Mental health deserves better: resisting the dilution of specialist pre-registration mental health nurse education in the United Kingdom.

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PERSPECTIVE

Mental health deserves better: Resisting the dilution of specialist pre-registration mental health nurse education in the United Kingdom

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Abstract

This article aims to draw attention to increasing genericism in nurse education in the United Kingdom, which sees less specialist mental health education for mental health nursing students and offers opposition to such direction. In 2018, the Nursing and Midwifery Council produced the 'Future Nurse' standards which directed changes to pre-registration nurse education. This led to dissatisfaction from many mental health nurses, specifically regarding reduced mental health content for students studying mental health nursing. Concerns have been raised through public forum and evolved into a grassroots national movement 'Mental Health Deserves Better' (#MHDeservesBetter). This is a position paper which presents the perspective of many mental health nurse academics working at universities within the United Kingdom. Mental health nurse academics collaborated to develop ideas and articulate arguments and perspectives which present a strong position on the requirement for specialist pre-registration mental health nurse education. The key themes explored are; a conflict of ideologies in nursing, no parity of esteem, physical health care needs to be contextualized, the unique nature of mental health nursing, ethical tensions and values conflict, implications for practice, necessary improvements overlooked and the dangers of honesty and academic 'freedom'. The paper concludes by asserting a strong position on the need for a change of direction away from genericism and calls on mental health nurses to rise from the ashes to advocate for a quality education necessary to ensure quality care delivery. The quality of mental health care provided by mental health nurses has many influences, yet the foundation offered through pre-registration education is one of the most valuable. If the education of mental health nurses does not attend to the distinct and unique role of the mental health nurse, standards of mental health care may diminish without assertive action from mental health nurses and allies.

KEYWORDS
mental health, nursing, population health, psychiatric nursing, students

INTRODUCTION

In the United Kingdom (UK), a student studying nursing complete the minimum of a 3-year bachelor's degree and gain the professional qualification of registered adult, child, learning disability or mental health nurse by meeting the professional standards set by the Nursing and Midwifery Council (NMC, 2023a). The pre-registration nursing programme includes periods spent in university completing 'theory' time, amounting to 2300 hours and

the other 50% in 'practice' spent on clinical placements in a variety of settings. While the UK is in the minority of countries offering a direct entry into the specialism of mental health nursing at the pre-registration level (International Council of Nurses, 2022), there are concerns that the specialism, despite being maintained on paper, is in actuality being diluted (Jones, 2023) and may be lost following changes to education standards, with the NMC and approved education institutions (AEIs) each holding a degree of responsibility.

The NMC has a role in setting standards, and then approving curricula (NMC, 2023b). Since the introduction of the Future Nurse standards (NMC, 2023a) in 2018, which were heavily influenced by the national 'Shape of Caring' review and its proposals for more physical health knowledge for mental health nurses (Willis, 2012, 2015), the UK has seen students practice assessment documents and pre-registration curricula become 'adult-nursing centric' (Glasper & Fallon, 2021), weighted to favour adult (physical health) nursing. Updates to the 2018 standards in 2023 reflected increased flexibility in simulation and entry requirements (NMC, 2023c), with no changes relating to educational content. While AEIs have been responsible for their interpretation of the standards and there is thus some variation between approved curricula, communications between members of mental health nurse academics UK has noted a trend of losing specialist mental health knowledge, with physical health education both at the expense of mental health education and not contextualized to the role of the mental health nurse (Warrender et al., 2023). This poses a risk to the preparedness of newly qualified mental health nurses and ultimately may lower standards of care. This debate is not new, and foreboding concerns had already been well-articulated in 2016, prior to the publication and implementation of the standards (Warrender et al., 2023). Mental health nurses and academics did raise concerns around the prospect of genericization in the NMC's consultation, though these concerns were not heeded (McKeown, 2023) and the practice assessment document used by students on placement was developed without a single practising mental health nurse or academic present (Evans, 2023).

