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2016

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Publication Details

Cowley, T., Sumskis, S., Moxham, L., Taylor, E., Brighton, R., Patterson, C. & Halcomb, E. (2016). Evaluation of undergraduate nursing students' clinical confidence following a mental health recovery camp. *International Journal of Mental Health Nursing*, 25 (1), 33-41.

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Evaluation of undergraduate nursing students' clinical confidence following a mental health recovery camp

Abstract

In the present study, we evaluate the impact of participation in a mental health recovery camp on the clinical confidence of undergraduate nursing students in dealing with individuals with mental illness. Twenty undergraduate nursing students who participated in the recovery camp completed the Mental Health Nursing Clinical Confidence Scale both before and directly after attending the camp. Data were analysed using descriptive and inferential statistics. Participation in the recovery camp was associated with a statistically-significant increase in students' level of overall confidence between the pretest and post-test data ($P < 0.005$). The results also demonstrated that students over the age of 25 years and who do not have a family history of mental illness are more likely to self-report a higher level of confidence in both the pre- and post-results. The clinical confidence of undergraduate nursing students improved through participation in an immersive clinical experience within the recovery camp.

Disciplines

Medicine and Health Sciences | Social and Behavioral Sciences

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Evaluation of undergraduate nursing students' clinical confidence following a mental health recovery camp

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INTRODUCTION

Mental illness is a significant issue that has an ongoing impact for affected consumers and their families, even when they are considered to be well or to have recovered (Kitchener & Jorm, 2010). Within the healthcare industry nurses make up the largest health professional group, and regardless of whether or not nurses are employed in a specific mental health setting, they will come into contact with consumers who experience mental health issues (Department of Health, 2009). Nurses have the potential to make a vital positive contribution to the care provided to consumers of health care from all age groups and in all settings. Unfortunately, nurses often display preconceived negative attitudes when caring for consumers who experience mental illness (Thornicroft, 2007), impacting on the quality of care provided. This is a trend that can be attributed to knowledge deficits and low levels of clinical confidence (Schafer, Wood, & Williams, 2011). Given the significant involvement of nurses in caring for and supporting consumers with mental illness across the health system, it is important to understand how undergraduate nursing education can best facilitate the acquisition of adequate mental health related skills and knowledge and clinical confidence in dealing with consumers who experience mental illness (Szpak & Kameg, 2013).

The expectation of new graduate nurses is to be work ready when they enter clinical practice, albeit at a novice level (El Haddad, Moxham, & Broadbent, 2012; Wolff, Regan, Pesut, & Black, 2010). However, there is a concern about new graduates and their readiness for clinical practice in spite of significant advancements in the foundational educational preparation of nurses (Schluter, Seaton, & Chaboyer, 2011). The perceived lack of preparedness for clinical practice is a common rationale for researchers exploring the clinical competence and performance of beginning practitioners (Lofmark, Smide, & Wikblad, 2006). Wolff et al. (2010) identified that to be work ready and be able to provide safe care, new graduate nurses must have a generalist foundation in nursing principles and some job-specific capabilities. Work ready new graduates must keep up with both the current realities and future possibilities, whilst possessing a balance of doing, knowing, and thinking. Because of longstanding beliefs, traditions, and dominant values in the larger nursing context, the understanding of readiness appears to differ among nurses and decision makers in various sectors (El Haddad et al., 2012; Wolff, Pesut, et al., 2010).

Work readiness is attained through the combination of on-campus theoretical learning and exposure to the realities of the clinical setting during industry placements (Walker, Dwyer,

Moxham, Broadbent, & Sander, 2012; Wolff, Regan, et al., 2010). Most mental health clinical placements occur within government run facilities and are conducted in either an acute inpatient unit or within the community mental health service (Health Workforce Australia, 2013). This is primarily due to the larger number of placement opportunities available in these areas. However, there is a shortage of suitable mental health clinical placements available to meet requirements of the undergraduate nursing students. This can mean that students are placed in a facility that does not meet their learning needs or the student has to travel extended distances to the placement.

