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Using Standardized Patients to Teach Mental Health in Baccalaureate Nursing Programs

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NURS 8000: Scholarly Project

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Abstract

Due to budget cuts to private and public mental health facilities, there have been limits to clinical placement sites in mental health for undergraduate baccalaureate nursing programs. This project explored whether simulation using standardized patients (SPs) could supplement some of the mental health clinical by reviewing the published literature about simulation using SPs as an adjunct to mental health clinical in undergraduate baccalaureate nursing programs. This literature review identified a dearth of studies about simulation using SPs in mental health undergraduate baccalaureate nursing programs (Brown, 2008). The outcome of this literature review discovered that simulation using SPs is a useful tool to develop student competence and confidence, decrease anxiety and fear, and enhance the use of therapeutic communication techniques in the mental health setting. There is a need for more studies about simulation using SPs in mental health undergraduate nursing education.

Due to the recent economic downturn there have been budget cuts to private and public mental health facilities, limiting possible clinical placement opportunities for nursing students in undergraduate baccalaureate nursing programs (Alexander & Dearsley, 2013). Limited funds available to both private and public schools have impacted how faculty in undergraduate nursing programs teach mental health curriculum. At times, mental health theory is combined with other courses, decreasing its importance. Undergraduate nursing programs have been lambasted repeatedly for the lack of time spent on teaching mental health (Happell, 2008). Compounding this shortage of clinical sites for student learning experiences is the increased patient acuity on many inpatient mental health units, causing an increase in nursing student anxiety levels.

The purpose of this scholarly project was to review the published literature about simulation using standardized patients (SPs) to teach mental health nursing in baccalaureate programs. Very few studies about the use of SPs to teach baccalaureate students about mental health nursing have been published in the literature (Brown, 2008, Rutherford-Hemming, 2012). Thus, this literature review explored the different uses of mental health simulation using SPs in the educational environment to teach undergraduate baccalaureate nursing students. The outcome of this review was to evaluate whether simulation using SPs is a useful tool to develop student competence and confidence, decrease anxiety and fear, and enhance the use of therapeutic communication techniques in a mental health setting. This review also evaluated if simulation-using SPs can replace part of

traditional clinical experiences while at the same time support transfer of learning objectives and outcomes to the clinical site.

Literature Review

The following definitions are from the International Nursing Association for Clinical Simulation and Learning (Meakim, Boese, Decker, Franklin, Gloe, Lioce, . . . & Borum, p. s9) were used to guide this project and conduct the review of literature. Simulation is defined as "a pedagogy using one or more typologies to promote, improve, or validate a participant's progression from novice to expert" (Meakim et al., 2013, p. s9). Standardized patient (SP) is defined as "a person trained to consistently portray a patient or other individual in a scripted scenario for the purposes of instruction, practice, or evaluation" (Meakim et al., 2013, p. s9). High fidelity is defined as "experiences using . . . standardized patients that are extremely realistic and provide a high level of interactivity and realism for the learner" (Meakim et al., 2013, p. s6).

For the review of literature, research articles were reviewed about mental health simulation using SPs in undergraduate baccalaureate nursing programs, including advantages and disadvantages of simulation. Benner's (1984/2001) seminal work, *From Novice to Expert: Excellence and Power in Clinical Nursing Practice,* and Kolb's (1984) experiential learning theory are discussed, along with their applicability to the use of simulation. Finally, *The Essentials of Baccalaureate Education for Professional Nursing Practice* (American Association of Colleges of Nursing [AACN], 2008), *Psychiatric-Mental Health Nursing: Scope and Standards of Practice* (American Nurses Association [ANA] & American Psychiatric Nurses

Association [APNA], 2014) are reviewed to demonstrate how these standards relate to and inform this project. Articles about the importance of communication in the mental health setting are also reviewed.

Use of Simulation to Teach Mental Health

Due to short placements in clinical practice settings, students have difficulty applying theoretical knowledge learned in the classroom during clinical experiences (Alexander & Dearsley, 2013; Happell, 2008). "Theoretical preparation is an important determinant of students' attitudes and experiences" (Happell, 2009, p. 44). According to Rodriguez (2013), there are many reasons for the shortage of clinical sites: "Shortage of RNs; a shortage of educated, qualified nursing faculty; safety and liability issues with hospitals; sometimes strained relationships between RNs in the practice setting and nursing students; lack of collaboration with other healthcare professionals; and the competition that exists for securing the limited sites available" (p. 3).

Simulation allows educators to enact "specific scenarios, assess outcomes, and reduce anxiety associated with unfamiliar skills in an often acute and frantic clinical setting" (Alexander & Dearsley, 2013, p. 152). Simulation using SPs offers a well-rounded experience that is safe and allows for real life clinical scenarios to be enacted. Students have the opportunity to apply theoretical knowledge to practice during a simulation experience.

Nursing students often experience great concern, fear, and anxiety about starting their mental health clinical rotation and this can affect the development of a therapeutic relationship with the mental health patient (Alexander & Dearsley,

2013; Brown, 2008; Buxton, 2011; Kameg, Clochesy, Mitchell, & Suresky, 2010; Kameg, Mitchell, Clochesy, Howard, & Suresky, 2009; Sleeper & Thompson, 2008). Fear and lack of confidence can inhibit student's ability to establish insight and absorb learning opportunities (Davis, Josephsen, & Macy, 2013). Students are afraid they will say the wrong thing, causing patient agitation, distress or harm (Sleeper & Thompson, 2008). If anxiety interferes with development of the therapeutic relationship it may have an adverse effect on patient outcomes (Szpak & Kameg, 2013). "Increased confidence and preparedness for clinical placement may contribute to reducing anxiety pre-placement" (Alexander & Dearsley, 2013, p. 159). Most students have little to no experience in a mental health setting and it likely contributes to this discomfort (Kameg et al., 2010).

Student's anxiety, for the most part, is due to uncertainty in using their communication skills (Sleeper & Thompson, 2008). Simulation allows educators to enact mental health scenarios to help relieve students' anxiety and improve communication skills with the "mentally ill" SP. Simulation helps students feel more prepared, thus decreasing their anxiety levels about mental illness and their clinical placement (Happell, 2008). In a study by Doolen, Giddings, Johnson, Guizado, and Badia (2014) about the use of SPs during a mental health simulation, 94 mental health undergraduate nursing students completed 11 questions using a Likert scale over three semesters. Students reported feeling less fearful, and the experience prepared them for mental health clinical. Using high fidelity manikins in a mental health simulation scenario, Lehr and Kaplan (2013) measured student anxiety levels before and after, and reported anxiety levels decreased after the simulation.

Happell (2008) states that unresolved anxiety may prevent nursing students from contemplating a career in mental health nursing. Szpak and Kameg (2013) investigated the effects of simulation on nursing student anxiety. A total of 44 students participated by completing a demographic questionnaire, a pre-and post-anxiety visual analogue scale, a pre- and post-State-Trait Anxiety Inventory, and a Simulation Evaluation Survey during two semesters in 2010. These researchers determined there were compelling positive changes in student anxiety levels after participating in simulation.

