Nurse Education Today 169 (2027) 107509

Contents lists available at ScienceDirect

Nurse Education Today

journal homepage: www.elsevier.com/locate/nedt

Contemporary issues

Parity of esteem by design - capability governance for pre-registration mental health nursing education in the United Kingdom

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ARTICLE INFO

Keywords:
Mental health nursing
Nursing education
Regulation
Parity of esteem
Practice learning
Competence

ABSTRACT

Parity of esteem between mental and physical health requires confidence that registered mental health nurses possess a consistent baseline of specialist capability. Current Nursing and Midwifery Council standards provide clear assurance of programme inputs and generic proficiencies but leave substantial discretion over how field-specific mental health knowledge, reasoning and relational practice are made visible, developed and assessed. This critical and contemporary discussion paper frames this as a capability-governance issue. Drawing on educational theory, practice-learning evidence and international comparison, it argues that hours, curriculum mapping and proficiency signoffs cannot alone demonstrate readiness for complex mental health practice. We propose the Capability-Critical Thinking Spiral for Mental Health Nursing (CCT-SMHN), which integrates field-specific capability expectations, staged learning, Entrustable Professional Activities, critical-thinking pedagogy, prepared assessors and outcome-focused quality assurance. The model is intended to align what students are taught, what they encounter in practice and what assessors are expected to judge, while avoiding reduction of relational practice to checklist compliance. Its feasibility and effects require empirical evaluation. Making specialist capability explicit would strengthen public protection, support educator and assessor sustainability, and give clearer meaning to mental health nursing as a distinct field of registration.

Relevance to mental health nursing practice: Parity of esteem in mental health nursing depends on more than educational exposure - it requires assurance that graduates can demonstrate specialist capability in practice. This paper identifies a capability-governance gap between generic regulatory standards, the field-specific knowledge, reasoning and relational work expected of mental health nurses. The proposed Capability-Critical Thinking Spiral for Mental Health Nursing links explicit capabilities with staged learning, Entrustable Professional Activities, critical-thinking pedagogy and prepared assessors. It offers a testable approach to strengthening graduate readiness, public protection and educator sustainability while retaining the distinctive contribution of mental health nursing.

1. Introduction

Parity of esteem requires mental and physical health to receive comparable priority in policy, services and professional preparation (Parliamentary Office of Science and Technology, 2015; House of Commons Library, 2020). In pre-registration education, however, parity has a practical test: what should the title 'Registered Nurse (Mental Health)' reliably tell a patient, family member or employer about what that nurse can do? Nursing and Midwifery Council (2024) recognises mental health nursing as a distinct field of registration, yet its generic outcomes leave substantial discretion over how field-specific judgement is taught and assured. This paper argues that public

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https://doi.org/10.1016/j.nedt.2026.107509
Received 7 April 2026; Received in revised form 1 November 2026; Accepted 3 November 2026
Available online 5 November 2026
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protection requires three things to be made explicit: the capabilities distinctive to mental health nursing, the reasoning needed to exercise them safely in real settings, and assessment that demonstrates actual proficiency rather than simply completion of documentation.

Although concerns about genericism in mental health nursing education are now well established, the debate has developed from identifying the potential dilution of specialist preparation towards considering how the distinctive knowledge, reasoning and capabilities of mental health nursing can be protected within contemporary education. Connell et al. (2022), Warrender et al. (2024), Warrender (2024) and Fisher (2025a) have articulated the risks associated with weakening field-specific preparation. More recent work has begun to address these concerns, with Fisher (2025b) advancing approaches to strengthening critical-thinking pedagogy and Fisher et al. (2026) demonstrating how a redesigned field-specific curriculum can reclaim professional identity and specialist content.

Building on these contributions, this paper extends the debate beyond what should be taught to consider how specialist mental health nursing capability can be explicitly defined, progressively developed, assessed across different practice environments and consistently assured in support of public protection. We describe this as capability governance and propose the Capability-Critical Thinking Spiral for Mental Health Nursing (CCT-SMHN) as a framework for translating these principles into curriculum design, practice learning, assessment and regulatory assurance.

Recent educational innovations provide further evidence of how the field is responding to this challenge. Cutts and Hitchcock (2024) offer a Proficiency Directory to help students and assessors interpret generic requirements, Baldwin et al. (2026) demonstrate how a Future Nurse programme can increase mental health content, while Kenwright et al. (2026) draw on established psychological intervention competence frameworks to make communication skills more explicit in teaching and assessment. These developments demonstrate that field-specific content and competencies can be made more visible within pre-registration nursing education. The unresolved system-level question is whether a student should encounter comparable expectations wherever they train and wherever they are assessed. CCT-SMHN therefore connects curriculum content to staged practice learning, entrustment decisions, educator preparation and quality assurance. Its novelty lies in this integration, rather than in claiming that spiral curricula, competency frameworks or field-specific teaching are themselves new.

2. Positionality and approach to the literature

This critical discussion paper is informed by the authors' experience across nurse education including mental health nursing clinical practice and research leadership. As such, it is shaped by an interest in how professional regulation, educational preparation and contemporary mental health practice intersect and by a belief that these relationships deserve better understanding. These observations are not presented as representative of all programmes, placements and educational contexts across the United Kingdom, but as reflections that resonate with wider debates within the literature and the profession. Where examples from educational practices are discussed, they are intended to illustrate challenges and opportunities rather than provide empirical evidence of prevalence. Literature was therefore selected purposively to inform the discussion across regulatory standards, mental health nursing identity, educational theory, practice assessment and educator workforce development.

The intention was not to undertake a systematic search or formal evidence synthesis, but to bring together relevant ideas and evidence to examine the issues under discussion and inform the development of CCT-SMHN. References to individual programme structures and placement experiences are therefore presented as illustrative professional reflections rather than empirical estimates of practice across the United Kingdom, with these observations distinguished from findings reported in the cited literature. Recognising the diversity of mental health nursing education and practice settings, CCT-SMHN is proposed as a conceptual framework for strengthening how field-specific capability is understood, progressively developed, assessed and assured, rather than as a prescriptive model for implementation across all programmes.

