Standing out on the margins: Using dialogical narrative analysis to explore mental health student nurse identity construction and core modules

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Literature and experience suggest that student mental health nurses feel marginalised in core modules. A focus group was held to explore mental health nurse students' experiences of whole-cohort core modules in nursing. Students from a university in the North of England attended a one-hour focus group followed by dialogical narrative analysis of transcripts. Stories of shared professional identity, marginal status, critical thinking, and practical application of theory were shared by the group. Greater presence of mental health stakeholders earlier in the programme and more applied field specific teaching offer a means to bolster professional identity in mental health nursing students.

Introduction

It has been argued that Mental health nursing is a unique and distinct discipline (McKeown and White, 2015; Butterworth and Shaw, 2017). Mental health nurses employ a necessarily broad set of specialist skills which can often be misread as a lack of ability in a sector (health) where narrow specialism is highly regarded (Hurley, 2009). Having their roots in asylums, where untrained "attendants" aided "mad doctors" in containing the disturbing elements of society (Pryjmachuk, 2018), some see the professionalization of mental health nursing as a far from finished business (Bull et al, 2018). Formalised training for mental health nurses was first delivered by psychiatrists as part of the initial process of professionalisation (Nolan, 1993) and now is delivered by nurses from all fields, indicating an external shift in the primary identification of mental health nurses, who are traditionally very cautious about speaking out about their work (Bladon, 2018). The origins of and continuing alignment with the NMC and the notion of "fields" of nursing demonstrate how the ideals and identities of other

professions and bodies have swayed and perhaps muddled mental health nursing's development of a sense of distinct professional identity (Nolan, 1993). The erosion of this sense of identity by revisions to education delivery and focus has been cited as threatening the very existence of mental health nursing as a distinct sphere of work (e.g. Hurley and Ramsey, 2008; McKeown and White, 2015; Lambert and Hemingway, 2015).

Student nurses in England must choose their field of practice (adult, child, learning disability, or mental health) at the outset of their course of study. How Universities in England structure courses of nurse education varies. The content is dictated to some extent by the regulatory standards of the Nursing and Midwifery Council, but the academic institution decides how to incorporate and deliver these to the four fields. Typically, nurse education in England is initially delivered in generic, whole-cohort modules (core modules) with all fields of nursing studying together (typically at the start of the course in what was previously known as the common foundation programme (NMC, 2004)), designed to ensure essential competencies for nursing are established in all students and professional standards are understood. This has been suggested to be a way of creating a collegiate nursing environment of mutual learning in which the fields enrich each other through the sharing of experience (NMC, 2004).

For learners in the smaller fields of mental health, child and learning disability nursing. whose specialist education begins after the core modules, this brings some issues of belonging and identity. Wood (2005; 2010) found mental health students to be of the opinion that the common foundation programme failed to acknowledge their field. Willis (2015) called for further development of this generic component, prompting respondents to Lambert and Hemingway to describe mental health nursing as

"under siege" (2016, p114) and at risk of deprofessionlisation. Evidence from Australia indicates that nurses receiving generalised education are reluctant to take up mental health nursing post-registration (Happell, 2009; 2019; Happell and Gaskin, 2012). Further international evidence regarding generic nursing education programmes concurs (Günüşen et al, 2017; Hastings et al, 2017; Waddell et al, 2020).

For some mental health nurse academics (Bull, Gadsby and Williams, 2018; Grant, 2002), this inability to define the profession on its own terms serves to continue an extant hierarchy amongst the fields, with adult nursing seen as "proper" nursing and mental health seen as "woolly" (Holmes, 2001). This may contribute to what Stickley and Timmons (2007) note is an uncritical move from lay beliefs to the medical model of understanding mental illness in nursing students. This effectively undermines the central tenet of the therapeutic relationship as interpersonal, with a technical approach dependent on evidence-based interventions for medical conditions rather than understanding of the stories of individuals as central to meaningful recovery (Grant and Radcliffe, 2015).

A need to come to terms with and make amends for past and present abuses of power has also been identified as necessary to moving the profession on from its current conflicted sense of identity (Gadsby, 2018; McKeown and Spandler, 2017). Some have suggested that the development of a more robust evidence-based approach to mental health nurse education is the answer (Butterworth and Shaw, 2017), whilst others contest the accepted model of evidence based practice based on medical applications (Grant, 2015; Rolfe, 2010). Whilst the education of mental health nurses is aligned to that of adult nurses, these issues will not feature in generic modules and there is little room left in the rest of the programme to address them adequately. Nor does it

encourage students to be vocal critical thinkers (Bull et al, 2018; Goodman and Morrall, 2013; Goodman, 2011), challenging theoretical and practical assumptions and traditions which may contribute to the iatrogenic harm of service users (Grant, 2015).

