening, use of open-ended questions and paraphrasing, eye contact, facial expressions, tone of voice, body language and posture.
- Articulate appropriate clinical terminology (example: inebriated instead of the term 'drunk').
- Demonstrate a non-threatening, empathic and non-judgmental attitude and approach.
- Define boundaries and articulate their implications within a clinical setting.
- Demonstrate an ability to identify barriers limiting effective communication, trust and therapeutic engagement (example: paranoid ideation).
- Define Transference and Countertransference and their implications within a clinical setting.
- Evaluate student's own non-verbal's and understand the implications of such to the service users.
- Describe and apply a Person-Centered Care Approach in practice.

ASSESSMENT

Nursing assessment is the first step in the nursing process. Nursing assessment is the gathering of information about a client's physiological, psychological, sociological, and spiritual status by a licensed registered nurse (Kozier, 2008).It also includes the assessment of the client for changes in mood, thought content, affect, behaviour, communication, speech, substance use, risk assessment, history of abuse or trauma and difficulties in coping with activities of daily living (Boyd, 2008).Nursing assessment is used to identify current and future client care needs (Giger, 2016). During the assessment process a number of psychometric tools may be used in order to gather objective and relevant information related to the presenting case.

LEARNING OUTCOMES

- Discuss the relevance and importance of conducting an in-depth client assessment as the foundation of person-centred care delivery.
- Demonstrate the ability to take a history from the client and their relatives/primary carers, then identify which aspects needs prioritisation.
- Assess for client's changes in mood, thought content, affect, behaviour, communication and speech.
- Analyse information related to a client's medical history and presenting parameters including but not limited to Blood Pressure, Pulse, Respiration, Blood Investigations, Drug and Pregnancy Screening.
- Analyse information related to a client's social and psychological history including but not limited to substance misuse, abuse or trauma, difficulties with activities of daily living, housing, employment, financial situation, thoughts of self-harm and suicide ideations.
- Recognise client progression or regression and differentiate between sociological problems and psychological needs.
- Co-ordinate and collaborate with other Mental health professionals for a complete and thorough assessment.
- Define and demonstrate under supervision a Mental State Examination including appropriate documentation and relevant nursing action.
- Identify and measure specific psychiatric symptoms using psychometric rating scales including but not limited to Beck's Depression Inventory, Broset Violence Checklist, GAD-7, Mood Disorder Questionnaire, Brief Psychiatric Rating Scale, Drug Use Questionnaire, SQUARE, Edinburgh Postnatal Depression.
- Recognise signs of neuroleptic malignant syndrome (NMS) and lithium toxicity

CARE PLANNING & COORDINATION

Care planning and coordination synchronizes the provision of care from various specialists (Ehrlich et al., 2009). Care planning and coordination involves discussion, negotiation and taking decisions between the multidisciplinary team and the client in order to define targets and identify strategies and services to attain such targets ultimately improving the client's health outcomes (Boyd, 2008). Proper care planning and coordination would result in a care plan which facilitates standardised, client-centered and holistic care (Sidani & Fox, 2014). Care plans are a legal document and a tool that prioritises the needs of the clients whilst providing continuity and quality care. Care planning focuses on 3 stages, namely, the immediate or short term, the mid term and the long term goals reflecting the client's own needs.

LEARNING OUTCOMES

- Analyse the information gathered through the assessment, observation and monitoring to identify the client's presenting needs and formulate a nursing diagnosis.
- Discuss the nurse's role in constructing a nursing diagnosis and the principles of care planning.
- Differentiate between the medical diagnosis and the psychiatric diagnosis however address them holistically.
- Discuss the scope and function of a care plan.
- Formulate a care plan in collaboration with the client, based on short and long-term goals reflective on the client's own needs and concerns.
- Monitor and evaluate for progress or regress of the patient according to the care plan milestones.
- Evaluate the importance of including the client and his/her caregivers (if client consents) in the care plan whilst collaborating with other professionals of the multidisciplinary team.
- Demonstrate handover skills between the parties (members of the MDT).
- Critically think and use evidence-based research to generate alternatives interventions based on the information gathered.
- Describe the admission process.
- Demonstrate appropriate collaboration and interaction with both formal and informal carers and other professionals.
- Discuss the impact of a client's social situation on their mental state (e.g. unemployment).

NURSING INTERVENTIONS

A nursing intervention consists of any act carried out by a nurse that implements the nursing care plan or any specific objective of that plan (Boyd, 2008). Nursing interventions are the actual treatments and actions that are performed to help the client reach the goals and targets set in collaboration with the multidisciplinary team. The nurse uses knowledge, experience, clinical judgment and critical-thinking skills to decide in collaboration with the client which interventions will attain the set goal/target identified in the assessment stage of the nursing process. Some examples of nursing interventions include psychotropic education including potential side-effects, dealing with aggressive behaviour, group therapy sessions and one to one sessions with clients.

LEARNING OUTCOMES

- Demonstrate knowledge about the different mental health conditions and understand the principles or concordance, compliance and treatment alliance.
- Assist clients with a mental illness to clarify treatment goals, develop living skills reflective of their abilities and according to their level of understanding.
- Differentiate between institutionalisation and deinstitutionalisation.
- Name the barriers in reaching treatment goals (example: lack of insight).
- Educate clients about their condition, medications, side-effects, relapse prevention, relative support and available services in a language and at a level that the client can understand.
- Demonstrate knowledge of medications, their side-effects and indications/consideration of use, especially but not limited to anti-depressants, antipsychotics, anxiolytics and mood-stabilizers.
- Administer and record medications including but not limited to oral, ear, eye, topical, rectal vaginal, sub-cutaneous and intramuscular medication.
- Demonstrate knowledge about the dangerous drug act, the psychotropic drugs listed under this Act (including dosages) and the DDA protocol.
- Describe insulin indications, documentation, dosage, storage, hypoglycaemia and hyperglycaemia episodes.
- Formulate a SWOT analysis with the client.
- Showing an understanding of group dynamics including conflict and hindering factors.
- Plan and conduct effectively under the supervision of the mentor a Group therapy session and a One to One session with a therapeutic aim.
- Participate in case reviews, give relevant feedback to the multidisciplinary team and liaise with other professionals to ensure an effective care plan.
- Perform a neurological observation and specimen collection including but not limited to urine.
- Measure and record height, weight, Blood Pressure, Pulse, Temperature, SpO2, Respirations including appropriate documentation, charts and awareness of normal and abnormal ranges.
- Monitor of clients during seclusion and/or raised level of supervision including an understanding of related documents.
- Prepare, monitor and care for a client prior to, during and after an ECT/TMS including the necessary documentation and consent.
- Demonstrate Infection Control practices including but not limited to handling and disposing of sharps.

MANAGING PSYCHIATRIC EMERGENCIES

The American Psychiatric Association (1994) defines Psychiatric Emergency as "a situation that includes acute disturbance in thought, behaviour, mood, or social relationship that requires immediate intervention as defined by client, family or social unit" (Ward, 1995, p.5). A psychiatric emergency is an urgent situation which may arise repeatedly requiring immediate action. Psychiatric emergencies encompass situations in which individual acts in a manner that is dangerous to himself/herself or to others. The client may either be aware or may lack insight of the danger his/her behavior poses. Even if the patient perceives that his/her actions are dangerous, s/he may be inclined to engage in these behaviors despite the risks. Mental Health emergencies mostly occur when the person's coping mechanisms fail, putting the person's life in serious risk. The client is often extremely agitated, distressed, may display poor judgement and irrational behaviour and places himself and others at risk.

LEARNING OUTCOMES

- Differentiate between a medical emergency, crises and a psychiatric emergency.
- Identify escalating behaviours and contributing factors leading to client escalation, whilst expressing themselves in a safe environment.
- Demonstrate awareness of different risk assessment tools, such as, "SQUARE" and be able to identify and conduct the most appropriate in the presenting situation, including client risk assessment and environmental risk assessment.
- Demonstrate knowledge of de-escalating techniques and engagement, chemical and physical restraints measures.
- Discuss theoretical concepts related to safety and risk management to the clinical setting, using clinical judgement.
- Identify safety issues when dealing with any kind of emergency.
- Avoid being in danger or place someone else in danger when addressing an emergency.
- Observe how qualified staff manage verbal or physical aggressive patients.
- Discuss with your mentor other possible resolutions to any emergency management.
- Trigger an emergency response if in difficulty whilst always aware of own limits, boundaries and emotions.
- Demonstrate knowledge of the Zero Tolerance policy.
- Identify appropriate documentation to report the incident.

ETHICAL ISSUES

Ethical issues are defined as problems or situations that require a person or organization to choose between alternatives that must be evaluated as ethical or unethical (Runciman, Merry & Walton, 2017). Beauchamp and Childress (1983, p. 149) distinguish two aspects of beneficence, that is, providing benefits (which include preventing and removing harm) and balancing benefits over harms. Medical ethics is based on a set of values that health care professionals can refer to in case of conflict or confusion. It is imperative to respect a client's autonomy, and provide care which is based on the core values of non-maleficence, beneficence, and justice. Thus, it is imperative to care of clients and provide interventions which respect the person's rights, autonomy and dignity irrespective of their diagnosis, gender, sexual orientation, ethnicity, religion, social status and cultural background.

LEARNING OUTCOMES

- Provide interventions that respect the client as an individual and as an autonomous human being with his/her own rights and dignity, irrelevant of his or her diagnosis, gender, sexual orientation, ethnicity, religion, social status and cultural background.
- Demonstrate moral and ethical behaviour with clients
- Differentiate between the Maltese Code of Ethics and Patient Charter.
- Demonstrate awareness of the different needs of the clients being religious, sexual or cultural and be able to adapt to such needs in a moral and non-conflicting way with a non-judgmental and non-discriminatory attitude.
- Respect client confidentiality.
- Identify the ethical implications of conducting nursing interventions such as, one to one and group sessions.
- Refrain from giving personal information outside the remit of the clinical environment, whilst being assertive and able to maintain professional boundaries.
- Discuss ethical dilemmas encountered within the clinical setting. Refrain from using offensive, degrading or discriminatory comments.

EDUCATION & RESEARCH

Mental health is crucial to the well-being of individuals, societies and countries. Ongoing education is also needed to assist nurses to further develop their knowledge and skills, foster changes in attitudes and beliefs and reorient them from custodial models of mental health care to patient-centered care that enhance recovery. Students are expected to keep up to date with the latest research, new developments within the mental health field by making use of resources such as journals, online resources and the library.

LEARNING OUTCOMES

- Demonstrate the latest research and developments within the mental health field by reading related articles in journals and/or online resources.
- Demonstrate self-directed learning
- Question and discuss any difficulty or query with the mentor.
- Conduct additional reading on areas highlighted by the mentor, and discuss any difficulties or queries that may arise.
- Compile a portfolio of work highlighting clinical cases, experiences, activities and difficulties encountered during the clinical setting.
- Act as a role model and promoting mental health wellbeing by being professional, portray a positive attitude, lead a healthy lifestyle and be conscious of self-care practices.
- Engage in activities that promote education, break myths surrounding mental illness, reduce stigma and support those with mental health issues in the clinical setting and beyond.
- Demonstrate the ability to identify and recognise common misconceptions in mental health, and provide adequate education to counter them.
- Empower clients to pursue realistic life goals, independency and decision making.
- Assist clients to take an active part in their community as well as be involved in mental health awareness and promotion events.

