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The future of mental health nursing education in the United Kingdom: Reflections on the Australian and New Zealand experience.

## **Introduction**

This paper provides a debate related to how proposed changes to preregistration nurse preparation in the United Kingdom (UK) may impact on the future of undergraduate mental health nursing workforce. In the first instance we set out the proposed changes and the underlying reasoning provided for these changes. We compare the proposals in relation to the present curricula and possible outcomes of mental health nursing education in the UK. Our discussion also considers if there are lessons to be learned from the Australian and New Zealand where nursing education underwent similar changes during the 1990s. We offer a critique of the underlying political, economic and ideological reasons for these radical changes to nursing education with due consideration of lessons learned by others.

## **Radical change needed?**

Undergraduate nursing education in the UK is now in a period of instability and flux and faces an immediate radical change (Hemingway 2016). Three major factors have influenced these proposed changes in the undergraduate curricula (Department of Health 2012, Francis 2013). Firstly, the apparent deficits in workforce numbers and the purported need to further develop skills for the increasing complex health needs of service users, in the face of austerity cuts implemented by the previous coalition government in the UK. In addition, we have recently witnessed a series of high profile scandals showing deficits in the practice of staff in health care (Department of Health 2012, Francis, 2013, Ion, 2015). Finally, the growing problem of age and the resultant challenge in having an ageing population and related chronic health problems (Prince *et al.* 2014).

The underlying narrative is that the present nursing undergraduate curriculum does not prepare the nurse for all practice eventualities and in its present four field ('silos') of nursing with the skills, patient care is considered compromised (Kleebauer, 2015). *The Shape of Caring Review* (Health Education England 2014) gave 34 recommendations that included that change was necessary for undergraduate nursing education. The review proposed that nursing students undertake a two year core generalist nurse training with adult (general nursing), child, learning disability, mental health and newly added public health nursing specialisms beginning in the third year and continuing in the fourth year preceptorship period (Rossler 2015). Importantly, there have also been some new developments in how nursing education will be funded. Specifically, moving from a funded course of study with a bursary to support students attending placements towards self-funding through student loans. According to the UK government position, students will be better off through the loan system rather than publicly funded support (Twycross 2015). The real reason for this economic re-structuring of nursing education is that there will be no cost to the taxpayer, in essence further advancing the austerity agenda.

Recently a plan was announced to create a new nursing support role of the nursing associate (similar to the state enrolled nurse). The person in this role will undertake "hands-on" care (ie: bathing, feeding, taking vital signs) allowing registered nurses to concentrate on more advanced clinical interventions (NHS Employers, 2016). In conjunction with the plan an announcement was made about potential new nursing career options. These options included prospective candidates still being able to access nurse education by an academic route at University or have an apprentice route available that includes work based learning and employment (DH 2015). This raft of changes will be subject to consultation, however overall the proposals signal a new direction and era for nurse education in the UK.

## **Mental Health Nursing**

The Shape of Caring (HEE, 2015) and Willis (2015) reports have far reaching implications for nursing in the UK and the future of mental health nursing. The present system allows a direct entry into one of the four specific nursing fields (Adult, Child, Learning Disability and Mental Health). Students then undertake the same theoretical aspects that are related to their specific field (Nursing and Midwifery Council 2010). The students over their 3 year programme are exposed to 2300 hours of practice placement time which represents 50% of their course (Edward *et al.* 2015). It is proposed implementing a '2 + 1 + 1' model of undergraduate nurse education (HEE 2015). Students will experience two years of apparently flexible, generalist education, proceeded by a specialist (i.e.: mental health) field year, and a further specialist year in preceptorship once qualified involving the graduate nurses employer.

One of the reasons for the proposed changes to student nurse education is an underlying need for nurses to be able to address all clinical possibilities (Warelow & Edward, 2007, Gray 2015). As such, nurses will be predominately working in the health care contexts where physical healthcare becomes the predominant focus and where they are expected to have mental health literacy (Coffey *et al.* 2015, Willis 2015). Conversely, this may mean nursing students who progress toward working in mental health to be more physical health literate, something recognised as a major change for the present workforce (Hemingway *et al.* 2014). Emphasis on physical health implies the biomedical model predominates the healthcare landscape and a social perspective of mental health problems taking a backseat. If the social perspectives of mental health nursing knowledge are minimised in nursing undergraduate programmes then one could argue mental health care will be provided to service users by an under-prepared mental health nurse.