Attempts to consolidate a new sense of identity defined by understandings of mental health rather than the practice of psychiatry have received a mixed response (Barker and Buchannan-Barker, 2011) but there is some evidence that a significant minority see mental health nurses as a distinct and positive group apart from other psy-professions (Barker and Buchannan-Barker, 2011; Dixon and Richter, 2017). These studies suggest an ambivalence toward mental health work in the general populace, and mental health nursing itself, reflected in the absence of mental health nursing in the broader curriculum. This creates difficulty in developing understanding of the profession and sphere of work in students at an early stage (Stickley and Timmons, 2007). This may contribute to feelings of unpreparedness reported by students and concerns raised by practice areas about field specific knowledge deficits.

Therefore, this research seeks to find out:

- What are the experiences of mental health nursing students on core modules?
- How do core modules affect the professional identity formation of student mental health nurses?

The review found very little previous research into this aspect of mental health nurse education. Locally, findings would assist the mental health team in establishing if there is a case for specialisation of more content and if so, what aspects need attention.

Method

Focus groups have the benefit over interviews of requiring less time commitment for participants (Arksey and Knight, 1999). As students had a very small

window in which they could participate, this method made it possible to accommodate more points of view without overburdening students in terms of time commitment. Focus groups aim to produce rich, in-depth data derived from the spontaneous interactions of group members (Stewart et al, 2007).

Design

This exploratory study was initially designed to employ three focus groups, allowing discussion of each year of the programme from students from respective cohorts. This design would allow comparison of stories told by students from different cohorts, at different stages in the programme. Unfortunately, commitments and concerns affected the third years to an extent which rendered their involvement impossible despite attempts to reschedule. Attrition was also a problem in the second-year group, reducing an initial uptake of sixteen students across three years in three groups to a single group of six students.

Ethics

This project was granted ethical approval by the Faculty of Health Sciences research ethics committee.

Setting

Nursing programmes in the UK have an equal time allocation for theory and practice. The theory elements are delivered at Academic Education Institutions, whilst the practice elements are completed on clinical placements with provider healthcare trusts. How these are achieved is interpreted differently across institutions, leading to a varied range of programme structures. The programme discussed in this paper delivered theory in blocks of teaching, with a mix of core modules (whole nursing cohort) and field

specific (mental health cohort) modules in all years of the programme. Year one was mostly core (what was formerly referred to as "common foundation", comprised of fundamental skills and professional standards), with a single mental health module at the end of the year. Year two had one core module and two field specific modules, with year three having one module of mental health content and a two-trimester core evidence-based practice, education and leadership module with generic lecture and some workshops with elements of field specificity. The first mental health module being in the last trimester of year one, and the last being in the first trimester of year three, the period in which students' academic programme reflected their field of practice was limited to five trimesters over three years.

The new Nursing and Midwifery Council standards for education and assessment of student nurses (NMC, 2018) offer the opportunity to re-write nursing programmes. Students and practice partners on our programme have commented that students do not feel core modules prepare them for mental health practice. In mental health nurse education, several scholars have argued that a critical approach to teaching, learning and practice are in danger of being abandoned if they have not already been (e.g. Rolfe, 2014; Grant, 2015; 2018; Bull et al, 2018). By bringing a research informed eye to our programme to understand mental health nursing students' experience of core modules, it is hoped we can inform a more coherent sense of identity for student mental health nurses through programme revisions.

Recruitment

Students were recruited through announcements on the Virtual Learning Environment. Attached were a copy of the recruitment flyer and consent form. Email lists and in-

lecture face-to-face announcements were also used. Respondents were sent copies of the participant information and consent sheet and asked to consider their decision before participation. Dates were sent out by diary invitation through the institutional email system to participants in advance of the groups. Two groups were cancelled due to low numbers and attrition.

Data collection

A single focus group lasting one hour was held in January 2019. Attendees comprised two second year and four first year mental health nursing students, placed across three different provider healthcare trusts. Representation was limited to six female students, of whom five were parents. Ages ranged from 20s to 50s. Students had a variety of academic backgrounds, with three having prior degrees. One student was a course representative for her cohort. Students signed consent forms at the beginning of the session prior to commencement of recording.

A question schedule was drawn up and passed through ethical approval prior to data collection (Appendix A). Content of the schedule was based on conversations with students and colleagues, although no formal process of piloting was employed. Participants were not given access to this schedule.

The focus group was facilitated by the sole author, who was a member of teaching staff on the mental health programme but has not taught any of the students present on core modules. The group was recorded on a secure digital device which remained in a locked location known only to the principal researcher. A statement about professional behaviour and confidentiality was read from the interview guide by the facilitator prior to commencement of the discussion. Further additional rules were invited from the group.

The schedule is brief, to allow sufficient opportunity for in-depth responses to develop and group members to interact. It has been suggested that the increasing number of items on focus group schedules over recent years have left little opportunity for the aims of focused research, humanistic interviewing, group interactions and in-depth data to be achieved (Stewart et al, 2007). The richness of generated narratives attests to this.

Analysis

Data was transcribed by hand by the principal researcher from digital audio file. Transcript was anonymised to protect participants and is available on request.

