





REVIEW ARTICLE

Utilizing the mental health nursing workforce: A scoping review of mental health nursing clinical roles and identities

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ABSTRACT: *Despite rising international needs for mental health practitioners, the mental health nursing workforce is underutilized. This is in part due to limited understandings of their roles, identities, and capabilities. This paper aimed to collate and synthesize published research on the clinical roles of mental health nurses in order to systematically clarify their professional identity and potential. We searched for eligible studies, published between 2001 and 2021, in five electronic databases. Abstracts of retrieved studies were independently screened against exclusion and inclusion criteria (primarily that studies reported on the outcomes associated with mental health nursing roles). Decisions of whether to include studies were through researcher consensus guided by the criteria. The search yielded 324 records, of which 47 were included. Retained papers primarily focused on three themes related to mental health nursing clinical roles and capabilities. Technical roles included those associated with psychotherapy, consumer safety, and diagnosis. Non-technical roles and capabilities were also described. These included emotional intelligence, advanced communication, and reduction of power differentials. Thirdly, the retained papers reported the generative contexts that influenced clinical roles. These included prolonged proximity with consumers with tensions between therapeutic and custodial roles. The results of this scoping review suggest the mental health nurses (MHNs) have a wide scope of technical skills which they employ in clinical practice. These roles are informed by a distinctive cluster of non-technical capabilities to promote the well-being of service users. They are an adaptable and underutilized component of the mental health workforce in a context of escalating unmet needs for expert mental health care.*

KEY WORDS: *mental health nursing roles, mental health nurse identity, scoping review.*

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INTRODUCTION

Mental health services in Western countries were struggling to meet the needs of their populations prior to the COVID-19 pandemic (Triliva *et al.* 2020). Deteriorating mental health outcomes have been occurring despite increasing expenditure in many of these countries (McCartan *et al.* 2021). Suicide rates, particularly for youth, have continued to increase despite focused attention on this issue (Glenn *et al.* 2020), and rates of depressive disorders, anxiety disorders, and adjustment disorders are also rising in developed countries (World Health Organisation 2017). Given the poor physical health status and pre-mature mortality of those with mental health problems (Happell *et al.* 2019), the negative impacts on well-being are significant. One key driver for this deterioration in the mental health of the population has been shortages of, and poor access to, specialist mental health clinicians (Delaney 2017).

BACKGROUND: SCOPE OF THE CHALLENGES

There is a high prevalence of mental health conditions across the general population, with youth particularly impacted (McGorry 2021). Further deterioration and heightened complexity of these problems can be expected if mental health service delivery is not improved in a timely manner. It has been widely recognized that the current mental health workforce is insufficient both in numbers and capability preparedness to address the needs of populations, particularly those with moderate to severe conditions (Delaney 2017; Productivity Commission 2020). Attracting health and social care professionals into mental health practice over other more profitable and less stigmatizing work options has been a long-standing challenge (Brenner *et al.* 2017). Historically, mental health nurses (MHNs) and other professionals have been practising within specific and arguably restrictive scopes of practice structured around health service need, rather than the holistic needs of service users. This already finite workforce consequently has a constrained scope of therapeutic practice, necessitating multiple and often ineffectual contacts with service users over extended periods of time (Productivity Commission 2020).

The global pandemic has exacerbated these structural weaknesses of mental health services whilst simultaneously increasing the acuity, complexity, and volume of service user need (Pierce *et al.* 2020). In

the search for strategies remedies to address these challenges numerous programmes and funding initiatives have been launched. Interestingly very few, if any, have recognized the psychotherapeutic potential of MHNs or collaboratively involved them as part of the solution. In Australia, the Federal Government increased access to psychologist services (Australian Medical Association 2020), despite recent reviews suggesting that the impact of this service has been minimal with benefits largely confined to urban centres for those who can pay top up fees (Productivity Commission 2020). In the United Kingdom, the National Health Service Mental Health Implementation Plan 2019/2020–2023/2024 excludes MHNs from clinical areas involving psychological therapies and psychotherapy (NHS England 2019). In Europe, the *European Commission Horizon 2020 Project* also excludes any role MHNs may have in contributing to mental health responses to COVID-19 (European Commission, ND). The rationale for excluding MHNs from treatment programmes, despite their scope of practice being well matched to meet the needs of the population, are unstated. However, in the context of multiple previous exclusions, it is probable that this reflects a shallow construction of the professional identity of the MHN and what clinical roles they might contribute (Molloy *et al.* 2016). Identity refers to key defining characteristics of an individual or group and is constructed internally by the individual or group, as well as being socially constructed (Eisenberg 2001; Giddens 1997). Where such external identity descriptions, explanations, and/or representations are finite and unrepresentative so too is the attributed worth and value of the performance roles of that identity (Gergen 1999). This is a barrier to MHNs to being fully utilized to ameliorate, prevent, and otherwise respond to the unmet mental health needs of the community.

Clarification of the role and identity of the MHN

Historically the clinical roles and identity of MHNs have been poorly understood and articulated (Peplau 1997). There is no undisputed definition of mental health nursing (Barker & Buchanan-Barker 2011) outside of the pragmatic position of holding a named specialist qualification in it (Australian College of Mental Health Nursing 2010). Having roots in the asylum model of care, MHN roles are often seen as primarily custodial, basic, and under their practice

under the direction of medicine (Wand *et al.* 2021). Despite the move to community models of mental health service provision some 40 years ago, the bulk of MHN workforce remains confined to in-patient settings (Australian Institute of Health & Welfare 2021). This perpetuates asylum-based perceptions of MHN roles and narrow constructions of the identity of the MHN. Constructing a counter narrative about MHN roles and hence identities is challenging. Much of the work of MHNs is undertaken out of public view, and the limited media attention it attracts is often negative (ABC News 2014; Tonso *et al.* 2016). The roles and identity of the MHN are difficult to reduce to a comprehensible essence due to the sheer diversity of roles being undertaken that encompasses settings from primary through to tertiary care. Internationally, the undergraduate preparation of MHNs has been found to be largely inadequate to commence specialty practice (Hunter *et al.* 2015) and mental health content in comprehensive nursing programmes is particularly weak (Happell & Gaskin, 2013), eroding the specialist identity of mental health nursing. This is then exacerbated with underprepared comprehensive graduates utilizing the title of MHN when working in mental health settings.

To date there has not been a comprehensive scoping of the evidence literature on the clinical practice roles of MHNs, as reported from the perspectives of MHNs. Such a scoping offers opportunity for enhanced understandings of the full scope of clinical practice of MHNs and hence, their identity. This can highlight the unutilized clinical worth of MHNs and better position them as an important strategic solution systemic challenges facing services and hence service users.

METHODS

As evident from our preceding critical discussions, there is a need for conceptual clarification and enhanced defining of mental health nursing clinical roles and hence identity. Scoping reviews are typically deployed to achieve these ends (Tricco *et al.* 2018a). Typically, a scoping review will seek a wide breadth of literature making a systemic critical appraisal of findings very difficult to undertake (Peters *et al.* 2015). In many cases a scoping review will also thematically analyse this breadth of literature in response to a wider objective for the review and a more specific research question (Pollock *et al.* 2021). Additionally, scoping reviews are used to collate the contexts of phenomena, in this case the contexts influencing mental health

nursing in clinical practice settings (Pollock *et al.* 2021; Tricco *et al.* 2018b).

