

# Managing the demands of the preregistration mental health nursing programme: The views of students with mental health conditions

## Authors

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## Abstract

An increasing number of students with a pre-existing mental health condition are enrolling on preregistration mental health nursing programmes. The challenges faced by these students in managing the demands of the programme have not been fully explored. Mental health and well-being is an integral part of providing a healthy university in which students can flourish.

The purpose of the study was to explore how students with an underlying mental health issue manage the demands of the mental health-nursing programme. The outcomes of the study are aimed at informing inclusive teaching and learning and current student support provision.

Ethics approval was given. Students from two universities in South East England who met the criterion of having a pre-existing mental health condition when enrolling on the mental health preregistration-nursing programme were invited to take part. Nine students took part in the study. Using an interpretative descriptive design, 1:1 face to face, audio taped, semi-structured interviews were undertaken.

The data was analysed using a framework approach and this revealed four main themes: timing of disclosure; managing lived experience in learning environments; students' coping mechanisms and experience of support.

Recommendations for practice was that approved education institutes (AEI's) should ensure they have a robust, inclusive practice by implementing strategies to develop these students' resilience, enhance their learning and the current support provisions. This will ensure the barriers to disclosing their mental health conditions are recognised and minimised to enable these students to fully contribute to their own learning and teaching experience.

**Keywords:** mental health nursing training, mental health nursing students, students with lived experience of mental illness, nursing students' mental health support, nursing students' disclosure of mental illness, mental health stigma in education.

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## Introduction

Mental disorders comprise of a wide range of mental health conditions which can cause clinically significant disturbance to an individual's mood, thoughts, perceptions, behaviour and relationship with others (WHO 2017). The number of higher education(HE) students self-reporting a mental health condition has increased from 0.4% (9,675) in 2007/08 to 1.3% (29,375) in 2011/12 (Equality Challenge Unit 2013) in the UK. The increasing number of mental health conditions in HE students has been reported globally in such countries as the USA (Douche and Keeling 2014) South America (Villacura et al 2015), China (Yang et al 2015) and Germany (Kress et al 2015). The drivers for the higher number of students reporting their mental health conditions in the UK have been attributed to the greater access to HE, a more acceptable and open culture towards mental health and AEs improvement in their student support provision (Institute for Employment Studies 2015).

Although there has been a shift to a more inclusive approach to HE due to widening participation over the past decades, a prevailing uneasiness about recruiting healthcare staff and students with a mental health condition has been reported (Knaak et al., 2017). Subsequent UK Government reports and guidance called for an end to discrimination in the workplace and legal frameworks such as The Equality Act (2010) made it unlawful to discriminate against applicants and employees on the grounds of mental illness. Under section 15 of the Equality Act (2010) and nursing regulator's standards (NMC, 2013) AEs, as well as having to undertake assessment of prospective students' health and character are also required, if they accept a student onto the mental health programme have to provide reasonable adjustments for those students who disclose their disability to support them in successfully completing their studies (King, 2018).

Most universities in the UK has a structured layers of support system such as induction to settle students into their new environment (Nelson et al 2012) but less intense in the remaining years of their study (Maunder et al 2010) with the expectations that students would have developed a sense of belonging by then. This includes student support and counselling services skilled in recognising and supporting students with mental illness to minimise the adverse impact of mental distress on students' academic performance (Deasy et al 2014) and referring those with a severe mental illness to psychiatric services (RCP 2011). However, it has been reported that students are reluctant to seek help and treatment despite the increasing number of referrals to university counselling services (RCP 2011).

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## Background

The literature on mental health students' undertaking a programme while managing a mental health problem presents with some interesting findings. However, there is limited exploration of students' experiences, which is highlighted in current literature. Drawing comparison on the nature of the programme content is also challenge as compared to most other countries' the generalist preregistration nursing education model in the UK offers a unique specialist mental health nursing qualification with some variations in how the NMC preregistration education requirements is implemented across AEs (Ramluggun et al., 2016).

