PROFESSORS' VIEWS ON MENTAL HEALTH NURSING EDUCATION IN THE BACCALAUREATE NURSING PROGRAMS OF ONTARIO: A GROUNDED THEORY APPROACH

by

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Abstract

According to the Canadian Nurses’ Association (2005), mental health (MH) nursing is currently undervalued in the nursing profession. The Education Committee of the Canadian Federation of Mental Health Nurses (CFMHN) (2009) reports that the length of MH theory and practicum varies enormously in the undergraduate nursing programs of Ontario and across the country. Interviews with 19 nursing professors representing programs with different MH components show a variation in their opinions about topics such as the degree of importance of a mandatory stand-alone MH component, whether MH nursing education should be students’ or professors’ responsibility, how professors relate themselves to the MH component, and their familiarity with and assessment of their program’s MH education. It remains unclear the extent to which these factors contribute to program design and, in turn, students’ knowledge of MH nursing. Further research in this area is required.

Keywords: mental health, psychiatric, nursing, education

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Chapter One: Introduction

This chapter introduces the reader to the research issue. It reviews the rationale for this study, what it aims to accomplish, and its significance. This chapter also explains the key terms and presents the research questions that were addressed in this study.

Nursing is a discipline that relies immensely on both theory and practice (MacFarlane et al., 2007). Only through a great quality, variety, and amount of education, will nursing students be able to become successful holistic practitioners (MacFarlane et al., 2007). With a history of negative beliefs regarding mental illness and years of inhumane treatment of the mentally ill (Boling, 2003), it is not surprising that the Canadian Nurses Association (CNA) (2005) reports that mental health (MH) is undervalued in the nursing profession. Chan et al. (1998), speaking on the behalf of the Canadian Federation of Mental Health Nurses (CFMHN), previously reported that in Canadian undergraduate nursing education MH theory and practicum are not well represented. In fact, some nursing programs do not offer a separate course dedicated to MH nursing and/or clinical practice in this area (CFMHN, 1998). According to a recent report by Tognazzini et al. (2009), on behalf of the Education Committee of the CFMHN, in-class time spent on MH theory in Canadian nursing programs ranges from one-and-a-half to seven-and-a-half hours per week for 12 weeks, with a mean of three hours per week. As for MH clinical experience, it ranges from 25-to-330 hours over a 12-week period with a mean of nine hours per week.

Many nursing programs now offer MH content as 'threaded' or 'integrated' throughout the program. This means that the MH content is dispersed throughout a number of nursing theory courses. As far back as 1998, the CFMHN reported that not all nursing graduates are able to perform a mental status assessment, which is especially disturbing as it is considered a basic nursing skill that plays a crucial role in early detection of mental illness or distress. In their most recent report, CFMHN (2009) voiced the same concerns.

Since 1955 two different models of MH nursing education have existed in Canada (Tipliski, 2004). While the western part of Canada has a distinct Registered Psychiatric Nurse designation and prepares nursing students specifically for MH/psychiatric nursing, the eastern part of Canada prepares only nurse-generalists who may choose to work in a MH nursing setting upon graduation (Tipliski, 2004). What is especially interesting is that not only are there no specialized MH nursing programs in Ontario, not all nurse-generalist programs offer a mandatory stand-alone course on MH nursing or a clinical practicum in this area.

The Registered Nurses Association of Ontario (RNAO) is the professional association representing Ontario's registered nurses. Promoting healthy public policy, the RNAO speaks out on issues that impact health, healthcare and nursing. During the Annual General Meeting in 2008 the RNAO membership passed Resolution #4, which called on the RNAO "to collaborate with and lobby all relevant sectors of the education and health care system to advocate for undergraduate nursing programs which include a clinical practicum in psychiatric/mental health nursing as well as advocate for the development of a consistent minimum level of

competency and content teaching about 'mental illnesses' in all basic nursing programs in Ontario" (RNAO Mental Health Nursing Interest Group, 2008). However, to date there appears to have been little movement in this direction.

Rationale for the Study

The quality, quantity and the delivery mode of MH content needs to be examined to determine the MH education that is provided to nursing students. It is also important to look at whether the 'threaded' delivery of MH content is indeed effective, or whether its 'threaded' nature makes it 'invisible' to students. Are students able to pick up MH concepts from a variety of courses and incorporate them into practice? Is MH nursing seen as a career choice? Canadian research needs to be conducted on nursing students' knowledge of MH theory and their perceptions of MH nursing. However, nursing professors' thoughts on what appears to be inconsistent MH nursing education in Ontario must be explored first. Nursing professors' perceptions of mental illness, MH clients, and the importance of providing MH education to nursing students need to be examined as nursing professors play an important role in curriculum planning and overall student education. The CFMHN (2009) questions whether nursing professors are perpetuating stigma towards persons with MH concerns and MH nursing.

Factors influencing nursing education may vary from funding to health care trends, to availability of teaching staff with appropriate expertise, to time constraints of the program and the guidelines set out by the accrediting body. The College of Nurses of Ontario (CNO) designated the Canadian Association of Schools of Nursing (CASN) as the official agency responsible for accrediting baccalaureate

nursing programs in Ontario. However, the collaboration that occurs among nursing professors has an equally great impact on nursing education. Nursing professors inevitably influence the depth and breadth of the nursing content and its delivery mode. It is important that their views on and attitudes towards MH nursing be explored in order to gain a better understanding of current MH nursing education trends.

Aims of the Study

The aims of this study were to explore nursing professors' thoughts about and attitudes towards MH nursing and MH education, and to determine whether these attitudes differ among professors from programs with considerable differences in the delivery of MH content. The results of this study may enable nursing professors to reflect on their personal beliefs and experiences, and to consider how they may be unknowingly and indirectly influencing the nursing profession and the well-being of many Canadians. This study will encourage further research in the area of MH nursing in Canada with a focus on nursing curricula in order to ensure that future graduates develop the competencies required to provide true holistic care.

Definition of Terms

Baccalaureate nursing program. Baccalaureate nursing program was defined as a (typically) four-year program leading to a Bachelor's degree with Honours in Nursing, Nursing Sciences or Science in Nursing and that qualifies successful graduates for the Canadian Registered Nurse Examination and subsequent practice as a registered nurse. In Ontario, there are fourteen nursing

degree-granting institutions and over twenty baccalaureate nursing programs altogether. The discrepancy between the number of nursing degree-granting institutions and the number of nursing programs is due to the fact that some institutions have more than one nursing program. For example, some universities have a 'compressed' program along with a 'standard', four-year program. So there may be two sets of students going through different 'streams'. Technically, they are enrolled in two different nursing programs but they all receive the exact same degree from that particular institution. This research study was arranged according to the degree-granting institutions rather than programs based on an assumption that if the same degree is awarded by an institution to students in all nursing programs steams, they are provided with the same curricula. Please refer to Appendix A for a complete list of the 14 baccalaureate nursing degree-granting institutions in Ontario.

Nursing professor. For the purposes of this study, a nursing professor was defined as any nursing faculty member who teaches nursing theory, nursing research, a clinical skills course or a lab regardless of whether they are a sessional instructor, an assistant professor or a tenured professor.

Mental health nursing. MH nursing was defined as an area of nursing that focuses on providing care to individuals with mental illness or in mental distress. MH clinical practicum was defined as any practical nursing experience that occurs outside the educational institution. It may involve settings such as community MH settings, MH units in acute care hospitals and tertiary care MH facilities. Mental

health nursing theory was defined as accepted knowledge in the area of MH and mental illness related to nursing care.

Significance of the Study

According to the Canadian Collaborative Mental Health Initiative (2006), one in five Canadians will experience mental illness in their lifetime. Worldwide, mental illness such as depression is on the rise (World Health Organization [WHO], 2009). According to the WHO, (2009), depression-related suicide is among the top three causes of death among persons aged 15 to 44. In 2009 seven million Canadians required MH support; however, many did not receive the necessary care due to the stigma that is still associated with mental illness (Mental Health Commission of Canada, 2009). Decreasing this stigma will enable more people to seek treatment and help foster a supportive environment within health care settings as well as the general public. Studies suggest that stigma decreases through education (Madianos et al., 2005; Webster, 2009), which should start with future frontline health care professionals such as nursing students.

Lack of visible MH education has the potential to decrease entry to the profession of potentially successful MH nurses (Happell & Gough 2007; Hoekstra, van Meijel, & van der Hooft-Leemans, 2009). Ensuring appropriate quality, quantity and delivery of MH education, that is consistent throughout Ontario's nursing programs, will have important and positive impacts on the health of Ontarians and the Canadian health care system. Mental health affects and is affected by all aspects of an individual's health. For this reason, every nurse must be able to assess their patients' MH and be able to recognize early signs of mental illness or

decompensation regardless of which area of nursing they choose to work in. Early identification, treatment, and education will allow for better patient outcomes. Because mental illness has tremendous effects on patients' families and friends (Mental Health Commission of Canada, 2009), improved patient outcomes will benefit all Canadians. Early identification and treatment will also decrease the economic burden that is frequently associated with chronic conditions that are left untreated (Mental Health Commission of Canada, 2009). Quality MH education throughout nursing programs will also benefit the nursing profession as a whole. Nursing graduates will better understand what mental illness entails and how to support those living with it. Mental health education and exposure to MH clients may spark students' interest in this often undervalued field and encourage more nursing students to pursue what the researcher believes to be an important and rewarding career.

There also are a number of `compressed' and `second-degree-entry' nursing programs in Ontario. Due to these programs' time constraints, the time devoted to providing nursing students with opportunities to gain knowledge of MH may come under scrutiny by nursing professors. Research to explore whether 'threading' MH concepts through a curriculum provides students with sufficient knowledge needs to be conducted. However, nursing professors' opinions regarding MH nursing and MH education must be examined first. Their views and attitudes provide insight into current MH education and the challenges associated with it.

Research Questions

This study addressed the following research questions: (1) how do nursing professors describe the mental health education and clinical practice they received as undergraduate students?; (2) what are nursing professors' views regarding the importance of including mental health nursing as a mandatory stand-alone part of the nursing curricula?; (3) how do nursing professors perceive their program prepares students in terms of mental health education?; and (4) to what extent is the emphasis that is placed on mental health education in baccalaureate programs related to the nursing professors' experiences and attitudes towards mental health nursing?

Chapter Two: Literature Review

A literature review was conducted to identify current issues related to MH nursing in Ontario, Canada. The goal was to investigate the following areas: (1) nursing students' attitudes towards mental illness, MH clients, MH nursing, and their perceived level of preparedness for this area; (2) effect of MH nursing education on student nurses' perceptions of MH nursing; (3) presence of stigma or negative attitudes among MH nurses; and (4) nursing professors' perceptions of mental illness, MH clients, MH nursing, and MH education. Also, literature looking at how nursing students' career choices are influenced was of interest.

Methods

A search of recent research was completed using the following search engines: ProQuest, MedLine, PubMed, ERIC, and Cochrane. Prior to starting the literature review, brainstorming and mind mapping exercises were performed. With the aid of these exercises, keywords were generated. Key words included the following: psychiatric, mental health, nursing, education, attitudes, perceptions, and curriculum. Several different combinations of keywords were used in each search. Full advantage was taken of search engines' advanced search options, such as suggestions for narrowing search results by subject. Consistency was observed, as all searches were done by one researcher.

To be included in this literature review, articles were to be recently published. Initially, a five-year limit was set in each search; only work published after January 2004 was to be considered. As well, articles were to be available in full text and in the English language. Scholarly work was of utmost interest. Restriction

tabs, such as 'Scholarly Journals' in ProQuest for example, were applied for this reason. Initially, only Canadian literature was to be included. However, as it became clear that the research related to MH nursing in Canada is very limited, studies from other parts of the world were included. For an international study to be included, its country of origin had to be available in English. In terms of content, articles had to provide insight into at least one of the areas of interest outlined earlier.

A primary exclusion criterion for this literature search was not meeting the inclusion criteria. As well, letters to the editor, opinion statements and studies which were found to be only loosely related to the topic of interest were eliminated.

Upon closer examination of retrieved studies, only noteworthy research was retained. In other words, only research providing insight into the above-mentioned four areas of interest was kept. In cases where a study was based on a significant amount of earlier research, its references were reviewed. This way, more studies were retrieved by authors' last names via the ProQuest database. Using this snowballing technique led to the time limits being extended to ten years because a number of valuable and relevant articles were published prior to the initial time limit that was set.

Results

A total of 26 studies were reviewed. Fourteen studies were from Australia, five from the United Kingdom, and one from each of the following countries: New Zealand, the Netherlands, Sweden, Greece, Israel, the United States of America, and Canada. These studies included qualitative and quantitative study methods such as focus groups, open-ended questionnaires, Likert-type pre- and post-intervention

surveys, quasi-experimental and time series study designs, and randomized controlled trials. Insight on the presence of stigma among MH nurses and MH clients' experiences was gained. Many studies looked at MH education in the nursing programs, its impact on students' attitudes towards mental illness and MH clients, and the popularity of MH nursing. There has been no research with a focus on nursing professors' perceptions of issues surrounding MH nursing and MH education. This study addresses this significant knowledge gap.

Students' attitudes towards mental illness, mental health clients, mental health nursing, and their perceived level of preparedness for this area. Research suggests that prior to MH nursing education, students' MH literacy level and views on mental illness and MH clients closely resemble those of the general public (McCann, Clark, & Lu, 2009). Negative attitudes and inaccurate ideas about MH clients such as blaming people with mental illness for their illness and anticipating aggressive and unpredictable behaviour are common (Curtis, 2007; Gough & Happell, 2009; Granksar, Edberg, & Fridlund, 2001; Happell, 2008a; Happell, 2008b; Happell & Gough, 2007; Happell & Rushworth, 2000; Happell, Robins, & Gough, 2008; Hayman-White & Happell, 2005; Hoekstra et al., 2009; Madianos et al., 2005; Nolan & Chung, 1999; Romem et al., 2008; Webster, 2009; Wynaden et al., 2000). People with mental illness may also be perceived to be irresponsible and incapable of leading a 'normal' life by the nursing students (Hoekstra et al., 2009). According to Hoekstra et al., (2009), nursing students without prior MH education may believe that the admission to a MH hospital is a way of protecting the public rather than seeking treatment for an individual. MH

hospitals and units may be visualized as fenced, isolated, and secure premises by nursing students prior to MH clinical practicum (Hoekstra et al., 2009; Nolan & Chung, 1999). Interestingly, students who know someone with mental illness do not perceive that person as dangerous, unpredictable, or different in any way. However, these students hold the same negative attitudes towards people with mental illness that they are not acquainted with, as their classmates who do not know anyone with mental illness (Hoekstra et al., 2009).

Studies show that students may feel that MH nursing is not well represented in their undergraduate nursing program (Hoekstra et al., 2009), and when a MH component is introduced, it may be perceived differently or as unrelated to the rest of nursing by the students (Wynaden et al., 2000). Students report feelings of anxiety, apprehension, and fear of the unexpected when asked to consider MH nursing (Happell & Rushworth, 2000; Henderson, Happell, & Martin, 2007; Webster, 2009). MH nursing is often disfavoured to the benefit of other areas which are perceived to be more technologically advanced and 'prestigious' (Happell & Rushworth, 2000; McCann et al., 2010), so MH nursing is rarely considered as a career option. When entering a nursing program, possibly due to general media portrayals, many students imagine nurses work primarily on medical/surgical floors (Hoekstra et al., 2009; McCann et al., 2010). Many students report that they were not planning to pursue a career in MH nursing as it simply had not crossed their mind as an option, and they were never formally introduced to it (Hoekstra et al., 2009). In some studies, students have cited that they were not aware of what MH nursing entails, including whether there is a potential for advancement and professional

growth in this area (Hoekstra et al., 2009). The effectiveness of psychosocial interventions and pharmacotherapy offered to MH clients is often underestimated and dismissed by nursing students with limited MH education (McCann et al., 2009). Many students have indicated feelings of hopelessness regarding patient outcomes (Munro & Baker, 2007) which also may have an impact on the popularity of MH nursing. In a study done by Nolan & Chung (1999), students perceive MH nurses to talk a lot and do little. Another reason that students may avoid MH nursing is their perceived lack of preparedness for and knowledge in this area (Hoekstra et al., 2009).

Effect of mental health nursing education on student nurses' perceptions of mental health nursing. MH nursing education is essential to decreasing negative attitudes towards mental illness and igniting interest in MH nursing (Curtis, 2007; Gough & Happell, 2009; Happell & Gough, 2007; Happell, 2008a; Happell, 2008b; Happell et al., 2008; Madianos et al., 2005; Munro, Watson, & McFayden, 2007; Webster, 2009; Wynaden et al., 2000). For example, in a study by Madianos et al. (2005), students expressed more humanitarian views of MH clients after completing a clinical practicum in this area. Negative attitudes decreased as students gained exposure and one-on-one contact with people with mental illness. In another study by Webster (2009) that looked at how clinical experience in a MH setting affects nursing students' empathy for persons with mental illness, students indicated that clinical experience let them see people with mental illness as 'real' people, rather than 'crazy' people. The importance of MH theory and allotting sufficient time for it has been outlined in a study by Happell (2009), which looked at

differences in nursing students' views on MH nursing among programs that varied greatly in the time that was devoted to a MH component. Schools' MH theory component varied from 30 to 160 hours for the duration of the program. Similarly, the number of hours spent in a clinical setting varied from 70 to 160 hours. An increase in MH theory was correlated to improved students' attitudes toward MH nursing and MH patients.

Some studies identified that students do not feel adequately prepared to begin their MH placement (Happell, 2008b; Wynaden et al., 2000). Students frequently pursue areas where they feel confident and have a good knowledge base, rather than unfamiliar areas (Hoekstra et al., 2009). There appears to be a relationship between the lack of knowledge and lack of desire to pursue MH nursing as a career (Hayman-White & Happell, 2005). Clinical placement is often an opportunity for the students to decide whether they are interested in an area in terms of a career or not (Henderson et al., 2007).

Although some anxiety regarding MH nursing may remain even after a clinical experience (Happell & Rushworth, 2007), students feel more confident, knowledgeable and generally satisfied with their placement (Curtis, 2007; Gough & Happell, 2009; Granksar, Edberg, & Fridlund, 2001; Happell, 2008a; Happell, 2008b; Happell & Gough, 2007; Happell & Rushworth, 2000; Happell et al., 2008; Hayman-White & Happell, 2005; Hoekstra et al., 2009; Madianos et al., 2005; Romem et al., 2008; Webster, 2009; Wynaden et al., 2000). In a study by Happell and Rushworth (2007), the popularity of MH nursing moved up from seventh to third spot in a group of students who attended MH clinical practicum. Initial popularity of MH

nursing remained the same in a group of students who did not attend a MH clinical practicum, and instead attended a clinical practicum in another area.

After a clinical placement in MH, students felt that MH nursing is indeed a valuable specialty that uses all of the previous nursing education they have received and is much needed in society (Hayman-White & Happell, 2005). Some studies indicate that students were so satisfied with their clinical experience and enthusiastic about working with this population that they would consider working in MH nursing upon graduation (Happell et al., 2008; Hayman-White & Happell, 2005; McCann et al., 2010; Wynaden et al., 2000). In a study by Curtis, (2007) which examined ways to increase the number of MH nurses, a small community in Australia increased the number of nurses going into MH nursing by simply providing their nursing students with extra MH nursing education.

