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Standards of proficiency for registered nurses—To what end? A critical analysis of contemporary mental health nursing within the United Kingdom context

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Abstract

Against the backdrop of cultural and political ideals, this article highlights both the significance of mental health nursing in meeting population needs and the regulatory barriers that may be impeding its ability to adequately do so. Specifically, we consider how ambiguous notions of 'proficiency' in nurse education—prescribed by the regulator—impact the development of future mental health nurses and their mental health nursing identity. A key tension in mental health practice is the ethical-legal challenges posed by sanctioned powers to restrict patients' freedom *at the same time as* the desire (and obligation) to promote patients' self-determined recovery. The genericism of the UK's *Future Nurse Standards* do little to prepare mental health nurses to navigate the tensions that ensue. This has consequences for nurses and patients alike, as both risk experiencing the distress and dissonance that attends giving or receiving poor care. We argue that more needs to be done to enable mental health nurses to define and articulate the nuances of the profession as part of becoming critical, thoughtful and confident practitioners. Educators can contribute to this mission by aligning curriculum, pedagogy and assessment to create meaningful opportunities for mental health nursing students to engage with the complexities of mental health nursing practice. Without this, the credibility of the profession will continue to be questioned; its future uncertain.

KEYWORDS

care provision, mental health nursing, personal recovery, professional obligation, professional socialisation, quality care, safety

1 | INTRODUCTION

In line with the sustainable developmental goals (World Health Organization, 2021), and to achieve set goals within the World Health Organisation's comprehensive mental health action plan 2013–2030, the *World Mental Health Report* in 2022 well articulates the need to transform environments that influence mental health care. The heart of this transformation is the urgent need for sufficient responses to the increasing mental health needs of the populace (World Health Organization, 2022). It is impossible to address individual and community mental health needs without acknowledging how structures impinge on the care and support that is (or is not) provided. One such structure is nurse education—the space in which new nurses are trained to meet health care system demands. Globally, a standardised approach to nurse education is lacking, despite the World Health Organization (2009).

Where there is regulation of nursing and nurse education, there are two educational 'routes' to acquiring nurse registration (or licensure) and nursing specialism. In Australia, the United States of America and Canada, undergraduate student nurses complete a generic nurse education first; specialisms by field, including mental health, are obtained only post-registration, usually at the post-graduate level. By contrast, the United Kingdom is one of few countries that offer specialist nurse education at the undergraduate, pre-registration level, allowing direct entry into adult, child, mental health and learning disability fields. The United Kingdom also offers a relatively new pre-registration postgraduate level (masters) programme, through which students qualify with a nursing specialism after 2 years. This is designed to enable prospective nursing students, already equipped with graduate-level academic skills, to advance to registration more quickly.

Arguments for and against both nurse education setups—generic training first, or direct entry into specialism—can and have been made (see e.g., Lakeman et al., 2024). The purpose of this discussion is to explore the quality of mental health nurse education in the United Kingdom as it exists in its pre-registration and direct entry form. We believe there is latent potential in retaining a direct entry route into the mental health nursing specialism, but that the current state of this route needs urgent attention.

This paper critically reflects on the regulatory standards that govern nurse education in the United Kingdom, the *Future Nurse Standards of Proficiency for Registered Nurses*, and particularly as they apply to the mental health nurse (Nursing and Midwifery Council, 2018). This reflection is set against the need for a nursing workforce with both generic nursing and specialist mental health skills (Nursing and Midwifery Council, 2018). Within this context, we examine the challenge of *Future Nurse Standards* that try to be 'all things, to all people, all at once', and in doing so, we question the ambiguous deployment of 'proficiency' and what it means in the context of the standards, nurse education and nursing practice in the United Kingdom. As such, we consider the liminal position of mental health nursing, as a field that struggles to articulate what it does. Finally, we explore the challenges and opportunities ahead for mental health nursing in the context of transforming mental health for all.

2 | BACKGROUND

The incidence of mental health conditions continues to increase worldwide (World Health Organization, 2023). This has been compounded by the coronavirus disease 2019 (COVID-19) pandemic, including people who are experiencing mental distress directly related to the pandemic, and people experiencing an exacerbation of pre-existing mental health difficulties (Kathirvel, 2020; Liu et al., 2021; Meaklim et al., 2021). This situation requires services to support by providing early biopsychosocial interventions via community services or, should the severity warrant this, through interventions in intensive or in-patient settings (Byrne et al., 2021; Vadivel et al., 2021). Theoretically, in the United Kingdom, mental health nurses are best positioned to meet these population needs; in reality, several unique barriers exist that threaten to prevent this.

In the United Kingdom, the nursing regulator, the Nursing and Midwifery Council (NMC), sets out standards that approved nursing programmes must 'meet' in their provision of education to nursing students. These standards are known as the *Future Nurse Standards of Proficiency for Registered Nurses* (Nursing and Midwifery Council, 2018). Adult, Child, Learning Disability and Mental Health students must all undergo training through an approved educational institution (AEI) with half the programme being theory-based at university, and half (2300 h at the very least) in clinical practice with direct patient and carer contact (Nursing and Midwifery Council, 2022). Following this training, nurses join the NMC register depending on their specialist field.

