

Is it ACE? The influence of the Advanced Choice of Employment scheme on new graduates' decisions to accept a position in the Nurse Entry to Specialist Practice in Mental Health and Addiction programme.

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Abstract

The nursing recruitment crisis has generated research into strategies to improve retention of newly qualified nurses. In New Zealand, all 20 DHB's are committed to the Nurse Entry to Practice (NETP) and Nurse Entry to Specialised Practice in Mental health and Addiction (NESP) programmes to help acclimatise new graduates to the realities of clinical responsibilities. These have had a positive impact on retention rates. The Advanced Choice of Employment (ACE) scheme was introduced in 2012 to ensure a fair process of recruitment. Using an instrumental case study approach this study explored the influence that the ACE process has on a new graduates' decision to accept a place on NESP. The 'case' comprised one NESP programme in one DHB. Semi-structured interviews were conducted with 14 participants who had accepted a position on NESP, but did not specify mental health and addiction on their ACE application form. A further interview was conducted with the NESP coordinator to ascertain the employer experience of ACE.

Thematic analysis of the interviews revealed one over-arching theme; 'ACE is omnipotent', and three sub-themes; 'The system', 'Nursing as a vocation' and 'Professional identity. The findings revealed that new graduates experience a form of marginalisation as they complete the ACE process. The pressure to secure a position can result in applicants accepting a position in NESP even if they have no interest in a career in mental health. The concept of nursing as a vocational occupation has the potential to ostracise these applicants, but the NESP programme can be successful at socialising new graduates into the mental health profession. ACE has considerable authority in the recruitment process and has created a socio-cultural lag. Education providers and DHBs can help to minimise the effect of this through preparing ACE applicants for the recruitment process.

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1 Chapter 1 - Introduction

1.1 Introduction

This thesis is an instrumental case study of a cohort of new graduate students enrolled in one New Entry to Specialist Practice in Mental Health and Addiction (NESP) programme in New Zealand. The aim of this research is to investigate whether the Advanced Choice of Employment scheme has influenced new graduates' decision to accept a place in mental health.

The purpose of this chapter is to explain the focus of this research and identify the phenomenon that will be studied. It starts with a discussion of the context surrounding this study and the contribution this research will make to nursing; there is also consideration of the intended audience. The second part of this chapter focuses on the positioning of self; this researcher's personal experiences and how these have contributed to the development of this study. Finally, there is an overview of the thesis chapters.

It is acknowledged that the field of nursing referred to in this thesis as 'mental health' relates to both 'mental health and addiction'. At times, the full title is used, at others just 'mental health' is referred to. The distinction between the two names is made to assist with the readability of the study. It is not intended to dismiss or diminish addiction as less important than mental health and any reference made to 'mental health' should be interpreted as including addiction.

1.2 Context of this study

1.2.1 Recruitment and retention in nursing

The recruitment and retention of new graduate nurses is a significant problem threatening the future sustainability of the profession throughout the world (North, Leung & Lee, 2014). This issue is exacerbated by a high attrition rate in newly qualified nurses (Bick, 2000; Bratt, 2009; Clark & Springer, 2012). Extensive research into this problem has highlighted several trends; including a stressful pattern of transition common for many new graduates (Bick, 2000; Bratt, 2009; Clark & Springer, 2012). The literature suggests that undergraduate nursing

education is too far removed from the clinical experience; new graduates are unprepared for the reality of nursing (Clark & Holmes, 2007). This phenomenon was first alluded to by Kramer in 1974 (cited in Bick, 2000); it is commonly referred to as 'reality shock' (Kramer, 1974, cited in Bick, 2000). New graduate programmes have been introduced throughout the world to help ease transition and improve retention (Dracup & Morris, 2007).

Recruitment of new graduate nurses into mental health and addiction is also an enduring issue across the globe (Happell, 2008a). This predicament is intensified by the current recruitment crisis across all areas of nursing (North, 2011). As more popular areas such as surgical and medical nursing become readily available, new graduates are even less likely to choose a career in mental health (North, 2011; O'Brien, Buxton, & Gillies, 2008). It is imperative that innovative and effective strategies are implemented to improve the recruitment and retention of new graduate nurses into mental health and addiction so the workforce can sustain itself (Gough & Happell, 2009; Happell & Gough, 2007).

1.2.2 New graduate programmes and ACE

In New Zealand, there are two distinct new graduate programmes. The Nurse Entry to Practice (NETP) and the Nurse Entry to Specialised Practise in Mental Health and Addiction (NESP). Every District Health Board (DHB) in the country is committed to providing NETP and/or NESP programmes for newly qualified nurses (Ministry of Health [MOH], 2017). To gain entry, every applicant must complete the same recruitment process; the Advanced Choice of Employment (ACE). ACE is the only access to NETP and NESP. The recruitment process is organised so that candidates can only obtain one offer from either programme. If an applicant wants to be considered for a position in NESP they must identify mental health and addiction as a clinical choice in their ACE application. Applicants who fail to gain a position are placed in a talent pool and can then approach any clinical area to enquire about potential vacancies. If an applicant is unable to secure a job, they must wait six months to re-apply through ACE. This could place considerable pressure on applicants in the talent pool to accept any position they can find regardless of clinical preference. This study developed from an interest in

whether ACE had any influence on new graduates' choice to pursue NESP, even if they had no long-term interest in pursuing a career in mental health and addiction.

1.3 This study

This study is intended to contribute to the substantial body of research into the recruitment and retention of new graduate nurses. There has been extensive international research into the efficacy of new graduate programmes across all nursing disciplines (Bratt & Felzer, 2011; Clark and Holmes, 2007; Clark & Springer, 2012) but insufficient studies that focus on mental health and addiction specifically. In New Zealand, there has been much research into the efficacy of the NETP programme (Haggerty, McEldowney, Wilson and Holloway, 2009; Huntington Wilkinson & Neville, 2014; Rydon, Rolleston & Mackie, 2008) but studies that focus specifically on NESP are sparse. There also exists a wealth of research into factors that influence undergraduate career choices with a specific emphasis on mental health (DeKeyser Ganz and Kahana, 2006; Happell, 2008; McCann, Clark & Lu, 2010), but very little that relates to the career choices of new graduates. ACE is a relatively new addition to nursing recruitment in New Zealand and so the influence of the scheme remains largely unexplored. It is important to investigate whether ACE has any influence on the clinical choices that new graduates make because of the impact this could have on the future workforce (MOH, 2017). The target audience for this study includes nurse educators, nursing lecturers, new graduate nurses and undergraduate student nurses; particularly those in their final year of study. The findings may also be of interest to those responsible for recruitment into mental health.

1.4 Positioning the self

According to Ezzy (2002), it is important for the researcher to consider their own position in the research they are conducting. He argues that this is not a self-indulgent act, but rather a responsible aspect of the research process; the researcher is declaring their role within the study (Ezzy, 2002). For this reason, the following account is written in the first person rather than using the traditional objective language expected in academic writing. The purpose of the following

account is to explain how this study came about and the personal experiences of this researcher that contributed to an interest in the recruitment and retention of new graduates in mental health.

Prior to starting my career as a mental health nurse, I worked as a health care assistant in medical and surgical environments. I enjoyed working with patients, but had no interest in the physical health aspects of the job. However, I did enjoy talking with people and when I decided to pursue a career in nursing, these experiences were instrumental in the decision to study mental health. In the UK students choose a speciality before they start the programme and so apart from the first 18 months, all my education and clinical experience focused on mental health. I began the course with great enthusiasm and curiosity. I did not consider that I would find it a challenge.

The curiosity soon dissipated and I felt increasingly overwhelmed by the environment. I was working in poorly maintained, old and under-resourced wards with people who had so many complex issues I did not know where to begin. I struggled to cope with hearing some of the experiences people had lived through. Education was not helping; the theory was confusing and despite considerable exposure, the clinical placements remained frightening. I realised early on that I held some very negative assumptions about the people I was working with. I had always considered myself a tolerant and non-judgmental person, but I was building a very negative attitude about people with mental illness. Looking back, I recognise that I was transferring the discontent I felt about my own feelings of helplessness to the people I was caring for. I became resentful of the people who evoked these negative feelings. I could not help them and it was easier to blame someone else than face my own inadequacy as a nurse.

The increasing pressure of this situation continued until I was faced with my own rapidly deteriorating mental health. Eventually, I had to accept there was a problem and seek help. I grieved for the life I would never have. How could I be a mental health nurse when I had a mental illness? In my perspective, I instantly became unemployable, I would be forced to adopt a different persona; the self-

stigma was over-whelming. Every assumption I had made about a person with mental illness, I now applied to me.

This period of my life remains the most humbling experience I have yet to encounter. My perspective of the people I was learning to care for changed. I took six months out of the programme to come to terms with my diagnosis and changed status in the world. I realised I was no longer looking through an observation window at an unusual species, I now belonged with them. All the overt and covert assumptions I had heard about people with mental illness now defined me and I accepted the stereotypes without question.

After a combination of counselling, psychology and medication, I began to understand that I was not defined by the label of depression. I gained insight into accepting and living with my own mental health. The principles of recovery and the theories I had learnt about mental health took on a different meaning and I found renewed hope. Inspired by a considerable amount of support, I returned to my studies and encountered my first experience of discrimination. An occupational health doctor reluctant to let me back onto the programme because of my mental illness advised me that I would probably never make a very good nurse. I demonstrated considerable mental reserve, kept my temper, and resumed my studies.

I qualified and started working in a 28-bed open acute ward. I felt unprepared and completely overwhelmed by the responsibility I now held. I attributed my lack of confidence and significant deficiency of experience and knowledge to the depression I had been diagnosed with; other nurses seemed to know what they were doing; it must be a fault in me. I began to suspect that the occupational health doctor was right; I was not a good nurse. It took several years for me to stop waiting for someone to recognise that I was an imposter and I assumed that my feelings during the first years of my career were due to my own inadequacy. After preparing for this study nearly 20 years later, I realised that I was experiencing a normal process of transition; 'reality shock' (Kramer, 1974, cited in Bick, 2000).

While writing this introduction, I have hesitated about whether it is appropriate to discuss my own experiences with mental illness. However, I have decided that this story is an important aspect of my reflexive experience because it influenced how I perceived mental health nursing and my transition as a new graduate. In addition, this study has a strong focus on the stigma and discrimination associated with mental health and I am passionate about challenging negative perceptions of mental illness because of my own experience. My beliefs about mental health nursing and new graduate transition have the potential, therefore, to bias this study and it is important to acknowledge them as part of the reflexive process.

Once I began to understand the role of a mental health nurse I become part of a culture of nurses; I belonged. The team I worked with were an eclectic mix and I started to feel like I was part of something that not everybody was privy to. During the preparation for the literature review for this study, I found an article by Humble and Cross (2010). They interviewed a group of veteran mental health nurses in Australia to identify what attracted people to the field. One finding was that nurses felt a sense of being different (Humble & Cross, 2010). This resonates with me; I started to feel satisfied with my career when I recognised that the job I did was 'different'. The conversations we have with people are very special and I cherish the opportunity to listen to a person's story; it is a privilege and I do not take that for granted. The article by Humble and Cross (2010) also refers to the protective impulse in mental health nurses; a recognition of the damage that society can cause to someone who is undervalued and misunderstood and wanting to put it right. I could certainly relate to that experience; I often challenged the assumptions that those around me make about people with mental illness. Once my attitude changed and my focus shifted to helping rather than judging, I had finally understood what it was to be a mental health nurse.

A move to New Zealand in 2005 provided an opportunity to experience mental health in a different cultural context. Despite practising on the other side of the planet, there were a considerable number of similarities; specifically, the responses of undergraduate students completing their mental health placements. I recognised and understood the apprehension and confusion expressed by students

and I found great satisfaction supporting them to make sense of their clinical experience.

This prompted a move into nursing education, initially as a clinical lecturer, then as a fulltime lecturer teaching mental health theory to second year students. One focus that evolved in my teaching was to dispel the mystery around what mental health nurses 'do'. I had spent all my training and a considerable period after qualifying waiting for someone to recognise that I had no idea what I was doing. If I could help students to unravel the mystery, I could help them to avoid years of doubting themselves. Furthermore, if they understood the role of a mental health nurse then surely they would want to become one? After all, if I could become a strong advocate of the profession after such adverse beginnings, there had to be hope for others. The aim, in my imagination, was to help students to master the subtle art of mental health nursing (in a mere five weeks) and then support them while applied this to practice (during a six-week clinical placement). I was frustrated that there was so little time allotted to covering mental health, but if I could inspire some interest, it was possible that students would return. I have been privileged to support many students through their mental health placement, but I have yet to achieve the high number of recruits that I had envisioned.

My experience followed a similar pattern each semester. A significant majority of students would anticipate their mental health placement with considerable anxiety, and finish with a germinating interest in this field of nursing. Many would express, with surprise, that they had enjoyed the experience and were even interested in mental health as a career. Most students would state that the experience had changed their opinion of people with mental health and the value of nurses working in this area. I would eagerly anticipate meeting these students again when they chose mental health in their transition placement. Unfortunately, the number of students who did come back was always very low; significantly lower than the number who had expressed an interest at the end of their mental health experience.

I became curious (and a little frustrated) that so many potential future colleagues were being drawn to medical and surgical environments. Was this a common

phenomenon? Consultation of the literature revealed several trends, first, my own experience as a newly qualified nurse was not unusual. Across all disciplines of nursing there was a considerable gap between the education of undergraduates and the reality of practice (Bick, 2000). Second, recruitment of new graduates into mental health was a long-standing problem (Hoekstra, van Meijel, & van der Hooft-Leemans, 2010), not helped by the introduction of comprehensive training (Happell, 1999b). Third, positive clinical experience had a significant impact on the attitudes of new graduate nurses to the field of mental health (Happell & Rushworth, 2000) but very few students pursued a career (Happell, 2002). The research also revealed that mental health was one of the least popular areas of nursing (Happell & Rushworth, 2000). Pervading stigma and prejudice towards people with mental ill-health was also ascribed to nurses who worked in the mental health setting (Gouthro, 2009). Whereas medical and surgical nurses are likened to the beneficent figure of Florence Nightingale; mental health nurses are compared with the less than flattering character of Nurse Ratched from Ken Kesey's novel "One Flew Over the Cuckoo's Nest". The character portrayal in the 1975 film immortalised the sadistic nurse and became an example that defined mental health nurses worldwide (de Carlo, 2007). It became evident that the trends I was recognising were consistent with historical patterns of recruitment into mental health.

In 2014, I made the decision to return to clinical practice. Not ready to leave education altogether, I continued to support students during their clinical placement, but now had the opportunity to support students and new graduates as a nurse as well as an academic. Exposure to new graduates in the clinical environment provided an excellent opportunity to work alongside some of the nurses I had supported as students. It was reassuring that so many people had decided to choose mental health as a career after all. There was obviously a discrepancy between the transition placement choices that students made and the new graduate programme. From experience, I knew that less than 10 transition students per cohort chose mental health for their last placement. In contrast, the NESP programme had a cohort of 40 students. In addition, I had many conversations with new graduates who expressed a frustration with the ACE

process and some admitted that they had not intended to join the mental health workforce at all. I became curious about whether ACE had any influence on these new graduates accepting a place in NESP.

This study has grown from a combination of this researcher's own difficulties with becoming a mental health nurse and a motivation to help others understand the uniqueness of this discipline. This researcher is a mental health nurse with a mental illness who opposes stigma and discrimination towards people with mental illness and the nurses who work with them. This researcher is a passionate educator of mental health and supports students to pursue mental health as a career. These are the experiences and perspectives that inspired this study. The experience of completing this research has led to the realisation that personal beliefs about mental health have the potential to influence the interpretation of findings. This researcher has been careful to acknowledge the potential for this bias and has consistently reflected on how personal perspective could affect interpretation of the data. During the process of thematic analysis this researcher became aware that the research questions were inspired by a belief that new graduates should only pursue a career in mental health if they have a passion for the discipline. So even before the study began this researcher was at risk of manipulating the research in a very subtle way. This realisation increased vigilance around the potential for bias and completing the study increased awareness of aspects of this researcher's identity as a mental health nurse.

1.5 Overview of chapters

Chapter one introduces the study and provides a personal account of this researcher's experience. Chapter two presents a contextual background for this study. It includes a current overview of the current nursing workforce; a history of the development of nursing education and the introduction of new graduate programmes in New Zealand. The chapter concludes with a detailed explanation of the ACE recruitment process. Chapter three provides a review of the literature relating to the career preferences of both undergraduate and new graduate nurses. There is a consideration of the theories explaining the transition experience of newly qualified nurses and the influence that ACE has had on the clinical choices

new graduates make. The literature focusing on the influence of stigma and discrimination is reviewed in context of both undergraduate and new graduate clinical preferences. Chapter four outlines the research design for this study and gives a detailed explanation for the research paradigm adopted. The recruitment and sampling is described along with the characteristics of participants included in the study. An explanation is given for the choice of data collection and the process used to analyse findings. Chapter five presents the findings from the interview with the NESP coordinator as a form of triangulation. The findings of the participant interviews are presented in relation to the categories, sub-themes and major theme that emerged during analysis. Chapter six provides a discussion of the findings with a consideration of the themes from the literature review. The chapter concludes with acknowledgement of the limitations of this study and recommendations for the future recruitment process for new graduate nurses. Chapter seven concludes the study; bringing together the pertinent points from previous chapters.

1.6 Summary of chapter

Recruitment and retention of new graduates into nursing is a long-standing global predicament. Recruitment into mental health is also an enduring problem, but the workforce shortages across all areas of nursing have compounded the issue. Across the globe, health services and education providers have worked together to establish new graduate programmes to improve recruitment and retention of newly qualified nurses with positive results. In New Zealand, all DHBs are invested in the NETP and NESP programmes. The ACE scheme is used to recruit newly qualified nurses into both programmes. ACE is the only method of recruiting to NETP and NESP. This study is focused on whether the ACE process has influenced applicants to accept a position in NESP when they had no interest in mental health as a career.

This researcher has worked as a single-registration mental health nurse for 18 years. The experiences this researcher had as a nursing student, qualified nurse and nursing lecturer have resulted in the belief that mental health is a valuable and important area of nursing. This researcher is acutely aware of the stigma and

discrimination that surrounds both mental health consumers and the nurses who work with them. This study developed from a curiosity about the influence of ACE. The experience of completing this research has led to personal and professional revelations about the identity of nursing.

2 Chapter 2 – Background

2.1 Introduction

This chapter focuses on relevant information as a background to this study. First there is an overview of nursing workforce trends both globally and in New Zealand and a specific consideration of recruitment and retention issues for new graduates. Second, a historical account of the evolution of New Zealand nurse education from specialised hospital-based training in the 1960s and 1970s to the present-day undergraduate degree programmes delivered by tertiary education providers. Third, an account of how and why new graduate programmes were introduced in New Zealand. Finally, there is a detailed explanation of the ACE process.

2.2 The nursing workforce

2.2.1 Global trends

There is considerable evidence of the recruitment and retention crisis in the nursing profession throughout the world (Halfer & Graf, 2006; Happell, 2008a; Kloster, Hoie & Skar, 2007; Reinsvold, 2008). The global population is ageing as the 'baby boomers' are now reaching retirement age (Kloster et al., 2008). Consequently, the nursing population is also ageing (Dracup & Morris, 2007) and it is predicted that this will result in a considerable workforce shortage. The Nursing Council of New Zealand (NCNZ) state that 40% of the current nursing workforce are aged 50 or over and are predicted to retire in the next 15 years (Nursing Council of New Zealand [NCNZ], 2014). The literature confirms similar trends across the globe (Clark & Springer, 2012; Reinsvold, 2008; Wright, Lavoie-Tremblay, Drevniok, Racine & Savignac, 2011).

The logical solution to this problem is to increase recruitment of newly-qualified nurses over the next decade. However, the current number of new graduate nurses is not meeting the potential shortfall due to a high rate of attrition across all clinical environments (Halfer, 2007). To exacerbate the problem further, the global population continues to increase (Rydon et al, 2008). Health issues are becoming more acute and complex due to greater life-expectancy. In addition, continued improvements in medical treatments mean that people are living longer with

chronic illnesses (Bratt & Felzer, 2011). These trends have resulted in more stressful clinical environments that contribute to a high attrition rate in newly qualified nurses across all areas of nursing (Bick, 2000; Bratt, 2009; Clark & Springer, 2012).

2.2.2 New graduate recruitment and retention

The difficulties with retention of new graduate nurses have been a topic of considerable research that spans four decades (Kramer, 1979, cited in Bick, 2000; Cleary & Happell, 2005; Duchscher & Cowin, 2004; North et al., 2014). It is also a global problem; Duchscher and Cowin (2006) identified that 35-60% of new graduates in Canada move or leave nursing in the first 12 months of employment. Similar trends were found in Australia (Levett-Jones & Fitzgerald, 2005) and the USA, (Kowalski & Cross, 2010). In New Zealand, it was reported that up to 50% of new graduates left the profession within the first 12 months (North, Johnson, Knotts & Whelan, 2006). Research has linked this trend to a pattern of transition common to many new graduates (Bick, 2000; Bratt, 2009; Clark & Springer, 2012; Reinsvold, 2008). There is consensus that newly qualified nurses require additional support to develop clinical skills and confidence (Clark & Holmes, 2007).

The financial repercussions of high attrition in new graduates is also well documented (Cleary & Happell, 2005; Halfer, 2007; Kowalski & Cross, 2010; North et al., 2014; Pine and Tart, 2007). It is suggested by Halfer (2007) that the cost of recruiting and then losing a new graduate within the first year is equivalent to a registered nurse's annual salary. With the on-going economic challenges facing health services, it is imperative that strategies are employed to maximise the retention of new graduates (Halfer, 2007). The introduction of new graduate programmes throughout the world have had a positive effect on retention (Bratt, 2009; Bratt & Felzer, 2011; Clark & Holmes, 2007; Cleary & Happell, 2005; Cleary, Horsfall & Happell, 2009a; Haggerty, Holloway & Wilson, 2012).

2.2.3 Recruitment and retention in mental health

Difficulty with recruitment and retention to mental health and addiction has also been a long-standing problem (Happell & Gaskin, 2013) and is now compounded by the competitiveness across all disciplines (Happell, 2008a; Happell & Gaskin, 2013; McCloughen & O'Brien, 2005). The issue is not exclusive to nursing; recruitment to the field of mental health is a challenge for all health disciplines, including doctors (Lampe, Coulston, Walter and Mahli, 2010; Lau, Kumar, & Robinson, 2004; Malhi, Parker, Parker, Kirkby, Boyce, Yellowlees, ...& Jones, 2002) and occupational therapists (Beltran, Scanlon, Hancock & Lockett, 2007; Scanlon, Still, Stewart & Croaker, 2010).

Considerable research has been conducted to identify reasons for the poor recruitment and retention of new graduates into mental health, (Duchscher & Cowin, 2004; Hazelton, Rossiter, Sinclair & Morrall, 2011; Proctor, Beutel, Deuter, Curren, de Crespigny & Simon, 2011; Pickens & Fargostein, 2006; Reinsvold, 2008). Increased workload, nursing shortages and negative perspectives of mental health contribute to the unpopularity of this discipline (Proctor et al., 2011). In addition, there is a wealth of research into the experiences of undergraduates intimating that negative preconceptions of mental health contribute to reluctance to work in this field (Fisher, 2002; Gough & Happell, 2009; Happell & Gaskin, 2013; Lambie & Stewart, 2010; Lampe et al., 2010). There is consensus throughout the literature that the lack of mental health content in undergraduate nursing programmes compounds the issue (Edward, Hercelinskyj, Warelow & Munro, 2007; Happell, 1999b; McCann et al, 2010). This suggests that students do not feel prepared for a career in mental health.

2.3 The history of nurse education in New Zealand

Prior to 1973, all registered nurse education in New Zealand was hospital-based (Department of Health [DOH], 1988). Students could choose between general and obstetric, psychiatric, psychopaedic or 'male' nursing (DOH, 1988). However, feedback from stakeholders indicated a growing discontent in the quality of the education students were receiving (DOH, 1998). The health service was concerned that newly registered nurses were poorly prepared for the increasing complexity

of patient health needs, students felt unsupported and unable to cope with the level of responsibility after inadequate theoretical preparation and nurse educators felt isolated and overwhelmed by increasing workloads (Carpenter, 1971). The result of this progressively unsustainable situation was a high attrition rate of trainees; 45% withdrew from the programmes in 1970 (DOH, 1988).

In 1964 The Nurses and Midwives Board accepted a proposal to phase out separate programmes for clinical specialties and instead implement a comprehensive programme across all nursing education by 1970 (DOH, 1988). However, very little was done to implement the changes at that point. In 1971 the government approached the World Health Organisation and requested a consultant to examine the current state of nurse education in New Zealand. The result; The Carpenter Report, was released in 1972 (DOH, 1988). The report acknowledged that the education of nurses needed to be updated in line with advances in medical interventions, the influence of research and the growing emphasis on evidence-based practice (Carpenter, 1971). The decision was made to transfer the responsibility of educating the nursing population from hospitals to tertiary education providers (DOH, 1988).

By 1987, all hospital-based training had ceased (DOH, 1988). Students enrolled in the comprehensive programmes reported feeling supported and able to manage clinical practice. The nursing workforce was growing and the introduction of 'post-basic' courses had started to extend the qualification status of a small number of the workforce selected for advanced roles (DOH, 1988). In 1990 technical institutes began to offer degree programmes (DOH, 1988). At present, students can choose between a Bachelor of Nursing qualification and a graduate entry pathway resulting in a Master's qualification. Access to postgraduate education is widespread; 40% of registered nurses hold a postgraduate qualification (NCNZ, 2014).

2.3.1 Comprehensive Nurse Education

In February 1998, the Ministry of Health (MOH) commissioned a taskforce to investigate the potential of nursing to contribute to the development of more

effective health service delivery (MOH, 1998). Findings from the report indicated many challenges that nurses faced, including negative attitudes from other health disciplines (MOH, 1998). Significant to this study is the feedback from stakeholders that comprehensive nurse education was insufficient to prepare graduates for specialised clinical practice.

The report acknowledged that the degree status of nurse education had been a positive influence on the promotion of nursing as a legitimate profession (MOH, 1998). However, it also highlighted that the comprehensive programme was unable to adequately cover the specialised content necessary for nurses to work effectively in mental health environments (MOH, 1998). This was compounded by the reduction of academic teaching weeks from 40 in the 1990s to 30/32 at the time of the report. This equates to a reduction of up to 30 weeks over the complete three year programme (MOH, 1998).

2.3.2 New Graduate experience

Stakeholders were also concerned about the experiences of newly graduated nurses not being work-ready (MOH, 1998). It was evident that the expectations of the industry and the education sector were different. The aim of comprehensive training was that new graduates would qualify with a 'beginning level' of theoretical and clinical ability (MOH, 1998). However, the industry expected graduates to be able to work in busy environments and manage a full caseload of patients on qualifying (MOH, 1998). Comparisons were being made between those nurses who had trained in hospitals and those coming from tertiary education providers. In mental health, the situation was even more concerning. The inadequate preparation afforded by the undergraduate programmes resulted in students feeling overwhelmed; many feared the mental health environment. Stakeholders reported a lack of skill and an increase in reportable clinical incidents resulting in restrictions on scope of practice (Haggerty, 2000). These apprehensions were not new to the Ministry of Health; Haggerty (2000) asserts that concerns had been raised while the transition from hospital training was still in progress in 1987. Other concerns were raised regarding the low numbers of newly qualified nurses choosing mental health and the impact this would have on

the workforce (Williams, 1986, cited in Haggerty, 2000) In response to feedback from stakeholders, the Ministry of Health considered the necessity of a mental health new graduate programme to increase competence and recruitment (Haggerty, 2000). This was not acted upon until 1994.

2.3.3 New Graduate Programmes

In 1994 Whitireia Community Polytechnic and Capital Coast Health Limited developed a programme for new graduates wanting to pursue a career in mental health (Haggerty et al, 2009). There was a focus on mentorship, specific mental health theory and clinical placements in a variety of settings. A review of the programme confirmed improved new graduate confidence and retention (Haggerty et al., 2009). The Ministerial Taskforce report in 1998 recommended that this programme be adapted for other areas of nursing and resulted in the model being rolled out across New Zealand (MOH, 1998). It was named the Nurse Entry to Practice programme (NETP). The separation of mental health from the rest of NETP was necessitated because of variations in the recruitment population for mental health and different funding bodies (Haggerty et al., 2009). The mental health programme was renamed the Nurse Entry to Specialised Practice in Mental health and Addiction (NESP) programme.

Currently, in New Zealand all DHBs are committed to the NETP and NESP to recruit new graduates (MOH, 2017). An evaluation of the recruitment process revealed a labour-intensive system where considerable inequality existed (MOH, 2017). The MOH recommended a national recruitment system be implemented that maximised the recruitment of new graduates in a manner that gave all applicants fair consideration. A system existed that recruited newly qualified doctors to their first clinical position. It was suggested that a similar process be adopted for nursing graduates (MOH, 2017).

2.4 The Advanced Choice of Employment scheme (ACE)

Very little literature could be found that describes the introduction of ACE in any detail. The MOH website provides a summary of the ACE scheme and there is an ACE website that describes the process and conditions for eligibility. An article by

Wilkinson, Neville, Huntington and Watson, (2016) gives a brief overview of the ACE process. Most of the following information is taken from these sources.

In November 2012, the ACE scheme was piloted across the DHBs in New Zealand (Wilkinson et al., 2016). The process was considered successful and approved for a further two-year period with an evaluation and revision planned for the end of 2014 (MOH, 2017). In 2012 the MOH provided a summary of the recruitment patterns for ACE applicants but no account of the review could be found on the MOH website. However, a report by Huntington, Wilkinson and Neville was commissioned by the MOH in 2014 (Huntington et al., 2014). This report looked at the factors that influenced applicants to choose speciality areas and is discussed as part of the literature review for this study.

