‘Thrown in at the Deep End’: A Qualitative Study with New Zealand New Graduate Nurses Working in Mental Health

A dissertation submitted for the
degree of Master of Health Sciences
(endorsed in Nursing - Clinical)

Centre for Postgraduate Nursing Studies
University of Otago

Deborah Jane Cracknell

December 2018

Abstract

This dissertation is a qualitative study with seven new graduate nurses who were enrolled on the New Entry to Specialist Practice in Mental Health and Addiction programme in New Zealand. The aims of this study were to explore how nursing education impacts on the decision to work in mental health and the transition into practice. The background context for this study is the global nursing recruitment and retention problem (Hooper, Browne & O'Brien, 2016) and the challenging socio-political environment of the New Zealand mental health system (Cassie, 2018a; Elliott, 2017). Mental health nursing has historically struggled to attract and retain qualified staff (Happell, 1999; Happell & Gaskin, 2013; Jansen & Venter, 2015). Nursing education tends to favour medical and surgical nursing and critics argue that nursing education does not adequately prepare nurses to work in the mental health field (Happell, McAllister & Gaskin, 2014).

Data were collected using individual semi structured interviews which were conducted, recorded and transcribed by the author. Thematic analysis was used to analyse the data which generated three major themes, eleven subthemes and three smaller subthemes. The first major theme was *Thrown in at the Deep End* relating to most participants' strong feelings that they had not been adequately prepared for post registration nursing practice. The five subthemes included *inadequate education, new graduate challenges, feeling unprepared, the mental health system* and *stigma*. The second major theme that emerged was *Feeling Supported* and the three subthemes comprised of *quality education, quality placements* and *healthy transitions*. The final major theme was *The Decision to Work in Mental Health* and this related to the range and variety of influences on the participants career decisions. This theme contains three subthemes: *wider nursing issues, life experiences* and *nursing education*, which also incorporated three smaller subthemes: *recovery principles, recruitment strategies* and *reducing stigma*.

It is concluded that the comprehensive nursing education system does not offer satisfactory preparation for nurses who choose to work in mental health. The central issue is that new graduates working in mental health feel they have been *thrown in at the deep end* and strategies to improve this situation are explored and recommendations made.

Acknowledgements

Firstly, I would like to send gratitude to the new graduate nurses who gave their time and energy to this project. Thank you for sharing your stories with me and it was a real privilege to listen to you all.

Thanks also to Shirley McKewen and Gail Houston for facilitating access to the new graduate nurses and for being positive and supportive towards this research.

To my dissertation supervisors, Dr Virginia Jones and Dr Jennifer Jordan, much appreciation for your wisdom, support and invaluable advice throughout the dissertation year.

Special acknowledgements to Professor Liz Ditzel and Jan Hill for reading draft copies and providing excellent feedback.

To my Mum, children and friends; deep thanks to you all for being so understanding and supportive, especially through the stressful times.

And finally, to my lovely colleagues at Otago Polytechnic; thank you all for listening and providing support and encouragement.

Table of Contents

Abstract....................i
Acknowledgements....................ii
Table of Contents....................iii
List of Tables....................vi
List of Figures....................vi
Abbreviations....................vii

CHAPTER 1 – Introduction....................1

1.1 Position of the Author....................1

1.2 Overview of the Dissertation....................2

CHAPTER 2 – Literature Review....................3

2.1 Nursing Workforce Issues....................4

2.2 The Socio-Political Context of the Mental Health System....................5

2.2.1 Stigma....................6

2.2.2 Seclusion....................7

2.2.3 Mental Health Inequalities....................8

2.2.4 Suicide Data....................9

2.3 Comprehensive Nursing Education in New Zealand....................9

2.4 Mental Health Nursing Recruitment....................10

2.5 The Advanced Choice of Employment Scheme....................12

2.6 Transition to Practice....................13

2.7 New Graduate Transition Programs....................13

2.8 New Graduate Mental Health Nursing Research....................14

2.9 Chapter Summary....................18

CHAPTER 3 – Research Methodology....................21

3.1 Qualitative Paradigm....................21

3.2 Qualitative Descriptive Design....................21

3.3 Research Proposal....................22

3.4 Research Aims....................22

3.5 Research Questions....................22

3.6 Sampling....................22

3.7 Inclusion and Exclusion Criteria....................23

3.8 Interview Questions....................23

3.9 Recruitment Process 24
3.10 Data Collection 25
3.11 Data Analysis 25
3.12 Ethical Considerations 26
3.13 Māori Consultation 27
3.14 Locality Approval 27
3.15 Reflexivity 27

CHAPTER 4 – Results.. 28

4.1 Participant Characteristics 28
4.2 Themes 29
4.3 Theme 1: Thrown in at the Deep End 30
4.3.1 Inadequate Education Subtheme 31
4.3.2 New Graduate Challenges Subtheme 32
4.3.3 Feeling Unprepared Subtheme 33
4.3.4 The Mental Health System Subtheme 34
4.3.5 Stigma Subtheme 36
4.4 Theme 2: Feeling Supported 38
4.4.1 Quality Education Subtheme 38
4.4.2 Quality Placements Subtheme 40
4.4.3 Healthy Transition Subtheme 41
4.5 Theme 3: The Decision to Work in Mental Health 43
4.5.1 Wider Nursing Issues Subtheme 44
4.5.2 Life Experiences Subtheme 44
4.5.3 Nursing Education Subtheme 45
4.5.3.1 Recovery Principles Subtheme 46
4.5.3.2 Recruitment Subtheme 47
4.5.3.3 Reducing Stigma Subtheme 48

CHAPTER 5 – Discussion.. 50

5.1 Research Question 1.. 50
How does nursing education in NZ prepare nurses to work in the mental health sector?
5.2 Research Question 2.. 55
How does nursing education in NZ impact on the decision to work in mental health?

5.3 Research Question 3 58
How can new graduate transitions into mental health nursing be enhanced in NZ?
5.4 Research Question 4..60
How can the recruitment of new graduates into mental health nursing in NZ be improved?
5.5 Strengths and Limitations of the Study 62
5.6 Chapter Summary 62

CHAPTER 6 – Conclusion 63

References 65

Appendices 84

A – CPNS Approval Letter 85
B – Change Request Letter 86
C – Participant Information Sheet 88
D – Consent Form 91
E – Conditional Ethical Approval 93
F – Response to Ethical Committee 95
G – Full Ethical Approval 96
H – Māori Consultation for Dunedin 98
I – Māori Consultation for Christchurch 100
J – Southern DHB Locality Approval 101
K – Canterbury DHB Locality Approval 102
L – University of Otago Declaration Form 111

List of Tables

Table 1. Key Issues from the Literature Review………………………………….20
Table 2. Interview Questions……………………………………………………...23
Table 3. Participant Characteristics……………………………………………….28
Table 4. Theme One: Thrown in at the Deep End………………..…………….30
Table 5. Theme Two: Feeling Supported…………………………………………37
Table 6. Theme Three: The Decision to Work in Mental Health…………………42

List of Figures

Figure 1. Literature Review Influences……..…………………………………..….3
Figure 2. Thematic Map……………………...…………………………………29

Abbreviations

ACE - Advanced Choice of Employment

BN - Bachelor of Nursing

CPNS - Centre for Postgraduate Nursing Studies

DHB - District Health Board

EN - Enrolled Nurse

HQSC - Health Quality and Safety Commission

MDT - Multidisciplinary Team

MHF - Mental Health Foundation of New Zealand

MHN - Mental Health Nurse

MoH - Ministry of Health

NCNZ - Nursing Council of New Zealand

NESP - New Entry to Specialist Practice in Mental Health and Addiction

NETP - New Entry to Practice

NETS - Nursing Education in the Tertiary Sector

NZ - New Zealand

NZCMHN - New Zealand College of Mental Health Nursing

NZNO - New Zealand Nurses Organisation

OP - Otago Polytechnic

RN - Registered Nurse

SoN - School of Nursing

SIT - Southern Institute of Technology

TA - Thematic Analysis

UK - United Kingdom

USA - United States of America

Chapter One - Introduction

This dissertation is a qualitative study with seven new graduate Mental Health Nurses (MHNs) who were enrolled on the 'New Entry to Specialist Practice in Mental Health and Addiction' (NESP) programme in New Zealand (NZ). The aims of this study were to explore how nursing education impacts on the decision to work in mental health and the transition into practice. The wider context for this study is the global nursing recruitment and retention problem (Hooper *et al.,* 2016) and the challenging socio-political environment of the NZ mental health system (Cassie, 2018a; Elliott, 2017). Mental health nursing in particular has historically struggled to attract and retain qualified staff (Happell, 1999; Happell & Gaskin, 2013; Jansen & Venter, 2015). Nursing education tends to favour medical and surgical nursing and critics argue that nursing education does not adequately prepare nurses to work in the mental health field (Happell, McAllister & Gaskin, 2014). There is very little qualitative research published internationally about the transition experiences of new graduate MHNs (Tingleff & Gildberg, 2014) and this includes scant data from NZ. This research project aims to address this gap in the literature, enhance existing knowledge on new graduate MHN transitions and also add a fresh NZ perspective.

1.1 Position of the Author

The author has a clinical background as a Mental Health Nurse (MHN) having trained in England during the 1990s. In the United Kingdom (UK), nurses have to choose a speciality at the start of their education from a choice of adult, child, learning disability or mental health nursing options. The last eighteen months of the authors nurse training focused solely on mental health nursing and she has only ever worked in this field. Currently the author is employed as a lecturer at Otago Polytechnic (OP) School of Nursing (SoN) and works specifically in the Bachelor of Nursing (BN) programme, across the second and third year clinical mental health papers. It has alarmed the author how few hours are dedicated to mental health theory and practice within the BN curriculum. As a MHN lecturer, the author is aiming to motivate and inspire nursing students into the speciality and hence, interest in this topic is driven by a desire to understand perspectives from those who have also recently chosen mental health nursing post-graduation.

1.2 Overview of the Dissertation

Chapter two presents the contextual background for this project. It includes a discussion of nursing workforce issues including the recruitment and retention problem and an overview of the current socio-political challenges present within the NZ mental health system. Nursing education, recruitment into mental health nursing and transition to practice programmes in NZ are explored. The current research regarding new graduate MHN transitions are discussed in detail.

Chapter three describes the research methodology for the project and introduces the qualitative paradigm. The research process includes the design, aims, research questions, recruitment processes and data collection methods. Thematic Analysis (TA) was chosen to analyse the data as it is widely used and especially useful for novice researchers when identifying, analyzing, organizing, describing, and reporting themes found within a data set (Braun & Clarke, 2006). The TA method advocated by Braun and Clarke (2006) is explained and applied. The ethical considerations are discussed including Māori consultation and District Health Board (DHB) locality approvals.

Chapter four includes the characteristics of the study participants before presenting the findings from the study, shown in relation to the three major themes, eleven subthemes and three smaller subthemes that emerged during analysis.

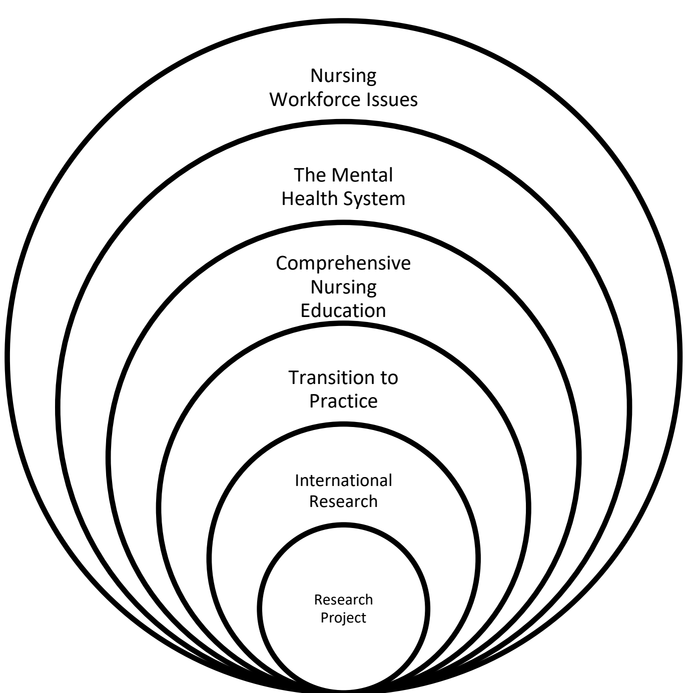
Chapter five provides a discussion of the findings in relation to the research questions and some of the key literature outlined in Chapter two. Implications for nursing practice, education and research are explored and recommendations made. Strengths and limitations of the study are acknowledged.

Chapter six presents the conclusions of the study and recommendations for training and future research.

Chapter Two - Literature Review

This chapter presents the contextual background for the research project. It begins with a discussion of current nursing workforce issues including the global recruitment and retention problem and the high attrition rate of new graduate nurses. A critical overview of the current socio-political challenges present within the NZ mental health system is presented and attention is given to contemporary issues related to MHN practice including stigma, seclusion, health inequalities and suicide data. Nursing education, recruitment into mental health nursing and transition to practice programmes in NZ are explored. The current research regarding new graduate MHN transitions are discussed in detail. The graphic below shows how the literature review has informed this research project.

Figure 1. Literature Review Influences



2.1 Nursing Workforce Issues

The global concern that the nursing profession is heading towards a significant shortage in the workforce due to a recruitment and retention crises is well documented (Halfer & Graf, 2006; Happell, 2008a; Hooper *et al.,* 2016; North, Leung & Lee, 2014; Te Pou, 2018a). Mental health nursing in particular has experienced historical problems in recruiting and retaining staff (Cleary & Happell, 2005; Happell & Gaskin, 2013; Nadler-Moodie & Loucks, 2011; Te Pou, 2018a). To manage the expected shortage, we need to recruit, train and successfully transition enough nurses into the profession (Boyd-Turner, Bell & Russell, 2016). New graduate nurses have an important role to play in the future success of the mental health nursing profession. Workforce surveys repeatedly show that nurses are the main occupational group in mental health and addiction services in NZ (Te Pou, 2018a).

Factors such as increased life expectancy and the ageing population are likely to raise the future demand for health and nursing services (Nana, Stokes, Molano & Dixon, 2013). Yet one central issue is that the entire nursing workforce is ageing and the average age of a NZ MHN is 51 years (Ministry of Health (MoH), 2016). In 2015, only 22 MHNs under 25 were working in the community compared to 453 in the 50-54 age bracket and this raises issues about workforce sustainability (Nursing Council of New Zealand (NCNZ), 2015). It is predicted that over half of the entire NZ nursing workforce will retire by 2035 and therefore the supply of future nurses must not only replace those retiring, but also meet the extra demands because of the population changes (Nana *et al*., 2013). It makes sense, therefore, to increase the number of new graduates entering into the nursing profession. But sadly this solution is not as simple as one might expect. There is a fear that the current number of new graduate nurses is not meeting the potential shortfall due to a high attrition rate (Halfer, 2007). Many newly qualified nurses leave the profession because of job stressors, poor organizational support, negative inter-professional relationships, unreasonable workloads, toxic work environments and difficulties transitioning into practice (Clark & Springer, 2012). Retrospective analysis of NCNZ's registration data between 2005-2010 showed that 18% of the graduate cohort had left the NZ nursing workforce within the first year (North *et al.,* 2014). Five years post registration, this attrition rate rose to 26% and younger nurses were significantly associated with leaving the profession

(North *et al*., 2014). Retention of new, young, graduate nurses is therefore vital for future workforce sustainability (North *et al.,* 2014).

Another contemporary workforce issue facing the nursing profession is bullying (Enoka, 2018) and while this is also a global problem, one recent NZ prospective cross-sectional survey showed that 40% of students reported experiencing bullying while on clinical placement (Minton, Birks, Cant & Budden, 2018). This highlights that nursing students are a vulnerable group and the consequences impact not only on the victims but also on patients, organisations, and the profession as a whole, including the retention of nurses (Minton *et al.,* 2018). Also, this year in NZ (2018), nurses voted to strike for the first time in over thirty years. While pay negotiations were important, nurses also campaigned for safe staffing levels in light of the chronic underfunding in the NZ health sector over the past decade. The NZ Nurses Organisation (NZNO) eventually agreed to a new collective agreement including pay increases and an agreement that the DHBs will work positively to implement safe staffing levels and healthy workplaces (NZNO, 2018).

2.2 The Socio-Political Context of the Mental Health System

A critique of the wider socio-political context of mental health care is necessary in order to understand the stressful environment in which new graduate MHNs are working and subsequently leaving. With the move from institutional care to community based mental health services, significant resource implications followed (Te Pou, 2018a). Furthermore, in line with international trends, increasing numbers of New Zealanders are seeking help from mental health services every year and this puts pressure on services and staff (MoH, 2017), including new graduate MHNs. Mental health services are frequently reported in a negative light in the media and are said to be in crisis and under-funded (Elliott, 2017; Goodwin, 2017; Scoop, 2017). Over recent years, some acute mental health facilities in NZ have had to close in light of a shortage of nursing staff (Johnston, 2016; Nursing Review, 2017). Inpatient MHNs face increasing stressors at work with high patient acuity, extreme workload demands and unpredictable client behaviours related to methamphetamine and other drug usage which create unsafe environments (Cassie, 2018a).

The *People's Mental Health Report* (Elliott, 2017) was published last year following a grassroots initiative inviting people to share their stories about using the NZ mental health system. Key themes from this report include difficulties accessing services, long wait times, lack of holistic treatment options and staff under strain (Elliott, 2017). Some have argued that the mental health system actually impedes rather than facilitates recovery (Hazelton, Rossiter, Sinclair & Morrall, 2011). The concept of service users as survivors of mental health services gained notoriety with the birth of the user-survivor movement in the 1970s and people began to articulate that their experiences with psychiatry were traumatic and that the system needed reform (O'Hagan, 2003). In early 2018, the government announced an inquiry into mental health and addiction services and the panel received over 5200 submissions and facilitated 26 regional meetings around NZ (Mental Health & Addiction Inquiry, 2018). The inquiry report was recently released and included 40 recommendations to transform the mental health and addiction sector with a much broader focus on prevention, responding earlier and more effectively and promoting mental health and wellbeing (Mental Health & Addiction Inquiry, 2018).

2.2.1 The Socio-Political Context: Stigma

From a sociological perspective, historical critics such as Goffman (1961) and Szasz (1974) identified the social control function of psychiatry a long time ago and yet the related concepts of social exclusion and alienation of people who use mental health services remains a contemporary issue in modern society. In the 1970s, Chamberlin (1978) coined the phrase "mentalism" referring to social stigma and discrimination against people who have been diagnosed with a psychiatric condition. People with lived experiences of mental distress continue to experience harmful and pervasive discrimination from all spheres of society including: family/whānau; friends; social, sports, lifestyle and religious groups; and employment, healthcare, and government agencies (Gordon, Davey, Waa, Tiatia & Waaka, 2017). In 1997 the "Like Minds, Like Mine" programme began which is funded by the government and led by the Mental Health Foundation (MHF), and aims to increase social inclusion and end stigma and discrimination towards people with experience of mental illness or distress (Like Minds, Like Mine, 2016).

2.2.2 The Socio-Political Context: Seclusion

New Zealand mental health services use among the highest rates of legal coercion and seclusion in the developed world; a concern that has been raised repeatedly by human rights bodies (Elliott, 2017). Seclusion is defined as where "*a consumer is placed alone in a room or area, at any one time and for any duration, from which they cannot freely exit*" (MoH, 2010, p.1). Seclusion and restraint are traumatising experiences for people receiving services and for people delivering services (Te Pou, 2018b). The use of seclusion creates a complex ethical dilemma for nurses, who in turn, experience emotional distress and suppress unpleasant emotions (Moran *et al*., 2009). The practice of seclusion is another problem that impacts on mental health nursing care in NZ and is likely to cause new graduate MHNs additional stress. One recent thesis (Ball, 2017), found that new graduate nurses are often exposed to a range of violent and aggressive behaviours which can have a considerable psychological effect at a formative stage of their nursing career. Paterson, McIntosh, Wilkinson, McComish and Smith (2013) suggest that only half of nurses exposed to violence are actually receiving appropriate clinical supervision. Similarly, Needham and Sands (2010) maintain that post seclusion debriefing is not routinely performed in practice. Repeated exposure to violence and aggression can result in trauma for staff and without adequate supervision and support, debriefing or training, staff can behave in destructive ways and organisations grow toxic (Paterson *et al*., 2013).

Minimising restrictive care is one key priority of the Health Quality and Safety Commissions (HQSC, 2017) mental health programme aiming to address the ongoing concerns about quality and safety in mental health. Some mental health wards have implemented the '*Safe Wards Model'* (Bowers, 2014) where interventions can produce decreases in the rate of conflict and in the rate of containment (Safewards, 2017). Much of the national quality improvement work in mental health is led by Te Pou which is the centre for evidenced-based workforce development. Some of the initiatives that Te Pou lead include: seclusion and restraint reduction, trauma informed care and sensory modulation (TePou, 2018b). There is an emerging evidence-base for using sensory modulation in adult and youth acute inpatient settings to deescalate violence and aggression and have a positive impact on some client experiences (Andersen, Kolmos, Andersen, Sippel & Stenager, 2017; Blackburn *et al*., 2016; Lloyd, King & Machingura, 2014).

2.2.3 The Socio-Political Context: Mental Health Inequalities

There are significant health inequalities present in NZ which impact on contemporary nursing practice and therefore new graduate MHNs. Ethnic inequalities between Māori and non-Māori are the most constant and overwhelming inequities in health in Aotearoa (Reid & Robson, 2006). This can be understood in terms of the history of colonisation and the inherent racism that continues to exist within modern NZ society. Registered Nurses (RNs) are suitably mandated to demonstrate the ability to apply the principles of the Treaty of Waitangi/Te Tiriti o Waitangi to nursing practice through the NCNZ *Competencies for Registered Nurses* (NCNZ, 2012). Specifically in mental health, young people from Māori and Pasifika communities have a higher prevalence of psychological disorders than other NZ European groups (MHF, 2014). Māori are over represented in specialist mental health services, have a higher rate of hospital admissions and are more likely to be secluded (McLeod, King, Stanley, Lacey & Cunningham, 2017). However, Māori are considered to be under accessing health services for mental health problems within primary care settings and community health services (Baxter, Kokaua, Wells, McGee & Oakley Browne, 2006). In light of these inequalities, promoting Māori health is an especially difficult challenge for nurses working in mental health and effectively this also impacts on new graduates.

Mental health inequalities are also abundant amongst other populations such as Pasifika groups, refugees, people with cognitive impairments and those from the rainbow communities and meaningful engagement with people is crucial (Te Pou, 2018c). Other inequalities in the mental health field which new graduate MHNs encounter in their daily work relate to the physical health needs of clients. People who have been diagnosed with a mental illness and or addiction in NZ die much earlier than the rest of the population, with two to three times greater risk of premature death (Te Pou, 2017). Two-thirds of this premature death is due to cardiovascular disease, cancer and other physical illnesses (Te Pou, 2017). This vulnerable group of consumers also suffer from higher rates of metabolic syndrome, viral and oral health problems, respiratory diseases and diabetes (Te Pou, 2017). Mental health nurses are best placed as front line staff to provide screening, monitoring and interventions to improve physical health outcomes for people with serious mental illness and addictions (Mwebe, 2017).