Not only are students ill-prepared for the mental health setting, many students have negative attitudes which can hinder their ability to develop communication skills necessary to be successful in this setting (Happell & Gough, 2007). Students' assumptions and beliefs about mental health nursing are often biased, contributing to fear and a lack of confidence in the mental health environment (Davis et al., 2013; Koskinen, Mikkonen, & Jokinen, 2011; Lang & Hahn, 2013; Robinson-Smith, Bradley, & Meakim, 2009). Two different studies suggest that preparing students with more classroom education and increased length of clinical placement in mental health nursing produces a better attitude (Happell, 2008; Happell & Gaskin, 2012).

In a study done by Dearing and Steadman (2008) 94 nursing students participated in a voice simulation study (VSE). Fifty-two students were in the experimental group and 42 were in the control group (Dearing & Steadman, 2008). It was surmised that nursing students' negative attitudes towards the mentally ill would change for the better after participating in this study. Both groups were

administered an 11-item Medical Condition Regard Scale (MCRS) used to measure attitudes and health care-related behaviors before orientation to a mental health clinical site and again at the end of the mental health clinical. The experimental group was given a 45-minute audiotape of simulated distressing voices to listen to and the control group did not receive the tape. The experimental group gained a significant amount of insight and a changed attitude towards mentally ill clients versus the control group who did not develop the same degree of insight and changed attitude.

A study done by Koskinen et al. (2011) in Finland using data collected about 39 critical incidents written by 20 Finnish second year nursing students during a 5-week mental health clinical found that the nursing students had negative attitudes and biases towards mental illness at the start of their mental health clinical. However, these attitudes gradually changed when students faced their own emotions and developed coping skills. Koskinen et al. (2011) also reported students' self-awareness and self-esteem increased, interpersonal skills deepened, the students learned new ways of coping, and they developed new nursing skills.

Another way to address the student's fears and beliefs is through simulation using SPs. A benefit of simulation is the ability to stop a scenario to immediately address less than optimal practice and reduce the chance for damaging or dangerous situations to occur (Alexander & Dearsley, 2013). The ability to stop a scenario allows the educator to address concerns or issues with students.

Equipping students with simulations that have a specific focus prepares them for their first mental health clinical. A pilot study by Alexander and Dearsley (2013)

using a convenience sample of 33 students explored the influence simulation has on clinical readiness in the mental health setting. Students participated in a pre- and post- clinical questionnaire developed by Alexander and Dearsley (2013) and reported feeling better prepared for mental health clinical following simulation, which positively influenced the development of the student/patient therapeutic relationship and increased confidence. The researchers also reported increased student interest in mental health after this innovative study. Half of the students elected to enroll in a mental health elective the final semester and half of these went on to apply for graduate programs in mental health. The researchers acknowledged, "a larger, more rigorous study is needed to validate the findings of this pilot study" (Alexander & Dearsley, 2013, p. 161).

Simulation using SPs is an excellent adjunct to mental health clinical placement, especially with the shortage of clinical sites (Webster, 2014). Simulation using SPs has been used to replace clinical experiences in mental health when there is an absence of actual clinical sites (Davis et al., 2013). An example of using simulation to exclusively teach mental health in a baccalaureate-nursing program is at Boise State University, Idaho (Davis et al., 2013). This innovative teaching strategy was implemented due to budget cuts for mental health treatment and a severe shortage of clinical placement sites.

In a research study done by Szpak and Kameg (2013), the majority of the 44 students who participated agreed that simulation should be included in the curriculum, but should not replace all of the clinical experiences. Kuiper, Heinrich, Matthias, Graham, and Bell-Kotwall (2008) agreed that simulation cannot replace

experiences with real patients but it offers a chance for students to participate in an array of different scenarios, presents a variety of different clinical problems, and allows the student to practice clinical reasoning skills.

Festa, Baliko, Mangiafico, and Jarosinski (2000) conducted a study about simulation with a SP and used videotaping of the interaction to provide feedback to 10 students. Noted by the researchers was the students' lack of experience observing nonverbal behavior in an SP. The videotaping was reported to increase student self-awareness, heighten their development of mental health skills, and be useful as a way to assess student comprehension of curriculum objectives and content. Most students reported increased learning, self-awareness and the ability to cope after the simulation experience.

According to Jeffries (2005), teaching is often instructor-centered in the classroom. In simulation, teaching is often student-centered while the instructor coordinates the students' learning experience (Jeffries, 2005). The instructor may take an active participant role or passive observational role during simulation depending on whether the simulation is set up for student learning or assessment (Jeffries, 2005).

Simulation can also encourage collaborative learning much like real life where everyone has to work together (Jeffries, 2005). Working together increases collegiality and teamwork, often results in faculty-student connection and bonding (Jeffries, 2005). Simulation helped 60 students develop professional and interprofessional communication skills in a non-experimental pilot evaluation study

done by Schoening, Sittner, and Todd (2006) and evaluation was done using a 10-item 4-point Likert scale and reflective journals.

Clear objectives are a must in simulation and should match the learner's level of knowledge and experience (Jeffries, 2005). Simulations should be high fidelity and match reality as much as possible for better learning outcomes (Jeffries, 2005). Complexity can vary and cues can be provided at different steps in the simulation to help the student progress through the scenario. Didactic knowledge learned in simulations may last longer than knowledge gained in traditional lectures and learning outcomes are just as good with simulations as they are with lectures (Jeffries, 2005). There is increased learner satisfaction, critical thinking skills, and self-confidence in simulation (Jeffries, 2005).

In study called the "Blast Model", Lang and Hahn (2013) integrated three phases of learning in a mental-health nursing course. The first phase involved didactic/lecture; the second phase used simulation with SPs; and the third phase and final phase used debriefing, reflection, and critical thinking. The researchers reported that all second-degree bachelor of science in nursing (BSN) program students who participated in the three phases of the Blast Model were prepared for their first mental health clinical and were ready to communicate with the mental health patient. According to Lang and Hahn (2013), the Blast Model decreased student anxiety and fear and increased their self-confidence in the mental health setting. Many students suggested that the Blast Model helped to link theoretical concepts taught in class with clinical experiences. Students thought that the reflection portion of the Blast Model was helpful and assisted them to become aware

of their own feelings and prejudices towards mental illness. The success of the Blast Model is associated with linking didactic classroom content with high fidelity simulation using a SP. According to Lang and Hahn (2013), a lesson learned with the Blast Model is that successful simulation requires sufficient training of the faculty. The researchers concluded that the Blast Model decreased student anxiety and improved self-confidence, which is a precursor to developing a therapeutic relationship with a mental health patient.

Results of the National Council of State Boards of Nursing Simulation Study

Simulation has been found to be a practical and effective substitute for some traditional clinical placements and may be a strategy to increase student enrollment when there is limited clinical placement sites (Sportsman, Schumacker, & Hamilton, 2011; Webster, 2014). The National Council of State Boards of Nursing (NCSBN, (2014) conducted a longitudinal, randomized, controlled study to investigate the efficacy of replacing clinical hours with simulation in pre-licensure nursing education. According to the NCSBN (2014), this study "is the largest, most comprehensive study to date that explores whether simulated clinical experiences can be substituted effectively for traditional clinical experiences in the undergraduate nursing program" (p. s6). A total of 666 out of 847 students completed the study and the demographic characteristics of the group who started the study were similar to the group who finished the NCSBN study. The students who consented to participate in the NCSBN (2014) study were randomly assigned to one of three groups: a control group with no more than 10% of clinical hours in the simulation laboratory, a group with 25% of their clinical hours replaced by

simulation, or a group with 50% of their clinical hours replaced by simulation throughout two years of enrollment in their nursing program.

