



Developing Criteria for the Selection of Contemporary Stimulus Material in Mental Health Nursing Education: Engaging Students and Meeting Curriculum Goals – Part 2: 'Authenticity' in Design and Core Values for Stimulus Material for Enquiry-Based Learning in Mental Health Nursing Education

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Purpose: To test the value of mental health stimulus material created/used by Australian academics to achieve learning outcomes through assessment tasks for students from a range of cultural backgrounds.

Methods: Case studies centred on two groups of students–Australian (Part 1) and those enrolled in Australia as international students (Part 2).

Results: The development of i) a set of principles for choosing 'authentic' stimulus material ii) a set of recommendations for choices of assessment tasks that ensure application of the principles irrespective of the culture and context in which graduates choose to work.

Conclusion: Stories taken from authentic clinical practice in mental health can be used in the education of undergraduate mental health nurses in curricula reliant on blended learning provided they are culturally comprehensible and selected according to core values for undergraduate mental health nursing courses and to guidelines for problem-based or enquiry/situation-based learning.

Keywords: Psychiatric/mental health nursing; Education; Cross cultural mental health; Stimulus material

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INTRODUCTION

"When I first began to work in Japan some 15 years ago, I began to realize that there were universal problems and so I thought there were universal solutions. However, over time I have come to think that while there are universal problems in many cases there are only cultural solutions. In our exchange of knowledge, we will not encourage the adoption of any particular solution. Rather we will ask how the unique political, economic and cultural factors of a country might influence the usefulness of any particular solution." (Underwood, 1999).

In Part 1 of this paper, approaches to online teaching and learning were reviewed, along with a summary of different types of simulation and blended (online and face-to face) learning in use today with undergraduates undertaking mental health nursing courses. The possi-

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bility of using authentic stories, clinical anecdotes taken from actual nursing practice in mental health nursing, was explored as one way to involve undergraduate students in real life situations. Responses to a selection of these stories from some Australian students were included.

This paper, Part 2, will look at responses from international students and then discuss ways to link authentic stories from clinical practice with a recommended framework for a curriculum for pre-registration mental health nursing programs and also to provide assessments which are strongly linked to this framework defining learning outcomes.

As Underwood (1999) remarks above there is a temptation to see universal problems in the teaching of mental health nursing regardless of culture or context. The following reflection, written by one of the authors of this paper, mentions the similarities of behavior in patients wherever they are; but also highlights an educational focus on physical care rather than on psychosocial care, and notes that this may makes the use of problem-based learning approaches difficult to implement in the first place, without a shift in educational focus.

As a mental health nurse of more years than I care to remember I am constantly kind of surprised about how familiar the mental health environment is when I visit and teach in China, Japan, Indonesia and Thailand. Even without speaking the language it is clear to see that clients experience the same kinds of emotions and respond with similar behaviours. Where the major contrast lies is in nursing responses to the clients. Stigma about mental health in South East Asia is generally a lot stronger than in the West. As a result, many people spend many years institutionalized and nurses, like the general public, tend to be somewhat wary of those with mental health problems and at a loss as to how to talk to them. Undergraduate education emphasizes physical interventions and there is little emphasis on psychosocial approaches. In my experience students in these countries at both undergraduate and postgraduate level have little experience in problem solving approaches in the classroom, and they may need some input on psychosocial approaches before being introduced to the types of stimulus material we use in the West.

This reflection is supported by comments from a Chinese nurse academic:

When talking about mental health there are many thoughts in my mind. As a nurse, most of us are not clear about how to communicate with patients who have mental health problems. Actually, we do have the course [on] mental health nursing in [our] school, but I don't think it's working. I think there are two reasons. I'm working as a teacher of nursing, every year there will be about one thousand nursing students [who] graduate and most of them will [become] a nurse,

but as far as I know, none of them wants to be a mental health nurse: First, the course of mental health nursing is an elective course; they have a very short class—one hour. Second, as suggested, stigma about mental health in China is a big problem; once someone has mental health problems, even his or her family will feel ashamed... in our language most time the word "psychiatric hospital" was used as a swear word, others will laugh at you if they know that you went there. I think the standard of the diagnoses of mental health illness is confused (Sun Yan Wan Wan, personal communication).

One of the authors of this paper reflected on attitudes to mental health patients in both Korea and in Australia:

Although Korean society has been trying to change in many ways e.g the healthcare system, approaches to mental health appears to be one area where difficulties endure. Mental health issues historically were treated as a curse and a taboo, unlike physical illness. I still remember how I felt when I went on a clinical placement in a mental health unit as a nursing student.