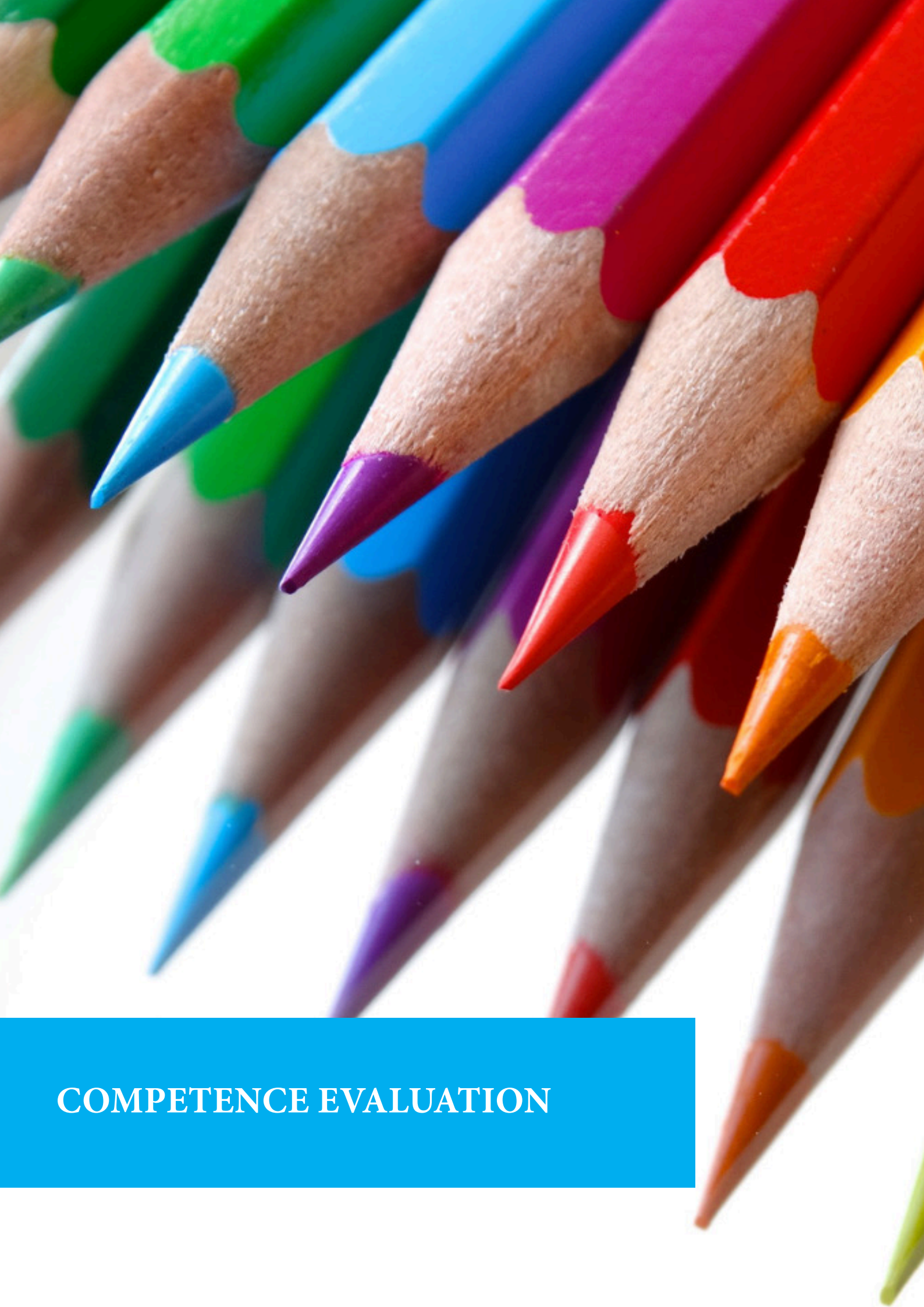
LEGAL IMPLICATIONS

Safe nursing practice requires an understanding the legal framework within the local health system. Understanding the legal implications of nursing practice demands critical reasoning skills to protect the client's rights as well as the nurse from liability. Society expects safe health care delivery, especially from nurses who are typically perceived as the most trusted profession. As client care practice improve and new developments in health care technologies emerge, the principles of negligence and malpractice liability are further more being applied and strengthened in challenging new situations. Nurses should not fear the law but rather practice equipped with critical thinking skills which result from judgment skills and knowledge.

LEARNING OUTCOMES

- Demonstrate awareness of the current Mental Health act (2012), Maltese and EU legal implication in relation to mental health nurse functioning within the Maltese mental health services.
- Discuss the Mental Health Act (2012) including the legal rights and responsibilities of both clients and staff and Mental Health Schedules with particular attention to schedules 1, 2, 3, 4, 5, 7 and 9.
- Differentiate between voluntary and non-voluntary admission and the legal implications of each type of admission.
- Demonstrate awareness of related forms and documents such as the appointment of responsible carer, consent to treatment, client complaint or suggestion forms.
- Demonstrate awareness of data protection legislation and show appropriate handling of data.
- Demonstrate adequate documentation techniques.
- Define the Data Protection Act, confidentiality breech, and appropriate ways to discuss cases with other mental health professionals or relatives/careers.
- Discuss the legal implications of abuse within a mental health setting both for the client and for the nurse.
- Evaluate the legal implications of conducting nursing interventions such as, one to one and group sessions.

NOTES



COMPETENCE EVALUATION

REFLECTION AND EVALUATION

In order to effectively monitor and evaluate the proficiency of the student in the competences outlined in this handbook, students are requested, to reflect throughout the placement on each of the 8 Domains of Competence and outline their progress in each domain. **Midway through the placement, the student has to complete pages 25-33 of the handbook**. This involves presenting a written account of your reflections for each of the 8 Domains of Competence, identifying those competencies that have been achieved and those which require further development. Students are encourange to familiarise themselves with the Bloom's taxonomy model as this model will help you develop the learning objectives and guide you in your reflective account. Bloom (2001) taxomony includes 3 domains, the Cognitive, Affective and Psychomotor Domains. The cognitive domain highlights 6 categorries which guide learning, namely *"Remembering"*; "*Understanding*"; *"Applying"*; "*Analysing*"; *"Evaluating"* and *"Creating"* (Fig 1). Students are encouraged to refer to these categories to showcase their progress in the Domains of Competence.

A mid placement meeting between the mentor and the student is to be held. This serves to identify any difficulties with the attainment of specific competencies and will enable the student together with their mentor to set an action plan with specific goals to guide, support and facilitate the attainment of the cited domains. **The mentor and the student are encouraged to keep a record of the meeting in the mid placement meeting form on pages 33 and 34. Students are strongly encouraged to keep a portfolio and reflective diary to document their learning outcomes.** The portfolio, together with the reflective diary and reflective notes on each of the 8 domains, provides additional documented evidence of learning and attainment of the outlined competences.

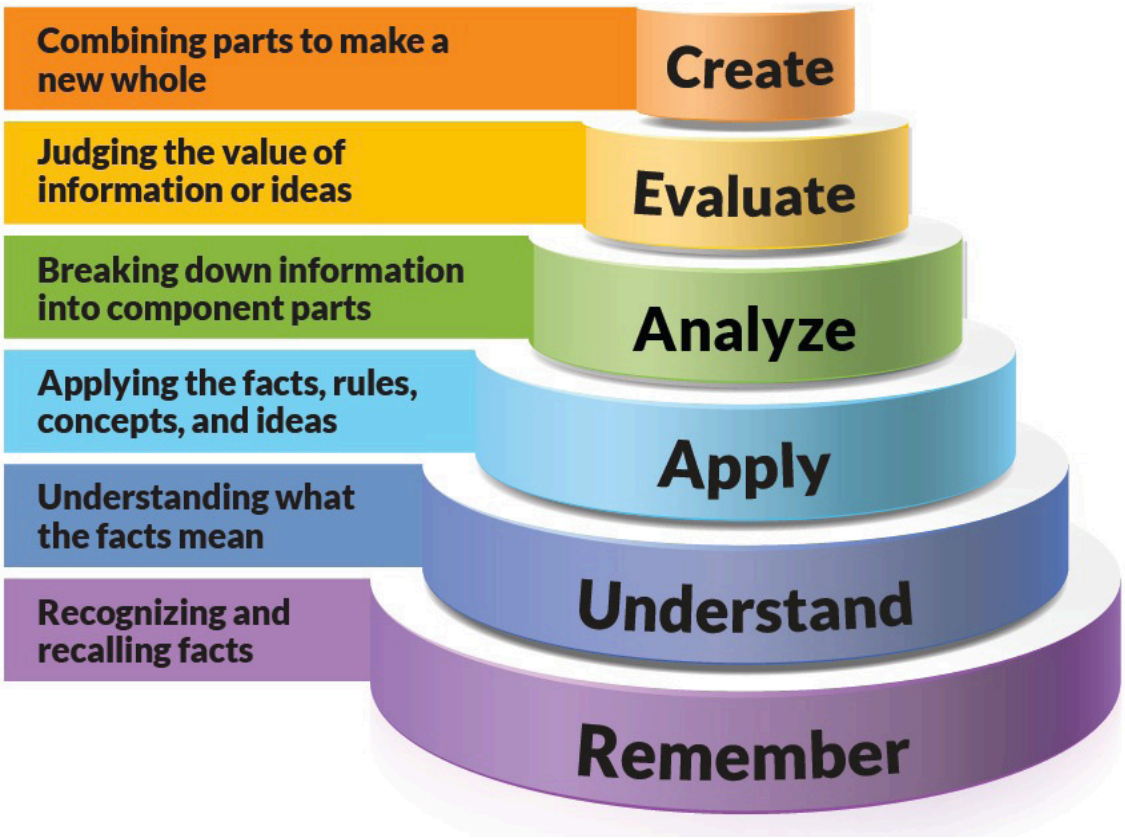


Figure 1. Bloom's Taxonomy Hierarchy (Shabatura, 2020)

REFLECTIVE ACTIVITY

THERAPEUTIC RELATIONSHIP

ASSESSMENT

CARE PLANNING & COORDINATION

NURSING INTERVENTIONS

MANAGING PSYCHIATRIC EMERGENCIES

ETHICAL ISSUES

EDUCATION & RESEARCH

LEGAL IMPLICATIONS

MID PLACEMENT MEETING

STUDENTS' COMMENTS _____

MID PLACEMENT MEETING

MENTORS' COMMENTS _____

RESOURCES

British National Formulary (BNF)
https://www.bnf.org/products/bnf-online/

Data Protection Act
http://www.justiceservices.gov.mt/DownloadDocument.aspx?app=lom&itemid=12839&l=1

Diagnostic and Statistical Manual of Mental Disorders(DSM–5)
https://www.psychiatry.org/psychiatrists/practice/dsm

Maltese Mental Health Act (2012)
http://www.justiceservices.gov.mt/DownloadDocument.aspx?app=lom&itemid=11962&l=1

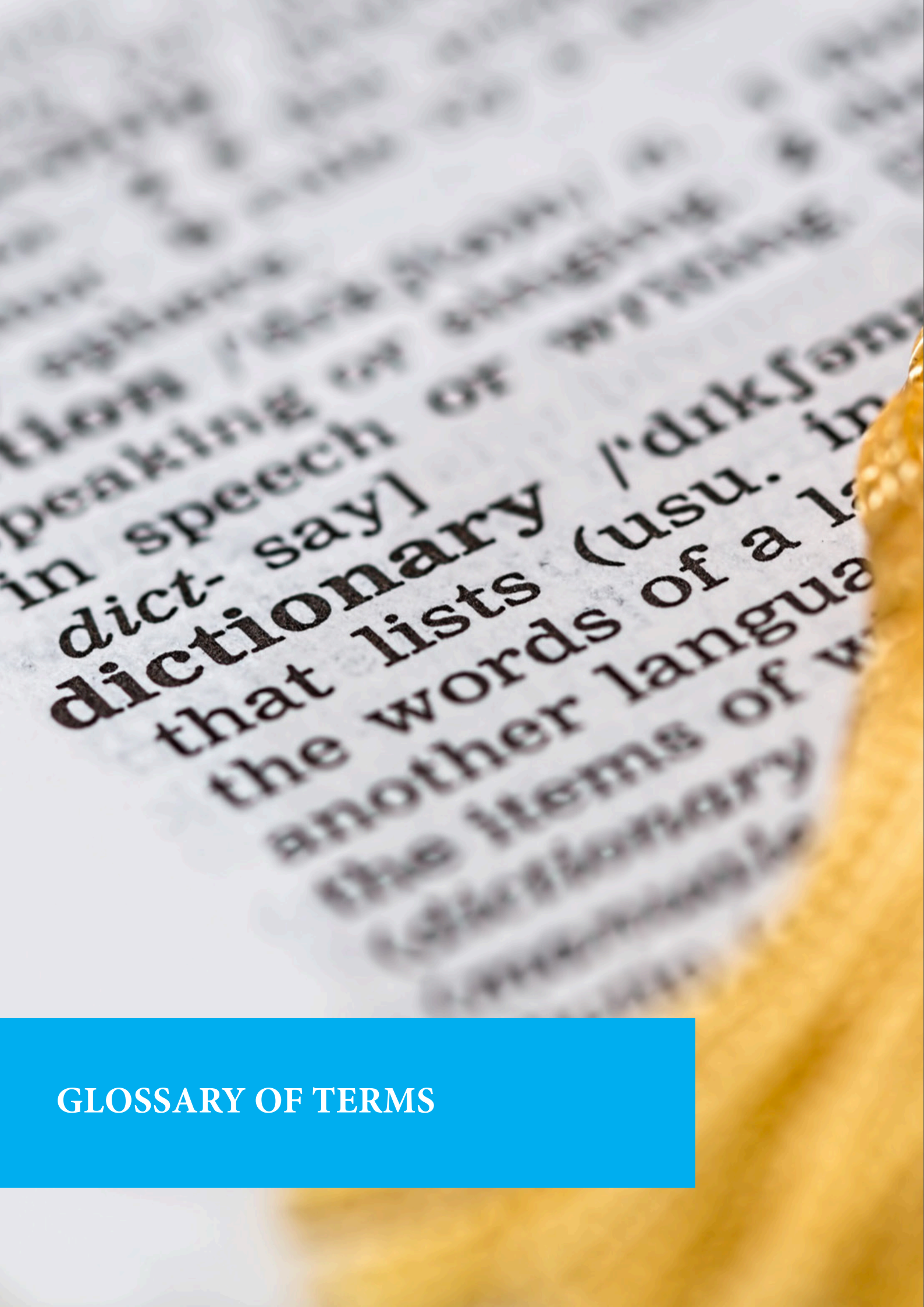
Maltese Nursing Code of Ethics
https://deputyprimeminister.gov.mt/en/phc/pdu/Documents/maltese_code_of_ethics_nurses.pdf

Medicine Storgae Guidelines
https://lookaside.fbsbx.com/file/Medicine%20storage%20guidelines%20ver%203.pdf?token=AWy25wnrLuLj1XXxzCuKL3LwdXEk5ZSArfW_EQlGoLMVYCGKXCugL0kgaZuNCBIHvAsOTIZUpItm_4dOn054egeJdL3cnD2o_hblBtu0tC1Py3obqdJU54yOUHOeiDBZ-VPZD0bDZYAzAQWNB6vYhnP8

National Institute for Health and Care Excellence Guidelines (NICE)
https://www.nice.org.uk/guidance/published?type=apg,csg,cg,mpg,ph,sg,sc,dg,hst,ipg,mtg,qs,ta

Patient's Charter
https://deputyprimeminister.gov.mt/en/hcs/Documents/Patient's%20Charter%202016%20(English).pdf

Psychiatric and Mental Health Nursing Standards
https://docs.wixstatic.com/ugd/6e82ff_802680f8242541fab906ccb17eb84090.pdf



GLOSSARY OF TERMS

Acute Phase (of illness) - A worsening of a person's positive psychotic symptoms, often leading to out-of-control or bizarre behaviour. Anti-psychotic medications are given to eliminate or reduce these symptoms.

