
Use of an adolescent in-patient unit

A. J. Cotgrove & S. G. Gowers

Adolescent mental health

Background and history

Adolescence is a transitional stage of development between childhood and adulthood. The physical changes of puberty are generally seen as the starting point of adolescence, while the end is less clearly delineated. Adolescence ends with attainment of 'full maturity', and a range of social and cultural influences, including the legal age of majority, may influence this. In developed societies, these tend to delay progression to adulthood. The extension of compulsory schooling and development of further education, with its economic consequences, generally contribute to a delay in reaching full independence. This may, in turn, lead to difficulties in adjusting to the responsibilities of the next stage of life.

The history of societies' concern with the mental health of adolescents, be it illness or adjustment, has been patchy. Teenagers with mental disorder were frequently admitted to asylums and private madhouses 250 years ago. Interest in the mental diseases of this age group increased in the mid-19th century. This followed a recognition of the physiological processes of puberty as potential contributors to the development of mental illness (Parry-Jones, 1994). By the end of the 19th century, this interest had flourished with growing attention to the phenomenology of dementia praecox and manic-depressive illness. With the growth of the child guidance movement in the 1930s, the new multi-disciplinary speciality of child psychiatry moved quickly into association with paediatrics. While younger adolescents were generally accommodated within the new services, those at the older end of the spectrum, particularly those with severe mental

illness, remained within the province of general psychiatry.

The growth of regional adolescent services in Britain in the late 1960s and early 1970s attempted to bridge the gap in services for adolescents, but these developments were generally in association with adult mental hospitals. This split, between community provision within paediatric services and in-patient and older adolescent provision within general mental health services, has continued in the 1990s, though the more recent development of community National Health Service trusts in Britain has begun to address this dislocation.

Epidemiology

Estimates of the epidemiology of adolescent psychiatric disorder vary according to the populations studied and the threshold for diagnosis. In community surveys, the prevalence of adolescent disorder tends to be higher than in the pre-adolescent age range, and slightly lower in boys than girls. The Ontario Child Health Study (Offord *et al.*, 1987) reported a prevalence of 18.8% in boys and 21.8% in girls aged 12–16 years.

Although there appears to be little evidence to support the notion of a change in prevalence of the major mental illnesses such as schizophrenia, bipolar disorder or depressive disorder over time, there are suggestions of increases recently in eating disorders, disorders resulting from alcohol and substance misuse and possibly antisocial disorders of conduct, particularly in girls. Delinquency (a legal concept) shows a marked gender bias but one which has reduced over time. Rutter & Giller (1983), for example, reported a change in the ratio of male:female adolescent delinquency from 11:1 to 5:1 between 1957 and 1977.

Andrew Cotgrove has been a consultant in adolescent psychiatry since 1993 at Pine Lodge Young People's Centre (79 Liverpool Road, Chester, CH2 1AW). His previous training was at the Tavistock Clinic, London. Simon Gowers is Professor of Adolescent Psychiatry at the University of Liverpool and Honorary Consultant at Pine Lodge Young People's Centre. Previously, he was Senior Lecturer and Honorary Consultant to the Adolescent Service, Prestwich, Manchester, for seven years.

The prevalence rates for selected groups at risk may significantly exceed general population figures. A study in Oxfordshire (McCann *et al.*, 1996), for example, found that 67% of adolescents aged 13–17 who were 'looked after' by the local authority had a psychiatric disorder. This figure rose to 96% of those in residential accommodation.

The proportion of cases with an identifiable disorder who actually receive psychiatric help is very small, and those who go on to receive in-patient treatment still smaller, probably making up only about 0.1% of those with a psychiatric disorder. Hence, the epidemiology of adolescent psychiatric disorder suggests that there are far more adolescents in need of help with mental health problems than are receiving it from specialist services.

