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**A career in mental health - still an unlikely choice for**

**Nursing graduates: a replicated, longitudinal study**

Running title

Student nurses still not interested in MH

**Abstract**

The lack of qualified mental health nurses is at critical level with the problem likely to worsen as the aging mental health nursing workforce retires.

This study investigates the career preferences of undergraduate nursing students by comparing preferences at the start, middle and end of the Bachelor of Nursing program. The comparison of the cohorts gave an indication of the change in preferences over the intervening years.

It replicates research completed in 1992, 1997 and in 2001 and develops a profile of nursing career preferences and the rationale underpinning those preferences in a cohort of students (n=150) who began their Bachelor of Nursing studies in 2007 and completed in 2009.

The main findings included that, like the previous studies, mental health nursing is one of the least desirable career choices for most nurses at the start of their course and remains so as they approach graduation. The reasons change but the outcome remains the same.

The current system of using the Bachelor of Nursing award to produce Mental Health Nurses in Australia is does not encourage nurses to consider a career in Mental Health Nursing. Which begs the question - where will mental health nurses in the future come from?

**A career in mental health - still an unlikely choice for**

**Nursing graduates: a replicated, longitudinal study**

Internationally, in developed countries, there is a shortage of nurses. This shortage will worsen as the current work force ages (Graham and Duffield, 2010, Nadler-Moodie and Loucks, 2011). For mental health nursing the current and worsening shortage is more serious, mental health nurses as a group are older than the general nursing population (Ng et al., 2010, Pickens and Fargotstein, 2006, Whitehead et al., 2007).

The literature has shown consistently that undergraduate nurses are less likely to choose a career in mental health nursing (Stevens and Crouch, 1995, Ward et al., 2003, Hayman-White and Happell, 2005, Charleston and Happell, 2006, Halter, 2008, Björkman, 2008, Ross and Goldner, 2009, Happell and Gough, 2007, Stevens and Dulhunty, 1992, Stevens and Dulhunty, 1997). At least part of the reason is that, in undergraduate nursing programs in Australia, students are encouraged to go into medical-surgical nursing after their studies, in order to consolidate their experience (Baker et al., 2010, Nadler-Moodie and Loucks, 2011).

Despite the reality of mental health nursing practice, the care of people with mental illness is considered routine and mundane in comparison with the excitement involved in the manipulation of technology in surgical and critical care areas of practice (Happell, 2001, Stevens and Crouch, 1995, Stevens and Dulhunty, 1992, Stevens and Dulhunty, 1997, Ross and Goldner, 2009). The studies reported by Stevens and Dulhunty (1992, 1997) and Happell (2001) indicated that not only had nursing education failed to rectify this situation but it had indeed assisted, through the process of professional socialization, in exacerbating it.

**The study**

In the light of the worsening shortage of qualified nurses in mental health care this study asks the question that, given the intervening years, has the developing body of knowledge, strategies and efforts to improve recruitment to mental health nursing from current Bachelor of Nursing programs encouraged students to consider mental health as a career option?

This longitudinal study replicates the Australian research by Stevens and Dulhunty (1992, 1997) and Happell (2001) that explored the career choices of student nurses (and the reasons for those choices) with regard to mental health nursing. The career choices of student nurses are examined from a cohort who began their studies in 2007.

**Aim**

The research aim was to develop a profile of nursing career preferences and rationale underpinning choices in a cohort of students who began their Bachelor of Nursing studies in 2007 and completed in 2009. It was expected that comparing preferences at the start, middle and end of the Bachelor of Nursing program would improve understanding of the impact of that program on student's career choices.

**Ethics**

Ethics approval was obtained from Southern Cross University's Ethics Committee. Students were advised verbally and in writing that participation was voluntary and that they could withdraw at any point without prejudice. Students were encouraged to identify themselves either by real or by some other code of their choice on the questionnaires so that their responses could be matched over three data collection points. They were advised that once the questionnaires were matched the data would be de-identified. They were informed that the return of a completed or partially completed questionnaire would be considered as an indication of informed consent.