Administrative Costs - Costs not linked directly to the provision of medical care. Includes marking, claims processing, billing, and medical record keeping, among others.

Affect - This word is used to described observable behaviour that represents the expression of a subjectively experienced feeling state (emotion). Common examples of affect are sadness, fear, joy, and anger. The normal range of expressed affect varies considerably between different cultures and even within the same culture. Types of affect include: euthymic, irritable, constricted; blunted; flat; inappropriate, and labile.

Affective Disorders - Refers to disorders of mood. Examples would include Major Depressive Disorder, Dysthymia, Depressive Disorder, N.O.S., Adjustment Disorder with Depressed Mood, Bipolar Disorder.

Agitation (psychomotor agitation) - Excessive motor activity that accompanies and is associated with a feeling of inner tension. The activity is usually non-productive and repetitious and consists of such behaviour as pacing, fidgeting, wringing of the hands, pulling of clothes, and inability to sit still.

Agoraphobia - Anxiety about being in places or situations in which escape might be difficult or embarrassing or in which help may not be available should a panic attack occur. The fears typically relate to venturing into the open, of leaving the familiar setting of one's home, or of being in a crowd, standing in line, or travelling in a car or train. Although agoraphobia usually occurs as a part of panic disorder, agoraphobia without a history of panic disorder has been described as also occurring without other disorders.

Amenorrhea - Absence or cessation of menstrual periods.

Amnesia - Loss of memory. Types of amnesia include: anterograde Loss of memory of events that occur at the onset of the etiological condition or agent. retrograde Loss of memory of events that occurred before the onset of the etiological condition or agent.

Anhedonia - Inability to experience pleasure from activities that usually produce pleasurable feelings. Contrast with hedonism.

Anorexia Nervosa (Also called anorexia) - An eating disorder in which people intentionally starve themselves. It causes extreme weight loss, which the National Institute of Mental Health (NIMH), defines as at least 15 percent below the individual's normal body weight.

Anti-depressant - Medication for the treatment of depression.

Anti-psychotic - Medication for the treatment of psychosis

Antisocial Personality Disorder - Persons with this disorder characteristically disregard the feelings, property, authority, and respect of others, for their own personal gain. This may include violent or aggressive acts involving or targeting other individuals, without a sense or remorse or guilt for any of their destructive actions.

Anuria - Failure of the kidneys to produce urine.

Anxiety - The apprehensive anticipation of future danger or misfortune accompanied by a feeling of dysphoria or somatic symptoms of tension. The focus of anticipated danger may be internal or external. Anxiety is often distinguished from fear in that fear is a more appropriate word to use when there exists threat or danger in the

real world. Anxiety is reflective more of a threat that is not apparent or imminent in the real world, at least not to the experienced degree.

Apathy - Lack of feeling, emotion, interest, or concern.

Assessment - A professional review of child and family needs that is done when services are first sought from a caregiver. The assessment of the child includes a review of physical and mental health, intelligence, school performance, family situation, and behaviour in the community. The assessment identifies the strengths of the child and family. Together, the caregiver and family decide what kind of treatment and supports, if any, are needed.

Attention Deficit/Hyperactivity Disorder (ADHD) - A behaviour disorder, usually first diagnosed in childhood, that is characterised by inattention, impulsivity, and, in some cases, hyperactivity.

Avoidant Personality Disorder - Persons with this disorder are hypersensitive to rejection and thus, avoid situations with any potential for conflict. This reaction is fear-driven, however, persons with avoidant personality disorder become disturbed by their own social isolation, withdrawal, and inability to form close, interpersonal relationships.

Binge Eating Disorder - A disorder that resembles bulimia nervosa and is characterized by episodes of uncontrolled eating (or bingeing). It differs from bulimia, however, because its sufferers do not purge their bodies of the excess food, via vomiting, laxative abuse, or diuretic abuse.

Blunt Affect - An affect type that represents significant reduction in the intensity of emotional expression.

Body image - One's sense of the self and one's body.

Body Mass Index (BMI) – is a value derived from the mass (weight) and height of a person. The BMI is defined as the body mass divided by the square of the body height, and is universally expressed in units of kg/m2, resulting from mass in kilograms and height in metres.

Borderline Personality Disorder (BPD) - Persons with this disorder present instability in their perceptions of themselves, and have difficulty maintaining stable relationships. Moods may also be inconsistent, but never neutral - their sense of reality is always seen in "black and white." Persons with borderline personality disorder often feel as though they lacked a certain level of nurturing while growing up and, as a result, incessantly seek a higher level of caretaking from others as adults. This may be achieved through manipulation of others, leaving them often feeling empty, angry, and abandoned, which may lead to desperate and impulsive behaviour.

BP - Abbreviation for Blood Pressure

BPRS - Abbreviation for Brief Psychiatric Rating Scale.

Catatonic Behaviour - Marked motor abnormalities including motoric immobility (i.e., catalepsy or stupor), certain types of excessive motor activity (apparently purposeless agitation not influenced by external stimuli), extreme negativism (apparent motiveless resistance to instructions or attempts to be moved) or mutism, posturing or stereotyped movements, and echolalia or echopraxia.

Catharsis - The healthful (therapeutic) release of ideas through "talking out" conscious material accompanied by an appropriate emotional reaction. Also, the release into awareness of repressed ("forgo en") material from the unconscious.

Delusion - A false belief based on incorrect inference about external reality that is firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not one ordinarily accepted by other members of the person's culture or subculture (e.g., it is not an article of religious faith). When a false belief involves a value judgment, it is regarded as a delusion only when the judgment is so extreme as to defy credibility. Delusional conviction occurs on a continuum and can sometimes be inferred from an individual's behaviour. It is often difficult to distinguish between a delusion and an overvalued idea (in which case the individual has an unreasonable belief or idea but does not hold it as firmly as is the case with a delusion). Delusions are subdivided according to their content. Some of the more common types are: bizarre; delusional jealousy; grandiose; delusion of reference; persecutory; somatic; thought broadcasting; thought insertion.

Dependent Personality Disorder - Persons with this disorder rely heavily on others for validation and fulfilment of basic needs. Often unable to properly care for themselves, persons with dependent personality disorder lack self-confidence and security, and are deficient in making decisions.

Depot Therapy - A long-acting form of anti-psychotic medication that is given by injection into a muscle approximately every 2-4 weeks.

Depression - A depressive disorder characterised by extreme feelings of sadness, lack of self- worth, and dejection.

Disorientation - Confusion about the me of day, date, or season (me), where one is (place), or who one is (person).

Drug-Induced Psychosis - Use of, or withdrawal from alcohol and drugs can be associated with the appearance of psychotic symptoms. Sometimes these symptoms will rapidly resolve as the effects of the substances wear off. In other cases, the illness may last longer, but begin with a drug-induced psychosis.

Dual Diagnosis - Literally the presence of two diagnoses at the same me. When speaking of psychotic disorders, the term is usually used to mean a person who has both a major psychiatric disorder such as schizophrenia, and a substance use or alcohol problem.

Dyslexia - Inability or difficulty in reading, including word-blindness and a tendency to reverse letters and words in reading and writing.

Dysthymia - Persistent mild depression.

Dysuria - is a symptom of pain, discomfort, or burning when urinating.

E.C.T (electroconvulsive therapy) - A procedure causing a brief convulsion by passing an electric current through the brain; used to treat some mental disorders.

Euphoria - A feeling of elation or well-being that is not based on reality and is commonly exaggerated.

Euthymic - is defined as a normal, tranquil mental state or mood. It is often used to describe a stable mental state or mood in those affected with bipolar disorder that is neither manic nor depressive, yet is distinguishable from healthy controls Extraversion-A state in which a en on and energies are largely directed outward from the self as opposed to inward toward the self, as in introversion.

Fantasy - An imagined sequence of events or mental images (e.g., daydreams) that serves to express uncon-

scious conflicts, to gratify unconscious wishes, or to prepare for anticipated future events.

Flashback - A recurrence of a memory, feeling, or perceptual experience from the past.

Flight of ideas - A nearly continuous flow of accelerated speech with abrupt changes from topic to topic that are usually based on understandable associations, distracting stimuli, or plays on words. When severe, speech may be disorganized and incoherent.

Grandiosity - An inflated appraisal of one's worth, power, knowledge, importance, or identity. When extreme, grandiosity may be of delusional proportions.

Hallucination - A sensory perception that has the compelling sense of reality of a true perception but that occurs without external simulation of the relevant sensory organ. Hallucinations should be distinguished from illusions, in which an actual external stimulus is misperceived or misinterpreted. The person may or may not have insight into the fact that he or she is having a hallucination. One person with auditory hallucinations may recognize that he or she is having a false sensory experience, whereas another may be convinced that the source of the sensory experience has an independent physical reality. The term hallucination is not ordinarily applied to the false perceptions that occur during dreaming, while falling asleep (hypnagogic), or when awakening (hypnopompic). Transient hallucinatory experiences may occur in people without a mental disorder.

Illusion - A misperception or misinterpretation of a real external stimulus, such as hearing the rustling of leaves as the sound of voices. See also hallucination.

Inebriated - Intoxicated

Insomnia - A subjective complaint of difficulty falling or staying asleep or poor sleep quality.

Introversion - Preoccupation with oneself and accompanying reduction of interest in the outside world. Contrast to extraversion.

Long-term Memory - The final phase of memory in which information storage may last from hours to a life me.

Mania - A mood disorder which may be characterised by extreme elation, impulsivity, irritability, rapid speech, nervousness, distractibility, and/or poor judgment.

M.A.W. - Abbreviation for the Mixed Admissions Ward.

M.C.H. - Abbreviation for Mount Carmel Hospital.

Medication Noncompliance - Not following a doctor's recommendation. This is very common among clients who are supposed to be taking anti-psychotic medications. In part, this isn't any different from other medical conditions, such as high blood pressure, where noncompliance is also very, very common.

MHA (2012) - Mental Health Act (2012).

MI - Abbreviation for Myocardial infarction.

Micturition - The action of urinating.

Mood - A pervasive and sustained emotion that colours the perception of the world. Common examples of mood include depression, elation, anger, and anxiety. In contrast to affect, which refers to more fluctuating changes in emotional "weather," mood refers to a more pervasive and sustained emotional "climate." Types of mood include: dysphoric, elevated, euthymic, expansive, irritable.

Narcissistic Personality Disorder - Persons with this disorder present severely overly- inflated feelings of self-worth, grandiosity, and superiority over others. Persons with narcissistic personality disorder often exploit others who fail to admire them, and are overly sensitive to criticism, judgment, and defeat.

Negative Symptoms - Think of these symptoms as features that are "taken away" or "subtracted" from the individual. They refer to experiences that should be present, but are absent. Some examples of negative symptoms include: blunted emotions, lack of energy or drive.

Neurotransmitters - Chemicals in the brain that regulate other chemicals in the brain.

Obsession - Recurrent and persistent thought, impulse, or image experienced as intrusive and distressing. Recognized as being excessive and unreasonable even though it is the product of one's mind. This thought, impulse, or image cannot be expunged by logic or reasoning.

Obsessive-Compulsive Disorder (OCD) - An anxiety disorder in which a person has an unreasonable thought, fear, or worry that he or she tries to manage through a ritualised activity to reduce the anxiety. Frequently occurring disturbing thoughts or images are called obsessions, and the rituals performed to try to prevent or dispel them are called compulsions.