The *Future Nurse Standards* articulate the knowledge and expertise expected from *ALL* registered nurses across specialisms. Despite the existence of four separate direct entry educations (Adult, Child, Learning Disability and Mental Health), a single set of standards is provided to AEIs by the regulator. The standards emphasise expectations pertaining to the delivery of 'safe', 'compassionate' and 'effective' nursing care (Nursing and Midwifery Council, 2018). In the current iteration of the *Future Nurse Standards*, the language used to capture this expectation is that of 'proficiency'—nurses are expected to be 'proficient' in their delivery of nursing care—whereas the previous standards hinged on the language of 'competency' (Nursing and Midwifery Council, 2014). Whatever the terminology, the *Future Nurse Standards* place high expectations on nurses to be knowledgeable and accountable practitioners.

The concept of 'proficiency' and learning contexts are inseparable (Delany et al., 2018). Learning contexts occur in real or virtual worlds and impact learners (nursing students) as it pertains to developing 'professional knowledge, skills and aptitudes' (Delany et al., 2018, p. 90) in both the theory and practice of nursing. However, the greater the difference between theory and practice learning contexts, the less easily this knowledge can be transferred from one learning context to another (Delany et al., 2018). Further,

the absence of a defined curriculum and pedagogy, as it applies to various learning contexts, makes issues relating to 'proficiency' highly contextual; what is 'proficient' knowledge, behaviour and attitude in one context, might not be quite right in another.

The introduction of the *Future Nurse Standards* has created concerns about the movement towards genericism in pre-registration nurse education and the erosion of necessary therapeutic skills, such as advocacy, use of self and connectedness that mental health nurses require to flourish (Connell et al., 2022; Haslam, 2023; McKeown, 2023a). To confound matters, during the COVID-19 pandemic, pre-registration mental health nursing, like other fields of nursing, shifted towards virtual and simulated methods of practice learning (Haslam, 2021). Models that support learning opportunities for mental health nursing skills, through simulation, are being developed (Harvey, 2023). However, these models are limited, and robust evidence is needed to prove their effectiveness (Harris et al., 2020; Lee et al., 2020).

Additionally, with the need to achieve several generic proficiencies on the Practice Assessment Record and Evaluation document (the practice placement assessment record in England, for instance), mental health nursing students are sometimes offered generic placements—where the medical model takes prominence—or short-term placements (typically 4 weeks) that focus on 'achieving' task-oriented proficiencies rather than mastering the art of delivering psychosocial interventions. Thus, there exists a theory-practice gap between the practice advocated in the university and what actually happens in practice (Warrender, 2021). This theory-practice gap in United Kingdom nurse education impedes self-efficacy, the capacity to think and plan adequately, as well as nurses' sense of control, composure and commitment within clinical environments (Martin & Marsh, 2008). Arguably, it also contributes to cultures of coercion and exclusion within psychiatry (Beale, 2021).

Once qualified, the roles that mental health nurses occupy are not fixed to a particular type of service within the UK health ecosystem. However, across all settings, nurses will confront complexities that require ethical reasoning to support defensible practices. Within forensic settings, there is an expectation for nurses to typically deliver care and keep custody of patients who have been convicted of crime for personal recovery purposes (Johansson & Holmes, 2023). Within acute inpatient settings, nursing staff often have to make clinical decisions that tend to be risk-averse amongst work-related pressures, such as documentation of care plans (McKeown et al., 2020). In emergency departments, mental health nursing staff experience a lack of autonomy while mental health nursing students feel unprepared due to limited training received (McCarthy et al., 2023). Currently, understanding of individual proficiency and capability, and what this does or *should* look like, is lacking within the mental health context specifically.

In the face of ambiguity, it is thus unsurprising that defensive practices predominate as nurses look for ways to protect themselves professionally (Bifarin et al., 2022). Defensive practices can manifest as 'staff protecting themselves from threat or possibilities for emotional laborious work by taking refuge in their offices—often justified by the need to complete the paperwork they profess to dislike' (McKeown et al., 2020, p. 452). Current evidence suggests that nursing students are also adversely affected by their dependent position within clinical settings. This is often characterised by staff uncooperativeness (Shadadi et al., 2018), discouraging asking questions (O'Mara et al., 2014), frequent incivility (Jack et al., 2018; Thomas et al., 2015) and belittling of students for speaking up (Fagan et al., 2021).

Given high-impact work-related stressors, associated with demands placed on mental health nurses and lack of organisational support, mental health nurses are arguably put in a precarious situation, yet expected to provide therapeutic interventions (Bui, et al., 2023). Protecting the populace's right to appropriate mental health care at the appropriate time requires acknowledgement that mental health exists on a complex continuum. The system must be adequately resourced so that care, across this spectrum, is provided. As a core staff group within the mental health care system, today's mental health nurses must draw upon a flexible and wide-ranging skill set that speaks to a variety of roles in primary, secondary and tertiary care services (Collier-Sewell et al., 2023). It is against this backdrop, that we offer a timely line of argument, focusing on *Future Nurse Standards* and what it means for developing evidence-based, critical thinking and 'proficient' mental health nurses.