2.4.1 The application process

All new graduates seeking a position on NETP or NESP must apply through ACE (MOH, 2017; Advanced Choice of Employment [ACE], n.d.1); the scheme runs twice a year to coincide with nursing students' graduation. ACE have organised annual presentations to all nursing cohorts throughout New Zealand and third year students are advised to attend these presentations whether they graduate that semester or the next. The presentation slides are also available on the ACE website for further reference (ACE, n.d.1, para. 1). This enables potential applicants to gain an understanding of how the process works and what they need to provide (ACE, n.d.1, para. 1). Once the process opens, all applicants need to create an online profile; they have four weeks to gather and submit all the required information (ACE, n.d.1, para. 2). The ACE application is online and there are several sections that need to be included. The application comprises a CV, two references, the applicant's academic transcript and a cover letter. Referees complete a standardised online reference and must submit them before the closing date. If the references are not completed, the application is not accepted. ACE stipulates that it is the applicant's responsibility to ensure that referees submit on time (ACE business rules, 2017, p4).

Each applicant can choose up to three preferred DHBs and three clinical areas (Wilkinson et al., 2016). The latter of these is of interest to this study. ACE gives advice regarding employer preferences and how to maximise success (ACE, n.d.2, para. 1-5). There is an option to change the order of preferred DHB after the application closing date so applicants can ensure the DHBs that offer an interview are higher up their list. Employers can be removed from the application but no new employer choices can be added (ACE, n.d.2, para 12). Under the section, 'Expected vacancies' ACE advises candidates to refer to the specific DHB websites to ascertain the availability of positions and the level of support they offer (ACE, n.d.2, para 12). It is clearly stated by ACE that they are not responsible for the accuracy of information and they recommend that applicants contact the NETP coordinator directly to confirm availability of positions (ACE, n.d.2, para 12). Information regarding NESP is found under a separate section (ACE, n.d.2, para 14-19).

After the closing date, ACE review all completed applications to check for eligibility and use a "nationally agreed scoring criteria" to assess the potential candidates (ACE, n.d.1, para. 14). This process includes consideration of references, academic transcripts and any scholarships that may have been awarded during undergraduate study (ACE, n.d.1, para. 14). ACE then send these details to the DHBs that applicants have specified as potential employers. The DHBs are responsible for shortlisting, interviewing and ranking potential candidates (ACE, n.d.2, para. 15). This process can vary between DHBs and needs to be completed within six weeks. ACE is not involved in the interviewing process (ACE, n.d.2, para. 15). At the end of six weeks, each DHB submits a list of preferred candidates along with a list of available NETP/ NESP positions (ACE, n.d.2, para. 15).

Once all employer preferences are submitted to ACE, an algorithm is used to match applicants with DHB (ACE, n.d.3, para. 1). ACE send the matched applicants to the separate DHBs and they are responsible for contacting successful candidates with an offer of a job (ACE, n.d.1, para. 22). Those applicants who are unsuccessful are placed into a 'talent pool'. ACE notify all candidates of the outcome of their application on the Wednesday after state final exams; DHBs send out job offers

later that same day (ACE, n.d.1, para. 23/24). If a candidate wishes to accept the position, they contact the DHB directly. There is a deadline for accepting an offer and applicants who do not meet the deadline will have the offer removed (ACE, n.d.1, para. 24). If a candidate declines an offer or fails to accept a place, they are removed from the entire ACE process and must wait six months to reapply (ACE, n.d.1, para. 24).

2.4.2 The algorithm

The ACE Business Rules (2017) explain that the algorithm gives priority to those applicants who were ranked highest by the DHB after interview. Consideration of an applicant's choice of employer is given second priority (ACE, n.d.3, para. 4). Applicants are only considered for a NESP position if they specify mental health and addiction on their application and they are only matched to a place if they are ranked by the employer as suitable for NESP (ACE, n.d.3, para. 4). ACE also advises that candidates wishing to gain a NESP position are more likely to be considered for NESP if they identify mental health and addiction as their first clinical choice (ACE, n.d.3, para. 4).

ACE advises applicants to choose more than one preferred DHB as this will increase the likelihood of securing a position. However, ACE also stipulates that applicants consider carefully their choice of employer and only identify those DHBs they are prepared to work for (ACE, n.d.3, para. 5). The rationale for this is that each successful applicant will only receive one offer and there is an expectation that the offer will be accepted. The Business Rules for ACE state that this condition was agreed on by all employers because of the large numbers of applicants and the labour-intensive process of reassigning candidates who had rejected positions (ACE, 2017).

Advice regarding clinical choice is somewhat unclear; ACE advise applicants to consider their clinical specialty carefully as they will be required to choose at least one as part of the application. They also suggest that applicants check their chosen specialities against employer availability to ensure a good match (ACE, n.d.3, para. 5). However, ACE also asserts that the applicant's clinical preference is not

considered during the match process, the algorithm only takes into consideration the preferred DHB (ACE, n.d.3, para. 5). Once an applicant has been matched to an employer, it is the employer's responsibility to assign a clinical area. ACE highlight to potential applicants that they are not responsible for assigning clinical placements and there is no guarantee that clinical preference will be granted (ACE, n.d.3, para. 5). This distinction is more applicable to NETP programmes because they cover a wide range of different clinical environments, including medical and surgical specialities, Older Person's Health (OPH), several Aged Residential Care (ARC) services and some public health placements (ACE, n.d.2, para. 15). In contrast, NESP only covers mental health and addiction services, so applicants who accept a position in NESP can only be placed in mental health and/or addiction (ACE, n.d.2, para. 15).

2.4.3 The talent pool

If an applicant is unsuccessful they are placed into a 'talent pool' (ACE, n.d.4, para. 1). This is then distributed to all employers. At this point, ACE ceases to have any involvement in recruitment until the next application rolls out (ACE, n.d.4, para. 3). The talent pool remains available until the next application process starts. Applicants are advised that they must contact potential employers directly to be considered for any remaining vacancies (ACE, n.d.4, para. 2). A candidate in the talent pool can decline an offer from a potential employer without sacrificing their place; this restriction only applies to applicants in the first round of ACE (ACE, n.d.4, para. 3).

2.4.4 Eligibility

There are several conditions that affect a candidate's eligibility to apply through ACE (ACE, n.d.5, para. 1). Applicants must be New Zealand citizens or permanent residents; international students are not entitled to funding (ACE, n.d.5, para. 1). These restrictions suggest that all international graduates and candidates who are not successful are limited to seeking employment in ARC, the private sector, non-government organisations (NGOs) and some public health providers. Each candidate can only apply four times over the 24-month period after graduation (ACE, n.d.5, para. 1). Candidates who fail to get a placement can only work for a

period of six months as a full-time registered nurse if they wish to reapply (ACE, n.d.5, para. 1). These restrictions do not apply to NESP. The NESP programme is also open to registered nurses who have previously worked in other areas, for this reason the funding is different and so there is more flexibility (TePou, n.d.).

These limitations have placed considerable pressure on applicants to secure a NETP/NESP position during the first application (Wilkinson et al, 2016). ACE acknowledges the competitive nature of the process in their information on nursing statistics (ACE, 2015). If an applicant is not successful in the first round, entry into the talent pool increases the pressure to find and secure any available vacancies. This progressively stressful process to obtain a new graduate position can result in applicants accepting a job anywhere, regardless of clinical preference (Huntington et al, 2014). Consultation of the statistics provided by ACE revealed that there is no record kept of the number of places filled in NETP or NESP during the first selection process. A similar search of the statistics held by the MOH confirmed that this was not being measured. However, during the interview with the coordinator of the NESP programme that is the focus of this case study, it was confirmed that the positions for NESP are rarely filled in the first round and NETP is usually oversubscribed. This is discussed further in the Findings chapter.

2.5 Summary of chapter

The move from specialised to comprehensive nurse education programmes in New Zealand caused a reduction in the mental health content being taught to undergraduates. This had a negative effect on the quality of mental health nursing practice and prompted the suggestion that a new graduate programme was necessary to address this. The successful implementation of NESP improved retention and the MOH recommended the development of NETP. To date, all DHBs in New Zealand are committed to NETP and NESP. ACE was introduced to facilitate a fair process for recruiting new graduates to both programmes and is the only way to obtain a position in NETP and NESP. Successful applicants are only offered one position, if the applicant declines the position they are removed from the process. ACE generates competitiveness and the restrictions of the eligibility

criteria place pressure on applicants to secure a position regardless of clinical preference.

3 Chapter 3 – Literature review

3.1 Introduction

This chapter focuses on the literature review for this study. First there is a description of the searches that were completed and the number of articles that were collected for review. Two broad themes emerged from analysis of the relevant literature; undergraduate experience and new graduate experience. There is a separate discussion of the effect of stigma and discrimination on recruitment and retention in mental health as this is relevant to both the undergraduate and new graduate categories. The final section considers the influence of ACE in relation to the findings from the literature and statistical records from the MOH (2017) and ACE (2015).

3.2 The search details

A search of CINAHL using different combinations of keywords 'New graduate', 'mental health', 'New graduate programmes', 'NETP', 'NESP', 'Advanced choice of employment', 'career choice' and 'New Zealand' resulted in a large body of literature. These studies were scanned for relevance and the results sorted into two broad categories; Career choice and NETP/NESP. The former category contained 51 articles that had some relevance and the second held 61. These articles were then analysed and sorted into categories in relation to significance.

After this process, the career choice category held seven articles considered important to this study. A further 12 had some relevance and 32 of the articles had some significance. The NETP/NESP category was heavily weighted towards general adult nursing with 44 of the 61 articles focused on NETP programmes exclusively. Of these, four articles were considered important; 13 had some relevance and 27 were borderline. The 17 articles that related to NESP revealed four of importance, five of relevance and eight that were borderline. One article (Nicholls, Mannix & Jackson, 2009) outlined the details of proposed research but the actual study could not be found despite repeated database searches.

The literature search revealed that there had been very little consideration of the influence that the ACE recruitment process could have on new graduate career choice. The small number of studies into mental health in relation to new graduates also indicates this is a relatively neglected area for research. All the articles in the career choice category related to mental health, however, these were mostly focused on the undergraduate experience and the influence of comprehensive undergraduate nursing programmes on recruitment and retention in mental health.

3.3 The undergraduate experience

Mental health nursing has never been a popular career choice (Happell, 1997; Happell & Gaskin, 2013). Recruitment has become more problematic since the introduction of comprehensive education due to increased competition with other disciplines (Haggerty, 2000; Rushworth & Happell, 1999). With the availability of specialised programmes, there was the guarantee that successful students would seek employment in mental health (Happell, 1997). Although the comprehensive programme was intended to supply future mental health nurses, recruitment numbers have been considerably lower since the replacement of specialised hospital-based programmes (Happell, 1997). This has inspired a great deal of research into the career aspirations of undergraduates and consideration of strategies to increase interest in mental health.

Much of the research into the impact of comprehensive education on recruitment to mental health has come from Australia. As the changes in nursing education reflect those in New Zealand many of the findings are relevant to this context. The research that focuses on the impact of undergraduate education on students' attitudes to mental health spans three decades. This indicates continued problems with recruitment despite numerous strategies to increase the efficacy of education and encourage interest.

3.3.1 Undergraduate nursing education

As previously discussed, the transition from hospital-based training to comprehensive programmes in New Zealand occurred between 1973 and 1987,

with the last cohort of psychiatric nurses qualifying from Poirua hospital in 1989 (Haggerty, 2000). In Victoria, Australia, specialised nurse education was abolished in 1993 with the introduction of the Nurses Act (Happell & Gaskin, 2013). Prior to this, Victoria was the only state in Australia to successfully introduce specialised psychiatric nursing into tertiary education (Happell, 1997). The Nurses Act of 1993 stipulated that any registered general nurse could work in mental health without additional training. However, mental health nurses could only continue to work in psychiatric settings (Happell, 1997). This indicated that the discipline of mental health was no longer considered a speciality (Happell, 1997). There was an expectation that the development of comprehensive nursing programmes would include an increase in mental health content. However, the Nurses Act gave no expectations regarding how much content should be included; resulting in inconsistencies across different programmes (Rushworth & Happell, 1999). Of the twelve available programmes, only three had changed their curriculum to include more mental health theory (Happell, 1997). It is suggested by Happell (1997) that the remaining programmes renamed the original general nursing courses as comprehensive and made no changes to the theoretical content. The result was a heavy emphasis on medical and surgical nursing (Happell, 1997).

3.3.1.1 Preconceptions of nursing

Within the literature, there are several studies that explore the effect of preconceptions on the career preferences of nursing students prior to commencing study (Happell, 1999a; Happell, 1999b; Happell & Gough, 2007; Rushworth & Happell, 1999; Spouse, 2000). Students enter undergraduate nursing programmes with pre-determined ideas of nursing drawn from popular media, cultural influences and personal experience (DeKeyser Ganz & Kahana, 2006; Happell & Gough, 2007; Leh, 2011; Spouse, 2000). In a study of the preconceptions of undergraduates, Spouse (2000) explored the influence of media images on societal perception of nursing identities. Citing the model of career choice developed by Ginzberg, Ginzberg, Axelrad and Herma (1951, cited in Spouse, 2000) the suggestion is made that school leavers will adopt a stereotypical ideology of the career they are embarking on. The iconic image of Florence Nightingale places

nursing in the context of a medical-surgical environment (Humble & Cross, 2010). An influx of popular hospital TV dramas convey a perspective of nursing that is fast-paced, high-tech and glamorous (Happell, 1999a; Humble & Cross, 2010). In contrast, negative stereotypes of mental health pervade societal perception (Happell, 1999a). The media is littered with examples of mental health consumers being unpredictable and dangerous (Anderson, 2003) and films portray mental health hospitals as the subject of nightmares (Goodwin, 2014; Anderson, 2003) In addition, western culture champions youth over age (Lovell, 2006).

It is not surprising then that the preferred career choices of student nurses when they commence their study are paediatrics, neo-natal nursing, operating theatre and ICU (Happell, 1999a; Happell, 1999b). The most unpopular choices are mental health and older person's health (Chenoweth, Jeon, Merlyn, & Brodaty, 2010; Happell, 1999a). A romanticised perspective of working with babies and children was the predominant reason for popularity in this area; 22.2% of respondents specified paediatrics before commencing study (Happell, 1999a). A preference for technology and the high-paced environment were cited as reasons for choosing intensive care and theatre nursing (Happell, 1999a). In contrast, reasons for the unpopularity of mental health included having insufficient knowledge, not being personally suited to the environment and negative assumptions about both mental health nurses and consumers; including fear and mistrust of people with mental illness (Happell, 1999b)

In a study of the reasons for the unpopularity of gerontology nursing, Stevens and Crouch, (1995) suggest that the 'cure: care dichotomy' contributes to students' beliefs about nursing. The emphasis on the life-saving, scientific aspects of the profession are viewed as more desirable than those disciplines that focus more on the art of caring. This argument is supported by the findings of Happell, (1999a); indicating that the technological aspects of nursing are more attractive because they are considered a step closer to medicine. Traditionally medicine was associated with the curing of patients while nursing was responsible for the caring role (Stevens & Crouch, 1995). Due to the lack of scientific influence, nursing was judged as subordinate to medicine; a vocation rather than a profession (Stevens &

Crouch, 1995). Therefore, those disciplines that emphasise care rather than advances in technology; including mental health, are considered to require fewer skills than medical and surgical nursing (Stevens & Crouch, 1995, Happell, 1999a).

Despite the negative assumptions of students at the commencement of their education, the experience of the undergraduate programme provides opportunity to increase knowledge beyond that of the layperson and experience nursing in a variety of contexts (McCann et al., 2010). There is potential for undergraduates to change their perceptions of mental health and develop more positive attitudes (Cowin & Johnson, 2011). In a comparison of students' career preferences at the commencement and conclusion of their nursing degree, Happell (2002) concluded that attitudes towards mental health consumers do change. The findings demonstrated a significant reduction in fear and apprehension and an increase in perception of people as human beings rather than stereotypical characteristics associated with diagnosis (Happell, 2002).

However, the unpopularity of mental health nursing so early in a student's experience does not bode well for future recruitment (Happell, 1999b). It is argued that students will place emphasis on those experiences that support their preconceived images of nursing and consequently, those experiences that do not conform are rejected or minimised (Spouse, 2000). If this is the case, the emphasis on physical health within the degree programme can lead to further reinforcement of the viability of medical/surgical nursing as legitimate career choices. Mental health, in contrast, is considered a last resort for those entering the discipline "as a matter of economic necessity" (Happell, 1999b, p. 483). It is recommended that for interest in mental health as a career to increase there needs to be considerable revision of the undergraduate nursing programmes with an increased emphasis on all areas of nursing as worthwhile career choices (Happell, 2002).

Two longitudinal studies conducted by Happell (2002) and McCann et al. (2010) explored how much influence education had on undergraduate career preferences. Findings of both studies held similarities, namely the preferences of students at the commencement of study. However, McCann et al. (2010) found a significant number of students did not specify a career pathway. This indicates that many

students enter undergraduate study with an open mind and that career preferences are influenced by the emphasis within the nursing programme (McCann et al., 2010).

After completing the undergraduate programme, more discrepancies between the two studies were evident. According to Happell (2002), there were changes in the most popular areas; fewer students identified midwifery and more students chose surgical nursing. Although there was an increase in the popularity of mental health it remained one of the least prevalent choices (Happell, 2002). The study identified fluctuations within the most and least popular groups but there was no significant change between them. The study concluded that education has a limited effect on career choices, but does acknowledge the fluidity of student perception (Happell, 2002). In contrast, McCann et al. (2010) found substantial change in the popularity of mental health; this moved from the second least to the second most popular choice, swapping places with midwifery. It is proposed by McCann et al. (2010) that the shift in consideration of mental health as a career could be because it was covered in both the second and third year of the programme they studied. There is also mention of the inclusion of consumers in delivering theoretical content as an influential factor (McCann et al., 2010).

3.3.2 The influence of undergraduate education

3.3.2.1 Theory

There is a consensus in the literature that undergraduate nursing programmes have inadequate theory to prepare undergraduates for a career in mental health (Edward et al., 2007; Happell, 1998; Happell, 1999a; Happell, 2009; Happell, McAllister & Gaskin, 2014; Henderson, Happell & Martin, 2007). In a study on the impact of theory and clinical experience on student perceptions of mental health, Henderson et al. (2007) identify that the problem is compounded by a lack of clarity regarding the aspects of theory that should be covered. There are differences in the length of time devoted to mental health, along with the discrepancies in content and method of delivery. This has resulted in a lack of consistency in the development of knowledge and skills. It is suggested by

Henderson et al. (2007) that content should focus on diagnoses, assessment and communication skills (Henderson et al., 2007).

However, Edward et al. (2007) emphasise that undergraduate programmes should focus on introducing the therapeutic use of self. They define this concept as a combination of personality, life-experience and skills, knowledge of mental health theory and professional capability. The purpose of the therapeutic use of self is to inspire trust in people experiencing mental illness and provide a safe, understanding environment where people can discuss their experiences without judgment (Edward et al., 2007). Many novice nurses find this prospect daunting and can feel overwhelmed by the idea of working with people in emotional distress for fear of making things worse (Fisher, 2002). It is imperative, therefore, that undergraduate theory introduces the importance of this aspect of mental health nursing in an environment where students can practise their skills safely and build confidence (Edward et al., 2007). It is evident from the comparison between Henderson et al. (2007) and Edward et al. (2007) that there is a lack of agreement regarding the specific content that should be taught to undergraduates. This incongruity within the literature reflects the challenges of developing a consistent programme across all tertiary education providers; different educators will have specific ideas about what they believe needs to be included and so the disparities are likely to remain.

Another challenge identified by Edward et al. (2007) relates to the apparent contradictions between evidence based nursing and mental health clinical practice. The importance of 'being with' a person and recognising that mental health is unique to the individual can often clash with the emphasis on best practice (Edward et al., 2007). This is confusing and students have expressed frustration at the differing messages between theory taught in the classroom and the advice and practice of nurses in the field (Edward et al., 2007). In addition, the presence of apprehension and anxiety can negatively affect the way a student nurse approaches a person with mental illness and further impede their learning (Fisher, 2002).

To maximise the efficacy of theoretical content several studies have focused on specific teaching approaches. Edward et al. (2007) report that the use of simulation helped to reduce apprehension and increase confidence in students prior to their clinical practice. Clinical feedback following the introduction of simulation reported an increased motivation in students and improved competence (Edward et al., 2007). The findings from the study conclude that the teaching strategy had a positive effect on recruitment to mental health. It is difficult to ascertain the accuracy of this claim, however, as the actual career choices of the students on completion of the programme were not recorded.

A study conducted by Happell, Moxham and Platania-Phung (2011) explored the efficacy of consumer involvement in the teaching of theory. They discovered that the inclusion of mental health consumers as teachers encouraged students to view people with mental illness as individuals rather than a diagnosis. The findings of the study indicated a positive influence on attitude towards mental health consumers although the study did not consider how this could effect change in recruitment. The positive influence of consumer participation, is supported by McCann et al. (2010), who cited this as a potential reason for increased interest in mental health as a career.

In an exploration of the efficacy of problem-based learning as a method of teaching, Happell and Rushworth (2000) sought to identify whether it would promote the development of mental health nursing skills and generate increased interest in the discipline. They highlighted the difficulty with covering mental health theory adequately in the short-allocated time and advocated problem-based learning as an effective method of resolving this while encouraging critical thinking (Happell & Rushworth, 2000). Findings from the study suggested that attitudes to mental health became more positive and interest in mental health as a career increased (Happell & Rushworth, 2000). They concluded that problem-based learning had the potential to change attitudes. Further studies by Happell, Robins and Gough (2008a/b) measured the impact of increased theoretical content by comparing two cohorts of students in the same education institution studying different curriculums. Their findings supported an increase in preparedness for mental

health clinical and increased interest in a career in mental health. However, whether positive attitudes led to an increase in recruitment to mental health has not been conclusively identified. The study by Henderson et al. (2007) asserted that increased knowledge, skills and attitude did not equate to increased motivation to choose a career in mental health.

It is suggested by Happell (2002) that much of the existing research has focused on the effect that exposure has on changing attitudes, but has not explored how this change in attitude influences career choice. Other studies have assumed that a change in attitude equates to an increased motivation to choose mental health as a career. However, none of the studies discussed collected data regarding actual recruitment choices on qualifying and so the impact of education could not be fully realised.

3.3.2.2 Clinical experience

Many studies consulted focused on the effect of clinical experience (Happell, 2008a; Happell, 2008b; Happell, 2008c; Gough & Happell, 2009; O'Brien et al., 2008) and the combination of both theory and clinical, (Happell, Robins & Gough, 2008b; Henderson et al., 2007). There is consensus in the literature that clinical exposure to the mental health environment has a positive influence on attitudes. A quantitative study conducted by Happell (2008a) sought to confirm the efficacy of clinical placement on students' interest in mental health by comparing the attitudes of students before and after their undergraduate mental health placement. The findings indicated that clinical experience had a significantly positive influence on students' attitudes to people with mental illness (Happell, 2008a). However, in a two-part study into the impact of theory and clinical experience on students' intentions to pursue a career in mental health Happell et al. (2008a/b) found that an increase in positive perspectives towards mental health did not translate into increased recruitment.

The study concluded that although students reported feeling better prepared to pursue graduate study in mental health after clinical experience, the sense of preparedness was much higher for medical/ surgical nursing (Happell et al.,

2008a). It would seem that the influence of medical and surgical nursing is stronger than that of mental health and efforts to improve attitudes and interest in the field are hampered by the continued emphasis on physical health within undergraduate nursing programmes (Happell et al., 2008b). However, it is acknowledged that the findings of the study do not provide information regarding cause and effect and it is suggested that the attitudes of undergraduate students prior to clinical exposure could have an influence on whether the placement is positive (Happell et al., 2008b). This could indicate that the perceived belief that clinical placements have a positive influence on recruitment to mental health is overrated and may explain the continued poor interest in mental health as a viable career.

In a cluster analysis study to identify factors that constituted a positive clinical experience. Gough and Happell, (2009) identify that regular contact with a preceptor, full eight hour shifts and exposure to the community were significant contributing factors. However, these conclusions were drawn from comparisons between two groups and chosen because they were prevalent in the group that indicated improved attitudes. It could be argued that other factors not evident in the data had an equally positive influence. Due to the quantitative design of the study, Gough and Happell (2009) acknowledge that they were not able to measure the quality of preceptorship, only the length of time and frequency of meetings. They recommend increasing the length of shifts, consistent preceptorship and rotation through community placements could help to improve attitudes. These recommendations were reinforced in a further study; concluding that contact with preceptors had a correlation with interest in mental health nursing as a career (Happell, 2008c).

In a mixed methods study, O'Brien et al. (2008) assert that the utilisation of clinical facilitators in clinical placements can provide support and encouragement for students. They state that a clinical facilitator can encourage students to reflect on clinical incidents and help them to 'make sense' of significant events (O'Brien et al., 2008). The findings of their study indicated positive feedback from students, nursing staff and facilitators themselves. One interesting factor about this study is

that the researchers compared the participants' perceived interest in a mental health career with the number of applications made to mental health services. They found there had been an increase, although they acknowledge that further investigation into the participants' attitudes would have indicated how long the influence of a positive mental health clinical experience lasted (O'Brien et al., 2008). This would be interesting as it could develop understanding regarding the comparison between the influences of mental health compared to medical surgical environments.

Another important consideration about the study by O'Brien et al. (2008) is the presence of qualitative research methods. All the other studies that focused on undergraduate experience are quantitative. Despite the advantage of having large numbers of students involved in the research conducted, there is a dearth of qualitative data that gives insight into the experiences of students. To fully exhaust this topic and gather an understanding of the complexity of influences on career choice, more qualitative research is necessary.

3.3.3 The relationship between attitude and behaviour

It is evident that theory and clinical experience can have a positive influence on undergraduate students' attitude to mental health (Happell, Robins & Gough, 2008b; Henderson et al., 2007). However, strategies to improve the impact of both theory and clinical experience have not resulted in an increase in recruitment (Happell et al., 2008b). This could explain why the topic has been studied repeatedly over three decades. Comparison between the literature for this review has revealed a lack of consistency in the assumed relationships between attitude to mental health, consideration of mental health as a career and joining the mental health workforce. Most of the studies alluded to the crisis in mental health recruitment as a motivation for research and assumed that a more positive attitude towards mental health was evidence of increased interest and recruitment (Edward et al., 2007; McCann et al., 2010). This is clearly not the case, otherwise the industry would have shown an increase in the mental health workforce.

To make sense of the influence that education has on career choice, there needs to be clarification of the concepts related to attitude. It is suggested by Happell and Gaskin, (2013) that there is an evaluative aspect to the concept of attitude that includes affective, cognitive and behavioural components. An individual's response to the evaluative aspect of attitude can be either conscious or sub-conscious (Happell & Gaskin, 2013). The complexity of this definition is very significant to the consideration of how education can influence career choice (Happell & Gaskin, 2013). It is acknowledged that a student may think and feel differently about mental health consumers and nursing, but to assume a linear connection that results in a career in mental health does not take into consideration other influences (Happell & Gaskin, 2013). A change in attitude towards mental health nursing does not necessarily result in a student choosing mental health as a career. This fact indicates that the complexity of the relationship between the cognitive and affective aspects of attitude and the behavioural component has not been conclusively explored (Happell & Gaskin, 2013).

The literature suggests that a strong emphasis on medical and surgical nursing in the undergraduate programme has a negative influence on an undergraduates' motivation to choose mental health as a viable career. In addition, it would seem that students attitude towards medical and surgical nursing has a stronger influence on behaviour than any recent change towards mental health (Happell & Rushworth, 2000).The brief introduction to theory and the single clinical placement in mental health may serve to change cognitive and affective attitudes towards people with mental illness and the nurses who work with them, but there are evidently other influences that override these because there is no consequent behavioural response of joining the mental health workforce.

3.4 New Graduate experience

There has been a great deal of research into the transition of newly qualified nurses that spans several decades (Kramer, 1974, (cited in Bick, 2000); Duchscher & Cowin, 2006; Dyess & Sherman, 2009; Kelly, 1998). The first year of clinical practice can be very stressful for new graduates and the consensus in the literature is that undergraduate programmes are too far removed from the reality of clinical

practice (Bick, 2000; Cleary & Happell, 2005; Cowin & Hengstberger-Sims, 2006). Regardless of whether undergraduate programmes are comprehensive or specialised; such as the nursing education in the UK, many newly qualified nurses find transition into their first clinical position stressful. This has been referred to as 'reality shock' (Kramer, 1974, cited in Bick, 2000). The literature concludes that reality shock is the primary reason for high attrition rates in new graduate nurses (Hazelton et al., 2011). This phenomenon is relevant to all nursing disciplines, but is particularly problematic in mental health (Hazelton et al., 2011). Some studies have suggested that reality shock has become more problematic due to increased acuity and the complex health needs of an ageing population (Bratt & Felzer, 2011; Dyess & Shermann, 2009)

3.4.1 The transition process

Many studies have focused on the transition journey of new-graduates (Kelly, 1998; Kowalski & Cross, 2010; McKenna & Green, 2004; Newton & McKenna, 2007). These studies have developed theories regarding the different developmental stages that newly qualified nurses pass through during the first 12 to 18 months of their careers. Theories range from two stages (McKenna & Green, 2004) to six (Kelly, 1998). Despite differences in the identified stages, all theories agree that there is a transition from an internalised focus to an externalised perspective (Kowalski & Cross, 2010). The first six months incorporates developing self-awareness, the maturation of clinical skills and coping with the clinical environment (Newton & McKenna, 2007). In the second six-months new graduates adopt an externalised focus; patient care is more of a consideration, along with professional relationships and professional development (Newton & McKenna, 2007; Kowalski & Cross, 2010). In a qualitative study of newly qualified nurses working in acute care, Duchscher (2008) identified three stages of 'doing', 'knowing' and 'being' that were important to the transition period. The three stages were marked by a focus on task-orientated practice (doing), an adaptation to the clinical environment and consequent move away from the academic domain (being) and eventual emergence into consideration of themselves as practitioners (knowing) (Duchscher, 2008).