Of late this debate has been approached with a renewed energy and organization, and with the benefit of having seen how the Future Nurse standards were actually implemented and realized, 'objections are arguably more potent and pointed' (McKeown, 2023). It has been argued that the seminal differences between mental health nursing and other fields of nursing have been overlooked (Connell et al., 2022), and the faint trace of specialism barely evident in many undergraduate curricula has led to descriptions of a ghost profession (Warrender, 2022a). Growing dissatisfaction from mental health nurses was also raised (and supported by learning disabilities nurses and children and young people's nurses) in a debate at the Royal College of Nursing Congress (2022). It has been further argued that without collective action from mental health nursing, all will be complicit in the professions demise (Haslam, 2023). A recent survey by the Royal College of Nursing's Mental Health Forum gathered 951 responses from across the UK, with 63% concerned that mental health nursing was being diluted (Jones, 2023). The survey identified the genericization of mental health nurse education as a key concern.

January 2022 saw the establishment of a working group called 'Mental Health Deserves Better' (2022) and the use of hashtag #MHDeservesBetter, connecting many mental health nursing academics concerned by the dilution of specialist content within AEI undergraduate curricula, and discussing how this may be addressed. This movement raised concerns through the publication of an open letter on the 21 of February 2023 which was addressed to the NMC, AEI's, chief nursing officers and relevant national organizations and was signed by over 100 mental health nurses, including mental health nurse academics working across 33 Universities (Devereux, 2023a; Mental Health Deserves Better, 2023). While the NMC and chief nursing officers published a response on the 5 of June 2023 (NMC, 2023d), the Mental Health Deserves Better group released a statement expressing their continued dissatisfaction, feeling 'disappointed that it has taken so long to receive a response that ultimately uses a lot of words to say very little' (Devereux, 2023b).

The act of writing this discursive position paper thus continues the debate, and is consistent with the duties of the nursing role; raising concerns when encountering situations which may put service user safety at risk (NMC, 2018). Key themes explored in this paper are; a conflict of ideologies in nursing, no parity of esteem, physical health care needs to be contextualized, the unique nature of mental health nursing, ethical tensions and values conflict, implications for practice, necessary improvements overlooked and the dangers of honesty and academic 'freedom'. Authors are firm in the belief that specialist mental health nursing education is a necessary foundation for a workforce capable of providing quality care to those who need it. While this paper addresses the context within the UK, these arguments are in the arena of human affairs and thus relevant for the profession of mental health nursing globally.

A CONFLICT OF IDEOLOGIES IN NURSING

Health Education England (2017, p. 90) pursue genericism through arguing it increases flexibility in the system, stating it 'broadens base training with generic based competencies, which feeds multiple professions and facilitates change within careers' and will 'ensure a more appropriate balance between generalists and specialists without losing sight of the importance of specialism

in medicine' (HEE, 2017, p. 92). Acknowledging that improving physical health outcomes, specifically for mental health service users who are disproportionately disadvantaged compared to the rest of the population, should be a priority, it should not be to the detriment of mental health care. Connell et al. (2022) argue that though underpinned by, or perhaps veiled by, noble aims to improve physical health outcomes of a nation (Willis, 2012, 2015), reducing nursing to a generic nursing programme is somewhat erroneous.

Connell et al. (2022) argue that mental health nursing is engaged in a war of attrition. Mental health nursing has been grossly undervalued and usurped by warped neoliberalist reductionist principles (Carney, 2008), replacing irreducible human connection with quantifiable procedures (Connell et al., 2022; Mckeown et al., 2017) which though easier to measure, are less relevant to the role. Good work such as connection, genuine advocacy and therapeutic use of self cannot be reduced to procedures or measurable proficiencies, often 'evidenced' through students' proficiency chasing, as they desperately tick off lists of skills in practice assessment documents.

We argue the NMC have endorsed a narrow skill set based on the underlying assumption that all nurses, regardless of speciality/field, are best supported and prepared for professional registration through the acquisition of generic, technical competencies that measure and define all nursing practice by a set of standardized skills, procedures and proficiencies predominantly in relation to physical health needs and at the expense of other, more nuanced, specialist mental health skills. The current approach fails to adequately capture the contested philosophical, conceptual, social and ethical dimensions of contemporary mental health care (McKie & Naysmith, 2014) and is failing to adequately prepare students for mental health practice contexts (Buescher & McGugan, 2022). As a result, service users, families, carers and wider communities are, too often, being failed.

