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Adolescent Psychiatry Services

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Background. The way in which psychiatric services for adolescents in the UK are developing will be affected by recent changes in the organisation of the National Health Service.
Method. The history of these services, and the different opportunities for development are reviewed.
Results. Ways in which high-quality clinical care can still be provided are indicated.
Conclusion. Adolescent psychiatric services should be judged on their ability to provide such care, not merely on their ability to survive.

Epidemiological studies (e.g. Rutter *et al*, 1976) suggest that the prevalence of significant psychiatric disorder among adolescents is around 15–20%, yet the majority of cases remain unknown to psychiatrists (Evans & Brown, 1993; Goodyer & Cooper, 1993).

Many adolescents receive support and counselling from GPs, teachers, social workers, counsellors and others. Those adolescents who are referred on to multidisciplinary child psychiatric services may be seen by psychiatrists or by psychologists, social workers, psychotherapists or other specialists.

Although some health districts have developed specialist out-patient adolescent services (e.g. Jaffa, 1994), most specialist adolescent psychiatry is still based on in-patients units. In recent years many of these units have lost their defined catchment areas and their relatively secure, even if inadequate, funding. Many are struggling to adapt to changes in the National Health Service (NHS), and to maintain a style of care that is clinically, politically and economically desirable within the context of a seemingly ever-changing environment. It is these specialist adolescent psychiatric services which are the subject of this paper.

History

Although the first UK in-patient psychiatric adolescent units were opened in the 1940s, it was not until the rising political discontent in the 1960s over adolescents being treated in adult psychiatric wards that a widespread network of such units became established. These varied widely as regards source of referral, type of patient, length of stay, style of treatment and other important aspects. Although such variation has tended to be seen as a problem, Wells (1989) gives a helpful example of two units in the same region offering very different treatment approaches for different groups of patients.

The 1980s witnessed growing concerns over specialist adolescent psychiatry services. In 1986 the NHS Health Advisory Service produced a report entitled *Bridges Over Troubled Waters*, much of which is still pertinent. Its findings included:

(a) a lack of data on psychiatric disorder in young people and on the effectiveness of interventions
(b) inadequate services for adolescents with physical, mental or sensory handicaps, as well as for older adolescents and delinquents
(c) divergence between the therapeutic orientation of units and the expectations of referrers
(d) a great diversity between units in terms of admission policies, treatment programmes and length of stay
(e) doubts over cost effectiveness
(f) poor development of academic adolescent psychiatry
(g) insufficient consultation and other work with other professions.

The report recommended that: "Psychiatric units for adolescents must each offer a range of methods of treatment and move towards more uniform admission policies. Emphasis should be placed on using the shortest stay compatible with the adolescent's therapeutic requirements".

The report generated much discussion (e.g. Wells, 1986) but had little immediate impact on the delivery of services. However, the late 1980s and early 1990s have seen new factors exerting pressure for change in

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somewhat similar directions, but this time with much greater force. The political demand for care in the community has made in-patient treatment for psychiatric patients less fashionable. It has increased the pressure for admission to be avoided if possible, or otherwise to be as brief as possible. This pressure has been reinforced by recent scandals concerning residential care of young people.

The changes in the NHS management structure have resulted in adolescent psychiatric services being incorporated into provider units, now mostly NHS trusts. In-patient adolescent units may not fit into the strategic planning of these trusts, not least because they tie up considerable sums of money in capital investment and in staff wages. In addition, purchasers may be resistant to paying what they see as expensive fees and may wish to fund fewer and briefer admissions. Inevitably they will attempt to influence adolescent units to manage those cases that cause the purchasers most concern, perhaps including some of those categories highlighted by the HAS report.

The future of specialist adolescent psychiatric services

In 1990 a survey by the Association for the Psychiatric Study of Adolescents listed 68 adolescent units in the UK and the Republic of Ireland. Nearly all of these offered in-patient treatment. In the past few years some of these units have closed, and a smaller number of new units have opened, particularly in the private sector. The challenge for all services is to adapt to their changing environment by developing new approaches to policy and to delivery of services. I will now discuss some of the common current themes and likely future developments.

