

Mental health nursing education: waking up on the edge of oblivion.

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2023

This is the accepted version of the above article. The final version of record will be published on the journal's website: <https://rcni.com/mental-health-practice>

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Abstract

Mental health nursing in the UK saw its preregistration education impacted by the introduction of the Future Nurse standards, introduced by the Nursing and Midwifery Council in 2018. Whilst concerns were raised during their development and implementation, the fears of many mental health nurse academics have been realized with both pre-registration curricula and practice assessment documents being criticized as diluting the specialist education of those who will become registered mental health nurses. This paper presents key arguments and debates, and also includes a reflection from John Hurley and Mike Ramsay, revisiting their seminal paper “Mental Health Nursing: Sleepwalking into oblivion” which warned of similar issues 15 years ago.

Introduction

In early 2022, significant discussion and consensus between mental health mental health nurse academics in the UK, bemoaned the dilution of specialist mental health nurse education following the introduction of the Nursing and Midwifery Council’s (NMC) (2018) Future Nurse Standards. This argument has not suddenly arisen from nowhere, with frustration amplified due to serious concerns being raised prior to implementation. A position paper by Mental Health Nurse Academic’s UK (MHNAUK) (2016) agreed that physical health skills are important for mental health nurses, but argued these should be complementary to mental health content, not at the expense of it. Nursing press highlighted views that any move to genericism would likely mean a bias towards adult nursing with a skillset skewed by the dominance in numbers of adult nurses in the profession (Stephenson 2016). There were pleas to review issues in other western countries where generic training had failed to prepare people to work in mental health settings (Stephenson 2016).

More recently, with warnings not heeded, concerns have been raised at the Royal College of Nursing Congress (RCN) (2022), the MHNAUK keynote lecture describing mental health nursing becoming a “ghost” profession (Warrender 2022a), and statement article on mental health nursing identity and it’s “seminal differences” from other fields of nursing (Connell et al 2022, p.3). This article covers the context and key arguments in this debate, and includes a reflection from Mike Ramsay and John Hurley, noting the repetition of history and continued concerns as they revisit their seminal paper “Mental Health Nursing: Sleepwalking Towards Oblivion” (Hurley and Ramsay 2008) (See Box 1).

Box 1: Mike Ramsay and John Hurley - Reflecting on ‘Mental health nursing: sleepwalking towards oblivion?’

Almost 15 years ago this journal published our wide-ranging philosophical opinion paper about the then recently concluded UK consultation survey from the Nursing and Midwifery Council (NMC) (Hurley and Ramsay, 2008). That paper generated considerable correspondence and provoked some controversy in Scotland, culminating in a right-to-reply piece in the next issue and our rejoinder to that. The paper has gathered a healthy batch of citations since, with a recent upsurge due to academic writing (Connell et al 2022, Warrender 2022b) on the status of mental health nursing and its education standards in the UK (NMC 2018) and also associated themes from across the world.

In the paper we summarised the professionalisation journey of mental health attendants into the family of nursing via a protracted spat between the then Royal Medico-Psychological Association (RMPA) and the General Nursing Council (GNC) (Chatterton 2004). The RMPA asserted that the GNC syllabus was too focused on “sick nursing” (Chatterton 2004, p.32); echoes from the past that we termed mental health nursing’s “...tortured infancy...” (Hurley and Ramsay 2008, p15). This issue is at

the heart and soul of the profession, and one resonating in the UK today, reminding us of playwright, Eugene O'Neill's musing "There is no present or future - only the past, happening over and over again - now" (O'Neill 1992, no page), therefore argument exists that this tortuous development continues.

The oblivion in question in 2008 was the spectre of advancing towards a generic pre-registration programme in the UK and the portents of problems of identity and how many mental health nurses seemed to be publicly unperturbed but privately expressing concerns. With passing time that identity oblivion is now imminent but there is also wider public debate being undertaken from within the discipline. This debate suggests mental health nursing may have finally awakened to see the realities of creeping genericism, a loss of specialist identity and a weakening of unique mental health nursing education. All these factors will culminate in mental health nurses being less useful to service users, in an era of growing unmet mental health need.