Indeed, the NMC and others may have believed that reducing nursing to the notion of being a nurse first and field of practice second, would solidify professional identity. This was foolhardy. An unexpected consequence of the move towards generic nursing has led to claims of 'nurse' identity being shaped in the likeness of adult nursing (Warrender, 2022a, 2022b), creating deeper divisions, with mental health nurses entrenching their position. The NMC has been criticized as wanting to both have their cake and eat it (Warrender, 2023), as they maintain direct entry onto the nursing register as a 'registered nurse (mental health)', while their standards are often interpreted in such a way which decreases the amount of mental health content in curricula. Specialist in name, while failing to protect specialist preparation.

The proclivity for resisting genericism is founded on one central notion, that it is the service user, that is constitutionally and morally entitled to care and treatment from a professional body that is sufficiently enabled to meet their needs. Unquestionably, the decision made with respect to the impact on service users is deepening divisions and compounding the argument that a move towards genericism is an act of folly. It is perhaps an indictment aptly levelled at the mental health nursing profession, of indolence in articulating professional value in contemporary services. It is conceivable that the profession has been subservient to other paradigms of care, and in that subserviency, we have failed to endorse our value, skill and importance in contemporary services.

NO PARITY OF ESTEEM

Achieving 'parity of esteem' across physical and mental health care has been central to developing the whole-person care approach (Willis, 2015), underpinning the move to greater genericism within current nursing education and practice assessment documentation. However, although at a broad level, national, regulatory and statutory efforts to prioritize mental health equally to physical health are welcome, the ways in which this has been enacted within the Future Nurse Standards have failed to achieve a true parity of esteem for mental health and, further, failed to recognize and support the 'seminal differences between the nursing fields, namely, mental health and adult (physical health) nursing' (Connell et al., 2022, p. 3). Serious questions can be raised at any claims the NMC standards respect the notions of specialism and parity of esteem, as experience sees many students receiving more focus on physical health, not in addition to, but at the expense of MH content. Put plainly, there is no evidence a generic approach will improve physical health (Happell & Cutcliffe, 2011) and it is hard to accept mental health nurses receiving less mental health content in their education as an improvement.

While standards and proficiencies, in general, have been critiqued as the antithesis of a learning environment which can develop all nursing students into critical thinkers (Collier-Sewell et al., 2023), one might argue this approach harms mental health nursing more than most. Unhelpfully, the Future Nurse proficiencies and their interpretation being placed in a created practice assessment document have seen a pronounced move towards the more easily measured biological aspects of health, meaning that not only are mental health nursing students 'chasing' physical proficiencies to be signed off, other fields of nursing have very little focus on the psychological manifestations of human existence. Despite the many claims of government papers, including no health without mental health (Department of Health and Social Care, 2011) and the International Council of Nurses (2022) describing mental health as an international priority which requires more attention in pre-registration programmes, mental health remains a peripheral part of nurse education. 'Generic' is best

defined as 'not specific' and though framed and defended as 'holistic' by the NMC (Holt & Dixon, 2022), each of these words does not correspond to a reality of equal representation, but a move towards the specific skills which best serve the largest group, this being adult nursing. A study into student nurse perspectives showed that the more teaching they received on mental health, the more confidence they felt in their ability to care for people with mental health problems (Thongpriwan et al., 2015). If mental health is left as an afterthought, it leaves all fields of student nurses unprepared to look after the 'whole' person in front of them.

There is recognition that mental health nursing students need to receive physical health theory and skills necessary to respond to the increasing complexity of health issues within the population they support. However, students have highlighted problems in both aim and infrastructure, feeling distracted from the act of mental health nursing and also feeling unable to meet the tasks they have been set while on placement. Students have described a discrepancy between the skills they need to sign off in their practice assessment document and the job they will actually do, with placements not offering the opportunity to achieve many physical health tasks, and many of the student supervisors not even trained in the skills they are being asked to assess (Critical Mental Health Nurses Network, 2022a, 2022b).

