great deal from them which in turn helped me in my work back home. I found too that there was considerable interest in recent developments of psychodynamic concepts in several countries on the Continent, especially in Germany, but more so in departments of psychosomatic medicine and among psychotherapists than among psychiatrists. I hope that the need to integrate the psychodynamic with the biological aspects will continue to gain recognition among psychiatrists, in this country and abroad, so that patients can benefit from this wider approach.

We have learnt with deep regret that Dr Wolff died on 2 June 1989. An obituary will appear in a future issue of the 'Psychiatric Bulletin'.

Psychiatric Bulletin (1989), **13**, 342–344

Why admit to a bed? Disposal of 1,000 referrals to a Regional Adolescent Service

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Twenty-five years ago, the Ministry of Health recommended that 20 to 25 beds per million population were needed for treating psychiatrically disturbed adolescents, a figure similar to that recommended by the Royal College in 1956/57. The College also recommended in 1976 the provision of one adolescent psychiatric team per half a million population. None of these norms has been met, nor are they likely to be this century. The decline in the teenage population may slightly reduce the need temporarily until the anticipated increase from the late '90s. Meanwhile, government financial restraints call for innovative and creative alternative solutions for the treatment of disturbed adolescents wherever possible without admitting to a residential unit. Indeed the pressure is so great that a number of adolescent units have already been closed, or their beds drastically reduced.

In his 1968 Isle of Wight study, Rutter estimated that around 21% of adolescents are suffering from socially handicapping disorders, of whom only one in ten were receiving professional help. Other surveys support his findings. The largest consumer group appears to be those exhibiting emotional and/or conduct disorders (around 90% of the disturbed population) and there is no current and reassuring evidence that such disorders are on the wane – on the contrary.

Mersey and the North West Regions are served by three adolescent units – one at the western end of Mersey Region with ten beds, and one in North Manchester with 20 beds serving the North West; my own unit, with 19 beds strategically sited at the eastern end of Mersey and south of Manchester, serves both regions. Referrals to us, amounting to around 250 a year, are about equal annually from each region.

Since we opened in 1970, the greatest demand on our service has been for treatment of the largest consumer group – emotional and/or conduct disorders – and indeed the diagnostic profile of referrals to us matches that shown in studies of adolescent disorder in the community; our in-patient population too appears to be a representative sample, although consisting of the more seriously disturbed. As psychotic adolescents appear to be harmed by placing them in the emotional turmoil of a unit treating serious conduct disorders, it was agreed when the unit in North Manchester was opened, that they would treat one portion of the psychiatric spectrum of disorder – including psychotic adolescents – leaving us to manage the more seriously acting out adolescents with emotional and conduct disorders. Between us we are able to offer two contrasting models which equip the service to meet differing needs as appropriately as possible. This integration enables the two teams to provide a reasonably comprehensive service.

The team based at the Young People's Unit in Macclesfield is largely community-based; only one-fifth of the referrals are admitted. Nevertheless the cost of admission remains high. Since the service is extremely thinly spread, it is essential only to treat those patients for whom treatment can reasonably be expected to be effective. A careful assessment process has been evolved. A majority of referrals are first assessed in the community in their own homes. Assessment is primarily concerned with three questions:

(a) Is the disorder treatable by the resources and skills of our team?
(b) If so, what changes do the family want?
(c) How much motivation to use help is likely to develop in the young person (and family

if involved) with encouragement from the team?

If the answer to these questions looks promising, negotiations continue, either at home or in the out-patients' department.

The assessment as a filter

Analysis of our first contact with 1,000 referrals over a five year period shows that 679 community assessments were made on 556 families, a further 298 young people were first seen in the out-patients' department or on hospital wards, and the remaining 146 young people were withdrawn before being seen.

As a result of these preliminary exploratory meetings, 59% reached closure before the need to embark on a more costly course of treatment. The reasons for closure were as follows.

(1)	Unsuitable because over or under age	2%
(2)	Psychosis needing in-patient treatment, or too dangerously out of control, or totally unmotivated	2%
(3)	Parents/young person refused further help before, or during assessment	20%
(4)	Default appointments and/or no response to letters	8%
(5)	Absconded	1%
(6)	Alternative solution preferred and arranged (e.g. return to school)	13%
(7)	"Cured" or "improved", so as to withdraw	9%
(8)	Consultation/advice/legal only	4%
	Total	59%

It is clear that the several initial meetings consist of many careful negotiations and transactions. This process respects the autonomy of the consumers and allows for developments to take place at the right pace (more urgent referrals may result in a crisis intervention team visiting the family the same day. Of 32 such visits, 12 ultimately resulted in an admission to the unit). Of the remaining 41%, about half receive out-patient treatment, usually in the form of family therapy, or by providing individual treatment programmes, and half require admission.