There was 'a lock up system' in place to enter the unit, the nurses' station was locked up and also there was a room where staff could place a patient who was acting out and [where the patient could] be restrained. Although some patients were sharing a room with between 4-6 others, this was common at times regardless of the type of unit. The patients were required to come to the common area in front of the nurses' station and queue up to have their medication. As a student I recall an impression of being scared for those patients, but pretended not to be. When I read their progress notes and histories, it was not uncommon to see the families had hidden the fact that the patient had mental issues or continually denied this. I could also feel the general atmosphere and nurses' attitude towards those patients with mental health issues. This situation had not changed much when I visited another mental health unit in the same province as an academic to supervise students' clinical placement almost 20 years later.

In Australia too, undergraduate students usually gain all their more specialized knowledge of mental health nursing from a single undergraduate unit offered over a semester, and with stigma still being an issue, the clinical speciality is not a popular choice among new graduates (ACMHN, 2018). However the writer of the above reflection noticed some changes in attitudes to mental health patients in Australia:

I have not had an experience of mental health settings in Australia, but in the area where I've been working, the patients and residents in those areas also have mental health issues. Given this, I could see the local nurses (including me) dealt with those people with more open and accepting attitudes than I had experienced back home. I think the difference in approach follows from the values espoused in society and

the general culture of trying to embrace the patients as people with illness rather than associated with a curse or something bad.

A reflection from a Japanese nurse academic made several telling points which support the above and also expand on them.

Japanese people became aware of the surging numbers of mental illness in our society, and certified nurses in mental health have been registered and providing education for health professionals across Japan. However, stigma remains strong.

I asked 3rd-grade nursing students in what speciality they want to work after graduating university for the past 5 years. Only a few, if any, preferred to work in mental health each year.

When Japanese nursing students are among their counterparts from other Asian countries as well as Western countries, Japanese students did not take initiative in group discussions but kept on being passive listeners. It [appeared that this] was not only caused by language problems but also deeply-rooted culture. Therefore, they may require more assistance to benefit fully from interactive education.

When I attended clinical practicum in Australia, I felt that general nurses lack the knowledge and skills of mental health. Also, mental health nurses lack the knowledge and skills of physical health (Mieko Omura, personal communication).

Once again, the reluctance of student nurses to enter the specialist field of mental health nursing is described, although efforts to develop education for the field are also described. Problems of using interactive methods in education are raised, with the reason suggested being not only language difficulties but also unfamiliarity with this style of teaching. The final comment is made about Australian nurses where the author notes a “blinkered” outlook because medical-surgical nurses are not conversant with mental health nursing skills while mental health nurses lack skills in physical assessment, which is disturbing given the growing number of reports about the poor physical health of mental health patients overall (McCloughen, Foster, Huws-Thomas & Delgado, 2012).

Core concepts in mental health nursing education—principles for choosing authentic stimulus material

One of the authors of this paper also considered teaching material and its development, noting the need for the developer of this material to encourage critical thinking with the use of authentic patient experiences. It has been said that the curriculum reflects what faculty are aiming for but the assessment system shows what the students are actually taking away from their classes.

When working in South Korea as an academic we used real cases of patient experiences when developing learning/teaching materials for nursing students. When I developed my teaching materials with real cases, it gave the students a chance to have a greater sense of reali-

ty by embedding strategies aimed at encouraging the students' critical thinking. Realistically this ambition was the most difficult point in my quest for active learning. I could see some teaching staff members were struggling themselves to apply basic principles of problem-based learning (PBL), as their personal experience as students was so different in the past and [in] developing the materials to give the students a real sense of becoming the contemporary competent professional. After all, working in the field requires whoever is developing the material to also think a lot. Once the material was well developed I could see the students were having fun and engaged with the material better. One of the challenges of active learning that remains to be overcome centres on the attitudes of the developer of learning materials.

Applying core values in teaching material and curriculum design

The Australian College of Mental Health Nurses (ACMHN, 2018) produced a National Framework for Mental Health Content in Pre-registration Nursing Programs (ACMHN, 2018) identifying six core values which are recommended to underpin undergraduate mental health nursing courses. Each core value is linked to a learning outcome reflecting that value.

Core value 1

Mental health consumers have a right to lead their recovery process. Carers and significant others have a right, with the consumer's consent, to collaborate in the recovery process.