Clinical experience within mental health settings can have a negative impact on nursing students as it can create a sense of fear and anxiety (Fisher, 2002). Caring for consumers who are experiencing acute episodes of mental illness can contribute to the idea that people who experience mental illness are like that all of the time (Kameg, Howard, Clochesy, Mitchell, & Suresky, 2010). This can perpetuate the preconceived stigma associated with mental illness amongst undergraduate nursing students (Kitchener & Jorm, 2010).

In conventional clinical placements students work a set number of hours a day similar to those worked by registered nurses, thus confining the students' interactions with consumers to the clinical environment (Levett-Jones & Bourgeois, 2010). Non-conventional clinical placements such as residential experiences, aim to educate and improve the understanding of illness and its impact on the individual through facilitating a presence in the persons' day-to-day life (Allsop, Negley, & Sibthorp, 2013). This study focuses on exploring the outcomes for students from the experience of a non-conventional clinical placement in mental health. The Recovery Camp involved undergraduate students attending a week long camp-based residential experience with consumers who experience mental illness. This placement sought to allow undergraduate nurses to develop an insight into the lived experiences and needs of consumers with mental illness and improve their understanding of delivering recovery oriented care within a Therapeutic Recreation framework. This study seeks to evaluate the impact of that participation on the students' clinical confidence in a mental health context.

Ethical Issues

Prior to study commencement approval was sought from the Human Research Ethics Committee of the XXXXX (Approval No. HE14/141). Students were informed that their decision whether or not to participate in research related to the Recovery Camp would not affect their relationship with the Academic unit or individual staff. By completing and submitting the pre and post intervention surveys it was assumed that consent was given to use the data as described in the Information Sheet. Consumers and Academic staff also provided informed consent to participate in both the Recovery Camp program and associated data collection.

METHODS

Design

A pre-test / post-test design was used in this study. A hard copy survey tool was distributed before and after participants attended the Recovery Camp to evaluate the impact of the camp experience on their clinical confidence in dealing with mental health consumers.

Intervention

The Recovery Camp is an initiative designed to provide a therapeutic intervention for personal recovery for people who experience mental illness. It also provides a clinical placement experience for 20 undergraduate Bachelor of Nursing (BN) students from the University of Wollongong, as well as students from psychology, exercise physiology and dietetics. The types of learning that occurs at Recovery Camp for students includes the development, maintenance and closure of a therapeutic relationship, interpersonal relationship skills through practicing active listening, history taking, collaborative goal setting and strategy formation, the value of interprofessional care and most importantly students learned directly from consumers. Spending such long, intense hours together (there was no 'down time or going home between shifts'), consumers were in the driving seat for learning. They helped students learn and understand the lived experience of mental illness. The kind of learning that is inherent as a result of socially shared cognition and knowledge development, promotes reflection and transformation (Cunningham &

Wilson, 2015). Cunningham & Wilson (2015) assert that such an approach leads to increases in clinical confidence.

This was a unique experience for both consumers and students as it involved residing for five days in an Outdoor Education & Recreation facility. The Camp has been run annually since 2013. The learning experience aims to promote an understanding of personal recovery whilst also facilitating an experiential and immersive interprofessional learning experience for both the student and people who experience mental illness (Moxham, Liersch-Sumskis, Taylor, Patterson, & Brighton, 2015). In addition to the undergraduate students, 30 people from the Illawarra and Shoalhaven communities in NSW aged between 24-70 years who had a diagnosed mental illness, four mental health nurse academics one of whom specialises in drug and alcohol, and an educational and therapeutic recreation specialist attended Recovery Camp.

This study investigated a single element of the Recovery Camp clinical placement experience. It was undertaken as a Bachelor of Nursing (Hons) project by ###, as such, it was a relatively small and contained project. Other elements of the broader evaluation of the Recovery Camp are beyond the scope of this paper and are reported elsewhere (Moxham et al., 2015).

Instrument

Data for this study was collected through completion of a demographic data sheet and the Mental Health Nursing Clinical Confidence Scale (MHNCCS) (Bell, Horsfall, & Goodin, 1998)(Table 2). This is a self-assessment tool and has been used previously to assess changes in clinical confidence resulting from clinical placement experience in acute inpatient facilities, forensic facilities and community mental health placements (Hayman-White & Happell, 2005; Prasetyo, Sulistyowati, & Mat, 2012; Ross, Mahal, Chinnapen, & Rana, 2013).

