Resisting genericization: Towards the renewal of mental health nursing

This editorial has been prompted by collective disquiet amongst the mental health nursing community about the future existence of mental health nursing as a distinct professional discipline (Warrender, 2022). The piece is thus written collectively by members of the *#mhdeservesbetter* – a diverse group of mental health nursing practitioners and academics. As such, we locate our existential anxieties about nursing futures within a wider frame of concern for mental health across society and provision of mental health care and support services particularly. To put it bluntly, we assert that recent policy and regulatory changes in the UK, also reflected on the international stage, are creating the conditions for a regressive genericization of mental health nurse education. We believe that, left unchallenged, this direction of travel will result in a degradation of mental health nursing work to the detriment of services and care outcomes.

Driven by the damning inquiry into failings at mid-Staffordshire Hospital, a series of reviews and reports culminated in the 2018 revision of NMC standards for pre-registration nursing education programmes. In Australia, where the move to genericization is more established there have been hugely detrimental problems with staffing of inpatient care with an acknowledged skills deficit impacting upon quality of care and driving a vicious cycle of workforce dilution.

Specific issues have been identified for mental health nursing students undertaking practice placements, where practice assessment documentation arguably emphasises physical health competencies at the expense of other valued realms of expertise. This can be further complicated by other factors including: damage to practice assessor-student relationships, especially when registered mental health nurses already perceive their role to be limited to care coordination; a disorientating theory practice gap; and exposure to blame cultures within services. In light of this, Bifarin (2017) calls attention to complexities surrounding the psychological and relational readiness associated with mental health nursing students' professional socialisation especially when different and sometimes contradictory expectations are placed upon them between university and placement settings. Students that enrol for mental health nursing might have positive professional socialisation, but some might struggle or simply endure adverse experiences whilst on placement. For instance, navigating clinical environments for mental health nursing students can be extremely challenging, notably when tensions exist between staff commitments to therapeutic relationship and available resources, with adverse implications for nursing leadership or role modelling. This might manifest in incivility within team relations that can proliferate stress and undermine a positive self-image for students. A fragile self-image can also be vulnerable to vicarious stigma, exacerbated by negative media coverage of the profession and services.

All in all, these unfavourable circumstances can be powerfully corrosive of a professional identity and public image already precarious due to the implicit challenge of genericisation (Connell et al. 2022). In university classrooms, mental health nursing students report feeing marginalised within core nursing modules. If this were not bad enough, this turn of events lands simultaneously with an eye-wateringly startling confluence of other adverse factors. Arguably we are in the middle of the most severe workforce crisis we have ever known. In the UK there is a shortage of approaching 50,000 nurses overall, with well over 11,000 mental health nursing vacancies in the NHS. This picture is mirrored internationally, and for poorer nations the situation is compounded by predatory recruitment from richer western countries. Furthermore, we also must contemplate escalating levels of societal mental distress driven by psychosocial reactions to other prevailing crises such as the pandemic, increasing inequality combined with absolute and relative poverty (with depressing specific concerns around access to energy and food), and perhaps the profound psychic disturbance resulting from the recognition of impending planetary catastrophes of climate change and mass

extinction. This situation flows from the inevitable economic instabilities of late capitalism, overseen by either increasingly corrupt and democratically illegitimate governments or, equally injuriously, incompetent governments wedded to a zombie neoliberal polity which is actually driving the crisis.

Too few nurses are expected to meet increasing demands for mental health care and support at a time when the specialised field of mental health nursing is under threat. This constitutes a perfect storm of circumstances and will require intelligent and committed navigation to steer us to safer ground. Our *#mhdeservesbetter* campaign aims to build a movement for change, to resist genericization and demonstrate the value of mental health nursing. A movement to revitalise mental health nursing will arguably require the support of the broader nursing family, other healthcare disciplines and the public at large. It will not suffice to simply scare people about supposed deleterious consequences of genericization, though a degree of honesty about such negative factors is warranted. Similarly, we need to take care not to precipitate divisive splitting between the various fields of nursing. Indeed, colleagues in children's and learning disability fields are engaged in their own resistances to creeping genericization and common cause in this regard is welcome.

Rather, we need to make a positive case for the continuance of mental health nursing as a valuable contributor to societal health and wellbeing in its own right. Articulating this in a comprehensible and persuasive way is not necessarily going to be easy. For starters, the story of nursing's professionalisation journey is salutary in demonstrating prevailing challenges and hence missed opportunities to clearly account for the value of nursing. Our aims speak to the very identity of mental health nurses (Connell et al. 2022) but describing what this actually is, or could be, is complicated. Mental health nursing may even represent the most difficult of nursing fields for answering such existential questions of what it is we do, what do we have to offer people in mental distress, and what, indeed, we are as mental health nurses?