To analyse this data, a dialogic narrative approach (Frank, 2010; 2012) was used. This involves examining transcripts for emergent stories. These stories can be whole or partial in their use of Labov's identified components for fully formed narratives[2] and are told to an audience (Frank, 2012) which influences the aim of the storyteller. The stories known to a storyteller form the limits of their resources from which they draw on to tell new stories. The stories known to an audience form the limits of their resources for interpreting the stories they hear. In sharing stories it is possible

[2] Labov's six classic clauses for narrative structure: Abstract, Orientation, Complicating Action, Evaluation, Resolution and Coda (Reissman, 2008). Citing a minimalist example of complicating action and coda explored by Sacks (The baby cried, the mother picked it up), Frank identifies that fragmentary stories can be effective as much as "complete" ones, their worth being tested by listeners. He suggests "What a story is should remain fuzzy at the boundaries." (Frank, 2012 p.42)

for new potential narratives to be made available to the parties involved to enable marginalised groups to develop stronger stories for themselves, by drawing on the increased set of resources made available to them.

A table was used to record and amend emergent stories which were then checked back against the transcript and the recording. The final list including amendments is found at appendix C. Amended stories are reported under erasure with reasons for their removal.

Findings

Stories which described a perception of being silenced or rebuked unjustly when displaying critical thinking or applying a mental health context were common, as were stories identifying factors common to all fields of nursing, emphasising the importance for practice of acknowledging this in class. Other stories focused on limitations in educational infrastructure.

Stories chosen for inclusion here as examples were regarded as the most formed and typical of type. Many fell into more than one type.

The typology of stories developed from this transcription includes:

Outsiders

Stories about experiencing a feeling of marginalisation were common. These included feelings that mental health staff and practice were under-represented in core modules. The resources to contextualise concepts (and in some cases, key concepts in mental health) were not offered to students and as a result they heard stories in which they did not feature. Some attempts by students to introduce elements and principals of mental health care to recontextualise stories were met with hostility or dismissal. In one story

students were met with a message that some skills were not worth their involvement as they would never use them. Cultural differences between fields were referred to in some stories. These suggest stereotypical characters of mental health nurses as offbeat or disruptive but also of adult nurses as staunch and rigid. At times, adult nursing students were portrayed as linear and disinterested in exploration of academic theory. This despite their sharing a classroom. Lecturers were described in these terms, with a suggestion that a quirky sense of humour is common to mental health nursing whereas rules and order are what defines adult nursing (interestingly, no stories of child or learning disability nursing were offered or discussed). Frank (2010; 2012) notes that in our telling stories to defend ourselves, others are inevitably attacked.

Commented [BT1]: Text moved from end of section

"We're always a little bit quirky, aren't we?" relates a well-trodden story about the nature of mental health students and staff. In invoking the notion of "quirkiness" in mental health nursing students, student 4 brings the group together, a suggestion from student from student 6 that the mental health students are quiet is incorporated into this notion of quirkiness and the group keeps its quirky cohesion. The differences between the lecturers from mental health and adult fields are brought up, adding to the Quirky identity of mental health workers, and taking in the differences in practice settings and the need to adapt some clinical processes for the mental health field.

4: I think that the mental health cohorts it, they're always a little bit, and this has been said to us, we're always a little bit quirky, aren't we?

6: I think we're a little bit quiet.

4: Do you?!

(Laughing)

3: How very quirky!

6: No-one from mental health shouts up in the lecture, in the big lectures

4: I do. Yeah when _____ sees me. I said I was going to get one of them fingers, foam fingers

(Inaudible comment)

5: What was good were practical ones when we were taught by mental health nurses rather than general, general nurse because they…

4: Because they're also a little bit out there aren't they?

5: can relate it to the mental health settings, because not every practice, every skill that you get taught works in a mental health the way we've been taught

4: They're not as stoic and staunch (J5: yeah) as the general nursing tutors (: ???? and laughs) and they've got a much more…positive approach, what's the word more encouraging. I mean we did have some general nurse tutors that was like "no, that's wrong" and unhelpful but the mental health ones was like "you could do it like that, OR, you could try it like this…"

Free thinkers

Stories about curtailed debates or rejected comments cut across this and the outsiders story type. The link to outsiders is strengthened by the depiction of the majority of students as unmotivated beyond obtaining their registration. On occasion these students were characterised as lacking maturity and motivation. In these stories, mental health students were the champions of free speech, the critical thinkers and the inquisitive students. Academic staff were portrayed as limited in knowledge and afraid of straying from the lecture content. The impossibility of engaging in academic discussion in large lectures or time pressured situations often framed or ended stories of frustration.

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In the story "An uproar", students related an incident where they had challenged what they believed to be uninformed opinion on mental health. Student 2 related how she had questioned a statement made by a lecturer from another field, who had suggested that a diagnosis of schizophrenia automatically meant the parent posed a danger to her child and the child should be removed. Affirmations from listeners leads to the assertion by student three, that the nuances of mental health practice are not understood by this lecturer, and by extension, other fields of nursing in general.

2: Yeah, I said they shouldn't have their child taken off them just because they've got schizophrenia and the child nurse was just like (loud gasp)

4: Surely you can't say that, that sentence though, don't that depend on how she's living her life?

