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Mental Health Division

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THIS ISSUE

Distributed with this Issue:

- "LSD - Problems and Promise", CMH Monograph Supplement #57 by Reginald D. Smart, Ph.D.

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CHILD PSYCHIATRY IN A GENERAL HOSPITAL

- Ronald B. Feldman, M.D.

FIVE YEARS AGO THE DEPARTMENT OF PSYCHIATRY at Montreal's Jewish General Hospital decided to establish and build a Children's Unit. For several years prior to this there had been a very active Department of Family and Child Psychiatry, an Adolescent In-Patient unit sharing the adult facilities, and strong community and school consultation services.

As part of the expansion program, the child psychiatric unit was designed for a variety of reasons. First, although the majority of children had been satisfactorily served on a purely out-patient basis, there was a growing number of children with problems requiring special facilities, together with the help of therapists from many professional disciplines. Two major groups were involved: the pre-school psychotic or the one exhibiting other major developmental disorders, and the school-aged child who was so disturbed that his school could no longer serve him. Second, it had often been observed that family therapy trainees tended to become much more skilled in interviewing and treating the parents than the children, who were frequently given much less attention in the treatment sessions. This was related to the insufficient exposure which the therapist had had to disturbed, or even normal, children. Third, with an in-patient unit it would no longer be necessary to transfer a child elsewhere if his condition worsened, or if long-term, intensive therapy were needed. Fourth, an in-patient unit would facilitate simultaneous hospitalization of parents and child, should this be necessary. Fifth, the in-patient children's unit would complete the range of services required for a comprehensive mental health approach, by offering psychiatric treatment to all ages, thus paralleling the other medical services in the hospital. Sixth, such a unit would extend even further the current range of post-graduate training facilities, as well as acting as a stimulant to other sections of the Department of Psychiatry. Finally, such a new service would facilitate clinical research that would otherwise not be feasible.

Planning the Unit

Originally in 1963 it was intended to develop the in-patient service mainly for short-term diagnostic purposes as an aid to family treatment, giving priority to children with intact families. It was planned to admit very few autistic children. However, since that time a number of new facilities have appeared in the community. There has been a dramatic increase in nursery school programs involving highly trained teachers capable of providing very good treatment to children with moderate behavior and learning disorders. The Protestant School Board of Greater Montreal began to operate small classes for emotionally disturbed children, and the schools are now able to handle many children who previously would have been entirely excluded. As a consequence, the new unit now tends to admit children who are more severely disturbed than had originally been intended.

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During the planning stages of a children's unit, very strong opinions about design or equipment may be held by some of the building committee members, reflecting strong subjective leanings toward a particular therapeutic approach. However, the committee must bear in mind that the unit needs to be sufficiently flexible to adapt to unexpected changes in personnel and other demands and factors which cannot be anticipated.

Location is another very important matter. We had a choice between a large area in a far wing of the hospital, or a smaller one adjacent to the adult psychiatric ward. Selecting the latter proved wise, since a telephone can never substitute for close and informal contact with colleagues. Whenever possible, a children's unit should be on the ground floor and open out into an enclosed, outdoor play area. Alternately, a roof garden with a high protective fence is a reasonable substitute. Unfortunately, neither of these possibilities were available to us, but we were able to include a small gymnasium within the unit which has proven to be particularly useful.

Building committee members were significantly helped by visits to other centres in Canada and the United States. By asking the right questions, these visits can be extremely productive. However, one must be sure to speak with the front-line staff - the nurses, child-care workers, teachers, etc., who are the most familiar with what goes into good or poor operational design. For example, the planners should begin by making a list of such mundane topics as lighting fixtures, plumbing, washroom facilities, hardware, locks, etc. This list must be detailed and precise. All measurements should be included and carefully recorded. It is the small details like the design and location of cupboards, bookshelves, etc., that cause the most irritating problems. Any changes in the plans made after they have been submitted for tender will be much more costly. For example, re-locating a dividing wall requires not only new floor plans, but revisions in plumbing, heating, electrical circuits, etc. Obviously, it cannot be over-emphasized that all details must be carefully scrutinized before the final submission. The treatment philosophy and working methods of the unit must, of course, come from those responsible for planning the unit. While the architect is able to offer many useful suggestions and advice on technical problems, he cannot be expected to possess expertise in the diverse design problems of a unit for disturbed children.

Finally, before the final submissions are made, it is advisable to have them reviewed very critically by someone who is in no way connected with those who have drawn up the plans. He may be able to recognize errors to which the planners have become desensitized because of their closeness to the project.