**Design**

This study used a repeated measures design. Data were collected at three time points over three years of an undergraduate nursing program and used non-probability sample of undergraduate Bachelor of Nursing students in the State of NSW Australia. The data collection commenced in February 2007 and was completed at the end of 2009 when this cohort of students neared completion of their undergraduate nursing studies.

**Data collection and analysis**

This study used a questionnaire developed by Stevens (1995). Students were asked to rank career preferences from 10 choices, where 1 was most popular and 10 least popular career destination. This instrument has been used to investigate nursing students' attitudes in studies by Stevens and Dulhunty (1992, 1997) and later modified and used by Happell (2001).

Data from the questionnaires were analysed using Statistical Package for the Social Sciences Version 19. The rankings between the three time points were then tested for statistical significance using non parametric statistics in particular the Wilcoxon Matched Pairs Signed Ranks test.

The questionnaire had a section that asked students to qualify their rankings by providing reasons for the most and least popular choices, as well as the ranking of three other specific areas; working with older people, mental health and intensive care nursing. Data were also collected on reasons for entering nursing, previous life and work experiences as well as the number of days that students could recall having spent on practicum in the ranked areas.

The responses to these open ended questions were analysed by the author for major themes using content analysis (Graneheim and Lundman, 2004). Where appropriate the themes were coded to match the equivalent themes developed from the earlier studies.

An audit of the qualitative component of 30 randomly chosen questionnaires was undertaken by a second experienced researcher. The process was aimed at improving the consistency of

the analysis of the open ended questions that were used to have students explain their ranking choices. The audit found that of the 30 questionnaires 30 were coded the same by the auditor and the author.

**Participants**

Six campuses within NSW were approached to participate in the study and eventually three agreed to be involved in the study.

The first stage of the study was undertaken within the first week of the first semester of the Bachelor of Nursing program at each site. With the cooperation of faculty the questionnaire was administered in lecture time in order to encourage a high return rate. Based on expected enrolment numbers at each location 300 survey questionnaires were distributed and 203 (68%) were returned completed. The second stage of the study was undertaken at the end of the 3$^{rd}$ semester or midway point of the programs. Based on remaining enrolment numbers 250 survey questionnaires were distributed and 189 (76%) were retuned. The third stage of the study was undertaken in the last week of lectures in the final semester. Two hundred survey's were distributed and 160 (80%) were returned. After the three years 150 of the questionnaires were matched at the three time points– these were used in the analysis for this study.

**Results**

As can be seen in Table 1 there were 150 participants whose questionnaires could be matched at each administration over the three years. Of these 124 (82.6%) were women and 26 (17.3 %) were men which is approximately 50% greater proportion of men than shown in the national registered nurse work force figures which are approximately 90% women and 10% men (AIHW 2009). The age of participants in the first stage of the study ranged from 17 years to 64 years and had a mean of 26 and a mode of 18 years. The first stage responses

indicated that 93 (62%) of participants had no previous experience working in health, 36 (24%) had been or were currently Assistants in Nursing (AIN) and 3 (2%) had been Enrolled Nurses (EN). A further 9 (6%) had experience in healthcare in other roles such as wards-people, and cleaners. Of those who were AINs all had been or were currently working in residential aged care and of these, 10 noted they had over 10 years experience.

INSERT TABLE 1 HERE

INSERT TABLE 2 HERE

Table 2 shows the rank order of career preferences for the three stages of the study. Those career preferences marked with an asterisk indicate that following analysis by The Wilcoxon Matched Pairs Signed Ranks test there was statistically significant movement of preference over the three stages (p<.01).

Table 2 shows that working in mental health and community health nursing were ranked 8th and 9th respectively in the first stage of the questionnaire, 7th and 8th in the second and third stages. The Wilcoxon Matched Pairs Signed Ranks test showed that movement over the three stages was not statistically significant (p=.345 and .2).

