PSYCHIATRIC NURSING SERVICES OF HEALTH BOARDS

REPORT OF WORKING PARTY NOVEMBER 1972

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I INTRODUCTION

1. The Working Party was appointed by the Minister for Health in May, 1970 with the following terms of reference—
"to examine and report on the psychiatric nursing services of health authorities and to make recommendations in regard to changes and improvements considered necessary".

2. The following is a list of the members of the Working Party: —
Mr. D. Condon, Principal Officer, Department of Health — Chairman.
Dr. J. V. Glass, former Chief Psychiatrist, St. Davnet's Hospital, Monaghan.
Miss K. Keane, Assistant Education Officer, An Bórd Altranais.
Miss P. M. Leonard, Psychiatric Nurse, St. Brendan's Hospital, Dublin.
Dr. P. D. McCarthy, Clinical Director, Cluain Mhuire Family Centre; Consultant Psychiatrist, St. John of God Hospital, Stillorgan.
Miss A. F. McGuinness, Chief Nursing Officer, North Hampshire Group, Hospital Management Committee, England.
Mr. J. Murphy, Head Male Nurse, Our Lady's Hospital, Cork.
Mr. M. Neary, Charge Nurse, St. Mary's Hospital, Castlebar, Co. Mayo.
Mr. D. O'Sullivan, Programme Manager, Southern Health Board (appointed in December, 1971).
Dr. B. Mac M. Ramsay, Assistant Inspector of Mental Hospitals, Department of Health.
Dr. D. J. Ward, Consultant Psychiatrist, St. Loman's Hospital, Ballyowen, Co. Dublin.
Mr. O. Hogan, Assistant Principal Officer, Department of Health, acted as Secretary to the Working Party.

3. The Working Party wrote to a number of organisations and individuals with a particular interest in the psychiatric nursing services, giving them the opportunity of submitting views. Most of the organisations and individuals concerned availed of the opportunity and a list of those who submitted views is attached as an Appendix.

4. The Working Party visited a representative number of psychiatric hospitals and other centres providing care for the mentally ill. It also met representatives of the nursing staff from all the psychiatric hospitals and day-care centres operated by health boards.

5. The Working Party would like to express its appreciation of the help received from the various organisations and individuals with which it came in contact in the course of its work. In particular the Working Party would like to thank those individuals and organisations who made the written submissions mentioned in paragraph 3. It would also like to thank the chief executive officers concerned as well as the chief psychiatrists and other staff of the hospitals and centres visited. It appreciated the excellent arrangements which

helped to make the visits and discussions so useful. The views expressed in the written evidence and in discussion were of great value and were carefully considered. The Working Party wishes to pay tribute to its Secretary, Mr. Oliver Hogan, who despite the many other calls on his time, spared no effort in serving the Working Party. The Working Party's thanks also go to Mr. Christy Hamilton and the other staff of the Department who helped.

6. In its examination of the psychiatric nursing services, the Working Party relied heavily on the Report of the Commission of Inquiry on Mental Illness, published in 1966. It recommends that persons reading this report should do so in the context of the Commission's Report which goes very fully into the history and development of the psychiatric services generally. The major change which has taken place in the structure of the health services since the Commission's Report was published has been the setting up of the health boards which took over the operation of the health services on 1st April, 1971 subsequent to the setting up of this Working Party. The Working Party took account of this change in framing its recommendations.

II SUMMARY OF MAIN RECOMMENDATIONS

Role of the Psychiatric Nurse

7. The need for more active involvement of nurses in positive therapeutic work requires that they should be given more training and experience in skills useful for developing personal relationships.

Recruitment and Selection

8. (1) Post-primary Leaving Certificate, or its equivalent, should be the required standard of education for student nurse candidates.
(2) There should also be an interview to assess aptitude and general suitability for nursing when recruiting students.
(3) Full information on the psychiatric nursing services, on career structure, on opportunities for advancement, on training facilities, on salaries and other conditions of service should be available in the form of a brochure for all school leavers.
(4) The upper age limit for student nurses should be raised to at least 35 years of age.
(5) There should be formal assessment of each student's potential and progress during the programme of training, particularly in the early stages, and those found unsuitable should not be retained.
(6) There should be open recruitment of qualified psychiatric nurses instead of the existing arrangements of recruiting student psychiatric nurses and appointing them automatically, on qualification, to permanent posts of qualified nurse in the hospitals in which they train.

Student Training

9. (1) An Bórd Altranais should have power to provide more effective monitoring of training programmes and should take more positive action to ensure that the syllabus is properly implemented.
(2) There should be a Nurse Education Committee in each hospital.
(3) Clinical teachers should be appointed in all hospitals.
(4) There should be one fixed time of student intake each year followed by a proper induction course.
(5) The block system should be used in all training hospitals.
(6) Instead of each psychiatric hospital being a nurse training school as at present, groups of hospitals should combine to form regional training schemes.
(7) The closest possible integration in training and registration should be aimed at for general and psychiatric nursing.
(8) Consideration should be given to a common basic nurse training course to be followed by further training and specialisation in the different fields of nursing.

Post Registration Training

10. As part of a positive staff development programme for all grades of staff,

post-registration education should be consciously planned at two levels:

(i) participation in an ongoing regular lecture and seminar programme within the hospital, and

(ii) extra-mural courses.

Facilities at both levels need to be extended, intensified and better co-ordinated if the necessary impact is to be made on the psychiatric nursing services.

Organisational Structure

11. (1) Staffing structure should be based on the following grades:

(i) Principal Nursing Officer — one in each hospital providing a comprehensive psychiatric service.

(ii) Senior Nursing Officer — the number in each hospital dependent on size of hospital and nature and extent of area served.

(iii) Executive Nursing Officer — to provide continued guidance, support, supervision and deployment of staff.

(iv) Unit Nursing Officer — in special circumstances where a small specialised unit is operated at a distance from the psychiatric hospital.

(v) Nursing Officer — to replace existing grades of Charge Nurse/Ward Sister.

(vi) Senior Staff Nurse — to replace existing grades of Deputy Charge Nurse/Deputy Ward Sister.

(vii) Staff Nurse — as at present.

(viii) Student Nurse — as at present.

(2) Acute treatment units at general hospitals should be staffed by qualified psychiatric nurses appointed to the units on a permanent basis and student psychiatric nurses should spend part of their training in the units.

System of Promotion

12. Promotion to all posts within the psychiatric nursing services should be on the basis of merit; selection to be made by means of an interview system which will give adequate recognition to work performance, potential and length of service.

Auxiliary Nursing and other Support Personnel

13. (1) The question of an auxiliary nursing grade should be examined following work studies into nursing practices and level of staffing particularly in the area of non-therapeutic activities.

(2) A review should be made of the existing practice in psychiatric hospitals where patients not suffering from mental illness are cared for by psychiatric nurses. This is wasteful of the skills and training of those nurses. Where patients of this kind cannot be discharged or accommodated elsewhere, it should be possible to segregate them within the psychiatric hospital and to make suitable alternative arrangements for whatever care they require.

(3) More domestic staff should be employed, particularly at ward level and domestic staffing arrangements should be on an organised basis under the direction and control of a Domestic Superintendent.

Research

14. Studies should be undertaken into selected aspects of nursing practices and procedures, particularly in relation to the problem of relieving nurses of duties of a non-therapeutic nature.

Duty Rosters

15. The spanned rota system should be introduced, (i.e. two day teams, one from early morning to early afternoon and one from early afternoon to late evening) with an overlay of staff during the normal working day when the special treatment and therapy programmes are in progress.

Integration

16. Integration of the sexes at both patient and staff level should be aimed at.

Communications

17. Committees on the lines recommended by the Commission of Inquiry on Mental Illness should be established in all hospitals so as to ensure good communications and harmonious relations between all staff which is essential for the creation of the therapeutic atmosphere so necessary for the patient.

III GENERAL

The Changing Pattern of Psychiatry

18. In its examination of the psychiatric nursing services the Working Party took note of the many changes which have taken place in the pattern of psychiatric care and treatment in this and other countries during the past few decades. Perhaps the biggest change has been the increasing tendency to treat patients outside the confines of the mental hospital. This change from in-patient to out-patient and community activity has been made possible mainly by a change in public attitudes, by the introduction of new methods of treatment and by the co-ordination of the social and welfare resources with the medical and nursing services which had previously formed the basis for the traditional and clinical approach to mental illness. Part of this tendency to divert treatments away from the large mental hospital has also been evident in the decision to site psychiatric units at general hospitals and to provide day-care at special centres.

19. This changing pattern of psychiatry has also paved the way for major changes within the mental hospitals themselves. Until comparatively recently the emphasis in these hospitals was mainly on custodial care and patients tended to be herded together in large groups within these hospitals where, isolated from the public and its conscience, they could be safely looked after and prevented from harming themselves or others. With the introduction of new treatment methods and the change in community attitudes, the way was cleared for mental hospitals to undergo a remarkable change, to become therapeutic centres in place of the former custodial institutions. It is now clear that the regimen in these old-style hospitals was not as effective as it might have been in curing some patients and in restoring them to their place in the community; it was for many patients positively harmful, in that it impeded recovery of independence of function and was detrimental to psychological well-being. The mental hospital regimen tended to deprive patients of initiative, of responsibility for their own actions, and even of their personal belongings. The system had detrimental effects on the staff also; they, too, tended to become institutionalised in their outlook and to lack initiative, job satisfaction and personal fulfilment.

20. With the development of modern treatments, together with the involvement of other trained personnel to complement the work of the doctors and nurses, a complete transformation has come about in the whole concept of psychiatric care. For many people there is no longer any need to enter hospital to be treated effectively; for those who have to enter hospital, the length of stay has been shortened and there has been a quickening of the tempo and the activity within the hospitals. The way has been cleared for these custodial-care institutions to become active treatment and rehabilitation centres even for those patients who of necessity have to remain in hospital. The segregating of patients into smaller groups has made disturbed patients more manageable and less aggressive with the result that the hospitals are now much more open and less restrictive than heretofore. The large walls surrounding many of the hospitals have disappeared. These developments have in turn helped to promote a more enlightened public opinion in regard to mental illness.