Australia offers UK mental health nursing's sobering insight into the inevitable outcomes of surrendering to calls for comprehensive undergraduate training. Graduates, service users, carers and supporters all identify that the comprehensive training fails to meet the needs of end holder stakeholders (Hurley et al, , 2022). Diminished specialist undergraduate education and theory-based post graduate courses creates an utterly predictable loss of advanced mental health nursing skills that over time narrows the scope of practice and professional identity of a mental health nurse to the most basic of roles. Those outside the profession then judge that this is the entirety of what mental health nurse's do and what we are capable of doing. It is a downward spiral of identity, capability and practice scope. If one were to use critical realist theoretical frameworks to evaluate the efficacy of Australian comprehensive nurse training, one can say 'it works'. However, critical realistic evaluation tells us that all programmes, even broken ones produce something and what is considered 'workable' varies according to whose perspectives you adopt (Linsley et al 2015). Current Australian nurse education works reasonably well for preparing medical and surgical nurses and propagating the careers of senior generalist nurses on national nursing bodies. However, it does not work for mental health nursing and most certainly does not work for service users (Lakeman et al 2022). It is a failed 35-year real world experiment that Australia needs to move on from, and the UK needs to resist, with assertive urgency.

As a discipline, mental health nurses must break their silence toward the worth of the roles they undertake. Mental health nurses must challenge through respectful but uncompromising conversations those who seek to limit who we are and who would challenge our capabilities. Our silence toward the healing created through complex technical and non-technical mental health nurse capabilities, which when combined with the limiting social constructions of us, is creating vulnerabilities to arguments for genericism.

In closing, we were pleased our paper enlivened debate in 2008 and perhaps are even more gratified that some have seen fit to highlight that its clarion call can not only still be heard but that it chimes with contemporary issues and writing. If we are saddened it is in the fact that the portents offered then have and are impacting on current mental health nurse education, identity and practice realities. Mental health nurses do important, complex and really useful work and now in 2023 we as a discipline need to lead the social discourses that construct the necessity for specialised undergraduate education and identity.

End box 1.

Modernising healthcare

The shape of caring review conducted by Lord Willis set out 34 recommendations under 8 themes, with many of these relating to pre-registration nurse education (Willis 2015). Most pertinent to this debate was the reports suggestion that mental health nursing programmes had insufficient focus on physical health, that all nurses required a “whole person core training” and flexible generic skillset, with advocacy for 2 years of core learning for all nurses, punctuated with 1 year of specialist field education (Willis 2015, p.42).

Ion and Lauder (2015, p.841) agreed that nurse education faced challenges and needed to evolve, but rejected the “simplistic view...” stated by the Willis report (2015) “...that a return to genericism will solve these difficulties”. Connell et al (2022, p.3) add that the subsequent approach has naively sought to rectify deep rooted systemic problems by improving physical health skills, tasks and procedures, yet has led to the “dissolution of mental health nursing identity”.

The future nurse standards (NMC 2018, p.6) which were developed in this context have noble aims, describing the need for all fields of nursing practice to meet the “person centred, holistic care needs of the people they encounter in their practice who may be at any stage of life and who may have a range of mental, physical, cognitive or behavioural health challenges”. The key arguments in this paper do not disagree with this ideal, rather acknowledge the real world consequence; that through poorly managed attempts to meet this aim, confounded by the standards lack of explicit articulation of mental health specific knowledge and skill, the NMC’s second aim, to provide “additional more advanced skills required to meet the specific care needs of people in their chosen fields of nursing practice” (NMC 2018, p.6), has been unfulfilled.