INSERT FIGURE 1 HERE

INSERT FIGURE 2 HERE

Figures 1 and 2 show the percentages of ranks over the three stages. Table 2 shows an improvement in mean rank of Mental Health Nursing from 8 to 7 and Community Mental Health Nursing from 9 to 8. Figures 1 and 2 show a corresponding trend to more positive rankings. For examples; the number of respondents ranking Mental Health Nursing as their first choice increased over the three stages from 3% (n=5) to 7% (n=12) and those who ranked it 10 decreased from 17% (n=26) to 12% (n=18). The number of people ranking

Community Mental Health Nursing 1, 2 or 3 increased between Stages one and three as well those ranking it 8, 9 or 10 decreased between stages.

**Experience and choice**.

Table 3 shows the number of days students calculated that they had spent in each of the ranked areas. Pearson's correlations were conducted on the number of days spent on practicum and the ranking changes over the three stages. The Table shows that the more days spent on practicum in community mental health significantly correlated (r = .240) with an increase in preference for it as career destination even though the average length of experiences was a relatively short duration of 4.8 days.

There are also correlations for numbers of days spent and the ranking changes for working with older people, operating theatres and community health. In the case of working with older people there was a large significant correlation (r=.825) with number of days spent on practicum and a decrease in the preference of working with older people as a career destination. In the case of operating theatres (r=.305) and community nursing (r=.240) the correlations indicated more time on practicum led to more favourable rankings. There was no correlation between days spent on practicum and mental health nursing (r=.025).

INSERT TABLE 3 HERE

**Reasons for Ranking Mental Health Nursing**

Responses were divided in to positive and negative reasons for choices and then coded into the five categories (See Tables 4 and 5) used in previous iterations of this survey.

The majority of reasons provided for ranking of the mental health career options were negative. There were total of 50 positive reasons compared to 292 negative reasons received over the three stages of the questionnaire (there were also 53 responses that were considered neutral or nonspecific and 45 questionnaires with no responses to these items).

INSERT TABLE 4 HERE

Positive responses were quite general and mostly non specific over the three stages. They provided little insight into reasons for choice and included comments like: I just think I would like it (Stage 1), because I feel I could be good at it (Stage 1), I can make a difference here (Stage 2), I loved the team I was with (Stage 3) and for community nursing: I don't really know what it is but sounds cool (Stage 1), the relaxed atmosphere, more one on one time for holistic care (Stage 3), I'd be out and about (Stage 3).

INSERT TABLE 5 HERE

Most negative comments were focused on the clientele in Stage 1 – they made comments on the nature of the people they would be working with like: "you would not be able to turn your back on them", "the uncertainty of psychiatric patients makes them terrifying", "you can't tell the staff from the patients", "it would depress me", "I am not personally suited to this area", "it's not an exciting career area", "I think I would go as crazy as they are".

By Stage 3 negative responses were, in the clear majority and focused on mental health nursing as a career option there was still some negativity about the people they would be working with. Comments included: "this is not where I can make my mark", "no career prospects here", "how would I ever get the skills to become a CNC (Clinical Nurse Consultant) here", "the staff at (name withheld) were unreceptive... they really turned me off going there", "psych drained me so emotionally that after a few days I'd had it", "I am not emotionally strong enough to work there", "despite all the education I still get the creeps and feel depressed about being there", "I am no longer afraid of the mentally ill but I would prefer patients who are going to get better", "I like to see people go home and know they are cured, that does not appear to happen in psych", "I can't stand crazy people".

To better understand the reasons for students career choices the findings related to choices of the more popular career options are reported.

INSERT FIGURE 3 HERE

The most common reason for ranking Intensive Care being ranked highly in the third stage was because the grandaunts reported it was a great place to develop skills and gain the experiences needed to have a successful nursing career (n=69 or 46%).

Some typical responses were: "this is where the action is, if I can learn the skills needed here I can do anything, work anywhere", "I feel I can build a long lasting meaningful career here".

**Reasons for Ranking Surgical Nursing and Others**

The area that grew to be ranked the most popular over the three stages was surgical nursing. Eighty nine (approx. 60%) Stage 3 students ranked Surgical Nursing in their top three choices. The majority (n=20) of the 26 third year students who ranked Surgical Nursing as their highest preference also stated that it was the best choice of destination for them to develop the skills and experiences needed to have a positive career in nursing.