Adolescent units

Models of service delivery

The concept of an 'adolescent in-patient unit' covers a multitude of different services and therapeutic philosophies. The service provided may focus purely on in-patient work or provide a range of other services including day patient, outreach and out-patient work. The therapeutic philosophy may follow a particular way of working, such as that of a therapeutic community, or it may be more eclectic. Historically, in the absence of clear evidence for good practice, the chosen philosophy would often depend on the beliefs and experience of a charismatic leader (Parry-Jones, 1995). Some units offer highly specialised services, such as for eating disorders, or provide secure facilities, while more commonly they provide a general purpose unit offering assessment and management for a wide range of mental health problems.

Attempts to provide therapeutic stability in the in-patient or day patient environment can be jeopardised by a wish to address the needs of those adolescents with the most severe mental health problems and requests for immediate admission. Despite this wide range of pressures placed on the adolescent unit, or perhaps because of them, the diversity of philosophies and operational policies in adolescent units around the country seems to be reducing. Units which previously provided a single therapeutic philosophy, or those which treated a narrow range of disorder, are now fast disappearing. In their place are emerging, for better or worse, less idiosyncratic and more eclectic services, which have commonly come to be known as general purpose adolescent units (Steinberg, 1994).

Aims

The adolescent unit should aim to address the needs of the referred patient, their family and referrers. Referrers from a range of disciplines have been shown to agree substantially about their requirements of a general adolescent unit (Gowers *et al.*, 1991). Chief among referrers' wishes is provision of emergency beds. There are, however, a number of problems associated with unplanned emergency admissions, including disruption to the therapeutic programme and its associated secure environment, longer waiting lists for treatment places and the loss of the benefits of planning prior to admission. A review of a new emergency service (Cotgrove, 1997) revealed that while only a small number of referred cases in a given period were admitted, referrers appreciated the availability of an urgent second opinion and of an emergency bed as an insurance policy. The majority of requests for emergency admission were on the grounds of safety owing to risk of deliberate self-harm. However, there is little evidence that admission following most forms of self-harm is effective in reducing suicide risk, although there is an absence of good studies in this area (Cotgrove *et al.*, 1995; Hawton *et al.*, 1998). What is often needed in such a case is a safe, containing, caring environment with some long-term security, rather than the possibility of another rejection after admission to a short-term emergency adolescent bed. It may be argued, then, that emergency admissions should be reserved for those adolescents presenting with a psychotic illness.

The aims of admission identified by referrers will usually focus on treatment of the principal disorder, usually by pharmacological and/or psychological therapies. The family may refer to specific difficulties identified during the assessment procedure. These may include the reduction of self-harming behaviour or the improvement of relationships within the family. Non-specific aims may include positive changes to an adolescent's lifestyle. An example might be an improvement in self-care.

An in-patient admission can provide an opportunity for a positive peer group experience, which, along with other achievements during an in-patient's stay, can improve self-esteem.

Finally, an aim for any admission should be to reduce the risk of, or severity of, long-term psychopathology. An intensive in-patient experience has the potential to impact significantly on the personality development of an adolescent in a way not available with more limited out-patient interventions.

Motivation and consent

Motivation has various aspects to it and concerns various parties. It is desirable, but not essential, to elicit motivation and cooperation from the adolescent, their family and the referrer. It is important that the adolescent and usually their family have a clear idea about the treatment programme available at the adolescent unit, and its likely benefits and consequences. In some cases, such as treatment of anorexia nervosa, an admission is far more likely to be successful when there is a clear motivation to change on the part of the adolescent and their family. In other cases, such as with psychotic illnesses, it is helpful if the adolescent and family are motivated to receive help, but in-patient treatment can still be indicated without it. It is also desirable that the referrer supports and cooperates with the treatment package offered by the adolescent unit, particularly in negotiating the admission and follow-up after discharge. On occasions, it may be that the adolescent and their family have no motivation for change or to receive treatment and the main customer is the referrer or another third-party professional. In such cases, admission is only likely to follow if it is supported by the Children Act 1989 wardship proceedings or the Mental Health Act 1983 (see below).