The MHNCCS is based on the desired nursing skills and attributes believed necessary for undergraduate nursing students to develop during their clinical placement (Bell et al., 1998). The scale items assess six domains; assessment, communication, education, medication knowledge, self-management and teamwork. The MHNCCS consists of 20 items rated on a four point Likert scale from one (not at all confident) to four (completely

confident) (Bell et al., 1998). A total score is calculated by adding the ratings of each item together (Bell et al., 1998).

Bell et al. (1998) reported the reliability of the total MHNCCS scale to have a Cronbach's alpha of 0.926, indicating a high level of reliability. Additionally, test-retest reliability indicated a strong correlation for all items between the two time periods, with a correlation of 0.859 (Bell et al., 1998).

Sample

Third year students enrolled at the UOW were invited to participate in the 2014 recovery camp as one of their mandatory mental health clinical placements to fulfil the needs of the mental health subject and meet the curriculum requirements for the Bachelor of Nursing (BN). Forty-five expressions of interest were received, and 20 students (44.4%) were randomly selected by academic staff to fill the available positions.

Data Collection

On arrival at Recovery Camp, participating students provided demographic information and completed the MHNCCS. This enabled baseline pre-test data to be collected. At the conclusion of the camp the students again completed the MHNCCS which provided the post-test data for comparison. All data collection was undertaken using paper based forms.

Data Analysis

The MHNCCS was completed in hard copy and data was entered manually into the Statistical Package for the Social Sciences (SPSS) Version 21 (IBM Corp., 2013). Data were then checked for missing or incorrect values and for accuracy of data entry. Data was then analysed using a combination of descriptive and inferential statistics. A value of $p > 0.05$ was considered significant.

RESULTS

Participant demographics

All twenty students who attended the Recovery Camp completed the pre-test and post-test survey, providing a response rate of 100%. There were two incomplete items in the post-test survey. Given this relatively small amount of missing data, no survey was excluded based on incomplete data.

The majority of participants were female (n=17; 85%), and were currently studying a Bachelor of Nursing course (n=19; 95.0%)(Table 1). Reflecting the diversity of the tertiary student population, ages of participants ranged from 20-56 years (Mean 31.4; SD 10.5). The age distribution is positively skewed with 40% of participants aged less than 26 years old.

Table 1 Participant Demographics

<u>Characteristic (n=20)</u>	N	%
Age (mean; SD; Range), years	(31.4; 10.5; 31.79)	
20 – 25 years	9	45.0
26 – 30 years	3	15.0
31 – 35 years	2	10.0
36 – 40 years	2	10.0
41 – 45 years	1	5.0
46 – 50 years	2	10.0
51 – 60 years	1	5.0
Gender		
Female	17	85.0
Male	3	15.0
Current Degree		
Bachelor of Nursing	19	95.0
Nursing BA	1	5.0
Family Members with a mental illness (could select multiple)		
No One	10	50.0
Parent	9	45.0
Sibling	6	30.0
Uncle/Aunt	4	20.0
Other relative	2	10.0
Respondent (Me)	1	5.0

Item analysis

Mean scores for the individual items in the pre-test survey ranged from 2.35-3.70 (Mean 2.84; SD=0.36), whilst the mean confidence scores items in the post-test survey ranged from 2.75-3.85 (Mean 3.36; SD=0.31)(Table 2). Mean scores for each item increased for all but one item from the pre-test to the post-test (Range -0.02-0.92; Mean 0.52). The only item that did not see an increase in confidence was regarding the ability to conduct a comprehensive psychosocial assessment of the client (Item 2). Additionally, only a small positive change in confidence level was seen in confidence regarding the ability to seek support from other members of the mental health team (change in mean score 0.15).

The largest change in the mean confidence score per item in the pre-to-post data was seen in items that included providing basic counselling for clients with a mental illness (Mean Change 0.95), conducting a mental state examination (Mean Change 0.92), assisting clients with a mental illness to clarify treatment goals (Mean Change 0.8), communicating effectively with clients with a mental health problem (Mean Change 0.75), providing client education regarding the effects and side-effects of medications (Mean Change 0.75), developing a nursing care plan on the basis of assessment (Mean Change 0.7), and contributing to client-related mental health information at a multidisciplinary meeting (Mean Change 0.65).