2.2.4 The Socio-Political Context: Suicide Data

It is also necessary to consider NZs sobering statistics pertaining to suicide. New Zealand has an elevated rate of youth suicide when compared to other Western countries and this has been linked to a toxic mix of high levels of child poverty, family violence, child abuse, teenage pregnancies and families where both parents are unemployed (Illmer, 2017). The suicide rate for Māori males aged between 15 and 24 is twice that of non-Māori of the same age and similarly the suicide rate of female Māori (across age groups) is five times higher than non-Māori populations (Snowdon, 2017). Furthermore, NZ has a high rate of farmer suicide associated with times of agricultural crises and the stressful nature of the work (Goffin, 2014). A high percentage of the NZ population live in rural communities and this is associated with poorer access to services because of socioeconomic deprivation, geographical barriers and distance, transport costs, telecommunication problems and the elevated cost of accessing services (National Health Committee, 2010). Suicide prevention, risk assessment and management are all routine nursing responsibilities and research shows that MHNs suffer traumatic loss and grief when patients suicide (Cross, 2015). This type of work will undoubtedly bring new graduate MHNs professional stressors such as going through organisational or legal processes after adverse events, alongside the impacts at a personal level.

2.3 Comprehensive Nursing Education in New Zealand

To qualify as a RN in NZ, a person has to complete a NCNZ approved BN, Bachelor of Health Science, or a Masters of Nursing programme from a Polytechnic, Institute of Technology or University (Nursing Education in the Tertiary Sector (NETS), 2018). There are eighteen SoN in NZ who offer these programmes and NCNZ stipulate that students must complete a minimum of 1100 clinical hours in a range of settings with health consumers across the lifespan (NETS, 2018). Registered nurse education in NZ includes mental health components (alongside medical-surgical, paediatric and primary care nursing) but leads to a comprehensive qualification so successful graduates can work as a beginner practitioner in any clinical setting.

Historically nurses were paid during hospital based training schemes and many have a 'rose-tinted' view of the old system which promoted caring, obedience and absolute devotion to duty (McKenna, Thompson, Watson & Norman, 2006). Some critics argue that modern new graduates are unprepared for nursing practice since their education is too far removed from clinical realities (Clark & Holmes, 2007). Cleary, Horsfall and Happell (2009) argue that new graduate nurses are less prepared for a career in mental health nursing than other areas of nursing. The move from specialised to comprehensive nurse education programmes in the late 1990s caused a reduction in the mental health content being taught to undergraduates (Ogden, 2017). Inadequate mental health nursing content in undergraduate nursing education is frequently cited in the literature since academic programmes are generally biased towards the general nursing field (Edward, Hercelinskyj, Warelow & Munro, 2007; Happell, 1999; Happell, 2009; Happell *et al*., 2014; Hayman-White, Happell, Charleston & Ryan, 2007; Henderson, Happell & Martin, 2007; Hooper *et al*., 2016; McCann, Clark & Lu, 2010). International commentators have observed that the comprehensive nursing education model creates a domino effect related to the detriment of mental health nursing recruitment, retention, skills, knowledge and attitudes (Hemingway, Clifton & Edward, 2016). Some nurses believe that a reform of the NZ mental health component in undergraduate education is needed to allocate additional time, more resources and an improved curriculum to support the specialty (Logan, 2018). The literature suggests that giving undergraduate student nurses clinical placement experiences in a mental health setting has a positive influence on their attitudes towards the specialty (Happell, 2008a; Happell, 2008b; Happell, 2008c; Gough & Happell, 2009; O'Brien, Buxton, & Gillies, 2008), but sufficient numbers of quality clinical placements are not always available in NZ (Spence, Garrick and McKay, 2012).

2.4 Mental Health Nursing Recruitment

Critics from Australia argued that the introduction of comprehensive training has not helped mental health nursing recruitment (Happell, 1999). One Australian quantitative study (Happell, 2008a; Happell, 2008b) investigated the effectiveness of undergraduate clinical mental health placements on student interest in mental health by comparing student attitudes pre and post placement experience. The results showed that clinical experiences had a significantly positive influence on student nurses' attitudes towards people diagnosed with a mental illness (Happell, 2008a; Happell, 2008b). The second

part of the study explored the impact of theory and clinical experiences on students' intentions to pursue a career in mental health nursing (Happell, Robins & Gough, 2008a; Happell, Robins & Gough, 2008b). The results showed that an increase in positive perspectives towards the mental health field did not necessarily translate into an increase in mental health nursing recruitment (Happell *et al*., 2008a; Happell *et al.,* 2008b). One systematic review of twenty-one studies about student nurses attitudes towards mental health nursing found that while theoretical preparation and longer clinical placement improved overall attitude, there was no indication that these aspects resulted in more graduates choosing careers in mental health (Happell & Gaskin, 2013). During the past decade hardly anything has changed regarding the recruitment and retention of new graduate MHNs, in spite of numerous research studies into the educational preparation of nurses for mental health practice (Hooper *et al*., 2016).

Students are warned that pursuing a career in mental health nursing equates to losing all their clinical skills and there is a very commonly held belief that once students have graduated they should spend their first year post registration in a medical or surgical nursing environment to consolidate what they have learnt (Shattell, 2009; Stevens, Browne & Graham, 2013). One longitudinal study (Happell, 2002) investigated undergraduate nursing students' career preferences at the start of their course and compared this with attitudes after course completion. Differences in preferences were found over time, however the tendency for students to prefer areas of high technology and work with children and babies remained high (Happell, 2002). The unpopularity of mental health nursing, aged care and community health presented as an issue of concern (Happell, 2002). Wilkinson, Neville, Huntington and Watson (2016) conducted a national NZ survey of recently graduated RNs and explored the factors that influenced their preference for employment with particular reference to three governmental priority areas, including mental health. The results indicated that new graduates prefer to work in surgical or medical areas to consolidate their technical skills and that these clinical experiences are viewed as providing a good foundation for future career pathways (Wilkinson *et al*., 2016).

One theory is that the negative portrayal of mental health within the media does not help the recruitment into mental health nursing (O'Brien *et al*., 2008). In a review of American films, De Carlo (2007) found that MHNs were portrayed as 'custodial

companions' and 'doctor's handmaidens'. Another theory is that the historical stigma and prejudice attributed towards people who use mental health services is also ascribed to the nurses who work in this field (Flaskerud, 2018; Gouthro, 2009). Gouthro (2009) reported that student nurses' perception of mental health nursing is similar to that of aged care and community health because it holds a second class status; has a lack of technological tools and a poor focus on curing illness. Furthermore, one ethnographic study of the MHNs role identity found that public perceptions of mental illness being a personal flaw and associated with being dangerous, unpredictable and blameworthy, are also associated with the nursing profession (Sercu, Ayala & Bracke, 2015). Mental health nurses were perceived as being neurotic, ineffective and unskilled (Secru *et al*., 2015). Some argue that to entice nurses to work in mental health, we need to break down the stigma related to mental health nursing (Flaskerud, 2018; Harrison, Hauck & Ashby, 2017). There is a clear absence of research which explores why some nurses originally choose to become a MHN and perhaps this knowledge would enable us to attract a future sustainable workforce (Harrison *et al*., 2017).

2.5 The Advanced Choice of Employment Scheme

In 2012 all DHBs in NZ participated in a national pilot of the Advanced Choice of Employment (ACE) scheme to recruit graduating and new RNs into two supported first year of practice programmes, namely the 'Nurse Entry to Practice' (NETP) and NESP programmes (Wilkinson *et al*., 2016). The ACE scheme requires nursing applicants to choose in order of preference up to four DHBs and three clinical areas where they would like to work. The NESP programme varies slightly from NETP in that the NESP requires participants to finish a postgraduate certificate as part of the programme (Te Pou, 2015). However, one study (Ogden, 2017) highlighted that the pressure students experience to secure a post registration position within the ACE system can result in some applicants accepting a position in NESP even if they have no interest whatsoever in pursuing a career in mental health nursing (Ogden, 2017). Conversely, other evidence suggests that some new graduate nurses who want to work in mental health nursing have been unsuccessful in securing a position through the ACE scheme in the first round (Cassie, 2018b). It appears that the ACE scheme is not working as anticipated and the anxiety that students express regarding the process may well be justified.

2.6 Transition to Practice

Kramer (1974) identified the phenomenon of *reality shock* in nursing over forty years ago, related to new graduate nurse experiences while transitioning into professional practice. Kramer's work (1974) underpins the modern understanding of the initial transition to professional practice for new nurses generally, across all clinical areas, not just mental health. Yet some argue that problems with transitions into clinical practice are more considerable for nursing graduates today (Dyess & Sherman, 2009).

More recently, Duchscher (2009) built on the work of Kramer (1974) to develop a more comprehensive '*Transitional Shock Model*' and associated conceptual framework. This model outlines how contemporary new graduates embracing the professional practice role for the first time are confronted with a broad range and scope of physical, intellectual, emotional, developmental and sociocultural challenges and changes (Duchscher, 2009). Duchscher (2009) offers this cumulative knowledge gained from a programme of research spanning ten years and four qualitative studies exploring new graduate transitions. Key words at the heart of Duchscher's (2009) work are loss, doubt, confusion and disorientation, since new graduates frequently identify their difficulties in adjusting to professional work in terms of feelings of anxiety, insecurity, inadequacy and instability. The Transition Shock conceptual theory emphasizes aspects of the new graduate's roles, responsibilities, relationships and knowledge that both mediate the intensity and duration of the transition experience and qualify the early stage of professional role transition in substantial detail (Duchscher, 2009).

2.7 New Graduate Transition Programmes

The purpose of the transitional year is to consolidate undergraduate learning and to provide support during the initial period as a RN (Cleary *et al*., 2009b; Hayman-White *et al*., 2007) and in NZ the NETP and NESP are available. Yet new graduate nurses perceive a wide variation in the quality of transition programmes and preceptors available to them (Pasila, Elo & Kaariainen, 2017). Haggerty, Holloway and Wilson (2013) reported on a longitudinal evaluation of NETP programmes in NZ and the findings acknowledged the importance of quality preceptorship as an integral component of any new graduate programme. Access to preceptors, the importance of the preceptor-new graduate relationship, preceptor preparation for their role and responsibilities, plus the overall culture of support are identified as being important

(Haggerty *et al*., 2013). Nursing leadership is additionally mentioned as a critical component to support effective preceptorship in any new graduate nursing programme (Haggerty *et al*., 2013).

Transition to practice programmes have been promoted as one strategy to address recruitment and retention in the mental health nursing field (Procter *et al*., 2011). The literature suggests that new graduate nurses who complete postgraduate study are more likely to stay working in the mental health nursing profession (Cleary *et al*., 2009; North *et al*., 2014). Te Ao Māramatanga The NZ College of Mental Health Nursing (NZCMHN) regards the NESP programme as the prerequisite for becoming a MHN but there is no regulatory requirement for a RN to complete this programme (Cassie, 2013). The NESP programme runs for one year and involves blocks of classroom teaching, online, self-directed and work place learning within the clinical setting, clinical preceptorship and supervision (Te Pou, 2018d). Te Pou (2015) report on feedback from the NESP student survey 2010-2014 indicating that the NESP programme is strongly supporting MHNs in areas such as developing values, skills, knowledge and applying their learning in the workplace. However, while these results are positive, they give us little insight into the experiences of the graduates in their adjustment to the clinical workplace since only minor qualitative data is provided.

2.8 New Graduate Mental Health Nursing Research

While there is a growing body of research about new graduate nurse transitions, there has been very little data exploring the mental health field (Tingleff & Gildberg, 2014). Exploration into the experiences of the new graduate MHNs is warranted given the workforce shortages, increasing pressure on mental health services and the high risk of attrition (Hooper *et al*., 2016). The first study to investigate new graduate MHN experiences was conducted by Prebble and McDonald (1997) over twenty years ago. This research was published in the *Australian and NZ Journal of Mental Health Nursing,* although it is unclear which specific country the study was conducted in. Prebble and McDonald (1997) used semi-structured interviews with four new graduates who had completed a comprehensive based training and who had started work in an acute psychiatric setting. Two major themes emerged relating to a less than adequate orientation process during the initial transition stage and a lack of ongoing supervision and support needed for the new nurses to become safe and competent practitioners

(Prebble & McDonald, 1997). The unique culture of mental health care was acknowledged as something that a new graduate MHN has to adapt and socialize into. While a lack of generalisability is one limitation of this study due to the extremely small sample size (n=4), it was ground-breaking and innovative in that it actually considered the new graduate MHNs perspectives and lived experiences.

The first review of the literature concerning new graduate MHN transition programmes was conducted a decade later in Australia by Hayman-White *et al*. (2007). There was still a dearth of literature regarding MHN experiences available at this point in time but new graduate nurse programmes had been accepted by then as an essential strategy for the development and sustainability of the mental health nursing workforce. Low levels of new graduate MHN confidence and competence were attributed to poor levels of theory and clinical mental health nursing content within undergraduate education courses (Hayman-White *et al*., 2007).

Furthermore in Australia, Procter *et al.* (2011) conducted the first comprehensive review and synthesis of qualitative research which sought to provide insight into the experiences of transition for new graduate MHNs. Nine studies were identified, with the majority being from Australia and two each from the UK and the United States of America (USA). New graduate MHNs faced a number of significant challenges including staff shortages, demanding workloads, limited career structures, declining numbers of experienced staff and negative attitudes towards the nursing specialty (Procter *et al*., 2011). The findings showed a disparity and incongruence between undergraduate perceptions of the role of the MHN and what was experienced during post registration clinical placements (Procter *et al*., 2011). Graduate MHNs were starting their careers with high levels of anxiety about whether or not they were suited for the job and if they could cope with the increased level of professional responsibilities (Procter *et al*., 2011). A limitation of this review arose from using studies from different countries who each have very different approaches to mental health care management and new graduate MHN transition programmes. Procter *et al.* (2011) concluded that further qualitative research was needed to understand new graduate MHN ambitions, aspirations and the ways they effectively transition into the workforce. "*Contextual understanding is critical as it provides clues as to why certain*

decisions are made – including decisions regarding whether to stay or leave the profession" (Procter *et al*., 2011, p. 260).

From Denmark, Tingleff and Gildberg (2014) presented a systematic literature review of published literature after the year 2000 on new graduate MHN transition programmes and transition experiences within mental health care. Thematic analysis was used to analyse 14 studies that were found from Australia, the UK, the USA, Denmark and Canada. Results showed four overall themes: nursing education, transitions programmes and evaluations, working environments and the new graduate role (Tingleff & Gildberg, 2014). The nursing education theme described how ill prepared the new graduate MHNs felt which led to feelings of stress because they felt unable to adequately act in the role of a registered MHN. This was also linked to limited clinical experiences and unrealistic perceptions (Tingleff & Gildberg, 2014). The theme relating to transition programmes and evaluations comprised of three subthemes: formal programmes, informal or short programmes and evaluations. The most common transition programmes were formal in nature but each had different names, lengths (ranging from three months to two years) and embraced different learning activities (Tingleff & Gildberg, 2014). Less common were informal or short programmes but again these varied greatly from two days to five weeks (Tingleff & Gildberg, 2014). In the evaluations theme, orientations, theoretical education, clinical rotations and preceptorship and mentorship were all important elements to facilitate successful transitions (Tingleff & Gildberg, 2014).

In respect of the working environment theme, this was subdivided into two categories, namely collegiality from colleagues and safety in mental health care (Tingleff & Gildberg, 2014). Collegiality meant that new graduate MHNs were dependent on acceptance from work colleagues and needed a positive team dynamic in order to integrate into the team and culture. However, some new graduate MHNs experienced a negative environment where they did not receive support from senior staff and furthermore, some observed unprofessional care which also led to feelings of stress and frustration (Tingleff & Gildberg, 2014). "*They are unable to identify the role models they need to learn from*" (Tingleff & Gildberg, 2014, p.541). The safety subtheme related to the importance for the new graduate MHNs of the working environment in contributing to and maintaining safety for themselves, their colleagues and their clients

(Tingleff & Gildberg, 2014). A variety of factors incorporating violence prevention, keeping a relaxed atmosphere on psychiatric wards, establishing and maintaining therapeutic relationships with clients and knowing risk alerts were all central features (Tingleff & Gildberg, 2014).

The last theme pertaining to the new graduate MHN role from Tingleff and Gildberg's (2014) thematic analysis relates to increased responsibilities and feeling unprepared to manage a clinical workload. Difficulties with therapeutic interventions, medication administration, assessment, and delegation to colleagues also led to potential feelings of stress and dissatisfaction. "*Skills and knowledge of communication and therapeutic interventions appear to be very important elements of the transition programme*" (Tingleff & Gildberg, 2014, p.542). Despite the rich data offered, Tingleff and Gildberg (2014) concluded that a deep and comprehensive understanding about new graduate MHN transitions was not possible due to the globally sparse reporting on the subject and that further research was indeed necessary. Tingleff and Gildberg (2014) also acknowledged the limitations of their review with respect to the range of different countries where the studies originated from and the disparities within nursing education across each country. They suitably question the generalisability of the findings across countries.

Finally, also in Australia, Hooper *et al.* (2016) conducted an integrative review on graduate nurse experiences of mental health services in their first year of practice and they linked negative clinical experiences with increasing levels of attrition during early career stages. A total of 22 studies were retrieved from the international community but none of these came from NZ. The review highlighted that despite the considerable global effort with transition programmes and preceptorship, the negative clinical experiences of new graduate MHNs continues at a high level (Hooper *et al*., 2016). Hooper *et al.* (2016) hypothesized that if a new graduate MHN started in the clinical environment with positive expectations but encounters a negative culture then he or she will become ambiguous about staying in the mental health nursing profession for their career. They conclude that the causes of the high attrition rate are (Hooper *et al.,* 2016):

i. changes to the educational preparation of nurses;
ii. role ambiguities;
iii. inadequate new graduate preceptorship;

iv. the harsh reality of mental health services;
v. and the role of the health service in transitioning the new graduates into practice.

They argue that further research into new graduate MHN experiences and how this relates to the culture of mental health nursing practice may clarify some of the reasons why nurses choose to leave or stay in the discipline, early in their career (Hooper *et al*., 2016).

2.9 Chapter Summary

The high attrition rate is concerning given the increasing demand for mental health services and the ageing population and pending retirement of the nursing workforce which is leading to an overall dilution of expertise in the clinical setting (Hazelton *et al.,* 2011). This will undoubtedly have a negative impact on the quality and safety of nursing care provided in mental health settings which are already functioning under pressure and regarded by critics as not meeting needs. New Zealand has high rates of health inequalities and suicide which bring new graduate MHNs a number of significant challenges in the workplace.

Comprehensive nursing education favours the general nursing field and recruitment into mental health nursing continues to be one of the least popular career choices. In NZ, the ACE system is used to recruit new graduates into the NESP transition programme but problems still exist. New graduates embracing a professional practice role for the first time are confronted with a broad range and scope of physical, intellectual, emotional, developmental and sociocultural challenges and changes (Duchscher, 2009).

There has been very little qualitative research conducted globally to explore MHN transitions into practice despite the first study being published over twenty years ago. Findings from the first comprehensive review and synthesis of qualitative research showed a disparity and incongruence between undergraduate perceptions of the role of the MHN and what was experienced during post registration clinical placements (Procter *et al*., 2011). A more recent integrative review concerning new graduate MHN transitions found that despite the considerable global effort with transition programmes

and preceptorship, the negative clinical experiences of new graduate MHNs continues at a high level which clearly impacts on the worrying attrition rate (Hooper *et al*., 2016).

Further global research exploring new graduate MHN transition experiences is undoubtedly warranted (Harrison *et al*., 2017; Hooper *et al.,* 2016; Procter *et al*., 2011; Tingleff & Gildberg, 2014) and this needs to include specific data from NZ to add to the international evidence base. Given the very difficult socio-political context described in this chapter, it is crucial that we gain insight into the experiences of the NZ new graduate MHNs. This will enable us to appreciate how well nursing education prepares them, or not, for their transition into professional practice.

The table below identifies the key issues highlighted from the literature review.

Table 1. Key Issues from the Literature Review	
Nursing Workforce Issues	Recruitment and Retention Crises Increased Life Expectancy and Ageing Population Ageing Workforce Pending Retirement High Attrition Rate of Young Nurses Bullying Culture Recent Strike Action in NZ
The Mental Health System	Increasing Demand Underfunded System in Crises Recent Government Inquiry Stigma and Social Exclusion High Seclusion Rates Health Inequalities Disturbing Suicide Data
Comprehensive Nursing Education	Reduction in Mental Health Components General Nursing Bias
Transition to Practice	Poor Mental Health Recruitment The ACE Scheme Reality Shock NESP Programmes
International Research	Ill Prepared Low Confidence Poor Orientations Lack of Supervision Inadequate Preceptorship Challenges in the Workplace – Negative Experiences Role Ambiguities

Chapter Three - Research Methodology

This chapter describes the research methodology for the project and introduces the qualitative paradigm. The research process includes the design, aims, research questions, recruitment processes and data collection methods. The Thematic Analysis (TA) method of data analysis advocated by Braun and Clarke (2006) is presented and explained. The ethical considerations are discussed including Māori consultation and DHB locality approvals.

3.1 Qualitative Paradigm

Qualitative research is a systematic, subjective approach to describing life experiences within the interpretive paradigm where analysis is situated within a particular context (Burns & Grove, 2009). There are many types of qualitative research but the one applied in this study is a descriptive design. Qualitative research is different from the positivist paradigm that seeks to obtain objective scientific knowledge and from the critical paradigm, which provides opportunities for emancipatory action. The interpretive paradigm allows for exploration of the depth, richness and complexity inherent in phenomena (Burns & Grove, 2009). Qualitative research is a holistic approach that frequently involves rich data collection from various sources to gain a deeper understanding of individual participant's opinions, perspectives and attitudes (Nassaji, 2015).

3.2 Qualitative Descriptive Design

The goal of descriptive research is to describe a phenomenon and its characteristics (Nassaji, 2015). The literature suggests that there are six key design features and techniques of qualitative descriptive research (Kim, Sefcik, & Bradway, 2017; Sandelowski, 2000) highlighted below:

i. researchers utilise naturalistic perspectives;
ii. it is less theory driven than the other qualitative approaches which offers flexibility when designing and conducting studies;
iii. data collection methods are typically either individual or focus group semi structured interviews;
iv. purposive sampling techniques are used;
v. qualitative content analysis or TA are often employed to analyse the data;

vi. and the study findings are candid reports which include comprehensive descriptive summaries and accurate details.

The justification for using a descriptive qualitative research design is that it supports rich data collection from a small group of MHN individual participants which can then be analysed by TA to provide a comprehensive descriptive summary of their experiences of nursing education and the impact this has had on their decision to work in mental health and their transition into practice.

3.3 Research Proposal

The research proposal was submitted and approved in February 2018 by the Centre for Postgraduate Nursing Studies (CPNS). The approval letter from CPNS (see Appendix A) suggested that the original title did not adequately reflect the research project and hence the title was subsequently changed in light of this feedback.

3.4 Research Aims

The aims of this study are to explore how undergraduate nursing education impacts on the decision to work in mental health and the transition into practice for new graduate MHNs in NZ. The research project seeks to address a gap in the literature, enhance existing knowledge on new graduate MHN transitions and also add a fresh NZ perspective.

3.5 Research Questions

1. How does nursing education in NZ prepare nurses to work in the mental health sector?
2. How does nursing education in NZ impact on the decision to work in mental health?
3. How can new graduate transitions into mental health nursing be enhanced in NZ?
4. How can the recruitment of new graduates into mental health nursing in NZ be improved?

