A critical analysis of the UK's Nursing and Midwifery Council pre-registration syllabus changes and subsequent impact on mental health nursing identity

Abstract

In this paper, We, the authors explain how and why the philosophical changes to the pre-registration nursing standards by the Nursing and Midwifery Council, have resulted in a paradigm shift for mental health nursing. We critically examine the changes to the education standards and offer an analysis of the problem with the shift towards a generic nursing syllabus that prioritises physical health intervention, skills and competencies for mental health nursing. We argue that mental health nursing skills and qualities such as connection, genuine advocacy and therapeutic-use-of-self have been undervalued and underrepresented by the new education standards. Consequently, we call on the NMC to reconsider the underpinning principles of the education standards and allot due consideration to the specific needs of the mental health nursing profession.

Introduction

In 2018, the Nursing and Midwifery Council ([NMC] the UK's nursing regulator) redesigned the pre-registration nursing syllabus and introduced a vision for nursing that would seek to tackle the health of a nation. This paper examines the NMCs vision for nursing, as We, the authors scrutinise the current direction of the NMC and offer a careful examination of the move towards a skills-based approach which is at the heart of the philosophical changes made by the NMC. Consequently, this paper does not offer a full ontological account of what mental health nursing identity is, or should be, but opens the debate on what it is to be a good mental health nurse. We accept that the concept of professional identity and that of mental health nursing identity, is imbued with complexity, therefore, this paper does not set out to establish a conceptual framework of what mental health nursing identity is, rather, offers; (1) a critical analysis of the conceptual changes to the nursing pre-registration education program, examining the unintended consequences, most notably to mental health nursing, and (2) in light of the changes to the syllabus, we describe some of the essential characteristics of mental health nursing which has been undervalued in the syllabus.

The Mental Health Nurse & NMC: A change in paradigm

This first section will examine syllabus changes made by the NMC (moving from the 2010 standards to the revised 2018 standards) and posit that these changes have resulted in a move away from a *mental health nursing*, person centred approach, towards a model, constructed on quantifiable skills and competencies that restricts the role of the mental health nurse. This section will set out a summary of the changes and outline the dogmatic principles that have underpinned and precipitated the changes made by the NMC, moreover, how the syllabus change has undermined the key features of a mental health nurse. Here, we argue that the conceptual changes at the heart of the new syllabus lead to the dilution of the mental health nurse role in favour of, a skill-based, generic nurse, that will alter the current paradigm of mental health nursing in the UK.

The NMC changed its education standards for the pre-registration nursing programmes in 2018, the change was precipitated by the Royal College of Nursing (RCN) who commissioned Lord Willis to conduct a review (Willis, 2012). The Willis reports, both Q*uality with compassion* (2012) and *Shape of caring: Raising the bar* (2015), were a culmination of an ongoing discourse to update and change the nurse education programme (cf. Francis report 2013, Keogh review 2013, Cavendish review 2013 & Prime Ministers Commission 2010). The RCN lobbied for a 'health check' on the state of nursing

education in the UK, the Willis review focused on one central question; "*What essential features of pre-registration nursing education in the UK, and what types of support for newly registered practitioners, are needed to create and maintain a workforce of competent, compassionate nurses fit to deliver future health and social care services?"* (Willis, 2015).

The Willis report (2015) set out to review nurse pre-registration education in the UK and made over 34 recommendations across 8 themes. It is not in the scope of this paper to provide a detailed analysis of the review but, to elicit the central coherence which narrates the changes made by the NMC. In sum, the Willis review (2015) central line of inquiry was to equip the future nurse work force with the *right skills* and develop access routes into the nursing profession in order to meet the needs of an ageing and co-morbid population. The Willis report (2015) sets out its plan to address the problem of an increasing comorbid and ageing population with an overstretched nursing workforce, by constructing a nurse education program that produces nurses that have prioritised and mastered skills in physical health assessment and intervention such as diabetes management, diagnostic assessment, cannulisation, chest and lung assessment… the deteriorating patient etc. (Willis, 2015). The Willis review prompted a response from Health Education England (HEE) [1]their central question was to understand; "*how…education and training of registered nurses and care assistants is fit for purpose to support them in the delivery of high-quality care over the next 10-15 years*?" (Health Education England, 2015). Consequently, HEE created a framework for future nurse education that is centred on a consensus that the nursing (both pre and post registrant) workforce requires skilling, upskilling, and re-skilling that circa the management of physical health in acute settings.

