King's Fund Centre

# MENTAL HANDICAP PAPERS

# 4

## PERSPECTIVES OF THE BRIGGS REPORT

A discussion paper on the future role and training of subnormality nurses, and their relationship with residential care staff.

London 1973

Price : £0.25

Printed by
*Health and Social Service Journal*,
27-29 Furnival Street, London, EC4A 1JR

# PERSPECTIVES OF THE BRIGGS REPORT

A discussion paper on the future role and training of subnormality nurses, and their relationship with residential care staff

KFC Reprint No. 837

# CONTENTS



. . .

## WHY THIS PAPER HAS BEEN PRODUCED

1. The future of nurses for the mentally handicapped is clouded with uncertainties; it requires a very careful look ahead: the problem facing nurses and others is not whether a change should take place in staffing and training, but what change is to take place.

2. As a result, the King's Fund decided last Spring that some attempt should be made to explore the perspectives of the Briggs Report as it applies to mental handicap nursing. Two residential seminars and two one-day seminars were held on an invitational basis, and in addition, one major day conference was held on an open basis. The number of mental handicap nurses involved never fell below 50% and was sometimes as high as 70%; but there were also present, psychiatrists, psychologists and social service workers. The conference and the seminars were complementary to one another, and eventually resulted in this discussion document.

3. This paper does not purport to lay down what should or must be done. It is an attempt to survey the existing scene and, in relation to that, to sketch out the likely result of various courses of action. It does not attempt to prejudge or predetermine any of the issues: but it may form a useful basis for constructive meetings and discussions. Whilst still in draft form, it was discussed at a conference of mental handicap nurses organised by the Royal College of Nursing, as a result of which a number of important modifications were made in the text. It is now being sent, as a King's Fund Centre Mental Handicap Paper, to interested statutory authorities, voluntary organisations and professional groups, in the hope that it may permit an objective examination of the problems involved.

* * *

4. Many nurses feel that they could give a better service to the mentally handicapped but that they are prevented in some way. They are faced with public expectations, fed by the White Paper, which they feel cannot be realised today. They are not helped by the occasional hospital scandal which they feel leads the public to assume that all nurses are tarred with the same brush. Interested groups of various kinds point out deficiencies, often without suggesting remedies, and nurses in the front line are held responsible. The future identity of the nurse has been questioned by the Briggs Report, whilst in Scotland an additional anxiety comes from the Batchelor Report.

5. Almost all mental handicap hospitals are inadequately staffed, whether up to official establishment or not; most are overcrowded, even when down to standard bed complement. As the hospital population reduces it is leaving an increasing proportion of the severely handicapped, the behaviour-disordered and the delinquent. Although nurses realise that helping this kind of person is at the very heart of the nursing role, inadequate staffing, and perhaps inadequate training, often prevents the adoption of a more positive role. If undertaken custodially, looking after this kind of patient can be unrewarding, and current staff ratios often seem to enforce custodialism, whether the nurse wants it or not.

6. Many nurses working in poor physical environments fear that the provision of new local units for the mentally handicapped will have the effect of halting any improvement in physical standards at the main mental handicap hospitals, which are still bearing a heavy burden.

7. Like most other people, nurses are fogged by the three-way split of the mental handicap service (health, education and welfare) just at a time when integration is supposed to be taking place. Local authorities will be providing a range of dispersed units, but nurses are not sure how they will fit in personally, nor how the career structure will be affected. They feel excluded from the local authority hostel set-up. Despite official policy, they also continue to feel excluded from field social work including assessment, admission-decisions, programme-planning, and discharge-decisions.

8. Public and professional awareness of the needs of the mentally handicapped has developed rapidly in the last few years, with the consequent emergence of specialists of various kinds. Their contribution is essential, although many nurses feel that they could participate more effectively with the specialists if only they were not so bound down by under-staffing and overcrowding; some nurses feel that only the "interesting" patients are taken on by the specialists, leaving the nurses to grapple with the "bottom of the barrel".

9. Despite progressive modifications of the syllabus, there is still much serious informed criticism of the implementation of training, which tends in many cases to remain clinically-orientated. Few nurses have been trained to deal with the individual needs of the various groups which exist not only inside but also outside mental handicap, for example the geriatric group, the paediatric group, the cerebral palsied, the blind and the deaf; nor have they always adequate training to fit changing therapeutic or behavioural approaches, for example individual and group psycho-therapy, or behaviour modification techniques.

10. Yet they have shown a remarkable capacity for change and innovation, though often in bad environments. Many nurses welcome new ideas and fresh strategies, but feel that they are blocked by poor resources, poor quality of general management, poor medical or nursing leadership, inappropriate training, or by the very low priority rating given to mental handicap in the general spectrum of health care.

11. In their nursing careers, mental handicap nurses are being largely excluded from climbing the managerial ladder, unless they are doubly or trebly qualified. The man or woman who is trained in mental handicap work and who has developed these skills in depth, is set aside in the competition unless he has also taken other, less relevant, nursing qualifications. The nursing career system is slanted in favour of the general trained nurse. Promising mental handicap nurses are often counselled to undertake general nurse training instead of being encouraged to develop more relevant skills in depth, within mental handicap.

12. Some mental handicap nurses value very deeply their contact with nursing and wish to continue to be associated with the nursing profession as a whole, and with its ladder of promotion; others wish to consider themselves as mental handicap specialists outside the nursing framework.

13. So far we have only looked at the darker outlook. It is worthwhile turning round and looking at the other horizon.

14. There is no doubt that all over the world, the atmosphere of mental handicap is more creative and optimistic than at any time in our history: the surveys and statistics are bearing fruit; the problems of the handicapped, and of those looking after them, are better understood; the problem is numerically predictable and well defined. The mental handicap ghetto is on the way out, and in its place will gradually develop a range of opportunities, residential and otherwise. The mental handicap hospital, instead of being a place for the "residue", will have a much better defined task, one important part of which is active socialisation. It is now recognised that the mentally handicapped can contribute far more than once was thought possible.

15. With clearer identification of need, there is a chance to use selective skills on selected patients, and in this process the nurse is being seen more and more as a creative homemaker who uses the social environment to produce change; instead of being a receiver or custodian.

16. Now that there is a real possibility of major change in behaviours which previously were thought to be unalterable, there is an exceptional opportunity for the nurse to participate in group and individual shaping of behaviour. The amount of psychiatric and other specialist time available is very limited. There has been a great demystification of techniques, and a battery of hitherto specialist skills is now being channelled to the handicapped through the agency of nurses.

17. In management there has been a growth of multi-disciplinary co-operation and this is being reflected managerially and clinically, though regrettably not everywhere. The individual case-conference for programme planning, in which the nurse plays such a central part, is beginning to take hold; in a few areas, nurses are increasingly involved in the community, in assessment before admission, and in follow-up after discharge. Responsible Medical Officers in some, though not all, areas, are recognising that they are one of several specialists, and that the nurse is another specialist with a central contribution. Many mental handicap hospitals are experimenting with new ways of enabling the various professions to work together, in which nurses play a key part.

18. On the educational front it is now increasingly being recognised that no child is ineducable; our understanding of learning processes is deepening and current research will clearly help this forward. It is now seen that social education can and should involve the whole hospital. A few student teachers and student social workers are now gaining experience in ward situations, and teacher-training now offers special education as a mainstream subject.

19. Mental handicap is politically and socially respectable: it is talked about, shown on TV screens, and discussed openly. The Government has expressed its intention in the White Paper, "Better Services for the Mentally Handicapped", which is supported by all major political parties in this country, and is regarded by many overseas countries as being a sought-after model.

20. By comparison with many other countries, our British social services are highly developed, and the handicapped can increasingly tap in on those good services. Despite cuts in capital programmes, many more local authority hostels have been approved than is at present apparent in bricks and mortar: the first of these are already coming into use.

21. Gradually, though only gradually, the public is becoming better-informed and more tolerant. Changing attitudes in hospitals are enabling relatives and ward nurses to co-operate in a way which was sometimes difficult a

few years ago. A number of universities are actively interested in the problems of mental handicap: the first British chair in mental handicap has been established at Manchester University; and the first professional Institute of Mental Subnormality has been set up with close links with Birmingham University.

