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Education of Hospital (Health) Play Specialists in Japan and the United Kingdom

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Introduction

Commissioned by the Japanese Ministry of Education, Culture, Sports, Science and Technology, the University of Shizuoka Junior College introduced the first hospital play specialist (HPS) training programme for working adults in 2006. In the subsequent 15 years, 213 HPSs have completed the programme.

In Japan, an HPS is a professional who supports sick and disabled children by means of play so that those who are receiving medical care can be treated in a way that does not deprive them of their sense of self-control and that makes their experiences of such care positive. It is believed that the functioning of these professionals will help not only the children and their families but also the medical staff, enabling better communication with the children, facilitating treatment, and enhancing recovery.

This section will briefly summarise what kind of theoretical research has been conducted on play to date and present issues in play research. It will then discuss the evolution of health play in Japan and its educational challenges, citing specific examples.

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Part 1 – Education for the Specialised Provision of Hospital Play in UK

‘Deprived of play, the child is a prisoner, shut off from all that makes life real and meaningful. . . .[Play] acts too as a safety valve, allowing [the child] to relive and come to terms with fears and anxieties which have become overwhelming.’

—Organisation Mondiale pour L’Éducation Préscolaire 1966

Over time, the shift from a medical model of paediatric healthcare to a more holistic approach now incorporates the provision of play and recreation, which enables children and young people to navigate complex and challenging healthcare systems. When observing children and young people in a healthcare environment today, one is likely to witness their engagement in a variety of imaginative, familiar, and reassuring play and recreational opportunities. Anecdotally, this scenario was succinctly captured by a child who, when visiting the outpatient's department, was overheard to say, ‘I come to hospital to play; oh, and when I’m here, I see the doctor as well.’ However, play in hospital does not happen by chance; it is the skilled intervention of the trained HPS who facilitates these meaningful and creative interactions. Employed in a variety of paediatric departments and clinical areas, the HPS is specifically trained to enable the sick child, young person, and family to assimilate and accommodate healthcare procedures into a more manageable and positive experience (Jun-Tai 2007).

The report to the Care Quality Commission (CQC) by Dr Sheila Shribman, recommended that specific children and young people’s services should be inspected by the CQC, including hospital play services, and that play specialists may be part of the inspection team (Shribman 2014). The training programme for the HPS is responsive to inspection frameworks and reflects the skillset required to address the patient’s treatment plan. However, this must begin with the fundamentals of building trusting relationships through advocacy, communication, and normalising play and recreation opportunities. Over a two-year training course, student play specialists will learn how to apply non-pharmacological approaches to prepare and distract patients during invasive procedures; these skills are transferrable to more specialised areas such as burns units, oncology, feeding programmes, diabetes, loss and bereavement

support etc. Given that the Department of Health (2003: 14) recognised that ‘there is evidence that play hastens recovery, as well as reducing the need for interventions to be delivered under general anaesthesia’, it is apposite that the profession is well trained in order to work with multi-professional colleagues in the provision of a whole systems approach to healthcare.

Historic context relating to the justification of a specific group of professionals, to be trained in delivering organised play in a hospital environment can be found in the Platt Report, (Platt 1959), including the need for play to be organised under skilled supervision. As with any profession it must evolve and adapt to meet service needs, and this mirrors the profession’s journey. The first training course in 1973 was delivered by Chiswick College as a post-qualification course, with applicants typically from a professional background in art and music therapy, nursing, teaching, social work, and nursery nursing. The establishment of the National Association of Hospital Play Staff (NAHPS) in 1975 identified a growth in the profession, and it became evident that a formalised curriculum should be aligned to an education body. NAHPS consulted widely and the formation of the Hospital Play Staff Examination Board (HPSEB) saw the first examinations taking place in 1988 (Save the Children 1989).

Further discourse with the profession, led to the change of title from HPSEB to the Hospital Play Staff Education Trust (HPSET), as this corresponded with the wider remit of becoming a registered profession. Analysis of the HPS role identifies an in-depth capacity to promote health and wellbeing in order to support healthcare interventions; therefore, the word ‘hospital’ in the title has been replaced by ‘health’, which is fully reflected in the learning outcomes of the training course. Today, qualified HPS are expected to re-register on an annual basis in line with other health professionals; therefore, students are prepared for this process through the reflective components of the summative assessments.

