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ORIGINAL ARTICLE

Informing the development of a fit-for-purpose mental health nursing curriculum: A survey of mental health nurse academics in Australia

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Abstract

Inadequate mental health nursing content in pre-registration nursing curricula has been the topic of debate and concern since the introduction of comprehensive nursing education in Australia. Government-initiated inquiries and the efforts of mental health professional organizations and leaders have not successfully addressed this problem. The aim of the current study was to garner the perspectives and experiences of mental health nurse academics regarding the adequacy of mental health content in producing graduates able to work effectively in mental health settings and identify barriers and enablers to implementing and sustaining sufficient mental health content in pre-registration programs. A survey was distributed to mental health academics in Australian universities offering pre-registration nursing degrees. In total, 44 complete responses were included in the analysis. The results demonstrated the following: Most participants considered the current mental health content, theory and clinical hours insufficient to prepare graduates for practice in mental health settings. They reported a scarcity of tenured mental health nurse academics to deliver content effectively. Most participants were dissatisfied with the comprehensive approach to nurse education and preferred a double degree (nursing and mental health nursing), or a direct entry mental health nursing program. These findings provide further evidence for the current crisis in mental health nursing education and highlight the need for urgent action. People accessing health services have the right to receive high-quality care from appropriately qualified nurses. The inadequacy of mental health content in these programs effectively denies vulnerable people the standard of care and treatment they should be entitled to.

KEYWORDS
comprehensive nursing education, mental health nursing, nurse education, undergraduate curriculum, workforce

INTRODUCTION

How to best prepare nurses to work in mental health settings and provide mental health care as needed to all users of health services has long been a contentious issue (Happell, 2010; Happell & Cutcliffe, 2011).

Australia moved from separate education and professional registration in general and mental health nursing, to a single register and university-based comprehensive pre-registration/undergraduate nursing training in the 1980s and 1990s (Happell, 2007). Since that time, numerous public inquiries (Productivity Commission, 2020;

State of Victoria, 2021) and multiple mental health nurse commentators (e.g. Holmes, 2006; Moxham et al., 2011) have asserted that the current model of education is not fit-for-purpose. That is, graduates are not adequately prepared to work in existing mental health services and severe workforce shortages are anticipated in public mental health services. In response to the Australian College of Mental Health Nurses (ACMHN) expressing concerns about the quantity and quality of pre-registration programmes, The Australian and New Zealand Council of Deans of Nursing and Midwifery and the Australian Nursing & Midwifery Accreditation Council (CDNMANZ & ANMAC, 2023) asserted that all 78 accredited undergraduate nursing programs across New Zealand and Australia have a discrete mental health unit of study and all meet the 'current quality requirements' (set by ANMAC in Australia). How this is operationalized in terms of hours or what counts as indicators of 'quality' preparation for mental health nursing (MHN) practice is far from clear.

The establishment of comprehensive nursing pre-registration programs in Australia led to a rapid and substantial decline in what might be termed MHN-specific content and a dramatic decline in exposure to mental health nursing clinical placements. In 1999, the average number of mental health theory hours in comprehensive programs across Australian states was 59.4 (ranging from 18h in Tasmania to 116h in Western Australia) (Clinton & Hazelton, 2000). The average number of clinical practice hours in mental health (excluding voluntary electives) was 120.3 (ranging from 40h in the Northern Territory to 260h in Western Australia) (Clinton & Hazelton, 2000). These leaders in mental health nursing (Clinton & Hazelton, 2000, p. 8) noted that only a handful of mental health nurses were being educated in Australia in 1999 and projected an urgent need to establish interdisciplinary post-graduate courses to enable and maintain mental health nurses who could deliver '… skilled interventions based on cognitive behavioural therapy, family therapy, and other evidence-based treatment modalities'.

In 2010, responsibility to accredit courses and register health professionals moved from states to the national Australian Health Practitioner Regulation Agency (AHPRA) and associated national boards. Since then, the status of mental health nursing as a speciality has diminished in Australia (Lakeman & Molloy, 2018). Mental health nurses (even those that have engaged in a voluntary credentialing program requiring post-graduate qualifications) are not recognized as having any psychotherapeutic capabilities and have been excluded from eligibility to provide the lowest tier of services subsidized by Medicare (Australia's universal health insurance scheme) (Hurley et al., 2020). Specialist mental health nurses are not even distinguished from enrolled nurses or comprehensively trained nurses in official counts of nurses in Australia (Lakeman, 2023).