Another interesting finding suggests that much may depend on students' attitude and mindset prior to their MH placement. According to Granksar et al. (2001), students who held negative views of mental illness may perceive their beliefs confirmed during their clinical experience if they are rejected by a client or deem their clinical experience unsatisfactory in any way. Feelings of dissatisfaction and inability to connect with clients may increase students' negative attitudes towards MH nursing, especially if they enter their first MH clinical with already negative beliefs and anticipating they will dislike it (Hoekstra et al., 2009).

Presence of stigma or negative attitudes among mental health nurses. Although MH nurses are clear on what is important in their work with MH clients, their attitudes towards patients may not always be favourable (Bertram & Stickley,

2005). In a study examining the attitudes of the staff of a MH residential rehabilitation unit towards clients, actions such as respecting individuality, providing choice, and being tolerant have been emphasized by MH nurses as crucial to MH clients' well-being (Bertram & Stickley, 2005). However, stigma and negative attitudes toward mental illness are still very real in MH care settings (Beal et al., 2007; Bertram & Stickley, 2005; Liggins & Hatcher, 2005; Munro & Baker, 2007). Moreover, according to two studies, MH nursing staff as well as the clients are very much aware of these negative attitudes (Liggins & Hatcher, 2005; Bertram & Stickley, 2005). Intolerance towards people with mental illness and their perceived incapability are just a few examples of the negative attitudes towards MH clients that are present in the MH care settings (Bertram & Stickley, 2005).

According to Liggins and Hatcher (2005), who investigated stigma towards MH clients in clinical settings, general practitioners indicated their uncertainty and a degree of fear in their work with MH clients. Pessimism, in terms of patient outcomes, is a common theme as the concept of the 'revolving door' is frequently cited by MH workers (Bertram & Stickley, 2005; Munro & Baker, 2007). In a study of MH nurses' attitudes by Munro and Baker (2007), clients reported that their nurses are not always friendly and supportive. The same study revealed nurses' uncertainty of mental illness etiology and the associated risk factors. Alternatively, one study suggests that although negative perceptions are still present, positive attitudes among MH nursing staff predominate (Munro & Baker, 2007). An interesting finding by the same authors illustrated just how important education is to decreasing stigma. MH workers holding lower status positions appeared to hold more negative

views towards mental illness compared to those with more advanced education and training (Munro & Baker, 2007).

A recent Canadian quality-improvement project showed that MH clients appreciate a therapeutic relationship in which they are listened to, respected, and valued for their positive attributes (Beal et al., 2007). Unfortunately, their experiences frequently include being stigmatized and ignored (Beal et al., 2007). What is even more worrisome is that MH clients report that they are not always included in decision-making and treatment-planning (Beal et al., 2007; Liggins & Hatcher, 2005). Such negative perceptions and unfair treatment are damaging to patients' MH outcomes as they strongly oppose illness management and patients' recovery (Munro & Baker, 2007).

Mental health clients' physical well-being may also be in jeopardy (Liggins & Hatcher, 2005). An example drawn upon by Liggins and Hatcher (2005) explains that when a client with a history of mental illness seeks help for physical concerns, the validity of their symptoms may be dismissed and attributed to their poor MH state (Liggins & Hatcher, 2005).

Stickley et al., (2010) investigated MH clients' assessment of students' ability to form a therapeutic relationship. When the assessments were negative, or unfavourable towards the students' therapeutic approach, those MH clients were deemed by the students as not able to produce an accurate assessment due to their mental state. Moreover, this notion was supported by the students' assigned nurses. It illustrates how MH clients' concerns regarding their treatment may be disregarded. All in all, it is clear that the attitudes of caregivers in MH settings

impact greatly not only nursing students' perceptions of persons with mental illness, but also their ability to provide care, and their patients' well-being.

Nursing professors' perceptions of mental illness, mental health clients, mental health nursing, and mental health education. At the time of this literature review, there were no studies found that examine nursing professors' attitudes toward mental illness, MH clients, MH nursing or their perceptions of MH nursing education in undergraduate nursing programs.

Gaps in knowledge. First, it is important to point out that only 26 relevant articles met the inclusion criteria. This in itself illustrates that the research in this area is limited. Moreover, only one study was Canadian. Research studies similar to those presented above must be conducted in Canada. However, the biggest identified gap is the lack of research on the perceptions of nursing professors. Because nursing professors have the ability to influence nursing curricula and shape the way MH nursing is taught, their attitudes are a crucial factor in nursing education and must be explored.

Literature Review Summary

There has been inquiry into the presence of stigma among MH nurses and general MH staff. Results of several studies indicate that pessimism and intolerance towards MH patients exist among MH nurses. It has also been illustrated that MH clients are aware of these attitudes. They report feeling ignored, not respected, and undervalued by nursing staff. Meanwhile, it has been suggested that the MH nursing education component in nursing programs decreases stigma towards and fear of MH clients. It also increases students' knowledge and confidence in MH nursing and the

overall popularity of this area. To date, there has been no research on nursing professors' perceptions and attitudes towards MH nursing or MH nursing education. Please refer to Appendix B for a brief overview of the current research findings and gaps in knowledge. The identified gaps in knowledge outlined in this chapter provided the impetus for this study.

Chapter Three: Design and Methodology

Chapter three outlines the design of this study. The focus of this chapter is on the procedural methods including the participant selection, data collection, tools used, and steps taken to ensure confidentiality. The theoretical framework and data analysis process are discussed in chapter four of this thesis.

Institution Selection

The first goal was to identify the actual MH theory and clinical delivery mode in each of the baccalaureate nursing programs in Ontario. A thorough review of all baccalaureate nursing programs provided by institutions listed in Appendix A was conducted. Each program's curriculum was examined in terms of its MH nursing education component. Initial data collection was done via the internet. On-line program and course calendars were accessed. In cases where on-line calendars did not provide the sought after information, schools were contacted directly via e-mail (see Appendix C). Determining program design and delivery with regards to MH component was essential to this study not only because it provided an overview of MH nursing education in Ontario, but also because it enabled participants' responses to be analyzed in the context of the program-type within which they teach.

Once this information was collected, a two-by-two table was created (see Appendix D). It consists of the following four quadrants: 'mandatory stand-alone MH theory course and a mandatory MH clinical practicum', 'mandatory stand-alone MH theory course and elective/absent MH clinical practicum', 'threaded MH theory and a mandatory MH clinical practicum', and finally the 'threaded MH theory and elective MH clinical practicum'. All fourteen degree-granting institutions were placed, in no

particular order, into one of the above-mentioned quadrants according to their MH content. The first program in each quadrant was included in this study. However, because quadrant C (programs with 'threaded MH theory and mandatory MH clinical practicum'), remained empty, a second school from another quadrant was added to the study in order to reach the desired sample size. This institution was picked from quadrant B, the 'mandatory stand-alone MH theory course and elective MH clinical practicum' quadrant, as the institution that was chosen to represent it showed the lowest initial response rate (n=2 as opposed to anticipated n=4).

Participant Selection and Tools

An invitation to participate (see Appendix E) was sent via e-mail to all nursing professors in the selected schools whose e-mail address was listed on their program's website. Invitations were also sent to the chair and/or the director of each program if their contact e-mail was provided on their program's website. A link to a survey (see Appendix F), requesting participants' basic demographic information, was included in the invitation e-mail. In order to fit within the identified timeframe, interested participants were encouraged to reply within two weeks of the receipt of the invitation. The invitation to participate also provided a brief description of the study, advised participants of their confidentiality and provided further instructions for those interested in participating. It was anticipated that approximately four to five participants per institution would represent each quadrant and therefore each program-type. This number was met or exceeded in each of the three quadrants. Altogether, the sample size for this study was n=19.

Please refer to Appendix G for an overview of the institution and participant selection process.

The demographic survey was created using Survey Monkey™ 2009 (www.surveymonkey.com). The survey consisted of eight basic demographic questions about gender, age, participants' education level, area of expertise, current teaching position, teaching experience, clinical experience in the MH field, and the MH education they received as a student. There were two questions requesting participants' contact information and a convenient time for a phone interview. The last section provided participants with the opportunity to make further inquiries and/or voice any concerns. Survey Monkey ™ 2009 was also used for e-mailing purposes. To increase response rates, both the invitation letter and demographics survey were designed to be brief and personable.

In two programs the response rate was below ($n<4$) the anticipated response rate ($n\geq4$). A second invitation letter, identical to the initial one, was sent to those individuals who had not yet responded. Once again, this was done via e-mail. Initially, the demographic data from the survey questions was to be used to select a final group of participants to represent each school. Groups were to be matched according to tenure status, area of expertise, and the length of teaching experience of potential participants. However, some members of the Research Ethics Boards recommended allowing all those who volunteered and dedicated their time to filling out the demographic survey to share their knowledge. Additionally, the response rates in some of the programs were not high enough to allow the researcher to be

selective in this manner. Therefore, all those who expressed interest were included in this study.

Data Collection

Semi-structured digitally-recorded phone interviews were conducted at a time convenient to each participant. Conducting interviews via phone made this study feasible by eliminating travel time and minimizing expenses. Semi-structured interviews were chosen for this research as they guided the interview yet allowed free expression at the same time (Creswell, 2007). Six open-ended interview questions were created (see Appendix H). In case any of the questions might be unclear to any of the participants, detailed clarification questions were also created. Each participant was presented with the same set of questions in the same order to ensure consistency. A digital voice-recorder was used for timing and recording of each interview. Once all the interviews were completed, they were transcribed verbatim. During the transcription process, digital recordings of participants' answers were reviewed a minimum of three times to ensure accuracy of the transcriptions. All data transcription and interpretation were completed by the same researcher.

Data Analysis

Data analysis was completed according to the Grounded Theory as prescribed by Strauss and Corbin in their book *Basics of Qualitative Research Techniques and Procedures for Developing Grounded Theory* (1998). This process is discussed in detail in the next chapter.

Ethics, Confidentiality, and Risks

Approval was obtained from the Research Ethics Board (REB) at the University of Ontario Institute of Technology prior to commencing this study. In addition, each school that was included in the study was contacted for their individual Research Ethics Board approval. Permission from the directors of the nursing faculties and schools of nursing was obtained whenever required by the REB. One of the schools included in this study did not require an REB approval. A written notice of the researcher's intent was sent to the director of that program.

There were no physical or psychological risks associated with or noted during this study. Prior to data collection, participants were informed that their participation was voluntary and that they could choose not to answer any of the questions and/or stop the interview at any time without any repercussions. This information was provided in the invitation e-mail. Participants were also briefed immediately prior to the interview (see Appendix H). In cases where participants withdrew from the study, all electronic correspondence with them was disposed of immediately.

Every effort was made to ensure participants' confidentiality. The names of participants and the names of the programs that they represent were not documented in any part of the study. Program-specific terms were either excluded from transcribed data or substituted with generic terms during the transcription process. Rather than using program names, each program was assigned the letter of the quadrant it represents which was then used throughout the study. All electronic

correspondence and audio recordings were erased immediately after the transcription and verification processes were complete.

Chapter Four: Theoretical Framework

While the previous chapter of this thesis laid out procedural steps of this study, this chapter explains the theoretical framework behind the data analysis. Background information on Grounded Theory, why it was chosen, and the elements that were utilized will be reviewed.

Grounded Theory

The theoretical framework that was chosen for this study is the Grounded Theory as prescribed by Strauss and Corbin (1998). Initially, Grounded Theory was created by two social scientists, Barney Glaser and Anselm Strauss (Moore, 2009). During 1960's, they felt that the qualitative methods of that time were excessively restrictive and that the results they produced were not generalizable and therefore inapplicable (Moore, 2009). Glaser and Strauss saw the need for qualitative methods that generated theory rather than just provided a description of an issue (Moore, 2009). According to Glaser and Strauss, such theory must be generalizable, verifiable, and readily applicable (Moore, 2009). This was to be achieved by grounding theory in data through a non-linear systematic data analysis (Moore, 2009). Such theory resembles the reality much closer than the results of many other types of qualitative methods (Strauss & Corbin 1998). Grounded Theory was created on the notion that the researcher has no preconceived ideas or theories to prove or disprove (Strauss & Corbin 1998). Therefore, Grounded Theory builds theory, rather than tests it (Strauss & Corbin, 1998).

With time, Glaser and Strauss moved apart in their interpretation of Grounded Theory. Glaser remained loyal to the original, more lenient principles of

Grounded Theory. Meanwhile, Strauss moved away from the original approach to data analysis toward a more detail-oriented, orderly, and structured approach (Moore, 2009). He suggested that the interpretation of data should be ongoing and theory should be continuously refined (Moore, 2009). Due to the split between Glaser's and Strauss' viewpoints, Grounded Theory remains somewhat ambiguous (Moore, 2009). It is important to point out, however, that the ambiguity lies in the methodological approach to Grounded Theory rather than its epistemological or ontological origins (Moore, 2009).

In the more recent years, Anselm Strauss collaborated with Julie Corbin to modify Grounded Theory (Moore, 2009). Corbin, a family nurse practitioner and a clinical instructor in community nursing, has spent many years in qualitative methodology and sociology research (Strauss & Corbin, 1998). She shared Strauss' interest in creating a structured approach to data analysis (Moore, 2009). Together, they created what may be the most structured approach to Grounded Theory (Moore, 2009). Their book *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory* (1998), was used as a sole guide to data analysis and theory formation in this study.

Grounded Theory was chosen because the goal of this study was to find a tangible explanation, either partial or complete, of current MH nursing education trends in Ontario's baccalaureate nursing programs. Structured methods, such as those presented in Strauss and Corbin's version of Grounded Theory, offered a clear way to generate results that are more objective and concrete than the results generated by other qualitative methods. Their approach was easy to follow and gave

the researcher the freedom to use only those elements of data analysis that the researcher found necessary. The next few paragraphs will present the methods of Grounded Theory that were used in this study. A summary of these methods is presented in Appendix I.

Data Analysis According to Grounded Theory

Just as is the case with all qualitative research methods, the results arise from and depend on the interplay between the data and the researcher (Strauss & Corbin, 1998). It would be naïve to claim that the researcher was able to dispose of her personal beliefs during the analysis process. However, before any data analysis took place, the researcher set out to become aware of what her position was on the subject matter.

The researcher is a registered nurse currently working in an acute adult MH inpatient unit and the MH emergency unit. This specialty area was chosen accidentally. During her final year of undergraduate nursing education, the researcher lost the lottery for the placement of her choice which was the neonatal intensive care unit. Seeing that MH nursing had many spots open, the researcher took up MH nursing placement as she enjoyed her initial MH nursing experience in the second year of the program. After a six-week placement in acute adult MH inpatient unit, the researcher, who was initially interested in neonatal nursing, switched direction to become a MH nurse. This experience is the basis of many of the researcher's questions and assumptions.

As a researcher, it is important to have a clear understanding of what assumptions drive the study. What is seen as the 'truth' by the researcher is

important as it will directly affect the results of the study. These beliefs were identified and then written down to remind the researcher of potential bias. Such a technique helped to distinguish between the real meaning of participants' responses and the meaning that the researcher is leaning towards (Strauss & Corbin 1998).

In this study, there were three main underlying assumptions. It was assumed that a mandatory stand-alone MH theory component and a mandatory MH clinical practicum are more beneficial to nursing students' learning experiences. The variation in MH nursing education across the province of Ontario was considered to be a contributing factor in the identified undervaluing of MH nursing and the lack of MH knowledge and skills of some new nursing graduates. Ultimately, this affects the quality of patient care and the nursing profession as a whole. Nursing professors' attitudes about the importance of MH nursing were also assumed to be a factor in these inconsistencies in MH education.

Microanalysis: open-coding. Line-by-line microanalysis was the initial step in the data analysis as prescribed by Grounded Theory; each line of transcribed data was analyzed. Microanalysis was done through open-coding, which is the process of breaking up raw data into small fragments. These fragments consist of single words, phrases, or even sentences that carry a single idea, thought, or information segment. Each such fragment is referred to as a code. Codes are the smallest building blocks of theory. Open-coding is referred to as 'open' because absolutely all of the data is subjected to this process. This step enabled the researcher to understand all data collectively and objectively, and prepare it for further analysis and comparison.

Once raw data was fragmented, each fragment was assigned a code name. Descriptive coding was avoided and theoretical coding was maintained. For example, a descriptive code name may be 'negative experience'. 'Negative' makes this code name descriptive. Meanwhile, a theoretical name for the same code may be 'personal experience' or just 'experience'. The latter code name is more abstract and does not bias the researcher as to whether this experience is regarded as negative or positive. Assigning abstract names instead of descriptive names also allowed the researcher to avoid an excessively large number of codes. For example, there were 'positive attitudes', 'negative attitudes' and 'neutral attitudes' on a subject. That is three different codes. Instead, the same three codes were placed together into one group of codes named 'attitudes'. This decreased the number of codes from three to one. Code names were primarily used to organize similar fragments of data together. Microanalysis and open-coding reduced the volume of data by retaining only those pieces of data that carry information. Starting in the microanalysis phase, codes or fragments of data deemed to contain relevant information were written out. This marked the beginning of a classification scheme. A classification scheme is analogous to a mind-map. It was expanded and modified throughout the analysis process. New codes and categories (groups of codes, which will be discussed later in this chapter) were added. The purpose of a classification scheme was to organize the data in a systematic and logical manner. It allowed the researcher to gauge variation in data and potential relationships between codes quadrant-to-quadrant. It also provided a general overview of the results, or the 'big picture'. Please refer to Appendix J for a succinct version of the classification

scheme. This appendix lists major categories that emerged in each question and some of the data fragments, or codes, that represent each category. Because code names were used for organizational purposes only, they were omitted from Appendix J. Data within this classification scheme will be reviewed in chapter five and analyzed in chapter six.

From the beginning of data analysis, as advised by Strauss and Corbin (1998), thoughts, interpretations and mini-theories of even the smallest fragments of data were written out in a series of memos. Questions and ideas for further investigation were also written out in these memos. Memoing is analogous to making side-notes. Just like the classification scheme, memos were reviewed and modified throughout the analysis process. They were beneficial during the concept integration and theorizing stages of data analysis (chapter six). The process of memoing gave the researcher a chance to consider alternative meanings of participants' responses. The tone or mood of the data was also noted in memos, and in cases where the responses were unclear, this information was used as a cue to help explain participants' interpretations of their experiences. According to Corbin and Strauss (1998), memoing is what gives theory depth and insight.

Selective-coding and categorizing. At this point, all transcribed data was fragmented, assigned abstract code names and noted in the classification scheme. The researcher then used her own knowledge of the subject matter, as well as what was emphasized by participants in the interviews and uncovered in the literature review, to remove irrelevant information and thereby further reduce the volume of data. This was done by selecting some codes and leaving out others.

Codes that frequently reappeared, were emphasized by the participants, provided insight into any one of the four research questions or were simply unanticipated were selected for further, selective-coding. As the name suggests, selective-coding was done only on selected parts of the data. The researcher continuously revisited extracted data and raw data to pick out as much relevant information from transcripts as possible. Once no more new information could be retrieved, the results were said to have reached 'theoretical saturation'. Such a 'back-and-forth' approach to data analysis, where the researcher goes back and forth between raw data and already extracted codes, ensures that the researcher does not rely on their initial, likely bias meaning of what he or she observes.