3. Conceptual framing

Three complementary theoretical lenses help explain the potential disconnect between meeting formal programme requirements and assuring consistent field-specific capability. Constructive alignment proposes that intended outcomes, learning activities and assessment should reinforce one another (Biggs, 1996; Biggs and Tang, 2011). Where regulatory attention centres on hours, curriculum mapping and proficiency sign-offs, programmes may evidence compliance without making field-specific reasoning equally visible in learning and assessment. This challenge extends into practice, where situated learning suggests that capability develops through participation in communities of practice (Lave and Wenger, 1991; Wenger, 1998). Students therefore learn from formal teaching and from the routines, language and norms of clinical environments, creating a hidden curriculum that may reinforce or undermine what is taught.

The relationship between learning, assessment and regulatory assurance introduces a further challenge because what can be readily documented may become more visible than the capability regulation intends to assure. Goodhart's law cautions that measures can lose their value when they become targets (Goodhart, 1984), while audit society theory highlights the authority afforded to documentation and verification (Power, 1999). These perspectives explain how evidence of educational activity can become more prominent than evidence of field-specific capability, without establishing that generic standards themselves cause poorer graduate outcomes. Addressing this gap requires explicit field-specific expectations, aligned opportunities to develop them and credible assessment of their demonstration in practice. Educators and practice assessors are therefore central to capability assurance, but their judgements require shared expectations, appropriate preparation and sufficient time to translate regulatory standards into consistent teaching, supervision and assessment.

4. Parity of esteem requires capability assurance

Parity of esteem between mental and physical health is a long-standing United Kingdom policy ambition (House of Commons Library, 2020; Parliamentary Office of Science and Technology, 2015), yet it remains fragile when the education of the workforce does not give mental health capability comparable visibility (Warrender et al., 2024; Warrender, 2024). Although investment, access and service capacity remain important dimensions of parity of esteem, Warrender et al. (2024) argue that the marginalisation of specialist mental health nursing education raises further concerns about how parity is understood and achieved. Building on this argument, we propose that parity must also be reflected in the curriculum and practice environments where professional identity, clinical judgement and capability are developed, ensuring that future mental health nurses receive the preparation necessary to demonstrate the specialist capabilities expected of their profession.

This is not an argument for adding ever more content to crowded programmes, nor for protecting professional territory for its own sake. The issue is whether the public can expect a consistent baseline from anyone registered as a mental health nurse, regardless of where that person trained. A graduate should be able to establish therapeutic relationships in profound distress, recognise and respond to risk without defaulting to containment, reason through questions of liberty and capacity, use least restrictive approaches and integrate physical, psychological, cultural and social information into care. When these capabilities are left largely to local interpretation, parity becomes

dependent on programme design, placement opportunity and assessor judgement rather than a shared regulatory expectation (Warrender, 2024).

Programme hours and practice requirements remain necessary because students require sufficient opportunities to learn and develop, but time primarily measures educational exposure rather than capability. Current Nursing and Midwifery Council requirements specify a 4600-h programme with a 50/50 theory-practice split, equivalent to 2300 h of practice learning, with up to 600 practice hours permitted in simulation (Community Nursing Now, 2024; Nursing and Midwifery Council, 2025). These requirements provide an important baseline for educational exposure, but neither time spent in education nor placement designation can, in isolation, demonstrate what a student has learned or is prepared to do (Collier-Sewell et al., 2023). Our experience across nursing education and practice suggests that the sequencing and visibility of specialist mental health content can vary between programmes, although this is offered as an illustrative professional observation rather than an estimate of national practice. The regulatory challenge is therefore to move beyond assurance of educational inputs alone towards demonstrating the progressive development, application and assessment of the field-specific capabilities that define readiness to join the professional register as a registered mental health nursing.

The significance of variation in practice learning becomes particularly important because placements are where formal curricula meet real clinical cultures. The NMC-commissioned independent rapid review undertaken by the Nuffield Trust and Florence Nightingale Foundation found substantial variation in supervision and learning quality, alongside identifiable features of positive learning environments (Palmer et al., 2024). In mental health nursing, this variation can shape how students learn to respond to distress, risk, coercion and uncertainty. Variation in educational preparation therefore extends beyond the learning experience because its consequences may ultimately be encountered by people receiving mental health care, including those in acute distress, those subject to compulsory powers and communities already affected by trauma, poverty, racism and social exclusion.

Fisher's (2023) account illustrates why experience within a mental health setting should not be assumed to demonstrate capability in itself. From a service-user perspective, the quality of nursing was experienced through whether care enabled the person to feel heard, respected and meaningfully supported, rather than through exposure to a particular setting or activity. This aligns with the Nursing and Midwifery Council's expectation that registered nurses provide evidence-based, person-centred and compassionate care while exercising professional judgement and preserving safety (Nursing and Midwifery Council, 2018). For mental health nursing education, the implication is that assurance must extend beyond where learning occurred and how many hours were completed to whether students can apply specialist knowledge, critical reasoning and relational skills in practice. We argue that this is particularly important when people are distressed, frightened, ambivalent about care or experiencing restrictions on their autonomy, because these situations require nurses to integrate therapeutic engagement, ethical and legal reasoning, professional judgement and respect for individual rights.

Some of the most consequential work in mental health nursing is also the hardest to reduce to a tick-box. There is no meaningful tick-box for establishing trust with a person who feels unsafe, unheard or profoundly disconnected, nor a simple metric that captures good judgement when autonomy, risk and safety pull in different directions. Admissions, contacts and adverse events can be counted, but they do not reveal whether a nurse recognised the person behind the event, used power proportionately or created the conditions for personal recovery. This tension between what can be readily measured and what constitutes skilled mental health practice is evident in risk assessment. Nathan and Bhandari (2024) argue that risk assessment cannot be reduced to the accurate prediction of future harm through standardised tools, but requires clinical decision-making shaped by professional judgement, relationships, context and organisational influences. An overreliance on measurable risk procedures can therefore create an impression of certainty while obscuring the more nuanced capabilities required to understand and respond to distress in individual circumstances. The educational challenge is not to abandon measurement, but to ensure that what is assessed reflects the complexity of the capability being developed. From this perspective, parity of esteem requires the less procedurally visible capabilities of mental health nursing to be specified and assured with the same seriousness as more readily observable clinical competencies. Where regulation provides clearer assurance of educational exposure and process than of these field-specific capabilities, the connection between parity as a policy commitment and what registration assures the public remains incomplete.

