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Introduction

Mental health nursing in the United Kingdom (UK) has developed as, and continues to be, a distinct area of nursing practice. In a previous article the history of the training of those who specialised in mental health nursing was discussed, covering the period up until 1948, which saw the introduction of the British National Health Service (Chatterton 2014). This article will continue the narrative from 1948 until the present.

The situation in 1948

At the end of the Second World War, British mental hospitals were severely overcrowded and seriously understaffed, an exacerbation of long standing problems in this sector (Chatterton 2015). 1948 also saw their inclusion in the new National Health Service (NHS). At this time, the period of conflict and division that had persisted throughout the inter war years about mental health nurse training was also finally coming to an end. There had been two rival training schemes in operation for mental health nurses, one run by the Royal Medico-Psychological Association (RMPA) and the other by the General Nursing Council (GNC), but at two meetings held between the RMPA and GNC in the May and June of 1946 agreement had finally been reached that the RMPA would discontinue their training scheme (Chatterton 2004). No new entrants would be accepted from December of that year and the last examination would

be held in November 1951. In addition the GNC had agreed to recognise holders of the RMPA certificate for admission to the register. They also agreed to the inclusion of psychology in the syllabus, as the RMPA requested (Chatterton 2004). The GNC was therefore finally successful in its, 'bid for total control of the mental nurses' (Nolan, 1995:253) and thus Carpenter (1988:33) argued, 'asylum nursing, dominated by psychiatrists, became mental nursing, dominated by former general nurses.' The implications of this were to be felt in the years to come as mental health nurses' training continued to remain contested ground.

The 1950s, '60s and '70s.

The 1950s began to see some important changes in the delivery of the psychiatric services. Consultants were now 'replacing the authoritarian medical superintendents of the 19th and early 20th century' (Nolan 1998: 373). Some introduced new and innovative practices such as the opening of some of the locked wards (Clark 1996). From a peak of 150,000 in 1954 the number of beds in the mental hospitals began to fall. The reasons for this remain open to conjecture and debate and a variety of factors seem to have been at work. In the 1960s the concept of institutional care and mental illness came under attack from what Jones (1993: 159) has described as the 'ideologies of destruction.' Writers such as Goffman (1963), Foucault (1964) and Szasz (1962) questioned the very basis of the concept of mental illness and highlighted the negative impact of institutionalisation and current treatment regimes on patients' lives. Their criticisms were reinforced by a series of hospital scandals during the 1960s, where poor care and ill treatment was found in a

succession of mental hospitals and mental handicap hospitals (Robb 1967). From within psychiatry itself, emerged critics of the current system, known as the anti-psychiatrists (Hopton 1997a) and government policy also began to change. In 1959 Derek Walker-Smith, then Minister of Health, proposed 'a reorientation of the mental health services away from institutional care towards care in the community' although it was 20 years before rhetoric became reality (cited in Jones 1993:155). The introduction of neuroleptic drugs in the 1950s may have also contributed, though the extent of their impact has been the subject of much debate. The decline in admissions had begun before their inception but they did offer the possibility of amelioration of some of the symptoms of mental illness (Clarke 2002).

Against this backdrop of change, a new syllabus for mental health nursing was introduced by the GNC in 1957 (initially experimental until it was formally adopted in 1965). According to Arton (1981:126), this 'brought a sense of liberation and advance' for mental nurses. It abandoned the common preliminary examination and replaced it with an intermediate one specifically for mental nurses. This was after some debate. At a meeting at the GNC in 1951 Miss Alexander (the Vice Chairman) argued that the GNC 'had been most anxious that there should be one portal Preliminary examination in order to avoid any feeling of superiority or inferiority amongst nurses training for different parts of the register.' Dr. Rees Thomas (one of the council members), however pointed out that only 10% of patients in a mental hospital were nursed in bed and that nurses were 'discouraged when they found they were required to cover a syllabus which contained only six lectures on psychology'

(GNC 1951).