Next, similar selected codes within each quadrant were grouped together to form categories. Essentially, a category is a frequently appearing concept. Categorizing was done separately, question-by-question, quadrant-by-quadrant. There was no inter-quadrant mixing of data. Selected codes are examples of the idea that the category captures. They are data fragments that represent that particular concept, or idea. The categories and some of the corresponding selected codes are listed in the succinct version of the classification scheme in Appendix J. Each category is reviewed in chapter five and analyzed in chapter six of this thesis.

Asking questions and making comparisons. One of the hallmarks of Grounded Theory is continuous comparison by way of asking questions and making comparisons. Asking questions and making comparisons is not a stage in data analysis, but rather an approach that is applied from beginning to the end of this process. Continuously asking questions is a way to discern a range of potential

meanings contained within the words used by participants and to generate theory that is truly reflective of reality. Some of the questions that were asked were abstract questions, meant to elucidate a response. For example, ‘is the participant suggesting that there is not enough staff to teach MH nursing?’ Another type of questions that was asked during the data analysis is theoretical questions. Theoretical questions are meant to deepen one’s understanding of what has already been clearly articulated. These questions put the researcher in the right frame of mind for the next step - theorizing. An example of a theoretical question may be ‘why is it the case that there are not enough educators with MH experience?’ Asking theoretical questions requires the researcher to look at other categories, or same categories but in other quadrants to find the answer. In a sense, theoretical questions compare and connect available data, look for relationships, and attempt to explain them.

Category integration and theorizing. During the integration and theorizing stage of data analysis, selected codes and categories were reassembled in a meaningful manner that would allow the researcher to answer the research questions outlined in chapter one of this thesis. They were examined in a new order and therefore from a different perspective. The researcher looked at how major categories relate to each other within the same quadrant and to same categories of other quadrants. Similarities and differences between categories of different quadrants are of utmost importance as differences indicate differences in opinions among nursing professors representing different program-types and similarities indicate no difference in opinions among nursing professors representing different

program-types. Such interpretation was crucial to theory generation. Essentially, this step involved reviewing large portions of information altogether, as a big picture.

The classification scheme (see Appendix J) was of most importance during this stage as it contains a large amount of data which is well-organized and ready for comparison. Reviewing memos enabled the researcher to give depth and variation to theory being formed. The research questions posed in the beginning of the study were answered during this stage of data analysis. They served as a guide to generating theory. Answers to the research questions built the theory that the researcher has generated.

Once theory was formed, all of the data analysis steps were reviewed to ensure that nothing was missed or misinterpreted. Memos and side-notes were reviewed. In this manner, the researcher ensured that the theory is truly grounded in data.

Verification of theory. According to Strauss and Corbin (1998), the 'fit' of theory to data from which it arises is the main measure of validity. Therefore, there are no validity tests per se. During data collection and analysis processes, the researcher kept in close contact with her supervisor who has extensive experience in nursing education and MH research. Emergent codes, categories, and their significance were discussed. Ideas and thoughts were exchange and compared to collected data.

To verify the validity of the results, the research questions were reviewed. How well the theory answers these questions given available data, gauges the

validity of the generated theory. Next, the classification scheme along with the codes and categories were reviewed in the context of the generated theory and alternative explanations to the research questions were considered. Finally, the elements of generated theory were compared to the literature review findings that are outlined in chapter two. Reassessing generated theory in the context of supporting and conflicting literature findings adds to the validity of theory.

Chapter Five: Results Overview

Chapter five consists of two parts. The first part provides the reader with an overview of the MH nursing component in the baccalaureate nursing programs in Ontario, general participant characteristics, and participant characteristics quadrant-by-quadrant. It also highlights noted differences in participant demographics between quadrants. The second part provides an overview of the categories which emerged from the raw data.

Mental Health Education in Ontario's Baccalaureate Nursing Programs

As mentioned in the Design and Methodology chapter, each nursing degree-granting institution's on-line calendar was examined to identify the structure of the MH nursing component in their nursing programs. Most institutions had this information readily available on their website; institutions that did not were contacted directly, via e-mail (please see Appendix C). There was no reluctance on the part of contacted institutions to provide this information.

Each program was placed into one of the four quadrants of the two-by-two table which may be found in Appendix D. The quadrants include the following: 'mandatory stand-alone MH theory course and a mandatory MH clinical practicum' (quadrant A), 'mandatory stand-alone MH theory course and an elective/absent MH clinical practicum' (quadrant B), 'threaded MH theory and a mandatory MH clinical practicum' (quadrant C), and 'threaded MH theory course and an elective/absent MH clinical practicum' (quadrant D).

There are over twenty-two nursing programs in Ontario and fourteen educational institutions that grant baccalaureate nursing degrees to graduates in

these programs. The reason for the discrepancy between the number of educational institutions and the number of programs is that many schools offer more than one nursing program, or 'stream'. These 'streams' are comparable in terms of content and structure. However, they differ in the location where they are offered (i.e. different campus, college, etc.), the sequence of courses (some compressed programs allow for students to take more than the widely accepted course load of five courses per semester) and the length of study.

Nine nursing schools provide their students with a mandatory stand-alone MH theory course or mandatory MH theory that is presented as a distinct part of another course, as well as a mandatory MH clinical practicum (quadrant A). Two schools provide their students with a mandatory MH theory course and offer MH clinical practicum as an elective (quadrant B). There are no nursing schools in Ontario that provide threaded MH nursing theory and a mandatory MH nursing clinical practicum (quadrant C).Three programs provide their students with threaded MH theory and an elective MH clinical practicum (quadrant D).

In summary, 11 institutions offer mandatory MH nursing theory as either a stand-alone course or as part of another course. Three institutions offer theory as threaded. In terms of clinical practicum, five institutions offer MH nursing as an elective and nine institutions offer it as a mandatory part of the curriculum. Thus, the majority of Ontario's baccalaureate nursing programs offer a mandatory stand-alone MH theory course and a mandatory clinical practicum in this area.

General Participant Characteristics

Altogether, 105 nursing professors from four institutions were invited to participate in this study. Twenty-two individuals, which is approximately 20 percent completed the survey and therefore agreed to take part in this study. Three of the participants withdrew from the study after completing the survey. A timing issue was given as the reason for two of the cases of voluntary withdrawal, and unexpected circumstances on the part of the participant was the reason given for the third voluntary withdrawal. A total of 19 participants were interviewed.

All but one of the participants were female. All participants were 36 years old or above. In terms of education, all held a master's or a doctoral degree in nursing or another discipline. Teaching experience ranged from '2-5 years' bracket to '>25 years' bracket. Participants held one of the following three positions within their institution – tenured professor (nine), assistant professor (seven), or sessional instructor (six). Two out of the 19 participants reported MH as their area of expertise. The remaining 17 identified medical/surgical, ICU, community nursing, or other specialty as their area of expertise. Eight participants reported having worked in the area of MH. In terms of their own MH nursing education, 17 participants had received both MH theory and MH clinical practicum. Two participants had neither MH nursing theory nor MH nursing clinical practicum as part of their undergraduate education. So half of the interviewed nursing professors had worked in MH, almost all had MH education as undergraduates, and only two identified it as their area of expertise.

Before comparing respondents' demographics it is important to review the timing of the study. Due to extraneous factors, participants representing quadrant A were contacted in June and July. Participants representing quadrants B and D were contacted in October and November. It is difficult to gage what impact timing has had on the response rates. It may be that collecting data during summer months when nursing professors may be away on be holidays balances out data collection in the middle of a semester, when nursing professors may be busy with midterm exams. The anticipated number of participants per quadrant that was set at the beginning of the study (n ≥4) was met in each quadrant. Please refer to Appendix K for demographic information on each quadrant.

The University of Ontario Institute of Technology was included in the review of Ontario's nursing programs and the two-by-two table. However, as it was not first of the randomly selected list of programs in its quadrant, it was not part of this study.

Quadrant A participant characteristics. As mentioned above, quadrant A ('mandatory stand-alone MH theory course and mandatory MH clinical practicum') represents nine institutions. Institutions within this quadrant offer MH content in what the researcher considers to be the most structured and obvious manner.

This quadrant was represented by four nursing professors. What sets quadrant A apart from the other two quadrants is that it delivered the highest response rate of all three quadrants (50 percent; 4/8) with the lowest withdrawal rate of zero. It may also be important to note that although this quadrant boasts a high response rate, the number of invitations to participate that were sent out to this quadrant (eight) is substantially lower in comparison to other quadrants (42 and 55). The

reason for this is that only eight nursing professors' e-mail addresses were available on that program's website. The target number of participants per each institution (n=4) was achieved on the first attempt, hence no repeat invitations were sent out.

All participants representing quadrant A were female and 46 years of age or older. Half of the participants held a master's degree with the other half holding a doctoral degree. Teaching experience of interviewed nursing professors ranged from '2-5 years' to '16-to-20 years'. One participant in this quadrant reported MH as their area of expertise; the other three reported 'other' as their area of expertise. Two participants representing quadrant A reported work experience in MH. All participants had MH theory and MH clinical practicum as part their undergraduate nursing education. Please refer to Appendix K for full demographic information on participants representing quadrant A.

Quadrant B participant characteristics. Quadrant B ('mandatory stand-alone MH nursing theory course and an elective MH nursing practicum') was represented by two institutions. Forty-two invitations to participate were sent out and nine nursing professors expressed their interest in participating. There were two voluntary withdrawals after completing the survey and before the actual interview process. For this reason, only seven nursing professors were interviewed. The response rate before withdrawals was 21.4 percent. Most participants were 46 years of age or older. One participant was male. In terms of education, four participants held a master's degree. Three participants held a doctoral degree. Participants' teaching experience ranged from the '2-5 years' bracket to '>25 years' bracket. One of the seven participants reported work experience in MH nursing. In

terms of MH education as a student, all but one reported having had both MH theory and clinical practicum. Please refer to Appendix K for full demographic information on quadrant B participants.

To compare the MH nursing component in this quadrant to that of quadrant A, the only marked difference is that institutions within this group offer MH clinical practicum as an elective rather than as a mandatory part of their program(s). This may also be regarded as 'absent' clinical practicum because unless the student specifically requests it, they will not be provided with such an experience. For this reason, programs in this group are regarded as having a less structured MH nursing component than the programs within quadrant A. Unlike quadrant A, where one participant indicated MH nursing as their area of expertise, none of the participants in quadrant B reported MH nursing as their area of expertise. This quadrant also had the lowest initial response rate and initially the target participant number ($n \geq 4$) was not achieved. For this reason, both schools in this quadrant were included in the study. As well, repeat invitations were sent to both schools. The withdrawal rate was the highest in this quadrant with two participants withdrawing after completing the survey. Because of the settings of the survey engine, it was not possible to remove the demographic information of these participants from the combined demographics. As a result, quadrant B demographics, shown in Appendix K, still contain the withdrawn participants' data. The reasons given for withdrawal were a scheduling issue and an unexpected life circumstances.

Quadrant C participant characteristics. Quadrant C ('threaded MH theory and a mandatory MH clinical practicum') does not contain any institutions.

Quadrant D participant characteristics. Quadrant D ('threaded MH theory and elective MH clinical practicum') was represented by three institutions. Fifty-five invitations to participate were sent out in this quadrant. Nine nursing professors indicated their interest in participating in the study (16.4 percent response rate). Because one person withdrew due to time scheduling issues, only eight participants were interviewed. As in the case of the withdrawn participants in quadrant B, the withdrawn participant's demographic data was not removed from the general group demographics. All participants in this quadrant were women; the majority were aged 46 or older. Two thirds held a doctoral degree and one third held a master's degree. Fifty-five percent indicated work experience in MH and one participant reported MH nursing as their area of interest. In terms of MH education, all but one participant received both MH nursing theory and clinical practicum as students. For full demographic information on participants representing quadrant D please refer to Appendix K.

In comparing this quadrant to the other two, this quadrant presents MH content in the least structured manner. There are three additional factors that set this quadrant apart from quadrants A and B. First, quadrant D had the lowest response rate (16.4 percent before withdrawals). However, because a large number of invitations were sent to this institution, the target number of participants was reached after the initial invitation. Second, five of the participants reported having work experience in MH, which is higher than in the other two quadrants. And

finally, participants from this quadrant had the most teaching experience. Over 70 percent of the participants reported having taught for more than 21 years.

As mentioned previously, the sample size was 19. Participant demographics may be found in Appendix K. One of the most striking differences between the three quadrants is the response rate. Quadrant A, which contains the most obvious MH nursing education component, boasts the highest response rate (50 percent). The lowest response rate was seen in quadrant D (16.4 percent) where MH nursing content in presented in the least structured manner (threaded theory and elective clinical practicum). Quadrant D boasts the greatest number of participants (nine) while the lowest number of participants (four) is in quadrant A. The possible significance of this date will be discussed in detail in chapter six. Another demographic that stood out is that over half of quadrant D participants reported having work experience in MH nursing and over 70 percent reported more than 20 years of teaching experience, which is significantly higher than the other two quadrants.

Interview Questions and Appearing Categories

This part of chapter five reviews categories that appeared in each interview question. First, each question is reviewed in terms of the information that was sought. During the interview, some of the questions were posed along with the clarifications to eliminate any confusion and for this reason, differ slightly from those shown in Appendix H. Questions presented in this chapter are the actual questions that were posed to the participants. Next, the categories that appeared in the responses to these questions are outlined and briefly summarized. Selected

codes that make up these categories are provided as examples. Irrelevant codes that were revealed during open-coding were omitted. Please refer to Appendix J for an overview of the classification scheme. It is important to note that this chapter merely presents the data that was gathered through the processes of open-coding, selective-coding, and categorizing. Differences and similarities between categories of different quadrants are pointed out; however, these differences and how they relate to each quadrant and provide insight into the research questions are discussed in the next chapter.

Interview question one categories. The first question asked the following: 'Could you describe the MH education you received as a student? So to clarify that, did you receive both theory and practice, was the MH component mandatory or elective, what was the length of your education and what were your thoughts about the placement'. Essentially, this question asked participants to recall their experience with MH education as students. Having participants recall their MH nursing experience illustrated the 'criteria' they used as nursing students to gauge what makes a MH education experience positive or negative.

This question generated the following three categories: 'Ambiguity - Mental Health vs. Psychiatric Nursing' category, 'Interpretation of Own Mental Health Education' category, and 'Basis for Interpretation' category. The 'Ambiguity - Mental Health vs. Psychiatric Nursing' category surfaced in quadrant A ('mandatory stand-alone MH theory and mandatory MH clinical practicum') only. The other two categories were present in all three quadrants.

Ambiguity - mental health vs. psychiatric nursing. This category, specific to quadrant A, raises an important question. Is MH nursing and psychiatric nursing the same subject? Nursing professors' thoughts on this subject were split into two groups. Some saw the two as essentially the same entity. This was evident when both terms were used interchangeably by the respondents and with the same frequency. Some explicitly stated that MH nursing is simply a newer term for psychiatric nursing. The following selected codes illustrate this notion:

> "Back then, it was considered under the psychiatry";
>
> "It was called psychiatric nursing".

Others, however, consider the term 'mental health nursing' to be a different, and perhaps more inclusive term than 'psychiatric nursing'. This is illustrated in the following selected codes:

> "We had no sense of mental health (…) it was psychopathology we were learning";
>
> "[There was] no continuing focus either on general mental health or a very specific psychiatric hospital-based nursing";
>
> "When I think of mental health, I think of problems such as anxiety, and depression, and sometimes substance abuse, communication issues, you know? Where [as] I think [of] psychiatry as a psychotic illness such as schizophrenia, certainly some of the depressions".

This category also draws attention to an issue that arose from the very beginning of the interviews in all three quadrants. Responses to questions about MH nursing demonstrated that participants can have very different interpretations of

MH issues and illnesses. Some mentioned stress and anxiety when discussing MH concerns, while others spoke about schizophrenia and mania. The significance of these different interpretations is discussed in chapter six.

Interpretation of own mental health education. This category appeared in all three quadrants. All but two participants (both from quadrant B) had MH nursing theory and MH nursing clinical practicum as part of their undergraduate education. Nursing professors' descriptions of their individual MH nursing education experience included:

> "I remember thinking: 'I shouldn't be here";
>
> "I quickly learned it wasn't something I would like to do";
>
> "I thought it was amazing";
>
> "I quite enjoyed it in some ways".

There was an even mix of positive and negative feelings across all three quadrants. Participants' answers indicate that most participants were confident about how they felt about their experiences. There appeared to be little or no doubt in their minds as to whether it was a positive or a negative experience.

Basis of interpretation. This category includes factors that formed participants' evaluation of their MH education. In other words, participants' answers reflect certain 'criteria' that they used to evaluate their own MH education. No difference in codes was noted between quadrants. Here are some selected codes that exemplify factors that shaped participants' experiences:

> "I don't think we were prepared to be dealing with high acuity patients";

> "We really had no background into the normal or into the variance of normal…we understood mental health as those who are very, very ill";
>
> "The fact that the ward was locked…was somewhat intimidating";
>
> "I had a really great preceptor";
>
> "I had two rotations, both inpatients, one on a psychiatric ward of a large hospital, and the other one in a psychiatric hospital…so I had a really good exposure".

Interview question two categories. This question asked the following: 'What does your program offer in terms of mental health nursing theory and practice to help prepare students to be holistic practitioners in whichever setting they choose to work in? And by 'your program', I mean the program in which you currently teach'. The goal of this question was to probe participants' awareness and knowledge of the MH nursing component in the program in which they teach. Program specifics including the number of hours and weeks were compared to what is known about the program from either the on-line calendar or via the program information request e-mail. This information is omitted from Appendix J as it poses a confidentiality risk.

The following two categories emerged: 'Relating to Mental Health Component' and 'Familiarity with Own Mental Health Component'. 'Relating to Mental Health Component' codes surfaced predominantly in quadrant B (mandatory stand-alone MH theory course and elective or absent MH clinical practicum). A code that would belong to this category surfaced once in quadrant D. Considering the

number of participants representing each quadrant, as well as the number of times this code surfaced in each quadrant, it was deemed insignificant information in quadrant D and therefore not included in the classification scheme presented in Appendix J. The second category, 'Familiarity with Own Mental Health Component' surfaced in all three quadrants.

Relating to mental health component. This category demonstrates participants' perception of how they see themselves in relation to the MH component. In other words, this category shows how participants perceive their involvement with the MH education that is provided in their program. It is an interesting category as it was not anticipated when considering the question. Most answers to question two from the participants in quadrant B contained one or more statements that fell into this category. Similar statements were also noted in other parts of the interviews of participants in this quadrant. Here are some of the selected codes that make up this category:

> "I am not the person to ask because I am not involved in that program. I cannot answer the question related to that because I am not involved in that [mental health education]";
>
> "I don't teach that component";
>
> "I don't teach in the mental health".

Such statements often preceded participants' responses; however, participants are generally aware of the MH nursing content in their program.

Familiarity with own program. Selected codes in this category were indicative of participants' knowledge of their own program in terms of MH content.

To compare the three quadrants, quadrant A responses gave very specific details about how many hours and weeks of MH education are provided in their program. This is likely due to the fact that quadrant A contains programs with a clearly structured MH nursing component. Participants also emphasized that MH is also a thread in a number of their courses. Here are some of the selected codes in this category in quadrant A:

> "Well, it's one semester, and it's offered [X] hours a week, and a placement of a [X] hours in long-term care and in acute care mental health, and community health";
>
> "It's a thread, as well as a course";
>
> "[Mental health] also encountered in other courses".