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## Mental health as a stressful and emotional endeavour

Preparing to become a mental health nurse can be a significant emotional stressful endeavour (Galvin, 2015). The susceptibility of pre-existing mental health problems may adversely impact on students' ability to successfully complete their studies (Cleary et al., 2011) and their practice for a profession that has the highest work-related stress related depression and anxiety compared to other healthcare professionals (Health and Safety Executive, 2017). It is widely acknowledged that students in the helping professions such as nursing and social work experience a high level of stress (Beck and Srivastava, 2011), with the demanding clinical component of the programme being

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3 particularly stressful (Chernomas & Shapiro, 2013). Compared to other HE students, nursing  
4 students face additional stressors due to the demanding nature of their training, which comprises of  
5 45 weeks a year study and an equal weighing of 2,300 hours in theory and practice of their  
6 programme as part of the European regulations (WHO, 2009). The draft consultation document for  
7 the new NMC Education Framework to be published in 2018 makes recommendation to empowered  
8 and enable students to become resilient (NMC 2018).  
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### 10 **Support for students with a mental health issue**

11 There have been significant developments in supporting students with mental health difficulties and  
12 promoting mental well-being generally in higher education by Universities UK (UUK). The emphasis is  
13 on reviewing approaches to teaching and learning, introducing techniques that help to support these  
14 students (Thorley, 2017).  
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16 One area for improvement included encouraging early disclosure to reduce the potential adverse  
17 impact on students' academic performance, as students fear professional repercussions following  
18 disclosure or exposure (Cvetovac and Adame, 2017). Disclosure of a mental health issue would also  
19 help to reduce attrition rates (Institute for Employment Studies, 2015). In the year 2014-15, the  
20 number of students who experienced mental health problems leaving university has trebled to 1,180  
21 from 380 in 2009-10 (HESA, 2017). Boardman (2016) argues that building student nurses' resilience  
22 by improving their self-efficacy can reduce these high attrition rates and is recommended in the  
23 draft consultation for the incoming NMC Education Framework (NMC 2018).  
24

25 However, despite an improvement in attitude to mental illness (Time to Change, 2015) related  
26 stigma persists, whereby; some nursing applicants feel they need to keep such conditions a secret  
27 (Gilbert and Stickley, 2012). In mental health settings the reported stigmatising attitudes in the  
28 workplace tend to devalue those with a mental illness (Abbey et al., 2012) and prevent health care  
29 professionals' disclosure and avoidance of seeking help and support for these conditions (Modgill et  
30 al., 2014). AEs' student support services are a valuable resource but tend to be underused due to  
31 perceived stigma by students and a lack of individualised support plans (Kendall, 2016).  
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### 33 **Living with a mental health and caring for others**

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35 There is a paradox of living with a mental illness and caring for others with similar conditions, which  
36 has been examined under the concept of 'wounded healers' by Jung (1951). Jung (1951) believed  
37 that the wounded physician occupies a favourable position to heal effectively. Thus, Jung (1951)  
38 proposes a link between those with past psychological wounds and their intrinsic motivation to want  
39 to become a helping professional because of the perceived ability to draw on it to facilitate healing  
40 in others (Zerubavel & O'Dougherty Wright, 2012). Differing views perpetuate the literature on  
41 whether such experiences should be kept separate or can be integrated into mental health practice  
42 (Khalid, 2011; Goldberg et al., 2015).  
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44 However, in the absence of empirical evidence on the effectiveness of the 'wounded healer' leads to  
45 the need for a discussion around the suitability of the recruitment of some individuals with a current  
46 mental health issue onto a professional mental health-nursing programme. The evidence of  
47 workplace stigma challenging wounded healers with the potential to worsen their health may leave  
48 them with the only option to withdraw from the course. Such experience is particularly significant  
49 for mental health nursing students as prospective registrants (Gilbert and Stickley 2012), as it could  
50 discourage students from the mental health-nursing programme. This debate which identified the  
51 need for NHS England to include effective workplace interventions in the management of staff  
52 mental health was underlined in 'The five year forward view for mental health' (The Mental Health  
53 Taskforce, 2016).  
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## **Lived experience of those with a mental health in mental health training**

The mental health of nursing students in HE (Wolf et al., 2015) and service user involvement in their own condition (Wallcraft, 2010) is well documented. However, the significance of their lived experiences in mental health training has not been adequately evaluated (Arblaster et al., 2015). There is a lack of literature exploring how these students experienced their training (Gilbert and Stickley, 2012) and only one study was found investigating the demanding nature of the training for a mixed group of social worker and mental health students, which explored practice learning (Gilbert and Stickley, 2012) excluding theory learning.