In the new syllabus' preface, it states that two new approaches were to be adopted. Firstly it spoke of the concept of the mental hospital as a therapeutic community, where the relationships between staff and patients and the activities and structure of the day all contribute to treatment. Its second approach was to stress the educational principle that learning is more meaningful if directly related to practice. The syllabus had three main components. Firstly it outlined a systematic study of the human individual. The second section outlined the skills required in dealing with the medical and psychiatric problems occurring in psychiatric patients. The third and last section described concepts of mental illness, psychiatry and psychopathology (Bendall and Raybould 1969). According to Nolan, (1998: 374) 'the syllabus emphasised psychology and the social sciences, and tried to replace a medical model of care with a caring model.' This did therefore mark a change in emphasis away from previous curricula and maybe as Dingwall, Rafferty and Webster (1988: 137) state, 'The price of GNC control was its toleration of a greater degree of diversity in the occupation it regulated.'

Another development in the field of nurse education had been the introduction since the 1940s of the enrolled nurse, the name originating from the roll established by the GNC to record nurses' names, as opposed to the register. Introduced initially in general hospitals, the first mental hospital was approved for enrolled nurse training in 1953. In 1964 the Nurses Act widened the roll to create three different parts– general, mental illness and mental subnormality. Those on the roll were to known as state enrolled nurses (SENs with the suffix of (M) after to denote a psychiatric nurse.) In

addition to those who underwent the two year training course, it was also accepted that nursing staff could apply for admission to the roll by virtue of experience for a limited period. By March 1967 16,158 nurses had been enrolled on the mental illness part to the roll by this route, without undergoing any formal training. (Bendall and Raybould 1969).

The 'new' syllabus – 1982.

The 1980s were to see the demise of the GNC. In 1979 the Nurses and Midwives Act, following on from the recommendations of the Briggs' Report, replaced them with a 'five body structure' (Le Var 1997a). This was the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and a national board for each of the four countries of England, Scotland, Wales and Northern Ireland, They assumed their statutory responsibilities in 1983.

The GNC had commissioned a new syllabus for mental nurses in 1981 which was introduced in 1982 and subsequently adopted by the new English National Board (ENB) the following year. This was to be the first syllabus that did not have any input from the Royal College of Psychiatrists. One of its aims, Nolan (1995: 260) argues, was 'to ensure the survival of mental nursing at a time when the structure of care for psychiatric patients was being radically rethought'. In addition to the ongoing changes in psychiatric provision and practices this may also have been influenced by the publication of the Jay Report in 1979 which advocated the demise of mentally handicapped nurses, arguing that a social, rather than a health, model of care might be more appropriate for this client group. Although this was not ultimately implemented it did cause some alarm in psychiatric nursing also (Norman 1998).

In the preface to the syllabus the GNC stated that this syllabus 'provided a model on which a skills-orientated curriculum can be constructed and an objective form of continuous assessment of students devised' (GNC 1982:2) It was divided into two parts. The first section, focussed on nursing skills, based on the four elements of the Nursing Process; assessment, planning, implementation and evaluation. The Nursing Process was a new approach to nursing care, drawn from North America, which stressed the importance of individualised patient care. Section two outlined the required knowledge base. This was subdivided into the social and applied sciences, nursing studies and professional studies.

With its emphasis on nursing skills it was very different to its predecessor, which was essentially a list of the contents to be covered (Norman 1998). For the first time the need for nurses to develop their therapeutic skills and the importance of having self-awareness was emphasised. In addition the knowledge base was radically shifted with a much greater emphasis on the social sciences (Sanker 1987). Its emphasis has been criticised, for example for Hopton (1997b: 493), it led the profession into 'wholeheartedly and uncritically embracing the theory and practice of humanistic/person-centred psychology and psychotherapy/counselling.' Clarke (1999: 32) has also argued that the views of Carl Rogers had become so influential on mental health nursing that his views have 'achieved a quasi-religious status'. Writers such as Gournay (1995) argued against this approach, advocating a more biological and pharmacological knowledge base within the curriculum. It did however mark some significant changes in attitudes towards to the knowledge base of psychiatric nursing and a lessening, perhaps, of the strong

influences of psychiatry and general nursing. It was also introduced in the final years of the large Victorian and Edwardian asylums, which were to close throughout the 1990s, as institutional provision was replaced by community care for the majority of those deemed to be mentally ill. This was to lead to significant changes in the working lives of psychiatric nurses and 'the weakening of occupational boundaries and the shift to community care created a serious identity crisis for nurses in the mental health services' (Rogers and Pilgrim 2001:141). However in addition, nursing education was also to undergo radical change so that within ten years of the 'new' syllabus being implemented it was obsolete.