Ideally, one would only admit adolescents with their informed consent and that of their parents. For the vast majority, this will be the case; however, there will be times when admission is deemed desirable by professionals, but either the patient or parent fails to agree. If an adolescent refuses treatment, but the parent and treating service feel strongly enough that admission is indicated, the adolescent's wishes can be overruled. Legally, parents have the right to consent to treatment recommended by doctors against their child's wishes. Only after their 18th birthday can the adolescent choose to refuse treatment recommended by doctors and supported by their parents. The precedent for this concerned a 17-year-old girl with anorexia nervosa, whose appeal against treatment was turned down by Lord Donaldson in favour of the wishes of her parents and doctors in 1992. Lord Donaldson also suggested that all legal options to pursue treatment against a child's wishes should be considered in preference to use of the Mental Health Act 1983 because of the possible life-long stigma associated with this legislation.

The concept of competence comes into play with adolescents under the age of 16 who wish to receive treatment against their parents' wishes. The Gillick ruling (*Gillick v. West Norfolk and Wisbech Health*

Authority and the DHSS, 1985) indicated that a 14-year-old should be allowed to receive treatment without their parents' consent, as long as their doctor judged they were competent to make an informed decision on the matter. Theoretically, an adolescent deemed 'Gillick competent' wishing to receive treatment in an adolescent unit, is entitled to do so against their parents' wishes.

It is extremely rare that professionals will wish to pursue an admission to an adolescent unit against both the parents' and the adolescent's wishes. This would normally only happen if the professionals considered the adolescent's safety to be severely compromised, either owing to the severity of their mental illness, or because there was evidence that they would come to significant harm if they remained with their parents. In the former circumstances, the Donaldson ruling suggests that a care order, or wardship (Children Act 1989) should take preference to use of the Mental Health Act 1983. However, many psychiatrists would prefer to use the Mental Health Act because of the safeguards to the civil liberties of the patient offered by the appeal process and the Mental Health Act Commission. If this course is chosen, an approved social worker can seek a court ruling to overthrow the specific authority of the nearest relatives in the matter. In a case where treatment in an adolescent unit is indicated but there is also evidence of significant harm while the adolescent remains at home, a care order would normally be utilised under the Children Act 1989. The local authority would then share parental responsibility, including for consent to treatment.

Indications for admission

Most general purpose adolescent units will treat a wide range of psychiatric disorders (see Box 1). However, a particular diagnosis is never the sole criterion for admission as all the conditions listed in Box 1 can, at times, be managed on an out-patient basis.

The main indications for admission can be classified as: a need for intensive assessment; a need to ensure safety; and the management of complex problems which cannot be resolved with out-patient treatment alone (see Box 2).

An in-patient adolescent unit can offer 24-hour-a-day assessment and supervision by a multi-disciplinary team to gather information to guide further management. This may include observing the effects of a specific intervention. An admission can also allow time for a range of investigations to be carried out, such as neuropsychiatric assessment, or investigations such as magnetic resonance

Box 1. The range of psychiatric disorders treated in a general purpose adolescent unit

Usually includes

Psychotic disorders
Emotional disorders, including depression, OCD, phobias and anxiety states
Eating disorders
Psychosomatic disorders
Complex psychiatric, family and social problems

Included in some units, excluded in others

Delinquency and conduct disorder
Alcohol and substance misuse
Severe learning disability

imaging or electroencephalography. In addition, admission can allow for assessment of the adolescent's difficulties out of their normal context. For example, an adolescent may appear severely depressed in the home or at school, but their mood may lift significantly in a different environment.