5. When generic standards leave specialist capability implicit

The central issue is not that the Future Nurse standards contain no mental health content (Nursing and Midwifery Council, 2018), but how clearly that content defines and assures the distinctive capabilities expected of a mental health nurse at registration (Warrender et al., 2024). Important mental health capabilities are dispersed across broad proficiencies and annexes, creating considerable scope for programmes to determine their visibility, sequencing and emphasis within teaching, practice learning and assessment (Pearson and Wallymahmed, 2020). Rights-based judgement, least restrictive decision-making, therapeutic engagement under distress, formulation-informed practice, culturally responsive care and restrictive-practice reduction may therefore be present in principle without being specified clearly enough to produce consistent expectations in practice. Mental health nursing can therefore become ‘buried’, with field-specific content remaining present while its visibility, depth and assessment depend on curriculum design, placement opportunities, service culture and assessor interpretation. Connell et al. (2022) similarly warn that generic standards risk weakening mental health nursing identity and diluting distinctive capability, which raises a wider question of regulatory assurance. Where mental health nursing is recognised as a distinct field on the professional register, the capabilities represented by that registration should be sufficiently explicit for students to develop them, assessors to judge them consistently and the public to understand what the professional title signifies.

Emerging empirical evidence reinforces concerns about how specialist mental health nursing capability is experienced within generic proficiency frameworks. For instance, in a cross-field study of 531 final-year nursing students, Kenwright et al. (2025) found that mental health nursing students reported the lowest confidence in their readiness for practice and greater difficulty demonstrating required proficiencies. Their accounts also pointed to a perceived mismatch between generic assessment requirements and the therapeutic work they associated with mental health nursing, with some describing themselves as ‘referral agents’ rather than practitioners equipped to deliver specialist therapeutic interventions. Although these findings reflect students' reported experiences and confidence rather than an objective assessment of competence, they provide an important indication of how generic proficiency requirements may be experienced within mental health nursing education. Viewed alongside concerns about professional identity and field-specific preparation (Connell et al., 2022; Warrender et al., 2024), the findings strengthen the case for making specialist capabilities more explicit in what students are expected to learn, demonstrate and be assessed against.

Painter and Bond (2023) similarly found that practice assessor comments placed greater emphasis on transformational attributes and personal qualities than on explicit task-focused competencies. Relational qualities are indispensable, but being compassionate, calm or personable cannot substitute for demonstrating assessment, formulation, risk reasoning, lawful decision-making and therapeutic intervention. A credible standard needs to make both the relational manner and the professional substance of mental health nursing visible. Parity of esteem

therefore requires the intellectual, relational and ethical capabilities of mental health nursing to be explicitly specified, taught and assessed with the same seriousness afforded to more visible procedural competencies, such as medicine administration, physical health assessment and clinical observations. Where these capabilities remain implicit, the concern extends beyond professional identity and curriculum design to the assurance of workforce readiness and public protection.

6. From educational provision to capability assurance

The tension between educational provision and clinical capability is longstanding. Project 2000 strengthened the academic foundations of nurse education yet concerns about the relationship between theoretical preparation and clinical learning persisted (Kirk et al., 1997; Maben et al., 2006). Its relevance to current reform is that structural requirements alone cannot resolve the theory-practice gap. Hours, documentation and mapped proficiencies remain necessary forms of assurance, but they cannot substitute for evidence that students can translate knowledge into safe professional action.

Current Nursing and Midwifery Council reform should therefore be considered through a capability test rather than primarily through changes to practice hours (Nursing and Midwifery Council, 2025). This position is supported by Kenny et al. (2025), whose systematic review of 49 studies found insufficient high-quality evidence to establish the number of practice hours required to achieve nursing competence, with no included studies examining the effect of different placement hours on patient outcomes. Greater flexibility in practice learning may offer benefits, but these findings reinforce the need for regulatory assurance to focus on what graduates can demonstrate rather than relying on time spent in practice as a proxy for capability. For mental health nursing, we argue that reform should preserve explicit expectations for therapeutic engagement, ethical and legal judgement, least restrictive decision-making, psychosocial intervention and culturally responsive practice. The priority is therefore to establish which field-specific capabilities graduates must demonstrate and how their achievement can be assessed consistently across educational and clinical environments.

7. What mental health nursing capability requires

Leaving capability implicit is particularly consequential because mental health nursing is not ‘adult nursing plus mental health’. Its distinctive professional terrain is shaped by personhood and recovery, therapeutic relationships and use of self, trauma-informed and psychologically informed care, and rights-based practice where liberty, capacity and safety intersect. It also requires cultural responsiveness, attention to power, physical health competence and sustained judgement under uncertainty (International Council of Nurses, 2024). Other nursing fields also depend on relational and ethical practice, but mental health nursing brings these commitments together in a distinctive context where the relationship itself may be an intervention and where professional decisions can directly affect autonomy and liberty.

Describing these capabilities as ‘soft skills’ understates the knowledge and judgement required to use them safely. Consider a person experiencing psychosis who is frightened, mistrustful and considered to present an immediate risk. The mental health nurse may need to establish sufficient trust to understand what is happening, recognise possible physical or medication-related contributors, interpret the person's account, consider capacity and legal authority, involve others appropriately, de-escalate the situation and justify any restriction of liberty. Making these judgements requires sophisticated clinical reasoning that cannot be adequately represented by generic expectations for communication or wellbeing.

Parity of esteem must therefore extend to the intellectual foundations that make such clinical reasoning possible. Law, ethics, human rights, social determinants, trauma, culture, pharmacology, physical health and psychological understanding provide the knowledge through which mental health nurses interpret distress, weigh competing explanations and determine how to act. Making these foundations explicit within education and assessment protects mental health nursing from being reduced either to a collection of tasks or to an ill-defined set of interpersonal qualities, while making clearer what specialist capability should mean in practice.