O.T. Department- Abbreviation for the Occupational Therapy Department.

Orientation - Awareness of one's self in relation to me, place, and person.

Panic Attacks - Discrete periods of sudden onset of intense apprehension, fearfulness, or terror, often associated with feelings of impending doom. During these attacks, there are symptoms such as shortness of breath or smothering sensations; palpitations, pounding heart, or accelerated heart rate; chest pain or discomfort; choking; and fear of going crazy or losing control. Panic attacks may be unexpected (untacked), in which the onset of the attack is not associated with a situational trigger and instead occurs "out of the blue"; situationally bound, in which the panic attack almost invariably occurs immediately on exposure to, or in anticipation of, a situational trigger ("cue"); and situationally predisposed, in which the panic attack is more likely to occur on exposure to a situational trigger but is not invariably associated with it.

Paranoid Ideation - Idea on, of less than delusional proportions, involving suspiciousness or the belief that one is being harassed, persecuted, or unfairly treated.

Person-centred Care - A way of thinking and doing things that sees the people using health and social services as equal partners in planning, developing and monitoring care to make sure it meets their needs.

Persecutory Delusion - A delusion in which the central theme is that one (or someone to whom one is close) is being attacked, harassed, cheated, persecuted, or conspired against.

Personality - Enduring patterns of perceiving, relating to, and thinking about the environment and oneself. Personality traits are prominent aspects of personality that are exhibited in a wide range of important social and personal contexts. Only when personality traits are inflexible and maladaptive and cause either significant functional impairment or subjective distress do they constitute a Personality Disorder.

Phobia - A persistent, irrational fear of a specific object, activity, or situation (the phobic stimulus) that results in a compelling desire to avoid it. This often leads either to avoidance of the phobic stimulus or to enduring it with dread.

P.O.P. - Abbreviation for the Psychiatric Out-Patients Clinic, Mater Dei Hospital.

Polyuria - Abnormally large production or passage of urine.

Positive symptoms - Symptoms that are 'added on'. They are features that are present but should be absent such as hallucinations and delusions.

Positron Emission Tomography (PET) Scan - An imaging test that helps reveal how your tissues and organs are functioning. A PET scan uses a radioactive drug (tracer) to show this activity.

Post-Traumatic Stress Disorder (PTSD) - A debilitating condition that often follows a terrifying physical or emotional event causing the person who survived the event to have persistent, frightening thoughts and memories, or flashbacks, of the ordeal. Persons with PTSD often feel chronically, emotionally numb. Once referred to as "shell shock" or "battle fatigue."

Psychotic - This term has historically received a number of different definitions, none of which has achieved universal acceptance. The narrowest definition of psychotic is restricted to delusions or prominent hallucinations, with the hallucinations occurring in the absence of insight into their pathological nature. A slightly less restrictive definition would also include prominent hallucinations that the individual realizes are hallucinatory experiences. Broader still is a definition that also includes other positive symptoms of Schizophrenia (i.e., disorganized speech, grossly disorganized or catatonic behaviour). Unlike these definitions based on symptoms, the definition used in DSM-II and ICD-9 was probably far too inclusive and focused on the severity of functional impairment, so that a mental disorder was termed psychotic if it resulted in "impairment that grossly interferes with the capacity to meet ordinary demands of life." Finally, the term has been defined conceptually as a loss of ego boundaries or a gross impairment in reality testing. Based on their characteristic features, the different disorders in DSM-V emphasise different aspects of the various definitions of psychotic.

Psychotropic Medication - Medication that affects thought processes or feeling states.

Residual Phase - The phase of an illness that occurs after remission of the florid symptoms or the full syndrome.

Schizoid Personality Disorder - Persons with this disorder are often cold, distant, introverted, and have an intense fear of intimacy and closeness. Persons with schizoid personality disorder are often too absorbed in their own thinking and daydreaming that they exclude themselves from an attachment with persons and reality.

Schizophrenia - One of the most complex of all mental health disorders; involves a severe, chronic, and disabling disturbance of the brain.

Schizotypal Personality Disorder - Similar to schizoid personality disorder, persons with this disorder are often cold, distant, introverted, and have an intense fear of intimacy and closeness. Yet, with schizotypal personality disorder, persons also exhibit disordered thinking, perception, and ineffective communication skills. Many symptoms of schizotypal personality disorder resemble schizophrenia, but are less mild and intrusive.

Secondary Gain - The external gain derived from any illness, such as personal attention and service, monetary gains, disability benefits, and release from unpleasant responsibilities.

Self-esteem - Feelings about one's self.

Separation Anxiety Disorder - A disorder with onset before the age of 18 consisting of inappropriate anxiety concerning separation from home or from persons to whom the child is a ached. Among the symptoms that may be seen are unrealistic concern about harm befalling or loss of major attachment figures; refusal to go to school (school phobia) in order to stay at home and maintain contact with this figure; refusal to go to sleep unless close to this person; clinging; nightmares about the theme of separation; and development of physical symptoms or mood changes (apathy, depression) when separation occurs or is anticipated.

Sick Role - An identity adopted by an individual as a "patient" that specifies a set of expected behaviours, usually dependent.

Social Adaptation - The ability to live and express oneself according to society's restrictions and cultural demands.

Stressor - Any life event or life change that may be associated temporally (and perhaps causally) with the onset, occurrence, or exacerbation of a mental disorder.

Stupor - A state of unresponsiveness with immobility and mutism.

Suicidal Ideation - Thoughts of suicide or wanting to take one's life.

Symptom - A subjective manifestation of a pathological condition. Symptoms are reported by the affected individual rather than observed by the examiner.

Syndrome - A grouping of signs and symptoms, based on their frequent co-occurrence, that may suggest a common underlying pathogenesis, course, familial pattern, or treatment selection.

Transcranial Magnetic Stimulation (TMS) - is a non-invasive procedure that uses magnetic fields to stimulate nerve cells in the brain to improve symptoms of depression. TMS is typically used when other depression treatments haven't been effective

Tolerance - A characteristic of substance dependence that may be shown by the need for markedly increased amounts of the substance to achieve intoxication or the desired effect, by markedly diminished effect with continued use of the same amount of the substance, or by adequate functioning despite doses or blood levels of the substance that would be expected to produce significant impairment in a casual user.

Tourette's Syndrome (TS) - A disorder characterized by repeated involuntary movements and uncontrollable vocal sounds. This disorder usually begins during childhood or early adolescence.

QT Interval - is a measurement made on an electrocardiogram used to assess some of the electrical properties of the heart. It is the period from the start of the Q wave to the end of the T wave (duration of ventricular electrical activity)

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Appendix B

Quality Mental Health Clinical Placements:
Perspectives of nursing students and their mentors

Maria Sapiano

Please tick the appropriate box and fill when necessary

Section A – Demographic Data

Gender ☐ Male ☐ Female

Age ☐ 20yrs-30yrs ☐ 31yrs-40yrs ☐ 41yrs-50yrs ☐ 51yrs- 65yrs

Work experience ☐ 1-5yrs ☐ 6 -15yrs ☐ 16 -25yrs ☐ 26 -35yrs ☐ 36 yrs +

Work setting

☐ Acute Care
☐ Child & Adolescent
☐ Rehabilitation
☐ Community
☐ Substance Misuse
☐ Long term care

How long have you been mentoring students on an informal and formal basis? ____yrs

What is your highest Nursing qualifications?

Doctor of Philosophy PhD	☐	Masters in Health Service Management	☐
Masters in Mental Health Nursing	☐	Masters in Nursing Studies	☐
BSc in Mental Health Nursing	☐	BSc in Nursing	☐
Diploma in Mental Health Nursing	☐	Diploma in Nursing	☐
Conversion or Traditional Nursing	☐		

Do you think that the current mentorship framework should be amended or revised?

Yes ☐ No ☐

*If you answered **YES** kindly indicate in what ways?*

What do you think are the key learning outcomes for students' during their mental health nursing placements?

Can you describe a typical day of mental health clinical placement for your students?

What was the worst experience regarding students on a mental health nursing placement?

Section B – Mentorship Core Skills

How important/relevant are these Domains when mentoring students?

Domain 1: Therapeutic Relationship

Please read each statement and circle to what extent you think it is not important to extremely important on a scale from 1 to 5, (1 being not important and 5 being extremely important).

a) Communicate effectively with clients with a mental health problems.

Not Important	Slightly Important	Fairly Important	Important	Extremely Important
1	2	3	4	5

If your answer was slightly important (2) to extremely important (5), kindly describe which aspects within this domain are relevant when mentoring students.

b) Using engagement techniques and appropriate verbal and non-verbal communication skills to establish the therapeutic alliance.

Not Important	Slightly Important	Fairly Important	Important	Extremely Important
1	2	3	4	5

If your answer was slightly important (2) to extremely important (5), kindly describe which aspects within this domain are relevant when mentoring students.

c) The needs of the client are identified and explored.

Not Important	Slightly Important	Fairly Important	Important	Extremely Important
1	2	3	4	5

If your answer was slightly important (2) to extremely important (5), kindly describe which aspects within this domain are relevant when mentoring students.

Domain 2: Assessment

Please read each statement and circle to what extent you think it is not important to extremely important on a scale from 1 to 5, (1 being not important and 5 being extremely important).

a) Gathering information and assessing the patient for changes in mood, thought content, affect, behavior, communication, speech, substance use, risk assessment, history of abuse or trauma and difficulties in coping with activities of daily living.

Not Important	Slightly Important	Fairly Important	Important	Extremely Important
1	2	3	4	5

If your answer was slightly important (2) to extremely important (5), kindly describe which aspects within this domain are relevant when mentoring students.

b) Carry out a comprehensive psychosocial assessment of clients.

Not Important	Slightly Important	Fairly Important	Important	Extremely Important
1	2	3	4	5

If your answer was slightly important (2) to extremely important (5), kindly describe which aspects within this domain are relevant when mentoring students.

c) Conduct a mental state examination.

Not Important	Slightly Important	Fairly Important	Important	Extremely Important
1	2	3	4	5

If your answer was slightly important (2) to extremely important (5), kindly describe which aspects within this domain are relevant when mentoring students.

d) The utilization of psychiatric rating scales in which the clinician measure psychiatric symptoms such as depression, anxiety, hallucinations, aggressive behavior. Scales such as SQUARE, Broset Violence Checklist, Beck's Depression Inventory, MARS, GAD-7, AUDIT, Mood Disorder Questionnaire, Life Events Checklist, Brief Psychiatric Rating Scale, Drug Use Questionnaire, Edinburgh Postnatal Depression.

Not Important	Slightly Important	Fairly Important	Important	Extremely Important
1	2	3	4	5

If your answer was slightly important (2) to extremely important (5), kindly describe which aspects within this domain are relevant when mentoring students.

Domain 3: Care planning and Coordination.

Please read each statement and circle to what extent you think it is not important to extremely important on a scale from 1 to 5, (1 being not important and 5 being extremely important).

a) Utilize the information gathered through the assessment, observation and monitoring to formulate the patient's problem/s and nursing diagnosis.

Not Important	Slightly Important	Fairly Important	Important	Extremely Important
1	2	3	4	5

If your answer was slightly important (2) to extremely important (5), kindly describe which aspects within this domain are relevant when mentoring students.

b) Collaborate with the patient, careers and other professionals involved, to determine mental health needs and plan interventions required.

Not Important	Slightly Important	Fairly Important	Important	Extremely Important
1	2	3	4	5

If your answer was slightly important (2) to extremely important (5), kindly describe which aspects within this domain are relevant when mentoring students.

c) Develop a nursing care plan on the basis of the assessment.

Not Important	Slightly Important	Fairly Important	Important	Extremely Important
1	2	3	4	5

If your answer was slightly important (2) to extremely important (5), kindly describe which aspects within this domain are relevant when mentoring students.

Domain 4: Nursing Interventions.

Please read each statement and circle to what extent you think it is not important to extremely important on a scale from 1 to 5, (1 being not important and 5 being extremely important).

a) Assist clients with Mental illness to clarify treatment goals

Not Important	Slightly Important	Fairly Important	Important	Extremely Important
1	2	3	4	5

If your answer was slightly important (2) to extremely important (5), kindly describe which aspects within this domain are relevant when mentoring students.

b) Assist clients to develop living skills.

Not Important	Slightly Important	Fairly Important	Important	Extremely Important
1	2	3	4	5

If your answer was slightly important (2) to extremely important (5), kindly describe which aspects within this domain are relevant when mentoring students.

c) Provide client with knowledge and education regarding medications and their side-effects.

Not Important	Slightly Important	Fairly Important	Important	Extremely Important
1	2	3	4	5

If your answer was slightly important (2) to extremely important (5), kindly describe which aspects within this domain are relevant when mentoring students.

d) Conduct group therapy sessions.