The intent of the NCSBN (2014) study was to furnish boards of nursing with "evidence on nursing knowledge, clinical competency, and the transferability of learning from the simulation laboratory to the clinical setting" (p. s6). The students who participated in the study were enrolled for the entire 2 years of their undergraduate nursing program in five associate degree in nursing (ADN) and five BSN in nursing programs throughout the United States. The study was divided into two phases. The first phase included a randomized, controlled study which occurred throughout the students' entire 2-year nursing program; and the second phase involved a follow-up survey of new graduates and their managers during the first 6 months of clinical practice. "The study measured students' knowledge, competency, and critical thinking as well as their perceptions of how well their learning needs were met" (NCSBN, 2014, p. s8).

During the NCSBN (2014) study, clinical competency was measured using three different instruments: the Creighton Competency Evaluation Instrument (CCEI), the New Graduate Nurse Performance Survey (NGNPS), and the Global Assessment of Clinical Competency and Readiness of Practice (GACCRP). The NGNPS was administered in the last weeks of the nursing program. Less than a one-point difference among the mean scores above 0.5 was reported among the three groups, meaning that students' instructors and preceptors rated students clinically competent. Preceptors and instructors rated students in all three groups on a scale of 1-10 (1 = *weakest students* and 10 = *best students*); the mean scores for all three

groups were above 8 and no statistical differences in the GACCRP were identified. Critical thinking was measured by using the Critical Thinking Diagnostic which has a reliability of 0.976 based on the Cronbach's Alpha Coefficient: all three groups had scores above 5 on a scale of 1-6, using a scale with 1 = the lowest rating and 6 = the highest rating.

Of great interest for the purposes of this project were the NCSBN (2014) study results for the mental health-nursing course. The mental health nursing knowledge assessments showed that the group with 50% of clinical hours replaced with simulation scored higher than the group with 25% of clinical hours replaced with simulation and the control groups. Results of the ATI Content Mastery Series examinations were significantly higher for the 50% group than the 25% and control group. The 50% and 25% groups had higher scores than the control group on mental health assessment. The Creighton Competency Evaluation Instrument (CCEI) score ratings reported for all groups were similar. Clinical scores were higher for the control group than the 25% and 50% group. These findings demonstrate that simulation is a good option to replace at least 50% of mental health clinical without compromising student knowledge acquisition and clinical competence.

The Clinical Learning Environmental Comparison Survey (CLECS) was used for the NCSBN (2014) study to assess students' perceptions on how well they believed their learning needs were met. The control group rated the clinical environment higher than the simulation environment, the 25% group rated

simulation in the middle with clinical environment slightly higher, and the 50% group rated the simulation environment higher in meeting their learning needs.

At the end of the NCSBN (2014) study, student knowledge was measured using the ATI RN Comprehensive Predictor 2010 based on 150 questions that are administered using a web-based, proctored exam. Findings reported by the NCSBN (2014) reported no statistically significant differences among the three study groups with a total score of (p=0.478). Data were collected about students during their entire 2-year nursing program and 6 months afterward and "found no significant differences among the three study groups' end-of-program educational outcomes" (NCSBN, 2014, p. s28). The NCSBN (2014) concluded, "there were no statistically significant differences among the three study groups in total score (p=0.478)" (p. s14).

The National Council Licensure Examination (NCLEX) measures the competencies needed to perform safely and effectively as a newly licensed, entry-level registered nurse after graduating from the nursing program (NCSBN, 2014). A total of 660 the 666 nursing students who participated in the NCSBN (2014) study took the NCLEX and the pass rate was 86.8% for the entire group, which was higher than the national average of 80.2%. The control group had an 88.4% pass rate, the 25% group 85.5%, and the 50% group 87.1%. Although the control group had a higher NCLEX pass rate than the other two groups it was not statistically significant.

The NCSBN (2014) study also included a follow-up 6-week survey with nurse managers: 135 surveys (38%) were included in the analysis, with the 3-month survey 89% of new graduates and 68% of managers responded, and with the 6-

month survey 86% of new graduates and 66% of managers responded. The managers completed the New Graduate Nurse Performance Survey (NGNPS, which consists of 36 items rated on a scale of 1-6 with 1 = lowest and 6 = highest) electronically and new graduates completed a self-assessment electronic survey. The results of the NCSBN (2014) 6-week manager survey showed significantly better results in clinical knowledge for the 25% and 50% groups over the control group and the critical thinking ratings for the 25% group were statistically better. Managers gave high ratings to new graduates using the critical thinking scale while new graduates rated themselves lower.

The NCSBN (2014) study had limitations: The schools participating in the study were not randomly selected, the preceptors and clinical instructors were not blinded as to which study group the students were in assigned, and the distribution of the end-of-program survey to clinical preceptors for the capstone course was the responsibility of the student. It was surmised that weaker students may not have given the surveys to their preceptors and likewise to their nurse managers making the results biased toward the stronger students. In summary, the NCSBN (2014) study found, "There were no significant differences among study groups regarding end-of-program nursing knowledge, clinical competency, or overall readiness for practice" (p. s36). Findings for all assessments measuring educational outcomes in the NCSBN study were consistent and support replacing up to 50% of clinical experience with simulation, under conditions comparable to the study.

The results of the NCSBN (2014) study "indicate that the skills learned in simulation transfer to the clinical setting" (p. s37). This has been the concern of

different researchers. For example, Kameg et al. (2009) reported that further studies were needed to evaluate the skills taught during a simulation experience and whether these skills are transferable to the clinical setting. Other studies support the findings of the NCSBN (2014) study. For example, a study conducted by Kirkman (2012) reported a significant transfer of learning from simulation to traditional clinical environment among 42 students who were observed and apprised. In a descriptive research using simulation experience with SPs, by Rutherford-Hemming (2012), reported that 14 acute care nurse practitioner students showed growth in their competency from the SP simulation to the clinical setting. Meyer, Conners, Qingjiang, and Gajewski (2011) conducted a study with 120 junior nursing students substituting 25% of clinical hours for simulation and found improved clinical performance evaluated with a Likert–style tool. The result of the NCSBN study question about whether skills taught in simulation transfer to the clinical setting has been answered in the positive.

Simulation Using Standardized Patients to Teach Mental Health Nursing

Faculty can use many creative teaching methods to teach mental health nursing including simulation-using SPs, the focus of this paper. Although the use of SPs to teach mental health nursing to undergraduate nursing students is reported to be an effective teaching method, there has been a dearth of research (Doolen et al., 2014). Many different simulation methods are used in nursing such as high fidelity manikins, human patient role-playing, SPs, and virtual patient simulation (Brown, 2008; Dreifuerst, 2010). Students take the part of the nurse, family member, patient, or observer to learn clinical skills in a safe environment. Students benefit

from observing simulation and learn just as much or more about communication from observing their peers who are interacting with an SP in a simulation (Lehr & Kaplan, 2013).