8. From critical thinking to credible assessment

Mental health nursing frequently requires decisions where there is no risk-free option. Nurses may need to balance autonomy and safety, distinguish understandable distress from clinical deterioration, recognise bias in risk judgements and decide when intervention becomes unnecessarily restrictive (Bifarin et al., 2021). Critical thinking is therefore a mechanism through which safe and therapeutic care is delivered. Fisher (2025a) identifies pedagogical approaches including Socratic questioning, reflexivity and case-based ethical learning, while Fisher et al. (2026) show how a field-specific curriculum can create space for such learning. The remaining assurance challenge is demonstrating that students can apply this reasoning in authentic clinical situations rather than describe it only in academic work.

Critical thinking cannot safely be assumed to emerge from accumulated hours, reflective logs or exposure to complex services. Students can learn best practice from clinical cultures, but they can also absorb defensive habits of surveillance, paperwork and containment. Programmes therefore need to teach reasoning deliberately and make it observable perhaps through related authentic assessment strategies. Students should be expected to explain the legal, ethical and professional basis of decisions, justify how rights and least restrictive principles were considered, integrate cultural and social context and recognise diagnostic overshadowing, structural racism and stigma in care pathways.

A further question concerns the expertise required to judge field-specific reasoning within shared or generic academic modules. It is plausible that assessment criteria and marker expertise influence whether students' mental health reasoning is recognised, but the extent and consequences of this effect require empirical investigation. Programmes should therefore consider field-specific assessment calibration, joint marking where appropriate and evaluation of inter-assessor consistency, rather than assume that generic module structures necessarily produce unfair marking.

9. Practice assessors as part of capability assurance

Practice assessors are therefore central to curriculum delivery because assessment involves both teaching and high-stakes professional judgement. Although UK frameworks define assessor roles, this does not ensure the preparation, protected time or field-specific expertise required to assess complex mental health capability (Palmer et al., 2024; Pearson and Wallymahmed, 2020). Whaley et al. (2023) found continuing role conflict and gaps in training and knowledge several years after implementation of the NMC supervision and assessment standards. When assessors lack time, preparation or shared criteria, the safest administrative response can become collecting evidence and completing documentation. The educational risk is that portfolio completion begins to stand in for professional judgement.

Cutts and Hitchcock (2024) and Kenwright et al. (2026) offer practical ways of reducing this ambiguity. A structured proficiency directory can help students identify appropriate evidence, while psychological intervention competence frameworks can make skilled communication more explicit. These are important advances, but tools do not assure consistent use across programmes and placements. The remaining governance task is to connect field-specific criteria to staged learning, observed practice, assessor calibration and quality assurance. CCT-SMHN is proposed to make that connection.

Evidence across clinical education shows that assessment and

mentoring are demanding roles and that confidence and competence vary with preparation and organisational support (Christiansen et al., 2021; Tuomikoski et al., 2020; Mikkonen et al., 2022). Read as an education-governance issue, assessor preparation is part of public protection: if assessors are expected to develop and assure capability, their readiness becomes part of the safety case.

Mental health practice introduces an additional vulnerability, and in this context, assessment can drift away from appraisal of observable capability and instead become shaped by subjective judgements about whether a student appears "fit" with the team, service culture, or interpersonal norm. By "fit," what is often being judged is not evidence-based capability but informal expectations about communication style, emotional presentation or conformity to local practice. It requires a clear and objective means of assessment of what mental health nurses must know, reason through and do, alongside how they work with people.

10. What international models reveal about capability assurance

International systems make different choices about where specialist capability is specified and assured. Ireland combines direct-entry mental health nursing with explicit programme standards and staged competence expectations (Nursing and Midwifery Board of Ireland, 2023). In parts of Canada, psychiatric nursing is regulated as a distinct profession with explicit entry-level competencies (Registered Psychiatric Nurse Regulators of Canada, 2025). Australia illustrates a more generic pre-registration route, alongside continuing debate about specialist capability development and workforce sustainability (Hurley et al., 2023; Lakeman et al., 2023).

The United Kingdom currently retains mental health nursing as a distinct field of registration while allowing substantial discretion over curriculum content, sequencing and how field capability is evidenced (Nursing and Midwifery Council, 2018). If field-specific pre-registration preparation is retained, a minimum capability baseline could clarify what the title represents at entry to the register. If preparation becomes more generic, robust post-registration credentialing would be needed to develop and assure specialist capability as adopted by the model in the United States. Without either mechanism, assurance is displaced onto educators and practice assessors, who must make high-stakes judgements without a sufficiently explicit shared benchmark.

11. From critique to capability governance: CCT-SMHN

The preceding analysis identifies a governance gap between field-specific professional identity and the mechanisms through which capability is taught, developed, assessed and assured. We propose the Capability-Critical Thinking Spiral for Mental Health Nursing (CCT-SMHN) as a field-specific response to this gap. Rather than introducing a new educational theory, the model integrates established principles of spiral curriculum design (Harden, 1999), constructive alignment (Biggs, 1996) and Entrustable Professional Activities (Ten Cate, 2005) within a capability-governance framework for mental health nursing. Students should know the principles they are expected to use before exercising them in increasingly complex situations, with responsibility increasing as they demonstrate that they can connect knowledge, reasoning and relational practice.

CCT-SMHN complements rather than competes with existing innovations. Baldwin et al. (2026) show how curriculum content can be strengthened, Cutts and Hitchcock (2024) help students and assessors navigate generic proficiencies, and Kenwright et al. (2026) make communication competence more explicit. CCT-SMHN asks how these kinds of advances might be connected across an entire programme and its practice partners through a common capability map, progressive entrustment, prepared assessors and outcome-focused assurance. That system-level integration is the paper's principal proposition and remains to be tested empirically.

The intended benefit is stronger alignment between preparation and assessment, with students assessed on capabilities they have been prepared to demonstrate and assessors given clearer expectations for progression. This could reduce reliance on variable placement exposure and local interpretation, although its effects on consistency, fairness and student experience require evaluation. Practice assessment is consequently treated as teaching and judgement rather than portfolio verification. Assessors would need preparation in coaching reasoning, recognising bias, giving feedback and making calibrated entrustment decisions against shared criteria. Entrustment must remain a holistic judgement based on multiple observations, not a new checklist. The model therefore succeeds only if capability language clarifies professional judgement without converting relational practice into another administrative exercise.