The Changing Pattern of Psychiatric Nursing

21. It was against the background of these rapid and continuing changes in the pattern of psychiatric care that the Working Party had to consider what changes are now necessary in the arrangements for the nursing services. Some of these arrangements are of a traditional nature and because of their deep roots will be difficult to change.

22. The transformation which has been taking place in the psychiatric services has been somewhat bewildering for many of those working in the service. This has applied to all classes of staff and not to the nurses alone. The old concept of nurses protecting and caring for the patient, attending to his every need, is, in many cases, now seen to be damaging to the patient and detrimental to his chances of recovery. The nurse's job is now seen in the context of his helping to build a free, independent and self-reliant person by permitting and encouraging the patient to do things for himself, thereby maintaining and, if necessary, restoring his independence and self-respect. Patients are now to be found often outside the hospital wards, in their own homes, at clinics, in workshops, and the nurse has also to move out of the hospital wards to where the patients are.

23. It will be appreciated that considerable changes have come about in the working lifetime of many of the existing staff, who have worked in the services for a considerable number of years and who were trained in nursing practices far different from what are now considered desirable. It is understandable that the staff concerned should find difficulty in coming to terms with the changed situation. There is a clear need to educate and to train nurses so as to give them a wider knowledge and maximum understanding of themselves in relation to their patients and the patients' social environment and of the therapeutic concept of their own role in the psychiatric team. It is also necessary to define clearly the functions and responsibilities of the nurse in relation to occupational therapists, psychiatric social workers, clinical psychologists and any other grades of staff working with patients. In considering these matters it became apparent to the Working Party that there is much uneasiness on the part of nurses which it was felt mainly arose from the ill-defined role of the psychiatric nurse. This, in turn, has led to feelings of insecurity and fears that the traditional role of the nurse was being encroached upon and eroded by new disciplines. Unfavourable working conditions in some areas do not help and the nett result is a general lack of job satisfaction.

24. The Working Party would like to make it clear at this stage that it is not concerned with apportioning blame for the deficiencies in the present situation. It is clear that nursing staff attitudes have often been inflexible in the past

and have not been helpful to progressive development. There has also been, however, evidence of the absence of the kind of dynamic leadership, which nurses could reasonably expect from management at administrative, medical and senior nursing levels.

25. The unsatisfactory features mentioned and other factors, referred to later in this report, have contributed to the unrest and dissatisfaction which have been so obvious within the psychiatric nursing profession in recent years and reached a climax with the withdrawal of their services by many nurses in November 1971. Action such as this must seriously retard the development of progressive nursing care in mental health, must impede programmes of care, and must gravely undermine public confidence in the service as a whole. The patient is inevitably the most vulnerable and the greatest loser. The Working Party recognises that some element of conflict is to be expected in a situation where patients' needs are required to be balanced against staff expectations. That the situation should have been reached where nurses caring for the mentally ill take strike action is, however, an index of a gravity which is outside the average cut and thrust of professional negotiation. That the dissatisfaction cannot be attributed solely to financial reasons is borne out by comparison with the British situation, perhaps the closest to ours, where the salaries of psychiatric nursing staff are lower than in this country. Furthermore, dissatisfaction has not been evident to the same degree within the general hospital nursing staff who are no better off financially than their psychiatric colleagues.

26. Mention of the strike by psychiatric nurses forces the Working Party to express its surprise at the inadequacy of the efforts made by management to publicise the reasons for the dispute. In the opinion of the Working Party this high-lights the need, where there can be great public concern, for public authorities to have access to the means of putting the issues fully before the public.

27. This report, which will be examining some of these problems, is mainly concerned with the organisation and more effective utilisation of the psychiatric nursing services. If the nurses are to play their full and proper role in looking after the mental health and welfare of the people a wholehearted effort on the part of all concerned will be required. Given the necessary goodwill and co-operation the task is still daunting.

IV ROLE OF THE PSYCHIATRIC NURSE

28. In the past the traditional role of the nurse in caring for the sick and incapacitated tended to be centred around the patient in a hospital bed or in assisting patients otherwise unable to care for themselves and whose every need had to be attended to. There is now an increasing emphasis on the need to encourage the patient, to help him towards independence, and to assist him to resume normal living. This need applies particularly to the psychiatric nurse as the nurse/patient relationship is of particular importance in his work. Research in the field of personal relationships has clearly shown the importance of this factor in relation to mental health problems. It follows that the quality of nurse/patient relationships, whether in the hospital or in the community, is something that is vital to the well-being of the patient. It also follows that this therapeutic potential must be developed in a positive way and not left to chance development. It need hardly be emphasised that in the hospital setting the nurse is the member of the therapeutic team who spends most time in close personal contact with the patient. The psychiatrist will, of necessity, spend relatively short periods with the patients in the deeper probing of their problems. The nurse on the other hand spends the full working day in the company of the patient. In addition to carrying out whatever the psychiatrist specifically directs the nurse should be in a position to build up and develop those relationships which play such an important part in the treatment of mental illness.

29. The Working Party stresses, therefore, the need for more active involvement of nurses in positive therapeutic work with individual patients and with groups of patients. Towards this end — apart from lectures — nurses should be given more actual experience under specialised tuition to equip them with the necessary skills and confidence in improving personal relationships. These skills are crucial in psychiatric nursing and are different from the skills required of the general trained nurse. The most important task of the psychiatric nurse is to help the patient to develop his personality to its maximum potential. It is primarily the function of the psychiatric nurse to teach the patient the necessary skills in the dimensions of life where he had failed. This may mean teaching the patient in the domestic sphere to look after his personal needs; teaching him not to under-estimate his own abilities; teaching him to identify himself with a group and feel that he is part of it and has a responsibility to society, and teaching him to establish friendships that are satisfying and lasting. The patient may have to learn to control his emotions, to accept disappointments, to develop insight and, in general, to cope with the realities of life.

30. Total care of the patient may be necessary in the initial phase of treatment when the patient may be either disturbed or anxious and unable to care for himself. For a time he may need the whole weight of responsibility lifted from him and be cared for completely; this total nursing of the patient during the

period when he is unable to care for his own needs is obviously important but it should clearly be seen that it consists of but a small part of psychiatric nursing.

31. The functions of the psychiatric nurse may be classified under the following broad headings:

(a) participating in positive therapeutic team-work with groups of patients or in work with individual patients in the hospital or other treatment centre;
(b) taking part in the giving of physical treatments such as ECT, drug therapy;
(c) observing the patients with a view to anticipating any regressive changes in their condition and reporting to the psychiatrist or senior nurse;
(d) working with patients in the occupational or industrial therapy departments of the hospital;
(e) working with patients in special occupational or industrial therapy units outside the hospital;
(f) supervising patients in those units, seeing that the appropriate pressure is kept on them and that they are progressing satisfactorily through their re-training programme;
(g) liaison with social workers, with the families or employers of patients and dealing with problems in the home or work situations;
(h) supporting the public health nurse in her responsibility for a group of families or individuals and helping with special skills as the occasion demands;
(i) assisting in running hostels, social clubs or similar centres and establishing and maintaining contact with voluntary organisations; and,
(j) encouraging and assisting the patients in the community as required.

In addition to the above professional functions the nurse, and particularly the senior nurse, will be involved in administration, staff training and development.

32. The range of functions mentioned gives some indication of what should be involved in the working day of the psychiatric nurse. It is clear that if psychiatric nurses are to undertake the range of duties envisaged, conditions must be such as will enable them to fulfil their role in the most effective way. The Working Party considers that the fundamental factors to be taken into account are, firstly, the therapeutic needs of the patient, secondly, the nature of the job to be done, thirdly, the adequate training and development of staff engaged in the work and, finally, the provision of a satisfactory working environment for the staff.

V RECRUITMENT AND SELECTION

33. It is accepted that the public image of psychiatric nursing in this country is far from satisfactory. The image of the nurse as "keeper" still persists to a surprising degree depite the many advances that have taken place in the practice of psychiatry. While psychiatric nursing has emerged from the custodial care of patients under "asylum" conditions, the old image still widely obtains, even among professional and teaching groups who might be expected to know better. So long as this image remains it will retard the development of the services as suitable people will not be attracted to employment. More public education and enlightenment in regard to mental health and the psychiatric services are necessary.

34. Inadequate facilities at the psychiatric hospitals such as poor hospital environment, outdated systems of care and management, inadequate teaching programmes, lack of domestic services at ward level and poor living conditions for staff, will militate against satisfactory recruitment. The Working Party is aware that considerable improvements have taken place and further improvements are in progress and in planning. Much still remains to be done, however, and it must be stated that as long as conditions continue to be unsatisfactory to any appreciable extent there will be cause for complaint. These complaints coming through the "grapevine" tend to be attributed to all hospitals and to colour the picture adversely for persons who would otherwise contemplate a career in pschiatric nursing.

35. The required standard of education for entry to psychiatric nursing has in general been below that required for entry to general nursing, largely because of the need to widen the field of recruitment as much as possible in order to obtain staff in sufficient numbers. While this lower standard may have achieved its immediate objective it has tended to reduce the status of the psychiatric nurse vis-a-vis the general nurse and to make entry to psychiatric training less attractive. The Working Party supports the view of the Commission of Inquiry on Mental Illness (1966) that "a high standard of general education is required if the students are to complete successfully the psychiatric nursing course" and a high proportion of the evidence submitted to the Working Party on this issue suggested that post-primary Leaving Certificate should be the specified minimum standard of education at entry. With the rapid expansion in recent years of the numbers receiving post-primary education it should now be possible to meet the staffing needs of the psychiatric nursing services with students of Leaving Certificate standard, or its equivalent, and it is strongly recommended that it should be made an essential requirement at the earliest possible date. It is desirable that there should be a uniform standard of education required for entry to both psychiatric and general nurse training.