22. In management, the Department is urging decentralised and multi-disciplinary decision-making: it is recognised that it is essential for nurses to share in the management of the mental handicap service.

23. Some of these gains have already taken place, others are just beginning to develop; but certainly there never was a more exciting time in mental handicap than now. Are the professionals geared up to use these immense changes to help mentally handicapped people?

## THE GOALS OF THE MENTAL HANDICAP SERVICE

24. Before proceeding further, it is necessary to clarify in our minds what it is that the service should be achieving.

25. Much of the thinking which went into our White Paper derived from the changing philosophies which began to develop, almost simultaneously, in many countries including our own. It is also related to the United Nations Declaration of Rights of the Mentally Handicapped. Rather than attempt to quote from all these sources, we choose instead paragraph 40 of "Better Services for the Mentally Handicapped", since this will be the British guideline for many years to come. This is what it says:

26. "The main principles on which current thinking about mental handicap is based ..... can be summarised as follows:

(i) A family with a handicapped member has the same needs for general social services as all other families. The family and the handicapped child or adult also need special additional help, which varies according to the severity of the handicap, whether there are associated physical handicaps or behaviour problems, the age of the handicapped person and his family situation.

(ii) Mentally handicapped children and adults should not be segregated unnecessarily from other people of similar age, nor from the general life of the local community.

(iii) Full use should be made of available knowledge which can help to prevent mental handicap or to reduce the severity of its effects.

(iv) There should be a comprehensive initial assessment and periodic reassessment of the needs of each handicapped person and his family.

(v) Each handicapped person needs stimulation, social training and education and purposeful occupation or employment in order to develop to his maximum capacity and to exercise all the skills he acquires, however limited they may be.

(vi) Each handicapped person should live with his own family as long as this does not impose an undue burden on them or him, and he and his family should receive full advice and support. If he has to leave home for a foster home, residential home or hospital, temporarily or permanently, links with his own family should normally be maintained.

(vii) The range of services in every area should be such that the family can be sure that their handicapped member will be properly cared for when it becomes necessary for him to leave the family home.

(viii) When a handicapped person has to leave his family home, temporarily or permanently, the substitute home should be as homelike as possible, even if it is also a hospital. It should provide sympathetic and constant human relationships.

(ix) There should be proper co-ordination in the application of relevant professional skills for the benefit of individual handicapped people and their families, and in the planning and administration of relevant services, whether or not these cross administrative frontiers.

(x) Local authority personal social services for the mentally handicapped should develop as an integral part of the services recently brought together under the Local Authority Social Services Act, 1970.

(xi) There should be close collaboration between these services and those provided by other local authority departments (e.g. child health services and education), and with general practitioners, hospitals and other services for the disabled.

(xii) Hospital services for the mentally handicapped should be easily accessible to the population they serve. They should be associated with other hospital services, so that a full range of specialist skills is easily available when needed for assessment or treatment.

(xiii) Hospital and local authority services should be planned and operated in partnership; the Government's proposals for the reorganisation of the National Health Service will encourage the closest co-operation.

(xiv) Voluntary service can make a contribution to the welfare of mentally handicapped people and their families at all stages of their lives and wherever they are living.

(xv) Understanding and help from friends and neighbours and from the community at large are needed to help the family to maintain a normal social life and to give the handicapped member as nearly normal a life as his handicap or handicaps permit.

## WHAT TASKS HAVE TO BE UNDERTAKEN TO REACH THOSE GOALS

27. These are the established principles of the service. Now we have to think out what is required of staff of living units in order to fulfil the principles of the White Paper.

28. The environmental and attitudinal background

Paramount is the development of a stable, warm human relationship between the staff member and the resident. Without this, all else is of no avail. Given such a relationship, we have to enable the handicapped individual to acquire his repertoire within his own kinship group if possible, and failing that, in the most appropriate setting. The handicapped individual needs staff help to perform better, so as to be able to relate to the customary mores of society in an increasingly acceptable way. How one person behaves to another influences the second person's behaviour dramatically: the nurse needs to recognise this fact, and continuously build onto the handicapped person's existing repertorie and to concentrate on developing his strengths towards culturally acceptable standards of behaviour. For the handicapped person in hospital care, there is a real need for continuity of ward staff so as to encourage friendly and understanding relationships in a homelike atmosphere, as well as developing and maintaining policy. This is a process which never stops.

29. Given this environmental and attitudinal background, there now follows a listing of a number of tasks which have to be undertaken to help the handicapped person to achieve independence, or to go as far along that road as possible. The list is not a complete inventory, and the tasks are not necessarily placed in priority. The intention is to give a sketch of the many-sided task which faces the nurse if the goal is to be realised. Many of the tasks involve collaboration with other professionals, but they should all involve the nurse.

30. Tasks which apply to most residential settings

Programme planning

Assessment of the problems of the handicapped person and his family
Deciding the programme of care and training for the individual
Deciding which residential setting is most suited to the programme
Implementing the programme
Reviewing progress by means of case-conferences, etc.
Preparing for discharge or transfer
Mobilising other specialist services

Group living

Exercising an influence on how individuals behave when they happen to be living in groups: group expression: group leadership: avoidance of scapegoating: conflict: toleration

Personal services

Food: cooking and serving in a way which helps to make relationships, and which teaches not only table manners, but the art of sharing and waiting one's turn.

Clothing: the discrete guidance of the handicapped, whilst encouraging them to express their own individuality.

Money: balancing the needs of safe custody, and avoidance of exploitation with the need for the handicapped person to learn to have an increasing control over his own resources.

Living space: trying to ensure, even in unsuitable buildings, that each individual has some bit of territory which is uniquely his.

Daily living: helping those unable to cope with basic daily living activities.

Social and recreational: encouraging the handicapped to use access to community facilities: alerting the community to the need to open up their social and recreational facilities to the mentally handicapped; encouraging the widest possible use of leisure in the hospital, even at a risk of disorganising or untidying the establishment.

31. Tasks with a particular relevance to the needs of the mentally handicapped

Imparting self-help skills: eating, dressing, toileting, washing

Developing motor skills: working with physiotherapists

Communications: language, reading, writing, numbers

Social skills: grooming, play, good manners

Behaviour: elimination of undesirable behaviours

Occupations: learning through work and co-op play

Industrial training: learning trade skills, social skills, work habit

Sheltered work: preparing the handicapped for semi-independency

Hostel life: preparing the handicapped for near-independency

Open work: job-finding

Independence: still some discrete follow-up

## PROGRESS TOWARDS THE GOALS

32. These tasks have to be done. How well is the service carrying them out?

33. It is unlikely that anyone would claim that any hospital, however good, is undertaking these tasks in a full and effective manner. Some hospitals are probably filling the bill to a considerable extent, others less so. To confirm this, we need look no further than these facts gleaned from the Department's own Statistical Report No.3, which is based directly on information furnished by hospital staff, including nurses:

At the end of 1970 -

- Of all the mentally handicapped people (aged 5 and over) in hospital - 59% were receiving no formal education or training.

- Although 63% of all patients were ambulant, were not severely incontinent, needed little or no help to feed, wash or dress, and had no severe behaviour difficulty - only 3% of patients aged 15 and over (including the mildly handicapped) had work outside the hospital.

- Although it is officially accepted that no child is ineducable - 50% are incapable of benefiting from education, according to hospital returns.

- Of all the mentally handicapped people in hospital -

  13% were non-ambulant
  20% were severely incontinent
  23% needed much help to feed, wash or dress
  16% had severe behaviour difficulty
  4% were blind
  3% were deaf
  21% never spoke
  73% were illiterate

Yet according to "Better Services for the Mentally Handicapped" -

"the standard of staffing is such that in many hospitals it is not possible to give the individual attention which the staff know is needed and wish to give. Many of the skills needed for assessment, education, training and treatment are not provided." (para.111)

"opportunities for modifying disturbed behaviour and incontinence by individual attention cannot be taken." (para.113)

34. In 1972 there were about 19,500 nursing staff working in mental handicap hospitals.

- Of these, 26% were over 55 years of age
- In nursing as a whole, only 12% were over 55 years of age.

