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

Authors

Pras Ramluggun, Mary Lacy, Martha Caddle-Nisbet, Mike Anjoyeb

Abstract

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

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

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

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

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

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

Introduction

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

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

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

Background

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

Mental health as a stressful and emotional endeavour

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

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

Support for students with a mental health issue

There have been significant developments in supporting students with mental health difficulties and promoting mental well-being generally in higher education by Universities UK (UUK). The emphasis is on reviewing approaches to teaching and learning, introducing techniques that help to support these students (Thorley, 2017).

One area for improvement included encouraging early disclosure to reduce the potential adverse impact on students' academic performance, as students fear professional repercussions following disclosure or exposure (Cvetovac and Adame, 2017). Disclosure of a mental health issue would also help to reduce attrition rates (Institute for Employment Studies, 2015). In the year 2014-15, the number of students who experienced mental health problems leaving university has trebled to 1,180 from 380 in 2009-10 (HESA, 2017). Boardman (2016) argues that building student nurses' resilience by improving their self-efficacy can reduce these high attrition rates and is recommended in the draft consultation for the incoming NMC Education Framework (NMC 2018).

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

Living with a mental health and caring for others

There is a paradox of living with a mental illness and caring for others with similar conditions, which has been examined under the concept of 'wounded healers' by Jung (1951). Jung (1951) believed that the wounded physician occupies a favourable position to heal effectively. Thus, Jung (1951) proposes a link between those with past psychological wounds and their intrinsic motivation to want to become a helping professional because of the perceived ability to draw on it to facilitate healing in others (Zerubavel & O'Dougherty Wright, 2012). Differing views perpetuate the literature on whether such experiences should be kept separate or can be integrated into mental health practice (Khalid, 2011; Goldberg et al., 2015).

However, in the absence of empirical evidence on the effectiveness of the 'wounded healer' leads to the need for a discussion around the suitability of the recruitment of some individuals with a current mental health issue onto a professional mental health-nursing programme. The evidence of workplace stigma challenging wounded healers with the potential to worsen their health may leave them with the only option to withdraw from the course. Such experience is particularly significant for mental health nursing students as prospective registrants (Gilbert and Stickley 2012), as it could discourage students from the mental health-nursing programme. This debate which identified the need for NHS England to include effective workplace interventions in the management of staff mental health was underlined in 'The five year forward view for mental health' (The Mental Health Taskforce, 2016).

Lived experience of those with a mental health in mental health training

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

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

Methodology

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

Ethics

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

Settings and participants

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

Data collection

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

Data analysis

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

Results/findings

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

Timing of Disclosure

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

Early disclosure

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Late disclosure

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

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

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

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

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

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

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

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

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

> "*It was okay surprisingly…on the back of the conversation, I've obviously found out that some of my peers have issues, which I wouldn't have known…... it didn't feel as scary as what I thought it would* (B1L74);
>
> "*I spoke with my Course Leader who was really helpful and understanding"* (A1L15)
>
> "*My Academic Advisor has got in touch with me, offered me support"* (A2L435)
>
> *"My link lecturer came and spoke to me, he was very understanding and not fazed by my self-harm…*(A3L174).

Students' coping mechanisms

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

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

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

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

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

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

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

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

Managing lived experience in learning environments

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

> "T*here are certain times where we've spoken about things like suicide, that it has, sort of, hit me a bit"* (B5 L272) or leading to introspection and self-diagnosis
>
> "*…because I am very analytical of myself, so I start, sort of, self-diagnosing"* (B1 L36).

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

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

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

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

Which they found satisfying:

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

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

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

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

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

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

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

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

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

Experience of support

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

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

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

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

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

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

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

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

Which addresses their particular needs:

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

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

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

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

Discussion

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

Disclosure

Early disclosure of mental health conditions was difficult for most students in this study because of the perceived and internalised stigma of their mental illness, as reported in other studies (Henderson, 2014; Abbey *et al.,* 2012). The attribute of stigma was reinforced by the apparent observation of unhelpful discourse by some of their peers and some staff in their placements. Such experience of working with a colleague or student with mental health conditions has been described as an onerous prospect (Joyce *et al.,* 2012).