The link between attrition rate and students with mental health conditions (Cameron et al., 2010) is of concern, especially with a notable increase of students enrolling on the programmes at the two universities in this study with pre-existing mental health conditions. Thus, this study looks at the student experience of undertaking a mental health-nursing programme while at the same time managing their mental health issues. This is to try and identify what AEI could possibly achieve to further support these students to successful completion of their programme.

## **Methodology**

This study adopted a qualitative research methodology anchored in a constructivist approach to enquiry that allowed for an in-depth approach to collecting and analysing the data as outlined by Cresswell (2013). To explore students' experiences a qualitative interpretive approach that assumes that knowledge is situated and experientially based (Cresswell 2013) was used to enhance understanding on how students experienced their training, managed the demands of a HE programme while at the same time handle their mental illness.

### **Ethics**

Both universities' ethics committees approved the study. Students were informed of the study using a recruitment poster on advertising boards in both universities. Invitation letters detailing the purpose of the study, consent forms and confidentiality were provided to students who expressed an interest in the study. Confidentiality was assured by assigning an identification code to each participant and verbatim quote was anonymised using an allocated code. To manage any potential effect of the dependent relationship, the researchers who have a close working relationship with the students did not interview the participants.

### **Settings and participants**

Mental health nursing students on the programme (n= 165) who met the criterion of having a pre-existing mental health condition was nine, from the two universities. These students were invited to take part in the study. There were 2 male and 7 female students aged between 22-32, on year 1 to year 3 of the programme. These students had a range of mental health conditions such as anxiety, mood disorders and psychosis. They agreed to take part in the 1:1 face-to-face semi-structured interview.

### **Data collection**

The students were interviewed using an interview schedule based on the available literature on the topic in a designated room at the universities. The interview schedule was subsequently revised as new topics arose from subsequent interviews. The 1:1 semi structured interviews lasting an average of 35 minutes were audio recorded and transcribed verbatim. Transcripts of the interviews were sent to participants to check for accuracy.

## Data analysis

Analysis of the interview data used an adapted framework analysis by Ritchie and Lewis (2003). The stages of the analysis were familiarisation with the transcript which was read and reread by the researchers followed by independent coding of the data by applying a label that best describes the data. The process continued by developing a set of codes to apply to all subsequent transcripts, summarising the categories for each transcript and developing the themes identified.

## Results/findings

The main themes identified from the data analysis were timing of disclosure, managing lived experience in learning environments, student coping mechanisms and experience of support.

### Timing of Disclosure

Most of the students interviewed disclosed their mental health conditions after their mental condition became worse while on the programme; although they thought of disclosing their conditions before enrolling, but decided against.

### Early disclosure

The early opportunities for disclosure were during the application process, recruitment events and health screening.

Some students reluctantly declared their mental health conditions in their applications through the centralised Universities and Colleges Admissions Service (UCAS) service:

*“It was, through my application and that as well, I was afraid that it would be held against me I suppose” (B3L31).*

They were apprehensive about being asked about their health condition in their 1:1 nursing interviews and expressed relief when this was not discussed:

*“I disclosed it in my application and then I was expecting it to be brought up in the interview, but it didn’t, which I was glad about” (A4L15).*

Those who did not disclose this information in their application feared they would not get an interview:

*“I thought they’d see that and write me off and not even expect me to come to an interview... because they thought she won’t be able to cope” (A4/L29).*

During their 1:1 nursing interviews most of them did not disclose their condition because of the perceived stigma of the interviewers and believed it may affect the decision of interview panel whether to give them a place on the programme:

*“It’s not something I particularly like to talk about like because of stigma and all that (A4L10)*

*“I feel like it might affect how they treat me, I felt I can’t mention about my own mental health because it’s like well if you can’t look after yourself then how can you look after someone else” (B2L37).*