The exposure of the service failures at mid Staffs hospital (Francis report, 2013) certainly meant that a review of nurse education was warranted, however what is most striking about the Willis reviews (2012; 2015) and the HEE review (2015; 2022) is the failure to adequately recognise or, sufficiently distinguish the seminal differences between the nursing fields namely, mental health and adult (physical health) nursing. Arguably, the move to cultivate physical health skills, procedures and management has resulted in a genericism across the future nurse NMC standards, although this was not necessarily the solution to problems of a systemwide failure and neglect in a General Hospital setting. Intentional or not, the prioritisation of improving physical health skills and procedures, has precipitated the dissolution of mental health nursing identity. Indeed, HEE (2022) recently published their manifesto and commitment to recover mental health nursing identity purporting to re-establish contemporary mental health nursing, however whilst HEE (2022) have acknowledged the loss of Mental health nursing identity, this is somewhat brief and is solely focused on a Continuing Professional Development (CPD) framework focusing upon core skills which should have been prioritised in pre-registration NMC syllabus.

Furthermore, there is a scarcity of discussion regarding; (1) the increasing demand for mental health care across adults and young people, (2) the dearth of understanding of the registered mental health nurse in the health care system (across the life cycle) (3) the unique position of the mental health service user in a health care service and (4) an erroneous assumption that registered mental health nurses perform the same role as registered adult (general) nurses.

Whilst we accept historical failings of mental health nurses to respond to the physical health needs of mental health service users, most notably, the inexcusable fact that service users experience disproportionate morbidity and mortality rates from treatable physical illnesses, it is erroneous to

[1] Health Education England's primary purpose is to consult and support the delivery of health care in England by ensuring that the workforce has the right numbers, skills set, values and behaviours to delivery care to a nation.

assume that mental health nurse role can be condensed down to a set of generic skills and physical health procedures. The fundamental error here, is that it is somewhat rash to assume that physical health and mental health are so inextricably linked (cf. Boorse, 1975; Fulford, 1991; Svenaeus, 2011; Wakefield, 1992) that a generic nursing education (centred on the agenda that physical health skills and procedures will improve the wellbeing of a nation) is sufficient to meet the needs of both a mentally and physically sick population. The critical assumption is that mental health nurses should enter the register with the same, or similar skill set as adult nurses, when in fact, the mental health nursing role requires an altogether different skill set. Other commentators on this topic (Hurley & Lakeman, 2021; Lakeman & Malloy, 2018) have cited our Australian counterparts as evidence that this move to a more generic model of nurse education is likely to result in lower levels of knowledge and confidence, a poor integration of theory and practice and students identifying more closely with adult nursing, to the detriment of other fields. Therefore, in virtue of the paradigm shift towards genericism, the profession moves back to a language and culture that places the service user at the pointy end of the diagnostic stick.

The NMC have accepted the Willis and HEE account and moved the nursing profession, including mental health nursing, towards nursing that is measured by skills and proficiencies (Key Performance Indicators) (Nursing and Midwifery Council, 2018b). The NMC have adopted the Willis and HEE recommendations and outline their conception of the future nurse standards and proficiencies in the education standards consultation report (Nursing and Midwifery Council, 2018a) which moves the nursing professions purposefully towards a communal skill set.

The NMC report is divided into two parts; (1) philosophical underpinnings (seven design principles of the new standards that are based on the findings of the Willis and HEE report) and (2) application of student assessment and supervision based on the underpinning principles. It is however, not with in the remit of this paper to examine and evaluate point 2, but, to examine the change to the underpinning principles and philosophy of the new standards.

The translation, or perhaps unintended consequence, of the Willis reports (2012, 2015), HEE (2015) to the new NMC standards, as applied to the mental health nurse, has been to move away from the skills of critical decision-making (the mental health nurses most powerful tool when balancing decisions that are disproportionately weighted in ethics and infinite values as compared to other fields) toward; a paternalistic 'tick-box' culture. Indeed, it is without doubt that all nurses from all fields engage in ethical and values-based decision making furthermore, nursing as a profession requires critical thinking skills to deliver gold standard care. However, it is central to the argument that mental health nurses require an altogether different critical skill set, one that is the antithesis of paternalism and is an expert in the navigation values conflict.