The current training programme is delivered as a Foundation Degree (FdA) in Healthcare Play Specialism, and when first validated, a scoping exercise was undertaken to identify how the FdA could be dovetailed into the existing NHS careers pathway, enabling the profession to be positioned within the existing

NHS Career Framework (Paulsen 2016). To achieve this, HPSET and NAHPS collaborated on the development of a Code of Conduct (2019a) and Standards of Proficiency Professional Standards (2019b)**.** Both documents are integral to the course curriculum.

The development and advancement of play in hospital is not unique to the learning experiences of students in the United Kingdom. Early exchanges of educational and professional practice in the 1980s were established when Child Life Specialists from the USA began a tradition of visiting the UK in order to observe HPSs in their work environments. This initiative is credited to Peg Belson, as was her strong connection to the Klicek Foundation in the Czech Republic, where a similar arrangement was made. In 2008, NAHPS joined the University of Shizuoka in Japan to establish an affiliation to promote high-quality play services for sick children and an alliance in sharing best practice in research and teaching.

Many HPSs have participated in the training programme since its inception in 1973, and today there are around 700 registered HPSs delivering differentiated, child-centred practice. The intervention of a trained HPS can increase the child and young person's resilience in an environment where 'children shall be cared for by staff whose training and skills enable them to respond to the physical, emotional and developmental needs of children and families' (European Association for Children in Hospital n.d.).

Education and training should evolve and be responsive to the needs of society, therefore NAHPS and HPSET consulted widely with NHS stakeholders in order to align the current training provision to the UK Government's drive for apprenticeships as organisations, including the NHS, with a salary bill of over £1.5 million are now required to make a financial commitment to upskill their staff. Historically, many play workers or play assistants employed in paediatric departments self-funded or sought charitable support to train as HPSs; therefore, the apprenticeship route has provided an opportunity to join the foundation degree students in embracing a wonderful profession.

The Institute for Apprenticeships require all apprentices to demonstrate knowledge, skills and behaviours at an academic and practice-based level, and

these have been mapped to the professions Code of Conduct (HPSET and NAHPS 2019) and Professional Standards (HPSET and NAHPS 2019). Following extensive engagement with NHS staff, education providers, parents, and patients, the Higher Apprentice Health Play Specialist standard was approved in 2019 and is currently delivered in England.

Steph Fairbain provides a personal reflection on the changing face of HPS training and the importance of professional mentoring for the HPS student, which is an integral part of the FdA qualification:

> Training and mentoring have been a privilege and passion for many years; in performance arts (from 1981), in management and organisational development (from 1994), play and youth work (from 2003) and mentoring HPSs since 2008.
>
> I have seen the development of play specialist training evolve from BTEC qualification (Level 4) to a Foundation Degree (Level 5) and now towards a new competencies-based assessment format (from September 2021). The benefits of competency-based assessment 'enables explicit articulation of skills that successful graduates have' (Bradley *et al.* 2008). Furthermore, the grading of competencies gives the student a clear understanding of their level of practice, with the top grading requiring the student to demonstrate both reflective and evidence-based practice. I believe that the strengths of the Foundation Degree reside in the assessment of work-based practice and the understanding of theories and evidence that underpin that practice carrying equal weight. I was involved in the introduction of Playwork National Vocational Qualifications when they were launched in the 1990's to a largely unqualified workforce, and I believe now as I did then that all children deserve an appropriately qualified workforce.
>
> My passion for training or coaching stems from the pleasure I get from observing the development of students, that light bulb moment when they suddenly 'get it'. For me, it is as satisfying as seeing an anxious child cope well with a procedure after receiving HPS preparation and distraction, and the joy shared when they realise: 'I did it!'.

Reflecting on the students I have supported over the years, I believe that one of the strengths of a mentor that comes with experience is an understanding that students' progress at different rates. There are plateaus in learning and practice where the student just does not seem to be moving forward, and the struggle and loss of confidence that then ensues can be both difficult to watch and frustrating for the mentor. An Open University (n.d.) session on Learning development, cites Atherton's learning curve model (Figure 2), which I believe more accurately depicts a learning curve than the smooth curve usually described.