Some of the students waited until their occupational health appointment to disclose their condition:

*“In the interview itself, I didn’t disclose it. I waited for my occupational health, because I was concerned that, that would be a barrier, within the interview” (B5L227).*

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3 Some had mixed feelings about declaring their condition and information about their illness even at  
4 their occupational health screening, which was attributed to being encouraged to talk about their  
5 mental health issues:

6 *"... the occupational health person I spoke to was really very good, he told me if I had any*  
7 *problems I had to speak to someone straightaway" (A2L87).*

9 While other students felt the focus was mainly on their physical health:.

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11 *"I think it was a lot more about physical health really, there was no kind of specifically, do*  
12 *you have any mental health need" (A3/L124)*

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14 Another factor impacting on early disclosure was a lack of readily available information about mental  
15 health on the universities' websites:

16 *"When I looked online, this university, I couldn't really find anything that said about*  
17 *disclosure, in terms of mental health condition" (B5L238).*

19 They also felt it would have been helpful to be able to discuss these health conditions in private  
20 during open day events:

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22 *"The event was quite busy... I think it would be helpful to have an appointment before an*  
23 *interview to be able to like to identify any worries or potential issues before starting the*  
24 *course... (A2L60).*

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26 Late disclosure

27 Most students reported they reluctantly disclosed later either at the university or during their  
28 placement with some having to take time off the programme:

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30 *"I told my personal tutor but I was very reluctant to" (B3L3); I had a panic attack, so I wasn't*  
31 *able to sit the exam... follow up from that was a meeting with my tutors, ... I discussed that*  
32 *I'd been suffering from anxiety" (B1L4)*

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34 *"I just couldn't balance placement and academic work at the same time whilst worrying*  
35 *about my own anxieties...that made me leave the course" (B2L5)*

36  
37 *"I had some personal problems I ended up taking an overdose and I disclosed that to my*  
38 *mentor at the time because I was on placement" (A3L9).*

39 A few students reported the attitudes of others to mental health issues made it difficult for them to  
40 disclose:

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42 *"Although the people I worked with were professional, did their jobs very well, some of the*  
43 *stuff they said in the office, ... about someone being selfish through self-harming ... I wouldn't*  
44 *want them to feel like they couldn't vent around me or they had to tiptoe around me"*  
45 *(A3L61)*

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47 One student reported that the disclosure limited her learning opportunities in practice because her  
48 mentor was being overprotective of her:

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50 *"I said to my mentor that I'd got a similar history to a patient and is there anything that I*  
51 *should read or be aware of... but his reaction was that I shouldn't work with any patients*  
52 *with a similar history (A2L117)*

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54 Nevertheless, most students reported a positive experience from their peers and staff at both the  
55 university and in practice in response to their disclosure. They discovered that some of their peers to  
56 whom they disclosed have similar health issues:

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3 *"It was okay surprisingly...on the back of the conversation, I've obviously found out that some*  
4 *of my peers have issues, which I wouldn't have known..... it didn't feel as scary as what I*  
5 *thought it would (B1L74);*

6 *"I spoke with my Course Leader who was really helpful and understanding" (A1L15)*

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8 *"My Academic Advisor has got in touch with me, offered me support" (A2L435)*

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10 *"My link lecturer came and spoke to me, he was very understanding and not fazed by my*  
11 *self-harm...(A3L174).*

### 12 13 14 **Students' coping mechanisms**

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16 Most of the students described their programme as challenging due to its multiple demands and  
17 busy schedules:

18 *"I was just exhausted all the time" (A3 L520).*

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20 Shift patterns and juggling academic work with clinical placements were commonly mentioned:

21 *"Trying to manage shifting times and work can be difficult "(A2 L521).*

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23 The students' coping mechanisms were tested by both the academic demands and the clinical  
24 stressors in placements such as the pain and discomfort they witness in their patients:

25 *"On my third placement a patient died, had a cardiac arrest in front of me, I was the first one*  
26 *on the scene and he died, I found it very hard to cope with the stress of the actual*  
27 *event" (B2L5).*

