4. In-patient treatment:
   a should always include individual therapy
   b is only beneficial when focused on clear aims and objectives
   c can help with self-confidence, self-esteem and development of independence
   d should usually involve the family if possible
   e should never be attempted with behavioural problems.

MCQ answers

1	2	3	4
a F	a F	a F	a F
b T	b F	b F	b F
c F	c F	c F	c T
d T	d T	d T	d T
e F	e T	e F	e F

Commentary

A. James & A. Javaloyes

We would like to comment on some issues raised by the very helpful paper by Cotgrove & Gowers.

Context: referral and admission

Adolescent psychiatric in-patient units should form part of a comprehensive service, delivered on a regional or sub-regional basis and integrated with community child and adolescent mental health teams. The key link to community services is through the consultation and referral process between the mental health workers, particularly consultant child and adolescent psychiatrists. An in-patient service should be available for consultations and second opinions, as well as providing in-patient and day patient services. As indicated by Cotgrove & Gowers, the most highly valued aspect of this service is the ability to make emergency referrals. However, not all emergency referrals result in admission – what is often required initially is a consultation between colleagues on difficult cases involving self-harm, behaviour difficulties or the onset of psychotic illness. Of course, emergency admissions are required. However, when possible, planned admissions are preferred, allowing time for engagement with the adolescent and family.

Adolescent problems are broad-ranging and no one institutional facility will be able to deal with or contain the entirety of adolescent disturbance. To aid correct placement of an adolescent, a careful and comprehensive psychiatric assessment is essential at the outset. This can be facilitated by multi-disciplinary teamwork, with an opinion from a specialist social worker. For instance, it could be argued that severe behavioural disturbance is best dealt with in a specialist children's home run by social services, rather than by an adolescent psychiatric unit. Given the high rates of identified psychiatric disturbance in this population (McCann *et al*, 1996), it is essential that regular psychiatric consultation is available to such homes. It is clear that admission practices vary and are dependent upon the network of services available locally, however, research has indicated that there are reasonable levels of agreement upon decisions to hospitalise adolescents (Strauss *et al*, 1995).

Teenagers in an adolescent in-patient unit often have severe psychopathology, although, interestingly, it is often not the level of psychopathology that dictates the need for admission to hospital. Frequently, those who are severely ill can be managed in the community if they have a stable family structure. However, the levels of comorbidity

A. James is a Consultant Adolescent Psychiatrist and A. Javaloyes is a Specialist Senior Registrar in Child and Adolescent Psychiatry. Both are based at the Highfield Family and Adolescnet Unit (The Warneford Hospital, Warneford Lane, Headington, Oxford OX3 7JX).

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are an important factor, particularly with substance misuse. Cotgrove & Gowers suggest that substance misuse is one of the indications for not admitting an adolescent to a unit. A primary diagnosis of substance misuse would usually warrant referral to a specialist drug dependency service, rather than an adolescent in-patient unit. Widespread illegal drug usage in youngsters means that it is now necessary to admit youngsters who misuse cannabis and heroin, etc. However, strict guidelines are needed, possibly with a contract and regular drug screening to ensure compliance with a programme aimed at reducing and eliminating such drug usage.

Adolescent in-patient units are not all-purpose, and cannot be expected to function as an adult acute admission ward. As described by Cotgrove & Gowers, the general purpose adolescent unit aims to provide a balance between therapeutic work and acute admissions and assessments. What they do not point out is the need for access to intensive care facilities for patients who demonstrate violent or severe behavioural disturbance, or present such levels of self-harm that constant observation and a high degree of nursing care is needed for long periods. Also, for a small but perhaps increasing number of adolescents, forensic secure facilities are required. Unfortunately, at the moment, the provision of intensive care facilities and National Health Service secure facilities for adolescents is woefully inadequate.

Consent to treatment

The law concerning the consent to treatment for adolescents has been profoundly influenced by the ruling of Lord Donaldson. In essence, this can be interpreted as a 'Gillick-competent' adolescent being able to consent to treatment, but at the same time not being able to refuse the treatment thought appropriate by parents or guardians – an invidious position. While it is possible to admit an adolescent without their consent, practically this would only apply to the very much younger adolescent. A particular example would be a 14-year-old school-refusing adolescent who, although Gillick-competent, refused in-patient treatment. Without the adolescent's cooperation, it is highly unlikely that one would be able to make much therapeutic progress, and admission under parental consent should not be considered lightly.

Use of the Mental Health Act 1983 in adolescence should be restricted as far as possible, as with adults, but where it is necessary, the argument about not applying it because of stigma is less than helpful. Clarity, as well as rights of appeal for the patient and safeguards for mental health workers, are important arguments for the appropriate use of the Mental Health Act.

Children's psychiatric in-patient units are licensed under the Mental Health Act, but are not legally required to follow the guidelines of the Children Act 1989. However, all adolescent units should, as far as possible, adhere to the principles laid down there, particularly involving the projection of children's rights, consent to treatment, etc. This has important implications for the inspection of facilities and, in general, for the provision of multi-disciplinary working with social services to ensure protection against abusive practices.