3.4.1.1 The first six months of practice

Despite the differences in theories regarding the transition of new graduates, there are similarities that exist. The first six months' experience of new graduates transitioning into the nursing workforce involves a shift from the educational environment to the workplace (Halfer & Graf, 2006). Graduates are overwhelmed by the responsibility for the welfare of patients and acclimatisation to the clinical environment (Hazelton et al., 2011). During the undergraduate programme, students are associated with the role of learner; there is support from both the education system and the clinical environment and a heavy emphasis on being supervised. Responsibility remains with the registered nurse (RN) they are assigned to and students sit outside the cultural association of the nursing team. Once qualified, the support of the education institution is removed and new graduates are expected to adapt to the role of RN almost immediately (Halfer & Graf, 2006). This includes a shift in loyalty from the education institute and surrendering of the student status. It has been identified by Halfer and Graf (2006) that new graduates go through a grieving process signified by the loss of the academic structure, weekends free and long holidays. In addition, the inconsistency of orientation within clinical areas results in new graduates feeling unprepared to start taking full caseloads and the resultant stress impedes ability to learn (Bick, 2000). New graduates are faced with the challenge of redefining their professional values and merging the ideals upheld by education with the realities and limitations of clinical practice (Duchscher & Cowin, 2006). This is compounded because veteran nurses become desensitised to the conflict between professional nursing values and the political focus of the health care system and are therefore less supportive of colleagues making this transition (Duchscher & Cowin, 2006). This leads to new graduates feeling disillusioned and frustrated with the systems they are working in.

3.4.1.2 The second six months of practice

Many studies link the process of transition with development of confidence (McKenna & Green, 2004; Oermann & Moffitt-Wolf, 1997; O'Shea & Kelly, 2007), self-awareness (Cleary, Horsfall, Mannix, O'Hara-Aarons & Jackson, 2011; Ronsten,

Andersson & Gustafsson, 2005) and socialisation (Duchscher & Cowin, 2004; Cowin & Hengstberger-Sims, 2006; Newton & McKenna, 2007). The second six months of practice involve a process of inclusion into the culture of nursing and a consideration of professional development (Newton & McKenna, 2007). As new graduates become more familiar with the realities of the clinical environment, their confidence in their clinical decision making and critical thinking skills develop and their focus shifts from survival to the welfare of patients (Oermann & Moffitt-Wolf, 1997). As new graduates receive validation from veteran colleagues, their self-awareness shifts to recognition of themselves as competent nurses (Ronsten, et al., 2005). This validation leads to increased consideration of themselves as making a difference and reflective practice occurs. The outcome of this process is a greater awareness of patients as individuals, more effective collaboration with colleagues and successful socialisation into the nursing culture (Ronsten et al., 2005).

3.4.2 Marginalisation and socialisation

A study by Duchscher and Cowin (2004) explored the concept of marginalisation in relation to the experience of new graduate nurses in their first clinical placement. They define marginalisation as “the experience of living between two cultures that have asymmetrical power” (Duchscher & Cowin, 2004, p. 289). Originally the term referred to those people who lived in a social situation that afforded attributes to those in power and deprived those without. The result is a socially enforced segregation that historically has been experienced by marginalised groups such as women, the poor, immigrants and the mentally ill. In the context of these groups, marginalisation has been experienced over a lifetime; a permanent marginalisation. However, Duchscher and Cowin, (2004) argue that the concept can refer to certain groups over a shorter period. They cite the work of Dickie-Clark (1966, cited in Duchscher & Cowin, 2004) to support the theory that any system that contains a hierarchy will include marginalised populations. Within nursing, new graduates would constitute one of these groups. Marginalisation refers to people who exist between two separate environments. For a new graduate these would be the academic realm and clinical practice. It is proposed

that for new graduates the experience is a transitional “marginalising situation” (Duchscher & Cowin, 2004, p. 290) and is identified by the potential alienation and vulnerability that new graduates experience during this period. It is suggested that the high attrition in new graduate nurses is related to this concept of marginalisation (Duchscher & Cowin, 2004).

It is argued that the first six months of transition is the most stressful for new graduates, resulting from the chaos that is caused by living between the two domains of education and clinical practice (Duchscher & Cowin, 2004). The realisation that the values developed within the undergraduate programme are different in the workplace can be disheartening and frustrating. This can lead very quickly to disillusionment and the belief that the career they have prepared for does not in reality exist (Duchscher & Cowin, 2004). Until socialisation occurs, new graduates remain between these two realms of education and clinical practice, belonging to neither. If a new graduate is unable to make the transition from one to the other, they are likely to leave both (Duchscher & Cowin, 2004).

Other studies have linked successful socialisation with job satisfaction. In a study focusing on the reasons for attrition within the nursing workforce, Sochalski (2002) asserts that low job satisfaction is a contributing factor, this is also supported by the findings of Reinsvold, (2008). Factors that negatively influence job satisfaction include staff shortages, high workloads, bullying, and “poor person-job fit” (North et al., 2014, p. 1815). Self-concept has also been attributed to the retention of new graduates (Cowin & Hengstberger-Sims, 2006). It is proposed that as a new graduate develops a concept of themselves as belonging to the nursing profession, they are more likely to stay (Cowin & Hengstberger-Sims, 2006).

It seems, therefore, that there is a significant link between job satisfaction and retention of new graduates. Job satisfaction is more likely to occur if newly qualified nurses are successfully socialised into the profession and socialisation is more likely to be successful if new graduates receive adequate support in their first clinical position.

3.4.3 New graduate programmes

There is a consensus throughout the literature, and across the globe, that new graduate programmes are an effective way to retain new graduates (Pickens & Fargostein, 2006; Pine & Tart, 2007; Tingleff & Gildberg, 2014). The elements of mentorship, supported clinical placements and additional specialised study are an effective combination that enables a new graduate to transition from student to competent and confident practitioner (Haggerty et al., 2009). Many studies have confirmed significant increases in retention of new graduates (Cleary et al., 2009a; Proctor et al., 2011; Tingleff & Gildberg, 2014). Some of the studies consulted look at specific programmes (Cleary, Matheson & Happell, 2009b; McCloughen & O'Brien, 2005; Nadler-Moodie & Loucks, 2011; Reinsvold, 2008); this is helpful as it provides an opportunity to compare retention rates before and after the programmes were introduced. All the studies confirmed a significant increase in retention of new graduates and a number also considered the fiscal implications of new graduate programmes (Dracup & Morris, 2007; Halfer, 2007; Hillman & Foster, 2011). These studies confirm that there are considerable economic benefits from implementation of new graduate programmes.

Other studies have focused on the elements that contribute to successful transition of new graduate programmes, (Bick, 2000; Haggerty, Holloway & Wilson, 2013; Halfer & Graf, 2006; Ho, 2006; North et al., 2006; Ronston et al., 2005). A frequent assertion throughout the literature is the efficacy of mentoring or preceptorship. Mentorship has the potential to support socialisation of new graduates, increase job satisfaction and increase the likelihood of newly qualified nurses remaining in the profession (Halfer & Graf, 2006). Effective preceptorship has the potential to reduce the stress associated with transition (Bick, 2000). In a study looking at the efficacy of a mentorship programme in the US, Ho (2006) estimated that new graduates were seven times more likely to leave if not included in the mentorship programme. It is concluded that veteran RNs have the potential to provide considerable support, advice and encouragement to new nurses, (Ho, 2006). Effective role-modelling is a powerful contributor to successful socialisation into the nursing profession (Ronsten et al., 2005) and an important element in new

graduate programmes. It provides the new graduate with a person they can approach to discuss clinical situations and learn the routine and culture of the ward. A mentor can demonstrate good practice and the new graduate can observe and question an experienced and knowledgeable colleague (Ronsten et al., 2005).

Within the literature examined there is little consideration of the content of additional theory. Mental health new graduate programmes provide an opportunity to focus on more specific theoretical content. In a report of the NETP programme in New Zealand, Haggerty et al. (2010) found that students consider the theory to be important, but that it was more useful when specifically focused on the practicalities of clinical. In a study of the movements of new graduates in the five years after registration, North et al. (2014) identified that new graduates who had completed postgraduate study were more likely to remain in the profession. Of particular interest, considering the difficulties with recruitment and retention in mental health, the studies by North et al. (2014) and Cleary et al. (2009b) concluded that new graduates were more likely to remain in mental health after completion of the new graduate programme. This is a significant finding that indicates the efficacy of NESP in encouraging successful socialisation of new graduates into mental health.

Research into the efficacy of new graduate programmes has provided valuable evidence that additional support and theory contributes to the retention of newly qualified nurses. However, none of the studies examined have considered how these programmes have influenced new graduates who have taken positions in clinical environments that they have no interest in. Several studies have acknowledged that graduates will accept a position in an undesirable clinical area because they are motivated by the necessity of finding work (Happell, 1999b, Huntington et al., 2014). It is also possible that these new graduates will move to a more attractive clinical position as soon as possible after completion of the new graduate programme.

It could be argued that increased retention rate indicates that new graduate programmes are very effective at helping to socialise newly qualified nurses to the mental health environment. However, no study could be found that examines the

rate of retention for graduates who did not initially want to work in mental health after completion of a new graduate programme. Regardless of the success of new graduate programmes, mental health remains an unpopular choice for undergraduates contemplating their first qualified clinical position. To understand this phenomenon, it is important to consider the influence of stigma and discrimination.

3.5 Stigma and discrimination

Many studies have considered the stigma and discrimination related to mental health (Gouthro, 2009, Halter, 2002, Nadler-Moodie & Loucks, 2011). Society holds very stereotypical beliefs regarding people with mental health issues (Gouthro, 2009). The pervading images of nightmarish asylums and dangerous patients are maintained through media coverage of mental health consumers and despite campaigns to encourage a more optimistic perspective, people with mental illness continue to be regarded as unpredictable and dangerous (Gouthro, 2009; Hoekstra et al., 2010, Anderson, 2003). Consequently, the lay-person's view of mental health is predominantly negative. There is a pervading belief that people who experience mental illness are responsible for their experience (Gouthro, 2009). In addition, it is assumed that, once unwell, a person can never recover, they will remain dependant on mental health services for the rest of their lives (Halter, 2002). This leads to the misconception that mental health nursing is less valuable, because they are not able to 'cure' people with mental illness (Happell, 1999b).

In addition to the negative perspectives of people with mental illness, Gouthro (2009) suggests that mental health nurses experience stigma by association. Society attributes the stereotypical characteristics associated with mental illness to the health care professionals working with them (Gouthro, 2009). Mental health nurses are viewed by other nurses as being less skilled; not 'real nurses' (Curtis, 2007). The assumption that mental illness cannot be cured results in the belief that mental health nurses are merely custodians; guardians whose primary role is to contain people and keep the public safe (Halter, 2002). The result is a lack of recognition or respect for the complexity of a mental health nurses' role (Surgenor, Dunn & Horn, 2005; Stevens, Browne & Graham, 2013).

Unfortunately, these negative associations extend to the classroom (Gouthro, 2009). The lack of emphasis on mental health nursing within the undergraduate degree indicates that it is considered less important than medical or surgical nursing (Curtis, 2007). Undergraduate nurses are discouraged from pursuing careers in mental health by nursing tutors (Gouthro, 2009; Shattell, 2009). The existence of the medical-surgical (med-surg) myth is further evidence that mental health is considered less significant than physical health. The belief is that new graduate nurses should spend a year in a medical or surgical clinical environment to consolidate their nursing skills. Students are warned that they will lose all their knowledge if they pursue a career in mental health first (Shattell, 2009; Stevens et al., 2013). In a response to this assumption, Shattell (2009) argues that the reverse is preferable; all new graduates should complete a year in mental health before considering a med-surg environment. The rationale is that experience in mental health is essential wherever a nurse is working (Shattell, 2009). The high percentage of people with mental illness in the general population indicates that a considerable number of patients within the med-surg environment will also have mental health issues (Shattell, 2009). It is reasonable, therefore, to suggest that the skills obtained in the mental health environment are invaluable and applicable in all clinical contexts (Shattell, 2009).

The stigma surrounding mental health nursing as a career is upheld by society, the nursing profession and academic faculty members. Undergraduates frequently experience fear and mistrust regarding exposure to mental health environments and the med-surg myth generates fear of becoming de-skilled if pursuing a career in mental health (Jansen & Venter, 2015). This situation is compounded by the insufficient coverage of mental health nursing in the undergraduate degree; students do not feel prepared or knowledgeable enough to pursue a career in mental health (Rushworth & Happell, 2000).

Much of the research into undergraduate and new graduate career preferences have focused on why these populations do not choose mental health. One study included in this review has instead looked at why some students pursue mental health as a career (Moir & Abraham, 1996). This is particularly helpful because it

identifies factors that contribute to mental health as an attractive choice. This study found that students pursuing mental health considered medical and surgical nursing as less satisfying (Moir & Abraham, 1996). This indicates that the same negative assumptions are made towards physical health when a student values mental health. It suggests that the two disciplines act as a rivalry. Each side considers their discipline to be a more important aspect of nursing and the other is, therefore, diminished. General nursing was viewed as routine; technology became a negative aspect of the role, less favourable than intuition and the therapeutic use of self (Moir & Abraham, 1996). Even the deprivation common in under-resourced mental health services was viewed as a positive aspect of the role. Students viewed themselves as overcoming the challenges of run-down environments (Moir & Abraham, 1996).

These arguments are supported by the findings of a study into the opinions of veteran mental health nurses by Humble and Cross (2010). They asserted that participants strongly identified themselves as being different, not only from other nurses, but from the whole of society (Humble & Cross, 2010). Participants described themselves as being 'united' with consumers against the pervading stigma that society held against mental health. The close relationships with mental health consumers resulted in a strong advocacy role; mental health nurses 'defend' people with mental illness from the prejudice and discrimination of those who did not understand (Humble & Cross, 2010). The findings from Moir and Abraham (1996) indicate that students become socialised into this perspective of mental health nursing and as they identify themselves with the culture of mental health they develop beliefs about the undesirability of other nursing disciplines. They become loyal to the plight of the mental health nurse.

3.6 The influence of Advanced Choice of Employment (ACE)

According to a summary of the ACE statistics in 2012, (MOH, 2017), the three most popular clinical areas that ACE applicants selected as their first choice were surgical, medical and mental health. This could indicate that the ACE recruitment process has an influence on applicants' clinical choice because the statistics differ considerably from findings in the literature. However, if taking into consideration

all three clinical choices made on the application form, mental health drops to sixth most popular behind public health, emergency department and paediatrics (MOH, 2017). Furthermore, the most recent statistic report provided by ACE (2015) indicates that mental health has dropped to the sixth most popular first choice after surgical, medical, paediatrics, perioperative care and public health. These figures reflect the findings of Happell (2002) and Stevens et al. (2013) and indicate a decline in preference for mental health. However, the ACE (2015) statistics also confirm that applicants are more likely to secure a position in NESP than NETP; 29.25% of applicants identifying mental health accepted an offer compared to 17.05% in surgical. These findings confirm that NETP is more popular, and therefore, more competitive than NESP. It is therefore feasible to suggest that applicants will select mental health because they have a higher likelihood of success rather than an interest in the area.

To date, only one report; by Huntington et al. (2014) has focused on the influence that ACE has had on new graduate career choices. In addition, an article was published by Wilkinson et al. (2016) that related to the findings of the report. The findings indicated that the med-surg myth remained highly influential and many new graduates would pursue a NETP position to consolidate their skills (Huntington et al., 2014). They also concluded that undergraduate clinical placements had an influence on clinical choice. If a placement had been positive, students were more likely to consider a career in that area (Wilkinson et al., 2016). Mental health was frequently considered as a possibility in long-term career plans, but new graduates considered this discipline as specialised, and therefore, not viable at the beginning of their career (Wilkinson et al., 2016). This is an interesting finding as it indicates that new graduates view mental health as highly complex, rather than unskilled as other studies have suggested. Students are also influenced by the opinions of family members and will pursue a career that conforms to societal perceptions of nursing (Huntington et al., 2014).

Regarding ACE, Huntington et al. (2014) state that the experience was a negative one for most applicants. The online application process and the ranking of applicants was considered stressful and intimidating (Wilkinson et al., 2016).

Some participants believed that only the students with high grades would be successful. Of importance to this study is the assertion that students who were unsuccessful in obtaining a position in NETP would accept a position in a clinical area they had no interest in because of the pressure to find work (Wilkinson et al., 2016). The fact that positions in NETP and NESP were only obtainable through ACE compounded this issue; students considered success in securing a position through ACE as critical to their future career (Huntington et al., 2014).

It is evident from the report by Huntington et al. (2014) that students invest considerable thought into the trajectory of their nursing career. Many participants had clear plans that extended beyond their first clinical placement and included further study and progression into management positions. This is particularly interesting as it indicates the importance that new graduates place on achieving their first clinical choice. It is also an indication that due to the pressure to find work, unsuccessful applicants will 'abandon' these plans in favour of securing a position (Wilkinson et al., 2016).

3.7 Summary of chapter

Mental health nursing is not a popular career choice for undergraduates. Undergraduate nursing programmes have insufficient mental health content to attract students, although theory and clinical experience has the potential to change a student's attitude towards mental health. Specific teaching approaches can influence attitudes and prepare undergraduates for clinical placement. Clinical exposure has the potential to positively influence students' perceptions of mental health consumers and mental health nursing. However, a positive change in attitude does not necessarily translate into a career in mental health. The heavy emphasis on medical and surgical nursing in the undergraduate programme is likely to have a stronger influence on students' perceptions of a rewarding career.

There is a high attrition rate amongst new graduate nurses; this is explained by the concept of reality shock. New graduate programmes have proved very effective in alleviating the stress associated with reality shock and improving retention. However, recruitment into mental health new graduate programmes remains a

challenge. Mental health nursing remains an unpopular career choice for new graduate nurses, because they continue to hold stigmatic attitudes towards mental health consumers and nurses.

The introduction of ACE as a recruitment process has created a stressful experience for applicants. There is considerable pressure on candidates to secure a position and start their nursing careers. This suggests that applicants forego their ideal clinical environment because of the need to find a job. However, there is a strong indication that students who complete a mental health new graduate programme will remain in mental health, particularly if they complete postgraduate study. Although the studies that confirmed this high rate of retention did not explore whether the participants had intentionally pursued mental health as a career, it could be reasonably assumed that the new graduate programme in mental health is successful in socialising new graduates to the mental health environment. It is suggested, therefore, that if new graduates can be persuaded to enrol in NESP, there is a strong likelihood they will stay.

There is a great deal of research available that supports the efficacy of new graduate programmes for increased retention of new graduates, but very few that focus on mental health programmes. In addition, there are very few longitudinal studies that look at the influence of mental health theory and clinical experience on final career decisions. Finally. There are no qualitative studies that consider the influence that ACE has on the recruitment of new graduates into mental health.

4 Chapter 4 - Methodology

4.1 Introduction

The focus of this chapter is to discuss the research methodology that informs the design of this study. This includes a discussion about qualitative research, the motivation for case study as a methodology, the use of semi-structured interviews as the method for collecting data and a discussion of thematic analysis as the approach for interpretation. The details of this study are explained along with the study aims, the research questions and characteristics of the target population. The discussion begins with the specific characteristics that underpin this researcher's paradigm for the design of this study (Denzin & Lincoln, 2011). Professional experiences have shaped this researcher's beliefs about reality and knowledge and these have influenced the focus and conduct of this study; these are discussed throughout the chapter.

4.2 The research paradigm

It is important to identify the individual researcher's interpretive framework because it has a significant influence on the research methodology chosen (Denzin & Lincoln, 2011). Identifying the researcher's interpretive framework involves consideration of the researcher's ontological, epistemological and methodological standing (Denzin & Lincoln, 2011). In their article for novice researchers, Baxter and Jack (2008) explain that the pioneers of case study research, Stake (1995) and Yin (2009) use a constructivist paradigm. This is described by Denzin and Lincoln (2011) as a combination of relativistic ontology, subjectivist epistemology and naturalistic methodology.

4.2.1 Ontological assumptions

Ontology is concerned with how a person defines reality. Researchers who define reality as being constructed by human beings and dependant on cultural and historical factors will favour relativist ontology (Guba & Lincoln, 2004).

Constructivism emphasises the social construction of reality (Baxter & Jack, 2008). The influence of experience, culture, environment and history are fundamental in the creation of reality and it is essential to understand these contexts (Baxter &

Jack, 2008). The relationship between the researcher and subject is important so the researcher can gain an understanding of the subject's actions through listening to the individual's account (Baxter & Jack, 2008).

Relativism is a broad concept as there are multiple realities (Denzin & Lincoln, 2011). This assertion compliments this researcher's beliefs about mental health. The field of mental health nursing challenges the assumption that there is ultimate truth (Jensen & Forchuk, 2009). Working with people who live with a different reality encourages mental health nurses to consider belief and truth as a construct of the individual (Jensen & Forchuk, 2009). Understanding how a person justifies their beliefs about the world is imperative if the nurse is to gain insight and empathy with the individual and the context they currently live in (Jensen & Forchuk, 2009). In case study research, the context that influences the subjects' actions is of particular importance (Gillham, 2000). The construction of reality is interwoven with the contextual characteristics of the 'case' and these must be taken into consideration if the researcher is to develop an accurate understanding of the actions of the subject (Yin, 2009).

The inspiration for the design of this study began with this researcher's belief that a multi-faceted combination of experience, assumption, intention and motivation influences a person's decisions. This researcher supports the concept that these combinations are unique to the individual and the characteristics of each impact differently because of the individual's cultural identity (Denzin & Lincoln, 2011). Reality is not a fixed tangible entity, instead it is fluid and influenced by the individual's interpretation of events (Denzin & Lincoln, 2011).

4.2.2 Epistemological assumptions

The epistemological assumptions held by the researcher are central to the research paradigm and affect every stage of the research process (Hesse-Biber & Leavy, 2004). Epistemology is the study of the nature and extent of knowledge and relates to the relationship between the researcher and the researched (Guba & Lincoln, 2004). It is essential that researchers have a clear understanding of the beliefs they hold about the origins and characteristics of knowledge because these will influence the research approach chosen (Hesse-Biber & Leavy, 2004). If a

researcher believes that empirical truth defines knowledge, they will adopt a methodology that is objective and separates the researcher from the subject (Hesse-Biber & Leavy, 2004). If a researcher considers knowledge as interpretive, they will focus on a methodology that emphasises the researcher's relationship to the subject (Guba & Lincoln, 2004). The constructivist paradigm supports a subjectivist epistemology. This approach assumes both researcher and subject are responsible for the construction of knowledge (Denzin & Lincoln, 2011).

This researcher's beliefs about the construction of knowledge stem from experience as a student and as a mental health nursing lecturer. This researcher's experience of learning to be a nurse was prescriptive and pedagogical. The construction of knowledge was the responsibility of the teacher, they imparted information and students were expected to learn it. There was no consideration of individuality and although classes did allow for discussion, this was quickly redirected if the teacher sensed it was unnecessary. This researcher felt disinclined to contribute to the classroom environment and found a great deal of the information uninspiring and difficult to apply.

It is proposed by Knowles (1984) that although pedagogy may be an appropriate teaching approach for children; it is less effective for adults because they learn differently. Adults come to the classroom with a wealth of personal experience and are less likely to accept the knowledge handed to them without question (Boud, 1986). Knowles (1984) suggests that andragogy is a more appropriate style of teaching for adults. Instead of a hierarchical environment where the teacher is in control, the construction of knowledge is the responsibility of both teacher and student (Knowles, 1984).

The experience of being a mental health nurse lecturer has also influenced this researcher's epistemological assumptions about knowledge. Developing and delivering material to help student nurses understand mental health nursing has contributed to this researcher's belief that previous understanding and experience influence the construction of knowledge (Boud, 1986; Race, 2005). Societal perceptions of mental health precede the learning of theory and need to be acknowledged before they can be challenged (Happell & Rushworth, 2000). The

use of problem-based learning has been advocated by Happell and Rushworth, (2000) as an effective method of engaging students in learning mental health theory. The use of scenarios encourages students to explore their own reactions and assumptions about people with mental illness (Happell & Rushworth, 2000). This approach has been implemented in this researcher's teaching and enabled a sharing of knowledge to occur. Students would discuss the various factors that inspired their responses and this researcher developed a greater understanding of how people construct knowledge about mental health.

These epistemological assumptions complement a case study design because they acknowledge the importance of learning about the context of the case from the perspective of the subject. Therefore, the design of this study had to provide opportunity for the participants to be heard and for their perspectives to be understood.

4.2.3 Methodological assumptions

The combined characteristics of a researcher's ontological and epistemological viewpoint will influence the choice of methodology (Denzin & Lincoln, 2011). Qualitative research methodologies provide opportunity for researchers to collect information from several different standpoints (Guba & Lincoln, 2004). There is no single interpretation, no ultimate truth or meaning to human behaviour, instead an individual will respond in relation to their interpretation of contextual influences and beliefs about the world (Denzin & Lincoln, 2011). This study has adopted a case study approach as methodology because it complements this researcher's paradigm.

4.3 Qualitative research as a method of inquiry

Qualitative research is defined by Hesse-Biber and Leavy (2004) as

“...a distinct field of inquiry that encompasses both micro and macro-analyses drawing on historical, comparative, structural, observational and interactional ways of knowing” (p. 1).

This definition describes the elements that contribute to qualitative beliefs about the development of knowledge. Qualitative research starts from the assumption that knowledge is developed from interpretation. This sits in the interpretivist school of philosophy that influenced the hermeneutic tradition (Harrison-Barbet, 2001).

The concept of hermeneutics was developed by Schleiermacher (Kenny, 2001). He argued that human action cannot be interpreted by scientific method; human acts must be understood as being influenced by the motives, intentions and choices of self and others (Harrison-Barbet, 2001). Gadamer later expanded the concept with emphasis on the “rootedness of human beings in historical and cultural contexts” (Harrison-Barbet, 2001, p. 415). The focus of qualitative research is to develop an understanding of human behaviour and the social processes that people engage in (Topping, 2010). The decision to adopt qualitative research as a method of inquiry for this study stems from these philosophical arguments. This researcher has a contextual understanding of the history and culture of mental health nursing. The focus of mental health nursing is the analysis of peoples’ responses to experiences as a method of helping them make sense of their situation (Barker, 2009a). Peplau defined mental health nursing as “...the diagnosis and treatment of human responses to actual or potential health problems” (1980, cited in Barker, 2009a, p. 5). This connection between human reactions and situational context has a great deal in common with the motivation of a qualitative researcher. Qualitative research is completed by “establishing relationships with people, places and performances” (Ezzy, 2002, p. xii). The researcher is encouraged not to separate themselves from the subject they are examining, but instead reveal how people make sense of their world by becoming immersed in their context. Finding out why people respond to phenomena is therefore central to both mental health nursing and qualitative research. The relationship between researcher and their study is one this researcher can relate to and is the definitive reason for choosing a qualitative approach. The focus of this study is the influence of ACE on new graduate’s career choices. These decisions are intrinsically linked to the individual’s personal experience and therefore need to be considered in the wider

context of social identity, history and culture. Therefore, it is appropriate to use a research approach that emphasises these factors.

The first phase of any research process is to establish the role of the researcher (Denzin & Lincoln, 2011). The qualitative researcher is directed by the belief that the individual “is present in the real world and able...to report on their own experiences” (Denzin & Lincoln, 2011, p. 11). In traditional interpretivist approaches, the role of the qualitative researcher is to provide an analysis of the personal accounts of subjects. Using a combination of objectivity and expert knowledge the researcher aims to interpret the experiences of the subject and ‘make sense’ of their experiences. Later, postmodernists and poststructuralists argued that this concept was too simplistic. They asserted that all human perspectives are influenced by cultural and historical factors and are always “situated in the worlds of- and between- the observer and the observed” (Denzin & Lincoln, 2011, p. 12). These concepts highlight that the relationship between the researcher and the subject are intrinsically linked.

4.4 Reflexivity

The concept of reflexivity is defined by Carolan (2003) as an awareness of the impact that a researcher has on the collection and analysis of data. It is acknowledged that personal and professional identity of the researcher will influence the choice of topic and research design but Carolan (2003) argues that the researchers influence is an important aspect of any qualitative study. A researcher must be self-aware and reflective of their presence; they are additional voice to those listened to during the collection of information (Carolan, 2003). The purpose of reflexivity is for the researcher to state their own position on the topic (Carolan, 2003). Values and beliefs are made transparent so a distinction can be made between the views of the researcher and the opinions of the participants (Carolan, 2003).

This researcher recognises a similarity between the above description of the role of a qualitative researcher and that adopted as a mental health nurse. This researcher has practised mental health nursing in a variety of clinical

environments. An essential role of the mental health nurse is to help a person understand their experiences by listening to their story (Barker, 2009b). Through the process of listening to the person's perspective, the nurse uses knowledge about different mental health theories to develop a clinical formulation that helps to make sense of the person's account (Barker, 2009b). The aim of this 'analysis' is to support the individual to identify internal and situational factors that could have been influential on their recovery journey (Barker, 2009b). It is not for the nurse to tell the person why something has happened, but to help them see how responses to situations can be influential. This is a complex and ever-changing process, complicated by the fact that it relies not only on the opinions of the individual, but those of all health professionals involved in their care (Barker, 2009b). In turn, all these opinions are influenced by culture, history and experience. This researcher has developed an appreciation that self-awareness is an essential component of nursing practice if this process is to be effective.