Core value 2

Mental health consumers have a right to be cared for and treated by nurses who have appropriate knowledge, skills and attitudes in mental health.

Core value 3

Mental health care and treatment involves advocating for mental health consumers, challenging discrimination and using a human rights framework.

Core value 4

The essence of mental health care and treatment is the establishment and maintenance of a therapeutic relationship with mental health consumers, carers, and significant others.

Core value 5

Mental health care and treatment incorporates the ability to plan, develop, implement and evaluate evidence-based initiatives that promote mental health, prevent and intervene early in illness, facilitate recovery, and promote wellbeing.

Core value 6

The recovery of mental health consumers is supported by mental health care and treatment that is broad and positively focussed on strengths and wellbeing (ACMHN, 2018)

The framework focuses on recovery and strengths, and emphasises the importance of advocacy and of the therapeutic relationship, as well as the need for evidence-based care. It is noteworthy that Core value 4, the maintenance of the therapeutic relationship, is expanded to include respect for a person's dignity, culture, values, beliefs and rights, and a recognition of the importance of understanding a person's cultural background as part of establishing that therapeutic relationship.

Authentic clinical anecdotes can be selected so as to stimulate discussion of these core values irrespective of the suite of symptoms reflecting either or both mental or physical health breakdown. Assessing knowledge of evidence-based care can be achieved by quizzes, or a variety of case-based assessments and development of and reflection on care plans; a deeper understanding of the core values is more easily gained through facilitative and collaborative discussion about shared experiences or responses to new patient care situations.

The six core values are followed by recommendations for twelve core components of every pre-registration mental health nursing course, including consideration of the "effect of cultural and social factors in mental illness on individuals, families and communities, for example, ethnicity, gender, LGBTIQ [sexual orientation], migration and refugee experiences, poverty, discrimination" (ACMHN, 2018).

Curriculum design is at the core of effective education; to achieve good design we need to discover the essentials of current nursing knowledge and best practice. "Probably the most important issue in designing constructivist environments is authenticity" (Jonassen, Davidson, Collins, Campbell & Haag, 1995) – from this "context, construction, collaboration, and conversation" (Jonassen et al., 1995) can be used both to plan teaching material, engage students and finally assess student learning, especially if the assessment is based on group work and group discussion, although this is only one possible assessment method.

Those elements of design are still relevant and in the contemporary e-learning environment there are potentially more opportunities for encouraging an enquiry-based approach within learning activities. This does mean discarding the irrelevant and outmoded, but not necessarily the difficult and often perplexing content which comes from real life examples. This is where authentic stimulus material is crucial, especially in a subject like mental health nursing which values ability to establish a thera-

peutic relationship and engage in therapeutic communications for which there is no "script" or "blueprint". Guiding principles and overarching concepts may be outlined; students may then develop understanding of these by exploring authentic stimulus material with their discussions being facilitated by educators who have clinical experience in the field.

However, if authentic stories from clinical practice are the central feature of the stimulus material, their very authenticity means that not all will demonstrate the core values listed above; therefore careful selection of all stimulus material offered over the entire program is needed, to ensure all values are included in a given selection of stories. Similarly, different educators and different student groups may not all discover or focus on the same topics or themes or values because these authentic stories are open to several interpretations or the educator may choose to highlight particular aspects of each story in order to cover what is outlined in the curriculum and/or to meet expectations for undergraduate or postgraduate study.

"What is learned (the meaning that is constructed by the learner) is indexed by the experience surrounding the learning, which assigns meaning to what is learned. As a result, what is learned in the process of solving real-world problems is much richer and better understood because of this indexing. Because classroom lectures provide little of this richness, few connections are made. Situated learning and social construction theorists also believe that learning is necessarily a social, dialogical process in which communities of practitioners socially negotiate the meaning of phenomena. That is, learning is conversation, and the thinking and intelligence of a community of performers or learners is distributed throughout the group. Knowledge and intelligence is not the privilege of an individual, but rather is shared by the community of practice" (Jonassen et al. 1995).

Recommendations for assessment tasks which are not culturally specific

"Constructive alignment (CA) is an outcomes-based approach to teaching in which the learning outcomes that students are intended to achieve are defined before teaching takes place" (Biggs, 2014). The ACMHN guidelines provide such learning outcomes. It is crucial that learning outcomes are assessable for the required skills, abilities and knowledge at the required standard. They also need to be relevant to the course being taught, and attainable for the student within the time set for the running of the course (University of Newcastle, 2018). Almost any content topic in any subject is taught so that students put that content to work in some way: to solve problems, to construct hypotheses, to apply to particular situations (Biggs, 2014).

