In the middle

**Abstract**:

Professional identities are important in defining workers' roles, and are concerned with attributes relating to those roles and how they are performed. Evidence shows mental health nurses undertake many different roles as part of their work. Yet the roles of mental health nurses are insufficiently understood by healthcare staff, service users and nurses themselves. Mental health nursing work has been deemed invisible and lacking in role clarity. Poor understandings about professional identity of mental health nurses result in difficulties recruiting to the profession, nurses lacking confidence articulating the value of their work, with misunderstandings apparent with service users about the specific role of mental health nursing in their care. The primary focus of this study, conducted in Wales, United Kingdom, was to examine how talk about mental health nursing was handled by participants from multiple perspectives. Data consisted of 17 individual interview transcripts with mental health nurses and 13 interview transcripts from mental health service users, and 3 focus groups with nursing students. Participants' talk was analysed using thematic analysis. This paper reports how participants described mental health nursing work having significant role overlap with other multi-disciplinary team members. Participants highlighted that mental health nurses often have an 'in the middle' label because the complexity of their work can be hard to describe. The implications are pertinent for nurses because if they are considered to be in a liminal position, they risk being perceived as neither one role nor another, resulting in nurses struggling with professional identities and role confidence.

## Introduction

How people understand their work is important for themselves, and for communicating this knowledge to others. It also helps staff advance the relevance of their work and its place in the health system and wider society. According to a review by Trede, Macklin and Bridges (2011) professional identity development focuses mainly on self-identity, structure and agency, a community of practice, situated and experiential learning, reflective practice, critical pedagogy, and to a large extent grows and develops along the way. In the absence of understanding professional identity, a profession may struggle to recruit new members, develop a knowledge base and demonstrate efficacy. Professional identity is how the self is perceived in relation to a profession, and is created through a person's beliefs and attitudes, values, motives and experiences in professional life (Tsakissiris 2015).

Miller, Adams and Beck (1993) identified basic attributes of a profession as including educational preparation, research, competence, continuing education and autonomy, which distinguishes professionals from other workers. In recent years nursing has focused on expansion of the profession in rapidly changing healthcare environments (Dikmen, Karataş, Arslan & Ak 2016), mainly due to social, cultural, scientific, and technological changes. The global economic crisis in 2008 and beyond has had huge impacts on health sector funding and employment, with austerity measures affecting service provision and all professionals groups including nurses (Buchan, O'May & Dussault 2013). With greater scrutiny of staff and skill mix, nurses have been encouraged to advance their roles often by extending their skills range. Nursing workforce shortages are evident, and with tight fiscal circumstances policy makers need to understand what is happening with the dynamics of the health workforce in general,

and nursing in particular, as the most numerous, visible, and trusted clinical workforce group (Oliver 2019).

Mental health nursing roles are reported to be ambiguous by virtue of nurses' engagement in a wide variety of tasks (Jormfeldt et al., 2018; MacAteer et al., 2016; Rungapadiarchy, Madrill & Gough, 2006) which can lead to nurses lacking identity within healthcare teams, sometimes resulting in perceptions that they lack knowledge or feel powerless. According to McKeown and White (2015) mental health nursing's relationship to bio-psychiatry is reflected in the organization of services and challenges nurses report due to professional subordination. Beresford (2004) suggests mental health nursing has operated primarily in a medical context, and although nursing has developed multifaceted approaches to address socio-cultural, political and economic issues, the association with the medical model has dictated nurses' roles and identities to a large extent.

Literature highlights role overlap with other health and social care staff (Hannigan & Allen 2011) and changes to nursing roles over time (Dryden 2010; Hercelinskyj 2010), which can result in role confusion for mental health nurses (Deacon et al. 2006). Role overlap in multidisciplinary teams can result in workers realising that the majority of therapeutic work are up for grabs (Hannigan 2014), with social workers and psychologists undertaking tasks that may have been the remit of nursing in the past, such as care planning and practical help. Increases in multidisciplinary working and role flexibility can leave nurses contemplating the specific nature of their contributions, perhaps wondering if their role lies solely around administering medication. Despite supposed direction from regulators (Australian Nursing and Midwifery Accreditation Council, 2012; Nursing & Midwifery Council, 2018), role confusion,

role overlap and role change contribute to mental health nurses' struggle to articulate their work impacting on recruitment, job satisfaction and a strong mental health nursing professional identity.

Professional identities have been explored frequently because without clear understanding of who and how a person identifies (in terms of professional discipline), it is unsurprising that service users and other health workers lack awareness about professional roles (Gregory & Austin, 2019). Professional identity formation is recognised as a key issue for health professional education because the transformation from person to profession is an important part of professionalization and includes the establishment of core values, principles, self-awareness and self-regulation (Cruess, Cruess & Boudreau et al. 2015). The practice of identity work is not static but dynamic, and continues long after initial registration. Professional identities of mental health nurses have been explored and written about frequently (Oates et al. 2017), with the nature of mental health nursing stated as unique (Santangelo et al. 2018), but acknowledging an absence of specific professional identity (Cleary, Jackson & Hungerford 2014).

