Editorial

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Should mental health nursing have a separate registration?

There has been debate over many years about whether mental health nursing should be a separate registration (along with learning disability nursing), or whether there should be one nursing registration. The current situation remains that there are separate registrations in the UK, though in Australia, there is only one registration for nursing.

There are common features to all nursing activity. Nursing is fundamentally about relationships and relatedness. It is about being alongside and helping people in pain, trauma, disability and distress. However, there are considerable differences in how these relationships are carried out in practice across different specialisms. To break nursing down into its most basic parts, we can say that it is about processes of *being with* and *doing for*. Viewed from this perspective, the differences become more apparent.

Traditionally, general nursing had a strong focus on task, *doing for*. This makes sense in a pressured work environment, where lives are at stake and routines are driven by the need for regular observations, care activities and treatments, with their attendant deadlines. We should remember that Florence Nightingale's early work was done in the military context of the Crimean War, and nursing has never fully lost its military origins, with its focus on uniforms, task allocation, routine and ritual. Although task allocation has given way to patient allocation and patient-centred care, the air of the barracks remains.

Mental health nursing, on the other hand, can lay claim to origins in the moral therapy and institutional care of the 18th and 19th centuries, which valued listening, talking and manual work as a humane response to mental distress and disturbance. The emphasis was on *being with*, and encouraging the mentally ill to *do for* themselves. There have, of course, always been elements of *doing for* the mentally ill as well. They sometimes need help with caring for themselves, or fail completely to do so. They need treatments, whether these are psychological or pharmacological.

However, the balance of these elements is different between general and mental nursing. The emphasis in general nursing remains on doing things for people who are temporarily or permanently unable to do things for themselves. In mental health nursing, the emphasis is on encouraging and developing independence, and being alongside the person in distress, to provide emotional comfort and relieve suffering. Arguably, the provision of emotional comfort is central to general nursing as well (Williams & Irurita 2004). However, this is not necessarily what general nurses believe they are held accountable for, nor is it the focus of nursing education.

Nurses learn by doing, and have at times struggled with theory-based education. Practical, hands-on learning has always been important, so practice placements are central to nursing education. Nurses learn as much by example and acculturation as they do from lectures or textbooks. So, the setting they learn in is very important. Learning on a general hospital ward, with its hierarchies and routines, will produce a very different nurse from one who has learnt their trade on a mental hospital ward or day centre.

Thinking about my own training and acculturation, I first trained as a mental nurse, where I learned the skills needed to be with a person who was distressed, disturbed, or unable to communicate their needs. Being a good listener, and being patient but firm when necessary, were valued highly. When I went to train as a general nurse, I found myself immersed in a very different culture, learning different skills. Here, efficiency was valued highly: an ability to compete tasks on time. Although lip service was paid to the need to be with and listen to patients, it was clearly not the priority. I learned to get things done, but I was never quite quick enough. I prioritised being with people, getting to know them and this slowed me up. I did not last long in the field of general nursing.

I ultimately found a balance between mental health and general nursing, by inhabiting the frontier lands in between them. I moved into liaison psychiatry, what became mental health liaison nursing, and a chance to combine my mental health and general nursing experience and expertise. I was able to transfer mental health skills and knowledge initially into A&E departments, then haematology and oncology, and palliative care. I was part of the rapid development of mental health liaison nursing, and was able to reflect on, and analyse, its overall place in nursing (Roberts 1997).

If we are looking to find the common elements in nursing, we do well to look at the work of Hildegard Peplau. She trained as a nurse before becoming very interested in interpersonal psychology. Applying this to nursing, she introduced key elements of psychotherapy into nursing and the nursing curriculum. In doing so, she identified something very important in understanding the nature of nursing: with its focus on relationships, it often has more in common with psychotherapy than it does with its other obvious comparison, medicine. Relationships are central to nursing, and these can be used for the direct benefit of the patient.

So, nursing has gained considerably from the transfer of theory and skills from mental health nursing into the care of the physically ill. This would be lost if this specialisation no longer takes place, if all nursing care is combined under the one registration. Both mental health and general adult nursing have much to offer each other, but it should be based on positions of strength and distinctiveness.

Roberts, D. (1997) Liaison mental health nursing: origins, definition and prospects. *Journal of Advanced Nursing* **25**, 101-108.

Williams, A, Irurita, V (2004) Therapeutic and non-therapeutic interpersonal interactions: the patient's perspective. *Journal of Clinical Nursing*, 13, 806-815.