Concerns around safety may be due to a psychotic process associated with disturbed and aggressive behaviour, which may put others at risk or cause risk to the self from disordered behaviour. Suicidal and self-harming behaviour raise obvious safety issues. These may be a result of depression or acting-out for other reasons. Caution is needed when considering admission for reasons of safety, as very often, unless there are other clear indications for admission, this is not the treatment of choice for self-harm, and other interventions are preferable (Hawton *et al*, 1998). Occasionally, extreme self-

Box 2. Indications for admission

Indications for admission

Intensive assessment
Safety
Treatment of complex disorders when out-patient treatment is insufficient

Reasons for non-admission

Treatment likely to be ineffective
Extreme risk of violence dangerousness
Specific expertise treatments not available
Problems with case mix

neglect may warrant an admission for reasons of safety, particularly where the adolescent is neglecting basic levels of hygiene and nutrition.

The final main indication for admission is the management of complex problems where out-patient work has failed, or the required intensity of treatment is not available elsewhere. Adolescents may present with problems pervading aspects of their life at home, at school and with their peers. For example, an adolescent may have suffered from neglect or abuse resulting in maladaptive behaviours, leading in turn to their being bullied at school, feeling depressed and suicidal, and then refusing to go to school. In these circumstances, out-patient work may be insufficient to make significant changes. Allowing such difficulties to remain untreated may well compound the adolescent's problems, further delaying age-appropriate development. In-patient treatment, on the other hand, may help improve the adolescent's level of independence and self-esteem, allowing a return to school and an improved chance of achieving educational and social milestones. It is particularly important with this group to be clear about the aims of an admission, as it is usually impossible to address all their difficulties. It is usually best to focus on those aims most likely to be achievable and result in the greatest benefits.

Reasons for non-admission are variable and often depend on local factors such as the structure of the building or availability of specific expertise. However, alternatives need to be found in these cases.

General purpose adolescent units are rarely secure and so are usually unable to deal with adolescents when there is a risk of extreme violence, or when a high degree of security is needed for other reasons.

Since a general purpose adolescent unit has to deal with a wide range of difficulties and disorders, there may be occasions when the admission of a particular patient is undesirable, either for themselves or for others in the unit because of the particular case mix at the time. Sometimes, that may mean delaying the admission of a particularly sensitive, vulnerable and impressionable adolescent, when there is a high level of disturbance in the unit. It could mean avoiding the admission of a patient with a disorder already prevalent in the unit, where there are fears that another similar case could undermine progress for those already admitted. In such cases, it may be possible to delay an admission and proceed with out-patient work until the case mix changes. However, if such a delay is not possible, then a referral on to another unit may be the only option. Sadly, adolescents continue to be admitted to general adult services on occasions.

The issue of whether or not an admission could cause more harm than good is one which can

sometimes be overlooked, but which should always be in the clinician's mind during an assessment. Even where there is full agreement about an admission, there are possible risks including increased dependence and institutionalisation. More concerning are the potential adverse effects of compulsory admission on self-esteem and locus of control, particularly where there are already problems in these areas.

Staffing

"In the broad field of adolescent psychiatry, there is work, multi-disciplinary work and teamwork" (Steinberg, 1986). Steinberg goes on to point out that although there is sometimes a belief that these terms should be considered synonymously, there are significant risks in doing so. For example, the 'tyranny of the team' or the wish for a united approach at all costs, can sometimes result in an individual professional's skills or talents being suppressed. On the other hand, a group of professionals in an adolescent unit all 'doing their own thing' may lead to chaos and loss of any sense of safety or security. Aiming for a compromise between these two extremes can often exercise a considerable amount of staff time.

Multi-disciplinary teams will contain representatives from some or all of the following professions: psychiatry, psychiatric nursing, social work, psychology and education. In addition, there will usually be administrative staff and housekeepers. Other specialist input may be provided by psychotherapists, occupational and creative therapists and research staff. Each of these disciplines may also have trainees passing through the unit for limited periods.

