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Nursing and Midwifery Students' Perceptions of Clinical Readiness Following the Use of Actors in Mental Health Assessment Simulations

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ABSTRACT

Aim: To examine nursing and midwifery (N&M) students' self-reported readiness for their professional experience placement (PEP) following the use of real-life actors, combined with Objective Structured Clinical Assessment (OSCA), in a Block Model.

Design: A cross-sectional convergent mixed method study.

Methods: Quantitative data ($n = 234$) were collected via an online survey following OSCA completion. Qualitative data ($n = 22$) were obtained through face-to-face interviews after completion of the Mental Health PEP.

Results: Responses to the 10-item online survey revealed that students reported positively on their learning experiences and perceived preparedness for clinical placements. Demographic factors, particularly students' living area and employment status, significantly influenced readiness scores. Qualitative responses were categorised into eight themes: Skills and Knowledge, Person-Centred Care, Understanding Symptoms, Therapeutic Communication, Trauma-Informed Care, Strength-Based Care, Recognising Clinical Deterioration, and Mental State Risk Assessment. Seven key insights frequently emerged, with both quantitative and qualitative responses suggesting that students perceived the involvement of real-life actors during simulations and OSCA as enhancing their readiness for PEP.

Conclusion: Real-life actors provide an innovative approach that students perceived as supporting their confidence, self-reported skill and knowledge development, and transition to PEP.

Implications for the Profession and/or Patient Care: Combining real-life actors with OSCA better prepares N&M students for PEP and transition into the workforce. Practicing communication skills in realistic, actor-led scenarios strengthens students' therapeutic relationships and patient-centred care. Immediate, in-role feedback from real-life actors facilitates reflective practice, improving students' reported clinical reasoning and patient interaction.

Impact: This study highlights the need for educational methodologies that reflect real-life clinical environments to support students' professional development and perceived readiness for PEP. These insights are valuable for educators, curriculum developers, policymakers, and future N&M students, ultimately improving patient care quality.

Reporting Method: The qualitative methodology and outcomes followed SRQR and COREQ standards.

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1 | Introduction

Mental disorders affect more than a billion people, yet mental health systems remain under-resourced, fragmented, inequitable and often inaccessible (World Health Organisation 2025). In Australia, the mental health nursing workforce is predicted to have the largest undersupply by 2030 (Productivity Commission Report 2020). Nursing discipline in higher education institutions, like many educational settings globally, faces preparation-practice gaps, resulting from limited clinical placement opportunities and increasing complexity of healthcare delivery (Hickerson et al. 2016; Roberts et al. 2019). Concurrently, increasing demand for mental health services and global workforce shortages continue to place pressure on healthcare systems, highlighting the need for innovative educational approaches that better prepare future nurses for contemporary mental health practice (World Health Organization 2022). Within this context, mental health nursing education requires undergraduate students to develop specialised skills in therapeutic communication, mental state examination (MSE), and risk assessment (RA), which are vital for supporting patient recovery and ensuring safety (Fawaz et al. 2024).

Globally, accredited Bachelor of Nursing (BN) programs incorporate both theoretical and practical experience program (PEP) assessments, yet significant variation exists in pedagogical approaches, with many relying heavily on PEP for face-to-face patient interaction (Immonen et al. 2019; Lee et al. 2021). Nonetheless, PEP in Australia typically provides limited exposure of 160h to patients presenting with acute mental health symptoms (Nursing and Midwifery Board of Australia 2024). This limitation creates a critical gap in skill acquisition, thereby highlighting the urgent need for greater emphasis on core mental health competencies within the university context (Harris and Panozzo 2019).

To address this gap, mental health academics at Victoria University (VU) have integrated real-life actors into simulation sessions and Objective Structured Clinical Assessment (OSCA) to better prepare nursing and midwifery students for mental health PEP. OSCA is a structured assessment framework used to evaluate students' clinical skills according to assessment contents, methods and established learning objectives (Liu et al. 2024). Simulation is widely recognised as an effective educational strategy for replicating real-life scenarios, offering students the opportunity to develop critical clinical skills such as MSE and RA in a controlled environment (Inglis and Nelson 2020; Alexander et al. 2018). These simulations prioritise essential skills required for successful patient recovery, such as safety planning, self-awareness, emotional intelligence and positive risk-taking, thereby improving students' readiness for PEP and reducing the likelihood of restrictive practices (Fawaz et al. 2024). Existing literature demonstrates that participation in these simulation sessions enhances knowledge and confidence among undergraduate

nursing students (Cant et al. 2018; Davies et al. 2024; Kim et al. 2025; Lewer et al. 2026).

Given the substantial role of PEP within the educational curriculum, institutions globally utilise OSCA/OSCE and simulation to foster students' professional growth, clinical skills, PEP readiness and employability (Kassabry 2023). However, the specific impact of real-life actors in enhancing students' readiness for PEP remains unclear (Stockmann et al. 2019).

This inquiry is pertinent especially in intensive, block-based teaching models. The VU Block Model (<https://www.vu.edu.au/study-at-vu/why-choose-vu/vu-block-model>) defined as curriculum delivery structure that delivers one unit of study at a time across 4-week blocks, as opposed to conventional 12-week semester lecture format (Thomas et al. 2024) which may exacerbate both learning consolidation and skill retention challenges. Therefore, this study aims to evaluate the effectiveness of integrating real-life actors into simulated mental health sessions, combined with OSCA, to enhance the readiness of undergraduate nursing and midwifery students for mental health PEP. Specifically, the research addresses the following questions:

1. What is the impact of integrating real-life actors in OSCA and simulated mental health sessions on the preparedness of nursing and midwifery students for PEP, particularly within a Block Model framework?
2. To what extent do real-life actor-based simulation and OSCA improve students' self-confidence and competence in MSE and RA prior to PEP?
3. How do students perceive the transferability of skills gained from actor-based simulation and OSCA to real-world mental health PEP?