A guiding principle now, for most adolescent units, is to involve the adolescent in a cooperative venture as far as possible. This should include the provision of all information upon treatments, side-effects of medication, and likely expectation of the outcome of treatment. The adolescent should be invited to attend case conference and planning meetings, and the parents and adolescent should be provided with written minutes of meetings. Planning discharge case conferences are best conducted with multi-disciplinary representatives, including, if possible the general practitioner. This naturally fits in with the Care Programme Approach for those adolescents over 16 years of age, and Section 117 planning meetings for those discharged from Sections 3 and 38 of the Mental Health Act 1983.

Therapy

The therapeutic milieu is an essential and very important part of the therapeutic process of an adolescent unit. It consists of the day-to-day interactions with nursing staff and other adolescents, within a structured approach to the day (regular meal times, structured activities, leisure activities and education, as well as time for individual and group therapy).

The overall running of a unit depends heavily on its organisational structure. There must be a clear hierarchy with clearly defined roles and areas of responsibility, and a crucial balance (often difficult to achieve) between permissiveness – to allow for adolescent exploration and expression – and rules and regulations, against which adolescents will often try, as part of the developmental process, to rebel. Extremes of these processes, too permissive or authoritarian, lead to an

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increased level of disturbance and poor therapeutic outcome.

Goal-directed treatment-planning (Nurcombe, 1989), and focal in-patient treatment-planning (Harper, 1989), have been advocated as a means of maintaining a clear focus for therapy, thereby reducing length of hospital stays. Problems are formulated with reference to individual dynamic, developmental and contextual factors and written in a standardised format with documented objectives and means of achieving them. These objectives are reviewed at ward rounds. Nurcombe (1989) contends that such an approach avoids the pitfalls of intuitive lead treatment-planning with the danger of secondary problems, often owing to the adolescent in a residential setting becoming an additional, but unnecessary, focus for treatment.

Cotgrove & Gowers point out that the focus is rightly away from single-model adolescent units, towards more general purpose adolescent units. Often, these units have a dual focus, of which a central part is the therapeutic milieu, incorporating some of the principles of a therapeutic community. Adolescence is a particularly powerful time for peer pressure, and this can be used therapeutically within such units. However, group processes are particularly difficult to manage. Splitting within the team, often mirroring difficulties within the adolescent's family or peer group, is replayed and re-enacted, particularly for those patients who have emerging borderline personality disorders, or those who have been sexually or physically abused (James *et al*, 1996).

The splitting process can be used therapeutically if it is understood, and if the staff group can work in a coordinated and sensible way in the face of the disturbed adolescent's projections. This requires a coordinated staff team, high staff morale, open communication and a forum for exploration of findings. A staff group which is facilitated by an outside, psychodynamically trained facilitator is often beneficial.

Cotgrove & Gowers also point out the need for family therapy as an essential part of therapy for adolescents. Distorted hierarchy and communication problems are often found within families of adolescents admitted to psychiatric units. In a survey of recent in-patients (details available from the first author upon request), 44% of parents were found to have psychiatric disorder, which rose to 66% if siblings and grandparents were included – underlying the need for a systemic approach.

Treatments

Most adolescent in-patient units now offer integrated therapies for specific disorders: depression, anorexic nervosa, schizophrenia, etc. There are guidelines and practice parameters available from journals, for example, the *Journal of the American Academy of Child and Adolescent Psychiatry* (JAACAP, 1997). Specific therapies practised by various disciplines include cognitive–behavioural therapy, family therapy and individual supportive therapies, as well as pharmacotherapy and group therapy. Such therapies need to be regularly supervised and audited. In the era of evidence-based medicine, an adolescent in-patient unit should use information technology to critically review the latest research from systematic meta-analyses, randomised control trials or even case reports (Geddes & Harrison, 1997).

Outcome

As indicated by Cotgrove & Gowers, there is limited evidence on the outcome of adolescent in-patient units. These units have been criticised as being expensive. All units, therefore, should be involved in regular audit with baseline measurements, using standardised instruments and questionnaires at admission, mid-therapy and at the time of discharge.

References

Geddes, J. & Harrison, P. (1997) Closing the gap between research and clinical practice. *British Journal of Psychiatry*, **171**, 220–225.

Harper, G. (1989) Focal in-patient treatment planning. *Journal of the American Academy of Child and Adolescent Psychiatry*, **28**, 31–37.

JAACAP (1997) Practice parameters. *Journal of the American Academy of Child and Adolescent Psychiatry*, **36** (suppl. 10).

James, A., Berelowitz, M. & Vereker, M. (1996) Borderline personality disorders in adolescence: a clinical study. *Journal of European Child and Adolescent Psychiatry*, **5**, 11–17.

McCann, J., James, A., Wilson, S., *et al* (1996) Prevalence of psychiatric disorders in young people in the care system. *British Medical Journal*, **313**, 1529–1530.

Nurcombe, B. (1989) Goal-directed treatment planning and the principles of brief hospitalisation. *Journal of the American Academy of Child and Adolescent Psychiatry*, **28**, 26–30.

Strauss, G., Chassin, M. & Lock, J. (1995) Can experts agree when to hospitalise adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, **34**, 418–424.

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