Aim

The aim of this review is to collate and synthesize peer-reviewed published data on what clinical roles and identities have MHNs been undertaking for the past two decades, from the perspectives of MHNs. This time period was chosen to ensure cotemporary relevance of those clinical roles to inform current and future utilization of MHN's therapeutic potential. The perspectives of MHNs were sought as they are the most central stakeholder to their roles and the holders of their professional identity. Additionally, a collation of peer-reviewed published data on their roles has not yet been undertaken. The purpose of systematically clarifying these clinical roles and hence professional identities is to contribute to the evidence base that would support this greater utilization of MHNs for service user's benefit. The review was guided by the following research question: what clinical roles and identities have MHNs been undertaking, from the perspectives of MHNs?

Design

Following the updated scoping review guidance of Pollock *et al.* (2021), this review used the JBI ScR framework and the PRISMA-ScR extension. Additionally, the design utilized the recommended 'PCC' format: *Population, Concept, and Context* (Peters *et al.* 2020).

-*Population* – Registered MHNs

-*Concept* – The clinical practice roles of MHNs construct the professional identity of the discipline

-*Context* – All MHN clinical practice settings.

The full protocol is outlined in Table 1:

Process

An initial email discussion was held with a university librarian and informatic expert in February 2021 to outline the research topic, aim, and research question, as well as suggested key terms. The university librarian ran multiple searches prior to a direct meeting with one of the researchers to further refine search terms and to select databases. Multiple searches were then undertaken using combinations of selected keywords over a range of databases in order to establish the most

TABLE 1 Protocol

	Inclusion criteria	Exclusion criteria
Time period	2001–2021	Pre-2001
Setting	All clinical health care settings, such as acute care, primary care, long-term care.	Non-clinical health care settings such as academic and educational settings.
Type of study design/ references	All peer-reviewed studies reporting data, i.e. Empirical studies: quantitative, qualitative; mixed methods, case reports; observations or reviews with thematic data.	Any peer-reviewed literature not reporting data such as editorials, letters to the editor, descriptive studies, opinion studies, commentaries, quality improvement projects, discussions, and any other papers including reviews not reporting data.
Participants	Registered Mental Health Nurses, Registered Psychiatric Nurses.	Enrolled Mental Health Nurses, Registered Nurses, nurses, physicians, other non-mental health nursing allied health care professionals.
Reported outcomes	Registered Mental Health Nurses roles in clinical practice settings, Registered Mental Health Nurses reporting findings on their clinical roles; Registered Mental Health Nurses reporting findings on their professional identity; Service users reporting findings on the therapeutic actions of Registered Mental Health Nurses; Other mental health disciplines reporting findings on the clinical roles of Registered Mental Health Nurses.	Non-clinical practice-based Mental Health Nurses activities.
Language	English	Translating papers into English was beyond the available resources for this study.
Databases	CINAHL, MEDLINE, PsycINFO, PubMed and Cochrane	Other databases.
Key words	Peer-reviewed papers from 2001–2021. Mental Health Nurse, Psychiatric Nurse, roles, clinical roles, identity	Non-practice or clinical-based roles.
Additional search terms, with which the central search terms were combined.	“Mental Health Nurs*” or “Psychiatric Nurs*” AND “clinical roles” or roles AND identity	

efficient collection of papers eligible within the protocol outlined in Table 1. All researchers then met to review this process and to confirm agreement with the use of database and search terms. The main second search was then undertaken on March 8th, 2021. Following this search and subsequent screening two researchers independently reviewed those papers excluded and those papers included from the reference list search of all retained papers and reached 75% agreement on those retained. The search strategy and yield are presented in Figure 1.

Study characteristics

There were 47 papers that reported the roles of the MHN within clinical settings. Most studies were undertaken in the Australia ($n = 17$) then EU countries ($n = 11$) and the United Kingdom ($n = 10$) followed by New Zealand ($n = 3$) and the United States of America ($n = 3$), as well as multinational settings ($n = 3$). The remaining papers were from a single country. The majority of the papers adopted qualitative methods. Of these, poorly defined qualitative methods were used in

($n = 13$), focus groups ($n = 7$), phenomenology ($n = 6$), survey ($n = 5$), ethnography ($n = 4$), grounded theory ($n = 4$), mixed survey and interview ($n = 2$), observational studies ($n = 2$), Delphi ($n = 2$), and other ($n = 2$).

RESULTS

See Table 2.

DISCUSSION

Data from scoping reviews can be structured into themes (Pollock *et al.* 2021). The following represents a narrative account of this body of research with respect to the broad content themes evident from a reading of the 47 included studies. The use of the terms ‘technical and non-technical’ offers contestability where such roles, identity, and capability merge. Other descriptors such as curative and supportive were considered along with soft skills such as inter-personal or social competencies and hard skills such as Intelligence