Despite policies which 'lump' all nurses together and largely confine them to employment in State or hospital services, successive inquiries and commissions project a massive shortfall of nurses prepared or capable to work in these services (Productivity Commission, 2020; State of Victoria, 2021).

Due to the declining workforce, overseas-trained nurses are sought after in Australia, with at least 20% of the total nursing workforce attaining their initial qualifications overseas (Department of Health and Aged Care, 2020). Hemingway et al. (2016) note that the Australian mental health workforce shortage appears more acute than in the United Kingdom, a jurisdiction considering adopting a comprehensive nursing model of training akin to Australia and New Zealand. This is apparently to address not only a shrinking workforce but the reality of mental health care being increasingly delivered in general health settings. In Europe, Ireland, Malta and the UK are the only countries to maintain specialist pre-registration MHN training leading to registration and protected title as psychiatric/MHNs. The authors note that existing models of specialist nursing training in the UK require 2300h of clinical placements across their specialist programs. Such exposure greatly exceeds the clinical placement hours of comprehensive programs in Australia (minimum of 800h). These specialist programs often exceed general placement hours in Australia's undergraduate/pre-registration nursing programs. Nevertheless, such relative specialists (those qualified as psychiatric or mental health nurses in Ireland or the UK) are registered as general nurses in Australia with a notation that restricts their scope of practice and potential employment to primarily public and private mental health services (Lakeman et al., 2022).

The anticipated nursing workforce crisis in Australia appears to be somewhat confined to areas such as mental health and aged care (both fields of practice have been scrutinized in numerous public inquiries) as domestic graduates of pre-registration nursing programs have greatly exceeded population growth (Department of Health and Aged Care, 2020). Ironically, it has taken until mid-2023 for Australia to announce its first National Nursing Workforce Strategy Taskforce which promises to create a strategy to enable nurses to work to their full scope of practice (Department of Health and Aged Care, 2023). Any strategy must acknowledge the inadequacy of the comprehensive training to deliver job-ready nurses to work in mental health and discriminatory practices which limit the opportunities for specialist mental health nurses to practice autonomously like other health professionals.

BACKGROUND

The content and process of undergraduate comprehensive nurse training in Australia varies across universities.

Mental health nursing specific content, the inclusion of experts-by-experience in the delivery of content, delivery of content by qualified mental health nurses, good quality mental health placements and quality clinical supervision are inconsistently, if ever offered in pre-registration nursing programs. Universities in Australia compete for both undergraduate and post-graduate students. In the last two decades, Universities have embraced new managerialism, the teaching workforce has become increasingly casualised and there has been a noted erosion of goodwill in academia (Cleary et al., 2023). This has contributed to occupational stress and mental health nursing academics (particularly early in their careers) having limited if any opportunities to influence how and what is taught in undergraduate and post-graduate programs (Lee et al., 2021). Junior or tenuously employed academics may struggle to advocate for more mental health content in already crowded curricula. Australia has introduced 2-year graduate-entry accelerated pre-registration programs (Neill, 2011), and post-graduate mental health nursing programs delivered entirely online (Lakeman et al., 2023). It remains far from clear whether these developments enhance the capabilities of nurses to work in mental health settings or with people diagnosed with mental illness. Given that universities actively compete to attract students and are thus concerned about maintaining a polished forward-facing public image it is difficult to obtain an accurate picture of what is taught, by whom and how across the sector. All pre-registration programs are accredited by the Australian Nursing & Midwifery Accreditation Council (ANMAC), so notionally produce 'good enough' comprehensive nursing graduates. However, this is clearly not the case in relation to preparation to work in mental health settings (Happell et al., 2020).

The last scoping study of mental health nursing content in undergraduate programs recommended increasing mental health content in curricula, strengthening mental health nursing leadership, increasing the participation of experts by experience in the design and delivery of educational programs and establishing a teaching resource repository (Moxham et al., 2011). None of these recommendations have been implemented nationally. Some commentators have subsequently suggested there has been a catastrophic failure of mental health nursing leadership, and that mental health nursing has become a meaningless category (Lakeman & Molloy, 2018). Successive public and judicial inquiries into the state of mental health care in Australia have noted the inadequate preparation of nurses to work in mental health settings, the pending nursing shortages in acute inpatient settings and have recommended a review of nursing education or a return to direct entry nursing training (Productivity Commission, 2020; State of Victoria, 2021). Notably absent from the public debate about mental health nursing preparation has been the views of mental health nurse academics who are presently teaching into pre-registration programs. There has been no prior literature reporting mental health nurse academics' perspectives on pre-registration nurse education.