5: Yeah

2: Yeah. Exactly. But it's. We didn't discuss that. It's like, "Oh my God, no, no, no, no. We must take her children taken off her because she's mentally ill and that's it"

5: Oh my God

2: Oh yeah, I really…

3: That then. I think that actually shows, there's an inadequate understanding of safeguarding

"Self-care and self-compassion" tells how students identify these as key skills for professional and academic life but feel that they are not sufficiently explored in module sessions. Students 3, 4 and 6 share a story of personal development and self-knowledge being overlooked in the scramble to teach technical skills and exam content. Student 3 tells how she has benefited from considering her own values base and thinks this should be available to all students (this is a mental health module). Agreement from students 6 and 4 then leads to reflection from student 6 that self-care is a skill which would be a good addition to the curriculum for everyone, whilst some of the focus on professional values in isolation is less helpful.

3: Also, I think the idea of self-reflection. I mean looking at the values-based modules thinking about "well what are your, do people sit and think about where have your personal values been constructed from and really looking at it in depth 'cause if you're looking at reflecting on your practice and how interact in certain situations then that self-awareness of your own vocational function. I don't know that you're really encouraged to engage on that level with yourself which is what you're talking about as to applying any of this. It's about having that starting point in self-awareness. Because it's just a, (???) and you're, a concept that'll be on your exam that you need to know. That should be focused on more I think

: (over 3) self-awareness is developed, y'know, it's part of like, wisdom if you like, innit?

6: Yeah, it's such a huge part of life

4: and it's a skill that you need to develop, don't you think? So I think, yeah, you're right it should be looked on with a bit more

6: Well I think the whole package surrounding the 6Cs. We've been told about the 6Cs but there's so much more, erm, like self-awareness, erm, like things like looking after yourself, erm, which I found from doing my essay

3: Self-care and self-compassion

6: But you nowhere is it talked about. There's no tutorial, maybe there should be more sort of, smaller tutorials

Professionals

There were stories of shared purpose and common interest across the fields of nursing in some lectures and outside of teaching. Stories of where care has fallen down for people with comorbid mental and physical health issues called upon a common set of skills and emphases for all practitioners across fields, with warnings about the consequences of their neglect. Parity of esteem and the need for greater understanding of mental health across the fields, stories which feature heavily in contemporary technical narratives of healthcare strategy, could be heard in these. These narratives brought with them the character of the mental health professional. This has been something much written about in the last twenty years as a technical-rational pursuit of a science of mental health nursing (Grant, 2015:2018). This was seen as a double-edged sword which could contribute to the fragmentation of care through narrow specialism. Parity was not evident in the content and delivery of core modules, although stories featured aspects of this popular narrative. A story about the lack of mental health knowledge in adult nurses and the enthusiasm amongst that cohort for this topic shows potential for development.

In "adult nurses were actually interested", student 6 relates the tale of how, when a mental health lecture was given to the whole cohort, there was a degree of interest form

adult nursing students which surprised the mental health cohort. This leads to the observation that the generic components of the course lack mental health content and consideration of the need for parity of esteem between mental and physical health, in the end bringing student 3 and 4 to conclude that specialism is the problem, creating too narrow a focus to develop holistic care approaches. Student 4 relates this to her work experience in turn alluding to a serious incident which she attributes to this compartmentalised mode of healthcare.

6: But it was interesting, when we had our mental health lecture, how many of the adult nurses were actually really interested. We'd suggest there perhaps should be a bit more. I know we're early stages but you know, there maybe should be a bit more of that because you know they were pretty enthusiastic

4: But the now mental health is a massive thing now innit (6:yeah) That as well so its swings and roundabouts

2:Yeah

5:Well I think it should be more equalised. I know we need to learn about more physical health but vice versa, no matter what field you go into, you're always going to have the metal health issues as well, which we don't seem to have a lot of training as a general health nurse

3: So is that like, based on this kind of idea of specialism, then. The mindset that that's what you have to be, you have to be a specialist, you know to deliver…rather than, looking at how do you relate to people? What generates that? Is it having those nice discrete boxes you're (a specialist this you're a deaf specialist?) so you won't be able to …It's kind of like, you've got to have more fluidity to your identity (2:yeah) than, than just kind of like, "there's your PIN" (someone laughs) that's it, that's you

4: My experience of working within the NHS because you do have your specialist nurses with their PIN in "you do that, you do that, you do that, you do that" it's been a lot more than I've, because I'm starting to look at jobs a lot more with more traditionally general nursing fields asking for mental health. LD nurses because they're recognising that, y'know people (inaudible?) it impacts their cognitive ability and their mental health in such a huge way that they're wanting to share that knowledge so in that sense I do think having core modules is a good idea because it, it kind of like, like you say gets you to think about the person as a complete person rather than "you do mental health, you do physical health. Well, its proof from all the SUIs in care for the last few years that that approach is not the way. It doesn't work. Some of the force "you do mental health; you do general health" because they fall through the net. No-one's chasing the ball (5:yeah) and then that's where obviously incidents (is?) and there will be repercussions (5:yeah) as we have seen in _____

Practical application

Students told stories relating how the theory and skills they were taught were not shown applied to mental health practice contexts. This intersects with the "outsiders" story of mental health nursing in omitting the specific and different set of scenes a mental health practitioner may encounter and the difference in role of mental health nurse. These stories featured characters who were sympathetic to the practice nuances of mental health but some features of the stories were more to do with a general absence of real-world context in teaching practical skills, often due to resource constraints.