The art of mental health nursing is an appreciation of the complexity of human behaviour and a recognition of the need to understand the individual (Barker, 2009b). This researcher believes it is logical to approach an understanding of the motives of any human being with the same consideration. This belief has influenced this researcher's clinical and teaching practice and guided the approach to this research.

4.5 Case Study methodology

Flyvbjerg (2011) states that the decision to conduct case study research is not so much a methodological choice than identification of what should be studied. The researcher identifies the case based on an interest in the world of the subject. Case study research is not limited to a specific philosophical approach and is conducted by both quantitative and qualitative researchers (Yin, 2009; Stake, 1995). This flexibility and adaptability has resulted in numerous variations of case study research over a wide variety of disciplines (Flyvbjerg, 2011). It is important to identify the type of case study that will be conducted; this will be determined by the specific details of the research being conducted (Baxter & Jack, 2008). For this study, an instrumental case study is the most appropriate choice.

Stake (1995) defines instrumental case studies as a method of understanding an element within the case, rather than the case itself. To illustrate; this study is not designed to understand the NESP programme; instead the intention is to shed light on what motivates new graduates to choose NESP and how ACE has influenced this motivation. Baxter and Jack (2008) identify that a “single case with embedded units” (p. 550) is best suited to studies where the researcher is interested in the decisions made by the subject. They assert that the opportunity to explore the individual units within the case; in this context, the new graduate students, is significant because it allows opportunity to analyse “within, between and across all the subjects” (Baxter & Jack, 2008, p. 550).

The primary reason that a case study approach has been chosen is the emphasis on the significance of context. The importance of context is highlighted by research theorists who support the case study approach (Baxter & Jack, 2008; Gillham, 2000; Flyvbjerg, 2011). This methodology is relevant when the researcher believes that contextual conditions are central to the research findings (Yin, 2009). For this study, the introduction of the ACE application process is a significant contextual factor. There has been considerable research into the factors that influence a new graduate’s career choice, however, the ACE process is a relatively new method of placing new graduates into NETP and NESP. It is necessary to explore whether this change in recruitment processes has influenced the decisions that new graduates make.

The decision to use a case study approach can come from “a puzzlement, a need for general understanding” (Stake, 1995, p. 3). For this study, the need came from the realisation that new graduate nurses who had not identified mental health and addiction as a clinical choice on their ACE application forms were accepting places on NESP. Given that mental health nursing has a negative reputation as a career choice (Gouthro, 2009), it seemed unusual that this was happening. This researcher became curious about the relationship between the ACE application process and trends in career choices for new graduates.

Another reason that a case study approach is well suited to this study relates to the need for a clear boundary that defines ‘the case’ (Gillham, 2000). For this study, the

boundary could be distinguished clearly; one cohort of students enrolled in one NESP programme. This helped this researcher to remain focused on the case and not become distracted by information that was outside the scope of this study.

4.5.1 Aim of study

The aims of this study are to explore the relationship between factors that influence new graduate nurses to choose NESP when they did not specify mental health on their ACE application and whether the generic ACE interview process influences a new graduate's career choice.

4.5.2 Research questions

What influences a new graduate's choice of NESP?

Why do new graduates choose NESP?

How has the ACE interview process influenced new graduates' choice of career?

4.5.3 Ethics

To maintain confidentiality, all the interview recordings were saved to a password protected folder on this researcher's computer. All identifying factors were removed from the transcripts, including service and facility names and locations. The interviewees were ascribed pseudonyms. These details were explained to all participants before data was collected.

Consideration was made of the potential for coercion. This researcher was not involved in the NESP programme and it was clearly stated in the information leaflet that participation would have no bearing on the new graduate's progression through NESP. Ethical approval was granted through the University of Otago Human Ethics Committee on 20th June 2015 and the DHB granted ethics approval on 30th October 2015.

4.5.4 Recruitment and sampling

This qualitative case study is focused on how the ACE recruitment process has influenced the clinical choices that new graduates make. The 'case' comprises one

NESP programme in New Zealand. An instrumental case study design has been implemented to gather information about a specific phenomenon within this NESP programme. It has been identified that there are new graduates enrolled in NESP who did not specify mental health and addiction as a clinical preference on their ACE application. This phenomenon suggests that they had secured a position from the talent pool and this study will explore the influencing factors that persuaded these new graduates to start their career in mental health and addiction. Ethical approval was granted through the University of Otago Human Ethics Committee on 20th June 2015 and the DHB granted ethics approval on 30th October 2015.

The study sample were selected from a cohort of students enrolled in one NESP programme for the 2015 intake. Of this population, participants were selected only if they had not identified mental health as a clinical choice in their ACE application. Semi-structured interviews were conducted with eligible participants to identify the factors that had motivated their decision to join NESP and specifically, whether ACE had influenced their choices. In addition, informed by the significance that case study research attributes to understanding context (Yin, 2009), a separate interview was conducted with the coordinator of the NESP programme. This was intended as a form of data triangulation and to increase the validity of the study (Burns & Grove, 2009). The purpose was to develop a comprehensive understanding of the experience of ACE from both employer and applicant perspectives within the context of the NESP programme chosen for this study.

4.5.5 Participants

This researcher introduced the study to the cohort of NESP students during a tutorial being held by the NESP coordinators. This enabled access to the whole group at once. Potential participants were given details about the study to read and asked to complete a short questionnaire to establish eligibility. This researcher left the session after explaining the study and returned later to collect the consent forms that had been signed [Appendix 1]. The questionnaire was consulted to identify potential recruits and these people were contacted individually.

There were forty new graduates enrolled in the NESP programme being studied. Ten members of this cohort did not identify mental health and addiction as a clinical option for ACE and were therefore considered eligible for this study. The selection and recruitment process revealed a further six new graduates who had completed ACE twice. On investigation, none of these students had chosen mental health and addiction as an option in their first ACE application but had in their second. This researcher believed this fact was relevant to the study and included these students in the selection list. Of these sixteen potential participants, one was excluded because it was later identified that they had not completed ACE and three were unable to be interviewed because they left the DHB as soon as the NESP course had finished. One student left for a position in a physical health environment elsewhere in New Zealand and two had moved overseas.

While participants were being selected, a group of pre-NESP students started. These students had completed their undergraduate degree mid-year and although they completed ACE to secure entry into NESP they were unable to start the course immediately because the programme only runs from February to November. In the interim period, the Specialist Mental Health Service (SMHS) employs these new graduates and they work for the DHB as registered nurses until NESP starts. This ensures that the mid-year cohort is not disadvantaged by having to wait six months between qualifying and starting their new graduate positions. After discussion with this researcher's supervisors this cohort was included in the study. Of the fifteen pre-NESP students only two were eligible for interview. One had applied through ACE twice. At the end of the selection process there were fourteen eligible participants; twelve current NESP students and two pre-NESP students. Seven of the participants had completed ACE twice. All fourteen of these new graduates consented to be included in the study.

Interviews were conducted between February and May of 2016. The initial study design aimed to interview participants at the commencement of NESP, however, delays were encountered. These included a delay in obtaining ethical approval from the DHB and difficulty arranging mutual times to conduct interviews. Eventually this researcher approached the Nursing Director of SMHS and asked if

participants could be approached while on shift. This was agreed and proved very effective; most interviews were completed in this manner. The result of the delay meant that most participants were interviewed after NESP had been concluded. Although it deviated from the original design of the study it proved fortuitous because participants inadvertently spoke about the effect that the NESP programme had on their experiences as new graduates and their perception of mental health and addiction nursing. In addition, it allowed for the pre-NESP cohort to be included in the study. The result was a rich variety of experience and motivation for accepting NESP, as well as a varied response to the ACE process. The interview with the NESP coordinator was also invaluable because it clarified much of the ACE process from the employer perspective and provided valuable insight into the perspective of someone responsible for recruiting new graduates and their experience of working within the ACE process.

4.6 Research methods – semi-structured interviews

“If you want to know how people understand their world and their life, why not talk with them?” (Kvale, 1996, p. 1)

This quote summarises the primary reason for choosing semi-structured interviews for the method of data collection. This researcher has confidence in the process of interviewing, though in different contexts to research. The skills of interviewing are transferable (Kvale, 1996), and it is prudent to use skills already present rather than attempting to learn a new method of collecting information (Wengraf, 2001).

An interview provides the opportunity for a researcher to listen to what people themselves tell about their experiences (Kvale, 1996). During the interview, the researcher hears the individual’s expression of their views and opinions in their own words. Interviews are used when the researcher wants to understand the world from the subject’s point of view (Kvale, 1996). For this study, it is important for this researcher to listen to the subject’s account of their reasons for choosing NESP. The subject’s understanding of the context of this case study will have had an influence on the decisions they have made and the actions they have chosen

(Denzin & Lincoln, 2011). For this researcher to understand the relationship between the subject's perspective and their behaviour, they must be able to tell their story.

When describing the role of the interviewer, Kvale (1996) uses the metaphor of 'traveller'. He describes the interviewer embarking on a journey and exploring phenomenon as it is discovered. This metaphor suits the concept of a case study. The researcher travels around the 'world' of the case, exploring different domains as they are revealed. The information collected on this journey is reconstructed as stories (Kvale, 1996). The knowledge gained is socially constructed, taking into consideration the environment and cultural identity of the interviewee. In the use of this metaphor, Kvale (1996) highlights the link between the traveller metaphor and postmodern constructivism. When an interviewer embarks on a journey through the contextual environment of the interviewee, they are being guided by the reality of the individual participating in the research (Kvale, 1996). In the same way that a traveller will explore the environment and culture of the places encountered on the journey, the interviewer explores the context of the subject through the interviewee's perspective; the language they use and the stories they tell.

Postmodern constructivism asserts that the meaning an individual applies to their own life experiences is influenced by the intellectual and cultural construction of reality (D'Andrea, 2000). The interviewer is endeavouring to make sense of the participant's experience by exploring these realities in context. This approach to interviewing is very attractive to this researcher because the process is comparable to the construction of clinical formulation in mental health nursing. The words 'journey' and 'traveller' complement the principles of recovery that are central to this researcher's nursing practice.

While preparing to conduct interviews for research, the novice researcher is advised to draw on previous professional experience of interviewing (Wengraf, 2001). It is also important to remain conscious of previous knowledge of communication and conversation; especially self-awareness (Wengraf, 2001). The skills of interviewing that have developed through this researcher's nursing

practice can be adapted to the context of research. Perhaps most importantly, this researcher trusts the process of interviewing as a powerful method of gathering relevant information and the perspective of the interviewee.

The research interview requires preparation and revision before it is conducted. The interviewer must consider both contextual knowledge and propositions while drafting the questions (Wengraf, 2001). The researcher must start with a good understanding of their own 'conceptual framework' and clearly defined research questions (Wengraf, 2001). This helps the researcher remain focused on the boundaries of the study, ensures that questions are pertinent and relevant information is being collected (Wengraf, 2001). The structure of questions, should be sufficiently open-ended to allow the interviewee to answer freely, but structured enough to illicit relevant information (Kvale, 1996). Regardless of how questions are delivered, the interviewer needs to be prepared for a significant degree of improvisation (Wengraf, 2001). However, improvisation, should not be confused with lack of preparation (Wengraf, 2001). Both Kvale (1996) and Wengraf (2001) argue that much time needs to be spent writing and adapting the initial open-ended questions. The improvisation begins when the interviewee starts to answer and the researcher recognises opportunities to seek clarification or send the interview in a different direction.

In preparation for this study, this researcher initially developed seven open-ended and one closed question. Pilot interviews were conducted with two previous NESP students who also gave feedback on the quality of the questions. The feedback was discussed with this researcher's supervisors and adaptations made. The final list can be found in Appendix 2.

All the interviews were conducted by this researcher and took between 15 minutes and one hour. A Dictaphone was used to record the interviews and they were saved to a password-protected computer file. This researcher transcribed all the interviews verbatim and proof-read them several times as a method of becoming familiar with the content. This also enabled this researcher to pay close attention to the enunciation of individual participants as they told their stories and gather insight into the emotions that were being expressed.

4.7 Thematic Analysis

Thematic analysis was the method used for interpreting the data collected. The exclusive focus of thematic analysis is the content of conversation and it is therefore well suited to interviews (Riessman, 2008). In addition, Boyatzis (1998) acknowledges that thematic analysis is a skill used in a wide variety of professions as a method of finding patterns within phenomenon. He argues that this process enables the analyst to find a meaning that is not immediately obvious to others (Boyatzis, 1998). Both Boyatzis (1998) and Riessman (2008) assert that thematic analysis is applied in nursing; the process of listening to a story and adapting the information into a formulation of what may be happening.

Boyatzis describes thematic analysis as a process of “encoding” qualitative information (1998, p. 4). This method of “sensing themes” (Boyatzis, 1998, p. 9) is present in the training for many professions. This researcher is familiar with the process in the context of mental health nursing and when supporting students to make sense of their mental health clinical placement. Recurrent topics are coded and categorised as a means of organising the information and identifying themes, or patterns, embedded within the qualitative data.

The novice researcher is cautioned against projecting or anticipating themes as this can bias the analysis. Instead, Boyatzis (1998) advises that becoming immersed in the data, memorising it, can help to prevent transference. Boyatzis (1998) highlights the advantage of excitement and curiosity in the data being analysed as this maintains motivation to reveal themes as they are.

This researcher recognises the necessity of understanding the reality of the interviewee as a method of understanding behaviour in context (Baxter & Jack, 2008). In addition, the epistemological belief that knowledge is constructed by both researcher and subject depends on a responsibility to allow the interviewee to tell their story without manipulating it (Gillham, 2000). This researcher has attended regular meetings with research supervisors throughout the process of analysis to help detect potential transference and engage in reflexivity. As this researcher became immersed in the interview transcripts and became familiar

with the individual context of each participant, conversations with supervisors helped to reveal the identification of codes. Despite considerable frustration and confusion, this researcher was encouraged to trust the process and allow the data to speak for itself. The development of the analysis from stage one to four was a journey of self-awareness and a recognition of the value of thematic analysis. The findings were a surprise to this researcher, a fact that indicates the analysis remained unbiased.

4.8 Summary of chapter

The methodology for this study has been inspired by this researcher's experiences as a mental health nurse and lecturer. The principles of reflexivity have enabled this researcher to outline the personal and professional influences that guided the research design. The research paradigm adopted for this study is constructivist in principle. The ontological assumptions made by this researcher are that reality is individually and socially constructed, the epistemological assumptions are that knowledge is constructed collaboratively between researcher and participant rather than the discovery of empirical truth. These factors have inspired this researcher to adopt a case study methodology primarily because of the importance of context and the ability to apply clearly defined boundaries around the case. The method of data collection is semi-structured interviews, chosen because this researcher has experience of interviewing in the nursing context and it seemed prudent to choose a familiar method. The data was interpreted using thematic analysis; this is also familiar to nursing.

5 Chapter 5 – Findings

5.1 Introduction

The focus of this chapter is to present the over-arching theme and three sub-themes that emerged from thematic analysis of the participant interviews. The chapter begins with a detailed description of each of the sub-themes; 'The system', 'Nursing as a vocation' and 'Professional identity'. Each sub-theme is defined and then considered in relation to the categories that contributed to it. Findings are used to illustrate the premise of the categories and support the definition of the sub-theme. Finally, there is contemplation of the relationship between the sub-themes and how they inform the over-arching theme 'ACE is omnipotent'. Before these findings are presented there is an account of the interview conducted with the NESP coordinator. These findings are treated separately from the participant interviews because they are focused on providing insight into the context of NESP. In addition, they also provide understanding of the employer's experience of ACE and how ACE influences recruitment into NESP. A comparison between the findings of this interview and the analysis of the participant interviews will be included in the discussions chapter.

5.2 Participant demographics

Of the fourteen participants 13 were female and one male. Ten were under 30 years-old, three were between 30 and 40 years-old and one was over 50 years-old. Eleven participants described their ethnicity as New Zealand European, one identified as African and two Indian. There were no Maori or Pacifica participants.

5.3 Employer perspective and experience of ACE

The interview conducted with the NESP coordinator represents a form of data triangulation (Denzin, 1989, cited in Burns & Grove, 2009). The purpose of triangulation is to increase the validity of qualitative study (Burns & Grove, 2009), and involves collecting different viewpoints as a method of developing a comprehensive understanding of the phenomenon (Flick, 2002). The aim of exploring diverse perspectives is to enable more in-depth interpretation of the findings (Flick, 2002). For this study, the interview with the NESP coordinator

provided an employer perspective of the ACE process and clarified how applicants were recruited. This enabled comparison to be made with the findings from the participants and an opportunity to gain "...a deeper and clearer understanding of the setting and the people being studied" (Taylor, Bogdan & DeVault, 2015, p. 94). It is recommended by Taylor et al. (2015) that interviews with different people should be conducted towards the end of data collection as a method of understanding the context and validating other perspectives.

The interview with the NESP coordinator was conducted after most of the participant interviews had been completed. The conversation was intended to gather information about the employer's relationship with ACE and the criteria used to identify potential candidates. It also provided additional context around the influence that ACE had on recruitment to NESP. The coordinator explained the recruitment interview and the criteria that the NESP programme is looking for. It is evident, from the findings that the selection process is complex and not just reliant on set criteria. The eligibility criteria stipulated by ACE relates to very specific information that is easily established:

"We have eligibility criteria for NESP that is laid down by the specifications. That is around being a New Zealand citizen or resident, having the relevant qualifications, so we don't have that requirement around working no longer than six months or any of that stuff, but having a Bachelor of Nursing.

Whereas the interviewers are looking for more subtle signs that a candidate is suited to mental health:

"In terms of the assessment centre, when we are selecting people, you can kind of get a sense if somebody is psychologically minded. Although we don't have that written down in our criteria, you do get a sense of that"

An interest in mental health is also considered important:

"...the important things that come out probably are the sense from the interview, so the notes around people, the connectedness [with other people]. Whether that really is their passion".

The assessors are mindful of the anxiety caused by the interviews and they factor this in when considering the candidates' performance:

“Obviously in an assessment centre you are quite limited because people will be anxious and will have a lot invested in doing well in that and presenting themselves in the best way that they can”

The potential disadvantage that could be caused by anxiety during the interview is accounted for. Assessors explore the potential reasons for poor performance and attempt to identify how anxiety could negatively influence a candidate:

“I think there are occasions where students don't do so well in the assessment centres, but we try and ameliorate that when we have the discussions...we'll be going "What might have been going on for them?", and actually the team is getting better at picking anxiety and thinking/hypothesising what might be going, and giving a bit of weighting around that stuff”

Assessment is also conducted at times when the candidates are unaware and this again is related to communication and behaviour towards others:

“...there is some down time stuff, where you get morning or afternoon tea...waiting for their interview, for their presentation, they are with other people so you see them engaging, and we tend to just be present there as well, just have social chit-chats and you can kind of assess people there, although you are not going with a tickbox, but how they manage their anxiety there”

NESP values certain qualities in candidates and looks for these in the group activity:

“Connectedness, rapport building, therapeutic engagement...We can see how they interact in the group exercise...how they might look out for each other in the group or their listening skills, being able to hold onto something that they think is really important and speak up within the group as well”

Academic ability is acknowledged but eligibility is assessed on more than grades; there is the indication that suitability for mental health is related to personal attributes:

“...some are more engaging and some have more of those intangible things that we don't sort of have a tick that says "emotional intelligence" but those are the sort of things that...self-awareness, resiliency, if you can get that from a 15-minute interview. You get a sense of peoples' connectedness and people skills, because we have in the past had people that have been academically really gifted but they can't apply it”

Clinical ability is highly influential and provides insight into how a candidate relates to the nursing environment; although there is recognition that the reports are not necessarily in a mental health context:

“We are looking for all-rounded people who have good self-awareness, who obviously have good clinical reports and, bearing in mind that not all of them do their transition in mental health, so we are not necessarily reading reports that relate to clinical experiences in mental health”

The references are also an important influence, although the design of the reference form is limiting and does not encourage extensive detail:

“...you are reading a lot into those referee reports...what people write in the comments. It gives you the context of how they are operating. Sometimes people don't actually say all of the good things that they are doing, because it is quite limited by the prescribed questions”

The NESP coordinator identified that NESP positions are usually available after the first round of ACE

“It would be very rare that I would fill it on the first round...A lot of mental health ones [throughout NZ] don't get filled firstly”

In contrast, there are usually few remaining vacancies in NETP and these usually exist because applicants have declined the offer or have pulled out of ACE for personal reasons.

“[NETP] don't have any problem selecting the people but sometimes people will withdraw for varying reasons, but they never get to the situation where they have not got enough people for the positions, it is just that it might be the people that they select may not be available so then they have their wait list. They always have a wait list. We don't necessarily always have a wait list, so that is when we would go to the talent pool”

It is therefore probable that applicants will accept a position in mental health from the talent pool because there it is more likely there will be places still available. The NESP co-ordinator clarified what happens regarding the clinical choices that candidates make. Applicants believe that because NETP and NESP are two separate programmes they are applying for one or the other. There was clarification that identifying mental health and addiction as a clinical choice did not affect the chance of being chosen for NETP:

“I...wonder whether splitting NESP and NETP off has been a good thing or not... because when I go to [Tertiary education provider] and talk to the students they were going "If we put NESP as one of our preferences, we understand that we will automatically go into that pile...we have had people that have put NESP down and we have not selected them, because we have said that they are more suited to the other areas that they have chosen. That is a risk I take...I have to be looking in the talent pool, but we want the right people for our positions”

The coordinator also responded to a misconception that putting mental health and addiction as an option guarantees a job:

“I'm going "You will but in the interview process we will be ascertaining whether you are actually suitable for the NESP programme, so just because you have put that there does not automatically mean that you are going to get a job there", but that is the perception”

During the conversation, some of the findings from the participants' interviews were raised; this was with the aim of clarifying some of the specific details about the ACE process. The NESP coordinator identified that some of the issues had already been addressed by ACE, particularly the lack of information and details about number of placements available:

“...they have put an awful lot of work into revamping the ACE website...ACE have actually made that much more explicit. How many positions are in there; we have to provide that data for them”

There was acknowledgement of the confusion that some candidates experienced. This is a significant theme in the participant interviews and the NESP coordinator confirmed that lack of understanding can affect an applicant's chances of success:

“...sometimes people have not understood the ACE process that well, and they have selected really specialist areas, and they have maybe not appreciated that they are applying for a really small pool of positions, so it has left them really vulnerable and I could see how they could perceive that they had just been left out.”

One important finding from the interview related to the inclusive nature of the NESP selection process and how this differs from NETP. The impression given is that NESP has the luxury of being able to consider all applicants who express an interest in mental health because they have fewer numbers to manage:

“We select as many people as eligible. Even the marginal ones. We kind of want to see as many people as we can...generally anybody who applies and meets our criteria, we will select for interview. For NESP we will...the NETP ones won't necessarily do that because they can't invite everybody to interview because of volume”

There is also a sense of loyalty to those students who have missed out before:

“If we have a...student who has gone through a couple of times then I will stick my hand up and say "Hang on a minute...why did they not get in last

time?" So we will give them an equal opportunity, so it is like a clean slate again"

This conversation led to speculation about the unpopularity of NESP compared to NETP and the influence of clinical exposure:

"...thinking about [tertiary education provider] and having the mental health experience at the beginning of the second year, I wonder if that is having an impact on our recruitment into mental health as well. Other training organisations have it in their third year and have quite a consolidated period of mental health in their third year. We would only be getting that in their third year if they were transition students"

The coordinator identified the characteristics of NESP that contributed to its success as a new graduate programme.

"NESP is not just about doing postgraduate study, it is about having rotations, it is about having support; it is about being challenged within a supportive, academic and clinical environment, so I don't think you can meet those needs with a wraparound programme that is done in isolation"

The importance of connectedness and belonging was also a significant factor:

"I think that sense of belonging is really important even if it is just belonging to a group of people who are on a similar journey, and not feeling isolated, and feeling like you have somewhere you can take things and brainstorm stuff or check things out"

The interview explored the coordinator's opinion on the efficacy of ACE, there was recognition that ACE is motivated to continue to improve the process and maximise the applicants' opportunity to succeed:

"I am aware that there have been some instances where incredibly well-regarded, highly-rated and highly-ranked students have ended up in the talent pool, and I think that is something to do with the algorithm, but I think they have addressed that so that it is not happening so much"

There was also acknowledgement of the positive influence that ACE has had on simplifying the recruitment process:

“I think it has given everybody a consistent approach and it is as fair as it can be. I think that the information they provide is good and they have been really responsive to any difficulties that have arisen. I think it means that students or prospective employees are not having so much time waiting and being put in situations where they have multiple offers. The one offer, one placement I think is really worthwhile and I think that works for them”

The ACE process is considered a positive method of recruiting new graduates because it is utilitarian:

“I know that it is not going to meet everybody's needs, but if it meets the majority and it is a consistent and fair process, then I think it is good”

Disadvantages are not necessarily the fault of ACE, instead they relate more to the size and scale of different DHBs and the method they use to identify potential vacancies. There is also the suggestion that being placed in the talent pool is not necessarily a negative experience:

“I think some people are disadvantaged if they are from small areas and some of the DHBs have been working to a vacancy model rather than a succession planning model, so that they might set minimal numbers when in actual fact they have capacity to take more people, so how they do that is through the talent pool later on”

An interesting point that was raised was the misconception that candidates perceived their first new graduate position as being highly influential for their career prospects:

I think there is still some poor understanding around that actually you can do your first year of practice in primary health, you can do it in mental health; you could do it in a rural and remote area. It's not what you've got,

it's what you do with it in that year. Some people are locked into if they don't do it that way, then that is it, that is their career over”

The value of a new graduate programme is perceived as more important than the actual clinical area the candidate is working in. There is a flexible nature to nursing and careers in other clinical areas are not necessarily affected by that first placement. This finding acknowledged that some applicants are motivated by getting a job and suggested it is not necessarily a negative start to their career:

“It does mean that some students are perhaps forced into taking a position, but I do think that students do need to rethink that first year of practice as first year of practice, not forever. I sometimes wonder whether some students really understand that, that it doesn't matter where you go, as long as you have a really robust first year of practice, and then you can move around if you are flexible”

The NESP coordinator advised that applicants should think carefully about the clinical choices they make. Not necessarily to identify where they most want to work, but instead to make sure they only choose an area if they are prepared to work there:

“I think ACE is working and I think as long as students are mindful of how many other people might be going for that position. So, they keep their choices quite broad. You know like the area that rocks their boat, the thing that really excites them and then another couple of areas. And the other thing is, that they also understand if they are going to put NESP there, we will look at them, regardless of where they put that NESP. So, if they really don't engage with mental health and don't want to be working in it they shouldn't be putting it as a choice”

5.3.1 Summary

There is a strong suggestion from these findings that the eligibility for NESP is influenced by the personal characteristics that candidates bring to the interviews. Aside from the criteria required by ACE, the assessors responsible for recruitment

into NESP are focused on the individual and whether they would thrive in the mental health environment. The interview clarified certain aspects of the ACE process and distinguished between the responsibilities that sit with ACE and those that belong to the DHB. In addition, there was evident support for the efficacy of the ACE process and how this had positively influenced recruitment into new graduate programmes.

5.4 Participant findings

5.4.1 Sub-theme – “The system”

The definition of this sub-theme is that the ACE has created a compulsory ‘gateway’ that all newly qualified nurses must pass through to access new graduate programmes. All applicants must complete the process to secure a new graduate position; participants perceive ACE to have complete control of their future career. The categories that underpin this sub-theme illustrate the complexity of the relationship that participants have with ACE and there is significant evidence that applicants view ‘the system’ as a negative influence on the recruitment. This sub-theme contributes to the over-arching theme that ACE is omnipotent because ‘The system’ controls all access to NETP and NESP. Participants believe the interviews are part of the ACE process and the DHBs make no contribution to the recruitment of new graduates; ACE is responsible for everything.

The categories included in this sub-theme are; ‘Powerless’, ‘Unfair’, ‘Impersonal’, ‘Confusing’, ‘Rumours’, ‘Strategic’ and ‘Traumatic’. These categories relate to each other to create a picture of how ACE influences new graduates’ choice of career (Fig. 1). Applicants are ‘powerless’; they must complete ACE. The system is perceived as ‘unfair’ because it is ‘impersonal’ which contributes to feelings of ‘confusion’ about what ACE is looking for. This confusion has inspired the creation of several ‘rumours’ to help guide applicants through the process and secure a new graduate position. These rumours are highly influential and encourage applicants to be ‘strategic’ about the clinical choices they make. The experience of navigating ‘the system’ is remembered as a traumatic event.

5.4.1.1 *Category 1 – Powerless*

The definition of this category is that applicants are powerless; they must complete ACE. This links to the sub-theme of ‘The system’ because it alludes to the image of ACE having ultimate control and applicants being completely dependent on the process to start their career. This category comprised 19 findings.

The language used by participants illustrated the resentment they felt having to complete the ACE process:

“it all sounded a bit tedious truth be told, I thought oh here we go another round of forms and consent things and that sort of hoo-ha” Sam

There were indications of suspiciousness about the motives of the system and the findings indicated a perception of ‘Us and Them’:

“Don’t necessarily trust the system with this one” Sam

The fact that there is no other route into the DHB new graduate programmes contributed to the powerlessness felt by participants. Nursing positions outside NETP and NESP were not ideal for starting a career:

“I found in the big wide world that you have to do it, you need NETP you need or NESP because they won’t take you, because I did not get a job the first time around, I did end up getting a job in the community, but it wasn’t very supportive and it just wasn’t the environment that I wanted to work in” Nat

Participants also expressed cynicism about the necessity of participating in the procedure:

“ACE...felt like a numbers game. It really felt like you needed to put down the right things to get a job and it wasn’t necessarily about how interested you were in something or anything” Rachel

CATEGORIES

Powerless - N = 19

Applicants have no choice, if they want a job they must conform with the ACE process. This creates resentment, cynicism and an 'us and them' perspective.

