OCCASIONAL PAPERS

A Post-registration Course in Child Psychiatry for Nurses

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The RMPA (1965)[1], in assessing the need for psychiatric in-patient accommodation for adolescents and children, recommended that there should be 20 beds available for children for every half million of the total population and a like number for adolescents. Hence a reasonable estimate of the bed needs for the United Kingdom is approximately 4,000. As present provisions fall far short of this, there should be a rapid expansion of residential facilities over the next decade.

It is generally accepted that a high nursing staff/child ratio is necessary in child psychiatric units. Haldane *et al.* (1965)[2] point out that their staff/patient ratio of 1:1 allows at best a ratio of 1:3 by day and 1:6 by night.

Two reasonable inferences from the above logistics are:
(a) that the nursing staff/patient ratio needs to be in the vicinity of 1:1
(b) that if nursing services are to keep step with residential facilities some 4,000 nurses need eventually to be found.

There is at present a serious shortage of trained nurses for this type of work and this is going to constitute an important limiting factor to expansion. At present relatively few nurses are child psychiatrically trained, except by virtue of experience. Of the above estimated number of nurses one would like to see a high proportion with a formal and systematic training to supplement their practical experience.

Who Needs Training?

The most urgent need is to train senior members of nursing staff. Initially they will have to set the pattern and be the guides and mentors of junior and untrained nurses. We therefore suggest that training be confined to those at staff nurse level and above. Using these criteria, and without taking into consideration the rate of attrition, approximately 1,000 nurses will need to be trained over the next decade.

Although there are a number of people who intuitively know how to handle children, and many who in the course of time have acquired certain skills, few would argue for the retention of training by virtue of experience alone. Many techniques and skills have been individually developed in the past but unless they are clearly thought out and formulated it is unlikely that they will be perpetuated. Imparting nursing skills through the trial and error management of patients is foolhardy and retrogressive when rapid changes and progress are occurring.

The Solution

The solution lies in the recruitment and training of nursing staff in readiness for the anticipated expansion. It was considered, therefore, that there is a need for a course that goes far beyond in-service training to provide comprehensive practical and theoretical education. We believe that to plan an experimental course properly one would need the backing of a reasonably large academic organization. Such an experimental course would also have to be adequately financed and one of us therefore approached the Nuffield Provincial Hospitals Trust, who kindly agreed to support this venture. Subsequently, arrangements were made for the course to come under the aegis of the Department of Adult Education, University of Newcastle.

Facilities and Background to the Course

Architecture of the Unit

The Nuffield Child Psychiatry Unit is a subdepartment of Professor Martin Roth's main Department of Psychological Medicine. It is a specially built unit, in the grounds, and as such is an integral part of the Fleming Memorial Hospital for Sick Children. Its facilities are extensive and so too are the ramifications and links of the department.

In 1957 Dr. Philip Connell[3] innovated, in the UK, the Day Hospital in Child Psychiatry in Newcastle. Thus there is a wealth of experience in Newcastle in the running of day hospitals. A year ago the day hospital facilities were combined with in-patient facilities to produce an integrated day and in-patient department as described by Kolvin (1968)[4]. This provides for up to 20 in-patients and 15 day patients. This unit is housed in a purpose-built L-shaped building. One wing of the L houses the outpatient facilities and provides accommodation for the outpatient professional staff. The other wing houses the dormitories and the activity rooms of the day and in-patient department.

The outpatient wing, in addition to consulting rooms, contains a suite of three rooms, including a conference room, all of them equipped for unobtrusive observation by sight and sound. These facilities are put to extensive use for teaching and demonstration purposes, enabling a number of students at a time to watch and learn from techniques of child management without exerting a disruptive influence.

Similar facilities are built into playrooms, schoolrooms and occupational therapy rooms. An active EEG department is contained in the unit and an electrophysiology laboratory for children, with telemetry facilities, is soon to be started.

The department runs up to 30 beds for children with psychiatric disturbances of a chronic nature in a convalescent hospital situated outside Newcastle.

Geography of Child Psychiatry in Newcastle

There are close links with the local authority child guidance services and a day school for the maladjusted. There are

well-established links with the Department of Child Health, University of Newcastle; with an otologist interested in child disorders; with the Speech Therapy Department, Newcastle University, and with local subnormality hospitals. There will also be links with the proposed centre for assessment of children with multiple handicaps.

The Fleming Memorial Hospital for Sick Children

The Nuffield Child Psychiatry Unit is an integral part of this established paediatric hospital. The Fleming already runs a successful four-year combined programme for general and paediatric registers, and a 13-month course in paediatrics for State-registered nurses. In these courses radical innovations have been made with the aim of minimizing undesirable qualities of passivity, inarticulateness and stereotyped response in nurses; they are designed rather to develop individuals possessing an outlook which is at once kind and sympathetic, balanced, critical and flexible (Sayer and Birch, 1967)[5].