Project 2000

Since the 1950s, it could be argued that a major theme of the debate concerning mental nursing (or psychiatric nursing as it was becoming known) was to distinguish it from other types of nursing and highlight its uniqueness. However reports at the time, such as Briggs 1972 and ENB 1985 (cited in Bradshaw 2001), which examined the future of nurse education, began increasingly to argue for the commonality of the different types of training.

In 1984 after much discussion between the ENB and the UKCC the latter took the lead in reviewing the nature of nurse training. Its educational advisory committee was given a target of two years to complete their work, which became known as Project 2000. Their remit was:

'To determine the education and training required in preparation for the professional practice of nursing, midwifery and health visiting in relation to the projected health care needs in the 1990s and beyond' (UKCC 1986).

The report went out for consultation and amendments were made to some of the original plans. Its implementation was carried out in waves, between 1989 and 1993. This was half the time that had originally been intended (Le Var 1997b). Project 2000 has been described as a 'radical new system of British nurse education' (Bradshaw 2001:xi). Amongst its main features were:

1. A three year pre-registration course, consisting of an eighteenth month common foundation programme (CFP) and an eighteen month branch programme in one of four branches – adult, child, mental illness and mental handicap nursing. Successful candidates would be known as registered nurses (RNs) and four new parts of the register were created (parts 12-15) to reflect the four branches.

2. A move away for schools of nursing based in hospital settings. These were to be amalgamated into larger departments within the higher education sector. Students would receive a diploma in nursing in addition to becoming a registered nurse. The emphasis was now on education rather than training.

3. Students would therefore no longer be salaried NHS employees but would receive a bursary. They would have supernumerary status (although this was modified to 80% of their course with 20% as rostered service.)

4. Enrolled nurse training should cease, with opportunities for enrolled nurses to become registered nurses (RNs).

5. Teachers should have wider educational opportunities and should have qualifications at degree level.

6. A change in emphasis from hospital based nursing to a community setting and from an illness model to a health promotion one.

7. The establishment of a new helper grade (the health care assistant)

This therefore led to enormous changes in psychiatric nursing (or mental health nursing as it was becoming known). Reactions to Project 2000 were mixed. For some it was seen as positive (Dolan 1993), others were less enthusiastic. In mental health nursing can be found some of its most vociferous critics. Ironically having established a separate training away from general nursing and mental handicap nursing mental health was once again joined together with them. In some ways, as Nolan (1993: 144) has argued, 'the CFP, although masquerading as a new phenomenon, is, in effect a return to the old preliminary examination', though of an even longer duration.

Amongst the concerns expressed about Project 2000 were the length and content of the CFP, which was felt to be too long, too adult focussed and often taught by nurse lecturers without a background or insight into mental health nursing. The move into higher education was blamed for exacerbating and widening the gap between theory and practice. There was also concern about the recruitment and retention of mental health nursing students, its higher academic standard, lack of application to the practice of mental health nursing and the financial problems of students, who no longer received a salary (Munro 1988). One Director of Nursing argued, 'The fear harboured for so long by psychiatric nurses that our unique role might be lost within a more generalised nurse model is now slowly becoming a reality.' The nursing profession, he says, 'are hell bent on creating an all-singing all-dancing nurse, capable of anything and everything, and this could result in the demise of mental health nursing' (Mcintegart 1990:72). Elkan and Robinson in their review of research into the implementation of Project 2000 have argued that McIntegart's fears have only been borne out to a 'limited extent' and that they had found that many of the earlier criticisms of the CFP had been 'successfully countered' (1995: 389). Clarke, however, accused them of dismissing these concerns too quickly (1996) and subsequently wrote a critique of Project 2000 in which he argues, 'what is required is an independent psychiatric curriculum with direct entry for applicants' (1999:123). He argued that research did not seem to reflect the opinion of those at grass roots level. Munro, in a discussion with mental health nursing students, stated unequivocally, 'the word is out: Project 2000 has failed' (1998:27).