In response to these issues, this study aimed to better understand the preparedness and factors influencing that preparedness, of undergraduate trained RNs to work safely and effectively in mental health settings from the perspectives of those delivering the training. To meet the aim this study posed the following overarching research questions:

What are the perceptions of mental health nurse academics regarding:

1. The adequacy of the current pre-registration programs to prepare graduates to work safely and effectively in mental health settings and
2. the enabling factors and/or barriers impacting their educational approaches to best prepare graduates to work safely and effectively in mental health settings.

METHODS

To best respond to these research questions a mixed methods approach was adopted. The analysis of open questions which generated considerable qualitative data and in-depth interviews with key respondents are reported elsewhere. This paper confines itself to descriptive analysis of quantitative data and some statements that explain or qualify ratings. All listed authors (who are all senior mental health nursing academics) met via Zoom on multiple occasions to formulate the survey items. Demographic questions and items on necessary skills or competencies for nurses working in mental health and proposed models of undergraduate preparation were derived from recent surveys of service users and supporters (Hurley et al., 2023; Lakeman et al., 2022). The EQUATOR network guidance informs the quantitative data reporting here (Vandenbroucke et al., 2007).

Data collection

This study was undertaken with approval from the Southern Cross University Human Research Ethics Committee (2023/015). The survey was hosted on the Qualtrics survey platform. Survey participants were sought in March 2023 from 36 Australian universities and undergraduate/pre-registration nursing education providers listed by the Council of Deans of Nursing and Midwifery (ND) who were contacted by email following a website search of staffing contacts (~50 people were emailed directly). Some universities had no publicly accessible contact details and deans or heads of schools were contacted and asked to disseminate the invitation to participate. Social media and snowballing were used

to further advertise the study. Survey responses were then checked for organizations that had not responded, with these providers being recontacted before closing the survey at the end of May 2023.

There were 63 survey responses which were then individually checked. Of these, 44 surveys were retained for analysis as they were fully completed, with the remaining being discarded. Staff from 24 Australian based universities and undergraduate nursing education providers were identified. One Head of School declined to pass on the study invite on grounds of the research topic, one university stated there were no MHN academic staff to participate, while the Head of School of another large university acted as gatekeeper to the research projects their academic staff could respond to and chose to not pass on the survey request.

Data analysis

Survey data were imported into Excel and descriptive statistics were calculated and are reported below. Correlational coefficients and paired sample *t*-tests were calculated for items relating to years of experience as a nurse and mental health nurse and other quantifiable items and no significant relationships were found.

FINDINGS

Respondents

The average age of those completing the survey was 49.5 years (SD = 11.4) with an age range from 28 to 68 years. The average years of MHN practice was 22 years (SD = 12.9) with a range of <1 year to more than 40 years. Those completing the survey had an average of 11.7 years' (SD = 10) experience teaching in undergraduate nursing programs ranging from 1 to 36 years. Sixty-four per cent of those responding were tenured full-time or part-time with the remaining being casual or recently returned to clinical practice. All but one respondent held an MHN qualification which ranged from Degree to Doctorate level with 32% (*n* = 14) holding credentialed status as an MHN. Seventy-one per cent (*n* = 32) identified having a teaching qualification ranging from Degree to Doctorate level, with 27% (*n* = 12) teaching in the undergraduate/pre-registration nursing program without reporting having a teaching qualification.

Essential skills of nurses working in mental health settings

Respondents were asked to rate the importance of specialist MHN skills graduates should possess (outlined in

Figure 1). The capability to demonstrate care, empathy and understanding towards those with mental health issues was identified by 98% of respondents as being extremely or very important. Being effective in mental health crisis-situation (96%) and in intervening to prevent suicide (93%) were identified as the next most important skills for effective mental health nursing. This was followed by a suite of non-technical works skills including working with diverse populations (93%), self-reflection (93%), advocating for mental health consumers (91%) and working with the service user's support network such as carers (91%). Capabilities aligned with special populations were least important such as working with youth (61%) and providing psychological therapies under a mental health plan (57%) although still identified as at least important by over 50% of respondents.