2 | The Study

2.1 | Aim

To examine the utilisation of real-life actors in three simulated mental health sessions, in combination with OSCA, on the readiness of second and third-year nursing and midwifery students for their PEP.

3 | Methods/Methodology

3.1 | Design

To determine the student's readiness for Mental Health PEP, a cross-sectional convergent mixed method design was employed to ascertain the convergence (match) or divergence of results and to validate the data, as well as to expand knowledge beyond the existing databases and relate it to current literature (Creswell and Creswell 2023).

3.2 | Theoretical Framework

The present study draws on Kolb's (1984) experiential learning theory, which encompasses a four-stage process. Initially, students engage in concrete experiences, immersing themselves with real-life actors and making decisions. Subsequently, reflective observation encourages nursing and midwifery students to review and reflect on their experience, identifying strengths and areas of improvement. In the next phase, abstract conceptualisation facilitates learning about patients with mental health conditions, care requirements, nursing practice and theoretical concepts. Finally, active experimentation enables students to adapt their approach based on their experiences, applying new knowledge to future simulation and real clinical settings. The efficacy of this process is contingent upon the student's perception of the simulation environment.

3.3 | Study Setting and Recruitment

The setting for this study is VU, Melbourne.

Between January 2024 and June 2024, convenience sampling was used to invite 510 second-year nursing and third-year midwifery students enrolled in the HNB2002 Mental Health unit to participate in this research study. On the first day of the unit, students were invited through the VU learning management system (Collaborate) Mental Health Unit News Feed by a person not involved in teaching nursing units (A.H.) to eliminate potential coercion. Additional information was communicated via flyers, group emails (A.H.), and displayed on the nursing bulletin board located at St Albans campus. Participation was voluntary, with the option to withdraw at any time, but there were no withdrawals. Subsequently, 234 nursing and midwifery students completed the online survey, with 60 consenting to post-PEP interviews. As the online surveys were anonymous, they were not linked to the respective interview responses. As a result, integration occurred at the group and theme level rather than through paired individual-level comparison.

3.4 | Inclusion and or Exclusion Criteria

All second-year nursing and third-year midwifery students enrolled in the HNB2002 Mental Health unit were considered eligible to participate in this research study, with no exclusion criteria applied.

3.5 | Data Collection

Quantitative data were collected via a cross-sectional online survey administered through a Qualtrics^{XM} platform straight after students completed their OSCA, whereas qualitative data were obtained through individual, face-to-face interviews following the completion of their Mental Health PEP. The online survey, consisting of 10 questions designed to assess students' readiness, employed a 5-point Likert scale ranging from strongly agree to strongly disagree. Additional questions

focused on demographic characteristics of the participants (see [Appendix](#)). The research team developed the questions to address the research question. As no existing validated instruments captured the constructs relevant to real-life actor-based OSCA in mental health, a study-specific readiness/perception questionnaire was developed. Although it was not formally pilot tested, it was reviewed by subject-matter experts to assess its content validity, clarity, and relevance, consistent with recommended questionnaire-development practice (Kishore et al. 2021), and revisions were made based on their feedback prior to implementation.

Students who expressed interest were given the opportunity to participate in a 15-min interview ($n=22$). This one-off interview was conducted in the PEP setting, with no one else present other than the student and interviewer. The time frame between OSCA and PEP varied between one to 6 months. Students obtained all information about the study from the Information to Participants and were provided the interview questions by the workplace placement facilitators. Mental health nursing experts contributed to the design of the research and interview questions but were not involved in the interviews in any way. Interviews were conducted by (CY), an independent and experienced female teaching and research academic with expertise in nursing education and interest in clinical preparedness. A total of 10 questions were asked to evaluate the participants' perceptions regarding the effectiveness of the real-life actors in enhancing their PEP ([Appendix](#): questionnaire). The face-to-face interviews were audio-recorded, with no field notes taken, and subsequently transcribed verbatim. Interviews were not returned to participants for comment/correction. One researcher transcribed the data using Zoom (CY) and it was validated by another researcher (KC).

The simulation scenarios were delivered across Weeks 1–3. All students participated in one of the three simulation scenarios: (1) a patient with mania, (2) a patient with major depression and (3) a patient with postpartum psychosis. In addition, all students observed all the simulation sessions and participated in the associated debriefing sessions. Debriefings were facilitated by mental health nurses with relevant clinical experience to consolidate learning, encourage reflection, and provide immediate feedback.

The OSCA took place in Week 4 and featured a scenario focused on a patient with major depression. During OSCA, students collaborated in pairs to apply professional and therapeutic communication skills and demonstrate the use of a MSE and RA for individuals with mental illness. Students were expected to establish baseline data by building rapport with real-life actors through open-ended questions. The OSCA ran for 30 min in total (15 min for the interview, followed by 15 min for assessor questions and verbal feedback). The real-life actors for the simulation and OSCA were sourced from the Health Education Australia Limited (HEAL) service. HEAL employs professional actors, referred to as 'simulated patients', who come from diverse backgrounds to portray patients in role-playing scenarios for teaching purposes. These individuals received thorough briefings from unit coordinators regarding the specifics of each scenario.