Simulation using SPs is rarely adopted to teach mental health nursing and research on the use of simulation in undergraduate mental health education has been limited (Brown, 2008; Crider & McNiesh, 2011; Hermanns, Lilly, & Crawley, 2011; Kameg et al., 2010). Because much of communication is nonverbal, the use of high fidelity manikins is thought to be ineffective when used in teaching students how to engage and communicate with mentally ill patients (Brown, 2008). Simulation using a high fidelity manikin proves to be inadequate in many respects because educators are challenged to provide a simulation environment that is realistic (Brown, 2008; Doolen et al., 2014).

Simulation can employ SP actors that are "carefully trained to present an illness or scenario in a systematic, unvarying manner" (Becker, Rose, Berg, Park, & Shatzer, 2006, p. 104). According to Becker et al. (2006), SPs are effective in assessing and teaching valuable skills such as therapeutic communication, patient education, history taking, interviewing, physical, and mental health assessment. Simulation can be used summatively to assess competence and formatively to assess skill acquisition (Brown, 2008). There are advantages to using formative learning in simulation including the ability to reflect on the experience, observe the student's performance, and realism of the scenario (Sideras, McKenzie, Noone, & Frazier, 2013). An SP is taught to give feedback to students on their interpersonal skills and to portray a mental health patient in a realistic manner (Doolen et al., 2014).

Robinson-Smith et al. (2009) did a study with 112 junior-level undergraduate nursing students with simulation using SPs to assess this approach to clinical learning. Student satisfaction, self-confidence, and critical thinking were evaluated using a modified Student Satisfaction Survey from the NLN and Self-Confidence in Learning Survey from the National League of Nursing. It was found that students were pleased with the instructional method of simulation using SPs and expressed an increased self-confidence with communication skills. Faculty was able to recognize when students weren't learning well and where they had clinical weaknesses so they could provide remediation.

Sideras et al. (2013) suggest using moulage in simulation to enhance realism. Moulage is the use of props, makeup and wounds in simulation. It is worthwhile to carefully prepare the simulation environment to imitate real patient situations. Simulation stimulates active learning and participation of the student nurse (Hermanns et al., 2011). It is important to use appropriate communication techniques when reporting off to another member of the healthcare team during simulation exercises. Lehr and Kaplan (2013) recommend using the Situation-Background-Assessment-Recommendation (SBAR) communication technique to give report to another healthcare provider during simulation exercises.

The increased use of simulation in nursing programs is a result of the nursing shortage, the ensuing expansion of nursing student enrollment, dwindling accessibility of clinical sites, increased affordability of simulation equipment, approval as a useful teaching method, necessity to focus on patient safety, and the documented capability of simulation to strengthen clinical practice (Kameg et al.,

2009). Simulation using SPs helps to meet the objectives of mental health nursing courses, which include the development of the following competencies: therapeutic communication, assessment, negotiation, advocacy, consultation, mental status exams, interpersonal skills, therapeutic nursing interventions, self-evaluation, professional socialization, and risk assessment; while at the same time reflecting the didactic content learned in lecture (Doolen et al., 2014; Edward, Hercelinskyj, Warelow, & Munro, 2007; Robinson-Smith et al., 2009). Therefore, the use of simulation using SPs is well suited to the educational environment of today's nursing programs. It is crucial that nurse educators conduct research into whether simulation, using SPs, is a successful teaching approach (Webster, 2014).

Debriefing

Debriefing is defined as an "activity that follows a simulation experience and is led by a facilitator" (Meakim et al., 2013). Participants are given feedback and encouraged to take a look at their own performance. Various parts of the simulation experience are discussed. Participants are prompted to reflect on how the experience made them feel and encouraged to give feedback to other participants. The *Psychiatric-Mental Health Nursing: Scope and Standards of Practice* (ANA & APNA, 2014) encourages nurses to obtain "informal feedback regarding practice from patients, peers, professional colleagues, and others . . . takes action to achieve goals identified during the evaluation process" (p. 80). The main purpose of debriefing is for the participants to be able to use what they learned in situations that come up in the future. "Debriefing . . . fosters the development of clinical reasoning and judgment skills through reflective learning processes" (Dreifuerst,

2009, p. 109). Debriefing objectives will have the nursing student reflect on his/her reactions, feelings, and interpretation of what happened during the simulation experience. It is well documented that reflective learning is an important adjunct to critical thinking and decision-making and should be integral to the debriefing experience (Dreifuerst, 2009, Kuiper et al., 2008, Schoening et al., 2006).

It is imperative that debriefing connect the simulation experience to mental health theory, objectives, and skills. According to Dreifuerst (2009), debriefing can be reflective and encourages nursing students to examine their beliefs and work toward mastering important nursing skills. Reflection involves looking back at what happened and using this knowledge in the present. Reflection is an essential educational method for nursing students in their mental health clinical (Koskinen et al., 2011). "Based on the theoretical framework of transfer of learning . . . the transfer of learning occurs whenever previously learned knowledge and skills affect the way in which new knowledge and skills are learned and performed" (Kirkman, 2012, p. 2). A nursing student is expected to anticipate what will be needed in the present by looking back at previous experiences. Debriefing can help students develop the ability to correct mistakes, especially when educators assist students to identify and resolve clinical and behavioral predicaments that happen during a simulation exercise (Kuiper et al., 2008).

Debriefing meets standard 5B of the *Psychiatric-Mental Health Nursing: Scope and Standards of Practice* (ANA & APNA, 2014) because nursing students seek "opportunities from the individual healthcare consumer for feedback and evaluation of the effectiveness of strategies utilized" (p. 55). Guided reflection is an important

approach that is implemented during debriefing (Dreifuerst, 2010). Reflective learning can happen regardless of the student's biases and negative attitudes in relation to mental illness (Koskinen et al., 2011). Reflectively writing about an incident may help students perceive their own beliefs, feelings, reactions, and the impact of the incident (Koskinen et al., 2011).

Debriefing is connected to clinical reasoning, clinical judgment, and clinical thinking skills. These skills are important traits needed to move from novice to expert nurse (Dreifuerst, 2009). According to Grant, Keltner, and Eagerton (2011), debriefing is as important as simulation and is most effective if done right after the simulation event. Unfortunately, debriefing is a teaching strategy that is inadequately understood and its importance is sometimes overlooked (Driefuerst, 2009; Jeffries, 2005). Nurse educators expect nursing students to connect knowledge learned from one situation to the next. A nursing student must build upon a situation and bring forth knowledge that will help provide safe and effective nursing care (Dreifuerst, 2009). According to Dreifuerst (2009), significant learning experiences are possible with debriefing for simulation.