The identity of the unit

Adolescent units mostly describe themselves as dealing with the most serious cases. Usually this will mean psychiatric illnesses such as severe mood disorder and psychosis. It may also include other problems, such as the consequences of being sexually abused, which may have equally profound effects on normal development. There will inevitably remain some variation in admission and treatment policies. Some units will undoubtedly continue to specialise in managing particular diagnostic groups e.g. eating disorders.

Much specialist adolescent psychiatric care will continue to be on an in-patient basis. However, expansion of day care and out-patient activity will result in more patients who would formerly have been admitted being treated while living in their own homes. There may be a tendency for units to style themselves 'serious disorder services' rather than solely as in-patient units.

An unpublished survey of adolescent units by T. Scannell in 1993 showed that of the 31 units which responded, 26 tended to admit patients for 1–6 months, three for 7–12 months and two for 12–18 months. This trend is likely to continue, with most units aiming at relatively brief admissions. Patients who stay in for a long time will mostly be those with intractable conditions who cannot be coped with elsewhere. A few units will probably continue to offer more lengthy in-patient treatments for those with deep-seated personality difficulties.

Criteria for admission and discharge

These criteria will probably be described in more explicit terms. An example might be the shift from admission because a patient has severe anorexia nervosa, to admission because the local services are unable to manage the patient's anorexia nervosa on an out-patient basis. This will then lead to a discussion of what must happen for the patient to be discharged and once more treated locally as an out-patient. In the case of the patient with anorexia nervosa, such criteria might include weight gain, establishment of a healthy eating pattern, or the ability of parents to persuade their child to eat. A more detailed description of this approach to admission and discharge is provided by Bruggen & O'Brian (1987).

Admissions are likely to fall mainly into the following four categories:

(a) When a period of intensive support and monitoring is required to reduce the risk of a depressed or psychotic patient harming themselves or (less likely) someone else; this period might be expected to last until there has been sufficient time for treatment to take effect and the risk of harm to be reduced.
(b) When the treatment required can only be provided on an in-patient basis; an example might be a patient with an obsessive–compulsive disorder requiring more intensive response prevention than could be provided at home.
(c) For assessment. This might include (i) diagnostic assessment, for instance to establish

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or exclude a diagnosis in adolescents who repeatedly injure themselves; (ii) assessment of response to treatment (see below).

(d) When out-patient treatment has failed; for instance, if a patient with a mood disorder or eating disorder does not respond to out-patient treatment and the condition appears to be becoming chronic, then a period of in-patient care may allow further assessment, including assessment of response to treatment under more controlled conditions.

Services will also define who they will *not* admit. This might include adolescents whose major difficulty is in family relationships, and where it can be predicted that although admission may result in speedy improvement, discharge would then result in relapse.

Treatment intervention

The complex and difficult cases which form the bulk of admissions require a range of treatments to be available including drug treatments, cognitive and behavioural treatments, family and individual therapies, and a variety of group therapies. The focus of these latter will vary and may include: problem-solving, social skills, health education, life skills, groups designed to facilitate expression of emotion or taking of personal responsibility, and those dealing with grief or the aftermath of sexual abuse.

A particular challenge is presented in determining the place of individual psychodynamic therapy. The psychodynamic psychotherapist can make an important contribution to the understanding of patients and of the relationships between patients and staff. As admissions become briefer, the treatment role of the psychodynamic psychotherapist will be to undertake brief focused in-patient psychotherapy, or to provide information which referrers can use in their subsequent management. Unfortunately many of these out-patient services will not be able to offer psychodynamic psychotherapy.

Consultation

Where the professional referrer contacts the specialist service because they feel they're stuck, the most helpful response may be the offer of a consultation. The principles of consultation and its use in child and adolescent psychiatry have been well described elsewhere (e.g. Steinberg & Yule, 1985; Dare *et al.* 1990). The task of the consultant is not to take over the case but to facilitate the referring professional's own work. The referrer describes the case, and its particular problems and dilemmas, to the consultant, who uses questions, advice or information to help generate a satisfactory management plan. The outcome of the consultation may be a referral for direct intervention with the patient, but this decision is not the responsibility of the consultant.