35. In 1972, there were 5,273 mental handicap nurses on the Register
and 4,044 " " " " Roll

36. In April 1972 there were:

2,512 mental handicap nurses in training for the Register
1,051 " " " " " Roll

37. These students and pupils were being taught in 53 separate training schools, an average of 67 students and pupils per school. Of all the tutors in all these schools, approximately 20 had the qualification RNMS.

38. Training figures for two consecutive years:

| | YE March,'72 | YE March,'73 |
|---|---|---|
| Students who commenced training for the Register | 1,320 | 1,218 |
| Students who discontinued in the same period | 399 | 444 |
| Pupils who commenced training for the Roll | 802 | 626 |
| Pupils who discontinued in the same period | 184 | 207 |

## WHY SERVICES ARE NOT BETTER THAN THEY ARE

39. Many reasons can be advanced for the undoubted gap between what could be achieved and what is being achieved. Amongst those often cited are:

the system, or climate, of management
attitudes of senior staff
lack of understanding by senior officials, or members of authorities
the physical environment
the lack of staff housing
the difficulty of meeting educational or social needs in a predominantly medical setting

lack of clarity as to what constitutes nursing duties,
in the mental handicap context
the 'responsible medical officer' system
recruitment of good quality outside lecturers to nurse-training schools
is inhibited by the low fees payable
the absence of specific task objectives
the absence of workers other than nurses at evenings and weekends
lack of supporting services
shortage of funds
shortage of staff
the system of training nurses

40. No doubt all these factors can play a part, and most of them need further study, but the purpose of this document is to concentrate on the last two factors, which obviously interlock: shortage of staff, and the system of training nurses.

41. The reasons why it is particularly essential to grapple with the staffing situation at this time are:

(a) Although there has always been, and still is, a shortage of trained subnormality nurses, they vastly exceed the number of trained residential care workers.

(b) There is at present a gross shortage of care staff trained for local authority residential care work, though the CCETSW is making great efforts to close the gap.

(c) There are entirely separate systems of training for NHS nurses and social services care staff in the mental handicap field, even though the heart of their job is identical.

(d) Even if we accept the need for two systems of training, there is a general feeling that the training of subnormality nurses, as actually delivered, does not relate sufficiently directly with the tasks listed in Section 4.

(e) Even if the present GNC system be exploited more fully, by means of experimental schemes, that can only last until such time as the Briggs main stream proposals are implemented, if and when that happens.

(f) It is difficult to predict what might be the effect of the Briggs main stream proposals: one view is that nurses achieving registration will not elect to work in mental handicap; the other is that exposure to mental handicap may attract nurses who otherwise would not have considered it.

(g) Since at present trained nurses represent so great a proportion of the work-force, they should be at the centre of any staff redeployment. Therefore, they must take a constructive and innovative lead, not wait to see what others decide for them.

(h) If the service is to reconcile the needs of the handicapped for care with the needs of the staff for a career, it is essential now to examine all the possibilities, and to make some attempt to assess what might be the implications of new staffing and training approaches.

## POSSIBLE CHANGES

Note: This section must be read in association with Appendices A-E.

42. In this section we consider:

(a) Creating a professional training common to both sets of workers - NHS and social services

(b) What might happen if nurses were to:

(i) stay within a reformed GNC system

(ii) adopt the Briggs Main Stream proposals

(iii) develop the Briggs New Caring Profession

(c) The timing of any changes

### Creating a common professional training

43. We start by trying to think out what might be the best system of training for people who give residential care to the mentally handicapped, whether in the hospital or in the social services sector. For ease of discussion, we call this the New Syllabus.

44. Whilst such a system might well, one day, become part of a unified national mental handicap service, it could easily be developed without statutory unification of the service. That is, it should be possible to train a body of staff capable of working anywhere in the mental handicap services, with common (or compatible) training and salaries systems. Experience is already showing up the problems which arise when people working side by side on parallel or even identical duties have different training, and different salaries and conditions of service.

45. The New Syllabus might be on the lines sketched out lightly in Appendix D, though a great deal of detail needs to be filled in. Some important features would be:

(a) A two-year course of basic training, but further modules of training in various mental handicap specialisms, or in community generic skills, could bring the total up to three years.

(b) Any practical attachments undertaken by the student would be for training purposes, not primarily for service purposes.

(c) The course would be planned so that at each stage, theory is matched by practical experience.

(d) Teaching would be based on the polytechnic, college of further education, or similar establishment.

46. This basic New Syllabus would be applicable to both classes of staff working in the residential care of the mentally handicapped, whether they work in the NHS or in the social services.

47. If the New Syllabus were ever to apply to a single, unified, National Mental Handicap service, then there might emerge some such organisation as a mental handicap Staff Training Board. But to concentrate on the here and now, compatibility of training might instead be achieved by collaboration between the two existing Training Councils, GNC and CCETSW. The aim should be to set the boundary between these two major professional groups of nurses and residential care workers, but to co-operate across that boundary. Certain sections of each council's syllabus could be established in parallel: for example the syllabus for residential care and personal services could be formulated by CCETSW but be applicable to both sets of trainees; similarly the GNC could be responsible for a basic syllabus, common to both groups, on the concepts and nature of mental handicap. This could leave the GNC to develop training in certain specialisms for NHS workers, whilst CCETSW, on its side, might develop community care specialisms for social services workers. (see Appendix E) Some sections or modules of training could be common not only to these two professions, but also to those staff whose training is about to be transferred from the Training Council for Teachers of the Mentally Handicapped to the CCETSW.

48. In addition, the basic concepts of special education ought to be familiar to both sets of workers, and could be taught by means of a common syllabus framed on the advice of the Department of Education.

49. There would still be two separate groups of workers, but a considerable proportion of their training would be identical.

50. Changes of this type should encourage parallelism of professional training, rather than divergence. Ease of movement between one service and another would be greatly enhanced. Polarisation between professional outlooks would gradually diminish. In years to come the two professions might begin to converge. But not necessarily so: even to achieve parallelism would be an enormous advantage to the handicapped and to those who serve them.

51. It will be seen that this idea of parallelism fits in with all the options: Reformed GNC syllabus; Briggs Main Stream; or New Caring Profession.

Reformed GNC Syllabus

52. This will still cover only those staff who work in the NHS.

53. It is often claimed that the fault of the present situation lies not in the nature of the system, but in the way it is used.

54. But since the Briggs Report recommends experiment, and since the GNC has always been ready to consider imaginative experimental schemes, it might be helpful if some experimental schemes could be launched now. Better still, one well-based scheme aligned as nearly as the GNC will permit with the suggested New Syllabus, could be tried out in a number of experimental areas.

55. Perhaps the New Syllabus might be contracted to provide the basis of the two years SEN training, and expanded to provide the basis of the three years RNMS training.

56. This experimentation, if well monitored and evaluated, would reveal:

(a) whether the suggested New Syllabus is appropriate to the task, in its content and orientation

(b) the degree to which harmonisation with the CCETSW syllabus is practicable

(c) what elements might best be incorporated in modules of main stream Briggs, if it is applied to mental handicap

(d) what elements might best be incorporated in a revised GNC system of training

(e) whether a two-year or a three-year period, or some other period, is necessary

(f) what further training is called for

(g) the mental handicap elements which might have to be added

(h) the mechanics of mounting courses on polytechnics and colleges of further education

(i) guidance on the elements which ought to be included in the in-service training of non-career staff.

Adopting the Briggs main stream proposals

57. If the Briggs main stream proposals are applied to mental handicap they will cover only those staff who work in the NHS.

58. Briggs training would seem to offer less clinical experience in mental handicap than the present GNC system; on the other hand, post-registration specialist training could be available. Although training would be within a medical-nursing framework, it would need to be reshaped so as to meet the social and educational goals of mental handicap.

59. Those entrants who are attracted by nursing as a career may not, at the end of a general training, opt for mental handicap.

60. Those entrants who are attracted by mental handicap as a career are likely to be put off by the thought of a three-year training, a considerable part of which may seem to them to be irrelevant to the needs of the mentally handicapped.

61. Nevertheless, if Briggs main stream proposals are applied to mental handicap nursing, the modules should incorporate the fundamental changes envisaged in the New Syllabus, including harmonisation with the CCETSW syllabus.

