Bridging – talking meaningfully about the care of people at risk

From Relationships to Partnerships

Within less than a decade, the concept of 'risk' has become a central focus of mental health policy and practice. Various processes of 'risk assessment' and 'risk management' are employed as a form of contemporary governance, attempting to control the actions of both service users and practitioners to best meet the fiscal needs of the organisation (Crowe and Carlyle, 2003). This suggests that the organisation – rather than the 'patient' – is most 'at risk' (of litigation).

Crowe and Carlyle (2003) saw a need for nurses to re-examine carefully their socially mandated role as 'guardians' of people at risk, if they were to continue to fulfil their espoused 'therapeutic' role. The 'nurse-patient relationship,' first described over fifty years ago, is a major 'given' of nursing practice: nurses spend time with patients and this (of itself) is therapeutic (Jackson & Stevenson, 1998). However, in Moyle's view, such 'close relating' did not come instinctively to all nurses. Instead, she found a clear dichotomy between the close relationship expected by patients and the distant relationship often provided by nurses (Moyle, 2003).

In the 1990's, the 'therapeutic relationship' was reframed by the business culture of healthcare as a 'partnership'. In her study of acute psychiatric care Cleary (2003) noted that the 'partnerships' concept was commonly cited as the 'cornerstone of integrated patient care' and even had been hailed as 'the nursing hallmark of this decade' (Cotroneo et al,1997). However, "when patients are denied the right to pursue a choice contrary to what the clinician considers best, the possibility of real partnership is precluded" (Cleary, 2003: 143).

A major problem with recent developments in mental health care involves the careless borrowing of concepts (like partnership or consumer) from business and commerce; re-applying them, with little critical consideration, to wholly different contexts. Given its in-built power imbalance, the 'partnership' between providers and recipients of mental health services could hardly be more different from the free-market of commerce. This suggests the need to 'unpack' the language of care and, perhaps, the need to generate more meaningful terminology.

The Emergence of the Observation Culture

At least within residential care, the commonest way that nurses have exercised their 'guardian' role has been through the practice of 'observation' (SNMAC, 1999). Although a longstanding aspect of nursing care (Davidhizar & Vance ,1993; Rogers, 1993), over the last 15 years 'observation' has been defined specifically in documented procedures, and mandated generally through policy directives (Duffy, 1995; Bowers et al, 2000; Clinical Resource and Audit Group, 2002). In too many setting, 'obs' (as it is euphemistically known) has become the *raison d'être* of acute care nursing. However, there is widespread consensus that observation fails to meet the needs of either users or professionals (Barker and Cutcliffe, 1999; Barker and Cutcliffe, 2000; Bowles et al, 2002), and there have been strong appeals to review the approach to supporting people at risk (O'Brien and Cole, 2003; Langham & Lindow, 2004; Meiklejohn et al, 2003).

To the layperson 'observation' must represent a curiously illogical response to a human crisis. If we thought that an electric plug was faulty and might catch fire, we would not 'put it on observation'. Similarly, if we though that someone might haemorrhage, we would not simply 'observe' the person. Observation would merely be a minor part of more complex process of examination and investigation, hopefully leading to decision-making as to 'what to do next'.

However, in Horsfall and Cleary's (2000) view the ineffectiveness of observation is linked to its reinforcement of the traditional medical hierarchy of power relations. The 'observation policies' that dominate practice, may emphasise succinctness and clarity. However, this is invariably at the expense of any consideration of patient rights, therapeutic processes and inherent ethical dilemmas. 'Observation' becomes something that is done 'to' people and, much research illustrates how unsatisfactory this is for service users. Langham and Lindow (2004) acknowledged how organisational cultures made many professionals 'practice *defensively* rather than *defensibly*'. However, they urged professionals to 'take appropriate risks' and 'talk about risk', looking holistically at a person's life, including other harms they may be experiencing, such as racism and trauma.

Updating Observation

In Scotland, the Clinical Resource and Audit Group (CRAG) published a review, which attempted to address many of the accepted weaknesses of observation. Although CRAG (2002), proposed that 'engagement' should be an integral aspect of 'observation', they ignored most of the original work on this concept, especially the philosophical and ethical arguments. In particular, Barker and Cutcliffe (1999; 2000) had argued that observation was a dimension of engagement – *not* vice versa. Professionals cannot fail to observe if actively *engaged* with the person in their care. However, as countless studies illustrate, professionals can (and frequently do) conduct 'observations' *without* any human engagement. Regrettably, CRAG's report, although a useful update on policy and process, conserved the use of the term 'observation', which has long outlived its usefulness.