2.1 | Theoretical framework and author positionality

Constructive alignment (CA) (Biggs, 1996, 2014) is a student-centred design widely known for synthesising key concepts in the discipline of education. Education, in this context, consists of *curriculum* (collection of ideas with intended learning outcomes); *pedagogy* (set of methods and practices for teaching a curriculum) and *assessment* (a systematic basis for making inferences about the learning and development of students). These are enabled by the learning environments, which, in nurse education, comprise both clinical and university settings. CA views knowledge as constructed through teaching and learning activities that students engage with through a systemic approach. It conceptualises meaningful education as an alignment of *curriculum*, *pedagogy* and *assessment* methods—for all components of education to work together, they need to complement and reinforce each other. We adopt CA as a framework to critically examine if and how nurse education is functioning consistently to educate mental health nurses who are 'proficient' and confident in their scope of practice. As experienced nurses, clinical-academics, researchers, and academics, we are inevitably influenced by our work within the field of nursing practice, nursing research and nursing academia. We therefore embrace a contextualist epistemology, which acknowledges that our experiences will, directly and/or indirectly, impact our interpretations throughout the discourse in this paper.

2.2 | Complexities of 'proficiency' in mental health nursing

This section addresses how a lack of clarity about what 'proficiency' means in the *Future Nurse Standards* (Nursing and Midwifery Council, 2018) results in subjective attempts to provide a definition, potentially creating more ambiguities (and further problems) than solutions. In the *Future Nurse Standards*, nursing practice is viewed as comprising generic skills, knowledge and attributes, where 'level of proficiency' dictates the difference(s) between one nursing field and another (Nursing and Midwifery Council, 2018). For example, the standards highlight the importance of proficient use of communication and therapeutic interventions for all fields of nursing. At the same time, it is acknowledged that 'the level of expertise and knowledge will vary depending on the chosen field of practice' (Nursing and Midwifery Council, 2018, p. 27). Focusing on therapeutic interventions, page 29 provides a list of nine psychological therapies or approaches that nurses require (Nursing and Midwifery Council, 2018). This list includes general approaches, such as talking therapies, distraction and diversion strategies, as well as more specific approaches, such as play therapy and cognitive behavioural therapy techniques. This list tells us little about what is expected and of which nurses: does this list apply to nurses in all fields of practice? To what extent should they be 'proficient' in utilising these approaches? And what is the reasoning for this?

By contrast, educational programmes for other professionals that support people experiencing mental health difficulties, such as psychology or counselling, provide clear standards around practice as well as rationales for employing the knowledge base that these approaches are associated with (British Psychological Society, 2023). In mental health nursing curricula, it is less clear if, how and why psychological and philosophical knowledge bases are combined within the teaching of the nine psychological therapies or approaches listed by the NMC. Simply introducing psychological therapies, without the relevant, underpinning knowledge, is a disservice to students who are keen to engage with practice at the higher education level, and who want to understand not only what they should do but why it is appropriate. Furthermore, it calls into question how effective the use of these approaches will be, and how 'proficient' nurses can be in using them, if underpinning knowledge is partially or completely absent. The term 'proficiency' relates to skill, expertise and technical mastery (Oxford English Dictionary, 2023). In a situation where a grounding in knowledge (expertise) is absent, it is the technical mastery and skills component that seems to take centre stage.

Regarding the *Future Nurse Standards*, the only guidance given to judge the required level of proficiency of a student nurse is that 'at the point of registration', the nurse must be able to demonstrate 'an appropriate level for their intended field(s) of practice' (Nursing and Midwifery Council, 2018). From this, we can understand that all nurses entering the register, irrespective of field, must be proficient in communication skills and therapeutic interventions. However, the *level or depth* of proficiency for each field of nursing is not made explicit—there will be differences, it is stated, but what these differences are unaddressed. Perhaps it is common-sense to infer that mental health nurses—those commonly delivering therapeutic interventions—would be expected to have a high degree of proficiency in comparison to nurses of other fields. But again, under the guidance of the standards, this is merely conjecture, presenting a challenge to interpreting the standards. We see then that a natural consequence of this gap in what the *Future Nurse Standards* provides concerns relating to understanding proficiency, and we—those tasked with delivering nurse education—start to fill in the gaps in an attempt to resolve the ambiguity. The risk here is that 'standards of proficiency' comes to mirror normative expectations of 'the way things have always been'.