12. Pillar 1: Define the philosophy and knowledge base

CCT-SMHN begins by protecting what is distinct about mental health nursing. Programmes should explicitly teach and assess at least six proficiencies that cut across settings: recovery, personhood; trauma-informed and psychologically informed care; rights-based and least restrictive practice; cultural safety and anti-racist practice; systems thinking and pathway navigation; and physical health competence in mental health settings without diagnostic overshadowing (International Council of Nurses, 2024). These should be taught not as isolated topics or fixed doctrines, but as applied philosophies that shape judgement and action in complex practice.

Mental health nursing draws on multiple models of distress and care, requiring students to reason across psychological, social, biological, cultural and rights-based perspectives without reducing practice to a single explanatory frame. Teaching should also locate these perspectives within the history of institutionalisation, coercion, recovery movements and survivor critique so that students understand the professional and political context of contemporary practice.

Within this model, cultural safety and anti-racist practice must include demonstrable capability in recognising and mitigating racialised risk attribution, disproportionality in detention and culturally unsafe formulation. At the same time, students must develop awareness of self, recognising that practice is always filtered through subjective lenses shaped by identity, experience, values and power. Mental health nursing therefore requires reflexivity alongside knowledge, so that students learn to use themselves critically, safely and ethically in practice.

13. Pillar 2: Make capability explicit through entrustable professional activities

Broad proficiencies should be translated into field-specific, assessable outcomes using Entrustable Professional Activities (EPAs): statements of what a new registrant can be trusted to do safely, with an appropriate level of supervision. An EPA map makes mental health capability explicit and prevents key areas of practice from being hidden within generic standards. It also allows programmes to show how core capabilities travel across the life course and across specialist contexts, including children and young people's mental health and perinatal mental health, where development, attachment, family relationships, safeguarding and relational risk must be understood alongside distress, diagnosis and care planning.

A minimum EPA set for mental health nursing could include the ability to:

- Collaboratively assess and formulate distress, integrating risk, strengths, trauma, culture, development, attachment and social determinants.
- Build and sustain therapeutic relationships under high distress, mistrust, altered mental state or relational rupture.

- Deliver de-escalation and safety planning consistent with least-restrictive principles and restrictive practice reduction.
- Work with self-harm and suicide risk using evidence-informed, relational approaches rather than risk-averse reflex containment.
- Deliver or co-deliver core psychosocial interventions appropriate to setting, life stage and role, including family, network and parent-infant work where relevant.
- Demonstrate psychopharmacology literacy and physical health monitoring, recognising and acting on deterioration.
- Practise lawfully and ethically where capacity, consent, safeguarding and liberty intersect.
- Work across and strengthen communication at system interfaces, including Accident and Emergency, primary care, urgent and crisis services, maternity services, health visiting, schools, housing, and voluntary, community and social enterprise sectors, in order to prevent system-induced harm.

EPAs are useful here because they answer a question that broad competency statements often leave unresolved i.e., what professional activity should a newly registered mental health nurse be trusted to undertake, and with what level of supervision? Used well, they could give students and assessors a shared language for progression and move assessment away from impressionistic descriptions of a 'good student'. Used poorly, they could become another sign-off exercise. Their value therefore depends on observation, narrative feedback, repeated evidence and assessor judgement rather than completion alone.

14. Pillar 3: Develop capability progressively

CCT-SMHN stages clinical exposure so students enter complex placements when they can articulate standards and reasoning. A simple three-stage structure can operate within existing hour requirements:

Stage 1 (Months 1–9): theory-heavy foundations (critical thinking, rights-based and trauma-informed practice, recovery, cultural safety, law and ethics) plus structured observational exposure and simulation to practise reasoning before immersion.
Stage 2 (Months 10–20): supported immersion placements with explicit coaching on EPAs, structured case-based discussions, and observed assessments focused on reasoning and therapeutic practice.
Stage 3 (Months 21–36): progressive responsibility with 'entrustment' decisions, ensuring graduates demonstrate capability across the EPA set, not just completion of hours and documentation.

The purpose of staged learning is not to keep students away from practice. It is to ensure that exposure becomes educative rather than accidental. Early clinical experience should help students observe, question and connect theory to practice; later placements should require progressively greater responsibility and defensible decision-making. This sequencing may also help students recognise and challenge poor local practice rather than reproduce it simply because it is familiar.

15. Pillar 4: Assess capability in practice

Assessment should therefore move beyond portfolio endurance towards demonstration of capability in practice. EPA-aligned assessment could include observed encounters, structured case discussions, narrative feedback and explicit exploration of reasoning: what did the student notice, what alternatives were considered, how were rights, risk and recovery balanced, and why was the chosen action justified? These methods do not make complex mental health practice simple to measure. They make the judgement process more visible and open to scrutiny.

Simulation can support rehearsal of de-escalation, communication and ethical decision-making, especially when placement opportunities are uneven (Palmer et al., 2024). It should complement rather than displace supported encounters with the relational complexity of real clinical practice. Programme-specific concerns about compressed field teaching may illustrate this tension but cannot establish the prevalence of curricular dilution nationally. Evaluation should therefore consider both the quality of simulation and its alignment with authentic, supervised field-specific learning.

16. Pillar 5: Prepare assessors and assure outcomes

If assessment is a teaching function, assessor preparation becomes part of the public protection infrastructure. Assessors and supervisors report uneven confidence and preparation, while structured support is associated with stronger mentoring competence (Mikkonen et al., 2022; Tuomikoski et al., 2020). Palmer et al. (2024) similarly emphasise the importance of supervision and learning-environment quality. Quality assurance should therefore ask more than whether hours were completed and documentation submitted. It should examine whether placements provide the intended learning, whether students demonstrate agreed capabilities and whether assessors have the preparation and time to make defensible judgements. Greater flexibility in hours or simulation should be accompanied by stronger, not weaker, outcome assurance.