3.6 | Data Analysis

3.6.1 | Quantitative

The survey data were examined for duplicate submissions, incomplete responses, missing values, and inconsistent entries before conducting the statistical analyses. Data cleaning involved removing incomplete responses, resulting in a final sample size of 234. For easy interpretation of the survey responses, students' responses to the 10 questions on their readiness were categorised into 'broadly agreed' and 'broadly disagreed' by combining agree and strongly agree into one category (broadly agree) and the other three options (strongly disagree, disagree and neutral/not sure) into the other (broadly disagree) (Kankaraš and Capecci 2025). To detect a moderate effect size of 0.35 to observe a significant association between students' readiness score and their socio-demographic factors at a power of 80% or above and a type 1 error rate of 5% (Cohen 1988; Hulley et al. 2013) a sample size of 126 was deemed necessary for a two-sided test. Two items in the 10 readiness questions responses had two missing values (0.9%). For participants with this small number of missing responses on the five-point Likert scale, missing item values were imputed using the respondent's mean score across the completed items within the same scale. Principal component analysis and factor analysis were conducted on the 10 items on readiness to develop the readiness factor and summed to calculate the total score of the readiness scale ranging from 10 to 50 where higher score means better readiness knowledge. Before conducting the factor analysis, the scales were reversed (from 1 = strongly agree 5 = strongly disagree to 1 = strongly disagree 5 = strongly agree) for easy interpretation and analysis. The reliability and construct validity of the 10-item readiness scale were established through internal consistency analysis and principal component analysis (PCA), demonstrating satisfactory Cronbach's alpha, acceptable communalities, and a substantial proportion of total variance explained by the extracted component(s). Due to the unknown nature of the population distribution and non-normal data with small sample sizes for sub-groups, a non-parametric Mann-Whitney test was conducted. This test aimed to evaluate the association between students' readiness score and sociodemographic factors. Along with descriptive statistics, Spearman's rank correlation was used to assess the association between the students' readiness score and their age. Statistical significance was determined at a *p*-value of 0.05. Data were analysed using SPSS Version 29 and R 4.2.2.

3.6.2 | Qualitative

A six-step reflexive thematic analysis framework based on Braun and Clarke's (2022) approach was used to analyse the qualitative data. The analysis was initially conducted independently by two researchers (CY & CL) who separately reviewed and coded the data. The researchers then engaged in a collaborative and reflexive process to compare interpretations, discuss discrepancies, and reach consensus on the meaning of the data. This approach aimed to achieve a more comprehensive/richer interpretation (Byrne 2022) of the student experience while maintaining consistency and consensus

in the findings. This thematic analysis, derived from the data, facilitated an exploration of student experiences with real-life actors and identification of similarities and differences between them.

NVIVO software was used to facilitate the analysis process in adherence to Braun and Clarke's six-phase approach. This approach assured transparency in the data analysis process (Dhakal 2022) and demonstrated credibility, trustworthiness, and validity of the findings. The findings were analysed and discussed both individually and comparatively, with data saturation considered, integrating descriptive statistics and textual presentation in tables.

3.7 | Ethical Considerations

The study received approval from VU Ethics Committee (approval number: HRE23-165). The first page of the online survey provided a detailed explanation of the study, with participation being construed as implied consent. The online quantitative questionnaire included a checkbox for students who wished to be contacted for a follow-up interview post-PEP to provide their email address. Recorded material was securely stored in a locked filing cabinet at the chief investigator's office at VU. The data generated from the audio-recordings was stored in the VU R: drive and only accessible to researchers involved in the study.

4 | Results/Findings

4.1 | Characteristics of Participants

A total of 234 students completed the online readiness survey, including 200 Bachelor of Nursing students and 34 dual degree Midwifery/Nursing students. Of these, 86.3% (*n*=202) were second-year nursing students, whereas 13.7% (*n*=32) were third-year midwifery students. Most participants were female (87.6%), with 10.7% male, and 1.7% (*n*=4) preferring not to disclose their gender. The average age of students was 25.9 years (*SD*=7.6), ranging from 19 to 55 years. Among respondents, 28.2% (*n*=66) were Division 2 nurses, who provide delegated nursing care as part of a multidisciplinary team, working under the supervision of a Registered Nurse (Nursing and Midwifery Board 2024), whereas 71.8% (*n*=168) were not. Additionally, 41.9% (*n*=98) worked in the healthcare sector, with the remaining 58.1% (*n*=136) employed in other sectors. The majority were from metropolitan Melbourne (93.2%), with only 6.8% (*n*=16) from regional Melbourne.

4.2 | Quantitative Results

In the survey, a majority (over 90%) of participants agreed that the simulation and OSCA with real-life actors had provided them with skills and knowledge they perceived as necessary to work in a clinical setting as student nurses (Table 1). Overall, responses to all 10 questions indicated that participants found the real-life actors during simulation and OSCA highly valuable in equipping them, in their view, with the

TABLE 1 | Participants' response to the readiness survey regarding the real-life actor during simulation and OSCA on their clinical placement.

	Broadly agreed (%/n)
1. You feel confident going out into clinical placement having completed the three simulation sessions and OSCA	91.5 (214)
2. The simulations with real-life actors and OSCA has influenced your growth and development as a professional nursing or midwifery student	99.6 (233)
3. The real-life actors during simulation and OSCA has given you the set of skills and knowledge to prepare for clinical placement	99.1 (232)
4. The real-life actors during simulation prepared you to better understand the symptoms of mental health illness/disorders in clinical placement	99.6 (233)
5. Having real-life actors during simulation and OSCA influenced your therapeutic verbal and non-verbal communication skills in preparing for clinical placement	99.6 (233)
6. Having real-life actors in your simulation and OSCA prepared you to provide Person-Centred Care on clinical placement	98.3 (230)
7. Having real-life actors in your simulation and OSCA provided you with adequate skills and knowledge to provide Trauma Informed Care (TIC) on clinical placements	93.2 (218)
8. The real-life actors in your simulation and OSCA provided you with adequate skills and knowledge to provide Strength Based Practice on clinical placements	95.7 (224)
9. The real-life actors in your simulations and OSCA provided you with skills and knowledge to recognise clinical deterioration in patients with mental health illness/disorders in clinical placement	97.0 (227)
10. Completion of simulation and OSCA with real-life actors prepared you in conducting a Mental State and a Risk Assessment on a real patient in a clinical placement	97.0 (227)

required knowledge and skills to perform effectively in mental health clinical placements, both as team members and independently (Table 1).