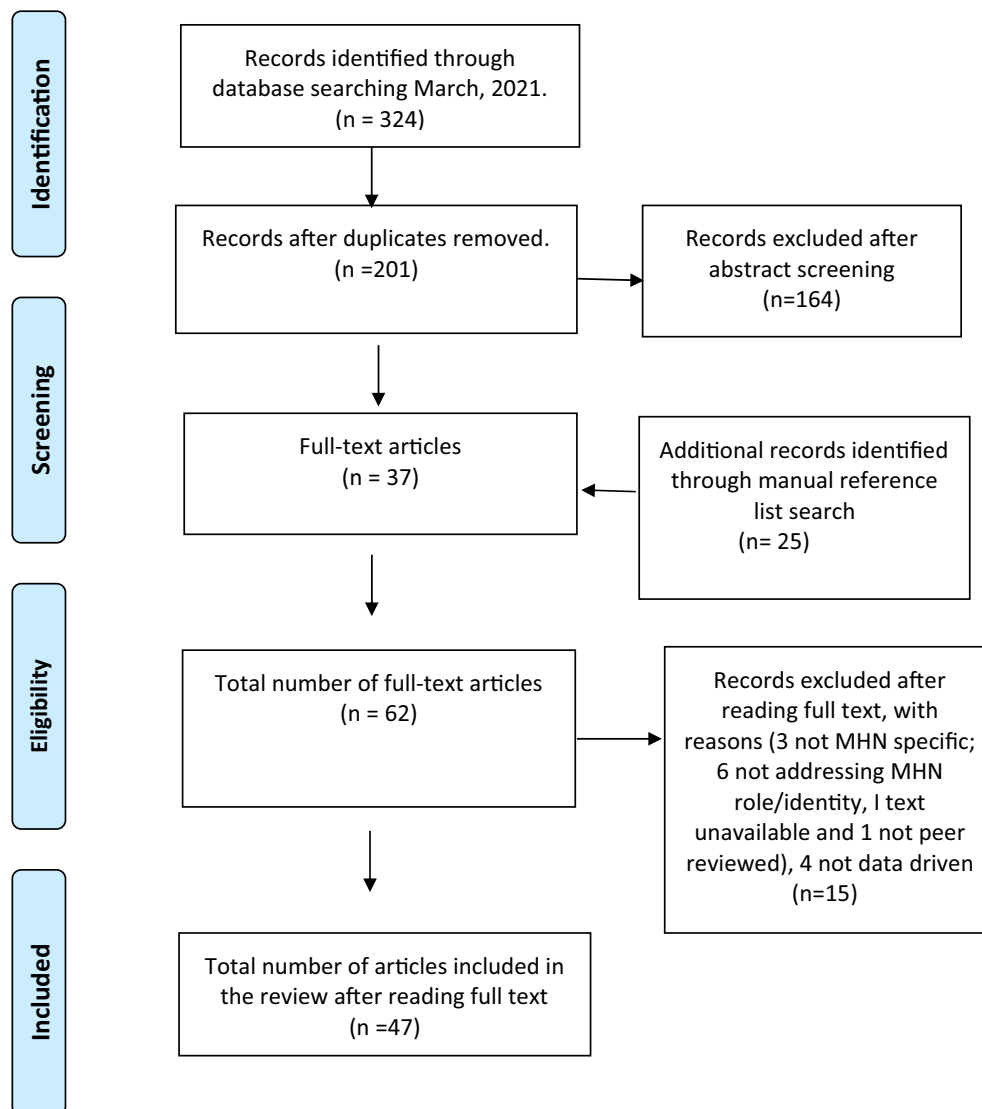


FIG. 1 PRISMA 2009 flow diagram.

Quotient. However, the terms technical and non-technical are reflective of the Organisation for Economic Co-operation and Development's (OECD) (2021) structuring of capabilities to enable work roles and were hence used. Non-technical capabilities are clustered around those of social and emotional capabilities such as communication, team-work, and situation-awareness skills.

Technical MHN roles

The acute unit-based observational study by Fourie *et al.* (2005) identified that maintaining consumer

safety was a central role of MHNs within acute in-patient settings. These assertions were also made in other studies (Debyser *et al.* 2018; Hamilton & Manias 2007; Hurley & Lakeman 2021; Seed *et al.* 2010). The reported role capabilities of the MHN to reduce aggression and promote safety included preventative assessment through observations, consumer engagement, and medication management, as well as promoting the use of emotional regulation skills with service users.

Providing psychoeducation especially regarding symptoms, symptom management, and medication use with service users and others in their social and

TABLE 2 *Scoping review results*

Author, year, country	Aim	Study design	Sample	Main findings on MHN roles and identities
Akerjordet <i>et al.</i> (2004). Norway	To explore MHN's experiences of using emotional intelligence in their clinical roles.	Hermeneutic phenomenology using semi structured interviews for data collection and thematic analysis.	7 MHNs with >5 years' experience (M = 23 years) mental health care. All female, ages 37–58 years (M = 48 years). All from a single in-patient setting.	It was concluded that emotional intelligence drives the MHN to deepen their understandings of their mental health nursing identity. Emotional learning and maturation processes are central to MHN role competence and identity. In addition, MHN clinical practice roles include the enactment of the moral character of the mental health nurse.
Neela <i>et al.</i> (2007). Ireland	To better understand how MHNs talk about psychological concepts and techniques.	Focus group data collection and thematic analysis.	59 MHNs across in-patient and community mental health settings.	Psychological domains of practice were found to be central to MHN clinical roles. Psychological techniques were used to support assessment roles and to give therapeutic interventions using both named therapies and less formal cognitive, behavioural, and counselling approaches. MHNs positioned themselves as undertaking psychosocial rather than medical roles. Time spent with consumers make MHNs their most central psychological resource. MHNs attributed low confidence in their expertise in these roles.
Carlyle <i>et al.</i> (2011). New Zealand	To identify the conceptual models that underpin mental health nursing roles in clinical settings.	Questionnaires and content analysis within a mixed method design.	48 MHNs across in-patient and community practice sites.	A key finding of the study was that MHNs applied multiple explanatory conceptual models in their roles. The MHNs employed psychodynamic frameworks to explain symptoms and illness yet undertook interventions informed primarily by a bio-medical model, such as monitoring symptoms and response to medication. This generates role and identity tensions. However, community-based and post graduate trained MHNs were more likely to engage in and value interpersonal clinical roles rather than medical-model

(Continued)

TABLE 2 (Continued)

Author, year, country	Aim	Study design	Sample	Main findings on MHN roles and identities
Cleary (2003). Australia	To understand how mental health nurses interpret their practice in an acute inpatient psychiatric unit.	An ethnography study by participator-as-observer + discussion groups + 10 face-to-face interviews with content and thematic analysis.	10 MHNs in observation and interview phase at a single acute in-patient unit.	informed roles compared to those in in-patient settings. MHN roles were within four themes (delivery of nursing care; relationships power and control; overwork; and professional attitudes and support). All nurses believed care co-ordination was part of their special contribution; documentation, patient safety, communication, working with other disciplines, psycho education, advocacy, and social interventions were undertaken to achieve patient stabilization. Increasing workload demands challenged offering best care. Workplace culture included unpredictability. Findings showed that organizational and administrative pressures that were outside of their ability to influence were a key barrier to MHNs meeting their own professional expectations.
Cleary <i>et al.</i> (2014). Australia:	To consider the impact of the perceived loss of professional identity on the collective resilience of the profession.	A Delphi study with thematic analysis.	1162 registered nurses from across Australia.	MHN scope of practice roles includes those to promote optimal physical and mental health, prevent physical and mental illness, and support the physical and mental health preferences. MHN identity includes personal resilience including a tolerance of uncertainty, having self-awareness, and sense making of disorder. This overlaps with the construct of emotional intelligence.
Crawford <i>et al.</i> (2008). United Kingdom	To explore how community mental health nurses perceived their working lives.	A qualitative interview study with thematic analysis.	34 mental health nurses working in one community mental health team.	MHN roles and their identity were based around promoting patient well-being, having a client focus, empowering, and enabling clients. Data on their identity included being invisible to others, not being seen as important or treated as a professional. The MHNs

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TABLE 2 (Continued)

Author, year, country	Aim	Study design	Sample	Main findings on MHN roles and identities
Deacon <i>et al.</i> (2006). United Kingdom	To develop a methodical analysis of the work undertaken by acute MHNs.	An ethnographic study over 3 years with thematic data analysis.	A case study of two acute adult mental health wards, one being PICU.	trained in psychotherapies and counselling to promote their professional status and to gain recognition for their work. MHN roles included being responsible for the whole unit environment and dexterously moving from delivering CBT to physical health care to then be assisting with social benefits forms. MHN identity in undertaking those roles was underpinned by the MHNs having a 'comfort of closeness', being proximal to patients and having the ability to be 'thriving and surviving chaos and crisis' which contextualizes acute care mental health nursing.
Debyser <i>et al.</i> (2018). Belgium	To clarify and understand the self-perceptions of MHNs and peer workers in order to identify the specificity and potential complementarity of both roles.	A qualitative descriptive design exploring critical incidents. Data collection was personalized case reports on the MHN's daily role. Analysis was by coding and thematic analysis.	Nurses ($n = 12$) and peer-workers ($n = 8$) (data-sets for each group separated out for analysis).	MHN roles included de-escalations, protecting vulnerable patients, behavioural modification, ameliorating emotional distress, and problem-solving counselling. Competencies supporting these roles included emotional regulation, empathy, critical reflection, teamwork, unconditional positive regard, relationship engagement, and advanced communication.
Delaney and Johnson (2014). United States of America, Australia and Europe	To learn how in-patient psychiatric nurses depict their work, define important aspects of their role, and view the impact of the unit environment on their clinical practice.	Metasynthesis of research on inpatient psychiatric nurses.	16 studies	The in-patient MHN roles are focused on creating consumer engagement with patients, maintaining ward safety, and educating consumers. These roles are enabled by cohesive team working and are challenged by multiple responsibilities for care and management of the milieu with only scant organizational support.
Elsom <i>et al.</i> (2007). Australia	To explore the extent to which community mental health nurses are engaged in expanded forms of practice.	Focus groups and thematic analysis was the adopted method.	27 nurses from metropolitan and rural Victoria (all with specialist qualifications in MHN).	MHN roles included influencing doctors for changes to medication, mental health act status, and ordering diagnostic testing.