Amount of content in pre-registration programs

Survey respondents who identified as having sufficient knowledge of a pre-registration program were asked to estimate the number of mental health nursing theory hours students received in that program. Several respondents qualified their answers by noting that they included notional self-directed learning time, whereas others noted just face-to-face lectures and tutorials. The upper estimates are likely comprised of self-directed learning time. The average number of mental health nursing specific hours was 103.2 (SD 100.8, range 6–375 h). Of those that responded 37% (*n* = 14) stated that their program had a mental health-specific elective unit (63%, *n* = 24 answered no). Only four respondents stated that most or all eligible students undertake an elective in mental health. Forty-one per cent (*n* = 16) reported that mental health content was integrated into additional units (Mean 3.5 Units, SD = 2.3 range 0–8).

Respondents were asked how many hours of clinical placement were undertaken in mental health specialist settings. Many respondents (>25%) qualified their estimates by stating that placement in mental health settings was either not mandated or offered at all. Additionally, of those who responded to this question (*n* = 38), 58% (*n* = 22) stated that mental health placements were undertaken solely in specialist mental health settings (e.g., acute inpatient or public community mental health settings). Forty-two per cent (*n* = 16) of respondents stated that clinical placements did not occur solely in mental health settings. The difficulty securing appropriate clinical placements in sufficient numbers was noted by some:

> It is heavily dependent on where a placement arises. This is why it is not foundational in their degree. They might go to a GP surgery, palliative care unit, brain injury unit, a community setting which supports people with mental illness, inpatient unit, crisis team,
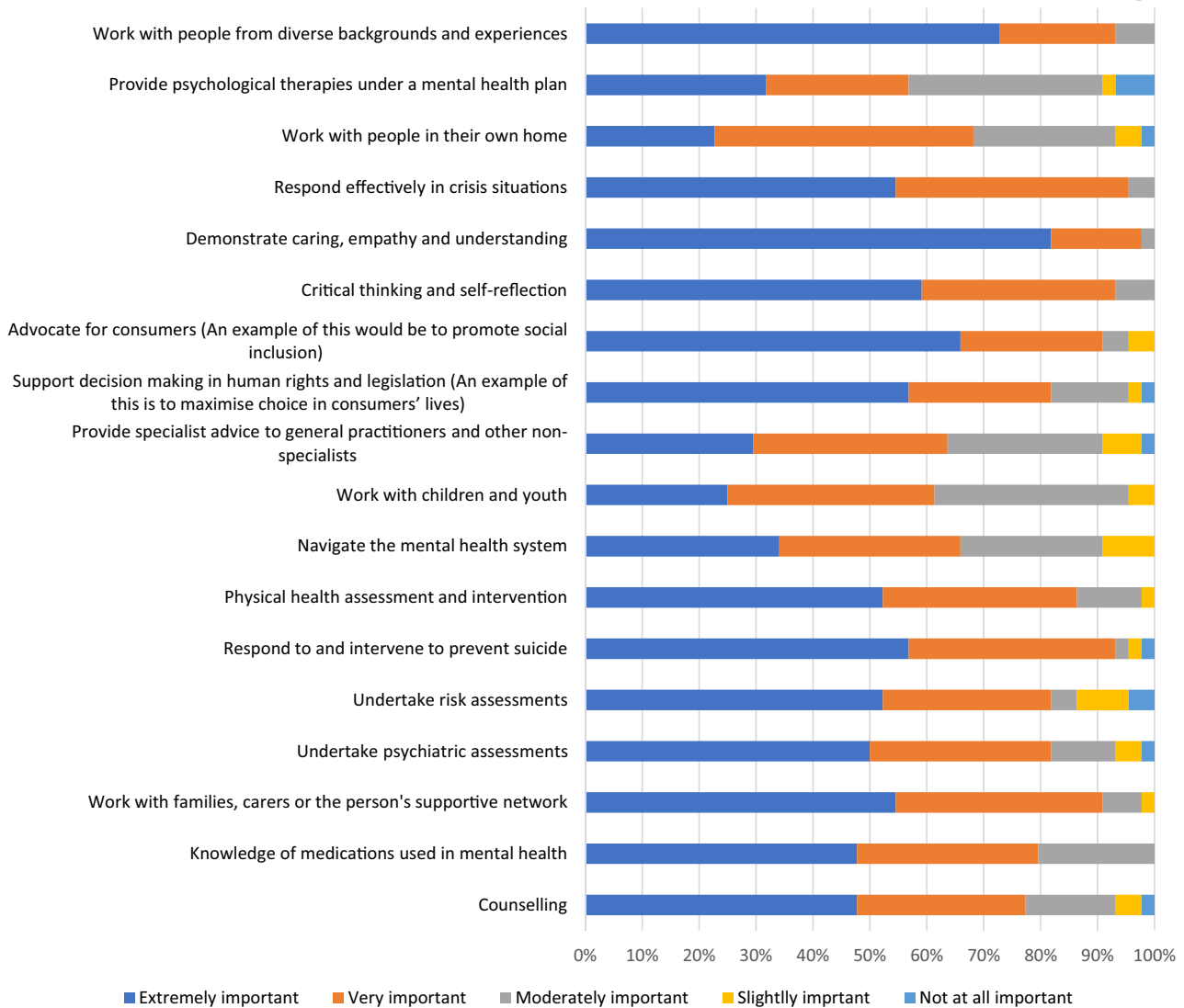
FIGURE 1 Essential mental health nursing skills.