Prior to the main analyses, the 10 readiness items were evaluated using principal component analysis and factor analysis. The results supported the construction of a single readiness scale, and the item scores were summed to produce a total readiness score ranging from 10 to 50, with higher scores indicating

greater readiness and knowledge. Principal component analysis and factor analysis on the data indicated a single factor for the 10 readiness questions, with this factor explaining 69.2% of the variance, and all item communalities above 0.5, meaning more than half the variability is explained by the readiness factor. Reliability analysis also demonstrated strong internal consistency, with a Cronbach's Alpha of 0.95, item variances above one, and all squared multiple correlation coefficients exceeding 0.4, demonstrating that the survey was consistent and reliable. Item deletions did not enhance internal consistency for any items. A summated score of the 10 items for the factor 'Readiness' was created for further analysis with scores ranging from 10 to 50 where a higher score means better readiness knowledge.

A non-parametric Mann-Whitney test was used to examine associations between students' readiness scores and sociodemographic factors. Employment status showed a significant association with readiness scores (Mann-Whitney $U=4055.5$, $Z=-3.54$, $p<0.001$, Eta-squared=0.053), suggesting a meaningful difference, with approximately 5.3% of the variability in readiness score explained by employment status. Students working as Division 2 nurses scored higher ($M=47.04$, $SD=5.14$) than those not working in this role ($M=45.13$, $SD=4.56$) following the simulation and OSCA. Readiness scores were also significantly associated with students' residential area (Mann-Whitney $U=1209.5$, $Z=-2.09$, $p<0.037$, Eta-squared=0.019), with metropolitan students scoring higher ($M=45.88$) than those in regional Melbourne ($M=43.25$) after attending the simulation and OSCA. Although statistically significant, the small effect size suggests only a modest association between residential area and readiness, with only 6.8% coming from regional areas. Indeed, qualitative perceptions were similar, suggesting little effect, and overall scores were high, suggesting good readiness, aligning with their perceptions. No other sociodemographic factors, including gender and age, were associated with participants' readiness scores ($p>0.05$).

4.3 | Qualitative Results

A total of 22 interviews were conducted. Responses were categorised into eight overarching themes derived from the interview questions: Skills and Knowledge, Person-Centred Care, Understanding of the Symptoms, Therapeutic Verbal and Non-Verbal Communication, Trauma-Informed Care, Strength-Based Care, Recognising Clinical Deterioration, and Mental State Exam (MSE) and Risk Assessment (RA). Additionally, 35 sub-themes emerged from the primary themes (please refer to Table 2).

Key insights include:

1. *Simulation and OSCA mirrors PEP*: Participants consistently highlighted that the scenarios undertaken by real-life actors during simulation and OSCA closely mirrored clinical environments, facilitating a seamless transition into practical settings.
2. *Preparedness for PEP*: Many participants emphasised that engaging with real-life actors during simulation and OSCA enhanced their perceived readiness for PEP.

TABLE 2 | Themes and sub-themes.

Skills and knowledge	Person centred care	Understanding of the symptoms	Therapeutic verbal and non-verbal communication	Trauma informed care	Strength-based care	Recognising clinical deterioration	Mental state risk assessment
20 Yes 2 Yes/no	21 Yes 1 No	17 Yes 1 No 4 Yes/no	20 Yes 1 No 1 Yes/no	14 Yes 8 No	16 Yes 6 No	16 Yes 2 No 1 Yes/no	14 Yes 9 Confidence
Mirrors clinical placement	Time factor between OSCA and placement	Time factor between OSCA and placement	Part of the OSCA • Easier to build rapport • Confident	Developed on clinical placement	Developed on clinical placement	Developed on clinical placement	Further developed during clinical placement
Preparedness • Confident	Easy to build rapport	Mirrors clinical placement	Real person not a manikin	Further developed during clinical placement	Part of the OSCA	Further developed during clinical placement	Part of the OSCA
	Easy to adapt and apply	Preparedness	Clinical language & body language	Part of the OSCA	No responses: • Time factor • Lack of understanding • not able to recall information	Part of the OSCA	Real person, not a manikin
	Easy to communicate		Feedback from actor • Lack of understanding				Time factor between OSCA and placement
	Mirrors clinical placement						
	Preparedness • Confident • Built their professionalism						

Note: Although these themes provided a comprehensive framework, several cross-cutting insights frequently emerged from highlighting the role that real-life actors during simulation and OSCA were perceived to play in their PEP experience. Colour shades explanation is underneath the Table-frequently emerging subthemes.

3. *Increased confidence*: Participants reported a notable increase in their confidence regarding their ability to manage clinical scenarios following their engagement in simulation and OSCA sessions.
4. *Impact of time*: The time interval between the completion of the unit and the commencement of PEPs was identified as a significant factor that influenced how effectively students could recall information and apply the acquired knowledge and skills into PEP.
5. *Skill (further) development during PEP*: Participants observed that while simulation and OSCA with real-life actors provided foundational knowledge, certain skills were further developed and refined during their PEP.
6. *Part of the OSCA*: Participants were able to recall the skills and knowledge as it was part of their OSCA.
7. *Real person not a manikin*: Participants underscored the realism of the scenarios, noting that the use of live actors, as opposed to manikins, significantly enhanced the overall experience.

These recurring sub-themes underscore the multifaceted role of real-life actors in simulation and OSCA in preparing nursing and midwifery students for PEP, emphasising both the strengths of real-life actors in simulation-based education and the opportunities for ongoing improvement in this area.

4.3.1 | Theme 1: Skills and Knowledge

Whether the integration of real-life actors during simulations and OSCA equipped students with essential skills and knowledge for their PEPs revealed two prominent sub-themes: simulation closely *mirrors clinical placements* and enhanced *preparedness* and *confidence*.