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TABLE 2 (Continued)

Author, year, country	Aim	Study design	Sample	Main findings on MHN roles and identities
Felton <i>et al.</i> (2018). United Kingdom	To explore how mental health practitioners experience tensions that may arise for offering care and enacting controls.	Multiple case study design using interview data collection and thematic analysis.	11 MHNs in one service	Mental health assessments, risk assessments, and communicating findings to the treating team were also described. MHNs operated at the edge of their practice prescribing medications and developing holistic management plans for GPs. MHN identity by some GPs reflected very high professional regard; however, 'The current study supports the existing literature that identifies attitudes of doctors as a potential barrier to expanded practice roles for nurses' (p. 426). MHN roles described in this study highlight risk minimization as a dominant theme of practice, impacting on how service-users are understood and how power is shared with them. The therapeutic relationship as a vehicle for recovery is identified, but that clinical closeness has been undermined by other roles typified by coercion or control. Maintaining unit safety was deemed fundamental to nursing roles in inpatient care
Fourie <i>et al.</i> (2005). New Zealand	To observe the range of activities that MHN's undertook; identify the perceptions of registered nurses toward their roles and compare the observed range of actual activities with the perceptions of registered nurses' roles.	A qualitative approach with non-participant observation (56 hours) and focus groups.	One large acute care inpatient unit in New Zealand.	The nonparticipant observations found nurses being involved in numerous therapeutic activities such as developing and maintaining supportive relationships, attending to physical and emotional needs, and administering medication. Not surprisingly, nurses perceived the therapeutic role to be their 'most important role' (p.136); there were perceptions that nurses were prevented from being therapeutic; 'The findings suggest that nurses believe that practice is driven more by the needs of the

(Continued)

TABLE 2 (Continued)

Author, year, country	Aim	Study design	Sample	Main findings on MHN roles and identities
Gunasekara <i>et al.</i> (2014). Australia	To explore consumers views about what makes and excellent mental health nurse?	Pragmatic enquiry using interview data collection and thematic analysis.	Interviews (3–10 min) with 10 inpatients, 8 'consumer companions', and 2 'recovery support workers' in one mental health service. Then followed some consultation and discussion with 'carers' and a small number of mental health nurses.	organization than the patient' (p.139). MHN roles and identity was expressed in a mind map of qualities. 'Best recovery oriented practice mental health nursing, according to service users is grounded in an empathetic approach, underpinned by respect and a friendly demeanour. Reflective practice, curiosity to know service users, collaborative teamwork and promoting rights and responsibilities of service users were identified. High levels of self-awareness and emotional self-care characterizes effectiveness in the role.
Hamilton and Manias (2007). Australia	To examine how nurses in an acute psychiatry unit used observation as a significant part of their everyday assessments of patients.	An ethnography method using Foucauldian concepts of gaze and of discipline for comparative analysis of field data.	12 MHNs in a single in-patient setting.	MHNs roles were to work covertly in order not to provoke patients with their work consequently being invisible to others. Observational assessment for mental state, emotional status, and social connectivity on the ward were core reported roles. Environmental scans were undertaken for risk assessment and social mapping.
Hercelinskyj <i>et al.</i> (2014). Australia	To explore participant's understanding of their role as MHN and the impact of this on their professional identity.	Theoretical framework of role theory utilizing qualitative explorative descriptive design, semi structured interviews and thematic analysis.	11 'MHN's' (10 female and one male) with at least 5 years' experience practicing in Victoria.	MHN roles were contextualized by organizational tensions between consumer focused practice identity and fiscal needs of the organization. Roles were reported as narrow, documentation and medication as well as being less specialized by working in the more generic structure of the multidisciplinary team. MHN roles and identity was also reported as ambiguous with 'challenges in describing their role to others' (p. 26).
Hinsby and Baker (2004). United Kingdom	To explore patients' and nurses' account of violent	A grounded theory analysis of interviews.	Four male nurses and four male patients from a 49-bed outer London MSU.	A core MHN role category, of 'control' was identified with five constituent themes:

(Continued)

TABLE 2 (Continued)

Author, year, country	Aim	Study design	Sample	Main findings on MHN roles and identities
	incidents on a medium secure unit.			the construction of identity of the perpetrator of violence; nurses' dual role of caring and controlling; aspects of parentalism involved in control; following set policies and procedures; and segregation from mainstream society.
Humble and Cross (2010). Australia	To gain understanding of the reasons why veteran MHNs had remained in the field of psychiatric nursing.	A Heideggerian phenomenological, hermeneutic approach was used with semi structured interviews and thematic analysis.	7 'veteran' (10+ years exp) MHNs, 4 women 3 men on one inpatient acute unit.	MHN identity was based upon 'being different' from the general population in relationship to mental health consumers. Capabilities of self-awareness, curiosity, acceptance, and understanding enabled self-confidence in their capability of working with these seriously unwell consumers. MHN roles reported were consumer advocacy and minimizing power differentials. The MHNs acknowledged their own vulnerabilities to develop a mental illness and sought to minimize power-differential with consumers, often through seeking better understandings of consumer's lived experience.
Hurley (2009). A qualitative study of mental health nurse identities. United Kingdom	To explore what, if any, are the unique abilities, behaviours, or attitudes MHN bring into the delivery of psychological therapies.	A descriptive phenomenological approach was used with semi-structured interviews and thematic analysis.	Twenty-five MHN were recruited across three geographical sites in the UK using purposeful sampling.	MHN roles identified were across a range of talk based psychological therapies offered to service users with complex needs and in unorthodox settings. Roles also included physical interventions, medications and social interventions. Consequently, identity characteristics constituted a unique contribution to talk-based therapies and the MHN as generic specialist and adopting a service-user focus. The MHN utilized their personal self in these roles.
Hurley (2012). United Kingdom	To explore what, if any, are the thematic resonances of MHN experiences of delivery talk-based	A direct phenomenological approach was used for semi-structured interviews and thematic analysis.	A purposive sample of MHNs within the UK was sought with recruitment stopping at 25 MHNs	MHN roles and consumer interactions had strong thematic resonance with four key constructs of emotional

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TABLE 2 (Continued)

