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Comments

TREATMENT, TRAINING, CARE OR CONTROL?

Are more adolescent in-patient places needed? This has been the recommendation of a number of national and local working parties (Ministry of Health, 1964; Royal Medico-Psychological Association, 1965; Association for the Psychiatric Study of Adolescents, 1975; Court, 1976; Royal College of Psychiatrists, 1976) and it would be echoed by many exasperated doctors and social workers up and down the country to whom the local adolescent unit seems always full or too selective. At present there are some 30–40 adolescent units scattered throughout the U.K. sometimes 50 miles apart, and they vary considerably in their treatment policies and therefore in the sort of young person they admit (e.g. see Warren, 1952; Turle, 1960; Allchin *et al*, 1967; Berg and Griffiths, 1970; Evans and Acton, 1972; Bruggen *et al*, 1973; Wardle, 1974; Framrose, 1975; Perinpanayagam, 1978; Wells *et al*, 1978; Bedford and Tennant, 1981). They have tended to become specialised in one direction or another in order to develop reasonably coherent management systems for their turbulent clientèle, so that in any given area one or other category of disturbed adolescent is likely to be left out, leaving many professional workers more conscious of what is missing in residential services than what is being done.

Over the years various proposals have been made for the ideal projected number of in-patient places for adolescents, usually of the order of 20–40 beds per million total population, which would require the present bed complement to be doubled or trebled. But as already indicated, there is no general agreement about what style of in-patient service should be provided. Evidence for the effectiveness of in-patient units is scanty (Gossett *et al*, 1973; Hersov and Bentovim, 1977; Rutter, 1979); and it is certainly far from clear what proportion of adolescents require hospital in-patient treatment. These are complex and difficult issues, but deserve close attention at a time when much thought is being given to extending services for young people in this country, and beginning the development of adolescent services from scratch in some countries abroad.

In Britain reliable studies indicate that some 10–20 per cent of adolescents in the community show identifiable psychiatric problems, variation depending on age group, locality and of course on the definition of disorder (Henderson *et al*, 1971; Graham and Rutter, 1973; Lesley, 1974; Graham and Rutter, 1977). Emotional turbulence is quite common in adolescence (Rutter *et al*, 1976), major social and educational difficulties frequent among those who are unhappy and misbehaving (Rutter, 1979), and the referral process for children generally rather arbitrary (e.g. see Shepherd *et al*, 1971; Gath, 1968; Bruggen *et al*, 1973; Milham *et al*, 1978; Bruggen and Westland, 1979; Steinberg, 1981). When admission to hospital is thought necessary, especially in emergency, it is often quite clearly as the result of a breakdown in family and social coping mechanisms rather than because the child or adolescent has an acute or deteriorating psychiatric disorder. Work has then to be done to reverse the process by which the particular boy or girl has become identified as a psychiatric patient, and in many cases, perhaps most, this does not require in-patient treatment (Bruggen *et al*, 1973; Steinberg, 1981, 1982). If hospital admission is necessary it is doubtful whether one type of residential unit could meet all the needs presented.

In a recent study of 500 consecutive adolescents referred to a regional unit on the fringe of London (Steinberg *et al*, 1981), some 70 per cent were categorized in the clinical groupings *emotional disorder*, *conduct disorder or mixed emotional/conduct disorder*, following the WHO classification criteria (Rutter *et al*, 1975). Many of these young people and their families were in the most painful and distressing situations, often compounded by educational, ethical and legal complexities not seen so often in younger or older patients, and in many cases problems were understandable without any clinical need for a diagnosis of individual disorder, and reversible without needing to resort to individual psychiatric treatment. This is a retrospective comment on how many of the boys and girls in these rather unsatisfactory clinical categories appeared and were managed; many of them would be more faithfully represented as presenting problems (their own or others') closer to what Taylor (1979) has described as predicaments rather than individual illnesses. This is not merely a semantic point; if an adolescent does not appear to need individual psychiatric treatment, is there any

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reason to admit him or her to hospital? The other patients referred included those with anorexia nervosa, phobic, obsessional and depressive states, schizophrenic, autistic and other psychotic disorders, drug abuse and problems of psycho-sexual identity. The patients' presentations included absconding, violent behaviour, school non-attendance and attempted or threatened suicide, the latter relatively few in number (11 per cent, mostly girls), consistent with the observation by Hawton *et al* (1982) that most could be managed on an outpatient basis after a brief emergency admission to a general hospital. Developmental delay, mental retardation, educational and social problems and physical ill health (especially epilepsy) were common.

The professional workers making referrals were a very varied group too, including many different medical, social, educational and child care specialists, all with very different experience of adolescents and their families, quite different ways of working with them, and very different expectations of what a hospital unit should provide. One thing very clearly expressed across all groups was that what was expected and wanted was *admission*, and offers or attempts to hold crises on an outpatient basis (if only to clarify the plan for ultimate admission) frequently caused misunderstanding and sometimes resentment.

If a single service were to have the capacity to meet the needs of all those referred, it would need (a) quite extensive resources for time-consuming crisis intervention and out-patient work, and in addition the following in-patient facilities: (b) provision for the *immediate* admission of violent or absconding adolescents, and the means for keeping them safely on the premises; (c) facilities for the *immediate* admission of those who have injured themselves or were actively threatening to do so; (d) staff and resources for a wide range of short, medium-term and long-term psychotherapy and psychiatric treatment; (e) the structure and organization to provide medium to long-term supervision and training of immature, chaotic adolescents unable to use psychotherapy or to manage at home or in schools or children's homes; and (f)–(h) medium to long-term facilities for both moderately and seriously handicapped young people with autism, mental retardation and psychotic illnesses. There are of course children's homes, special residential schools and community homes for some of these young people, but adolescents are referred as unmanageable from such settings.