"Care planning" begins with a suggestion that the content of care planning sessions in the curriculum is too narrow in focus, missing the essential mental health concept of recovery. This is expanded on when it is suggested that the content of the module need not change, but the focus must be on mental health practice

3: I think in terms of looking at care planning, I would have liked to have more input in actually looking at concepts like recovering and how that's been constructed in mental health

2: Yeah

3: Erm, and why understand the value of looking at dominant mainstream models I actually think, (sighs) are more mental, although, a more mental health specific look at. How how they're constructing care plans and on what basis and what, and what you're trying to achieve through it would be, erm, more relevant to mental health nurses. And looking, properly looking at the idea of recovery and what we're trying to achieve and how best to achieve that from y'know

In one story, first years related how they were dismissed during a clinical skills session. "You will never use this…" tells of how silo working has an impact on perceptions of staff regarding the students they teach and how they approach teaching. Students 3 and 2 expand on student 6's story by suggesting that this experience has led them to feel that

they are required not to think beyond the narrow parameters of their prescribed proficiencies for practice with no opportunity to develop ideas further within the mental health context. Student 4 points out that it is not known what the practice area of students will be once they qualify.

6: Yeah, we had a lecturer say straight up to us "you will never use this because you are a mental health nurse" and I thought that was particularly insulting and …stupid to say because you do use it. You use all nursing skills in all fields so it's a little bit silly and it just makes you feel a bit rubbish

4: Well they don't know where you're going end up

3: I think for me, on certain occasions, there's almost like an (anti epidemic?) sometimes that they don't want you to think. It's like "this is what you need to know" and that's what, I think that's quite dangerous to make presumptions about "this is the knowledge that you need to know" you know? This is where the start or for the springboard for you to then explore…So I think sometimes, the creativity and the exploring of ideas wasn't there. It's very much "this is your package. Put it in your brain and then this is all you need".

2: Yeah, it was almost frowned upon to think outside of those parameters, like "we don't do that, we don't do that" (:yeah). Well actually it's quite important to know and explore different ideas about…

Discussion

Mental health students told stories in which they were part of a wider professional group, but within which they felt overlooked. They told stories which called out their estrangement from their own field of practice owing to not being offered the resources to incorporate technical accounts of skills development into real-world settings and not having an early set of resources for constructing narratives of mental health practitioners. Amongst cohorts of generically educated nurses, there is a general perception of not being prepared to deal with people in mental distress (Happell et al, 2019), with mental health nurses perceived as not "real" nurses, lacking in skills, and stigmatised by association (Waddell et al, 2020), ideas echoed by respondents to

Günüşen et al (2017), who added that peers regarded them negatively for choosing mental health nursing.

Mental health nursing students are perceived by themselves and others as inquisitive, outspoken, and quirky in these stories. This could indicate a kind of narrative entrapment (Grant, 2013; Corbally and Grant, 2016) in which students internalise stories told about mental health nurses, which express a long-standing stigma by association (Peplau, 1982). At the same time, these characteristics are dismissed, leaving students in an impossible position where they must not typify their profession as perceived by themselves and others in order to be able to meet the requirements for joining that profession. As identified in previous research, mental health students express a sense of being on the fringes of core modules (Wood, 2005; 2010). The stories available to mental health nurses are diminished by the lack of resources made available through core modules which offer a narrative of nursing derived from adult nursing lore, based on a medical model. Accounts from research into genericised programmes show a pattern of diminishing mental health content (Hayman-White and Happell, 2005; Flaskerud, 2018).

The job of mental health workers has been described as one of reclamation (Barker, 2001), mutual escape from narrative entrapment engendered by historically lacklustre services which have perpetuated iatrogenic harm (Grant, 2015) and socially constructed meaning which offers hope (Barker, 2004). Pursuing an agenda of prescriptive technical solutions to these contested problems is insufficient to meet the needs of the many and varied people and problems mental health nurses encounter (Grant, 2015). A rich repository of stories is required to work with such diverse people and needs. Mental health nursing requires a distinct and critical applied approach to theory and practice (which necessarily includes research). This demands a reflective

strategy facilitated by a breadth of people with diverse experience of mental health and illness, in awareness of the history of this sphere of work. Whilst this is currently the guiding ethos of the programme, fifty percent of that programme does not meet this description owing to a lack of ownership or at least input. Our suggestion is that this would be best met by developing a greater proportion of mental health specific programme content, mental health developed and delivered sessions in core modules and applied skills sessions (including research) specific to mental health practice scenarios. Work conducted by Happell et al (2018; 2019) indicates the benefits of consumer academics in contributing to programmes of education, a suggestion echoed by Graham et al (2020). This is a long-standing but under-developed area of practice in the programme under discussion above. Service user and survivor narratives and experiences are often limited to mental health students' specific education. The role of the consumer academic as an integrated member of the course team offers a more meaningful contribution to design and delivery of education than simply relating lived experience narratives.