At the level of interpretation, there is no standardised curriculum or pedagogy that outlines how proficiency in mental health nursing (or any other field) should be achieved or evaluated. As such, students have little to benchmark their personal growth against, nor their readiness for the depth and challenges associated with building therapeutic relationships. They risk, for example, being unprepared for transference and countertransference in the process of relating, or being unaware of how their own histories, psychological needs, values and unconscious beliefs influence their ability to emotionally regulate and coregulate with their patients (Ryu et al., 2022). Mental health nurses should be able to enter 'relationships' *with* patients where they use their own sense of self as a skill (Kallergis, 2019). In the absence of alignment or consistency between curriculum, pedagogy and assessments in learning about self and use of self with others (both across and between clinical and academic settings), there is a risk of 'othering' patients as those who are 'ill', 'struggling' and fundamentally different (*nontypical*) from mental health nurses who are deemed well, healthy and without mental health struggles due to their professional status (Nye et al., 2023).

Being a proficient mental health nurse at the point of registration is arguably equivalent to occupying a liminal space, that is, a 'jack of all trades' with a weakened sense of professional identity that would be counterintuitive to the ostensibly holistic and person-centred aims of the *Future Nurse Standards*. Certainly, it is welcome that there is a professional commitment for all nurses, irrespective of the field, to be good communicators, equipped with therapeutic skills and interventions (Nursing and Midwifery Council, 2018). However, failure to determine the level of proficiency required and how this is achieved for each field of practice, will potentially lead to differing interpretations. This issue is further amplified when we try to determine where general levels of proficiency end and specialism starts. For instance, psychological therapies and therapeutic interventions within a mental health context are impinged upon by the unique ethical-legal dimension of mental health legislation (such as the Mental Health Act 2007/1983). This unique and determining dimension is dealt with in the standards through a generic approach, making it incumbent upon the nurse to simply know (perhaps intuitively?) the level of proficiency required to be an 'appropriate' ethical reasoner for their field of practice when delivering psychological interventions (Nursing and Midwifery Council, 2018, p. 8).

A key difference between mental health and other fields of nursing practice when delivering psychological interventions relates to the mental health nurse's authority to potentially treat a 'fully conscious adult of normal intelligence' without their consent (Fulford, 2009, p. 62). However unwanted, this power can lead to care outcomes that have a controlling element where mental health patients' freedoms are restricted against their will (Duxbury, 2015; O'Brien & Golding, 2003). The ability to restrict freedom stems from the societal creation of laws that give the mental health nurse, state-sanctioned powers to assist in the management of patients with mental health difficulties (Morse, 1977; Smith, 2018). This power is viewed as being explicit and implicit; where explicit power is directly relatable to the law, implicit power is more subtle and usually takes the form of monitoring-type activities (Roberts, 2005; Smith, 2016). With this unique ethical-legal dimension, the field-specific challenge for the mental health nurse is balancing these forms of power against the need to be recovery-focused, which includes promoting patients' autonomy (Giménez-Díez et al., 2020; Sturm, 2004; Waldemar et al., 2019).

Being recovery-focused is a power-sharing process and this process can conflict with the power to restrict freedoms; the two sit in tension (Waldemar et al., 2019; Woodbridge & Fulford, 2004). The ethical endeavour that the mental health nurse embarks on, without always intentionally knowing, is to manage and navigate a way through this tension (Smith, 2016)—with power comes moral responsibility (Miller, 2021). This involves, for example, acknowledging that while the *Future Nurse Standards* require nurses to assess and minimise risk of harm, in the mental health nursing role, 'harm' might be differentially defined by patients, carers/families and clinicians. What a clinician may determine as minimising risk might, simultaneously, engender harm associated with loss of liberty or personal freedoms, even if temporarily.

The mental health nurse may use policies, practice guidance, professional frameworks, and ethics-related learning to ethically reason a way forward (Smith, 2016). From these sources, there is the professional expectation that mental health nurses will use this guidance to ensure they fulfil their professional obligations and 'do the right thing' (Coady, 2021). This requirement includes being able to practise in situations that are uncertain, and where fast-paced decisions must be made (Welsh & Lyons, 2001). Nevertheless, irrespective of the circumstances of the situation, the mental health nurse will always have to be able to ethically justify the consequences of their decisions (Smith, 2016). Thus, there is a considerable professional expectation that the mental health nurse is a proficient ethical reasoner when delivering psychological interventions, *even if* the level of proficiency is not explicit within the *Future Nurse Standards*.

Ethical decision-making as a proficient ethical reasoner includes paying careful attention to the presence of coercive power within the nurse–patient relationship (Roberts, 2005). Due to this power dynamic, ethical reasoning within mental health nursing is often fraught and rarely truly egalitarian. Additionally, due to the practical nature of mental health nursing, ethical reasoning must be a here and now process (Woodbridge & Fulford, 2004). Being able to reason ethically in real-time emphasises the need for mental health nurses to continuously develop their ethical reasoning skills throughout their career (De Casterlé et al., 2008). It is also important to recognise that ethical reasoning is not a separate activity from everyday clinical decision-making (Smith, 2016). The 'good' in good clinical decision-making is the dimension of ethical reasoning in the clinical decision-making process, which is informed by frameworks and protocols combined with the considered use of practice knowledge (De Casterlé et al., 2008; Smith, 2018). This multidimensional approach is built on good practice habits but, crucially, is combined with the ability to be imaginative and to balance difficult ethical problems where there may not be a straightforward 'answer' (Smith, 2018). And so, in the context of 'proficiency' in therapeutic interventions, we can see the complex expectations surrounding mental health nursing practice that emerge when we scrutinise what 'proficient' practice might mean and involve.