case management, aged care in a dementia/behaviour unit, homeless team. It varies hugely.

The mean number of mental health-designated clinical hours (for those above zero) was 97.1 (SD 51.5, range 6–210h).

Adequacy of current undergraduate preparation of nurses

Figure 2 illustrates responses to questions about the adequacy of specific programs which respondents were familiar with and/or delivering. Fifty-one per cent of respondents held some level of agreement that graduates have the essential skills listed in Figure 2, with 41% actively disagreeing. Thirty-six per cent perceived their graduates to be adequately prepared to work safely in MHN settings, with 55% perceiving their graduates were

not prepared for safe effective mental health nursing practice.

Undergraduate clinical placements to enable the developing of these skills were identified by 77% as being inadequate, compared to 16% who reported adequate clinical undergraduate placement. Theoretical MHN preparation was perceived as sufficient by 39%, with 59% identifying there was insufficient MHN theory in their program. The dataset was split into those who agreed that their program provided adequate preparation in mental health ($n=10$) and those who did not ($n=20$). There were no significant differences between these groups on any comparative variable. However, those who agreed reported more theory hours in their programs ($M=151.9$, $SD=124.4$) compared to those who reported their programs were inadequate ($M=91.1$, $SD=84$). Contemporary high-standard MHN content was reported in 54% of programs, with 45% identifying that their content was not at this standard. Eighty-seven per cent agreed that undergraduate training is primarily
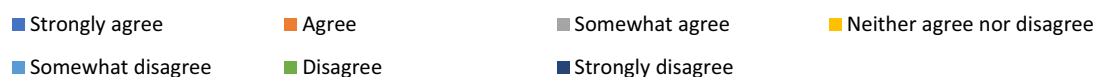
FIGURE 2 Adequacy of current undergraduate preparation for nurses and support for mental health nursing.

focused on generalist nursing, with 64% also agreeing that graduates are encouraged by other academic staff to avoid going straight into specialist MHN settings upon completing their training. Twenty-eight per cent of respondents stated that the program they were familiar with was adequately staffed by specialist MHNs, compared with 62% reporting inadequate specialist MHN academic staffing. Sixty-four per cent reported having colleagues who were supportive of mental health nursing with 48% perceiving that their academic nursing leadership values MHNs. Forty-one per cent reported not being respected or valued by leadership, 44% reported that their institute did not value MHNs, while 49% perceived being valued. Thirty-three per cent (*n* = 13) of respondents stated that service users or 'experts by experience' were involved in the delivery of pre-registration programs. Seventy-seven per cent (*n* = 26) reported no involvement of service users at all. Involvement of service users was largely reported to be via occasional guest lectures, or via course advisory groups. One novel form of involvement of service users was the 'recovery camp' as a clinical placement, utilized by several Universities as an elective placement (Taylor et al., 2017). Most comments regarding service user involvement indicated

that sustained and paid involvement of people with lived experience occurred transiently or rarely, and that most mental health nurse academics supported greater involvement.