Mental health nurses formulate and appraise evidence that it is different to other, more empirically led fields of nursing. Against the backdrop of a care system that is enshrined in medical paternalism[2], we use ourselves in the relational; delving into people's lives and past trauma and often navigating conflicting values, transferences and countertransference. The paternalistic culture and language of proficiencies, tasks, and skilling is, therefore, an antithesis to a therapeutic milieu, undermining the seminal characteristics and subsequent work of the good mental health nurse. In its stead, a problem-focused, task-orientated, market-driven nurse is prioritised (Warrender, 2021; McAllister & Moyle, 2008), resulting in a reduced understanding of how to balance and cultivate living well in-the-world for our service users. The shift towards quantifying mental health nursing through technical skills is therefore a folly, moving us further away from the essence of mental health nursing; a position that mental health nurses have resisted for decades.

Although both the Willis review and NMC standards acknowledge values and principles that are endorsed by the mental health nurse, there is insufficient understanding of the identity and unique role of mental health nursing. Mental health nursing is indeed a unique and varied profession, occupying a unique space in contemporary health care that is difficult to define and explain but, a phenomenon that is observable and currently, undervalued. Consequently, the preregistration syllabus has been reviewed, consulted, and designed without the assiduousness that the mental health nursing profession warrants. In the next section we articulate the difficulty in modelling a mental health nurses' sense of identity and open the debate on what a model of mental health nursing might entail.

Mental health nurses: A struggle to define and measure its value

In the preceding section we explained that mental health nursing was not adequately captured in recent reviews, resulting in a preregistration syllabus that failed to cater for the role of mental health nursing in the current health care climate. We acknowledge that the identity of mental health nursing is not fully agreed upon, furthermore, trying to establish an identity which is made more difficult when said identity is founded on interlacing irreducible concepts, such as empathy, compassion, genuine advocacy and connectedness is problematic. Therefore, this paper raises a fundamental question: what would contemporary mental health care miss if the mental health nurse role is confined and reduced towards an outcome focused generic nursing [2]role? Our aim is, not only to stimulate an academic discourse which culminates in a model that captures the crux of what it is to be a *good* mental health nurse, but to influence future nurse standards on a global stage. In the final section we explain, in practical application, how the common misconception, the 'jack of all trades fallacy', conceals two concepts, genuine advocacy[3] and connectedness. We attempt to describe two of the essential core qualities of mental health nursing and invite others to comment and contribute to a model of mental health nursing identity.

Professional identity is in part constructed through a community of shared values, beliefs and attitudes underpinning the professional behaviours of nurses (Andrew & Ferguson, 2008; Hallam, 2000) yet, there is a tangible incongruence, between the fields of nursing themselves. It is outside the scope of this paper to examine the differences between the two professions but, it is worth highlighting those two professions, whilst recognised as one professional body, are conceptually very different. We will unpack this further in the third section. Given the rich history of mental health nursing, the mental health nurse in particular, has been slow to move towards defining a clear professional identity with little agreement or empirical research relating to the conceptualisation of professional identity in mental health nursing (Mazhindu et al., 2016) or how mental health nursing work is captured and valued in the wider healthcare arena (Crawford, Brown, & Majomi, 2008). Mental health nursing has been described as both a multi-layered construct and one that is fluid and dynamic in nature (Rungapadiachy et al. 2006) that is often unrecognisable to anyone outside the profession but, tacitly known for those in the inner circle (Hurley & Lakeman, 2021).

[2] The recent NMC changes have shifted the focus of the nurse curriculum to that of; proficiencies, competencies and skills targeted at a more generic nurse that is equipped to meet the physical needs of an ever-increasing morbid population. The authors do not reject that skills are needed to meet this need, this is not in question but, we defend the argument that supplanting critical mental health nursing skills (skills that are critical for mental health care but difficult to capture, measure and report in a health care market) is a folly.

[3] Genuine advocacy: a concept which is not to be confused with an advocate, a role with the mental health act which can often be a superficial, tick box approach which does not contain the same irreducible qualities that are established in the mental health nurse patient relationship.