36. Although general educational attainment is important, other personal at-

tributes are also required for the adequate functioning of the psychiatric nurse and it is considered that there should be an assessment of personality suitability. This, it is felt, can best be achieved by an interview system designed to assess aptitude and general suitability for nursing and the interview board should include representatives of the senior nursing and medical personnel, from the hospital or group of hospitals concerned.

37. Recruitment to the psychiatric nursing services in this country — with the probable exception of Dublin and Cork areas — has been mainly from those resident in the particular area served by the hospital and indeed, often in undue proportion from certain districts in the area. Once recruited as students, staff are employed permanently in the hospital concerned with little prospect of movement to other psychiatric hospitals. Apart from the most senior posts which are filled by open competition through the Local Appointments Commission or at local level, a "closed shop" well-nigh exists in each hospital. Insofar as recruitment is concerned this situation deters from entering the service those who wish to train in a particular hospital and on qualification feel free to move to other hospitals. It also deters those who would find it necessary or who might wish to train in a hospital a distance from home in the expectation of returning to their local hospital as qualified nurses.

38. The introduction of the health boards and the recommendations made later in this report that there should be fewer training schools than at present should lead to a departure from the traditional method of local recruiting for each psychiatric hospital. This would facilitate the direction of good quality candidates from areas where they may be in excess of local needs to other areas where there is a shortage of such candidates.

39. At present each psychiatric hospital automatically appoints to its staff of qualified nurses those student nurses who have successfully completed their course of training in that hospital. In the case of general nursing it is not the practice for the training hospital so as to provide permanent employment as qualified nurses for students on completion of their training. The Working Party considers that the system of appointing staff nurses in general hospitals should be applied to the psychiatric hospitals also and that psychiatric hospitals should recruit qualified psychiatric nurses to fill staff nurse vacancies. Such an arrangement would introduce some element of mobility of staff which could be beneficial to the staff and would certainly be in the interests of the service. At present nurses who seek to widen their experience by working in other psychiatric hospitals are obliged to leave the public service and seek posts elsewhere, normally in Britain, with consequential loss of pension rights. The proposed arrangement of open recruitment of qualified nurses would necessitate the allowing of incremental credit to nurses with experience transferring from one hospital to another. The Working Party noted that student psychiatric nurses, unlike their general nurse student colleagues, are permanent officers (on probation) from the date of their

appointment as students and it would be necessary to preserve their pension rights under the new system. It should be stressed that the mobility of staff which the Working Party has in mind is the voluntary transfer of staff seeking to widen their experience or wishing to transfer for domestic or other reasons—and not transfers of an obligatory nature.

40. The grouping of psychiatric hospitals within the functional areas of the new health boards should make it possible to arrange for common recruitment and training on a regional basis, with nurses on qualifying being free to seek employment in any psychiatric hospital of their choice wherever staff nurse vacancies are on offer either within the board area or outside it. With proper manpower planning and forecasting of student intake it should be possible to ensure that nurses on registration should have no problem in securing permanent employment.

41. It is only in the actual training school and hospital situation one can assess the capacity and willingness of students to apply themselves to the training programme, to achieve a good working rapport with fellow students and staff nurses, and to exhibit the sympathy and involvement with patients so vital in psychiatric nursing. For this reason it is imperative to have a formal and regular assessment of each student's potential and progress during the training programme, particularly in the early stages. This should be based on progress reports from the principal nursing officer, the tutor and the student's more immediate supervisors. Students who at this stage are found to be clearly unsuitable should not be retained. In the past some unsuitable students were allowed to remain, either for want of such an assessment or for compassionate reasons, or in the hope that examination failure would make it unnecessary for the hospital authority to reach a decision. Should they succeed in qualifying they are unlikely to make satisfactory nurses and management will be faced with the problem of their placement. Unsuitable or unsuccessful students retained beyond a reasonable period may find it difficult to obtain suitable alternative employment and this, combined with the loss of confidence caused by repeated failure in examinations, may create serious personal problems for the persons concerned. The retention of unsuitable students may also mean the loss of a more suitable candidate for whom a vacancy might not in consequence be available. The Working Party noted that student psychiatric nurses under the terms of their employment are obliged to become qualified within four years of their appointment. Extensions of this period in individual cases should only be granted for the most compelling reasons.

42. With the appointment of personnel officers and the development of the personnel function under the health boards it is to be expected that improvements will be brought about in the recruitment procedures. To increase the number of suitable candidates for psychiatric nursing it will be necessary to provide a good deal more information on the present and future scope of the psychiatric nursing services and to disseminate it widely and constructively so that post-primary school leavers will have sufficient information to enable them to appreciate fully the position in regard to psychiatric nursing when deciding on a

career. School leavers should be fully briefed on career structure and opportunities, training facilities provided, salaries and other conditions of service. While adequate local publicity and information is essential it can only be really effective if combined with a national dissemination of up-to-date information on all aspects of the services. This can best be achieved by the compilation of a special career brochure which should be undertaken without delay and widely circulated to post-primary schools. Needless to remark national effort would not obviate the need for local recruiting campaigns which would still have a valuable role to play.

43. Finally, the Working Party considers that the upper age limit for entry to the psychiatric nursing profession should be raised considerably, if not removed entirely. At present the upper age limit is 26 years of age — or 28 where a person's name has been entered on a panel for recruitment before reaching the age of 26. Provided there is adequate screening of those seeking entry, it is considered that initially there is no reason why the limit should not be raised to at least 35 years of age to permit of suitable persons keenly interested in embarking on a career in psychiatric nursing to do so.

VI STUDENT TRAINING

44. The Working Party noted that a revised syllabus had been issued recently by An Bórd Altranais and would like to stress the need for a continuing review of the syllabus because of the rapid changes evolving in the practice of psychiatry. A major problem in regard to a nurse training programme lies in ensuring that the syllabus is implemented at local level. The syllabus is laid down by An Bórd Altranais and the overall responsibility for the implementation of the training programme rests not with the professional Tutor who immediately supervises education but with the hospital administrative head of nursing, usually Matron. Matrons are thus placed in the invidious position of being dually responsible for the day to day staffing of the hospital as well as overall student training. In such a situation the educational needs of the student often tend to be subjugated to the staffing needs of the hospital. The current system places the Tutor in a difficult and at times frustrating position. While it is accepted that the services of the hospital must be kept going it will be readily appreciated that where work demands too frequently take precedence over teaching demands standards of training tend to fall, to the ultimate detriment of patient care. To meet this difficulty the Working Party is strongly of the opinion that An Bórd Altranais should have power to provide more effective monitoring of training programmes and should take more positive action to ensure that the syllabus laid down is properly implemented.

45. When dealing with the role of the psychiatric nurse the need for more active involvement in positive therapeutic work was stressed and it was indicated that the nurse should be given more actual experience, under specialised tuition, in the skills of personal relationships. In this regard the syllabus of training could also be strengthened by making more provision for case supervision, for attitude training in student groups, for individual confidence training, for participating in therapeutic groups with patients, for role playing with other staff members and for discussion groups centred on recommended reading.

46. The following are examples of unsatisfactory training situations which came to the notice of the Working Party during visits to hospitals, from discussions with the staffs' representatives, and from the evidence submitted:

(a) frustration on the part of the nursing staff at the amount of the non-nursing activities with little, if any, therapeutic content — mainly domestic chores — which they had to undertake; (This is a problem which applies not only to students and one which will be mentioned later in the report but it affects nurse training particularly in so far as much of the non-nursing work falls to the lot of the student);

(b) students commence working in the hospitals at different times during the year and are thrust into service on the wards often without any introductory programme whatsoever;

(c) in some hospitals it was found that students were given lectures for some months before the preliminary examination with a resumption of lectures about six months or so prior to the final examination and formal training between these two intensive periods was limited;
(d) a frequent criticism was that student nurses are moved around too often for training purposes;
(e) nurse training arrangements are on a single sex basis;
(f) lack of ward teaching;
(g) the recommendation of An Bórd Altranais that students should spend a period of three months training in a general training hospital was not always observed and this was particularly true in the case of the male student;
(h) inadequate classroom, library, and teaching facilities, and
(i) rostering arrangements on the day-on day-off system results in students missing lectures or in lectures having to be duplicated.

47. Some of the faults in the present system could be fairly easily remedied. The dissatisfaction appears to have roots in the unsatisfactory training school authority structure referred to in paragraph 44, a lack of understanding on the part of senior ward staff of their role in the teaching of students and the tutor's major commitment with classroom teaching.

48. The introduction of the grade of Principal Nursing Officer — see paragraph 68 — should improve the position as regards the training arrangements. It is widely accepted that unification of nursing staff under a single nursing head has definite advantages not only for the nursing services but also for the administration of nurse training. The Principal Nursing Officer will not be immersed in the day-to-day matters that arise in the running of the hospital and will therefore be able to take a more objective and detached view where there is conflict between the training needs and the service needs of the hospital. An essential requirement in each hospital is a properly constituted Nurse Education Committee which will ensure that the nurse training programme is properly adhered to and not allowed to suffer at the expense of the other needs of the hospital. On the question of ward teaching, in addition to the more active participation by the qualified staff, it is necessary that the services of clinical teachers should be introduced in hospitals where this has not already been done. Student nurses could be relieved to a considerable extent of non-nursing chores which have little, if any, therapeutic content through the provision of a properly organised domestic service, particularly at ward level.