The profession of mental health nursing cannot be considered to have a uni-professional position. Historically until around the turn of the 21st century nurses were clear about nursing domains and nursing work. Hannigan and Allen (2011) noted in community mental health teams there is a high degree of occupational boundary blurring between nurses and social workers, with more generalist roles apparent. Hannigan (2014, p.406) reports 'there's a lot of tasks that can be done by any', and stresses the need for greater understanding of systems so longer term implications for occupational groups are recognised.

Mental health nurses can work in a wide variety of clinical (and other) settings and this may certainly influence the nature and perception of their role. Role differences may vary according to region and nation, which includes differences in education, preparation and employment of mental health nurses too. That said, the mental health field has been considered an 'unpopular choice' for nursing in Australia, New Zealand, the US, the UK and South Africa (Jansen & Venter, 2015), so mental health nursing has work to do to ensure people are educated about what the role entails, and to promote rewarding aspects. There is still a sense that mental health nursing involves invisible and subtle skills (Dryden, 2010; Michael, 1994) which are difficult to articulate.

In this study people training to be nurses, those already practicing as qualified nurses and people using services were asked to talk about the work of mental health nurses, and this paper specifically reports on data concerning roles and nursing work. The larger study on which this paper reports set out to analyse the talk about mental health nursing work in the context of a climate of supposed service user involvement (xxx & yyyy, 2019), with limited involvement reported and participants stating than nursing work was mainly task-focused at the exclusion of involving service users in collaborative care planning.

## Method

### *Design*

A qualitative approach was selected for this study, with thematic analysis to examine research interview data from nursing students in training, qualified nurses in practice and people who

have used mental health services. The six steps of Braun and Clarke (2006) were followed in order to analyse the data. In order to explore participants' talk and how they displayed their understandings on particular topics (Garfinkel, 1967), dialogue, pauses and how participants expressed talk were considered. Findings are reported in accordance with COREQ guidelines (Tong, Sainsbury & Craig 2007).

*Sampling and data collection*

Semi-structured research interviews were used with a purposive sample of n=17 mental health nurses, n = 13 mental health service users (with characteristics shown in Tables 1 and 2), and focus groups were held with three groups of mental health nursing students. A range of participants were sought including male and female participants, nurses with varying lengths of experience since qualifying and from a variety of mental healthcare settings. Qualified mental health nurses were recruited from former cohorts of students of one university in the UK. Service user participants were recruited via voluntary and charitable organisations. Nursing students from one university in the UK were invited to participate in focus groups across two campus sites as part of this study.

Mental health service users' accounts were historical, and inclusion criteria required they had encountered mental health nurses during their care in the past ten years. Participants were provided with a copy of the participant information sheet at the recruitment stage and invited to contact the researcher. Examples of semi-structured interview questions appear in Figure 1 and were developed by the author in response to early literature searching (xxx, 2018). All

research interviews were audio recorded and transcribed with participants' consent, with reassurance that confidentiality would be observed and anonymity maintained.

**Table 1: Mental health nurse participants – number of years qualified and type of work setting**

| MHNurse participant | Pseudonym | No. of years qualified | Length of interview | Current role/area |
|---|---|---|---|---|
| 1. | Mary | 18mths | 59mins | Acute inpatient |
| 2. | Ann | 11 | 1hr 3mins | Day centre |
| 3. | Josie | 3 | 1hr 8mins | Day centre |
| 4. | Jenny | 3 | 1hr 8mins | Rehab house |
| 5. | Pippa | 4 | 1hr 13mins | Community |
| 6. | Paula | 4 | 42mins | Community |
| 7. | Tina | 3 | 1hr 11mins | Acute inpatient |
| 8. | Denise | 2 | 1hr 14mins | Older people inpatient |
| 9. | Dora | 2 | 1hr 14mins | Community |
| 10. | Ben | 4 | 58mins | Community |
| 11. | Laura | 4 | 1hr 4mins | Nursing home |
| 12. | Lucy | 5 | 57mins | Rehab house |
| 13. | Sally | 4mths | 55mins | Forensic ward |
| 14. | Emma | 4 | 1hr 10mins | Forensic ward |
| 15. | Lorraine | 4mths | 1hr 14mins | Independent sector |
| 16. | Nicola | 4 | 1hr 2mins | Community |
| 17. | Angela | 4 | 1hr 5mins | Community |