Preferred model of education to develop mental health nursing proficiency

Figure 3 outlines responses to questions about how nurses should be prepared for mental health practice. When asked to describe a preferred model of undergraduate preparation for effective mental health nursing, 16% held some level of agreement towards leaving the current comprehensive program as it is, with 61% disagreeing with this. Agreement with continuing the current comprehensive program increased to 57% if there was significantly enhanced mental health content. The most preferred model was a double general nursing/MHN degree with 81% agreeing this would be the most effective, while 5% disagreed. Seventy-five per cent endorsed direct entry specialist training, with 9% disagreeing with that option. Ninety-three per cent supported requiring post-graduate qualification in mental health nursing for
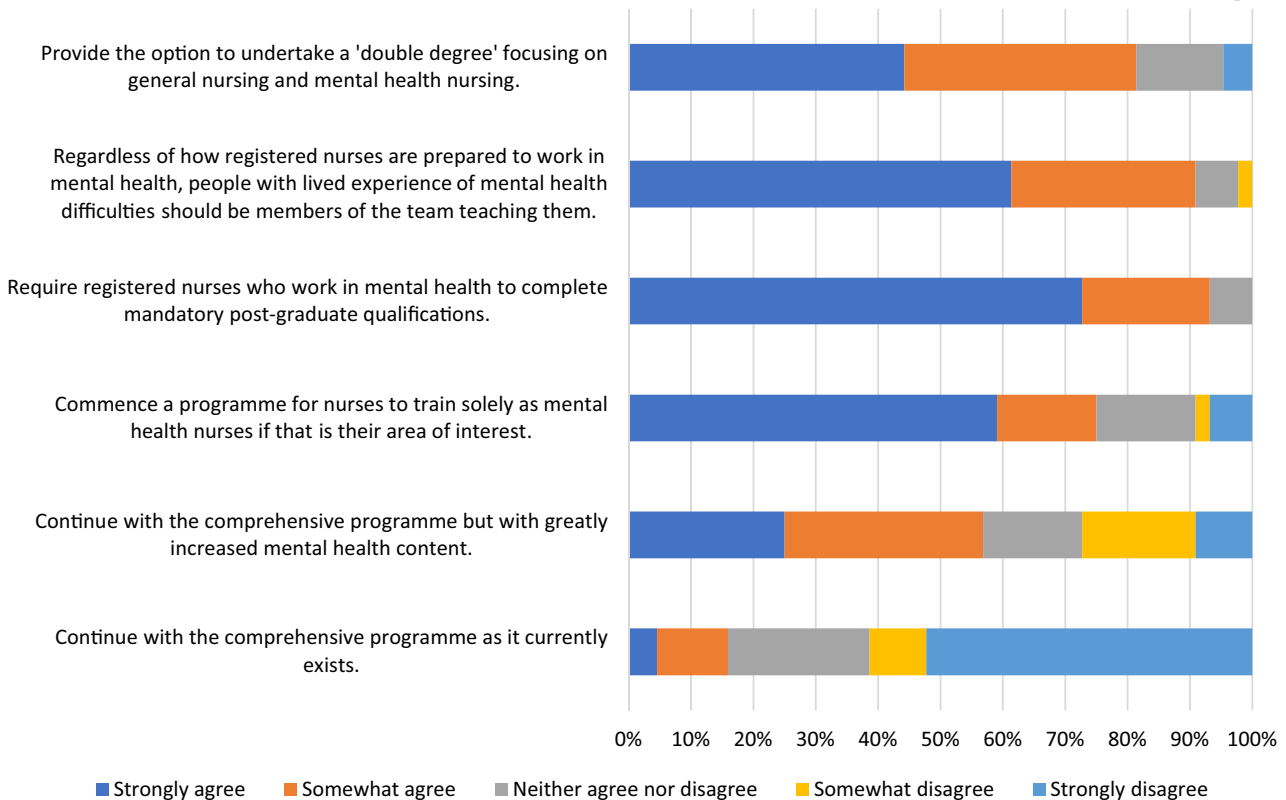
FIGURE 3   Preferences for educational preparation of mental health nurses.