The Staff and their Teaching Commitments

The staffing structure is as follows: three full-time consultants and two part-time consultants, including a consultant psychotherapist; four full-time psychiatric social workers and two part-time; three full-time psychologists and one part-time; three full-time psychiatric registrars and one part-time; three teachers; two occupational therapists; one assistant matron for the unit; three sisters; eight staff nurses; 10 SENs or nursing assistants; one full-time EEG technician and one part-time technician.

As regards nurses, there is a hard core of permanent staff who do not take duties in the paediatric wards (with the exception of the assistant matron with occasional duties in the main hospital).

The teaching commitments of the professional staff are as follows.

- (i) medical undergraduate teaching
- (ii) medical postgraduate teaching.
  - (a) DPM students (university)
  - (b) DPH students (university)
  - (c) paediatric staff (in-service)
- (iii) social workers
  - (a) Applied Social Studies Course (university)
  - (b) Child Care Course (Department of Adult Education)
- (iv) nurses
  - (a) Health Visitor Courses (College of Commerce)
  - (b) paediatric nurses (hospital)
  - (c) psychiatric nurses (hospital)
- (v) teachers
  - advanced courses for teachers training for special education in the University of Newcastle Institute of Education
- (vi) psychologists
  - Diploma in Clinical Psychology (university).

The writers therefore feel that the current teaching commitments and programme of the hospital provide a body of teaching experience affording a fertile ground for the inception of a nurses' teaching programme in child psychiatry.

The Patients

Children with a wide variety of disorders are admitted to the unit for a full and careful assessment, either because they are not responding to outpatient treatment or because they need more intensive management and therapy. The average length of stay is 10 to 12 weeks, which we consider reasonable for a medium-stay unit. The age range of the children depends on whether they are coming in on a day patient or in-patient basis. We admit in-patients up to 12, and day patients up to 14 years of age. The unit is not geared to coping with testing-out, acting-out, violent or agressive adolescents.

Recruitment

We anticipate that interest will be shown in the course by nurses with psychiatric, paediatric, general mental subnormality training. Haldane *et al.* (1965)[2], in trying to compare and contrast child psychiatric nursing with nursing care of adults, tentatively concluded that there are significant differences in the day-to-day work of the staff and what is demanded of them; that the goals of therapy need not be radically different though the techniques of therapy are; that the nature of the relationships between staff and patients is different, and that present-day nurse training is inadequate preparation for child psychiatric work.

Haldane was contrasting adult and child psychiatric nursing but we believe that these conclusions would hold good for other kinds of training. The previous experience and training of such a nurse would provide her with some superficial introduction to child psychiatric nursing, insufficient for effective working in the psychiatric setting.

In planning a course we should have to assume the minimum of knowledge in all the nurses and allow the course to be flexible enough so as to make good any special deficiencies associated with a particular kind of training. One other pertinent point raised by Haldane concerns the personalities of the nurses and whether these need to differ significantly for different types of nursing.

Sayer and Birch (1967)[5] confined their training programmes to girls with high intellectual and educational potential. We believe this is going to be even more necessary for nurses attempting this course. They will have to assimilate concepts not only from adult psychiatry and child psychiatry but also from other related subjects such as psychology, social work, education, occupational therapy and hospital and community administration.

The dual task of this course, therefore, will be first to provide specific theoretical and practical training in child psychiatric nursing and secondly to make up the deficiency from one kind of training to the other.

The Prospective Child Psychiatric Senior Nurse

Roles and Skills

Haldane (1965)[2], in discussing the roles and skills of the psychiatric nurse, points out that John *et al.* (1963)[6] suggest that seven main skills should be possessed: basic nursing skills, technical nursing skills, occupational and recreational skills, organizational skills, interpersonal skills, observational skills, skills of communication with patients and co-workers.

Haldane goes on to say that, in his unit, nurses will be called upon to exercise all of the above skills with the proviso that they will rarely be called upon to use technical nursing skills.

There are indeed variations between departments, and in our department where we have a special interest in borderline disorders between child psychiatry, paediatrics and medicine (such as brain damage and epilepsy with behaviour disorders, anorexia nervosa, asthmatic disorders, the occasional necessity to deal with mechanical blockages in encopretics) certain technical nursing skills become very necessary.

Selection

With our first batch of students we shall, in the main, use interview techniques to decide whether they are suited to child psychiatric work. However, we realize that more sophisticated objective techniques should be used and we will be considering using these in the future. We believe the child psychiatric nurse needs to be motherly and understanding by intuition and also capable of firm and decisive action when necessary. In addition to the skills listed above she must be capable of responding with versatility while providing continuous care of children in the unit. Krug (1951)[7], Hallman (1960)[8] and Haldane (1963)[9] all attest to the importance of continuity of nursing care. The nurse must also become a parent figure while taking care not to alienate the children from their parents and homes. As such, she must undertake not only a number of parental domestic chores such as supervising or directly helping with dressing, feeding, bathing and bedding but also indoor and outdoor play or other activities on an individual or group basis.

Nursing staff relationships with children either on an individual or group basis are all-important. Inasmuch as nurses help the child to feel better and play and occupy themselves more happily and constructively their activities must be considered broadly therapeutic. Often the recovery from maladjustment has more to do with the learning of new, acceptable responses, than the unravelling of the old unacceptable ones.