3.6 Sampling

Purposive sampling was utilised in this study. A purposive sample is a non-probability sample that is selected based on characteristics of a population and the objectives of the study (Crossman, 2018).

3.7 Inclusion and Exclusion Criteria

Inclusion criteria for participants were that the new graduate MHN had completed a BN in the previous year, was currently enrolled on a NESP programme and was agreeable to the interview being audio or video recorded. Exclusion criteria was knowing the researcher previously through her role as clinical lecturer at the local OP SoN.

3.8 Interview Questions

Interview questions and prompts are shown in the table below:

Table 2. Interview questions

Question	Prompts, if required
Please discuss how your nursing education prepared you for the transition into mental health nursing?	Did you have relevant clinical experiences? Did you have enough theoretical knowledge? Did you feel supported? Were you adequately prepared?
At what stage of your education did you decide to work in mental health nursing?	What were the factors that affected your decision?
Were there any positive aspects of your nursing education that impacted on your decision to work in mental health?	Do you have any specific examples? Did you have a role model? Were your clinical placements positive? Was mental health framed positively in the nursing school?
What were the negative aspects of your nursing education that have impacted on your transition?	Can you give any specific examples? How did you feel? Can you expand on how this affected you?
How could your transition from undergraduate to new graduate working in mental health nursing have been improved?	What supports would have been helpful – from the nursing school or clinical environment? Is the organisational culture positive towards your transition?
How do you think we can improve the recruitment of new graduates into mental health nursing in NZ?	What can we do to change perceptions and stigma associated with the role of the mental health nurse in NZ?
Would you like to add any other comments?	Do you have any other experiences, thoughts or feelings you would like to share?

Two of the research questions (namely Were there any positive aspects of your nursing education that impacted on your decision to work in mental health?; and What were the negative aspects of your nursing education that have impacted on your transition?) have

been adapted and applied to a NZ MHN context, from the work done by Boyd-Turner *et al.* (2016) who explored how student nurse placement experiences influence the decision to work in paediatric nursing in Australia.

3.9 Recruitment Process

The initial plan to recruit participants was via the local Dunedin NESP co-ordinator (whom the author knew previously due to past clinical work), who was willing and happy to assist with recruitment. The role of the author was to recruit the participants and the role of the NESP co-ordinator was facilitating access to the NESP group during one of their study days. The proposed strategy was for the author to meet the local group of seventeen NESP MHNs face to face to promote the research project and provide written information about how they could volunteer to participate. If insufficient numbers of participants were recruited locally in Dunedin, then the plan was to access further new graduate MHNs through the Christchurch NESP co-ordinator, who also agreed to assist. It was anticipated that contact could be made with this group of new graduate MHNs (a potential pool of fifty) by video conferencing and that these interviews would also be conducted by Zoom, instead of face to face interviews.

However, the recruitment strategy had to be changed in light of time restrictions and a request was made in writing to the University of Otago Human Ethics Committee (Health) (see Appendix B). The revised plan being recruitment through email contact from the NESP co-ordinators instead of face to face introductions with the researcher. The author wrote an email explaining about the project and invited the nurses to apply with an attached information sheet (see Appendix C) and sent this to the NESP co-ordinators, who then forwarded this email onto the new graduate NESP nurses. Potential participants could then make contact with the author if they wished to participate in the study.

A total of eight participants responded but only seven could be interviewed as the author knew one nurse from being a clinical lecturer at the local OP SoN. Once participants made contact then consent forms (see Appendix D) were emailed and a mutually convenient time and place for interview was arranged. For participants who chose to have an interview by video conferencing, obtaining consent was done remotely

and signed forms either scanned or photographed and sent back to the author who witnessed the forms and sent a copy back to the participants.

3.10 Data Collection

Individual semi-structured interviews were used to collect the data and it was anticipated that between six and ten participants would be sufficient to reach data saturation point. Seven interviews took place between 17th July and 3rd September 2018 with the interviews lasting between 25 and 50 minutes each. One person chose to have their interview at home, one person was interviewed in a University of Otago office and the other five participants were interviewed via Zoom video conferencing. The interviews were audio recorded and then transcribed verbatim by the author. Following transcription each participant had the opportunity to review their own data to increase validity (Lincoln & Guba, 1985) and each person partook in this process. Given that only seven eligible nurses engaged in the research, saturation point was not achieved as new themes still emerged during the final interview. However because no other new graduates came forward to participate in the research and due to time restrictions in the dissertation year, the research process had to continue regardless.

3.11 Data Analysis

Thematic Analysis (TA) is a widely used qualitative research method for identifying, analyzing, organizing, describing, and reporting themes found within a data set (Braun & Clarke, 2006; Braun & Clarke, 2013; Clarke & Braun, 2017; Nowell, Norris, White & Moules, 2017). The TA method advocated by Braun and Clarke (2006) was used to analyse the data in this research project. Braun and Clarke (2006) identify six phases of thematic analysis: familiarizing with the data, generating codes, searching for themes, reviewing themes, defining and naming themes and finally, producing the report. Consistent with this, the author read the transcripts and listened to the recorded interviews numerous times to become immersed in the data and note initial ideas using lists and mind maps. The data set was then coded systematically and collated into potential themes and checked again. Codes and themes were discussed and checked with supervisors to increase validity. A selection of transcripts was also reviewed and coded by the supervisors with discussion of any discrepancy to reach consensus. The specifics of each theme were then defined and named before the final analysis. Vivid

extract examples were selected and related back to the original research questions and are available literature in the following chapter.

3.12 Ethical Considerations

Ethical approval was sought from the University of Otago Human Ethics Committee (Health) and conditional approval was given in April 2018, reference H18/050 (see Appendix E). The main ethical issue that arose when designing the study was that the author works at the local OP SoN so may have had previous contact with some of the eligible participants. This conflict of interest was managed by excluding anyone who knew the author previously from this role. The University of Otago Human Ethics Committee (Health) requested further information about any current relationships that the author had with potential participants, such as employment relationships, and a letter of response was sent explaining that no such relationships existed (see Appendix F). Full ethical approval to proceed was then granted in May 2018 (see Appendix G).

Another ethical issue identified was the potential power imbalance and suitable participants having concerns about whether their participation had any effect on their NESP or job position. This was managed by ensuring confidentiality and explaining very clearly to potential participants that the study was being undertaken by a student undertaking a Masters degree at the University of Otago and would have no impact on their employment. An information sheet was provided to participants and written informed consent obtained prior to participation. Participants were informed that they could withdraw from the project at any point without any disadvantage to themselves, of any kind.

Transcripts were de-identified and pseudonyms used to protect participant's confidentiality. The information was securely managed by having password access on files and data was backed up using the University of Otago file storage system. Full disk encryption was activated on the project laptop to ensure safety if the device was lost. Transcribed data were kept in a locked drawer as per the University of Otago policy. At the end of the project, the recorded video conferencing files will be deleted. Participants were made aware that the transcripts of recordings would be kept for 10 years.

3.13 Māori Consultation

Māori consultation was conducted by audio conference with the Māori Research Advisor on May 8th 2018 (see Appendix H) for the Dunedin locality. It was recommended that ethnicity data be collected from each participant in accordance with the MoH guidelines which involves the use of the Census 2013 question. A further recommendation was that dissemination of results should include appropriate Māori health stakeholders and also the community from where the data originated. Māori consultation was further approved for the Christchurch locality on July 5th (see Appendix I).

3.14 Locality Approval

Local authorization was obtained from Health Research South for the Southern DHB on 14th June, reference 01455 (see Appendix J) and from SMHS Research Committee for the Canterbury DHB on 10th August, reference 18054 (see Appendix K).

3.15 Reflexivity

Qualitative researchers have to critically think about the dynamic interaction between the self and the data during analysis and this process is called reflexivity (Burns & Grove, 2009). The researcher should explore personal feelings and experiences that may influence the study and integrate this understanding into the study (Burns & Grove, 2009). In this study the researcher used a diary to record thoughts and feelings throughout the research process.

Chapter Four – Results

This chapter describes the characteristics of the study participants before presenting the findings from the study, shown in relation to the three major themes, eleven subthemes and three smaller subthemes that emerged during analysis.

4.1 Participant Characteristics

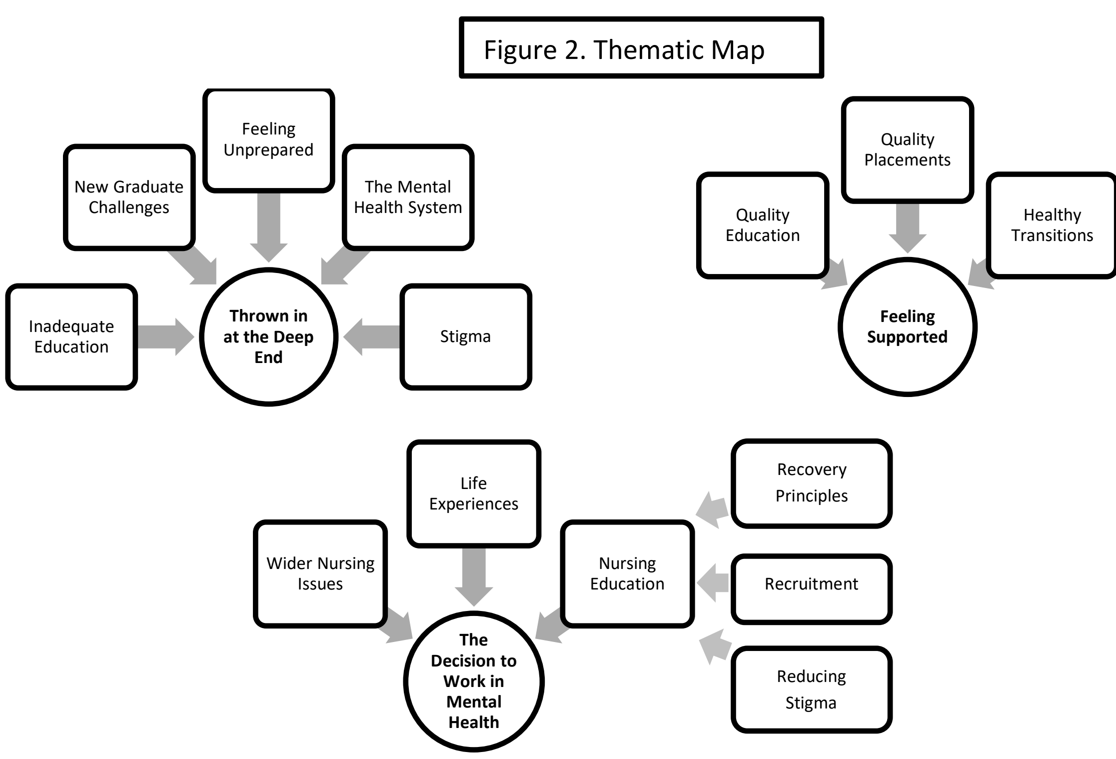
In total seven NESP nurses participated in the study and all of them were female which unfortunately does not reflect the gender balance in the current MHN workforce. Male nurses make up only only nine percent of the general nursing workforce but the largest groups of male nurses are found in inpatient and community mental health areas, where they represent a quarter of the workforce (NCNZ, 2018). The age range of participants was 22 to 35, with the mean age being 24 years of age. Regarding ethnicity, three participants identified themselves as NZ European and one identified herself as British/NZ European. The other three comprised one Māori participant, one Indian participant and one Filipino participant. Concerning their undergraduate nursing education, the participants had studied at Ara, Institute of Canterbury (Christchurch), OP (Dunedin) and the Southern Institute of Technology (SIT) (Invercargill). The group were registered in the Christchurch and Dunedin NESP programmes.

Table 3. Participant Characteristics		
Gender	All Female	
Age Range	20-25 years	5
	26-30 years	1
	31-35 years	1
Ethnic Background	NZ European	3
	Māori	1
	Indian	1
	Filipino	1
	British / NZ Euro	1
Educational Institution	Ara	4
	OP	2
	SIT	1
NESP Program	Christchurch	4
	Dunedin	3

4.2 Themes

Three major themes, eleven subthemes and three smaller subthemes emerged during analysis and the following section explains these in detail. Each major theme section starts with a table including the associated subthemes and a direct quote from a single participant to highlight the nature of that subtheme. The narrative that follows then defines, describes and illustrates each major theme and the associated subthemes.

The thematic map below shows how the themes fit together (Figure 2). The first major theme is *Thrown in at the Deep End* and this includes five subthemes including *inadequate education, new graduate challenges, feeling unprepared, the mental health system* and *stigma*. The second major theme is *Feeling Supported* and this includes three subthemes of *quality education, quality placements* and *healthy transitions*. The third major theme is *The Decision to work in Mental Health* and this contains three subthemes: *wider nursing issues, life experiences* and *nursing education*, which also incorporates three smaller subthemes: *recovery principles, recruitment strategies* and *reducing stigma*.



4.3 Theme One: Thrown in at the Deep End

Table 4. Theme One: Thrown in at the Deep End		
Major Theme	Subthemes	Findings
Thrown in at the Deep End	Inadequate education	And second year they didn't really teach us all that much about mental health. I learnt more in the third year, but still I feel overall it's not really covered all that much in the nursing degree (Participant 1)
	New graduate challenges	What my preceptors understanding of what it was to be a preceptor was to assist me with my paperwork during the NESP programme, but not to assist me with life on the ward or debriefing or anything like that. So I would say I didn't feel adequately supported, just thrown in the deep end, just two or three days of orientation and straight in on numbers (Participant 5)
	Feeling unprepared	But the reality of the workplace was quite different in terms of the pressure that would be put on us as new grads, and the actual risks as well, because we were not prepared for that at all (Participant 6)
	The mental health system	It's not necessarily the NESP programme that needs to change its approach. It's the current climate in acutes, and that kind of stuff. Yeah, my experience of nursing would be dramatically different if we weren't always short staffed; if we weren't always using casual pool nurses who weren't familiar with the ward and our patients; if the building and infrastructure was better (Participant 5).
	Stigma	We were always told from people that weren't in mental health, if you don't get anywhere else, you can go into psych. Real nurses don't go into mental health (Participant 6)

Thrown in at the Deep End Theme

The first major theme relates to some of the participants strong feelings that they had not been adequately prepared for practice as RNs working in the NZ mental health field and this was associated with a range of overwhelming negative factors, which affected their transitions. The subthemes included inadequate education, new graduate challenges, feeling unprepared, the mental health system and stigma.

4.3.1 Inadequate Education Subtheme

The inadequate education subtheme related to concerns that the undergraduate nursing education the participants received did not include enough mental health components, including both theoretical knowledge and clinical exposure. *"And second year they didn't really teach us all that much about mental health. I learnt more in the third year, but still I feel overall it's not really covered all that much in the nursing degree"* (Participant 1). Alongside this were some opinions that the mental health nursing education they did receive was of poor quality. In relation to the research questions, elements of the nursing education that some of the NESP nurses received can be seen to have impacted on their transitions into practice in a very disappointing way. A common sentiment was that the participants wanted a deeper level of understanding, highlighted by the comment below:

"And what was requested of us was that we would know a very kind of superficial amount of information about extrapyramidal side effect instead of having to know all twelve. We just had to know one. I think education was relatively superficial. We were just kind of ticking boxes, for the purposes of the degree as opposed to developing knowledge and insights and a passion for working in mental health"(Participant 5).

Another aspect of this subtheme related to the participants experiences as student nurses where they felt unprepared for their clinical mental health placements. *"All my classes around different types of mental illnesses and things didn't happen until after I'd already finished the clinical placements. I had no idea what to do"* (Participant 2). Some participants also discussed their frustrations with only having an observer role during their clinical placements.

"I think the placements, because you're a student, you don't actually get that much responsibility and so you kind of have to take on an observant role because in mental health a lot of it is, I suppose, talking to people and stuff and so as a student you end up just doing a lot of observing and so you don't feel that you are actually practicing the essential skills that you need" (Participant 3).

The final aspect of this subtheme related to participants feeling unsupported from both academic lecturers and clinical preceptors, including infrequent contacts and changes in

personnel. Of particular concern were the experiences of the one Māori participant, as she did not feel that her cultural identity was addressed or supported appropriately:

"I could talk for days about the lack of cultural support. But because I'm Māori, that in itself wasn't really addressed properly within the undergraduate degree. So, that made it really hard from a cultural perspective because it was quite lacking" (Participant 6).

4.3.2 New Graduate Challenges Subtheme

The new graduate challenges subtheme pertains to the difficult issues that the participants had confronted since being on the NESP programme, including negativity from others, poor supports and orientation systems, difficulties accessing clinical supervision and the stress of managing work and study.

"What my preceptors understanding of what it was to be a preceptor was to assist me with my paperwork during the NESP programme, but not to assist me with life on the ward or debriefing or anything like that. So I would say I didn't feel adequately supported, just thrown in the deep end, just two or three days of orientation and straight in on numbers" (Participant 5).

One nurse felt she had been unsupported by her NESP co-ordinators and other participants reported negative attitudes from nursing colleagues. *"Where I work the older nurses are not so supportive of accepting a new grad as part of the team, you still get treated like a student"* (Participant 1). A very common experience was that the NESP participants received an inadequate level of orientation to the RN role. One participant explained that: *"there doesn't seem to be much structure teaching us everything or like I always feel like there are holes, like big holes, and there's like no orientation kit"* (Participant 3). Another participant highlighted the culture of poor supports being available:

"I have talked with other people from my class and they have only met their preceptor maybe a couple of times and worked with them a couple of times but otherwise they have been dropped in the deep end and given their own students to take care of" (Participant 1).

A further aspect of this subtheme is that participants reported difficulties accessing clinical supervision. *"I wasn't active with supervision, until, I think it was seven or eight months into my practice"* (Participant 5). *"I thought it wasn't going to happen because he only wanted to meet on the Tuesday and then I said, oh, well because of shift work, it's kinda hard to just schedule supervision on a Tuesday"* (Participant 4). Finally, each participant discussed the impact of stress and the challenges of managing work and study. *"To me this year feels like, it's worse because you're working full time and you're doing your post grad certificate, you know, with the NESP. Very stressful"* (Participant 4). *"I've never been this tired or this stressed but the work I'm doing is really worthwhile"* (Participant 2).

4.3.3 Feeling Unprepared Subtheme

The feeling unprepared subtheme relates specifically to the participants sense of being overwhelmed and unready for the realities of being an RN working in mental health. *"But the reality of the workplace was quite different in terms of the pressure that would be put on us as new grads, and the actual risks as well, because we were not prepared for that at all"* (Participant 6). Many of the NESP nurses identified specific skills they would have liked to possess at the start of their careers and in particular, extra preparation for the role of being a shift leader was especially important amongst the group. While this subtheme is strongly related to the other subthemes of poor education, new graduate challenges and the mental health system, it qualified as a distinctive subtheme in its own right as it was an intense feeling identified by the majority of participants.

"It's a very steep learning curve from the theory of the classroom and even going in as a student where you're guided by your preceptors and you don't really have any responsibility…to suddenly taking on a case load of people who are really unwell and having no idea how to help them" (Participant 2).

Two participants in the study had undertaken their final undergraduate transition placement outside of the mental health field and both acknowledged that this added to their feelings of being unprepared.

"I felt that I wasn't really, you know, like up to date in terms of knowledge with everybody else. Like I didn't know about the different sections of the mental health act and what the culture of the hospital was. Whereas yeah, people who did their placement in mental health transition would be more prepared" (Participant 7).

However even those participants who did experience a mental health transition placement, still discussed a wide range of mental health nursing skills that they were unable to adequately implement in their first few months of clinical practice.

"Motivational interviewing would have been good if it was done during the first week because we had it in the middle of the year during one of our study groups. And so we were thinking, oh, if you had delivered this at the beginning of the year that would have been good for us" (Participant 4).

Other specific skills that the participants felt unprepared to implement included: interview techniques, distress management, anxiety management, managing aggression, talking therapies and sensory modulation. Furthermore, some NESP nurses identified that having more personal skills of assertiveness and self-care would have helped them be more prepared. *"And then we talk about carer's fatigue, but you know, what do you even do for that eh? I don't know"* (Participant 2). The final aspect of this subtheme was linked to the participants' sense of feeling unprepared to be a shift leader on the wards. *"Once or twice experiencing the role of shift lead in a really supportive environment, that would've prepared me so well for the work place and that would've been my preference"* (Participant 5).

4.3.4 The Mental Health System Subtheme

The mental health system subtheme incorporates all the elements that the participants discussed relating to working within the under-resourced environment of psychiatric services.

"It's not necessarily the NESP programme that needs to change its approach. It's the current climate in acutes, and that kind of stuff. Yeah, my experience of nursing would be dramatically different if we weren't always short staffed; if we weren't always using

casual pool nurses who weren't familiar with the ward and our patients; if the building and infrastructure was better" (Participant 5).

Many of these stories were linked to the high stress of working within acute in-patient units, although workload issues were also discussed in the context of community practice. This subtheme also includes wider management issues pertaining to poor leadership and an overall negative organizational culture. Many of the NESP nurses expressed their anxieties about working in acute psychiatric units with unsafe staffing levels and having to manage high risk situations, illustrated below:

"there was one particular instance where we had to put a patient into, a low stimulus area, which is out the back of the hospital, but I hadn't had my restraint training yet and this was a month in actually, but I hadn't actually had my restraint training and I was paired with a nurse who was too old to do restraints! And we were taking our most volatile person, sorry, into a low stimulus area. And so to be fair, instances like this, when I didn't have the confidence to say no" (Participant 6).

Another participant discussed heavy workloads in a community setting: *"people will be supportive but it's still not fair because the other two preceptors have like over a hundred patients on their case load. And then sixty for the NESP. So it's not really fair"* (Participant 7). The personal impact of working in the mental health system was also discussed by many of the NESP nurses. *"Basically because of the lack of safety, as a nurse, but also the work life balance and being able to leave work at work. You can't, it's hard. It's difficult to do that within acutes"* (Participant 6). Participants further discussed their concerns about seclusion practice and how it was difficult to observe for the first time and later take part in as a RN.

"It was the acute mental health one and I'd found that one very confronting. It had just, people in seclusion and stuff like that. And I think as a student, no one really stopped to take the time to fully explain to me, you know, the ins, the outs, like the ethical side of it and all those sorts of things because it was really hard to watch someone be laid down and injected when they didn't want to be and like, you know, just like move on" (Participant 3).

This subtheme also includes issues associated with a lack of leadership, poor management practices and low staff morale. *"We had an acting charge nurse manager and an acting director of acutes and I don't think it's unique to me, but I could see how things fell through the gaps. In a very, very under pressure system"* (Participant 5). Furthermore, there was a distinctive feeling amongst some participants that nursing staff were not being adequately supported by management personnel.

"So there's only a pool EN on and they're just going to leave a brand new nurse in a very specialized unit in charge with nobody else to consult with….. I just looked around and I said, look, I've been here for three months. And they just…..it just kind of went over their heads. They didn't get it at all" (Participant 7).

There was a real sense that some of the NESP nurses felt both unsafe and devalued and the quote below eloquently summarizes this.

"There have been issues raised that are quite horrific….that after an assault, the management don't do basically anything about it. Like they would give you a $5 pizza as a "hope you're ok". And it's almost like a slap in the face" (Participant 7).