49. It is extremely difficult to organise an adequate introductory course when students are recruited at different times as staff vacancies occur. Some hospital authorities consider, however, that it would be virtually impossible to run the hospital services if staff vacancies which arise throughout the year are not filled immediately. Here again it would seem that service needs take precedence over the training needs. This difficulty could be resolved by proper manpower forecasting specially geared to the requirements of student intake and by filling casual vacancies as they arise through the employment of temporary staff — other than students — until such time as the fixed time of student intake occurs. In this way a proper induction course for each group can be undertaken. With fixed times of regular intake there should be specific recruiting for each intake and the system of establishing panels from which students are recruited over a period of up to two or three years should, where it still obtains, be discontinued. The arrangement of fixed times of intake would also fit in with the block system of training which the Working Party feels should be more widely used and which would in turn eliminate the problem of students missing lectures due to being off duty.

50. In regard to the problem of too frequent movement of students in training it is noted that Bórd Altranais has recommended that students should remain for a specified period on designated types of wards or units and it should be a matter for each Nurse Education Committee to see that this is carried out.

51. The problem of integration is discussed later in the report and if progress is to be made in that direction it will be necessary to tackle the problem at training level.

52. An Bórd Altranais recommends that student psychiatric nurses should spend a specific period in a general training hospital but it is understood there is some difficulty in accommodating students in this respect, particularly in regard to male students. Greater effort should be made to implement An Bórd's recommendation.

Regional Training Schemes

53. After much deliberation the Working Party reached the conclusion that all the district mental hospitals should not be recognised as nurse training schools as under the present arrangements. What the Working Party would like to see would be the number of training schools reduced to not more than eight and that these should be staffed and equipped adequately. This is not to say that some hospitals would have no student nurses but that a group of hospitals — including acute treatment units at general hospitals — would have a combined training scheme with students rotating through the different centres on a planned basis. This would give these students a wide range of experience in the varied activities undertaken in the hospitals throughout the group. In the light of the development of specialised services within the psychiatric services and with the regionalisation of the health services generally it is recommended that regional training schemes along such lines should be planned. Such a regional scheme would be under the guidance and control of a regional training officer assisted by a Training Committee representative of the hospitals participating in the scheme. The Working Party urges that a controlled pilot project for this purpose should be set up

without delay, preferably in an area where it can be combined with a general nurse training school operated by the same authority.

54. An added reason for suggesting that each hospital should not necessarily recruit and train its own requirements of qualified psychiatric nurses and that there should be open recruitment at qualified nurse level is that, with the expected continued run-down of psychiatric in-patient numbers and the likely removal of the ban on employment of married women in permanent posts, the required intake of students in the future will probably not be sufficient in number to make nurse training practical in the smaller psychiatric hospitals.

Common Basic Training

55. The Commission of Inquiry on Mental Illness (1966) favoured the development of a common basic training course for all nursing grades with further courses of specialisation in particular fields of nursing such as psychiatry, midwifery, mental handicap and general nursing and recommended that An Bórd Altranais should encourage individual training schools to experiment with schemes of common basic training for all nursing grades. The Working Party notes with regret that to date no such experimental schemes have evolved.

56. The Working Party considered whether it was any longer desirable to train general and psychiatric nurses separately. With the developing integration of psychiatry and general medicine which is culminating in the accepted principle of smaller psychiatric hospitals and the aim of placing as many of these as possible within the general hospital complex, such an integration of training systems appears a likely development. It would seem logical in a situation in which health services generally are trying to close the gap between general medicine and psychological medicine. General medicine and nursing is now showing an increasing awareness of the psychological needs of the physically ill. Indeed it is now generally accepted that emotional problems underlie many physical illnesses. More general trained nurses are spending part of their basic training within a mental hospital service and the title "general trained" is now regarded by many experts as a misnomer unless the training has included a significant degree of the theory and practice of psychological/psychiatric principles. On the other hand there must continue to be a proportion of the psychiatric nurse training devoted to general medical and surgical nursing. Some psychiatric patients require physical nursing skills—these include some acutely emotionally disturbed or psychotic patients, the psychogeriatric patients, patients with a clear-cut physical illness in association with psychiatric disorder and those patients suffering from a variety of complaints which can be loosely described under the heading of psychosomatic disorders.

57. The Working Party would like, therefore, to see the early evolvement of a common basic training course for a truly general trained nurse, one whose basic training equips him for a post-basic career in general medicine or psychiatry,

with of course further training and qualification in the field of nursing in which the nurse decides to specialise. A scheme for common basic training could possibly best be based on the regional technological centres with student nurses circulating through the general medical and psychiatric hospitals for their practical training. The introduction of common basic training followed by specialisation is, of course, a very big issue which will require study by those responsible for all branches of nurse training.

58. The fact of the registered psychiatric nurse being on a separate part of the register of nurses — very often referred to as the supplementary register — emphasises a gap which many feel favours the general nurse and militates against up-grading the image of the psychiatric nurse. This feeling is also evident in the desire of many psychiatric nurses to undertake general nurse training although for women the desire is more likely to be motivated by the fact that general training as well as psychiatric training is still an essential requirement for senior nursing posts despite the recommendation of the Commission of Inquiry on Mental Illness that this should not be necessary. The Working Party wishes to point to an anomaly in the situation whereby general nurse training is the essential qualification for those undergoing the course for tutor training. This can result in a situation where a qualified Tutor can take up a teaching post in a psychiatric hospital without having qualified in psychiatric nursing.

59. These are the principal factors, affecting student training, which contribute to unrest and dissatisfaction. The Working Party considers that the closest possible integration in training and registration would go far to remove any grievances which exist.

VII POST REGISTRATION TRAINING

60. From the information available to it, the Working Party is satisfied that arrangements for post-registration training and development of nursing staff in all grades are not adequate. This is especially true in the very important sphere of training in the work situation. This inadequacy is particularly undesirable where such fundamental changes have taken and are taking place and where a full understanding and awareness by nurses of what is happening is essential. At the same time the Working Party noted that there was apathy on the part of qualified nurses regarding post-registration training, as instanced in the poor response to the recently advertised Advanced Course in Psychiatric Nursing. There appears to be a two-fold problem of inadequate leadership on the part of some senior personnel and a lack of motivation on the part of some of the nursing staff. This lack of motivation is to some extent due, no doubt, to the practice of promotion by seniority to posts of Deputy Charge and Charge Nurse; this practice can hardly act as an incentive to undertake further training.

61. The Working Party also noted that there was little awareness of research values and methods which might be applied to nursing procedures to test the efficiency of accepted psychiatric nursing practices.

62. Changes in medicine, the changing pattern of psychiatry and the possibility of interchange of staff, demand that nurses keep abreast of new knowledge so as to ensure continued improvement in patient care. As part of a positive staff development programme, post-registration nurse education should be consciously planned at two levels:

(i) participation in an ongoing regular lecture and seminar programme within the hospital, and
(ii) attendance at extra-mural courses.

63. Planned inservice training would not only assist staff in gaining further knowledge — newly qualified nurses will probably in any event have a very limited knowledge of many of the special areas in the psychiatric field — but it will also give personnel a greater sense of belonging and a feeling of job satisfaction. They will be motivated to improve patient care by updating their knowledge and practices and working relationships will improve. The Working Party considers that "on-the-job" training is likely to pay more immediate and greater dividends than sending small numbers on extra-mural courses. Inservice training should be regarded as a normal extension of the teaching activities of the hospital with the full involvement of Tutor and Nurse Education Committee. Programmes should be devised to teach a skill such as communication which is one of the essential functions of a psychiatric nurse—namely, to make contact with a person who is mentally ill and to understand him. Continuing education programmes (including orientation courses) can be devised to further the knowledge and the ability of the nurse or to help maintain knowledge already gained.

64. In regard to extra-mural courses Bórd Atlranais has introduced management courses for nurses and the Working Party also noted the following interesting recent developments:

(i) The Regional Technical College in Dundalk has organised a course in hospital management suitable for training nurses in administrative posts and to prepare personnel for extended responsibilities in these areas. The course, organised by the College in conjunction with the Health Board and nursing interests in the area, is comprised of some 160/180 hours tuition run on a day-release basis over a period of 30 weeks. The current programme has 17 participants, 6 of whom are from psychiatric hospitals in the area.

(ii) In the Dublin area the Rathmines College of Commerce (Incorporating Schools of General Management and Professional Studies) organises courses in first line management for nursing staff.

(iii) Bórd Altranais recently organised an Advanced Course in Psychiatric Nursing in collaboration with the Order of St. John of God and the College of Industrial Relations. This course is a full-time course for one academic year covering lectures in psychiatry, psychopharmacology, developmental psychology, epidemiology, statistics, psychopathology, social and case history recording, psychology economics, sociology and personnel management. This course caters for 20 students — 16 of whom are selected from psychiatric nursing staff of health boards. Satisfactory completion of this course and qualification in the ensuing examination should, in the view of the Working Party, merit recognition in the form of the award of a recognised diploma.

(iv) The development of a College of Nursing, a faculty of nursing at the Royal College of Surgeons in Ireland and a degree course at University College, Galway, are at present under consideration. Regardless of the outcome of these considerations the Working Party notes that An Bórd Altranais is charged with the statutory functions of post-registration as well as student training and would like to see more appreciation and recognition of its functions in the post registration field.

65. An Bórd Altranais is of course already engaged in the provision of a variety of refresher courses and there is a steady increase in the volume being organised at local level. The Institute of Public Administration and the Institute of Hospital Administrators also provide courses of interest in this field. Better organisation and co-ordination of courses is called for and in exercise of its statutory functions in this field Bórd Altranais should be facilitated in its efforts to take a more active part in achieving better arrangements. The Working Party is fully appreciative of all these developments but it feels nevertheless that facilities for both inservice training and refresher courses will need to be consider-

ably extended and intensified if the necessary impact is to be made on the psychiatric nursing services. With changing techniques and practices it is as important to enable experienced staff to review their methods and update their knowledge as it is to introduce new talent and it should be emphasised that this new talent will not realise their potential unless their seniors are in a position to support and instruct them.