Stories about the need for more comprehensive skills learned and practiced in the mental health field indicated a perceived deficit in current practice, caused by growing specialisation of specific fields. In some stories, raising this issue would be met with dismissal or rebuttal, further feeding the narrative of being outsiders despite the continued presence in the media and official governmental literature of a narrative of parity of esteem between physical and mental health (Department of Health, 2011; 2018). There was perceived inequity between the demands for broader skills across the fields and the lack of mental health input in core modules. There was also a frustration with the lack of exploration of key concepts and theory in current mental health debates and practice. Flaskerud (2018) reports that the lack of applications to direct mental

health nursing study is a contributor to the reduction in mental health content, suggesting further genericisation would exacerbate this problem. Further problems are raised by increased lists of required technical competencies, which do not reflect many mental health practice areas, and could be incorporated as part of specific training for roles as required, post-registration (Graham et al, 2020).

The absence of mental health team members in the core module teaching teams, coupled with what is seen by some students as an uncritical reference to a biomedical model of psychiatric care and a technical rational approach to nursing care which provides the milieu for most mental health nursing practice (Grant, 2010; 2015; McKeown and White, 2015) and repeated messages about parity of esteem between physical and mental health which portray contested constructs as "fact" (Stickley and Timmons, 2007; Gouthro, 2009) limits the stock of stories available to mental health students. Caught between the technical accounts of nursing science and the "outsider" stories of being on the fringe of nursing, some stories expressed an ambivalence towards the profession, proud to be different but proud to be the same. Forced to attend core lectures in which they are not participants. Expected to stand out and criticised for standing out.

It would seem generic nursing programmes do not attract people with a particular interest in working in mental health. More than this, they do not promote the development of this interest. Hastings et al (2017) explored the use of a mental health awareness course on nursing students in a generic programme, discovering that whilst mental health literacy was improved amongst the cohort, interest in mental health nursing was not. This raises questions about the usefulness of the suggested increase in

mental health theory content to promote uptake of the profession at qualification as suggested by Günüşen et al (2017) and Happell et al (2019).

It can't be ignored that many of the authors cited here identify adult nurses' educational experiences as lacking mental health content, causing serious issues for the quality of care offered to people in mental distress or with longstanding mental health issues when they come into contact with healthcare practitioners. More theoretical input on mental health has been suggested as having a positive effect on attitudes towards mental health in nursing cohorts in general (Happell, 2009; Happell et al, 2018). To this end, Happell, et al (2019) call for the maximisation of current mental health contributions to the nursing curriculum, including the involvement of consumer academics.

This issue is arguably a different one, with a tangible solution (Hastings et al, 2017), to the problem of the reduction in uptake of mental health nursing where it is not offered as a dedicated programme of study. It could be argued that recruiting mental health workers from a generic cohort of nursing applicants is not desirable, given the report of unpreparedness for practice (Happell, et al, 2017), undervaluing of interpersonal skills (Günüşen et al 2017), and of mental health work in general (Happell, et al, 2013). A lack of distinct identity in the profession, arguably due to the conflicting contest of "ownership" by the broader nursing profession, and historic alignment with psychiatry (Sercu et al, 2015), an unwillingness to engage in open and honest reflections on historic and current abuses and public perceptions, silence on the differences, as well as the similarities, with other fields of nursing, and a lack of access to service user/survivor/refuser experiences unmediated by professionals' defensive tendencies or official propaganda, leads students up the garden path and sets them up for a cognitive dissonance, the exploration of which is beyond the scope of this paper (see Sercu et al,

2015), which creates doubt and fear in a significant minority of students approaching qualification.

Günüşen et al (2017) discovered differing values and priorities within students who chose mental health nursing as a first choice and those for whom mental health was a last choice. Those with a preference for mental health had a focus on the relational aspect of nursing, whilst the last-choice group showed more interest in the technical aspects. Sercu et al (2015) found that mental health nurses in practice had a particular set of motivations which caused them to experience discomfort during their education. Placement experiences were cited by some respondents to be a reason for an aversion to mental health settings. A feeling that they had not been sufficiently prepared was a common feature of responses to Günüşen et al (2017), Cam and Arabaci (2010). Günüşen et al (2017) also heard reports that examples offered in practice were negative and uninspiring. The genesis for this paper was reports from students and practice partners that they were entering placement areas unprepared. Whilst this paper concerns a particular aspect of nursing programmes, it must be remembered that half of those programmes, at least in the UK, are conducted in practice settings, and negative experiences, whilst not the norm, do exist and have significant effects on students, potentially jarring with their academic instruction. Sercu et al (2015) offer evidence that this is a continuing phenomenon in practice once qualified.