4.3.5 Stigma Subtheme

The stigma subtheme is related to the negative and disrespectful attitudes that the participants have been exposed to both during their undergraduate years and post registration working in the mental health field. This stigma and discrimination was related to mental health nursing as a career choice and negative attitudes were displayed from academic staff and other nurses from across the wider nursing community. *"We were always told from people that weren't in mental health, if you don't get anywhere else, you can go into psych. Real nurses don't go into mental health"* (Participant 6). All participants discussed the powerful role that the media plays in perpetuating negative mental health images.

There was a communal sense that mental health nursing is seen as a secondary career choice by the profession as a whole. *"I think mental health has been pigeonholed as undesirable as far as the nursing profession has gone"* (Participant 2). Some participants discussed how academic staff did not show any enthusiasm for mental

health. *“The rest were not into mental health, more into pathophysiology and so they were kinda like mental health (laughs). And I find that happens a lot”* (Participant 1). Other nurses talked about people trying to discourage them from working in mental health: *“I heard of one of my mates was told not to go into mental health, because she was too nice”* (Participant 5). A number of the NESP group expressed their disappointment that no-one from previous NESP groups had presented in a question and answer panel, alongside NETP nurses, to share their experiences about the programme and each of the participants related this to mental health stigma from their educational institution and also from having a poor relationship with the local DHB. The final aspect of this subtheme relates to the stigma that the NESP nurses have felt from other nurses who work in general nursing areas, articulated below:

“but the overwhelming attitude towards mental health is not always very positive from other nurses in the hospital. They're not always keen to have our help on their wards because they think we know nothing kind of thing. And they're always really, hesitant to come over and give us a hand” (Participant 7).

4.4 Theme Two: Feeling Supported

Table 5. Theme Two: Feeling Supported		
Major Theme	Subthemes	Findings
Feeling Supported	Quality education	It really prepared me for my mental health education because we had tutorials, we had lectures and then that's prior to going to placement. If I remember correctly, this was two years ago, when we had four weeks of block sessions just for mental health. And then after that we had a week of kind of like a simulation practice in our clinical practice unit. So that's where we had sort of like interviews, kind of activities to practice on our communication skills. And then after that we had our six week placement (Participant 4)
	Quality placements	And what it was, was the kind of the support that I got from them and in seeing some of the nursing practice that kind of cemented it all; actually psych is really where I want to be and no other area even came close (Participant 6)
	Healthy transitions	I feel like I've been one of the lucky students from my class because I've been quite supported with going through the transition. For myself I've had a preceptor from day one and I work with her still and if I have any questions or anything she's really good at answering those things, plus I see my supervisor often and the team are all really good (Participant 1)

Feeling Supported Theme

The second major theme relates to the NESP nurses feeling supported and all the other positive aspects that have influenced the transition of the study participants. The three subthemes comprise of quality education, quality placements and healthy transitions.

4.4.1 Quality Education Subtheme

This subtheme incorporates the beneficial aspects of the undergraduate teaching and learning that the NESP nurses experienced as part of their nursing education, including the level of support they received.

"It really prepared me for my mental health education because we had tutorials, we had lectures and then that's prior to going to placement. If I remember correctly, this was two years ago, when we had four weeks of block sessions just for mental health. And then after that we had a week of kind of like a simulation practice in our clinical practice unit. So that's where we had sort of like interviews, kind of activities to practice on our communication skills. And then after that we had our six week placement" (Participant 4).

Most of the group reported that they had gained some understanding of the basic psychiatric bio-medical model: *"I think my nursing education helped me gain a better understanding of what the conditions are"* (Participant 5). Only two members of the group spoke very highly of the education they had received, summarised below:

"And even the communication bit that was during my education was, yeah, it was very well executed and they gave you lots of examples of how to basically carry out a conversation with somebody, you know, like the whole motivational interviewing, the paraphrasing and how to carry yourself and your body language. Just little things that you don't really think about. But I think it was so well done that, like, everyone was a bit more mindful and it was because it was so well done" (Participant 7).

The value of having mental health theory and simulations before clinical placements was viewed as being important. Some participants discussed how they found the theoretical parts of the degree interesting: *"actually, I quite liked the coursework that we had to do while we're on placements for mental health. Like it had a case study and all that and reflections"* (Participant 3). Furthermore, having some choice and sense of control regarding the clinical placements was meaningful: *"I really appreciate (the educational institution) facilitating my change and my preference over my requested final placement. They did their best to slot me in where I requested"* (Participant 5).

This subtheme also includes the support that the participants received from the academic staff and many found certain lecturers inspiring and motivating: *"and also the person delivering it was a very experienced nurse and she also works as a clinical team coordinator in a hospital. She's very experienced, so that's really good"* (Participant 4). The support given to students during their clinical placements was also

really valued by the group. *"Tutors who would come and visit us on placement were very supportive and very, very keen to answer my questions, which was good because I probably would have floundered otherwise"* (Participant 2). Additionally, one participant also recognized the importance of peer support throughout her education: *"I really drew strength from the cohort and from my fellow grads, undergrads really that were doing psych"* (Participant 6).

4.4.2 Quality Placements Subtheme

This subtheme involves all the positive elements that the study participants discussed in the context of their undergraduate clinical placements.

"And what it was, was the kind of the support that I got from them and in seeing some of the nursing practice that kind of cemented it all; actually psych is really where I want to be and no other area even came close" (Participant 6).

It also includes the NESP nurses descriptions of working alongside a motivated preceptor and receiving adequate supports from them. *"So I think that's what makes a good preceptor is someone who asks you to learn, someone who asks you questions in a way that makes you think a bit more"* (Participant 3). There was a consensus that the clinical environment was the best place for learning and many of the group had experienced enjoyable placements and felt inspired by the nursing practice they observed. *"Most of my learning was in the actual placement. The preceptors and what not that's where I did most of my learning. I definitely felt more supported by the people on my placement than the nursing school supervisors"* (Participant 1).

However it was not just individual nurses that inspired the study participants as some made reference to the wider multidisciplinary team (MDT). *"Seeing how the nurses communicate and how the nurses make time for their patients despite their very busy schedule and then seeing how the MDT works for the benefit of the clients"* (Participant 4). Also, having a broad range of clinical experiences was valued by the group as they wanted to see the bigger picture of both hospital and community based services: *"so I*

saw the transition from an inpatient unit, to a community as well and then at the time I also did a week of kind of like a crisis resolution" (Participant 4).

The students who had undertaken their longer transition placement in mental health settings during their third year spoke favourably of their experiences. *"The nursing team and occupational therapist in my transition placement, were really great. They demonstrated to me the application of talking therapies and developing a therapeutic relationship with rapport"* (Participant 5). *"As a transition student, I was really well supported and actually had the best team behind me…. it was a bonus that I knew that I was going into psych"* (Participant 6).

4.4.3 Healthy Transitions Subtheme

This subtheme refers to all the other supportive elements that have influenced the successful transition of the study participants into the workforce, including the NESP programme coordinators, clinical supervision and working in an encouraging team.

"I feel like I've been one of the lucky students from my class because I've been quite supported with going through the transition. For myself I've had a preceptor from day one and I work with her still and if I have any questions or anything she's really good at answering those things, plus I see my supervisor often and the team are all really good" (Participant 1).

Feeling supported by others was an essential component identified to enable a healthy transition into the mental health nursing workforce.

"I've always had people, you know, every shift whom I've been able to talk to and things, you know, if things… I'm unsure about or things I didn't feel very good about and you know because things do go wrong and things haven't always gone the way I've planned them this year with my care people either so I've always had someone to debrief with and talk things out so that's been really good and I think without the support of the team that I've got, I wouldn't still be working" (Participant 2).

A few participants talked about the role of nurse coaches who had helped them with following policies when working on the wards in the "pre NESP" period; post registration but before the NESP programme had officially began.

"Fortunately, on acute wards on the afternoon shift and on the weekend, there are nurse coaches and part of the job, there is just one on each shift, but their job is to support us should we need it, over things like admissions, paperwork and secluding someone. So that was really beneficial" (Participant 5).

Developing long term relationships with preceptors who have time to give to the NESP nurses was also highly valued. *"I do have a preceptor, she's a very experienced nurse. She's almost close to retirement, really, so you can just imagine the knowledge that she has"* (Participant 4).

Most nurses interviewed spoke warmly about their NESP coordinators: *"in NESP this year, my nurse educator, she's excellent. Like I've had all the support from her that I've ever required and yeah, she's always been there"* (Participant 7). *"And I've got a nurse educator who meets with me every three weeks and that's religiously. And so we meet for an hour every three weeks and we discuss whatever comes up"* (Participant 4). Access to clinical supervision was also viewed as an important element to facilitate successful transitions. *"We have group supervision and we also have individual supervision as well and I've had access to both and they've both been great"* (Participant 7).

One person recognized that having three NESP rotations in a variety of clinical settings was positive for her transition: *"I'm one of the lucky ones that get three rotations"* (Participant 7). Conversely, another nurse specified that having an undergraduate placement and new graduate position in the one, same clinical environment was beneficial for her transition.

"My transition was pretty smooth and having a placement in the second year on the same ward, I think that really helped. I was familiar with the place and some of the staff and kind of how things worked so it wasn't a completely new scary environment" (Participant 1).

4.5 Theme Three: The Decision to Work in Mental Health

Table 6. Theme Three: The Decision to Work in Mental Health		
Major Theme	Subthemes	Findings
The Decision to Work in Mental Health	Wider nursing issues	Well when I originally applied for a new grad placement, I didn't apply to mental health at all. I got this job out of the (ACE) pool. Yeah, it wasn't really my plan (Participant 2).
	Life experiences	Mental health is everywhere so I think that pushed me into it because I've had close friends with mental health problems and you know they try and chat to me about things and I myself have had some kind of mental health problems in the past and I think being able to use my own experiences when I'm talking with others has kind of helped a lot and that got me interested to start with anyway (Participant 1)
	Nursing education	I think probably because one of the tutors I enjoyed the most in my training was my mental health tutor and he kind of sold it to me through our classes after the original placement had gone down and I thought, you know, I can work with people with mental illness like anything else (Participant 2)
	Smaller Subtheme: Recovery Principles	I like the idea of being able to kind of work with people when, in their own way, when they feel like they have really achieved something and so that's quite satisfying for me because I quite liked teaching and stuff so I feel like that's kind of linked to mental health, sort of like working alongside people to kind of reach their own goals (Participant 3)
	Smaller Subtheme: Recruitment	I think posing it as a really innovative sort of sector would be cool because that's where you want it to be. You want it to be innovative and exciting and people to feel like they're allowed to try new things and experiment with new ideas and skills and not just tasks and stuff and you can actually do that and like having that empathy side where you actually really like do get to know people in a way that kind of helps them move forward and actually seeing recovery (Participant 3)
	Smaller Subtheme: Reducing stigma	If we kind of started to focus on some of the positives and you know, try and change the perspectives because all you're getting is all of this stigma and discrimination and judgement when in actual fact if we just tried to change.... change it positively, then maybe that could have some impact! (Participant 6)

The Decision to Work in Mental Health Theme

The third major theme relates to the range and variety of influences on the participants decision to work in mental health nursing. This theme contains three subthemes: wider nursing issues, life experiences and nursing education which also incorporates three smaller subthemes: recovery principles, recruitment strategies and reducing stigma.

4.5.1 Wider Nursing Issues Subtheme

This subtheme involves some of the participants' experiences in the wider nursing community which had pushed them towards working in mental health nursing. *"Well when I originally applied for a new grad placement, I didn't apply to mental health at all. I got this job out of the (ACE) pool. Yeah, it wasn't really my plan"* (Participant 2). One participant was very clear that she had not planned on working in mental health at all but it was the ACE system which had offered her a position in a mental health setting: *"I was desperate for work"* (Participant 2). In contrast, a different participant cited a general dislike of hospitals as being a factor in her decision to work in mental health: *"I don't like the hospitals. I just….I never have, even in first year I walked in there, I was like… this is not for me at all"* (Participant 3). Finally, another participant disclosed how a negative experience in a general hospital setting during her transition placement in third year, had been the driving force behind her decision to work in mental health.

"The two placements that I had in the local DHB were quite awful in terms of how busy like you would get, the gen-med overflow, and the oldest staff would kind of treat you really crappy. And this wasn't just me, like I've had so many people say the same thing and the parking there is awful, so I guess just having that experience repeat itself for the second time in my transition and I was just like, nah, I'll just go back to mental health" (Participant 7).

4.5.2 Life Experiences Subtheme

This subtheme involves some of the participant's life experiences outside of the nursing community which had pushed them towards working in mental health nursing. One participant discussed how her own experience of mental distress and also that of her family and friends, had been influential in her decision.

"Mental health is everywhere so I think that pushed me into it because I've had close friends with mental health problems and you know they try and chat to me about things and I myself have had some kind of mental health problems in the past and I think being able to use my own experiences when I'm talking with others has kind of helped a lot and that got me interested to start with anyway" (Participant 1).

Another participant described how her experiences working as a support worker with teenage mothers and also within her religious community had impacted on her decision.

"I think through being more embedded in where I live in our neighbourhood and seeing the gaps in our neighbourhood in terms of mental illness in loneliness and isolation as well as working with these girls, it gave me a bit of an interest in mental health" (Participant 5).

One study participant had made the decision to work in mental health nursing before her degree had even started and she related this to doing her own research.

"I read this article about mental health nursing and I thought that's really fascinating. So I had this mind-set that I'm going to do nursing to become a mental health nurse. And so even before going into nursing, that was my plan" (Participant 4).

4.5.3 Nursing Education Subtheme

This subtheme describes how the participants nursing education journey has impacted on their decision to work in mental health nursing.

"I think probably because one of the tutors I enjoyed the most in my training was my mental health tutor and he kind of sold it to me through our classes after the original placement had gone down and I thought, you know, I can work with people with mental illness like anything else" (Participant 2).

There was an overall sense that nursing education had a powerful and positive influence on many of the study participant's career choices. *"I suppose it gave me the idea of going into mental health nursing, because I don't think I really had any broad clue what it was"* (Participant 3). Most of the group decided to work in mental health during

their second year and some made the decision in the third year: *"after my first placement; I actually really enjoyed that. Because it was in inpatients, it was my first kinda taste of everything and it was exciting every day, new people, so after that I was really excited about it"* (Participant 1).

This subtheme also includes how the NESP nurses talked about some of the academic lecturers as positive and inspiring which further influenced their decision.

"Definitely that tutor, he was just absolutely brilliant. And I mean while my mental health placement was difficult for a number of reasons, there were some things that I saw and observed that were really quite lovely. He was wonderful and he was so passionate about the area and he could bring it out in anyone else" (Participant 2).

One person found her educational institution as a whole to be encouraging about working in the mental health sector: *"if anything we got encouragement from them because they say that there's not a lot of people who go into mental health. So it would be a good decision"* (Participant 4).

4.5.3.1 Recovery Principles Subtheme

Within the context that nursing education had impacted on many students decision to work in mental health, this smaller subtheme specifically relates to the influence that the principles of recovery had in drawing people towards a career in mental health. This includes the lived experience of clients and inspirational recovery stories that the students had exposure to during their nurse training.

"I like the idea of being able to kind of work with people when, in their own way, when they feel like they have really achieved something and so that's quite satisfying for me because I quite liked teaching and stuff so I feel like that's kind of linked to mental health, sort of like working alongside people to kind of reach their own goals" (Participant 3).

There was a real sense that the NESP nurses wanted to make a genuine difference for people in an authentic way.

"I had this client who had bipolar and so she was assigned to me. I was a student and then I remember her telling me about her journey. This was because it was part of the portfolio that we had to complete. And then, at the time when I met her she was sort of, you know, getting better, so I didn't see her manic phase. So she was telling me her journey and she said, you know, this, this place did so much for me, like the nurses really helped me in getting better. And so, like, she really values the nurses' time. Because for her it's, it's having someone listen to her that's making her, making her feel better. And I thought, oh, if I can make a difference to a person's life, just, you know, by mainly spending time and listening to them, then you know, this is very rewarding. Like you don't cure it. But you know, you're making a difference. For me, that's the reward of it" (Participant 4).

A common element that the NESP nurses discussed was a passion for watching the recovery model in action: *"one of the things I loved about it was, unlike surgical medical where you patch people up and send them home… in mental health, you do see a lot of people and you see how they change and grow"* (Participant 2). *"A lot of the positive things, we're basically all the cases that I saw in the psych hospital and seeing the kind of change in people in the presentation and realizing that that didn't all come from medication"* (Participant 6).

4.5.3.2 Recruitment Subtheme

Within the context that nursing education had impacted on many student's decision to work in mental health, this smaller subtheme specifically relates to the participants' ideas about recruitment strategies to increase the numbers of nurses who are drawn towards a career in mental health. Generally there was a sense that mental health nursing could be promoted as a more innovative and exciting sector and there needs to be much more sharing of stories and information related to the role of the MHN.

"I think posing it as a really innovative sort of sector would be cool because that's where you want it to be. You want it to be innovative and exciting and people to feel like they're allowed to try new things and experiment with new ideas and skills and not just tasks and stuff and you can actually do that and like having that empathy side where you actually really like do get to know people in a way that kind of helps them move forward and actually seeing recovery" (Participant 3).

One participant beautifully described what she called “magic moments” of working as a MHN within an MDT and how similar stories need to be shared with students.

“The magic moments of working with our tangata whaiora; like moments where you feel like you've done a flipping good job for someone and heard their requests and you've worked really hard to incorporate them into a treatment plan and you've had a yarn with the MDT, the Māori culture advisor, to see what's possible there and it's not just you working with this person delivering care. It is that you've got a whole team of people working together and you're able to put together a really great plan for someone” (Participant 5).

“Teaching people in the undergraduate programme that mental health nursing is about walking a journey with someone. It's not about doing something to someone like doing a wound dressing or giving them pills. It's just about walking a journey with someone that is recovery focused” (Participant 6).

The NESP group further felt that nursing educators should fully describe all the different and varied areas that MHNs can work in post registration as there was a belief that most students do not appreciate the full spectrum of services available. Furthermore, some of the group felt strongly that the relationship between the DHBs and educational institutions must be improved to promote the NESP programme at undergraduate level: *“just to be invited to talk about their experiences and how well it's going for them. I think that would invite students to go into mental health”* (Participant 4). Other participants thought that more reassurance was the key to improving recruitment: *“and reassuring people. There's a lot of stuff that goes on, but people still work here and people still enjoy it and not everyone's burnt out”* (Participant 5). One nurse suggested that professional development was needed for some academic staff as a wider recruitment strategy: *“in terms of changing the staff attitudes towards mental health and therefore the recruitment into it, I do think that the judgmental ones or the people that haven't worked in psych do need some experience in it”* (Participant 6).

4.5.3.3 Reducing Stigma Subtheme

Within the context that nursing education has impacted on many student’s decision to work in mental health, this smaller subtheme specifically relates to the broader idea that

as a society we need to reduce stigma in order to influence other people to decide to work in the mental health sector.

"If we kind of started to focus on some of the positives and you know, try and change the perspectives because all you're getting is all of this stigma and discrimination and judgement when in actual fact if we just tried to change.... change it positively, then maybe that could have some impact!" (Participant 6).

It is important to point out that this is a cross cutting theme, which also relates to the bigger Stigma Subtheme (4.3.5) from Theme One: Thrown in the Deep End, which is related to the negative and disrespectful attitudes that the participants had been exposed to both during their undergraduate years and during post registration practice. The study participants talked about the need for positivity and openness at all levels, from challenging self-stigma that individuals have, through to challenging the media stereotypes at a national level and social media was viewed as a good platform to address this: *"from the public point of view, we just, we need to change the narrative from negative to positive and that can be done through, I think the most powerful way to do it would be through social media"* (Participant 6).

"So I think just by telling people, you know, as many people as you know, that, you know, mental health is not something to be feared and nowadays it needs more attention than ever. I guess, you know, for me that's the way of reducing stigma. Being more open. Sharing your experiences. I know social media, I thought that's really good. You know what the Florence's[1] are doing on Facebook. You know, making people aware" (Participant 4).

Finally, one participant identified that nurses within formal organisations could be more proactive in addressing stigma at a national level: *"the media stigma could be challenged and positive stories be released about nurse's experience of enjoying their jobs; being released from a platform that's respectable, like from the DHB, or the union, it would definitely be fantastic"* (Participant 5).

[1] The Florence's is a reference to a successful movement on Facebook #hear our voices to raise awareness of the issues that health professionals face within the struggling healthcare system in NZ.

Chapter 5 - Discussion

This chapter provides a discussion of the findings in relation to the research questions and some of the key issues outlined in the literature review. Implications for nursing practice, education and research are explored in detail. Based on the study findings and other evidence in this area, 24 recommendations are made throughout the chapter that relate to improving the preparation of new graduate nurses to work in the mental health sector in NZ. Strengths and limitations of the study are also acknowledged.

5.1 Research Question 1.
How does nursing education in NZ prepare nurses to work in the mental health sector?

The literature review suggested that nursing education does not prepare students well for a career in mental health nursing when compared to other areas of nursing (Happell *et al*., 2014) and some NZ critics have argued for an educational reform (Logan, 2018). Most participants in this study were very disappointed with the mental health components of their undergraduate education and only two spoke highly about their preparation to work in the specialty. Nursing education can work well for some students in preparing them for post-registration mental health practice when mental health theory and simulations occur before clinical placements and when students are adequately supported by inspiring lecturers and motivated preceptors. The value of the final transitional placement in a mental health setting is crucial for setting up post registration success and the NESP nurses who do not experience a mental health transitional placement in the third year have greater needs post registration which should be addressed by the NESP and DHB orientation processes.

However, many of the group reported poor levels of theory and clinical mental health nursing content within their degree and this is in line with the review by Hayman-White *et al.* (2007). It appears that NZ education still has a psychiatric-bio-medical focus and new graduate MHNs want a deeper and broader knowledge base. The findings indicate that new graduate MHNs are not adequately prepared with their clinical skillset and undergraduate education programmes should have a greater focus on supporting students with developing clinical competence. This could involve more theory and clinical preparation on the following skills: assertiveness training, motivational

interviewing, interview techniques, distress management, anxiety management, managing aggression, talking therapies and sensory modulation. Interactive workshops should be available for third year students which consist of theoretical content followed by video clips, role play, case studies and lastly standardised simulations where students can practice their skills in a safe environment (Jansen & Venter, 2015). Furthermore, in light of how stressful the NESP MHNs find the first year post registration and also how difficult the working environment of the mental health services can be, it would make sense to include stress management techniques and exploring self-care strategies in the undergraduate and/or NESP curriculums to support the development of a sustainable workforce. This study also points towards the need to include education regarding stigma and de-stigmatisation strategies as an essential part of nursing curriculum.

The literature review emphasised a number of significant inequalities for the Māori population (Reid & Robson, 2006). One particular issue of concern that this research project has highlighted was the lack of cultural supports available for the Māori student nurse during her training period. Strengthening the Māori health workforce is critical (Cook, 2009) and the recruitment of Māori MHNs is an issue of national importance (Te Pou, 2018a). Māori learners tend to engage better and be successful when they feel connected to their educational programme and it is culturally relevant to them (Prebble *et al*., 2004). The retention of indigenous nursing students in NZ is a central issue and attrition factors include financial hardship, staff and peer insensitivity to cultural issues, lack of same ethnicity mentors, fewer resources, lack of educational preparation and study skills, limited whānau experience in tertiary education and ongoing family obligations (Wilson, McKinney & Rapata-Hanning, 2011). Nursing educational programmes are mandated to be receptive to the needs of their Māori students and offer additional supports to facilitate success. In 2012 the Responsiveness to Māori Nursing Students Scorecard was published to provide a system-level picture of the responsiveness of NZ SoN to Māori undergraduate students as part of the national workforce development programme (Ngā Manukura o Āpōpō, 2014). Nursing educational programmes should facilitate access to Māori RNs as role models and mentors and clinical practice experiences in Māori health settings that validate the students' worldview, and prepare them to work effectively within Māori communities (Ngā Manukura o Āpōpō, 2014). Furthermore, in 2015 Te Ao Māratanga NZCMHN

Māori Caucus joined with Te Rau Matatini to develop the campaign 'Every whānau should have a Māori nurse', which prioritises strategic leadership for Māori workforce development and acknowledges the special role that Māori nurses have in improving the health of whānau, hapu and Iwi, towards an upgraded quality of life (Te Rau Matatini, 2015).

