Future nursing participation in the appointment of consultant psychiatrists

DEAR SIRS

There has been considerable discussion in our Division on the topic of nursing participation in medical appointment committees in the specialty of psychiatry. Though opinions differ, the Division has asked me to write to you to sound out opinion in the profession generally.

The composition of consultant appointment committees is statutorily limited. Any change allowing the inclusion of a nursing member at such committees would have to be made by the Department of Health in the relevant statutory regulations. To achieve such change we would need a concerted initiative on the part of the psychiatric profession.

Judging by the discussion held within our Division there are a significant number of consultants (myself included) who feel that modern psychiatric treatment methods are so crucially dependent on team work, co-operation and shared responsibility between medicine and nursing that it is becoming essential to have a responsible nursing voice on senior medical appointments (and vice versa). May I, through this letter, use your columns to invite comment from those of similar and opposite views? If it proves that there is a significant body of opinion in favour of changing the regulations, I hope that this correspondence will put like-minded people in touch to mount an approach to the Department of Health.

ELIZABETH MCLEAN

Springfield Hospital
London SW17

Secure facilities for adolescents

DEAR SIRS

I was interested to read the article 'The Need for Secure Provision for Adolescents within the NHS' (*Bulletin*, October 1984, **8**, 198–200).

The Secure Adolescent Unit for the North-West Regional Health Authority (The Gardener Unit) started admitting in-patients (20 beds), age-range 13 to 18, from mid-January 1985.

The delay in in-patient beds opening, which I initially found so frustrating, has in fact meant that I have had to work closely with caring agencies and district health facilties and consider ways other than admission in trying to tackle successfully the problems that 'disturbed' adolescents can present.

This has highlighted for me many of the issues addressed by the Working Party and in particular has helped me to distinguish those adolescents who can, with a service input from a Regional unit, be helped without the need for in-patient admission and those who need care and treatment within a secure in-patient health setting.

Legislation: In my own practice, working with Social Services departments within the Region, I would agree that the amendments in Child Care legislation of April 1983 are leading to more referrals to the NHS. My work within the Prison Service would also lead me to suggest that there are a small, but nonetheless significant, number of psychotic adolescents aged between 16 and 18 who have come into conflict with the Law and who find themselves within the penal system. This group, I would envisage, could be admitted to our Unit under Sections 35, 36, 37 and 38 of the Consolidated Act.

Nature of security: Our own security will be compatible with that of some, but not all, of the Adult Regional Secure Units, but I would very much support the authors' view that the security and care is dependent on adequate numbers of well-trained staff.

Criteria for admission to a secure NHS facility: Adolescents referred to date have displayed either a psychotic illness or features of a mixed emotional conduct disorder. A significant number of the adolescents are of below average or dull-normal intelligence and often show a range of minor physical handicaps. Behaviours giving rise to concern to the referring agency have included risk to self and others, substance dependency, inappropriate sexual behaviour and fire-setting.

Needs and location of the Unit: Our Unit is sited on the campus of an adult psychiatric hospital, located in an urban area. We are adjacent to an open adolescent unit and teaching staff are shared between the Units. I value the links with the adolescent unit and with other specialist Regional units.

Legality of secure detention: This area has proved exceedingly complex. Advice has been sought from many sources, but the opinions received have often conflicted. It would appear that admissions will be about equally divided between those subject to the Consolidated Mental Health Act and those subject to Secure Care Orders.

Further problems and conclusions: It is fairly apparent that many of the adolescents who have been referred have had considerable help and treatment in the past and so I in no way underestimate the task we have set ourselves if we are to try and help these youngsters within a secure health setting. Some youngsters may be some distance from home and incorporated into our Unit are two flats where families may stay, so that we can, particularly with the younger adolescents, work with the total family. I had some reservations about the willingness of families to be thus involved, but experience so far has been positive.

In trying to cater for broad categories of disturbed adolescents it appears inevitable that our mix of in-patients may at times prove problematic in that I could foresee us having some adolescents for a short in-patient admission where, for instance, a psychotic youngster was at least temporarily proving difficult to manage within the district health setting. There will be other youngsters where our commitment to them is more long-term and here I recog-

nize that staff will need great support to maintain an input of work with these youngsters when the change that they see in them may only be slight. With youngsters with whom we have an on-going commitment it would appear essential that we are able to obtain accommodation outside a secure setting, e.g. group homes or perhaps hostels so that we can gradually re-introduce them back into the community.

