

MENTAL HEALTH SIMULATION MODEL: A PLACE FOR LEARNING IN A NEW ZEALAND CONTEXT

Suzie Bartlett

INTRODUCTION

Simulations in various forms are becoming an essential pedagogical addition to clinical training within the health sector. Simulation using human actors/performers are both cognitive and affective in nature and therefore, present students with a realistic and meaningful experience that is high in authenticity and engagement, but low in risk. In terms of knowledge acquisition and skill development, the literature shows that there is a place for simulation in undergraduate nursing education. The simulated experience helps to demystify misconceptions of and presupposition associated with mental health. Placing simulation within a sequenced series of educational events better prepares students for their subsequent clinical practicums. There are real benefits of simulation introduced to a nursing curriculum not as a stand-alone activity, but aligned within broader developmental learning processes. A new model The Simulation Cycle of how this alignment can be achieved is presented in this paper:

Background

Simulation is having a profound impact on the direction of training for healthcare professionals (Brown, 2008). These advances offer exciting possibilities for many areas of healthcare education, including mental health nursing. Human actors utilised in simulation are able to replicate complex states associated with facial expression and body language essential in identifying dispositions, attitudes and thought processes critical in mental health assessment (Bartlett, 2014). In these cases, mental health nurses who have proficient knowledge of patients with acute mental illness can be used as performers/actors. These performers/actors are often used in simulation experiences to replicate a high fidelity of realism exposing students to real life clinical scenarios and teaching skills in decision making, problem solving, and communication in a safe, non-threatening learning environment. (Brown, 2015). In this authentic, supportive environment, students are exposed to various mental health conditions in an accurate and consistent manner, without risk to themselves or patients/clients (Knudson, 2013).

Simulations offers an excellent approach to create a clinical environment that are representative of real life scenarios, without risk to the public (Robinson-Smith et al., 2009). However, simulation needs to be carried out in the correct sequence of educational events for students to gain the most benefit. Simulation has been well documented as being beneficial to learning, (Boynton et al., 2007; Razack et al., 2007; Morgan et al., 2006; Yule et al., 2006) but to gain the most leveraging potential from all course components including theory, simulation and clinical practice, simulation needs to be embedded into the curriculum and not added to the curriculum (Bartlett, 2014)

The Bachelor of Nursing (BN) programme comprises a mental health component that is presented in year two and three of the three year degree programme. The mental health content is provided as a clinical course including a simulation which is often students' first introduction to mental health within the curriculum. Mental health can be a challenging specialty within nursing practice (Choi, 2012). Myths and stereotypes formed by society and the media related to psychiatric service users can heighten student anxiety and create fear among students (Choi, 2012). Simulation, when embedded into an educational sequence helps to demystify this complex and

challenging environment (Bartlett, 2014). Immersion in a realistic clinical scenario prior to clinical practice has the ability to reduce student anxiety and increase the effectiveness of students' therapeutic interactions, with authentic experiences to draw on when they are working alongside health professionals and clients in practice (Choi, 2012).

Students can be unprepared when entering the mental health clinical field, which can be a challenging, and confronting environment. Student's anxiety can increase and cause them to fear people suffering from mental illness if they do not have adequate classroom preparation prior to being immersed in this clinical environment. If students fear the placement then therapeutic communication with clients/patients can be difficult (Luther-Szpak & Kameg, 2013).

Simulation experience

Anecdotal evidence from students suggests that exposing students to mental health environments without adequate preparation could be detrimental to their ability to form therapeutic relationships and engage with service users. Student nurses completing the mental health component of their BN programme are, immersed in simulation. The expectation is that the simulation acts as a mediating tool between students' classroom (theory) and clinical (practice) experience. Trained actors are utilised to portray acutely unwell psychiatric patients, suffering from psychotic symptoms associated with schizophrenia. Schizophrenia is a disorder characterized by a major disturbance in thought, perception, thinking and psychosocial functioning; it is a severe mental illness. The students carry out a risk assessment and mental state assessment with the simulated patient. To assist in this exposure a new model The Simulation Cycle (Figure 1) developed by the author to demonstrate how simulation can be embedded into, rather than just "added to" a nursing curriculum, in order to offer greater benefit to student learning.