The results from this study strongly suggest the need to improve the preparation of nurses to work in mental health settings. Given the group consensus that the clinical environment was the best place for learning, it could be argued that different models of clinical education need to be explored further and some areas in NZ have started to introduce Dedicated Education Units (DEUs). Dedicated Education Units are health care environments enhanced by the strategic collaboration between nurse-clinicians and faculty academics to provide students with a more valuable and richer clinical experience (Edgecombe & Bowden, 2014). Research into the value of mental health DEUs is warranted. A different and probably cheaper idea (from the author) would be to develop mental health nursing communities of practice within undergraduate educational institutions, to offer additional supports and learning opportunities for students particularly interested in working in mental health. Communities of practice are based on the assumption that engagement and participation in social practice is the fundamental process by which we learn. "*Communities of practice are groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis*" (Wenger, McDermott & Snyder, 2002, p.4). Having a mental health nursing community of practice in place could provide increased opportunities for students to access professional role models and network with each other (either in person, via telephone, or online) which would not only assist with their learning, but also provide a sense of belonging, mutual supports and the development of a professional identity which would help prepare them more effectively to work in the specialty. There is no research currently available concerning mental health nursing communities of practice in undergraduate education yet this option should be explored further.

The literature does have examples of research initiatives which have aimed to improve the educational preparation of nurses to work in mental health. One Australian study (Curtis, 2007) implemented preclinical workshops with students using problem-based

learning and role plays with scenarios developed in collaboration with experienced clinicians. The results showed that the workshops were beneficial in helping to prepare students for clinical placements and along with other collaborative measures, more new graduates subsequently decided to work in mental health (Curtis, 2007). In NZ, Spence, Garrick and McKay (2012) reported on a review of the mental health components in one nursing degree curriculum by working collaboratively with clinicians and introducing three courses: mental health science, inpatient practice and primary community mental health practice which totalled 450 hours of learning. The results showed that significant improvements were achieved in terms of student satisfaction; the breadth and depth of theoretical teaching; increased numbers of clinical hours, and the opportunity for every student to experience an acute as well as a community mental health placement (Spence *et al*., 2012). While both clinical and academic staff were pleased with the increased proportion of both mental health theory and practice, they noted that problems still existed and success was highly dependent on gaining sufficient numbers of quality clinical placements (Spence *et al*., 2012).

In light of the difficulties that do exist with limited clinical mental health placements being available, one SoN in Australia has developed a unique *Recovery Camp* as an accredited clinical experience in one undergraduate nursing degree (Perlman *et al.*, 2017). *Recovery Camp* immerses student nurses, academics and people with lived experience of mental illness in a five day recreation camp where everyone engages and participates in a wide array of physical, social and creative activities and experiences which are grounded in the recovery movement (Perlman *et al.*, 2017). The findings of the research indicated that *Recovery Camp* enhanced the students understanding about stigma, developed their professional knowledge base and applied skills, and further helped them gain insights into the role that a consumer plays in his or her recovery journey (Perlman *et al.*, 2017). These research projects demonstrate that improvements in mental health nursing clinical education can be made and ultimately this is a significant area that requires ongoing research, development and critical evaluation.

An additional option to improve the preparation of nurses to work in mental health is to formalise the mental health components in undergraduate nursing curriculums in NZ. Logan (2018) identified that specific mental health nursing educational standards are required and suggested that collaboration between government, academia and industry

professionals, with increased peer and service user involvement are all structural necessities to support this. Although all SoN have to meet NZNC standards there are substantial discrepancies around the country in respect of theoretical content, duration, and type of mental health placement experiences available to students (Spence *et al*., 2012). There are frameworks already available that could be utilised to adapt the mental health components of NZ nursing curriculum. In 2008 the MoH introduced the *Let's get real* framework and Te Pou have recently refreshed this work following sector consultation (Te Pou, 2018e). *Let's get real* has three components; values, attitudes and the seven Real Skills, with the intent being to have shared values and attitudes when working with people and whānau with mental health and addiction needs and to develop the knowledge and skills of the workforce (Te Pou, 2018e). The seven Real Skills are: working with people experiencing mental health and addiction needs; working with Māori; working with whanāu; working within communities; challenging discrimination; applying law, policy and practice and maintaining professional and personal development (Te Pou, 2018e). Furthermore, in 1995 the NZCMHN first published the *Standards of Practice*, with the most recent edition being issued in 2012 (NZCMHN, 2012). The *Standards of Practice* are concerned with the performance of MHNs in NZ and include practice outcomes and attributes of knowledge, skills and attitudes (NZCMHN, 2012). The values, attitudes and seven Real Skills identified in *Let's get real* (MoH, 2008) are also reflected in the standards (NZCMHN, 2012) so both of these frameworks naturally lend themselves to positively influence the undergraduate mental health nursing curriculum across NZ.

A more radical option is to create a specialist mental health stream within undergraduate education, based on the model in the UK (Logan, 2018). "*If students do not receive suitable opportunities for learning and specific competency-related feedback, demands for the development of a separate programme in mental health nursing may well be justified"* (Spence *et al*., 2012, p. 416). In Australia, Happell (2015) used a qualitative approach to explore the idea of undergraduate specialisation in mental health with nursing directors (n=13) who were very supportive of the idea. Thematic analysis revealed four main themes: perceived advantages of the specialist stream; knowledge and experience; increased recruitment; and commitment (Happell, 2015). The results from this study suggest that it is also time for the NZ mental health

nursing community and stakeholders to seriously debate and research whether undergraduate specialisation would be beneficial for workforce development.

Recommendations

1. Nursing education has an increased focus on more detailed mental health theory and role-play simulations prior to clinical placements.

2. Māori students should receive cultural supports within undergraduate nursing education, in line with national strategic policy documents.

3. Mental health theoretical components in nursing degrees need to be much bigger and have a broader focus and include how to challenge stigma.

4. Stress management and self-care techniques need to be integrated into undergraduate and NESP curriculums.

5. Nurse educators need to continue developing and researching improvements for the teaching and learning of clinical skills appropriate for mental health settings.

6. Mental health nursing DEUs and communities of practice require further exploration and research.

7. National undergraduate educational standards for mental health nursing should be set using the existing frameworks already available.

8. NESP and DHB orientation processes should offer additional input and supports to NESP nurses who did not experience an undergraduate mental health transitional placement.

9. NZ mental health nursing communities should debate and research the potential for undergraduate specialisation in mental health.

5.2 Research Question 2.

How does nursing education in NZ impact on the decision to work in mental health?

The results showed that nursing education has the power to positively influence career decisions to work in mental health. Exciting and positive clinical experiences and inspirational lecturers can encourage students to consider mental health nursing post registration. All of the participants in this study were taught mental health in the second and third year of their nurse training, yet Melrose and Shapiro (1999) suggested that introducing mental health to students during their first year could be useful for reducing student fear and anxiety. Early introduction to mental health is more realistic and this could positively impact on recruitment (Jansen & Venter, 2015). Yet the influence of

wider nursing issues and life experiences on the decision to work in mental health are also important and these deserve further research attention. Given that the ACE system is so competitive, many new graduates are forced to consider mental health to secure a position (Ogden, 2017); therefore, it would be worthwhile to study this group to ascertain if they intend to stay working in the specialty and what impact this might have on the quality of care provided.

Many of the NESP nurses felt drawn towards working in the mental health field after exposure to friends, family members and neighbours with mental health needs which suggests that involving people with lived experiences in educational programmes could have beneficial effects on recruitment. Interestingly none of the study participants discussed having service users directly involved in the delivery of their undergraduate degrees despite this idea being first promoted around twenty years ago when the author was a student nurse. Service user involvement in NZ sits within the broader government policy agenda of increasing consumer engagement and HQSC (2015) published *Engaging with consumers: A guide for DHBs,* to assist the sector given ad hoc implementation nationwide. Similarly, at national policy level, the *New Zealand Health Strategy* (Minister of Health, 2016) includes 'people powered' as one main strategic theme which moves towards a stronger customer-focused approach supporting consumer engagement principles. In the education sector, the University of Auckland reported positively on the active involvement of service users in undergraduate mental health nursing education adding that it was well received by students (Schneebeli, O'Brien, Lampshire & Hamer, 2010). The shift from passive recipients of care to active educational roles provides benefits to both students and service users (Schneebeli *et al.,* 2010). In the UK it is a requirement of all pre-registration nursing courses that service users are actively involved given that learning from service users in the classroom is not the same as learning from service users while on clinical placements because students do not always encounter service users when they are well (Terry, 2012). Nurse educators should embrace and embed increased user involvement activities in nurse education in a meaningful way and further longitudinal research is needed to establish the influence of user involvement in the classroom on student nurses' attitudes and practice over time (Terry, 2012).

A further point for discussion is one participants' disclosure of her own personal experiences of mental distress being an important factor in her choosing to work as a MHN. There is a growing body of evidence that people with lived experience have a significant contribution to make to the mental health nursing profession. One recent study (Oates, Drey & Jones, 2017) explored how MHNs (n=27) own personal experience of being mentally unwell informs their practice with a specific focus on direct work with clients. The study results showed that personal experience can impact on work in three positive ways: as a motivation for potential MHNs to join the profession; in developing empathetic and credible relationships with service users; and in enhancing expert understanding of service users (Oates *et al*., 2017). "*We must address the taboo of disclosure within clinical nursing practice*" (Oates *et al.,* 2017, p.471).

Previous ethnographic research exploring mental health worker's experiences of mental ill-health noted how their personal experiences were 'strategically disclosed' or 'actively concealed' and at odds with public messages from the workers employment organisations to be open and talk about mental health issues (Moll, Eakin, Franche & Strike, 2013). Disclosure of mental illness can be associated with vulnerability, bullying and concerns regarding professional competence (Moll *et al.,* 2013). This can be understood in terms of the stigma in society and the prejudice and discrimination that is present across nursing communities which all of the study participants had witnessed. Yet there are signs that mental health nursing culture is slowly changing and in 2017 the Australian College of Mental Health Nurses awarded the MHN of the year, to a nurse called Matt Ball who was admitted to a psychiatric unit and underwent electro convulsive therapy over 20 years ago (Ball, 2017). Matt had heard voices since the age of 13 and now works as a nurse practitioner facilitating alternative approaches to working with people who hear voices and experience other unusual realities (Ball, 2017).

"The award is an important part of the mental health nursing profession recognising recovery, not as rhetoric or legislative requirement, but working towards the rights of any individual experiencing psychosis, voice hearing or any mental distress towards their own personal goals. A role any professional or supporter might facilitate"

(Ball, 2017, para. 21).

Recommendations

10. Further qualitative research is needed exploring why nurses choose to work in mental health and if they intend to stay working in the specialty.

11. Service user involvement should become an integral part of all pre-registration nurse education courses in NZ.

12. Research is required to determine how user involvement can be successfully managed and evaluated effectively in classroom settings and curriculum delivery.

13. Mental health nurses with lived experience of mental distress should be able to openly disclose into a service culture where their experiences are highly valued.

5.3 Research Question 3.

How can new graduate transitions into mental health nursing be enhanced in NZ?

The results from this research project are similar to one theme that Prebble and McDonald (1997) identified over 20 years ago, namely, less than adequate orientation processes. However the other theme Prebble and McDonald (1997) noted was a lack of supervision and support and thankfully, most NESP nurses in this study did have some access to clinical supervision and felt supported by other team members and NESP personnel. Nevertheless the findings from this study are congruent with the Australian review (Procter *et al.,* 2011) in respect of the new graduate MHNs facing a number of significant challenges including staff shortages, demanding workloads and negative attitudes towards the specialty. The results also have similarities with the Danish study (Tingleff & Gildberg, 2014) which described how ill prepared new graduate MHNs feel in relation to managing a clinical workload which then leads to feelings of stress. And finally, sadly this research project further aligns with the findings from Hooper *et al.*'s (2016) integrative review which recognised that despite the considerable global effort with transition programmes and preceptorship, the negative clinical experiences of new graduate MHNs continues at a high level.

So how can we improve new graduate transitions into mental health nursing? As previously discussed the educational preparation of nurses needs to considerably improve at undergraduate level. In addition, it could be argued that the NESP programmes and DHBs may well support new graduates in a more suitable way by providing more intensive training and skills based preparation before the new graduates

actually start clinical practice. Most of the difficulties that the research participants faced were in relation to the culture and pressures of working in acute facilities and feeling they were unprepared and *thrown in at the deep end*. There seems to be an incongruence and dichotomy in the system whereby we want new graduates to be dynamic and recovery focused to work in partnership with clients and yet during early career stages they find themselves in situations where they are in charge, understaffed and managing high risk situations in environments that are not well designed for safety. Is this an unspoken MHN cultural '*rite of passage'* where a new graduate earns his or her stripes or is it time our profession addresses this, makes changes and extends additional supports to them? Mental health nurses have a right to be safe, supported and valued in their workplaces. Feeling supported by others was an essential component identified to enable a healthy transition into the mental health nursing workforce.

Ultimately, we need to address the high attrition rate, and preparing and supporting new graduate MHNs more effectively could have an impact. One option is to equip the MHNs with realistic skills required not only to survive the NESP year, but also to enable them to thrive and develop professionally. This would require closer working relationships between nurse educators at undergraduate and NESP levels to develop stair-casing and ascertain what should be taught and when and this needs to be a national discussion with all stakeholders. Also, educational institutions could track students post-graduation and conduct follow-up interviews or surveys to ask the NESP nurses which parts of the degree were helpful and what else could have assisted them in preparation for practice.

Another preference would be to transform the socio-political environment of the mental health system so the NESP nurses have better staffing, the correct skill-mix and suitable environments for safety so they do not find themselves in such uncompromising situations. Many nurses are hopeful that the recent mental health inquiry will prompt the government to make fundamental changes within the mental health system which is in dire need of extra funding and resources and a fresh approach. This study indicates that at management, level nurses require strong leadership and a positive organisational culture that endeavours to nurture and grow new graduates as opposed to relying on them to fill gaps in staffing or take on responsibilities they do not feel ready to manage. The research findings also show that new graduate MHNs ought to have: better

orientation processes; improved access to clinical supervision; debriefing support systems; guaranteed time with preceptors; gradual exposure to taking on shift leader roles; specific training and support in managing high risk situations; and extra assistance in preventing, managing and dealing with the personal emotional impact of seclusion events and other adverse outcomes.

Recommendations

14. MHNs need to be taught realistic skills and closer working relationships between nurse educators at undergraduate and NESP levels are required to develop knowledge and skill stair casing.

15. The NESP programme and DHBs could improve by offering new graduates a more intensive training period before clinical practice starts.

16. New graduate MHNs need more systematic approaches to workplace orientations with steady and structured increases in clinical responsibilities including preparation for the role of shift leader.

17. Access to regular clinical supervision is important from the on-set of post-registration practice.

18. Extra assistance in preventing, managing and dealing with the personal impact of seclusion events and other adverse outcomes should be offered.

19. Mental health nursing leaders and managers must create cultures that value the new graduates and prioritise their safety and growth.

20. Further research into new graduate MHN transition experiences is certainly required.

5.4 Research Question 4.

How can the recruitment of new graduates into mental health nursing in NZ be improved?

The literature review explored recruitment issues, and mental health nursing remains an unpopular choice (Jansen & Venter, 2015). All of the study participants had experienced some form of stigma about working in the mental health sector and negative attitudes had been displayed from academic staff and wider nursing colleagues. The study participants talked about the need for positivity and openness at all levels, from challenging self-stigma that individuals have, through to challenging the media stereotypes at national level. Schulze (2009) suggested that members of the

psychiatric disciplines can at the same time be stigmatizers, stigma recipients and powerful agents of de-stigmatization. In this study, the nurses all agreed that challenging stigma was an essential MHN role and that reducing stigma was one solution for improving recruitment. Hopton (1995) advised MHNs to forge political alliances with service users to help reduce the stigma surrounding mental illness. "*There is a need to ensure positive stories about mental health nursing get into the media – radio, TV, local papers, social media etc. This could be done in partnership with service users*" (Te Pou, 2018a, p. 18). Similarly, Morrall (1998) called for a new anti-psychiatry realm of mental health nursing where social-political action and campaigning could address issues such as polypharmacy and suicide awareness. The study findings support the idea that mental health nurses need to become more vocal and actively involved in local and national campaigns to reduce societal stigma and discrimination. Alongside this MHNs should specifically target challenging the stigma that our own nursing colleagues hold towards the mental health specialty and people who experience mental distress. Nurse leaders and educators could facilitate basic mental health awareness training to support these endeavours across DHBs and educational institutions.

Another strategy for improving mental health nursing recruitment is to enhance the working relationships between DHB personnel and educational institutions. Nurses who work in mental health clinical areas should be frequently invited to speak with undergraduates to share information about their roles and promote working in the specialty. Also NESP co-ordinators and new graduates on the programme should always be included in undergraduate nursing career events.

Recommendations

21. MHNs need to become more vocal and actively involved in local and national campaigns to reduce stigma and discrimination.

22. Nurses who do not work in mental health would benefit from updated mental health awareness training from MHN leaders and educators.

23. Educational institutions and DHBs need closer working relationships to promote the NESP programme and showcase the variety of MHN roles to students.

24. Further research is needed to explore best strategies for stigma reduction.

5.5 Strengths and Limitations of the study

Strengths of this study include the richness of the data and the focus on the actual experiences of the new graduate nurses working in the mental health sector in NZ. Another strength is that the participants included a Māori nurse and a nurse with lived experience of mental distress, which may increase the potential transferability of the findings.

One main limitation of the study is that no male nurses participated and therefore the all-female sample does not really reflect the gender balance in the current MHN workforce. A further limitation is that saturation point was not achieved as only seven eligible participants came forward but the research process had to progress due to time restrictions. In addition, the research only includes NESP nurses from two of the main centres in the South Island of NZ, which may not necessarily represent rural settings in NZ or the North Island. Furthermore, there are wide variations in both undergraduate and NESP programmes across NZ so the results may not be generalizable to other areas.

5.6 Chapter Summary

Most participants in this study were disappointed with the mental health components of their undergraduate education and only two spoke highly about their preparation to work in the specialty. The results strongly suggest the need to improve the preparation of nurses at undergraduate level to work in mental health settings post registration. Most of the difficulties that the research participants faced were in relation to the culture and pressures of working in acute facilities and feeling they were unprepared and *thrown in at the deep end*. Based on the study findings and other evidence in this area, 24 recommendations have been made throughout the chapter relating to the improvement of new graduate nurse preparation to work in the mental health sector in NZ.

Chapter 6 – Conclusion

This qualitative study sought to explore how nursing education impacts on the decision to work in mental health and the transition into practice. The findings are important as voices from NZ new graduate nurses working in mental health can now be added to the international literature to enhance the existing knowledge base on new graduate MHN transitions. The positive aspects from the study findings include the level of support that some of the nurses experienced and the genuine authenticity of the group in valuing recovery principles and wanting to work with people in a meaningful way. The results showed that exciting clinical experiences and inspirational lecturers can encourage students to consider mental health nursing post registration. Yet the influence of wider nursing issues and life experiences on the decision to work in mental health are also important and these deserve further research attention. In this study, all the nurses agreed that challenging stigma is an essential part of the MHN role and reducing stigma is one strategy to improve recruitment. Mental health nursing leaders and educators should facilitate mental health awareness training in order to address the stigma that is ascribed to our speciality from other nursing colleagues. The mental health nursing professional group could advance this by working in partnership with service users and tackling stigma and discrimination at local and national levels through all media channels.

The new graduate nurses in this study shared many experiences which indicate that the comprehensive nursing education system does not offer satisfactory preparation for nurses who choose to work in mental health. The central issue is that new graduates working in mental health nursing in NZ continue to have negative transitional experiences and feel *thrown in at the deep end*. Therefore, in order to address the pending recruitment and retention crises, and to accommodate the challenges inherent within the mental health system, systemic changes need to be made in how we prepare and transition nurses into mental health. Happell (2015) questioned whether there is a better way to prepare nurses for mental health nursing practice and this dissertation concludes that this is indeed the right question to be asking.

Suggested options for upgrading undergraduate education include making generic improvements to mental health nursing teaching strategies; developing communities of

practice for students interested in the specialty; formalising a national curriculum and incorporating active service user involvement as a central feature. Furthermore, closer working relationships between nurses from the DHBs and NESP are required with undergraduate educators to share the variety of MHN roles and to promote the NESP programme to students. The more extreme option of developing an undergraduate mental health speciality stream should be explored and researched by the profession.

To improve the transition experiences of nurses who choose to work in mental health we need to teach useful stress management and self-care skills. The NESP programme and DHBs could improve this by offering new graduates a more intensive training period before clinical practice starts, but it must be stressed that if the quality of undergraduate nursing education was better and if the acute wards were not as difficult to work in, this would not necessarily be required. Developing mental health nursing knowledge and clinical skill stair-casing to ascertain what should be taught and when across undergraduate and NESP curriculums would also support the sustained growth of new graduate nurses. Feeling supported by others was an essential component identified in this study to enable a healthy transition into the workforce and thus opportunities to expand support networks or enhance current systems should be welcomed.

Further research into new graduate MHN transition experiences in NZ is certainly required. It would be interesting to replicate this research in other parts of NZ and areas where there are higher Māori populations. Perhaps mixed method research with quantitative surveys involving bigger samples and qualitative interviews exploring similar themes to this research would also be helpful. Other areas for ongoing future research include and discovering the best strategies for involving service users in curriculum delivery and for reducing stigma. It would also be worthwhile conducting further qualitative research with new graduate nurses working in mental health to explore if they intend to stay working in the specialty.

References

Andersen, C., Kolmos, A., Andersen, K., Sippel, V. & Stenager, E. (2017). Applying sensory modulation to mental health inpatient care to reduce seclusion and restraint: A case control study. *Nordic Journal of Psychiatry, 71*(7), 525-528. doi: 10.1080/08039488.2017.1346142.

