Mental Health Nurse Academics UK (MHNAUK) was formed in 2003 and represents more than 60 Higher Education Institutions engaged in Mental Health Nursing Education, Research and Policy Development. MHNAUK members began a discussion at their last meeting, in June 2017, on the implications of the draft NMC education standards and proficiencies for developing mental health nurses able to work alongside people experiencing mental health difficulties and their families to facilitate recovery. Following this meeting core questions from the NMC’s consultation survey were circulated amongst the group’s 150 academic members. A twitter chat was co-hosted with WeMHNurses to scope wider responses, including from people with experience of mental health problems, mental health nurses, other academics and students (http://www.wecommunities.org/tweet-chats/chat-details/4044). The replies to these exercises have been used to inform this response to the NMC education consultation.

Standards of Proficiency

In its position paper on the future of mental health nursing Mental Health Nurse Academics UK outlined a clear case for retaining fields at pre-registration level (https://mhnauk.wordpress.com/position-papers/). MHNAUK welcomes the retention of the field and the flexibility offered by the framework to apply the proficiencies to the context of mental health. Recognising that all nursing professionals should be able to meet fundamental mental and physical care needs of people with mental health problems is commended and has the potential to enhance the care experience of people with mental health problems across service boundaries. MHNAUK is also appreciative of the recognition of clinical supervision as an important approach for supporting staff wellbeing and resilience.

However, the proficiencies in their current format do not adequately reflect the requirements of the mental health nursing profession. There are significant omissions in the outcomes and the skills annexes that would be required to be added in order for graduate nurses, at the
point of registration, to effectively meet the needs of people with mental health difficulties and their families. We are concerned that the language does not reflect the philosophy and values of contemporary mental health nursing, in particular a lack of reference to recovery, which is enshrined in the evidence base of the profession alongside mental health policy.

There is limited evidence of the integration within the proficiencies of the recommendations from 2017’s ‘Playing our Part’ (https://www.fons.org/resources/documents/Report-Playing-our-Part,-the-work-of-graduate-and-registered-mental-health-nurses.pdf), a national review of mental health nursing supported by the Foundation of Nursing Studies which outlined the future direction for mental health nurses following wide stakeholder consultation.

The topics of the domains in the draft proficiencies largely reflect the focus of mental health nursing i.e. assessing needs, planning care, leading teams and so on. However, the detailed outcomes under these domains do not appear to fully account for the nature of mental health nursing work. An example is the omission of co-production and recovery under the planning and delivery of care. The outcomes of the latter domains are largely focused on the delivery of physical interventions and procedures, providing limited examples of the psychosocial approaches employed daily by mental health nurses. This might include therapeutic risk taking, problem solving, recovery planning, self-management, physical and relational security, and the use of evidence based approaches such as those generated through the ‘Safewards’ research programme (http://www.safewards.net/). The outcomes make reference to understanding health legislation, yet MHNAUK members have some concerns that the in-depth knowledge required by mental health nurses of the Mental Health Act, Mental Capacity Act, rights based legislation (and conventions) and laws specific to each of the UK’s four countries (for example, the Mental Health (Wales) Measure) could be overlooked. This involves recognition that some service users experience mental health care as coercive and mental health nurses have legal duties in this context. There is also perhaps a missed opportunity to recognise roles such as the Approved Mental Health Professional AMHP role as part of the extended skills for mental health nurses (as discussed in Playing Our Part), which undergraduate education provides an important foundation for. Additionally, as recognised in the current NMC competencies (2010) but absent from the draft proficiencies mental health nurses need to act in a manner which minimises the power imbalance between the nurse and service user in the unique context of compulsory care.
We are concerned that the current emphasis in the outcomes, therefore, does not provide parity across the fields and could result in significant gaps in skills for graduate mental health nurses. It has also been noted that these proficiencies fail to account for the wide range of agencies that all nurses, but in particular mental health nurses will be working with including professionals outside the health and social care system (for example, in criminal justice organisations and in the education field).

Within standard 3 there appears to be an emphasis on the biological knowledge base to underpin nursing assessment. Whilst it is recognised this is essential knowledge for all nurses, and other forms of knowledge are briefly mentioned, the bias towards this theoretical foundation does not fully acknowledge the contested nature of mental distress and the expertise of mental health nurses at employing a biopsychosocial approach, working within an individuals’ own interpretation/understanding of their experiences.