Author, year, country	Aim	Study design	Sample	Main findings on MHN roles and identities
	interventions with the construct of emotional intelligence.		working across community, inpatient and academic settings.	intelligence: T1: Knowing yourself; T2 Developing others; T3 Managing the self; T4: Acknowledging others.
Hurley <i>et al.</i> (2014). Australia	To better understand the views and experiences of clinicians and managers working within the MH Nursing Incentive Programme (MHNIP).	An exploratory phenomenology using semi-structured interviews and thematic analysis.	11 clinical and non-clinical managerial staff working in MHNIP for at least one year.	MHN roles were reported as being holistic, 'not just simply in the form of biomedical-psychological capabilities, linking the physical and the mental, but included a significant capacity to respond to consumers' social contexts.' (P. 19). Roles reported included crisis response, case management, advanced psychological therapies across multiple approaches, medication management, risk assessment, and initial assessments. These were undertaken with a consumer centric approach.
Hurley and Lakeman (2011). United Kingdom	To better understand how MHNs in England and Scotland form their identity, both personal and professional.	A direct phenomenology study with semi-structured interviews and thematic analysis.	24 MHNs in Scotland (17) and England (7) engaged in talk-based therapies, 13 female, 11 male.	Cognitive behavioural therapy was a core MHN role identified in the study. MHN identity was linked to having a consumer focus in their clinical roles and by being influence by consumer experiences and stories. MHNs sought job titles that attracted greater worth from others than their nursing job title and often used these to exit the profession or hold dual identities as nurse and therapist.
Hurley <i>et al.</i> (2020). Australia	To better understand how MHNs integrated psychotherapeutic capacities into their practice?	An open-ended online survey supplemented by semi-structured interviews. Each stage had its own recruitment, with the 12 being interviewed coming from the 153 survey respondents.	153 MHNs (survey) + 12 MHNs (interviews) with experience of integrating psychotherapy into their practice.	Reported MHN roles were clustered around the delivery of psychotherapy as this was the focus of the study. The MHN psychotherapist is a different MHN and a psychotherapist with a difference particularly though offering psychological therapies, physical interventions and psychiatric input, often in one care episode. MHN clinical practice was contextualized as operating in hostile policy conditions. MHN identity

(Continued)

TABLE 2 (Continued)

Author, year, country	Aim	Study design	Sample	Main findings on MHN roles and identities
Hurley <i>et al.</i> (2021). Australia	To clarify what roles mental health nurses identify as being within their scope of practice in clinical settings.	Social constructionist discursive literature review.	122 papers were included in the study.	was found to be tied to working with consumers with severe to complex issues. 6 themes. T1: MH's provide a range of psychotherapy approaches to consumers; T2: MH's actively advocate for consumers predominantly for stigma reduction and supporting consumer involvement in their own care planning and delivery; T3: MH's assess and then seek to improve the physical health of those with complex mental health conditions across in-patient, community mental health, and primary health settings; T4: MH's perform medication-based roles that include limited prescribing; administering medications; promoting medication adherence; and reacting to iatrogenic outcomes of the medications; T5: MH's establish therapeutic relationships with consumers with no clearly expressed purpose for doing so; T6: MH's respond to consumer violence and aggression and undertake interventions to reduce aggression, coercion, and seclusion.
Crowther & Theresa Ragusa (2011). Australia	To ascertain the nature of contemporary mental health nursing practice in New South Wales.	Focus group study with thematic analysis.	32 MHNs in rural settings over 5 focus groups.	MHN identity was poorly recognized and poorly respected by colleagues compared to non-MH colleagues. Traditional roles were being taken over by allied health staff. The lack of specialist undergraduate preparation had implications for identity around professional standing and visibility of MHNs.
Kudless <i>et al.</i> (2007). United State of America.	To compare the competencies of basic and advanced practice nurses with accepted psychiatric-mental health nursing competencies and to assess	A Likert survey with 163 accepted MHN competencies listed.	40 community MHNs in the United State of America.	MHN roles included case management services, psychosocial assessments, psychoeducation, counselling, psychotherapy, monitoring consumers for safety and

(Continued)

TABLE 2 (Continued)

Author, year, country	Aim	Study design	Sample	Main findings on MHN roles and identities
	the nurses' roles and division of work time among various roles.			medication responses, physical assessments, risk assessments, and mental state assessments. All those survey reported undertaking the same competencies with the frequency of performed competencies being the key difference between basic and advanced level nurses.
Landeweer <i>et al.</i> (2010). Netherlands	To map the (cultural) changes that occurred during coercion & restraint reduction projects and to develop recommendations to enable the projects to adjust their strategies during implementation.	A philosophical participatory method of empirical ethics.	Nurses involved in one restraint reduction project in one hospital.	Key findings were that the MHN reflected upon and developed their identity in the context of critical situations. Co-working with consumers and having team work as a core value were central to the provision of good psychiatric care. MHN identity and roles were summarized as: 'Mental health nursing is a professional, client-centered, goal-directed activity based on sound evidence, focused on the growth, development, and recovery of people with complex mental health needs. It involves caring, empathic, insightful, and respectful nurses using interpersonal skills to draw upon and develop the personal resources of individuals and to facilitate change in partnership with the individual and in collaboration with friends, family, and the health care team' (P. 225).
Lakeman (2012). Ireland.	To clarify What is good mental health nursing.	Online survey with inductive thematic analysis.	30 MHNs	MHN identity was the focus of this study. Relevant findings were that the MHN was largely the invisible or absent. MHN had ambiguous or blended identities with low attributed value and sophistication (unflattering descriptions; they lack authority and/or expertise).
Lakeman <i>et al.</i> (2021). International	To reduce and describe the professional discourse of mental health nurses about themselves.	Discourse analysis	117 printed articles	MHN roles included, amongst others, working and communicating with others,
MacNeela <i>et al.</i> (2010). Ireland	The aim of this study was to identify a set of core elements of mental health	A Delphi methodology with thematic analysis.	279 mental health nurses working in three sites across	

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TABLE 2 (Continued)

Author, year, country	Aim	Study design	Sample	Main findings on MHN roles and identities
	nursing acceptable to nurses working in different settings in Ireland.		Ireland were invited to take part in the study.	documentation of care, admitting and assessing clients, and acting as a facilitator for the family and MDT. The nurse's role in the coordination and organization of care was a major role to emerge from the study. Outcomes of MHN roles present a model based on personal ability to cope, psychosocial functioning, family perceptions, and the care process such as achievement of trust, client satisfaction with care, provision of appropriate care package, identification of risks, and organization of care.
Magnusson <i>et al.</i> (2004). Sweden	The aim of the study was to describe psychiatric nurses' experience of how the changing focus of mental health care, from in-patient treatment to community-based care, has influenced their professional autonomy.	A qualitative study using thematic analysis.	Four men and seven women were included in the study. Their ages ranged from 36–59 years, and most had worked as a nurse for more than 11 years.	MHN roles were found to be focused on consumer responsibility, clinical judgement, and control through support and supervision. Described roles were medication adherence and mental state assessment. The context of the roles was that were undertaken in community settings with more consumer choice than what MHNs had experienced within in-patient settings.
McKenna <i>et al.</i> (2014). Australia.	To ask nurses to reflect on and describe current practice within acute inpatient services that are not overtly recovery-oriented.	This was a focus group study with Nvivo content analysis.	46 in-patient MHNs from Australia.	MHN roles reported included building cultures of hope, supporting recovery; promoting consumer autonomy and self-determination through medication choices and psychoeducation; enacting advanced communication to build engagement and ethical awareness around mental health legislation. The MHN's roles were enacted with a holistic perspective to care.
Moe <i>et al.</i> (2013). Norway.	The aim of this study was to explore and reflect upon mental health nursing and first-episode psychosis.	The design was grounded theory with seven focus groups and thematic analysis.	7 community centres interviewed 6-7 participants from rural settings.	MHN roles were found to be a process named 'working behind the scenes' with a client focus. Findings are examined in a context of