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30 Some described their adjustment as a positive adaptive process using a variety of useful self-care  
31 strategies in developing their resilience to cope with stress. Whereas others were limited in their  
32 ability to rationalise their feelings and were unwilling to receive help:

33 *"I felt like I couldn't accept any help,... it was like I can't do this anymore, I'm done, it isn't for*  
34 *me" (B2 L57).*

### 35 36 37 **Managing lived experience in learning environments**

38 Education topics had the potential to resonate with students' own lived experience. Some found this  
39 emotionally challenging:

40 *"There are certain times where we've spoken about things like suicide, that it has, sort of, hit*  
41 *me a bit" (B5 L272) or leading to introspection and self-diagnosis*

42 *"...because I am very analytical of myself, so I start, sort of, self-diagnosing" (B1 L36).*

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44 Additionally, external stigma from their peers impacted on how the students used their lived  
45 experience in learning environments:

46 *"Suicide is selfish, is one of the views I've heard, which kind of surprised me, hearing other*  
47 *mental health students say that" (B5 L284).*

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49 Subsequently, they used their lived experience circuitously in the classroom and practice learning  
50 environments:

51 *"I've made up a patient to discuss my experience" (A3 L301).*

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55 Which they found satisfying:

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3 *"Being able to... say, 'No, what you're saying is wrong,' is quite a good feeling" (B5 L312).*

4 Conversely, some felt empowered to share their lived experience with peers:

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6 *"I felt like I had something to contribute because I had a sort of a personal angle" (B3 L47);*

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8 *"Here my vulnerability makes me weak, whereas when I was an artist, or a performer, my*  
9 *vulnerability gave me strength" (A2 L199).*

10 For many their lived experience significantly contributed to an increased empathy for their patients  
11 in clinical placements:

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13 *"I think my experience of mental health does really help me empathise with people" (A2*  
14 *L374).*

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16 They reported being aware of the dual roles as a student and a patient but were able to maintain  
17 boundaries:

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19 *"I could distance myself from my experience and go with what I knew was best from a*  
20 *professional point of view" (A3 L436);*

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22 *"I didn't project my own depression issues onto that person" (A4 L236).*

### 23 **Experience of support**

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25 The overall support experience in both university and placement were reported as positive. Students  
26 felt the academic team was very helpful:

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28 *"I spoke with my link lecturer and he was really supportive, disclosed to him and then I also*  
29 *spoke with my AA' (A3);*

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31 *"The mentor was really experienced, very kind of nurturing" (A3L154)*

32 However, students raised some issues with a general consensus on better promotion of the services  
33 available to them in the university:

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35 *"I don't think it's advertised as well as it could be..." (B5).*

36 Availability of appointments was not clear to see someone for support:

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38 *'I was still able to see a counsellor when it fitted in with placement, but obviously placement*  
39 *is demanding on your time and access to a counsellor and all your other commitments, it's*  
40 *sometimes hard to see somebody' (B3L115), a need for a well-coordinated seamless service*

41  
42 *"All of the services individually I find really helpful, but it also kind of gets a bit complicated*  
43 *because you have to explain everything to every person you see what you're doing with*  
44 *everybody else!" (A2L437);*

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46 Which addresses their particular needs:

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48 *"I've found the support helpful from the Disability Service but there's not like a specific*  
49 *mental health section in the support team..." (A1L41) and suggesting a need for a dedicated*  
50 *mental health support*

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52 *"I think a specific mental health part to the Wellbeing Team... available on each campus...*  
53 *could liaise with other department in the University (A1L89).*

54 In a few practice areas students reported there was a much better handling of their mental health  
55 history, which did not limit their learning opportunities:

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3 'He (mentor) *could be quite over protective and that if he knew about my mental health then*  
4 *he wouldn't let me do things, which I need to experience to become a Mental Health*  
5 *Nurse...*' (A2L118)  
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## 8 **Discussion**

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10 There is a need for students to disclose a mental health issue prior to starting their mental health-  
11 nursing programme, as this will enable students to better manage their experiences during their  
12 training. Following disclosure students can develop coping strategies and gain support during their  
13 studies. However, there are barriers to this ideal and some of these issues are discussed here.  
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### 15 **Disclosure**