2.3 | Challenges to coherent mental health nursing identity/ies

Having established the lack of clarity about 'proficiency' in the *Future Nurse Standards*, we next consider how this impacts the construction of nursing identities, that is, behaviours and thought process learned through socialisation. Ambiguity relating to 'proficiency' may contribute to a lack of clarity about what mental health nursing itself is. Compared with other fields of practice in the mental health arena (e.g., psychology and counselling), research suggests that contemporary mental health nursing continues to fall short in terms of credibility (McKeown, 2023b). Criticisms of mental health nursing range from compassion deficits to being complicit with iatrogenic harms caused by biopsychiatry. McKeown and White (2015, p. 725) aptly described three notable threats to the legitimacy of mental health nursing as 'an alleged failure of compassion, the scandal of unmet physical health needs among people with serious mental health problems, and the attachment of mental health nursing to a psychiatric episteme'. Hurley et al. (2022) also highlight the tensions between custodial and therapeutic aspects of the role, as previously discussed.

Addressing these criticisms, the *Future Nurse Standards* appear to have formulated proficiencies that are all-encompassing, with a view to ensuring that all nurses, irrespective of field specialism, attend to the physical and mental health needs of patients. While well intended, this could also be partly responsible for the dilution of mental health nursing within nurse education generally (Warrender et al., 2023). It contributes to ambiguity about how to align curriculum, pedagogy and assessment in developing the specific sorts of ethical reasoning and critical thinking that mental health nurses require in mental health-specific contexts. In the absence of educational activities that make explicit the kind of critical thinking needed in mental health settings—particularly in light of mental health legislation and how it is applied—it becomes difficult to create

opportunities for students to test out their reasoning skills and to understand, through feedback, where there is further nuance or complexity that they may have overlooked. Similarly, in the absence of adequate exposure to critical reasoning in practice settings, due to finite resources such as staff time and numbers, students could be compelled 'to do as they are told' to pass, as opposed to being given time to cultivate critical thinking in action through learning on the job (Delany et al., 2018, p. 40). The overall lack of clearly defined curricula, pedagogically rich activities and assessment methods for key components of mental health care delivery tend to stifle professional socialisation, which can contribute adversely to students' professional development (Monrouxe & Rees, 2017).

The professional identity of mental health nurses can be difficult to articulate due to the complexities and varieties of mental health nursing roles, something that carries adverse implications for role confidence (Terry, 2020). Not being able to explicitly describe mental health nursing proficiencies relates to the mental health role being regarded with ambivalence (Barker et al., 1999). Hemingway et al. (2016, p. 332) asserted that 'emphasis on physical health implies that the biomedical model predominates the health care landscape, and a social perspective of mental health problems take a backseat'. Against the backdrop of the ongoing debates about genericism (Mental Health Deserves Better, 2023), the notion that mental health nurses are not in control of the direction of their profession further erodes a sense of identity within the profession. That the *Future Nurse Standards* do not provide specific guidance on mental health nursing only seems to confirm that the specialism is somehow secondary or dispensable.

Similarly, without adequate philosophical, theoretical or historical understanding of mental health nursing and its features (Stickley et al., 2009), the role can seem as if it is devoid of meaning, leaving the future in a precarious state. Where professionals occupy a liminal position and feel used within a plethora of clinical settings for performative or rhetorical purposes (McKeown, 2023b), morale is negatively impacted. Nurse education will need to do more by learning from recent service failings to facilitate a system-focused education and robust ethics/morals training (Wagstaff et al., 2023). Specifically, it will need to address—across the trinity of curriculum, pedagogy and assessment—how to develop knowledgeable, psychologically conscious individuals who can balance the centring of the therapeutic relationship alongside the ethical-legal challenges unique to mental health nursing. To achieve this, inconsistencies within existing curricula and the negative impact of hidden curriculum that is, 'unwritten social and cultural values, rules, assumptions, and expectations' (Wear & Skillicorn, 2009, p. 452), must be addressed if mental health nurses are going to meet the aspirations of the *Future Nurse Standards*.

Concerns about the identity of mental health nursing are long-standing and familiar. The policy priorities behind the *Future Nurse Standards* (Nursing and Midwifery Council, 2018) were driven by a model that failed to take sufficient account of the needs of fields of nursing practice outside of adult nursing. Furthermore, the lack of clarity around mental health nursing proficiencies perpetuates the ambivalence by which many outside the profession regard mental health nursing. In essence, despite the physical, emotional, cognitive and organisational labour attributed to the role (Jackson et al., 2021), the work mental health nurses do remains underestimated.