The broader and more complex determinants and presentation of mental health issues require a unique and specially developed set of values, skills and knowledge to be embedded within AEI curricula and reflected within practice assessment documents and frameworks. Sadly, overlooking this complexity, the current direction within education contains a startling absurdity; that the physical health of people with mental health problems is given more attention than the mental health of people with mental health problems. Moreover, physical health is still not given the right attention.

PHYSICAL HEALTH CARE NEEDS TO BE CONTEXTUALIZED

The narratives of those who find themselves in a mental health system for any amount of time are as varied and complex as are the experiences that have brought them there. In terms of barriers to improving physical health, Tabvuma et al.'s (2022) integrated review highlights low confidence, amotivation, experience of existential loss, poor health literacy, loss of agency and loss of the capacity to work. This is alongside diagnostic overshadowing, whereby physical health symptoms are attributed to mental illness, negative staff attitudes, access to physical activity and meaningful exploration of the indications and contraindications of prescribed medications and other substances (Hemmings & Soundy, 2020; Roberts & Bailey, 2013). Mental health nurses, therefore, need to be able to engage in attuned listening to service users' experiences, and from this begin a process of sense making. The unpicking of this experience in itself supports both the service user and the mental health nurse to understand external and internal influences impacting on recovery, putting both in a better position to address these barriers.

An increased genericism in mental health nursing, moving towards a physical intervention approach, is in danger of diverting attention away from these very factors that support engagement with mental and physical health recovery (Happell et al., 2012). This is because the causes of early mortality, such as poor collaboration with service users and between services, and mortality including dying through suicide, are in danger of being side-lined for a focus on recording and monitoring of physical health status. For example, recording national early warning signs (NEWS) of physical deterioration without meaningful conversation does little to promote a sense of agency and health literacy, and, therefore, it has little evidence for improved physical health outcomes in the mental health service user population. It is not that the seriousness of physical health problems is not recognized, but that the vehicles to address the issues for mental health service users are further distanced from the mental health nurse as they move towards genericism. Indeed the Australian comprehensive model of nurse education which produces a generic non-specialist nurse, who may then go on to work in mental health settings, has been criticized for failing to deliver its promise of improved physical health outcomes for people experiencing mental health problems (Happell & Cutcliffe, 2011).

Ultimately, implications are that unless there is co-production of plans to care for physical health through positive interpersonal communication and attention to the therapeutic relationship, there will be an impasse; the physical health of those with significant mental health problems is unlikely to improve (Tabvuma et al., 2022). If mental health nurses are to effectively support the agenda for improving the physical health of service users, the underpinning philosophy of mental health nursing should support therapeutic engagement, positive interpersonal communication, trust and co-production, as well as a focus on dismantling stigmatizing structures that reduce service user autonomy, choice, personal recovery and the promotion of hope. While mental health nurses do need to raise their game in working with the physical health needs of people with mental health problems, the practice focus must be centred on the key roles of remaining purposeful (stating intention), connected (listening, empathizing, validating), facilitation (making things happen with the service user), supportive (being emotionally attuned) and influential (working towards positive change; HEE, 2020).

Having a trusting relationship, connection and understanding, mental health nurses may be able to influence behaviour change and effectively signpost to

help, potentially influencing health outcomes through smoking cessation, harm reduction of substance use and advising on weight management and sexual health (Ion et al., 2020). Facilitation and making things happen may also include more practical assistance to improve health, such as help with benefit forms and housing applications which will help people access food and shelter (Ion et al., 2020). Including this health pragmatism in mental health nurse education is certainly a more sensible use of time than cloning of the adult nurse skillset.

THE UNIQUE NATURE OF MENTAL HEALTH NURSING

Although mental health and physical health are inextricably inter-connected, they are, in relation to epistemology and ontology, not the same. It is overly simplistic to believe one can readily translate the relatively linear nature of diagnosis, treatment and outcome that exists within physical healthcare practice, to the more ambiguous, social and contested field of mental health care. Diagnoses in mental health settings tell us little about the individual's lived experience and even less about how to respond, what support they need or indeed want. Psychiatric diagnosis, for example, still the dominant means of directing treatment, has been criticized as biased by subjective judgement and social norms, not able to explain distress, not lessening stigma and discrimination and removing personal meaning (Boyle & Johnstone, 2020). Mental health, in sharp contrast to physical health, simply does not have an agreed and shared paradigm, and it could be argued a political, organizational and societal human failing that emotional distress is still seen at a macro level as a malign biomedical condition.