Unfair - N = 31

The process is inflexible and does not allow for personal issues or circumstance. Participants felt betrayed by the system. Advice was inconsistent or confusing.

Impersonal - N = 16

Participants resented the process of being depersonalised. This created further mistrust of the process.

Confusing - N = 26

Participants were uncertain about all aspects of ACE. The algorithm is a mystery. Participants did not know that the DHB was responsible for the interview.

Rumours - N = 23

The confusion surrounding the ACE process has inspired the development of rumours. These have significant influence on the choices that applicants make, how they perceive ACE, mental health and nursing as a profession.

Strategic - N = 41

Students became very strategic about ACE. They sought out tips and became pragmatic about the clinical choices. There was sense that students were sacrificing their principles to secure a position.

Traumatic - N = 35

Participants described their experience of ACE in emotive terms. Being rejected by the system was considered devastating.

SUB-THEME

THE SYSTEM

ACE has effectively altered how new graduates gain access to the nursing profession. The process is viewed as a final test of their suitability for nursing. It is faceless and therefore unfathomable. This creates considerable anxiety and suspicion around how to navigate the process and what to do to maximise success.

The words used by participants suggest an image of a selection process where the participants have no idea what they face; A rite of passage.

Figure 1: Sub-theme 1 - The System

Other participants expressed scorn because ACE professed to be objective, but was influenced by human opinion:

“...because it is being done by humans. Who does the input in the computer? It's a human. Who does putting the feedback? They can say whatever they want to say and you don't even have access. You can't even contest” Lisa

This finding also illustrates the vulnerability that applicants felt because they had no influence over the decisions made, again reinforcing the sense of powerlessness.

Another aspect of the process that added to the experience of feeling powerless was the evident competitiveness created by the limited number of positions and the large number of people attending the interviews:

“...being put in a room with about 30 other people, the competitiveness of it. That I think everyone was competing, for that, for those jobs” Michelle

This finding indicates reluctance to be involved in a competition for places and a sense of not having any other choice.

Other participants allude to the suggestion that some applicants were guaranteed to fail. This again contributes to the powerless position that applicants are in; they should prepare for the high possibility that they will not be successful:

“I knew that there was going to be a limited number of people who were going to be picked” Elizabeth

This category indicates that ACE calls all the shots. Applicants must conform if they want a chance to secure a new graduate position otherwise they are left to fend for themselves. This unyielding situation inspires a suspiciousness regarding how ‘the system’ works and participants begin to separate themselves from the ACE process; it is not to be trusted.

5.4.1.2 *Category 2 – Unfair*

This category comprised of 31 findings and indicated that there were many factors about ACE that participants viewed as unfair. These opinions were inspired by the powerlessness that participants experienced during the ACE process. This category relates to the sub-theme ‘The system’ because it focuses on the many and varied complaints that participants had about their experience and these all related to the complexity of the bureaucratic process. Several participants recalled that they had been disadvantaged by the inflexibility of ACE. Personal circumstances that were unavoidable had resulted in increased stress and indecision:

“I had to make that decision, I was sick for the first three weeks of placement so I wasn’t there and I had to make a decision for my ACE application within the first five weeks of my placement but for me it was only actually the first two weeks...I probably by the end of it I might have put it as my top...I’m glad I didn’t now but, but, at that time I might have so most people had five weeks but because I was sick, I only had two” Rachel

“I had a sick child at home so I missed the study day when they came into, erm, tech and spoke to the students there” Barbara

Other participants referred to being disadvantaged because ACE only came to speak to them once a year:

“They did [a presentation] but it was at the beginning of the year. It was in the first semester and then I didn’t apply for ACE until the end of the year... I still felt unprepared when I went to it. I guess there just always the unknown and it’s kind of a big thing so it’s just a...I felt like I knew what was going to happen but not quite fully prepared for it” Pat

“I think it would of being more beneficial if it was actually round the time of when we were actually doing it, especially when you have lots of other things that you are worrying about” Nat

Another aspect that was considered unfair was the lack of information regarding availability of positions; participants lamented the fact that they were disadvantaged because they had limited knowledge:

“they don’t give you any information about how many positions are available really...if I’d have known the amount of positions I would have put different DHBs down...then after we applied, we found out and if I’d realised that only like three people got a position in paediatrics..... I would have made different decisions” Alice

“I think that was a big that first round to pick those areas, even though I was really interested and wanted to do [placement] down the line, to pick those areas I thought well I am interested in and I will get started here but not realising there was very little positions that were available” Rebecca

Failure to secure a position led participants to analyse the fairness of ACE. Participants began to consider that the system disadvantaged them because it favoured aspects that could be easily compared and ignored factors that were harder to measure:

“...on paper, academically I don’t stack up the best, practically I’m much better but you can’t enter that into a box into a how would you rate this performance...where I picked up points in my training...was through my placements” Sam

Other participants suggested that ACE favoured specific characteristics in applicants and gave opportunity for these to excel over others:

“...I kind of feel that it kind of disadvantaged those who weren’t really loud in a way at times” Michelle

“I really struggled in the group...there were about 12 of us in the group and about 6 in it became like the leaders of the group and tried to take charge and so it left the rest of us to be the followers so I didn’t really have an opportunity to say very much...reflected to the assessors that I wasn’t

probably keen...and then I get really nervous so with my presentation, I had it planned and I actually knew it off by heart but I spoke very, very, quickly so what I had to say I think it was really good, but I didn't really...perform it as well as I could have" Pat

Participants who had applied through ACE twice also felt the system disadvantaged them because they had no access to updated information and were in competition with applicants who had just finished their degree:

"...it was really scary for me" It was really yeah, I didn't feel, even especially the second time because I was there with girls who had just finished and you know so, I had been off a year and I felt a little out of my league that time...maybe they had ACE people going to or talking to them, or some more information, because they had presentations that were just amazing...and me with a little speech was quite you know god, I'm going up against these girls, it was scary" Rebecca

Others referred to the restrictions imposed by the eligibility criteria; specifically, the limited time applicants can work as a registered nurse (RN):

"You just have to reapply to ACE and then I don't know if they have changed it...how can you stay...without working as a nurse and still remember? And you cannot work as a nurse for more than six months" Lisa

The findings in this category suggest that participants were left feeling vulnerable because they perceived the system disadvantaged them. This was compounded by confusing information that did not clarify expectations and was delivered at times that were not helpful.

5.4.1.3 Category 3 – Impersonal

Category three related to discontent with the 'facelessness' of ACE and comprised 16 findings. Participants disliked the fact that all applicants were reduced to statistics and their individual journey was not taken into consideration. This underpins the sub-theme because it alludes to the impersonal nature of a bureaucratic system. There is no consideration of the individual and all applicants

are treated equally. Participants were frustrated with the perceived illogical conclusion of the process. The lack of understanding of how the process worked resulted in resentment directed at 'the system':

"I don't think it takes in account to any like how you've transitioned from year one to year three and how like, yeah, how hard some people worked compared to others, and how far some people have come compared to others at the end of those three years when you are qualified" Michelle

Applicants who were 'good students' missed out, while those who had not been considered successful were given coveted positions. There were no explanations why high-achieving students failed to secure a position and this was a source of frustration:

"it did seem like, from looking at my cohort that went through there were these amazing people that all missed out on jobs and I couldn't understand why...wondered what it was based on" Kay

This caused resentment towards those who had secured a position and were perceived to be unworthy.

"we had people who had been told from day one nursing is not for you, you should not be a nurse and got a job over a person like me who got like amazing reports on clinical and I formed really good relationships on clinical and they said they really wanted to have me back and all that sort of stuff" Nat

Participants greatly resented the impersonal nature of ACE. Findings that referred to the interview panels revealed that applicants perceived ACE to be responsible for the whole recruitment process. Participants lamented that the DHB staff they had worked with were not involved in recruiting:

"I just found it very frustrating and the most frustrating part was, I found out that people from [town] got the job I really wanted and they had never

worked on the ward didn't know the people when I had worked there, knew the routine and got on with the staff there" Anne

"I don't like the system at all, I think you should come in here, be like meet the manager, meet the boss, face to face, no points, yeah you look at my grades if you want...you could just go somewhere and you've no idea what you're doing, you haven't met the people, you've only met the, I don't know who interviewed me but I've never seen them again" Nicole

"Some of the people that got interviewed were, the choice of who made the decision for the interviews...it wasn't actually, it was people that weren't even working on the ward" Alice

Being reduced to a collection of statistics and then ranked in relation to an unknown system was perceived very suspiciously:

"...it does feel that it's all about the numbers and what you write down rather than maybe your strengths" Rachel

Applicants have no choice but to complete the ACE application process if they wish to secure a position in a DHB new graduate programme. The fact that ACE is designed to put all applicants on equal footing is not considered a positive aspect; instead it is perceived as unfair to the individual. The impersonal nature of ACE compounds the indignity of the process. Applicants have no person to make a connection with and this leaves them feeling frustrated.

5.4.1.4 Category 4 - Confusing.

This category links to the previous ones in this sub-theme; the combination of powerlessness, unfairness and the impersonal nature of ACE inspires perplexity in applicants. There were 26 findings that suggested elements of confusion.

Applicants try desperately to make sense of what is expected of them because ACE is the only access to NETP and NESP and so there is considerable pressure to succeed. This category informs the sub-theme 'the system' because confusion is attributed to the rigidity and facelessness of the process along with the perceived illogical decisions regarding who is successful. In addition, participants discussed

the ACE application process, the interview and the selection process inclusively indicating a lack of knowledge regarding the parameters of ACE. This also contributed to a sense of bewilderment.

Confusion pervades all aspects of the application and recruitment process. This includes the long and complicated process of applying:

“...it was kind of complicated going online yeah and doing all the drop boxes and being a bit unsure about which areas whether you were picking the right area cos there’s probably about a hundred different areas” Kay

“I didn’t find it very clear...there was so many things to it you know?” Alice

These findings allude to the image of ACE as a complex and unwieldy bureaucratic process. The influence of clinical choices caused additional uncertainty:

“There was a lot of kind of confusion about how [the clinical choices] that works” Rachel

“I had a bit of trouble with selecting... think I went in four or five times to change my preferences” Pat

Participants expressed their lack of understanding regarding how applicants are ranked and why some applicants were unsuccessful:

“...the point system, however they do that, it all went over my head a little bit” Nicole

“I don’t know exactly how the selection is chosen so I guess that’s something I can’t comment on” Pat

Other areas that caused puzzlement included the expectations of the interviews:

“I didn’t realise that the interview was actually going to be completely scenario based and you didn’t really get that much chance to talk about your stuff and your strengths and things I expected that to be in the, the presentation they didn’t really make that clear” Rachel

Participants believed this was the responsibility of ACE rather than the DHB. The focus of the group activity was also identified as bewildering:

“I was under the impression that the group activity would be about a nursing scenario and so I was completely thrown off when it was completely non-related to that” Pat

Although ACE visits tertiary education providers to explain to potential applicants what the process involves, this contributed to the confusion. There was little understanding of the intricacies of the process; specifically, the use of the algorithm to place applicants:

“A lady come down from...somewhere else independent...and she did like a lecture on it and ran it through, had a PowerPoint with lots of confusing stuff on it {laughs}” Michelle

“Erm, we had someone come to talk to us... and she just went through how it all works and everything, but we were all quite confused afterwards still about how it all worked...I remember the first time it was just kind of a confusing process” Alice

The findings in this code indicate that applicants only receive a certain amount of information regarding their responsibilities and the information they did receive caused more confusion and insecurity than reassurance:

“...you get told all these things, you hear something else, you’re not quite sure which way to go with it” Sam

“I didn’t know what was going on or how the process worked or how they choose and pick, you know what I mean? Because I thought you know maybe it was grades and looking at you know how we do in clinically, but, yeah wasn’t too sure what they were looking at when they pick” Jo

The sense of confusion contributed to the vulnerability that participants felt; there is a sense that applicants viewed themselves as ‘victims’ at the mercy of the system.

5.4.1.5 Category 5 – Rumours

A significant category within this sub-theme was the existence of several rumours that had been passed to participants while they were completing their ACE application forms; there were 23 findings for this topic. Rumours came from previous applicants, but were also mentioned by nursing tutors and clinical nurses. This category relates to the sub-theme because it suggests that previous applicants had deliberated over ways to navigate the system and secure a position. They advised new applicants how to avoid the mistakes made by their predecessors. This also contributes to the sense of ‘us and them’ a continued separation between ACE and the applicants. Regardless of how inaccurate rumours are, they hold considerable influence over participants and all relate to the clinical choices they should make on their ACE application forms. People who completed ACE twice were heavily influenced by these rumours. Participants were very hesitant when discussing them:

“Errrr, if people put mental health down I think yeah that would be, erm, people would like to... erm I just think that mental health it’s a, it’s such a, not many, there wer... when I applied it was, you know, there was a demand for nurses in it and so I think if people did put mental health down, they’re quite likely to get an interview yeah, but I don’t know I just assumed that, it’s just what I heard yeah {very hesitant}” Alice

The following section describes the four rumours that were identified:

5.4.1.5.1 Mental health will cancel out other clinical choices

Participants stated that they had been told that putting mental health down as a clinical choice would rule them out for other clinical areas. Consequently, participants left mental health off to give themselves a chance with their other clinical choices:

“Um...I know people were saying if you pick mental health you will get mental health regardless, if you put physical health first, medical first and mental health third, you will get mental health” Anne

“I, really liked mental health, it was up in my top three really...I think originally I had mental health as second and then I gave into the rumours and I took it off completely...I thought that if I put like mental health as a second choice I thought that then they wouldn't even consider me for recovery, so I left it off completely and then didn't get offered a job.” Pat

5.4.1.5.2 Putting mental health will guarantee a job

This rumour carried weight because the rationale given was that no-one wanted to work in mental health. Participants still did not choose mental health however:

“...a lot of people said put down mental health because you are guaranteed to get a job, lots of people told me that.” Nat

“I don't know if it was a rumour or if it's correct, but that if erm, you put mental health down that guar...increases your chances of getting a job” Pat

5.4.1.5.3 Creating a fourth choice

This rumour indicated an attempt to beat the system. Try your luck with other clinical choices and if you fail you can always try mental health instead; an unofficial fourth clinical choice:

“...yeah that rumour went round as well, that if you put down mental health then it would lessen your chance for opportunities for, and that you could go back and get a job in mental health anyway so just don't put it down” Kay

5.4.1.5.4 If mental health is not your first choice they will not take you

This rumour was less common, but still powerful. This participant left mental health out because it was not their first choice:

“I almost put it down, but, um...when I was in my last year of nursing school, they said that if you put mental health as your third choice, they won't accept you...they said, they'll look at that and think they don't really want to do it and they won't accept you, which isn't true at all...otherwise I would have probably put it down” Rachel

The existence of these rumours contributed to an overall anxiety about the importance of making the correct clinical choices to secure a position. It gives the impression of someone choosing lottery numbers as an attempt to win a jackpot. The third rumour listed indicates that some applicants were attempting to 'beat the system' and guarantee success. These images contribute to the perception that ACE is viewed by these participants as a malevolent entity that has no regard for them as individuals. It is indicated that the system is bureaucratic and unnecessary.

5.4.1.6 Category 6 – Strategic

The confusion relating to the ACE process inspired applicants to think strategically about how they would succeed; there were 41 findings for this category indicating it was a significant focus during the interviews. This topic relates to the sub-theme because it describes how applicants responded to being part of the system. Faced with the inevitability of having to complete ACE, applicants attempted to achieve success by considering their options very carefully.

The confusion regarding how ACE worked and the influence of rumours resulted in participants focusing on clinical choices as the key to success:

“it’s not necessarily gonna be your grades and your interviewing or whatever that gets you a job and that that’s why I think that it really does come down to your preferences” Rachel

Rumours influenced participants to become strategic about how to obtain a position and participants in this study were already passing their wisdom on to others. The findings for this code were consistent across all participants. This approach to the ACE process indicates the separation between the applicants and the ACE system. Participants alluded to the need to be tactical in their movements, almost like preparing for battle:

“...we’ve got some students on the unit at the moment...I’m already saying to them, look don’t get sucked into that trap, be smart about it. Think, pick

strategically, don't pick on what you want coz once you're in the door, you're in the door, you can move around, the trick is to get there" Sam

For participants who had completed ACE twice, there was a sense of learning that the system could not be trusted and they had to respond by thinking more strategically. The experience had stripped them of their belief that they would be treated fairly:

Well because {pause} I had started to become more practical in the sense that... I strategically applied for -DHB simply because it's conjoint with - DHB... So, so that was my sort of plan going in" Barbara

"I just said "You have to be strategic". Even others [students] were talking about "You have to be strategic this time..." Lisa

The ACE system was considered as a test of wits:

"Strategically...saying, right, be smart about it...looking at it from a practical point of view and being smart about it" Sam

Many participants referred to the variation of advice they had been given about clinical choices. This was often contradictory and led to considerable deliberation over which combination would guarantee success:

"Um and then you got the tutors that were telling you to be ambitious and put down the areas that you really wanted to work...Um, I think it, what I recall is being told to pick whatever area you were interested in, that you really wanted to work in and only pick an area if you were willing to work in that area." Anne

Some findings did not specify the sources of advice, instead the generic use of the pronoun 'they' gave the impression that applicants felt isolated from both the undergraduate realm and the profession of nursing. They were left to work out the answer alone:

“...they just emphasised that you probably should try to be broad rather than specific about areas that, because there’d be more options or, and then, or they did kind of say as well that you might want to strategically think about areas” Kay

Other participants alluded to the need to be instinctive, that making the right clinical choices was influenced by intuition:

“...it felt like you needed to guarantee yourself a position, you had to put down broad things like medical surgical or you needed to put down mental health” Rachel

Participants also described trying to find unique solutions through the amalgamation of conflicting advice they had been given:

“But I tried to kind of take both pieces of advice, to be general, plus go for what I wanted, I tried to combine it” Anne

The more advice that was received, the more participants took care to choose correctly; the experience was stressful:

“...where will I put down and if I put down this will I get a job will I not? What am I suited to you know?” Nicole

Prior to completing the ACE application and specifying clinical choices, many participants were focused on which clinical area they were interested in. As the experience of making clinical choices became more stressful, participants described compromising. The aim was no longer obtaining the ideal job, instead the focus shifted towards getting through the ACE doorway successfully:

“Informally, I was cautioned by a number of sources, not to go too specific... they said don’t go too specific cos the spots are limited... from there the people that have done it, that I was talking to were saying that the reason to go broad, it keeps your options open... even if you went med-surg and didn’t get what particular ward that you wanted... you could still land yourself in [a] ward” Sam

“the first time I based it around like surgical, medical I thought they are the places that are going to have the most jobs even though like I didn’t really want to work in medical but I put it because I was like, oh it’s a foot in the door, like that sort of stuff, to me it didn’t really matter where I got in the end, and then I knew I could go somewhere else once I had got that experience and got the foot in the door and I am in the DHB, you know I could go somewhere else later” Nat

Failure to secure a position resulted in participants widening their strategy to include mental health with the intention of moving back to physical health when they had completed NESP:

“if you go in to mental health and do it for a year, if you don’t like it you can bounce back into med-surg if you wanted to...so your creating more options than you are closing doors” Sam

“I was its only temporary, I just have to get through this year and then I can transfer...I was always thinking it was just going to be a short-term thing.”
Ann

In contrast to the deliberation over clinical choices, participants had more straight forward reasons for their choice of DHB:

I was very certain that I wanted to stay here because my family’s here so that’s what, that chose what region...I only applied to DHB I didn’t apply anywhere else” Michelle

“well I only put CDHB cos I wasn’t prepared to move so that was easy” Pat

5.4.1.7 Category 7 – Traumatic

This category referred to the emotional effect that completing ACE had on participants; there were 35 findings relating to this topic. Throughout the interviews participants made emotive comments about ACE and often their body language reflected the distress they had felt during the experience. These responses suggest that the ACE process has a significant and lasting emotional

impact on new graduates. The sub-theme of 'the system' is underpinned by this category because it describes how the ACE process affected applicants and reinforces the effect that powerlessness had on individuals:

"I didn't like it I didn't hm, I didn't like it, I couldn't go through it again...I really admired a friend of mine who missed out, she went through it two more times and I really admired her" {considerable hesitancy and discomfort} Elizabeth

Other participants used emotive language to express their opinion on the recruitment process:

"I absolutely hated it" Michelle

"No, I think it's horrible, I think it's really tough" Nicole

Specific aspects of the ACE process and interview caused considerable distress. Participants recalled feeling daunted by the expectations of the interview:

"It was the scariest thing, I didn't want to do it, I didn't want to go to the day, I didn't wanna do the group work, didn't want to do a presentation about myself urgh" Nicole

"...there was a group activity, do a presentation, you'd have an interview and yeah and it took half the day and was really stressful!" Michelle

"It was terrifying, it really was" Rebecca

The stress experienced was magnified by how much was riding on the interview:

"...anxiety provoking, especially as now we've come all this way" Sam

Another element of the process that participants found distressing was the length of time it took:

"The process is quite arduous...it's a lot of tick boxes and a lot of, like you have to have your CV all up to date which is fair enough, it's just a lot to kind

of have online and you had to do your choices and you had to upload your transcripts and all these things and it took quite a long time” Rachel

“it was quite lengthy yeah, you had to be prepared for it I think it was a lot more, I think it was just a lot more lengthy than it needed to be” Alice

“...and then the waiting process I didn’t like. Ok so you got a date for when your interview is and then you had to wait for the interview and then you had to wait a period of time till you found out” Anne

Participants indicated that the experience was humiliating:

“So demoralizing” Nat

Particularly when they were not successful:

“...you put it all out there and rejection is hard” Elizabeth

There is acknowledgement that perception could be influenced by failure to secure a position, but this is qualified with the suggestion that the trauma experienced was disproportionately high in relation to a recruitment process.

“I guess it is sort of probably tainted my view of things because I did not get a job the first time, and I went through hell because of it” Nat.

Overall, participants found their journey through the ACE process to be a distressing and arduous experience. Underlying these findings is a resentment that they had to comply with the process instead of using the conventional method of applying for jobs. Considering that all participants had eventually secured a new graduate position through ACE the negative responses to ‘the system’ remained at the forefront of their recollections.

5.4.2 Summary

Analysis of the findings revealed that ACE was perceived as complex system that applicants had to navigate if they wanted to start their nursing careers. The emotive language and visible distress that participants elicited while discussing

their experience of ACE highlighted the trauma that people experienced. Participants were resentful of having to endure the process, especially because they were initially unsuccessful.

5.4.3 Sub-theme 2 “Nursing as a vocation”

The Oxford Advanced Learner’s Dictionary defines vocation as “a strong feeling that one is specifically fitted for a certain type of work or way of life” (1995, pp. 1331-2). The description goes on to identify “Nursing is a vocation as well as an occupation” as an illustrative example (1995, p. 1332). This researcher purposely sourced non-nursing definitions to ascertain whether nursing was perceived as a vocation in layperson’s terms. The above definition alludes to the merging of lifestyle and occupation; there is a personal connection between the individual and the decision to become a nurse. This sub-theme relates to the suggestion that participants consider themselves to have a personal rather than a professional relationship with nursing. The subjective language used to describe experiences implies that nursing is perceived as more than a job; it is a calling, a vocation. These beliefs contribute to the assumption that success is related to personal attributes rather than academic achievement. There are seven categories that comprise this sub-theme; ‘Personal influences’, ‘Clinical influences’, ‘Stigma and discrimination’, ‘Alienation’, ‘Wanting a job’, ‘ACE is ineffective’ and ‘Positive aspects of ACE’ (fig. 2).

The identification of this sub-theme stems from the journeys that participants had travelled to become nurses. Varied personal influences initially led participants to consider nursing as a career. As they commenced study, conventional preconceptions about nursing continued to be reinforced by family and peers, but another significant authority was the undergraduate programme. This is indicated by the different levels of influence that clinical experience had on undergraduate preference for clinical areas and how these translated to clinical choices made for ACE. Participants recalled having been drawn to physical health environments even when they had enjoyed mental health more. Stigmatised beliefs from various sources contributed to the segregation of mental health from physical health and

so participants invested in the belief that to become a nurse they must pursue a career in a physical health environment.

CATEGORIES

Personal influences – N = 20

Participants perceive a personal relationship with nursing.

Clinical influences – N = 27

Participants used subjective factors to determine the success of a clinical placement. The most recent placement was the most influential

Stigma and Discrimination – N = 39

Mental health is segregated from the realm of nursing as a vocation.

Alienation and exclusion – N = 29

Missing out on ACE with no clear rationale why led participants to feel alienated not just from ACE, but from nursing overall.

Wanting a job – N = 15

Participants expressed embarrassment and shame when they 'admitted' they had chosen mental health because they needed a job. These responses reinforced the concept of nursing as a vocation.

Ineffective -N = 10

Several participants concluded that ACE is not an effective process because it did not consider applicants as individuals

Positive aspects of ACE – N = 15

Aspects of ACE that allowed for a personal connection were considered positive.

SUB-THEMES

NURSING AS A VOCATION

The language that participants use indicate a very personal relationship with nursing. The reasons for starting a nursing career, the beliefs that participants have about the kind of nurse they want to be and the emotions that are expressed when they are not successful indicate that nursing is associated with their value as a person.

Of particular interest is the reaction that many participants expressed when they admitted that they accepted NESP to get a job. Many were hesitant and embarrassed. Others defended their actions with explanations. From the perspective of this researcher, the reactions of the participants were not initially viewed as unusual. The perception of nursing as a vocation is a subtle, but important influence on the nursing culture. The motivation to accept NESP because it is a job is covertly viewed as an abandonment of that moral standing and therefore a source of shame.

Figure 2: Sub-theme 2 - Nursing as a Vocation

This sub-theme contributes to the theme that ACE is omnipotent because it relates to the way that new graduates prepare to socialise into nursing and how this has been influenced by the ACE process. The introduction of ACE has disrupted the personal connection between an applicant and their identity as a nurse because it removes the individual from the recruitment process. In effect, ACE has changed the process of socialisation from student to nurse.

5.4.3.1 Category 1 – Personal influences

This category explores the various sources that contributed to participants' beliefs about nursing and the development of their personal identity as a nurse. There were 20 findings that related to this topic. This category contributes to the sub-theme of 'Nursing as a vocation' because the influences suggest that participants develop a personal relationship with their role as a nurse. Many of the sources identified were present before participants started to study nursing; indicating that they were powerful and subjective inspirations.

Seven of the participants had nurses as family members and had a very specific view of what a nurse was. Their accounts suggested that the relationship between the participant and their family member was interwoven with their individual perception of being a nurse. There is a desire to replicate the journey of family members; a tradition that they have invested in on an intimate level and this influences how they perceive they will be as nurses. The idea that nursing is inherited through generations is a further suggestion that nursing is perceived as a vocation. The children of established nurses prepare to 'inherit' their predecessor's role and identity. Participants make a strong connection between the family member and the area of nursing they worked in and this in turn, influenced where participants perceived they would work:

"I put cardiology down and that's because my mum is a cardiology nurse and I was really interested in that...and I went to the...lab and I thought that was really awesome and my grandmother works there and so I've got lots of, like I had experiences that weren't necessarily within my um study"

Rachel

“It was simply because that, well I come from a family, like my mum, she’s a post-surgical nurse and my dad is a doctor and he ran hospitals so like it was always towards med-surg so I was just following you know, my parents...following tradition, yeah” Barbara

This connection was less significant for the children of mental health nurses. This participant did not pursue the career pathway of family members, despite advice to the contrary:

“All nurses, all of which I’m more or less related to.....saying just go mental health straight...off the bat” Sam

Family also had an influence on how participants prioritised different clinical areas and viewed a career in mental health:

“I think actually my step-mum she’s a nurse...a surgical nurse...she...didn’t try to give me that opinion but just all the time saying about mental health and that she’d never work there and it was the bottom of the pile of the nursing thing” Pat

This participant is alluding to the segregation of mental health from the vocation of nursing. It is less valued by other nurses and therefore less desirable as a career.

Personal experiences of the health service were other inspirational influences and allude to the concept of ‘giving back’:

“Um, growing up I had a sick relative and she was always in a medical ward and after she passed, I was like I want to work in medical so I can help people like that and so it was kinda inspired by that yeah, and so I never considered surgical until I had done my surgical placement” Anne

Although again, this did not apply to those who had experienced mental health services:

“I have got family members who have depression and anxiety and even they didn’t want me to go into mental health” Nat

This distinction suggests that medical and surgical nursing is a rewarding experience even when a person dies; mental health is not even valued by people who use the service and therefore is considered less rewarding.

While studying to be a nurse, participants were also influenced by the opinions of other nursing students:

“Well to be honest and it sounds silly but it was just like a one-track tunnel, like all my friends were doing NETP, no-one, none of my group looked at mental health. I’d made up my mind right from the start that I’d never go into mental health and here I am” Nicole

Previous exposure to mental health through work experience increases awareness of the potential for a career, but other factors become influential once the individual starts to study nursing. This participant was led to nursing through working in mental health, but by the end of the degree had been influenced by the prospect of working in other areas. This indicates that conventional assumptions about the identity of nursing had become more influential at the time of choosing a career pathway:

“I always knew that I probably wanted to go down that pathway anyway cos I was always interested in mental health and that’s what brought me into nursing to begin with” Kay

Participants identified various personal influences that contributed to their identity as nurses. Some of these inspired the decision to pursue a nursing career and others developed during their studies. Although the significance of these influences was specific to the individual, several similarities were apparent; mental health lost influence over the course of undergraduate study and participants had begun to segregate mental health from the ‘vocation’ of nursing.