The names we give to things denote the nature of the thing itself, how it 'works' and perhaps also our relationship to it (Wittgenstein, 1965). There is a world of difference between 'observing' and 'engaging'. If we wish to emphasise and value the kind of activities associated with engagement, logic would determine that we begin by not calling it observation.

Given that observation has acquired (rightly or wrongly) such a bad name, the need to reframe it is not a linguistic luxury. A decade ago, nurses in the UK acknowledged that their old 'psychiatric' title either was 'bad' or inadequate for describing their work. So, they renamed themselves 'mental health' nurses. It is ironic that nurses have not felt similarly motivated to jettison the terminology of 'observation'.

To be is to do

In the early development of the Tidal Model (Barker, 1997) attempts were made to represent more precisely 'what' nurses did in the name of caring – especially for people at risk, who often retreat from human contact. It was obvious, therefore, that professionals needed to 'reach out' in some way, to make contact with the person. Such contact was the necessary first step to gain access to the person's 'lived experience', from which might develop an appreciation of the appropriate caring response. This process was called '*engagement*' (Barker, 1998; 2000; Barker and Buchanan-Barker, 2004).

Through workshops and ongoing discussion with colleagues in various Tidal Model evaluation projects, we have had an opportunity to revisit the 'naming' of the caring process we described for supporting people at risk. Although 'engagement' was useful originally in distinguishing it from the limited scope of mainstream 'observation', it is not without its problems.

'Engagement' now features in both policy documents and the published literature, and this has led to a blurring of meaning. 'Engagement' can mean a 'moral commitment', which fits neatly with the value base of the Tidal Model. However, 'engagement' can also mean 'an encounter between hostile forces'. As fewer people become 'engaged' to be married, and the media report more and more 'engagements' on battlefields around the world, the hostile connotation of the word is reinforced.

Over the past year we have reviewed alternative names for the supportive human process necessary to reach out to people in distress, in an effort to *connect* with them, meeting them – at the very least - halfway. We have re-named this process – *bridging*.

Bridging – it means what it says

Bridging provides an apposite metaphor for the necessary work of *supporting* people in distress, or otherwise 'at risk'.

- People have constructed (physically) bridges since the dawn of humankind, across all societies and cultures, and the 'need to build bridges' between alienated individuals, is a popular English metaphor.

- 'Bridging' is the necessary function of all bridges, whether architecturally grand or simply functional. All bridges 'do' the same thing. The *purpose* of 'bridging' is connect – to make contact – thus allowing existing paths to continue and join.
- 'Bridging' involves constructing a means of crossing threatening water, so that

we might reach something of *importance* on the other side. As with any bridge, (physically) there are always two sides and there is always a gap. Metaphorically, this represents the way people are separated by differences of understanding, power or status.

- The gap can be 'bridged' (physically) using any kind of material – from the rope bridge over a gorge in the Andes, to the steel and rivets of the Forth Rail Bridge. Metaphorically, this illustrates how we can use any means at our disposal to 'reach across' the gap that appears to separate two people.
- The 'bridge' is not a judge – it connects everyone who expresses the desire to cross over, no matter who they are or where they have been.
- 'Bridge' traffic is not one-way, but allows those using it to move back *and* forwards if they wish.
- When two people meet on a 'bridge', there is no fixed meeting place, in the same sense that the bridge is a 'seamless' connection between two opposites.
- In snooker and billiards, the 'bridge' – which may be an actual device or simply the shape of the player's free hand – provides the support necessary for playing a difficult shot. This offers a fine metaphor for the challenge nurses face in dealing with risk.

In mental health care, we need to 'cross' the threatening waters of madness; to 'reach' the person in distress. The bridging metaphor aptly suggests the necessary creativity and effort involved in building a bridge to connect with a person who may be alienated, isolated, threatened and fearful. It acknowledges that the activity of 'bridging' has inherent dangers. Bridge builders need to act *skillfully* and *carefully*, acknowledging all the risks that might be involved. They also need to ensure that the 'basic building blocks' are in place, before any further develop takes place. Again, in mental health care, these 'building blocks' are human – not bureaucratic - processes. These powerful metaphors communicates a desire to depart radically from the bureaucratic system that has overtaken the mental health system; one which has dehumanized both professionals and the people in their care.