INSERT FIGURE 4 HERE

In contrast working with children was ranked most preferred career destination by students in the first stage of the survey but had declined in preference to 6th most popular choice by the third stage. The most common reason it would seem for this fall in popularity from Stage 1 was due to exposure to paediatric nursing throughout the duration of the program and the discovery that the clientele and type of work was not as imagined on commencement.

INSERT TABLE 6 HERE

As can be seen from Table 6 the findings from this study are similar to the findings from the previous studies.

**Discussion**

This replicated longitudinal study of student nurses, disappointingly for mental health nursing, has produced similar results as Stevens and Dulhunty (1992, 1997) and Happell (2001). In addition it is consistent with the literature in demonstrating that working in mental health remains among the least desired career choices of student nurses. This is despite the actions of Governments, education providers and mental health nurses on the worsening critical shortage of mental health nurses.

The pre-course career intentions (i.e. Stage I responses) of the students shows that inpatient and community mental health nursing are among the least popular choices; ranked at 8 and 9 respectively. The reasons given by students, for these rankings in Stage I, were dominated by concerns for their own sense of well-being and by stereotypical fear of people with a mental illness.

As can be seen in Table 1, there was a small (non-statistically significant) improvement in the rank order of both categories of nursing mentally ill people by Stages II and III. During their course they are exposed to numerous socialising factors which appear to reinforce their negative perceptions of this work on one hand, but appear to negate many of the stereotypes about the clientele on the other. This improvement corresponds with a change in the sentiments and descriptions provided in the open ended responses of the questionnaire. Response emphasis moved from concerns about their well-being and dislike of the clientele to concerns about effects on career and their institutions and the type of work anticipated.

Unlike previous iterations of this study, the number of respondents ranking Mental health Nursing as their first choice increased over the three stages from 3% (n=5) to 7% (n=12) and those who ranked it 10 decreased from 17% (n=26) to 12% (n=18). The number of people

10

ranking Community Mental Health Nursing 1, 2, 3 increased between Stages 1 and 3 as well those ranking it 8,9 10 decreased between stages.

Overall however, students have indicated, throughout this research, that they viewed working as mental health nurses negatively. They would rather work in areas associated with medical technology. For example, like the previous iterations of this study, the category of surgical ward nursing advanced in rank over the three stages to become the most popular career intention of respondents. With respondents indicating this is the best option for career development and likely future job satisfaction.

Despite efforts to promote the independent contribution of Nursing (Finn, 2001, Hayes et al., 2010, Holden, 1991, Willis, 1993) it appears that throughout the Bachelor of Nursing program students continue to graduate believing that work in areas associated with the manipulation of technology is high status and rewarding nursing. Indeed Table 1 can almost be divided in two halves. The top ranked (with the exception of community nursing) categories are generally considered areas that are reliant on medical and technical changes in treatment. Yet the lower ranked half of Table 1 is a list of nursing practice areas where medical technology has not infiltrated and indeed is often seen as areas neglected by the medical profession such as working with old and/or mentally ill people. It would appear that the pre-registration programs do not promote areas of nursing practice where nursing practice alone makes the biggest impact on client care such working with people with a mental illness. This is of concern for the future of the nursing profession in general and mental health nursing in particular.

There is an irony in students believing that their careers will be better served by choosing a 'high-tech' destination – an area which is the most resourced and least likely to contribute the health of the community (World Health Organisation, 1986, World Health Organisation, 1990). The areas considered 'high-tech' are already dominated by medicine. As these are

often the areas for the medical treatment of illness the practice of nurses in these areas is limited and more often than not led by medical professionals and least likely to value the contribution of Nursing.

On the other hand, the more consumer focused areas such as mental health rely heavily on the skills and practice of nurses. As noted in the literature and government reports above there will be an increasing need for competent nurses in this environment in light of the inevitable global movement of decreasing affordability and therefore reliance on tradition tertiary settings especially in dealing with chronic disease management and illness prevention.

**Limitations**

The findings from this study used data from 150 out of a possible 300. This study could have been improved if more demographic data were collected from the participants. This could have given an indication if those variables impacted on decisions and perhaps an indication of the differences between the participants who chose to be involved and those who did not complete the data collection. The decision not to collect specific demographic data was made in an effort to maintain both confidentiality and the students' confidence in that confidentiality.