Clear guides which incorporate a sensible set of principles to nursing management have been adumbrated by Rogers (1965)[10]. Group skills and the principles of group psychotherapy as outlined by Martinez (1958)[11] should be taught. Opportunities for using the latter will depend on the nurses' training, attitude, ability and the orientation of the department.

Most child psychiatric units operate as therapeutic communities where the nurse is a member of a team. The work of each discipline with the

team should dovetail and overlap with that of other disciplines. Each discipline must learn its essential roles and functions and while making use of productive overlap avoid wasteful and obstructive duplication. A most important skill is the observational one—to be accurate reporters of behaviour as well as providing inferential accounts of children's behaviour.

Outline of the Course

The theoretical part of the course will cover three academic terms of 10 weeks each, while practical experience will be provided throughout the year. During each term the post-registration students will be given formal lectures, attend routine unit conferences and special seminars, undertake outside visits and receive practical training.

Throughout the academic year a number of conferences are routinely held but only some of these are considered appropriate for nurse training: first there are the 'day and in-patient' conferences; second there are a series of weekly lecture conferences which consist of more formal lectures, related to child psychiatry or associated subjects which alternate with case conferences; and thirdly a monthly paediatric-psychiatric meeting.

In addition to the above there will be:

(a) *Weekly seminars*—general and review.

(b) *Visits* to other agencies or institutions (schools for the maladjusted, ESN schools, school for the deaf, school for the handicapped, training centres, children's homes, probation departments, special units in mental subnormality institutions, etc.).

(c) *Lectures*

(1) The normal and abnormal physical and emotional development of the child.
(2) History and background of child psychiatry.
(3) An elementary classification of adult and child disorders.
(4) Adult psychiatric illness.
(5) Child psychiatric disorders including subnormality.
(6) Mental defence mechanisms.
(7) Therapy in child and family psychiatry.
(8) General principles of management of children on a residential basis.
(9) General principles of management of disturbed children on a residential basis.
(10) Principles of paediatric nursing.
(11) Community services such as child care, education, probation, etc.
(12) Psychiatric social work including the basis of social history taking, case-work, links with the community, dynamic intra-family interactions and relationships, social and family problems.
(13) Psychology—brief introduction to personality and its measurement, intelligence and its measurement. Also an introduction to the elements of the two main schools of psychology.
(14) An outline of progressive primary educational methods and the educational management of disturbed children.
(15) Special topics such as special sense disorders and their consequences, the EEG and child psychiatry.
(16) Principles of occupational therapy with maladjusted children.
(17) Play and activities at different stages of childhood.

(d) *Written child studies*—each nurse will undertake special reports on her observations of selected children over a prolonged period.

(e) *Creative skill*—each nurse will be encouraged to develop some art or craft skill which will appeal to a child's imagination. Such creative skills can be invaluable to grown-ups in helping them make the beginnings of a relationship with apathetic children.

It is proposed to spread the lectures over the academic year. They will be given by psychiatrists, paediatricians, psychiatric social workers, psychologists, occupational therapists, nurses, teachers or lecturers in special education, speech therapists, child care officers and probation officers. Some of the sessions will be formal whereas others will incorporate teaching on cases under observation in the unit. In this way the nurses will be provided with both direct and indirect demonstration of the phenomenology of child psychiatry and techniques of management of child psychiatric disorders.

Attractions and Prospects

A word must be said about the generally attractive nature of child psychiatric nursing. Many women prefer working with children rather than adults. Children are reasonably plastic creatures by nature and child psychiatric disorders are eminently reversible conditions. This means that in the main the nurse will be working in an atmosphere of hope and anticipation of improvement. Furthermore, the trained psychiatric nurse as a member of a multi-disciplinary team working in a therapeutic community atmosphere will help with the psychological diagnosis and be a key figure in the management of the children. He or she should, therefore, have equal status with other disciplines forming part of the team.

The prospects of the trained child psychiatric nurse taken in the national context of a dearth of trained nurses are excellent, especially during an initial period of expansion. They should be able to gain reasonably rapid promotion. Their skills can, furthermore, be used in other contexts, namely as a housemother or housefather in schools for the maladjusted or in children's homes or hostels; or as housemother, housefather or matron in schools for the physically handicapped or multiple handicapped assessment units; or perhaps just as a balanced, sensible wife and mother.

The prospects of the course depend essentially on whether individual departments setting up courses throughout the country can obtain a high standard and whether a measure of agreement and uniformity between courses can be achieved so that we can ultimately look forward to recognition by the General Nursing Council.

Conclusions

(1) A rapid expansion of child and adolescent psychiatric residential facilities is envisaged.

(2) A concomitant increase in nursing personnel to keep pace with this expansion must be planned.

(3) There is a serious dearth of nurses specifically trained for this kind of work.

(4) It is suggested that there is a need for training courses.

(5) A description is provided of the proposed Newcastle course which has been subsidized by the Nuffield Provincial Hospitals Trust.

(6) It is suggested that the career prospects for such trained nurses would be outstandingly good.

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