The introduction of an apprentice style system alongside the existing undergraduate

route is another major variation to nurse education. This could be seen as merely a reintroduction of the apprentice route for nursing alongside renaming enrolled nurses as nursing associates propping up a flagging nursing workforce. Whether it is looking forward or going back to old educational frameworks it signals a radical transformation to nursing education and we believe it bodes a reversal of the progress that has been achieved in the perception of nurses as professionals who are 'thinkers' not just 'doers'. Furthermore, the reintroduction of an apprenticeship styled education route could signal a reversal of the preparation of student nurses for practice by the higher education route introduced in the 1990s. To truly consider the potential outcomes of the overhaul of undergraduate nursing education it is relevant to consider the Australian and New Zealand context. The comprehensive preparation in nursing education has been employed for some time in both Australia and New Zealand, and in both countries enrolled nurses were retained rather than abolished as was the case in the UK three decades ago.

### **Lessons from Australia**

Australian nursing education moved into the tertiary sector from hospital training during the 1990's as seen in many countries around the world at that time. In subsequent years there was a move away from the multiple speciality nursing registers that previously existed across multiple states (ie: mental health, intellectual disability, midwifery, maternal health, enrolled nurse, general/adult) to a two register approach (general/adult nursing and midwifery) and a national registration board. Comprehensive nursing education was designed to equip the graduating nurse for all practice possibilities and in any setting. However there remains deficits in students acquiring mental health nursing skills as indicated by some studies into mental health nursing abilities in comprehensive nursing degrees (Happell & Cutcliffe, 2011, Happell & McAllister, 2014). In addition, attitudes of nursing students towards mental health

nursing is also variable with a predominately negative attitude towards mental health nursing as a career option (Happell & Gaskin, 2013). Changes related to the acknowledgement of specialist skills through the Australian Nursing and Midwifery Board (established in 2010) has also closed off the option for mental health nurses to have their specialist skills recognised in a separate register (which existed prior to 2010). The Australian College of Mental Health Nurses developed a credentialing program in 2004 as a professional self-regulation initiative for mental health nurses and this program supports the recognition of specialised mental health nursing skills that is currently unavailable other than as a registration endorsement upon registration (ACMHN 2015).

During the changes to mental health nursing in Australia, there was a decrease in the number of students motivated to undertake mental health nursing as a career choice. Recently Edward et al. (2015) conducted a cross sectional study of student nurses from a dedicated mental health nursing program in the UK and student nurses in a comprehensive nursing programme in Australia. The purpose of the study was to illuminate student's motivations for considering mental health nursing as a career choice. Their cohorts comprised of students from two UK universities' and four Australian universities (n=395). The findings suggested the motivations of students for choosing mental health as a speciality career stream appeared to be influenced by prior exposure to mental illness. Prior exposure to mental illness has the potential to demystify mental illness and therefore potentially reduce stigma related to mental illness, reduce uncertainty about the role of the mental health nurse, and help students develop pro-social behaviours that may manifest as an altruistic desire to help those less fortunate. In their study Edward and colleagues found that in the UK cohort 54% had previous experience of mental illness compared to the Australian cohort where over 60% had never had previous experience of mental illness. Career immersion in comprehensive nursing programmes may offer a means for students to have greater

exposure to specialty career options facilitating clinical exposure (Hercelinskyj *et al.* 2013). However, limited opportunities exist in comprehensive nursing programmes to facilitate lengthy immersions for all speciality nursing streams but brief immersion (i.e.: clinical practicum without the distraction of other classes) is possible. Nevertheless, clinical practicum as a means of immersion however brief may be challenging for students since no standard approach exists across clinical settings and little is known about the impact of diverse clinical settings on relationships between registered nurses and student nurses (Rebeiro *et al.* 2015).