**Implication for practice**

The direct implication of the literature and these data is that they suggest the continuation of mental health care as an area of nursing practice is under very real threat. Clearly nursing bachelors degree programs fail to encourage nurses to consider, positively, the prospect of a career in mental health nursing. Therefore with the introduction of the nursing professional degree the profession, as a whole, should be deeply concerned for the future as well as for the continuation of quality care for people living with a mental illness. This area of practice will be led by other less qualified occupational groups unless much more thought and resource,

than is currently allocated, is provided to making a career in mental health more appealing to nursing graduates. This study suggests that an alternate pathway to registration for those wanting a career in mental health nursing needs to be re-considered.

Further holistic person centred care is the business of all nurses. If the mental health aspects of care are undervalued in comparison to bo-medical aspects nurses are not being properly prepared for their role.

## Tables and Figures

**Table 1** *Demographic data for the 2010 study*

|  | **2010** |
|---|---|
| Matched questionnaires n= | 150 |
| Female | n=41 (82%) |
| Male | n= 26 (17%) |
| Mean age (SD) | 26 (6.2) |
| Age range in years | 17-64 |
| No previous experience | 93 |
| AINs n= | n=36 |
| ENs n= | n=3 |

**Table 2** *Student career preference rankings*

|  | **Stage 1** | | **Stage 2** | | **Stage 3** | |
|---|---|---|---|---|---|---|
| Career options | **Rank** | mean | **Rank** | mean | **Rank** | mean |
| *Children | 1 | 3.19 | 1 | 3.70 | 6 | 4.93 |
| *Operating.Theatre. | 2 | 4.25 | 2 | 3.79 | 4 | 4.60 |
| *Intensive.Care. | 3 | 4.28 | 3 | 4.08 | 2 | 3.97 |
| *Surgical | 4 | 4.58 | 5 | 4.75 | 1 | 3.50 |
| Medical | 5 | 4.72 | 4 | 4.50 | 3 | 4.34 |
| *Community Health | 6 | 5.40 | 6 | 5.85 | 5 | 4.89 |
| *Older People | 7 | 6.87 | 10 | 7.53 | 9 | 7.61 |
| Mental health Nursing | 8 | 6.90 | 7 | 6.00 | 7 | 5.92 |
| Community Mental | 9 | 7.00 | 8 | 7.01 | 8 | 6.45 |
| Develop. Disability | 10 | 7.40 | 9 | 7.50 | 10 | 8.01 |

*Indicates that statistically significant (p<.01) change has occurred in rankings over the three stages of the study

**Table 3** *Correlation between practicum days and rankings over three stages in the 2010 study*

|  | Days on prac n= | Correlation r= |
|---|---|---|
| Paediatrics | 2.6 | .023 |
| Operating Theatres | 4.7 | .305 |
| Intensive Care | 3.2 | .000 |
| Surgical | 10.8 | .049 |
| General Medical | 13.2 | .000 |
| Community Health | 6.3 | .240 |
| Working with older people | 15.7 | .825 |
| Mental health Nursing | 10.0 | .049 |
| Com Mental Health | 4.8 | .240 |
| Developmental Disability | 0.3 | .005 |

**Table 4** *Positive responses to choices for a career in Mental Health Nursing*

| Total positive responses | Stage 1 n= 10 | Stage 2 n=20 | Stage 3 n= 20 |
|---|---|---|---|
| A Negative view of clients | 20% | 20% | 20% |
| B. Negative view of the institutions and type of work found there | 30% | 25% | 25% |
| C. Negative effect on self esteem | 30% | 25% | 25% |
| D. Negative effect on career pathway | 20% | 30% | 20% |
| E. negative experience specific to the course | 0 | 0% | 10% |