When stories from clinical practice are used they will need to be organised according to overarching principles so that they can be used to explore and then assess agreed core concepts in men-

tal health nursing education. If a story does shows an aspect of care which was 'messy' or which seems initially not to be an example of best practice, it can still be used as stimulus material, as students discuss what could have been done better or why the episode of care ended as described in the story. "There is a broad concern that the reification of models of learning and teaching, while meeting organisation needs for transferable, multi-use products, will dominate and stifle professional practice development" (Moule, 2007).

Teaching and learning online in diverse cultures

Story 3 (see Part 1) is useful for the facilitator to stimulate discussion of an episode which initially appears not to be an example of best practice, although subsequently the nurse achieved a good result from what began badly. An international student comment on this story read "*The phrase 'Here is the smallest violin' is completely inappropriate and unprofessional in this particular setting. It should not have been said*". However, the student made no other comments on this story nor on the first two, apparently finding Story 3 the one which most captured her attention. Further interrogation prompted by a facilitator in either a traditional classroom or within an online forum, was warranted in an effort to encourage the student to provide a rationale for the reaction.

Learning design creates the pedagogy but as Salmon (2011) reminds us, it is the empathetic teacher and this human intervention which allows the learning; "self-awareness, interpersonal sensitivity and the ability to influence" are crucial qualities in online teachers (Salmon, 2011).

Online learning is "neutral" because there is often no image of the student so students can find encouragement to "be themselves" (Salmon, 2011). This means that programmes of study which seek wide access and openness, "crossing industry, professional and international boundaries and applying research to practice are therefore well served" (Salmon, 2011). However there are particular considerations which need to be taken into account when the student group is drawn from many different cultures and these include styles of address and the associated hierarchy and authority; view of women; a reluctance to ask questions of an instructor as this is viewed as disrespectful; critiquing; making personal disclosures; and not using preferred names (Salmon, 2011)

METHODS

In a project which received Ethics Approval from both the University of Newcastle and the University of New England (H-2016-0269) undergraduate mental health nursing students were

presented with three authentic clinical anecdotes (see Part 1) and invited to write their responses to them based on a framework of six questions (What are the consequences of the actions described? What are the intended consequences? What results are beneficial? What results are not beneficial? How could things have been done better? What results were unexpected?). The first group of students who were invited to participate responded at the end of the trimester in which they undertook their mental health nursing course (see Part 1) but the second group responded at the beginning of the trimester in the following year, i.e. the second group was a new enrolment to the course. Both groups included a large number of 'international' students who might return to their home countries as well as Australian students. The second group responded after completion of a three day intensive in which all major course content was taught as a block. The third group who were invited also enrolled at the beginning of the new trimester but were on campus students; once again, this group contained a large group of international students.

A small group consisting of one tutorial group from off campus enrolment with both Australian and international students in it was provided with paper copies of consent, information statement and stories with survey to allow an opportunity to respond without going online. Two on campus tutorial groups were the final groups to be provided with paper copies as an alternative to responding online. In these two groups most of the international students were from Nepal or from the Philippines, although there were also some from India, China and African countries.

RESULTS

The outcome of considerable efforts to target international students appear to confirm the previous commentary on the differences in responses to mental health issues across cultures. While two international students signed the paper consent they did not complete the survey at all; another returned both signed consent and completed form. When one of the authors of this paper approached several colleagues in China and Japan for their reflections on the teaching of mental health nursing in their countries only two responded.

A response from one international student showed a lack of understanding of the basic facts outlined in Story 1 with the comment *Being left in the community with no help* being given as a consequences of the actions described in the story, although the story clearly describes a transfer from an inpatient unit to input from the afterhours team to a booked appointment at the community health centre following this. This may reflect a cursory reading of the story or a lack of understanding of how the differ-

ent teams in an Australian mental health service interact in the transfer of care. However, an Australian student was similarly confused about this, commenting on results not beneficial *No results or plan for care nor history or risk assessed* which also reveals a lack of understanding of how the process of care unfolded. Neither student noticed the synchronous breathing.