One example of an effective teaching method for simulation is Debriefing for Meaningful Learning (DML) developed by Kristina Thomas Dreifuerst for her dissertation project at the University of Indiana in Bloomington, IN (2010). Dreifuerst's project explored the effect of the DML method on the development of clinical reasoning compared to the usual debriefing methods. Dreifuerst reported that there were positive statistical differences between DML and traditional debriefing methods. According to Dreifuerst, clinical reasoning and critical thinking

are advanced through simulation where faculty inspire, direct, and encourage reflection activities. The DML debriefing method uses guided reflection and concept mapping as teaching-learning strategies (Dreifuerst, 2010). This method allows the student to have increased understanding, self-assurance, and skills learned can be used from one experience to the next.

Therapeutic Communication

The mental health setting involves the use of therapeutic communication techniques rather than the usual set of psychomotor skills needed in other settings and can therefore catch students off guard if they are not properly prepared (Kameg, et al., 2010). According to Gilje, Klose, and Birger (2007), therapeutic communication is the first of eight critical clinical competencies in mental health nursing. Therapeutic communication impacts the formation of nursing interventions, which augment patient health, wellbeing, and progress towards objectives.

The mental health nurse "demonstrates effective clinical interviewing skills that facilitate development of a therapeutic relationship" (ANA & APNA, 2014, p. 44). Students have a chance to practice communication skills during simulation using SPs. Communication is a fundamental skill needed in all areas of nursing, particularly the mental health setting (Becker et al., 2006; Grant et al., 2011; Kameg et al., 2010; Sleeper & Thompson, 2008). Using simulation, educators are able to observe students without disturbing the development of the therapeutic relationship between the student and SP, unlike clinical learning experiences (Kameg et al., 2010).

According to the *Psychiatric-Mental Health Nursing: Scope and Standards of Practice* (ANA & APNA, 2014) two areas of concern for mental health nurses are "self-harm and self destructive behaviors" (p. 21) and "violent behavior" (p. 21). Students need communication skills when working in the clinical mental health environment to manage patient issues, such as escalating behavior. Communication skills are needed to help deescalate patient behavior. Simulation allows for a safe, controlled environment to practice and develop essential communication skills while at the same time decreasing student anxiety (Doolen et al., 2014). Szpak and Kameg (2013) conducted a study, in which 44 students participated, and examined whether simulation can decrease nursing student anxiety. Using a pre- and post-anxiety visual analogue scale and pre- and post-State Trait Anxiety Inventory, Szpak and Kameg (2013) found a significant decrease in the level of anxiety after the simulation experience.

Simulation can also help nursing students learn to establish boundaries and develop a therapeutic relationship with a patient. In a non-random assignment, quasi-experimental study done by Kameg et al. (2010) using two teaching methods, traditional lecture and high fidelity human simulation, 46 students had improved self-efficacy of communication skills measured using the General Self-Efficacy Scale and two self-efficacy visual analogue scales after a simulation experience. Even though there are limited studies investigating simulation using SPs as a method to teach communication skills, simulation is reported to assist undergraduate nursing students to become competent in communication while practicing essential mental health nursing communication skills (Kameg et al., 2009).

According to Kameg et al. (2009) misunderstandings due to lack of communication compromises patient safety. Nurse educators must develop effective approaches to teaching students practical and competent communication skills (Kameg et al, 2009). Students must learn effective communication skills in order to provide safe nursing care.

According to Sleeper and Thompson (2008), multiple barriers to teaching and developing therapeutic communication skills exist in nursing education. Large class size and lack of available time make it difficult for nurse educators to educate students about therapeutic communication, let alone find time to practice these skills and assess the student's competency. It is important that nursing students practice therapeutic communication skills and develop this competency.

The usual communication teaching methods are often inadequate and challenging to employ. Yoo and Yoo (2003) conducted a quasi-experimental research study using a written test to evaluate clinical judgment and a clinical skills checklist to evaluate students' clinical skills. A total of 36 students experienced simulation using SPs and scored higher in communication skills than a control group comprised of 40 students who received traditional lecture and laboratory method.

Research targeting students' feelings using SPs also needs to be conducted to evaluate the effects of using simulations with SPs on communication skills (Sleeper & Thompson, 2008; Szpak & Kameg, 2013; Webster, 2104). According to Kameg et al. (2009) additional studies are needed to determine how simulation can assist the student in learning therapeutic communication techniques to develop therapeutic relationships with the mental health patients.

Therapeutic Use of Self

Therapeutic use of self is the second competency identified by Gilje et al. (2007) and is the skill of using one's personality intentionally and perceptively, with complete presence and purpose. The *Psychiatric-Mental Health Nursing: Scope and Standards of Practice* (ANA & APNA, 2014) lists some characteristics of the artful use of self, "respect for the person or family, availability, spontaneity, hope, acceptance, sensitivity, vision, accountability, advocacy, and spirituality" (p. 27). The therapeutic use of self is required in mental health nursing and involves using different features of a nursing student such as personality, experience, knowledge, and life skills (Edward et al., 2007). The mental health patient must be able to trust a person and feel safe in order to disclose confidential information that he/she may not have talked about before.

The *Psychiatric-Mental Health Nursing: Scope and Standards of Practice* (ANA & APNA, 2014) includes a measurement criterion in Standard 5F stating that a registered nurse "provides support and validation to healthcare consumers when discussing their illness experience" (p. 61). This is a skill that can be practiced during the simulation experience using an SP. Simulation allows the educator to observe the nursing student's competency with mental health skills since it is often difficult to directly observe students to evaluate the use of self in the mental health clinical environment (Alexander & Dearsley, 2013). Simulation using SPs is also useful in addressing issues such as ethics, end of life care, and determining the student's competency with therapeutic communication and the therapeutic use of self.

Challenges

The successful implementation of simulation using SPs for mental health in undergraduate baccalaureate nursing programs has many challenges. The challenges include difficulty in recruiting a large pool of human actors that can authentically play the role of a mental health patient, determining the optimal level of complexity for each situation, and providing feedback that is useful about deficiencies while remaining positive (Davis et al., 2013). Other challenges related to advantages and disadvantages of simulation follow.

Advantages of simulation using SPs for mental health nursing include: Creating real life situations for nursing students without incurring risk to the patient, interactive learning, enhanced decision making and assessment, ability to stop a simulation in order to replay events or critique performance, and ability to standardize training for students (Kameg et al., 2009; Sportsman et al., 2011). Simulation allows the educator to present the same patient problem to students in conjunction with what is being taught in class. Students can also practice skills in a less threatening and controlled environment (Becker, 2006; Keltner, Grant, & McLernon, 2011).

Disadvantages of simulation using SPs for mental health nursing include: cost of equipment, training staff and space needed, and lack of studies looking at the cost-benefit ratio to higher education (Kameg et al., 2009). Additional disadvantages include: Simulation debriefing requires a great deal of time to prepare, difficulty in engaging certain groups of students, and inability to assure that all students will prepare appropriately for the simulation experience. It takes

considerable time to plan simulation scenarios in which personal, family, social history along with accurate emotional states to represent the patient's personal history (Becker et al., 2006). According to Brown (2008), the literature shows a lack in evaluation of simulation activities making it a priority that educators develop a tool measuring effectiveness.