Differences in total confidence scores

A Paired t-test was used to calculate the difference in mean total confidence score between the pre-test (Mean 56.20) and post-test (Mean 66.85). This demonstrates a statistically significant ($p < 0.000$) increase in the participants' perceived confidence following participation in the Recovery Camp.

Table 2 Change in Mean Confidence Score by Item

Item No.	Item	Mean - pre	Mean -post	Mean difference	p- value
1	I can communicate effectively with clients with a mental health problem	2.95	3.70	0.75	0.001*
2	I can carry out a comprehensive psychosocial assessment of clients	2.40	3.30	0.90	<0.001*
3	I can conduct a mental state examination	2.80	3.25	0.45	0.035*
4	I can develop a nursing care plan on the basis of my assessment	2.65	3.35	0.70	<0.001*
5	I can assist clients with a mental illness to clarify treatment goals	2.70	3.50	0.80	0.001*
6	I am able to provide basic counselling for clients with a mental illness	2.50	3.45	0.95	<0.001*
7	I am able to be empathic with a range of clients with a mental illness	3.35	3.85	0.50	0.014*
8	I can provide information and education for clients regarding their diagnosis	2.70	3.00	0.30	0.110
9	I am able to assist clients to develop living skills	3.05	3.50	0.45	0.058
10	I have a basic knowledge of antipsychotic medications and their side-effects	2.65	3.00	0.35	0.049*
11	I have a basic knowledge of antidepressants and their side-effects	2.65	3.10	0.45	0.046*
12	I have a basic knowledge of anti-anxiety medications and their side-effects	2.65	3.05	0.40	0.017*
13	I have a basic knowledge of mood stabilizers and their side-effects	2.60	3.05	0.45	0.016*
14	I am able to provide client education regarding the effects and side-effects of medications	2.45	3.20	0.75	0.002*
15	I can fit in with the nursing team on a mental health clinical placement	3.15	3.70	0.55	0.017*
16	I can contribute client-related mental health information at a multidisciplinary meeting	2.95	3.60	0.65	0.006*
17	I can handle clients who are verbally aggressive	2.65	3.05	0.40	0.104
18	I can handle clients who are physically aggressive	2.35	2.75	0.40	0.072
19	I am able to establish my own personal boundaries when relating to clients with a mental illness	3.30	3.60	0.30	0.083
20	I can seek support from other members of the mental health team	3.70	3.85	0.15	0.419

*significant value

Impact of demographics on clinical confidence

Age group

To further explore the data we examined the impact of participant demographics on clinical confidence using Mann Whitney U test. Participants aged 25 years and under (n=8), were compared with those aged over 26 years (n=12). The cut-off of age of 25 years was selected as it dichotomised the sample. From the pre-study data, participants aged 25 years and under were more likely to report that they were not confident in their basic knowledge of anti-anxiety medication compared to those aged over 25 years ($p=0.04$)(Table 3). For all other items the two groups were not significantly different. The post-study data demonstrates several statistically significant differences between the confidences in the two age groups that were not present in the pre-study data. Over half of the items (n=12) post-study demonstrated statically significant differences between the two groups. In all of these items, the respondents aged 25 years and under were less likely than those aged over 25 years to report being confident.

Table 3 Impact of Age on Mean Confidence Score by Item

Item	Effect size	P-value
17 Handle verbally aggressive clients	0.48	0.03*
1 Communication with mental health client	0.52	0.021*
2 Psychosocial assessment	0.60	0.01*
5 Clarifying treatment goals	0.56	0.02*
8 Provide information and education	0.60	0.01*
9 Developing client living skills	0.54	0.02*
10 Knowledge of antipsychotic medication	0.60	0.01*
12 Basic knowledge of anti-anxiety medications	0.57	0.01*
11 Basic knowledge of antidepressants	0.57	0.01*
13 Basic knowledge of mood stabilisers	0.59	0.01*
14 Provide client education regarding medications	0.59	0.01*
18 Handle physically aggressive clients	0.50	0.03*

*significant value

Familiarity with mental illness

A further demographic factor that we explored was the presence of a family member with mental illness. The pre-test data demonstrates three items with statistically significant difference in levels of confidence (Items 5, 17 and 18). Respondents with family members who experience mental illness were more likely to report lower confidence to clarify treatment goals compared to those that reported knowing no one with mental illness ($p=0.03$). Additionally, those who had family members with mental illness are less confident in both handling verbally aggressive ($p= 0.03$), and physically aggressive ($p= 0.04$) consumers compared to those that reported no family history of mental illness.