DISCUSSION

Choices about stimulus material for nurses warrant careful consideration. These stories were selected because they were considered to be open to many interpretations that a facilitator could cause students to explore and to include interpretations being made by students from different cultural backgrounds. In Story No 1 ‘mindfulness of the breath’ can be understood not just by Australian students who have learned this technique either as part of a mental health nursing course or for their own personal development; in Story No 2 ‘cultural beliefs about suicide’ and ‘cultural constraints about nurses showing emotion in front of patients’ can be rich sources of discussion; and in Story No 3 the idiomatic “the smallest violin in the world playing just for you” might puzzle Australian students as well as students from other countries because the literal meaning of this expression does nothing to suggest what it actually means when used ironically in a context such as the one described in Story No 3.

While the responses to the request for specific feedback on the narratives were limited they did cause the researchers to reflect on the students' responses to complex situations in mental health, the need to provide a contemporary framework of mental health nursing that might have application irrespective of culture and context and the need for any educator to review their approach at the end of each semester. While working in an online environment poses particular challenges for both teachers and students, it is important for the teacher to accommodate emerging technologies that are part of the daily experiences of students, health professionals and the consumers/clients themselves. Assessment will be to the forefront of any student's thinking and is the essence of learning. Hence careful thought needs to be given to what the assessment tasks are asking of students and the extent to which learning outcomes as a result of these tasks are instilling in students the values and processes that align judgments and actions with optimal patient care.

The low response rate across several large cohorts of undergraduate students, both Australian and international may reflect a discomfort with the specialty of mental health nursing and a reluctance to reveal this discomfort, although students were advised that there was no ‘right or wrong’ response. It may reflect a

different attitude to teaching and learning in the international group with an expectation of a didactic style of teaching and a very structured and closed curriculum. It may be a result of the lack of free time often experienced by students today who may also be working and raising families or supporting family members in other ways. It may be because at undergraduate level students cannot be expected to understand the value of nursing research. It may be simply an unwillingness to undertake anything which is not directly related to course progression and accruing enough marks to pass!

When considering cultural differences between different student groups, it may also be helpful to consider whether mental health nursing has its own distinctive culture (Holyoake, 2013), one which may be troublesome for any group of students to access and understand initially. That fact that there is no single “textbook” interpretation of the three stories (see Part 1) may suggest the very real difficulty of introducing students to this new nursing culture which, while sharing features with all branches of nursing, yet presents a way of working and thinking which has some features that are unique to the specialty. Common difficulties in interpreting the stories appeared in responses from both Australian and international students; similarly reflections from nurse academics from China and from Japan (see above) highlighted issues in teaching mental health nursing which are also common in Australia.

Students can be assessed on conceptual and information knowledge, professional employment related skills, common (generic) skills, and attitudes and values, all of which lend themselves very well to discussion of stories like the ones above. Students can be required to formulate a response to the situation/problem (taken from or reporting on actual practice) using appropriate frameworks e.g. a care plan, a plan of action, patient management plan, or a clinical record of intervention. Where the story describes a completed episode, students can be asked to propose alternatives or to justify the actions taken as described in the story.

PBL is a combination of five strategies simultaneously

Use of real world scenarios to provide a context for learning

A focus on thinking skills (critical thinking, situation analysis, problem-solving/clinical reasoning, reflection)

Integration (thinking, doing and being, and knowledge from different disciplines)

Development of self-directed learning skills

Use of small groups (not necessarily facilitated) to support collaborative learning.

Using authentic clinical anecdotes does fit with all of these. Stories come from the real world of practice and “unpacking” them calls for critical thinking and problem solving as well as a degree of personal reflection. A successful and in-depth understanding of these calls for integration of thought and potential action, and group work, whether facilitated or not, brings skills in self-directed learning.

The following checklist provides a guide to educators for the design of problem-based learning or enquiry/situation-based learning activities that place the students in the decision-making role e.g. as a nurse working in mental health. Some stimulus material will focus on particular concepts or assessment of particular learning outcomes within a PBL cycle ([Appendix 1](#)).