Despite being the largest professional discipline in mental health care, mental health nursing struggles to clearly define its nature and function (Lakeman & Molloy, 2018) and make its mark as an alternative paradigm of care. Hurley and Lakeman (2021) offer the view which explains that mental health nurses across the globe assume different roles which are dependent on the service that each nurse is embedded. Evidence of this expansion can be seen in the UK as the mental health nurse role expands to fill the gaps in services, assuming new roles and responsibilities (Felton, Repper, & Avis, 2018) that are inclusive of mental health law, prescribing and psychological therapies etc. (Hurley, 2009). However, subsuming multiple roles across the spectrum of contemporary mental health care has perpetuated a lack of distinctiveness, a professional identity without a clear model or aim that underpins the professional practice. By not clearly defining their unique contributions and evidence of these, mental health nurses have placed themselves at a disadvantage, the legitimacy and recognition for the essential work carried out is failed to be fully recognised, with superficial gratitude, or is acknowledged as a subgroup of another paradigm (Browne, Cashin, & Graham, 2012; Fourie, McDonald, Connor, & Bartlett, 2005). Perhaps this is due to the nature of mental health nursing itself, in that, mental health nursing has prioritised responding to patient needs and that of holes in services to bridge the gap between psychiatry, psychology and social work. As a consequence, mental health nursing has often been defined as an adjunct to the ontic sciences, a profession lacking a theoretical framework that demarcates the practice of nursing from other professions. However, Health Education England (2020) acknowledges the 'uniqueness' of mental health nursing and encourages those in the profession to emphasise the 'unique selling point' that mental health nursing has, but, mental health nurses themselves often find it difficult to fully explain its uniqueness (Hurley & Lakeman, 2021) or how it might differ from other branches of nursing.

Booth, Tolson, Hotchkiss, and Schofield (2007) writes that nursing in the UK, has traditionally defined itself and aligned its own professional development through a medical lens with nurses once being the subordinates to the medical profession. Throughout the literature, mental health nurses appear keen to distance themselves from the 'task-orientated' and hierarchical culture of other branches of nursing (Awty, Welch, & Kuhn, 2010) and appear to identify more with the mental health field, rather than nursing itself (McCrae, Askey-Jones, & Laker, 2014). It is however, without question, that mental health nursing has evolved against the backdrop of other professions, namely, psychiatry and more recently psychology. Both have a rich history of theorising in the field of mental health that is underpinned by empiricism, however, the ontic sciences have not escaped criticism for their models they have employed to understand the phenomena of mental health. This criticism has perhaps been allayed, in practice, by the mental health nursing profession who have resisted the paternalistic model, recognising that; values, recovery, discovery and empowerment are more effective tools. Therefore, 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. Mental health nursing, as a profession in contemporary mental health care, forms a nurturant milieu by being specialists in the therapeutic use of self, experts in the formation and the maintenance of the therapeutic relationship (Hurley, 2009) resulting in a unique understanding of another's reality. It is in part, concepts such as the therapeutic use of self, genuine advocacy, building therapeutic relationships (with patients on the edge of reality or society) that have been grossly undervalued by the Willis reports, HEE and NMC syllabus. Consequently, the Nursing and Midwifery Council (2021) review on minimum education standards have thus, pursued the wrong lines of inquiry when trying to understand what the minimum requirements are for the registered mental health nurse. Furthermore, the Nursing and Midwifery Council (2021) post registration consultation is again heavily focused on physical health and nurse prescribing. Thus, the NMC have set out a pre-registration education program that further reduces the role and identity of mental health nursing by

shifting nurse education to a generic skills-based nurse that can respond to the physical health needs of an increasingly aging and co morbid populace.

Attunement and genuine advocacy is the 'jack of all trades' fallacy

Thus far, this article has established that mental health nursing offers much more than what is objectively quantifiable, moreover, the Willis and HEE review have fallen foul of adequately understanding the role of mental health nursing in the current health care climate. We recognise and accept the global challenges to reduce comorbidities and improve the health of nations however, this cannot be at the cost of moving an already stretched critical resource to meet this challenge. This next section will describe *some* of the critical and core elements that mental health nurses do that meet the needs of an already underrepresented and vulnerable population. Here we will discuss the concept of genuine advocacy, therapeutic use of self and connectedness in mental health nursing, two concepts which are under recognised and undervalued.

So far, we have indicated that mental health nursing holds a unique position in health care, and in the proceeding section we will introduce two concepts that go some way to describing the unique contributions of mental health nursing. However, it would be prudent to establish why mental health nursing holds such a unique position, in contrast to our physical health counterparts. While acknowledging our solidarity and common ground across all fields of nursing, holding strong to our unique identity.