Developing the Briggs New Caring Profession

62. This approach is the only one which would automatically cover staff working in hospital and in social service units.

63. The New Syllabus would be applicable, whether organised by GNC and CCETSW in collaboration, or by the new Central Nursing & Midwifery Council envisaged by Briggs, or by some new form of Training Board.

64. But NHS nurses have undergone the immense change of Salmon, and are facing the still greater changes of the NHS re-organisation. Can they at present face still further change, this time in the statutory position of the nurse? Many (though not all) nurses see this, rightly or wrongly, as a threat to their professional status.

65. The Briggs Report itself recommends moderate changes in the short term, and seeks longer term change by evolution, as part of a broader group of changes. Presumably this means changes in the entire structure of social services, health services, and education?

66. In this crucial issue, nurses have to decide whether a new caring profession would produce better services for the mentally handicapped. If the answer is 'no', then the other options must be explored. If the answer is 'yes', then they have to consider how soon; whether sudden or gradual; and whether the New Syllabus might constitute an experimental first step. The choices are shown in the diagram in Section 8.

## The timing of changes

67. Since the CCETSW is about to complete its proposals for training residential care workers in the social services, and is soon to take over the work now undertaken by the Training Council for Teachers of the Mentally Handicapped, this is a most suitable time to consider the possibility of harmonising various approaches to training, remembering that residential care is only part of the total need of the handicapped person.

## THE CHOICES STEP BY STEP

### IN TODAY'S SITUATION

| A | B |
|---|---|
| No change in existing GNC syllabus and system | Reshape GNC training on completely new lines |
| Applies only to NHS staff | Applies only to NHS staff, but could develop some modules of training in parallel with social services |
| Unlikely to improve on today's situation | Permits considerable change now, and also paves the way for C or D, if Briggs is adopted |
| Top of career ladder is in general nursing management | Top of career ladder is in general nursing management |

### IF BRIGGS REPORT IS ADOPTED

| C | D |
|---|---|
| (if Main Stream is chosen) | (if New Caring Profession is chosen) |
| Shape mental handicap training modules on completely new lines | Combined system of mental handicap training, not designed to fit in with nursing career structure |
| Applies only to NHS staff, but could develop some modules of training in parallel with social services | Applicable both to NHS and social services staff |
| Top of career ladder is in general nursing management | Top of career ladder is in management of mental handicap services |

If A is chosen — little real change is likely

If B is chosen — it permits change now, and would provide valuable experience in the event of a move to positions C or D.

B would also permit the development now of syllabus material by the GNC in parallel with CCETSW, greatly easing problems of interchange should position D, or some variant of it, ever arise.

# APPENDIX A

# THE GNC SYLLABUS FOR THE TRAINING OF THE SUBNORMALITY NURSE

Training in England and Wales for the Certificate of the Nursing of the Mentally Subnormal (RNMS) is governed by the General Nursing Council for England and Wales. Whilst some aspects of the syllabus may be more relevant than others to this discussion, the syllabus is reprinted in full, by kind permission of the General Nursing Council. Study of the syllabus will reveal the subjects which would not be covered by a residential care qualification; it will also permit a comparison of approaches to subjects which are included both in nursing training and in residential care training.

## Notes on the Syllabus of Training for Nurses for the Mentally Subnormal

In compiling this syllabus of training for the student nurse in hospitals for the mentally subnormal the Council has had in mind the need to provide a training which will give a comprehensive insight into, and an understanding of, the problems of the mentally handicapped and to prepare the student for the duties which a nurse is called upon to perform in the care of the mentally handicapped.

Medical progress, socio-economic advancement and the greater integration of hospital and community services will engender changes in patterns of care of the handicapped members of society. The syllabus seeks to ensure that the nurse is fully conversant with all aspects of the care, education and training of the mentally handicapped both in the hospital and in the community. It is set out in broad terms to permit interpretation and adaptation necessary to meet changing needs.

The selection of the syllabus content has been based on the principle that all subject matter should be capable of being integrated with, and applied to, the total nursing care of the patient. It is stressed that the various sections are not separate subjects, but related fields of study in which students prepare to undertake their roles in the care of the mentally handicapped. Topics given under separate headings are not offered as comprehensive lists, but as guidance to studies which should vary in depth and extent in accordance with a subject's significance within the structure of the syllabus and relevance to the students' future responsibilities.

The syllabus covers four broad fields of study:—

(i) a systematic study of the human individual.

(ii) concepts of mental subnormality and the nursing, teaching, training and treatment of the mentally handicapped including the legal and administrative aspects.

(iii) fundamentals of community care.

(iv) the nursing of bodily disorders commonly associated with the mentally handicapped.

It is intended that these four main streams of learning should be unfolded side by side during the three years of training. It is essential that the theoretical preparation of the nurse must throughout be closely related to the practical aspect of the nurse's work in a hospital for the mentally subnormal and in the community. Throughout the training the psychological, social, educational, habilitative and physical aspects of the care of the mentally handicapped should be developed, elaborated and integrated.

Approaches to teaching will be various, but the total amount of time allocated for study days or blocks will not be less than 120 days, and not more than 140 days, inclusive of a 30-day introductory course, during a 3-year period of training.

Although emphasis is rightly placed on the role of the nurse in the education and welfare of the mentally handicapped, the need for understanding of the physical functions of the body and physical care has not been overlooked. In order, too, to give the nurse confidence in undertaking total care of the patient, some special physical nursing procedures are included in the syllabus.

The systematic study of the human individual (Section 1) is intended to provide a framework of knowledge which will enhance the student's understanding of subsequent sections of the syllabus. Emphasis should be placed upon the relationships between functions, disorders, and the evolvement of mental, social and physical handicaps.

The purpose of the new subject of social biology and related aspects of sociology (Section 1) is to provide an introduction to man in relation to the society in which he lives and to the customs and practices of that society.

A section on preparation for management has been included; this should be taught at an elementary level with a view to preparing the student nurse for the responsibility of a senior student nurse and newly qualified staff nurse and to form an introduction to subsequent management courses.

The aspects which should be included are those of ward management, organisation of work communications within the ward and with outside agencies concerned with the care of the patient, and the nurse's role in teaching nursing skills.

Wherever possible the term "mentally handicapped" has been used throughout the syllabus instead of "mentally subnormal" in anticipation of a possible change in legislation. Where the reference is a legal one, however, the use of "mental subnormality" and "mentally subnormal" has been retained.

## THE SYLLABUS

### SECTION 1

### AN INTRODUCTION TO THE STUDY OF MIND AND BODY

**(1) Human development and human behaviour within the family and society**

Growth and development of the child.

Mother, child and family relationships. Need for security and love. Effects of separation from mother; rejection and over-protection. Rivalry and jealousy.

Intellectual and social development during school years.

Physical and emotional changes during puberty and adolescence; attitude towards sex, family and the community.

Attainment of maturity; responsibility, integration of personality.

Control of behavioural responses to emotion. Occupational and social relationships in adult life. Marriage and parenthood.

Adjustments to middle-age and old age. Physiological and psychological changes.

Reactions to occupational responsibilities; children's independence.

Retirement, decline in mental and physical capacity.

**(2) Introduction to psychological concepts**

Concepts of emotion and behaviour. Needs and drives; influence of heredity and learning; effects on behaviour. Abnormalities of emotion and behaviour.

The psychology of individual differences. Personality traits and types. Methods of psychological assessment of personality characteristics. Abnormalities of personality.

Perception. The organisation of perceptual experience. Varieties of perception. Abnormalities of perception.

The psychology of learning. Types of learning (conditioning, rote learning, insightful learning). The laws of learning and memory. Learning and memory disorders.

Concepts of intelligence. Influence of heredity and environment. Reasoning and problem solving. General and specific intelligence. Methods of assessment.

Abnormalities of intellectual functioning.

Applied psychology. Remedial education. Behaviour therapy. Industrial psychology.

Clinical psychology.

Reaction of individuals to the patient's and family's psychological disturbance (guilt feelings, anxiety, rejection, etc.).

Unconscious mental activity. Dreams and symbols. Nature of emotional conflict. Mental defence mechanisms and their relationship to personality disorder and mental symptoms.