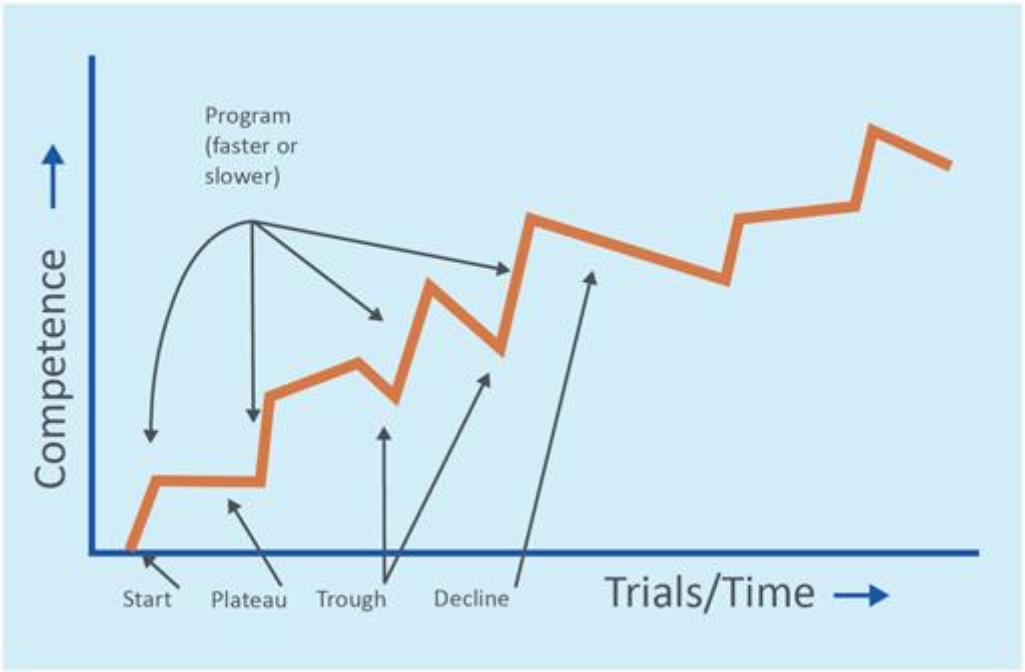

Figure 2: A typical learning curve (Atherton 2013, cited by the Open University n.d.)

Awareness that the learning curve is not steady and continuity is key, along with an understanding that progression is a 'process that contains growth, peaks, troughs and plateaus' (ibid). Experience has shown me that there are few students who do not suddenly bloom with a 'light bulb' moment, and it is the calm confidence a mentor can bring that will support the student through.

In developing my own mentoring skills, alongside the training provided by HPSET, I found 'The Nurse Mentor's Handbook' (Walsh 2014) to be a

useful tool. Through reading this I now use the SWOT analysis (Strengths, Weaknesses, Opportunities, Threats) to help students identify their transferable skills and learning objectives (applied slightly differently than suggested in the book) and this has cemented my understanding of the need to provide students with different learning approaches to meet different learning needs.

In researching the mentoring role, there seemed to be little emphasis on the impact of a passionate mentor. I opened this reflection by stating training and mentoring have been a privilege and passion and I believe that passion and the ability of the mentor to express this is the foundation of a great mentor, underpinned by knowledge and good practice. The mentor/student relationship is stronger when viewed as a partnership where both can learn from each other. Therefore, a mentor needs to be able to critically appraise their own work and to be open to change and new ideas.

‘The greatest of mentors inspire their mentees and become a living example to emulate. They do so by exuding a genuine passion for their work.’ (The One Thing n.d.)

Part 2 – The Evolution of Hospital Play in Japan

Overview and Issues of Play Research

By reviewing previous studies on play, this section discusses the difficulties in defining play and what kind of theoretical exploration is needed in hospital play research in the future, and for what purpose theoretical research is required.