The postcode lottery of university curricula

The NMC’s (2022) role in education is setting standards, with approved education institutions (AEIs) implementing standards and setting curricula, then the NMC responsible for final approval of education programmes. Alarming, professional communications through MHNAUK has uncovered a postcode lottery, with a spectrum of university curricula ranging from students having field specific modules throughout their training, to having entirely generic content throughout, receiving identical content to other fields of nursing. Questions must be asked. If the standards can be interpreted in different ways, with very different curricula all able to meet the standards, what do the standards offer in terms of protecting specialist education, and what level of specialist knowledge and skill one can expect in the future when they encounter a mental health nurse? Whilst the huge variation in AEI interpretation needs to be considered, the NMC must consider that their standards may be too broad if they allow such breadth of interpretation and acknowledge that they have overseen a dubious process, being responsible for approving very different courses, which all achieve the same degree and place on the NMC register.

Diverse curricula range between the extremes of total specialism or total genericism, though reports are that the majority have adopted the Willis (2015) model of 2 years core, 1 year specialism. Recent research has shown students feeling ‘core’ or generic content is not adequately contextualised to mental health settings (Buescher and McGugan 2022). If specialism is an afterthought, squeezed into a single final year rather than being built from the ground up, ‘core’ content will not prepare students for transition into 3rd year university level study of mental health nursing. This will simultaneously overwhelm yet still underprepare students, with mental health nurse academics desperately trying to make up for 2 years of omissions (Warrender 2022b).

The practice assessment document

Whilst university curricula vary, there are shared concerns regarding the practice assessment document (PAD) used on students clinical placements. Annexe B in the future nurse standards, nursing procedures, are deemed necessary for all nurses (NMC 2018) and have shaped the PAD. These encompass a huge list of procedures, and include (amongst many more) venepuncture and cannulation, catheterisation, blood transfusions, nasogastric tubes, rectal examination and manual evacuation. Students have articulated that there appears to be a mismatch between the practice assessment document and the job a mental health nurse will actually do (Critical Mental Health Nurses Network 2022a). Students experience mental health services which are not set up to deliver these physical health skills, meaning little opportunity for practice, and the absurdity that practice supervisors signing students PADs may not have been trained in these skills (Critical Mental Health Nurses Network 2022b).

A further danger is creating an illusion of competence, with students signed off as competent, yet skills underutilized post-registration and quickly lost. Students have expressed that if upon registration they are finally faced with a situation where these skills are warranted, that “their only suitable action will be to refuse to do them, on the grounds that it has been too long since they practiced them and they no longer feel competent” (Critical Mental Health Nurses Network 2022b). Skills mental health nurses may not need are taking up a lot of time on placement learning, and it has been argued that the complex role of mental health nursing has been overlooked for “redundant procedural based competencies and proficiencies” (Connell et al 2022 p.8).

Mythbusting: Don't mental health nurses understand the need to address physical health needs of people with mental health problems?

A myth which needs explicitly addressed is that in expressing dissatisfaction with practice assessment documents and some academic curricula, that mental health nurse academics do not care about or understand the physical health needs of people with mental health problems. This is untrue, and arguments are twofold: 1) that physical health education should not come at the expense of mental health education, and 2) that physical health education is contextualised to the role of mental health nursing, rather than simply cloning the adult nurse skillset. Whilst the UK still has a specific entry onto the NMC register which designates registrants as specialists in their field of nursing, that field of nursing needs to be appropriately respected and prioritized through their pre-registration education. If this is not the case, one may argue that entry onto the register as a specialist is at best disingenuous.

The Department of Health and Public Health England (DH and PHE) (2016) acknowledge people with serious mental health problems are at risk of poor physical health and on average die 15-20 years earlier than the general population, and in response produced a document “Improving the physical health of people with mental health problems: actions for mental health nurses”. Action areas emphasized are support to quit smoking, tackling obesity, improving physical activity levels, reducing alcohol and substance use, sexual and reproductive health, medicine optimization, dental and oral health, and reducing falls (DH and PHE 2016).

The document indicates complex reasons for poor physical health such as the social determinants of health, harmful impacts of medicine and diagnostic overshadowing, and emphasises action through utilization of the therapeutic relationship - developing person-centred action plans and assistance with behaviour change (DH and PHE 2016). Whilst this appears to be a sensible approach to complex physical health problems, mental health nurse academics describe education so laden with physical health procedures and skills that it overlooks the importance of the therapeutic

relationship, giving it inadequate attention and thus harming the ability to develop one of the conduits through which physical health could actually improve.