Mental health nurses manage and balance the complexity and constant fluctuation between paternalism and subjectivism in tandem, in addition to employing self-awareness of own values. Paternalism concerns legislative power and coercion, and subjectivism concerns patient autonomy. Such a deep and constant balance is a unique professional position. Unlike patients accessing physical health services, (where the priority is to work with an organ, system or part of the body that requires medical examination and, perhaps, a secondary emphasis on holistic assessment), the mental health nurse must meet the person, in the first instance, as whole, in the service users [4]world.

The priority for the mental health nurse is to gain access to the personhood, to engage with the person, as whole and navigate concepts such as a person's connection to reality, an understanding of the self or deeper self, deeply held values and principles and ways of living in-the-world. It is only when we have *an-understanding* of the person-in-the-world, that the mental health nurse can begin to work therapeutically, reducing risk, working towards discovery or recovery and improving wellbeing. Evidently, we are able to deduce that it is *not* the mental health nurse that holds the unique position in health care, but the service user who commands this unique position. It is rightly so, that the specialist role of the mental health nurse is to meet and access the service user in-the-service-users-world. It is therefore, a combination of skilful navigation and advocation of the service user's world [5] foregrounded by the conflict of values in the value laden field of mental health care that we can start to point to the essential work of mental health nurses. Whilst we acknowledge that values in physical health are not always agreed upon, there is far more consensus across the physical health arena compared to its psychiatric and mental health cousin (Fulford, 1991). The conflict arises when, the person's handle on reality, their sense of self, their most deeply held values are challenged by psychiatry and foregrounded by paternalism. Considering that psychiatry tends to emphasise a

[4] The authors accept that the term service user is not fully agreed upon by those whom use mental health services but, we use this language to differentiate the service user from patient for argumentative purposes.
[5] We use the term service user's world to bridge the concepts of; principles, values, understanding of deeper self, connection to reality…etc.

diagnostic-and-treatment approach (construed more often than not biomedically), it is up to mental health nurses to meet the person, where the person is, in order to improve outcomes for the service user. The mental health nurse forms the balance between; care and protection; establishing a shared understanding, genuine collaboration and connections made through humane relating, these qualities are not solely confined to the mental health nursing profession but, are uniquely realised in the therapeutic relationship in mental health nursing.

Peplau (1988) has consistently advocated the interpersonal domain as the proper focus of mental health nursing and views the nurse-patient relationship as predicated on the nurse's ability to connect, communicate and understand in order to promote a therapeutic bond (Ward, 2016). Building and constructing therapeutic relationships (often against the backdrop of working with patients who are disconnected from reality or on the fringes of society), connecting and nursing patients in a mental health service requires dexterity of interpersonal communication. Peplau (1988) described the nurse-patient relationship as the foundation for nursing practice, the uniqueness of the dyad is a phenomenon that is at the very core of mental health nursing, side by side, co-constructing towards recovery or discovery (Desmet et al., 2021; Hartley, Raphael, Lovell, & Berry, 2020). The literature refers to this as the therapeutic relationship, or therapeutic alliance, or even perhaps the nurse-patient relationship. However, there is little agreement of what these individual concepts mean or what specific characteristics make up the relationship, alliance or nurse-patient relationship (Browne et al., 2012; McAllister, Robert, Tsianakas, & McCrae, 2019; McAndrew, Chambers, Nolan, Thomas, & Watts, 2014). Furthermore, the therapeutic use of self to create the alliance or relationship is difficult to define and the impact of the core components are difficult to conceptualise (Browne et al., 2012). Perhaps, it is the variation in which mental health nurses conduct their work across the various contexts, often hidden away in the intimacy and safety of the dyad, mean that both the phenomena, that of adroit interpersonal connection and genuine advocacy are failed to be observed and captured. Nonetheless, the therapeutic alliance/relationship and specifically the use of connectedness and genuine advocacy is the very basis upon which engagement and connections, that are critical to recovery, are forged (Delaney & Johnson, 2014). Consequently, those outside the profession, including nurses who are not registered as mental health nurses, miss the opportunity to observe the practice of the mental health nurses and fully value what it means to nurse a patient towards mental health recovery. It is these qualities and characteristics, which are ill-defined, concepts which are not fully agreed upon that are often undervalued or overlooked when trying to empirically capture what a mental health care system needs.