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Author, year, country	Aim	Study design	Sample	Main findings on MHN roles and identities
Neela <i>et al.</i> (2007). Ireland	This study aimed to identify and analyse how nurses talk about psychological concepts and techniques.	Focus groups with content analysis.	10 focus groups involving 59 mental health nurses from 8 mental health services over 2 regions.	autonomy and paternalism. MHN care is undertaken along continuums between autonomy and paternalism and between ethical reflective and non-reflective practice. MHN roles in this study were found as: <ul style="list-style-type: none"> • the formal use of psychological techniques and the description of nursing work, • making sense of clients' experience through diagnostic terms and symptoms, • using the interoperability and perceived legitimacy of psychological discourse to lend further technical credibility to nursing work, and • positioning nursing care as psychosocial and distinct from medical treatment. Nonetheless, a complex relationship is illustrated by phenomena such as • ambiguity toward formalizing psychological work, • use and rejection of diagnostic labels, and • doing psychological work but seeing it as an inadequate performance' (p.507).
Oates <i>et al.</i> (2017). United Kingdom	The study aimed to explore the influence of the MHN's experiences of mental ill health on their clinical practice.	A sequential mixed methods study.	Of the 27 participants, 22 were female. They had worked as MHNs for between a few months and 26 years. The MHNs worked in a range of mental health settings and roles in UK.	MHN identity was found to include utilizing personal experiences at work through disclosure and boundary crossing. This was undertaken to improve relationships with consumers, grow their own empathy towards consumers, and to remain in the discipline.
Rasmussen <i>et al.</i> (2017). Australia & Denmark	The aim of the study was to explore a conceptual framework for CAMH nursing practice using a social constructivist framework.	Exploratory qualitative study.	9 CAMHNs in Australia and Denmark.	Mental health nurses working in CAMH worked to their scope of practice as determined by their qualifications and expertise in the specialty. This included family therapy, the provision of teaching and psycho-education. A blurring of roles was noted, and

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TABLE 2 (Continued)

Author, year, country	Aim	Study design	Sample	Main findings on MHN roles and identities
Rydon (2005). New Zealand	The study aimed to explore with users of mental health services, the attitudes, knowledge, and skills that they need in mental health nurses. This was undertaken through focus groups within a feminist post-structuralism theoretical framework.	Qualitative descriptive study.	21 users who attended support groups for users of mental health services in a city in New Zealand. There were three audiotaped focus groups each of approximately 1 hour in duration. Two focus groups were held with individuals who experienced mental illness and the third focus group with family members.	whilst team working was valued, it was perceived that the unique input of nurses (which was not articulated) was not valued by the wider MDT. Desired attitudes included: being professional, conveying hope, working alongside, knowing and respecting the person, human quality, and connection. Interpersonal skills included three subcategories: personal touch, attending to and counselling. Practical skills: Support, follow-up, and assistance from nurses were identified as essential for service users to live in the community whilst coping with their mental illness; knowledge: personal and professional; service users perceived that nurses had considerable power which they wished nurses to use benevolently.
Santangelo <i>et al.</i> (2018a). Australia	The study aimed to explore models of mental health nursing practice to provide a theoretical framework for contemporary and productive client focused practice. The study used constructivist grounded theory.	Grounded theory techniques.	36 Australian Mental Health Nurses who identified their practice as autonomous. Mental health nurse participants were overwhelmingly female (<i>n</i> not given), over 40 years of age and with at least 10 years' experience in mental health nursing. Eighty-six per cent of participants were working in a community setting of which 58% were currently engaged in primary care settings. The remaining 14% were working in hospital-based settings.	Ten attributes which distinguish mental health nurses from others were formulated and expressed as the 'Ten P's. Mental health nurses are 'present', 'personal', 'participant partnering', 'professional', 'phenomenological', 'pragmatic', 'power-sharing', 'psycho-therapeutic', 'proud', and 'profound'.
Santangelo <i>et al.</i> (2018b). Australia	This qualitative study explored the nature, scope, and consequences of mental health nursing practice using a grounded theory approach and seven focus groups.	Grounded theory.	Australian based study with 36 MHNs, 5 service users, and 1 colleague in 2012 (see Santangelo <i>et al.</i> , (2018a).	The study offers a distinct nature and identity of mental health nursing. The mental health nursing perspectives are based upon relational interplay between the nurse and the client that in turn supports recovery focused

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Author, year, country	Aim	Study design	Sample	Main findings on MHN roles and identities
Schoppmann and Lüthi (2009). Switzerland	To describe contemporary duties and activities of MHNs.	Participant observation.	Observation on 14 wards in Switzerland.	<p>practices: Mental Health Nursing is ‘... client-focused and flexible in its practice boundaries in order to better satisfy client needs, achieving this through an intimate caring relationship with clients. It is executed in a “special” way that co-constructs interaction, understanding and meaning between the mental health nurse and their client in order to develop therapeutic interventions that aid the recovery process. The consequences of the nature and scope of this practice result in positive outcomes that are led by the client and facilitated to the optimum level of functioning with life, that is acceptable to the client they serve’ (p.270).</p> <p>Identified 12 categories of activity were drawn from the data-set namely: Creating the Ward Milieu, Interdisciplinary Collaboration, Medical Care, Shaping Nursing Situations, Planned Nursing Interventions, Cooperation with other Wards and Institutions, Documentation and Information, Having an Eye for the Whole Thing, Teaching and Learning, Shaping Relationships, Reflection and Humour. These categories are exposed for discussion around determining MHN competencies in these countries.</p>
Seed <i>et al.</i> (2010). United States	The aims of this study were to describe the amount of time nurses spend on ten components of the inpatient psychiatric nursing role and to explore these roles against job satisfaction.	A time in motion study.	73 MHNs in one county across 7 psychiatric inpatient units in the USA	The components of the MHN role were derived from a literature review and included: taking care of the patient (TCP), completing admissions and discharges (CAD), documenting and paperwork (DPW), managing medications (MM),

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TABLE 2 (Continued)

Author, year, country	Aim	Study design	Sample	Main findings on MHN roles and identities
				communication with physicians (CP), communicating with health care team (CHT), keeping the unit safe (KUS), developing therapeutic relationships (DTR), teaching symptom management (TSM), and developing supportive work relationships (DSWR). They found that nurses spent little time teaching symptom management compared to undertaking paperwork. Correlations between time spent in specific functions and job satisfaction indicate that nurses who spent more time with direct patient care were more satisfied.
Sercu <i>et al.</i> (2015). Belgian	To explore how does stigma influence mental health nursing identities.	Ethnography derived from participant observation and semi-structured interviews.	33 MHNs, 2 units, Ghent, Belgium.	Nursing identity is in tension between autonomy and the challenges of detaching from psychiatric medicine. Stigma was positioned as a modulating phenomenon upon that identity. Working as a mental health nurse is thought of as overcoming the ambivalence inherent in the relationship between psychiatric stigma and the psychiatric system. It was found that MHN identity crisis becomes more evident in contexts of deinstitutionalization.
Sharrock and Happell (2001). Australia	The study explores the role of psychiatric consultation liaison nurse.	Descriptive case study.	Explored referral to one consultation liaison nurse and the activities they engaged in over 19 weeks in 1999.	Explores role in three areas – case consultation, administrative consultation, and liaison. Study identifies the importance of role and the types of referrals/patients seen and interventions used and role diversity are clarified. The most common interventions described were Advice/guidance/recommendations/liasing with treating team members (32.7%), Other documentation related to consultation with patient