**(3) Human Biology**

Attributes of living organisms, with special reference to man.

Interaction between living organisms and their environment.

The living cell as a unit of life.

Genetic basis of heredity.

Chromosomal development in relation to subnormality.

How the human race is reproduced. The functions of the male and female reproductive organs.

General structure of the human body; position and relationships of principal organs.

Relationships between form and function.

How the body moves; the skeleton and its functions; joints and muscles and their functions in relation to movement (no detailed anatomy is required).

Circulation of the blood; how this is carried out and why.

Composition and function of the blood.

Respiration; how this is carried out and why.

Why the body needs food and fluid, and how these are used; fluid balance.

Principles of nutrition; basic requirements in infancy, childhood and adult life.

Elimination; how the body disposes of waste; functions of the skin and urinary system.

Control of activity by the nervous system and hormones.

The effects of emotional states on physical states.

How emotion can affect the functions of the skin, muscles, heart, lungs, bladder and alimentary system.

The reaction of the nervous system and endocrine glands to emotional stress.

Appreciating our environment; the senses of sight, hearing, smell, taste and touch.

**(4) Social Biology and Related Aspects of Sociology**

Evolution and development of societies.

Nature and problems of rural and urban societies, e.g. intergroup tensions and crime.

Development of attitudes towards cultural and sub-cultural groups, employment, management and leisure, personal and social health.

Effect of cultural, social and economic background on attitude formation.

Codes and conventions. Influence of current world problems, scientific and technical advances on society.

Development and consequence of agencies of persuasion, e.g. mass media.

Changes in class structure, social mobility and educational opportunity.

Human beliefs including religion; changes in social significance and organisation.

Social psychology. Social and cultural influences on personality development.

Dynamics of group behaviour, interpersonal interaction in groups, motivation and meaning of group behaviour.

Social and cultural factors in psychiatric illness.

Effects of admission to hospital on the individual and family; separation from the family, work and community; social, economic and domestic difficulties.

**(5) Psycho-physical disturbances and physical illness**

Main groups of disorders.

Psychosomatic conditions.

The effects of illness upon behaviour.

Infection by micro-organisms, congenital conditions, deficiency diseases, injury, new growths, degenerative changes.

The causes, signs, symptoms, course and treatment of diseases, including injuries, commonly associated with mental subnormality.

**(6) Preparation for Management**

Principles of management.

Principles of teaching.

Communications.

## SECTION 2

## CONCEPTS OF MENTAL SUBNORMALITY NURSING, TEACHING, TRAINING AND TREATMENT OF THE MENTALLY HANDICAPPED

**(1) Introduction**

Outline of the history and background of nursing with special reference to the nursing of the mentally handicapped.

Outline of the Mental Health Service.

The Hospital for the Mentally Subnormal, its various departments and functions.

Objectives of care and training.

Personal qualities and attitudes required of the nurse in the care of the mentally handicapped.

Standards of ethical conduct.

Relationship between the nurse, the patient and his relatives.

The role of the nurse in the team; relationship with hospital and community workers.

**(2) Concepts and nature of mental subnormality**

Aetiology:
genetic, metabolic and cultural factors;
pre-natal, natal and post-natal causes.

Handicap assessment and continuing assessment;
history, examination, observation, diagnosis, prognosis.

Clinical syndromes:
Chromosomal anomalies.
Metabolic and endocrine conditions.
Other genetic conditions.
Mental subnormality associated with congenital malformations of the brain and skull.
Mental subnormality associated with neurological disorders.
Infections and intoxications of the nervous system.
Behaviour and personality disorders.
Relationship between mental subnormality and mental illness. The common forms and symptoms of other mental disorders.

**(3) The Mentally Handicapped in Hospital**

Creation of family atmosphere in the ward.

Fostering confident relations between nurse and patient.

Habit training; instruction of children and severely subnormal adults in techniques of dressing, washing and feeding themselves; control of bowels and bladder; personal tidi-

ness and cleanliness. Special encouragement of good physical, social and moral habits; monetary and other awards.

The nurse's part in educational training; principles of and apparatus for teaching the subnormal and severely subnormal; play therapy, sense training and co-ordinated exercises.

The role of the nurse in occupational training; general principles; choice of suitable occupations; industrial training; ward and domestic occupation; utility departments.

Recreational and social training; play, excursions, concerts, dancing, swimming, games, and other entertainments; group participation; holidays.

Management of various behaviour patterns including those shown by withdrawn, isolated, overactive, destructive and aggressive patients; prevention of self injury. Accompanying patients.

The active role of the nurse in psychological methods of treatments; psychological aspects of occupational, recreational and social therapy; individual psychotherapy; group therapy; the art of listening; relief of emotional tension; counselling.

The nurse's part in current physical methods of treatment, including physiotherapy, remedial surgery, speech-training, and electroconvulsant therapy.

The nurse's part in habilitation; parole, leave of absence, suitable employment training centres; after-care; outpatient clinics.

The nurse's part in assessing patients for discharge to the community.

**(4) The mentally handicapped in the community**

Schools for the mentally handicapped child.

Home teaching of the mentally handicapped.

Role of the nurse in the training of the mentally handicapped in the family setting: teaching the family techniques of habit and social training; responsibilities regarding support of the family and meeting the needs of the mentally handicapped individual.

Day centres; junior and senior training centres.

Industrial training units and sheltered workshops.

Choice of suitable employer and employment.

Consultative role of the nurse and co-operation with social and field workers regarding the patient, the patient's family, hostel staff, the employer and the local authority; the use of social services including family planning and marriage guidance.

Problems facing the mentally handicapped in the community:
Suitable residential accommodation, e.g. hostels, homes.
The need to earn a living.
The need for family environment.
Sexual relationships.
Marriage, social life, companionship and loneliness.
Physical handicaps, including those of the special senses.
The task of looking after themselves.
The use of leisure time.

**(5) Education and training of children and adults**

Co-ordination of school and ward teaching.

Methods of communicating with the mentally handicapped.

General principles of learning and teaching.

Special problems met with in the teaching of the mentally handicapped.

Ways of developing the use of speech.

Techniques and apparatus for development of muscular skills.

Play, art, and music therapy; sense training and social training in the school and ward situation; habit training in the school situation.

Scholastic education; suitable types of patient, use of special textbooks, visual and other aids, choice of subjects, realism in presentation.

Techniques of class management.

Special requirements of adult patients.

**(6) Occupational therapy and industrial training**

Definition, aims and principles of occupational therapy and vocational training.

Suitable employment for various types of patients in the wards and elsewhere.

Liaison with industry.

**(7) Psychological methods of treatment**

The importance of the role of the nurse in suggestion and persuasion.

Behaviour therapy, operant conditioning, use of reward.

Psychological aspects of occupational, recreational, social and other forms of therapy.

Individual and group counselling.

**(8) Social training, recreation and habilitation**

Principles and inter-relationship of recreational and social activities.

Choice of activity according to intelligence, sex, physical capability, behaviour, hospital facilities and prevailing conditions.

Role of the nurse with regard to supervision, participation, stimulation of interest, and encouragement.

Physical, mental and social benefits accruing from participating in such activities as games and physical education, hobbies, sports clubs, outings, holidays.

**(9) Legal and Administrative Aspects**

The structure of the National Health Service; General Practitioner, Local Authority and Hospital Services.

National Health Service Acts, Health Services and Public Health Act, 1968.

The Mental Health Services; hospital and community care services (junior, adult and other training centres, day centres, industrial therapy organisation (I.T.O.), sheltered workshops).

The Mental Health Act 1959; methods of informal and compulsory admission, continued detention, leave of absence and discharge. Unauthorised absence. Mental Health Review Tribunals.

Duties of Local Authorities, Children's Acts; care of children during illness of parents; guardianship; work of the Children's Officer, Probation Officer and Juvenile Court.

Education Acts as they affect the mentally subnormal; outline of the work of the Department of Education and Science.

Protection of patients; ill-treatment, sexual intercourse, consent for anaesthesia and surgical operations, Abortion Act 1967, correspondence, management of patients' property, Court of Protection.

Civil rights; marriage, divorce, contracts, wills, voting.