We are, by nature, social beings who share a world, time and space with others, some near and some far (Crowther & Thomson, 2020). However, the patient and the mental health nurse inhabit a unique shared space in-the-world, specifically, the domain of mental health nursing and recovery from mental ill health. Mental health nurses and patients share time together and connect with each other and the way we exist in that share space in-the-world is structured and forged in light of the attunement, connectedness and understanding. It is being-with the patient and navigating this shared space in mental health nursing which is the craft of the mental health nurse which is so difficult to capture, especially as a health service metric. This connection between the nurse and patient is perhaps best understood by the concept developed by Gadamer (1975), a phenomenon which is best captured by a fusion of horizons. The integration of one thing and another can be said to be a fusion of horizon (Austgard, 2012; Dibley, Dickerson, Duffy, & Vandermause, 2020). In thinking of the other in the context of our own understanding a new awareness becomes apparent in the co-creation of a new situation (Dibley et al., 2020). Mental health nurses and patients come together from their own horizons and connect or fuse to share a new horizon, the nurse and patient now experience an attunement in which access to the lived experience is granted. In that connection, the nurse and the patient are connected to each other. Schutz (1962) writes of connection that refers to an embodied

experience described as a thou-reciprocal-orientation, a *we relationship,* a face-to-face connection between two people, a genuine connectedness that is experienced by being with the person, co-constructing in the shared experience. A connection manifested between people, that the mental health nurse is adroit at sensing, navigating and protecting in this demographic. It is this alignment, which is developed through the use of self in the therapeutic relationship (Warrender, 2021?) which leads to genuine advocacy. The fundamental element is, 'being-there for the patient' when the patient needs them is paramount (Delaney & Johnson, 2006), being-with is achieved when a genuine connection is established, when the patient and the nurse are in a *we relationship*. Once the connection is established, other interpersonal qualities, such as kindness, are required by mental health nurses (Cleary, Hunt, Horsfall, & Deacon, 2012) to cement the relationship.

Brownlie and Anderson (2017) highlight the importance of the everyday impact of kindness, despite often being minimised, and describe it as atmospheric, in that we know it when we see and feel it, yet, resulting in significantly shifts in mood, mental state and ultimately recovery. Hercelinskyj, Cruickshank, Brown, and Phillips (2014) found that when staff spent time 'being-with' a patient and engaging in everyday practical activities helped to normalise situations and were valued by patients, the practical activities acting as gateway for a connection (Jones, Wright, & McKeown, 2020). The subtle nuances of connection, genuineness and kindness are not missed by the service users who observe this connection and use language such as respectful, empathic, friendly and available (Sheridan Rains et al., 2021; Stevenson & Taylor, 2020) in an attempt to describe what has facilitated recovery or discovery (Bolton). The fertile grounds for understanding and valuing what mental health nursing is or does well, is the field of the aforementioned concepts and just how important they are to the patients and service we serve. It through genuine connection that we influence and demonstrate how mental health nurses help individuals lead the life they define as meaningful. Such work requires mental health nurses to be present with patients and to cultivate the openness and connection that is the essential platform for the unfolding narrative. It is when mental health nurses understand the narrative that we can begin to genuinely advocate for the service users under the care of services. To nurture growth of the specialty it is also essential to move beyond the notion of engagement to a more nuanced understanding of the interplay between the mental health nurse and patient. It is, however, this aspect of mental health nursing which is undervalued and in danger of being displaced by metrics that prioritise task focused outcomes as a consequence of the nursing syllabus. The NMC syllabus has undermined the unique work of mental health nursing and placed far too much emphasis on a course that is littered with redundant skills-based competencies and proficiencies.

Conclusion

We stated at the beginning of the article that under the NMC (2018) preregistration syllabus, this specialism of mental health nursing is now under threat. We have argued that the NMC, HEE and Willis reviews failed to fully understand the service user's distinct status in health care, furthermore, failed to recognise or fully value, the distinct work of the mental health nurse. We have argued that the NMC (2018) standards are constructed in a way that lends priority to generic/ adult field of nursing focused education over the core elements which are required for mental health identity despite, the NMC purporting that the standards are interpretable in a mental health context.

We take the position that, the fundamental roles and values of mental health nursing will inevitably be weakened by the NMC changes, a more generic nurse will emerge and ultimately, lead to a poorer standard of care for service users. We call on the NMC to reconsider their approach to the pre-registration nursing programme and work with the profession to carefully examine the uniqueness of

mental health nursing. We would like to end the article with the question we originally posed to ourselves in order to construct this article; *what would contemporary mental health care miss if the mental health nurse role is confined and reduced towards an outcome focused generic nursing role?*

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