2.4 | Construction of coherent mental health nursing identity/ies

Having considered the challenges that ambiguity about mental health nursing 'proficiency' causes, we next consider what is required for the construction of coherent mental health nursing identity/ies. First, as the primary medium by which psychological interventions are delivered in mental health nursing, it is imperative to better understand therapeutic engagement and relating, to ensure that necessary interventions are proportionate (Bifarin, 2017). Clinical settings can already be tense spaces due to fractured therapeutic relationships with patients, possibly resulting from coercive practices, traumatic incidents between staff and patients and perceived lack of less coercive options (McAllister & McCrae, 2017; McAllister et al., 2019, 2021). Additionally, bed shortages and inadequate staffing levels fail to afford mental health nurses the opportunity to be proactive rather than reactive (McKeown et al., 2019). Perhaps, this might explain why staff could be reframing restrictive practices as a 'last resort'—this move attempts to justify their dissonance and yet, moved to employ this rationale of 'last resort' more and more often (McKeown et al., 2020; Riahi et al., 2020).

Existing evidence suggests a discord between staff and patients concerning the use of chemical restraint, with patients being left re-traumatised and with poor experiences of 'care' (Muir-Cochrane & Oster, 2021). In the context of the professional identity of mental health nurses, this has created a culture of defensive practices, which contradicts the ethos of personal recovery and creates a tendency to objectify and dehumanise patients (Wagstaff et al., 2023). This culture could be responsible for the emphasis placed on quantifying risk (Beale, 2021), even despite repeated evidence that multiple risk assessment tools have poor predictive value (Chan et al., 2016; Runeson et al., 2017). Given that the delivery of high-quality engagement and therapeutic relationships with patients can be complex, interventions must be multifaceted (McAllister et al., 2021). There is a need for mental health nurses to practise defensibly and take positive risks, informed by therapeutic engagement with patients and robust evidence to justify coercive practice when applied. This would be possible if mental health nurses were able and encouraged to articulate what they do, underpinned by pedagogical approaches aligned with a standardised and well-developed curriculum, and evaluated through in-depth assessment relevant to the mental health specialism rather than generic 'nursing'.

Countries like Australia have a generic approach to nurse education, which has been found inadequate in preparing nursing graduates to practice within mental health settings (Lakeman et al., 2024). The Australian model has also been found to contribute to high attrition rates of staff working within inpatient settings, as

well as skills deficits, and overall poor mental health care (McKeown, 2023a). Even though UK field specialist nurse education gives the impression of a fundamentally different model to that of Australia, existing evidence shows an erosion of specialist mental health nurse education at the undergraduate level (Haslam, 2023; Warrender et al., 2023). Lack of preparedness for mental health nurses within the context of developing critical thinkers and evidenced-based practitioners might perhaps explain existing defensive practices where staff are managing their cognitive and emotional dissonance by attending to bureaucracy activities (McKeown et al., 2020)—as opposed to addressing the gap of delivering evidence-based psychological therapies in inpatient mental health settings (Berry, Raphael, Haddock, et al., 2022; Berry, Raphael, Wilson, et al., 2022).

To support students within complex clinical mental health environments, nurse education should focus on pedagogies that are generative and develop practitioner's ability to build therapeutic relationships with patients. This is essential, especially in the current economic climate where practitioners are expected to do more with less. This brings us to a second, and relating, imperative for mental health nurse education: exploration of the 'self' and how the self and 'other' relate. Meaningful interventions involve the application of 'self'; it is the self that mediates therapeutic relating. To do this, nurses themselves need to be cognisant and curious about their selfhood and what they bring to interactions. In the absence of this, patients may experience interventions as othering, punitive, overpowering and humiliating (Hawsawi et al., 2020).

The threats confronting mental health nursing occur at a time in which an increasing number of people need mental health support, creating, in the words of McKeown (2023a, p. 1), a 'perfect storm'. To reduce the damage created by this 'perfect storm', it is important to ensure that positive trends, such as increases in student applications and the nursing mental health workforce, are not undermined by early exit from the profession (Oxtoby, 2023). Implementation of the research strategy plan for nurses (NHS England, 2021), improved career progression pathways for mental health nurses (Brimblecombe, 2023) and efforts within the profession, patients, other professionals and policymakers to establish greater role clarity for mental health nurses are some of the ways in which this might be achieved.

2.5 | Challenges and opportunities ahead

So far, the discussion has highlighted that the *Future Nurse Standards* fail to clarify what it means to be a 'proficient' mental health nurse, nor do they contribute to articulating a coherent and positive identity for the mental health nurse. We have also addressed the danger this poses building for therapeutic relationships and delivering evidence-based interventions. Next, we consider the social and policy factors that make it imperative for mental health nursing to define and maintain its distinct identity and skill set. Despite introducing new roles, such as practice supervisors, practice assessors and academic assessors to student supervision and assessment (Nursing and Midwifery Council, 2018), there clearly needs to be a concerted effort made by AEIs and health care organisations to ensure adequate implementation of field-specific proficiency standards for registered nurses (Leigh & Roberts, 2018).