Students emphasised the resemblance of the scenarios in simulations and OSCA closely mirrored actual clinical situations, as stated by Participant 1,

So, it's like very similar to what I work in the labs, you know, like dual diagnosis...the actors have a case where they have a dual diagnosis, or they have an eating disorder, or they're having a mental health episode. And then we came here and it's like similar conditions as well. So, it was like, I had like a background knowledge of it. So, it was good.

Participant 2 added,

I feel like the actors really helped me prepare for this placement, because the actors they had a range of different mental health backgrounds, such as PTSD, OCD, Bipolar disorder, which reflected well in what we faced in real life. So... I was familiar, and that made me feel more comfortable when I came into this placement.

Participants also noted increased *Confidence*, *Communication* skills, *Professionalism* from their experiences with real-life actors.

Participant 4 shared,

It has given us a lot of confidence to talk to patients face-to-face ...because the actors got the acting skills and it felt surreal. So, I feel like it has definitely helped in the confidence building on how to interact with patients.

These responses illustrate how the real-life actors in simulations and OSCA helped bridge theoretical knowledge and practical application, ensuring students felt more prepared to engage with patients in a clinical setting.

4.3.2 | Theme 2: Person-Centred Care

Students' ability to provide Person-Centred Care during their PEP following simulations and OSCA with real-life actors revealed six sub-themes, two of which were reoccurring: *Mirrors Clinical Placement* and *Preparedness*, contributing to increasing their *Confidence* and building *Professionalism*. The remaining four sub-themes are related to *Time Factor* between placements and academic unit completion and how *Easy it is to Build Rapport*, *Adapt* to different situations, and *Communicate* with patients.

The time interval between completing the academic unit and starting PEPs emerged as a factor influencing how well students could translate the skills in practice. Some students felt this delay reduced the immediate applicability of their learning. Participant 5 remarked:

Yeah... I mean as a nurse in general person-centred care is our priority... but ...relating to OSCA. hmm! These are so far back. It was like, half a year ago.

Many students noted that simulations and OSCA helped them build rapport, adapt to clinical settings, and improve their communication skills.

Participant 7 shared:

The real-life actors give me a very deep understanding of how to do person-centred care. It allowed me to connect and better understand the patient when I did my placement.

Participant 2 emphasised how simulation-based preparation made her approach to patient care more effectively:

With what we prepared through our Sims and OSCA, I have been able to do really well with therapeutic communication, reassurance, and also just handling myself in a more professional way.

Most students credited that real-life actor in simulation and OSCA enhanced their patient-centred care skills. However, the time lapse between completion of the unit and commencement of the placement affected their recall of OSCA's impact on skill acquisition.

4.3.3 | Theme 3: Understanding of the Sign and Symptoms

The notion of *Preparedness* and *Mirroring Clinical Practice* emerged as a contributing factor to students' understanding of the signs and symptoms of mental illnesses.

Participant 2 explained:

It has been an eye-opener, because what you read in textbooks versus what you see acted out is totally different. And sometimes what you see through (real-life) actors is a very eye-opening experience. So, I feel like that has broadened my understanding of what a bipolar disorder might look like versus what you read.

4.3.4 | Theme 4: Therapeutic Verbal and Non-Verbal Communication

Therapeutic verbal and non-verbal communication included four sub-themes, one of which focused on incorporating such communication in an OSCA facilitated *Building rapport* with patients *Easier*, which contributed to increased *confidence* among participants. Participant 10 articulated:

Yes, it is very important to build a rapport with the client or consumer that you're working with and in the time of OSCA we were assessed on how we managed to build a rapport with the client. Now it is easy to communicate with the client, because I've been through that experience through the actors... even if they get agitated, I know some strategies to calm them. So, it's easy to carry out the activities. You know better because you have got the experience while being in OSCA.

The third sub-theme pertains to the advantages of *Utilising a Real-life Actor Instead of a Manikin* in refining both *Clinical Language and Body Language*, as expressed by Participant 11:

Yeah, it's helped with, the type of language we should be using, and especially for documentation as well. After the OSCA just going through with the preceptors you can report back, and it helps with that clinical language almost. It also helped with, your body language, the actual patient, like how you should be sitting and everything.

The fourth sub-theme highlighted how immediate *Feedback Provided by the Real-life Actors* facilitated reflective practice,

leading to opportunities for improvement before going out into clinical placement, Participant 2 reflected:

Absolutely because through that I was able to get feedback based on how I'm talking, how assertive I can come off, how upfront I can come off and if it hadn't been for the actors, then I wouldn't have had that feedback that would have equipped me to come here because from day one it's all been pretty self, directed. From day one, we haven't really had a buddy nurse to shadow with. It's always been you go, and do the assessments yourself, so I feel like having that feedback has made me definitely feel more comfortable with verbal and nonverbal cues.

4.3.5 | Theme 5: Trauma Informed Care

The findings revealed that 14 students affirmed the benefits of real-life actors during simulation, and OSCA provided a solid foundation for delivering Trauma Informed Care. Some students noted that *OSCA contributed to their skill development*, which they *further refined during clinical placement*. However, 8 students raised concerns about their understanding and practical application of these concepts, stating that they *developed the skill primarily during clinical placement*. These responses highlight a dichotomy in student experiences, and a clear *gap in their knowledge*.

Participant 12 acknowledged that she developed this skill during PEP.

We have like patients who are having PTSD, so they have a lot of traumas in their life before, and that goes now as well, which is becoming complex. So, it provides me as like skill how to cope with them...I just developed here.

In contrast, Participant 13 learned the skill during OSCA and further refined it during PEP,

Yeah, I would say so...what I received from the OSCA was a bit of the baseline information and then based off that, I can relate to things. So, when I learn.../... picked up a few things from placement so you kind of link them a bit, too.