Mental health nursing, being such a varied role, has been described as a jack-of-all-trades with values and attributes (e.g. honesty, trustworthiness, communication skills, resilience, empathy, compassion, non-judgementalism, genuineness and curiosity) that could be applicable in other professions and branches of nursing (McCrae et al., 2014). Nevertheless, a distinct professional identity and skillset exist, which emerges through educational exposure to a diverse range of people with mental health issues in different contexts (Hurley et al., 2022). Although guided by an empirical perspective, mental health nurses operate largely within and across subjective, relational spaces where the answer to most questions is, 'it depends'. This ambiguity requires mental health nurses to navigate complex ethical situations of care without 'fixed recipes' and demands that pre-registration programmes equip students with the ability to move beyond narrow conceptions of instrumental and technical care, becoming multi-skilled, critical and reflexive (McKie & Naysmith, 2014).

Mental health nurses care for vulnerable people, with complex needs that vary across acute distress and suicidality, social isolation and poverty, to the pursuit of individual growth and educational development (Connell et al., 2022) and the spiritual dimension through the way we make sense of ourselves, others, the world and beyond (Warrender & Macpherson, 2019). It is a multifaceted role which requires mental health nurses to be a psychotherapist, advocate, physical health therapist, psycho-pharmacological therapist, relationship-focused therapist and aggression management therapist (Hurley & Lakeman, 2021). In addition, mental health nurse activity involves undertaking risk assessment and management, understanding recovery principles, person and family-centred care, having good communication skills, a sense of humour, knowledge about mental distress and diagnoses and treatment, being able to evaluate research, promote physical health and physical and psychological interventions (Moyo et al., 2022). Nonetheless, despite this formidable list of activities, the core of the role may perhaps be found in the following quote; 'the most powerful 'interventions' occurred where the professional mask dropped and, even momentarily, there was authentic human-to-human connection' (Collier-Sewell & Melino, 2023, p. 3). This cocktail of unique skills, most valued through genuine human connection, cannot be tick-boxed after being taught quickly or read from a textbook alone. It needs to be nurtured through immersion in relational practice, a depth of exploration into varied theories and models and requires the space to develop over time through good critical thinking, role-modelling, experience and reflection.

In asserting the unique role of mental health nurses and resisting genericism, a question is posed: would care be enhanced if the future workforce was primed with physical health-centric nurses, veiled by the notion of generic or holistic nursing (Warrender, 2022a), to lead care with service users in contemporary mental health services? We argue not, and that mental health deserves better. An alternative is preferable; a professional who is acutely aware of both the challenges and pleasures of working, primarily, to understand the gravity of relational connection, established during the therapeutic interlocutor and navigating the interpersonal domain with expertise. Mental health nursing offers much more than an empirical perspective, it is a philosophy, a foundation of principles based upon a universal idea that, apt mental health care, is to connect and offer 'genuine' advocation (Connell et al., 2022, p. 5).

ETHICAL TENSIONS AND VALUES CONFLICT

One of the most prominent reasons for a unique skill set as compared to other fields of nursing is due to the navigation of values conflict whereby mental health nurses balance being in the roles of both carer and controller, in place as a result of a power differential caused

by legislation which can remove human rights (Connell et al., 2022), namely the Mental Health Act (1983/2007). Through this, simultaneously and perhaps paradoxically, mental health nurses can restrict autonomy under the guise of promoting autonomous recovery. It is inherent in this dilemma, among others, that mental health nurses are continuously exposed to the ethical tension of navigating conflicting values and moral injury. The duty of maintaining a therapeutic connection while applying legislative powers of coercion and exerting control (Austin et al., 2009; Brown & Reavey, 2019; Cheetham et al., 2018; McAllister et al., 2019; Otte et al., 2019; Peternelj-Taylor, 2004) such as restraint (McKeown et al., 2020), result in a collective skillset which is difficult to quantify. Such power, control and authority are present physically and interpersonally and can operate counter to the relational by othering service users rather than connecting with them as fellow human beings (Peternelj-Taylor, 2004). There are inherent difficulties from the offset for service users to be on an equal footing with mental health nurses, due to such power differences (Foucault, 1989/2003). 'Power lies with the one who holds a ward key' (Gildberg et al., 2016, p. 124), or metaphorical key to admission or discharge. Only a skilled professional can navigate such complexity while maintaining congruency with ethical, professional and therapeutic principles such as; connecting with a person in their world and supporting them in gaining a self-defined meaningful life. Said navigation has been grossly undervalued by those outside the profession.