Ball, C. (2016). *Are we ready yet? New graduate nurses' experience of workplace violence and aggression and their sense of readiness.* (Thesis, Master of Health Sciences) University of Otago, Christchurch. Retrieved from: http://hdl.handle.net/10523/7069

Ball, M. (2017). *Matt Ball: My journey from psychosis to 2017 Mental Health Nurse of the Year.* Retrieved from: http://samentalhealthcommission.com.au/matt-ball-journey-psychosis-2017-mental-health-nurse-year/ (5/11/18)

Baxter, J., Kokaua, J., Wells, J., McGee, M., & Oakley Browne, M. (2006). Ethnic comparisons of the 12 month prevalence of mental disorders and treatment contact in Te Rau Hinengaro: The New Zealand mental health survey. *Australian & New Zealand Journal of Psychiatry, 40*(10), 905–13. Retrieved from: 10.1080/j.1440-1614.2006.01910.x

Blackburn, J., McKenna, B., Jackson, B., Hitch, D., Benitez, J., McLennan, C. & Furness, T. (2016). Educating mental health clinicians about sensory modulation to enhance clinical practice in a youth acute inpatient mental health unit: A feasibility study. *Issues in Mental Health Nursing, 37*(7), 517-25. doi: 10.1080/01612840.2016.1184361

Bowers, L. (2014). *The safewards model.* Retrieved from: http://www.safewards.net/images/pdf/Safewards%20model.pdf (13/8/2017)

Boyd-Turner, D., Bell, E. & Russell, A. (2016). The influence student placement experience can have on the employment choices of graduates: A paediatric nursing context. *Nurse Education in Practice, 16,* 263-268. doi: 10.1016/j.nepr.2015.10.001

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. doi: 10.1191/1478088706qp063oa

Braun, V. & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners.* London: Sage Publications.

Burns, N. & Grove, S. (2009). *The practice of nursing research: Appraisal, synthesis and generation of evidence.* St Louis, Missouri: Saunders, Elsevier.

Cassie, F. (2013). What is a mental health nurse again? *Nursing Review, September.* Retrieved from: http://nursingreview.co.nz/what-is-a-mental-health-nurse-again/ (2/2/18)

Cassie, F. (2018a). Nurses should not be scared to come to work. *Nursing Review, June.* Retrieved from: http://nursingreview.co.nz/nurses-should-not-be-scared-to-come-to-work/ (17/9/18)

Cassie, F. (2018b). New grad stats show mental health applicants turned away. *Nursing Review, January*. Retrieved from: http://nursingreview.co.nz/new-grad-stats-show-mental-health-applicants-turned-away/ (17/3/18)

Chamberlin, J. (1978). *On our own: Patient controlled alternatives to the mental health system.* New York: Haworth Press.

Clark, T. & Holmes, S. (2007). Fit for practice? An exploration of the development of newly qualified nurses using focus groups. *International Journal of Nursing Studies, 44*(7), 1210-1220. doi: 10.1016/j.ijnurstu.2006.05.010

Clark, C. M. & Springer, P. J. (2012). Nurse residents' first-hand accounts on transition to practice. *Nursing Outlook, 60*(4), E2-E8. doi:10.1016/j.outlook.2011.08.003

Clarke, V. & Braun, V. (2017). Thematic analysis. *The Journal of Positive Psychology, 12*(3), 297-298. doi: 10.1080/17439760.2016.1262613

Cleary, M. & Happell, B. (2005). Promoting a sustainable mental health nursing workforce: An evaluation of a transition mental health nursing programme. *International Journal of Mental Health Nursing, 14*(2), 109–116. doi: 10.1111/j.1440-0979.2005.00367.x

Cleary, M., Horsfall, J. & Happell, B. (2009). Transition to psychiatric/mental health nursing programs: Expectations and practical considerations. *International Journal of Mental Health Nursing, 18*(4), 265–273. doi: 10.1111/j.1447-0349.2009.00606.x

Cook, L. (2009). *Report to the Minister of Health: An evaluation of the need for a nurse education and training board for the oversight of nursing education and training in New Zealand.* Retrieved from: http://www.moh.govt.nz/notebook/nbbooks.nsf/ 8b635a98811e8aed8 5256ca8006d4e51/ 9943a4089f23ef13cc2576150007745f/$FILE/nurse-education-training-board-nz-aug09-v2.pdf (5/5/17)

Cross, K. (2015). *The impact of patient suicide on mental health nurses.* Retrieved from: https://repository.digitalnz.org/system/uploads/record/attachment/780/the_impact_of_patient_suicide_on_mental_health_nurses.pdf (20/5/18)

Crossman, A. (2018). *Understanding purposive sampling: An overview of the method and its application.* Retrieved from: https://www.thoughtco.com/purposive-sampling-3026727 (17/9/18)

Curtis, J. (2007). Working together: A joint initiative between academics and clinicians to prepare undergraduate nursing students to work in mental health settings. *International Journal of Mental Health Nursing, 16*(4), 285-293. doi: 10.1111/j.1447-0349.2007.00478.x

De Carlo, K. (2007). Ogres and angels in the madhouse: Mental health nursing identities in film. *International Journal of Mental Health Nursing*, *16*, 338-348. doi: 10.1111/j.1447-0349.2007.00488.x

Duchscher, J. (2009). Transition shock: The initial stage of role adaptation for newly graduated Registered Nurses. *Journal of Advanced Nursing, 65*(5), 1103– 1113. doi: 10.1111/j.1365-2648.2008.04898.x

Dyess, S. & Sherman, R. (2009). The first year of practice: New graduate nurses' transition and learning needs. *Journal of Continuing Education in Nursing, 40*(9), 403-10. doi: 10.3928/00220124-20090824-03

Edgecombe, K. & Bowden, M. (2014). Introduction. In K. Edgecombe & M. Bowden (Eds.), *Clinical learning and teaching innovations in nursing: Dedicated education units building a better future,* (pp. 1-25). Dordrecht: Springer Science + Business Media. doi:10.1007/978-94-007-7232-8_1

Edward, K., Hercelinskyj, J., Warelow, P., & Munro, I. (2007). Simulation to practice: Developing nursing skills in mental health: An Australian perspective. *International Electronic Journal of Health Education, 10*(3), 60-64. Retrieved from: http://link.galegroup.com.cmezproxy.chmeds.ac.nz/apps/doc/A166622667/AONE?u=otago&sid=AONE&xid=b591afcb.

Elliott, M. (2017). *The people's mental health report, a crowdfunded and crowdsourced story based enquiry into the public mental health system in Aotearoa.* Action station. Retrieved from: https://www.peoplesmentalhealthreport.com/ (8/8/17)

Enoka, M. (2018). *'Nurses eat their young' – the profession that can't shake it's bullying problem.* The Wireless, NZ Herald. Retrieved from: https://www.nzherald.co.nz/nz/news/article.cfm?c_id=1andobjectid=12025907 (30/5/18)

Flaskerud, J. (2018). Stigma and psychiatric/mental health nursing. *Issues in Mental Health Nursing, 39*(2), 188-191, doi: 10.1080/01612840.2017.1307887

Goffin, A. (2014). *Farmers' mental health: A review of the literature.* ACC Policy Team. Retrieved from: https://www.mentalhealth.org.nz/assets/ResourceFinder/wpc134609.pdf (8/11/2018)

Goffman, E. (1961). *Asylums: Essays on the condition of the social situation of mental patients and other inmates.* Garden City, New York: Anchor Books.

Goodwin, E. (2017). Resourcing, culture issues found in 9B stay. *Otago Daily Times.* Retrieved from: https://www.odt.co.nz/news/dunedin/health/resourcing-culture-issues-found-9b-stay (13/8/17)

Gordon, S., Davey, S., Waa, A., Tiatia, R., & Waaka, T. (2017). *Social inclusion and exclusion, stigma and discrimination, and the experience of mental distress.* Auckland: Mental Health Foundation of New Zealand. Retrieved from: https://www.mentalhealth.org.nz/assets/Our-Work/Social-Inclusion-and-Exclusion.pdf (9/11/18)

Gough, K. & Happell, B. (2009). Undergraduate nursing students attitude to mental health nursing: A cluster analysis approach. *Journal of Clinical Nursing, 18*(22), 3155.

Gouthro, T. (2009). Recognizing and addressing the stigma associated with mental health nursing: A critical perspective. *Issues in Mental Health Nursing, 30*(11), 669-676. doi:10.1080/01612840903040274

Haggerty, C., Holloway, K., & Wilson, D. (2013). How to grow our own: An evaluation of preceptorship in New Zealand graduate nurse programmes. *Contemporary Nurse, 43*(2), 162-171. doi: 10.5172/conu.2013.43.2.162

Halfer, D. (2007). A magnetic strategy for new graduate nurses. *Nursing Economic$, 25*(1), 6-11. Retrieved from: http://link.galegroup.com.cmezproxy.chmeds.ac.nz/ apps/doc/A160332315/AONE?u=otago&sid=AONE&xid=765494d6

Halfer, D., & Graf, E. (2006). Graduate nurse perceptions of the work experience. *Nursing Economic$, 24*(3), 150-155. Retrieved from https://search-proquest-com.cmezproxy.chmeds.ac.nz/docview/236937968?accountid=14700

Happell, B. (1999). Who wants to be a psychiatric nurse? Novice student nurses' interest in psychiatric nursing. *Journal of Psychiatric and Mental Health Nursing, 6*(6), 479-484. doi:10.1046/j.1365-2850.1999.00249.x

Happell, B. (2002). The role of nursing education in the perpetuation of inequality. *Nurse Education Today, 22*(8), 632-640. doi: b>10.1016/S0260-6917(02)00104-1

Happell, B. (2008a). The importance of clinical experience for mental health nursing – Part 1: Undergraduate nursing students' attitudes, preparedness and satisfaction. *International Journal of Mental Health Nursing, 17*(5), 326-332. doi:10.1111/j.1447-0349.2008.00555.x

Happell, B. (2008b). The importance of clinical experience for mental health nursing – Part 2: Relationships between undergraduate nursing students' attitudes, preparedness, and satisfaction. *International Journal of Mental Health Nursing, 17*(5), 333-340. doi: 10.1111/j.1447-0349.2008.00556.x

Happell, B. (2008c). In search of a positive clinical experience. *Mental health practice, 11*(9), 26-31. Retrieved from: https://search-proquest-com.cmezproxy.chmeds.ac.nz/docview/217210972?rfr_id=info%3Axri%2Fsid%3Aprimo

Happell, B. (2009). Influencing undergraduate nursing students' attitudes toward mental health nursing: Acknowledging the role of theory. *Issues in Mental Health Nursing, 30*(1), 39-46. doi:10.1080/01612840802557113

Happell, B. (2015). A better way to do this? Views of mental health nursing directors about preparation for mental health nursing practice. *Australian Health Review, 39,* 211–216. doi.org/10.1071/AH14099

Happell, B. & Gaskin, C. (2013). The attitudes of undergraduate nursing students towards mental health nursing: a systematic review. *Journal of Clinical Nursing, 22*(1-2), 148–158. doi:10.1111/jocn.12022

Happell, B., McAllister, M., & Gaskin, C. (2014). Opportunity lost? The major in mental health nursing in Australia. *Nurse Education Today, 34*(6), e13-17. doi:10.1016/j.nedt.2013.10.004

Happell, B., Robins, A., & Gough, K. (2008a). Developing more positive attitudes towards mental health nursing in undergraduate students: Part 1 – does more theory help? *Journal of Psychiatric and Mental Health Nursing*, *15*(6), 439–446. doi: b>10.1111/j.1365-2850.2007.01203.x

Happell, B., Robins, A., & Gough, K. (2008b). Developing more positive attitudes towards mental health nursing in undergraduate students: Part 2 – the impact of theory and clinical experience. *Journal of Psychiatric and Mental Health Nursing*, *15*(7), 527-536. doi: b>10.1111/j.1365-2850.2007.01233.x

Harrison, C., Hauck, Y. & Ashby, R. (2017). Breaking down the stigma of mental health nursing: A qualitative study reflecting opinions from western Australian nurses. *Journal of Psychiatric and Mental Health Nursing*, *24*(7), 513-522. doi: 10.1111/jpm.12392

Hayman-White, K., Happell, B., Charleston R. & Ryan, R. (2007). Transition to mental health nursing through specialist graduate nurse programs in mental health: A review of the literature. *Issues in Mental Health Nursing, 28*(2), 185-200. doi: 10.1080/01612840601096354

Hazelton, M., Rossiter, R., Sinclair, E. & Morrall, P. (2011). Encounters with the 'dark side': New graduate nurses' experiences in a mental health service. *Health Sociology Review, 20*(2), 172-186. doi:10.5172/hesr.2011.20.2.172

Health Quality & Safety Commission (2015). *Engaging with consumers: A guide for district health boards.* Wellington: Health Quality & Safety Commission.

Health Quality & Safety Commission (2017). *New mental health and addiction quality improvement programme.* Retrieved from: https://www.hqsc.govt.nz/our-programmes/other-topics/news-and-events/news/2954 (13/8/17)

Hemingway, S., Clifton, A. & Edward, K-L. (2016). Essays and debates in mental health. The future of mental health nursing education in the United Kingdom: Reflections on the Australian and New Zealand experience. *Journal of Psychiatric and Mental Health Nursing, 23,* 331–337. doi: 10.1111/jpm.12312

Henderson, S., Happell, B., & Martin, T. (2007). Impact of theory and clinical placement on undergraduate students' mental health nursing knowledge, skills, and attitudes. *International Journal of Mental Health Nursing, 16*(2), 116–125. doi:10.1111/j.1447-0349.2007.00454.x

Hooper, M-E., Browne G. & O'Brien, A. (2016). Graduate nurses' experiences of mental health services in their first year of practice: An integrative review. *International Journal of Mental Health Nursing, 25,* 286–298. doi: 10.1111/inm.12192

Hopton, J. (1995). User involvement in the education of mental health nurses: An evaluation of possibilities. *Critical Social Policy*, *42,* 47-60.

Illmer, A. (2017). What's behind New Zealand's shocking suicide rate*? BBC News.* Retrieved from: http://www.bbc.com/news/world-asia-40284130 (8/10/2017)

Jansen, R. & Venter, I. (2015). Psychiatric nursing: An unpopular choice. *Journal of Psychiatric and Mental Health Nursing, 22*(2), 142-148. doi: 10.1111/jpm.12138

Johnston, M. (2016). Staff shortages force closure of beds at Auckland mental health unit. *NZ Herald.* Retrieved from: https://www.nzherald.co.nz/nz/news/article.cfm?c_id=1& objectid=11714686 (20/5/18)

Kim, H., Sefcik, J. & Bradway, C. (2017). Characteristics of qualitative descriptive studies: A systematic review. *Research in Nursing & Health, 40*(1), 23-42. doi:10.1002/nur.21768

Kramer, M. (1974). *Reality shock.* St Louis: Mosby.

Like Minds, Like Mine (2016). *About.* Retrieved from: https://www.likeminds.org.nz/about/ (19/9/18)

Lincoln, Y. & Guba, E. (1985). *Naturalistic inquiry*. London: Sage.

Lloyd, C., King, R. & Machingura, T. (2014). An investigation into the effectiveness of sensory modulation in reducing seclusion within an acute mental health unit. *Advances in Mental Health*, *12*(2), 93-100. doi.org/10.1080/18374905.2014.11081887

Logan, S. (2018). Addressing mental health nursing workforce shortages. *Kai Tiaki Nursing New Zealand, 24*(8), p. 17-19.

McCann, T., Clark, E. & Lu, S. (2010). Bachelor of nursing students career choices: A three-year longitudinal study. *Nurse Education Today, 30*(1), 31-36. doi: 10.1016/j.nedt.2009.05.014

McKenna, H., Thompson, D., Watson, R. & Norman, I. (2006). The good old days of nurse training: Rose tinted or jaundiced view? *International Journal of Nursing Studies, 43*(2), 135-137. doi: 10.1016/j.ijnurstu.2005.09.007

McLeod, M., King, P., Stanley, J., Lacey, C. & Cunningham, R. (2017). Ethnic disparities in the use of seclusion for adult psychiatric inpatients in New Zealand. *The NZ Medical Journal, 130*(1454). Retrieved from: https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2017/vol-130-no-1454-28-april-2017/7225 (25/4/2018)

Melrose, S. & Shapiro, B. (1999). Students' perceptions of their psychiatric mental health clinical nursing experience: A personal construct theory explanation. *Journal of Advanced Nursing, 30,* 1451-1458. doi: b>10.1046/j.1365-2648.1999.01231.x

Mental Health and Addiction Inquiry (2018). *Executive summary: Government inquiry into mental health and addiction.* Retrieved from: https://mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga/executive-summary/ (6/12/18)

Mental Health Foundation of New Zealand (2014). *Young people's experience of discrimination in relation to mental health issues in Aotearoa New Zealand: Remove the barriers for our young people from yesterday, today and tomorrow.* Auckland: Mental Health Foundation of New Zealand. Retrieved from: https://www.mentalhealth.org.nz/assets/Our-Work/Young-People-2014.pdf (7/10/17)

Minister of Health (2016). *New Zealand Health Strategy: Future direction.* Wellington: Ministry of Health. Retrieved from: http://www.health.govt.nz/system/files/documents/ publications/new-zealand-health-strategy-futuredirection-2016-apr16.pdf (13/8/17)

Ministry of Health (2010). *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992.* Wellington: Ministry of Health. Retrieved from: https://www.mentalhealth.org.nz/assets/ResourceFinder/seclusion-guidelines-feb10.pdf (28/10/18)

Ministry of Health (2016). *Health of the health workforce 2015*. Wellington: Ministry of Health. Retrieved from: https://www.health.govt.nz/system/files/ documents/publications/health-of-health-workforce-2015-feb16_0.pdf (2/2/18)

Ministry of Health (2017). *Office of the Director of mental health annual report 2016.* Wellington: Ministry of Health. Retrieved from: https://www.health.govt.nz/system /files/documents/publications/office-of-the-director-of-mental-health-annual-report-2016v4_0.pdf (2/2/18)

Minton, C., Birks, M., Cant, R. & Budden, L. (2018). New Zealand nursing students' experience of bullying/harassment while on clinical placement: A cross-sectional survey. *Collegian.* doi:10.1016/j.colegn.2018.06.003

Moll, S., Eakin, J.M., Franche, R.L. & Strike, C. (2013).When health care workers experience mental ill health: Institutional practices of silence. *Qualitative Health Research, 23*(2), 167-179. doi: 10.1177/1049732312466296.

Moran, A., Cocoman, A., Scott, P., Matthews, A., Staniuliene, V. & Valimaki, M. (2009). Restraint and seclusion: A distressing treatment option? *Journal of Psychiatric & Mental Health Nursing*, *16:* 599-605. doi: 10.1111/j.1365-2850.2009.01419.x

Morrell, P. (1998). Agents of social control. *Mental Health Care, 11*(9), 309-310.

Mwebe, H. (2017). Physical health monitoring in mental health settings: A study exploring mental health nurses' views of their role. *Journal of Clinical Nursing*, 26(19–20), 3067–3078. doi: 10.1111/jocn.13653

Nadler-Moodie, M. & Loucks, J. (2011). The implementation of a new-graduate nurse residency training program directly into psychiatric-mental health nursing. *Archives of Psychiatric Nursing, 25*(6), 479–484. doi:10.1016/j.apnu.2011.03.002

Nana, G., Stokes, F., Molano, W. & Dixon, H. (2013). *The future nursing workforce: Supply Projections 2010-2035*. Nursing Council New Zealand. Wellington: BERL. Retrieved from: http://www.nursingcouncil.org.nz/Publications/Reports-and-workforce-statistics (1/2/18)

Nassaji, H. (2015). Qualitative and descriptive research: Data type versus data analysis. *Language Teaching Research, 19*(2), 129-132. doi-org.cmezproxy.chmeds.ac.nz/10. 1177/1362168815572747

National Health Committee (2010). *Rural health: Challenges of distance, opportunities for innovation.* Retrieved from: http://www.rgpn.org.nz/Network/media/documents /pdfs/rural-health-challenges-opportunities.pdf (20/4/18)

Needham, H. & Sands, N. (2010). Post seclusion debriefing: A core nursing intervention. Perspectives in Psychiatric Care, *46*(3), 221-23. doi: 10.1111/j.1744-6163.2010.00256.x

New Zealand College of Mental Health Nurses (2012). *Standards of practice for mental health nursing in Aotearoa New Zealand* (3rd Edition). Retrieved from: http://www.nzcmhn.org.nz/files/file/330/NZCMHN%20Std%20Practice2012.pdf (12/11/18)

New Zealand Nurses Organisation (2018). *Unions reach pay settlement with DHBs.* Retrieved from: https://www.nzno.org.nz/about_us/media_releases/articletype/articleview/articleid/654/unions-reach-pay-settlement-with-dhbs (6/11/18)

Ngā Manukura o Āpōpō (2014). *The performance of New Zealand Schools of Nursing: Responsiveness to Māori nursing students – Scorecard 2014.* Whangarei, New Zealand: Northland District Health Board. Retrieved from: http://www.ngamanukura.co.nz/Portals/73/PDF/Nga%20Manukura%20o%20Apopo%20Scorecard%20Nov%202014%20FINAL.pdf (20/5/17)

North, N., Leung, W., & Lee, R. (2014). New graduate separations from New Zealand's nursing workforce in the first 5 years after registration: A retrospective cohort analysis of a national administrative data set 2005-2010. *Journal of Advanced Nursing, 70*(8), 1813-1824. doi:10.1111/jan.12339

Nowell, L., Norris, J., White, D. & Moules, N. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, *16*, 1–13. doi: 10.1177/1609406917733847

Nursing Council of New Zealand (2012). *Competencies for Registered Nurses.* Retrieved from: http://www.nursingcouncil.org.nz/Nurses/Scopes-of-practice/Registered-nurse (4/9/18)

Nursing Council of New Zealand (2015). *The New Zealand nursing workforce: A profile of nurse practitioners, registered nurses and enrolled nurses.* Retrieved from: http://www.nursingcouncil.org.nz/Publications/Reports-and-workforce-statistics (28/10/2018)

Nursing Council of New Zealand (2018). *The New Zealand nursing workforce: A profile of nurse practitioners, registered nurses and enrolled nurses 2016 - 2017.* Retrieved from: http://www.nursingcouncil.org.nz/Publications/Reports-and-workforce-statistics (1/6/2019)

Nursing Education in the Tertiary Sector (2018). *Nursing education in New Zealand.* Retrieved from: http://nurseducation.org.nz/Nursing-Education-in-NZ (27/5/18)

Nursing Review (2017). Mental health nursing shortages a 'recipe' for more acute bed closures. *Nursing Review, October.* Retrieved from: http://nursingreview.co.nz/mental-health-nursing-shortages-a-recipe-for-more-acute-bed-closures/ (20/5/18)

Oates, J., Drey, N. & Jones, J. (2017). 'Your experiences were your tools:' How personal experience of mental health problems informs mental health nursing practice. *Journal of Psychiatric and Mental Health Nursing, 24*(7), 471-479 doi: 10.1111/jpm.12376

O'Brien, L., Buxton, M., & Gillies, D. (2008). Improving the undergraduate clinical experience in mental health nursing. *Issues in Mental Health Nursing, 29*(5), 505-522. doi: 10.1080/01612840801981355

Ogden, E. (2017). *Is it ACE? The influence of the Advanced Choice of Employment scheme on new graduates' decisions to accept a position in the Nurse Entry to Specialist Practice in Mental Health and Addiction programme.* (Thesis, Master of Health Sciences). University of Otago, Christchurch. Retrieved from http://hdl.handle.net/10523/7907

O'Hagan, M. (2003). *Force in mental health services: International user / survivor perspectives.* Keynote address: World Federation for Mental Health Biennial Congress. Melbourne. Retrieved from: http://www.maryohagan.com/resources/Text_Files/Force%20Paper.pdf (13/8/17)

Pasila, K., Elo, S. & Kaariainen, M. (2017). Newly graduated nurses' orientation experiences: A systematic review of qualitative studies. *International Journal of Nursing Studies, 71,* 17-27. doi: 10.1016/j.ijnurstu.2017.02.021

Paterson, B., Mcintosh, I., Wilkinson, D., Mccomish, S. & Smith, I. (2013). Corrupted cultures in mental health inpatient settings: Is restraint reduction the answer? *Journal of Psychiatric and Mental Health Nursing*, *20*(3), 228-235. doi: b>10.1111/j.1365-2850.2012.01918.x

Perlman, D., Patterson, C., Moxham, L., Taylor, E., Brighton, R., Sumskis, S. & Heffernan, T. (2017). Preparing nursing students for mental health care: The impact of a recovery-oriented clinical placement. *Issues in Mental Health Nursing, 38*(8), 663-668. doi:10.1080/01612840.2017.1312650

Prebble, T., Hargreaves, H., Leach, L., Naidoo, K., Suddaby, G., Zepke, N. (2004). *Impact of student support services and academic development programmes on student outcomes in undergraduate tertiary study: A synthesis of the research.* Wellington: Ministry of Education.