Compared to the pre-study data, the significant differences relating to clarifying treatment goals and verbal aggression based on the presence of a family member with mental illness were not apparent post-study. However, respondents with family members with mental illness remained less likely to report being confident to handle physically aggressive consumers compared to those that don't have family members with a mental illness ($p=0.02$).

DISCUSSION

Non-conventional clinical placements such as the Recovery Camp can facilitate student understanding of the experience of living with mental illness and of person centred care more effectively than conventional placements (Cunningham & Wilson, 2015). Research also indicates that students tend to have more favorable attitudes towards mental health nursing when they receive more hours of theoretical preparation and undertake longer clinical placements (Happell & Gaskin, 2013). Immersive clinical placements allow students and consumers to develop therapeutic relationships in less time than they would have taken on conventional clinical placements (Tratnack, O'Neill, & Graham, 2011). The results from this study demonstrated that there has been a statistically significant ($p=0.000$) improvement in the clinical confidence of undergraduate nursing students who attended the camp based mental health placement experience, confirming the suitability of the Recovery Camp as a teaching appropriate educational approach for recovery focused mental health nursing. Clinical confidence increased when performing competencies such as psychosocial assessment and mental status assessments. It could be hypothesised that these skills, which are founded upon the ability to communicate effectively, were

enhanced as a result of the immersive nature of Recovery Camp. Students became increasingly comfortable speaking with consumers as the week progressed. This is significant because these are critical skills that underpin all components of effective mental health nursing practice and which can provide a firm foundation to reduce future challenges in their nursing profession (Chadwick & Porter, 2014). A further reason for this increase in confidence was that Recovery Camp enhanced participants knowledge and insight not only into the person's illness but also into what it means to live with these often pervasive conditions (Faro, 1994; Schick Makaroff, Scobie, Williams, & Kidd, 2013; South, 2010; Totten & Fannesbeck, 2002). Increased clinical confidence has a positive impact for students because the ability to conduct, and be clinically competent in mental health nursing assessments is an important component of work readiness.

The age of the participant was identified as a factor in determining the gain in clinical confidence. Over half of the items in the post-test survey showed a statistically significant difference, in favour of those participants aged 26 years and over. That is, participants aged 26 years and older were more likely to report a higher level of confidence across a number of areas such as providing education about mental health and medications, communication, assessment, verifying treatment goals, and dealing with verbal and physical aggression. Tratnack et al. (2011) acknowledged that the strength of an immersive practicum was the ability to understand the trials and tribulations associated with the daily routine of living with a mental illness, something that the mature aged students did more successfully. The maturity of the older students gives them an advantage in regards to mental health nursing as they are more likely to have also insight gained through their own lived experiences than those younger students (Keogh, O'Brien, & Neenan, 2009). Henderson (2007) also suggests that older undergraduate nurses have a greater interest in nursing people experiencing mental health problems due to their self-reported knowledge, skills and attitudes that come from experience across time, and as such regard the ability to understand mental illness higher than younger students (Chadwick & Porter, 2014).

Of note, participants that reported to have mental illness in their family history, were more likely to self-report a lower level of confidence, particularly in the pre-test results. One might ordinarily assume that having a family member with mental illness would lead to higher levels of confidence. Results of this study did not find this. The association of a family history of mental illness and its impact on clinical confidence has not been

previously explored in the literature and warrants further investigation. Possible explanations for these results include that it is possible that extremely inexperienced students do not know what they do not know (Ross et al., 2013). Another explanation is that the self-reported higher level of confidence could be explained by the lack of understanding about mental illness or the lack of understanding about what is required from a mental health nurse by those participants who do not have a family history (Happell, 2007; White & Roche, 2006). Chadwick and Porter (2014) identified that students do not perceive the significance of mental health tasks while on clinical placement. For example students did not perceive talking with consumers and developing a therapeutic relationship as a clinical skill. Within mental health nursing though, these interventions are essential in order to determine the person's mental state. The application of this information to this research suggests that those students who do not have a family history of mental illness may not understand the value of each of the items, or may have more confidence due to lacking previous challenging experiences.