Quadrant B selected codes in this category were similar to those in quadrant A. The only marked difference was that some of the participants reported MH clinical practicum as mandatory when it is actually an elective. This is the only quadrant where such an inaccuracy was noted. Here is what some of the professors representing quadrant B had to say:

> "They have an intensive (…) course and then a clinical practice";
>
> "It's a [X] week course…students, still, have a thirteen week placement in a mental health type setting".

Selected codes in quadrant D answers were much more subject-related. Participants were able to name which aspects of MH nursing students cover in their studies. This is likely because this program offers MH nursing content threaded

through the curriculum rather than in a structured mandatory stand-alone format. Here are a few examples:

> "We learn basics (…) signs of depression, referral services";
>
> "We study anxiety, how to do interviews and communicate (…) MMSE";
>
> "Mental health issues that we study include anxiety, depression, suicide (…) We look at individuals living with schizophrenia".

Interview question three categories. The third question asked the following: 'Some programs offer a separate course on mental health nursing, while other schools provide this content as 'threaded' through the curriculum. Similarly, some programs provide clinical practicum in mental health nursing, while others do not or offer it only as an elective. How important do you think it is for nursing students to have a separate course dedicated to mental health nursing and a clinical placement in this area?' This is an important question as it aligns closely to one of the research questions in this study. The intent was to probe participants' personal as well as professional opinions about the manner in which MH nursing content should be provided. Participants' answers focused on education theory, nursing theory, ongoing curriculum debates, and their personal thoughts and experiences. A number of interesting arguments arose in the data pertaining to this question, which will be examined in detail in the discussion chapter.

Two categories emerged from the data pertaining to this question. These are the 'Perceived Level of Importance' and 'Rationalizing'. The former category is the direct answer to the question, while the latter category justifies participants' answer. Resulting codes in the 'Perceived Level of Importance' category were

generally reflective of a program's structure. In other words, nursing professors appear to think that the appropriate level and structure of MH nursing education that should be provided is similar to what the program they teach in provides. Because these two categories are closely connected, they will be reviewed together.

Perceived level of importance and rationalizing. To compare responses in quadrants A, B and D, it appears that as the nursing program's design becomes less structured, participants' responses were less uniform in what they see as the best approach. All responses in quadrant A were in favour of a mandatory theory course and a mandatory clinical placement. Some of their responses included:

> "I support offering it as a required stand-alone course";
>
> "It is essential that [students] do get a placement and get the theory";
>
> "It's important to get both".

In quadrant B there was a greater mix of responses with regard to the importance of having a mandatory stand-alone MH theory course and a mandatory clinical. Most participants voiced the need to have both theory and clinical as mandatory, stand-alone course in the following ways:

> "Extremely important";
>
> "Very important";
>
> "All programs need both".

However, unlike quadrant A, some participants representing quadrant B felt that having a theory course only will suffice:

> "It's important to have a theory course, but in terms of a clinical placement…I don't think it's necessary";

> "I am not sure about the clinical (…) I would like a separate course on it".

Here is how participants from quadrants A and B rationalized their beliefs:

> "At least they're exposed to it";
>
> "If we just leave it to the faculty to thread it in their courses, because every faculty has different teaching styles, it will be lost";
>
> "It may get lost in programs where it's threaded through (…) [Students] are not able to necessarily put all the pieces together";
>
> "It's unique (…) in terms of learning, practicing, how to communicate (…) how to diffuse a volatile situation";
>
> "When you get the theory and not the practicum, obviously you're not competent (…) it doesn't help you understand that as a career choice";
>
> "Being able to apply all those concepts in a practical setting (…) is important".

Quadrant D showed the most varied selected codes. Some participants felt that having a mandatory MH nursing component is important, while other participants were sceptical of this notion. Some examples of what participants had to say included:

> "It would be helpful for students [to have both mental health nursing theory and clinical] (…) even if they are not going to practice in mental health specifically";
>
> "It would be great that all students went through that [mental health nursing course and clinical]";

> "I don't think that it should be a required course (…) but there should be a supplementary way that the students can fit this material if he or she wants to pursue that";
>
> "I am not convinced [theory] should be mandatory";
>
> "I think [mental health theory] is quite important (…) whether it's mandatory that they have practicum there I don't know".

Here is how participants representing quadrant D rationalized their thoughts regarding a separate MH nursing component:

> "Students are ill-prepared to integrate the mental health needs into care";
>
> "[Students] all work in acute care environments, and a lot of the patients in particular , have many issues that go the whole scope of mental issues that they have to deal with";
>
> "I don't believe our students are disadvantaged because they do not have a specific course that teaches mental health or practicum where they can practice skills related to mental health".

Interview question four categories. Question four asked participants the following: 'What do you see as difficulties associated with including more MH in the curriculum?' A predictable category that emerged from the data is the 'challenges' category.

Challenges. A large number of challenges were reported by participants from all three quadrants; there was no notable difference between quadrants. For

this reason selected codes in the 'challenges' category will be discussed altogether irrespective of the specific quadrant.

Some of the challenges include finding placements, sharing placements with other colleges and universities, having the right faculty expertise, clinical faculty-to-student ratio, and availability of registered nurses willing to mentor students. Timeframe and curricula are described as 'jam-packed' and 'always crowded' and as such it is difficult to add more content.

Some participants mentioned less foreseeable challenges. One participant explained that therapeutic approaches to mental illness and the nature of psychiatry in general are changing in a way that decreases access to practicum placements:

> "In my day, which was over [X] years ago, they had [people with mental illness] institutionalized – a lot of psychiatric treatment and care. So there were a lot of inpatient units and inpatient hospitals. That has changed, and a lot of care is provided in the community (…) for example, we can send one or two to a community placement, but in the old days you could sent a group of six or eight students to inpatient mental health units".

Another interesting point that was mentioned is that students may not be interested in MH:

> "Having the students who want to go into that area, because of stigmatization [is another challenge]. Stigma and the media have a lot to do with it. Any time there is an incident, it's all over the front pages

> without giving some of the background understanding of people’s behaviour”.

Another participant stated the following:

> “And it’s not a ‘sexy topic’. I think, you know, early on, a lot of people, not all of them, but you know, a fair amount of nurses come in, you know, looking for that excitement and skills, the thrill of the ER or the operating room, you know, paediatrics, etcetera. Whereas working with mental health may not be as ‘sexy’ or inviting as (…) or they may not see the need for it”.

There is also a concern that health care facilities may have strict rules and regulations that may limit what students can and cannot do. For example, some facilities do not allow students to administer medication.

Interview question five categories. The fifth question asked the following: ‘Do you feel that your program adequately prepares students who are interested in a career specifically in mental health?’ This question asks for participants’ assessment of the MH nursing education that is provided in their program. Just like question one, this question invited participants to share the ‘criteria’ they use to gauge the quality of MH nursing education from an educator’s point of view. The significance behind this will be discussed in chapter six.

This question generated five categories. ‘Perceived Level of Preparedness’ and ‘Basis for Perceived Level of Preparedness’ categories surfaced in all three quadrants. The ‘Program vs. Program’ category was noted only in quadrant A and the ’Self-Identifying’ and the ‘Generalist’ categories emerged in quadrant D only.

Perceived level of preparedness. This category contains data that illustrates participants' thoughts about how well their students are prepared for a career in MH, if that is something that interested them. All of the participants in quadrant A were certain that their program provides their students with adequate MH education. Some of their answers included:

> "Yes [it does]";
>
> "[The program] introduces them [to mental health]";
>
> "The program provides them with basic competencies";
>
> "We provide them with opportunity to be prepared".

Unlike quadrant A, quadrant B responses indicate that not all interviewees perceive their students' preparedness in terms of MH nursing as adequate. Some of the selected codes that make up this category in quadrant B include:

> "We do give students a good foundation (…) overall we do a pretty good job";
>
> "It certainly gives them the ability to see whether that would be something they would like to choose (…) we are giving them foundation knowledge";
>
> "There is room for improvement";
>
> "Probably not (…) but I would also qualify that and say that we don't prepare students for other specialties".

There were also a few participants in quadrant B who were unable to answer this question:

> "Not sure";

> "Cannot answer that question";
>
> "I am unable to answer this question because I am not sure of the exact content in our program".

Quadrant D is quite similar to quadrant B in terms of the mix of positive and negative codes:

> "Yes I do";
>
> "Satisfactory";
>
> "In our program we do a good job";
>
> "Coming out of the program – no, not right away";
>
> "As much as it prepares them for other specialties. Is it adequate - I don't know";
>
> "I do have concerns that students can go through virtually the whole program and may not have any clinical experience and have minimal theoretical learning associated with mental health".

As highlighted above, participants representing quadrant A appear to believe that their program adequately prepares their nursing students for a career in MH. Quadrants B and D responses differed as there were a few participants who felt that there is room for improvement. Some of the participants in quadrant B could not answer this question as they were unsure of either the MH content or how well it prepares their students.

Basis for perceived level of preparedness. This category highlights participants' reasoning and demonstrates how, from an educator's point of view, the quality of an education experience is assessed. Selected codes in this category were

comparable across all quadrants. The main criteria that were used are students' feedback and their increased interest in this area of nursing:

> "Based on the senior year people who want to do psychiatric nursing";
> "Few students say to me that they would really like to [do a] practicum in mental health and they enjoyed the course that was offered";
> "Many students select it as a pre-grad preceptorship experience or seem to go on into".

One participant mentioned the high passing rate of CRNE in their school as an indication of adequate MH education:

> "Our students have a very high [CRNE] pass rate so in that sense they do get a basic overall preparation".

Program vs. program. This category is exclusive to quadrant A. When evaluating the quality of their nursing program, participants frequently referred to other programs. In all cases, participants felt that the program they teach in is superior to others. A few examples include:

> "[Mental health education] in this program compared to other programs – adequate";
> "Many students have chosen [mental health], surprisingly enough, which is not that case, I think for other programs";
> "I think our students are better prepared (…) I think our students have a better understanding".

Self-identifying. This category is exclusive to quadrant D. It captures the notion of students knowing where they would like to work and based on that being

able to tailor their nursing education to that area. The selected codes that make up this category include:

> "If the students self-identify to be interested in mental health – yes…if they early-on self-identify";
>
> "If the students are really keen they can shape their learning through various courses and clinical experience";
>
> "Students who have identified in early years interest in pursuing mental health, those options are there for them";
>
> "Students who have a specific interest in mental health (…) we do a fairly good job of helping those students to get mental health experiences".

The significance behind this category and how it fits within the context of programs found in quadrant D will be discussed in chapter six.

Nurse-generalist. This category appeared in all quadrants. Selected codes within this category illustrate participants' beliefs about the objective of the nursing programs in Ontario. Examples of their responses include:

> "[Students are] adequately prepared to be novices";
>
> "Like most programs in Canada, the emphasis is really one of nurse-generalist (…) and with that comes some dilution of skills";
>
> "I don't think nursing programs should prepare nurses for a specific stream period (…) We are responsible for educating students at a generalist level";
>
> "They need to be beginning practitioners in a whole variety of areas".

Interview question six categories. The sixth question asked the following: 'Do you think there should be a greater or lesser emphasis on mental health nursing education, or do you feel that the amount of mental health nursing education provided to nursing students today is adequate?'. This was an opportunity for interviewees to share any final thoughts or concerns about current MH nursing education either in their program or generally. The major category that was noted in all three quadrants was the 'emphasis' category, which holds fragments of responses that directly answer interview question six.

Emphasis. When asked about whether participants feel the need to increase, decrease or maintain the emphasis on MH nursing education in nursing programs as is, some participants answered generally, while others provided answers specific to their program. No major differences between quadrants were noted. Although a few participants were unable to answer the question, the vast majority reported that their program provides students with adequate MH education. However, they also felt the need to increase the emphasis and this was echoed even by participants in quadrant A ('mandatory stand-alone MH theory course and mandatory MH clinical practicum'). Here are some selected codes that make up this category:

> "There could be room for improvement";
>
> "There's need for more in-service";
>
> "We could do a better job (…) You really gain an appreciation when you get the theory and then go and practice";
>
> "I don't know. I really can't comment on that as I am not aware of other programs";

> "I cannot answer that question as I am not sure of the exact content in our program".

This chapter provided an overview of categories that were extracted from data. These categories were presented according to the respective questions that were asked. Selected codes that make up these categories were presented as illustrations of what participants had to say. Some of the differences and similarities among quadrants were noted as well. All of the data presented here can also be found in Appendix J. The next chapter focuses on analyzing the similarities, differences and relationships between categories and quadrants, while also answering the research questions.

Chapter Six: Theorizing and Discussion

This chapter begins by analyzing the variances in participant demographics that were outlined in the previous chapter. It then proceeds to answer the research questions through category comparison and data integration. The theorizing stage of Grounded Theory involves re-assembly of the data fragments (selected codes and the categories they collectively make up) in a meaningful manner to answer research questions (Strauss & Corbin, 1998). Next, theory (Strauss & Corbin, 1998) explaining nursing professors' views on MH nursing education in the baccalaureate nursing programs of Ontario and how they may contribute to apparent variations in content and delivery format of the MH nursing curriculum is created (Strauss & Corbin, 1998).

In Grounded Theory, final theory must be grounded in the available data. To increase the validity of this study's results, the elements of final theory were compared to the literature findings discussed in chapter two of this study. Analyzing theory in the context of supporting and conflicting literature findings strengthens the theory (Pandit, 1996).

Variation in Participant Demographics

As outlined in the previous chapter, three major differences between the quadrants' participant demographics were noted. These differences include nursing professors' response rate, work experience/expertise in MH nursing and teaching experience.

The highest response rate was seen in quadrant A (50 percent: 4 responses to 8 invitations), the middle response rate in quadrant B (21.4 percent: 9 responses

to 42 invitations), and the lowest response rate in quadrant D (16.4 percent: 9 responses to 55 invitations). Considering this demographic in the context of the structure of the MH nursing content of the programs in each of the quadrants raises an interesting possibility. Quadrant A (programs with the most structured and obvious MH nursing component – a mandatory stand-alone theory course and a mandatory clinical practicum) showed the highest response rate. Analogous to this, quadrant D (programs with the least structured and obvious MH nursing component - threaded theory and elective/absent clinical practicum) showed the lowest response rate. This may be indicative of a bias among nursing professors. In other words, it could be that nursing professors from programs committed to providing MH nursing as a separate and mandatory part of their program reflect this same commitment and so were more interested in participating in a research study on this issue. While nursing professors from programs where MH nursing may not be seen as a priority may share a similar perspective and their view was reflected in declining to participate in this study. Another possibility is that the nursing professors who recognize MH nursing is not a strength of their program, and yet they feel that it should be more of a priority, were reluctant to talk about this 'weakness' in their program. On the other hand, such variance in response rates may simply be due to the fact that invitations were sent out during different times of the school year or the fact that schools received varying numbers of invitations, which may misrepresent the actual response rate.

The second major difference in participant demographics is participants' work experience and expertise in MH nursing. In quadrants A and D 50 and 55% of

participants respectively report having worked in MH nursing, meanwhile only 10% of participants in quadrant B report work experience in this area. Similarly, there are no participants in quadrant B who consider MH nursing as their area of expertise, while in quadrants A and D 10% and 11% of the respondents respectively, report MH nursing as their area of expertise. Combined, these two demographics make quadrant B participants the least immersed in the area of MH nursing as compared to those in quadrants A and D.

In terms of teaching experience, 66% of quadrant D participants report teaching experience greater than 20 years. Meanwhile, there are no participants in quadrant A and only 33% of participants in quadrant B, who report teaching experience of that length. According to this demographic, participants in quadrant D are the most experienced in terms of teaching and the associated responsibilities which include curricula planning.

Due to the small sample size, the demographic data collected for this study may not be representative of actual faculty demographics in each quadrant/institution. For this reason, the differences in participant demographics between quadrants are in no way representative of the actual differences between quadrants; they simply demonstrate participant pool differences. To sum up the differences in demographics, participants from quadrant A boast the highest response rate (quadrant D the lowest), participants from quadrant B are the least familiar with MH nursing, and participants from quadrant D boast the most teaching experience (quadrant A the least).

Answering Research Questions and Theorizing

The research questions that this study set out to answer are as follows: (1) how do the nursing professors describe the mental health education and clinical practice they received as undergraduate students?; (2) what are nursing professors' views regarding the importance of including mental health nursing as a mandatory stand-alone part of the nursing curricula?; (3) how do nursing professors perceive their program prepares students for a variety of settings in terms of mental health education?; and (4) to what extent is the emphasis that is placed on mental health education in baccalaureate programs related to the nursing professors' experiences and attitudes towards mental health nursing? Essentially, the last research question brought together answers to the first three questions and in this way generated a theory which provides insight into how nursing professors' views may affect MH nursing education in the baccalaureate nursing programs of Ontario.

Each research question was answered by looking at emergent categories. Special attention was paid to differences between categories among quadrants. As mentioned earlier in this chapter, categories were compared to each other and across quadrants. Potential relationships between categories and program-types being represented were investigated.

Research question one. How do the nursing professors describe the mental health education and clinical practice they received as undergraduate students? The significance of this question is that the participants' attitudes towards and thoughts about MH nursing may have taken root in their own MH education as students. For most participants, this experience was likely their first encounter with MH services

and as such left a lasting impression. Given the demographic data, all but two (17 out of 19) participants received both, MH theory as well as MH clinical practicum, in their undergraduate education. Two participants, one from each of the quadrants B and D, did not receive any MH nursing education. It was of interest to see what the nursing professors' perceptions of this experience were, whether they differed among quadrants and what their evaluation of this experience was based on. The significance behind this was that the criteria participants used to evaluate their MH education as students would later be compared to the way they evaluate the MH education in their program as educators to see whether there is a gap between what students value in their MH education and what MH educators feel is important in MH education.

The first research question parallels the first interview question fairly closely. To answer it, two categories from the first interview question were reviewed: 'Interpretation of Own Mental Health Education' and 'Basis of Interpretation'. The third category, `Ambiguity – Mental Health vs. Psychiatric Nursing' did not provide any relevant information for answering the research question.

The 'Interpretation of Own Mental Health Education" category was present in all three quadrants. It captured nursing professors' thoughts about the MH education they received as students. No difference in responses between quadrants was noted. Each quadrant contained a mix of responses. Some participants enjoyed this experience very much while others did not. Some found it exciting in terms of it being a 'unique' experience; meanwhile others felt that it was 'not helpful' and

'quickly learned that it is not something [they] want to do'. Participants were certain in their feelings about it; there was little hesitancy in their responses. A few participants could not remember their feelings with regard to the MH education they received as undergraduate students.

There was no significant difference between quadrants in terms of how many nursing professors received MH education as students, the kind of education they received (theory vs. practice) and how they felt about it. This suggests that their experiences in MH as students are not related to the nursing program in which they teach. So if there is a difference in nursing professors' attitudes and thoughts about the importance of MH education in nursing programs, it is unlikely that this difference is due to participants' own MH nursing education as undergraduate students.

The 'Basis of Interpretation' category was also present in all three quadrants. Participants' interpretation of their experiences was based on a number of factors. Aspects such as the level of preparedness and comfort in MH prior to beginning clinical practicum, understanding the spectrum of mental illness and its effects on an individual, the quality of the clinical instructor, preparedness for new/unexpected clinical settings (i.e. locked ward) prior to clinical practicum, and the ability to observe a diverse range of MH settings (MH emergency, acute inpatients, community MH, etc.) have all affected nursing professors' perceptions of their MH education. Just like in the previously discussed category, there was little difference between the quadrants in terms of the answers that were provided.