Until now, play has been examined from diverse perspectives not only in social welfare studies, on which this paper is based, but also in anthropology, sociology, psychology, childcare studies, and many other fields, and there is a vast body of research on the subject. When it comes to play research, Huizinga’s *Homo Ludens* (1963) and Caillois’s (1967) work, which succeeded Huizinga's research and revised it, are probably the first to be mentioned.

According to Ellis (1973), the study of play is divided into three major stages after the appearance of Huizinga. Although somewhat rough, Ellis's classification of the three phases is as follows: classical theories of play prior to Huizinga's appearance, modern theories of play by Huizinga and his successors, and modern theories of play after Huizinga.

Prior to Huizinga, play studies discussed play as a by-product of some action. Therefore, play itself was not discussed as a substantive act. Three points deserve special mention in Huizinga's study: first, he treated play itself as an entity that exists in an independent realm; second, he typified play by focusing on its form and defined it as something that is located at the centre of culture; and third, while acknowledging the essence of play to be fun, he dismissed as impossible any theoretical interpretation of fun.

Caillois, who took over Huizinga's work, modified the unity of play as presented by Huizinga and typified play into four types: agon (competition), mimicry (simulation), area (luck), and inkus (dizziness). Thus, Huizinga's definition of play as the centre of culture was redefined as play as a domain of culture. Kohara (2011) commented on Caillois's revision, 'Caillois tried to overcome the problems of Huizinga's theory by adding more elements to the theory and by narrowing the scope of the theory, but many unclassifiable hobbyist activities remained.'

What Huizinga and Caillois have in common in their definition of play is that they assume fun to be its essence, but they do not give any theoretical interpretation of or meaning to fun. In other words, they treat fun as an *a priori* concept wherein fun accompanies play or lies at its heart.

The above assumption of fun has been considered by later researchers, especially Ellis and Csikzentmihalyi, who explain the fun of play in psychological terms as an equilibrium/transition of information content or psychic entropy through their own concepts such as 'optimal arousal' (Ellis 1973) and 'flow' (Csikzentmihalyi 1990). Csikzentmihalyi's flow theory is often referred to in today's play research, especially in psychology and related fields. From this, it can be regarded as an attempt to explain play from a psychological aspect using some kind of index or theory.

There also exist approaches from a completely different perspective than these psychological ones. One of these is the research focusing on the interaction of play as seen in Goffman's (1961) study. Here, using play as a model, a unique way of constructing the world based on the nature of interaction is examined. Goffman's study of play is an extension of Bateson's (1972) framing theory, which concerns interpretive frameworks and which states that the meaning of a given action depends on what kind of interpretive framework is used to understand the mutual actions of the players. To summarise Goffman's argument, what constitutes play is left to the player receiving the message. The major difference from other studies is that Goffman tries to define what play is rather than to categorise it.

There are various other studies of play, including an attempt to understand play from a phenomenological perspective (Henriot 1969) and a study that discusses play from a sociological perspective (Inoue 1981), but all of them seem to be struggling with the question of how to understand play.

It should be clear from the discussions in these previous studies that it is very difficult to define play in general. However, it is crucial to seek a theoretical standpoint for what kind of play should be considered in hospital play research. The question is what frames of reference are used by sick children, their families, and the HPS to interpret play, and what frames of reference can be shared and used to construct a world of meaning together. These issues are not limited to the level of theoretical research. Yano (1996) once described play as something that 'brings radiance to life'; however, it is also a clinical challenge to practice play that imbues life with such radiance when dealing with sick children and their families.

The next section will discuss the evolution of health play in Japan, the challenges they currently face, and their achievements, with specific examples.

Health Play Specialism in Japan

The techniques used by an HPS can be broadly categorised into the following areas:

- Normal Play
- Therapeutic Play
- Play Preparation
- Distraction Therapy
- Post Procedural Play
- Distraction
- Post Procedural Play
- Sibling Support
- Individual Referrals

All children are eligible to participate in HPS activities. Whether a child is mildly or severely ill, the HPS realises an environment in which the child has access to some form of play, and all the areas listed above come under the remit of the HPS. Unfortunately, in Japan, preparation is the only recognised nursing technique; however, the role of the HPS is not confined to preparation, and the HPS knows that unless play-based support is incorporated into the entire treatment programme from the time a child is admitted to hospital to the time they are discharged, preparation will not be fully effective.