Participants' confidence in their ability to be empathetic, establish personal boundaries, communicate effectively with consumers with a mental health problem, and provide basic counselling saw a marked improvement between pre-test and post-test data. These results have significance because of the impact of this improved level of confidence in the participant's interactions with consumers, thereby improving the participants ability to create a therapeutic relationship and maintain personal boundaries contributes to an effective consumer relationship (Moxham, Dwyer, Reid-Searl, Robson, & Broadbent, 2013). Clinical practice with people who experience mental illness is required to provide students with a clear, holistic understanding about mental illness. Unlike conventional clinical placements the Recovery Camp provided students with an opportunity to learn and develop professionally through lived experienced teaching. The paucity of practical lived experience learning programs from consumers about their activities of daily living is influenced by the medical model of care which places a strong emphasis on pharmacological methods of treatment rather than the person centred care of the recovery philosophy (Gale & Marshall-Lucette, 2012). There are strong links between therapeutic recreation and a recovery-orientated philosophy of care. Developing undergraduate nurses understanding of the impact of mental illness on consumers helps create a stronger feeling of empathy. This in turn makes it easier for undergraduate nurses to understand the needs of the consumer and creates a greater sense of awareness, making it easier to both communicate and provide basic counselling (Happell, 2008).

Implications for practice

Several important implications for practice became evident within this study. Firstly, the positive impact of the Recovery Camp experience on the clinical confidence of this small cohort of nursing students demonstrates that such immersive placements have a role to play in preparing nurses to be work ready. The differences in clinical confidence outcomes based on student demographics indicate that further work is required to explore the relationship between student characteristics and optimal clinical placement settings. The somewhat unique nature of the learning experience offered by the Recovery Camp provides a challenge in outcomes measurement. As greater opportunities are developed in this sector, further work is required to test current and develop revised measurement strategies for the range of learning outcomes students achieve through participation in such activities. Finally, this study highlights the value of demonstrating to students that personal recovery from mental illness is embedded within everyday life and beyond the acute care setting.

Limitations

This study has a number of limitations. The main limitation is that the data were derived from a small pre-test / post-test study conducted at a single Australian university. The students who participated self-selected to attend the Recovery Camp and so may be somewhat different to the broader population of nursing students.

A second limitation is that the survey instrument, although previously tested in acute and community placements, proved to not capture some of the elements of the recovery philosophy present in this non-conventional placement experience.

This paper reports a Bachelor of Nursing (Hons) project and, as such, was necessarily confined to a small component of the broader evaluation of the Recovery Camp. The self-assessment measure used in this study meant that the participants self-reported their level of clinical confidence rather than objectively measuring skill improvement (Holland, Middleton, & Uys, 2012; Hunter & Schmidt, 2004; Ross et al., 2013). Student's self-evaluation within the pre-test showed a tendency for a high degree of self-assuredness despite observed gaps in knowledge during the placement. Whilst this analysis reports the findings from a single self-report instrument, the broader program of work involves collection of both qualitative and quantitative data around a range of aspects related to

educational and skill outcomes. Such further research combining objective and subjective measures would enhance the knowledge base around the impact of the placement on broader clinical performance.

CONCLUSION

Clinical placement is integral to the educational experience of undergraduate nurses and contributes to developing nurses into confident and competent work-ready graduates. Much research has been undertaken exploring the factors affecting clinical confidence in the conventional mental health clinical placement environment. This study, however, sought to fill the gap of our understanding around non-conventional clinical placements and their impact on undergraduate nurses' clinical confidence. This is an important contribution to knowledge because nurses from all disciplines will have interactions with consumers who experience mental health concerns.

Findings arising from this study represent the first research evidence exploring the use of immersive, recovery orientated therapeutic recreation interventions as a non-conventional clinical placement and their role in improving the clinical confidence of BN students. As such this is an original and unique contribution to nursing knowledge. It is clear from the evidence that non-conventional mental health nursing clinical placements can provide a quality learning environment for pre-registration nursing students.