The coexistence of accountability, power and subjection can lead to difficult experiences and emotions, impacting the individual and working relationships and could have a negative impact on staff experience and wellbeing (Mooney & Kanyeredzi, 2021). One mental health nurse has articulated that 'you get this conflict between you as a person, and you in your role. And that eats at you… You're kind of put in a position that it kind of changes you as a person… we talk about, kind of wearing two hats… and we can try and imagine we're just doing it because it's what we're told to do. But it is us, we do have control over what we choose to do and don't choose to do, and we kind of have to own that' (Mooney & Kanyeredzi, 2021, p. 1706). The complexity of formulating and appraising evidence to navigate unrelenting ethical dilemmas against a milieu of hierarchical control (Connell et al., 2022) is foundational to the craft of mental health nursing. Such complexity in the core balance of paternalism and subjectivism, inherent in the mental health nursing role, while being self-aware of own values, demands a highly self-aware and critical thinker (Connell et al., 2022).

Mental health nurses must dynamically reflect upon the impact of their own values while delving into the service user's world, and often trauma, to deeply connect with them (Connell et al., 2022). They gain a unique understanding of another's world, meeting them and being with them (Jones, 2022), through the use of self (Warrender, 2020), connection and genuine advocacy, in which they should be specialists. This may be a big ask for a newly qualified nurse with limited focus on the development of such skills in their generic and procedural-focused programmes, in addition to navigating an identity crisis, being smothered under other professions, all while being present for and connected with the people that hold the most important position and should matter most; service users.

IMPLICATIONS FOR PRACTICE

The current NMC standards direct mental health nursing students in a false search for certainty; instructed by notions of tick-box practice geared predominantly towards physical health needs and predetermined by professionally led outcomes not suitable to respond to the ever-increasing complexity of the mental health needs of the population. Such an approach fails to capture and prepare for the more emotionally laden and intrinsically close nature of authentic relational practice inherent in mental health nursing where the therapeutic 'use of self' sets it apart from other fields of nursing (Hurley, 2009). Furthermore, such an approach may fail to capture the voice of service users mental health nurses are advocating for, and in fact, service users in Australia have expressed a preference for mental health nurses to undertake a specialist undergraduate preparation (Hurley et al., 2023).

The essence of mental health nursing should be directed towards the realization of human, not technical, goals and this demands a form of care that is underpinned by a more specialist, subjective and dynamic learning experience than is currently supported. A combination of increasing genericism in the practice assessment document and a reduction in face-to-face contact with service users, due to the COVID-19 pandemic, has led to a substantial decline in practical opportunities for nursing students to develop core skills such as engagement, relationship building and reflective practice. As academics, we have increasingly experienced mental health nurses expressing concerns that student levels of understanding of the skills and qualities needed to be a good mental health nurse are shallow. The impact of the pandemic on clinical services shifted the weight of responsibility for education towards AEIs more so than clinical placement, yet sadly there are no guarantees this responsibility has been effectively met.

However, in this post-COVID-19 pandemic period, which has spotlighted the demand for high-quality mental health nurses, overstretched academic staff and curricula lack the scope for these qualities to be embedded into a skillset that enables our students to be there and interact therapeutically (Connell et al., 2022). Mental health nursing students have already described

feeling marginalized in core modules, with generic components of a course lacking mental health content, and theory and skills not being contextualized to mental health care environments (Buescher & McGugan, 2022). Academics too have been embarrassed by the courses they offer and questioned their future in nurse education (Warrender, 2022b). If too little time is afforded to embedding the values, and qualities needed to produce mental health-focused skills, there is a risk of producing a workforce with a reduced ability to serve its target population (McCrae et al., 2014). Amidst evidence of a direct relationship between professional identity and student retention in nursing education (Worthington et al., 2013), further impediment to the cultivation of professional identity in mental health nursing is an act of sabotage.