16 Early disclosure of mental health conditions was difficult for most students in this study because of  
17 the perceived and internalised stigma of their mental illness, as reported in other studies  
18 (Henderson, 2014; Abbey *et al.*, 2012). The attribute of stigma was reinforced by the apparent  
19 observation of unhelpful discourse by some of their peers and some staff in their placements. Such  
20 experience of working with a colleague or student with mental health conditions has been described  
21 as an onerous prospect (Joyce *et al.*, 2012).  
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23 Despite the increasing awareness of mental illness and initiatives to combat negative stereotypes  
24 this study indicates that stigma is still a barrier to seeking help, as reported by Papish (2013). This  
25 echoes a survey undertaken by Time to Change (2015) an anti-stigma campaign, which reported that  
26 ninety percent of participants revealed that disclosing a mental condition would have a negative  
27 impact on their job prospects. However, positive experiences of disclosure in helping to dispel  
28 mental illness related stigma has also been reported (Brohan *et al.*, 2010). Therefore, it is also worth  
29 addressing the barriers to applicants' disclosing their mental health conditions at the earliest  
30 opportunity before or after enrolment on the programme, especially, as according to Harris *et al.*  
31 (2014) students' mental ill health is a contributing factor to nursing students' attrition rate reported  
32 to be up to 50%.  
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34 The high attrition rate is compounded by other influential factors, such as students' not seeking help  
35 to facilitate their management of emotional situations and improving on their coping mechanisms  
36 (Rosenthal and Wilson, 2008). This study showed that students' educational background could also  
37 affect their readiness to ask for help. Interestingly, it underlined how students' past artistic  
38 educational engagement provided an outlet without stigma for creative expression of their mental ill  
39 health compared to their nursing education. Remarkably, where they once espoused a positive  
40 ideology about their mental illness allowing their self-belief to flourish from a position of strength  
41 this was now perceived as a weakness through the protective lens by those supporting the student's  
42 learning in clinical practice. This finding raises the significance of the lived experience of the  
43 wounded healer in the development of their professional practice.  
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### 46 **Managing lived experience**

47 Students' theoretical orientation on handling self-disclosure was to adopt a neutral stance. Whilst  
48 this demonstrates their recognition for professional boundaries in the therapeutic relationship, it  
49 does not however reveal how this boundary was effectively managed. Some students explicitly  
50 showed awareness of potential pitfalls such as over identification or projecting own experience onto  
51 a patient (Goldberg *et al.*, 2105). The intricacies of the relationship between staff with these  
52 personal experiences and their patient are unclear (Oates *et al.*, 2017).  
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54 Some students were self-aware that as recipients of mental health care they did not follow the  
55 advice they gave in the role as student nurse. As explained by Hawkins and Shohet (2012) it is safer  
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3 to be in the role of the helper than the one being helped as the latter can reveal ones' own needs  
4 and vulnerability. This could offer a possible explanation for their thinking that as student nurses  
5 they need to be strong because their mental illness may be perceived as a sign of weakness and  
6 vulnerability. The identity transition from patient to clinician is a complex one during which students  
7 will need to differentiate between their own experience and that of the patients. Assistance may be  
8 needed in processing feelings about violations of boundaries for the benefit of both patient and  
9 clinician (Goldberg *et al.*, 2015). Concern expressed by some participants that mental illness may be  
10 perceived as a sign of weakness and vulnerability echoes those of Israeli social work students with  
11 mental conditions who questioned, in an early phase of their transition, the ability of a patient to  
12 also become a therapist (Goldberg *et al.*, 2015).

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14 The evidence from the literature tends to support potential benefits of acknowledging and sharing  
15 of such personal vulnerability by clinicians in building therapeutic alliance with their patients  
16 (Unhjem, 2018). This is evidenced in the deepening of the peer workers' close relationship in the  
17 empathetic sharing of their mental health experiences (Faulkner *et al.*, 2013). However, the  
18 appropriateness of this personally informed approach in the context of the nurse patient  
19 relationship in mental health settings is clouded with controversies. The practical implication for  
20 using such an approach requires careful consideration (Khalid, 2011) and further investigation.