Some students expressed their lack of understanding like Participant 14, who said 'Trauma informed care; I'm not sure what that is'. Participant 16 explained that she could not recall the information because, 'It's mostly because it was a while ago'.

4.3.6 | Theme 6: Strength-Based Practice

The findings pertaining to Strength-Based Practice demonstrated a range of perspectives among students. Thirteen students expressed affirmation, indicating that OSCA contributed

positively to their learning experience. Conversely, eight students disagreed, citing either a *Time Constraint* that hindered their ability to *Recall Information*, a *Lack of Understanding of the Skill*, or the *Development of this Skill during Clinical Practice*.

Participant 17 noted 'I did more in the placements actually. Learned more on the placements than the Sims and OSCA'. Whereas some students emphasised the structured learning opportunities provided during OSCA sessions, with Participant 11 commenting '...when the OSCA actors were doing it, it was helpful...'. Similarly, Participant 3 remarked 'I think OSCA definitely helped me develop those skills'.

Among the eight students, some responses suggested uncertainty about the concept, potentially related to the time lapse since completing the unit.

4.3.7 | Theme 7 Recognising Clinical Deterioration

The findings indicated that 18 students reported reoccurring sub-themes including *Developed on Clinical Placement*, *Part of the OSCA* and *Further Developed during Clinical Placement*. Two students responded negatively without any further explanation.

Participant 8 commented,

...the simulation and OSCA prepared us to recognise clinical deterioration because even in the OSCA when the patient's condition deteriorates and here, also, happens the same thing. So, it helped us, and it relates as well.

4.3.8 | Theme 8 Mental State Risk Assessment Tool

All students positively emphasised the impact of real-life actors during simulation and OSCA on their ability to conduct Mental State Risk Assessment during PEP. Nine participants specifically highlighted the simulation sessions enhanced their *Confidence*.

As Participant 7 articulated,

Definitely...the simulations helped me a lot. I built my confidence on how to do the MSA and allow me to ask a right question and make the informed decision about the patient care.

The remaining reoccurring sub-themes identified were *Further Developed during Clinical Placement* and *Time Factor*. Although the students

...felt quite confident. I'd say 8 out of 10 in confidence... I did my mental health unit 3 months ago, so it was kind of like a refresher doing it here the first two

times. But as you go, you gain the confidence, and I feel like I'm pretty confident.

(Participant 2)

4.4 | Mixed Method: Convergence and Divergence

The analysis reveals that the readiness scores among metropolitan students were significantly higher than those of their regional counterparts. Notably, interviews conducted with students participating in regional PEPs indicated that their perceptions regarding the influence of real-life actors on their readiness for PEP were similar to those of students in metropolitan settings. The regional and metropolitan mental health inpatient units provide the same level of care for patients under the Mental Health and Well being Act 2022.

Student readiness for placement is predominantly shaped by the knowledge and skills acquired during university education. However, developing this knowledge and essential competencies is intrinsically linked to the specific clinical environment in which students are placed. Factors such as 'staff engagement', 'the availability of resources' and 'opportunities provided for student growth' emerged inductively under the theme *developed on placement*, where participants attributed their skill development to aspects of the clinical placement environment. For instance, Participant 19 articulated their preparedness concerning the influence of real-life actors on their therapeutic verbal and non-verbal communication during clinical placements, stating,

Again, if I talk about therapeutic verbal and non-verbal communication skills, I gained these skills more in my placement rather than from simulation and OSCA, because I did not put much emphasis on that time and literally did not develop much knowledge...so I developed these skills more during my placement.

This highlights the role that educators, researchers, and policymakers may have in shaping student readiness. Table 3 illustrates the notable similarities in the experiences derived from both quantitative and qualitative data regarding the real-life actors utilised during the simulation and the OSCA on their readiness for PEP. However, as the quantitative data were anonymous, it was not linked to individual interview responses, such that integration occurred at the group and theme level. A majority of students responded 'Yes' regarding the positive impact of real-life actors on their knowledge and skill development, indicating a proactive engagement in their learning process. Some students expressed mixed responses, 'Yes and No', emphasising that certain skills are either developed or further enhanced during the PEP, thereby emphasising the students ongoing responsibility in their educational journey. A small portion of the responses were 'No', acknowledging the students' active role in their skill development and highlighting the universities' responsibility to restructure content delivery to better emphasise the identified skill sets.

TABLE 3 | Participants' response to the readiness questions regarding the real-life actors during simulation and OSCA on their clinical placement.

	Broadly agreed (%/n)	Participants response
		Yes/no
1. The real-life actors during simulation and OSCA has given you the set of skills and knowledge to prepare for clinical placement	99.1 (232)	20 Yes 2 Yes/no
2. The real-life actors during simulation prepared you to better understand the symptoms of mental health illness/disorders in clinical placement	99.6 (233)	17 Yes 4 Yes/no 1 No
3. Having real-life actors during simulation and OSCA influenced your therapeutic verbal and non-verbal communication skills in preparing for clinical placement	99.6 (233)	20 Yes 1 Yes/no 1 No
4. Having real-life actors in your simulation and OSCA prepared you to provide person-centred care on clinical placement	98.3 (230)	21 Yes 1 No
5. Having real-life actors in your simulation and OSCA provided you with adequate skills and knowledge to provide Trauma Informed Care (TIC) on clinical placements	93.2 (218)	14 Yes 8 No
6. The real-life actors in your simulation and OSCA provided you with adequate skills and knowledge to provide Strength Based Practice on clinical placements	95.7 (224)	16 Yes 6 No
7. The real-life actors in your simulations and OSCA provided you with skills and knowledge to recognise clinical deterioration in patients with mental health illness/disorders in clinical placement	97.0 (227)	16 Yes 1 Yes/no 2 No
8. Completion of simulation and OSCA with real-life actors prepared you in conducting a Mental State and a Risk Assessment on a real patient in a clinical placement	97.0 (227)	Yes 22