VIII ORGANISATIONAL STRUCTURE

66. Returns from the psychiatric hospitals in mid-1971 showed the following position in regard to numbers in the different grades of nurse:

Senior nursing posts (including 3 Chief Nursing Officers, 12 Assistant Chief Nursing Officers, 20 Matrons, 27 Deputy Matrons, 18 Head Nurses, 25 Deputy Head Nurses, 18 Head Night Nurses (Male), 17 Deputy Head Night Nurses (Male), 20 Head Night Nurses (Female), 18 Deputy Head Night Nurses (Female) and 22 Tutors)	200
Charge Nurses and Ward Sisters	558
Deputy Charge Nurses and Deputy Ward Sisters	550
Staff Nurses	2,185
Student Nurses	1,497
General Trained Nurses	93
	5,083

67. The Working Party gave a great deal of consideration to the organisational structure which would be best suited to the requirements of a modern psychiatric nursing service. The Working Party fully supports the view that, as far as possible, the titles given to posts of responsibility in the organisational structure should not be such as to imply that some posts have no proper functions of their own and for this reason the prefixes "assistant" and "deputy" should be avoided wherever possible. Likewise, the Working Party agrees that titles which emphasise the sex of the holder (or indicate that the holder should, indeed, be of a particular sex) should also be avoided. Except in situations where the major responsibility attaching to a post is to provide protection or cover for the patients, specific functions and responsibilities should be assigned to all posts of responsibility and appropriate job descriptions or specifications should be drafted for them.

68. It is the considered view of the Working Party that the staffing structure for the psychiatric nursing services should be along the following lines:

(1) *Principal Nursing Officer*

The Commission of Inquiry on Mental Illness (1966) recommended that with the increased integration of psychiatric services for male and female patients that all nurses, male and female, should be under the control of one person instead of the traditional system of Matron in charge of all female nurses and a Head Male Nurse in charge of all male nurses. It is understood that Chief Nursing Officers (which the Working Party terms Principal Nursing Officer in order to avoid confusion with the British concept of Chief Nursing Officer who is responsible for all nursing services in a group of hospitals) have been appointed to date in six of the psychiatric hospitals. While there seems to be

general acceptance in principle of the concept of the Principal Nursing Officer there seems to be considerable delay in introducing the new system which, of course, involves changes affecting the status of existing holders of senior posts. It is now generally accepted that the unifying of the nursing services under one head is necessary to meet the needs of modern psychiatry as well as for administrative efficiency. It is urged, therefore, that Principal Nursing Officer posts be introduced as quickly as possible in the remaining hospitals which provide a full psychiatric service including short, medium and long-stay in-patient care as well as community care. In view of the wide variation in size of hospitals and areas of responsibility the grade of Principal Nursing Officer need not necessarily attract a uniform salary scale in all areas. The Principal Nursing Officer should be mainly concerned with policy matters, with the co-ordination of activities, with ensuring that all staff in the structure are facilitated to carry out their proper functions and with seeing that these functions are efficiently conducted. The Principal Nursing Officer should also take a strong positive interest in staff development in all its aspects.

(2) *Senior Nursing Officer*

This officer would, subject to the direction and control of the Principal Nursing Officer, be responsible for the general control of an area of the hospital's activities including satellite services such as day centres, acute treatment units, out-patient and community services. The number of such posts would be related to the size of the hospital and the nature and extent of the area served. The Working Party does not envisage more than two Senior Nursing Officers in any hospital other than the exceptionally large hospitals with more than 1,000 beds and in the case of a few smaller hospitals with less than 200 beds the question of whether more than one Senior Nursing Officer is necessary would need special consideration having regard to their total commitment including community services. Broadly speaking the duties and responsibilities of the post would include the following: programming services and putting policy into operation; monitoring standards and performance; assessing the quality of nursing care; supervising and deploying staff; in-service training and on-going education in co-operation with the teaching staff; personnel matters, including staff appraisal and reporting.

(3) *Executive Nursing Officer*

Later in this Report in the section dealing with rostering it is recommended that a spanned-day rota system of staffing should be operated with one team of nurses commencing duty early in the morning when the night staff go off duty and working into early afternoon and a second team operating from early afternoon to time night staff resume duty. There should be sufficient Executive Nursing Officers to each Senior Nursing Officer to provide continued guidance and support for staff, for supervision and deployment of staff, and to ensure that agreed policy is carried out effectively.

(4) *Unit Nursing Officer*

This is a grade which might be called for in special circumstances where a small specialised unit is operated at a distance from the parent mental hospital, e.g. an acute treatment unit at a general hospital. The question of whether a Unit Nursing Officer would be required would depend on the size, location and area of responsibility of the particular unit.

(5) *Nursing Officer*

This grade would replace the existing grades of Charge Nurse and Ward Sister. The concept of the new grade would be different from the grades it replaced in that the person appointed would be the leader of a therapeutic team responsible for a specific group of patients and would be expected to concentrate his time and energy in pursuit of this aim. It would not necessarily mean that the Nursing Officer's function was to manage a ward. Ward units should be seen as places where patients sleep and dine, where they may relax in the evenings and at weekends, and where they may sometimes receive "therapy" of a kind which is best done in the ward environment. As in the world outside, however, the working part of the day would often be spent away from "home" under the general guidance and supervision of the team leader. The team leader (Nursing Officer) would plan the daily activities of his group of patients, be responsible (under general direction) for devising and implementing patient programmes on an individual and group basis. The purpose of the programmes would be to ensure that those patients who need trained supervision would have this planned but would not necessarily receive it in their "own" ward.

Because it is undesirable to have more than one leader for any team, and in the general interest of continuity of patient care, it is considered that the Nursing Officer should work the normal working week during hours when senior staff in medical and administrative structures, and heads of departments, are on duty. Later in this report in the section dealing with auxiliary nursing personnel it is recommended that a housekeeping service independent of the nursing services should be provided and such a measure would relieve Nursing Officers of stock-keeping and other domestic responsibilities.

(6) *Senior Staff Nurse*

The Working Party considers that the Nursing Officer controlling the team's activities should have immediate support from two Senior Staff Nurses each of whom would overlap daily to some extent with the Nursing Officer thus, again, ensuring continuity of patient care and allowing for a proper reporting relationship with the team leader. The Senior Staff Nurse grade would replace the existing grades of Deputy Charge and Deputy Ward Sister and would be responsible under the direction of the Nursing Officer for the implementation of the team's therapeutic programme.

(7) *Staff Nurse*
(8) *Student Nurse*

} No structural changes are envisaged for these grades.

Units at General Hospitals

69. The Working Party recommends that acute treatment units at general hospitals should be staffed by qualified psychiatric nurses recruited and appointed

on a permanent basis to a fixed establishment of posts for each unit; student psychiatric nurses should spend part of their training period in such units. The person appointed as Unit Officer should have a psychiatric qualification. The selection of the qualified nursing staff, including Unit Nursing Officer, should be made by a board including representatives of the Psychiatrists working in the unit, the Senior Psychiatric Nursing Personnel of the psychiatric hospital concerned and the Senior Nursing Personnel of the General Hospital. The general supervision of the unit would come within the jurisdiction of the Matron of the General Hospital in full co-operation and liaison with the Senior Nursing Officer responsible.

General

70. The staffing structure now proposed will not, it is reckoned, result in any overall increase in staff numbers. No variation to any extent is expected in the number of senior nursing posts or at Nursing Officer level. The change suggested at Senior Staff Nurse level would have the effect of creating a much greater number of posts in this grade than there are at present in the grades of Deputy Charge and Deputy Ward Sister. The Working Party would envisage, however, that there should be as a result a corresponding reduction in the number of Staff Nurse posts. In effect what is proposed will involve creating more posts of responsibility among the Staff Nurses.

71. On the question generally of promotional outlets the Working Party considers that the position will continue to improve with the further decentralising of the psychiatric services through the introduction of acute treatment units in general hospitals, day-centres, hostels, etc. and the better segregation and grouping of patients in the parent hospitals. A trend in this direction is already evident. Between June 1966 (See Appendix F of Report of Commission of Inquiry on Mental Illness) and June, 1971, the number of senior nursing posts increased from 171 to 200 and posts of Charge Nurses/Ward Sisters and their deputies increased from 959 to 1,108. During this period the number of in-patients decreased from 17,584 to 15,392, while in the same period there was a rapid increase in out-patient activity. Also it might be mentioned, the number of staff nurses and students increased from 2,795 to 3,682, largely due to the introduction of shorter working hours.

72. The Working Party holds the view that there is need to improve nursing administration, especially at the senior level, so as to ensure that they can contribute effectively to the management of the psychiatric nursing services. This will also help to make the higher posts of the nursing career structure in hospitals more satisfying and attractive. Each level of management should have the appropriate management training provided for it. Just as changes in nursing practices and techniques call for continual updating of knowledge so also new forms of management demand new skills and there is need for retraining in this field also.

IX SYSTEM OF PROMOTION

73. Consideration of the organisational structure of psychiatric nursing inevitably raises the issue of the method of making promotional appointments in the service. Under the existing arrangements the senior nursing posts of Chief Nursing Officer, Assistant Chief Nursing Officer, Matron, Deputy Matron, Head Male Nurse and Deputy Head Male Nurse are filled by open competition through the Local Appointments Commission which operates at national level. Posts of Head Night Nurse and Deputy Head Night Nurse — male and female — and Tutors are filled by open competition at local level. For all the foregoing posts (other than Tutor) adequate supervisory experience is essential and this, of course, is generally obtainable as Charge Nurse/Ward Sister or as their deputies. For many years the system of promotion from the basic grade of staff nurse to Deputy Charge Nurse and Deputy Ward Sister and from Deputy Charge Nurse/Deputy Ward Sister to Charge Nurse and Ward Sister has been an issue between the staff and management sides with the staff insisting on promotion by seniority which obtained in the days of custodial care when the role of the psychiatric nurse was considerably different from what it is today.