Most significantly, unlike 'observation', which is a thing (noun), 'bridging' is *indicative*, denoting the *activity* involved in caring. 'Bridging' cannot exist outside of the interpersonal relationship between professional and person in care. 'Bridging' can only develop as the two people begin to make contact. We can only know how bridging 'works' by examining the shared outcomes of 'bridging' as a human encounter. Much like playing a musical instrument or riding a bicycle, we can only learn to *do* 'bridging' by doing it.

The Personal Security Plan: Archie's story

A Tidal Model assumption is that risk (to self or others) is related to the human state of 'emotional insecurity' (Barker and Buchanan-Barker, 2004). Mainstream 'risk management' aims to keep the person 'safe'. Usually, this involves carefully *managing* the social and physical environment, so preventing the person from acting harmfully towards self or others. Often little or no attention is paid to the private*,* *intrapersonal*, world of the person's 'lived experience'. However, If people can become more 'emotionally secure', within themselves, they will by consequence be 'safer' within the interpersonal and physical environment.

The Tidal Model employs a specific 'care plan' to address emotional insecurity. Archie was seriously suicidal person with a long experience of 'being on obs'. However, he believed that observation was a 'waste of time' because 'the problem isn't *out there* (pointing to his body) but *in here* (pointing to his head)'. Although he had no idea how nurses could 'get inside' his head, Archie gave his time over several months to help explore ways that nurses might understand better the 'private world of experience'. The outcome was the original 'Security Plan'. On the advice of a wide range of people who have since experienced the process, it was renamed the Personal Security Plan, emphasizing ownership by the person in care.

The Personal Security Plan is a single sheet of paper, on which the nurse and the person in care, co-construct a provisional plan, which aims to help the person feel more secure within him/herself and the wider social environment. It is written in the person's own voice, and revised at least once a day, in an effort to become part of the person's lived experience of risk. This collaborative form of 'risk assessment' and ' collaborative care planning, has been practiced within Tidal Model projects at home and abroad for over five years. It is worth noting that Langham and Lindow (2004) called for just this kind of this kind of collaboration, focused on accessing the person at risk's 'lived experience'.

However, writing words on paper is easy. The real challenge lies in the process necessary to find those all-important words. 'Bridging' exemplifies the way nurses might use themselves to reach out, connect and begin to share the reality of living with risk.

Meaning in the Metaphor

Policies, procedures and protocols now securely underpin the bureaucratic culture of Western health and social care. However, ethical practitioners need to continue questioning the philosophical and ethical underpinnings of these processes. What are they for? On what ideas (or evidence) are they based? Who is the intended beneficiary?

Although we framed the concept of 'bridging' specifically for the 'risk' context, experience tells us that this is the key building block of all therapeutic encounters – in bridge-building terms it is the 'keystone'. Although we have psychotherapy and counseling backgrounds, we believe that 'bridging' – like many other human encounters necessary within the Tidal Model – is *not* psychotherapy or counseling. It is more important than that: it is *conversation*. The very ordinariness of these ‘bridging’ conversations can render them quite extraordinary, for both parties.

In supervision, we have been privileged to watch and listen to lots of nurses attempt to ‘bridge’ with people in deep distress. We hear them address issues such as:

- How to bridge when trust appears to be absent?
- How to bridge when very differing points of view exist?
- How to bridge when the two parties are beginning from very different starting points?
- How to bridge when reaching understanding appears impossible?
- How to bridge when the nurse and the person in care, clearly have very different beliefs?

Critics will argue that using metaphor is too subtle or complex for care-face staff to understand. We could not disagree more strongly. The support that people at risk need must be sensitive, compassionate and creative. We cannot afford to offer less. More importantly, since the experience is invariably ‘beyond words’, metaphor fulfils a key role in expressing the inexpressible. Indeed, the rigid template of most ‘observation guidelines’ may have led many practitioners to simply follow the ‘letter of the law’, giving up thinking and feeling their way towards the person in distress.