All adolescent units will have their own unique mix of the above staff, both in proportions and in absolute numbers. However, at the core of most adolescent units will be sufficient nursing staff to provide care and therapeutic input 24 hours a day. This will inevitably result in nurses outnumbering most other disciplines, and perhaps being seen, and seeing themselves, as the core of the unit. Although smaller in numbers, the other two professions commonly at the heart of any in-patient unit are psychiatrists and teachers. In terms of roles, it generally falls upon the nursing staff to provide day-to-day care and containment for the adolescent, as well as, to a greater or lesser extent, specific therapeutic activities. Psychiatrists often take on the roles of assessment and diagnosis and may also take on a leadership role, with clinical responsibility resting with a consultant. However, leadership may be shared by senior professionals from different disciplines.

The role of teachers and the importance of schooling varies considerably between adolescent units. In some units, schooling may be addressed separately by a team of teachers who are solely involved in the educational side of the service. In other units, education may take a lesser and perhaps a less specialised role, and the teachers may become involved in a range of activities around the unit.

Social workers have a particular role in liaising with social services departments over accommodation issues for 'looked after' adolescents, and will have particular expertise in the use of the Children Act 1989 and in child protection matters. Psychologists provide psychometric assessments and, often, behavioural therapy or cognitive analytic therapy, in which other professions are less likely to be trained.

In-patient treatment

Adolescent units can provide a unique opportunity for intensive treatments over an extended time period. This can allow the use of a range of different therapeutic interventions. Modern adolescent units are unlikely to draw entirely on any particular theory, model or philosophy and tend to use varied and multiple treatments to reflect the individual needs of the adolescent who will be presenting with a wide range of disorders. Treatments available usually include psychopharmacology; individual, group and family therapies; behavioural programmes; social skills training; educational support; and outward-bound activities. Programmes are designed to treat specific disorders and alleviate symptomatic disturbance, as well as to promote self-esteem, consolidate a stable sense of identity, improve confidence to manage independent living and help in the formation of realistic vocational goals (see Box 3).

It is beyond the scope of this article to describe the specific therapies in detail, but what follows is a brief outline of the main interventions and how they fit in with the overall therapeutic milieu of an adolescent unit.

Generally, adolescent units have a core of communal activities that involve most or all of the adolescents. These will usually include regular community meetings, where staff and residents can discuss day-to-day practical issues arising from the adolescents living together. Sometimes such meetings may include the discussion of individual emotional difficulties, or difficulties the adolescents may have in relationships with each other. Schooling or other educational activities also often form part of the core life of an adolescent unit, and in some units most of the day will be taken up in schooling.

Box 3. Therapeutic interventions*Specific therapies*

Group work including: group psychotherapy, art and drama therapy, outward-bound activities, social skills

Family therapy

Individual work including: psychodynamic therapy, cognitive and behavioural therapy, daily living skills

Psychopharmacology

General therapeutic benefits

Therapeutic milieu

Safe, containing and responsive environment

Beyond these core activities the ratio of communal therapeutic activity to specific individual therapy is quite variable. Historically, many adolescent units drew on therapeutic community principles, whereby little or no specific individual work took place. While this mode of working is no longer viable, with individual psychotherapies (particularly brief focal therapies and cognitive-behavioural approaches) increasingly being employed, some therapeutic community principles are still used. Indeed, some units still describe themselves as modified therapeutic communities.

When working with adolescents there are some significant advantages in using the peer group to facilitate positive change. Group activities can include group psychotherapy, creative therapies such as art and drama, and outward-bound activity. Group work in an in-patient setting can have the added power of working with a group of adolescents who are also spending a great deal of the rest of their time together. This enables them to work on relationship skills by looking at their relationships with each other with an intensity that would not normally be possible in out-patient group work. Creative therapies such as art and drama therapy, and other physical activities, can provide an opportunity for adolescents to work on their emotional difficulties in ways that do not rely heavily on verbal communication skills.

Family work is usually considered an essential part of the work of most adolescent units. Regular family meetings allow a formal regular exchange of views regarding the adolescent's progress. Parents can find out how their child is doing in the unit, and the family workers have the opportunity to gain information about the adolescent's progress in their parents' eyes, for example, when they are home on

weekend leave. This work can take place alongside family therapy aimed at addressing difficulties within the family.