74. From the management's side it has been argued that merit, assessed by interview boards, has been the basis of promotion generally within the public service for all officer grades with the sole exception of the grades of psychiatric nurse mentioned. They argue that promotion on the basis of seniority is archaic and must have serious ill effects on any service in which it operates. It is not conducive to the development and improvement of the mental health services where it is essential that every effort should be made to raise the standard of nursing care. They assert that any practice which might tend to nullify these efforts should not be allowed to persist or develop; that where promotion by seniority exists there is no incentive for staff to improve their knowledge and methods when they know they must wait for years for advancement. It becomes a matter for the staff of keeping one's record clean rather than developing enthusiasm initiative and ambition in reasonable measure. Junior staff, feeling they have no opportunity of advancement until they have reached the top of the seniority list, tend to lose their initiative and interest to the detriment of the service.

75. The staff side put forward the view that the system of promotion on the basis of seniority has worked well in the past and has not given cause for complaint. They say that to maintain that under the system of promotion by seniority nurses tend to lose their initiative and interest to the detriment of the service is unfair to the psychiatric nurse and ignores the obvious dedication of all nurses in their unremitting efforts, in spite of difficult conditions and deficiencies in the services, to tend to the needs of their patients in a way that often goes far beyond their obligations. They point out that the change of emphasis from custodial care to positive treatment and the introduction of new techniques and new drugs has

proceeded apace within the existing staff structure and under the effective leadership of nurses promoted by seniority. The staff side also argue that a system of promotion based on the principle of "may the best man win" or "may the devil take the hindmost" would seriously disrupt the existing harmony among the nursing staffs to the detriment of patients and nurses alike. Furthermore, they distrust and dislike selection board procedures, and, finally, they point out that the failure of hospital managements to provide the necessary facilities to assist and encourage the longer serving nurses to keep abreast of developments in psychiatric medicine has placed the more senior nurses at a disadvantage with the younger nurses who have benefitted from improved educational and training facilities.

76. It is obvious that there is no easy solution to this problem which has bedevilled the psychiatric nursing services in this country for so many years. The Working Party noted that an agreement reached at conciliation level in 1965, whereby a system of competition would be introduced with provision for compensation for the most senior nurse if unsuccessful in competition, was subsequently repudiated by the staff side. Later, a Labour Court recommendation in 1968 that 50% of vacancies in promotional grades be filled by open competition and 50% filled on the basis of seniority was also rejected by the staff side. Since then efforts have been made in a few areas to resolve the problem at local level but these efforts have failed to provide a general solution.

77. The Working Party accepts that senior staff with their long years of practical experience have a valuable contribution to make towards the betterment of the services. It is convinced, however, that promotion made on the basis of seniority alone must be rejected. It might be claimed that the position is not too bad in so far as the more senior posts i.e. those above Charge Nurse and Ward Sister, are filled by open competition at either local or national level. It should, however, be noted that an essential qualification for any of these posts is adequate supervisory experience and this can only be obtained in the lower supervisory posts which are filled on seniority. It is clear, therefore, that all supervisory posts can be affected by the staff side's insistence on the maintenance of promotion by seniority.

78. The settlement terms of the psychiatric nurses' dispute in November, 1971, which had led to a withdrawal of their labour, included the following provisions in relation to promotion:

Promotion

(i) Management will provide opportunities for post-qualification training for all nurses on their hospital staffs. The training will normally take place in the hospitals. Arrangements for this training to be made in consultation with the unions.

(ii) Whenever management considers that a nurse is not showing promise of development in his career, it shall as occasion arises call the nurse's attention to this, in private, and suggest ways of improvement.

(iii) A nurse who under present practice would be regarded as qualified to act as substitute for supervisory staff during annual, sick or other leave shall be placed on a panel, from which appointments to permanent supervisory posts will be made.

(iv) If any nurse, whose name is on the panel, fails to show suitability for discharging the duties and responsibilities of supervisory posts, management will inform him accordingly and suitably counsel him. If after three such counsellings formally recorded he still fails to show suitability his name shall be removed from the panel.

(v) A nurse aggrieved by the removal of his name from the panel, may appeal to a tribunal consisting of one representative of management, one union representative and an agreed outside person as Chairman. The decision of that tribunal shall be final.

(vi) A nurse whose name has been removed from the panel may after the lapse of a period of at least two years be restored to the panel provided that in the interval he has proved himself of adequate suitability.

(vii) The most senior nurse on the panel shall be appointed to any vacancy that arises.

(viii) The unions shall have the right to make representations on behalf of their members at all stages of the foregoing procedures.

(ix) The foregoing arrangements are to be reviewed in the light of any recommendations that may be contained in the report of the Working Party reviewing the Psychiatric Nursing Service.

79. The Working Party studied the terms of the settlement. While it fully appreciates the very difficult conditions which existed at the time, it is convinced that a major weakness in the settlement terms stems from articles (iii) and (iv). The existing practice of selecting holiday and other substitutes is, in the view of the Working Party, altogether too casual and haphazard for it to form the absolute basis for the creation of a panel from which full time promotions will be made later on the sole basis of seniority. The Working Party is of the opinion that the provisions in article (iv), for the removal of a person's name from the panel, are too cumbersome and are unreasonably weighted in favour of the staff. Under the settlement terms reached in November, 1971, adequate allowance was not made for the quality of leadership and clinical skills, and the ability to direct and control staff which should be the main criteria in the selection of supervisory staff. Granted that one's past performance is a pointer to future expectation, it does not necessarily follow that because a nurse is quite good at his job of nursing he will make a good team leader. Under the existing practice a nurse of average ability deemed capable of substituting for his immediate superior for short-term annual and other leave periods would presumably remain on the panel and be promoted in due turn on seniority.

80. In the context of a modern therapeutic psychiatric service with its wide range of treatments and therapies and intensive activation programmes, the direction and control of staff is of far greater importance than in the days of custodial care when the supervising nurse was mainly concerned with the safety of patients, and with ensuring that no patients escaped or harmed themselves or others. Under the old system with its reliance on physical restraints, height and other physical attributes were important considerations in the selection of nurses. In this report we have indicated that the present day supervisor should be an effective leader of a therapeutic team. He should be capable of supervising the implementation of the treatment programme prescribed for each patient or group of patients under his care. The importance of the job demands that the person available with the best skills and leadership qualities should be selected to fill the post. This will not necessarily happen if promotion is made by seniority alone.

81. It is the Working Party's considered view therefore that promotion within the psychiatric nursing services should be on the basis of merit determined by as objective a system as possible and one in which work performance, value of experience, and seniority are all given due regard. What must be done is to devise a procedure which, while keeping the primary objective of patient care clearly in mind, will go as far as possible to meet the reasonable expectations of the staff for opportunities of advancement. It is essential that the factor of experience which is usually expressed in seniority should not be undervalued and it is accepted that any scheme which does not have regard to long and efficient service would have a bad effect on the morale and general efficiency of the psychiatric nursing service. Selection board procedures should be clearly defined; the aim should be to produce a fair and uniform judgement of an individual's ability and potential. This judgement should be based primarily on the assessment by his different supervisors of his record in past and present jobs so as to ensure that work performance would not be overshadowed by performance before interview boards. The interview board should have available to it reports on candidates based on records or regular staff appraisal and review, carried out under a system to be devised in consultation with the staff's representatives.

82. The Working Party wishes to emphasise that great care should be taken when introducting the new selection procedure to ensure that injustice is not done to staff with long service. The marking system to be adopted by interview boards should take special account of this especially in the case of staff recruited more than say, ten years ago. Staff recruited since then would not, in the opinion of the Working Party, have the same claim to special consideration because they would have been aware of the promotion issue from the time of their appointment. Selection boards should exercise great care to ensure that undue weight is not given to the performance of candidates at interview. The Working Party considered whether it should recommend a marking system and, after much discussion, decided to put forward the following for consideration as an example of what might be suitable for promotion to Senior Staff Nurse and Nursing Officer posts.

1.	Service (one mark for each year of service after registration up to 10 years and two marks for each year of service after that, subject to a maximum number of 25 marks)	25
2.	Nature of experience and value gained by the candidate from it	10
3.	Supervisory experience	15
4.	Additional qualifications	10
5.	Capacity for leadership organisation and team work	25
6.	General suitability	15
		100

The foregoing marking system has been devised to meet the special situation which now exists; because of this and the need for re-examination in the light of experience, it is considered that any system adopted should be reviewed after it has been in operation for a few years.

X AUXILIARY NURSING AND OTHER SUPPORT PERSONNEL

83. The W.H.O. Report, the Nurse in Mental Health Practice, (1963) referring to the ratio of qualified psychiatric nurses in a comparative study of 21 European countries stated that the lightest potential case-load was borne by Ireland with a ratio of one qualified professional nurse practising psychiatric nursing to every 1,059 of the population. A 1971 W.H.O. publication — 2nd Interim Report of a Working Group on Classification and Evaluation of Mental Health Service Activities — again lists Ireland at the top of the European league table in numbers of psychiatric nurses related to the population of each country. Both reports drew attention to the difficulty of drawing valid comparisons of this nature because of differences in the criteria employed to describe what is a psychiatric nurse. In general it seems that the unique Irish situation is attributable to two main factors — one being the unusually high rate of psychiatric hospital beds provided and the other being the absence of significant numbers of auxiliary nursing personnel in the mental health services of this country. In the earlier section of this report dealing with organisational structure reference was made to the number (5,083) of qualified and student nurses engaged in the public psychiatric services of this country in mid 1971 and at the same date returns showed that in addition there were 150 staff engaged on semi-nursing duties. The extent to which auxiliary nursing staff are engaged in other countries would seem to depend largely on the availability of qualified nursing staff and presumably the plentiful supply of nursing personnel in this country is largely responsible for the absence of the auxiliary grade.

84. At present there would appear to be no pressure for the introduction of an auxiliary nursing grade and the absence of pressure is, no doubt, due to the plentiful supply of nurses. It is later recommended in this report — see Research — that studies should be undertaken into nursing practices and levels of staffing, particularly in the area of non-therapeutic activities and the Working Party considers that the question of an auxiliary nursing grade should be further considered in the light of the outcome of such studies.