Not Important	Slightly Important	Fairly Important	Important	Extremely Important
1	2	3	4	5

If your answer was slightly important (2) to extremely important (5), kindly describe which aspects within this domain are relevant when mentoring students.

e) Provide one to one sessions towards clients.

Not Important	Slightly Important	Fairly Important	Important	Extremely Important
1	2	3	4	5

If your answer was slightly important (2) to extremely important (5), kindly describe which aspects within this domain are relevant when mentoring students.

f) Participate in case reviews and liaising with other professionals to ensure safety and effective care plan.

Not Important	Slightly Important	Fairly Important	Important	Extremely Important
1	2	3	4	5

If your answer was slightly important (2) to extremely important (5), kindly describe which aspects within this domain are relevant when mentoring students.

Domain 5: Managing Crisis and Psychiatric Emergencies.

Please read each statement and circle to what extent you think it is not important to extremely important on a scale from 1 to 5, (1 being not important and 5 being extremely important).

a) *Complete risk assessment and use de-escalation techniques to lessen aggressive behavior before considering use of restraints.*

Not Important	Slightly Important	Fairly Important	Important	Extremely Important
1	2	3	4	5

If your answer was slightly important (2) to extremely important (5), kindly describe which aspects within this domain are relevant when mentoring students.

b) ***Assess and recognize psychiatric emergencies and provide safe environment for the patient to express his/her feelings.***

Not Important	Slightly Important	Fairly Important	Important	Extremely Important
1	2	3	4	5

If your answer was slightly important (2) to extremely important (5), kindly describe which aspects within this domain are relevant when mentoring students.

c) Can handle clients who are verbally and/or physically aggressive.

Not Important	Slightly Important	Fairly Important	Important	Extremely Important
1	2	3	4	5

Domain 6: Mental Health Promotion and Relapse Prevention

Please read each statement and circle to what extent you think it is not important to extremely important on a scale from 1 to 5, (1 being not important and 5 being extremely important).

a) Act as role model and promote mental health wellbeing.

Not Important	Slightly Important	Fairly Important	Important	Extremely Important
1	2	3	4	5

If your answer was slightly important (2) to extremely important (5), kindly describe which aspects within this domain are relevant when mentoring students.

b) Engage in activities that promote education, break myths surrounding mental illness and reduce stigma.

Not Important	Slightly Important	Fairly Important	Important	Extremely Important
1	2	3	4	5

If your answer was slightly important (2) to extremely important (5), kindly describe which aspects within this domain are relevant when mentoring students.

c) Assist patients to take active part in their community.

Not Important	Slightly Important	Fairly Important	Important	Extremely Important
1	2	3	4	5

If your answer was slightly important (2) to extremely important (5), kindly describe which aspects within this domain are relevant when mentoring students.

Domain 7: Ethical Issues

Please read each statement and circle to what extent you think it is not important to extremely important on a scale from 1 to 5, (1 being not important and 5 being extremely important).

a) Provide interventions that respect that patients an individual and as an autonomous human being with his/her own rights and dignity; irrelevant of his or her diagnosis, gender, sexual orientation, ethnicity, religion, social status and cultural background.

Not Important	Slightly Important	Fairly Important	Important	Extremely Important
1	2	3	4	5

If your answer was slightly important (2) to extremely important (5), kindly describe which aspects within this domain are relevant when mentoring students.

b) Provide ethical and moral behavior all times.

Not Important	Slightly Important	Fairly Important	Important	Extremely Important
1	2	3	4	5

If your answer was slightly important (2) to extremely important (5), kindly describe which aspects within this domain are relevant when mentoring students.

c) Maintain professional boundaries and refrain from engaging in social, intimate, sexual or business relationship with patients.

Not Important	Slightly Important	Fairly Important	Important	Extremely Important
1	2	3	4	5

If your answer was slightly important (2) to extremely important (5), kindly describe which aspects within this domain are relevant when mentoring students.

Domain 8: Research

Please read each statement and circle to what extent you think it is not important to extremely important on a scale from 1 to 5, (1 being not important and 5 being extremely important).

a) **Keep up to date with the latest research, new developments within mental health by reading related articles in journals and online resources.**

Not Important	Slightly Important	Fairly Important	Important	Extremely Important
1	2	3	4	5

If your answer was slightly important (2) to extremely important (5), kindly describe which aspects within this domain are relevant when mentoring students.

Domain 9: Legal Implications

Please read each statement and circle to what extent you think it is not important to extremely important on a scale from 1 to 5, (1 being not important and 5 being extremely important).

a) **Be aware of current Mental Health act (2012), Maltese and EU legal implication in relation to mental health nurse functioning within the Maltese mental health services.**

Not Important	Slightly Important	Fairly Important	Important	Extremely Important
1	2	3	4	5

If your answer was slightly important (2) to extremely important (5), kindly describe which aspects within this domain are relevant when mentoring students.

b) **Be informed about the legal rights and obligations of the patients which fall under his/her care.**

Not Important	Slightly Important	Fairly Important	Important	Extremely Important
1	2	3	4	5

If your answer was slightly important (2) to extremely important (5), kindly describe which aspects within this domain are relevant when mentoring students.

c) **Demonstrate awareness of data protection legislation.**

Not Important	Slightly Important	Fairly Important	Important	Extremely Important
1	2	3	4	5

If your answer was slightly important (2) to extremely important (5), kindly describe which aspects within this domain are relevant when mentoring students.

Are there any other domains not listed above which you feel are important for mentoring students?

Comments or Suggestions to Improve the quality of Mental Health Placements?

What do you think is the most measure of support given by mentor appreciated most by the student?

What piece of advice would you give a student going on mental health nursing placement?

What one piece of advice would you give to a mentor having a student on a mental health nursing placement?

Section C

Please tick the appropriate box

	Not Important	Slightly Important	Fairly Important	Important	Extremely Important
Assist patient with comfort and sleep					
Provide emotional support to patients					
Provide dignity					
Recognise when an individuals' condition is deteriorating					
Demonstrate knowledge of drug therapeutic uses, normal dosage, action, side effects, precautions, contraindications					
Participate in preparing individuals for discharge or transfer					
Recognise and value the role and responsibilities of other members of the caring team					
Adhere to risk assessment policy and protocol					

Dealing with a patient's hallucinations and delusions					
Demonstrating empathy					
Dealing with a psychiatric emergency					
Prepare a patient for ECT					
Monitoring a patient during ECT					
Caring for a patient after ECT					
Teaching relatives about mental illness					
Teaching a patient about budgeting					
Be aware of Admission process					
Write a nursing report					
Conduct hand-over					
Assessing patient risk for vulnerability and neglect					
Monitoring a patient during seclusion					
Administer Depot injections					
Awareness of Non-pharmacological treatment.					
Efficient use of resources: - Time - Financial - Human (e.g. ability to delegate).					
Managing untoward incidents.					
Be aware of community Mental Health services					
Medical emergencies.					
Risk Management & Elevated level of supervision.					
Awareness of Standard operation procedures					
Mental Health disorders and management					
Recognize signs of neuroleptic malignant syndrome (MNS)					
Recognize signs of lithium toxicity					
Recognize the necessary blood investigations related to the drug medication prescribed					
Assessing and recording a blood pressure, pulse, respiratory rate, temperature and glucose monitoring					
Making an unoccupied bed					
Assisting a semi-dependent patient in bathing (inc eye and ear care)					
Assisting a fully dependent patient in bathing (inc eye and ear care)					
Mouth Care					
Moving a patient from bed to armchair					
Assisting patients with walking					
Assisting patients with eating and drinking					
Assisting patients with elimination					
Specimen collection					

Oxygen therapy					
Aseptic technique and change of dressing					
Neurological observations					
Administering and recording oral medication					
Administering and recording sub-cutaneous medication (exc insulin)					
Administering and recording intramuscular medication					
Administering and recording a DDA drug					
Administering and recording of medications via the rectal route					
Administering and recording of ear medications					
Administering and recording of eye medications					
Teaching a patient how to make an unoccupied bed					
Making an occupied bed					
Care after death					
Inserting a naso-gastric tube and providing care.					
Inserting a urinary catheter and proving care.					
Removal of sutures					
Measure and record height and weight					
Cleanse hands at appropriate times and use alcohol gel appropriately					
Assisting patient with CPR					
Handle, segregate and dispose of clinical waste safely including soiled and/or infected linen					
Handle and dispose of sharps to reduce risk of injury (including needles and razors)					

Appendix C

Dear Mr. Gafa'
Practice Development Nurse
Mount Carmel Hospital

My name is Maria Sapiano and I am currently reading for a Master of Science in Mental Health Nursing at the University of Malta under the supervision of Dr. Josianne Scerri. As part of my course requirements I am conducting a research study entitled, "Quality Mental Health Clinical Placements: Perspectives of nursing students and their mentors". The benefit of this research would provide an understanding of the students' experience whilst mentored during the mental health nursing placement.

In order to safeguarding anonymity and confidentiality, I would like to ask if you would be willing to act as an intermediary and distribute and collect the questionnaire in the envelope provided to all the nurses working within the hospital who render mentoring services to the University of Malta. I wish to assure you that participation is strictly voluntary and that no information capable of identifying potential participants will be requested. Potential respondents are free to decline participation in the study and no pressure is to be made on mentors to fill the questionnaire. Participants will only be asked to share data that is necessary for the research. They are also free to withdraw from the study at any time without giving a reason. The questionnaire takes approximately 10 minutes to complete. Anonymised data can be viewed by myself, the supervisor and examiner/s. Data will be stored in a password protected computer.

In order to apply and get approval to conduct this research from the University of Malta Research Ethics Committee, I would need to obtain permission in writing from your kind self, agreeing to act as an intermediary and assist in the study by distributing and collecting the questionnaires provided, in conjunction with an information letter that is to be kept by the participants. Completed questionnaires are to be returned in the appropriate labelled and sealed box placed in your office.

If you accept to assist in this research, please fill in the required details in the consent section below. Your support in this research is highly appreciated. For further information, do not hesitate to contact either myself on maria.sapiano@gmail.com or [redacted] or my supervisor Dr. Josianne Scerri, University of Malta on josianne.scerri@um.edu.mt or 23401175.

Yours respectfully
[redacted]
Maria Sapiano
Masters in Mental Health Nursing
University of Malta

If you accept to assist in this study please sign the declaration below:

After reading the above, I, Kevin Gafa', give my consent to assist in this study.

Signature
[redacted]

Dear Mr. Javier Degiorgo,
Administrator

My name is Maria Sapiano and I am currently reading for a Master of Science in Mental Health Nursing at the University of Malta under the supervision of Dr. Josianne Scerri. As part of my course requirements I am conducting a research study entitled, "Quality Mental Health Clinical Placements: Perspectives of nursing students and their mentors". The benefit of this research would provide an understanding of the students' experience whilst mentored during the mental health nursing placement.

In order to safeguard participant anonymity and confidentiality, I would like to ask if you would be willing to act as an intermediary and distribute and collect the provided questionnaires to all undergraduate students enrolled in the BSc Mental Health Nursing and 2nd year undergraduate nursing students enrolled in the Higher Diploma in Health Sciences (Nursing Studies) (Full-Time) and Bachelor of Science (Honours) Nursing (Full-Time) within the University of Malta. I wish to assure you that participation is strictly voluntary and that no information capable of identifying potential participants will be requested. Potential respondents are free to decline participation in the study and no pressure is to be exerted on students to fill the questionnaire. Participants will only be asked to share data that is necessary for the research. They are also free to withdraw from the study at any time without giving a reason. The questionnaire takes approximately 10 minutes to complete. Anonymised data can be viewed by myself, the supervisor and examiner/s. Data will be stored in a password protected computer.

In order to apply and obtain approval to conduct this research from the University of Malta Research Ethics Committee, I would need to obtain permission in writing from your kind self, agreeing to act as an intermediary and assist in the study by distributing and collecting the questionnaires provided, in conjunction with an information letter that is to be kept by the participants. Completed, questionnaires are to be placed in the provided sealed box placed in your office.

If you accept to assist in this research, please fill in in the required details in the consent section below. Your support in this research is highly appreciated. For further information, do not hesitate to contact either myself on maria.sapiano@gmail.com or [redacted] or my supervisor Dr. Josianne Scerri, University of Malta on josianne.scerri@um.edu.mt or 23401175.

Yours respectfully
[redacted]
Maria Sapiano
Masters in Mental Health Nursing
University of Malta

If you accept to assist in this study please sign the declaration below:

After reading the above, I, Javier Degiorgio, give my consent to assist in this study.