For many critically minded mental health nurses, this quest should be nested within a more wide-ranging politics of mental health, seeking progressive, relational transformations of the social realm alongside radical changes to services. Though a relational politics for change in mental health services might draw upon the same inspirations and activist practices necessary for transforming wider society, a unifying politics of mental health is not necessarily readily available or fully understood amongst mental health nursing colleagues. Moreover, solidarity connections with potential allies, especially radical service user, survivor and service refuser groups, are only weakly established or not present at all. Critical mental health nurses do exist, as do critical user, survivor and refuser groups and there are some examples of constructive dialogue and campaigning. That said, the desirability of effective cross-sectional alliances aimed at creating better mental health services and provoking a more progressive social appreciation of mental distress remains as necessary as when called for by Peter Sedgwick in the early years of neoliberalism.

Several impediments exist to realising such alliances and the formation of a viable politics of mental health. These barriers to solidarity include: matters of legitimacy wrapped up with professional subordination to bio-medicine, increasingly coercive services compounding various anomalies of inequity for people needing care, accusations of political passivity and failure to live up to stated ideals of advocacy and relational practice, and a tendency for debates to collapse into unhelpful binaries. Of course, there is an imperative to improve physical health outcomes for individuals under the care of mental health services, for whom mortality and morbidity in relation to treatable health problems, often exacerbated by psychiatric medications, is an acknowledged scandal. Mental health nursing's legitimacy has notably been called into question because of the above, but education and practice framed by more authentic person-centred, relational skills offers a road to redemption (BLINDED FOR PEER REVIEW). An over-emphasis within nurse education on certain competencies at

the expense of others arguably will not substantially impact these physical health detriments but risks restricting learning of relational and communicative skill sets. In the UK context, perhaps one of the unintended consequences of erosion of a mental health specialism can be nursing staff within mental health inpatient settings focusing solely on avoiding physical harm with very limited attention placed on psychological safety of patients. In such circumstances patients are unable to raise concerns and together with informal carers they are met with defensive practices.

Interestingly, a concerted effort to resolve some of these issues could go a long way to addressing the questions regarding distinctness and value of mental health nursing. We might even argue that a failure on the part of the mental health nursing profession to energise and engage with such dialogue and critical debates should accelerate the eventual demise of the profession. Alternately, a more concerted exercising of our collective radical imagination can herald alternative futures where the mental health workforce is more appreciated and rewarded in their work and people in need of care are better and more equitably served (Dillard-Wright et al. 2022).

Working effectively to support people with mental health needs requires people to tolerate a level of uncertainty, with often unclear aetiology and no sure-fire strategies guaranteed to facilitate recovery/discovery. Furthermore, the activity of establishing, maintaining and ending therapeutic relationships, whilst acknowledging a huge power dynamic which can include use of legislation such as the Mental Health Act. 1983 and the removal of human rights, are a dynamic of almost infinite possibility. Mental health nurses thus should be prepared through engagement with a variety of models, theories and critical understandings, which allow them to appreciate the variety of perspectives in understanding human experiences and acknowledge how different perspectives may influence subjective wellbeing and also treatment approaches. There needs to be a relational excellence, honed through simulation and critical reflection, and built upon a depth of self-awareness. Reflecting on scandals of abuse and neglect broadcast in recent television documentaries, mental health nurses should never be complacent and think “that will never be me”. Reviewing history, the potential for an ethical drift may not be an inevitable consequence of the human condition but must be perpetually guarded against where the exercise of power and dominance is legitimated, especially in combination with adverse and austere social conditions.

We should acknowledge that the UK professional regulatory body, the NMC, does consult on major changes and did so in relation to the Willis review and new nurse education standards. There is some irony that this review was provoked by identified catastrophic failings in the general hospital services of Mid Staffordshire NHS Trust but the most detrimental consequences could be for mental health nurses. We know from our membership that individuals and representative organisations did raise concerns around genericization in the relevant consultation, but apparently these were not heeded. To some extent nurses could not have predicted what has come to pass, and now objections are arguably more potent and pointed. Whilst undoubtedly there were efforts to consult with nurses across fields, as well as people with service users and members of the general public, any curriculum which links to the experience of the general public should be a living document. Akin to our understanding of consent as an ongoing process rather than a tick-box or one time event taking place in a limited window, the door for consultation should never be closed.

We feel our objections involve demands that unify all fields of nursing against genericization. We believe this is in nobody’s interests, not mental health nurses and not, in fact, adult nurses or other fields, and least of all is it in the interests of the public and people in need of mental health care. Occupational resistance, however, opens up the possibility for a more broadly based set of demands for better services, a more progressive social settlement and a fully renewed profession of mental health nursing. It has been clear from publications and public lectures throughout 2022, that mental

health nurses in the UK are deeply concerned about the impact of the future nurse standards and the weakening of specialist education, and this is not to be ignored. If mental health nurse practitioners and academics are trusted to deliver education they should also be trusted, and taken very seriously, when they raise concerns about the quality of that education.

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