The most frequently re-appearing selected codes that make up this category revolve around the level of preparedness. Nursing professors felt that limited theoretical preparation such as knowledge of the effects of mental illness on a person, therapeutic communication techniques, and other skills left them 'ill-prepared' for clinical practice. Interestingly, one participant stated that having little insight into the 'variance of normal MH' made it difficult to study about mental illness. This suggests that it may be beneficial for students to begin MH education by first learning about what constitutes a healthy mental state and then learning about mental illness afterwards.

Participants who were not made aware of the common characteristics of a MH unit, such as it being locked and the potential for physical restraints, felt overwhelmed and apprehensive. This, in turn, led to the experience being perceived as negative. Another concern was the acuity level of the setting in which participants had their clinical practicum. Many professors felt that as students they were placed in too acute an environment. They reported feeling unprepared to care for some of the patients they were assigned. This also led to an experience being perceived as negative. One participant described an event where their patient had committed suicide and unfortunately, this student was not provided with the appropriate skills to handle such an event. This underlines the importance of providing students with appropriate tools for coping with unexpected events such as the suicide, sudden decompensation, or elopement of a patient, and meeting a former patient outside of the clinical setting.

So to summarize the answer to research question one, nursing professors across all three quadrants reported a mix of experiences, from positive to negative. No difference between quadrants was noted in either category ('Interpretation of Own Mental Health Education', and 'Basis of Interpretation'). None of the participants were uncertain or neutral in how they felt about the MH education they had received as students. A few individuals could not recall their feelings on this subject as it was a long time ago. Nursing professors' evaluation of what made these experiences either positive or negative points to adequate theoretical preparation as an absolutely necessary part of a 'positive' clinical experience.

Research question two. What are nursing professors' views regarding the importance of including mental health nursing as a mandatory stand-alone part of the nursing curricula? This question is central to this study. By examining participants' personal and professional thoughts about the importance of a mandatory stand-alone MH nursing component and comparing it to the program in which they teach, it may be possible to find out whether the variation in MH education is in some way related to nursing professors' varying opinions about it. To answer this question, the following categories were analyzed: 'Ambiguity – Mental Health vs. Psychiatric Nursing' (interview question one), 'Perceived Level of Importance' (interview question two) and 'Rationalizing' (interview question three).

The 'Ambiguity – Mental Health vs. Psychiatric Nursing' category surfaced in quadrant A only. As mentioned earlier in this chapter, this category, although exclusive to quadrant A in this study, may be present in all three quadrants in

reality. This category captured the concept of uncertainty as to whether MH nursing and psychiatric nursing are indeed the same subject. If not, then what exactly is the difference? Such ambiguity may be present among nursing professors of other, or even all, nursing programs. It is interesting that such a notion is present in quadrant A, as programs within this quadrant have a structured MH component. At first glance, such program design was suggestive of a clearly identified content. Regardless of whether it is MH nursing or psychiatric nursing the researcher was anticipating participants would be certain about which subject is taught within their program. Appearance of this category when looking at nursing professors' thoughts on the importance of including MH nursing as a mandatory stand-alone part of the curricula in a nursing degree program of study is very important.

This category points to discord among the nursing professors as to whether MH nursing and psychiatric nursing are the same discipline. Participants were split into two groups. Some felt that the two terms refer to the same subject. These participants pointed out that MH nursing was previously referred to as psychiatric nursing. So for them, MH nursing is a newer, perhaps more politically correct term. As well, nursing professors who fell into this group used the terms interchangeably throughout the interview without pointing out any distinction between the two. Other participants referred to the two terms as different subjects. For example, one participant stated that as a student, they were learning psychiatric nursing as opposed to MH nursing. This suggests that the two are different.

This category brings up a number of important questions. Is MH nursing and psychiatric nursing really the same subject? If the two are in any way different, then

what are these differences? And finally, can such a lack of clarity lead to problems with prioritizing MH content and in turn, planning curriculum?

Participants' interpretation of what constitutes a psychiatric/mental illness and which skills/tools are required to care for patients differed as well. Some participants mentioned stress, poor adaptation and dementia as examples of mental illness and described relatively universal nursing skills such as therapeutic communication and relationship-building as those used in MH nursing. Other participants mentioned schizophrenia, depression and suicidal ideation and more MH specific skills such as recognizing early signs of mental illness and the ability to resolve a volatile situation. Indeed, all of the above mentioned illnesses and skills fall under the psychiatry/MH umbrella. However, if a nursing professor considers a highly anxious patient to be a person with mental illness and believes the necessary skills to provide students with are relationship-building and therapeutic communication, they may feel that this can be accomplished in a general, medical-surgical setting. In contrast, a nursing professor who thinks of schizophrenia when they hear psychiatry/MH nursing and believes their students require skills such as recognizing paranoid behaviour or someone with a serious suicidal intention, is more likely to feel the need for a separate MH nursing course and a mandatory clinical practicum. This suggests nursing professors' perceptions of mental illness and what skills are required for MH nursing may affect the manner in which they feel this topic should be taught.

Such a difference may be due to the varying professional backgrounds of the nursing professors. For example, nursing professors may have come in contact with

different types of psychiatric/mental illnesses, which required different care. It may be that these experiences contribute to the varying thoughts about what constitutes psychiatric/mental illness and the skills that are most frequently used in this area. Another contributing factor is the changing nature of psychiatry. In fact, this point was brought up by one of the participants from quadrant B. In the last few decades, there have been great changes in what is considered a psychiatric/mental illness, available treatments and the approach to patient care. These changes contribute to the ambiguity as to what constitutes psychiatric/mental illness, which illnesses are encountered most frequently and which skills are required to care for patients with these illnesses. There has also been a major shift in patient care delivery, from lengthy admissions to inpatient institutions to primarily community-based care. This last point contributes to the challenges in providing students with placements and will be discussed later in the chapter.

To summarize, it may be nursing professors' own interpretation of what MH or psychiatric nursing is that shapes their opinion about the importance of a mandatory stand-alone MH component. Could this contribute to the variations in MH education among nursing programs in Ontario?

The 'Perceived Level of Importance' category surfaced in all three quadrants. It captured nursing professors' thoughts on the importance of offering a mandatory stand-alone MH component in baccalaureate nursing programs. The codes in this category differed from quadrant to quadrant. Generally, participants' thoughts on this issue mirrored their own program's structure.

All of quadrant A responses were strongly in favour of having both theory and clinical practicum as mandatory and stand-alone. This is not surprising as this quadrant represents schools with this exact structure. What was unexpected is the fact that many of the participants emphasized the need to thread MH content through the program in addition to having a mandatory stand-alone theory course. This is an unexpected finding because this study is based on an assumption that a separate MH component will ensure adequate MH education. However, nursing professors in a program with this exact structure stated that this format of MH education alone may not suffice and MH content should also be threaded throughout the program to ensure that the students are able to apply MH knowledge in all areas of nursing.

Quadrant B responses were similar to quadrant A responses in that many of the nursing professors representing this quadrant strongly favoured the need for a mandatory stand-alone theory course as well as a clinical practicum in spite of the fact that their program does not offer a mandatory practicum in this area. Once again, threading MH concepts in addition to a mandatory stand-alone MH component was mentioned on a few occasions. What sets this quadrant apart from quadrant A is that unlike in quadrant A, two professors felt that having a theory course only is sufficient. Mental health clinical practicum was deemed to be unnecessary by these two participants. Such responses in this quadrant are not surprising as quadrant B programs offer a mandatory stand-alone theory course without a mandatory MH clinical practicum.

Quadrant D provided the greatest mix of responses. Some participants felt that having a mandatory stand-alone clinical in this area would be a good idea. Others, however, felt that having a mandatory clinical practicum is unnecessary. Some participants stated that threaded theory and an elective practicum, just like the program in which they teach, is the ideal program structure. One participant felt that while there is no need for a mandatory MH course, offering it as an elective for students who are interested in this area or are looking to try a new area of nursing would be beneficial. To compare responses in this quadrant to responses in quadrants A and B, there was the least consensus among participants on this issue.

The ‘Rationalizing’ category contains selected codes that illustrate participants’ reasoning behind their responses in the category above. Rather than reviewing this category quadrant by quadrant, participants’ rationalizations will be reviewed cross-sectionally, according to what they feel is the optimal way to provide MH nursing education. In other words, reasoning behind similar responses will be looked at together.

To review the previous category, nursing professors’ thoughts were reflected in one of the following statements: it is important to have both, mandatory stand-alone MH theory and MH clinical practicum; it is important to thread MH theory through the rest of the curriculum in addition to a separate MH course; it is important for MH theory to be mandatory and stand-alone while clinical practicum may be elective; it is not important to have a mandatory stand-alone MH course or a clinical practicum, threaded theory and an elective clinical practicum will suffice.

Participants who felt that it is important to have mandatory and stand-alone theory and clinical practice justified their reasoning by suggesting that the alternative approach, threading the theory, may result in some of the MH concepts being lost. Below are some of the selected codes that illustrate this reasoning:

> "If we just leave it to the faculty to thread it in their courses, because every faculty has different teaching styles, it will be lost";
>
> "[Mental health theory] may get lost in programs where it's threaded through";
>
> "Students are not able to necessarily put all the pieces together";
>
> "It's really more challenging when they get these threaded concepts to consolidate that information";
>
> "When you get the theory and not the practice, obviously you're not competent (…) it doesn't help you understand [mental health] as a career choice".

One of the concerns with the threaded format lies with the fact that each nursing professor has their own teaching style and uses their own discretion. This inevitably results in some variation in MH education and there is the potential for the MH nursing concepts to get lost. For example, nursing professors trying to include MH concepts related to their subject may feel that their course is too full and decide to leave that concept(s) out. Or, they may feel that it is irrelevant/does not fit with the rest of the content or they may simply forget to include the concept(s). This was the main concern among nursing professors who felt that having a mandatory MH theory course is necessary. However, it may be argued that having a

separate MH course does not necessarily guarantee that none of the theory will be left out.

One of the nursing professors who felt that it is important to thread MH theory through the rest of the curriculum in addition to having a separate MH course explained this idea in the following way:

> "The downside is that using that approach [mandatory stand-alone mental health component] sometimes means that (…) that content and that kind of experience can be ignored in other areas of the program (…) we need to see this area of nursing potentially as being an area that (…) involves not just an identified, or patients who are identified through (…) hospitalizations or specialty units, but rather that we recognize that patients with (…) mental health and psychiatric concerns are also found in med-surg areas and in maternal child areas and in cardiac areas, and so on. And that we can't compartmentalize patients. And so, always when you make, an experience a required experience (…) you also have to pay attention to the rest of your program that you also bring in that content through in other areas of the program".

Below is an excerpt of a response to interview question one provided by a quadrant A participant. Because this stage of data analysis allows for data to be re-assembled in a way that the researcher finds meaningful, the piece below provides a good illustration of the concept being reviewed:

> "Everything that we were learning was about psych and mental health and the care of patients with mental health conditions and otherwise. So

> we were able to focus very specifically on those pieces as opposed to having it kind of intermingled and meshed in other courses. Now, that said, there were times when, you know, we were doing other clinicals, med-surg for example, and we had patients who had mental health conditions [but] it was a bit hard for us to kind of translate those experiences across to patients with multiple conditions".

So there is a concern about MH content being seen as unrelated to the rest of the nursing curricula and also that nursing students will have difficulty transferring this knowledge to other specialties such as maternal/child or medical/surgical nursing. Threading MH theory in addition to having a separate course is thought to be a way of addressing this concern.

Nursing professors who feel that it is important for MH theory to be mandatory and stand-alone while clinical practicum may remain elective emphasized that they believe that MH is indeed an increasing concern. They stated that because it's an area unlike any other specialty, it does require a separate course. However, in terms of a clinical practice, some nursing professors felt that because other areas of nursing such as maternal/child and occupational health do not have a clinical placement in their program it would also be acceptable to not have a placement in a MH setting. .

Nursing professors who feel that it is not important to have a mandatory stand-alone MH course and clinical practicum, and that threaded theory and elective clinical practicum will suffice believed that the students are able to pick up the required MH knowledge and skills from a variety of non-MH specific courses and

clinical settings. Some of the professors from quadrant D (threaded MH theory and elective/absent MH clinical practicum) stated that they do not feel that their students are at a disadvantage because they do not have a MH theory course or clinical practicum. Here is what one professor stated:

> "[Students] all work in acute care environments and a lot of the patients in particular have many issues that go the whole scope of mental issues that they have to deal with".

A concern with this reasoning is that there is no guarantee that all of the students will have a chance to work with a person with mental illness and practice their MH nursing skills. Additionally, threading MH concepts throughout the program makes it difficult to ensure that students have been provided with sufficient MH knowledge and skills before they encounter a patient with MH issues and that the skills they have been provided with meet the needs of that particular patient. It may be the case that a MH patient is encountered before students are ready, meaning that not all of the MH concepts have been covered. Another professor, also from quadrant D expressed the following concern:

> "From our course, I do have concerns that students can go through virtually the whole program and may not have any clinical experience and have minimal theoretical learning associated with mental health".

To return to the earlier discussed category of 'Ambiguity – Mental Health vs. Psychiatric Nursing', it may be that professors who hold this belief (having a mandatory stand-alone MH theory course and a clinical practicum is not important; threaded theory and elective clinical practicum will suffice) think of MH disorders

such as anxiety and depression and skills such as therapeutic communication rather than, say, mania and recognizing signs of suicidal ideation.

The category of 'Rationalizing' provides valuable insight into nursing professors' reasoning about what is the best way to provide students with the MH nursing content. Nursing professors' reasoning may originate from their work and teaching experience as well as their own beliefs rather than from their own MH education, given that there were no differences between quadrants in terms of participants' education and their feelings about it. To answer the question about why some nursing professors feel the need for a MH clinical practicum while others find that MH concepts can be learned in general medical/surgical settings, it may be worthwhile to investigate which mental/psychiatric disorders and which MH nursing skills nursing professors see as a priority for the students to learn.

To summarize the answer to the research question two, nursing professors' perceived importance of a mandatory stand-alone MH theory course and a clinical practicum vary between quadrants and therefore programs. Comparing professors' attitudes towards this matter in the context of the quadrant they represent, it has become evident that collectively, as a group, their attitudes closely parallel the manner in which MH content is offered within the program in which they teach. Nursing professors representing quadrant A (MH theory and clinical practicum are mandatory and stand-alone) were in agreement about the need to keep it this way. Some professors suggested threading MH concepts throughout the rest of the program, in addition to having a separate MH course. Quadrant B (MH theory is mandatory and stand-alone, and clinical practicum is elective/absent) had similar

responses to quadrant A. However, some participants in this quadrant were doubtful that the clinical practicum should be mandatory. Nursing professors in quadrant D (MH theory is threaded and clinical practicum is elective/absent) were the most varied in their responses. Some of the professors indicated that they would like to see this content separate. Others felt that only the theory should be mandatory and then there were those who felt that having the MH component threaded with an elective clinical practicum will provide nursing students with an adequate level of MH nursing education and experience in this area. Nursing professors appeared most concerned that with threaded MH content, concepts might be missed by either the students or the professors. In programs with a mandatory stand-alone MH theory course and clinical practicum the concern was that without also having MH content threaded through the program students may not be able to relate, or transfer, their knowledge to other clinical settings.

Research question three. How do nursing professors perceive their program prepares students for a variety of settings in terms of mental health education? This question sought to gauge nursing professors' knowledge of what is offered in terms of MH nursing in the programs in which they teach. The answers to this question also revealed what participants deem to be indicative of how well their program prepares their students for a variety of settings in terms of MH education. The following seven categories provided data to answer this question: 'Relating to Mental Health', 'Familiarity With Own Program', 'Perceived Level of Preparedness', 'Basis for Perceived Level of Preparedness', 'Program vs. Program', 'Self-Identifying' and 'Emphasis'.

Although the 'Relating to the Mental Health Component' category appeared only in quadrant B (mandatory stand-alone MH theory course and an elective/absent MH clinical practicum), it is noteworthy as it captures participants' perception of their ability as educators to discuss the MH nursing component of their program. Most nursing professors in quadrant B pointed out that they do not teach in the MH area and are likely not the right person to be speaking to about the MH nursing component. Such statements preceded the participants' actual responses to the posed question, which may suggest that these participants see themselves as detached from the MH component in the curriculum. They may have wanted to preface their answer because they were not confident in their knowledge of the MH nursing component of their program. This may also suggest that not all of the faculty actively participate in curriculum planning, especially when it comes to areas of the curriculum they do not perceive to be their area of expertise.

The 'Familiarity with Own Program' category contains data fragments that demonstrate participants' knowledge of the MH component in the program in which they teach. This category emerged in all three quadrants. Professors' responses were compared to what was previously known about their program's structure. All participants in quadrants A (mandatory stand-alone MH theory course and a mandatory MH clinical practicum) and D (threaded MH theory and elective/absent MH clinical practicum) were unmistakably aware of what their program offers in terms of MH nursing. In other words, they were able to describe their program's MH component accurately. In contrast, two participants representing quadrant B (mandatory stand-alone MH theory and elective/absent clinical practicum) erred

when describing the MH component in their program. They believed that the clinical practicum is mandatory in their program. In reality, however, the MH clinical practicum is not mandatory; students may choose it as an elective in the upper years of the program. Interestingly, this is the quadrant in which most participants pointed out that they do not teach in the MH area and therefore are not the right people to answer this question. It may be that the interviewees were indeed not sure what their program offers and justified this uncertainty by pointing out that they do not teach MH nursing.

Most participants' responses were very detailed in terms of how many hours and weeks are spent on MH nursing (quadrants A and B). Quadrant D (threaded MH theory and an elective/absent clinical practicum) professors were able to recall which MH topics are covered within their course or another course that they know of. This suggests that although there is no mandatory stand-alone MH course in programs within this quadrant, the MH component is prominent enough for the nursing professors to provide examples of what is taught. Although this may be due to self-selection bias or participants' preparation for the interview, as they were aware of the subject matter, it may also be indicative of participants' actual awareness of what is offered within their program in terms of MH nursing.

'Perceived Level of Preparedness' category captured nursing professors' perceptions of how prepared the students are for a variety of clinical settings in terms of MH nursing. This category was present in all three quadrants. Nursing professors representing quadrant A were the most certain that their program provides students with adequate MH education for whichever nursing career they

choose. This was evident in that each participant stated this. Professors in both quadrants B and D showed a mix of responses. Although many of them stated that their program does provide good MH nursing education, there were those who voiced the need for improvement. None of the participants indicated that their program does a poor job of providing students with MH education. This may be indicative of faculty feeling an allegiance to the nursing program they are teaching in, which in turn influences their views of the program.

The 'Basis for Perceived Level of Preparedness' category captured data fragments which demonstrate the principles by which the nursing professors gauge how prepared their students are for a variety of settings in terms of MH nursing. This category also emerged in all three quadrants and no difference was noted in terms of how their level of preparedness was assessed.

The criterion that was cited by nearly all of the nursing professors as indicative of students' preparedness level is their choice of MH as a clinical placement or a career choice. As one professor explained, such a choice may speak to students' level of comfort and skill in that area. An interesting point for discussion was brought up by a professor who spoke about a high passing rate on the Canadian Registered Nurse Exam (CRNE) in their school. According to this professor, passing the CRNE is indicative of preparedness for practicing nursing, whatever the specialty area may be. However, contact with the Canadian Nursing Association via e-mail, confirmed that the CRNE is a general exam that does not look at each area specifically. A general passing score (the number of correctly answered questions regardless of the subject matter) for a particular CRNE is set by a panel of

experts representing every provincial and territorial jurisdiction that uses the CRNE. So indeed, it may be possible for a student to pass the CRNE without answering all of the MH nursing related questions correctly.