2.5.1 | Implications for mental health clinical environments

Due to the prominence of self-harm, the associated risk of suicide, and bearing in mind the latest guidance (Self-Harm: Assessment, Management and Preventing Recurrence [NG25]) (National Institute for Health and Care Excellence, 2022), patients can present anywhere across the health and social care system, and they need better support. The guidelines highlight a need for wider system integration of primary and secondary healthcare, emergency services, education and criminal justice to meet these needs when they are both acute and long-term. Further, the guidelines evidence the role of empathy during service provision and the need to resist aversive treatments. The guidelines suggest that psychosocial assessments should be offered instead of risk assessments, and that interventions and aftercare are priorities (Mughal et al., 2023).

A recent rapid review into data on mental health inpatient settings in England (Department of Health & Social Care, 2023) reported significant gaps in mental health nurses' knowledge of therapeutic care, poor care outcomes and ward culture. They also reported a need for proactive approaches that make it psychologically safe for patients, carers and staff to raise concerns. The administrative burden on staff was found to increase risks relating to patient safety, with staff members not having (or prioritising) time to engage with patients in basic ways, let alone to provide in-depth therapeutic interventions. The *Future Nurse Standards* intend to 'allow for greater independence of assessment, offers the potential for greater innovation by placement providers, and the development of placements in a wider range of settings' (Leigh & Roberts, 2018, p. 1071), yet while so much time is spent on administrative tasks, the *intended* clinical expertise of mental health nurses is not put to best use. The *Future Nurse Standards* might have good intentions—to create a nursing workforce that can provide 'holistic care' to people of any age and stage, and who may be living with mental, physical, cognitive and social difficulties—yet the loose representation of *proficiencies* will have huge repercussions for mental health nurses being able to deliver the kind of support the guidelines are calling for.

2.5.2 | Implications for retention in mental health nursing

Given the global shortage of health care professionals, there is a need to analyse effective recruitment and retention strategies on a national and international basis. The public face of nursing during the COVID-19 pandemic has been identified as one factor behind a 43% rise in the number of confirmed places to study nursing in

England (UCAS, 2021). Specifically, 30% more students applied for mental health nursing courses compared to 2019 (UCAS, 2021). Similar increases in total applications for nursing programmes have been reported internationally (Keystone Healthcare Studies, 2021). Set against these positive trends in student registrations is the impact of the pandemic upon global exit rates from the qualified workforce, which has worsened existing nursing shortages (Buchan, 2022). Over the decade 2011–2020, there was an increase in the total NHS nursing workforce in England, but the number of mental health nurses declined from 39,024 to 38,540 (Brimblecombe, 2023). This was especially prevalent in early and mid-career mental health nurses (Oxtoby, 2023). This has created an imbalance in the structure of the workforce. Over half (52%) of mental health nurses are estimated to be aged 45 and over, while one-in-five (21%) are aged 55 and over (Palmer et al., 2023). Higher numbers of new registrants will be needed to maintain the existing size of the workforce. The size of the mental health nursing workforce needs to be considered in the context of reports (e.g., Office for Health Improvement and Disparities, 2022) about increases in the prevalence of mental health difficulties among the UK population.

The experiences of mental health nurses and patients are closely intertwined. Projected increases in the number of people experiencing mental health difficulties are a major reason why the NHS Long Term Workforce Plan (NHS England, 2023), projects a shortfall of 17,000 full-time equivalents in the mental health and learning disability nursing workforce (the plan does not distinguish the two nursing fields). Another example of the interconnectedness of mental health professionals and people using services is the association between the lived experience of mental health difficulties and the intention of taking up a career in mental health (McKenzie et al., 2020). However, this study also revealed that participants were more likely to prefer becoming a psychologist than becoming a mental health nurse, which could be explained by the difference in credible epistemology between those fields, earlier discussed.

The literature on career motivation also needs to be considered alongside what we know about professional identity. Nurses are concerned that the public perceptions of nursing are outdated and fail to recognise the complexities of mental health nursing tasks (Rasmussen et al., 2021). Equally, an individual's perceptions of their professional identity are shaped by experiences of working with other professionals and there is scope to consider how mental health nurses influence or are influenced by working in interprofessional teams (Sukhera et al., 2021). In this context, it is striking that there have been variable levels of development of new roles and advanced skills in the mental health nursing workforce compared with other health professionals (Brimblecombe, 2023).

Furthermore, an increase in applications to study mental health nursing will not necessarily result in an increase in the mental health nursing workforce if student experiences on practice placements, and as newly qualified nurses, are overly generic or unsatisfactory; that is, they do not match up to why students applied to do mental health nursing in the first place. Addressing the NHS Long-Term Plan priorities, it is crucial that NMC representation of 'proficiencies' is well-tailored for specific fields of nursing. The mental health nursing role must be meaningful for people who want to make a difference in this field. Rethinking the notion of 'proficiency' from a social constructivist lens could help to consider the gap between ideal expectations, that is, delivering holistic care (Nursing and Midwifery Council, 2023a) and realities, that is, dissatisfaction with mental health work (McKeown, 2023b).