The function of special hospitals.

Outline of the work of the Department of Employment and Productivity.

Government Industrial Rehabilitation Units and Training Centres; Work of the Disablement Resettlement Officer; Disabled Persons Act.

Outline of the work of the Social Security Department of the Department of Health and Social Security and relevant provisions for the mentally subnormal. Family Allowances Acts.

## SECTION 3

## CARE AND MANAGEMENT OF THE PATIENT

## ENVIRONMENTAL MANAGEMENT

## FIRST AID

**(1) Environmental Management**

Ventilation, heating and lighting.

Care and use of clinical and domestic equipment.

Care, storage and handling of food.

Care and storage of linen and other materials.

Daily and weekly routine.

Precautions with regard to poisons and other potentially dangerous articles.

Fire precautions by day and by night.

General duties, routine observations, keeping of records and nurse's notes.

**(2) Elements of nursing care and patient management**

Reception and admission of patients.

Care of the patient's clothing and other belongings.

Observing and recording the patient's mental and physical conditions and behaviour.

Taking the patient's history and other particulars.

Bathing in bed and in the bathroom.

Personal cleanliness and hygiene.

Care of the teeth and mouth.

Care of the skin and of hair, hands and feet.

Prevention and treatment of infestation.

Care of patients confined to bed. Treatment of pressure areas.

Care of incontinent patients.

Disinfection and disposal of soiled linen.

Giving and removing of bedpans and urinals, use of commodes.

Disposal and disinfection of excreta.

Bedmaking, moving and lifting patients.

Serving meals.

Feeding children and adults. Observing and reporting food and fluid intakes.

Special diets.

Observation of the effects of drugs.

Recording weight and sleep.

Transfer and discharge of patients.

**(3) Special physical nursing procedures**

Principles of asepsis; methods of sterilization and disinfection, central sterile supply. Aseptic techniques; dressings and other sterile procedures; control of cross-infection.

Preparation of patients and apparatus for physical examination and diagnostic tests; observation and collection of specimens; urine testing.

Taking and recording temperature, pulse, respiration and blood pressure.

Positions used in nursing care.

Care of the unconscious patient.

Administration of drugs; observing and reporting their effects.

Dangerous Drugs Act; regulations under the Pharmacy and Poisons Act; rules for the storage and administration of drugs; weights and measures.

Care of the dying; last offices.

Administration of oxygen.

Artificial feeding.

Lavage, irrigation and catheterisation.

Preparation and administration of suppositories and of various types of enemata.

Use and application of heat and cold.

**(4) First Aid, Applied Anatomy, and treatment in emergencies**

Aims of first aid treatment.

General principles and rules to be observed.

Improvisation of equipment.

Principles and methods of moving and carrying injured persons.

Haemorrhage, arrest of bleeding, principal pressure points, effects of loss of blood.

Shock; signs and treatment.

Exposure to cold; hypothermia.

Causes of asphyxia and methods of resuscitation.

Loss of consciousness.

Fits and convulsions.

Fractures, dislocations and sprains.

Wounds and contusions.

Burns and scalds.

Poisoning: signs, indications of type of poison, methods of treatment. (See also Section 3 (3).)

Emergencies, e.g. fire and accidents in the ward.

# APPENDIX B

# THE CCETSW PATTERN OF TRAINING FOR THE RESIDENTIAL SOCIAL WORKER

The Central Council for Education and Training in Social Work, which was set up in 1972 inherited two different patterns of training for residential social work. These were originally operated by the Central Training Council for Child Care and by the Council for Training in Social Work. These schemes of training have not yet been modified in any way by the new CCETSW.

**2. Qualifying Training**

(i) *Basic* The C.C.E.T.S.W. offers two forms of basic qualification in residential work. These are the Certificate in the Residential Care of Children and Young Persons and the Certificate in Residential Social Work (previously awarded by the C.T.C. and the C.T.S.W. respectively). There are considerable differences between the two qualifications. The C.R.C.C.Y.P. can be obtained after one year of full-time study, although there are also part-time courses open to those who have previously attended a P.R.C.C. course or completed an In-Service Study Course and received the Council's Statement of Attendance to this effect. Although entry is restricted to those who have experience in the care of children or young people, this experience need not be extensive and on such courses, particularly the full-time ones, nearly half the candidates are aged under 25 and are therefore near the start of their professional careers. The Certificate in Residential Social Work courses on the other hand, are open to senior staff of Health and Welfare Homes (matrons, superintendents and their deputies) and, exceptionally, to other suitable candidates. To be eligible for C.R.S.W. courses, applicants must already hold a position of responsibility and the students tend, therefore, to be considerably older (65% aged more than 40). Holders of either of these qualifications are seen to have specialised in the residential care of a particular group: children and young persons, the elderly, or the handicapped. Hitherto, the vast majority of students on the C.R.S.W. courses have been concerned with the care of the elderly; very few have been concerned with the care of the mentally ill or handicapped and none with the rehabilitation of offenders. At present there are 16 full-time and 14 part-time courses leading to the Certificate in Residential Care of Children and Young Persons, and 9 courses leading to the Certificate in Residential Social Work.

(ii) *Advanced* In addition to these basic courses, there are three advanced courses leading to the Senior Certificate in the Care of Children and Young Persons. These are full-time one-year courses and are predominantly for senior staff.

(iii) *Integrated with Field* There are five courses which train field and residential workers together in a two-year programme. The residential option is for child care only and residential workers who satisfactorily complete the course obtain the C.C.E.T.S.W.'s Certificate of Qualification in Social Work, the basic qualification awarded by the Council for all fieldwork courses. The child care component in the residential option was originally selected when these courses were child care fieldwork courses. Since this title has disappeared from field social work its retention for the residential option is somewhat anomalous.

**3. Non-Qualifying Courses**

(i) *In-Service* There are a number of non-qualifying courses which make a significant contribution in residential work. The C.C.E.T.S.W. has assumed responsibility for the two In-Service Study Schemes sponsored by the two previous Councils. These schemes were designed to help staff in post by providing an organised day-release programme. The In-Service Study Course for Residential Child Care Staff is available to those working in establishments caring for children and young people and has led to a Certificate of Attendance. A Statement of Attendance is given to those who complete a course within the In-Service Study Scheme for senior staff of Health and Welfare Homes. There has been no day-release programme of this kind for assistant staff in Health and Welfare Homes or for care staff in hospitals, probation or after-care hostels. Having these omissions in mind, the Council has recently decided to promote a single In-Service Study Scheme for all staff with a caring function in any kind of residential establishment. The new scheme will be implemented from September 1973. There are 81 courses within the scheme for residential child care staff and 55 in the scheme for senior staff in Health and Welfare Homes. Both these courses have offered stimulating learning experiences to their students, many of whom have sought full-time qualifying training as a result.

(ii) *P.R.C.C.* The Council is also responsible for 55 courses leading to the Preliminary Residential Child Care Certificate. These courses provide an opportunity for young people interested in working with children to maintain and develop this interest during the period between leaving school and becoming old enough for employment (minimum age usually 18 years). In these courses there is a strong further education bias, some practical work with children (not seen as training) and no final employment "strings". A Working Party which recently considered these courses recommends that the Council should retain an involvement in preliminary courses, that the care component should be extended to fields of residential work other than child care and that the Council should issue a Preliminary Certificate to young people who had satisfactorily completed such a course.

(iii) *Short Courses* There are also short courses supporting the training programme.

In 1972 the Central Council for Education and Training in Social Work decided that there was an urgent need to formulate its policy concerning training for residential work, and that this would require an appraisal of the existing pattern of courses for which the Council had inherited responsibility, and a review of the training implications of the changes which had occurred since the publication of the reports of the Williams and Seebohm Committees.