REFERENCES

- Allsop, J., Negley, S., & Sibthorp, J. (2013). Assessing the Social Effect of Therapeutic Recreation Summer Camp for Adolescents with Chronic Illness. *Therapeutic Recreation Journal*, 47(1), 35.
- Bell, A., Horsfall, J., & Goodin, W. (1998). The Mental Health Nursing Clinical Confidence Scale: A Tool for Measuring Undergraduate Learning on Mental Health Clinical Placements. *The Australian and New Zealand Journal of Mental Health Nursing*, 7(4), 184-190.
- Chadwick, L., & Porter, J. (2014). An Evaluation of the Effect of a Mental Health Clinical Placement on Mental Health Attitudes of Student Nurses. *Nursing and Health*, 2(3), 57-64. doi: 10.13189/nh.2014.020301
- Cunningham, S., & Wilson, M. (2015). *Global learning experience – narratives of European immersive clinical nursing exchanges*. Paper presented at the RCN Education Conference, Nottingham, UK.
http://www.rcn.org.uk/_data/assets/pdf_file/0008/613682/5.3.4-Cunningham.pdf
- Department of Health. (2009). National Mental Health Policy 2008 *National Mental Health Strategy*. Commonwealth of Australia.
- El Haddad, M., Moxham, L., & Broadbent, M. (2012). Graduate registered nurse practice readiness in the Australian Context: An issue worthy of discussion. *Collegian*, 20(4), 233-238.
- Faro, B. Z. (1994). Summer Camp as a Clinical Placement for Graduate Students in Pediatrics. *Journal of Nursing Education*, 33(2), 91-92.
- Fisher, J. E. (2002). Fear and Learning in Mental Health Settings. *International Journal of Mental Health Nursing*, 11(2), 128-134.
- Gale, J., & Marshall-Lucette, S. (2012). Community Mental Health Nurses' Perspectives of Recovery-Oriented Practice. *Journal of Psychiatric and Mental Health Nursing*, 19(4), 348-353. doi: 10.1111/j.1365-2850.2011.01803.x
- Happell, B. (2007). Mental Health Nurses or Nurses Working in Mental Health Settings? *Mental Health Practice*, 11(3), 18-20.
- Happell, B. (2008). 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.
- 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.
- Hayman-White, K., & Happell, B. (2005). Nursing Students' Attitudes Toward Mental Health Nursing and Consumers: Psychometric Properties of a Self-Report Scale. *Archives of Psychiatric Nursing*, 19(4), 184-193. doi: <http://dx.doi.org/10.1016/j.apnu.2005.05.004>

- Health Workforce Australia. (2013). Clinical Training 2012. In S. C. o. Health (Ed.).
- Henderson, S., Happell, B., & Martin, T. (2007). So What is so Good About Clinical Experience? A Mental Health Nursing Perspective. *Nurse Education in Practice*, 7(3), 164-172. doi: 10.1016/j.nepr.2006.06.003
- Holland, K., Middleton, L., & Uys, L. (2012). Professional Confidence: A Concept Analysis. *Scandinavian Journal of Occupational Therapy*, 19(2), 214-224. doi: 10.3109/11038128.2011.583939
- Hunter, J. E., & Schmidt, F. L. (2004). *Methods of Meta-Analysis: Correcting Error and Bias in Research Findings*: Sage.
- IBM Corp. (2013). IBM SPSS Statistics for Windows, Version 22.0. from <http://www-01.ibm.com/support/docview.wss?uid=swg21476197>
- Kameg, K., Howard, V. M., Clochesy, J., Mitchell, A. M., & Suresky, J. M. (2010). The Impact of High Fidelity Human Simulation on Self-Efficacy of Communication Skills. *Issues in Mental Health Nursing*, 31(5), 315-323. doi: 10.3109/01612840903420331
- Keogh, B., O'Brien, F., & Neenan, K. (2009). The Clinical Experiences of Mature Mental Health Nursing Students in Ireland. *Nurse Education in Practice*, 9(4), 271-276. doi: 10.1016/j.nepr.2008.10.013
- Kitchener, B. A., & Jorm, A. F. (2010). Mental Health First Aid Manual (Vol. 67, pp. 45): New South Wales Nurses Association.
- Levett-Jones, T., & Bourgeois, S. (2010). *The Clinical Placement: An Essential Guide for Nursing Students*. Chatswood, N.S.W: Elsevier Health Sciences.
- Lofmark, A., Smide, B., & Wikblad, K. (2006). Competence of Newly-Graduated Nurses-a Comparison of the Perceptions of Qualified Nurses and Students. *Journal of Advanced Nursing*, 53(6), 721-728. doi: 10.1111/j.1365-2648.2006.03778.x
- Moxham, L., Dwyer, T., Reid-Searl, K., Robson, P., & Broadbent, M. (2013). *Nursing Student's Adult Mental Health Clinical Survival Guide*. Frenchs Forest, NSW: Pearson Australia.
- Moxham, L., Liersch-Sumskis, S., Taylor, E., Patterson, C., & Brighton, R. (2015). Preliminary outcomes of a pilot therapeutic recreation camp for people with a mental illness: links to recovery. *Therapeutic Recreation Journal*, 49(1), 61-75.
- Prasetyo, H., Sulistyowati, D., & Mat, S. (2012). Psychiatric Clinical Placement Upon Nursing Students Perceived Knowledge in Caring for Mentally Ill. *Nurse Media Journal of Nursing*, 2(1), 305-313.
- Ross, C. A., Mahal, K., Chinnapen, Y., & Rana, R. (2013). The Effects of Clinical Placement on Students' Confidence in their Mental Health Nursing Competencies. *Nursing Education Perspectives*, 34(4), 268-269.
- Schafer, T., Wood, S., & Williams, R. (2011). A Survey into Student Nurses' Attitudes Towards Mental Illness: Implications For Nurse Training. *Nurse Education Today*, 31(4), 328-332. doi: <http://dx.doi.org/10.1016/j.nedt.2010.06.010>