I was pleased to note the comments the Working Party made about the importance of on-going evaluation of a Unit such as ours and the obligation we have to become involved in research and looking at the effectiveness of what I would like to stress is not just an in-patient Unit, but a Service.

SUSAN M. BAILEY

Prestwich Hospital
Prestwich, Manchester

Use of the Nursing Process in psychiatry

DEAR SIRS

The use of the Nursing Process in psychiatry continues to cause debate. May I be permitted to make the following observations.

Inherent in the New Syllabus of Training for psychiatric nurses is a requirement to change the framework within which psychiatric nursing is practised. It assumes that care is organized within a 'needs meeting and problem solving concept'. This approach defines nursing as a deliberate, planned and scientific activity, tailoring nursing care to the unique needs of each patient. In its purest form the requirement is that each patient is assessed as to their nursing needs, goals and objectives are set, and a care plan is formulated and implemented. Subsequently, the plan is evaluated in terms of effectiveness in achieving the stated goals, and modified or changed accordingly.

The use of the Nursing Process in such a pure form in psychiatric nursing is seen as problematic by many experts in the field. Schrock[1] pinpoints one of the main reasons for this: 'with the advent of a multidisciplinary approach to patient care, the planning of nursing care as such, may become counter effective, as a separate nursing care plan may simply be duplicating the effort, and may unintentionally exclude some nurses from the full multidisciplinary plan.'

It is advisable that psychiatric nurses gain the support of the multidisciplinary team in organizing individual care plans and consider the views of other disciplines involved.

Should this not occur, the early achievement of clearly defined objectives remains doubtful.

D. M. COX

Broadgate Hospital
Beverley, W. Yorks.

REFERENCE

[1]SCHROCK, R. A. (1980) Planning nursing care for the mentally ill. *Nursing Times*, 17 April.

Practice of psychiatry in the 1880s

DEAR SIRS

We read Dr Parry-Jones's article (*Bulletin*, November 1984, **8**, 208–209) on the practice of psychiatry in the 1880s with interest. We would like to add a few points about that period from our own published research here in Ireland.

The RMS of the Richmond Asylum (now St Brendan's Hospital) at the time, Dr Conolly Norman (1886–1908), together with his nursing staff, were very concerned with the strict economies imposed by the Asylum Governors. Infectious diseases were endemic within the institution. The patients' clothing, received from the hospital stores, was often eaten by rodents. However, the Governors were not too sympathetic.[1]

Between 1857–1885 the number of inmates rose from 600 to 1,100. The RMS became worried at the large numbers being admitted for legal reasons. An Act of 1867 allowed the courts to order committal in the case of insane persons who were apprehended whilst attempting to break the law. The Lord Lieutenant required to be satisfied by two doctors of the patient's recovery before the criminal lunatic could be discharged. Admissions, as a percentage of total admissions, coming under these regulations, rose from 66–88 per cent between 1868 and 1885. By 1898 this asylum had 2,375 inmates. The 1890s saw three major outbreaks in the Asylum of beri-beri.

Nurses had to be locked in with their charges. A special pass was required before they could leave the grounds. The arms of any inmate who broke glass were secured. Violence led to solitary confinement, and vile language led to 'degradation' to the 'Frantic Ward'. However, the education of doctors and nurses at the Richmond Asylum was acknowledged by Hack Tuke and others as being superb.

What diagnostic system was in use in Dublin's main asylum in the 1880s? We found the following categories in a consecutive series of 38 male admissions from 1 January 1888: alcohol-related—10 cases; 'hereditary'—12 cases; epilepsy—7 cases; 'self-abuse'—4 cases; 'trauma' and GPI—2 cases each; and 'old age'—1 case. There were sufficient data available on the first 50 male admissions of that year to make the following retrospective diagnoses: schizophrenia—42 per cent; organic brain syndrome, alcoholism and mental subnormality—14 per cent each; psychotic depression—10 per cent; GPI—4 per cent; and one case of (? abnormal) grief reaction. The three most common reasons for admission to the same hospital in 1980 were: schizophrenia—37 per cent; alcohol-related—21 per cent; and organic brain syndromes—17 per cent.[2]

BRIAN O'SHEA
JANE FALVEY

St Brendan's Hospital
Dublin 7

REFERENCES

[1]O'SHEA, B. & FALVEY, J. (1984) A history of St Brendan's Hospital, Dublin. *Psychiatric Nursing*, **2**, 27–34.

[2]FALVEY, J. & O'SHEA, B. (1983) Psychiatric case recording in the 1880s: Outdated lessons? *Psychiatric Nursing*, **2**, 23–26.