DISCUSSION

A strength of this survey is that it elicited the opinions of nurse academics with a deep understanding of undergraduate nursing programs in Australia who are directly involved in teaching pre-registration nursing students. The voices and opinions of these individuals have to a large extent been ignored, subjugated or silenced in the debate about mental health nursing education in pre-registration programs. Academics from most higher education institutions in Australia contributed, although as noted previously several Universities were not represented for various reasons. There was (as expected) considerable variability in the reported mental health content, process, clinical placement opportunities and collegial ethos at different Universities. Few academics reported that the current content or process in existing pre-registration programs was adequate, which is in keeping with multiple government inquiries (Happell, 2010). In approximately 25 years, the actual reported content and clinical placement time offered in most Universities has not increased at all despite repeated exhortations from industry to do so (Clinton & Hazelton, 2000; Moxham et al., 2011). As respondents

made clear that some courses appear to have no associated specialist mental health nursing placement opportunities, or little to no mental health specific teaching. Whilst there are some reported exceptions, this research highlights a serious deterioration in the pre-registration mental health nursing preparation.

These findings from mental health academics are entirely in accord with the views of heads of schools of nursing in Queensland as surveyed by Happell and McAllister (2014). They found that overall participants did not believe that current programs adequately prepared graduates for beginning level practice in mental health settings and cited such influences as overcrowded curriculum, lack of availability of quality clinical placements, the strength (or otherwise) of the mental health teaching team and the degree of consumer focus as impacting on the overall quality of the teaching experience. Happell and McAllister (2014, p. 330) concluded that '…the current model of nursing education in Australia does not provide an adequate foundation for mental health nursing practice and alternative approaches should be pursued as a matter of urgency'.

Even earlier, Happell and Cutcliffe (2011) argued persuasively that there is no evidence to suggest that comprehensive nursing education has led to improved service user outcomes, improved attitudes towards people diagnosed with mental illness or improved physical health outcomes for service users. Indeed, despite record levels of expenditure in Australia on

all RNs working in mental health settings. Ninety-one per cent supported having those with lived experience teaching in any undergraduate preparation model.

access to focussed psychological strategies (note that nurses are excluded from providing these services) and medical treatment (primarily medication and other somatic therapies such as rTMS) in recent years, the mental health of the nation has not tangibly improved, and the life expectancy gap for those diagnosed and treated for mental illness remains unacceptably large (Lakeman, 2021). Despite worsening mental health statistics, increasing health disparities between those diagnosed with mental illness and the general population, and many calls for urgent reform over several decades there has been a lack of urgency in reforming the process or in enhancing the content and process of undergraduate programs. Indeed, the ACMHN has recommended a return to direct-entry mental health nursing degrees (ACMHN, 2019) but to no end. Mental health nursing majors have been introduced in some Universities but those that offer specialism have declined over the last 15 years (Happell, McAllister, et al., 2015). Some have promoted accelerated double degrees (likely to be completed in 4 years). However, it is unclear whether such options will address the systemic issues driving the current projected workforce shortages and poor outcomes in mental health settings.

An exceptionally clear finding from this survey is that comprehensive pre-registration training is perceived as inadequate in its current form as preparation for nurses to work in mental health settings. The few respondents who perceived it ought to be retained also qualified their responses with the expectation that post-graduate education was also necessary. Both the theoretical content and clinical placements in mental health were perceived as inadequate by the majority of respondents. One solution to address the problem of variability across programs is for ANMAC to specify the minimum number of mental health specific theory and clinical hours in all programs and to require mental health nursing theory to be delivered primarily by tenured credentialled mental health nurses. Such specifications are conspicuous in countries which retain nursing specialities (e.g. the UK and Ireland). For these countries contemplating a transition to a comprehensive nursing registration, the findings from this survey suggest that this would likely lead to a reduction in Australia's attempting to recruit their specialist graduates who are perceived as superior to comprehensive graduates. It is also likely that, consistent with the Australian experience, the general mental health of the population and the physiological health of those with diagnosed mental illness will not improve and likely deteriorate. Other mental health nursing pre-registration options such as direct entry programs and double degrees or majors were supported by respondents in this study, suggesting that a range of pre-registration pathways towards becoming a mental health nurse is preferred.

To preserve the anonymity of respondents we have not identified details about mental health content or delivery at any specific university. However, we do recommend that in the interest of transparency, and to enable potential students to make informed choices that universities publicly disclose details about how much mental health specific content is included in their programs and by whom it is delivered by. The marketing of courses and programs is presently driven by neoliberal and managerial imperatives which value competition and market share over collegiality and quality (Lakeman & Molloy, 2018). Currently, marketing of nursing programs obfuscates important issues such as these and amplifies other factors such as graduate employment prospects, salaries or university ratings.