5.4.3.2 Category 2 – Clinical influences

This code highlighted the complexity of undergraduate clinical influences and comprised 27 findings. The language used to describe the experiences was subjective: ‘loved’, ‘enjoyed’, indicating that participants gauged the success of a

placement based on how much they responded to the experience personally rather than building professional knowledge. This contributes to the sub-theme of nursing as vocation because participants felt a personal connection with the nursing environment:

“Good, yeah, yeah, I enjoyed every placement I did. I mean there were obviously negatives and positives for each of them but almost every single placement I enjoyed” Rebecca

“I loved my cardiology, oncology, paediatrics” Alice

Many participants considered all their clinical experiences to be positive:

“I had great experiences in all my placements...” Anne

This compounded the difficulty of choosing areas for ACE:

“I think that was why I had a really tough decision picking where I wanted to go because all of my placements I enjoyed so it was difficult to pick the one I wanted the most so, yeah” Pat

The language used here indicates that the choice was a personal one. Enjoyment of the experience led to the desire to claim ownership: “I wanted”.

Undergraduate placements had an influence on the decisions made for ACE, however there were some anomalies. While it is understandable that students who did not enjoy mental health did not choose it:

“...that also contributed because I hated my mental health placements... forensics where I got chased down a corridor by someone and um, ah it was just really, I didn’t get debriefed or anything. I just really didn’t like that environment there erm and I was you know, sort of, erm, in a position like he could have got to me and they were trying to pull him back and it was really scary for me as a second year yeah and I just didn’t like the environment out there” Alice

Students who had enjoyed their mental health placements did not consider mental health as an option:

“I had a great time on [mental health] placement I really enjoyed that” Sam

“I had really good placements. My first was at forensics and that was really good, interesting and although that was quite restricting as a student because that is such a safe environment they don’t get to do a whole lot but it was still quite interesting” Rachel

Students who did not enjoy their transition placements did pick them and left off mental health even though they had enjoyed the experience:

“[med-surg] ...I didn’t like it at all {laughs} so I knew that like medical surgical stuff after that and then doing some other stuff it wasn’t what I really wanted to do. I was more interested in mental health, yeah, I loved my mental health stuff and then I’d loved community stuff” Kay

“med-surg...did enjoy it, didn’t enjoy it as much as I thought I was going to... then getting there, was like, nah, this is completely not what I was expecting...in truth I actually enjoyed the previous placement in [mental health] more” Sam

Participants who had entered nursing because of experience in mental health were influenced to look at other options by the end of their degree; mental health was viewed as a limiting option:

“I was thinking about mental health I wasn’t necessarily saying...definitely...I was always interested and always wanted to go back to it, but I wasn’t limiting it to just going into there, but I was, you know opening some opportunities for that” Kay

Successful placements were quickly replaced by consequent positive experiences so by completion of the degree, students were focused on obtaining a place in transition:

“I think that each time I went to a placement I thought I want to work in this area and then I’d go to the next placement and I’d like that just as much and there was a bit of ambivalence and that happened all the way through” Pat

“...I thought medical nursing, but I didn’t really know about surgical, so when I went to surgical I loved that, but then after I did my transition placement I fell back into medical. I kinda going in I was thinking medical, then half way I thought surgical and then at the end because I was back in medical, it was medical” Anne

These comments gave the impression of clinical placements building up in layers; by the end of the degree the final placement had the most influence. The findings for this category also indicate that the segregation of mental health has continued into the selection of clinical choices for ACE. Despite positive clinical placements in mental health, they are not identified as options. This suggests that there are other influences more powerful than clinical experience affecting undergraduates’ choice of career. The participants of this study perceived their vocation in relation to medical and surgical environments and this was so well integrated into their beliefs that they did not realise it until after the recruitment process had ended:

“...retrospectively I should have gone mental health to start with” Sam

“At that point I was like, yeah, I’ll give it a go, I was like why haven’t I looked into it?” Nicole

5.4.3.3 Category 3 – Stigma and discrimination

There is evidence that stigmatised beliefs about mental health nursing were prevalent in many contexts identified by participants. These ranged from the perspective of others to subtle assumptions that participants themselves continue to hold. There were 39 findings in this category; indicating that it was a substantial topic. This category links to the sub-theme of nursing as a vocation because it highlights that mental health nursing is perceived differently compared to physical health nursing. The advice given by others continues to segregate mental health

from the rest of the nursing profession; it belongs outside of the vocation of nursing.

There was significant evidence that participants held stigmatised beliefs about mental health. These remained very influential throughout their undergraduate programme and strongly affected clinical choices for ACE:

“I didn’t put mental health because I was probably scared that I have to work here, at least I know I like surgical nursing so if I didn’t like mental health it was like I was stuck here for a year and you hear all the stories and it does it scares you” Nat

“I was so scared and nervous if I am being honest. You know what people say about mental health, you feel out there” Lisa

The attitudes of society were also influential:

“...there’s always the negative stereotypes and things that you hear and care in the community and so I didn’t think that I would like it” Pat

Participants were reluctant to include mental health in their choices for ACE as they were concerned about the effect it would have:

“...because I wanted a job in public health nursing and I didn’t want to taint that by putting down mental health” Kay

These preconceptions also influenced how participants perceived NESP would affect their nursing careers:

“I loved the physical things and I thought oh I’m gonna lose, lose all my skills and what will I be doing and it’s gonna be working in all those gross wards” Alice

Many participants referred to the belief that mental health was not real nursing:

“I hadn’t put mental health down, probably in the background, it was always, it was my, partly my thing, but I thought to be a real nurse you had to, I don’t know” Elizabeth

The fact that this perspective was also held by other nurses and peers reinforced the validity of the belief.

“some nurses have said about it oh, it’s not actually nursing... and I did kind of have that kind of frame of mind about it” Alice

Participants gave the indication that they were left with no choice but to work in an area that was excluded from the rest of the profession, effectively creating the impression that if applicants accepted mental health they were excluding themselves from the vocation of nursing.

“mental health had always been downplayed as oh you don’t want to go there, it’s horrible, you’re not a real nurse if you go to mental health...other students and my family was quite big on it, yeah” Anne

Findings also reflected the fear and vulnerability that participants felt and these emotions reinforced the stigmatised beliefs:

“...I’d had absolutely no experience in an, in [mental health] hospital, type thing and was shit scared and didn’t really know what I’d expect” Michelle

Mental health continues to be perceived as dangerous and the characteristics ascribed to mental health nurses are still very stereotypical:

“I am not really big and tough and you know and all that sort of stuff, and I am quite naive so I haven’t really experienced that sort of thing before” Nat

“...my in-laws...they were like don’t go there it’s really hard try maybe different line and do mental health later on...it made me quite nervous first time about choosing mental health and I sort of put that to the side”

Rebecca

These varied examples illustrate the complexity of stereotypical assumptions about mental health nursing. The combined examples all serve to separate mental health from the rest of the nursing profession. Findings suggest that applicants perceived they were faced with the prospect of choosing the vocation of nursing that they had invested in, or disregarding this 'calling' and joining a different career pathway.

Participants inadvertently supported the view that physical health skills were more valuable than those acquired in mental health and this view influenced plans for their careers:

"I still don't think it's for me long term, but there have been parts of it which I have loved, and I've realised how hard and how skilled and stuff, it actually is and how there still so much like co-morbidities that come with it and I haven't lost, well I haven't got strong got strong physical nursing but I've still been keeping my hand in a wee bit" Alice

Erm, I love my job here, erm, but I think I'd like to go back to gen, gen med. I just feel that I've forgotten a lot of things, a lot of skills and erm... you get small opportunities here like...physical obs and ECGs and things like that, but to flush a line, I wouldn't have a clue any more so like I'd like to go back just to dip my foot in and probably come back" Nicole

Even those participants who acknowledged that they had held misconceptions of mental health, then reinforced the belief that physical health was more important:

"I shouldn't have had that feeling because I worked in [Older person's mental health] and that was, there was a lot of physical stuff as well, in my only mental health placement at that stage" Elizabeth

These statements indicate that the concept of the cure-care dichotomy remains highly influential for the participants of this study.

After exposure to the realities of mental health nursing, participants expressed a growing realisation of the presence of stigma and discrimination in relation to mental health particularly in the undergraduate programme:

“...and there’s a lot of maybe stigma around going and being a mental health nurse, which is a bit of a shame and there’s some cool opportunities for some placements, but it’s almost like you get that vibe that even in the polytech that they’re still encouraging you to do other stuff not mental health as well, so there’s not a big push at all for your final placement to do mental health so it’s not like they really strongly bring it up or stuff like that” Kay

ACE is not helping to dispel these misconceptions because it also separates mental health:

“I don’t think [ACE] it’s helping it coz the feedback that I got from others when we were doing the ACE application form is you put mental health down for pretty much a guaranteed job, you know if you put mental health down, you’re going to get a job. But if you put it down that’s the job you’re going to get” Anne

Participants validated their continuation in NESP by measuring mental health against physical health and justifying its importance:

“Um, well, I kinda thought about it and I thought well realistically it’s everywhere, mental health is everywhere so even if, you know, if in three years’ time I was to turn around and say you know I’ve had enough, no matter really where you go, there is, it’s gonna be, it’s gonna come through with some people” Michelle

At first this statement seems to be countering stigmatised beliefs about mental health nursing as a career. However, there is also an underlying sense that participants were reassuring themselves that they were not wasting their time by starting their career in mental health.

Additional experience of working in clinical environments through NESP had helped to dispel some of the negative stereotypes about mental health nursing. This led to a realisation that the participant had the talent to do the job:

“Because it is like when people perceive mental health as undoable, but if you are in there you find that yeah not all days are good, some days can be bad, but it just balances out. You just have to have a good attitude and team work” Lisa

This category suggests that stigma and discrimination towards mental health has a significant influence on new graduates’ perceptions of career choice. Some of these misconceptions are so subtle that participants were not aware of the stigmatised assumptions they were making; namely that physical health skills are more valuable than mental health.

5.4.3.4 Category 4 – Alienation

‘Alienation’ represents the relationship between participants and their future career as a nurse and indicates this was very subjective. This category included 29 findings and links to the sub-theme of nursing as a vocation because participants suggested they had been rejected and the language used indicated this was a personal banishment:

“...I had to literally assume that they didn’t want me...” Barbara

Some participants stated that they anticipated they would not be successful through the ACE process, they were already beginning to sense they did not belong to the nursing world:

“...because I, perhaps I had a feeling I might miss out of the NETP and erm, I knew I probably. Yeah, there was a part of me, yeah” Elizabeth

“I didn’t think I was going to get lucky” Barbara

Other participants described that they had not considered the possibility of failing. This was generally due to their grades and performance on placement. They

perceived they had been accepted into the vocation of nursing because of success in the undergraduate programme:

“I just thought of course I’ll just easily get a position, it was silly really but I had good feedback from my placements” Alice

I was quite a high achieving student and I got really good marks and good feedback on my placements so I never assumed that I wasn’t going to get a job, so that was quite hard” Pat

This indicates the presumption that acceptance into clinical environments and success academically was considered by participants to sufficiently identify them as nurses.

Failure to secure a NETP position evoked a range of responses in participants but they all relate to a feeling of exclusion. If nursing is a calling, these participants felt they had been found wanting. Participants expressed very emotive responses when they were not accepted, they felt abandoned, betrayed and alienated:

“I was gutted that I didn’t get a job and I was like no I’m not because I didn’t get a job...so I didn’t bother [seeking feedback]. I didn’t want anything to do with it” Anne

Other participants had contacted ACE to find out the reason they were not successful. The answer was unsatisfactory and reinforced the belief that clinical choice had been the only reason, but this was also perceived to be reassuring because it did not indicate a personal flaw in the applicant:

“I even rang ACE, um, to ask them what, if there was any big reason why I didn’t get a job, cos otherwise I had really good grades and really good feedback but there’s nothing that kind of, and they said my interview went well and they said that it was just a what I’d put down it just depends on your preferences, they even said that so... [but it was reassuring [because it wasn’t something that was wrong with you?] yeah” Rachel

This indicates an incongruence between the reasons applicants are not successful and how participants perceived the reason for rejection. ACE states that the process is objective but applicants interpret failure as resulting from their own inadequacies as a person:

“when that didn’t work out for me I thought well, I’ll give it a try, if they don’t like me then tell me and I’ll go away” Barbara

Some participants linked their failure to secure a position with undergraduate clinical experiences:

“coz I was thinking when I failed the [placement] the first time, erm, there was always this feeling that I wasn’t good enough perhaps and but I didn’t choose, I got ended up, being put back, that was a med-surg ward and I ended up getting put back that there for [transition], even though I’d asked to go I sort of thought I was good with the elderly and I could see myself in a stroke ward or something” Elizabeth

This finding implies that the participant believed they were purposely sent to a clinical area that would guarantee failure and therefore exclusion from nursing. This perspective seems to contradict the belief that ACE is all powerful. However, other participants also associated their failure to secure a position because of communication between ACE and the clinical environment indicating that ACE had the power to ensure undesirable candidates would be excluded.

“My last placement as a student nurse, it just went horrible...so I figured that may have somehow affected my not even getting an interview for [the] DHB” Barbara

This indicates that participants believed individual clinical units had the ability to influence ACE before the process even started. The suggestion being that the DHBs and ACE colluded to exclude specific people. Participants felt that they had already been rejected from the profession because they did not fit. The language again implies that this was a rejection of them as a person. This feeling of exclusion and alienation was expressed by other participants in different situations:

“...and I got the feeling, cos I did, you know have an outside opinion... I remember looking around the group and thinking oh, I’m getting some funny looks from my peers and I looked at the instructors who were just on their clipboards, assessing and carrying on” Sam

“People did say you may not get a position, don’t stress if you don’t there is other ways to get jobs” Rebecca

The impression that comes from the findings for this code is that nursing is an ‘exclusive club’. Admittance into the club is not based on the ability to do the job, but instead on how you as an individual ‘fit’. If you are not accepted, then it is due to a flaw in your personality. This contributes to the sense that nursing is a vocation; only certain people are considered suitable for the job. Once rejected, participants feel a sense of alienation and resentment:

“for me it was disappointing that I, you know, spent three years of my life working at -DHB, getting no money for it, doing all the crap work and not being given a chance to prove myself” Barbara

Alienation from NETP encouraged participants to look elsewhere for a position. This participant indicates that the prospect of being left behind encouraged her to join NESP. The idea of being alienated from friends as well as the nursing profession motivated the decision to join mental health:

“cos at the time I was staying with my friends who were already working down here in mental health, cos they wanted to do mental health...and they had started their job...so I was like you know left behind kind of thing and...I was talking to them a lot and it just sounded actually quite nice, like not as bad as what I thought” Alice

Participants also felt alienated because they were only offered one position and never found out how they would have fared in other areas:

“I will never know; I will never know if I might have been able to get a job in surgical...would have been nice to have been considered for elsewhere if that is where, obviously, I wanted first.” Nat

This again alludes to the perception of nursing as a vocation. For the participant, the first clinical choice is where they were ‘called’ to work. Anything less is frustrating:

“I don’t really know, I think that with the ACE programme it was a hard pill to swallow that you would never know who accepted you, you know that you would only know that one job you got and um yeah so I think that’s quite hard to sort of wrap your head around to go okay so [DHB] chose me but did I do better with [DHB] this time? Would they have picked me this time? Would I do better with them up there? I will never know” Rebecca.

The findings for this category highlight how participants responded when they did not secure a new graduate position. Reactions were emotive and rejection was taken personally. The assumptions that participants made regarding the reasons for not being accepted led to feelings of alienation. Applicants who failed to secure their preferred clinical choice have had to reconcile themselves to the fact that they must sacrifice their calling. These findings suggest that participants grieved for the loss of their identity as a nurse.

5.4.3.5 Category 5 – Wanting a job

There were 15 findings for this category. Participants identified that they accepted a position in mental health because they wanted, or needed a job. This correlates with the sub-theme because the belief that nursing is vocational contributes to the discomfort expressed while talking about motivation to accept NESP. Some participants were embarrassed to acknowledge they were motivated to join mental health to secure a new graduate position:

“{Whispers} it was only because I wanted a job” Nicole

Others felt obliged to justify their actions:

“I needed a job, I had a \$20,000 student loan and I’ve got 3 children”

Barbara

One finding indicated the compulsion to clarify being motivated by more noble factors:

“...but that didn’t really apply to me because I wasn’t doing it just to get a job. I wanted a job that I actually wanted” Pat

Participants expressed their discomfort when discussing their rationale for accepting mental health:

“{considerable hesitancy} I thought well, you know and then I didn’t get, because I didn’t apply for mental health and didn’t get...the other physical position I was just so couldn’t believe it and then I just thought well, I’m just gonna do it...” Alice

These reactions revealed an interesting factor inherent in this category.

Participants assumed that being influenced by the need to secure work is not acceptable for nurses. The reality of the situation; completion of a three-year degree, accumulated student loans and the need to secure a new graduate position in a DHB, placed considerable pressure on individuals to secure a position. Their careers as nurses hang in the balance; if an applicant was unsuccessful through ACE their options were limited. This participant tried to find work outside of the DHBs:

“I just had no option because there were no jobs. I tried to look for a job in the private sector, they were not taking new grads at all...They were saying "No we don't want you" to new grads. Even in the rest homes they were not taking new grads. I even applied for a job as a caregiver and they were saying "No, cos you’re a nurse" so it was just hard” Lisa

It is understandable that participants would do what they could to secure a job. However, the fact that participants would consider working as a caregiver before

accepting a position in NESP is further evidence that mental health is an undesirable clinical choice

The findings for this category suggest that participants believed they would be judged; they had sacrificed their moral standing as a nurse because they had been motivated by something as mundane as earning a living. The language used by participants hints at an image of nursing as a moralistic, sacrificial 'calling'. It inadvertently suggests that nurses would continue in their role whether they were paid or not. If an applicant is not successful the first time they apply through ACE they must wait until they secure a position in the clinical area they are 'called' to work in. To be swayed by the fiscal aspect of employment is considered unworthy.

5.4.3.6 Category 6 – ACE is ineffective

Many participants agreed that ACE was not an effective method of placing new graduates; there were 10 findings in this category. While this viewpoint could be influenced by the resentment participants' felt when they failed to secure a position, the findings indicated more subtle reasons. Participants resented that the process did not consider them as individuals. This category relates to the sub-theme of 'Nursing as a vocation' because the findings emphasise that the relationship between new graduates and nursing is a personal one. There was evident frustration that the recruitment process did not view applicants the same way. Participants were most resentful that ACE did not consider, or value, the personal investment they had made to the nursing environment. Participants used emotive language to describe their opinion of ACE as a recruitment process:

“I just think the way they select, the matching process is just really stupid way of knowing how and you know like there's a limited amount of interviews erm, they don't give out information how many positions are available and erm I just yeah I think it's just ridiculous, I think there's so many of us and they tried to just narrow it down in the system but I don't think it was very effective at all” Alice

Others were sceptical of the claim that ACE was fair and indicated they were critical of the process even before applying:

“I thought that it was a bit, in my own terms, airy-fairy, a bit sort of this is how it works and it’s a fair process and this that and the other” Sam

Participants acknowledged that their opinion could have been influenced by their failure to get a job:

“I don’t think it is the B-all end-all and I don’t think it is good as everyone sort of puts it out to be, but I guess that could be because that is my experience I guess if I had a job first time around, yeah ACE is great, you know?” Nat

Others maintained that they were left feeling they had not had the opportunity to perform at their best:

“but I don’t think um, it was the best way to, I don’t know if it was just me and my experience but, to show myself, I didn’t, I left feeling that I hadn’t done a very good job” Pat

The common theme that is suggested in this category is that ACE is not effective because it tries to do too much with too many people. Participants felt that the personal connection they had made with clinical areas received too little emphasis.

5.4.3.7 Category 7 – Positive aspects of ACE

Despite the strong emphasis on the stressful nature of ACE, there were aspects that participants found positive. There were 15 findings for this category and they contribute to the sub-theme because participants judged aspects to be positive when a connection was made with other people. This further emphasised the value that participants ascribed to the personal connections made with the world of nursing:

“It was better than I thought it would be because everyone there was so lovely it was a really nice relaxing experience” Pat

“The interview I didn’t, at the time, I actually quite enjoyed it cos I had a bunch of people I could sit there and talk to and they had to listen to me, captive audience” Sam

Other aspects related to elements that were beneficial for applicants, such as the option to change clinical choices:

“...and I liked how you could go in and change your preferences, right up until it closed off” Anne

Those aspects of ACE that acknowledged individuality, encouraged human contact and allowed for flexibility were given as examples of factors that were positive. This contributes to the suggestion that participants value a personal connection with nursing.

5.4.4 Summary

The sub-theme ‘Nursing as a vocation’ relates to the perception that new graduates invest in a personal relationship with nursing. Participants elicited shame and embarrassment when disclosing that they had accepted a position in NESP even though they did not want to work in mental health. This further reinforces the concept of nursing as a vocation; participants seemed to judge their actions as immoral because they were motivated by wanting to start their career rather than waiting to be accepted in the area they were ‘called’ to work in.

The findings in these categories suggest that participants perceived the world of nursing as exclusive and some participants describe feeling that they were rejected even before they applied through ACE. The use of language indicated that this exclusion was related to personal aspects rather than lack of academic achievement and reinforces the belief that nursing is a vocation. The overall sense of these categories is that mental health only became an option when participants realised that they were not accepted into the ‘real nursing’ environment.

5.4.5 Sub-theme 3 “Professional identity”

The definition for this sub-theme is that nursing as a profession is an elitist group. Acceptance into the group is influenced by successful professional socialisation. When participants failed to secure a NETP position, they felt a sense of rejection from the profession, but acceptance into NESP inspires a change in their opinion of mental health. The NESP programme effectively reveals the secrets of mental

health nursing and the sense of rejection fades. Instead, new graduates are successfully socialised into a profession within a profession. The categories that contribute to this sub-theme are 'inadequate undergraduate preparation', 'Transition placements', 'Clinical choices', 'Advantages of NESP' and 'Socialisation, validation and acceptance' (fig.3). All these categories relate to aspects that influence the development of professional identity and assumptions about the nursing profession overall.

'Professional identity' relates to the over-arching theme 'ACE is omnipotent' because it explores how the recruitment process has influenced the professional socialisation of new graduates. ACE has changed the way that newly qualified nurses are recruited and this has affected change in the process of socialisation. Prior to the introduction of ACE, undergraduates would focus on their transition placements as the beginning of their career. ACE has removed that connection; it is powerful enough to alter the transition of new graduates into the nursing profession.

5.4.5.1 Category 1 – Inadequate undergraduate preparation

This category is focused on how undergraduate study influenced participants' clinical choices for ACE and had 24 findings. This topic highlights the factors that influence a student nurse's perception of the nursing profession and how they fit in to it. During the interviews, participants began to speculate on why mental health had not been an option for them. This was inspired by the accounts of clinical placement experiences, where several participants acknowledged that they had enjoyed mental health more than medical, surgical or transition. Even so, in the final clinical choices, mental health was missed off. The conclusion that many participants came to was that there is insufficient

CATEGORIES

Inadequate undergraduate preparation – N = 24

The under-representation of mental health in the undergraduate programme influences applicants' perceptions of the professional identity of nurses. Participants assumed that professional identity relates to a career in physical health nursing.

Transition – N = 14

The transition placement continues to be the environment where undergraduates invest effort in integrating into the nursing profession. This indicates that undergraduates have not adapted to the new process that ACE has introduced.

Clinical choices – N = 16

The choices that applicants made for ACE reflect societal perceptions of professional nursing identity. Most applicants put their transition placement as a choice; many their first.

Advantages of NESP – N = 16

NESP has a positive influence on the socialisation of new graduates. The support and the mental health focused theory contributed to the perception that mental health is a viable and rewarding career.

Socialisation/Validation/Acceptance – N = 35

Acceptance into the culture of nursing was a significant and complex aspect influenced by both the undergraduate programme and ACE. Many factors influenced either successful or unsuccessful socialisation.

SUB-THEME

PROFESSIONAL IDENTITY

There is a sense that the profession of nursing is an elitist group with a hierarchy of importance. The comparison of comments made about NESP and the undergraduate programme are interesting because they give the impression of two very different groups. Participants were excluded from the first but accepted into the second. As a result, the secrets of mental health nursing were revealed and found to be completely different from societal (and nursing) understanding. For some participants, this elevated mental health into a different sphere from the mundane med-surg environment. This creates the image of initiation rituals and ceremonies. Unfortunately, the ACE process gives the impression of NESP sweeping up the 'rejects'. This has the potential to further reinforce the misconception that people only go into mental health if they are unemployable elsewhere and that new graduates join mental health because they have no other choice.

Figure 3: Sub-theme 3 - Professional Identity

mental health content in the undergraduate programme and this influenced the belief that mental health was not included in the profession of nursing:

“...in the undergrad, there was not enough push, or enough coverage or, you know, I don’t know, I just, from memory, I just always remember NETP, surgical, medical” Nicole

“...and I think at the time I hadn’t paid any attention to NESP because for me it was like I’d never done mental health I never felt like I’d even done mental health ever at polytech” Michelle

I feel like the course doesn’t give us enough for mental health...I feel like I really didn’t learn much at all...we get a little bit, but we don’t really get enough to work in an area like this, you know, we don’t get enough to actually use with the patients” Nat

Some participants believed this was due to where mental health had been placed in the three years:

“I think that it is a shame that mental health does get forgotten about when it is in the 2nd year, so after that you’ve got three other placements and you do stuff and mental health gets forgotten about and people think that they should go into the other stuff first” Kay

“Yeah, we only cover that mental health in [year] 2 and it was just kinda quick done and over, you know I don’t even think there was much in state about mental health I mean, there was but not, you know” Nicole

The impression given is that students have a taste of mental health and then the subject is never revisited:

“...and I think looking back on it, there needs to be more yeah especially like when you think about how much there is when you get working and that, you know there is mental health the whole way through the medical system

and so I don't see why when we were doing assessments at polytech we weren't considering them" Michelle

This became evident to participants after they had studied mental health in more detail in NESP. Prior to that they did not question the heavy emphasis on med-surg nursing:

"When I first came into mental health [NESP], I felt like I knew nothing, I wasn't prepared to come to mental health, I'd never planned on it. So, when I first started working in acutes I felt completely out of water" Anne

However, after completion of NESP, participants became aware of the absence of mental health content in the undergraduate programme:

"I would say that now, definitely [mental health is under-represented]"
Michelle

Several participants had completed their mental health placement in Older Person's Mental Health (OPMH); the consensus from these students was that the experience had not prepared them for mental health because they had not been exposed to 'real' mental health issues:

I guess the reason why I wasn't, I didn't necessarily want to work in mental health but I think it was because of the placement I was in [OPMH], so I didn't really get a mental health placement, like a real mental health placement, so it was all sort of like a big scary thing that I had never really experienced" Nat

I went to [OPMH} for my placement which I absolutely loved, I loved it, erm, and it's not classed under mental health...so for me it was kind of, it wasn't going to be a choice because it would be just like putting something where I had absolutely no idea what it was" Michelle

"[OPMH]...was very stable. We didn't get to see the acute cases...It doesn't really prepare you for this kind of stuff that you get here" Lisa

This category relates to the sub-theme 'Professional identity' because it suggests that the construction of professional identity as a nurse begins when students embark on the undergraduate programme. The perceived absence of mental health from most of the course content contributes to the separation of mental health nursing from the profession overall. Students do not consider a career in mental health because they develop the belief that it is not part of the nursing occupation.

5.4.5.2 Category 2 – Transition placements

This category highlights the perceived importance of transition placements and the influence they have on clinical choices for ACE; there were 14 findings that related to this topic. 'Transition placements' relates to the sub-theme 'Professional identity' because the transition placement is perceived as the first stage of a voyage into the professional realm of nursing.

“...my transition to practice placement which was your big one at the end you got to choose” Rebecca.

Transition placements are enormously important to undergraduates. They prepare to start their career in the environment where they complete transition:

“I remember someone saying you were best to pick what you had for transition, if you'd got on well and if you'd done well at transition that that was kinda a really good place to start” Michelle

This advice alludes to an assumption that new graduates will pursue a career in the area they are placed for transition. It is also evidence that this belief is influential when applicants are making clinical choices for ACE.