Interestingly, the criteria that the nursing professors use to evaluate the MH nursing component in their program were different from the criteria they used to evaluate their own MH nursing experience as a student. Adequate preparation for a new environment, having nursing professors with the appropriate expertise, understanding the multiple effects of mental illness on a person, and exposure to a variety of placements, which were important to the nursing professors when they were students, were not mentioned now as aspects of a successful MH nursing education process. This may demonstrate that when assessing the quality of a program there is a gap between students' and professors' perspectives. Could involving students in curriculum planning help close this gap and in turn improve nursing education? To the researcher's surprise, meeting the National Competencies set out by the College of Nurses of Ontario (CNO) for entry-level Registered Nurse practice was not mentioned as one of the criteria for ensuring adequate MH nursing education. This may be indicative of the notion that MH nursing is a specialty. However mental illness is not exclusive to the area of MH nursing. Mental health challenges are encountered in all areas of nursing and all nursing students require the knowledge and skills to provide competent, holistic care.

'Self-Identifying' is a category exclusive to quadrant D. This category captured the notion of students needing to identify their interest in MH nursing as a

required condition to shape their own learning and in turn receive adequate MH nursing education. Consequently, this suggests that without self-identifying MH nursing as an area of interest early on in the program, students may not receive appropriate MH education. This may speak to nursing professors' possible lack of awareness of the high prevalence of mental illness and the fact that it is encountered in all areas of nursing. No matter where a nursing graduate chooses to work, they must have the knowledge and experience in dealing with MH challenges. For this reason, it is concerning that MH nursing education may be left up to students' discretion. This may cause nursing to lose potentially successful MH nurses and to leave some nurses out of an area of practice that they could have found fulfilling. Here are some of the responses that the nursing professors from quadrant D provided when asked about how well their program prepares students in terms of MH education:

> "Students who have a specific interest in mental health (…) we do a fairly good job, I think, of helping those students to get mental health experiences";
>
> "If the students are really keen they can shape their learning through various courses and, clinical experience to be able to pursue their interest";
>
> "If they haven't thought about it before-hand, and if they just end up deciding on mental health, let's say in the second term of their last year, they may not be as adequately prepared as they should be".

This category draws attention to the following question. Can a student with no/minimal exposure to MH nursing identify it as an area of interest? Given the program structure in quadrant D, students may not think about MH nursing as a career choice. Are nursing students in this program able to see this field as an entity of its own? And finally, is it the students' responsibility or the nursing professors' responsibility to ensure programs provide adequate nursing theory and practicum experiences to prepare graduates to meet the current health care trends and needs of Canadians? The response has the potential to affect nursing curriculum. For example, if it is partially the students' responsibility, then they should be informed from the very beginning that it is up to them to explore the various areas of nursing and tailor their education to their own interests. However, if it is the nursing professors' responsibility, they should be made aware of this and ensure they introduce their students to as many potential fields of nursing as they can.

The 'Program vs. Program' category appeared in quadrant A (mandatory stand-alone MH theory course and mandatory MH clinical practicum) only. It captures the notion of using other programs as gradient for comparison of one's own program. So rather than focusing on the National Competencies (the competencies required for entry-level registered nurse practice), the professors are using what they perceive as the success level of other schools to compare the success of their own program in terms of how well it prepares students for MH nursing.

Participants in this quadrant (mandatory stand-alone MH theory course and a mandatory clinical practicum) felt that their program provides better MH nursing

education than other programs. Here are a few examples of codes within this category:

> "In this program compared to other programs [mental health education is] adequate";
>
> "Many students have chosen that [mental health as a senior preceptorship] surprisingly enough, which is not the case, I think for other programs";
>
> "I think our students are better prepared (…) I think our students have a better understanding".

The 'Generalist' category appeared in all three quadrants. It represents the idea that nursing programs are to prepare students to be 'general practitioners'. This means that the students are to be prepared for a variety of settings rather than for one specific setting. What the nursing professors often refer to as 'specialization' is to be done on-the-job or through extra courses. One participant spoke about the 'dilution of skills' that comes with such an approach to nursing education. Students, needing to be ready for a wide variety of areas, develop only basic competencies in each area. This means that only the minimum knowledge and skills that are required to be effective in a particular area are taught. This dilution of skills applies to all specialties in nursing, however, to a varying extent. It is not clear whether the varying manner in which MH nursing is taught across the province of Ontario is similar to the way in which other specialty areas, such as maternal and child health for example, are taught. The presence of this category in all three quadrants suggests that although program structure varies across programs, all programs aim

to produce 'nurse-generalists', not nurses specialized in any one area. This excludes the possibility that any variation in program objectives is the source of the identified variations in MH nursing education in Ontario's baccalaureate nursing programs.

The 'Challenges 'category captured the issues that the nursing professors may face in trying to provide their students with MH education, both theory and clinical practice. This category surfaced in all three quadrants. No significant difference was noted between quadrants, and therefore program-types. This illustrates that the challenges are similar across programs. Most of the challenges that were cited were predictable.

The challenges that were noted most frequently revolved around the logistics of clinical placements and finding the faculty with the right expertise. In terms of clinical placements, many professors reported that there are not enough of them for the number of students that they need to accommodate. Clinical settings must now be shared by a number of nursing programs. The inpatient units may refuse, or limit, the number of students they will take due to issues with understaffing. With deinstitutionalization and the push to move MH/psychiatry services out into the community, which was touched upon earlier in this chapter, the number of available in-patient practice settings has decreased dramatically. Therefore, students may now be required to go well outside of their geographic boundaries for MH nursing placements.

A less-frequently cited challenge was health agencies restricting students' scope of practice while in the clinical setting. For example, there are some MH

units/hospitals in Ontario that do not allow students to administer medication. This, in particular, may have a negative impact on students' perceptions of what MH nursing is. The less tangible nature of most of the MH nursing skills may make them appear non-existent to students. Taking away students' ability to administer medication may make MH nursing appear 'slow' or even 'boring'.

In terms of MH theory, finding staff with a MH background and having the appropriate teaching resources were cited as the main challenges. One participant spoke about other nursing specialty areas having 'teaching kits' designed for nursing professors with limited expertise in that area. Such teaching kits include a course outline, required theory concepts, and exercises for students. However, according to the same participant, no such teaching kit is available for MH nursing. It may be worth investigating whether indeed, there are no such teaching aides available for MH nursing, whether they are not accessible, or whether the nursing professors are simply not familiar with them.

Other challenges that were mentioned include students' lack of interest in this area. Nursing professors speculate that it may be due to the media portrayals or the few skills that MH nursing is assumed to require:

> "The media has a lot to do with it. Anytime there is an incident (…) it's all over the front pages without giving some of the background understanding of people's behaviour";
> "It's not a 'sexy topic' (…) A fair amount of nurses come in, you know, looking for excitement and skills, the thrill of the ER".

Because the challenges were so similar among quadrants it is unlikely that any of the inconsistencies in MH education among nursing programs in Ontario are due to the various challenges facing nursing programs.

The category of 'Emphasis' appeared in all responses to question six in all quadrants. It illustrates participants' concern about the amount of MH education that is currently provided to their students. It is directly related to the nursing professors' attitudes as it shows the connection between professors' perceptions of how much emphasis is currently placed on MH and how much emphasis they think there should be. No major differences among quadrants in this category were noted. The majority felt that there needs to be an increase in the content and the clinical exposure to MH issues not only to generate skilful nurses, but also to decrease the stigma that is still associated with mental illness. One participant pointed out the following:

> "The more experience we provide, the more exposure perhaps, the greater the understanding".

Many participants also cited that an emphasis should be placed on MH education within the general public, as those may be the views that the students take with them into clinical setting. Some nursing professors were unsure about whether there should be a change in the emphasis on MH nursing. These participants stated that they do not possess the required knowledge to comment on this.

In summary, this research question sought nursing professors' thoughts about how well their program prepares their students for a variety of clinical

settings in terms of MH education. To answer this question, nursing professors had to demonstrate a certain level of familiarity with their program. All but two nursing professors, both of whom were from quadrant B (mandatory stand-alone MH theory course and elective/absent MH clinical practicum), were aware of the MH component in their program. Because these two participants were incorrect in their description of the MH component, their perceptions of how well their students are prepared in terms of MH education are likely misguided.

Nursing professors representing programs with a mandatory stand-alone MH theory course and a mandatory MH clinical practicum (quadrant A) are in agreement that their program provides students with adequate MH education. In fact, a few of them indicated that their program does a better job in MH education when compared to other programs. Nursing professors representing programs with a mandatory stand-alone MH theory course and an elective/absent MH clinical practicum (quadrant B) and threaded MH theory and elective/absent MH clinical practicum (quadrant D) also believed that their programs do a good job in MH education. However, unlike in quadrant A, some of the participants in both quadrants B and D indicated that there is room for improvement. However, a few professors from quadrant D (threaded MH theory and elective/absent clinical practicum) pointed out that they do not believe that their students are at a disadvantage in terms of the MH education they receive even though their students do not have a MH course or a clinical placement in this area.

The criteria on which the nursing professors based their evaluation are similar in all three quadrants. The most commonly stated indicator of adequate MH

nursing education was students' interest in this field, either as a preceptorship placement or as a career choice. Nursing professors' criteria for the evaluation of the quality of the MH component in their program are unlike the criteria that they used to evaluate their own MH nursing education. This, as mentioned earlier in this chapter, is indicative of a gap between what the nursing professors believe is a positive MH education and what students think a positive MH education is. Surprisingly, ensuring that the National Competencies for entry-level registered nurses outlined by the CNO are covered was not part of these criteria.

When describing the MH education in their programs, professors representing quadrant D emphasized the need for students to self-identify their interest in MH nursing in order to tailor their education in a way that will provide them with the most exposure and knowledge in this field. This notion was stated as a required condition in order for students to receive adequate MH nursing education in their program.

It is also important to mention that many of the nursing professors believed that their program should not prepare the students for MH nursing or any other nursing specialty upon graduation. Nursing graduates are generalists who should have the knowledge and skills to enter any area of nursing they wish to upon graduation. Such a belief among participants in all three quadrants illustrated that the program objectives and goals are same and thus are not likely a contributing factor in the variations in program structure. So whether the nursing professors feel that it is their responsibility to ensure that the students are exposed to as many

areas of nursing as possible, or the students', likely has an effect on program structure.

The challenges with providing MH education that were mentioned by the nursing professors were similar in all three quadrants as well. As such, they are also unlikely to be contributing factors in the variations that exist in MH nursing education in Ontario. And finally, the emphasis on MH nursing that the nursing professors hope to see in the nursing programs did not differ between the quadrants. The general consensus was that there should be a greater emphasis on MH education for nursing students as well as the general public.

Research question four. To what extent is the emphasis that is placed on mental health education in baccalaureate programs of Ontario related to the nursing professors' experiences and attitudes towards mental health nursing? This research question connects the responses to the first three research questions. Essentially, this is the main question that this study attempted to answer. To do so, the categories that were discussed in questions one through three were brought together and reviewed in the context of the impact that they may have on the curriculum. Some of these categories were then merged into themes. Themes were then divided into two groups. The first group contains themes which in this study have shown a relation to the nursing professors' attitudes towards MH nursing and, in turn, may affect the emphasis that is placed on this subject. The second group contains themes which in this study have shown no relation to nursing professors' attitudes. The term 'relation' refers to a connection that has been identified during data analysis in the form of similarities or differences between categories of various

quadrants or unexpected concepts that according to the researcher's expertise may have an effect on the research matter. Whether this relationship is causal or associative is unclear.

The answer to this question constitutes the final theory as it suggests which aspects may contribute to the varying emphasis that is placed on MH education within the nursing programs in Ontario. Because this study is based on the Grounded Theory as prescribed by Strauss and Corbin (1998), the theory is grounded in available data only. All of the themes explaining the research issue have been generated from nursing professors' responses. The next few paragraphs endeavour to answer this question through the process of theorizing as described by Strauss and Corbin (1998). Theorizing here refers to the process of identifying themes as a way of providing a possible explanation of the research issue.

The following themes have shown no difference among quadrants: nursing professors' personal MH education, the challenges encountered with the delivery of MH theory and clinical education, the emphasis that the nursing professors feel must be placed on MH education, and the program objectives. Such consistency in responses is indicative that the given themes are unlikely to be a factor in the varying emphasis that is placed on MH education in baccalaureate nursing programs of Ontario.

Emerging categories that may affect the MH education in the baccalaureate nursing programs of Ontario were combined together to form the following six new themes: 'Mandatory Stand-Alone Mental Health Component: Nursing Professors' Views', 'Relating to Mental Health Component', 'Familiarity With and Assessment of

Own Program's MH Education', 'Ambiguity - Mental Health vs. Psychiatric Nursing', 'Mental Health Nursing Education: Students' vs. Professors' Responsibility', and 'Mental Health Education Evaluation: Other Programs vs. Regulating Body Competencies'. Please refer to Appendix L for a diagrammatic representation of these six themes which according to available data contribute to variances in MH education.

'Mandatory Stand-Alone Mental Health Component: Nursing Professors' Views' is a theme illustrating that the nursing professors' perceived level of importance of having a mandatory stand-alone MH component is different between the three program-types. The nursing professors' perceptions tend to mirror their own program's structure (theory and practicum). This theme suggests the nursing professors do not see any immediate need for curriculum changes in the MH nursing component of their program. In terms of the nature of this relationship, it is unclear whether it is a causal or an associative one. In other words, it is unclear whether the nursing professors' views on MH nursing education influenced the structure of their nursing program or whether the program has shaped their views.

The second theme is the 'Relating to Mental Health Component'. This was an unanticipated theme. However, it provides insight into the research problem. It shows that the nursing professors may see themselves as detached from the MH component in their program. This theme may also suggest that curriculum planning may not be a collective faculty activity, but rather an activity done by a smaller group of nursing professors. As such, not all nursing professors' interests/beliefs may be represented in this process.

The 'Familiarity With and Assessment of Own Program's MH Education' theme highlighted nursing professors' knowledge of the program in which they teach and their thoughts about how well it prepares their students in terms of MH for whichever nursing field students choose to work in. Nursing professors' awareness of what is taught within their program is absolutely crucial to providing students with adequate MH education. Without it, the professors are unable to judge the quality of the MH nursing component of their program. Their perceptions of how well it prepares the students will influence the way in which MH education is shaped. The difference in the way nursing professors and nursing students evaluate the MH education component of their program may have an impact on nursing curricula and hence the manner in which MH nursing is taught in Ontario programs.

The fourth theme that has been shown to have an impact is the 'Ambiguity - Mental Health vs. Psychiatric Nursing'. It points out the ambiguity between MH nursing and psychiatric nursing. Are the two different or the same subject? Such uncertainty may affect the way professors prioritize MH content. As well, variance in what is understood by psychiatric/mental illness, and the skills required to take care of patients with such illnesses, may affect what curriculum is taught to students, the sequence in which it is presented and of course, the clinical placements where they are to apply their learning and practice their MH nursing skills.

The fifth theme that may affect the emphasis that is placed on MH education is the 'Mental Health Nursing Education: Students' vs. Professors' Responsibility' theme. As the name implies, this theme captures nursing professors' views about

who is primarily responsible for planning students' MH nursing education experience – the students, or the professors? Is it the students' responsibility to identify their interests and goals and plan their education accordingly? Or is it the nursing professors' responsibility to expose their students to all areas of nursing? This, once again, speaks to whether the nursing professors see MH nursing as a separate nursing specialty or part of general nursing practice. If nursing professors see MH nursing as a separate specialty it is not unusual to allow students to make the decision as to whether they would like to study this area of nursing. However, if MH nursing is considered as part of general nursing practice then it is unlikely that it will be left up to the students to decide.

The sixth theme is the 'Mental Health Component Assessment: Other Programs vs. Regulating Body Competencies' theme. When evaluating how well their programs prepare students in terms of MH education, professors may compare what their program is doing with what the other programs are doing rather than how well the competencies set out by the CNO have been met. Regardless of the program structure, comparison to other programs may not be the best curriculum evaluation method.

Final Theory

The goal of this study was to examine the nursing professors' views and attitudes towards MH nursing and MH nursing education. Upon interviewing nursing professors from four nursing programs representing three different program-types (mandatory stand-alone MH theory course and a mandatory MH clinical practicum, mandatory stand-alone MH theory course and an absent/elective

MH clinical practicum, threaded MH theory and an absent/elective MH clinical practicum), a number of categories emerged. Each category represents a notion, or an attitude. They were analyzed in terms of the similarities and differences between them and in the context of the quadrant which they represent. More importantly, the impact that each category may have on MH education was examined. Categories were divided into those which, according to available data, have little impact on MH nursing education and those which, according to the available data, have great impact on MH nursing education. The categories which have been deemed to have great impact on MH nursing education were combined to form six themes which may affect MH nursing education.

It was theorized that the following six themes contribute to the variation in Ontario's MH nursing education: the ambiguity between MH and psychiatric nursing, whether MH nursing education is primarily students' or professors' responsibility, nursing professors' thoughts about the importance of a mandatory stand-alone MH component, how they relate themselves to the MH component of their program, their familiarity with and assessment of their program's MH education, and lastly the notion of comparing MH education to other programs vs. the competencies set out by the regulating body.

To look at this theory in the context of the literature findings which were discussed earlier in this thesis, few themes parallel what has been pointed out in current scholarly literature. Most other themes require further research to investigate their validity. The theme of ambiguity and lack of clarity between MH nursing and psychiatric nursing is not been mentioned in any of the reviewed

literature. Interestingly, however, some of the studies address the subject as MH nursing, others as psychiatric nursing, and there are some that combine both terms together and address this subject as psychiatric/MH nursing. Although this may be due to the fact that the studies come from different parts of the world, it may be worthwhile to investigate this theme and its potential to influence MH nursing education.

The second theme speaks to the question of whether it is the students' or professors' responsibility to ensure that the students receive stand-alone MH education. Nursing professors representing the program where MH nursing theory is threaded and the clinical component is elective often mentioned that students who self-identify MH as their interest, preferably in the early years of their program, are provided with adequate MH education. However, it has been cited in the literature that often times MH nursing simply does not cross students' minds during their education (Hoekstra et al., 2009) , Generally, students entering nursing programs have an image of nurses working primarily on medical/surgical floors (Hoekstra et al., 2009; McCann et al., 2010). Additionally, nursing students' often perceive MH patients as aggressive and at fault for their illness (Curtis, 2007; Gough & Happell, 2009; Granksar, Edberg, & Fridlund, 2001; Happell, 2008a; Happell, 2008b; Happell & Gough, 2007; Happell & Rushworth, 2000; Happell, Robins, & Gough, 2008; Hayman-White & Happell, 2005; Hoekstra, van Meijel, & van der Hooft-Leemans, 2009; Madianos et al., 2005; Nolan & Chung, 1999; Romem et al., 2008; Webster, 2009; Wynaden et al., 2000). Although there is no literature that directly addresses this concern, the above-mentioned findings conflict with the idea

of students being able to identify MH nursing as their interest early on in the program. Given the prevalence of MH issues and the fact that nurses encounter people with mental illness in all areas of nursing, MH nursing education should not be left up to the students. A mandatory stand-alone MH component which includes both, theory and practice should be part of every nursing program.