Signature
[redacted]

Appendix D

“Quality Mental Health Clinical Placements: Perspectives of nursing students and their mentors”

Maria Sapiano

Demographic Section

1. **Gender:** ❑ Male ❑ Female

2. **Age:**

18-29	30-39	40-49	50 or older
❑	❑	❑	❑

3. **Placement Setting:**

- ❑ Acute Mental Health
- ❑ Old Age/Chronic
- ❑ Child and Adolescent
- ❑ Learning Disability
- ❑ Rehabilitation
- ❑ Community
- ❑ Substance Misuse

3. **Course:**

- ❑ Bachelor of Science Mental Health Nursing
- ❑ Bachelor of Science Nursing
- ❑ Higher Diploma in Health Sciences

MENTAL HEALTH NURSING EDUCATION SURVEY – Part 1

By Happell (2008)

For each of the statements below, please indicate the degree to which you disagree/agree by CIRCLING the appropriate number: **1 = Strongly Disagree** **7= Strongly Agree**

	Strongly Disagree						**Strongly Agree**
1. I feel well prepared for my psychiatric/mental health clinical placement	1	2	3	4	5	6	7
2. Psychiatric/mental health nursing makes a positive contribution to people experiencing a mental health problem	1	2	3	4	5	6	7
3. I am anxious about working with people experiencing a mental health problem	1	2	3	4	5	6	7
4. I have a good understanding of the role of a psychiatric/mental health nurse	1	2	3	4	5	6	7
5. I am uncertain how to act towards someone with a mental illness	1	2	3	4	5	6	7
6. I will apply for a Graduate Program in psychiatric/mental health nursing	1	2	3	4	5	6	7
7. I feel confident in my ability to care for people experiencing a mental health problem	1	2	3	4	5	6	7
8. People with mental illness are unpredictable	1	2	3	4	5	6	7
9. Mental illness is not a sign of weakness in a person	1	2	3	4	5	6	7
10. The theoretical component of psychiatric/mental health nursing has prepared me well for my clinical placement	1	2	3	4	5	6	7
11. This clinical placement in psychiatric/mental health nursing will provide valuable experience for my nursing practice	1	2	3	4	5	6	7
12. I intend to pursue a career in psychiatric/mental health nursing	1	2	3	4	5	6	7
13. If I developed a mental illness, I wouldn't tell people unless I had to	1	2	3	4	5	6	7
14. My course has prepared me to work as a graduate nurse in a medical-surgical graduate program	1	2	3	4	5	6	7
15. I am familiar with the needs of people with mental illness	1	2	3	4	5	6	7

16. My course has prepared me to work as a graduate nurse in a psychiatric/mental health graduate program	1	2	3	4	5	6	7
17. I will work in a medical-surgical setting for at least a year before considering a career in mental health nursing	1	2	3	4	5	6	7
18. Someone I know has experienced a mental health problem	1	2	3	4	5	6	7
19. When a person develops a mental illness it is not their fault	1	2	3	4	5	6	7
20. Mental health services provide valuable assistance to people experiencing a mental health problem	1	2	3	4	5	6	7
21. People with mental illness can't handle too much responsibility	1	2	3	4	5	6	7
22. I feel safe about this psychiatric/mental health placement	1	2	3	4	5	6	7
23. The way people with mental illness feel can be affected by other people's attitudes towards them	1	2	3	4	5	6	7
24. People with mental illness are more likely to commit offences or crimes	1	2	3	4	5	6	7

Attitudes towards Mental Illness Questionnaire

by Luty et al., (2006)

Please read the following statement and Please tick ☑ the answer which best reflects your views:

A. John has been injecting heroin daily for 1 year.

1. Do you think that this would damage John's career?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

2. I would be comfortable if John was my colleague at work?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

3. I would be comfortable about inviting John to a dinner party?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

4. How likely do you think it would be for John's wife to leave him?

Very likely	Quite likely	Neutral	Unlikely	Very unlikely	Don't know

5. How likely do you think it would be for John to get in trouble with the law?

Very likely	Quite likely	Neutral	Unlikely	Very unlikely	Don't know

B. Tim is depressed and took a paracetamol overdose last month to try and hurt himself.

1. Do you think that this would damage Tim's career?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

2. I would be comfortable if Tim was my colleague at work?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

3. I would be comfortable about inviting Tim to a dinner party?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

4. How likely do you think it would be for Tim's wife to leave him?

Very likely	Quite likely	Neutral	Unlikely	Very unlikely	Don't know

5. How likely do you think it would be for Tim to get in trouble with the law?

Very likely	Quite likely	Neutral	Unlikely	Very unlikely	Don't know

C. Steve has been drinking heavily for 5 years. He is now going for treatment and has started attending Alcoholics Anonymous meetings.

1. Do you think that this would damage Steve's career?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

2. I would be comfortable if Steve was my colleague at work?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

3. I would be comfortable about inviting Steve to a dinner party?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

4. How likely do you think it would be for Steve's wife to leave him?

Very likely	Quite likely	Neutral	Unlikely	Very unlikely	Don't know

5. How likely do you think it would be for Steve n to get in trouble with the law?

Very likely	Quite likely	Neutral	Unlikely	Very unlikely	Don't know

D. Robert is a convicted criminal. He has spent time in prison for several convictions for theft and shoplifting and is currently on bail for fraud and burglary.

1. Do you think that this would damage Robert's career?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

2. I would be comfortable if Robert was my colleague at work?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

3. I would be comfortable about inviting Robert to a dinner party?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

4. How likely do you think it would be for Robert's wife to leave him?

Very likely	Quite likely	Neutral	Unlikely	Very unlikely	Don't know

5. How likely do you think it would be for Robert to get in trouble with the law?

Very likely	Quite likely	Neutral	Unlikely	Very unlikely	Don't know

E. Peter has diabetes. He needs to inject insulin every day and has a special diet.

1. Do you think that this would damage Peter's career?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

2. I would be comfortable if Peter was my colleague at work?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

3. I would be comfortable about inviting Peter to a dinner party?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

4. How likely do you think it would be for Peter's wife to leave him?

Very likely	Quite likely	Neutral	Unlikely	Very unlikely	Don't know

5. How likely do you think it would be for Peter to get in trouble with the law?

Very likely	Quite likely	Neutral	Unlikely	Very unlikely	Don't know

F. Steve is a practising Christian. He attends church every Sunday and attempts to lead a Christian life.

1. Do you think that this would damage John's career?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

2. I would be comfortable if John was my colleague at work?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

3. I would be comfortable about inviting John to a dinner party?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

4. How likely do you think it would be for John's wife to leave him?

Very likely	Quite likely	Neutral	Unlikely	Very unlikely	Don't know

5. How likely do you think it would be for John to get in trouble with the law?

Very likely	Quite likely	Neutral	Unlikely	Very unlikely	Don't know

G. Michael has schizophrenia. He needs an injection of medication every 2 weeks. He was detained in hospital for several weeks 2 years ago because he was hearing voices from the Devil and thought that he had the power to cause earthquakes. He has been detained under the Mental Health Act in the past.

1. Do you think that this would damage Michael's career?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

2. I would be comfortable if Michael was my colleague at work?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

3. I would be comfortable about inviting Michael to a dinner party?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

4. How likely do you think it would be for Michael's wife to leave him?

Very likely	Quite likely	Neutral	Unlikely	Very unlikely	Don't know

5. How likely do you think it would be for Michael to get in trouble with the law?

Very likely	Quite likely	Neutral	Unlikely	Very unlikely	Don't know

Thank you for taking the time to complete this survey.

“Quality Mental Health Clinical Placements: Perspectives of nursing students and their mentors”

Maria Sapiano

Demographic Section

1. **Gender:** ❑ Male ❑ Female

2. **Age:**

18-29	30-39	40-49	50 or older
❑	❑	❑	❑

3. **Placement Setting:**

- ❑ Acute Mental Health
- ❑ Old Age/Chronic
- ❑ Child and Adolescent
- ❑ Learning Disability
- ❑ Rehabilitation
- ❑ Community
- ❑ Substance Misuse

3. **Course:**

- ❑ Bachelor of Science Mental Health Nursing
- ❑ Bachelor of Science Nursing
- ❑ Higher Diploma in Health Sciences

MENTAL HEALTH NURSING EDUCATION SURVEY – Part 2

By Happell (2008)

For each of the statements below, please indicate the degree to which you agree by CIRCLING the appropriate number: **1 = Strongly Disagree** **7= Strongly Agree**

	Strongly Disagree						**Strongly Agree**
1. I felt well prepared for my psychiatric/mental health clinical placement	1	2	3	4	5	6	7
2. Psychiatric/mental health nursing makes a positive contribution to people experiencing a mental health problem	1	2	3	4	5	6	7
3. I am anxious about working with people experiencing a mental health problem	1	2	3	4	5	6	7
4. I have a good understanding of the role of a psychiatric nurse	1	2	3	4	5	6	7
5. I am uncertain how to act towards someone with a mental illness	1	2	3	4	5	6	7
6. I will apply for a Graduate Program in psychiatric/mental health nursing	1	2	3	4	5	6	7
7. I feel confident in my ability to care for people experiencing a mental health problem	1	2	3	4	5	6	7
8. People with mental illness are unpredictable Psychiatric/mental health nursing can assist people with a mental illness in their recovery	1	2	3	4	5	6	7
9. Mental illness is not a sign of weakness in a person	1	2	3	4	5	6	7
10. The theoretical component of psychiatric/mental health nursing prepared me well for my clinical placement	1	2	3	4	5	6	7
11. This clinical placement in psychiatric/mental health nursing has provided valuable experience for my nursing practice	1	2	3	4	5	6	7
12. I intend to pursue a career in psychiatric/mental health nursing	1	2	3	4	5	6	7
13. If I developed a mental illness I wouldn't tell people unless I had to	1	2	3	4	5	6	7
14. My course has prepared me to work as a graduate nurse in a medical-surgical graduate program	1	2	3	4	5	6	7
15. I am familiar with the needs of people with mental illness	1	2	3	4	5	6	7
16. My course has prepared me to work as a graduate nurse in a psychiatric/mental health graduate program	1	2	3	4	5	6	7

	Strongly Disagree						Strongly Agree
17. I will work in a medical-surgical setting for at least a year before considering a career in mental health nursing	1	2	3	4	5	6	7
18. Someone I know has experienced a mental health problem	1	2	3	4	5	6	7
19. When a person develops a mental illness, it is not their fault	1	2	3	4	5	6	7
20. Mental health services provide valuable assistance to people experiencing a mental health problem	1	2	3	4	5	6	7

21. People with mental illness can't handle too much responsibility	1	2	3	4	5	6	7
22. I felt safe during this psychiatric/mental health placement	1	2	3	4	5	6	7
23. The way people with mental illness feel can be affected by other people's attitudes towards them	1	2	3	4	5	6	7
24. People with mental illness are more likely to commit offences or crimes	1	2	3	4	5	6	7
25. I was encouraged by nursing staff to consider psychiatric/mental health nursing as a career	1	2	3	4	5	6	7
26. I was well oriented to my placement	1	2	3	4	5	6	7
27. I felt supported by nursing staff during my clinical placement	1	2	3	4	5	6	7
28. My clinical placement was long enough to consolidate my understanding of psychiatric/mental health nursing	1	2	3	4	5	6	7
29. Nursing staff were too busy to provide me with proper support	1	2	3	4	5	6	7
30. I felt better supported in this clinical placement than I have on other clinical placements	1	2	3	4	5	6	7
31. I felt supported by my clinical teacher/preceptor	1	2	3	4	5	6	7
32. I was encouraged to become involved with patients care whilst on placement	1	2	3	4	5	6	7
33. Nursing staff were welcoming of students on placement	1	2	3	4	5	6	7
34. Nursing staff were prepared for my arrival	1	2	3	4	5	6	7
35. Nursing staff were familiar with the learning objectives of my course	1	2	3	4	5	6	7

	Strongly Disagree						Strongly Agree
36. I enjoyed my psychiatric/mental health placement	1	2	3	4	5	6	7
37. The nursing staff demonstrated a high level of clinical skill	1	2	3	4	5	6	7
38. The nursing staff treated patients with respect and dignity	1	2	3	4	5	6	7
39. The nursing staff were responsive to my requests for clarification or assistance	1	2	3	4	5	6	7

Attitudes towards Mental Illness Questionnaire

by Luty et al., (2006)

Please read the following statement and Please tick ☑ the answer which best reflects your views:

A. John has been injecting heroin daily for 1 year.

1. Do you think that this would damage John's career?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

2. I would be comfortable if John was my colleague at work?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

3. I would be comfortable about inviting John to a dinner party?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

4. How likely do you think it would be for John's wife to leave him?

Very likely	Quite likely	Neutral	Unlikely	Very unlikely	Don't know

5. How likely do you think it would be for John to get in trouble with the law?

Very likely	Quite likely	Neutral	Unlikely	Very unlikely	Don't know

B. Tim is depressed and took a paracetamol overdose last month to try and hurt himself.

1. Do you think that this would damage Tim's career?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

2. I would be comfortable if Tim was my colleague at work?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

3. I would be comfortable about inviting Tim to a dinner party?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

4. How likely do you think it would be for Tim's wife to leave him?

Very likely	Quite likely	Neutral	Unlikely	Very unlikely	Don't know

5. How likely do you think it would be for Tim to get in trouble with the law?

Very likely	Quite likely	Neutral	Unlikely	Very unlikely	Don't know

C. Steve has been drinking heavily for 5 years. He is now going for treatment and has started attending Alcoholics Anonymous meetings.