A further noteworthy finding of this survey was the near-universal support to incorporate 'lived experience' perspectives in more tangible ways in the undergraduate preparation of nurses. Mental health nurses have long championed partnership with lived experience academics (Happell, Wynaden, et al., 2015). Engaging with people with lived experience is a proven method of improving the attitudes of nurses towards service users and towards working in mental health (Byrne et al., 2014; Happell, Platania-Phung, et al., 2019; Happell, Waks, et al., 2019). Nevertheless, this solution to enhance recruitment of graduates to work in mental health is inconsistently implemented (Happell, Platania-Phung, et al., 2015). The perceived required skills or expected competencies of mental health nurses were also remarkably congruent with those of service users and supporters (Hurley et al., 2023; Lakeman et al., 2022). Unsurprisingly all of the competencies and skills listed were rated highly and considered extremely important or moderately important by these respondents, as has often been the case when experts are asked to rate the importance of recovery-focused competencies (Lakeman, 2010). Seven per cent of these respondents considered the provision of focused psychological strategies under a mental health plan as 'Not at all important' which may reflect the currently limited opportunities for MHNs to work in primary care settings in Australia. Above all, graduates need to demonstrate empathy, caring and understanding. However, they also need to demonstrate competency in working with individuals and groups in crisis, those with complex and severe mental health conditions, and/or experiencing extreme states and suicidality. Again, this is entirely consistent with descriptions of good mental health nursing as described by expert MHNs (Lakeman, 2012). It remains far from clear that current models of pre-registration nurse training deliver the required knowledge and skill development to address these, or even can.

Neither service users nor their supporters want the current model of undergraduate preparation in Australia to continue. In a recent survey, only a very small minority of those surveyed supported continuing the current model with 81% wanting specialist direct entry undergraduate MHN training (Hurley

et al., 2023). Additionally, the capabilities that service users and supporters want are not intentionally developed under the current model (Lakeman et al., 2022). Dissatisfaction with comprehensive preparation has also been found in multiple studies of nursing students and graduates (Happell et al., 2018; Ward & Barry, 2018). Broad stakeholder agreement of those with mental health expertise is arguably evident; the 30-year trial of comprehensive nurse preparation has not met the needs of mental health consumers or the mental health sector. Indeed, outside of the generalist nursing bodies there appears to be limited appetite for this approach to MHN education. Universities however are one grouping that does benefit from the current model. The large numbers of homogenously prepared nursing students attract significant commonwealth-supported funding in Australia. There is limited evidence indicating that income derived from comprehensive nurse training is invested back into resources to enhance future nurse training. The findings from this study adds further weight to the consistent findings across several decades that the current model of comprehensive nursing education in Australia is inadequate to meet current or future needs for the provision of quality mental health care or service reform.

RELEVANCE TO PRACTICE

Comprehensive nurse education in Australia has failed to consistently prepare nurses to safely commence working in mental health settings or with people diagnosed with mental illness. Little tangible change has occurred over 30 years despite repeated and urgent calls for reform. In the absence of radical change and vague statements about existing programs meeting quality standards, regulatory bodies (such as ANMAC) ought to reinstate a minimum number of mental health specific theory hours taught by credentialled mental health nurses, and the minimum required supervised clinical placement hours in specialist mental health settings in accredited pre-registration programs. In the interests of and to inform pre-registration nursing students' choice of course, providers of programs ought to also quantify the theory and clinical placement hours dedicated to areas of speciality including mental health.

AUTHOR CONTRIBUTIONS
All the authors were involved in the conceptualization and design of this study, questionnaire construction, composition, editing and review of the manuscript. Richard Lakeman undertook the descriptive quantitative analysis, the initial drafting and the final review of the manuscript.

CONFLICT OF INTEREST STATEMENT
All the authors are employed in various capacities by universities and have taught pre-registration nursing programs in Australia. Kim Foster is an Associate Editor of the International Journal of Mental Health Nursing.

DATA AVAILABILITY STATEMENT
Research data are not shared.

ETHICAL STATEMENT
In accordance with the International Committee of Medical Journal Editors guidelines all the authors meet the authorship criteria and all the authors are in agreement with the manuscript. This project received approval from the Southern Cross University Human Research Ethics Committee (2023/015).

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