Implications for the curriculum - a new model

If students are exposed to simulation without delivery of the necessary guidance (theory/practice) beforehand then this is likely to impede the learning process (Bartlett, 2014). If students are not well prepared prior to simulation they can become unable to continue with the simulated scenarios due to not being able to make the necessary clinical judgments to move forward and provide solutions and best outcomes for the patient. Debrief sessions, as part of the simulation experience are an important part of the simulated learning sequence (AL Sabei & Lasater, 2016). The debriefing process, immediately after the simulation, allows students to reflect on the experience; how they behaved; what they did well and what they would change in the future. Debrief also offers an ideal teaching context where expert knowledge and experience are engaged with and become a part of the conversations at appropriate times.

The Simulation Cycle illustrates a hybrid model that combines action of simulation with the preparation and reflection inherent with debrief sessions. This model details the sequence in which simulation can be embedded into the nursing curriculum to maximize its potential to augment learning and demystify practice.

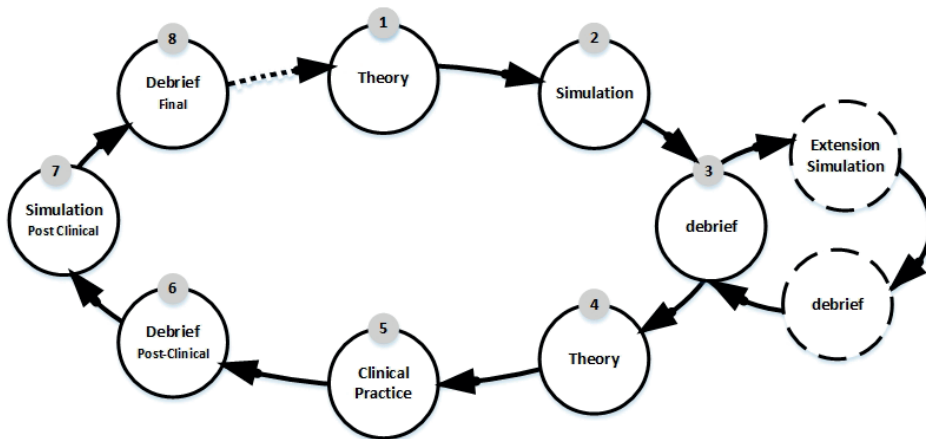


Figure 1. The Simulation Cycle. Source: Bartlett (2014)

Elements of the Simulation Cycle Model

The Simulation Cycle details the sequence in which the simulation can be embedded into the nursing curriculum. The aim is to maximize the leveraging potential simulation can add to existing program components. This model has eight elements it is recommended all of these elements be engaged with for beneficial results (Bartlett, 2014).

The first element of the model is related to and titled, *Theory*. Students are required to attend tutorial sessions where information regarding assessment and communication skills, theoretical models, required frameworks and legislation are introduced and discussed. The students take part in scenario work to introduce them to mental state and risk assessment, suicide assessment, application of the Mental Health Act 1992 (Compulsory Assessment & Treatment), recovery and medication. There is an expectation students complete the online resources prior to presenting for simulation that have been designed to give the students' knowledge needed to progress through the simulated event. In this element of the model the students are in a state of equilibrium, they feel comfortable with content presented and are able to achieve what is asked of them easily, without feeling confronted.

The second element of the model is *Simulation*. Students are required to take part in the simulated event where they are asked to complete a mental state and risk assessment on a client. The client in the scenario has co-existing problems with drug and alcohol misuse. Students are put into roles including: Registered Nurse/student nurse/family member or peer observer. They then read the provided information needed to complete the scenario. Students are reassured that the scenario is a safe environment for them to learn in where they are able to make mistakes without any 'real world' risk to clients and where they can speak freely with supporting lecturing staff. The

lecturer takes notes on the students' performance and discusses this further with them at the time of the post simulation debrief. Students in the debrief stage can become anxious and feel uncomfortable in a situation that is unfamiliar.