Exemplar of a Mental Health Simulation

An exemplar of mental health simulation using a SP involved the author of this paper. With 22 years of experience working in an intensive inpatient psychiatric unit, the author participated in a mental health simulation scenario at a liberal arts university in the Midwest as part of her graduate program. The author played the part of the patient who was diagnosed with post-traumatic stress disorder, depression, and panic attacks. After the scenario, the author participated in an expert mental health panel to debrief nursing students and answer their questions. The students appreciated this relaxed form of debriefing, asked and answered many questions about the mental health scenario, and learned about mental health in general while achieving the learning outcomes of the simulation experience. This author's experience is confirmed by findings reported in the literature for example, simulations have been found to stimulate discussions between faculty and students that support the accomplishment of course objectives (Jeffries, 2005).

Theoretical Frameworks

Benner's novice to expert theory (1984/2001) informs and relates to the use of simulation using SPs to teach mental health in baccalaureate nursing programs.

Benner's theory proposes that providing real life situations can assist the student nurse to practice and improve their clinical competence. Simulation is an ideal method to practice and improve competence. According to Benner (1984/2001), nursing practice grows with experiential learning. To obtain excellence in nursing practice one must take action and use critical thinking skills in certain situations. "Experiential learning in high-risk situations requires courage and supportive learning environments" (Benner, 1984/2001, p. VII). Simulation is an ideal method for the student nurse to gain experience without the risk. Benner believes that a nurse must be intent to improve helping and caring practices. Caring practices help patients and families deal with their illnesses. Simulation can help a student nurse develop caring practices and the therapeutic use of self. According to Kameg et al. (2009), the therapeutic use of self is a primary tool used in mental health nursing.

Benner (2004) uses the Dreyfus model of skill acquisition that observes a practice situation to determine a person's skill level. The Dreyfus model emphasizes a person's strengths and practice capacities. The ability to recognize patient problems takes practice. Perceptions change as a nurse gains experiences with impact and when a nurse learns something new, practice can be transformed (Brown, 2008). Simulation can provide a safe place to practice therapeutic communication techniques. Whether the student demonstrates good rapport or poor communication, it can help increase their ability to self-reflect and gain insight. This insight can teach a student something new about their practice, and when mistakes happen, corrective action can be taken. Simulation focuses on the good in a situation and corrective actions when mistakes occur.

Benner (1984/2001) teaches that skills are taught holistically, as a whole, not in individual parts. In order to master a skill, one must have experience in performing it. According to Benner, ethical and clinical knowledge are in tandem, one cannot function without the other (Altmann, 2007). "At some point during the mental health practice, students will witness or become involved in incidents that may challenge their professional ethics and arouse strong emotions" (Koskinen et al., 2011, p. 623). Nursing students must come to terms with their emotional responses because these responses affect their moral beliefs. It is very important to examine one's belief system, lest emotional responses come as a surprise. It is important for the students to come to terms with personal beliefs and biases before beginning their of mental health clinical. As Altmann (2007) asserts, "We acquire personal knowledge, at least in part, by immersing ourselves in practice" (p. 16). Simulation is a safe environment to explore emotional reactions to personal beliefs and biases toward mental illness. It is important to enter the clinical environment armed with self-knowledge to avoid negative nonverbal behavior. The mentally ill patient is often attuned to the subtle nuances of nonverbal communication and able to perceive a student's negative reaction. This could inhibit the development of the student-patient therapeutic relationship.

Students must gain experience before they can develop expertise in an area. Simulation provides a safe environment for students to gain experience in interacting with a mentally ill patient and practicing therapeutic communication techniques with this population. As students develop their communication skills, they become increasingly comfortable, and experience decreased stress as they

enter the mental health environment. Simulations are an ideal method for the learner to practice situations and make decisions. Simulations provide learners with situations they may not encounter in an actual clinical experience but are essential to learning. Acquiring new skills can modify perception and change clinical judgments (Benner, 1984/2001). Simulation using SPs fits in well with Benner's theory.

Kolb's theory of experiential learning (1984) is also applicable to the use of simulation and SPs to teach mental health nursing. In Kolb's theory, a concrete learning experience is followed by observation on the experience, followed by the formation of abstract concepts and conclusions, which are used to hypothesize future situations (Davis et al., 2013). Learning is knowledge that is created through a transformational experience. Often the experiences happen in real life situations. According to Doolen et al. (2014), two events happen during the transformational experience, the first is grasping the experience (apprehension); the second is transforming the experience (comprehension). During simulation the participant has a concrete learning experience followed by observation and reflection on the experience in debriefing. During the simulation and debriefing the participant will form abstract concepts and come to conclusions. The intention is that the simulation and debriefing experience will be used to hypothesize and inform future situations during clinical experiences.

Mental Health Standards and Competencies

The use of SPs may improve the competency of nursing students who work with patients with mental health disorders no matter the clinical setting (Doolen et

al., 2014). Many state boards of nursing allow simulation to replace part of clinical hours and recognize that simulation is a valuable teaching method. However, as previously described, there is a scarcity of literature and research applicable to clinical competencies in mental health nursing education (Gilje et al., 2007).

Nursing programs in the United States use national standards with core competencies as the foundation to their curriculum (Gilje et al., 2007). *The Essentials of Baccalaureate Education for Professional Nursing Practice* (AACN, 2008) states that nursing education should work with practice environments to coordinate both the practice and education environment. Safety is fundamental to the mental health environment and undergraduate baccalaureate nursing students should learn fundamental basics of safety, be able to work with the interprofessional team to provide a safe, and caring milieu. Safety is the fourth competency in mental health nursing developed by Gilje et al. (2007). This fourth competency is to be persistent in the care of physical and emotional wellbeing of patients, self, and others. Physical and emotional safety includes independence from mental and physical harm. Standard 5F in *Psychiatric-Mental Health Nursing: Scope and Standards of Practice* (ANA & APNA, 2014) states, the registered nurse "Conducts ongoing assessments of the healthcare consumer in relation to the environment to guide nursing interventions in maintaining a safe environment" (p. 60). Nursing faculty should teach students evidence-based safety practices. Safety practices can be taught in the simulation environment.

According to Gilje et al. (2007) the eight critical competencies required of mental health nursing students include therapeutic communication, therapeutic use

of self, nursing process, safety, clinical learning, dialogue, faculty guidance, and professional conduct. Gilje et al. (2007) explain the competencies were developed because these competencies contribute to evidence-based judgment to inform curriculum improvements in teaching mental health. Gilje et al. (2007) state that these eight competencies are just a beginning list of competencies in mental health nursing, there are many more. The competencies related to therapeutic communication (first competency), therapeutic-use-of-self (second competency), and safety (fourth competency) have already been addressed previously in this project; the following paragraphs address the remaining five competencies identified by Gilje et al. (2007).

The third competency addressed by Gilje et al. (2007) is the nursing process. The nursing process is the application of "assessing, planning, implementing, and caring interventions for selected mental health patients" (Gilje et al., 2007, p. 523). The nursing process is discussed in the *Psychiatric-Mental Health Nursing: Scope and Standards of Practice* (ANA & APNA, 2014) in the Standards of Care, standards 1-6. In standard 4, the registered nurse "prioritizes elements of the plan based on the assessment of the healthcare consumer's level of risk for potential harm to self or others and safety needs" (p. 50). The entire nursing process is used throughout simulation using SPs.