Annexes

Annexe A – The emphasis on communication is welcomed as interpersonal relations form such a fundamental part of mental health nursing practice. The skills were noted as being broad and there was an absence of consideration of how specific communication techniques might be used to support people with a range of distressing experiences, such as those who hear voices or who are suicidal. Again this may mean differentiating between techniques that all nurses might use to offer comfort and the specific approaches employed by mental health nurses to foster relationships and facilitate change. It is unclear where the evidence for the specific techniques mentioned on p32 arises as these are a sample of many approaches that could be identified and there is concern these could become too prescriptive in a constantly evolving area. It has been suggested that “psychosocial interventions” may offer an umbrella term that would capture these and other interventions whilst providing the scope to incorporate new approaches in line with the evidence base.

Annexe B – The procedures outlined in this annexe are focussed on physical healthcare skills, largely in the context of hospital focussed acute medical/critical care which was of significant concern to MHNAUK members. Whilst mental health nurses need to provide care that addresses holistic care needs, and there are a range of physical conditions that people
with mental health problems are more vulnerable to, Annexe B does not fully address the context in which this care is delivered by mental health nurses (including for example access to equipment). Some skills such as wound care and respiratory health may be required in more depth for mental health nurses whilst others such as Doppler skin assessments may be rarely used. There is a lack of clarity within the annexe regarding what would be required for all nurses and what would be required for some. It has been highlighted that it is essential for all nurses to also be able to identify when to draw on the specialist skills of others in coordinating and providing care for people with complex healthcare needs.

Concerns have consistently been raised within responses from MHNAUK members regarding the time which these standards imply would be spent within the curriculum developing skills to carry out procedures that may be rarely (and in some cases never) used by mental health nurses. This also raises questions about the maintenance of proficiency at the cost of time in the programme which might otherwise be spent on core mental health nursing skills. The term ‘procedure’ often has less relevance for mental health nursing as support is interpersonal and framed within a psychosocial context. MHNAUK therefore recommends that the skills annexes are field specific, which does not preclude some skills appearing for more than one field and opportunities for shared learning.

**Education Standards**

MHNAUK welcomed the opportunity for some practice supervisors to come from outside nursing and this may provide some extended placement opportunities for students in the field of mental health for example in the voluntary sector. However, this has potential to be open to abuse, as practice and academic assessors coming from outside the field might undermine students' capabilities in relation to mental health. Training for supervisors and assessors should have some quality assurance mechanisms and there has been some suggestion that there could be some further “light-touch” guidelines from the NMC in this area and/or benchmarking of minimum standards.

There was support for the removal of the cap on simulated practice hours and a recognition that simulation would be essential for mental health students to achieve proficiency in many
of the procedures in the draft competencies. The group was clear that simulated hours should not exceed practice hours. Investment would be needed in developing high quality realism in mental health specific simulated scenarios.

A UK wide practice assessment document would be encouraged (for example such as the one that has already been introduced in Wales). However, MHNAUK identify that this should be field specific and mental health nursing should be well represented in development groups to ensure this fully meets the needs of the field.

The education standards do provide capacity for institutions to be flexible and creative in their delivery which was welcomed. However, there were some areas of uncertainty that MHNAUK members were apprehensive about including, the lack of numeracy and literacy requirements at the point of entry, unclear requirements for preparation and standards for assessors, the potential for academic and practice assessors to be out of field resulting in non-mental health experts undertaking assessments of mental health nursing students without context or expertise in the area.

These issues should be addressed in any amendments:

- Recovery in the context of mental health should be enshrined within the proficiencies and clearly evident within the outcome statements across the domains
- Mental health nursing is characterised by establishing, maintaining and ending therapeutic relationships which incorporates nurses using basic counselling skills and interpersonal techniques. Both the outcomes and annexes need to more fully address these skills and the underpinning knowledge that supports their development.
- The annexes should be mutually agreed by all four fields and we recommend that these are field specific.
- The language of the annexes should be revised in recognition of the limited ‘procedures’ in mental health care.
- The emphasis should remain, as in the current NMC competencies, on psychological, social and biological theoretical foundations.
It appears overall the shared proficiency statements and skills annexe represent a shift towards reducing the distinctive nature of each nursing field as there is limited reflection of the specialist areas of knowledge, skills and values that are core to each profession and we feel this should be addressed to ensure graduate mental health nurses can continue to provide high quality recovery orientated care.

Thank you for consideration of this response

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