In 1992 the Minister for Health announced the establishment of a Mental Health Nursing Review team, chaired by Professor Tony Butterworth. Their remit was to explore the 'impact of changes in society and social policy since the late sixties and their implications for practice, education, research and management in mental health nursing' (DoH 1994: 4). In their 1994 report they stated that they found widespread concern that Project 2000 was not 'enabling students to develop sufficiently the essential skills of mental health nursing' (DoH 1994:41) Amongst their 42 recommendations were that the balance of time and emphasis given to the four branches within the CFP should be reviewed and for the inclusion of mental health users in teaching and curriculum development. Three years later in a report commissioned by the Sainsbury Centre, 'Pulling Together' (1997) it was also argued that Project 2000 was not meeting the educational needs of mental health nurses.

Another important facet of Project 2000, which was to have major implications for

the nature of the curriculum in mental health nursing, was that it moved away from the concept of a syllabus. Casey (1996:115) has described this as the 'curriculum revolution' which aimed to produce new practitioners who would be 'emancipated, critically reflective, creative and autonomous in their practice.' Prior to Project 2000, English nurse training had 'been an apprenticeship system, controlled through statutory syllabuses and informed by nursing textbooks. The syllabuses demonstrated the formal curriculum, specified by the statutory body of nursing, the General Nursing Council' (Bradshaw 2001:1). In Project 2000 the concept of a national syllabus was 'entirely abandoned' (Bradshaw 2001:25). Instead of specific content or skills, a list of broad competencies applicable to all registered practitioners, was introduced and thus Bradshaw (2001: 25) argues 'brought fragmentation into the curriculum as educational institutions designed their own courses.' Traditional assessment methods such as formal examinations of theory and practice were replaced by more adult learning centred approaches such as learning contracts, critical incident analyses, reflective accounts and continuous assessment of practice. Studies however revealed that there was 'uncertainty and fragmentation about what made for competency and how it was assessed' (Bradshaw 2001:61).

'Making a Difference' 1999

Concerns about Project 2000 persisted. Just over a decade after the government had accepted Project 2000 the UKCC set up a commission, led by Sir Leonard Peach, whose report, 'Fitness for Practice', was published in 1999 (UKCC 1999). In the same year the government announced that they intended to reform nurse education and had published in July, their paper, 'Making

a Difference' (DoH 1999). The two reports led to major changes in the delivery of nurse education. Commonly referred to as the 'MAD curriculum' (Lord 2002), it was implemented at a series of pilot sites in 2003. Some of the principles of Project 2000 remained, such as supernumerary status and place in higher education, as did the concept of competencies and the common foundation programme. However there were some major changes. The CFP was reduced to one year with a corresponding increase in the branch programme to two years, therefore allowing more time for mental health students to spend in their chosen branch. More flexible career pathways into and through nursing with wider access were introduced. There was also a stronger focus on practice with longer placements and greater emphasis on the development of skills. Another important development at this time was the establishment of a new Nursing and Midwifery Council (NMC) in 2002 to replace the UKCC and four national boards.

The new millennium

'For mental health nursing, there is continued debate about finding the best paradigm for practice, particularly in the context of its relationships with other mental health disciplines and its relatively ideological base' (Chan and Rudman 1998: 143). The debate about the knowledge base required for mental health nursing was ongoing and highly contentious as mental health nursing entered the twenty first century. Powerful tensions remain within the mental health system, as current debate over legislative reform illustrate. Debates about the philosophy and ideology of caring for people with mental health problems illustrate a divergence of opinion about what constitutes mental health nursing practice and what its future should be. Owen and

Sweeney (1995:17) argued that there was a 'current lack of a common vision in mental health nursing' and this continues to militate against attempts to establish a common knowledge base. The NMC have, as a result of its review of pre-registration nursing review between 2006 and 2009, attempted to establish a generic foundation for nursing students. A new framework was introduced and generic competencies and essential skills clusters were introduced for student nurses of all branches (or fields as they have been retitled) (Wood 2010).