Further implications, should the direction of generic continue or even move further towards a single generic direct entry nurse registration in the future, might be the lack of a competent workforce to provide mental health care in the UK. Studies have shown that nurses on Australia's generic nursing programme are unlikely to choose a career in mental health nursing (Stevens et al., 2013) with the field often the least popular area of nursing (Happell & Gaskin, 2013) perhaps partly due to stigmatizing attitudes towards mental health present in undergraduate nurses (Bingham & O'Brien, 2018). The reluctance to undertake mental health nursing is not due to any deficit in individuals, yet it may be a sign that students themselves recognize that it is an entirely different field of nursing, which is deserving of apprehension without a robust and specialist training. Indeed, some nursing students have felt anxious about working with people with mental health problems due to negative stereotypes, yet this can be countered by a good preparation for the role (Happell et al., 2014). One could argue that to safeguard the future of the mental health nursing workforce in the UK, we should carefully nurture the interest of students in mental health, and not lose their interest (and thus create attrition from education) through courses which are distracted from that specialist interest. Both recruitment and retention have already been identified as an issue for mental health nursing in the UK (Jones, 2023), and we might honour recruitment to a specialist registration with genuinely specialist preparation, and in doing so, increase the potential of retaining better-prepared graduates.

NECESSARY IMPROVEMENTS OVERLOOKED

Frustration mounts as mental health nursing recognizes the need for necessary improvement (Warrender, 2022a), yet the ill-thought-out emphasis on physical health skills may be a barricade to progress which is more pertinent. Suggested improvements include a need to move away from biomedicine and provide alternative understandings of mental distress (Grant & Gadsby, 2018) and consider effective responses to trauma (Ion et al., 2020), while the future of the role should focus on the therapeutic relationship, with a de-emphasis on psychiatric medication, psychiatric diagnosis and custodial practices (Wand et al., 2021). This cannot be achieved without the weighting of mental health nursing courses respecting it as a specialism, and allowing education to address both mental and physical health in a distinct way. Evidence from peers in Australia has shown wide criticism of their generic approach to nurse education, which though also initially framed as holistic, has led to an under-prepared nursing workforce with inquiries into mental health services proposing the return of specialist training (Lakeman et al., 2022; Warrender et al., 2023). It has already been considered a critical issue by academics and students in the UK that mental health nurses may lack the knowledge to provide comprehensive psychosocial interventions (Jones, 2023). This is in desperate need of improvement, given that some mental health nurses when better prepared for therapeutic engagement feel more able to tolerate risk and decrease their use of restrictive practice (Warrender, 2015).

Mental health nurses operate within a professional paradigm that is uniquely relational, requiring reciprocity in both co-constructing and advocating on behalf of service users that they work alongside and may involve fighting against and resisting iatrogenic discourses they have previously been beholden to (McKeown & White, 2015). Values may clash with existing approaches in wider systems, for example, no-harm contracts (where care may be withdrawn should a person harm themselves) are used despite being unsupported by evidence (Lewis, 2007), and criminal sanctions are still commonplace for suicidality (Thomson et al., 2022). These unsophisticated and negligent approaches exist in the culture of mental health care, and education needs to be assertive enough to equip students with alternative approaches, and the courage to advocate for service users in a system which can harm them. Mental health nurse academics have argued for an education which focuses on reflexivity and self-awareness (Colwell et al., 2023) and confronts students with systemic failures which have harmed service users, in doing so facilitating a deep-dive into morality and ethics (Wagstaff et al., 2023). Given the further problems in providing mental health-specific placements to students in the UK, it has been argued that simulation may be a valuable opportunity for quality bespoke mental health nurse education (Harvey, 2023), given the NMC now allow 600 of students 2300 practice hours to be achieved in this way (NMC, 2023e).