Although referrers may be irritated when their request for admission results in an offer of consultation, judicious use of consultation can not only facilitate the work of the local professional but may also avoid unnecessary admissions.

Emergency service

Not unreasonably, referrers and purchasers demand that services respond to emergencies (Hill, 1989; Gowers, 1991). Unfortunately units cannot easily afford the staffing levels needed to cope with night-time or weekend admissions. An empty 'emergency bed' is not earning money, and an occupied 'emergency bed' is no longer available for emergency admissions.

There are a number of measures which, in combination, may solve this problem. One is to have a steady throughput of patients admitted for 1–2 weeks, usually for assessment. This means that a bed is always likely to become available in the near future. Another possibility is to have a flexible number of beds and to be able to employ extra staff as needed. A third is to work in cooperation with referrers who appreciate the problem and with whom it is possible to discuss how a situation can be managed until a bed can be made available. This might involve interim intensive out-patient support, day patient care, or enlisting the help of another in-patient unit.

Leadership

Specialist adolescent psychiatric services require strong clinical leadership from a consultant psychiatrist who is trained in child and adolescent psychiatry. The psychiatrist will need close working relationships with the managers of the service, the heads of the various disciplines involved within the service, and those responsible for negotiating the contracts which allow the continued funding of the service.

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Training

Such services benefit greatly from a strong commitment to education and training, both of their own team members and of mental health professionals in their catchment area. Unfortunately, financing this training activity is likely to become increasingly difficult.

Research and development

There has been little clinically helpful research on outcome in adolescent psychiatry. Among the notable exceptions is the demonstration of the effectiveness of family therapy for adolescents under 19 years of age suffering from anorexia nervosa of recent onset (Russell *et al*, 1987). More such research is needed, to inform clinical practice and to persuade purchasers that effective treatments are available.

As units become better at describing what they do, the development of treatment packages will become more feasible. Given that the possibilities of treatment are often as much determined by social, family and personality factors as by the nature of the illness, packages will need to allow much flexibility and may take the form of guidelines and identification of decision points. They will allow more meaningful communication between units, will facilitate training and may be a focus for research into processes and outcomes.

Relationship with district services

District child and adolescent psychiatry services will continue to become more community-oriented, developing close relationships with their local general practitioners (GPs), social workers, schools and voluntary agencies. Some district services will continue to develop particular areas of expertise in, for instance, forensic adolescent psychiatry, and may market these services to neighbouring districts.

Basu *et al* (1991) found that 80% of a sample of child and adolescent psychiatrists had made use of regional in-patient child and adolescent psychiatry units in the previous two years. This pattern is likely to continue, and specialist adolescent services will tend to have a network of district child and adolescent psychiatrists as their main referrers. Referral by GPs and social workers will be more frequent in situations where they control budgets and may purchase services directly. It is of interest that the Association of Metropolitan Authorities (1993) has recommended that the government "provide adequate funding to local authorities to enable them to purchase and/or provide the required level of therapeutic residential and day provision for children and young people".

Good working relationships with adult psychiatry services will allow the planning and coordination of services to the 16–19 age group, some of whose needs are best met by adult psychiatrists, others by adolescent psychiatrists. It will facilitate the transfer of patients as they get older and require the help of adult psychiatrists. It will also allow transfer of skills and knowledge between the two services. At the moment, adult psychiatric services are perhaps under-informed on issues relevant to the management of their younger patients: for instance, developmental and family perspectives. Adolescent units may not be up-to-date in the pharmacological advances in the treatment of schizophrenia.

Conclusion

Assessing the significance of what happens today and predicting what will happen tomorrow are inexact sciences. It is clear that specialist adolescent psychiatry services are evolving in the context of their changing environments. Their survival depends on them continuing to do so. It must be hoped that this constant change and adaptation will enhance rather than impair the services' ability to do what they are there for, namely provide high-quality clinical care. It is on this criterion, and not just their ability to survive, that services should be judged.

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