- Schick Makaroff, K., Scobie, R., Williams, C., & Kidd, J. (2013). Let's Go to Camp! An Innovative Pediatric Practice Placement. *Journal of Pediatric Nursing, 28*(5), 492-496. doi: 10.1016/j.pedn.2012.12.007
- Schluter, J., Seaton, P., & Chaboyer, W. (2011). Understanding Nursing Scope of Practice: A Qualitative Study. *International Journal of Nursing Studies, 48*, 1211-1222.
- South, L. (2010). My View. Summer Camp as a Clinical Site for Student Nurses. *CompassPoint, 20*(4), 1.
- Szpak, J. L., & Kameg, K. M. (2013). Simulation Decreases Nursing Student Anxiety Prior to Communication with Mentally Ill Patients. *Clinical Simulation in Nursing, 9*(1). doi: 10.1016/j.ecns.2011.07.003
- Thornicroft, G. (2007). Most People with Mental Illness are Not Treated. *The Lancet, 370*(9590), 807-808. doi: 10.1016/s0140-6736(07)61392-0
- Totten, J. K., & Fannesbeck, B. (2002). Camp Communities: Valuable Clinical Options for BSN Students. *Journal of Nursing Education, 41*(2), 83-85.
- Tratnack, S. A., O'Neill, C. M., & Graham, P. (2011). Immersion Experience in Undergraduate Psychiatric Mental Health Nursing. *Journal of Nursing Education, 50*(9), 532-535. doi: 10.3928/01484834-20110531-02
- Walker, S., Dwyer, T., Moxham, L., Broadbent, M., & Sander, T. (2012). Facilitator versus preceptor: which offers the best support to BN students? *Nurse Education Today, 33*(5), 530-535.
- White, E., & Roche, M. (2006). A Selective Review of Mental Health Nursing in New South Wales, Australia, in Relation to Clinical Supervision. *International Journal of Mental Health Nursing, 15*(3), 209-219. doi: 10.1111/j.1447-0349.2006.00424.x
- Wolff, A. C., Pesut, B., & Regan, S. (2010). New graduate nurse practice readiness: perspectives on the context shaping our understanding and expectations. *Nurse Education Today, 30*(2), 187-191. doi: 10.1016/j.nedt.2009.07.011
- Wolff, A. C., Regan, S., Pesut, B., & Black, J. (2010). Ready for What? An Exploration of the Meaning of New Graduate Nurses' Readiness for Practice. *International Journal of Nursing Education Scholarship, 7*(1). doi: 10.2202/1548-923x.1827