The third element of the model is *First Debrief*. Students move away from the simulation room and are escorted to a separate debriefing room. Debrief is aimed at promoting reflective thinking. Learning is dependent on the integration of experience and reflection (Decker, et al., 2013). Students use the reflective process during the debriefing phase which facilitates them to view the simulated clinical scenario from different angles, identify their learning style and improve their decision making and problem solving ability. Reflection is the conscious consideration of the meaning and implication of an action, which includes the assimilation of knowledge, skills and attitudes with pre-existing knowledge (Decker et al., 2013). Students are able to unpack their learning with an expert lecturer and begin to understand how this applies to their clinical practice. In effect, students are blending the learning from simulation and theory, and transferring knowledge to the clinical environment. Students are able to think about how they feel during simulation, what learning they are experiencing, and how they can improve on their clinical judgments.

Debrief allows students to come back to a state of equilibrium where they feel comfortable and have the knowledge required to proceed to the clinical environment.

After the *First Debrief*, an extension simulation can be included if required. Students may want to transfer knowledge gained from the first debrief into a second *Extension Simulation* directly after the debrief process. This enables students to consolidate their knowledge and remember the correct way in which the scenario should be carried out. Following the *Extension Simulation*, another debrief is required for decompression and "unpacking" of new learning. The reflective process is used once again to understand the simulation experience.

The fourth element is related to and titled, *Theory*. Again the students are put into a state of equilibrium as they are exposed to more theory in the form of tutorials, with expert mental health lecturers, before being exposed to the mental health clinical environment. This is a chance to identify with students any additional knowledge they need that is critical in order for them to make good clinical judgments in their practicum.

The fifth element is *Clinical Practice*. Students are now ready to be immersed in the mental health clinical environment. Students have a clinical preceptor who is a registered nurse with whom they work closely for the duration of their clinical practicum. Preceptor's support the students by encouraging them to reflect on their practice, teaching them practical skills, and adding to the knowledge gained from the educational institution. This element of the model places students back into a state of disequilibrium due to the challenging and sometimes confronting environments that mental health facilities can induce.

The sixth element is *Post Clinical Debrief*. The students return to class post clinical practice for a follow up debrief of their clinical experience. The students reflect on their clinical placement by sharing their experiences. They are able to discuss ethical issues that arose for them, challenging situations, how these were dealt with and whether

they thought this management was effective, what they could have done to improve their clinical experience, what they learnt from their placement and how this new knowledge would influence their future nursing practice. From this process, students are able to pass on the knowledge they have gained from their own experience, engage with fellow students and learn from each other's experiences. Students are now in a state of equilibrium again as they begin to feel comfortable with the new knowledge acquired and how the different contexts of practice and theory interrelate.

The seventh element is *Second Simulation*. A second simulation experience can be added here so students could apply all knowledge that they have learnt from theory, clinical, debrief and their first simulated experience. This is an excellent way for students to consolidate and reinforce their knowledge. This stage places students back into a controlled state of disequilibrium, as simulation is anxiety provoking regardless of students' preparation.

The eighth element is *Final Debrief*. Debrief is again implemented as outlined in the third element of the model, a reflective piece of writing may or may not be required. Students will finally be in a state of equilibrium where they feel comfortable with the knowledge procured, capable and empowered to make the necessary theoretical links to their mental health clinical practice.

DISCUSSION

Ideally, students should have theory related to clinical practice taught in the classroom by expert lecturers in the field of mental health nursing, before simulation. The *Simulation Cycle* demonstrates the most beneficial sequence for student learning using educational events as presented in (Figure 1).