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TABLE 2 (Continued)

Author, year, country	Aim	Study design	Sample	Main findings on MHN roles and identities
Smith and Macduff (2017). U.K.	To explore the experience of nurses who had completed a six-month training course in solution focused brief therapy.	Qualitative descriptive study.	The study population was a convenience sample made up of former students who had completed the SFBT course at Robert Gordon University (RGU). Participants were invited to take part in the study via an online professional support group for SFBT practitioners, all of whom had completed the above training course. In all, 75 potential participants were contacted with an information sheet about the project, a copy of the project proposal and a link to a dedicated web page on the RGU web site, and 31 (41%) responded. Of these 31, due to actual availability of respondents to be interviewed, 20 interviews took place at various locations across Scotland.	(9.5%), Monitoring of mental health needs of patient via staff (9.1%), Supportive counselling of patient (7.4%), and Monitoring of mental health needs of patient (4.6%). Five main themes emerged from analysis of the 20 interviews. Many of the participants reported increased trust in their clients and enhanced role satisfaction. T1: Client Empowerment; T2: Training fitted with personal values; T3: Success in use of SFBT; T4: SFBT training provided a framework for practice; T5: The majority of participants had some experience of CBT type therapeutic work, arguably reflecting the near-paradigmatic status this approach has come to have within mental health care.
Terry (2020). U.K.	The primary focus of this study was to examine how talk about mental health nursing was handled by participants from multiple perspectives.	Descriptive	30 interviews were conducted in the UK with service users ($n = 13$) and nurses ($n = 17$), and three focus groups were held with first- and third-year nursing students ($n = 18$), amounting to 2022 min of audio-recorded data. The six steps of Braun and Clarke (2006) were followed in order to analyse the data.	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 following were reported to be major themes: 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.
Waddell <i>et al.</i> (2020). Canada	To explore the association between stigma and mental health nursing as an occupation.	Secondary analysis of data gathered in a mixed methods study.	Canada. Localized to one province (Manitoba) sample size not apparent.	Invisible role, not 'real nurses' working with a stigmatized population and lack of recognition of role and specialized training. Associative stigma alluded to, not overtly throughout and

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Author, year, country	Aim	Study design	Sample	Main findings on MHN roles and identities
White and Kudless (2008). United States	The study was designed to engage CMHNs nurses in a dialogue in order to learn about their roles, concerns, and issues related to job satisfaction.	Participatory Action Research.	Six focus groups were conducted to address the nurses' concerns. 36 Registered Nurses in total.	adds to low-status of MHN work. Three major conceptual themes emerged: struggling for an identity and a collective voice; valuing autonomy; seeking role recognition.
Zeeman <i>et al.</i> (2002). Australia	To obtain information regarding the current role of the community mental health nurse (CMHN).	Questionnaire	All community mental health nurses working in one Adult Program in Fremantle, Australia ($N = 12$).	Core roles of the MHN were found to be working with consumers experiencing psychosis within the home environment, responding to community crisis needs and home visiting consumers, as well as ongoing case management. Other core roles included liaising with the wider mental health team, undertaking a range of complex assessments and meeting the consumer needs for health, finances, mental health and social factors. MHNs were key in maintaining consumers with complex needs in least restrictive environments.

support network consumers was a technical role capability used by MHNs across multiple studies, which also made reference to communication micro skills (MacNeela *et al.* 2010; McKenna, *et al.* 2014; Rasmussen *et al.* 2017; Seed *et al.* 2010). Psychological interventions including (but were not limited to) cognitive behavioural therapy (CBT) and solution-focused brief therapy (SFBT) were provided by MHNs to service users with serious mental health within the papers reviewed (Browne & Hurley 2018; Carlye *et al.* 2011; Deacon *et al.* 2006; Hurley 2009; Hurley 2012; Hurley & Lakeman 2021; Neela *et al.* 2007; Smith & Macduff 2017). These psychotherapy roles were prized by MHNs as evident in Hurley and Lakeman (2011 p.747) 'You then want to focus more on the counselling aspect of the mental health nursing role, that's because that is where you see yourself most effective'. These findings were echoed in a recent Australian national survey of MHNs by Hurley *et al.* (2020). Findings here indicated MHNs are highly capable of adapting or providing psychotherapy to people with moderate to severe mental

health problems, whilst also fulfilling other roles, including physical health care interventions.

However, these distinct technical capabilities within in-patient settings were reported as being obscured by more generic roles: 'Sharing life experiences and engaging in activities which "normalize" the situation were valued highly by a number of respondents' (Hercelinskyj *et al.* 2014, p.29). This covertness of the MHN role repertoire and identity, especially within in-patient settings, was also found in studies by Hamilton and Manias (2007), Delaney and Johnson (2014), and Moe *et al.* (2013).

Elsom *et al.* (2007) in their qualitative study of community-based MHNs identified expanded practice roles where MHNs were leading holistic assessments, mandated assessments under State Mental Health Acts, as well as formulating, diagnosing, and recommending medications to prescribers or adjustments to medication regimes. Expanded roles were also described by Kudless and White (2007) in their survey of MHNs in the United States of America. These included

medication prescribing, monitoring, and responding to side effects, as well as bio-psycho-social assessment and offering psychological therapies. However, Crawford *et al.* (2008) linked MHN expanded roles, to nurses leaving the discipline due to their practice being restricted by a lack of recognition.

Non-technical MHN roles

MHNs build therapeutic connections to promote well-being or ameliorate emotional distress with service users utilizing their personal lived experience. This was reported in a United Kingdom-based mixed methods study (Oates *et al.* 2017) with the use of the personal self also evident in the qualitative United Kingdom-based study by Hurley (2009). In their small phenomenological study of Norwegian MHNs, Akerjordet and Severinsson (2004) identified emotional intelligence (EI) capabilities as being pivotal for MHNs to be able to construct trusting and positive relationships with consumers and carers: 'High quality nursing care may emerge when the MHN is able to create a relationship, characterized by mutual confidence and trust' (p.166). EI capabilities such as resilience were connected to MHN identity by Cleary, Jackson, and Hungerford (2014), whilst those of self-awareness, emotional regulation, and developing and acknowledging others were also identified by Hurley (2012) as enabling MHN technical capabilities in psychological therapies.

Similarly, self-understanding and authentic self-reflection were identified as essential capabilities for MHNs within intervention roles with people experiencing emotional distress. In their phenomenological study, Humble and Cross (2010) found that MHNs reported a respectful curiosity towards the lived experience of Australian military veterans receiving care. Rydon (2005) undertook a focus group study of MHN capabilities valued and needed by service users and their family members in New Zealand. Participants placed high value on the MHNs capability to enact inter-personal communication that builds hope and mutual respect through MHN self-awareness and minimization of power differentials between MHNs and those they worked with. Delaney and Johnson (2014) identified generating consumer engagement as a core MHN role within in-patient settings. These findings were closely mirrored by consumer participants in an Australian-based qualitative study by Gunasekara *et al.* (2014), and MHN participants in Santangelo, Procter, and Fassett's (2018a, 2018b) grounded theory study.