Prebble, K. & McDonald, B. (1997). Adaptation to the mental health setting: The lived experience of comprehensive nurse graduates. *Australian & NZ Journal of Mental Health Nursing, 6*, 30-36.

Procter, N., Beutel, J., Deuter, K., Curren, D., de Crespigny, C. & Simon, M. (2011). The developing role of transition to practice programs for newly graduated mental health nurses. *International Journal of Nursing Practice, 17,* 254–261. doi: 10.1111/j.1440-172X.2011.01932.x

Reid, P. & Robson, B. (2006). *The state of Màori health.* Retrieved from: https://www.otago.ac.nz/wellington/otago067740.pdf (25/4/18)

Safewards (2017). *The evidence behind the safewards model.* Retrieved from: http://www.safewards.net/managers/evidence (14/8/17)

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health, 23*(4), 334–340. doi: 10.1002/1098-240X(200008)23:4<334::AID-NUR9>3.0.CO2-G

Schneebeli, C., O' Brien, A., Lampshire, D. & Hamer, H. (2010). Service user involvement in undergraduate mental health nursing in New Zealand. *International Journal of Mental Health Nursing, 19*(1), 30-35. doi: 10.1111/j.1447-0349.2009.00642.x

Schulze, B. (2009). Stigma and mental health professionals: A review of the evidence on an intricate relationship. *International Review of Psychiatry, 19*(2), 137-155. doi: 10.1080/09540260701278929

Scoop (2017). *New Zealand's mental health system in crises.* Retrieved from: http://www.scoop.co.nz/stories/GE1705/S00206/new-zealands-mental-health-system-is-in-crisis.htm (13/8/17)

Sercu, C., Ayala, R.A., & Bracke, P. (2015). How does stigma influence mental health nursing identities? An ethnographic study of the meaning of stigma for nursing role identities in two Belgian Psychiatric Hospitals. *International Journal of Nursing Studies*, *52*(1), 307–316. doi:10.1016/j.ijnurstu.2014.07.017

Shattell, M. (2009). Advice to new graduates: get (at least) one year of psychiatric/mental health nursing experience before working in medical-surgical settings. *Issues in Mental Health Nursing, 30*(1), 63. doi: 10.1080/01612840802557568

Snowdon, J. (2017). Changes in the age pattern of New Zealand suicide rates. *The New Zealand Medical Journal*, *130*(1448). Retrieved from: https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2017/vol-130-no-1448-13-january-2017/7121 (25/4/2018)

Spence, D.; Garrick, H. & Mckay, M. (2012). Rebuilding the foundations: Major renovations to the mental health component of an undergraduate nursing curriculum. *International Journal of Mental Health Nursing, 21*(5), 409-418. doi/10.1111/j.1447-0349.2011.00806.x/Fnew

Stevens, J., Browne, G., & Graham, I. (2013). Career in mental health still an unlikely career choice for nursing graduates: A replicated longitudinal study. *International Journal of Mental Health Nursing, 22*(3), 213-220. doi: 10.1111/j.1447-0349.2012.00860.x

Szasz, T. (1974). *The myth of mental illness: Foundations of a theory of personal conduct.* New York: Harper & Row.

Te Pou (2015). *New entry to specialist practice: Mental health and addiction nursing, survey data analysis 2010-2014.* Retrieved from: https://www.tepou.co.nz/uploads/files/ resource-assets/NESP-survey-data-analysis-report-2015.pdf (15/01/2018)

Te Pou (2017). *The evidence: Equally well.* Retrieved from: https://www.tepou.co.nz/initiatives/the-evidence/43 (13/8/2017)

Te Pou (2018a). Recruitment and Retention. *Handover, 42*. Retrieved from: https://www.tepou.co.nz/news/handover-issue-42---july-2018-out-now/1144 (6/11/2018)

Te Pou (2018b). *Reducing seclusion and restraint.* Retrieved from: https://www.tepou.co.nz/initiatives/reducing-seclusion-and-restraint/102 (4/11/18)

Te Pou (2018c). *Engagement essentials, 2nd Ed.* Auckland, New Zealand: Te Pou. Retrieved from: https://www.tepou.co.nz/uploads/files/resource-assets/TP%20180717%20LGR%20Engagement%20Essentials_v%C6%92%20WEB.pdf (4/11/2018)

Te Pou (2018d). *New entry to specialist practice: Mental health and addiction nursing*. Retrieved from: https://www.tepou.co.nz/initiatives/new-entry-to-specialist-practice-mental-health-and-addiction-nursing/47 (15/01/2018)

Te Pou (2018e). *Let's get real: The right knowledge, skills, values and attitudes to effectively support people using services.* Retrieved from: https://www.tepou.co.nz/initiatives/lets-get-real/107 (4/11/18)

Te Rau Matatini (2015). *"Every whanau should have a Māori nurse": Māori mental health nursing consultation document.* Wellington. Retrieved from: http://teraumatatini.com/sites/ default/files/FINAL%20Maori%20MH%20Nursing%20Consultation%20Doc%20%20Jan%20%2028%202015_0.pdf (5/5/17)

Terry, J. (2012). Service user involvement in pre-registration mental health nurse education classroom settings: a review of the literature. *Journal of Psychiatric and Mental Health Nursing, 19*(9), 816-829. doi:10.1111/j.1365-2850.2011.01858.x

Tingleff, E. & Gildberg, F. (2014). New graduate nurses in transition: A review of transition programmes and transition experiences within mental health care. *International Journal of Mental Health Nursing,* 23, 534–544. doi: 10.1111/inm.12087

Wenger, E., McDermott, R. & Snyder, W. (2002). *Cultivating communities of practice: A guide to managing knowledge.* Boston: Harvard Business School.

Wilkinson, J., Neville, S., Huntington, A. & Watson, P. (2016). Factors that influence new graduates' preferences for specialty areas. *Nursing Praxis in New Zealand, 32*(1), 8-19. Retrieved from: https://search-proquest com.cmezproxy.chmeds. ac.nz/docview/ 1779878242?rfr_id=info%3Axri%2Fsid%3Aprimo

Wilson, D., McKinney, C., & Rapata-Hanning, M. (2011). Retention of indigenous nursing students in New Zealand: A cross-sectional survey. *Contemporary Nurse, 38*(1-2), 59-75. doi:10.5172/conu.2011.38.1-2.59

Appendices

A – CPNS Approval Letter……………………………………………………………85

B – Change Request Letter……………………………………………………………86

C – Participant Information Sheet………………………………………………...……..88

D – Consent Form……………………...……………………………………...…...91

E – Conditional Ethical Approval…………………………………………………......93

F – Response to Ethical Committee…..…………………………………………………..95

G – Full Ethical Approval…………………………………….………………….96

H – Māori Consultation for Dunedin………...……………………….………………..98

I – Māori Consultation for Christchurch……………………………….………………..100

J – Southern DHB Locality Approval…...……………………………………………101

K – Canterbury DHB Locality Approval…………………..………………………102

L – University of Otago Declaration Form……………………………………..…..111

Appendix A – CPNS Approval Letter

6673835

28 February 2018

Deborah Cracknell
50A Brockville Road
Glenross
Dunedin 9011

Dear Deb

Research Proposal: Master of Health Sciences (Nursing-Clinical)

Thank you for submitting your research proposal. The Research Proposal Review Panel is pleased to **approve** your research proposal and supervisory arrangements as follows:

Title: " Exploring how nursing education impacts on the transition experiences of new graduate mental health nurses: A New Zealand context."

Supervisors: Primary Supervisor: Dr Virginia Jones
Second Supervisor: Dr Jenny Jordan

When the reviewers discussed your research proposal, the following points were raised for your benefit and consideration (and for discussion with your supervisors):

- It is noted that you are addressing two specific issues within the objectives for this research, both the transition into the work role but also the decision to enter into a career within mental health. You may want to consider reflecting this in the title of your study.

Memorandum of Understanding for Supervision
We strongly encourage you to develop a formal Memorandum of Understanding with your supervisors outlining the supervisory relationship and responsibilities so that expectations are clear and documented for all parties. A template Memorandum is enclosed for your use. Please feel free to modify it to suit your individual situation.

Ethical approval
You are reminded that your research cannot begin until ethical approval, where appropriate, has been granted. Once granted, a copy of the Ethics Approval must be sent to your Programme Administrator, to be filed along with your research proposal.

I wish you all the best with your studies.

Yours sincerely,

AClifford

Amanda Clifford
Postgraduate Administrator
cc Virginia Jones, Jenny Jordan, Ruth Helms, Linda Munro-Innes

Centre for Postgraduate Nursing Studies
School of Medicine & Health Sciences, University of Otago, Christchurch
PO Box 4345, Christchurch 8140, New Zealand
Tel +64 3 364 3850 • Fax +64 3 364 3855 • Email nursingstudies.uoc@otago.ac.nz
www.uoc.otago.ac.nz

Appendix B – Change Request Letter

Dr V Jones
Centre for Postgraduate Nursing Studies (Chch)
72 Oxford Terrace,
Levels 2 and 3
University of Otago
Christchurch

Academic Committees Office
Te Tari kā Komiti Mātauraka
Academic Services
University of Otago
PO Box 56, Dunedin 9054

11th June 2018

To The Ethics Committee,

Reference code: H18/050

I am writing to you to request some changes please to the recruitment strategy, data collection and transcribing details in the study "New graduate Mental Health Nurses in New Zealand: Exploring how nursing education impacts on the decision to work in mental health and the transition into practice."

Unfortunately, the locality approval from SDHB did not come through in time for the student researcher to meet and recruit the Dunedin New Graduate nurses on their study day on June 7th. The next Dunedin New Graduate planned study days are at the end of August which does not leave enough time for the recruitment, interviews and subsequent analysis and write up of the report in time for the December submission deadline.

To enable to the student researcher to recruit the New Graduate nurses in a timely fashion, an alternative strategy proposed is to contact both the Dunedin and Christchurch New Graduate nurse groups by e-mail, via the NESP co-ordinators, who have already agreed to assist with this project. The student researcher will write an email explaining about the project and inviting the nurses to apply (with an attached information sheet) and send this to the NESP co-ordinators, who will then forward the email onto the New Graduate nurses. A copy of the email to send to the NESP coordinators is included with this email. Potential participants can then contact the student researcher if they wish to participate in the study.

Another change requested regarding the data collection, is that any potential participant could choose to have the interview conducted online, via zoom, instead of just offering this to the Christchurch group. The Dunedin NESP co-ordinator has informed that a number of the New Graduate nurses who study in Dunedin actually live out of town (from Invercargill to Timaru) so this would enable access to them sooner than their next planned study days in Dunedin at the end of August. Face to face interviews could still be an option for participants who live in Dunedin.
One final requested change is that the student researcher will privately fund a person to complete the transcribing of the interviews rather than conduct this herself, again, to save time. An experienced transcriber familiar with dealing with confidential material will be used. The transcriber will be asked to sign a confidentiality agreement regarding all content of the audio

tapes and digital data. A secure process for getting digital files to and from the transcriber will be used with encryption for files and passwords communicated separately.

Finally, in relation to Maori consultation, I have attached evidence that this is now completed.

Many thanks for your time.

Yours sincerely,

Deborah Cracknell
Student Researcher

Appendix C

Participant Information Sheet

Study title:	**New graduate Mental Health Nurses in New Zealand: Exploring how nursing education impacts on the decision to work in mental health and the transition into practice.**	
Principal investigator:	**Dr Virginia Jones** **Centre for Postgraduate Nursing Studies** **Lecturer**	Contact phone number: 033643850

Introduction

Thank you for showing an interest in this project. Please read this information sheet carefully. Take time to consider and, if you wish, talk with relatives or friends, before deciding whether or not to participate.

If you decide to participate we thank you. If you decide not to take part there will be no disadvantage to you and we thank you for considering our request.

What is the aim of this research project?

Very little previous research has been conducted with new graduate mental health nurses to explore how nursing education has impacted on their decision to work in mental health and prepared them for the transition. This project aims to address this gap in the literature and to add a fresh NZ perspective. The research is being undertaken as part of the requirements for Deborah Cracknell's Masters Degree in Health Science (Clinical Nursing).

Who is funding this project?

The Centre for Postgraduate Nursing Studies, Otago University.

Who are we seeking to participate in the project?

We are recruiting participants who are newly qualified registered nurses, who have completed a Bachelor of Nursing in the past 12 months and who are currently enrolled on the New Entry to Specialist Practice program. Inclusion criteria also includes that participants in Dunedin are agreeable to a face to face interview being audio recorded and participants in Christchurch are agreeable with a video conferencing interview being recorded on Zoom. We aim to interview between 6 and 10 participants.

If you participate, what will you be asked to do?

Should you agree to take part in this project, you will be asked to:

- Meet the researcher at a mutually convenient time and place to participate in a semi-structured interview, possibly through video conferencing.
- The interview will take approximately 30 minutes.
- Post interview you will be given a written copy of the interview and asked to read and verify the information.

Is there any risk of discomfort or harm from participation?

It is not anticipated the research will cause any discomfort or harm to you and you are free to withdraw at any point, with no disadvantage to yourself, of any kind.

What specimens, data or information will be collected, and how will they be used?

- Demographic information will be collected and participants will be asked to talk about their nursing education, reasons for choosing mental health and transition into professional practice.
- There are three people in the research team who will have access to your information. The student researcher is Deborah Cracknell and the two Otago University Supervisors are Dr Virginia Jones and Dr Jenny Jordan.
- The information will be securely managed by having password access on files and data will be backed up using the Otago University file storage system. Full disk encryption will be activated on the project laptop to ensure safety if the device is lost. Tape cassettes and transcribed data will be kept in a locked drawer as per Otago University policy. At the end of the project, the recorded video conferencing files will be deleted and the audio tape cassettes will be taped over with white noise.
- The data collected will be securely stored in such a way that only those mentioned above will be able to gain access to it. Data obtained as a result of the research will be retained for **10 years** in secure storage. Any personal information held on the participants will be

destroyed at the completion of the research even though the data derived from the research will, in most cases, be kept for much longer.

What about anonymity and confidentiality?

Transcripts will be de-identified and pseudonyms will be used to protect your confidentiality in the dissertation and any publications.

The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand) but every attempt will be made to preserve your anonymity and confidentiality.

If you agree to participate, can you withdraw later?

You may withdraw from participation in the project at any time and without any disadvantage to yourself of any kind.

Any questions?

If you have any questions now or in the future, please feel free to contact either:

Dr Virginia Jones **Lecturer** **Centre for Postgraduate Nursing Studies**	Contact phone number: 03 3643850
Dr Jenny Jordan **Senior Research Fellow & Clinical Psychologist** **Department of Psychological Medicine**	Contact phone number: 03 3726700 x 6746
Deborah Cracknell **Student Researcher** **Centre for Postgraduate Nursing Studies**	Contact phone number:

This study has been approved by the University of Otago Human Ethics Committee (Health). If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (phone +64 3 479 8256 or email gary.witte@otago.ac.nz). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.

Appendix D

New graduate Mental Health Nurses in New Zealand: Exploring how nursing education impacts on the decision to work in mental health and the transition into practice.

Principal Investigator: Dr Virginia Jones 033643850 virginia.jones@otago.ac.nz

CONSENT FORM FOR PARTICIPANTS

Following signature and return to the research team this form will be stored in a secure place for ten years.

Name of participant:…………………………………………..

1. I have read the Information Sheet concerning this study and understand the aims of this research project.
2. I have had sufficient time to talk with other people of my choice about participating in the study.
3. I confirm that I meet the criteria for participation which are explained in the Information Sheet.
4. All my questions about the project have been answered to my satisfaction, and I understand that I am free to request further information at any stage.
5. I know that my participation in the project is entirely voluntary, and that I am free to withdraw from the project before its completion.
6. I know that the interview will explore my nursing education, my reasons for choosing mental health and my transition into mental health practice and that if the line of questioning develops in such a way that I feel hesitant or uncomfortable I may decline to answer any particular question(s), and /or may withdraw from the project without disadvantage of any kind.

7. I know that when the project is completed all personal identifying information will be removed from the paper records and electronic files which represent the data from the project, and that these will be placed in secure storage and kept for at least ten years.

8. I understand that the results of the project may be published and be available in the University of Otago Library, but that I agree that any personal identifying information will remain confidential between myself and the researchers during the study, and will not appear in any spoken or written report of the study.

9. I know that there is no remuneration offered for this study, and that no commercial use will be made of the data.

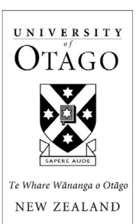
10. Please tick this box if you wish to receive a summary of the research results and provide address details ☐

…………………………………………………………………………………………
…………………

Signature of participant: Date:

Name of person taking consent Date:

Appendix E – Conditional Approval



H18/050

Academic Services
Manager, Academic Committees, Mr Gary Witte

Dr V Jones

22 April 2018

Centre for Postgraduate Nursing Studies (Chch)
72 Oxford Terrace, Levels 2 and 3
University of Otago, Christchurch

Dear Dr Jones,

I am writing to let you know that, at its recent meeting, the Ethics Committee considered your proposal entitled "**New graduate Mental Health Nurses in New Zealand: Exploring how nursing education impacts on the decision to work in mental health and the transition into practice.**".

As a result of that consideration, the current status of your proposal is:- **Conditional Approval**

For your future reference, the Ethics Committee's reference code for this project is:- **H18/050**.

The comments and views expressed by the Ethics Committee concerning your proposal are as follows:-

Please address the following comments before proceeding with the research:

Risk of harm (question 8.1)

The Committee noted the consideration given in relation to how the potential risk of conflict of interest on the part of the student investigator, Deborah Cracknell, is to be managed. It is stated, in 8.1, that participants will be excluded who knew Deborah previously through her work at the local Polytechnic School of Nursing. The Committee asks for clarification, however, on what Deborah's relationship to potential participants is now. Is there an employment relationship, for example? If so this could potentially bias responses given by participants.

Locality approval

The Committee would like to remind you that locality approval will be required from both Canterbury District Health Board and the Southern District Health Board. Please provide evidence, when this becomes available.

Maori Consultation

This research is of interest to Maori. Please supply the Committee with evidence that consultation is underway with the Ngāi Tahu Research Consultation Committee (Te Komiti Rakahau ki Kāi Tahu). If you wish to discuss this please contact Karen Keelan Māori Health Research Advisor, karen.keelan@otago.ac.nz.

Before approval of the research to proceed can be granted, a written response must be received addressing the issues raised above. Please provide the Committee with updated documents, where changes have been necessary. The Committee expects that the above comments will be addressed before recruitment of participants begins. Please note that the Committee is always willing to enter into dialogue with applicants over the points made. There may be information that has not been made available to the Committee, or aspects of the research may not have been fully understood. Responses are reviewed outside the normal meeting cycle and only one copy is required. Please email your written response and revised documentation to Gary.Witte@otago.ac.nz or Jo.Farrondediaz@otago.ac.nz. Your response will be reviewed and correspondence will be sent to you within 3-5 days of receipt. Yours sincerely,

Mr Gary Witte

Manager, Academic Committees
Tel: 479 8256
Email: gary.witte@otago.ac.nz

c.c. Dr P Seaton Director, Senior Lecturer Centre for Postgraduate Nursing Studies (Chch)

Appendix F – Response to Ethical Committee

Dr V Jones
Centre for Postgraduate Nursing Studies (Chch)
72 Oxford Terrace,
Levels 2 and 3
University of Otago
Christchurch

Academic Committees Office
Te Tari kā Komiti Mātauraka
Academic Services
University of Otago
PO Box 56, Dunedin 9054

30th April 2018

To The Ethics Committee,

Reference code: H18/050

Thank you for the Conditional Approval. I am writing to you to clarify my position as student researcher in the study "New graduate Mental Health Nurses in New Zealand: Exploring how nursing education impacts on the decision to work in mental health and the transition into practice."

In relation to question 8.1, risk of harm, the committee asked about my relationship with potential participants. I am currently employed only by Otago Polytechnic and do not work for either DHB. Some of the potential participants may know me if they completed their nursing degree at Otago Polytechnic and that is why I have excluded them from participating in the research project. I have no other relationships to declare.

In relation to Locality Approval, I will provide the evidence that I have obtained this once confirmation is received from SDHB. My plan is to contact CDHB only if I am unable to recruit enough participants locally and if this occurs, I will again provide evidence that I have obtained locality approval from CDHB, prior to undertaking the research.

In relation to Maori consultation, I did have a booking last week with Karen Keelan (UOC) but it was cancelled due to illness. We will reschedule as soon as possible and I will provide the evidence you require once available.

Many thanks for your time.

Yours sincerely,

Deborah Cracknell
Student Researcher

Appendix G – Full Ethical Approval

UNIVERSITY of OTAGO
Te Whare Wānanga o Otāgo
NEW ZEALAND

H18/050

Academic Services
Manager, Academic Committees, Mr Gary Witte

2 May 2018

Dr V Jones
Centre for Postgraduate Nursing Studies (Chch)
72 Oxford Terrace, Levels 2 and 3
University of Otago, Christchurch

Dear Dr Jones,

I am again writing to you concerning your proposal entitled "**New graduate Mental Health Nurses in New Zealand: Exploring how nursing education impacts on the decision to work in mental health and the transition into practice.**", Ethics Committee reference number **H18/050**.

Thank you to Deborah Cracknell, student investigator on the above project, for her email of 30th April 2018 with response attached addressing the issues raised by the Committee.

On the basis of this response, I am pleased to confirm that the proposal now has full ethical approval to proceed.

The standard conditions of approval for all human research projects reviewed and approved by the Committee are the following:

Conduct the research project strictly in accordance with the research proposal submitted and granted ethics approval, including any amendments required to be made to the proposal by the Human Research Ethics Committee.

Inform the Human Research Ethics Committee immediately of anything which may warrant review of ethics approval of the research project, including: serious or unexpected adverse effects on participants; unforeseen events that might affect continued ethical acceptability of the project; and a written report about these matters must be submitted to the Academic Committees Office by no later than the next working day after recognition of an adverse occurrence/event. Please note that in cases of adverse events an incident report should also be made to the Health and Safety Office:

http://www.otago.ac.nz/healthandsafety/index.html

Advise the Committee in writing as soon as practicable if the research project is discontinued.

Make no change to the project as approved in its entirety by the Committee, including any wording in any document approved as part of the project, without prior written approval of the Committee for any change. If you are applying for an amendment to your approved research, please email your request to the Academic Committees Office:

gary.witte@otago.ac.nz

jo.farrondediaz@otago.ac.nz

Approval is for up to three years from the date of this letter. If this project has not been completed within three years from the date of this letter, re-approval or an extension of approval must be requested. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing.