17. Implementation and evaluation

The next stage in developing CCT-SMHN is to establish how the model can be operationalised and evaluated across different educational and practice settings. Implementation will need to account for placement capacity, programme structures, educator workload and the preparation and calibration of assessors. A particular consideration is preserving the model's emphasis on demonstrated capability, rather than allowing Entrustable Professional Activities to become another layer of procedural sign-off. An initial feasibility phase could co-design the capability map with service users, students, educators, practice assessors and regulatory stakeholders, followed by piloting a small number of Entrustable Professional Activities across contrasting settings. Evaluation could examine acceptability, educator and assessor workload, implementation fidelity, assessment consistency, student progression, equity across placement experiences and resource requirements, alongside any unintended consequences. This would provide the evidence needed to refine CCT-SMHN and determine its potential for wider implementation as an approach to strengthening capability assurance in mental health nursing.

18. Implications for educator workforce sustainability

Capability governance also has direct implications for educator workforce sustainability because generic regulation does not remove specialist educational work; it can relocate that work to educators and practice assessors. When field-specific expectations are implicit, academics must decide what mental health content receives protected curriculum space, translate broad outcomes into assessment criteria and defend specialist judgement within shared programme structures. Practice assessors perform similar interpretive work while balancing supervision with clinical demands. Regulatory ambiguity therefore has a workforce cost as well as a curriculum consequence.

The responsibility for sustaining field-specific mental health nursing capability also shapes academic identity, as mental health nurse educators are expected to maintain and transmit expertise within a philosophically distinctive field while working across increasingly shared curricula, interdisciplinary teaching structures and standardised approaches to assessment. Where field-specific capability is insufficiently explicit, educators may carry additional responsibility for maintaining its visibility within the curriculum and translating broad regulatory expectations into meaningful learning and assessment. Whaley et al. (2023) describe role conflict and preparation gaps following

implementation of the NMC supervision and assessment standards. The answer cannot be to ask educators to compensate indefinitely for ambiguity through additional effort. A sustainable system needs clearer field-specific outcomes, educator development, assessment calibration and protected opportunities to maintain scholarly and clinical credibility.

Educator sustainability is therefore about professional authority, working conditions and career development as well as headcount. A shared capability framework could reduce avoidable local interpretation, but it could also create new assessment work if introduced without workload allocation and institutional support. Any evaluation of CCT-SMHN should consequently examine educator workload, confidence, professional identity and retention alongside student outcomes.

19. Clinical academics as part of the learning system

Maintaining coherence between what mental health nursing students are taught and what they encounter in practice requires stronger connections between university and clinical learning environments, particularly where specialist knowledge, assessment expectations and service realities may diverge. Warrender (2022) identifies the separation between academic and clinical mental health nursing as a persistent theory-practice challenge and highlights the potential contribution of clinical academic roles in bridging these environments. Within CCT-SMHN, clinical academics could support this connection by helping translate emerging evidence into curricula by being involved in the earliest stages of the programme development, informing assessment and educator development, and evaluating how educational innovations operate in practice. Their contribution could therefore extend beyond maintaining clinical credibility to strengthening the learning system across classroom teaching, simulation, placements and assessment, although this requires protected time, organisational support, career recognition and equitable access to clinical academic pathways.

20. Recommendations for the NMC and education partners

The argument leads to five linked recommendations. They are directed to the NMC in partnership with approved education institutions and practice providers because capability cannot be assured by any one part of the system alone.

1. Publish a field-specific minimum capability dataset for mental health nursing, such as an EPA map, aligned with existing proficiencies.
2. Bring core mental health capabilities into the main programme and proficiency standards rather than relying on dispersed mapping or annex-only articulation.
3. Set minimum expectations for mental health practice learning, including exposure to crisis, community and inpatient therapeutic work, co-occurring substance use and family or network practice.
4. Require appropriate preparation and protected time for practice supervisors and assessors undertaking supervision, coaching and assessment.
5. Strengthen quality assurance by requiring evidence of field-specific capability at registration, alongside evaluation of practice learning environments and systematic incorporation of student and service-user feedback into programme improvement (Palmer et al., 2024; Kenwright et al., 2025; Nursing and Midwifery Council, 2025).

These recommendations are intended to make the meaning of mental health registration more consistent. They address different points in the same assurance chain: standards define capability, curricula teach it, placements provide opportunities to develop it, assessors judge it and quality assurance tests whether the system is working. Weakness at any one point can leave the public title of 'Registered Nurse (mental health)' carrying less certainty than it should.

21. Conclusion

Parity of esteem requires confidence that newly registered mental health nurses can translate specialist knowledge into safe, lawful and therapeutic action when people are distressed, frightened, ambivalent or subject to restrictions on their liberty. Current debates have established the risks of genericism and the importance of protecting field-specific education. The remaining task is to make specialist capability sufficiently explicit for universities to teach it, students to develop it, assessors to judge it and regulators to assure it. CCT-SMHN provides a framework through which this task can be translated into educational and regulatory practice, bringing established educational approaches together within a field-specific capability governance model that connects mental health nursing philosophy with progressive learning, authentic assessment, educator and assessor preparation, and outcome-focused quality assurance. Its feasibility and effectiveness remain to be demonstrated, and implementation must avoid turning entrustment into another checklist. The public, however, should not need to know which university a nurse attended to understand what registration means. If parity of esteem is to be more than policy language, the title 'Registered Nurse (mental health)' should carry a reliable promise of specialist capability, supported by an educator workforce with the authority, preparation and time to develop and assure it.

CRediT authorship contribution statement

Oladayo Bifarin: Writing – original draft, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Walter Ugwuocha:** Writing – review & editing, Validation, Project administration, Investigation, Formal analysis. **Dan Warrender:** Writing – review & editing, Validation, Formal analysis, Data curation. **Deborah Morgan:** Writing – review & editing, Validation, Investigation. **Ruth Gaballa:** Writing – review & editing, Validation, Formal analysis. **Philomene Uwamaliya:** Writing – review & editing, Validation, Formal analysis, Data curation. **Viki Whaley:** Writing – review & editing, Validation, Formal analysis, Data curation. **Maria Caves:** Writing – review & editing, Validation, Data curation. **Christopher Kiely:** Writing – review & editing, Validation, Investigation.