To achieve this objective, the Council appointed in July 1972, the Working Party on Education for Residential Social Work, with the following terms of reference:

1. To review the existing pattern of training for residential work
2. To consider the levels of training needed
3. To develop proposals for a scheme of training in residential social work
4. To report its recommendations

The Working Party has now produced a Discussion Document, with the following recommendations:

## RECOMMENDATIONS

1. There should be a single pattern of training for residential and field workers.
2. Training provision should be made for social workers and for welfare workers.
3. All staff employed in the statutory and voluntary social services should have the right to training advice.
4. The basic qualification for all social workers should be the Certificate of Qualification in Social Work.
5. The basic qualification for all welfare workers should be the Certificate of Qualification in Welfare Work.
6. The Certificate of Qualification in Welfare Work should be obtained on the completion of a training contract which will consist of units of part-time study, practical work and project work.
7. The minimum length of a C.Q.W.W. programme shall normally be two years.
8. The Council shall set up Regional Training Advisory Panels to approve C.Q.W.W. training programmes, to assess candidates and to make recommendations concerning the award of the Certificate.
9. Selected training units of the C.Q.W.W. programme should be available to all staff, whether holders of qualifications or not, who work in the social service field.
10. Members of other professions should be able to negotiate a suitable training contract and obtain the C.Q.W.W.
11. For a limited period special one-year C.W.S.W. courses should be set up to enable holders of existing residential qualifications to obtain the C.Q.S.W.
12. The C.Q.S.W. should be seen as the appropriate qualification for social work in both field and residential settings.
13. The C.Q.W.W. should be seen as the appropriate qualification for welfare work in both field and residential settings and should be reflected in salary scales.
14. Within ten years there should be a minimum number of 18,000 C.Q.S.W. holders working in residential centres.
15. Within ten years there should be between 18,000 and 36,000 C.Q.W.W. holders working in residential centres.

# APPENDIX C

## THE BRIGGS COMMITTEE'S PROPOSALS FOR MENTAL HANDICAP STAFF

The Report occupies 327 pages, but one small section is of vital importance to this discussion. It recommends a gradual realignment of the health and social services staffing. This section is reproduced below.

### New Career Developments

557. The proposals outlined above apply, at least in the short run, to all branches of nursing and midwifery, and we have stressed that opportunities for advancement should be open equally to all nurses and midwives capable of undertaking senior posts. In the long run, however, we envisage fundamental changes taking place in the care of the mentally handicapped, with implications for staff employed in that field.

558. All mentally handicapped people may need services of three kinds to which nurses at present make a significant contribution:

(a) therapeutic – for physical illness or disability or psychiatric disorder;
(b) education, and occupational and social training;
(c) "home" (or "parental") care.

Doctors, teachers, occupational therapists and other specialists all contribute to meeting these needs, but staff are also essential with a wider responsibility for the patient's personal care, and with understanding of and able to supplement the contribution of the specialist in the daily living situation. At present this wider responsibility for the three services outlined above generally falls to the nurse.

559. The extent to which individuals need these different elements of service varies widely. At present, for many of those in hospitals the predominant needs are those in the second and third categories, and it is generally accepted that when adequate community facilities are developed such people will no longer be admitted to hospital. Increasingly, therefore, hospitals will look after only those for whom therapeutic needs are predominant, although Cmnd. 4683[1] estimated that it may take some fifteen to twenty years before hospital patients are confined to those in this group. Yet even after this change hospital patients will not be limited to those whose physical or mental disabilities are so serious that their therapeutic needs alone need be considered, and social training, along with occupational and "home" care will remain an element in the service which hospitals for the mentally handicapped will have to provide for their patients. It will be essential even in the long run for hospitals receiving mentally handicapped patients to include within their establishments sufficient numbers of suitably trained and experienced staff to meet this provision.

560. The idea of creating a new professional group of "care staff" to undertake all but purely physical or mental nursing functions has been put to us in evidence from several bodies. Amongst the arguments used are:

(a) that large numbers of mentally handicapped people in hospital have no significant physical or psychiatric disability requiring clinical nursing;

(b) that too much emphasis in nursing care has been and is devoted to medical and "health" aspects and too little to the social development and needs of the mentally handicapped person as an individual or as a member of a group;

(c) that it is illogical to regard the social and home-making aspects of care as "nursing" and to provide totally different training for those performing these duties in hospitals and in the community;

(d) that this is also undesirable as likely to hinder the change in balance between hospital care and community care advocated in Cmnd. 4683[1];

(e) that division of care into "nursing" and "social and domestic" elements, each to be provided by separate professions, would draw on a wider field of recruitment and thus help to relieve the staff shortages which currently present a major obstacle to improvement of the service.

561. Some people also point to evidence of "anti-therapeutic" features, such as regimentation, block treatment, depersonalisation and social distance in residential units managed by nurses as compared with those managed by child care staff. Others question the significance of this evidence and argue that it more truly reflects environmental differences and staffing standards than the relative abilities of different groups of staff. Contrary arguments have also been put, for example, that the introduction of an additional profession into hospitals would present serious difficulties through extending lines of communication and that nurses would see in the employment of "care staff" a diminution of their responsibility, a denigration of their past achievements and a threat to their career structure which would or could have a devastating effect both on morale and on recruitment.

562. Some of these arguments, on both sides, are very powerful; the significance of others may be exaggerated, but cannot entirely be discounted. From our own observation on visits and in taking evidence from individuals and bodies concerned with the care of the mentally handicapped, we believe that much of the most successful nursing care being given at present in this field embraces the wider functions envisaged for "care staff", and that ultimately a new profession probably will, and should, emerge. We consider, however, that such a change should proceed by evolution and not by revolution as part of a broader group of changes.

563. We are reinforced in this view by the knowledge that major changes are at present taking place in the education and role of the social service professions, to which we believe "care staff" in the field of mental handicap, certainly those based in the community, would rightly belong. At a time when the environment for care of the mentally handicapped is changing, and when the social services are already under pressure, we think an attempt to introduce a totally new caring profession would be neither feasible nor desirable. Instead, we recommend more moderate changes in the short term, allowing for experimentation and development towards a realignment in care of the mentally handicapped between the health and social services.

564. First, we envisage a role for residential care staff of the kind now employed by local authorities working alongside nurses in mental handicap hospitals. In our view the appointment of staff with a suitable training in residential social work is to be encouraged. Such staff should be introduced gradually, if only because at present there are very few people with the right training. Gradual introduction would also minimise the problems of integrating them into the hospital staff structure.

565. Second, in the education of nurses working in the field of mental handicap emphasis should be placed on the social as well as the medical aspects of care, and there should be opportunities to develop this side of care at the Higher Certificate level. Our educational proposals, set out in Chapter IV, stressed the need for this change of emphasis. Nurses prepared in this way could ultimately have the opportunity to become the leaders of a new caring profession.

# APPENDIX D

## A SUGGESTED SYLLABUS

for training hospital and social services staff
to meet the needs of the mentally handicapped
for residential care

1. The aim of the syllabus is to provide a training over a two-year period consisting of six modules of practical experience which will provide a comprehensive insight into, and an understanding of residential care for the mentally handicapped and associated services. By extending the period to three years, the syllabus would also permit further modules of training in various mental handicap specialisms or in community generic skills.

The basic two-year syllabus covers two broad fields of study:

(i) personal services

(ii) provision of individual care programmes

2. Personal services

This part of the syllabus should cover the provision of personal services in the living situation, in the form of food, clothing, warmth, and general creature comfort, an important feature contributing to the well-being of the residents.

However, of at least equal importance as the provision of services is how these services are delivered - the effect of caring on the quality of life offered to the residents.

It would be of critical importance for this section of the syllabus to bring out the caring role of the staff and to ensure understanding by the student of her role and her responsibility for the overall well-being of the residents.

Some of the subjects the syllabus would need to cover are:

(i) helping the residents in the daily living situation

(ii) counselling

(iii) social, recreational and religious facilities

(iv) first aid, and home nursing

(v) the provision of individual living space

(vi) housekeeping

3. Provision of individual care programmes

In this section of the syllabus, the student would be given an insight into the concepts and nature of mental handicap, the aims of residential care, and the considerations needed in implementing good care programmes for the residents.

This part of the syllabus would need to cover:

(i) assessment and monitoring

(ii) planning and implementation of the care programme

(iii) the care of special groups such as the multiply handicapped, the blind, the deaf, and those with cerebral palsy

(iv) the social education of the mentally handicapped

(v) provision of other services

(vi) group dynamics

(vii) admission to residential care, and preparation for discharge

(viii) rehabilitation

4. Practical experience

Practical experience for the student could be made available in the following departments and would seem appropriate for people who are required to assist the residents as individuals.