5 | Discussion

Simulation is an integral part of nursing skill-based education as it is mainly designed to reflect real-life conditions while stimulating a number of the learner's senses (Alharbi et al. 2024). Various simulation types exist (Kim et al. 2024), and they are all designed to enhance students' self-esteem and confidence by 'standardization of cases, promotes critical thinking, allows supervision of patient care, provides immediate feedback, and helps students to assimilate knowledge and experience' (Koukourikos et al. 2021). The present study aligns with Kolb's (1984) experiential learning theory, which frames simulation as a cyclical process of concrete experience, reflective observations, abstract conceptualisation and active experimentation. Through real-life actor interactions, students first encounter authentic mental health scenarios (*concrete experience*), then debrief to analyse performance (*reflective observation*), link observations to theoretical frameworks of MSE and RA, and recovery-oriented care (*abstract conceptualisation*), and finally refine their approach for future encounters (*active experimentation*). The efficacy of this cycle hinges on the perceived realism of the simulation environment, which is a strength amplified by trained real-life actors who portray nuanced psychiatric presentations with emotional depth and unpredictability (Luebbert et al. 2023).

The integration of real-life actor's in simulation and OSCA creates a immersive, high fidelity learning environment that bridges the theory-practice gap (Marshall and Honey 2023). Participants in this study reported perceived gains in confidence, therapeutic

communication, MSE and RA proficiency and risk identification prior to PEP and these findings are consistent with prior literature (Cant et al. 2018; Davies et al. 2024). Within Kolb's framework these outcomes reflect successful progression through the experiential cycle: real-life actor-driven scenarios provide vivid *concrete experience* that prompt deeper *reflective observation* during debriefing, enabling *abstract conceptualisation* of complex mental health concepts and supporting *active experimentation* in subsequent simulations or OSCA practice (Kolb 1984; Bresolin et al. 2022). Moreover, the controlled yet dynamic nature of real-life actor-based simulations may foster self-efficacy and autonomy, potentially more so than unstructured patient exposure (Felton and Wright 2017; Koch 2017), particularly in the sensitive context of mental health nursing.

However, the temporal alignment between simulation and PEP remains critical. Delayed placement opportunities in Australian Nursing Disciplines in Higher Education institutions, and educational settings globally, are experiencing preparation-practice gaps resulting from limited clinical placement positions available (Hickerson et al. 2016; Roberts et al. 2019) that risk recall decay and diminished skill transfer. In Kolb's model, prolonged gaps in between *abstract conceptualisation* and *active experimentation* in real clinical settings may weaken learning consolidation. This is consistent with the findings of this study, which indicated that some students struggled to understand concepts like Trauma Informed Care. A significant concern is that students are not being exposed to enough clinical skill development in mental health nursing units in the undergraduate degree (Warrender

et al. 2024). The implementation of mental health simulations with real-life actors appears to promote a smoother scaffolding to PEP, allowing students to make the maximum benefits of the skills gained in the simulation labs. As such, it is critical to highlight that the intensive VU Block Model can be an advantage, in that students are exposed to the real-life actors regularly in a short space of time, generating greater confidence prior to starting their PEP. However, while the VU Block Model promotes focused engagement, there could be some challenges if PEP scheduling lags behind the mental health unit, due to high demand for the mental health places available across institutions (Davis et al. 2025). As a result, students may not have the opportunity to apply the skills learned in the simulations in a timely manner during their PEP. Fortunately, the inherent flexibility of block scheduling can be advantageous for minimising any time gap.

The placement drought and workforce shortage (New Zealand Trade and Enterprise 2023), are driving increased enrolments in University's, further straining simulation-to-placement gaps. Given the strong student endorsement of real-life actor-based simulation and OSCA as realistic which mirror PEP underscores their adoption beyond its current use as a preparation, but as core curriculum components. Through Kolb's lens, repeated experiential cycles within the academic setting scaffold progressive mastery, compensating for reduced clinical hours (Warrender et al. 2024). The findings of the socio-demographic impact on students' readiness for PEP further highlight the need for standardised, real-life actor simulation and OSCA across universities to ensure equity in skills development (Bond et al. 2022).

5.1 | Strengths and Limitations of the Work

A key strength of this study was its mixed-method convergent design, which integrated quantitative and qualitative data to provide a more comprehensive understanding of students' readiness for PEP and perception of the effectiveness of real-life actors. The two data sources were collected at complementary time points: survey data were gathered following OSCA completion, whereas interview data were obtained during the PEP, between 1 and 6 months later. The study also drew on a representative sample of students who, upon completing their courses, will serve the community as healthcare professionals. This study has several limitations. First, the cross-sectional design restricts the ability to draw causal inferences. Second, the survey and interviews were not a matched pre-and post-placement measure of the same participants; rather they captured different data at different stages, so changes with individuals over time cannot be determined. Third, the reliance on self-reported data introduces the potential for recall bias, although common questions in both survey and interview diminish this likelihood. Finally, while the quantitative survey accounted for various sociodemographic factors, it may not have captured all relevant contextual influences on clinical readiness, such as socioeconomic status.

5.2 | Recommendations for Further Research

Future studies should examine the effectiveness of real-life actors in mental health units and other relevant health units, such

as paramedicine where rapid mental health assessments and therapeutic engagements are critical pre-hospital contexts. A specific follow-up study could involve a randomised control trial comparing real-life actor-based simulations with traditional training methods to assess their impact on student experience and knowledge retention. Additionally, it is essential to examine the impact of time lapse between PEP and study unit on student experience and knowledge retention. Students have also indicated that the simulations and OSCA have motivated them to become mental health nurses in the future, and this should be examined further in research to determine if there is a link.