The 21% who appear to need in-patient treatment go through a step by step process to evaluate whether or not admission is likely to prove effective. Crucial to the satisfactory evolution of the process is our insistence where possible, on involving the parents and young person as partners, and where appropriate, negotiating a written therapeutic agreement which identifies in simple language what changes the family and young person have undertaken to work towards. Where possible too, the referring agency is involved as a partner and their role in the process identified. Responsibility for the patient is often shared rather than completely transferred. This fosters a close working relationship with other agencies, of the kind recommended in the recent Health Advisory Report on adolescent psychiatric services, *Bridges over Troubled Waters*.

The therapeutic agreement is a potent motivator which can be used to remind a youngster what he has agreed to do. Refusal to work may result in the young person being given time out. No useful purpose can be served by detaining any youngster who constantly breaks the agreement, although as a junior partner he is able to re-negotiate the terms. Each new admission undergoes a three week assessment, and we are currently testing an assessment instrument to evaluate it as a predictor of outcome. Paradoxically, giving the young person the freedom to meet the challenge or abandon the task results in not many leaving before the average stay of three months. About one-fifth leave during the first five weeks, not always because they have abandoned the task.

Apart from the financial considerations, our system is based on a belief that help is an agreement. Making the contract explicit helps to demystify the transaction in which far too much can otherwise be assumed – often incorrectly – by the professional and the patient.

What are beds for?

The President of the Royal College of Psychiatrists, speaking in 1984 on the topic, 'Psychiatry in Jeopardy', said "the doctors have fouled the pitch by imposing their medical model on the scene, inducing a sort of myopic reductionism which vitiates true understanding".

A few colleagues appear to have a mental set which would exclude almost all but the seriously mentally ill from in-patient beds. As mentally ill adolescents comprise only a tiny minority, this line of thought could lead to the near extinction of the profession – it is worrying to see for example a recent leader in the *British Medical Journal* headed "I don't want you to see a psychiatrist" (Wilkinson, 1988) which suggested that most non-psychotic conditions should be, and are already, more appropriately treated by other professions.

A case apparently has to be made for the profession to continue to be involved in treating psychiatrically disturbed adolescents, who are not mentally ill. Some of the opposing views that have been encountered by my own team run like this:

"These cases should be managed by Social Services or by the penal system".

Reply (1)

The young people referred to us are referred "for treatment". Two-thirds of our referrers are medical,

https://doi.org/10.1192/pb.13.7.342 Published online by Cambridge University Press

and about one-quarter are referred by Social Services. Where else should they receive treatment?

"Many of those we admit from Social Services establishments should be treated on site".

Reply (2)

This is a complex issue. When asked to help a very disturbed resident of a community home for children, there are a number of possible responses. Sometimes supporting the staff in doing what they already do may be enough. If I know the staff and their skills well enough, I may assist them plan and implement treatment on site. For many, however, I know that I can only provide effective treatment by admitting to a bed. The reasons are complex, but include the available skills of residential staff in community homes, their lack of numbers and rapid turn over, and the fact that in a primary care setting, giving one child a programme involving a lot of staff attention can create enormous problems.

It is pertinent to ask, how those psychiatrists who do not have any experience of treating say, serious conduct disorders, on their own units, can presume to tell Social Services how to treat them?

Primary care is a different ball-game to treatment. A child and adolescent psychiatrist, given his diagnostic skills, training and development and experience in using family therapy, individual psychotherapy, behaviour therapy and other techniques is at a vantage point from which to make therapeutic interventions when they are likely to prove most effective. In this field, experience, timing and setting are crucial. One is reminded that currently there are 120,000 children in care, and adolescent psychiatric teams should not assume that caregivers are necessarily aware of what a valuable ally psychiatry can sometimes be.

"Improvements made on adolescent units are not sustained when the adolescent returns to his usual surroundings".

Reply (3)

Our two follow-up studies produced convincing evidence that for the majority, improvement *is* sustained for at least two years after discharge (Wells *et al*, 1978; the second study will be the subject of a further paper).

When our own current in-patient population is scrutinised it is difficult to avoid the conclusion that none of them could be exposed to a sufficiently intensive treatment programme in the community, given our vast catchment area. Nor would it be an economic deployment of our small team. Until there are more local resources, it is more economic to treat the more seriously disturbed adolescent on a regional unit. Failure to do so is likely to result in neglecting perhaps a last opportunity to bring about beneficial change at a crucial developmental phase. Research shows that disturbed adolescents do not "grow out of it" (Masterson, 1967). Admission for an average period of three months may also be the only way of ultimately keeping a family intact.

The indications are that we have evolved a well developed screening system providing the optimal conditions for avoiding separation of a young person from his family if change can be achieved in any other way. There remains a hard core of young people for whom adequate and effective treatment can only be provided on an in-patient unit, but for whom we try to make the separation as short as possible. The long-term human and financial gains when young people learn through treatment to manage their destructive behaviour more successfully must be very considerable. It seems a short-sighted financial policy indeed, to impoverish further such an over-stretched service.

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