Suggestions that media representations of mental health service users, services and nurses are responsible for a lack of interest in the profession (Cleary, et al, 2018) and a stigmatisation of these groups within the nursing profession (Sercu et al, 2015; Flaskerud, 2018; Waddell et al, 2020), provides some weight to the argument that nurses and nurse educators need to engage in a process of critical self-reflection (Gouthro, 2009), as they advocate in their students. Furthermore, Gouthro (2009) and

Grant and Radcliffe (2015) suggest a programme of education less dominated by technical rationality, informed by critical social theory, would facilitate more meaningful and illuminating explorations of mental health and illness, and mental health work. “There is apparently *a long way to go* for nurse educators in facilitating a truly enthusiastic response by nursing students about caring for persons with mental illness”, say Hastings et al (2017). Perhaps this gives away something about the belief that mental health is just a subgenre of nursing. Perhaps these things are more different than we allow ourselves to think. The students who contributed to this paper were enthusiastic to contribute to mental health nursing, but found themselves under attack when they spoke up about their field of practice, ignored when they sought to be included in skills development. They often did not feel welcome in the clinical skills suite or in the classroom, when part of the larger group. Moves towards ever more generic nurse education come with real risks for services and the people who use them. Mental health nurse educators must address this locally and globally.

Half of the theoretical content of the current mental health programme is delivered in generic core modules (with all four fields of nursing taught together). When students spend much of their time going through the process of identity formation associated with adult nurses, their skills may not match what they are expected to do and the context within which they practice (Wood, 2005; 2010). At the institution under discussion, this effect was perhaps compounded by having the core modules spread throughout the programme, with mental health students returning to the whole cohort group for generic lectures during the second and third years. Module evaluation data indicates students find this unhelpful and frustrating. The mental health team would like to know if giving more of the curriculum to mental health specific teaching will help students gain a more coherent sense of what mental health nursing is or could be for

them.

This work aimed to report the stock of stories drawn on by mental health nursing students to defend the vulnerable position as marginal to a large nursing cohort. The pressures and threats of contested evidence base (Barker and Buhcannan Barker, 2011; Grant, 2014; 2015), inability to define the profession due to its marginal status within nursing (Nolan, 1993; Bull, Gadsby and Williams, 2018; Grant; 2002), skewed focus of the common foundation (Wood, 2005; 2010), broad skill set (Hurley, 2009) and inability to escape or come to terms with the profession's sometimes shameful and disturbing past (Barker and Buchannan-Barker, 2011; Pryjmachuk, 2018; Gadsby, 2018; McKeown and Spandler, 2017) indicate what these may be.

Limitations

The original proposal was to hold three focus groups allowing discussion of each year of the programme by students from respective cohorts. Unfortunately, commitments and concerns affected the third years to an extent which rendered their involvement impossible despite attempts to reschedule. The lack of representation of third year students meant that the largest of the core modules, which runs for two trimesters in the third year, was not discussed. Their absence also meant that insights into programme content with the benefit of a longitudinal perspective was not available either.

The stories told by students in the group often captured a sense of what they felt was not mental health nursing. This may well be due to the number of questions in the schedule which could be seen to be steering things more than was necessary and obstructing the emergence of narratives. Dialogical narrative analysis assumes that storytellers are using stories to do work of identity construction and defending the self against anxieties (Frank, 2012). As the sole identifier of stories, I acknowledge that my

own resources and biases are influential in my identification of emergent stories. I hold my own views about the education of mental health workers and the identity issues facing this group of people, to which I belong. Having only once used this method before, I am aware that my skills of phronesis (which Frank (2012) describes as a sense of stories "calling out" to the researcher) is nascent.

As someone new to facilitating focus groups, I may have not provided sufficient steering in the schedule of questions to keep participants on track. As someone known to participants it may have hindered their frankness in responding. Whilst not a teaching team member on the core modules under discussion, it is likely that my presence would have the potential to colour responses through social desirability bias. It is also possible that responses could have been more aggrieved due to the suggestion by my presence that there could be some immediate redress. In a focus group setting, it is possible for certain voices to dominate and for some to be silenced. Some elements of dialogue were indistinguishable for transcription.

Conclusion

Preliminary conclusions are that stories of mental health nursing as lived out by the teaching staff and practitioners from local partnerships are not available as a narrative resource for students during the formative part of the course. The resources available to students comprise of Nursing as defined through adult care often delivered in hospitals, psychiatric technical accounts of mental illness, media accounts of mental health and family and personal experiences. These often jar. Applied theory set within the context of mental health practice at the outset of the programme may offer a way to increase the store of stories with which mental health students can create their own identities and "hold their own" (Frank, 2010; 2012) in ways which do not exclude other fields of

nursing within a broad profession which often sidelines their experience and concerns. Recommendations include greater mental health staff and content presence in core modules; field specific lectures early in the programme; workshops and simulations to apply skills in context with mental health staff; greater exploration of theory in the context of mental health; applied research modules from year one. Developing these elements in collaboration with consumer-activist-survivor academics

It is a challenge to propose such a move in the face of increasing centralism in nurse education delivery. The growth of online content and increasing list of skills to demonstrate pressures the time available to devote to these matters and demands a creative approach. However, without sufficient attention to the specific settings and issues relating to mental health practice in the execution of these skills and theories, our students remain unprepared for practice. Furthermore, a move to a more generalised form of education risks taking mental health nursing in the UK in the same direction as other areas of the world, where attendant problems in recruitment of mental health staff can be linked to the move to generalism.