In the middle

**Table 2: Mental health service user participants**

| Service user participant | Pseudonym | Recruited from: | Length of interview | Interview setting |
|---|---|---|---|---|
| 1. | James | Third sector group | 51mins | Participant's home |
| 2. | Judy | Third sector group | 1hr 36mins | Health board education centre |
| 3. | Brenda | Third sector group | 1hr 10mins | Participant's home |
| 4. | Gary | Third sector group | 26mins | Third sector |
| 5. | Emlyn | Third sector group | 56mins | Third sector |
| 6. | Jack | Third sector group | 40mins | Third sector |
| 7. | Steve | Third sector group | 16mins | Third sector |
| 8. | Amy | Third sector group | 1hr 14mins | Third sector |
| 9. | Sian | Third sector group | 1hr 29mins | University |
| 10. | Simon | Third sector group | 1hr 4mins | Third sector |
| 11. | Doreen | Third sector group | 34mins | Third sector |
| 12. | Sandra | Third sector group | 57mins | Third sector |
| 13. | Irene | Third sector group | 53mins | University |

Figure 1: Examples of semi-structured interview questions

| Examples of semi-structured interview question topics |
| --- |
| • being a mental health nurse (e.g. role, duties, responsibilities)<br>• becoming a mental health nurse (the journey to professional socialization)<br>• the process to becoming a qualified mental health nurse<br>• mental health nurses working in partnership with service users<br>• student nurses working in partnership with mental health service users<br>• mental health service users' perspectives of mental health nurses<br>• mental health service users' perspectives of mental health nurse education<br>• do/how do mental health nurses undertake service user involvement?<br>• Mental health service users' experiences of mental health nurses in a climate of increasing involvement |

*Data analysis*

Transcripts were read and re-read to gain familiarity with the data, and then were coded, with categories created from these codes. An initial list of early codes was developed into short descriptors which were discussed at regular intervals in supervision sessions (the study was the author's PhD). Codes were then grouped into categories of similar meanings and patterns sought and agreed in these data (further examples in xxx & yyyy 2019). Following data familiarisation, analysis of participants' accounts focussed on participants' talk about service user involvement in nursing processes to examine displays of understanding. Initial analysis of these data followed the approach suggested by Braun and Clarke (2006). Displays of

understanding are one way of seeing how individuals make sense of their experiences and show their awareness of these experiences to others (Garfinkel, 1967). People's talk is purposeful and intentional, and allows researchers an opportunity to examine talk about events produced for the purposes at hand. Through their talk people show how they produced and used understandings, in this case in relation to mental health nursing and mental health nursing work. Data analysis was informed by Orbuch's (1997) view of accounts, defined as story-like interpretations that help gain insight into human experiences within participants' social worlds. In examining participants' talk we can see how people show awareness of events, what they prioritise and how features of everyday speech such as pauses, stumblings and absences give clues to uncertainties and difficulties in retelling experiences. This approach enabled an examination of how participants interacted about the topic under study, and how they characterised the topics they talked about.

*Ethical considerations*

At the outset this study was approved by the University research ethics committee. All participants were given written and verbal information about the study. Participants were informed that participating in this study was voluntary and that they had the right to withdraw at any time. Each focus group began with the facilitator reading aloud focus group ground rules, which included maintaining the confidentiality of opinions expressed in discussions.

## Results

Thirty individual research interviews were conducted with service users (n=13) and nurses (n=17), and 3 focus groups were held with first and third year nursing students (n=18) 1st and

3rd years, amounting to 2022 minutes of audio-recorded data. As the study approach centred on individual talk, authentic mannerisms have been maintained to reflect the real world nature of participants' speech, which include hesitations and pauses. The following findings show how professional identities were accounted for by participants in their talk about mental health nurses and mental health nursing.

This paper focuses on findings concerning how nurses and service users accounted for mental health nurses' roles and how participants viewed an 'in the middle' position. The findings are reported below using category labels representing major patterns in these data:

- Nurses are co-ordinators of everybody else
- Nursing work is limited by co-ordination
- Bridging the gap
- Jack of all trades and master of none
- Being in the middle

*Nurses are co-ordinators of everybody else*

Nurse participants were asked about their expectations of nursing prior to starting pre-registration programs and how their nursing journeys had developed so far. The following extract is taken from a research interview with Laura, which lasted for 64 minutes. Laura had been qualified as a mental health nurse for 4 years at the time of the interview, and had misgivings about her future in mental health nursing. She said she had struggled with the nursing role in practice and others' perceptions of the role.