**Table 5** *Negative responses to choices for a career in Mental Health Nursing*

| | Stage 1 n= 93 | Stage 2 n=105 | Stage 3 n= 94 |
|---|---|---|---|
| Total negative responses n= | | | |
| A Negative view of clients | 32% | 21% | 13% |
| B. Negative view of the institutions and type of work found there | 21% | 29% | 18% |
| C. Negative effect on self esteem | 21% | 10% | 7% |
| D. Negative effect on career pathway | 25% | 30% | 54% |
| E. negative experience specific to the course | 0 | 12% | 7% |

**Table 6** *Comparison of Ranks and means scores between the 2010 and 1997 studies*

| | Stage 1 | | | | Stage 2 | | | | Stage 3 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Rank | | Mean | | Rank | | Mean | | Rank | | Mean | |
| | 2010 | 1995 | 2010 | 1995 | 2010 | 1995 | 2010 | 1955 | 2010 | 1995 | 2010 | 1995 |
| *#Children | 1 | 1 | 3.19 | 3.42 | 1 | 2 | 3.70 | 4.24 | 6 | 2 | 4.93 | 4.44 |
| *#O.T. | 3 | 2 | 4.28 | 4.06 | 3 | 4 | 4.08 | 4.36 | 2 | 4 | 3.97 | 4.73 |
| *#Intensive C | 2 | 3 | 4.25 | 4.20 | 2 | 3 | 3.79 | 4.28 | 4 | 6 | 4.60 | 4.90 |
| *#Surgical | 4 | 4 | 4.58 | 4.49 | 5 | 1 | 4.75 | 3.85 | 1 | 1 | 3.50 | 3.79 |
| Medical | 5 | 5 | 4.72 | 4.50 | 4 | 5 | 4.50 | 5.00 | 3 | 5 | 4.34 | 4.67 |
| *#Com Health | 6 | 6 | 5.40 | 5.50 | 6 | 6 | 5.85 | 5.99 | 5 | 3 | 4.89 | 4.35 |
| *#Older people | 7 | 7 | 6.87 | 6.62 | 10 | 10 | 7.53 | 7.64 | 9 | 9 | 7.61 | 7.03 |
| Develop dis | 10 | 8 | 7.40 | 6.93 | 9 | 7 | 7.50 | 6.81 | 10 | 10 | 8.01 | 7.42 |
| Psych nurse | 8 | 9 | 6.90 | 7.60 | 7 | 8 | 6.00 | 6.88 | 7 | 7 | 5.92 | 6.81 |

| #Com M Hlth | 9 | 10 | 7.00 | 7.66 | 8 | 9 | 7.01 | 7.00 | 8 | 8 | 6.45 | 6.83 |

