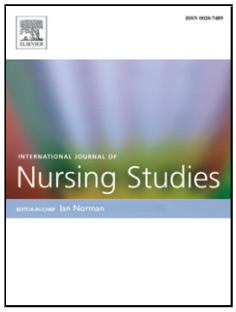

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Guest Editorial

Hold on to the good: change vs continuity in nursing on acute mental health care wards.

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I recently met someone with whom I had worked on a psychiatric ward over 20 years ago; he had been an exceptionally skilled mental health nurse who had reached a senior managerial position in mental health services but had quit because he would not tolerate being accountable for decisions which he knew would be detrimental to nurses and patients. I asked if he would ever consider returning to work in mental health care. "*Never*," he said, "*because the job we did doesn't exist anymore"*. Has mental health nursing changed this much? Is it worse than it was 25 years ago when I first started, or 50 years ago? How would we know?

The UK Care Quality Commission (CQC) (2017) report '*The State of Care in Mental Health Services. 2014-17'* highlights some of the current challenges*:* a 12% fall in the number of mental health nurses working within the British National Health Service (NHS) since 2010; bed occupancy on acute admission wards of 89% in the three months to 31 March 2017; an increase of 26% in the total number of detentions each year under the Mental Health Act from 2012/13 to 2015/16; requests for temporary mental health nursing staff increasing by two-thirds from April 2013 to December 2014 (King's Fund, 2015). I can look back to 25 years ago when I was a student nurse on a 16 bedded acute ward in the UK. On each day shift, there were five members of

nursing staff, four of them Registered Mental Health Nurses, one in the then new role of Health Care Assistant. I returned to the same ward (in a different role) recently. A day shift consisted of four staff, two of them registered, two of them health care assistants. It's at least possible that this slow dilution of skill mix has indeed changed the role of the mental health nurse on an acute ward. The following quotation from a respondent to a survey by the British Royal College of Nursing (RCN) suggests that staffing does have an effect on the nurse and on patient care: *"Today was an unusual occasion to be fully staffed, but the difference it makes to patient care and morale is immeasurable. In contrast, the week before I worked a 15.25-hour shift, having to stay late with no break in a different mental health unit. I left exhausted, upset that I could not offer more to patients due to workload and unsure of how long working at this pace was sustainable. Sadly, days like these are far too common."* (RCN, 2017; 1). If mental health nurses have too many 'days like these', perhaps this does this change the fundamentals of their role, in particular their ability to offer time and interaction to patients and through this to form therapeutic relationships.

In 1972, Altschul published her seminal study of nurse-patient interaction on acute mental health wards, drawing the conclusion that it was difficult to find evidence of the formation of therapeutic relationships arising from interactions between nurses and patients. Subsequent reports seem to indicate that this is still the case: Acute Problems (Sainsbury Centre for Mental Health, 1998) reported a lack of engagement between staff and patients in acute wards, a finding replicated in Behind Closed Doors (Rethink, 2004). Sweeney et al (2014) argued that the culture and practices on acute mental health wards can create poor nurse-patient relationships and recommended further research to explore the reasons why nurses are not developing relationships through their interactions with patients. In contrast, the British Care Quality Commission (2017) assessed the great majority of mental health trusts in the British National Health Service as either good or outstanding for the 'caring' domain, commenting on the level of compassionate care observed. However, they did report their concern about safety for both patients and staff arguing that the national shortage of mental health nurses in the UK was having most impact on acute wards, with patients reporting a lack of one-to-one interactions with nurses. Only 28% of acute wards and psychiatric intensive care units were rated as 'good' for safety and only 1% as 'outstanding'. The picture is one of generally caring and compassionate nurses

working in circumstances which make it difficult to move beyond this to developing therapeutic relationships; but Altschul's work suggests that this has long been the case, so has anything changed? It's interesting to look back at Altschul's subsequent textbook '*Psychiatric Nursing'* (Altschul, 1973) which contains chapters beautifully and pragmatically depicting the formation of therapeutic relationships through ordinary, daily interactions and activities with patients; still relevant today as seen in the inspiring accounts by nurses in '*Talking with Acutely Psychotic Patients*' (Bowers et al, 2009). However, the book also has a chapter on caring for patients undergoing insulin treatment, which no current practitioner would recognise. The point may be that in the years since the 1970s, *treatment* has improved but *care* has not moved on at all.