This last point leads to the first of three questions.

Which of this range of needs really has to be met by removal from the child's existing home or school? Our impression was that a large proportion of those referred specifically for admission in fact did well with alternative help, for example through consultation with the Children's Home or school staff, work with the family or by finding an alternative but non-hospital setting, thereby meeting what appeared to be the child's developmental and educational needs rather than presuming to treat non-existent mental disorder. What is needed includes better training, support, supervision and indeed status for the staff in non-clinical settings. It also requires difficult and time-consuming out-patient, family and consultative work by psychiatric teams, but hospitals are not very adaptable institutions and are slow to shift resources from "beds" to such approaches; once a hospital is built and staffed, keeping adolescents out of hospital by the efforts of highly trained staff may be more expensive than admitting them. Recent developments in approaches which keep young people out of hospital (e.g. see Bruggen *et al*, 1973; Bruggen and Davis, 1977; Bruggen and Westland, 1979; *Journal of Family Therapy*, 1979; Bentovim and Gilmore, 1981; Hildebrand *et al*, 1981; Steinberg, 1981) deserve careful evaluation before expansion in residential psychiatric care for adolescents can be planned on a rational basis.

Second, which of the adolescents who had to be removed from their present scene really needed a primarily psychiatric service? In-patient psychiatry is a powerful therapeutic tool, with side effects. It is at its best and most appropriately prescribed where the nature and intractibility of an individual adolescent's problems justifies a complex, integrated biological, psychological and social approach to diagnosis and management and where 24 hour observation and monitoring by psychiatrists and psychiatric nurses are needed. It tends towards the technical, emphasises individual disorder, is expensive, carries a degree of stigma which is often under-estimated, and can operate against the very autonomy, responsibility and indeed normality which it hopes to encourage in its clientele (Steinberg, 1982), disadvantages particularly significant for developing adolescents whose needs are for as normal as possible care, upbringing, education and peer relationships. Many referred for admission need not psychiatric help but properly organized and carefully supervised looking-after by sensitive, competent adults, which is not the same as psychiatry, but comes very close to some forms of adolescent psychotherapy and is often confused with it. What has happened in practice is that the lack of resources for proper care for many disturbed adolescents has led to this normal need being met by a medical resource, the hospital-based therapeutic community. It is far from clear how many adolescents need a therapeutic community rather than proper care. Nor is it clear that the therapeutic community is the most appropriate

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form of adolescent care for a psychiatric service to provide. Both special care and residential psychotherapy for adolescents require high levels of skill and stamina, but neither are the special province of psychiatry. On the contrary, proponents of the therapeutic community model of care tend to give high priority to getting right away from the concepts and methods of the medical approach.

Third, which of the very different demands made on the adolescent service could reasonably be met by a single type of unit? Certainly not all, although this seems to be the expectation of those making referrals. Because adolescents needing psychiatric treatment also need care and education (i.e. they need a therapeutic social milieu, although this is not only what they need), those in charge of adolescent units have to take care of the overall balance of the current in-patients as well as the needs of those newly referred. The frequent, very brief admissions of large numbers of adolescents who have taken overdoses, or of more than a small number at a time of determinedly delinquent or mentally retarded young people, or orientating a unit around the containment of violence or the prevention of absconding can all seriously jeopardise the care of adolescents needing less structured help. Certainly adult psychiatric hospitals have found it necessary to develop different wards and units e.g. for acute admissions, psychotherapy, behaviour therapy, chronic illness, mental retardation and the containment of violence.

The first step towards clarifying who should provide what for whom requires an attempt to distinguish those who need good and even highly specialized care and control from those who need psychiatric diagnosis and treatment. This may be difficult but it is expensive and unhelpful to continue to allow the distinction to remain blurred. The second step is to plan the widest range of *psychiatric* provision from the minimum number of hospital units. On the basis of our 500 referrals the most widely applicable psychiatric service for adolescents would need four components.

First, a general psychiatric unit for adolescents, sub-regional rather than serving millions. This would be for those actively threatening suicide; those for whom psychiatric treatment programmes exist but which are impracticable or unsustainable on an out-patient or day-patient basis; those with complex neuropsychiatric problems who need comprehensive assessment and trials of different (e.g. biological and psychological) types of treatment; and those adolescents in one of the above categories who also need psychotherapeutic or social help of the somewhat limited type possible in a general psychiatric setting.

Second, regional longer-stay units for adolescents with chronic psychotic illnesses; and third, for those mentally retarded boys and girls who need to be in hospital, two groups relatively few in number but cumulative and grossly underprovided for.

Fourth, collaboration is required between adolescent unit, acute general medical service and adult psychiatric hospital over very urgent and perhaps very brief admissions, perhaps an obvious enough suggestion but one which can be surprisingly difficult to arrange in practice.

A four-part network like this would need to maintain close liaison and consultation with other services for young people, support and encourage their development, and operate as a base for information, teaching and research, academic and clinical functions which would both gain from the emergence of some clarity about the limitations as well as the uses of psychiatry for this age group. This type of service would be consistent with the view expressed by Eisenberg (1973) that as psychiatry clarifies the nature of the problems with which it is presented, such knowledge should become the property of less specialized workers. Quite possibly more in-patient places for adolescents are needed, if only to make up for regional deficiencies, but it is difficult to see how rational planning and development can proceed when there is such a wide range of problems and possible solutions in the field of adolescent care, and so little general agreement about the place of psychiatry within it.

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