The role of the mental health nurse: distinct and misunderstood

Philosopher Gilles Deleuze put forth the notion that identities do not form and reform in isolation, instead, difference is actualized into specific forms of identity (May 2005). This line of reasoning may be more useful, shifting from commonalities across fields of nursing to the specific differences between them. There are many. 'Mental health' is an arena of competing ideology, with understandings of distress and treatment approaches the source of much more disagreement than that of physical health (Connell et al 2022). It is certainly hard to argue that the physical systems of the body, which can be objectively studied and measured, are not imbued with a degree of simplicity when compared to that of mental states and human experience. Unlike lungs, heart and bladder, experience cannot be held and studied.

Mental health care has been criticized as being authoritarian, paternalistic and not recovery oriented, with an overreliance on medication (Wand et al 2021). It has been argued in this arena of paternalism, often overseen by psychiatry which favours depersonalizing diagnosis, that the role of mental health nursing should be to provide genuine advocacy, respecting the persons subjectivity through an ethos which is to "meet the person, where the person is" (Connell et al 2022, p.6). However, Connell et al (2022) adds that the NMC future nurse standards have undervalued and underrepresented key skills such as human connection, genuine advocacy and therapeutic use of self.

Furthermore, whilst all nurses build therapeutic relationships, one of the key differences in mental health nursing, is that these are developed and maintained in a context which includes the mental health act and a power over people. Mental health nurses have felt the moral dilemma and delicate decision making of ensuring restrictive actions are only taken in accordance with the proportion of risk and as a last resort, and experience a conflict between a sense of accountability and their own values (Mooney and Kanyeredzi 2021). This immediately imbues relationships with a significant delicacy and is not a minor complication to be treated lightly.

Connell et al (2022) argue that it is ultimately the service user of mental health care who holds the unique position from which the role of mental health nursing should develop. That position is one in which people may be considered to need care yet not all want it, with human experience a dynamic labyrinth of subjectivity, no consistent route to mental distress, no universally guaranteed recovery pathway, and significant power over people which can both make relationships harder to develop and maintain. Power imbalances can also lead to serious iatrogenic harm, as risk not only comes from the person but also from poor care delivery. Thus, whilst it has been argued that the things which service users may value are simple, feeling cared for, shown compassion, and mental health nurses making a genuine effort to get to know them (Gunasekara et al 2014), what makes the simple very complex are these activities being done well in this context.

Mental health nurses require excellent interpersonal skills, ability to navigate ethical dilemmas and values conflicts, and be a genuine advocate for service users in a contested area of practice (Connell et al 2022) where there is enormous potential to help, but also enormous potential to do harm (Warrender 2022a). These areas of knowledge and skill require a significant depth of exploration in education and should be prioritized accordingly to fulfill the NMC's (2018) aim of ensuring new registrants are equipped with advanced field specific skills. Mental health nurse education requires difficult to grasp 'threshold concepts', with uncomfortable learning integrating phenomenon and

leading to both intellectual and emotional development (Stacey and Stickley 2012). This cannot be rushed or tokenistic.

A specialism lost for the illusion of holism

One may ask the NMC how they considered true holism to be achieved in the standard model of educating nurses within three years. Dove (2018) stated that nursing curricula was already “fit to burst”, and that including more may suggest the need for a 4 year programme. With the introduction of much more physical health theory and skills for mental health nursing students, how was it ever pragmatically possible to achieve both an increase in physical health skill, and also maintain the depth of specialist knowledge necessary to do a job which still has its own distinct place on the NMC register? It could be considered belittling to mental health nursing itself that this version of ‘holism’ has led to less mental health for many students studying mental health nursing. Perhaps the idealism of holism has naively overlooked the brutal pragmatism of how it was to be achieved, with a disconnect between ideas and reality. Whilst it could be argued impossible to give nurses absolutely everything and achieve holism within 3 years (certainly if it is truly being done well), as long as the appropriate boxes are ticked, you can at least make it look like it from the outside.