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22 Furthermore, vulnerability was also felt in class when discussing mental health topics. Given that  
23 healthcare practice involves contact with distressing material there is a need to use effective  
24 strategies on handling these materials in a safe space (Kumagai *et al.*, 2017). Whilst there is some  
25 evidence to support the value of classroom topics that can potentially trigger intrusive distress and  
26 the use of trigger warnings in alerting and preparing students (Beverly et al 2017) robust evidence is  
27 needed on how to effectively facilitate such discussions (Boysen, 2017).

28  
29 This study raises the question about the students' awareness of their motivation to become helpers.  
30 Self-awareness is an important tool in helping nurses to identify how personal and professional  
31 attributes and attitudes impact on the development of the nurse patient relationship, and various  
32 approaches have been suggested to improve this aspect of care (Rasheed, 2015). Psychodrama  
33 techniques to re-enact the helper-helped dynamic in developing and improving self-awareness has  
34 been suggested (Ofiaz *et al.*, 2011). It is worth noting that given the significance of stigma reported  
35 in this study, consideration would need to be given to how perceived and actual stigma may act as a  
36 barrier for the adopted strategies.

### 37 38 **Coping mechanisms**

39  
40 There were underlying issues in these students' ability to handle the demands of the programme.  
41 The exposure to the reported set of circumstances such as the stressful heavy workload,  
42 assessments and uncomfortable emotional experiences in practice indicates a level of  
43 unpreparedness and a potential trigger for relapse. Thus, suggesting there is a need to strengthen  
44 their resilience to such situations. The inherent emotional demand of mental health nursing and its  
45 resulting effect on nurses' mental distress is widely acknowledged (Balducci *et al.*, 2014). However,  
46 any nursing student may become impaired whereby their mental distress can impact upon their  
47 clinical practice (Zerubavel, O'Dougherty & Wright, 2012). From this study it is not possible to  
48 ascertain if these students were more vulnerable or ill prepared for the realities of their practice  
49 compared to other nursing students who are also not immune to high levels of stress (Wolf *et al.*,  
50 2015).

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52 A review of the literature showed that the evidence for a clear approach to stress-reduction  
53 interventions for undergraduate nursing students is limited but some benefits are evident in the  
54 application of transformative education (McCarthy *et al.*, 2018) which is aimed at enhancing  
55 students' self-awareness and their stress coping mechanism from their learning experience. One of  
56 the university in this study has included the management of stress and time management in its new  
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2 curriculum, where students are invited to attend a workshop run by the University Wellbeing  
3 Directorate in each year of their programme. The Health and Safety Executive's most recent report  
4 on 'Work-Related Stress, Depression or Anxiety' (HSE, 2017) also highlights the level of mental  
5 health difficulties in the health profession with Nurses and Midwives reporting the highest level of  
6 cases out of 100,000 workers (3,090), which underscores the importance of embedding the need for  
7 resilience training into the curriculum. As suggested by McDonald *et al.* (2013) a reflective space for  
8 facilitating critical and creative thinking complemented with a package of psycho-education to teach  
9 key aspects of resilience such as positive coping strategies, self-nurturance and problem-solving skills  
10 advocated by Boardman (2016) is worth considering.

### 11 **Student support**

12  
13  
14 The study highlighted positive appraisal of support at university and in practice settings, but it was  
15 also noted that students did not always fully benefit from the learning in practice because of their  
16 perceived vulnerabilities. This study indicates that the independence and collaboration deemed to  
17 be vital in striking a balanced mentor/mentee relationship (Eller *et al.*, 2014) could be hindered if an  
18 overprotective stance is adopted. So, it is important to explore how clinical staff manage the  
19 facilitation of learning of these students in practice.