**Figure 1**

*Student Nurses Ranking of a Career Working in Mental Health*



**Figure 2:**

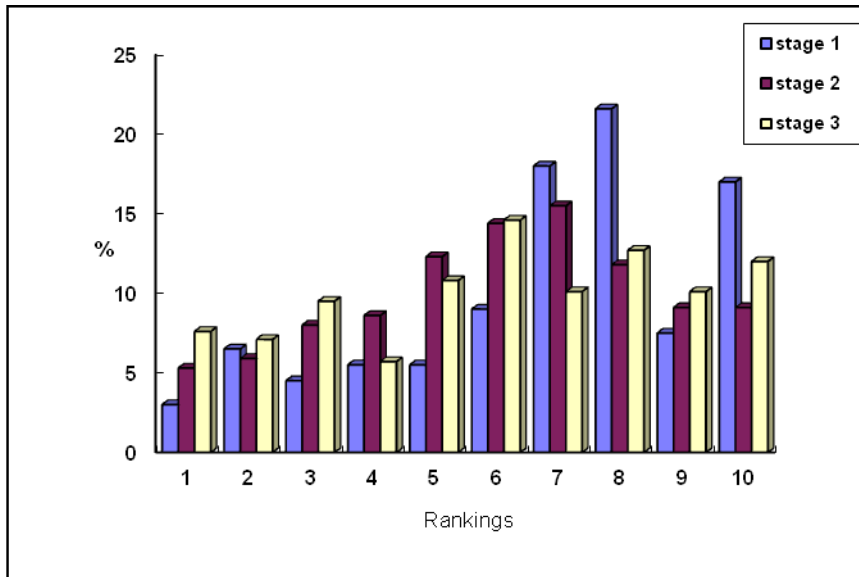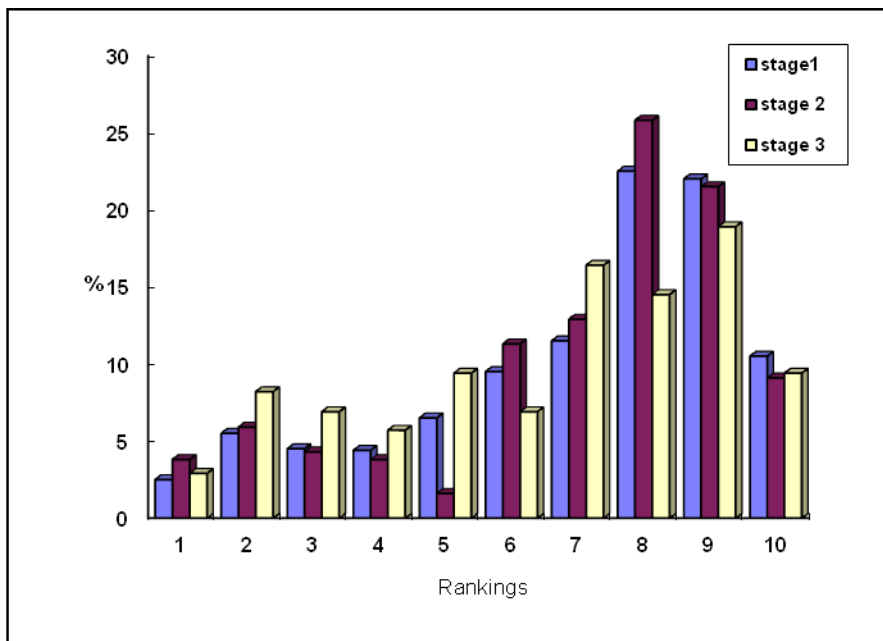*Student Nurses Ranking of a Career Working in Community Mental Health*

**Figure 3**
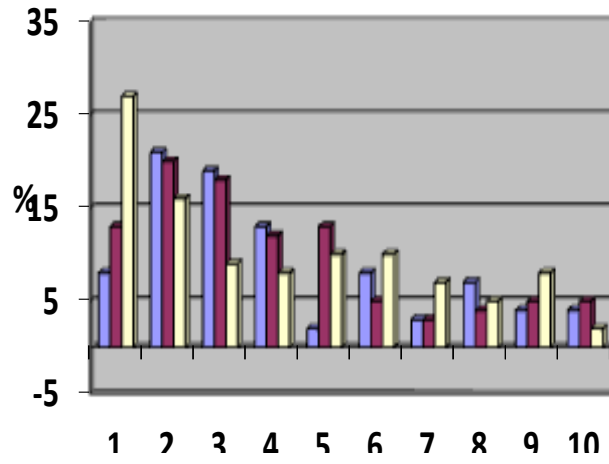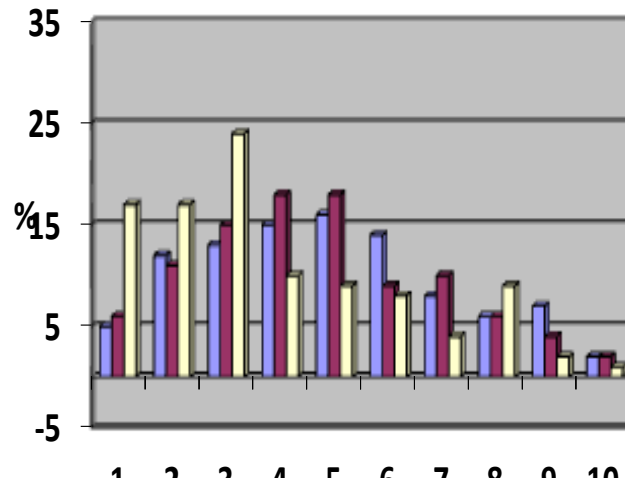
*Rankings of Working in Intensive Care*



**Figure 4**

*Rankings of Working in Surgical Nursing*

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