Despite the increasing awareness of mental illness and initiatives to combat negative stereotypes this study indicates that stigma is still a barrier to seeking help, as reported by Papish (2013). This echoes a survey undertaken by Time to Change (2015) an anti-stigma campaign, which reported that ninety percent of participants revealed that disclosing a mental condition would have a negative impact on their job prospects. However, positive experiences of disclosure in helping to dispel mental illness related stigma has also been reported (Brohan *et al.,* 2010). Therefore, it is also worth addressing the barriers to applicants' disclosing their mental health conditions at the earliest opportunity before or after enrolment on the programme, especially, as according to Harris *et al.* (2014) students' mental ill health is a contributing factor to nursing students' attrition rate reported to be up to 50%.

The high attrition rate is compounded by other influential factors, such as students' not seeking help to facilitate their management of emotional situations and improving on their coping mechanisms (Rosenthal and Wilson, 2008). This study showed that students' educational background could also affect their readiness to ask for help. Interestingly, it underlined how students' past artistic educational engagement provided an outlet without stigma for creative expression of their mental ill health compared to their nursing education. Remarkably, where they once espoused a positive ideology about their mental illness allowing their self-belief to flourish from a position of strength this was now perceived as a weakness through the protective lens by those supporting the student's learning in clinical practice. This finding raises the significance of the lived experience of the wounded healer in the development of their professional practice.

Managing lived experience

Students' theoretical orientation on handling self-disclosure was to adopt a neutral stance. Whilst this demonstrates their recognition for professional boundaries in the therapeutic relationship, it does not however reveal how this boundary was effectively managed. Some students explicitly showed awareness of potential pitfalls such as over identification or projecting own experience onto a patient (Goldberg *et al.,* 2105). The intricacies of the relationship between staff with these personal experiences and their patient are unclear (Oates *et al.,* 2017).

Some students were self-aware that as recipients of mental health care they did not follow the advice they gave in the role as student nurse. As explained by Hawkins and Shohet (2012) it is safer

to be in the role of the helper than the one being helped as the latter can reveal ones' own needs and vulnerability. This could offer a possible explanation for their thinking that as student nurses they need to be strong because their mental illness may be perceived as a sign of weakness and vulnerability. The identity transition from patient to clinician is a complex one during which students will need to differentiate between their own experience and that of the patients. Assistance may be needed in processing feelings about violations of boundaries for the benefit of both patient and clinician (Goldberg *et al.,* 2015). Concern expressed by some participants that mental illness may be perceived as a sign of weakness and vulnerability echoes those of Israeli social work students with mental conditions who questioned, in an early phase of their transition, the ability of a patient to also become a therapist (Goldberg *et al.,* 2015).

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

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

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

Coping mechanisms

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

A review of the literature showed that the evidence for a clear approach to stress-reduction interventions for undergraduate nursing students is limited but some benefits are evident in the application of transformative education (McCarthy *et al.,* 2018) which is aimed at enhancing students' self-awareness and their stress coping mechanism from their learning experience. One of the university in this study has included the management of stress and time management in its new

curriculum, where students are invited to attend a workshop run by the University Wellbeing Directorate in each year of their programme. The Health and Safety Executive's most recent report on 'Work-Related Stress, Depression or Anxiety' (HSE, 2017) also highlights the level of mental health difficulties in the health profession with Nurses and Midwives reporting the highest level of cases out of 100,000 workers (3,090), which underscores the importance of embedding the need for resilience training into the curriculum. As suggested by McDonald *et al.* (2013) a reflective space for facilitating critical and creative thinking complemented with a package of psycho-education to teach key aspects of resilience such as positive coping strategies, self-nurturance and problem-solving skills advocated by Boardman (2016) is worth considering.

Student support

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

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

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

Strengths and Limitations

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

Relevance for clinical practice

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

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

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

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

Conclusion

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

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

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

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

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