2.5.3 | Implications for evidence-based mental health nurse education and practice

Nurses are expected to consistently meet seven platforms within *Future Nurse Standards* (Nursing and Midwifery Council, 2018) namely: promote health and prevent ill-health; assess need and plan care; provide and monitor care; lead, manage nursing care and work in teams; improve safety and quality of care and coordinate care. To ascertain this, nurses are expected to be evidence-based practitioners. That is, provide care that is precise, proven and personal. The research strategy plan by the Chief Nursing Officer of England (NHS England, 2021) has the propensity to give mental health nurses control over their profession. More specifically, it is important that mental health nurses are supported to actively engage with research as it pertains to their professional identity and patient care. While there are promising developments, true clinical-academic roles within mental health nursing are scarce. Much activity relies on self-motivation or is heavily embedded within the higher education sector (Jones & Keenan, 2021), forcing nurses out of the clinical setting where there are already precious few (Warrender, 2021). The role of nurses in research is important because nurses ostensibly enter practice with good intentions and a desire to preserve patient safety, yet often end up functioning, consciously or unconsciously, in paternalistic ways that help neither themselves nor patients (McKeown et al., 2017). Rather, making the process of knowledge mobilisation transparent, with conscious effort directed at not trivialising peoples' (staff and patient) experiences, would be liberating, breed creativity and innovation.

Research around the professional socialisation of mental health nurses, with a focus on the influence on socioeconomic and political paradigms, would be a good place to start. Future research needs to provide more evidence around the relationship between various pre- and postregistration models of nurse education across the globe and implications for patient clinical and social outcomes as well as patient satisfaction/experiences. This understanding would aid curriculum design and provide opportunities to better understand the impact of genericism on the professional identity of mental health nurses. Focusing on on-the-ground knowledge will strengthen the voice of mental health nurses and could encourage bottom-up approaches to the challenges facing mental health services. This could include a proactive approach to developing policies, identifying and addressing gaps within existing career pathways and ultimately, reinforcing arguments for new models of workplace democratisation (McKeown et al., 2017). Furthermore, knowledge from mental health nurses

would deepen discourse around patient safety beyond evidence captured on health and social care systems or by the inspectorate.

Within the context of quality improvement using an evidence-informed approach in the United Kingdom, drawing on the 'invisible work' (skills and expertise) and highlighting facilitators or barriers associated with working within a complex biopsychosocial system, we turn to what the role of mental health nurses are within inpatients settings as an example. Lakeman and Hurley (2021) asserted that mental health nurses need to take more control of the trajectory of their profession and change the narrative from being *docile* to being *specialist*. Mental health nurses being empowered to articulate what they do is crucial, to further increase the number of mental health nurses needed for adequate care provision to the population they serve. This is particularly important at a time when patient safety research and policy are beginning to place more emphasis on complexities that could be associated with operationalising a 'just' culture (Cribb et al., 2022).

One way to do this might be to create constructivist alignment in mental health nurse education such that all aspects of education are genuinely working towards a common purpose. Learning from recent significant mental health service failure would require nursing as a profession to respect different philosophies underpinning different fields of nursing and by doing so, move swiftly away from regurgitating and misconstruing generic values (Wagstaff et al., 2023) to enforcing evidence-based nursing practice, which draws on relevant knowledge from other disciplines. At present, leaving AEIs to interpret the *Future Nurse Standards* is leading to the erosion of the mental health nursing identity (Devereux, 2023), arguably at the detriment of the population being served. As substantiated within a response to an open letter from 'Mental health deserves better' campaign to the NMC, there is an urgent need for quality assurance to review the implementation processes involved in translating standards into practices (Nursing and Midwifery Council, 2023b), with a specific focus placed on the relationship between pedagogy, curriculum development, nature of assessments within both academic and clinical settings.

3 | CONCLUSION

The implementation of proficiencies in nurse education is ubiquitous. However, as we have demonstrated, what 'proficiency' means in the context of field specialty remains undetermined and, unhelpfully, open to interpretation. To mitigate this, taking a constructivist alignment approach to education could help to engender consistency across curriculum, pedagogy and assessment—consistency that would help mental health nursing students (our future nurses) to see how and why we (and they) do what they do, and to have a better sense of what they are aiming for, as well as their own professional identity. The ethical-legal context of mental health nursing poses challenges for mental health nurses that genericism overlooks. To improve the experiences of people living with mental health difficulties, the value of education is clear—nurses need to be able to deliver evidence-based, therapeutic and relational approaches that they can reason and justify. Cementing this in mental health nurse education will mean a shift in the NMC's role. Either, the NMC will need to articulate, monitor and evaluate education more closely, that is disaggregated by field specialism, *or* the regulator will need to reduce the grip and extent of standards in general—even if they remain generic in orientation—such that field-specific content and pedagogy is not crowded out by AEIs desperately trying to 'fit everything in' to succeed in validation. Either way, combating the dilution of mental health nursing and mental health nurse education in the United Kingdom will require a systems-level change. The question then becomes, is there a real and significant commitment, beyond grassroots groups such as Mental Health Deserves Better, to combat that dilution?

CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no datasets were generated or analysed during the current study.

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