1. Do you think that this would damage Steve's career?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

2. I would be comfortable if Steve was my colleague at work?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

3. I would be comfortable about inviting Steve to a dinner party?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

4. How likely do you think it would be for Steve's wife to leave him?

Very likely	Quite likely	Neutral	Unlikely	Very unlikely	Don't know

5. How likely do you think it would be for Steve n to get in trouble with the law?

Very likely	Quite likely	Neutral	Unlikely	Very unlikely	Don't know

D. Robert is a convicted criminal. He has spent time in prison for several convictions for theft and shoplifting and is currently on bail for fraud and burglary.

1. Do you think that this would damage Robert's career?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

2. I would be comfortable if Robert was my colleague at work?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

3. I would be comfortable about inviting Robert to a dinner party?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

4. How likely do you think it would be for Robert's wife to leave him?

Very likely	Quite likely	Neutral	Unlikely	Very unlikely	Don't know

5. How likely do you think it would be for Robert to get in trouble with the law?

Very likely	Quite likely	Neutral	Unlikely	Very unlikely	Don't know

E. Peter has diabetes. He needs to inject insulin every day and has a special diet.

1. Do you think that this would damage Peter's career?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

2. I would be comfortable if Peter was my colleague at work?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

3. I would be comfortable about inviting Peter to a dinner party?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

4. How likely do you think it would be for Peter's wife to leave him?

Very likely	Quite likely	Neutral	Unlikely	Very unlikely	Don't know

5. How likely do you think it would be for Peter to get in trouble with the law?

Very likely	Quite likely	Neutral	Unlikely	Very unlikely	Don't know

F. Steve is a practising Christian. He attends church every Sunday and attempts to lead a Christian life.

1. Do you think that this would damage John's career?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

2. I would be comfortable if John was my colleague at work?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

3. I would be comfortable about inviting John to a dinner party?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

4. How likely do you think it would be for John's wife to leave him?

Very likely	Quite likely	Neutral	Unlikely	Very unlikely	Don't know

5. How likely do you think it would be for John to get in trouble with the law?

Very likely	Quite likely	Neutral	Unlikely	Very unlikely	Don't know

G. Michael has schizophrenia. He needs an injection of medication every 2 weeks. He was detained in hospital for several weeks 2 years ago because he was hearing voices from the Devil and thought that he had the power to cause earthquakes. He has been detained under the Mental Health Act in the past.

1. Do you think that this would damage Michael's career?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

2. I would be comfortable if Michael was my colleague at work?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

3. I would be comfortable about inviting Michael to a dinner party?

Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know

4. How likely do you think it would be for Michael's wife to leave him?

Very likely	Quite likely	Neutral	Unlikely	Very unlikely	Don't know

5. How likely do you think it would be for Michael to get in trouble with the law?

Very likely	Quite likely	Neutral	Unlikely	Very unlikely	Don't know

Thank you for taking the time to complete this survey.

Appendix E

SKILLS CHECKLIST

SKILL COMPETENCE	YES	NO	MENTOR SIGNATURE
Administer and record oral, ear, eye, topical, rectal and vaginal route medication.			
Administer and record sub-cutaneous medication including insulin indications, documentation, dosage, storage, , hypoglycaemia and hyperglycaemia episodes.			
Administer and record an intramuscular and a depot medication			
Administer and record a DDA drug, including knowledge about the DDA protocol and the drugs listed under the dangerous drug act (including dosages).			
Recognise signs of neuroleptic malignant syndrome (NMS) and lithium toxicity.			
Recognise the necessary blood investigations related to the prescribed drug.			
Adequate use of documents related to drug administration including treatment charts, depot chart and blood investigation results.			
Demonstrates proper handling and disposal of sharps.			
Engage in a meaningful and appropriate therapeutic relationship.			
Carry out an admission including all the necessary documentation pertaining to the admission process according to the ward policy.			
Prepare, monitor and care for a client prior to, during and after an ECT including the necessary documentation and consent.			
Measure and record height, weight, Blood Pressure, Pulse, Temperature, SPo2, Respirations including appropriate documentation, charts and awareness of normal and abnormal ranges.			
Monitor clients during seclusion and/or raised level of supervision including an understanding of related documents.			
Conduct a risk assessment as well as shows aware of risk management techniques in a variety of situations including preventive and during a psychiatric emergency.			
Perform a neurological observation and specimen collection including but not limited to urine and faeces.			

Appendix F

Ms Veronica Grech
Office of the Registrar
Room 207
Administration Building
University of Malta
Msida

Ms. Maria Sapiano
[redacted]

Dear Ms Grech,

My name is Maria Sapiano and I am currently reading for a Master of Science in Mental Health Nursing at the University of Malta. As part of my course requirements I am conducting a research study entitled, "Quality Mental Health Clinical Placements: Perspectives of nursing students and their mentors". This research investigates the student' perspectives towards mentoring within the mental health placement. The benefit of this research would provide an understanding of the students' experience whilst mentored during the mental health nursing placement.

To be able to conduct this research, I would like to distribute two questionnaires packages, at the start and end of the mental health clinical placement, to all undergraduate nursing students enrolled in BSc Mental Health Nursing and 2nd year undergraduate nursing students enrolled in Higher Diploma in Health Sciences (Nursing Studies) (Full-Time) and Bachelor of Science (Honours) Nursing (Full-Time) within the University of Malta. The participation is strictly voluntary and no information capable of identifying particular respondents will be requested. Confidentiality and anonymity is therefore guaranteed. Participants will only be asked to share data that is necessary for the research. They are also free to withdraw from the study at any time without giving a reason. Anonymised data can be viewed by myself, the supervisor and examiner/s. Data will be stored in a password protected computer.

Distribution and collection of the questionnaires will be carried out by an intermediary, namely Mr. Javier Degiorgio (Administrator, Faculty of Health Sciences) who already consented in writing. The questionnaires take approximately 10 minutes to complete (copy attached).

In order to apply and get approval to conduct this research from the University of Malta Research Ethics Committee, I would need to obtain permission in writing from your kind self, allowing me to collect data.

I would be grateful if you would give me permission to collect data and give your consent in writing. Your support in this research is highly appreciated. For further information, do not hesitate to contact either myself on maria.sapiano@gmail.com or [redacted] or my supervisor Dr. Josianne Scerri, Head, Department of Mental Health, Faculty of Health Sciences, University of Malta, on josianne.scerri@um.edu.mt or 23401175.

Thanking you in advance.
Yours respectfully

[redacted]
Maria Sapiano

L-Università ta' Malta

Office of the Registrar
University of Malta
Msida MSD 2080, Malta

Tel: +356 2340 2385/6
registrar@um.edu.mt

www.um.edu.mt

21st February, 2019

Ms Maria Sapiano [redacted]

Dear Ms Sapiano

I refer to your request for permission to contact students to participate in your study.

The Office of the Registrar finds no objection to your request, subject to the approval of the Faculty Research Ethics Committee.

Yours sincerely

[redacted]

Veronica Grech
Registrar

Dr. Roberta Sammut
Dean
Faculty of Health Sciences
University of Malta

I provide permission for the conduct of [redacted] this research study
19/02/2019

Ms. Maria Sapiano
[redacted]

Dear Dr. Sammut,

My name is Maria Sapiano and I am currently reading for a Master of Science in Mental Health Nursing at the University of Malta. As part of my course requirements I am conducting a research study entitled, "Quality Mental Health Clinical Placements: Perspectives of nursing students and their mentors". This research aims to examine the students' perspectives towards the mental health clinical placement. The benefit of this research would provide an understanding of the students' experience whilst mentored during the mental health nursing placement.

To be able to conduct this research, I would like to distribute two questionnaires packages (Psychiatric / Mental Health Nursing part 1, Psychiatric, Mental Health Nursing part 2 and The attitudes to Mental Health illness Questionnaire) to all undergraduate students enrolled in BSc Mental Health Nursing and 2nd year undergraduate nursing students enrolled in Higher Diploma in Health Sciences (Nursing Studies) (Full-Time) and Bachelor of Science (Honours) Nursing (Full-Time) within the University of Malta. Participation is strictly voluntary and no information capable of identifying particular respondents will be requested. Confidentiality and anonymity is therefore guaranteed. Participants will only be asked to share data that is necessary for the research. They are also free to withdraw from the study at any time without giving a reason. Anonymised data can be viewed by myself, the supervisor and examiner/s. Data will be stored in a password protected computer.

Distribution and collection of the questionnaires will be carried out by an intermediary, namely Mr. Javier Degiorgio (Administrator, Faculty of Health Sciences) who has consented in writing. The questionnaire takes approximately 10 minutes to complete (copy attached).

In order to conduct this research, I would require your approval in writing, which would allow me to collect data from the aforementioned student groups.

I would be grateful if you could support this research. For further information, do not hesitate to contact either myself on maria.sapiano@gmail.com or [redacted] or my supervisor Dr. Josianne Scerri, Head, Department of Mental Health, Faculty of Health Sciences, University of Malta, on josianne.scerri@um.edu.mt or 23401175.

Thanking you in advance.
Yours respectfully

[redacted]

Maria Sapiano
Masters in Mental Health Nursing
University of Malta

Dr. Josianne Scerri,
Head
Department of Mental Health
Faculty of Health Sciences
University of Malta

Ms. Maria Sapiano
[redacted]

Dear Dr. Scerri,

My name is Maria Sapiano and I am currently reading for a Master of Science in Mental Health Nursing at the University of Malta. As part of my course requirements I am conducting a research study entitled, "Quality Mental Health Clinical Placements: Perspectives of nursing students and their mentors". This research investigates the students' perspectives towards mentoring within the mental health placement. The benefit of this research would provide an understanding of the students' experience whilst mentored during the mental health nursing placement.

To be able to conduct this research, I would like to distribute two questionnaires packages, at the start and end of the mental health clinical placement, to all undergraduate nursing students enrolled in BSc Mental Health Nursing within the University of Malta. The participation is strictly voluntary and no information capable of identifying particular respondents will be requested. Confidentiality and anonymity is therefore guaranteed. Participants will only be asked to share data that is necessary for the research. They are also free to withdraw from the study at any time without giving a reason. Anonymised data can be viewed by myself, the supervisor and examiner/s. Data will be stored in a password protected computer.

Distribution and collection of the questionnaires will be carried out by intermediary, namely Mr. Javier Degiorgio (Administrator, Faculty of Health Sciences) who has already consented in writing. The questionnaires take approximately 10 minutes to complete (copy attached).

In order to apply and obtain approval to conduct this research from the University of Malta Research Ethics Committee, I would need to obtain permission in writing from your kind self, allowing me to collect data from BSc Mental Health nursing students.

I would be grateful if you would give me permission to collect data and give your consent in writing.

Thanking you in advance.

I wish to thank you for your help.
Yours respectfully

[redacted]
Maria Sapiano

Dr Josianne Scerri PhD (Nott.)
Head, Department of Mental Health
Faculty of Health Sciences
University of Malta

[redacted]

19/2/2019.

L-Università ta' Malta

DEPARTMENT OF MENTAL HEALTH

Faculty of Health Sciences

Mater Dei Hospital
University of Malta
Msida MSD 2080, Malta

Tel: +356 2340 1830
mentalhealth.healthsci@um.edu.mt

www.um.edu.mt/healthsciences

19-02-2019

Dear Ms Grech,

I am writing this letter in my capacity as the dissertation supervisor of Ms Maria Sapiano who is reading for a Master of Science (Mental Health Nursing) and is in her second year of studies.

I confirm that her research study entitled, "Quality Mental Health Clinical Placements: Perspectives of Nursing Students and their Mentors" is related to the aforementioned course that Ms Sapiano is currently following.

Please do not hesitate to contact me should you require further clarification.

Regards,

[redacted]

Dr Josianne Scerri PhD (Nott.)
Head,
Department of Mental Health
Faculty of Health Sciences
University of Malta

Dr. Maria Cassar,
Head
Department of Nursing
Faculty of Health Sciences
University of Malta

Ms. Maria Sapiano
[redacted]

Dear Dr. Cassar,

My name is Maria Sapiano and I am currently reading for a Master of Science in Mental Health Nursing at the University of Malta. As part of my course requirements I am conducting a research study entitled, "Quality Mental Health Clinical Placements: Perspectives of nursing students and their mentors". This research investigates the student' perspectives towards mentoring within the mental health placement. The benefit of this research would provide an understanding of the students' experience whilst mentored during the mental health nursing placement.