Implications for the present and the future

The postcode lottery in education may mean a varying depth of specialist knowledge in newly qualified mental health nurses, and a worrying trend of some universities advertising for lecturers in ‘nursing’ without specifying field of practice may be an indication of increasingly generic approaches. The UK may have a future mental health nurse workforce with dormant, underutilized and therefore irrelevant physical health skills, and a deficit of knowledge and skill which would prove much more useful in mental health settings. There is serious potential for attrition of mental health nursing students, concerns regarding retention of unprepared mental health nurses, and implications for retention of mental health nurse academics who may not stay to teach courses they do not believe in (Warrender 2022b). However, the primary and paramount concern is that of service users.

Connell et al (2022) argue that the future nurse standards will weaken mental health nursing, introducing a more generic nurse with less specialist knowledge and skill, which will then lower the standards of mental health care. Taking this concern seriously and looking to the future, the UK would be prudent to review experiences in Australia, a failed experiment for mental health nursing care. Reviews in Australia have found their ‘comprehensive’ training ill-prepared nurses to work with people in mental health settings, with calls for a return to specialist training (Lakeman et al 2022).

Bladon (2022) asks, following recent appalling scandals seen in TV documentaries, if mental health nursing is going backwards? These scandals undoubtedly add weight to the suggestion that mental health nursing requires dedicated focus on the therapeutic role, the ethics of coercive and custodial practice, and trauma informed care (Ion et al 2020, Wand et al 2021). However, it may be challenging to move forwards and sufficiently prioritize these areas in current status quo, with mental health nursing not able to decide its own future, and its direction decided by those outside the profession (MHNAUK 2016).

An issue for all smaller fields of nursing

Whilst mental health nursing has perhaps been more vocal around the impact of the future nurse standards on specialist education, concerns have also been raised by Children and Young Peoples

(CYP) Nursing, with academics voicing “serious concerns that the CYP nursing students were missing out on vital information pertinent to their field of practice” (Glasper and Fallon 2021), and the RCN Congress (2022) matter for discussion raised by the mental health forum gaining public support from CYP and Learning Disabilities Nursing during the debate. It has been argued that what was sold, and perhaps genuinely intended to be truly generic (though framed as ‘core’ or ‘holistic’), has been pragmatically realized as “adult-nursing-centric tuition” (Glasper and Fallon 2021), and all nurses shaped in the likeness of adult nurses (Warrender 2022b).

Waking up on the edge of oblivion – The ‘Mental Health Deserves Better’ Movement

In January 2022, discussions amongst mental health nurse academics frustrated with the dilution of education led to the formation of a working group ‘Mental Health Deserves Better’, the hashtag #MHDeservesBetter, and publication of an agreed manifesto (Mental Health Deserves Better 2022). This grassroots movement collects concerned academics, clinical staff, students and interested others, and may not represent a universal view but show that some within the profession have ended their sleepwalking and are finally awake. Over 25 years ago, Barr and Sines (1996, p.277) wrote that “generic nursing must not arrive by default due to nurses’ lack of conviction, apathy, a sense of creeping inevitability, a perception of powerlessness or a combination of the above”. It is in this spirit that ‘Mental Health Deserves Better’ is making a genuine attempt to bring mental health nurses together, resisting the loss of specialist education, and looking towards the future.

Conclusion

There is much consensus within the mental health nursing profession that education is headed in an unsatisfactory direction which will not improve the quality of mental health care offered by mental health nurses and will instead lead to poorer care. Whilst the most urgent action needed may be simply to ‘stop the rot’ in education, there is further pressing need to develop and consolidate mental health nursing identity through philosophical argument. The profession must acknowledge key distinctions between fields of nursing, define how mental health nurses operate within multidisciplinary teams, and work alongside service users and families in developing the evidence base for mental health nurse activity and interventions. Whilst debate is needed around the direction of mental health nursing education, a growing consensus within the profession may start with one area of agreement. Not this.

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