CONCLUSION

Although it proved very difficult to attract participants in the study both in Trimester 2 2018 and in Trimester 1 2019 the responses received showed that it cannot be assumed that students will read and comprehend the bare facts of a story, whether the student is ‘International or Australian’. Moving from the outline to an in-depth appreciation of what the nurse actually contributed to the patient’s care is therefore likely to be challenging. Each of the 3 stories are authentic anecdotes (see Part 1) and can be used as stimulus material for discussion of the elements of a true ‘therapeutic relationship’ that is needed in mental health care. Students can find this concept difficult to understand, often focusing on the basic skills of professional communication which they are taught early in their studies, and failing to appreciate that the therapeutic relationship in mental health nursing involves more complex communication skills and a nuanced and highly developed professional relationship. A superficial reading of Story number 1 may leave a student with a sense that the patient’s needs were disregarded unless the educator leads a discussion on the occurrence of the unexpected in that encounter; similarly a beginning understanding of what happens in Story number 2 may not lead the student to an appreciation of the genuine grief experienced by a nurse following a therapeutic relationship which ends in tragedy, and the importance of clinical supervision for all mental health nurses who care for vulnerable patients—rather students may reveal a sense that expression of feelings from the nurse is always inappropriate. Story number 3 can be used to stimulate a discussion of the power of an apology when a nurse inadvertently causes distress to a patient and the way in which genuine communication can eventually lead to a significant therapeutic outcome.

However an attitude which stigmatises and/or is fearful of

mental health patients is likely to prove a barrier to the sort of open discussions which a skilled educator could lead based on these stories. This will compound the difficulty of finding stories which are useful in teaching with students from diverse cultures. Thus there may be a culture of blaming or fearing or shunning mental health patients among nurses from many different countries (as described in the reflections above) along with misunderstandings likely to occur among specific groups of students because of stories about episodes of care which took place in cultures different from their own.

RECOMMENDATIONS

1. The opinions from educators teaching mental health nursing such as those in Asia should be sought by inviting them to reflect on the current methods used in their country (as the nurse academics from China and Japan do in the personal communications above).
2. A collection of authentic stimulus material from diverse countries should be made to minimise the likelihood of misunderstanding of patients/clients by students based solely on unfamiliarity with the particular cultural aspects.
3. These stories should be workshopped by a group of experienced educators from different countries to ascertain whether they are fit for purpose to prepare students for practice in Australia and whether they follow the guidelines set by the [AC-MHN \(2018\)](#).
4. Assessment tasks should then be linked to these guidelines which set out learning objectives. They could also be based on group discussion and group submission of a summary of that discussion thus linking them to real-life ways of working as a nursing team assessing patients and planning care.
5. Focusing solely on the mental health aspects of the story to the exclusion of physical assessment and care should always be avoided. In Australia undergraduate education is meant to be ‘comprehensive’ i.e. to address the range of symptoms that clients present to nurses; specialist education, while attempting to focus on a particular suite of symptoms, nevertheless also needs to take a holistic view of assessment and this should be incorporated into any discussion of authentic clinical anecdotes.

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Appendix 1. Enquiry/Situation-Based Learning Design Criteria (developed by Little & McMillan, 2017)

	Not at all	To some extent	To a reasonable extent	To a great extent
<p>Format: mental health subject/unit outline:</p> <ul style="list-style-type: none"> Relates to Objectives Is consistent with a list of curriculum concepts, principles, values Involves session plans including directions for discussion Provides scenario and related information to support learning outcomes Provides clear instructions or suggested approach to students Provides a facilitator guide (expected responses to suggested approach) Considers related learning events (clinical labs, lectures etc) (optional) Has a relationship to course/subject 				
<p>The stimulus materials (scenario, simulated activity)</p> <ul style="list-style-type: none"> Is realistic and authentic Relates to the concepts intended for learning Presents some aspect of the situation as "problematic" Requires the learner to adopt a role Provides a specific context (time, place, location, etc) Provides enough patient/client information for students to identify the problem(s) and to formulate relevant hypotheses Provides a sequence of situations that require a response. Requires the learner to make a decision or take an action Requires the learner to justify their decision or actions by applying the learning issues (concepts) to the specific situation Provides feedback on proposed actions or decisions taken. 				
<p>Instructions to students in the student guide (online or paper-based)</p> <ul style="list-style-type: none"> Provides a systematic approach to analyse the situation Provide the steps of a clinical reasoning strategy relevant to the profession or discipline Direct students to identify learning issues (relevant concepts) Requires the students to formulate a response to the situation /problem using appropriate frameworks e.g. care plan; a plan of action; patient management plan; a clinical record of intervention etc. Requires students to justify their response to the situation using relevant concepts Suggests resources (optional) 				
<p>The facilitator guide for team members provides:</p> <ul style="list-style-type: none"> Expected responses from students' enquiry and analysis of the situation or scenario e.g. list of problems; hypotheses; learning issues etc. The preferred response to the problem (or set of responses) e.g. plan of care; management plan Suggestions for learning resources 				