85. The 1971 W.H.O. publication referred to shows that in the United Kingdom during the year 1969, 32,704 psychiatric nursing staff (including enrolled nurses) were engaged and also 9,912 auxiliary nursing staff, so that the auxiliary staff (not including enrolled nurses) accounted for nearly 25% of the overall nursing staff in that country. In the case of the United Kingdom the combined figures for qualified and auxiliary nursing staff represent one for every 1,145 persons of the total population as compared with one for every 592 population in this country. This has to be considered in the context of further statistics in the same report which indicate the rate of provision of mental hospital beds in the United Kingdom was 2.84 per 1,000 population as compared with 5.96 for this country. The abnormally high number of patients in psychiatric hospitals in this country is generally attributed in considerable part to the special

social and demographic features of the country which result in many people, such as socially inadequate people, who are not suffering from psychiatric illness, being accommodated in them. Nevertheless when they are accommodated in these hospitals they are looked after by psychiatric nursing staff. The Working Party regard this arrangement as both wasteful of the skills of the psychiatric nurse and frustrating to the nursing staff concerned. If these patients cannot be discharged to the community or to alternative accommodation it should be possible to segregate them within the psychiatric hospital and make alternative arrangements for whatever care they require, if any. They should not have to be looked after by psychiatric nursing staff.

86. Concern was expressed about the position of nurses engaged on non-nursing duties, which have little, if any, therapeutic content. At present all grades of psychiatric nursing staff with perhaps the exception of some administrative staff, community nurses, and tutors, express concern at the amount of their non-nursing duties, by which they usually mean "hotel" and domestic chores, undertaken by student nurses, staff nurses, deputy charge nurses and deputy ward sisters and even ward sisters and charge nurses. Ward cleaning and responsibility for ward stock are cited most frequently in this context both in written evidence submitted to the Working Party and also in the course of discussions in hospitals visited. In the era of custodial care, these chores were accepted as part of the day's work but modern concepts, with their emphasis on therapeutic activities, mean that these non-nursing duties are a distraction from the more important work which could otherwise be undertaken; they are also a most uneconomic way of using a skilled nurse's time. It is recognised that many patients, as part of their recovery process, may need to perform the sort of domestic chores they will face on their return to normal life; in that case participation by the nurse in carrying out such chores would be essential in encouraging and leading the patient towards recovery. Here the performance of certain domestic chores by the nurse in conjunction with the patient is essentially related to the patient's treatment and is merely a means to this end rather than an end in itself. It is the latter situation which nursing staff find so frustrating. However, the solution to the problem is by no means clear-cut or simple. It was clear from the discussions which took place that staff had not always clarified in their own minds what functions they could substitute for these non-nursing duties. It was obvious to the Working Party that the desired improvement in patient care would not come about unless positive action were taken to introduce therapeutic activities which would fully utilise the nurse's time.

87. Returns submitted to the Working Party in mid 1971 showed that there were some 800 domestic staff engaged in the mental health services at that time and it would appear that there has been considerable expansion in the employment of such staff in recent years. Most of these were employed in kitchen and laundry services. The Working Party welcomes this development and would suggest that there is still further scope for employment of non-nursing personnel

XII DUTY ROSTERS

92. The problem considered here is that of manning a psychiatric service for 24 hours a day, seven days a week and at the same time providing for a situation where the bulk of the clinical therapeutic work and general activity occurs largely during the normal working day from Monday to Friday.

93. The three main systems of rostering nursing staff for duty — with some comments on each are:

(1) *The "long day" system*

Advantages:

(a) It enables staff to have a complete break from the working situation;
(b) It enables the person in charge to see the work of the nurses over the total span of day-duty, and,
(c) It may result in fewer staff being required to care for the patients in a ward or department, and fewer persons taking responsibility for the management of the ward.

Disadvantages:

(a) The break in continuity of care and awareness of change in the activities of the ward is too great for present day purposes;
(b) It is highly improbable that any nurse can give of his best for 10-12 hours at a time;
(In the past, the work of a psychiatric nurse was controlled to a large extent by internal regulations and statutory requirements, and rules were clear cut and obedience insisted upon, the emphasis being on a negative rather than a positive approach; for example, patients were prevented from escaping, they were not allowed to injure themselves or others, they were not permitted to retain certain possessions, sexes were not allowed to mix except at prescribed times. Frustrating though this state of affairs was, it was, to many, far less demanding than the present situation, in which the social quality of the nurse's expertise rates high importance), and
(c) It must be expected that if the nurse's role is to be properly evaluated, it is unrealistic to expect any person to perform specialised function or functions at the proper standard over a very long, continuous period.

(2) *8-hour Rotas*

Advantages:

(a) The length of the working day is not excessive and, therefore, the nurse can be expected to give of his best;
(b) The system lends itself to internal rotation, that is to say that each member of staff, excluding possibly the Nursing Officer, undertakes a period of night duty and samples each of the 8-hour rotas;
(c) It permits of an established pattern which makes arrangements of off-duty easier, and,
(d) It provides continuity of care.

Disadvantages:

(a) It is considered that more staff is required to man this system;
(b) Ideally there should be more supervisory staff, i.e. one senior person to each rota, and,
(c) The transport arrangements for staff can constitute a real problem, particularly if one rota ends between the hours of 9 p.m. and midnight.

(3) *Spanned Rotas*

Advantages:

(a) In many ways this would seem to be the near ideal arrangement of duty hours. It provides a clear night rota, two day-duty teams and, what is strongly recommended in the Salmon Report in Britain and in many other reports on nursing, one "manager" in charge of each ward and department;
(b) The Senior Staff Nurse heading up each day rota is given a good measure of responsibility and authority, while at the same time having the benefit of the knowledge and experience of the Nursing Officer during part of the rota, and,
(c) The person in charge is available during the normal working week, during hours when senior staff in medical and administrative structures and heads of departments are on duty.

Disadvantages:

It could be said that the Nursing Officer is less able to understand the full implications of ward control, since they do not ordinarily or frequently see the work at the beginning and end of the day; (against this it could be said that in most such systems the person-in-charge is expected to work an early morning and a late evening rota, say, once a fortnight).

94. The main system of rostering in operation in the Irish psychiatric services is the long-day system or day-on day-off system as it is also known. Very often it means a rota of four days on duty followed by three days off duty. Some staff, however, work a five-day week with week-ends off duty and there are many variations of rostering but by and large the long-day system obtains throughout the service. This system has its roots in the past and the case made for it is that the mental hospital environment is so potentially damaging to the nurses health, that complete absence from it on a frequent basis is desirable in the interests of all concerned. The Working Party holds the view that the long-day system does not allow for adequate continuity of nursing care and also that it is highly improbable that nursing staff can give of their best over such long

stretches of duty. Some compromise on this issue seems necessary if the psychiatric nursing profession is to move with modern psychiatric practice in the interest of nurse/patient care without imposing undue hardship on those staff who have grown up in a system which they did not envisage would alter significantly and which enabled many of them to undertake a second job. Many of the nurses involved will not be interested in changing the pattern of working life they have developed.

95. It does seem that those nurses whose role has become more meaningful and positively therapeutic, as for instance the community nurse or the nurse specially involved in rehabilitation programmes or group activities, have opted for the week-end off system when it had become abundantly clear that for the satisfactory performance of their work this rota had become essential. It is particularly with the short and medium stay patient that continuity of care seems most essential. It may, therefore, be possible to compromise so that those nurses who firmly wish to adhere to a day-on day-off system can be associated more with long-stay and psychogeriatric patients whose routine may suffer less from the interruption of nurse/patient care resulting from the system. In short and medium stay units it does seem that the bulk of clinical therapeutic work and general activity occurs during the normal working week and that there should be a concentration of nursing staff at these times. Also as nurses in the psychiatric services become increasingly engaged in community work and are integrated with a team of community workers, the normal working day system must obtain. Mention has earlier been made of the difficulty of operating a proper training programme for student nurses under the day-on day-off system. Finally, it must be stated that with the general trend towards shorter working hours unless there is to be a departure from the long-day system as now operated on a wide scale in the psychiatric nursing services, the stage may shortly be reached where the nurses will have a three-day week, giving them more days off than on duty.

96. In general, therefore, the Working Party considers that the spanned rota system (say, 8 a.m. to 2.30 p.m. and 2.30 p.m. to 9 p.m.) should be introduced with an overlay of extra staff from 9 a.m. to 6 p.m. to help carry through the special treatment and therapy programmes which would be active in that period. This arrangement would be in accord with an earlier suggestion that the Nursing Officer should work a 9 a.m. to 6 p.m. normal working day with two Senior Staff Nurses (one with each day team) responsible under the guidance and/or in the absence of the team leader for the implementation of the team's therapeutic programme.

97. An example follows of the type of roster the Working Party has in mind.

SUGGESTED DAY DUTY ROTA

	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.	(80 hrs. fortnight)
enior Staff Nurse aff Nurse udent Nurse								
First Week	8.00 a.m. – 2.30 p. m.	8.00 a.m. – 2.30 p.m.	8.00 a.m. – 2.30 p.m.	8.00 a.m. – 2.30 p.m.	8.00 a.m. – 2.30 p.m.	Off	Off	30 hrs. ½ hr. to be given for meal.
Second Week	2.30 p.m. – 9.00 p.m.	2.30 p.m. – 9.00 p.m.	2.30 p.m. – 9.00 p.m.	2.30 p.m. – 9.00 p.m.	2.30 p.m. – 9.00 p.m.	8.00 a.m. – 8..00 p.m.	8.00 a.m. – 8.00 p.m.	50 hrs. ½ hr. for meal (Mon. – Fri.) 1 hr. for lunch 1 hr. for tea (Sat. and Sun.)
ursing Officer								
	9.00 a.m. – 6.00 p.m.	9.00 a.m. – 6.00 p.m.	9.00 a.m. – 6.00 p.m.	9.00 a.m. – 6.00 p.m.	9.00 a.m. – 6.00 p.m.	Off	Off	40 hrs. per week (1 hr. for lunch each day)

SUGGESTED NIGHT DUTY ROTA

First Week	9.00 p.m. – 8.00 a.m. (11 hrs.)	9.00 p.m. – 8.00 a.m. (11 hrs.)	9.00 p.m. – 8.00 a.m. (11 hrs.)	9.00 p.m. – 8.00 a.m. (11 hrs.)	9.00 p.m. – 8.00 a.m. (11 hrs.)	8.00 p.m. – 8.00 a.m. (12 hrs.)	8.00 p.m. – 8.00 a.m. (12 hrs.)	79 hrs. The other hour can be divided for handing over and take over time.
Second Week	Off	Off	Off	Off	Off	Off	Off	80 hrs. per fortnight.