The fifth competency, clinical learning, "is to actively participate in all clinical learning experiences" (Gilje et al., 2007, p. 523). During simulation using SPs the nursing student is actively involved in the learning experience.

"The sixth competency is to dialogue openly and clearly, both, verbally and in writing, with assigned clinical faculty" (Gilje et al., 2007, p. 523). The nursing student dialogues with the assigned faculty during simulation using SPs when they give report using the SBAR technique, during debriefing, and assignments handed in to faculty.

"The seventh competency is to seek faculty guidance when incorporating faculty feedback into practice" (Gilje et al., 2007, p. 524). During simulation the student nurse or faculty can call a time out to get/give guidance that can be incorporated into simulation using an SP.

"The eighth competency is to demonstrate professional conduct" (Gilje et al., 2007, p. 524). The student nurse must have professional conduct during all simulation exercises. According to the *Psychiatric-Mental Health Nursing: Scope and Standards of Practice* (ANA & APNA, 2014) a mental health nurse "uses the *Code of Ethics for Nurses with Interpretive Statements* (ANA, 2001) to guide practice" (p. 67). Nursing students need to adhere to the code of ethics during all simulation exercises and practice situations.

Communication is an essential competency in nursing programs that is mandated by national nursing organizations such as the AACN (Kameg et al, 2010). Nurse educators must be prepared to teach communication techniques to undergraduate nursing students and give them feedback regarding their competency in communication skills (Kameg et al., 2010). Communication skills are specifically addressed in *The Essentials for Baccalaureate Education for Professional Nursing Practice* (AACN, 2008). According to Lehr and Kaplan (2013), the focus of

The Essentials is on outcomes, strong critical reasoning, clinical judgment, communication, and assessment skills.

Mental health nursing is "committed to promoting mental health through assessment, diagnosis, and treatment of behavior problems, mental disorders, and comorbid conditions across the lifespan" (ANA, 2007, p. 19). According to the *Psychiatric-Mental Health Nursing: Scope and Standards of Practice* (ANA & APNA, 2014), "Psychiatric-mental health nursing intervention is an art and a science, employing a purposeful use of self and a wide range of nursing, psychosocial, and neurobiological evidence to produce effective outcomes" (p. 1). Nursing is responsible for a safe milieu and this pertains to nursing students who have not had experience with mental health patients. Nursing students can practice and develop safe mental health nursing skills in simulation learning environment without the fear and anxiety that real life mental health clinical experiences often produce. Ultimately, the literature suggests the use of simulation with SPs advances the goals of mental health nursing by improving the quality of student learning experiences while protecting the safety and well-being of mental health patients.

Conclusions and Recommendations

There is a lack published research of mental health focused simulation using SPs for undergraduate baccalaureate nursing students. The purpose of this paper was to review the published literature about simulation using SPs to teach mental health in baccalaureate nursing programs. After reviewing the literature and perusing different articles about simulation, as well as evaluating professional and academic standards that inform curriculum development in baccalaureate nursing

programs, the following conclusions about the use of simulation with SPs to teach mental health nursing can be made:

1. Nursing students' competence and confidence increased,
2. Nursing students experienced decreased anxiety and fear,
3. Nursing students improved the use of therapeutic communication techniques while participating in a mental health simulation using SPs, and
4. Mental health learning objectives and student learning outcomes and transferability to clinical can be accomplished with simulation using SPs.

Unfortunately, simulation using SPs is rarely adopted to teach mental health nursing and research about the use of simulation using SPs in undergraduate mental health education has been limited (Brown, 2008; Crider & McNiesh, 2011; Hermanns et al., 2011; Kameg et al., 2010). With the recent release of the NCSBN (2014) findings related to the use of simulation in undergraduate nursing programs, a new sense of urgency exists among nursing faculty to evaluate how simulation using SPs may be used in nursing programs to teach mental health nursing.

There are many gaps in mental health simulation research and multiple opportunities to expand simulation with SPs. The need for research with a focus on simulation using SPs and the impact on communication in undergraduate mental health nursing courses is paramount. The opportunities to do research that improve the quality of teaching mental health in undergraduate nursing education are endless. Let us begin.

References

Alexander, L., & Dearsley, A. (2013). Using standardized patients in an undergraduate mental health simulation a pilot study. *International Journal of Mental Health, 42*(2-3), 149-164.

Altmann, T. (2007). An evaluation of the seminal work of Patricia Benner: Theory of philosophy? *Contemporary Nurse, 25,* 114-123.

American Association of Colleges of Nursing. (2008). *The Essentials of Baccalaureate Education for Professional Nursing Practice*. Retrieved from http://www.aacn.nche.edu/education/pdf/BaccEssentials08.pdf

American Nurses Association, & American Psychiatric Nurses Association. (2014). *Psychiatric–mental health nursing: Scope and standards of practice*, 2014 edition. Silver Spring, MD: Nursebooks.org

Becker, K., Rose, L., Berg, J., Park, H., & Shatzer, J. (2006). The teaching effectiveness of standardized patients. *Journal of Nursing Education, 45*(4),103-111.

Benner, P. (2001). *From novice to expert: Excellence and power in clinical nursing practice:* [Commemorative edition]. Upper Saddle River, NJ: Prentice Hall. (Original work published 1984)

Benner, P. (2004). Using the Dreyfus model of skill acquisition to describe and interpret skill acquisition and clinical judgment in nursing practice and education. *Bulletin of Science Technology & Society, 24*(3), 188-199. Retrieved from http://bst.sagepub.com/content/24/3/188 doi:10.1177/0270467604265061

Brown, J. (2008). Applications of simulation technology in psychiatric mental health nursing education. *Journal of Psychiatric and Mental Health Nursing, 15,* 638-644.

Buxton, B. (2011). Interaction, unscripted: An effective use of drama to stimulate the nurse-client relationship. *Journal of Psychosocial Nursing, 49*(5), 28-32.

Crider, M., & McNiesh, S. (2011). Integrating a professional apprenticeship model with psychiatric clinical simulation. *Journal of Psychosocial Nursing, 49*(5), 42-49.

Davis, S., Josephsen, J., & Macy, R. (2013). Implementation of mental health simulations: Challenges and lessons learned. *Clinical Simulation in Nursing, 9*(5), 157-162. doi:10.1016/j.ecns.2011.11.011

Dearing, K. & Steadman, S. (2008). Challenging stereotyping and bias: A voice simulation study. *Journal of Nursing Education, 47*(2), 59-65.

Doolen, J., Giddings, M., Johnson, M., Guizado, G., & Badia, L. (2014). An evaluation of mental health simulation with standardized patients. *International Journal of Nursing Education Scholarship, 11*(1), 1-8. doi:10.1515/ijnes-2013-0075

Dreifuerst, K. (2009). The essentials of debriefing in simulation learning: A concept analysis. *Nursing Education Perspectives, 30*(2), 109-114.