The debate over the concept of a generic nurse, a registered nurse able to work with a wide variety of different client groups and where mental health nursing no longer exists as a separate entity, continue. Such developments have already taken place in other counties for example North America, Australia and New Zealand. In their review of the arguments in this area Cutliffe and McKenna (2000a,b) described the move towards genericism as the nemesis of psychiatric/mental health nursing because it would signal its demise as a separate profession. In the most recent report on nurse education, 'The Shape of Caring Review', usually known as the Willis Report (Willis, 2015), it was recommended that nurses should undergo two years of generic nursing followed by a year of specialisation and then a year of preceptorship. For Lord Willis (2015), education should develop registered nurses who can provide person-centred care in a range of settings, based on patient need and pathways. For example, it could be argued that mental health nurses working in child and adolescent mental health services (CAMHS) need skills that encompass the mental health field and child field of nursing practice. Some commentators urged caution though. For example Simpson argued that a

move towards generic training, 'threatens to diminish the attention given to mental health nursing in the curriculum because the focus on adult nursing is overwhelming' (cited in Pearce 2015:18).

Other writers have, however, argued that rather than ally itself with other branches or fields of nursing, mental health nurses should look to other professions working in this area. As Haines (1997:63) argued, 'It may be appropriate for those working in the area of mental health to sever their links with nursing ...The needs of patients may be more adequately met by mental health workers forming alliances with service users for the provision of care.' Warne (2000) in a two year study of the mental health nursing workforce found that over 50% of the respondents (a combination of practitioners, users and educationalists) felt that mental health nurses should share pre-registration and preparation with occupational therapists, social workers and psychologists. Kitson (2001) comments that this may be true for all health care workers and points towards a move to multi or inter-disciplinary working and education. The need for mental health nurses to work effectively in multi-disciplinary teams was also one of 17 key recommendations that resulted from the Chief Nursing Officer's (in England) 'Review of Mental Health Nursing' (DoH, 2006).

Another controversial area in nursing education was the call for nursing to become a graduate profession, with some institutions offering mental health nursing at degree level as well as diploma level. Following the review of pre-registration nurse education in the UK by the NMC in 2009, this became a reality in 2010, when the entry route into becoming a registered nurse, including mental health nurses, became at undergraduate degree level only (O'Donnell

2010). There are also ongoing debates about skill mix in nursing and the increasing role of the support worker or health care assistant (HCA) in the delivery of mental health nursing care.

Conclusion

In this article an overview of the changing nature of the curriculum in pre-registration mental health nursing since 1948 has revealed a variety of influences on its development. An examination of the formal curriculum has noted the changes in content and emphasis that have occurred over time depending on ideas about the nature of the knowledge base needed by those who nursed the mentally ill. This article has only concentrated on the debate concerning the knowledge base of student nurses and the author acknowledges that from the 1960s the need for post-registration training and education in mental health nursing has been accepted and implemented. This is also a contentious area.

A historical examination of the changing nature of the curriculum in mental health nursing knowledge can thus help reveal the social, political and professional beliefs that have influenced it. The long struggle between medicine and general nursing for control over mental health nursing's training and curriculum has, it could be argued, hindered mental health nursing from developing a coherent knowledge base of its own. As a result mental health nursing could be seen as having an identity crisis as debates continue about the role of the mental health nurse in the UK (McKie and Naysmith 2014). Maybe as Hopton (1997b: 496) states, 'The sad reality, however, is that mental health nursing has not yet developed an approach to mental health care which is truly its own, but continues to "mix and match fashionable theories about mental health.' This debate remains as lively as ever in the twentieth first century.

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First to Care: Sisters of Charity of Nazareth in Civil War Louisville, Kentucky

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The U.S. Civil War was the deadliest war in American history. During the four years between 1861 and 1865 it is estimated that 750,000 soldiers lost their lives. The majority of the deaths resulted from disease rather than battlefield injuries. For every three men killed on the battlefield, five died from disease (Messmer, 1972). The most common causes of morbidity and mortality were typhoid and dysentery. Hygiene was poor, living conditions were crowded, adequate shelter was rare and food was scarce, so a host of infectious diseases were present.

Most Americans would tell you the cause of the Civil War was 'slavery', but it also involved states' rights (the right of each state to make their own laws independent of federal control), federal taxation and whether the country was to remain a primarily agrarian society or move toward increased industrialisation. During the war Kentucky was one of five 'border states'. These were states that had traditionally been considered part of the southland where it was legal to own slaves, but they did not