*Laura: I just get a sense nurses have been erm - had everything taken away from them. But they've been left with this position of erm…supposed professional status. But actually we can't do anything (laughs), because everything we do, we're just like a - a coordinator really of everybody else*

*Interviewer: Yes, yes*

*Laura: Occupational therapists, physiotherapists, doctors, social workers. They're the ones that have the kind of proper roles and it seems to me the nurse in the middle just kind of (3.0) coordinates it*

*I: Yes*

*Laura: Which is like an administration role.*

*I: Mmm*

*Laura: It's strange to me, to have gone through university for three years to be in that kind of position.*

[Laura, Mental health nurse 11]

Laura's account positions nurses as having limited power and standing, which she contrasts with other professionals. She advances the claim that nurses have been made powerless in some way. Laura minimises the role as little other than an administrator/co-ordinator function. Other professions are claimed to have "proper roles", and she implies nursing as subordinate with only "supposed professional status". When she argues "We can't do anything" she presents nursing as restricted and far from enabled. Although she does not expand her claim she suggests this position is something she found undesirable.

This "in the middle" position can also be found in the following data extract taken from a 65 minute interview with Angela, who worked in a community setting.

*Angela: I've had conversations with service users where they've said well you know she's just…you know my nurse, yes, she's someone who pops out once a month or I come into you know…the mental health team base to see her once a month. And she'll give me an injection or something, that's her job*

In the middle

*I: Yes, yes*

*Angela: But then other people I think see you as their kind of main port of call really*

*I: Yes, yes*

*Angela: In everything that's going on. I suppose that's about care co-ordination really, they see you as erm…you're the one in the middle trying to kind of fit all the other pieces of the jigsaw together with them. Erm, people have said I know that I can just give you a ring and you're at the end of the phone if I need anything.*

[Angela, Mental health nurse 17]

In Angela's account being "in the middle" could be framed neutrally. Seeing nurses as "trying to fit all the other pieces of the jigsaw together" could imply the work of co-ordinating care is challenging. The care coordination Angela is referring to means the organisation of care and treatment planning. In England and Wales systems to organise people's care in secondary mental health services have been evident since 1991 (Department of Health, 1990). Devolved health responsibilities has seen some divergence since so that in Wales a legislative framework, the Mental Health (Wales) Measure, has led to care and treatment plans (CTPs) and care co-ordination as a statutory requirement (Welsh Government, 2012). Registered mental health nurses are one of the stipulated professions who are allowed to act as a care co-ordinator. They are the largest professional group and so it is central to their role and responsibilities to work as care co-ordinators, and potentially provides an opportunity to positively influence care.

During Angela's interview she implies certain vagueness around nursing roles, which is visible in Angela's report that the nurse will give "an injection or something". Angela uses this account from someone else as one example of an extreme formulation and then counters this with another set to show that some service users have a broader view of what the nurse is for via her expression 'main port of call'. This is central to the idea of care co-ordination, that the role-holder is a go-to person with key responsibilities for a person's care. However, this role may

not always be viewed positively by nurses as they may have resistance to such responsibilities which is evidenced in the next data extract.

*Nursing work is limited by co-ordination*

Perceived inconsistencies about nursing roles may affect everyday understandings of what it is to be a mental health nurse. Uncertainties were apparent in the talk of mental health nurse participants in this study particularly when nurses spoke about care co-ordination. The extract below is from a research interview with a mental health nurse, Ben, who had been qualified for 4 years and was working as a Community Mental Health Nurse. Ben talked about concerns regarding role ambiguity in relation to his professional identity.

*Ben: Although you were the care co-ordinator in (local town) but here [in different town] you are- you are everything in a sense. Social workers will deliver medication, but we'll do housing*

*I: Right*

*Ben: There's no, "we refer to the social worker", because as care coordinators we do that. And I find…I find that limits our nursing role massively and I think this - the one thing I've said in one of my essays for my Masters is that this care coordinator role has had a massive impact on erm how we are as nurses in the community. You know, if we didn't have to do all these housings and referrals and everything like that then we'd be able to actually do the nursing with the patient which to be honest with you I rarely do.*

*I: Yes*

*Ben: You know I can assess and engage, I can do all that, but you know spending more than an hour with a patient is…is….hardly ever happens unless they're in crisis.*

[Ben, Mental health nurse 10]

Similar to Laura and Angela, Ben also reports a sense of the care co-ordinator role being an all-consuming part of the mental health nurses' professional identity and work. Ben's comment

"you are everything in a sense" implies a multi-faceted role. His implication was that in his current team the care co-ordinator role was comprehensive, and close to that envisaged by legislation and policy (Welsh Government, 2012). He is expressing a view that this is not what he believes he should be doing as a nurse. Ben presents this as a complaint; he suggests he is not doing nursing. However, he does not elaborate on this in the wider interview and say what this nursing is or how it differs from what he is doing. Policies around care co-ordination have been around for over thirty years, as guidance in England and Wales had designated that each service user in secondary mental health services must have a care co-ordinator. Ben draws a comparison between his previous place of employment and the current one, and there appears to be a difference in practices and fidelity to the policy between both sites and it is this he uses to argue his case.