Dreifuerst, K. (2010). Debriefing for meaningful learning: Fostering development of clinical reasoning through simulation. (Unpublished doctoral dissertation). Indiana University, Bloomington, IN. Retrieved from https://scholarworks.iupui.edu/bitstream/handle/1805/2459/KTD%20%20Final%20Dissertation.pdf?sequence=1

Edward, K., Hercelinskyj, J., Warelow, P., & Munro, I. (2007). Simulation to practice: Developing nursing skills in mental health: An Australian perspective. *International Electronic Journal of Health Education, 10,* 60-64. Retrieved from www.files.eric.ed.gov/fulltext/EJ794196.pdf

Festa, L., Baliko, B., Mangiafico, T., & Jaronsinski, J. (2000). Maximizing learning outcomes by videotaping nursing students' interactions with a standardized patient. *Journal of Psychosocial Nursing & Mental Health Services, 38*(5), 37-44.

Gilje, F., Klose, P., & Birger, J. (2007). Critical clinical competencies in undergraduate psychiatric-mental health nursing. *Journal of Nursing Education, 46*(11), 522-526.

Grant, J., Keltner, N., & Eagerton, G. (2011). Simulation to enhance care of patients with psychiatric and behavioral issues. *Journal of Psychosocial Nursing, 49*(7), 43-49.

Happell, B. (2008). The importance of clinical experience for mental health nursing-Part 1: Undergraduate nursing students' attitudes, preparedness, and satisfaction. *International Journal of Mental Health Nursing, 17,* 326-332.

Happell, B. (2009). Influencing undergraduate nursing students' attitudes toward mental health nursing: Acknowledging the role of theory. *Issues in Mental Health Nursing, 30,* 39-46. doi:10.1080/01612840802557113

Happell, B., & Gaskin, C. (2012). The attitudes of undergraduate nursing students towards mental health nursing: A systematic review. *Journal of Clinical Nursing, 22,* 148-158. doi:10.1111/jocn.12022

Happell, B., & Gough, K. (2007). Undergraduate nursing students' attitudes towards mental health nursing: Determining the influencing factors. *Contemporary Nurse, 25,* 72-81.

Hermanns, M., Lilly, M., & Crawley, B. (2011). Using clinical simulation to enhance psychiatric nursing training of baccalaureate students. *Clinical Simulation in Nursing, 7,* 41-46.

Jeffries, P. (2005). Designing, implementing, and evaluation simulations used as teaching strategies in nursing. *Nursing Education Perspectives, 26*(2) 96-103.

Kameg, K., Clochesy, J., Mitchell, A., & Suresky, J. (2010). The impact of high fidelity human simulation on self-efficacy of skills. *Issues in Mental Health Nursing, 31,* 315-323. doi:10.3109/01612840903420331

Kameg, K., Mithchell, A., Clochesy, J., Howard, V., & Suresky, J. (2009). Communication and human patient simulation in psychiatric nursing. *Issues in Mental Health Nursing 30,* 503-508.

Keltner, N., Grant, J., & McLernon, D. (2011). Use of actors as standardized psychiatric patients. *Journal of Psychosocial Nursing, 49*(12), 34-40.

Kirkman, T. (2012). High fidelity simulation effectiveness in nursing students' transfer of learning. *International Journal of Nursing Education Scholarship, 10*(1), 1-6. Doi:10.1515/ijnes-2012-0009

Kolb, D. (1984). *Experiential learning: Experience as the source of learning and development*. Upper Saddle River, NJ: Prentice Hall.

Koskinen, L., Mikkonen, I., & Jokinen, P. (2011). Learning from the world of mental health nursing students' narratives. *Journal of Psychiatric and Mental Health Nursing, 18,* 622-628.

Kuiper, R., Heinrich, C., Matthias, A., Graham, M., & Bell-Kotwall, L. (2008). Debriefing with the OPT model of clinical reasoning during high fidelity patient simulation. *International Journal of Nursing Education Scholarship, 5*(1), 1-14.

Lang, C., & Hahn, J. (2013). Blast model: An innovative approach to prepare second-degree accelerated BSN students for inpatient psychiatric clinical experiences. *Journal of Psychosocial Nursing, 51*(3), 38-45.

Lehr, S., & Kaplan, B. (2013). A mental health simulation experience for baccalaureate student nurses. *Clinical Simulation in Nursing, 9*(10), e425-e431.

Meakim, C., Boese, T., Decker, S., Franklin, A., Gloe, D., Lioce, L., Sando, C., & Borum, J. (2013). Standards of best practice: Simulation standard, Standard I: Terminology. *Clinical Simulation in Nursing, 9,* S3-S11.

Meyer, M., Connors, H., Qingjiang, H., & Gajewski, B. (2011). The effect of simulation on clinical performance a junior student clinical comparison study. *Simulation in Healthcare, 6*(5), 269-277.

National Council of State Boards of Nursing (2014). The study replacing clinical hours with simulation in prelicensure nursing education. *Journal of Nursing Regulation, 5*(2), s1-s64. Retrieved from https://www.ncsbn.org/JNR_Simulation_Supplement.pdf

Robinson-Smith, G., Bradley, P., & Meakim, C. (2009). Evaluation the use of standardized patients in undergraduate psychiatric nursing experiences. *Clinical Simulation in Nursing, 5,* e203-e211. Doi:10.1016/j.ecns.2009.07.001

Rodriguez, S. (2013). The impact of limited clinical sites on prelicensure nursing education programs: Current issues and recommendations for the future. *Master of Arts in Nursing scholarly projects,* Paper 73. Retrieved from http://sophia.stkate.edu/ma_nursing/73/

Rutherford-Hemming, T. (2012). Learning in simulated environments: Effects on learning transfer and clinical skill acquisition in nurse practitioner students. *Journal of Nursing Education, 51*(7), 403-406.

Sideras, S., McKenzie, G., Noone, J., & Frazier, M. (2013). Making simulation come alive: Standardized patients in undergraduate nursing education. *Nursing Education Perspectives, 34*(6), 421-425.

Sleeper, J., & Thompson, C. (2008). The use of high fidelity simulation to enhance nursing students' therapeutic communication skills. *International Journal of Nursing Education Scholarship, 5*(1), 1-12.

Schoening, A., Sittner, B., & Todd, M. (2006). Stimulated clinical experience nursing students' perceptions and the educators' role. *Nurse Educator, 31*(6), 253-258.

Sportsman, S., Schumacker, R., & Hamilton, P. (2011). Evaluating the impact of scenario-based high-fidelity patient simulation on academic metrics of student success. *Nursing Education Perspectives, 32*(4), 259-264.

Szpak, J., & Kameg, K. (2013). Simulation decreases nursing student anxiety prior to communication with mentally ill patients. *Clinical Simulation in Nursing, 9,* 13-19.

Webster, D. (2014). Using standardized patients to teach therapeutic communication in psychiatric nursing. *Clinical Simulation in Nursing, 10*(2), e81-e86.

Yoo, M., & Yoo, Y. (2003). The effectiveness of standardized patients as a teaching method for nursing fundamentals. *Journal of Nursing Education, 42*(10), 444-448.