5.3 | Implications for Policy and Practice

To better prepare nursing and midwifery students and enhance their PEP experience, it may be beneficial for institutions and mental health training programs to integrate real-life actors into their curricula. A structured approach to preparing students for PEP is vital, as it anchors the knowledge retention acquired between coursework and PEPs. Also, the integration of real-life actors may facilitate reflective practice, allowing students to identify their strengths, further refine their skills, and engage in realistic training assessments.

The findings extend beyond nursing and midwifery, with potential application to other health professions such as paramedicine, where rapid mental health assessments and therapeutic engagements are critical in pre-hospital contexts. Integrating real-life actors into simulations and OSCA is therefore a valuable approach that should be adapted and enhanced for future use across health professions education. This can be achieved by incorporating students' sociodemographic characteristics into targeted intervention programs, whereas future research explores cross-disciplinary efficacy, time-relapse effects on skill retention, and the motivational link to career specialisation in mental health.

6 | Conclusion

The integration of real-life actors into simulation and OSCA sessions was associated with positive student-reported perceptions of their confidence, skills development, knowledge acquisition, and overall readiness for the transition to PEP, with sociodemographic factors showing limited association. By engaging with real-life actors who simulate patients and various mental health scenarios, students are provided with the opportunity to practice their skills in a controlled and safe environment. This immersive approach may support students' self-reported critical thinking and communication skills, helped students feel more confident and prepared. These skills are vital for effective patient care and may equip students to navigate a variety of clinical mental health situations. Consequently, students reported feeling better prepared to respond with confidence in actual health-care settings.

Author Contributions

Caglayan Yasan: conceptualization, methodology, data curation, formal analysis, project administration, writing – original draft,

writing – review and editing, investigation, validation, visualization, supervision. **Chunxiao Liu:** conceptualization, methodology, writing – original draft, software, validation. **Alan Hayes:** conceptualization, methodology, project administration, supervision, writing – original draft, writing – review and editing, validation. **Kim Cabral:** conceptualization, methodology, writing – original draft, formal analysis, investigation. **Christopher Saunders:** conceptualization, methodology, writing – original draft. **Abdi Osman:** conceptualization, methodology, writing – original draft, writing – review and editing, supervision. **Renju Joseph:** conceptualization, methodology, writing – original draft. **Jahar Bhowmik:** conceptualization, methodology, writing – original draft, writing – review and editing, data curation, formal analysis, validation, visualization.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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Appendix : Online Survey Questions

1. Do you identify yourself as
 - a. Male
 - b. Female
 - c. Non-binary
 - d. Transgender
 - e. I prefer not to comment
2. How old are you?
3. What is your Postcode?
4. Which degree are you currently enrolled in: Bachelor of Nursing or Dual Degree of Midwifery/Nursing student?
 - a. Nursing
 - b. Dual degree
5. What year level are you currently enrolled in?
 - a. Year 2 Nursing
 - b. Year 3 Midwifery
6. Are you currently working in health care?
 - a. Registered Undergraduate Student of Nursing (RUSON)
 - b. Registered Undergraduate Student of Midwifery (RUSOM)
 - c. Patient care attended
 - d. Disability support worker.
 - e. Other
7. Are you currently working as a division two enrolled nurse?
 - a. Yes
 - b. No
8. If so, have you worked in a mental health unit?
 - a. Yes
 - b. No
9. You feel confident having completed the three simulation sessions and OSCA going out into clinical placement
 - a. Strongly agree
 - b. Agree
 - c. Neutral
 - d. Disagree
 - e. Strongly disagree
10. The simulations with real-life actors and OSCA have influenced your growth and development as a professional nursing or midwifery student
 - a. Strongly agree
 - b. Agree
 - c. Neutral
 - d. Disagree
 - e. Strongly disagree
11. The real-life actors during simulation and OSCA have given you the set of skills and knowledge to prepare you for clinical placement
 - a. Strongly agree
 - b. Agree
 - c. Neutral
 - d. Disagree
 - e. Strongly disagree
12. The real-life actors during simulation prepared you to better understand the symptoms of mental health illness/disorders in clinical placement
 - a. Strongly agree
 - b. Agree
 - c. Neutral
 - d. Disagree
 - e. Strongly disagree
13. Having real-life actors during simulation and OSCA influenced your therapeutic verbal and non-verbal communication skills in preparing for clinical placement?
 - a. Strongly agree

- b. Agree
 - c. Neutral
 - d. Disagree
 - e. Strongly disagree
14. You can provide a Person-centred Care on clinical placement post your simulation and OSCA
- a. Strongly agree
 - b. Agree
 - c. Neutral
 - d. Disagree
 - e. Strongly disagree
15. The simulation and OSCA have provided you with adequate skills and knowledge to provide Trauma Informed Care on clinical placements
- a. Strongly agree
 - b. Agree
 - c. Neutral
 - d. Disagree
 - e. Strongly disagree
 - f. I do not know what trauma-informed care means
16. The simulation and OSCA have provided you with adequate skills and knowledge to provide Strength Based Practice on clinical placements
- a. Strongly agree
 - b. Agree
 - c. Neutral
 - d. Disagree
 - e. Strongly disagree
 - f. I do not know what strength-based practice means
17. The simulations and OSCA have provided you with skills and knowledge to recognise clinical deterioration in patients with mental health illness in clinical placement
- a. Strongly agree
 - b. Agree
 - c. Neutral
 - d. Disagree
 - e. Strongly disagree
18. Completion of simulation and OSCA prepared you in conducting a Mental State and a Risk Assessment on a real patient in a clinical placement
- a. Strongly agree
 - b. Agree
 - c. Neutral
 - d. Disagree
 - e. Strongly disagree