It is very destabilising for students when they do not have a successful transition placement because this is perceived as a significant step in socialisation to the nursing profession. Unsuccessful transition placements also created difficulty when making clinical choices for ACE:

“I was in oncology, but because I didn't put it in as my first choice. There were various reasons for that...I was a bit worried because, um, I just felt

that the staff were, they were quite split against each other so it wasn't a nice environment a lot of the time and it was very stressful area, but I don't know if that's why, so sometimes I would feel supported and other times not and I had never had that before and that was a bit disconcerting and I kinda wasn't sure and there was a lot of cattiness on the ward and I was like I don't actually know if I want to work here and that's why I didn't put it down as my first choice... and I hated it so but I still put it in there but it wasn't my first" Rachel

For this participant, the difficulty with socialising into the nursing team was the reason that the placement was not enjoyable. This indicates that assimilation into the ward culture is a primary objective of students in transition. The inability to do this created a sense of doubt regarding the suitability of the clinical area as a career choice. However, belief that the transition placement should be the first clinical experience as a new graduate was more powerful and it was consequently chosen for ACE. The transition placement is considered the step up from undergraduate status to new graduates; participants invested considerable energy becoming accepted into the nursing teams and felt that they were prepared to fulfil the role of RN:

"The ward that I did my transition placement on, I got really good feedback from my manager and my preceptor there and they told me that they would be happy to have me back...I just thrived on that ward, yeah. I just kind of got into my groove, d'you know what I mean?" Anne

"my cardiology one was my final placement and I absolutely loved that one and I thought I was going to get a job there and I had my hopes up real high" Nicole

"I really did enjoy my time in [transition] and that was also feeding into my perceived plan... I enjoyed the acuity, the not dithering around part, the right get them in, assess, the triage and I'd think right. Lots of hands-on, there was lots of hands-on stuff and I liked that. The critical thinking and that sort of thing had to do some catching up, but the hands-on things, I

really enjoyed that running obs, doing assessments all that stuff we learnt as undergrads it all pulled together everything just...tightened up. I had opportunity to do just about everything” Sam

These findings indicate that participants had made strong connections with their identity as nursing professionals. The study was being consolidated and the concept of nursing was beginning to fall into place. None of the participants completed transition in mental health. The approach and attitudes towards transition placements reflected the process that would have been used to recruit prior to the introduction of ACE. Transition students worked hard to be accepted, create a good impression and convince the managers that they would be an asset to the team. The process was very personal and probably very unfair. The connections that participants made between success in their transition placements and clinical decisions for ACE indicate that the undergraduate perspective has not yet caught up with the recruitment process:

“I didn’t have my placement in mental health for the last year or anything like that, I guess because I was in surgical, they were like you know it was just a given I would put surgical” Nat

5.4.5.3 Category 3 – Clinical choices

This category focuses on the clinical choices that participants had made for their ACE applications; there were 16 findings identified. The clinical choices that participants made for their first ACE applications reflected the national statistics regarding the most popular areas. This indicates that participants associated the physical health environments with the nursing occupation and had invested their development of professional identity towards careers in these areas. Most participants identified medical and/or surgical placements:

“I picked med-surg, and I picked medical, and I picked paediatric surgical”
Barbara

“Erm, just NETP, cardiology and general med or paediatrics” Nicole

I went general but I really wanted medical so I put medical for my first, but then my other two choices I went general so I did surgical and community”
Anne

Other choices that were popular included paediatrics and community. Many participants chose two broad areas and one that was more specific. Others took a chance:

“I put...intensive care...and then I put surgical and then medical for my three choices” Michelle

“I put cardiology down...and I just put the other one down as a stab in the dark” Rachel

Participants were influenced by their long-term career aspirations:

“my picks went emergency trauma, medical, community...my big goal right from the start was to get into emergency trauma and that sort of thing and in my last placement I got into [placement]...I had a preconceived plan of what was going to happen, it was all going to be great and I’d live happily ever after” Sam

This participant did acknowledge that they had enjoyed mental health but did not select it:

“I was thinking, I should really go into mental health cos I really enjoyed that” Sam

The prospect of emergency trauma was more appealing, even though there were very few places available and a likelihood of failing to secure a position. All the participants put down the area they had been in for transition, further reinforcing the relationship between this placement and their future career.

5.4.5.4 Category 4 – Advantages of NESP

This category represents the comments made about participants’ experience of NESP; there were 16 findings that related to this topic. Although NESP was not a

specific focus of the study, it was mentioned by many participants during the interviews and was clearly an influence on their opinions about mental health. This category relates to the sub-theme 'Professional identity' because it identifies NESP as a major influence in the realisation that mental health nursing is a valid profession. This enables new graduates to invest in the development of their professional identity as nurses and replace their previous assumptions that they must pursue medical or surgical nursing careers to be included in the profession. From the findings, it became apparent that NESP is very effective in changing new graduates' perceptions of mental health and dispelling much of the stigma surrounding the role:

"...its really, really supportive...I was quite scared to come on this placement thinking...I am going to get assaulted...but you know you are not often in a situation where...you are not around other people and you don't have support from someone else or like that sort of stuff and I think it is it is a lot less scarier than what I thought it was. Yeah" Nat

This participant is also alluding to the process of successful socialisation into mental health; the feeling of not being alone. Participants identified specific aspects of NESP that were positive. These included the considerable support:

"...so that's what I appreciate about the NESP programme really, cos it's so well supported" Barbara

"...yeah [NESP influenced] quite a lot...need the support of your colleagues, especially in mental health, you do need that. You are not on your own. It has to be team work..." Lisa

The opportunity to complete postgraduate study; even though it posed a challenge:

"The postgrad stuff really sold it for me at the time, actually, um the idea of getting to do some further study" Michelle

"I'd heard from people that had done both NETP and NESP that NESP was a lot harder but that it was a lot more beneficial and had more of a purpose

and it was harder work but it kind of because you had the [postgraduate] certificate you were kind of working towards a purpose. Which I really agree with it was a hard year but...well worth it” Pat

Participants valued the relevance of NESP coursework; it helped to make sense of what mental health nurses do:

“...doing the [NESP] coursework, it just gave me a better understanding of what I was actually doing” Anne

Participants identified that NESP had greatly increased their understanding and changed their perspective of mental health:

“Well, it has changed my perspective in it a lot...I just had this...belief...I thought it would be a certain way from the [undergraduate] placement that I had” Alice

“I am learning a lot more, I am studying in areas that I find really interesting and gaining a lot more information” Nat

This category indicates that NESP validates mental health as a nursing profession. The increase in knowledge and the level of support that new graduates have access to changes their perspective and they realise that they have chosen a worthwhile occupation.

5.4.5.5 Category 5 – Socialisation, validation and acceptance

‘Socialisation, validation and acceptance’ is a significant category with 35 findings. The topic infiltrated much of the conversation in the interviews. It relates to the sub-theme of ‘Professional identity’ because many of the findings refer to the influence that successful socialisation has on the development of professional identity. If a new graduate is accepted into the clinical area, they feel validated and socialisation into the culture of nursing has started. Failure to be accepted disrupts this process and results in alienation from the profession overall.

Participants described negative clinical experiences. These were interpreted as a form of rejection from the whole profession and caused participants to question

whether they were suitable for nursing. Support from educators is considered less influential:

“my preceptor and I we were on different wavelengths, so even though I was supported by [tertiary education provider], the nursing staff, I didn’t feel supported by them at all to the point where I left er, my placement and I just didn’t think I would ever become a nurse, it made me feel really, really, bad I didn’t think I would be successful as a nurse” Barbara

Another participant described a situation where some students were accepted, while others were not:

“...many nurses told me that if you liked that area, let the charge nurse know and they might...say that they would put a good word in for you...or they would want you for a...NETP position...this is what the nurses told me, the other nurses who’d been through the NETP programme...tell the charge nurse, and ...I said I wanted to stay on here if I had the chance and she said oh no that doesn’t happen, she said you’re wrong that doesn’t happen and then when the nurse asked me, she said did you talk to the I said oh she said that doesn’t happen, she looked at me very puzzlingly and I said it’s all right, I sort of felt, yeah {considerable hesitancy} Elizabeth

This led to a professional vulnerability and indicated there were elements of favouritism. This was alluded to by other participants:

“then I went to my [next mental health] placement... they didn’t really want students so...I spent the whole time in the office doing my work, I went on one visit the whole time I was there” Alice

“...who got the job that I was going for initially...fitted into that ward culture a lot better ...that was working against me a wee bit” Sam

In contrast, experiences where students felt validated suggested they felt accepted into the professional environment. This was particularly powerful if the situation involved acceptance of personal circumstances:

“During my second year, I became pregnant with my son so I was going to placements and my preceptors they were aware of that and they were very supportive in that regard and er yeah, so I managed to go on my placements and then towards the end of the year, I had my son so that, that, worked out fine for me” Barbara

Reflected a talent in the individual:

“I even got a report saying that I’ve got a bit of, and I quote “Knack” for mental health” Sam

Or involved a connection between the student and a professional individual:

“I had actually spoken to the head of theatre and had a really long conversation with her and I thought that might go towards something but you know even though I had not had a placement there, I thought I would give it a go” Nat

Individual health professionals have a significant influence on how participants view their integration into the nursing profession. Just as negative experiences leave students questioning their suitability, positive experiences act as reassurance that they will be included:

I sat next to a lady who was, erm, a mental health nurse and I think that had some influence, she was lovely and I just felt a connection with her”
Elizabeth

“Erm, one of the ladies came up to me in the interview and she had seen some of my previous work, and I had worked at [name removed] she was like you know, that’s already a base for mental health why don’t you come over there you’ll be great” Nicole

Mental health became more attractive as an option when feedback from mental health nurses indicated an individual could do the job. Exposure to the mental health environment resulted in participants realising the importance of the role. This happened when participants perceived they were making a difference:

“I was a case manager there and I had a small caseload of my own and I had these four teenage girls that I was working with individually on one of my sessions and just making the impact I did, just being able to see the change from week to week and just knowing that you know by them coming to see me and doing some work they were, you know, they were doing better at school and they were able to do more things. They had anxiety” Anne

“...actually sitting down and talking with them and digging a bit deeper so that’s why I like this area, we get to know our guys so well which is really cool” Rebecca

“forming those really strong therapeutic relationships with those patients, like I was really sad to leave and my patients were really sad that I was leaving, like they didn’t want me to go and that was really touching, and I found that I got a lot from that placement” Nat

These findings indicate the socialisation into the nursing profession occurs when new graduates recognise that they can fulfil the role and receive validation from others.

When participants were successfully socialised into the mental health environment, they invested in the professional identity of a mental health nurse:

“I wouldn’t go anywhere else...I’ve just fallen in love with the job. I never imagined that I would, but now I don’t see myself doing anything else.”
Anne

“...and I do feel like I’m really glad that I’ve gone down this pathway and I really love it and it meets all things I like about nursing and want to do as a nurse and stuff like that” Kay

“I have found my niche here I love mental health and I...really love forensics” Rebecca

“I’m actually much more satisfied being where I am now than where I potentially could have been I’ve got no intention to go back to [med-surg] anytime soon” Sam

The use of subjective language indicates the connection is personal as well as professional. The moral sacrifice that participants made due to the need for a job has been re-established, because they are now personally invested in the profession.

One interesting aspect of this code was how participants that had been successfully socialised began to perceive the medical and surgical environment. Comparisons continue to be made between the two as if they are separate occupations. However, med-surg now becomes the unpopular, less important area of nursing:

“I was talking to someone the other day and we were actually thinking that this is real nursing and physical health is kind of like is just like a care giver, I mean you get people up and shower them and take their blood pressure and that kind of thing, whereas here you’re really dealing with a hallucination or things like that, you’re really you know doing things for them instead of just taking their blood pressure and giving them medications” Anne

Once mental health is accepted, the physical skills associated with medical and surgical nursing lose their importance.

Other aspects that are criticised include the hierarchy:

“I’ll pursue it [mental health] hands down I wouldn’t go back into [med-surg] not after hearing what some of my colleagues have said...they do enjoy it but it’s a very hierarchical system. It’s a lot more collaborative over here and after three years of nursing training I’m certainly not gonna be pushed around. I do have a degree in my own right” Sam

The concept of socialisation is significant when considering the experiences of new graduates, it is a subtle influence and many participants were unaware that it had

happened. Successful socialisation was evident in the language used and how perspectives changed towards mental health.

5.4.6 Summary

The journey through the undergraduate degree has a significant influence on students' perceptions of nursing as a profession. The heavy emphasis on physical health and the dearth of mental health content results in the two areas being segregated. Mental health nursing is not considered as part of the profession of nursing. Participants suggested that they invested considerable energy into developing their professional identity and this concluded with the transition placement. Their clinical choices for ACE reflected where they perceived their professional career would begin. Failure to obtain a position in their preferred clinical area disrupted the socialisation process, but this was resumed once they commenced NESP. Inclusion in the new graduate programme helped to resolve the lack of experience and knowledge about mental health and the support provided by the programme helped to successfully socialise new graduates into the mental health profession. Once this had happened, participants continued to segregate mental and physical health but they viewed the former as more valuable.

5.4.7 Theme – ACE is omnipotent

The Compact Oxford English Dictionary (2003) defines omnipotent as “...having unlimited or very great power” (p. 785). ACE controls all access to new graduate programmes in the DHBs in New Zealand. It is an omnipotent system. It forces applicants to become strategic and more flexible in their choices for their new graduate clinical environment. It also guarantees some applicants will fail. Anticipation of failure compels applicants to either conform and ‘guess the right answer’ or rebel and ‘beat the system’

The exclusiveness of ACE has caused significant confusion. This has prompted applicants to analyse and interpret their experiences and try to make sense of the reasons why certain people succeed. The conclusions they have reached are then passed as rumours to other students preparing to apply. These rumours have a significant influence on NG career choices and are perceived as advice that will

help applicants to succeed. Rumours are perceived as helpful suggestions to help navigate through ACE and so applicants place considerable faith in the validity of them. The reality is that they are inaccurate and contain stigmatic attitudes to mental health and addiction that dissuade applicants from considering NESP.

Sub-theme one is focused on how participants perceive the ACE process. It segregates applicants from ACE and the language used suggests that participants viewed ACE as a system that was not to be trusted. The categories in the sub-theme support the theme that ACE is omnipotent because they provide a comparison between the power that ACE has over the future careers of new graduates and the vulnerability that applicants feel when they must conform to the process (fig. 4).

Sub-theme two relates to the subjective connection between participants and their identity as nurses. Throughout the undergraduate programme students are developing a personal relationship with the nursing world. They are already influenced by the societal perception that nursing is a vocation and this concept is validated as they progress through their studies; success in clinical environments provides reassurance that they are suited to the role and their identity as nurses begins to develop. Participants measure their suitability for nursing using very subjective criteria; there is a need to enjoy the experience, it must be personally rewarding (fig. 4).

The ACE process of reducing applicants to a series of objective ranking criteria has removed the influence that these personal connections have on new graduates' career prospects and the effort that participants have made is perceived to have been wasted because it is not taken into consideration. Prior to the introduction of ACE, new graduate nurses could gauge the likelihood of securing a position in their chosen clinical area based on how well they fitted into the environment. The participants in this study are still using the same measures and they feel alienated from the vocation when they do not secure a position in the clinical area they most identify with.

SUB-THEMES

THE SYSTEM

Applicants are segregated from ACE and participants viewed ACE as a system that was not to be trusted. The categories in the sub-theme provide a comparison between the power that ACE has over the future careers of new graduates and the vulnerability that applicants feel when they must conform to the process.

NURSING AS A VOCATION

Participants are influenced by the societal perception that nursing is a vocation and this concept is validated as they progress through their studies. The exclusivity of ACE has increased competitiveness in applicants; they need to secure a position to gain access to the DHBs. The decision to accept NESP because of the need for work is a betrayal of the nursing vocation.

PROFESSIONAL IDENTITY

The omnipotence of ACE has changed the significance of transition placements, but undergraduates continue to be influenced by the culture of transition. This causes distress for applicants who are not successful because they perceive rejection from the nursing profession.

THEME

ACE IS OMNIPOTENT

ACE controls all access to new graduate programmes in the DHBs in New Zealand. It is an omnipotent system. It forces applicants to become strategic and more flexible in their choices for their new graduate clinical environment. It also guarantees some applicants will fail. Anticipation of failure compels applicants to either conform and 'guess the right answer' or rebel and 'beat the system'.

Figure 4: Over-arching theme - ACE is Omnipotent

Sub-theme three represents the development of professional identity. The process of moving from undergraduate student to new graduate nurse has traditionally happened during the transition placement. Students invest considerable time and effort becoming integrated into the nursing team, consolidating their knowledge and skills with the aim of beginning their professional career in that environment. The omnipotence of ACE has changed the significance of transition placements, but undergraduates continue to be influenced by the culture of transition. This causes distress for applicants who are not successful because they perceive rejection from the nursing profession (fig. 4).

The omnipotence of ACE has influenced some new graduates to choose NESP because they perceive they have no other choice. They are influenced by the need to get a job and the prospect of being excluded from all DHBs leaves unsuccessful applicants with limited opportunities to find nursing positions elsewhere. The limitations that ACE places on eligibility criteria results in new graduates having to decide between working and waiting to try again. Each time an applicant applies through ACE they are six months further away from their undergraduate training and have no practical experience to fall back on. The result is that applicants feel more daunted and less hopeful of success.

ACE has introduced a new approach to recruiting new graduates. This is an example of the powerful influence that ACE has. Applicants have not adapted to the ACE system yet. They continue to be guided by the previous influence of transition placements. ACE has created a discordance and this is influencing applicants' clinical choices. ACE maintains its dominance of the recruitment process by giving information that creates an air of mystery. The algorithm is an unknown entity; applicants have no idea how it works and so it demands faith in the system. The findings suggest the concept of fate, ACE is unpredictable and elusive and this inspires resentment in applicants who consequently find the process traumatic.

5.5 Summary of chapter

The findings from the participant interviews have revealed the influence that ACE has on the personal and professional socialisation of new graduates into nursing.

Analysis of the interviews revealed three sub-themes relating to participants' experiences of ACE and their transition from student to practising nurse. These sub-themes underpinned one over-arching theme that ACE is all powerful. The ACE process has changed the recruitment of new graduates because it controls employment into all the DHBs in New Zealand. The interview with the NESP coordinator gave insight into the ACE process from the perspective of the employer and as a form of data triangulation supported the analysis of the participant interviews.

6 Chapter 6 – Discussion

6.1 Introduction

The purpose of this chapter is to identify and discuss factors that stem from the findings and consider them in relation to the themes from the literature review. The discussion begins with a comparison between the coordinator and participants' interviews and consideration of the discrepancies between these different perspectives of the ACE process. The second part of the chapter is focused on exploration of three topics that have evolved from analysis of the findings.

The sub-themes that stem from the findings all relate to the influence that ACE has had on the process of transition from student to registered nurse. 'Marginalisation and successful socialisation' is the first topic and has evolved from all three sub-themes. It is argued that failure to secure a new graduate position through ACE can be a marginalising experience for applicants and this can have a negative effect on socialisation. Consideration is also made of the influence that NESP has on resolving the marginalised experience and supporting the socialisation of new graduates into mental health nursing.

The second topic explores the influence that the concept of 'Nursing as a vocation' can have on the marginalised experience of new graduates. This contributes to the concept of marginalisation and explores assumptions that are made regarding what should motivate a new graduate to accept a position in NESP. The final topic is 'The culture lag created by ACE'. This relates to the over-arching theme that 'ACE is omnipotent' and the sub-theme professional identity. The topic stems from the fact that ACE has changed how new graduates are recruited into NETP and NESP.

6.2 Comparison between coordinator and participant interviews

The interview with the NESP coordinator explained the DHB's responsibilities in the recruitment process. A comparison between this information and the findings from the participant interviews highlighted that applicants held a misconception that ACE had significant control over entry into the new graduate programmes. This assumption contributed to the participants' belief that the recruitment

process is a paper exercise and had no consideration for the individuality of applicants. In fact, ACE has no influence over the interview or assessment of candidates and that is stated on the ACE website (ACE, n.d.2, para. 15). Another significant difference is related to the participants' belief that applicants were selected only using impersonal criteria. On the contrary, the assessments made during the interviews include consideration of personal attributes as well as academic and clinical performance. The NESP coordinator gave a detailed explanation of the role of assessors and the subjective criteria used to identify whether candidates had an aptitude for mental health nursing.

The NESP coordinator also clarified the misapprehensions that have contributed to the rumours influencing applicants' clinical choices. The belief that choosing mental health and addiction cancelled out NETP is inaccurate. The two programmes are separate, but this is only for funding and eligibility reasons. The ACE application gives access to both NETP and NESP, not one or the other. If a candidate does not put down mental health and addiction, they will only be considered for NETP. If they include mental health as a choice, they will be considered for both NETP and NESP. Due to the smaller numbers expressing an interest in mental health and addiction, candidates are more likely to be called for interview if they specify an interest in mental health and addiction, but this does not guarantee a position.

There was validation of the findings from participant interviews that many applicants were confused about the influence that clinical choices have on securing a new graduate position. The contradictory advice that candidates had received from varied sources had contributed to the confusion and indecision about which areas to choose. However, the NESP coordinator confirmed that choosing three specialised areas can limit a person's opportunities and suggested that one area of particular interest and two broad choices was the best option. The number of DHBs identified in the application is also a major influence on applicants' chances for securing a position. ACE advises applicants that they have a better chance of success if they choose three DHBs because more possibilities become available (ACE, n.d.2, para. 1-5). However, DHB choice was not discussed in the interviews

with as much consideration as the clinical choices made. Participants briefly referred to the reasons they could not move to a different DHB; indicating that the decision is more black and white.

The NESP coordinator also alluded to the influence that ACE had on changing the significance of the first new graduate position. The confusion that new graduates are currently experiencing leads them to place too much emphasis on the importance of their first clinical area. The fluidity of nursing as a career is highlighted and the point is made that after completion of the NESP programme, people can move around different clinical areas. This challenges the assumption that starting a career in mental health excludes nurses from opportunities in other health environments. It also emphasises that there is not an expectation that completion of NESP will result in nurses only wanting to work in mental health. The findings from the NESP coordinator interview highlight the need to address the segregation between mental health and medical-surgical environments by acknowledging that the nursing workforce can and will move between the two during their careers.

This emphasis makes an interesting contribution to the concept that nursing is a vocation. During the recruitment interviews the assessors are considering whether candidates have the personal attributes that would complement mental health nursing and whether applicants have a 'passion' for the speciality. This suggests that an interest in mental health is a precursor to being offered a position and therefore people would be discouraged from accepting a position just because they want a job. However, it is also evident from both the coordinator and the participant interviews that NESP has the potential to change attitudes towards the validity of mental health nursing. It is suggested that many assumptions made about nursing as a vocation are held sub-consciously and are contradicted by the influence of the NESP programme.

6.3 Marginalisation and successful socialisation

A significant factor that has been revealed by analysis of the findings is the concept of marginalisation and how it relates to the socialisation of new graduates. The

literature review for this study included one article that considered marginalisation in relation to new graduates (Duchscher & Cowin, 2004). In the article, Duchscher and Cowin (2004) refer to the alienation that new graduates experience while making the transition from student to practising nurse. The findings of this study suggest that many of the experiences that participants described related to the theory of marginalisation suggested by Duchscher and Cowin (2004). A new search of the literature was conducted to identify whether there were other articles relating to this topic. Only four articles were found that gave further insight into the concept of marginalisation; none of these related to the experience of new graduates. Two of these articles were written nearly a century ago and are considered the pioneering work relating to the concept of marginalisation in society (Duchscher & Cowin, 2004). They are included in this discussion because aspects of the arguments are still relevant to the findings in this study.

The concept of marginalisation was originally suggested by Park (1928). In a study of the experiences of migrant people, Park (1928) identified “a period of inner turmoil and intense self-consciousness” (p. 893) relating to the transition between two cultures. Although Park (1928) is referring to the experiences of people belonging to different ethnic or religious cultures, he also suggests that these feelings can be attributed to less permanent situations. It is proposed by Park (1928) that “it is in the mind of the marginal man – where the changes and fusions of culture are going on – that we can best study the processes of civilisation” (p. 893). This quote supports the qualitative methods used in this study. The use of semi-structured interviews and thematic analysis have provided opportunity to explore the marginalised ‘mind’ of new graduates as a way of understanding the processes of transition into nursing and how this has been influenced by ACE.

It has been suggested that new graduate nurses experience a “transient marginalising situation” (Duchscher & Cowin, 2004, p. 290). Until they are successfully socialised into the world of nursing, new graduates exist between the realms of academia and clinical practice (Duchscher & Cowin, 2004). An article by Hall, Stevens and Meleis (1994) identified seven characteristics that define

marginalisation; 'Intermediacy', 'Differentiation', 'Power', 'Secrecy', 'Reflectiveness', 'Voice' and 'Liminality'. The study conducted by Hall et al. (1994) is focused on the marginalisation of users of health services. However, each of these factors can also be linked to the findings of this study and have revealed the complexity that relates to the marginalising experience of a new graduate.

The first characteristic, 'Intermediacy', refers to the boundaries that distinguish between different groups. These boundaries are influenced by various factors, including "individual perception...and cultural influences" (Hall et al., 1994, p. 26). For this study, the participants suggested boundaries that separated mental health from the nursing profession. This segregation is evident from the findings in the category 'Stigma and discrimination' under the sub-theme 'nursing as a vocation'. Participants recalled that they had believed mental health was not 'real nursing' and that this had been influenced by the perspectives of family, peers and society. It is acknowledged in the literature that this is a common misconception (Happell, 1999; McCann et al., 2010). The findings also indicated that participants did not consider mental health as a viable career because it was not adequately covered in the undergraduate programme; a finding that is also substantiated in the literature review (Edward et al., 2007; Happell & Gough, 2012; Henderson et al., 2007). The participants of this study placed significant importance on the development and maintenance of physical health skills and identified the loss of these as a reason for not considering mental health as a potential career option. This evidence supports the concept of the cure-care dichotomy suggested by Stevens and Crouch (1995) and suggests a significant boundary between mental health and the rest of the nursing profession.

Other boundaries that are indicated in the findings relate to the segregation of applicants who failed to secure a position in NETP from those who were successful. The category of 'Alienation' that underpins the sub-theme 'Nursing as a vocation' in the findings of this study, identifies the exclusion felt by participants when they did not receive an offer. These feelings related to personal characteristics; participants concluded that they were not good enough to be accepted. It is suggested, therefore, that applicants inadvertently began to consider themselves

as a marginalised population when they were excluded from NETP. It is also argued that these feelings were amplified when participants had to consider joining NESP to secure a new graduate position. Their preconceptions that mental health was separated from the rest of nursing created an additional marginalising experience. This suggestion is upheld by the findings in the 'Stigma and discrimination' category regarding assumptions that participants made about the experiences they would encounter while working in mental health. References to fear, not being physically strong enough and "having to work on those gross wards" (Alice) along with a concern that they would lose their physical health skills indicate that participants felt excluded from the nursing profession and instead forced to join a peripheralised occupation that would affect their career prospects.

A final boundary that is suggested in the findings, relates to the distinction between new graduates who chose NESP because they are interested in mental health and those who joined because they needed a job. The reactions of participants when they talked about the motivation for joining mental health ranged between shame and defiance. It is suggested that applicants who join NESP because they need a job will be more at risk of marginalisation than those who joined for more 'noble' reasons. This argument will be elucidated later in the chapter because it also relates to other characteristics of marginalisation.

The second category identified by Hall et al. (1994) 'Differentiation', describes the development of identities that define the marginalised group. As segregation occurs, the dominant group differentiates between themselves and those people who have been marginalised. This again relates to the negative perception of mental health by the rest of the nursing profession. The belief that mental health is not real nursing is a form of peripheralisation (Gouthro, 2009). One of the examples that Duchscher and Cowin (2004) identify as a marginalised population is people with mental illness. In addition, it has been suggested that mental health nurses experience stigma by association, (Gouthro, 2009) and so it is feasible to conclude that mental health nurses experience differentiation from their nursing colleagues. The same can be said for new graduates who join NESP.

The discussion by Hall et al. (1994) alludes to the comparison between the collective identity of the dominant group and the differing identities within marginalised groups that serve to separate them further and maintain peripheralisation. However, the findings by Humble and Cross (2010) and Moir and Abraham (1996) suggest that members of a marginalised group can develop their own identity that positively distinguishes them from the dominant group and creates an inclusive relationship between members. In both these studies, participants discussed their reasons for joining and committing to the mental health profession. In doing so, they distinguish between mental health and the rest of the nursing profession and perceive mental health as more important than other nursing disciplines. Although Humble and Cross (2010) and Moir and Abraham (1996) do not specifically discuss marginalisation in their articles, both studies are focused on the experiences of mental health nurses; a marginalised group. It is feasible, therefore, to relate their conclusions to this discussion. In addition, there is evidence in the findings for this study, under the 'Socialisation, validation and acceptance' category, that participants had invested in the inclusive identity as mental health nurses as they were successfully socialised into the profession.

This phenomenon also alludes to the idea that applicants who accept NESP out of necessity are at risk of inadvertently experiencing marginalisation from peers who chose mental health because of an interest in the area. Both the articles by Humble and Cross (2010) and Moir and Abraham (1996) are focused on nurses who chose mental health nursing. Those new graduates who chose mental health to secure a job may perceive themselves as different from the group who want to be mental health nurses and this results in a differentiation which serves to isolate them further (Hall et al., 1994).

The third characteristic, 'Power', is described as the hierarchical influence that the dominant group has over the marginalised one. The definition of this characteristic includes the words 'authority' and 'control'. The category 'Powerlessness' in the findings of this study provided insight into the behaviour of participants in response to the control that ACE had over the recruitment process. Although the article by Stonequist (1935) was written over 80 years ago, his observations of

how marginalised populations respond to the authority of dominant groups remains relevant to this study and although Stonequist's writing has been cited many times since 1935 none of the articles consulted were as pertinent to this study as the original message. It was suggested by Stonequist, (1935) that people would either seek acceptance from the powerful group or they look for inclusion in the ostracised group. Those who sought the latter option and remain resentful of their exclusion often rebelled against the controlling power (Stonequist, 1935). The findings of this study provide examples of all these responses. In the category 'Powerless' that informs the sub-theme 'The system', findings indicated both the attempts made to conform with the requirements of ACE and the growing resentment and cynicism that hinted at the potential for rebellion. The participants of this study continued to seek acceptance from the powerful group, but were rejected and instead sought admission into the ostracised group represented by mental health nursing.

It is suggested by Hall et al. (1994) that the dominant group relies on power to maintain their authority. They argue that the marginalised group will attempt to achieve "horizontal power" (Hall et al., 1994, p. 28) as a way of taking some control back. This occurred when some of the participants in this study began to view mental health nursing as superior to medical and surgical environments and therefore more important. Another example of "horizontal power" is evident in the category of 'Rumours' that underpins the sub-theme 'The system'. These findings suggest that previous applicants of ACE have handed down advice to help others navigate the system and re-establish some control. All the rumours identified in this study were presented as warnings to help applicants avoid making mistakes and reducing their chances. They were perceived by participants as helpful and were highly influential. One rumour gave the impression of an attempt at rebellion. The suggestion that leaving mental health as a hidden fourth option if the applicant does not achieve any of their other choices could be interpreted as an effort to 'beat the system'.