CONCLUSION

Embedding simulation into a curriculum as a collection of sequenced elements is of greater benefit to students than just 'adding in' simulation as a stand-alone activity to fit with curriculum timetabling. The *Simulation Cycle* (Figure 1) was developed to give students the best leveraging potential from all aspects of the curriculum including theory, clinical practice, debriefing, online teaching and simulation. If all of these educational aspects of the curriculum are considered carefully, an optimal learning process can be achieved for students in order for them to maximise their learning potential through the simulated experience. The simulation cycle outlines how this can be achieved through embedding simulation correctly into an undergraduate nursing curriculum.

Acknowledgments, Thank you to Russell Butson and Dr Jean Ross for providing detailed editorial feedback.

Suzie Bartlett is a Senior lecturer in the School of Nursing at Otago Polytechnic. Suzie has 17 years clinical nursing experience in mental health, primary health, cardiology and also acute medical surgical environments. She completed a Masters Degree in Higher Education at Otago University in 2015, her thesis topic was "Evaluating the merits of mental health simulations in an undergraduate nursing degree programme, using standardised patients".

Correspondence to Suzie Bartlett, School of Nursing, Otago Polytechnic, Private Bag 1910, Dunedin, New Zealand.
Email: suzie.bartlett@op.ac.nz

REFERENCES

- AL Sabei, S.D. & Lasater, K. (2016). Simulation debriefing for clinical judgement: A concept analysis. *Nurse Education Today*, 45, 42-47.
- Bartlett, S. (2014). *Evaluating the merits of mental health simulations in an undergraduate nursing degree programme, using standardised patients*. Unpublished Masters dissertation. University of Otago, Higher Education Development Centre, Dunedin, New Zealand
- Boynton, J.R., Green, T. G. & Johnson, L. A. (2007). The virtual child: Evaluation of an internet based paediatric behaviour management simulation. *Journal of Dental Education*, 71, 1187-1193.
- Brown, A.M. (2015) Simulation in undergraduate mental health nursing education: A literature review. *Clinical Simulation in Nursing*, 11, 445-449.
- Brown, J.F. (2008). Applications of simulation technology in psychiatric mental health nursing education. *Journal of Psychiatric and Mental Health Nursing*, 15, 638-644.
- Curtis, J. (2007). Working together: A joint initiative between academics and clinicians to prepare undergraduate nursing students to work in mental health settings. *International Journal of Mental Health Nursing*, 16 (4), 285-293.
- Decker, S., Fey, M., Sideras, S., Caballero, S., Leland, R., Boese, T., Franklin, A.E. &... Borum, J.C. (2013). Standards of best practice: Simulation standard VI: The debriefing process. *Clinical Simulation in Nursing*, 9(6), 26-29.
- Knudson, L. (2013). Integrating simulation into student learning experiences. *AORN Journal*, 97(4), 5-6.
- Luther-Szpak, J. & Kameg, K.M. (2013). Simulation decreases nursing student anxiety prior to communication with mentally ill patients. *Clinical Simulation in Nursing*, 9, 13-19.
- Ministry of Health (2000). *Guidelines to the mental health (Compulsory Assessment and Treatment) Act 1992*. Wellington, New Zealand: Author
- Morgan, P., Cleave-Hogg, D. & Desousa, S. (2006). Applying theory to practice in undergraduate education using high fidelity simulation. *Medical Teaching*, 28, 10-15.
- Razack, S., Meterissian, S. & Morin, L. (2007) Coming of age as communicators: Differences in the implementation of common communications skills training in four residency programmes. *Medical Education*, 41, 441-449.
- Robinson-Smith, G. Bradley, P.K., & Meakim, C. (2009). Evaluating the use of standardised patients in undergraduate psychiatric nursing experiences. *Clinical Simulation in Nursing*, 5, 203-211.
- Yule, S., Flin, R., Paterson-Brown, S. (2006). Development of a rating system for surgeons' non-technical skills. *Medical Education*, 40, 1098-1104.
- Yun-Jung Choi. (2012). Exploring experiences of psychiatric nursing simulations using standardised patients for undergraduate students. *Asian Nursing Research*, 6, 91-95.