Declaration of competing interest

Oladayo Bifarin is a National Institute for Health and Care Research Leader. The views expressed in this article are those of the author(s) and not necessarily those of NIHR or the Department of Health and Social Care.

Acknowledgements

This research was supported by the Office for Life Sciences and the National Institute for Health and Care Research (NIHR) Mental Health Translational Research Collaboration Mission, hosted by the NIHR Oxford Health Biomedical Research Centre. The authors would like to also thank Rebecca Hall and Freya Collier-Sewell for their critical review of the manuscript and their thoughtful comments, which helped strengthen its clarity and development.

References

Baldwin, L., McLeod, J., Bage, R., Nicol, F., Dixon, M., Khan, L., Alcock-Towse, H., Gordon, D.-M., Shiels, C., 2026. Changing a future nurse undergraduate nursing programme to include more mental health content: initial evaluation. Br. J. Nurs. 35 (16), 813–817. https://doi.org/10.12968/bjon.2025.0485.

Bifarin, O., Felton, A., Prince, Z., 2021. Defensive practices in mental health nursing: professionalism and poignant tensions. Int. J. Ment. Health Nurs. https://doi.org/10.1111/inm.12936.

Biggs, J., 1996. Enhancing teaching through constructive alignment. High. Educ. 32 (3), 347–364. https://doi.org/10.1007/bf00138871.