In 2013, mental health nurses in Australia numbered about 7% of the nursing workforce (where 1 in every 16 nurses worked principally in mental health) and this number comprised of registered nurses and enrolled nurses (AIHW 2015). Enrolled nurses are an associate to the registered nurse and their core responsibilities include providing patient centred nursing care and assessment and evaluation of functional states of patients. Where state law allows, enrolled nurses may also administer prescribed medicines in accordance with their educational preparation. Most enrolled nurse education is 12-24 months and education can facilitate a pathway to registered nurses education at university dependent upon meeting university specifications. Of concern, the aging workforce in Australia in mental health nursing continues to be problematic with over 60% of those already in mental health roles are aged 45 years and above (average age 47 years) (AIHW 2015). This is in light of fewer new graduates are opting to undertake mental health nursing as a professional pathway .

A significant development in Australia was that Government financial support for tertiary education changed with the introduction of the Bradley report during the late 2000's where universities moved to a demand driven approach for all university students and the caps on student numbers were removed (Bradley *et al.* 2008). The Bradley review was established in response to not meeting targets for high level skills

within the populations as seen in other OECD countries (Putnam & Gill 2011). Whilst this classic economic approach of demand and supply may enable universities to offer more places commentators have suggested it does not provide good quality education for vocational subjects (Stokes & Wright 2012). Furthermore, in Australia there appears to be some suggestion that some universities have reduced their minimum tertiary entrance scores to attract more applicants to their nursing courses (DH Australia 2013). Whether this was a response to acute nursing shortages (Francis *et al.* 2011) or a way of increasing student numbers and income to educational institutions it may compromise the level of credibility nursing has developed in the tertiary setting as a profession worthy of the high achieving applicants.

### **Lessons for the UK**

The Australian experience provides the UK nursing educational organisations and regulatory boards a few pointers as to what could happen in the UK as a result of implementing similar nursing education reform. Specifically, there is a recognised shortage of mental health nurses in Australia when compared to the UK. Contributing factors may be both the lack of targeted recruitment of mental health nurses for degree programmes 'majoring' in mental health (Happell *et al.* 2015), as well as the lack of career immersion opportunities (Edward *et al.* 2015). While the Australian model is adequate for nursing registration generally, several Australian commentators have suggested that the comprehensive system does not adequately prepare undergraduate students with the skills, knowledge and competence for mental health practice (Warelow & Edward 2009, McCann *et al.* 2009 Happell *et al.* 2015). New Zealand sought to address similar issues with the innovation of increased mental health content into nursing curriculums, as well as implementing a transition to practice process across all nursing specialities not withstanding mental health (Haggerty *et al.* 2012). The New Zealand College of Mental Health Nurses also offer a credentialing



program based upon skills, knowledge and education and used to assign specific clinical responsibilities to health practitioners in the domain of mental health (NZCMHN 2016). Such recognition offers a professional standard across MHN that may otherwise not be as specific through general registration for practice (Warelow & Edward 2009, Spence *et al.* 2012).

The transition to practice innovations in New Zealand (Spence *et al.* 2012) and Mental Health Majors in Australia (Happell *et al.* 2015) have produced some encouraging results. However in New Zealand they found cannot rely on busy overstretched preceptors solely when supporting nursing graduates' transition to practice (Haggerty *et al.* 2012, Spence *et al.* 2012). In Australia some Universities have not been able to sustain the mental health major due to unsupportive infrastructure, lack of staff and a curriculum with a dominant adult/general nursing focus (Warelow & Edward, 2009). While we know mental health nursing recruitment is relatively healthy in the UK when compared to its Australian counterpart (Edward *et al.*, 2015), retention also compares well from the UK perspective (Prymachuk *et al.* 2009). Therefore, the question becomes, 'why is the UK nursing education framework moving to a system that may produce drastically reduced numbers of mental health nurses?' Moving towards a comprehensive nursing education model will create a domino effect as seen in other countries related to mental health nursing recruitment, retention skills, knowledge and attitudes.

The cap on places in the present UK system means over half of applicants are turned away. The demand and supply nature of recruitment Australian universities have followed may potentially recruit high student numbers and interestingly this is the same argument currently deployed by George Osborne in the Comprehensive Spending Review (Ford 2015). While the Australian experience has demonstrated increasing university capacity for student enrolment this does not necessarily lead to more nurses

since the capacity for clinical placements and nurse supervisors (nurse mentors in the UK) can only cater for a limited number of students in an already crowded clinical arena (Merrifield 2016). The demand and supply argument has received its critics and ironically the UK targeted healthcare workforce growth of 1997-2005 was recognised as a successful targeted governmental investment when the Bradley report proposal was being laid out (Segal & Bolton 2009).