Over the last few years we have been conducting experiential workshops in different countries. We usually begin by asking the group: “what would you want for one of your loved ones, were they to experience ‘a breakdown’, and become a risk to themselves or others?” So far, none of the 2,500 participants has ever said - ‘*put on observation’*. Instead, we have been struck by the way professionals demand compassionate, sensitive and creative *caring* for their loved ones. In the real world of professional practice there is little support, for ‘caring by guidelines’, at least where real people at risk is concerned.

Although CRAG (2002) stated that *anyone* could be called upon to conduct observation, in our experience the nurse is, almost always, the ‘care face’ practitioner, to whom this onerous responsibility falls. It seems appropriate, therefore, for nurses – and the discipline of nursing - to begin to develop its own language for the discrete processes necessary to care for people at risk, rather than

– as so often has been the case – have the story of care written for them, by others.

References

Barker P (1997) Towards a meta theory of psychiatric nursing. *Mental Health Practice,* 1(4) 18-21

Barker P (1998) Its time to turn the tide. *Nursing Times* 94(46) 70-72

Barker P (2000) The Tidal Model: The lived experience in person-centred mental health care. *Nursing Philosophy* 2 (3) 213-223

Barker P and Buchanan-Barker P (2004) *The Tidal Model: A guide for mental health professionals* London: Brunner Routledge

Barker P and Cutcliffe J (1999) Clinical risk: A need for engagement not observation. *Mental Health Practice* 2(8) 8-12

Barker P and Cutcliffe JR (2000) Creating a hopeline for suicidal people: A new model for acute sector mental health nursing. Mental Health Care 3(6_ 190-92

Bowers L, Gournay K & Duffy D (2000) Suicide and self-harm in inpatient psychiatric units: a national survey of observation policies *Journal of Advanced Nursing* 32 (2) 437-444

Bowles N, Dodds P, Hackney D, Sunderland C & P Thomas (2002) Formal observations and engagement: a discussion paper *Journal of Psychiatric and Mental Health Nursing* 9 (3) 255

Cleary M (2003) The challenges of mental health care reform for contemporary mental health nursing practice: Relationships, power and control. International Journal of Mental Health Nursing 12(2) 139-47

Clinical Resource and Audit Group (2002) Engaging People: Observation of People with Acute Mental Health Problems : A Good Practice Statement Scottish Executive, Edinburgh

Cotroneo M, Outlaw FH, King J and Brince J (1997) Integrated primary health care:

Opportunities for psychiatric-mental health nurses in a reforming health care system. Journal of Psychosocial Nursing and Mental Health Services 35, 21-7

Crowe M & Carlyle D (2003) Deconstructing risk assessment and management in mental health nursing Journal of Advanced Nursing
*43(1)*19-26

Cutcliffe J and Barker P (2002) Considering the care of the suicidal client and the case for ‘engagement and inspiring hope’ or ‘observations’*. J Psych and Mental health Nursing 9 (5)*

Davidhizar R & Vance A (1993) The management of the suicidal patient in a critical care unit *Journal of Nursing Management* 1, 95-102

Duffy D (1995) Out of the shadows: a study of the special observation of suicidal psychiatric in-patients *Journal of Advanced Nursing* 21, 944-950

Horsfall J & Cleary M (2000) Discourse analysis of an 'observation levels' nursing policy *Journal of Advanced Nursing* 32(5) 1291-97

Jackson S and Stevenson C (1998) The gift of time from the friendly professional. *Nursing Standard* 12 (51) 31-33

Langan J and Lindow V (2004) *Living with risk: Mental health service user involvement in risk assessment and management* London: The Policy Press

Meiklejohn C, Hesmondhalgh M and Mason-Penny L (2003) Nursing observations in a medium secure unit: A review of practice Mental Health Practice 7(3) 12-14

Moyle W (2003) Nurse-patient relationships: a dichotomy of expectations. *International Journal of Mental Health Nursing* 12 (2) 103-9

O’Brien L and Cole R (2003) Close-observation areas in acute psychiatric units: A literature review *International Journal of Mental Health Nursing* 12(3) 165-176

Rogers P (1993) Assessment and treatment of a suicidal patient *Nursing Times* Vol 90, No 34, 37-39

Standing Nursing and Midwifery Advisory Committee (SNMAC) [1999] *Practice Guidance: safe and supportive observation of patients at risk: mental health nursing – Addressing acute concerns.* London: Department of Health

Wittgenstein L (1965) *Philosophical Investigations*. New York: The Macmillan Company