The role of psychopharmacological intervention for specific adolescent disorders is growing rapidly. While individual practice remains variable, and there is a reluctance on the part of some adolescent psychiatrists to prescribe, these issues are not specific to in-patient work. Generally, however, those working with mental illnesses such as psychoses will utilise pharmacological treatments where they have proven efficacy.

Negotiating a contract for admission with clear aims and objectives can provide the material for the focus of therapeutic work. However, the adolescent unit also has the opportunity to provide a safe, caring and containing environment in which this work can be carried out. For some, the experience of consistent and responsive adults may be a new one, and over a period of time could be internalised. Such an experience can have positive spin-offs in terms of personality development and self-esteem. Hence, the overall experience for some in an adolescent unit may be as useful as, if not more useful than, any individual therapeutic intervention.

Outcomes

General

Adolescent units have not, at least until recently, been good examples of evidence-based practice. Assessments of the quality of treatment in adolescent units have been addressed through measures of referrer satisfaction (Gowers *et al*, 1991) and reviews of general outcomes of series of admissions. A study of consumer views of an adolescent service suggested that the factors which determine parents' and patients' satisfaction may vary with the nature of their difficulties and, in particular, their agreement with the referral (Gowers & Kushlick, 1992). The development of routine clinical outcome measures, such as the Health of the Nation Outcome Scales for Child and Adolescents (Gowers *et al*, 1999), will potentially enable better outcome data to be provided. These should help guide service developments and inform decisions on issues such as length of stay. In turn, it should prove easier to compare services, which may inform commissioning and referrer decision-making.

Specific disorders

A number of services have reported follow-up data on specific syndromes such as psychotic illness

(Cawthron *et al*, 1994), obsessive-compulsive disorder (Bolton *et al*, 1983), eating disorders (North *et al*, 1997) and conduct and emotional disorder (Wells & Farragher, 1993). Although the outcome of these has often been quite good, particularly in comparison with the same presentations in adults, it is difficult to disentangle the effects of admission *per se* from other aspects of treatment.

Summary and conclusions

Adolescent units find themselves in a demanding position. They are a scarce resource and a highly specialised one, expected to meet a huge range of needs. They generally cover an age range, for example 13–19 years, which includes youngsters at quite different developmental stages. They are usually expected to treat adolescents with the full range of psychiatric disorders. Sometimes they are expected to support other agencies, such as social services and education, in containing a disturbed young person while other provision is obtained. Finally, they are expected to admit immediately when there is a crisis in the community, but at the same time provide an environment which is safe, containing and secure for those who need longer-term treatment.

Despite these challenges, by and large, adolescent units are able to meet the vast majority of the varied demands made upon them. Often, the greatest criticism concerns an insufficiency of beds: despite occasional reservations about their function, many adolescent units are in great demand and have to operate a waiting list for admission.

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Multiple choice questions

- Admission to an adolescent unit:
 - always requires the Mental Health Act 1983 in the absence of an adolescent's consent
 - may be harmful
 - is usually conducted as an emergency
 - has to address educational needs
 - rarely has the agreement of the adolescent.
- General purpose adolescent units:
 - tend to specialise in behavioural problems
 - rarely prescribe medication
 - no longer apply therapeutic community principles
 - are rarely based with paediatric services
 - increasingly measure clinical outcomes.
- When considering admitting a 15-year-old to an adolescent unit:
 - the Mental Health Act 1983 should never be used
 - the final decision always rests with the parents
 - delaying admission to plan aims and objectives is never justifiable
 - admission is more likely to be beneficial when there is a clear motivation to change
 - if first-episode schizophrenia is suspected, admission should always follow.

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 Adolescent Unit (The Warneford Hospital, Warneford Lane, Headington, Oxford OX3 7JX).