Challenges faced through HPS training education

We have been providing HPS training and education for 15 years, but the road has not been a smooth one. Japan adopted the United Nations Convention on the Rights of the Child (UNCRC) in 1989, and it was ratified in 1994 (Runnels Ranck *et al.* 2016). However, in the fourth and fifth periodic report of Japan on measures taken to implement the UNCRC in January 2019, Committee Experts suggested that Japan ‘did not seem to be as child-friendly as one would wish’ and that only three per cent of health establishments carried the ‘child-friendly’ label (Office of the High Commissioner on Human Rights 2019).

This is reflected in our healthcare establishments, where even now, there are many hospitals in which parents are not allowed to be present during procedures such as drawing blood from their children. We are still using restraint belts and other methods to restrain children during procedures. It is

unfortunate that the rights of the child are not being protected in Japan, a developed country, and HPSs have been making changes under the slogan of ‘child-friendly medical care’ by strategising their approach and encouraging each other.

This has a lot to do with the culture in Japan, where hospitals are very hierarchical, and it is not easy to make people understand the importance of including the HPS in the paediatric care team. Often, when I raised the issue with a paediatrician, advocating that children had the right to play, I was rebuffed, the paediatrician saying that play in the hospital sometimes had the potential to deprive a child of their right to life. A particular point raised was the question of how to present the evidence for the effectiveness of HPS. It is clear that the medical model leans towards numbers. On the other hand, there are many physicians who believe that it is impossible to prove everything numerically. We, as HPSs, decided to prove our value by accumulating case studies and have been publishing such studies every year since 2009. As of the current year (2022), which marks the 13th anniversary of beginning this project, more than 100 case studies have been published and undoubtedly represent the birth of the HPS in Japan.

Japan is a country with universal pensions and universal health insurance, but one aspect that differs slightly from the UK healthcare system is the concept of medical fees. In Japan’s medical fee system, points are awarded to doctors, nurses and pharmacists for their professional activities, and payment is determined on the basis of these points (Shinya 2017). For example, when a doctor explains a treatment to a patient, the doctor receives a corresponding score, and the amount paid to the hospital is determined accordingly. In order for an HPS to be eligible for reimbursement as an independent professional, it will be necessary to award points for some of their professional activities. We will be discussing this in the future, but we believe that preparation and distraction will be the easiest activities to understand in order to be awarded points.

We do not deny the value of expressing efficacy in terms of numbers, but we are certain that the benefits an HPS brings to sick children can be seen only by observing the interaction between the HPS and the children. We believe that when truths that cannot be expressed numerically are ignored, medicine walks alone, away from the child.

How paediatricians evaluate play for sick children

While preparation and distraction are a form of support that needs to be standardised in Japanese paediatric medicine, the role that HPSs have come to believe they have a responsibility to develop goes beyond this. The reasons for this are explained below.

In this 15th year of HPS training and education, we planned a study based on interviews with physicians to identify factors that promote and inhibit retention in health play specialism. Five paediatricians who work with a Japanese HPS were selected for this qualitative study. Semi-structured interviews were conducted according to four main themes:

- The changes that have occurred as a result of working with an HPS
- What they want and do not want from an HPS
- The knowledge, skills, and attitudes required of an HPS
- The role an HPS plays in paediatric care

The results are very interesting: the physicians appreciated the preparation and distraction that an HPS provides, thereby helping them do their jobs, and they talked about the need to standardise preparation and distraction. However, they expected the HPS to go further.

A paediatrician who treats children in medical care talked about the meaning of play for sick children as follows:

‘Play is a way of life, isn’t it? You’re the one who can do your best to stay alive for one more week, and for medical-care children, HPS is the way to go.’

A second paediatrician said the following:

‘I think it’s play that gives children the opportunity to have a transformative experience in the hospital.’

A third paediatrician praised the activity as ‘bringing the true voice of the child to us’.

A fourth paediatrician said, ‘I think the wards have started to move in the same direction since hospital play was introduced.’ He then stated that he would like HPS to ‘develop support that goes beyond the boundaries of hospitals’ and to ‘work within hospitals is a matter of course’. He added, ‘I would like HPS to become a human resource that can deliver play support to children with chronic diseases living in local communities.’