(i) special schools

(ii) junior schools

(iii) pre-school groups

(iv) adult training centres

(v) residential care: mentally handicapped homes
children's homes
old people's homes

(vi) LA social worker department

(vii) hospital for the mentally handicapped

(viii) paediatric unit

(ix) assessment centre

The training programme should make sure that practical experience and theoretical instruction are consistent, meaningful, and carefully related to each other so that the student has been given theoretical support before meeting the practical situation.

Such a training scheme could well be centred on a polytechnic college, where the residential care student would come into daily contact with other students preparing for complementary professions.

# APPENDIX E

## A SUGGESTED METHOD OF DEVELOPING SYLLABI IN PARALLEL - SEE PARA.47

(diagrammatic only)

<table>
<tr><td colspan="2">The training of NHS staff</td><td>The training of social services staff</td></tr>
<tr><td>Training special to NHS staff</td><td>Training common to NHS and social services staff</td><td>Training special to social services staff</td></tr>
<tr><td>Special medical aspects of mental handicap</td><td>Residential care and personal services<br><br>Syllabus formulated by CCETSW</td><td rowspan="2">Special aspects of community care</td></tr>
<tr><td>Special psychological approaches and techniques</td><td>Concepts and nature of mental handicap<br><br>Syllabus formulated by GNC</td></tr>
<tr><td></td><td>Concepts of special education<br><br>Syllabus approved by Department of Education & Science</td><td></td></tr>
</table>

Note: (i) Not all the subjects have been shown

(ii) Some modules could be used by CCETSW for the training of those staff formerly trained by the Training Council for Teachers of the Mentally Handicapped.

# APPENDIX F

## CAMPHILL SEMINAR

Community as a Path of Learning

### THE SEMINAR

The Camphill Seminar as an institute for the training in remedial education has been in existence since 1949. Its aims are the following:

- to learn to understand the human being and his handicaps, and thereby to acquire the fundamentals for responsible activity in the realm of curative education. Courses, conferences and clinical demonstrations are serving this end.
- to establish such human relationships in daily living with children and adults as may become the basis of a therapeutic community.
- through artistic activities to heighten the powers of perception and to develop new forms for the experience of one's Self.

First year

Students live in family units and are under the supervision of the Child Guidance College. They are responsible for the personal guidance and care of a small group of children and are required to attend staff- and case- conferences.

Second year

A student's life with a group of children continues, but emphasis shifts to a fresh aspect of the work in which first-hand knowledge is gained of the teaching and remedial methods used in classes, under the guidance of the College of Class Teachers.

Third year

To a student's experience of his group and class work is added a practical acquaintance with specific therapies in either individual or group sessions. This area of work is supervised by the Therapy College.

LECTURES, tutorials and demonstration classes constitute a further part of the seminar and are as follows:

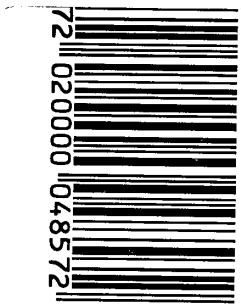
First year

Introductory tutorials in remedial education
Principals of metamorphosis and evolution
Human science (the study of the nature of man)
Child care and hygiene
Child at play

First year (continued)

Child development (early years)

To these subjects is added the study of one of the basic books by Rudoph Steiner



Second year

Introductory tutorials in paedagogical methods
Embryology
Child development (school child)
Psychology
The remedial educator
Life processes

The reading of basic books continues

Third year

Child and environment: sense physiology, maladjustment
Diagnosis and therapy of developmental handicap with clinical demonstrations
Introductory tutorials in special therapies
Students participate in project work

Reading continues.

ART COURSES in the following areas are distributed throughout the three years:

Eurythmy, painting, drama, toy-making, lyre, drawing, modelling, choir, recorder, folk-dancing

Each term an assessment and evaluation of the student's progress is conducted by their respective tutors. After the third year each student is entitled to receive a certificate.

The international character of the Camphill Seminar is one of its important aspects. The student may go through his training in any Camphill centre. The complete course takes three years and may, when possible, be taken in more than one of the seven Camphill places in Europe, Africa and America.

The Camphill Community began with the common decision of a group of teachers, doctors and artists of Middle European origin, to make it their life's task to serve the needs of handicapped children. This group formed around the Viennese physician Karl König (1902-1966) and started its work in Scotland in 1939.

In response to the manifold social needs of our time the Camphill Community came to accept remedial education not only as its task but as a far-reaching social attitude.

Community living in the Camphill centres is always understood as a self-renewing task, involving everybody, the handicapped children and adults, the older co-workers and their children, Seminar students and short-term helpers. The Community is in a continuous state of development. Thus the Seminar as such is complemented by the experience of community living and the processes of human understanding.

## THE PARTICIPANTS

The King's Fund would like to thank the people who helped to make possible the production of this discussion paper. It is an amalgam of some, but not all, of the ideas and viewpoints they expressed in seminars and in open conferences. Not all the people who helped will find themselves able to support all the views expressed in this paper, but what has emerged is a collection of facts, an array of opinions, and a description of some choices and their possible consequences, which we hope will help towards logical and constructive discussion, principally by mental handicap nurses, but also by mental handicap workers in other professions.

Thanks are especially due to the following men and women, each of whom took part in at least one of the seminars and meetings:

| | | |
|---|---|---|
| Mr. S.J. ALCOCK | Inspector of Trng. Schools | General Nursing Council |
| Mr. G. BANNER | Assistant Director | Wiltshire Social Services Dept. |
| Sister CELESTE | Principal Tutor | St. Joseph's Hspl., Midlothian |
| Mr. T. FRENCH | Regional Trng. Officer | South West Metropolitan RHB |
| Mr. J.C. GARDNER | Chief Nursing Officer | Leavesden HMC |
| Mr. V. GORMAN | Principal Nursing Officer | Northgate & District HMC |
| Miss J. GUY | Assistant Director | CCETSW |
| Mrs. M.F. HENDRY | Principal Nursing Officer | Sheffield No.2 Group HMC |
| Mr. N. HILL | Nursing Officer | DHSS |
| Mr. C.A. HULBERT | Chief Nursing Officer | Calderstones HMC |
| Dr. H. HUNTER | Medical Superintendent | Balderton Hospital, Newark |
| Mr. D. JAMES | Director, Adult Education | University of Surrey |
| Mrs. E. KEANE | Principal Nursing Officer | West Suffolk HMC |
| Dr. G. KERR | Consultant in M.Handicap | DHSS |
| Dr. A. KUSHLICK | Dir., Research in Subnorm. | Wessex RHB |
| Mr. P. MELLOR | Nurse Officer (Psychiatric) | Royal College of Nursing |
| Mrs. B. NICOLAS | Education Officer | General Nursing Council |
| Mr. R. O'TOOLE | Principal Nursing Officer | East Birmingham HMC |
| Mrs. D. OTTLEY | Assistant Director | Social Work Serv. Group, DHSS |
| Miss M. PAYNE | Training Project Officer | Leeds RHB |
| Dr. T.L.PILKINGTON | Senior Lecturer | Usher Institute, Edinburgh |
| Mr. D.H. RYE | PNO(Education Division) | North West Surrey Group HMC |
| Mrs. Joan RUSH | Project Officer | King's Fund Centre |
| Mr. J. SHEAHAN | Tutor | Royal College of Nursing |
| Miss D. STOREY | Assistant Director | Social Services Dept., Newcastle |
| Mr. D. THOMAS | Senior Psychologist | Northgate Hospital, Morpeth |
| Mr. C. WILLIAMS | Sen.Clinical Psychologist | Lea Hospital, Bromsgrove |

Great help was also given by the many nurses and others who spoke up in conferences at the King's Fund Centre on 10 May 1973, and at the Royal College of Nursing on 27 September, 1973.

In the end, responsibility for this final draft fell to me, and I hold no-one else accountable for its defects.

November, 1973

JAMES R. ELLIOTT

Printed in England by 'Health and Social Service Journal,' 27-29 Furnival Street, London EC4A 1JR