Description of the Unit

Our unit occupies a portion on the 4th floor of a new wing of the hospital. It shares a common entrance with the adult and adolescent psychiatric ward, but is set apart by a short corridor and a set of swinging doors. These doors prevent patients from excessive wandering from one unit to the other. Thus the unit is an integral part of the department of psychiatry, effectively separated, but not physically isolated. One enters a small bright waiting area, to the right of which are the senior staff offices. To the left is a much larger section which includes the play therapy rooms, classrooms,

psychologist's offices, research areas, secretarial and storage space. Several rooms have two-way mirrors for observational and teaching purposes. Closed circuit TV will also be available for this purpose.

At the north end of the unit is the children's ward itself, separated by a locked, windowed door. The ward contains three bedrooms, an occupational therapy room, a small lounge and dining-room, and a gymnasium which can be divided into two activity rooms.

The nursing station is situated so as to provide a clear view of the entire area. None of the staff wear uniforms and every effort is made to see that each patient has some identifiable area of his own. The decor is sunny and cheerful and the color scheme predominantly burnt orange with yellows and dark wood trim. Safeguards such as shatter-proof glass and stable furniture are quite unobtrusive.

The unit accommodates seven in-patients and twenty day-patients. With the exception of the bedrooms, all facilities are shared and activities are organized according to therapeutic need, irrespective of day-patient or in-patient status.

Admissions

All admission referrals are made directly to the secretary of the section of Family and Child Psychiatry, who records the identifying data. The case is then thoroughly evaluated by a psychiatric social worker. She interviews the family, conducts a detailed investigation of previous treatment, and usually makes a family home visit as well. The case is then discussed in conference and if it seems that long-term hospitalization may be indicated, the child is then admitted to the day-centre for an intensive three-day evaluation. On the first day the child is assessed by the educational consultant and by the occupational therapist. The second day the child is interviewed, together with his family, by the director of the Unit and in the presence of the entire ward staff. Often the psychopathology of the "identified patient", i.e., the child, reflects the disturbed functioning of the family unit as a whole. A comprehensive evaluation of a child demands a clear understanding of his role within his family and of his relationships to the other family members. The third day the child is involved in group activities on the ward and his behavior is closely noted. During the entire three days, psychological assessment and psychiatric examination of the identified patient are carried out.

After three days the child is discharged from hospital, unless it is obviously necessary that he remain. The results of the evaluations are then thoroughly discussed at ward conference, where further recommendations for treatment are made. Often, even when a patient has been expressly referred to the Children's Unit for hospitalization, we have decided that out-patient therapy would be better for him. The intensive evaluations in the day-centre thus serve to avoid unnecessary and protracted hospitalizations. When hospital treatment is recommended, either on an in-patient or on a day-patient basis, the three-day evaluations have enabled the staff, the patient and his family to get to know one another reasonably well before the child returns to hospital. Because of this there is much less initial anxiety and acting-out when he is re-admitted for long-term therapy.

Activities

The atmosphere in the unit is very much like a good nursery school. There is a similar range of activities available, but the size of the groups is considerably smaller. During the carefully planned day, the child will receive individual and group therapy. He has his meals on the ward, has sessions with the teacher and participates in sports and other activities. Usually, he also has scheduled individual play therapy. We try to get our in-patients back to school as soon as possible. Special arrangements have been made with the neighborhood schools, for which we provide a continuing consultation service, to accept the children on a part or full-time basis, according to the child's particular requirements. The schools have been cooperative and this has been an extremely important adjunct to the therapy program, since it precludes the necessity for the hospital to duplicate existing educational programs. We have also instituted a trial program of reinforcement therapy for some children on the ward.

Staff

The staff includes both male and female nurses, child-care workers, an educational consultant, an occupational therapist, social workers, psychologists, psychiatric residents, and child psychiatrists.

Conclusion

Growing pains are inevitable. So are the relentless and often destructive energies of disturbed children. Nevertheless, our experience has certainly seemed to demonstrate that a general hospital can be a very suitable setting for a child psychiatric unit. Child psychiatry is often perceived as being mysterious, distant and forbidding to those who are not actively engaged in it. But the presence of a children's psychiatric unit within a general hospital makes people aware of the potentiality and usefulness of this service.

HISTORICAL MATERIAL ON PSYCHIATRY

All manner of historical items relating to Canadian psychiatry are being sought. Early annual reports, photographs, newspaper clippings, scrap-books, correspondence, bibliographies and references, reprints with references to earlier psychiatric history, and any other items felt to be of historical interest. Send for cataloguing and ultimate centralization to:

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