The background to these statements is the existence of children who have long lives despite being ill, and the fact that the need to support children in the community is emerging as genetic diagnostics develops and we can assume our own life expectancy to some extent.

The value that HPS adds to healthcare

One of the doctors suggested in the interview that he thought Japanese medicine was the same as Western medicine, but the way of thinking about and providing medicine was different. I find this a very thought-provoking statement.

As we have explained, by incorporating play into the hospital environment and into treatment, children can feel the kindness of medical care and remember it as an experience. The HPS maximises the power of play and applies it to the hospital environment to provide concrete ways to support sick and disabled children. However, as I train and educate people in health play specialism, I realise that the meaning of training for this profession in Japan goes beyond the *how to* of teaching and spreading HPS techniques, and that we need to find answers to the *why?* questions.

The following examples will show why health play specialism must challenge the question of *what is the value of its presence in hospitals and what is the significance of providing play for sick children and their families?*

There was a child with whom an HPS was involved who was able to play very richly during his hospitalisation. When it was decided that the child would be discharged from the hospital after his surgery, the child cried and got angry saying, ‘No, I don't want to leave the hospital, I still want to stay in the hospital’. We told the child that he could come back and play anytime he wanted, and we were on our way. But one of the medical staff who was watching said, ‘That’s a mistake; a child shouldn’t like hospitals. You have to make the child feel a little scared of the hospital.’ The HPS was surprised to hear the child crying and saying that he did not want to go home and, seeing he was still there, wondered where this difference in perception came from. This case leads to the question of what a hospital should be like for an adult or a child. It also raises the fundamental question of what kind of experience a child’s relationship with healthcare should be.

In 2003, the UK Department of Health published The National Service Framework for Children, Young People and Maternity Services. In a supporting document, there is a passage that says, ‘Children will become adults; and there is a growing understanding of the effects of childhood experiences, including illness, on their adult life’ (Department of Health 2004: 10). In other words, the experience of interacting with medical care as a child continues into adulthood, and recognition of this leads to the idea of including an HPS in the medical team. I think it is important to create a system that allows children to grow up healthily while trusting and utilising Japanese medical care rather than disliking it or disliking medical staff because of their involvement with it.

Conclusion

The next stage is to give the HPS a Japanese name. This will require a thorough examination of the role of the HPS in paediatric care in Japan. Until then, it will be important to continue training and education for HPSs.

During this process, we are currently facing the need to deepen clinical research and increase awareness of the meaning of play for children and the value of integrating play with medical care. Anyone who is involved with children knows that play is an essential activity for their development, but in order to incorporate play into paediatric medicine, discussing it must be limited to matters related to development, and it is necessary to understand the depth of play. In fact, play has fascinated researchers in many fields since ancient times. Plato said, ‘You learn more about a person by playing with him for an hour than by talking with him for a year’, and the historian Johan Huizinga (1963) argued that ‘all cultures have developed from play’. Clinical pedagogue Satoji Yano (2006) said, ‘Children connect with the world through play’, and mathematician Kiyoshi Oka (2008) explained the importance of emotion in scientific research: ‘Academic discoveries are guided by the keen joy of discovery that children feel when they see a beautiful butterfly.’

In particular, when we talk about play in the context of medical care, we would like to focus on the fact that play has the power to create trust and empathy, which are the foundations of human relationships. Play cannot develop without such feelings towards others, and it is very important for these feelings to be created and nurtured between the therapist and the child and to continue after treatment. In addition, it is important that children who are at a remarkable stage of growth and development experience rich human relationships based on trust and empathy even though they are undergoing medical treatment, or even because they are undergoing medical treatment, and that they return to general society with the seeds of building relationships based on trust and empathy in them. I believe that all adults, not just those involved in the care of children, have a responsibility to create such a world and that play is not merely an

activity to pass the time for children undergoing medical care but a medium to connect the medical care and the children. It is precisely because modern medicine protects *life* by making full use of advanced modern science that we conclude that it is necessary to combine science with play, which inspires *life* in children and fosters the joy of interacting with others.

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