Biggs, J., Tang, C., 2011. Teaching for Quality Learning at University: What the Student Does, 4th ed. McGraw-Hill/Open University Press.
Christiansen, B., Averlid, G., Baluyot, C., Blomberg, K., Eikeland, A., Strand Finstad, I.R., Holm Larsen, M., Lindeflaten, K., 2021. Challenges in the assessment of nursing students in clinical placements: exploring perceptions among nurse mentors. Nurs. Open 8 (3), 1069–1076. https://doi.org/10.1002/nop2.717.
Collier-Sewell, F., Atherton, I., Mahoney, C., Kyle, R.G., Hughes, E., Lasater, K., 2023. Competencies and standards in nurse education: the irresolvable tensions. Nurse Educ. Today 125. https://doi.org/10.1016/j.nedt.2023.105782, 2023 Jun. 105782.
Community Nursing Now, 2024. NMC launches review of nursing and midwifery practice learning. Retrieved 25th of January, from. https://www.communitynursingnow.co.uk/news/nmc-launches-review-of-nursing-anmd-midwifery-practice-learning.
Connell, C., Jones, E., Haslam, M., Firestone, J., Pope, G., Thompson, C., 2022. Mental health nursing identity: a critical analysis of the UK'S nursing and midwifery council's pre-registration syllabus change and subsequent move towards genericism. Ment. Health Rev. J. 27 (4), 472–483. https://doi.org/10.1108/mhrj-02-2022-0012.
Cutts, M., Hitchcock, K.-H., 2024. Mental health nursing students and generic proficiencies: how educators can support assessment. Br. J. Nurs. 33 (20), 956–962. https://doi.org/10.12968/bjon.2024.0117.
Fisher, J., 2023. The true value of a mental health nurse: the lessons that I learned by becoming a mental health service user. British Journal of Mental Health Nursing 12 (1), 1–3. https://doi.org/10.12968/bjmh.2023.0001.
Fisher, J., 2025a. The genericization of mental health nursing: a personal perspective. Int. J. Ment. Health Nurs. 34 (4), e70013. https://doi.org/10.1111/inm.70013.
Fisher, J., 2025b. Critical thinking and mental health nurse education. Int. J. Ment. Health Nurs. 34 (2), e70021. https://doi.org/10.1111/inm.70021.
Fisher, J., Baverstock, S., Bell, G., Firestone, J., Ingleby, A., McCartney, J., Potts, E., Roberts, D., Smith, M., Steele, D., 2026. The development of a new mental health pre-registration nursing curriculum: reclaiming professional identity and field specific content. Int. J. Ment. Health Nurs. 35 (2), e70255. https://doi.org/10.1111/inm.70255.
Goodhart, C.A.E., 1984. Problems of monetary management: The UK experience. In: Goodhart, C.A.E. (Ed.), Monetary Theory and Practice: The UK Experience. Macmillan Education UK, pp. 91–121. https://doi.org/10.1007/978-1-349-17295-5_4.
Harden, R.M., 1999. What is a spiral curriculum? Med. Teach. 21 (2), 141–143. https://doi.org/10.1080/01421599979752.
House of Commons Library, 2020. Mental health: achieving “parity of esteem”. https://commonslibrary.parliament.uk/mental-health-achieving-parity-of-esteem/.
Hurley, J., Foster, K., Campbell, K., Edan, V., Hazelton, M., Kennedy, H., Roper, C., Lakeman, R., 2023. Mental health nursing capability development: perspectives of consumers and supporters. Int. J. Ment. Health Nurs. 32 (1), 172–185. https://doi.org/10.1111/inm.13074.
International Council of Nurses, 2024. In: International Council of Nurses (Ed.), Guidelines on Mental Health Nursing 2024. https://www.icn.ch/sites/default/files/2024-07/ICN_MentalHealthNursingGuidelines-2024_EN_web.pdf.
Kenny, A., Knight, K., Garrow, A., Leigh, J., Roberts, D., 2025. Pre-registration student nurse placement hours, competency, and outcomes: a systematic review. Nurse Educ. Today 154, 106851. https://doi.org/10.1016/j.nedt.2025.106851.
Kenwright, M., Bye, C., Doherty, D., Leese, D., 2026. Achieving “parity of esteem”: how educators can enhance the teaching and assessment of communication skills. Br. J. Nurs. 35 (17), 870–875. https://doi.org/10.12968/bjon.2025.0577.
Kenwright, M., McCrorie, C., Bye, C., Awty, P., Doherty, D., Cromar-Hayes, M., 2025. How do mental health nursing students in the United Kingdom experience assessment against the NMC generic standards of proficiency? A cross-field comparison. Int. J. Ment. Health Nurs. 34 (5), e70133. https://doi.org/10.1111/inm.70133.
Kirk, S., Carlisle, C., Luker, K.A., 1997. The implications of project 2000 and the formation of links with higher education for the professional and academic needs of nurse teachers in the United Kingdom. J. Adv. Nurs. 26 (5), 1036–1044. https://doi.org/10.1046/j.1365-2648.1997.00419.x.
Lakeman, R., Foster, K., Hazelton, M., Roper, C., Hurley, J., 2023. Helpful encounters with mental health nurses in Australia: a survey of service users and their supporters. J. Psychiatr. Ment. Health Nurs. 30 (3), 515–525. https://doi.org/10.1111/jpm.12887.
Lave, J., Wenger, E., 1991. Situated Learning: Legitimate Peripheral Participation. Cambridge U.P.
Maben, J., Latter, S., Clark, J.M., 2006. The theory-practice gap: impact of professional-bureaucratic work conflict on newly-qualified nurses. J. Adv. Nurs. 55 (4), 465–477. https://doi.org/10.1111/j.1365-2648.2006.03939.x.
Mikkonen, K., Tomietto, M., Tuomikoski, A.-M., Miha Kaučič, B., Riklikiene, O., Vizcaya-Moreno, F., Pérez-Cañaveras, R.M., Filej, B., Baltinaite, G., Cicolini, G., Kääriäinen, M., 2022. Mentors' competence in mentoring nursing students in clinical practice: detecting profiles to enhance mentoring practices. Nurs. Open 9 (1), 593–603. https://doi.org/10.1002/nop2.1103.
Nathan, R., Bhandari, S., 2024. Risk assessment in clinical practice: a framework for decision-making in real-world complex systems. BJPsych Adv. 30 (1), 53–64.
Nursing and Midwifery Board of Ireland, 2023. Registered Nurse Programmes Standards. Nursing and Midwifery Board of Ireland, Dublin. Retrieved 28th of January from. https://www.nmbi.ie/NMBI/media/NMBI/Registered-Nurse-Programmes-Standards.pdf?ext=.pdf.
Nursing and Midwifery Council, 2018. Future nurse: Standards of proficiency for registered nurses. Retrieved 28th of January, from. https://www.nmc.org.uk/globalassets/sitedocuments/education-standards/future-nurse-proficiencies.pdf.
Nursing and Midwifery Council, 2024. In: Nursing and Midwifery Council (Ed.), Standards for Pre-Registration Nursing Programmes.
Nursing and Midwifery Council, 2025. NMC proposes changes to standards to improve practice learning. https://www.nmc.org.uk/news/news-and-updates/nmc-proposes-changes-to-standards-to-improve-practice-learning/.
Painter, J.M., Bond, C., 2023. What are nurse practice assessors' priorities when assessing student mental health nurses? A qualitative content analysis. Nurse Educ. Pract. 72, 103776. https://doi.org/10.1016/j.nepr.2023.103776.
Palmer, W., Reed, S., Hemmings, N., Julian, S., Bodea, M., Oaten, R., Plotkin, L., 2024. Practice learning in nursing and midwifery education: an independent rapid review. Nuffield trust and Florence Nightingale Foundation (commissioned by the NMC). https://www.nmc.org.uk/globalassets/sitedocuments/education-standards/reviewing-nursing-and-midwifery-practice-learning/2024/nuffield-trust---fnf---nmc-practice-learning-review_web.pdf.
Parliamentary Office of Science and Technology, 2015. Parity of esteem for mental health (POSTnote 485). https://researchbriefings.files.parliament.uk/documents/POST-PN-485/POST-PN-485.pdf.
Pearson, S., Wallymahmed, M., 2020. The new NMC standards: changes to student supervision and assessment. J. Diabetes Nurs. 24 (3), 136. https://diabetesonthenet.com/journal-diabetes-nursing/new-nmc-standards-changes-student-supervision-and-assessment/.
Power, M., 1999. The audit society: rituals of verification. Oxford University Press. https://doi.org/10.1093/acprof:oso/9780198296034.001.0001.
Registered Psychiatric Nurse Regulators of Canada, 2025. Registered Psychiatric Nurse entry-level competencies. Retrieved 28th of January, from. https://static1.squarespace.com/static/665dd49260a4ca14a92ba9ee/t/6839b7c4c2f1206b0936dde1/1748613073592/RPN+ELC+ENG+%2828-05-2025%29+FINAL.pdf.
Ten Cate, O., 2005. Entrustability of professional activities and competency-based training. Med. Educ. 39 (12), 1176–1177. https://doi.org/10.1111/j.1365-2929.2005.02341.x.
Tuomikoski, A.-M., Ruotsalainen, H., Mikkonen, K., Kääriäinen, M., 2020. Nurses' experiences of their competence at mentoring nursing students during clinical practice: a systematic review of qualitative studies. Nurse Educ. Today 85, 104258. https://doi.org/10.1016/j.nedt.2019.104258.
Warrender, D., 2022. Mental health nursing and the theory-practice gap: civil war and intellectual self-injury. J. Psychiatr. Ment. Health Nurs. 29 (2), 171–173. https://doi.org/10.1111/jpm.12808.
Warrender, D., 2024. The memoir of a ghost: the invisible plight of mental health nurse education in the United Kingdom following the nursing and midwifery council's move towards Genericism. Int. J. Ment. Health Nurs. 33 (6), 2386–2393. https://doi.org/10.1111/inm.13405.
Warrender, D., Connell, C., Jones, E., Monteux, S., Colwell, L., Laker, C., Cromar-Hayes, M., 2024. Mental health deserves better: resisting the dilution of specialist pre-registration mental health nurse education in the United Kingdom. Int. J. Ment. Health Nurs. 33 (1), 202–212. https://doi.org/10.1111/inm.13236.
Wenger, E., 1998. Communities of Practice: Learning, Meaning, and Identity. Cambridge University Press.
Whaley, V., Hay, J., Knight, K.H., 2023. Preparing nurse educators for NMC standards for student supervision and assessment: the impact 4 years on. Br. J. Nurs. 32 (3), 130–135. https://doi.org/10.12968/bjon.2023.32.3.130.