Ben's account overall implies a sense of dissatisfaction with his nursing role. He says he could spend more time with patients and do nursing, but does not elaborate. He alludes to blurred roles in that he indicates there is a sharing of tasks between workers. Ben also says that he perceives differences in 'how we are as nurses in the community' which suggests a concern about professional identity but no further detail is provided as to why this might be. Ben's version is that care co-ordination "limits our nursing role massively", and admits that he rarely gets to 'do the nursing'. Ben does not suggest what 'the nursing' actually might be, but his talk implies it involves spending long periods of time with people, which he says rarely happens.

*Bridging the gap*

In the middle

Users of services also commented on the co-ordination work that nurses undertake. Sian, had one admission to an adult inpatient unit followed by visits from a community mental health nurse (CMHN), and reported her experiences of mental health nursing roles.

*Sian: Obviously I know there's a difference between psychologists and psychiatrists, and psychiatrists are the medication people and the psychologists are the…the talking people erm but again I'm on a waiting list for that.*

*I: Yes, yes. So, I have to ask this. So what are the nurses?*

*Sian: Well, they have to bridge the gap, don't they, between the two. They have to make sure that your medication is - And, as I say, it was like the situation where…you know with the sleeping tablets [mentioned earlier in interview]. It was that sort of saying, well, what can we do to help you in that situation. Erm, but also being there to listen, and you know erm almost talking therapy really, isn't it?*

[Sian, Service user 9]

Sian shared her views on some of the roles of different members of the multidisciplinary team and presented two categories; 'medication people' (psychiatrists) and 'talking people' (psychologists). She saw nurses as having to "bridge the gap". Sian's use of categories here are inference rich, can be readily understood, and function as shorthand for background expectancies of what everyone can understand about people who fit those categories. The term 'bridge the gap' portrays nurses in a kind of 'in-between' role. For example, in the UK the Francis inquiry into poor care at the Mid-Staffordshire NHS trust stressed that the "nurses are the glue that keeps together delivery of the service to patients" (Francis, 2013). Albeit the nurses referred to in the report are general nurses, the word glue perhaps implies an in-between or in the middle type role that is essential for the whole system to function.

In her wider account Sian highlights nursing roles are about "making sure", "helping" and "listening". However, Sian is clear that nurses only offer "almost talking therapy" which is

distinct from the real thing. Evidence-based talking therapies have been promoted as a cost effective treatment for mental health problems (Wiles et al. 2016), and Sian's reference to her own talking therapy prioritises the aspect uppermost in her mind which is the wait for treatment. In the wider interview Sian spoke about how much she valued the therapeutic relationship with her CMHN, and that it was the reason she had volunteered to participate in the research interview, knowing the study was about nursing. However there was a sense from participants' talk that people saw mental health nurses' competence differently to that of other professionals, which is apparent in the next extract below.

*Jack of all trades and master of none*

Talk from participants about 'being in the middle' and bridging the gap indicates that speakers saw mental health nurses as requiring the skills to be many things to many people. This notion appeared in mental health nurse participant accounts and at times was labelled with the expression 'Jack of all trades and master of none'. This expression is centuries old and refers to membership of trade guilds which was a defining factor in obtaining employment as a skilled craftsperson. The phrase 'Jack of all trades' has been used in relation to the mental health nursing profession because duties of the role have been considered increasingly varied and diverse (Deacon, 2004; McCrae, Askey-Jones & Laker, 2014). The term can signify that mental health nursing work encapsulates a range of skills and is a multi-faceted role, or conversely is considered an occupation requiring multiple skills at a purely superficial level. The following data extract is taken from a 70 minute research interview with a mental health nurse participant who worked in a forensic inpatient setting, and had been a qualified nurse for 4½ years. Emma talked about how she saw her nursing role.

*Emma: I think you are that Jack of all trades, master of none in some respects, or you become very exceptional in the area of which you work. I mean I…I've worked here for 4½ years; if I had to go over to EMI [elderly mentally ill] to work tomorrow I'd probably be less than useless. 'Cos I think even though we're registered mental health nurses I think you special - specialise within the area of which you work really, that's where your expertise comes.*

[Emma, Mental health nurse participant 14]

Emma's initial use of the idiom "Jack of all Trades" did the work of emphasising the multiplicity of professional identities that mental health nurses are perceived as having. The 'Jack of all Trades' expression may be a notion that individuals take pride in a sense of flexibility in their work roles, with adaptability seen as a form of mastery. Emma highlights benefits to the mental health nurse by focusing on the needs of a specific patient population group, and stresses it is how expertise develops and moves away from a "Jack of all Trades" dichotomy. Emma's suggestion may be an example as to why mental health nurses wish to avoid a multiplicity of roles where they may be accused of lacking specific skills and knowledge.