Additionally, recovery-based values of respect, validation, and trust building were evident in a focus group study of McKenna *et al.* (2014), a qualitative study on coercion reduction by Landeweer *et al.* (2010) and a study focused on reducing stigma in Belgium by Sercu *et al.* (2015). This is in contrast to Magnusson *et al.* (2004) study where MHNs were reported to assume paternalistic roles to fulfil perceived duties to services and service users.

MacNeela *et al.* (2010) in their Delphi study on essential elements of MHN care found the coordination, organization, and communication of care was a core role of the MHN, as did Schoppmann and Lüthi (2009) in their observational study on the roles of the in-patient MHN. Similar capabilities were found by Cleary (2003) where simultaneous demands of decision-making and prioritizing multiple tasks were core MHN roles. These roles differ from organizational administrative tasks through being aligned to meet consumer needs. Therapeutic dexterity was a prominent capability identified by Deacon *et al.* (2006), a term used to describe the MHN navigating between organizational administration, care coordination, and direct therapy roles. The philosophical and explanatory positioning of MHNs also showed inherent tensions, often between psychodynamic and interpersonal models of care contrasting with medical model roles (Carlye *et al.* 2011; Rydon 2005).

Generative contexts of roles and identity

The roles and identities within the reviewed papers were reported as being undertaken within contexts that influenced those roles and identities. In an acute unit case study design, Deacon *et al.* (2006) found that the 24 hour a day proximal contact between MHN and service user within chaotic and unpredictable contexts were formative and unique experiences for MHNs. These experiences engendered a connection to service users and a foundation for an empathic relationship which other disciplines were challenged to replicate. Cleary (2003) reported similar in-patient contexts of unpredictability and intense workload demands. Rydon (2005) in their consumer-based study identified that the roles and even attitudes of MHNs varied depending on community and in-patient context, a finding also evident in the MHN study of Carlye *et al.* (2011). Hinsby and Baker (2004) in their small secure unit-based study. Here, tensions between care and risk control roles in order to optimize safety were reported as influential, a finding also evident in Felton, Repper,

and Avis's case design study of both in-patient and community settings.

Fourie *et al.* (2005) and Seed *et al.* (2010) uncovered the role tensions for MHNs who are responding to perceived unaligned organizational administrative needs and the therapeutic needs of service users. This combination of administrative, coordinating, and therapeutic roles was also found to lead to heavy MHN workloads in in-patient settings (Cleary 2003), consultant liaison roles (Sharrock & Happell 2001), and in community settings (Zeeman *et al.* 2002). This mirrored Terry's (2020) findings in a qualitative study of MHNs and service users. Here the role tensions between administration and care provision were found to give rise to a blurring of roles and ambiguity of professional identity. This role blurring was also evident in Browne and Hurley's (2018) and Lakeman and Hurley's (2021) studies where the psychotherapeutic MHN roles clashed with those associated with psychiatric roles as required by Mental Health Acts and other legislation.

Low perceived worth towards MHN clinical roles was another influencing context. This was reported in Elsom *et al.*'s (2007) community setting. Here limiting attitudes of medical doctors towards MHN expanded practice capabilities were a prominent barrier, whilst the limiting attitudes of non-nursing community clinicians were reported by White and Kudless (2008, p.1079) 'It doesn't matter how educated we are or what we can do. Advanced degrees do not mean anything. We are not recognized for the complex care we can provide.' The limiting of MHN roles and identity was also reported in Sercu *et al.* (2015) ethnographic case study and observation paper where MHN identification with the medical model and its associated stigma directly influenced MHN identity. Medical model hegemonic influences upon MHN identity were also found by Lakeman (2012) in an Irish survey regarding what counted as good mental health nursing. Government policy on MHNs delivering clinical services was evident in the Hurley *et al.* (2014) study of the mental health nurse incentive programme and in a subsequent national survey Hurley *et al.* (2020) reporting MHN's as being at the service of medical disciplines and of less importance than other mental health professionals. This finding echoed that of Crawford *et al.* (2008), where interviewed MHNs reported an identity of public servant, were subservient and subordinate to medicine, and lacked recognition. Some 12 years later, Waddell *et al.* (2020) in their survey and focus group

study also found the value MHN work was not recognized. Similarly, Crowther and Theresa Ragusa's (2011) study of MHNs in rural Australia found low regard towards MHNs compared to other disciplines with a consequent challenge in recruiting new people.

Limitations

This review sought to clarify potential therapeutic roles of MHNs, and hence needed to be broad in its approach. Consequently, differences in educational structures, tiers of MHN practice, or mandated scopes of practice were not considered. Incorporating international papers allowed for the full breadth of MHN role potential to be captured. However, a limitation of this decision is that there are distinct differences in the MHN role across these settings that require further research. Additionally, in line with scoping review methods a critical analysis on the quality of the research design within each was not undertaken (Tricco, *et al.* 2018b). However, there is worth highlighting that variances were apparent in the stance of how the roles of the MHN were described across the 47 papers. These variances were widely typified by a lack of critical examination of the efficacy of the MHN roles being reported. Papers such as Rydon (2005) were part aspirational and part observational. Such aspirational positioning of the MHN role was also evident in Hercelinskyj *et al.* (2014) through espousing the worth of MHN counselling roles in the absence of describing them. Further, more focused reviews are indicated.

CONCLUSION

This scoping review sought to clarify the clinical roles and hence identities of the MHNs. The results of this review suggest that MHN clinical practice can be highly technical. Such roles include those promoting safety, aggression reduction, and suicide prevention, as well as psychotherapy roles for people with complex and challenging needs. Complex assessment, diagnostic, formulation, prescribing, and physical health promotion and maintenance roles were all reported as being undertaken and often led by MHNs. These technical capabilities were enacted alongside and often embedded within a cluster of values, interpersonal capabilities, and communication-based roles that reflect what the OECD refer to as non-technical based roles and capabilities (OECD 2021).

Data from the scoping review suggest that both these technical and non-technical practice roles of the MHN are influenced by multiple mechanisms. Often, these were characterized by tension. These included tensions between psychodynamic, biomedical, and interpersonal models of care, tensions between administrative, coordinating, and therapeutic roles and also those between psychotherapeutic and roles required by legislation (Lakeman 2012).

The breadth of MHN clinical capabilities and roles found within this review suggest the identity and therapeutic potentials of MHNs can be whatever they, health services, or service users want them to be. The MHN could as easily be a psychotherapist in the community as they could be managing aggression in an in-patient setting. Arguably, the MHN non-technical capabilities, as well as their capacities to navigate role tensions and challenging work environments, are poorly understood in terms of how they enable the more visible technical roles and capabilities. Findings from this review can be argued as positioning the MHN as an underutilized, versatile and valuable addition to future workforce reforms to meet consumers' needs.

Relevance to clinical practice

Across the papers reviewed there are varying and often conflicting opinions about the role of the MHN. Much of this situation would seem to stem from the profession itself. An examination of the role of the MHN immediately offers opportunity for differing beliefs about how nurses contribute to the therapeutic interventions. The breadth of clinical focus areas within the scoped papers was reflective of the diversity in which MHNs seek to situate their clinical activities. Findings here indicate the MHN has capabilities to ameliorate distress and improve both mental and physical well-being for service users. However, MHNs have been poor in articulating what it is they do, and this subverts the contribution they make to the care of people with mental illness.

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