As there were no studies addressing nursing professors' attitudes towards MH nursing or MH nursing education, there is no data supporting or challenging the following four themes: nursing professors' thoughts about the importance of a mandatory stand-alone MH component, how they relate themselves to the MH component of their program, their familiarity with and assessment of their program's MH education, and lastly the notion of comparing MH education to other programs vs. the competencies set out by the regulating body.

Chapter Seven: Final Thoughts

Chapter seven discusses further some of the issues surrounding MH nursing and presents the researcher's thoughts on this issue. As the terms 'stigma' and 'attitudes' are important in this thesis, this chapter presents the reader with the definition of each term. Following that, strengths and limitations of this study are reviewed. Next, recommendations to address the research issue and potential direction for future studies are discussed. Finally, a quick mention of researcher's personal insight that was gained from this study concludes this chapter.

According to Halter (2008), MH nurses face an 'image problem'. This image problem stems from many years of stigma towards people with MH problems that extends to those who are in close contact with them. Some experts refer to this as 'stigma by association'. Stigma by association is defined as negative attitudes towards a certain group of persons which are extended to those who are close to them (Gouthro, 2009; Halter, 2008). Stigma by association may be experienced by MH nurses, psychiatrists, and even friends and family members of mentally ill persons.

Health care professionals in fields other than MH, like the general public, hold unsubstantiated negative beliefs towards health care professionals who make the decision to practice in MH settings (Halter, 2008; McCann et al., 2009). Such a decision may be regarded as evidence of a personality or psychological flaw. According to an earlier mentioned study by Halter (2008), MH nurses and physicians may be regarded as introverted, unskilled, and lacking empathy by their

colleagues in other health care fields. In contrast, emergency room nurses are considered autonomous and skilful and paediatric nurses – caring and empathetic.

Ajzen and Fishbein (1980), define attitudes as 'learned tendencies to respond either positively or negatively in a consistent fashion towards an object, issue, or event. Attitudes are learned or developed as a result of experience and remain fairly constant in the absence of a strong reason to change them' (Happell, 2009, p. 44). As this definition points out, attitudes are learned. They are likely learned from the media and hearsay. Media depictions such as Nurse Ratched (One Flew Over the Cuckoo's Nest) where MH professionals are portrayed as anxious, controlling, uncaring, illogical, or even having a mental illness themselves contribute to such attitudes (Gouthro, 2009; Hoekstra et al., 2009). It is not surprising that numerous studies show that nursing students' attitudes towards people with mental illness mirror the attitudes of the general public (Halter, 2008; McCann et al., 2009). It is important to note that attitudes remain unchanged without a strong reason, or a push to change them. In nursing education, such a 'push' is exposure to MH, both theory and clinical practice. Without MH education in nursing programs, students' negative attitudes towards people with mental illness may remain unchanged.

Goffman (1963) defines stigma as the 'mark of discredit that sets a person apart from others'. Unlike persons with a physical illness, persons with MH problems are often discredited and their concerns dismissed. Mental illness is more difficult to relate to than physical illness, as many of us have experienced numerous physical illnesses. As well, mental illness remains a mystery to many members of

the general public. The most effective way to de-mystify mental illness is through education and exposure to individuals who have a mental illness. It is important not to mistake tolerance towards mental illness for genuine understanding and humility towards individuals living with mental illness.

It has been suggested that negative attitudes towards MH nursing are reinforced throughout nursing education and nursing professors are the perpetuators of these attitudes (Halter, 2008). An example drawn from his study was that of professors advising students to go into areas that make 'better use' of their knowledge and skills (Halter, 2008; Stuhlmiller, 2006). Interestingly, similar advice was given to the researcher when she was a nursing student. But does MH nursing really require less skill than other areas of nursing? This may be true if a very narrow definition of the word 'skill' is used. A 'skill' is often assumed to be a tangible action, one requiring an instrument or a set of instruments to complete. However, many of the skills used in MH nursing such as communication and observation skills are less tangible and do not require any instruments. Building a rapport with a newly admitted patient who is experiencing persecutory delusions, differentiating between psychotic symptoms and behavioural issues, and being able to diffuse a volatile situation in a fair and time-efficient manner are only a few of the MH nursing related skills and just like any other skill, these skills require a strong knowledge foundation and extensive practice in order to be used effectively in a MH related situation. Contrary to common belief, MH nursing requires many skills which can only be gained through theoretical education and practice. Certainly, the importance of MH nursing education is not in question. Its importance was

highlighted and emphasized by the participants in this study. However, the question remains as to what is the best way to provide MH nursing education and how to ensure that the MH education provided to nursing students is consistent across the province and the rest of Canada. This study was based on an assumption that having a mandatory stand-alone MH component is the best way to ensure adequate MH nursing education. Contrary to this assumption, nursing professors interviewed in this study pointed out a concern with this format of MH education and they suggested it may be a good idea to thread MH content throughout the program as well.

It may not be the amount of hours or the placements that need to be reviewed, but rather the approach to MH nursing education. In a study by Stuhlmiller (2006), MH component was changed from teacher-only delivery to including MH clients and MH nurses in action-oriented activities and workshops. This resulted in an increased interest in this field. Students reported being fascinated by mental illnesses and voiced the desire to learn skills that they can use in a MH setting. In addition, Stuhlmiller (2006) points out that students' anxiety needs to be 'channelled' in the right direction and used as a learning force.

Recommendations

Based on the findings of this study, a number of recommendations have been developed. These recommendations are organized according to the target audience – nursing faculty and professional nursing associations.

Nursing faculty. Nursing faculty can have an immense impact on the nursing curricula. Nursing faculty's level of participation in curriculum development and the

extent to which it is a collaborative process, will have an effect on the content and structure of the program and in turn, the competency of nursing graduates and their ability to meet the healthcare needs of Canadians. Recommendations for nursing faculty include:

- Reflect on how the personal views of individual faculty members may influence curriculum development and content in nursing programs
- Reflect on how colleagues and the structure and content of a nursing program may influence the personal views of individual faculty members
- Be knowledgeable about all aspects of the nursing program, including the mental health component
- Be actively involved in curriculum planning and development, and in ensuring that the mental health nursing component of the program reflects the mental health care needs of Canadians
- Look for opportunities to incorporate mental health concepts/principles into all years of the nursing program
- In planning and developing curriculum, focus on the competencies outlined by the professional associations and the standards established by the accrediting body rather than looking at other programs' curricula
- Promote self-reflection on mental health and illness and work to eliminate stigma among both the nursing faculty and student body
- Promote inter-faculty collaboration in order to increase the mental health awareness among all faculty and students

Professional associations. The Registered Nurses Association of Ontario (RNAO), the Canadian Nurses Association (CNA) and its associate group, the Canadian Federation of Mental Health Nurses (CFMHN) have each advocated for the inclusion of both mental health theory and practicum in nursing programs. Through collaboration and lobbying, these professional associations may become an even

greater voice for the nursing profession and be able to influence the development and content of nursing curricula. Recommendations for the professional nursing associations include:

- Follow-up on Resolution #4 ("Therefore be it resolved that RNAO collaborate with and lobby all relevant sectors of the education and health care system to advocate for undergraduate nursing programs which include a clinical practicum in psychiatric/mental health nursing as well as advocate for the development of a consistent minimum level of competency and content teaching about mental illnesses in all basic nursing programs in Ontario"), which was passed April 2008 at the RNAO Annual General Meeting

- Engage in dialogue with individual schools to discuss how Resolution #4 can be applied to their nursing curriculum

- Engage in discussions with the accreditation body (CASN) to determine how the accreditation process can ensure that mental health nursing theory and practicum are included in all nursing programs in Ontario

Limitations and Future Research

The decision to participate in this study may reflect those nursing professors' interest in MH. Therefore, the participant pool may be more representative of professors with a certain interest in this field. In terms of responses, participants may have felt the need to answer in a certain manner or to say what they feel may be expected of them. Finally, there was some discussion between participants who had been interviewed and those who were yet to be interviewed. One participant revealed that a nursing professor who had already been interviewed spoke about some of the interview questions. Therefore, some of the participants had a chance to consider the questions and to think about their answers beforehand. This may be a limitation as not all of the participants had the same opportunity. On the other hand, this illustrates that this study prompted further reflection and discussion among

nursing professors about MN nursing education and as such, it is a strength of this study.

As this is a qualitative study, transferability of results is important. Transferability refers to the degree to which the results of a qualitative study may be transferred to, or applied to, other contexts (Strauss & Corbin, 1998). Transferability of the results to other areas of nursing education or other provinces is limited but not impossible. Applicability of theory generated in this study depends on the extent to which this research issue and its setting resemble the research issue to which this theory is being applied.

The area of MH nursing education requires further research. First and foremost, the MH nursing proficiency level among nursing graduates should be examined as it may be the only way to identify whether students across Ontario and the rest of Canada have a similar knowledge base upon graduation. However, simply having a knowledge base does not necessarily generate interest in this area. As suggested in a study by Gouthro (2009), interest in MH nursing may be increased by placing greater emphasis on this subject in undergraduate nursing education. This is best done by increasing the number of theory and clinical hours spent on MH education. In the study by Curtis (2007), such increased emphasis translated into a greater number of nursing graduates choosing to work in MH settings upon graduation. For this reason, it may be worthwhile to investigate how the nursing students choose their specialty area, and what other aspects of the nursing program may trigger an interest in pursuing a particular field of practice.

There also needs to be further inquiry into which factors affect the planning and development of nursing curricula. This would strengthen the program evaluation process by ensuring changes/revisions are evidence-based. The structure and grading of the CRNE may need to be revised. It may be beneficial to structure this exam in such a way that every area of nursing that is represented on it requires a passing grade in order for a student to achieve an overall pass. There may also be a benefit to reviewing how other areas of nursing are represented in nursing programs throughout Ontario.

This study explored nursing professors' thoughts about and attitudes towards MH nursing and MH nursing education in order to determine whether these attitudes differ among professors from institutions offering programs with considerable differences in the delivery of MH content (theory and clinical practicum). Essentially, the goal of this study was not only to determine whether there is a difference in attitudes, but also to examine how varied attitudes may impact curriculum planning and contribute to the MH nursing education inconsistencies that exist among baccalaureate nursing programs in Ontario. Nursing professors have a tremendous opportunity to address both the stigma of mental illness and stigma associated with MH nursing. The results of this study may encourage nursing professors to reflect on their personal beliefs and experiences, and to consider how they may be indirectly and unknowingly influencing the nursing profession and the well-being of many Canadians.

Personal Insight

First and foremost, this study has provided the researcher with qualitative research skills, in particular, research methodology according to Grounded Theory by Strauss and Corbin. This knowledge will enable the researcher to understand other qualitative research and works based on Grounded Theory. In terms of research inspirations and future career goals, I would like to continue qualitative inquiry in the field of nursing education and MH nursing. It is part of my learning goal to review how other researchers have Grounded Theory to their work.

The researcher was also able to review different types nursing programs and program designs. As a nurse who is interested in nursing education, this knowledge is invaluable. Nursing professors' interest in this study and their positive feedback about demonstrated that MH nursing is indeed valued in nursing education. This also provided me with enthusiasm and stimulus to do more work in this direction.

The results of this study have provided me with greater insight into nursing curriculum planning, how nursing professors' views and attitudes contribute to it, and factors unrelated to nursing professors' views and attitudes that contribute to it. Most importantly, some of the assumptions outlined earlier in this thesis have changed as a result of this research.

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Appendix A

Ontario's Baccalaureate Nursing Degree-Granting Institutions

Brock University

Lakehead University

Laurentian University

McMaster University

Nipissing University

Queen's University

Ryerson University

Trent University

University of Ontario Institute of Technology

University of Ottawa

University of Toronto

University of Western Ontario

University of Windsor

York University

Appendix B

Literature Review Overview

- mental health clients notice lack of therapeutic relationships and poor communication

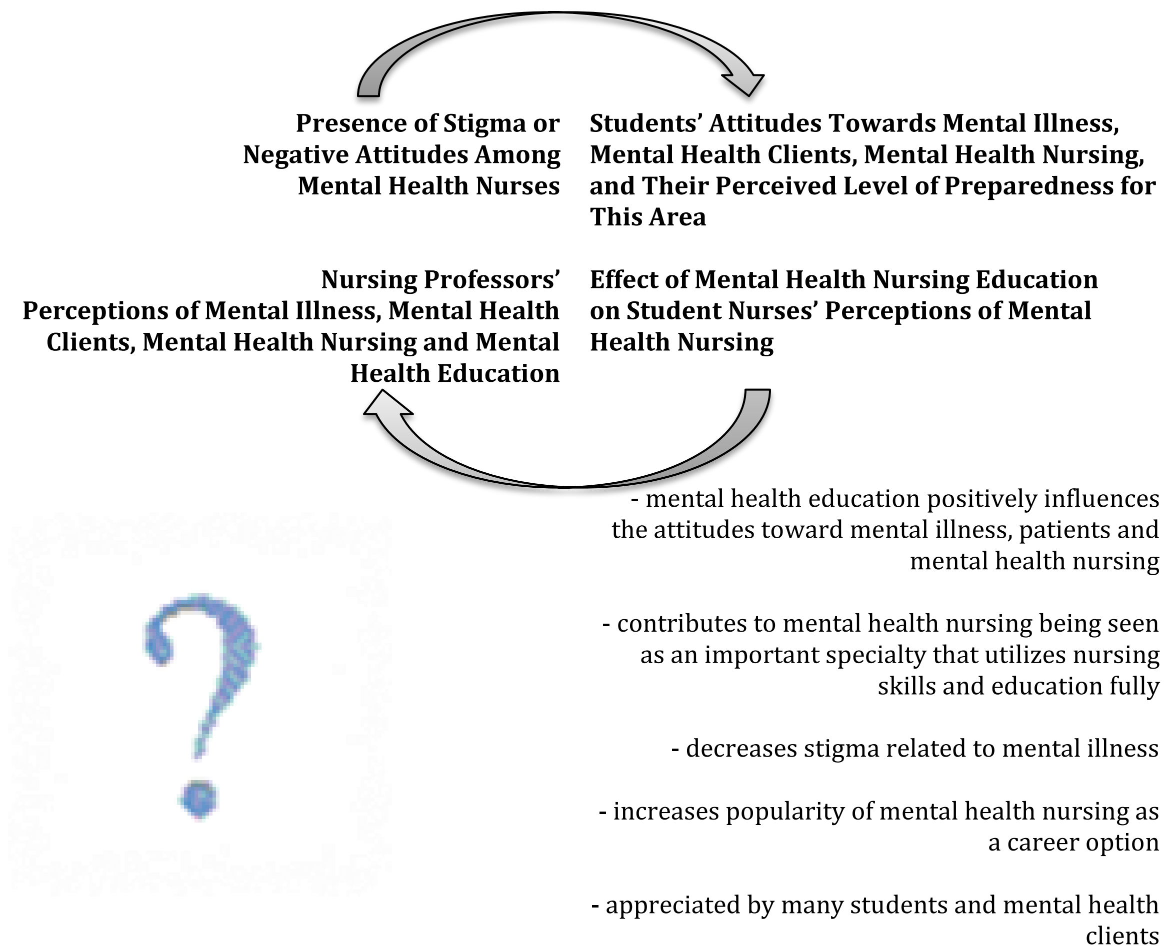
- mental health clients feel uninvolved in the planning of care

- mental health clients value nurses' approachability and would like to be listened to and appreciated for their positive characteristics

- students' attitudes reflect those of general public: mental health clients are at fault for their illness; they are violent, unpredictable, and unable to lead a normal life

- mental health nursing not popular due to students' perceived lack of preparedness for and limited exposure to this field

- mental health nursing perceived as 'boring' and making little use of nursing skills/education



Appendix C

Program Description Request

Subject: Mental Health Nursing Component

Hello,

My name is Olga Boyko. I am a graduate student in the Master of Health Sciences program at the University of Ontario Institute of Technology. For the research that I am completing, I would like to find out the mental health content in your program. I am primarily interested in the following:

1- In which of the following ways does your program offer mental health content – 'threaded' through the program, part of a course, or separate course dedicated to mental health nursing?
2- Does your program offer mental health practicum?

If so, is it required or elective?

Your efforts are greatly appreciated. Thank you.

Sincerely,

Olga Boyko

Phone: (905) 925-9645

E-Mail: Olga.Boyko@uoit.ca

Appendix D

Ontario's Nursing Institutions According to Mental Health Theory and Clinical Practicum: Two-by-Two Table

		Mental Health Practicum	
		Mandatory	**Elective/Absent**
Mental Health Theory	**Mandatory Stand-Alone Course (or Specific Part of a Course)**	**Quadrant A** 9 Institutions 1 Institution sampled 8 Invitations 4 Responses 4 Nursing Professors Interviewed	**Quadrant B** 2 Institutions 2 Institutions sampled 42 Invitations 9 Reponses 7 Nursing Professors Interviewed
	Threaded	**Quadrant C** 0 Institutions	**Quadrant D** 3 Institutions 1 Institution sampled 55 Invitations 9 Responses 8 Nursing Professors Interviewed

Appendix E

Invitation to Participate Letter

Hello,

My name is Olga Boyko and I am a graduate student in the Master of Health Sciences program at the University of Ontario Institute of Technology (UOIT). I would like to invite your participation in a study that I am conducting.

This study consists of a brief demographic survey followed by a short phone interview (20-30 minutes) at a time convenient to you. The interview will be recorded and erased upon transcription. The purpose of this study is to examine nursing professors' attitudes towards mental illness, mental health nursing, and mental health education in nursing programs. This information will give insight into current mental health education trends in Ontario.

There are no risks or discomforts associated with this study. It has been approved by the Research Ethics Board at the UOIT (#09-077) and ____________ (#_____). You have the right to withdraw from this study at any time, without any repercussion. Your name and the name of the nursing program you represent will not appear anywhere in the study to ensure full confidentiality. The information you provide will not be used for any other purposes. The findings of this study will gladly be shared with you.

To partake in this study, please complete a brief demographic survey within the next two weeks at the following link http://www.surveymonkey.com/s.aspx

Your efforts are greatly appreciated.

Sincerely,

Olga Boyko
Phone: (778) 991-9645
olga.boyko@uoit.ca

To opt-out of receiving further messages, please use the following link http:
http://www.surveymonkey.com/optout.aspx

This server is housed in the US and may be subject to the USA Patriot Act which allows authorities access to the records of internet service providers. This survey does not ask for personal identifiers. IP address of the computer that you use to access the survey is recorded but no connection is made between your data and your computer's IP address. If you choose to participate in the survey, you understand that your responses to the survey questions will be stored and accessed in the USA. The SurveyMonkey security and privacy policy may be found at http://www.SurveyMonkey.com/monkey_privacy.aspx ".