It is acknowledged that these findings come from a small study and further research, taking in a greater number of students and institutions is required to provide a fuller picture. It is hoped that such work can begin soon, incorporating a greater number of institutions.

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Appendix A – Interview guide

Interview guide student focus groups

Please remember this is not a module evaluation like the one you complete at the end of the module. This exercise is specifically trying to understand your experience of core modules as mental health students. Please also remember the professional code of conduct and show respect for other persons taking part in this exercise and arising from this discussion.

1. **General question about core modules** What is the best thing about having shared lectures with all fields of nursing together?
    a. What do all fields have in common, do you think?

2. **Specific to module:** What is working well on this module for mental health students?

    a. Is there anything you would have liked to explore further in lectures?
    b. Is there anything you felt did not apply to mental health nursing?
    c. Is there any aspect of the style of delivery which you find particularly helpful?
        i. Is there any aspect you find unhelpful?
    d. Is there any change to the assessment which you think would benefit mental health students?

3. **Practice:** How does the theory component of the core module(s) you have taken or are taking this year match up with your practice experience, would you say?
    a. What would help to make the theory more relatable to practice?
    b. What elements of theory are more aligned with mental health practice?

4. **Programme:** How is the mental health programme working out for you?
    a. Is there anything you would change about it?
    b. What could be done to improve the mental health programme to improve your experience of core modules, do you think?

Table 1. Stories identified from dialogical narrative analysis

Story	Location	Subject	Type
“How can you call yourself a nurse…”	p.1-2	Similarity between fields in basic skills, which are essential to all. Too much separation can lead to clinical failings.	Professionals Practical application
“We’ve expanded our general nursing but it’s not been done the other way”	p.2	An apparent lack of representation of “small fields” in core content	Outsiders Professionals
Scratching the surface	p.2	Lack of application of practical skills to mental health	Practical application
Perhaps there should be a bit more	p.3	Specialism may be hindering representation of all fields despite student interest	Professionals Outsiders
“You will never use this because you are a mental health nurse”	p.3	MH students told content does not apply to them	Outsiders Practical application
They don’t want you to think	p.3	Early content a tick-box exercise?	Free thinkers Practical application
Adult nurses were actually interested	p.3-4	Students are interested in each other’s fields of practice and the overlap is a good case for core modules.	Nurses together Practical application Free thinkers

When we're on our own	p.4-5	Large class sizes inhibit involvement and field specific content on these modules would help	Outsiders Practical application
We're always a little bit quirky, aren't we?	p.5-6	Mental health nurses interact with other students well but benefit from field specific lecturer involvement	Outsiders Practical application
Told off	p.6	Following rules and challenging rules highlight cultural differences, perhaps, between fields	Outsiders Free thinkers
~~Practical ones~~	p.6	Part of story above	
~~Youngsters today~~	p.7		Not sure if this is relevant
Communications	p.7-10	Some topics are not explored in enough depth. Whose responsibility is this?	Free thinkers
~~Critical thinking~~	~~p.8~~	Part of previous story	Part of communications
~~Ethics~~	p.8-9	Students suggest that motivation to study is lacking in many students. Perhaps	Part of communications

		continuation of above?	
~~"I just want to pass"~~	p.9		Part of communications
Self-care and self-compassion	p.10	Knowledge of self is essential for professional and academic development	Free thinkers Practical application
Care planning	p.11	Mental health specific issues are overlooked in care planning content	Outsiders Practical application
Running round with microphone	p.13	Lecturers who enjoy their topic and engage with students have made an impact on MH students	Professionals
~~Cardio man~~	p.13-14		Part of above
Fifty slides in fifty minutes	p.14	The lectures are pressured, with too much content	Practical application Free thinkers
It's about exploration, innit?	p.15-16	Some assessments do not seem appropriate for the topic or have sufficient application to practice, in particular field specific practice	Free thinkers Practical application
~~You can know a lot, but it's what you're actually testing~~	p.17		Continuation of It's about exploration, innit?

The peg's not there	p.17-18	The programme does not provide sufficient theoretical depth or have an identity of its own	Free thinkers Practical application
More mental health specific	p.19-20	Mental health context from the beginning of the programme would have been appreciated	Practical application Outsiders
Logistics	p.21	Students who travel far to come to university and/or have caring duties find their needs are not considered	Outsiders
An uproar	p.22	A lecturer in a core module makes a spurious statement about safeguarding and is unwilling to discuss alternatives	Outsiders Practical application Free thinkers
Quite a lot of repetition	p.22	Some core modules repeat content without any perceived added depth of analysis.	Free thinkers Practical application

The authors would like the mental health students who gave their time and shared their experiences to produce this work.