Another mental health nurse participant, Angela (mentioned earlier in this paper) also used the 'Jack of all trades' term.

*Angela: I agree that erm you need to be in some level a specialist in what you do, rather than a Jack of all trades. Erm, you know, I'm not saying that we should do absolutely everything. I'm not an occupational therapist, you know they've got skills and knowledge that I certainly don't have. Erm, I'm not a psychologist or whatever. Erm, but a lot of it I think, well, why can't we do that, if it's part of our role? If it's going to improve services or improve me as a nurse or improve outcomes for the people that I'm working with, then you know why can't we do that? Just because we've always done it that way doesn't mean to say we've got to carry on doing it.*

[Angela, Mental health nurse 17]

In the middle

Angela gives the notion of a mental health nurse being a ‘Jack of all trades’ short shrift and instead she seemed to indicate she would like to diversify in order to help service users. Angela was clearly stating here that being “in some level a specialist” is preferable to the ‘Jack of all trades’ concept. Conversely the ‘Jack of all trades’ metaphor could at times subsume a sort of Magpie identity, where the sophisticated mental health nurse legitimately 'steals' aspects of other specialist roles. Angela’s resistance to the ‘Jack of all trades’ term was shown in the way she moved swiftly on to use the idea of specialism, and put forward the moral case in terms of improving services. The diversification that Angela suggested would include skills not typically considered to be part of the mental health nursing role. I suggest Angela’s resistance to the term ‘Jack of all trades’ indicated her agency in choosing to pursue specialist roles over generalist routes. Both Emma and Angela’s accounts suggest that a more specialist role for nurses is preferable to ‘in the middle’ type work, but this could be indicative of their level of experience as being qualified for over four years one could expect them to be taking more senior and specialist roles.

*Being in the middle*

The following extract shows evidence of participant talk about being ‘in the middle’, and is taken from an interview with Laura, a mental health nurse participant (whose data appears earlier in this paper).

*Laura: You're kind of in the middle of everything. So you're constantly…sort…It’s like a computer, you're constantly being fed and given information. It’s like constant data entry in your head (laughs) and you have to do something with all that information, and you're constantly trying to remember things. Because you're not sat at a desk with a phone and an email, you're constantly having to remember stuff to write it down, to ring somebody*

*I: Yes*

*Laura: You know, you know what it's like. And you're kind of treated…I just get a feeling that perhaps in my experience I'm treated like…(sighs) a bit of a skivvy to be honest (laughs).*

*I: Mmm. What's that about?*

*Laura: Lack of respect I think for the role, certainly by families*

[Laura, Mental health nurse 11]

Laura highlighted the 'in the middle' position with nurses seen as being at the hub of all activity, which suggests similarity with the co-ordinator role that nurses have. At the start of this extract from Laura the nurse can be viewed as having a key role and central to the workings of the care environment. She stresses that the interactive nature of nursing work is constant, and that the nurse is required to act on all types of information given implying a sense of accountability that rests on nurses' shoulders. However, having stressed the key role of nurses in the care setting, Laura then voices how she feels treated like "a bit of a skivvy" and sighs to emphasize the strength of her feelings. Laura's reply indicates it is a lack of respect for roles that has led to poor attitudes towards nurses, which brings into question the public's understanding about what nurses do and reinforces their unenviable position.

**Discussion**

There are a range of individuals and groups who have a stake in what mental health nursing is held to be and how it is viewed, which is why a range of perspectives were sought in this study. Participants in this study highlighted in their talk that mental health nurses occupy an 'in the middle' type role. Frustrations have been voiced previously that nurses have not succeeded in clearly 'articulating what their profession adds to the care and treatment' of mental health

service users (Koekkoek, van Meijel, Schene & Hutschemaekers, 2009, p.822), nor have they necessarily achieved role recognition (White & Kudless, 2008).

It has been argued that only medicine is a true profession (Flexner, 1915; Woodbridge-Dodd, 2017). According to Witz (1992), medical men used gendered exclusionary strategies to maintain a male monopoly of registered medical practice, resulting in areas such as nursing, radiography and physiotherapy being seen as only semi-professional. Mental health nursing, like social work, has been considered invisible, with suggestions that it is completed in isolation with ambiguous outcomes (Dryden 2010; Morriss, 2014). If work is considered ambiguous and nurses seen solely in a co-ordinator type role, the profession could run the risk of being replaced with administrators, unless this is work requiring skilled interpersonal interactions. Nurse participants in my study held negative views about these roles. An alternative position is that coordinating work is very important, and demands effort by interpersonally skilled practitioners. According to Hannigan, Simpson, Coffey, Barlow and Jones (2018) co-ordinating care is linked to system complexity, and nurses might do well to embrace this key role openly, recognising the skills and knowledge it requires.