The Human Ethics Committee (Health) asks for a Final Report to be provided upon completion of the study. The Final Report template can be found on the Human Ethics Web Page http://www.otago.ac.nz/council/committees/committees/HumanEthicsCommittees.html

Yours sincerely,

Mr Gary Witte
Manager, Academic Committees
Tel: 479 8256
Email: gary.witte@otago.ac.nz

c.c. Dr P Seaton Director, Senior Lecturer Centre for Postgraduate Nursing Studies (Chch)

Appendix H – Māori Consultation for Dunedin

CHRISTCHURCH

11 May 2018

Dr Virginia Jones
Centre for Postgraduate Nursing Studies
University of Otago, Christchurch

Mā te rangahau Hauora e tautoko te whakapiki ake te Hauora Māori.
All health research in Aotearoa New Zealand benefits the Hauora (health and wellbeing) of tangata whenua.

Tēna kōe Virginia,

Thank you for taking the time to discuss your research with me at my office on the 8th May 2018. Your research study is titled:

"New Graduate Mental Health Nurses in New Zealand: Exploring How Nursing Education Impacts on the Decision to Work in Mental Health and the Transition into Practice"

I note that you are the Principal Investigator for this study and that Ms Deborah Cracknell, a postgraduate student completing the research requirements for a Master's degree with your department will be involved in undertaking the study.

Commentary on Proposed Research Project
It can be difficult to recruit new nursing graduates into mental health. In fact, some new nursing graduates find it stressful in mental health and leave. At present, there is no published literature about the experience of new graduate mental health nurses in New Zealand, so this project aims to address that. Qualitative interviews will be conducted with new graduate nurses who have chosen to work in mental health and explore treasons for choosing this field, and if their education has prepared them for it, or not. Exploring the experiences of new graduate nurses will help to better understand the New Zealand situation.

You inform that 6-10 new graduate nurses will be recruited from the Ara Institute (Canterbury) and Otago Polytechnic (Dunedin) and invited to participate in the study. Interviews will be conducted face-to-face in Dunedin, or by video conferencing if the nurse participant is in Christchurch.

Māori Health Gain
As a population Māori have a much higher risk of developing mental health problems compared to other population groups in New Zealand. A sustainable mental health nursing workforce, including the recruitment and retention of Māori nurses is critical to help support and deliver treatment to this population. It is anticipated that the results from this study will help to better understand the experiences of new graduate nurses working in mental health from which to inform future mental health nursing recruitment and retention strategies.

Ethnicity

Research and Development Christchurch
University of Otago, Christchurch
PO Box 4345, Christchurch 8140, New Zealand
Tel +64 3 364 0237 • Email research.uoc@otago.ac.nz
otago.ac.nz/christchurch

Whilst this study does not target Māori participation, the ethnicity of participants is a key variable for understanding the health experiences of different population groups leading to the development of more effective policies and programmes. Therefore, it is recommended that ethnicity data is collected from each participant in accordance with the Ministry of Health guidelines, which involves the use of the Census 2013 question.

Consent
Issues regarding informed consent for study participants recruited to the study were discussed. You must ensure that study participants are explicitly aware that consent is for this study only.

Potential Further Support Resources
Further resources that you might want to access to strengthen your responsiveness to Maori within your research are: 1. HRC's Ngā Pōu Rangahau Hauora Kia Whakapiki Ake Te Hauora Māori 2004-2008, 2. Article by Dr Papaarangi Reid (2017). "Achieving Health Equity in Aotearoa: Strengthening Responsiveness to Māori in Health Research." and 3. The Health Research Strategy to Improve Māori Health and Well Being 2004-2008. For regional data relating to Māori in each District Health Board (DHB) region, the District Health Board (DHB) Māori Health Profiles (2015) published by the Ministry of Health New Zealand will help to create a picture of the health status of a DHB's population at a given time. The other reference that is available is 3. Hauora Māori Standards of Health IV: A Study of the Years 2000-2005 by Bridget Robson and Ricci Harris, Māori Health Research Unit, Wellington School of Medicine, University of Otago, Wellington. The publication Tātau Kahukura: Māori Health Chart Book 2015, Ministry of Health, 2010 (3rd edition) is an update relating to the socio economic determinants of health, health status and service utilisation of the Māori population. Further references are available from the HRC's Guidelines for Researchers on Health Research Involving Māori. All provide Maori specific information on a range of health issues.

Dissemination of Results
The HRC's Guidelines for Researchers on Health Research Involving Māori, is important in terms of how your research results may contribute to Māori health gain. This should occur not only in an academic forum, but also within the community from where data is drawn. In terms of dissemination to a Māori audience, I have recommended that a summary of your study results be sent to appropriate Māori health stakeholders including Te Runanga o Aōtearoa (Māori Governance Group of the New Zealand Nursing Organisation). You also inform that a summary of the results will be made available to all study participants and that you will be presenting your study findings at the Southern District health Board Mental Health Nursing Day. As such, these avenues will allow an opportunity for the consideration of feedback into any discussion going forward.

Ngā manaakitanga,

Karen Keelan
Kaitohutohu Rangahau Māori/Māori Research Advisor

Appendix I – Māori Consultation for Christchurch

5th July 2018

Deborah Cracknell
Centre of Postgraduate Nursing Studies
University of Otago, Christchurch

RE: New graduate Mental Health Nurses in New Zealand: Exploring how nursing education impacts on the decision to work in mental health and the transition into practice.

Tēna koe Deborah,

Ka nui te mihi tēnei ki a koe me tou roopu o nga Kairapūkōrero ki te hapai o te kaupapa whakahirahira mou, mōku mo tātou katoa. Ko Rapunga Korero te mea nui. No reira tēnā koe me te roopu o nga Kairangahau, tēna koutou katoa.

Thank you for submitting the above research proposal to Te Komiti Whakarite, the Canterbury DHB Māori Health Research committee for Māori consultation.

When providing Māori consultation for multi-site applications we are satisfied any concerns we may have, have been covered by the lead site, University of Otago, Karen Keelan, Kaitohutohu Māori, Māori Research Advisor.

We have read your proposal, which you are undertaking as a research paper for your Master's, with Dr Virginia Jones your supervisor.

We have read your proposal which is clear about how the researcher will take participants cultural needs into account. We are happy to offer our support regarding any further culturally responsive practice and guidance you may seek advice on.

Ethnicity data is a key variable for understanding the health experiences and priorities of different population groups that can lead to the development of more effective policies and programmes.

Ultimately this type of research has the potential to reduce the health disparities between Māori and non-Māori.

We wish you every success in your research and the Komiti would appreciate a summary of your findings on completion of the current project. Te Komiti Whakarite would be willing to assist in the dissemination of your findings to the appropriate Māori organisations, Māori health professionals and Māori researchers.

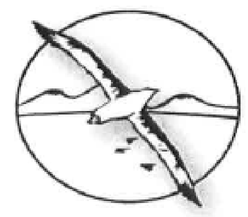
I hope this letter will suffice in terms of the application. Please contact me should you need any other information that may not have been included in the letter relevant to your research.

Heoi ano

Eru Waiti
Chairperson - Te Komiti Whakarite

Te Komiti Whakarite
245 Antigua Street, Christchurch. Private Bag 4710, Christchurch, New Zealand
Telephone: (64) (3) 364 0640 Ext: 88474 Facsimile: (64) (3) 378 6018

Appendix J – Locality Approval for Southern DHB



Health Research South

14/06/2018

Project ID 01455

COPY

Prof Stephen Robertson
DSM

Dear Stephen

SUBJECT: **New Graduate Mental Health Nurse in New Zealand: Exploring how nursing education impacts on the decision to work in mental health and the transition into practice.**

This letter is to confirm that Health Research South has granted Locality Authorisation, allowing you to proceed with the above mentioned project.

According to our records:

This project is due to commence on: 14/06/2018

It is anticipated that this project will be completed by: 1/01/2019

Please note that we would appreciate receiving a copy of ***your final report to the Ethics Committee*** once your project is completed.

If you have any questions with regards to this process, please contact Health Research South, quoting the project ID number shown above.

Yours sincerely

Ruth Sharpe
CLINICAL RESEARCH ADVISOR

C.C. LOUISE TRAVERS, SOUTHERN DHB
DEBORAH CRACKNELL, CENTRE FOR POSTGRADUATE NURSING STUDIES

Health Research South, PO Box 56, Dunedin 9054
hrs@otago.ac.nz; www.otago.ac.nz/hrs

Appendix K – Locality Approval for Canterbury DHB

Research Office Project ID	RO# 18054

2017 Request for Locality Authorisation Form
(Non-commercial/Non-government/Government Research Projects)

Instructions:

1. Complete the form. ***Only typed applications will be accepted. Please provide detailed answers as the CDHB Locality Authorisation will **ONLY** be provided for that outlined in this application.

2. Print the form and **obtain approval from the Clinical Director and Service Manager** of the host department where the research project will be conducted.

NEW

3. If using the services of Canterbury Health Laboratories and/or Pharmacy for services outside of standard of care please note that signatures are now required or a copy of the quote.

4. The following **MUST** accompany your Locality Authorisation Form:
   a. Ethics Approval Letter
   b. HDEC Online Locality Authorisation Request (cdhb.researchoffice@otago.ac.nz) where applicable
   c. CDHB Te Komiti Whakarite Maori Consultation Letter
   d. Source of Funding – e.g., contracts, email confirmation, proof of funding document
   *** Please note – additional documentation or evidence may be requested by the Research Office to assist in the processing your application*

5. Send the completed Locality form along with the required documentation to Research Office, Level 5, University of Otago, Christchurch or send via email to cdhb.researchoffice@otago.ac.nz.

6. The Research Office will endeavor to process your locality within 5 working days WHEN ALL THE REQUIRED DOCUMENTATION HAS BEEN RECEIVED.

7. STUDENT RESEARCH. If you are a student, please complete your details in the "Other parties involved" box. Please ask your supervisor to complete the "coordinating Investigator (CI)" box and request that they sign the form as CI.

Locality Authorisation Form, March 2017 Page 1

RESEARCHER TO COMPLETE AND ATTACH ALL REQUIRED DOCUMENTATION

1. Research Team

CDHB Principal Investigator (PI)	Dr Jennifer Jordan PhD Dip Clin Psych, FNZCCP Senior Research Fellow & Clinical Psychologist	Email:	jenny.jordan@otago.ac.nz
CDHB Contact Person:	Jennifer Jordan	Email:	jenny.jordan@otago.ac.nz
Coordinating Investigator (CI) and Organisation:	Dr Virginia Jones, Senior Lecturer, Otago University, Centre for Postgraduate Nursing Studies	Email:	virginia.jones@otago.ac.nz
(if CDHB is not the lead site) Contact Person:		Email:	

Other parties involved (e.g. Sponsors, Collaborators, other Sites)

Dr Jenny Jordan, Department of Psychological Medicine, jenny.jordan@otago.ac.nz

Deborah Cracknell, Student Researcher, Centre for Postgraduate Nursing Studies crade079@student.otago.ac.nz

2. Project Details

2.1 Research Office Project ID:

RO# 18054

2.2 Project Title/Protocol Number:

"New graduate Mental Health Nurses in New Zealand: Exploring how nursing education impacts on the decision to work in mental health and the transition into practice."

2.3 Project timeline *(If applicable, project start and end dates should be consistent with HDEC answer a.1.4)*

Project start date:	June 2018 (in Dunedin)
Recruitment start:	June 2018
Recruitment end:	Oct 2018
Project end:	Dec 2018

2.4 Brief Summary of the Overall Project *(If applicable, copy answer from HDEC question a.1.5 in the box below)*

It is difficult to recruit nurses into mental health and we are heading towards a shortage in the workforce. New graduates find it a stressful area to work in and some leave early. Exploring how nursing education impacts on the decision to work in mental health and

Research Office | Canterbury District Health Board & University of Otago, Christchurch | PO Box 4345, Christchurch Mail Centre, Christchurch 8140, New Zealand Tel +64 3 364 0237 ▪ Email cdhb.researchoffice@otago.ac.nz www.otago.ac.nz/christchurch/research

prepares nurses for this transition will afford us greater understanding in this area where very little previous research has been conducted globally and especially in NZ.

Purposive sampling will be used to recruit participants who are new graduate registered nurses who have chosen to work in mental health nursing. The inclusion criteria for participants is that the new graduate mental health nurse has completed a Bachelor of Nursing in the previous year, is enrolled on a New Entry to Specialist Practice (NESP) program, and is agreeable to the interview being recorded in Zoom. Exclusion criteria is knowing the student researcher previously through her role as Clinical Lecturer at Otago Polytechnic School of Nursing.

A qualitative research design will be used to explore the new graduate nurses experiences about how their education has impacted on their decision and transition into mental health practice. Participants will be interviewed individually in a semi-structured manner through Zoom or skype video conferencing. It is anticipated that between 6-10 participants will be needed to reach data saturation point. The data will be analyzed using the thematic analysis method advocated by Braun & Clark (2006).

2.5 Describe the methods/ procedures that will occur within CDHB (Note that locality authorisation will only cover the procedures that are detailed here)

The student researcher will email Gail Houston, the NESP co-ordinator, and ask her to forward an email to the NESP group informing about the research project and inviting them to apply.

2.6 Outline which of those procedures in 2.4 above fall **within** standard of care.

N/A

2.7 Outline which of those procedures in 2.4 above fall **outside** standard of care. *(if applicable, copy answer from HDEC question r.1.1)*

N/A

NEW

2.8 Are you using the services of Canterbury Health Laboratories (including **within** standard of care)?

NO

If **YES**, please:

1. Attach a copy of the quote for services,

OR

2. Obtain the signature of Kirsten Beynon, General Manager of CHL (Table 5).

Research Office | Canterbury District Health Board & University of Otago, Christchurch | PO Box 4345, Christchurch Mail Centre, Christchurch 8140, New Zealand Tel 64 3 364 0237 • Email cdhb.researchoffice@otago.ac.nz www.otago.ac.nz/christchurch/research

2.9 Are you using the services of Pharmacy outside of standard of care? NO

If **YES**, please:

1. Attach a copy of the quote for services,

OR

2. Obtain the signature of Paul Barrett, Pharmacy Manager (Table 5).

Research Office Project ID	**RO# 18054**

3. CDHB Resources Used

3.1 **CDHB Participants** - Please outline the Recruitment Process and Number *(if applicable, copy answers from HDEC questions a.6.2 and p.2.1 in the box below)*

The recruitment process involves the student researcher emailing the NESP co-ordinator who will be asked to forward the email to the NESP group of nurses to inform them about the project and inviting them to participate.

3.2 **Access to CDHB Patient Data** – Please specify data source (e.g. HealthOne, Health Connect South, Existing patient registry, Tissue bank samples, Data warehouse, non-electronic Clinical Records)

NONE

3.3 **CDHB Staff** – please outline key CDHB staff and their specific tasks for this project

	Name	Department	Role in the Project	Key tasks
1	Jennifer Jordan	Clinical Research Unit SMHS	Supervisor	Oversight of project, supervising thesis (UOC role)
2	Gail Houston			Assist with recruitment
3				
4				
5				
6				
7				
8				

3.4 **CDHB Facilities** *(list specific location/s and department/s where the project will be conducted e.g., Burwood, Orthopaedic Dept.)*

	Location / Department	Methods / Procedures at this Facility
1		
2	N/A	

3.5 Other Resources Required – please specify

N/A

Research Office Project ID	

4. Evidence Required – THE FOLLOWING SHOULD BE SENT ALONG WITH THE COMPLETED LOCALITY AUTHORISATION FORM:

4.1 Ethical Approval or 'Out of Scope' Letter

a. If the project is "outside ethics review" then CI / PI should sign and date

b. If the project has been approved by HDEC, please ensure to request locality on-line via the HDEC website. You will need to type in our email address cdhb.researchoffice@otago.ac.nz

	Reference Number	Date of letter
HDEC :		
HDEC – Out of scope :		
Institutional approval :	The University of Otago Human Ethics Committee H18/050	2nd May 2018
Not required :	(sign here)	(date)

4.2 Local Maori Consultation from Te Komiti Whakarite:

Date of letter received :	TKW request sent 25/6/18 Maori consultation with Otago University letter dated 11th May 2018

4.3 Funding: If any procedures have been outlined in **Question 2.7**, please detail how costs will be covered

(attach proof of funding document e.g., contract, confirmation letter/email)

No funding.

4.4 Proof of Indemnity for CI or PI

Is your role in this project within your CDHB or UOC employment capacity? YES

If NO, please attach proof of Professional Indemnity Insurance from your Institution/Organisation.

Research Office Project ID	RO# 18054

RESEARCHER TO ORGANISE APPROVAL FROM RESPECTIVE MANAGERS

CDHB Coordinating Investigator or CDHB Principal Investigator: I hereby confirm that all information contained within this application is true and correct. I will take professional responsibility to conduct this research at CDHB and ensure all consents and approvals are obtained and sighted by the Research Office before research commences. Further, I confirm that conducting this research at CDHB will have no adverse effect of the provision of publicly funded health care at this locality. **(Must be CDHB staff)**	
Signed: [signature] **Name:** Jennifer Jordan	**Date:** 18.7.17

5. Approval From All Areas Where Resources are Accessed

Approvals: I hereby authorise this application to undertake this research within this CDHB Department and guarantee the availability of adequate facilities, equipment, staff and any special support which may be required as detailed in the application. I confirm that it is in accordance with current CDHB policy.

Department name:	**1. Clinical Research Unit, SMHS, CDHB**	**2.**	**3.**
Clinical Director - Name	Dr Richard Porter		
Signature	[signature]		
Date	19.7.18		
Service Manager - Name			
Signature			
Date			
Other Approving Manager Name			
Title	General Manager		
Signature			
Date			

RESEARCH OFFICE TO FACILITATE APPROVAL FROM CDHB GENERAL MANAGER/S

General Manager sign-off

This research will take place in your hospital, do you approve it?

Hospital 1	*Name:*	*Signature:*	*Date:*
Hospital 2	*Name:*	*Signature:*	*Date:*

Research Office | Canterbury District Health Board & University of Otago, Christchurch | PO Box 4345, Christchurch Mail Centre, Christchurch 8140, New Zealand Tel +64 3 364 0237 • Email cdhb.researchoffice@otago.ac.nz www.otago.ac.nz/christchurch/research

Research Office Project ID	RO# 18054

RESEARCHER TO ORGANISE APPROVAL FROM RESPECTIVE MANAGERS

CDHB Coordinating Investigator or CDHB Principal Investigator: I hereby confirm that all information contained within this application is true and correct. I will take professional responsibility to conduct this research at CDHB and ensure all consents and approvals are obtained and sighted by the Research Office before research commences. Further, I confirm that conducting this research at CDHB will have no adverse effect of the provision of publicly funded health care at this locality. **(Must be CDHB staff)**	
Signed: **Name:**	**Date:**

5. Approval From All Areas Where Resources are Accessed

Approvals: I hereby authorise this application to undertake this research within this CDHB Department and guarantee the availability of adequate facilities, equipment, staff and any special support which may be required as detailed in the application. I confirm that it is in accordance with current CDHB policy.

Department name:	1.	2.	3.
Clinical Director - Name			
Signature			
Date			
Service Manager - Name			
Signature			
Date			
Other Approving Manager Name	**Canterbury Health Labs** Kirsten Beynon	**Pharmacy** Paul Barrett	
Title	General Manager	Manager	
Signature			
Date			

RESEARCH OFFICE TO FACILITATE APPROVAL FROM CDHB GENERAL MANAGER/S

General Manager sign-off

This research will take place in your hospital, do you approve it?

Hospital 1	Toni Gutschlag General Manager Mental Health Name: Peri Renison	*Signature:* [signature]	*Date:* 2/8/18
Hospital 2	Chief of Psychiatry Specialist Mental Health Service Name: Canterbury District Health Board	*Signature:* [signature]	*Date:*

Research Office I Canterbury District Health Board & University of Otago, Christchurch I PO Box 4345, Christchurch Mail Centre, Christchurch 8140, New Zealand Tel +64 3 364 0237 • Email cdhb.researchoffice@otago.ac.nz www.otago.ac.nz/christchurch/research

Canterbury District Health Board Te Poari Hauora ō Waitaha	Specialist Mental Health Service **Research Locality Assessment**

Step one: Researcher to complete this section
Researchers name: Dr Virginia Jones, Dr Jenny Jordan & Deborah Cracknell
Research title: New graduate Mental Health Nurses in New Zealand: Exploring how nursing education impacts on the decision to work in mental health and the transition into practice.

Proposed timeframes
Start: June 2018
Completion: **Dec 2018**

Research location: Dunedin
Please attach proposal.
Have you sought funding? No, self-funded If so, from where?
Are there any resource implications for SMHS (staffing or other costs)? If so, what?
Participants will be recruited by email via NESP co-ordinator and interviewed by video-conferencing from a location of their choice.

Is it your intention to publish any part of this research or findings? The research is being conducted as part of a Masters in Clinical Nursing Degree and will be available at Otago University library. It may be published in journal articles.

Is ethics approval required? Yes, obtained
- If no, briefly state why?
- If yes, has application been made for ethics approval? Attach copy of application.
- If ethics approval has been given, attach copy of approval.

The researcher accepts accountability for ensuring that all ethical and/or regulatory obligations are met and that appropriate consultation is undertaken.

Researcher's signature:	Designation:	Date:
[signature]	**Student researcher**	**14/6/18**

Step two: Service Leadership Team member to complete this section
SLT approves the research being undertaken and will monitor progress of the research. The proposal is recommended for approval.

Chair's signature:	Name:	Designation:	Date:

If SLT is not appropriate for the monitoring function, the SMHS Research Committee will appoint an appropriate monitor.
A scanned copy of this form and proposal is to be emailed to SMHS Research Committee now
SMHSResearch@cdhb.health.nz

Step three: SMHS Research Committee to complete this section

Prior to approval, the SMHS Research Committee will consider the following:	**Yes/no**
Vulnerable populations' rights are protected	y
Privacy issues are identified and mitigated	y
Health Information Privacy Code 1994 is adhered to	y
Benefits and risks (including mitigations) are transparent and acceptable	y
Resource implications for SMHS (staffing and other costs) are transparent and acceptable	y
The proposed study meets generally accepted ethical standards	y
The locality is suitable	y
Local researcher has the ability to undertake the study	y

Authoriser: SMHS Research Committee
SMHS Research Locality Assessment
Page 2 of 2
Issue date: 5 December 2017
Issue: 10

SMHS Research Committee approves the proposal and recommends the General Manager approve.			
Chair of Research Committee signature:	Name: TONY FARROW	Designation: NURSE MANAGER	Date: 1-8-18

Step four: General Manager approves the research to commence.		
Name:	Signature:	Date: 2/8/17

Toni Gutschlag
General Manager
Mental Health

Appendix L – University of Otago Declaration Form

DECLARATION CONCERNING DISSERTATION PRESENTED FOR THE DEGREE OF

MASTER OF Health Sciences (Nursing-Clinical)

I Deborah Jane Cracknell (full name)

of 50A Brockville Rd, (address)

Glenross, Dunedin, 9011

solemnly and sincerely declare, in relation to the dissertation entitled:

'Thrown in at the Deep End': A Qualitative Study with New Zealand New Graduate Nurses Working in Mental Health

(a) That work was done by me, personally

and (b) The material has not previously been accepted in whole, or in part, for any other degree or diploma

Signature: DJC Date: 7/12/18

To be included in Soft Bound copies only