To be able to conduct this research, I would like to distribute two questionnaires packages (Psychiatric / Mental Health Nursing part 1, Psychiatric / Mental Health Nursing part 2 and The Attitudes to Mental Health illness Questionnaire) to all undergraduate students enrolled in BSc Mental Health Nursing and 2nd year undergraduate nursing students enrolled in Higher Diploma in Health Sciences (Nursing Studies) (Full-Time) and Bachelor of Science (Honours) Nursing (Full-Time) within the University of Malta. The participation is strictly voluntary and that no information capable of identifying particular respondents will be requested. Confidentiality and anonymity is therefore guaranteed. Participants will only be asked to share data that is necessary for the research. They are also free to withdraw from the study at any time without giving a reason. Anonymised data can be viewed by myself, the supervisor and examiner/s. Data will be stored in a password protected computer.

Distribution and collection of the questionnaires will be carried out by an intermediary, namely Mr. Javier Degiorgio (Administrator, Faculty of Health Sciences) who already consented in writing. The questionnaires take approximately 10 minutes to complete (copy attached).

In order to apply and get approval to conduct this research from the University of Malta Research Ethics Committee, I would need your approval in writing, allowing me to collect data from 2nd year undergraduate nursing students enrolled in Higher Diploma in Health Sciences (Nursing Studies) (Full-Time) and Bachelor of Science (Honours) Nursing (Full-Time).

I would be grateful if you would give me permission to collect data and give your consent in writing. Your support in this research is highly appreciated. For further information, do not hesitate to contact either myself maria.sapiano@gmail.com on [redacted] or my supervisor Dr. Josianne Scerri, Head, Department of Mental Health, Faculty of Health Sciences, University of Malta, on josianne.scerri@um.edu.mt or 23401175.

Thanking you in advance.
Yours respectfully

[redacted]

Maria Sapiano
Masters in Mental Health Nursing
University of Malta

Permission granted.
[redacted]
Maria Cassar.
19/2/2019.

Mr. Stephan Sultana
Chief Executive Officer,
Mental- Health Malta Health Services

Ms. Maria Sapiano
[redacted]

Dear Mr. Sultana

My name is Maria Sapiano and I am currently reading for a Master of Science in Mental Health Nursing at the University of Malta. As part of my course requirements I am conducting a research study entitled, "Quality Mental Health Clinical Placements: Perspectives of nursing students and their mentors". This research investigates the students' perspectives towards mentoring within the mental health placement. The benefit of this research would provide an understanding of the students' experience whilst mentored during the mental health nursing placement.

To be able to conduct this research, I would like to distribute a questionnaire to all nurses working within the hospital who render mentoring services to the University of Malta. I wish to assure you that participation is strictly voluntary and that no information capable of identifying particular respondents will be requested. Confidentiality and anonymity is therefore guaranteed. Participants will only be asked to share data that is necessary for the research. They are also free to withdraw from the study at any time without giving a reason. Anonymised data can be viewed by myself, the supervisor and examiner/s. Data will be stored in a password protected computer.

Distribution and collection of the questionnaires will be carried out by an intermediary, namely Mr Kevin Gafa' for which he has already consented in writing. The questionnaire takes approximately 10 minutes to complete (copy attached).

In order to apply and obtain approval to conduct this research from the University of Malta Research Ethics Committee, I would need to obtain permission in writing from your kind self, allowing me to collect data from mentors currently providing their services in hospital.

I would be grateful if you would support this research. For further information, do not hesitate to contact either myself on maria.sapiano@gmail.com or [redacted] or my supervisor Dr. Josianne Scerri, Head, Department of Mental Health, Faculty of Health Science, University of Malta on josianne.scerri@um.edu.mt or 23401175.

I wish to thank you for your help.
Yours respectfully

[redacted]
Maria Sapiano
Masters in Mental Health Nursing
University of Malta

Mr. Oswald Balzan,
Data Protection Act officer.
Health- Mental Health Services

Ms. Maria Sapiano
[redacted]

Dear Mr. Balzan

My name is Maria Sapiano and I am currently reading for a Master of Science in Mental Health Nursing at the University of Malta. As part of my course requirements I am conducting a research study entitled, "Quality Mental Health Clinical Placements: Perspectives of nursing students and their mentors". This research investigates the students' perspectives towards mentoring within the mental health placement. The benefit of this research would provide an understanding of the students' experience whilst mentored during the mental health nursing placement.

To be able to conduct this research, I would like to distribute a questionnaire to all nurses working within the hospital who render mentoring services to the University of Malta. I wish to assure you that participation is strictly voluntary and that no information capable of identifying particular respondents will be requested. Confidentiality and anonymity is therefore guaranteed. Participants will only be asked to share data that is necessary for the research. They are also free to withdraw from the study at any time without giving a reason. Anonymised data can be viewed by myself, the supervisor and examiner/s. Data will be stored in a password protected computer.

Distribution and collection of the questionnaires will be carried out by an intermediary, namely Mr Kevin Gafa' for which he has already consented in writing. The questionnaire takes approximately 10 minutes to complete (copy attached).

In order to apply and obtain approval to conduct this research from the University of Malta Research Ethics Committee, I would need to obtain permission in writing from your kind self, allowing me to collect data from mentors currently providing their services in hospital.

I would be grateful if you would support this research. For further information, do not hesitate to contact either myself on maria.sapiano@gmail.com or [redacted] or my supervisor Dr. Josianne Scerri, Head, Department of Mental Health, Faculty of Health Science, University of Malta on josianne.scerri@um.edu.mt or 23401175.

I wish to thank you for your help.
Yours respectfully

[redacted]

Maria Sapiano
Masters in Mental Health Nursing
University of Malta

[redacted]

Approved.
[redacted]
DPO/MCH

Mr. Stephen Sultana - CIB
Chief Executive Officer
Mental Health Malta
24/2/19

MEDICAL RECORDS
MOUNT CARMEL HOSPITAL
ATTARD - ATD 9033

Dr. Vicky Sultana
Director of Nursing,
Health- Mental Health Services

Ms. Maria Sapiano
[redacted]

Dear Dr. Sultana

My name is Maria Sapiano and I am currently reading for a Master of Science in Mental Health Nursing at the University of Malta. As part of my course requirements I am conducting a research study entitled, "Quality Mental Health Clinical Placements: Perspectives of nursing students and their mentors". This research investigates the students' perspectives towards mentoring within the mental health placement. The benefit of this research would provide an understanding of the students' experience whilst mentored during the mental health nursing placement.

To be able to conduct this research, I would like to distribute a questionnaire to all nurses working within the hospital who render mentoring services to the University of Malta. I wish to assure you that participation is strictly voluntary and that no information capable of identifying particular respondents will be requested. Confidentiality and anonymity is therefore guaranteed. Participants will only be asked to share data that is necessary for the research. They are also free to withdraw from the study at any time without giving a reason. Anonymised data can be viewed by myself, the supervisor and examiner/s. Data will be stored in a password protected computer.

Distribution and collection of the questionnaires will be carried out by an intermediary, namely Mr Kevin Gafa' for which he has already consented in writing. The questionnaire takes approximately 10 minutes to complete (copy attached).

In order to apply and obtain approval to conduct this research from the University of Malta Research Ethics Committee, I would need to obtain permission in writing from your kind self, allowing me to collect data from mentors currently providing their services in hospital.

I would be grateful if you would support this research. For further information, do not hesitate to contact either myself on maria.sapiano@gmail.com or [redacted] or my supervisor Dr. Josianne Scerri, Head, Department of Mental Health, Faculty of Health Science, University of Malta on josianne.scerri@um.edu.mt or 23401175.

I wish to thank you for your help.
Yours respectfully

[redacted]

Maria Sapiano
Masters in Mental Health Nursing
University of Malta

Approved subject to FREC clearance

[redacted]

Dr. Victoria Sultana
Director Nursing
Mental Health Malta

Dear Mentor,

My name is Maria Sapiano and I am currently reading for a Master of Science in Mental Health Nursing at the University of Malta. As part of my course requirements I am conducting a research study entitled, "Quality Mental Health Clinical Placements: Perspectives of nursing students and their mentors". The aim of this study is to provide a framework that would enable you as mentors to facilitate students during the mental health placement. Your participation in this study would help us gain a better understanding of the mentors' perspectives of the Mental Health Clinical Placements.

With this letter, I would like to invite you to participate in this study. Your participation will be greatly appreciated. I wish to assure you that participation is strictly voluntary and that no information capable of identifying you as a participant will be published. Confidentiality and anonymity is guaranteed. Anonymized data can be viewed by myself, the supervisor and examiner/s. You will only be asked to share data that is necessary for the research. You are also free to withdraw from the study at any time without giving a reason. Data will be stored in a password protected computer.

If you accept to take part in this study, please complete the accompanying questionnaire. This questionnaire should take about 10 minutes to complete. Please read the instructions carefully before commencing to fill the questionnaire. It is important that all questions are answered as incomplete questionnaires will be considered null. By completing the questionnaire, you are giving your consent to participate in the study. You can keep a copy of the information letter. Your personal opinion is highly valued therefore please do not discuss your opinions with others prior to completing this questionnaire. Once completed, please post the questionnaire in a labelled and sealed box in the office of Mr Kevin Gafa.

Although there is no immediate benefit from the study, your participation will help provide information that may assist in improvements within the clinical experience and support for students whilst on their mental health clinical placement.

If you require any further clarification regarding the study, please do not hesitate to contact either myself on maria.sapiano@gmail.com or [redacted] or my supervisor Dr. Josianne Scerri, University of Malta on josianne.scerri@um.edu.mt or 23401175.

Yours Sincerely,

Maria Sapiano

[redacted]

Maria Sapiano

Researcher

[redacted]

Dr Josianne Scerri

Research Supervisor

Dear Student,

My name is Maria Sapiano and I am currently reading for a Master of Science in Mental Health Nursing at the University of Malta. As part of my course requirements I am conducting a research study entitled, "Quality Mental Health Clinical Placements: Perspectives of nursing students and their mentors". The aim of this study is to examine the experience of mentorship in the mental health placement for future students' cohorts. Whilst there is no harm in participating in this study, your participation would allow for a better understanding of students' perspectives of the mental health clinical placements.

With this letter, I would like to invite you to participate in this study. Your participation will be greatly appreciated. I wish to assure you that participation is strictly voluntary and that no information capable of identifying you as a participant will be published. Confidentiality and anonymity is guaranteed. You are free to withdraw from the study at any time without giving a reason. You will only be asked to share data that is necessary for the research. Anonymized data can be viewed by myself, the supervisor and examiner/s. Data will be stored in a password protected computer.

If you accept to take part in this study, please complete the accompanying self-report questionnaires, once on commencement of your mental health placement and again on the last day of your mental health clinical placement. Two brief self-report questionnaires will be used to assess your attitudes towards mental health and your recent clinical experience. This questionnaire package includes the Psychiatric / Mental Health Nursing part 1, Psychiatric, Mental Health Nursing part 2 and The attitudes to Mental Health illness Questionnaire.

These questionnaires should take approximately 10 minutes to complete. It is important that all questions are answered as incomplete questionnaires will be not be included in the study. By completing the questionnaire, you are giving your consent to participate in the study. You can keep a copy of the information letter. The questionnaire will be distributed and collected by Mr Javier Degiorgio (Administrator, Faculty of Health Sciences) who will place the completed questionnaires in the sealed box placed in his office.

Although there is no immediate benefit from the study, your participation will help provide information that may assist in improvements within the clinical experience and support for students whilst on their mental health clinical placement.

If you require any further clarification regarding the study, please do not hesitate to contact either myself on maria.sapiano@gmail.com or [redacted] or my supervisor Dr. Josianne Scerri, Head, Department of Mental Health, Faculty of Health Sciences, University of Malta on josianne.scerri@um.edu.mt or 23401175

Yours Sincerely,

Maria Sapiano

[redacted]

Maria Sapiano

Researcher

[redacted]

Dr Josianne Scerri

Research Supervisor

Appendix G

Gmail Maria Sapiano <maria.sapiano@gmail.com>

Research

Brenda Happell <Brenda.Happell@newcastle.edu.au> Tue, Oct 30, 2018 at 2:37 AM
To: Maria Sapiano <maria.sapiano@gmail.com>

Hi Maria,

Please find the pre test and post test questionnaires attached and take this as my permission for you to use them.

Best of luck with your studies.

Regards

Brenda

[Quoted text hidden]

2 attachments

MHNE1 final.doc
82K

MHNE2 final.doc
96K

Gmail Maria Sapiano <maria.sapiano@gmail.com>

Tool Permission

Jason Luty <jason.luty@yahoo.co.uk> Tue, Dec 4, 2018 at 9:59 AM
Reply-To: Jason Luty <jason.luty@yahoo.co.uk>
To: Maria Sapiano <maria.sapiano@gmail.com>

By all means use the AMIQ - the oringianl references in Cunningham 1993 which is in the paper. Jason Luty

---

From: Maria Sapiano <maria.sapiano@gmail.com>
To: jason.luty@yahoo.co.uk
Sent: Monday, 3 December 2018, 14:28
Subject: Tool Permission
[Quoted text hidden]