Mental health nurse participants in this study reported frustrations regarding restricted time they have with service users, and reduced opportunities to engage in evidence based psychosocial interventions. Simpson (2004) coined the term ‘limited nursing’, which refers to CMHNs being unsatisfied that when they act as care co-ordinators and administrators they report feeling at risk of becoming non-therapeutic and are no longer doing nursing. Whilst airing frustrations about limited time for nursing, participants in my study did not venture specifically what nursing might look like, which supports the notion that articulating the role

is difficult. Rationale for limited time appeared to relate to blurring of roles in multi-disciplinary teams. I argue that if mental health nurses continue to have difficultly articulating the specifics of what they do in practice the profession will continue to be misunderstood, difficult to recruit to, and risk misinterpretation by regulators and others who may use this for their own advantage.

Participants in this study had background expectancies about mental health nursing work. Hercelinskyj (2010) suggests that nurses often internalize new role expectations or re-shape their role to fit with their sense of professional identity, which implies acceptance of changes that were not foreseen. Nurses' perceptions of their roles may be subject to influence by a number of factors, such as government policies, service user needs, and regulators' requests (Brookes, Davidson, Daly & Halcomb, 2007). In addition nurses may be influenced by their own experiences of being a nurse and how these fit with their role expectations. If nurses have particular expectations of their roles, but find experiences to the contrary, this could challenge previously held views and certainties. Background expectancies and perceptions may therefore be fulfilled or unfulfilled, and this may impact on nurses as they carry out their work, and engage with service users.

According to Dryden (2010, p.6) nurses can perceive other multi-disciplinary team members as "taking all the 'clean' and 'tidy' work that can be neatly categorised" into their specialist protocols. The untidy work that remains, Dryden suggests, can refer to service users who have complex issues that cannot easily be pigeon-holed who are often referred to the nurses. Teams that function is this way have led to role ambiguity for mental health nurses, and were echoed in participants' talk in my study. Role ambiguity is reported to be a perceived lack of job-

related information concerning expectations and goals (Tarrant & Sabo, 2010), and can be detrimental causing burnout and dissatisfaction with workload (Konstantinou et al., 2018). As confusion around mental health nursing's main focus has been reported by participants as ambiguous, there are concerns that the role is akin to being solely administrative or managerial in nature. Peplau (1952) recognised a managerial role in mental health nurses, however reports suggest that managerial work has a negative impact on therapeutic work and contributes to the physical distancing from patients (Foster, 2000; Rungapadiarchy et al., 2006), which was voiced by both nurse and service user participants in this study. Implications that nurses exist to 'bridge the gap' between other workers bears reference to unrecognised and uncategorised work, that whilst is important, but no other profession wants to undertake.

Crawford et al. (2008) highlight a point of tension between mental health nurses assuming the identity of a 'Jack of all trades' and the need to accomplish a clear professional identity. The term 'Jack of all trades' has been used by mental health nurses themselves about their professional identity in studies in Australia (Cleary, 2004), New Zealand (Bishop & Ford-Bruins, 2003) and the United Kingdom (Crawford et al., 2008; Skidmore, Warne & Stark, 2004). The maxim 'Jack of all trades and Master of none' has been considered to reflect the low status with which mental health nursing has sometimes been viewed (McCabe, 2000). Hurley (2009) suggests the term generic specialist is more apt in terms of a role label as it highlights a multi-skilled approach with specialist knowledge. The 'Jack of all Trades' expression has been compared to a handyman identity, in terms of someone fixing something uncomplicated (Hurley, 2009). Whilst flexibility in a role can be seen as desirable (Crawford et al., 2008), others have noted the pejorative language in such metaphors, including 'general dogsbody' (Cleary, 2004). In my findings, participant Emma's use of the phrase highlighted she saw mental health nurses as doing so many roles; they may not be viewed as having

specialist skills. Nurses have been considered by other professional groups to be skilled generalists, with limited specialist skills (Sheppard, 1991), with a focus on collecting information and performing a range of co-ordinating and administrative tasks (Gijbels, 1995; Nolan, 1993), suggesting limited scope for specialist knowledge and application. Oliver (2016) claims generalist roles are no less expert, and 'expert generalists' have a lot of specialist knowledge and skills that overlap, deemed useful as patients often present with a number of co-morbidities. It may be that the 'Jack of all Trades' term, or the use of the word generalist, signify a wider anxiety from health professionals about roles and the place of nursing in modern healthcare. If nurses' therapeutic skills are considered limited one may ask about the focus of nursing work, with a need to identify factors that limit scope to provide helpful and effective care and treatment. Given complaints that mental health nursing can be invisible, limited to co-ordinating others and about bridging gaps; it is unsurprising that professional identities involved in mental health nursing work are often misunderstood. Countries that have withdrawn mental health nursing specific education, have found students on general nursing programmes have only limited exposure to mental health placements. McCabe (2000) suggests a body of mental health nursing knowledge is becoming harder to identify, one reason being nurses are not afforded such placement experiences.