The fourth characteristic identified by Hall et al. (1994) is 'Secrecy'. It is suggested that the dominant group withhold information from the marginal group as a

method of maintaining control. In the category 'Confusion' that underpinned the sub-theme 'The system' participants of this study described perplexity regarding how ACE worked. This related to a lack of understanding about the process, how the algorithm worked and which aspects of the process were the responsibility of ACE. The description of this characteristic specifies that the marginalised group are often "...stymied by bureaucratic red tape because they do not know the "secrets" or shortcuts that insiders are privy to" (Hall et al., 1994, p. 29). The argument by Hall et al. (1994) suggests that the dominant group is actively secretive with the intention of creating confusion. This study is not implying that ACE is purposely confusing applicants, on the contrary, significant effort is made to explain the process and maximise the applicants' opportunities for success. However, evidence from the findings indicates that the process remains confusing and this contributes to the marginalising experience of new graduates. A comparison between the categories 'ACE is ineffective' and 'Positive aspects of ACE' that sit under the sub-theme 'Nursing as a vocation' reveal that participants resented the unyielding bureaucracy of the ACE process but valued aspects of ACE that allowed for flexibility and acknowledged the individuality of applicants. This indicates that elements of the process that students found less confusing were those they perceived as beneficial. The aspects that were perplexing related to those factors that were viewed as complicated and inconvenient.

Another factor that relates to the characteristic of secrecy is the influence that NESP has on new graduates. Under the sub-theme 'Professional identity' the category 'Inadequate undergraduate preparation' reveals that many participants did not consider mental health because they did not feel they had studied the subject sufficiently. This issue is also raised in the literature as a contributing factor to poor recruitment of new graduates into mental health (Happell, 2008; McCann et al., 2010). The findings of this study reveal some interesting insights into the effect of removing secrecy and how this affects the professional identity of new graduates. The NESP programme includes specific mental health theory and supported clinical practice; in effect revealing of the 'secrets' of mental health nursing. The category 'Advantages of NESP' that informs the sub-theme 'Professional identity' highlights the influence of relevant postgraduate study and

clinical placements as contributing to the perception that mental health was a valid career. Elsewhere in the findings, participants described the realisation that mental health is highly skilled and experiencing that mental health nurses can make a difference. The clarification of the theory behind mental health nursing, additional exposure to clinical environments and support from veteran nurses, peers and educators encouraged professional socialisation and resolved the feelings of marginalisation.

Characteristic five relates to 'Reflectiveness' (Hall et al., 1994). It is suggested by Hall et al. (1994) that traumatic "subjective experiences" (p. 30) separate a marginalised person from the dominant group. In response, the individual internalises the event, becomes introspective and begins to adopt the stereotypes that are enforced by the dominant group (Hall et al., 1994). The result is a developing sense of isolation that fragments a person from both the dominant group and the marginalised one. For this study, the subjective experience would be failing to secure a NETP position; a traumatising experience compounded by the fact that it is perceived as an inevitable outcome for some applicants of ACE. Participants were forced to consider their situation in comparison with those applicants who were accepted. In the category 'Alienation' that underpins the sub-theme 'Nursing as a vocation', participants described analysing themselves when they did not secure a NETP position and concluding that they were not good enough to be accepted. For some participants, failure to secure a position came as a shock, for others the marginalising experience had begun in the undergraduate programme. All the participants found the experience traumatic and felt a separation from both peers and the nursing workforce.

The description of this characteristic parallels the development of self-stigma; another marginalising experience. According to Corrigan, Bink, Schmidt, Jones and Rusch (2016) self-stigma occurs when a person agrees with and adopts the negative stereotypes imposed by society. The result is a reduction in self-esteem and a decrease in the motivation to challenge the stigma. The marginalised person reflects on their subjective experience, recognises that they are separated from the dominant group and consequently adopts the characteristics that are assigned to

the marginalised population as an explanation for their experience. In this study, some participants had already begun to accept the inevitability of failure, others had not. Some participants sought feedback from ACE to help them make sense of why they were not accepted, others rejected this option because of the alienation they felt. The differing processes of reflection indicate that participants invested considerable effort in making sense of the difficult situation they found themselves in.

The developing acceptance of self-stigma is evident in the findings of this study. For the participants, this involved accepting that they were not good enough for NETP and instead had to settle for NESP. An argument that is supported by the relief that Rachel felt when told that failure to accept a position was due to clinical choices rather than personal reasons. It is also evident from the assumptions that other participants made that they were not wanted. The findings in the category 'Wanting a job' provides other examples of the acceptance of stereotypes. The emotional responses of participants indicate that they believed that they were less deserving of being a nurse because they were motivated by needing a job. The hesitancy and whispering of Alice and Nicole suggests embarrassment and a fear of being 'caught out' and judged. Barbara became defensive and rationalised her decision; while Lisa alluded to desperation and an apologetic: "I just had no option because there were no jobs". The response given by Pat further supports the discomfort that participants felt by their motivation to accept a NESP position. There is a definite attempt to separate from the others by specifying "that didn't really apply to me because I wasn't doing it just to get a job. I wanted a job that I actually wanted". This comment is further evidence that the belief that nursing is a vocational occupation is highly influential. It reinforces the stereotype that those who are motivated by the need for a position are less deserving, contributes to the development of self-stigma and compounds the marginalising experience.

The sixth characteristic identified by Hall et al. (1994) is 'Voice'. This is described as a form of communication developed by marginalised populations that distinguishes them from the dominant group (Hall et al., 1994). In permanently marginalised populations this often relates to language, however, Hall et al. (1994)

also refer to a construction of “experience in the form of storied knowledge” (p. 32). In this way, marginalised groups preserve their history and develop a narrative as a form of facilitation for future members (Hall et al., 1994). In this study ‘storied knowledge’ is an effective way of explaining the development and influence of ‘Rumours’, the category that informs the sub-theme ‘The system’. These are passed as advice from applicant to applicant as an attempt to help people navigate the ACE process. The content of such communications is described by Hall et al. (1994) as an interactive process that serves to readdress the power imbalance experienced by marginalised groups. The rumours identified in this study provide a sense of solidarity; new graduates are supporting their peers and preparing the way for future generations. Through the process of relating actual events, the narrator develops context around the experiences of marginalised people and these ‘stories’ become highly influential both to the marginalised person and as an opportunity to alter the relationship between the dominant and subversive groups (Hall et al., 1994). In the findings for this study, participants describe the significant influence that rumours had on their clinical choices and the belief that the advice given was reliable. This indicated a change in the power and influence from the dominant group; in this case ACE, and the marginalised one; new graduates. The information provided by ACE was replaced in significance by the recalled experiences of previous applicants.

Another aspect of ‘Voice’ identified by Hall et al. (1994) relates to the use of language. It is argued that the hierarchical influence of the dominant group results in information being conveyed using the language of those in power (Hall et al., 1994). This further segregates the marginalised population because they have less understanding or experience of the language used. This concept is evident in this study; participants described the confusion they felt regarding the expectations of ACE and the limited effect of explanations. As Alice explains: “Erm, we had someone come to talk to us... and she just went through how it all works and everything, but we were all quite confused afterwards still about how it all worked”. The presentations conducted by ACE representatives are created by people who work for ACE and use language that other ACE employees understand in context. This does not necessarily translate to the applicants who are trying to

make sense of the process from the outside. This argument is further supported by the responses participants gave to presentations conducted by previous students: “we had some past students come...they were better” from Michelle. The findings indicate that participants place more value on the information that is conveyed by people who have been through the same experience; stories from previous applicants and advice that is intended to help has more power than the information that is given by the dominant group.

The final characteristic identified by Hall et al. (1994) is liminality. The Compact Oxford English Dictionary (2003) defines this as “Relating to a transitional or initial stage of a process” (p. 653). Evans and Kevern (2015) assert that the concept of liminality is rooted in anthropology, and is attributed to the work of van Gennep (1909) and later developed by Victor Turner (1966). Although Turner’s work is over 50 years old, it remains highly influential in modern-day exploration of liminality (Evans & Kevern, 2015) and his observations are relevant to the findings of this study.

In anthropological terms, the liminal state is frequently associated with rites of passage and is distinguished as a period when an initiate is between two worlds (Turner, 1966). The effect of this experience is anonymity; the initiate is without social status or influence and is expected to conform to the dominance of the group they wish to be accepted into (Turner, 1966). If the individual shows humility and obedience they will proceed through the transition and be recognised. If accepted, the initiate is then able to create an identity within the group (Turner, 1966). In the context of this study, the successful applicant begins the development of professional identity through completion of NETP or NESP. The category ‘Strategic’ that underpins the sub-theme ‘The system’ gives examples of how participants attempted to navigate the ‘rite of passage’; the ACE process and join the NETP programme. Applicants tried to conform, they obeyed the instructions of ACE and deliberated over their clinical choices as the key to success.

Those applicants who fail in the process, or ‘rite of passage’ develop “altered and intensified perceptions of...self-image that characterise and result from marginalising experiences” (Hall et al., 1994, p. 33). For the participants in this

study, these altered perceptions relate to the assumption that they were not good enough to join NETP. The change in self-image can be related back to the earlier discussion regarding self-stigma and the sense of alienation. It is suggested by Hall et al. (1994) that the experience of liminality can result in a shift in belief about the individual's rightful place in the world. For the participants of this study, that shift related to a change from the assumption that they would begin their nursing careers in NETP and develop professional identities as medical or surgical nurses. The period of liminality that all new graduates experience as they pass from academia to clinical practice was prolonged for the participants of this study. The failure to be accepted by the group they were transitioning towards, caused a change in direction. In addition, the assumptions made about the motives of ACE, the beliefs about the unfairness of the process and the trauma that resulted from the recruitment experience have all been influenced by the sense of being marginalised.

Although marginalisation is presented here as traumatic, Andersson, (1995) argues that there are positive aspects to the experience. Citing the work of Ktuithof (1990), Andersson (1995) supports the belief that marginalisation can inspire creativity and individual growth. People who are marginalised can examine and challenge the norms and values held by the dominant group (Andersson, 1995). This has the potential to effect change in societal perceptions and result in better outcomes for all (Ktuithof, 1990, cited in Andersson, 1995). The findings of this study provide an example of how this has happened within the NESP programme. The participant interviews revealed that negative stereotypes were held about mental health nursing before people were obliged to accept a place on NESP. The positive influence of the programme enabled participants to challenge the misconceptions they held and reconsider mental health as a viable career. Several new graduates who would have possibly continued to hold stigmatic beliefs about people with mental illness have changed their perspective. The NESP programme has enabled participants to see that they can make a difference; they are effective mental health nurses and they belong in the profession. The result of successful socialisation is the ability to challenge the stigma and discrimination that exists towards mental health consumers and nurses from within.

6.4 Nursing as a vocation

The findings for this study highlighted that some assumptions about mental health nursing are very subconscious and did not become obvious until rigorous exploration of qualitative data had been completed. This researcher began this study from a curiosity that new graduates were joining the mental health workforce even though they had no interest in a career in mental health. The findings from the interview with the NESP coordinator also identified that a passion for mental health was considered important when selecting candidates. The participants expressed embarrassment and shame that they had accepted NESP because they needed a job rather than having an interest in mental health. These views are also upheld in the literature. Happell (1999b) raised concern that the mental health workforce could not sustain itself if the focus was merely on raising numbers. Instead, Happell (1999b) suggests that mental health nursing "...requires nurses with the knowledge, skills, and perhaps more importantly the desire to work within this field" (p. 483). These examples indicate the powerful belief that mental health nursing is a vocation and suggest that mental health nurses find it unacceptable that new graduates would join mental health for any other reason than a passion for this field of nursing.

The concept of nursing as a vocation has roots as far back as biblical references (Lundmark, 2007). Florence Nightingale referred to 'good nurses' as being called from God (Lundmark, 2007). These factors make a connection between the theological calling attributed to religious leaders and the relationship between the nurse and their occupation (Lundmark, 2007). The concept of vocation is also linked to the caring aspect of the nursing profession (White, 2002). It is argued by White (2002) that nurses are valued by the people they care for because of the personal nature of the relationships formed rather than technical expertise. Therefore, if a nurse perceives their role as vocational they attribute morals and values as intrinsic to the profession (White, 2002). The issue of whether people should pursue nursing as a job has evoked passionate counter-argument (Miller, 2007). Nurses are uncomfortable with the prospect that a person will become a nurse for the wrong reasons. It is perceived and defended that students should be

led to nursing by more moral and ethical motivations than wanting to earn money (Miller, 2007). A study completed by Eley, Eley, Bertello and Rogers-Clark (2012) supports the belief that many people embark on a nursing career because they perceive it as their vocation.

The concept of nursing as a vocation is significant to this study for several reasons. The embarrassment expressed by participants in the category 'Wanting a job' suggests that new graduates are not only aware of the belief that nursing is a vocation, but also that they perceive that they have betrayed their 'calling'. This contributes to the marginalised experience of applicants who accept a position in NESP because they needed to find work. The care-cure dichotomy (Stevens & Crouch, 1995) reinforces the perception that mental health nursing is vocational because it is considered a caring profession; separate from the more scientific nature of medical and surgical nursing. In addition, the stigma that is attributed to people with mental illness encourages mental health nurses to become protective of the people they care for (Humble & Cross, 2010). This may provide an explanation for the belief that new graduates should only pursue mental health if they have an interest in the area. It is suggested by Humble and Cross (2010) that mental health nurses adopt the role of advocate to protect the people that they care for as an attempt to counter societal discrimination. If the mental health nursing workforce includes people who have no interest in mental health, they are at risk of upholding the negative stereotypes that are held by society and this presents a challenge for protecting people.

Nevertheless, the reality is that new graduates are now faced with a very stressful, competitive system of recruitment that guarantees a percentage of applicants will not be successful. It is understandable that after three years of study, a substantial student loan and the need to find a job, applicants will accept a position in a programme that was not their original choice. The profession should be aware of the effect that this can have on new graduates when they are judged for making this choice, however subtly. If a new graduate recognises that their decision to accept NESP is disapproved of by their colleagues, it creates another form of marginalisation. Not only from the mental health profession but also from their

peers; those new graduates who chose mental health for more noble reasons. The fact that this researcher did not recognise the potential damage this belief can have on a new graduate suggests that the concept of mental health nursing as a vocation is infiltrated throughout the workforce. This adds to the potential that new graduates will consider themselves as imposters and this can affect their performance and ability to socialise into the mental health profession.

The mental health nursing workforce needs to challenge the belief that only people interested in mental health are suited to the profession because this contributes to the marginalising experience of new graduates who choose NESP out of necessity. It also supports the misconception that new graduates who accept mental health because they have no other choice will not be effective mental health nurses. The evidence from the findings of this study is that NESP is very effective at supporting new graduates to socialise into the mental health workforce. It is suggested, therefore, that the reason for joining mental health is less important for recruitment and retention than the motive for staying in the profession after completion of NESP.

6.5 The 'socio-cultural lag' created by ACE

The concept of 'cultural lag' (Ogburn, 1922, cited in Schaefer, 2010) originally referred to the discordance that occurs when material culture changes and non-material culture has yet to adapt. The concept was originally developed by Ogburn (1922, cited in Schaefer, 2010) to explain the impact of the industrial revolution on society. Material aspects of society advance much faster than cultural norms, values and ethics. The result is a period of maladjustment that continues until the two aspects are realigned (Ogburn, 1922, cited in Schaefer, 2010). The phenomenon was renamed socio-cultural lag by Allen (1971, cited in Brinkman & Brinkman, 1997) because it was argued that lags also occurred in social circumstances. The theory of socio-cultural lag has some relevance to the context of this study.

The introduction of the ACE process has changed the way that new graduates are employed into the nursing profession. The over-arching theme that 'ACE is

omnipotent identifies that ACE is all powerful. It controls access to NETP and NESP and has removed the significance of the final undergraduate clinical placement. The traditional method of recruiting new graduates placed a heavy emphasis on socialising into the transition placement (Major, 2010). Students were encouraged to integrate into the ward team and begin the transition process to new graduate nurse during their final semester as undergraduates (Nash, Lemcke & Sacre, 2009). The transition placement was therefore considered very carefully by students and the expectation was that they would chose an area where they wanted to start their career (Major, 2010). According to the analysis report provided by ACE for mid-year 2015, 53% of all applicants were placed into new graduate positions. Of these, 67% gained employment in the clinical area where they completed transition (ACE, 2015). This means that only 29% of all applicants were employed by the area they transitioned in. These statistics suggest that the ACE process has unintentionally removed the significance of the transition placement as a first step for new graduate career pathways. Instead it effectively draws a distinction between undergraduate experience and new graduate opportunities. The 'Transition placement' category that underpins the sub-theme 'Professional identity' indicated that participants invested considerable effort integrating into their transition areas. Consequently, they felt a sense of betrayal and rejection when they did not secure a new graduate position. The fact that participants selected their transition placement even when they had not had a positive experience is a further indication of the significance this final undergraduate clinical experience had on perceptions of professional identity. In some cases, participants chose the transition area over mental health even though they had enjoyed the latter placement more.

These factors provide evidence that undergraduates have not adapted to the change in recruitment. The participants of this study described feelings akin to grieving. The confusion they experienced is common when a socio-cultural lag exists and people within the social group grieve for 'the way things used to be' (Ogburn, 1922, cited in Schaefer, 2010). The group of new graduates who participated in this study applied through ACE soon after it was introduced and the undergraduate programme was still influenced by the previous emphasis on

transition placements. It is reasonable to assume that the nursing profession will acclimatise to the changes that ACE has caused and that future generations of new graduates will find the process less traumatising.

6.6 Summary of chapter

This study has highlighted that ACE has a temporary marginalising influence on new graduates. The recruitment process is dominant and the applicants are subversive. The experience of applying through ACE creates liminality akin to a 'rite of passage'. Those who succeed in acquiring a position proceed to develop professional identity in the dominant group; those who do not are forced down a different route. Unsuccessful candidates must decide whether to abandon their calling into NETP and instead accept NESP. This creates a vulnerable group of new graduates that are subject to the ACE recruitment process.

Candidates still place emphasis on the transition placement as the starting point for their career. The reality, however, is that most applicants through ACE will not gain employment in the area they transitioned in. Those applicants who failed to secure the clinical position they wanted have been forced to consider areas deemed less attractive. They experience rejection and alienation because they have not been accepted into the field of nursing they identify with. They are also at risk of experiencing marginalisation within the group they have joined because of the subconscious reinforcement that a new graduate must begin with a passion for the area of nursing they pursue. However, the findings of this study also suggest that the NESP programme has enough influence to successfully socialise reluctant new graduates into the mental health profession.

7 Chapter 7 - Conclusion

This chapter concludes this study. First, there is a summary of the research process and a discussion of the findings in relation to the research questions. Second, there is a consideration of the limitations of this study. Finally, recommendations are made in relation to the findings and the discussion chapter.

This thesis has used an instrumental case study research design to explore the factors that influence new graduates to accept a position in NESP. There has been specific consideration of the influence that ACE has on clinical choices made by applicants. Semi-structured interviews were used to collect the perspectives of fourteen new graduates who had been recruited into one NESP programme but had not specified mental health on their ACE application form. A further interview with the NESP coordinator was completed as a form of data triangulation and provided insight into the employer's experience of ACE. In addition, this interview also contributed to interpretation of the findings from the participant interviews.

Thematic analysis was used to identify themes from the findings. This process revealed one over-arching theme that 'ACE is omnipotent' and three sub-themes; 'The system', 'Nursing as a vocation' and 'Professional identity'. A comparison of these findings with the literature review identified a strong correlation with the concept of marginalisation and how this relates to the socialisation of new graduates. In addition, the belief that nursing is a vocational occupation had a significant influence on the attitudes of participants and their decision to accept a position on NESP. Finally, the concept of culture lag was explored in relation to the influence that ACE has had on the recruitment of new graduates.

7.1 The influence of ACE

The introduction of ACE for recruiting new graduates has had a significant influence on applicants. The process is highly competitive and this causes considerable anxiety. For those applicants who are not chosen in the first round, the competition becomes more intense because they enter the talent pool and must enquire about positions that are still available. This creates a marginalised

population within the cohort of graduating new graduates. Those who have positions become the dominant group; accepted into the nursing profession. Those in the talent pool perceive themselves as ostracised. The interview with the NESP coordinator confirmed that most of the positions available to the talent pool are in NESP. This highlights another marginalising experience; mental health is ostracised from the nursing profession because it is not considered real nursing. Many applicants in the talent pool must consider a career in mental health if they want to secure a new graduate position and this creates another marginalising experience. Those new graduates who accept NESP because they needed a job are segregated from their peers who want to be mental health nurses. This marginalisation is influenced by the belief that nursing is vocational; participants for this study expressed embarrassment and shame when explaining their reason for accepting ACE. This is due to the assumption that nurses are motivated by more moral objectives than needing to earn money.

This population of new graduates are more at risk of vulnerability and attrition from the nursing profession because they have already been rejected from the clinical area they are interested in. The participants of this study identified alienation and rejection as significant experiences during the ACE process. The fact that they have become part of a workforce that is considered, by other nurses and society, to be less than real nursing compounds the sense of being ostracised. It is reasonable to assume that these new graduates are at greater risk of leaving the workforce altogether.

However, ACE has also started to breakdown the segregation of mental health from the nursing profession. The pressure to secure a new graduate position is forcing some new graduates to consider mental health as a start to their career. Many of the participants for this study supported the belief that mental health is not real nursing when they started NESP. Many intended to move to a medical or surgical environment after they had completed NESP. The experience of further education and clinical experience changed their perspectives, validated mental health as a rewarding career and now they plan to stay. It could be argued that

many of the participants for this study would not have considered joining the mental health workforce if ACE was not so competitive.

7.2 Recommendations

- The ACE process remains confusing to new graduates despite efforts to provide explanation. Further clarification is needed to explain the ACE process to applicants, particularly the role of the DHB
- Participants found the ACE presentations confusing. This is possibly due to the use of 'insider' language that is unfamiliar to applicants. Many participants talked about the benefit of having past applicants come and talk about their experiences. ACE could consider consulting previous applicants to help develop resources, and clarify some of the terminology used
- ACE could introduce visual aids to help clarification of the process and expectations
- The website could use more bullet-points rather than prose to explain the process; these would be easier to refer to.
- ACE could amalgamate the information relevant to applicants from the Business rules and statistic reports; some information is only present in these reports and is easily missed.
- ACE could consider bi-annual presentations so applicants receive information when they need it rather than six-months before; alternatively, ACE could record the presentation and make it available on their website
- ACE needs to provide more clarification about the relationship between NETP and NESP with specific reference to the inaccuracy of rumours.
- Education providers need to address the mental health content in the undergraduate courses because this contributes to the marginalisation of mental health nursing in comparison to physical health.
- The coordinators of NESP need to remain aware of the vulnerability of those new graduates who have joined out of necessity.
- Finally, there needs to be consideration of the existence of socio-culture lag when a new process is introduced and consideration of how to support

those who are vulnerable because of the change. It is suggested that undergraduate education providers, new graduate programme coordinators, ACE and the DHB employees responsible for recruitment consider how to prepare applicants for this change in process and resolve the confusion around the significance of transition placements. This would help to reduce the alienation and vulnerability of those applicants who do not receive places in their chosen clinical areas.

7.3 Limitations of this study

This study has only focused on applicants who did not secure a position in the first round of ACE. It is understandable that this group would be resentful of the process they perceive has let them down. A comparison study of successful and unsuccessful applicants would clarify whether the unpopularity of ACE is consistent across all new graduates. In addition, this study only examined one NESP programme in New Zealand. There are variations in the delivery of NESP across the country and so the effectiveness of NESP in supporting new graduates to socialise into mental health may not be generalisable to other areas.

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This document is 7 pages long, including the Consent Form. Please make sure you have read and understood all the pages.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of the study is to identify what individual factors can influence a new graduate to choose a placement on NESP. The aim is to find possible relationships between these factors and whether the ACE interview process has had any impact on the decisions you have made. This information will help build an understanding of the new graduates' experience of ACE. In addition, it will add valuable insight to existing research about graduate nurses' career choices.

The study will be conducted by a student of the University of Otago to contribute to a Master's Qualification. The student will work under the direct supervision of two experienced researchers employed by the University. You may contact any or all three of these people via email or phone.

WHAT WILL MY PARTICIPATION IN THE STUDY INVOLVE?

You have been chosen to participate because you are enrolled on the NESP programme with the CDHB and the University of Otago. If you have entered the programme as a new graduate and used the ACE interview process, you are an ideal candidate.

Initially the study will involve collection of specific details such as age, gender and ethnicity. You will also be asked to include the clinical and DHB choices you made on your ACE application form and how many times you have applied through ACE.

Depending on the answers given, you may be invited for an interview to further discuss your experience. If this is the case, you retain the right to refuse without any further contact or consequences. It is anticipated that the interview will take approximately 1 hour.

WHAT ARE THE POSSIBLE BENEFITS AND RISKS OF THIS STUDY?

The study has no focus on your health status and you will not be required to disclose any sensitive information. The study has no bearing on your current education status, employment or future career. The information collected will be anonymous and will remain in the possession of the researcher. Once the data has been analysed and the report is written up, all copies of the information collected will be destroyed.

WHO PAYS FOR THE STUDY?

There will be no costs incurred during this study. The interviews will be arranged at a location and time that does not require extra travel or parking costs.

WHAT ARE MY RIGHTS?

Participation in this study is entirely voluntary. You are free to decline to participate or withdraw from the research at any practicable time, without experiencing any disadvantage to your education or future career.

You have the right to access any information collected as part of the study and will have the opportunity to check any transcripts of interviews to ensure accuracy of content and context.

Participants selected for interview will be contacted via email or telephone. The interviews will take place in a private room with no chance of being overheard. Any information recorded during the interview, or transcribed afterwards, will have all names and identifiable information removed. The data will be saved in encrypted files on the researcher's own computer. Hard copies of recorded interviews will be kept in a locked box in the researcher's possession.

WHAT HAPPENS AFTER THE STUDY OR IF I CHANGE MY MIND?

Once the study is complete all data will be destroyed securely. Electronic files will be deleted permanently from the computer and interview recordings deleted. You are entitled to receive a copy of the report. If you wish to please indicate on the consent form at the end of this document

WHO DO I CONTACT FOR MORE INFORMATION OR IF I HAVE CONCERNS?

If you have any questions, concerns or complaints about the study at any stage, you can contact:

*Name, **Dr. Dave Carlyle***

*Position: **Senior Lecturer in Mental Health Nursing***

Telephone number:

*Email: **dave.carlyle@otago.ac.nz***

Consent Form



Please tick to indicate you consent to the following

I have read, or have had read to me in my first language, and I understand the Participant Information Sheet.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I have been given sufficient time to consider whether or not to participate in this study.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I have had the opportunity to use a legal representative, whanau/ family support or a friend to help me ask questions and understand the study.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I am satisfied with the answers I have been given regarding the study and I have a copy of this consent form and information sheet.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I consent to the research staff collecting and processing my information.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If I decide to withdraw from the study, I agree that the information collected about me up to the point when I withdraw may continue to be processed.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I understand that my participation in this study is confidential and that no material, which could identify me personally, will be used in any reports on this study.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I know who to contact if I have any questions about the study in general.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I understand my responsibilities as a study participant.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I wish to receive a summary of the results from the study.	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Declaration by participant

I hereby consent to take part in this study.

Participant's name:

Signature:

Date:

Declaration by member of research team:

I have given a verbal explanation of the research project to the participant, and have answered the participant's questions about it.

I believe that the participant understands the study and has given informed consent to participate.

Researcher's name:

Signature:

Date:

Demographics for Interview Selection

Name (Optional): _____

Email address: _____

Alternative Contact: _____

Age: _____

Gender: _____

Ethnicity: _____

Preferred clinical area/s **before commencing** undergraduate degree

Preferred clinical area/s **after finishing** undergraduate degree

How many times have you applied to ACE? _____

Please list the clinical areas you chose on your ACE application form

1. _____
2. _____
3. _____

Please list the DHBs you chose on your ACE application form

1. _____
2. _____
3. _____

11 Appendix 2 – Interview questions: New graduates

The main aim of this interview is to gather an understanding of how the ACE recruitment process has influenced your decision to accept a place on NESP. I also want to explore are any other factors that may have been influential. Please consider how your attitude to mental health has developed and changed over the course of your study both as an undergraduate and a new graduate.

1. Could you tell me what information you were given about the ACE application and the CDHB recruitment process (consider formal and informal sources)?
2. What advice have you been given by other students, tutors and nurses about which clinical areas to identify on your ACE application form?
3. What was your experience of the ACE application process?
4. What was your experience of the interview and recruitment process?
5. Do you consider ACE to be an effective method of placing new graduates?
6. Please tell me about your clinical experience as an undergraduate?
7. How influential was your clinical experience on your clinical choices for the ACE application?
8. Were there any other factors that influenced your choice?
9. What are your thoughts about a career in mental health nursing?
10. Is there anything else you would like to tell me?

12 Appendix 3 – Interview questions: NESP coordinator

The main aim of this interview is to gather an understanding of the ACE application and the CDHB recruitment process and how you identify potential candidates.

1. Please explain the criteria for accepting a person into NESP.
2. What specific qualities or capabilities are you looking for in applicants?
3. What information in the ACE application form influences your decision to interview someone?
4. How has the ACE application process influenced recruitment?
5. What are the advantages and disadvantages of the recruitment process both nationally and locally?
6. How do you attempt to fill spaces after the first recruitment round?
7. What support is available for pre-NESP students?
8. Is there anything else you would like to tell me?