The continued use of Enrolled Nurses in Australia does seem to have been a success in terms of allowing a different route into nursing and therefore complementing a more diverse workforce. The introduction of the nursing associate in the UK seems to be targeted at increasing accessibility for candidates who want to pursue a nursing career (Traynor *et al.* 2015). It will be interesting to observe the outcomes of this new innovation alongside the introduction of nursing apprenticeships. We strongly fear that rather than increasing a competent and caring nursing workforce, the real reason is simply to give a cheaper alternative route into nursing and healthcare provision (McPake *et al.*, 2015). For example, mature students may use this route as a result of the abolition of the current financial structure of degrees. It is interesting enrolled nurses are an increasing part of the mental health nursing workforce in Australia and this certainly could be mirrored in the future in the UK.

The act of decreasing academic entry levels also deserves some consideration. One of the reasons behind university education was to validate nursing as a healthcare profession and produce nurses who can analyse situations critically and contribute to a case as a knowledgeable member of the multidisciplinary team. Whether academic entry scores are reviewed and lowered is conjecture at the moment, however this does spell a major reversal of previous policies. Also, whether or not such a change is implemented to increase student capacity we feel this will not guarantee producing the type of nurse who the Willis Report (2015) envisages.

In the UK in recent years nurse academics and commentators have questioned the value and indeed the future existence of mental health nursing as a profession. Recruitment problems, a cut in the number of student places, limited career prospects and the dilution of the mental health nurse role within clinical practice have led to an identity crisis for many mental health nurses. Coupled with the focus on recovery and peer support workers the notion that the profession is “sleep walking towards oblivion” has taken hold (Hurley & Ramsey 2008, Stickley *et al.* 2009). Where then does this leave the mental health nursing profession in the UK? Time will tell but there appears to be an ideological shift in how the current Conservative government of the UK views and values the role of mental health nurses within the current workforce (Coffey *et al.* 2015). The past five years has seen a loss of one in 10 of the entire mental health nursing workforce in England even though the number of people in contact with NHS mental health services has increased by around 40% over the same time frame (The Guardian 2016). It is possible mental health nursing profession is not sleep walking towards oblivion, but the profession, like many others, is undergoing a transformation and realignment as a result of globalisation and neoliberal policies which has led to the “commodification” of patients, healthcare workers and healthcare systems. Mental health nursing and the education of mental health nurses in the UK, is now fully embedded into a business model predominated by reducing costs, increasing efficiencies and increasing productivity (Civaner 2013, McPake *et al.* 2015). We suggest the UK government’s proposal to marketise nurse education is ideologically driven. Thus the education of healthcare professionals and in our case mental health nurses is being driven out of the public sector and into the realms of private and individually funded programmes which exist to service the free-market, hardly reflecting a caring society (Hemingway *et al.* 2013).

## **Conclusion**

We have attempted in this paper to provide a balanced critique of the impact of the proposed changes to mental health nursing will impact by drawing on lessons from Australia and New Zealand. However we feel it is very difficult not to be very concerned about what these changes signal. The education of mental health nurses is a protean concept and current approaches tend to reflect contemporary political and economic paradigms. In the UK strong winds are blowing and nursing students will be expected to financially shoulder the burden of their own education coupled with the potential move towards a more comprehensive programme of study. The marketisation of nurse education in the UK is rapidly entering uncharted territory and we strongly plead that, lessons from examples drawn from the Australian/New Zealand models need considering before it is too late so as to avoid consequences that may be detrimental to the future of mental health nursing in the UK and people in their care.

If nurse education is to move in the same directions as other countries such as Australia and New Zealand, learning lessons is central with regards to navigating the issues that follow such a change such as recruitment, professional recognition of skills and knowledge and acquisition of specialist nursing skills in order to maintain excellence in the mental health nursing workforce. It is not just a question of how we deliver or even fund nurse education, but how we value the caring professional role and the vulnerable community members who receive care from mental health nurses.

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