Like Hughes, Abbott implicates social, economic and technological changes as potential sources of system disturbance. System change can encompass the disappearance of some areas of work and the emergence of others, and a waxing and a waning in the fortunes of different groups. Abbott also emphasises the importance of interprofessional competition. Externally-driven changes in systems, for example, can present as opportunities for occupational groups to seize control of existing or emergent areas of work. For Abbott, what makes professions distinct in this context is their appeal to the possession of abstract knowledge, which is used to

advance occupational status claims. Abstract knowledge, Abbott argues, is not an absolute but a relative concept; what matters to a profession's survival is 'abstraction effective enough to compete in a particular historical and social context' (Abbott, 1988, p9). According to Hannigan and Allen (2006) dynamic systems jurisdictions are liable to change, in response to both internal and external forces, and with jurisdictions constantly in flux, and the fact that (over time) knowledge and control of work move between professions this tends to undermine these type of essentialist assertions around roles.

Nurses can be said to have an 'in the middle' position, which can viewed as a strength or a position of vulnerability. Being in the middle can imply flexibility, but is usually considered to be limiting. Nurses have been described as occupying a liminal space, with studies referring to the transition of nursing students into qualified nurses (Allan et al., 2015) or those in nurse practitioner type roles (Brown & Olshansky, 1997). Historically the concept of liminality, first described by Van Gennep (1909) then Turner (1959), refers to the intermediate state in which individuals are neither here nor there and are betwixt and between positions ordered by law, custom and convention. For example, Simpson, Oster and Muir-Cochrane (2018: p.668) report peer support workers to have a liminal occupational identity as their roles are nuanced and complex, and whilst they are not fully staff, neither are they fully in a lived experience role either, and are described as 'in the middle somewhere'. I argue that the same 'in the middle' label can be applied to mental health nurses because the complexity of their work can deem their professional identities as hard to describe, meaning they lack role clarity. Mental health nurses can be said to occupy a professional liminal space, with talk from participants in this study about nurses being 'in the middle'. Liminality research in the occupational context highlights the negative consequences associated with being in a permanent state of liminality (Beech, 2011). In its application to organizational contexts liminality is commonly understood

as ‘a position of ambiguity and uncertainty’ (Beech 2011; p. 287). Traditionally professionals seek to protect jurisdictional boundaries they see belonging to their role and demarcate spheres of practice with regard to other groups (Abbott 1988; Evetts 2013). Instead of mental health nurses bemoaning their plight about limited nursing, it is time for us to clearly define our roles and articulate them, so others fully recognise our contribution and understand that being in the middle can be a vital and essential role in mental health care.

## Conclusion

The findings from this study suggest that role blurring and a focus on administration and co-ordination duties have contributed to mental health nurses experiencing role ambiguity and a lack of focus on nursing work. As population needs change and policymakers’ and regulators’ requirements shift, it is imperative that nurses are able to clearly articulate the work in which they are engaged. If nursing work does predominantly include co-ordination, and ‘tasks that can be done by any’ (Hannigan, 2014), nurses need to be aware of their specific contributions to collaborative working, and take greater ownership of their required knowledge and skills. Owning and articulating mental health nursing work will impact positively on nurses’ confidence and professional identities.

## Study limitations

This study was carried out within one region of the UK, which may reflect bias in terms of culture and local context. However, previous studies about mental health nursing roles (Crawford et al., 2008; Stenhouse, 2009) have reported findings that resonate with this study in terms of nursing time with service users being limited and roles reported as unclear. Talk

produced for the purposes of research interviews is just that, and whilst interactional, cannot be considered as naturally occurring conversation which again may impact on the accounts provided.

## Relevance for practice and education

Talk from nurses, nursing students and service users about mental health nursing lacking clarity regarding specifics of professional identities and contributions to patient care. Implications are that the nursing roles focuses on co-ordinating care overall, with nursing input being limited, and that nurses lack the ability to fully articulate their nursing work. Educating nurses and nursing students to better communicate their professional roles and contributions to service users' care will go some way in de-mystifying nursing work and raise awareness about the influence and impact that nurses have. Students need exposure to notions about practice pressures, policy directives, and competing versions of how to be a mental health nurse. Educators and practice staff can draw attention to these for students, as they learn how to balance requirements placed on them.

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