Despite this patchy history, therapeutic relationships are still highly valued by patients. Patients in the studies above consistently said that they valued contact and interaction with nurses and that the availability of nurses helped them. Seed et al (2016), in an integrative review of patients' experiences of involuntary detention, concluded that when staff behaved in a 'connecting' way, this reduced emotional distress. Bee et al (2008) found that patients valued both 'professional' and more personal, social interactions with nurses. But although the therapeutic relationship is valued by patients, supported by theorists and practitioners, and all raise concerns about its absence, any link between forming a therapeutic relationship and the outcomes of nursing care has not been clearly demonstrated. The British National Institute for Health & Care Excellence (NICE) (2015) guidelines, just to give one example, state that more research is needed into the association between therapeutic relationships and violence and aggression. The impact of the core intervention in mental health nursing – forming a therapeutic relationship – has not been measured, so we just do not know if care has got better or worse over time.

To know what to measure, theory is needed to guide observations and provide hypotheses to test, or otherwise our measurements might as well be random and will not produce knowledge. Kim (2010) argues that there has been a paucity of theory in the domain of patient-nurse relationships. There has been a tendency to adapt theory from, for example, medicine and psychology to explain client-nurse interaction instead of investigation of the particular nature of the nurse-patient relationship. This is the difference between what Kim (2010) calls the use of theories *in* nursing and the development of theories *of* nursing. As Kim (2010) states: *"Although there has been a great deal of*

rhetorical emphasis on the importance of client-nurse relation in the delivery of nursing care, very little real work has been done either in theory development or in empirical testing of theories" (p. 288). There is certainly an *ad hoc* approach to theory testing. Nolan (2012) argues that theory development in general and mental health nursing in particular has been non-cumulative and that this has led to fragmentation of nursing theory and allegiances to different knowledge sources within the profession. I would also argue that there has been a stultifying, top-down approach to theory development which compares poorly with knowledge development in other fields. In 1964, the physicist Richard Feynman famously described the 'key to science' in 63 seconds:

"In general, we look for a new law by the following process: First we guess it; then we compute the consequences of the guess to see what would be implied if this law that we guessed is right; then we compare the result of the computation to nature, with experiment or experience, compare it directly with observation, to see if it works. If it disagrees with experiment, it is wrong. In that simple statement is the key to science. ***It does not make any difference how beautiful your guess is, it does not make any difference how smart you are, who made the guess, or what his name is — if it disagrees with experiment, it is wrong*****"** (author's emphasis).

In quoting this, I am not re-opening the sterile debate about whether nursing is an art or a science. Kim (2010) takes the stance that there are two equally valid knowledge domains: epistemological realism – objects exist and operate independently of human inquiry, and emancipatory epistemology – the acceptance of the unique perceptions of humans and their inter-subjective experiences. The synthesis of these in working with people is the joy of nursing. Feynman's quotation speaks directly to nursing in saying that knowledge development starts with nature, experiment or experience, in other words, practice. Kim (2010) advises that all nursing research must start with practice. Fawcett and Garity (2009) go further in stating that Practice = Research; practice and research are the same process and nurses are knowledge producers as well as consumers. All theories are guesses – they should be continually refined by their use in practice. Let mental health nurses describe, measure and test what they know already and build on this to develop theories of nursing instead of imposing theory on practice.

I work in a faculty of nursing housed in a building which, at its entrance has a mural quoting Einstein's acknowledgement of the pioneering work of James

Clerk Maxwell. Mental health nurses can similarly acknowledge the work of pioneers such as Hildegard Peplau, Annie Altschul and Felicity Stockwell and build on their work, testing what works and what doesn't. With this approach, we can know, not simply whether mental health nursing has got worse or better over the last 50 years, but what knowledge we need to retain and develop and what we need to discard. In this way, we will be able to improve the treatment and care offered to patients. As Bowers has stated: "*We hope for and look forward to a time when nursing interventions are repetitively tested, placing our guidance on an even more sound footing.*" (Bowers 2016; 407)

Does the job my colleague and I did 20 years ago still exist today? The challenges set out in the British Care Quality Commission (CQC 2017) report suggest that it might not possible to do the same job in the same way, but that caring is still observable. The Feynman quotation cautions us that it doesn't matter what we think caring, therapeutic relationships should look like, if this isn't seen in practice, it's our theories that need to change. Perhaps therapeutic relationships between nurses and patients on acute mental health care wards do exist but not in the way we expect them to. Mental health nurses are the people to develop knowledge in this area because they already know what they are doing, but they will need the skills to transparently test and examine their practice. The knowledge and skill needed to work as a mental health nurse is steadily increasing: compare for example, the 309 pages and 18 chapters of '*Nursing the Psychiatric Patient*', a textbook by Burr and Andrews (1981) with the 712 pages and 42 chapters of '*The Art and Science of Mental Health Nursing*' by Norman and Ryrie (2013). The draft standards for pre-registration education from the British Nursing and Midwifery Council (2017) indicate a practitioner with a range of clinical knowledge and skill, together with proficiency in research and audit, which is far greater than I had as a newly qualified nurse over 25 years ago. This must be a change for the better.

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