20  
21 University counselling and disability support services were equally valued but were not well  
22 promoted and coordinated for students to access the right support at the right time. Students not  
23 being able to use university-counselling services because of the opening hours clashing with  
24 students' placement have been reported (Galvin *et al.*, 2015). Similar findings for the need for a well-  
25 coordinated and individualised support (Kendall, 2016) reflect the National University Survey (NUS)  
26 on mental distress (Kerr, 2013), which reported that 64% of students experiencing mental distress  
27 did not access 'formal' services within or outside of their institution. AEs and practice partners have  
28 a collective responsibility to provide a safe and supportive learning environment for students and  
29 support for those experiencing mental distress is currently high on their agenda (UUK, 2017). AEs'  
30 have individual policies and structures for offering nursing students support, which are  
31 fundamentally underpinned by both the Equality Act 2010 and NMC guidelines (2013), with an  
32 increasing number of other agencies developing formal mental health policies (UUK, 2015).  
33 Therefore, a formal mental health policy underlining clear and accessible support pathways for the  
34 two universities in this study would be useful.

35  
36 Students also valued the informal support from their peers to handle their mental health difficulties.  
37 Peer support networks can be vital to students' mental wellbeing and the evidence points to friends  
38 and families being the preferred option of support (Galbraith *et al.*, 2014) rather than professionals  
39 because of the fear of being labelled as weak (Galvin *et al.*, 2015). Therefore, the current reflective  
40 support group in practice could be incorporated into the curriculum within a clinical supervision  
41 framework as a mandatory requirement.

### 42 43 44 **Strengths and Limitations**

45  
46 The findings in this study report the views of a small purposive sample from two universities. Hence,  
47 it may not fully reflect the perceptions of students with mental health conditions from other AEs. A  
48 larger study surveying the views of these preregistration mental health students randomly selected  
49 across the UK may provide a more accurate picture. Nevertheless, there were some commonalities  
50 for both universities for most of the issues discussed and as the first study investigating this issue it  
51 provides a platform for other research in this area of study.

1  
2 **Relevance for clinical practice**  
3

4 The pertinent issues underlined in this study is of huge significance for AElS and the Healthcare  
5 Services in ensuring these students are better equipped for their programme. It is imperative that  
6 prospective applicants and students do not feel defined by their mental illness and feel able to  
7 access help and support at the earliest opportunity.

8  
9 A review of the AElS' mental health policies and referral processes would be useful to improve  
10 mental health literacy, accessibility of mental health support services in clearly promoting and  
11 coordinating these services. The accommodation of these students' reasonable adjustments needs  
12 to be underpinned by an informed approach to managing their practice learning that is not self-  
13 limiting.

14 A collective responsibility between AElS and the NHS as main practice partners to explore  
15 interventions to promote and improve students' resilience and develop a more robust support  
16 system that maximises the benefits of peer support reported in this study such as a peer support  
17 clinical supervision framework would be useful.

18  
19 An informed discussion on the benefits and clinical implications of self-disclosure including clearer  
20 guidance on its use would be valuable in effectively managing professional boundaries in practice  
21 (Brohan et al 2010)  
22  
23  
24

25 **Conclusion**  
26

27 The study has highlighted several pertinent issues which have implications for both AElS and the NHS  
28 as future mental health workforce. The findings from this study underline the collective  
29 responsibilities of AElS and practice partners in addressing the challenges faced by students affected  
30 by mental health issues in the academic and clinical learning environments. Ways to uphold the AElS  
31 and practice partners' inclusive and supportive ethos to enable these students' successful  
32 completion of their academic and practice education were underlined.  
33

34 How close the 'One in four' figure widely cited as the number of people who suffer from mental  
35 health problem in the UK to the mental health workforce is unclear but the natural attraction of  
36 these student to the mental health field is understandable. So it is essential that these students feel  
37 a sense of acceptance to settle in to university life. These students may feel better connected with  
38 their teaching and learning if their programme is more attuned to their potential challenges to fulfil  
39 their academic and professional potential. The study identified the issue of internal mental health  
40 stigma, the barriers and facilitators for early disclosure by these students.  
41

42 The study also raised some pertinent issues on the training of a future mental health workforce with  
43 lived experience of mental illness. It highlighted the need for a candid discussion on how lived  
44 experience can be effectively included in mental health nursing education and training.  
45

46 Further research aimed at exploring the significance of these students' lived experience, the roles  
47 played by all those actively involved in facilitating these students theoretical and practice education  
48 would be useful to equip these students to meet the demands of their programme and better  
49 prepare them as the future mental health workforce.  
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