Appendix F

Demographic Survey

Question	Answer Options	
1. Gender	Male Female	
2. Age	<25 26-35 36-45	46-55 56-65 >65
3. Highest Degree Held	College Diploma/Certificate Bachelor's Degree (Nursing) Bachelor's Degree (Other) Master's Degree (Nursing)	Master's Degree (Other) Doctoral Degree (Nursing) Doctoral Degree (other)
4. Years Teaching	<1 2-5 6-10 11-15	16-20 21-25 >25
5. Position	Tenured Professor Assistant Professor	Contract/Sessional Lecturer Clinical/Laboratory Instructor
6. Which one of the following areas of nursing do you consider to be your area of expertise?	Medical/Surgical Obstetrics/Labor & Delivery Intensive Care Unit Emergency Room	Mental Health (including community) Community Other
7. Years of work experience as a registered nurse in mental health setting?	0 <1 1-5	6-10 11-20 >20
8. Did you receive mental health education as a student?	Yes, theory and clinical Yes, theory only	Yes, clinical only No
9. Please indicate two times when you would be available for a short (20-30 min) telephone interview.	Time #1____________ Date #1____________	Time #2 ___________ Date #2 ___________
10. Please provide a phone number where you can be reached, including the area code and the extension number.	Area Code __________________ Telephone Number_________ Extension__________________	
11. Would you like to receive the results of this study?	Yes No	
12. Thank you for your time. Your efforts are greatly appreciated. If you have any concerns or questions regarding this study, please indicate so below. All comments will be addressed as soon as possible.		

Appendix G

Institution and Participant Selection Process Overview

1. According to the program-type, each school was placed into a corresponding category. A two-by-two table shown to the right was used for organizational purposes (see Figure 1).

Figure 1.

	Mental Health Practicum - Mandatory	Mental Health Practicum – Elective/Absent
Mental Health Theory – Mandatory and Separate	? (quadrant A)	? (quadrant B)
Mental Health Theory – Threaded	? (quadrant C)	? (quadrant D)

2. Programs were listed in no particular order
3. First school in each category was chosen for participation (see Figure 2).
4. Participation invitations were sent to all nursing professors in each school whose e-mail address was listed on their program's website including directors/chairs.
   Altogether, the sample size anticipated was n=19 (four schools representing three quadrants).

Figure 2.

	Mental Health Practicum - Mandatory	Mental Health Practicum – Elective/Absent
Mental Health Theory – Separate Course	Institution 1 ← A Institution 2 Institution 3 Institution 4 Institution 5 Institution 6 Institution 7 Institution 8 Institution 9	Institution 1 ←B1 Institution 2 ←B2
Mental Health Theory – Threaded		Institution 1 ←D Institution 2 Institution 3

Appendix H

Interview Flow

Greeting and Briefing	Hello. You indicated that this would be a convenient time for you to answer a few questions. Is this still a good time? (If not, another time will be arranged) Firstly, I would like to remind you that you may choose not to answer any question or withdraw from the interview as a whole at any time. This interview will be recorded however the recordings will be disposed of after transcription. All names (your, other faculty and program names) will be excluded from transcription to ensure confidentiality. If you are not sure about any of the questions, please ask for clarification. Once again, thank you very much for agreeing to partake in this study. Onto the interview. There are four questions.
Question #1	**First question. Could you describe the mental health education you received as a nursing student?**
Clarification	Did you receive both theory and practice; was the mental health component mandatory or elective, the length of your education and what your thoughts were about that placement?
Question #2	**What does your program offer in terms of mental health theory and practice that is useful in preparing students to be holistic practitioners in whichever setting they choose?**
Clarification	How does your program prepare students in terms of mental health for whichever setting they may choose?
Question #3	**How important do you think it is for nursing students to complete a separate course dedicated to mental health nursing including a mental health nursing clinical placement?**
Clarification	Some programs offer a separate course on mental health nursing while other schools provide this content 'threaded'. Similarly, some programs offer clinical practice in mental health nursing while others do not. How important do you think it is for nursing students to have a separate course dedicated to mental health nursing and a clinical placement in this area?
Question #4	**What do you see as difficulties associated with including more MH in the curriculum?**
Clarification	Which factors may influence the presence or absence of a separate course in MH or MH practicum?
Question #5	**Do you think your program adequately prepares students who are interested in a career in mental health?**
Clarification	Do you believe that nursing graduates of this program are adequately prepared in terms of mental health nursing to practice in a variety of settings as well as the mental health area?
Question #6	**Do you think there should be more or less MH education in the curriculum?**

Clarification	Do you think there should be a greater or less emphasis on MH education or do you feel that the amount of MH education provided to the nursing students today is adequate?
Closing	Do you have any comments that you would like to add at this time? (pause) Thank you for taking the time to participate. Have a good day/evening/night.

Appendix I

Grounded Theory Data Analysis

Stage	Method	Results
Microanalysis: Open – Coding	- fragmentation of all raw data - 'theoretical coding' - abstract code naming - beginning of classification scheme - beginning of memoing	- abstractly named codes
Selective – Coding and Categorizing	- insignificant codes omitted - some codes selected for further coding - the researcher wavers between raw data and selected codes until 'theoretical saturation' is reached - similar codes arising in each question in each of the quadrants are grouped together into categories - no inter-question or inter-quadrant mixing of codes in categories	- codes which provide insight into research question(s) only - categories
Category Integration and Theorizing	- classification scheme used to answer research questions - categories within the classification scheme reviewed in the context of the program-type from which arise - categories compared to each other - similarities and differences in categories across quadrants noted - selected-codes re-assembled in a way that answers research questions - memos are reviewed - research question are answered	- research questions answered - theory explaining the research issue generated
Verification of Theory	- validity measured by 'fit' of theory to available data - research questions and answers reviewed - data analysis steps and memos reviewed - alternative theories considered	- 'fit' of theory to available data assessed and modified as needed

Appendix J

Classification Scheme Overview

Category Name	Quadrant A Selected Codes	Quadrant B Selected Codes	Quadrant D Selected Codes
Question One: Could you describe the mental health education you received as a student? So to clarify that, did you receive both theory and practice, was the mental health component mandatory or elective, the length of your education and what your thoughts about the placement were.			
Ambiguity - Mental Health vs. Psychiatric Nursing	"Back then, it was considered under psychiatry" "It was called psych nursing" "[There was] no continuing focus either on general mental health or at very specific psychiatric hospital-based nursing" "Narrow focus of psychopathology [rather than mental health]' "We had no sense of mental health…it was psychopathology we were learning" "When I think of mental health, I think of problems such as anxiety, and depression, and sometimes substance abuse, communication issues, you know? Where I think psychiatry as a psychotic illness such as schizophrenia, certainly some of the depressions"		
Interpretation of Own Mental Health Education	"I thought it was amazing" "I quite enjoyed it in some ways" "[it was a] rich kind of experience" "Intimidating" "I (…) did not enjoy it" "[It was] not helpful" "Struggling (…) I remember thinking: 'I shouldn't be here'"	"I did not, at that time, have any deep thoughts regarding it" "Excellent rotation" "I enjoyed it" "I enjoyed the placement" "It was excellent" "It [the mental health element] worked" "[It was]intimidating (…) I was petrified (...) it was overwhelming"	"I can't remember" "Excellent rotation" "I actually really did enjoy it" "[I was]anxious" "I found it a challenge and yet I very much liked the area" "I did not like it at all" "I quickly learned it wasn't something I would like to do"
Basis of Interpretation	"We were not prepared" "I had two rotations, both inpatients, one on a psychiatric ward of a large	"I found it (…)beneficial to my education" "I always had interest in (…) mental health"	"It [mental health component] was very limited" "It was going in and not knowing what to expect"

	hospital, and the other one in psychiatric hospital (…) so I had a really good exposure" "I don't think we were prepared to be dealing with high acuity patients" "We were to chat with patients (…) but not at a therapeutic level" "We really had no background into the normal or the variance of normal [mental health] (…) we understood mental health as those who are very ill" "I had a really great preceptor" "The fact that the ward was locked (…) was somewhat intimidating"	"I enjoyed the group work" "We were able to focus on that particular specialty…[but] it was a bit hard for us to translate those experiences across to patients [on other units]" "[There was] nothing about the placement that would encourage me to work there"	"The recipients of care (…) were very ill" "Lack of knowledge and stigma associated with [mental health]" "I found it very different (...) required adjustment" "We were not provided with appropriate tools and skills (…) to help those patients" "We didn't have an option [to have a mental health placement] (…) I would much rather attend another clinical"
Question Two: What does your program offer in terms of mental health nursing theory and practice to help prepare students to be holistic practitioners in whichever setting they choose to work in? And by 'your program', I mean the program in which you currently teach.			
Relating to Mental Health Component		"I don't teach it" "I don't teach in the mental health" "I am not the person to ask because I am not involved in that program (…) I cannot answer the question related to that because I am not involved in that" "I don't teach that component"	
Familiarity With Own Program	"It's a thread, as well as a course" "[Concepts are]incorporated straight through" "It's a thread of assessment course" "We don't focus of psychopathology" "[Mental health course]deals with the experience of mental illness through 'phenomenology', stigma as a barrier, mental health vs. mental illness" "[Mental health] also encountered in other	"They have an intensive (…) course and then a clinical practice" "Students can choose that area to do their final clinical course" "It's a [X] week course…students, still, have a thirteen week placement in a mental health type setting" "I don't believe they [mental health placements] are mandatory (…) but most students go	"We learn basics (…) signs of depression, referral services" "A student can select mental health as one of their clinical areas" "[Mental health component]permeates the entire curriculum" "Mental health issues that we study include anxiety, depression, suicide (…) we look at individuals living with schizophrenia" "It's required that they be exposed to the areas or concepts in relation to mental

	courses" "[Students are] exposed right from the get-go" "Well, it's one semester, and it's offered [X] hours a week, and a placement of a [X] hours in long-term care and in acute care mental health, and community health"	through a mental health placement" "I am not sure of the percentage of students that actually get that placement" "I am not sure about the clinical"	health" "Clinical placements [are] offered in mental health, but they are not mandatory" "We study anxiety (…) how to do interviews and communicate (…) MMSE" "They do receive pathophysiology perspective [on mental health] (…) pharmacology will include medications [used in mental health]" "education depends on their selection"
Question Three: Some programs offer a separate course on mental health nursing, while other schools provide this content as 'threaded' through the curriculum. Similarly, some programs provide clinical practice in mental health nursing, while others do not or offer it as an elective. How important do you think it is for nursing students to have a separate course dedicated to mental health nursing and a clinical placement in this area?			
Perceived Level of Importance	"Extremely important" "I support offering it as a required and stand-alone course" "[Mental health] should be identifiable part of the curriculum" "Very important" "It is essential that [students] do get a placement and get the theory" "It's important they get both [mental health theory and practicum]"	"All programs need both [mandatory stand-alone theory and practicum]" 'important' "Extremely important" "Everything should be separate" "Very important" "It's critical that it's a separate specialty, same as we have child-health, clinical-surgical nursing" "I am not sure about the clinical (…) I would like a separate course on it" "Important to have a theory course (...) but in terms of a clinical placement (…) I don't think it's necessary" "We should thread it through the curriculum as well"	"A clinical placement in the area is really helpful" "I don't think that it should be a required course (…) but there should be a supplementary way that the students can fit this material if he or she wants to pursue that" "It would be very relevant for it to be mandatory" "I am not convinced [theory] needs to be separate" "I think [mental health theory] is quite important…and then clinical, whether it's mandatory that they have practice there I don't know" "It would be helpful for students [to have both mental health nursing theory and clinical](…) even if they are not going to practice in mental health specifically" "It would be great that all students went through that [mandatory stand-alone theory and clinical]"
Rationalizing	"At least they are exposed to it" "Students need that exposure right from the beginning"	"I don't think we pull those pieces [mental health pieces] through our program well	"Students need to be exposed to mental health problems and (…) therapeutic approach to handling them"

	"The downside of [separate mental health content] is that kind of experience can be ignored in other areas of the program…you have to pay attention to the rest of your program"	enough" "When you get the theory and not the practicum, obviously you're not competent (…) It doesn't help you understand that as a career choice" "It's really more challenging when they get these threaded concepts to consolidate that information" "If we just leave it to faculty to thread it in their courses, because every faculty has different teaching styles, it will be lost" "It's unique (…) in terms of learning, practicing, how to communicate (…) how to diffuse a volatile situation" "Being able to apply all those concepts in a practical setting (…) is important" "It may get lost in programs where it's threaded through (...) [Students] are not able to necessarily put all the pieces together"	"Students are ill-prepared to integrate the mental health needs into care" "I think we find that that works fairly well [threaded content and elective clinical]" "[Students] all work in acute care environments, and a lot of the patients in particular, have many issues that go the whole scope of mental issues that they have to deal with" "I don't believe our students are disadvantaged because they do not have a specific course that teaches mental health or practicum where they can practice skills related to mental health" "There are mental health issues in all those sites (med-surge, maternity, etc.) (…) they could end up with [mental health] patients"
Question Four: What do you see as the possible challenges associated with including mental health in the curriculum?			
Challenges	"Difficult to find placements (…) difficult to find placements of appropriate level" "There is an awful lot that the students have to know" "Limited resources for teaching mental health" "There isn't enough faculty with sufficient background in mental health nursing" "[Mental health nursing is] seen as a specialty course or post-grad" "Curriculum always crowded" "Mental health care is moving	"Finding appropriate placements" "[Facility] policies and procedures (…) [such as] passing of medication' "Availability of registered nurses who are willing to mentor" "Faculty-to-student ration for mental health placements" "Sheer numbers and logistics (…) I don't think it's the theory as much as it is the clinical	"[There are] way more students than we have placements" "Availability of the clinical areas (…) having the expertise" "Time efficiency" "Finding faculty who have specialized knowledge" "Programs don't have enough resources to have a faculty member with each of the areas in nursing" "As far as inserting clinical placement - that could be difficult" "Lack of placements (…) not all

	away from hospitals and out into the community (…) less opportunity for students to find placements" "Community placements unable to accommodate large groups of students"	practicum" "Having the students who want to go into that area, because of stigmatization" "I don't see any challenges (…) unless there wasn't any faculty to teach it (…) unless there aren't any placements' "We're always challenged to fit in all the competencies in the timeframe that we have" "Stigma and the media has a lot to do with it" "Willingness of a facility to take students"	faculty have the capacity or the comfort with mental health" "Sharing placements with a number of different colleges" "Curriculum is jam-packed (…) adding another course - I am not sure where that would fit in the curriculum" "Not sure we have that many clinical faculty that would be able to teach mental health clinical practicum rotation"
Question Five: Do you feel that your program adequately prepares students who are interested in a career specifically in mental health?			
Perceives Level of Preparedness	"Yes [it does]" "Seems to" "[The program] introduces them [to mental health]" "[The program] provides them with basic competencies" "[Mental health component] wets their appetite" "We provide them with opportunity to be prepared"	"Not sure" "There is room for improvement" "We do give students a good foundation (…) overall we do a pretty good job" "It certainly gives them the ability to see whether that would be something they would like to choose (…) we are giving them foundation knowledge" "Probably not (…) but I would also qualify that and say that we don't prepare students for other specialties" "I am unable to answer this question as I'm not sure of the exact content in our program" "Not certain for sure they feel adequately prepared to pursue that type of a career"	"Satisfactory" "Coming out of the program – no, not right away" "Yes I do" "As much as it prepares them for other specialties. Is it adequate - I don't know" "In our program - we do a good job" "I do have concerns that students can go through virtually the whole program and may not have any clinical experience and have minimal theoretical learning associated with mental health"
Basis for Perceived Level	"Based on feedback" "Many students select it as a	"Students have chosen the area of mental	"Our students have a very high [CRNE] pass rate so in that

of Preparedness	pre-grad preceptorship experience or seem to go on into" "[Mental health nursing is] one of the more popular areas that students choose upon graduation" "The choice to go into mental health nursing speaks to their level of comfort or their level of confidence" "We certainly had students in the past say 'Oh, this is what I am going to do'"	health as a career" "There are some good people who teach it" "Few students say to me that they would really like to practice in mental health, and they enjoyed the course that was offered"	sense they do get a basic overall preparation" "Based on the senior year people who want to do psychiatric nursing"
Program Vs. Program	"[Mental health education] in this program compared to other programs – adequate" "Many students have chosen [mental health], surprisingly enough, which is not that case, I think for other programs" "I think our students are better prepared (…) I think our students have a better understanding"		
Self-Identifying			"if the students self-identify to be interested in mental health – yes (…) if they early-on self-identify" "If the students are really keen they can shape their learning through various courses and clinical experience" "I think the students who have identified in early years interest in pursuing mental health, those options are there for them" "Students who have a specific interest in mental health (…) we do a fairly good job of helping those students to get mental health experiences"
Nurse-Generalist	"[New grads] require additional training which is either on the job or through extra courses or whatever" "[Students are] adequately prepared to be novices"	"Like most programs in Canada, the emphasis is really one of nurse-generalist (…) and with that comes some dilution of skills"	"I don't think nursing programs should prepare nurses for a specific stream period (…) we are responsible for educating students at a generalist level" "They need to be beginning

			practitioners in a whole variety of areas"
Question Six: Do you think there should be a greater or lesser emphasis on mental health education, or do you feel that the amount of mental health education provided to the nursing students today is adequate?			
Emphasis	"In general, not adequate" "There could be room for improvement" "Inadequate [because] programs are not addressing stigma' "We probably need to increase the emphasis" "I don't know. I really can't comment on that as I am not aware of other programs"	"There should be more emphasis on stigmatization (…) in the general public' "The more experience we provide, the more exposure perhaps, the greater the understanding" "We could do a better job (…) you really gain an appreciation when you get the theory and then go and practice" "I cannot answer that question as I am not sure of the exact content in our program" "I don't think it's adequate"	"There's need for more in-service" "I think there should be a greater emphasis" "I think there could be a greater emphasis on those particular skills [relationship building, communication](…)we could do a better job" "[Mental health content in nursing programs] merits a review"

Appendix K

Participant Demographics by Quadrant

Response Rate/ Completed Survey/ Interviewed	**Quadrant A** 50% / 4 / 4		**Quadrant B** 21.4% / 9 / 7		**Quadrant D** 16.4% / 9 / 8	
Age	50% 50%	46-55 56-65	11.1% 55.5% 33.3%	36-46 46-55 56-65	11.1% 22.2% 55.6%	36-45 46-55 56-65
Gender	100%	Female	89.9% 11.1%	Female Male	100%	Female
Education	25% 50% 25%	M Nursing PhD Nursing PhD Other	55.5% 22.2% 22.2%	M Nursing PhD Nursing PhD Other	22.2% 11.1% 33.3% 33.3%	M Nursing M Other PhD Nursing PhD Other
Years Teaching	25% 50% 25%	2-5 6-10 16-20	22.2% 22.2% 22.2% 22.2% 11.1%	2-5 6-10 16-20 21-25 >25	11.1% 11.1% 11.1% 33.3% 33.3%	2-5 11-15 16-20 21-25 >25
Position	75% 25%	Tenured Professor Sessional Lecturer	44.4% 11.1% 44.4%	Tenured Professor Assistant Professor Sessional Lecturer	22.2% 66.7% 11.1%	Tenured Professor Assistant Professor Sessional Lecturer
Area of Expertise	25% 75%	Mental Health Other	11.1% 11.1% 33.3% 44.4%	Med-Surge ICU Community Other	11.1% 88.9%	Mental Health Other
Work in Mental Health	50% 25% 25%	0 6-10 11-20	89.9% 11.1%	0 1-5	44.4% 11.1% 33.3% 11.1%	0 <1 1-5 >20
Mental Health Education as a Student	100%	Both, theory and clinical	89.9% 11.1%	Both, theory and clinical Neither theory nor clinical	88.9% 11.1%	Both, theory and clinical Neither theory nor clinical

Appendix L

Themes That May Affect the Mental Health Nursing Education in Ontario