The development of the self is crucial, as further challenges arise in that even with specialist education, student nurses exist within the theory-practice gap and often face a challenge to resist socialization when bringing in new ideas and maintaining their values. It

has been argued that 'academia attempts to present practice with a gift, which may unfortunately be received as a threat' (Warrender, 2022c, p. 171). However, without a quality specialist underpinning, there will be no gift to reject and conformity may be inevitable as newly qualified staff will be limited in their breadth of alternative understandings and approaches. Furthermore, with limited specialist training, the nurse may become less influential and useful in the multidisciplinary arena, carrying with them a deficiency of specialism, which was sacrificed for the illusion of holism.

THE DANGERS OF HONESTY AND ACADEMIC 'FREEDOM'

Fisher (2009) highlighted the influence of capitalism on the business ontology of education, stating an unresolved confusion and tension between the dual position of students as consumers of a service, and simultaneously products of that service. In the case of mental health nurse education, the current approach fails in both regards, neither meeting the needs of a consumer with a keen interest in mental health, and thus impacting on recruitment and retention of students driven by this specific interest, nor producing a product able to provide quality mental health care, and thus potentially lowering the standards of care offered to the population. Furthermore, despite the justifiable alarm which should be raised regarding this potential dual failure, the people in the best position to recognize this and articulate the need for improvement may also be kept silent.

Darbyshire et al. (2021, p. 367) observe that 'nursing schools often fail to explicitly promote academic freedom… due to fear of possible threats to tenure or reputation' and this is a serious issue for mental health nursing. Being outnumbered in nursing, and within AEIs, one way to have a genuine voice is through academic writing. However, there is an inherent conflict between the idea of caring, and the business model and marketization of nursing courses (Hemingway et al., 2016). Fisher (2009 p.44) astutely suggests 'all that is solid melts into PR', and that in capitalist societies, value is not derived from what a company actually does but instead from beliefs and perceptions about its performance. Thus, anything which publicly critiques the quality of education provision is considered a threat to the interests of AEIs, which may be more accurately described as 'monetised nurse factories'. In nursing, it has been found that people who speak up and raise issues can be accused of being unprofessional, cast as a problem to be managed and even themselves become the object of scrutiny and subject to disciplinary action (Jackson, 2022). Thus, if there has been silence this is understandable, though this silence is not necessarily agreement. Dissenters may not be taken out by snipers, though may be scolded by human resources or denied career advancement. The authors of this paper certainly feel reassured by a strength in numbers which they may not experience when speaking or writing alone, and this is a model for how our profession must move forward; together.

CONCLUSION

As mental health nursing academics and, more importantly, as registered mental health nurses, we strongly believe we have both a professional and ethical duty to adequately prepare mental health nursing graduates to be able to support and advocate on behalf of service users across multiple settings, where they will be faced with unique ethical terrains and, often, competing value-bases. Supporting and responding to complex mental health needs requires both a curriculum and practice assessment framework that defies the current reductionist, technical, instrumental and (predominantly adult nursing) set of values and skills that are embodied within the Future Nurse Standards. We firmly believe that in the present guise, these are not fit to adequately prepare mental health nursing students to support the mental health needs of service users.

It is, therefore, incumbent on mental health nurses, in the UK and across the globe, to rise like the phoenix and emerge from the ashes (Warrender, 2022a) to vanguard the future of mental health nursing with a primary focus on striving to meet the needs of the general public. This article calls upon the profession and its allies to engage with those who would seek to reduce mental health nursing to a generic nurse role and argue its foolishness. We petition to shape the evidence as to what it is to be a good mental health nurse and rebuild the future of mental health nursing, striving to meet the needs of people we support.

While we acknowledge the responsibility of AEI's in implementing the NMC standards, we nonetheless must ask a question of our regulator. As it is the NMC who initiates and is responsible for finalizing this process; if so many mental health nurse academics, students and clinical staff are unsatisfied with the provision of mental health nurse education, can NMC approval of programmes be considered a mark of quality? We certainly think not, and in following guidance from our professional code, the NMC may seriously consider these arguments, investigate further and embody their principle 'duty of candour'; being open and honest that things have gone wrong, apologizing to those affected and acting immediately to put the situation right (Nursing and Midwifery Council, 2018).

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