XIII INTEGRATION

98. It is now widely accepted that any community system which separates the sexes excessively tends to distort the behaviour of individuals within that community as compared with the general population from which they are drawn. To avoid this there has been in recent years a growing tendency for men and women to mix more freely in psychiatric hospital day-rooms, in occupational and industrial therapy departments, in group therapy, in general recreation and at meal times. It is generally recognised that this mingling of the sexes tends to promote more socially acceptable behaviour whereas a single sex environment more readily leads to regressive tendencies in personal habit, in hygiene and in social interaction. The achievement of this greater integration of patients appears to have been impeded, however, by difficulties in integration of staff. There are a number of reasons for the reluctance of some staff to accept integration. Men are apprehensive that they will lose certain promotional outlets to women and it was also discovered that there was a fear on the part of men that they would have to work under the direction and control of a female supervisor, oftentimes likely to be a much younger person. There is also, it would appear, some anxiety on the part of the men that integration is in fact only another name for substitution i.e. that male nursing staff would be phased out and replaced by female nursing staff. Again, some men are afraid that through working on female wards they might be subject to unjustified accusations of misconduct.

99. The Working Party, while appreciating the staffs' concern regarding these issues, feels that the staffs' attitude stems largely from the fact that psychiatric nursing has evolved from single sex units both of staff and patient, unlike that of the general hospital situation where our customs readily accept the concept of female staff looking after both male and female patients. On the psychiatric side the problem does not seem to present itself in the community services and where nurses are involved in the management of patients of both sexes such as in day-centres, industrial and occupational therapy units, and hostels. It is at hospital ward level that the main difficulty arises. Integration of staff should in fact lead to an increase in the number of promotional outlets for men as with so many women retiring from the nursing field on marriage — or even for family reasons in the event of the ban on married women holding permanent posts being removed — career prospects generally would seem weighted in favour of the male staff. In such circumstances it is difficult to visualise senior male nurses having to work under the charge of much younger female staff but rather the reverse situation would seem likely to be the pattern. In fact the Working Party sees a possibility of men taking over the vast majority of supervisory posts and to avoid an undue narrowing of promotional outlets for either sex it considers that a certain limited number of posts might be reserved for each and the balance filled by open competition.

100. While recognising the immediate problems and emotional implications involved the Working Party nevertheless recommends that integration of the sexes at both patient and staff level should be a positively pursued policy in each psychiatric unit or hospital.

XIX STAFF COMMUNICATIONS

101. Although staff morale was high in some of the psychiatric hospitals it did appear that, in general, there is still a rather rigid hierarchical structure which inhibits real communication between nurses of different grades and between them and their medical and lay administrative colleagues. The importance of interpersonal relationships has already been stressed in this report and in the area of staff relations much depends on the influence and attitudes of those in charge. Frequently tension develops in hospital wards due almost entirely to lack of communication in the hospital. All grades should be made aware of decisions affecting their work and of the reasons for these decisions. In this connection it is recommended that this report should be made available to the staff; certainly it is assumed that there will be consultation with their representatives before any of the recommendations affecting existing staff are implemented.

102. Communication is simply the imparting of information to all those involved in the provision of the services and, of course, to be really effective there should be an uninterrupted two-way flow of communication at all levels. The information must be clear and precise. People with ideas and suggestions should be given the opportunity to voice them and also if anyone feels he has a grievance he should be given an opportunity for a hearing. The big problem is to establish proper lines of communication and to ensure that they are kept open and functioning properly. The Commission of Inquiry on Mental Illness (1966) considered this problem and recommended the establishment of medical, nursing and joint committees (including lay representatives). In addition to the Nursing Committee, the Commission considered there should also be Divisional Committees so that junior nursing staff also are given an opportunity of expressing their views. In paragraph 48 of this report the Working Party laid stress on the need for a Nurse Education Committee to ensure that a proper training programme is implemented.

103. The creation of committees as recommended should not present any problem and would, given the necessary co-operation and goodwill, result in good and harmonious relations between all staff which, as pointed out by the Commission, is essential to the creation of the therapeutic atmosphere so necessary for the patient.

XV CONCLUSION

104. The Working Party recommends that its report should be seen as an effort designed to improve the quality of the psychiatric services as a whole, with benefits alike for patients and staff. It is clear that many of the recommendations will call for additional commitment from management; likewise there are recommendations which will call for an added contribution from staff. It is, therefore, essential, in the Working Party's opinion, that the report should be viewed in its entirety and that its recommendations should be examined and assessed only in the context of the report as a whole.

Signatures to the Report

D. Condon, (Chairman),

J. V. Glass,

Kathleen Keane,

Patricia Leonard,

Patrick Desmond McCarthy,

Anne F. McGuinness,

John Murphy,

Michael Neary,

Donal O'Sullivan,

B. Mac M. Ramsay,

Dermot J. Ward.

Signed: O. HOGAN (*Secretary*)

2nd November, 1972.

APPENDIX

Organisations and Persons who submitted views:

An Bórd Altranais
Association of Professional Psychiatric Administrators
Association of Secretaries/Chief Clerks of Psychiatric Hospitals
Chief Executive Officers of Health Boards
Irish Nurses Organisation
Irish Transport and General Workers Union
Mental Health Association of Ireland
Miss A. Altschul, Lecturer, University of Edinburgh
Mr. L. Bennett, Mrs. H. Henry, Mr. T. McLaughlin, Senior Nursing Staff, Our Lady's Hospital, Cork
Dr. J. Bergin, Clinical Director, St. Ita's Hospital, Portrane
Mr. J. Bergin, R.P.N., Central Mental Hospital, Dundrum, Dublin 14
Dr. B. Blake, Chief Psychiatrist, St. Dympna's Hospital, Carlow
Professor I. Browne, Programme Manager, Special Hospital Care, Eastern Health Board
Messrs. Coleman, Hynes, Moclair, R.P.Ns, St. Brigid's Hospital, Ballinasloe, Co. Galway
Mr. C. Collins, R.M.N., Acting Charge Nurse, St. Anne's Hospital, Skibbereen, Co. Cork
Dr. D. F. Dunne, Clinical Director, St. Stephen's Hospital, Sarsfieldscourt, Cork
Dr. T. Egan, Chief Psychiatrist, Newcastle Hospital, Greystones, Co. Wicklow
Mr. P. English, Tutor, St. John of God Hospital, Stillorgan. Co. Dublin
Dr. T. Fahy, Clinical Director, St. Loman's Hospital, Ballyowen, Co. Dublin
Dr. J. J. Fennelly, Chief Psychiatrist, St. Joseph's Hospital, Limerick, (formerly Chief Psychiatrist, St. Conal's Hospital, Letterkenny)
Miss W. F. Flynn, S.R.N., St. Brendan's Hospital, Dublin 7
Dr. T. J. Foley, Chief Psychiatrist, St. Columba's Hospital, Sligo
Dr. M. J. Gilvarry, Chief Psychiatrist, St. Mary's Hospital, Castlebar, Co. Mayo
Dr. P. Grace, Chief Psychiatrist, St. Senan's Hospital, Enniscorthy, Co. Wexford
Dr. J. V. Halpenny, Chief Psychiatrist, and Staff, St. Patrick's Hospital, Castlerea, Co. Roscommon
Mr. P. Harnett, Programme Manager, Mid-Western Health Board
Dr. P. J. Hill, Chief Psychiatrist, and Senior Nursing Staff, St. Fintan's Hospital, Portlaoise
Mr. T. Keogh, R.P.N., St. Loman's Hospital, Ballyowen, Co. Dublin
Dr. S. Lennon, Chief Psychiatrist, St. Otteran's Hospital, Waterford
Professor T. Lynch, Clinical Director, St. Brendan's Hospital, Dublin
Dr. R. A. McCarthy, former Chief Psychiatrist, Our Lady's Hospital, Cork
Dr. K. McDaid. Clinical Director, St. Anne's Hospital, Skibbereen, Co. Cork
Mr. P. McDaid, Personnel Officer, North-Western Health Board
Dr. P. A. Meehan, Chief Psychiatrist, St. Luke's Hospital, Clonmel, Co. Tipperary
Mr. Daniel P. Murphy, Charge Nurse, Our Lady's Hospital, Cork

Dr. J. J. O'Connor, Chief Psychiatrist, St. Finan's Hospital, Killarney
Dr. S. O'Hanrahan, Senior Psychiatrist, St. Joseph's Hospital, Limerick
Fr. O. O'Sullivan, O.F.M. Cap., Chaplain, St. Brendan's Hospital, Dublin
Dr. P. J. Power, Chief Psychiatrist, Our Lady's Hospital, Ennis
Mr. J. Quinn, R.P.N., St. Fintan's Hospital, Portlaoise
Dr. J. R. Shea, Chief Psychiatrist, St. Brigid's Hospital, Ballinasloe, Co. Galway
Mr. J. Taheny, St. Mary's Hospital, Castlebar, Co. Mayo
Dr. J. J. Wilson, Chief Psychiatrist, St. Brigid's Hospital, Ardee, Co. Louth