TYPES OF PSYCHIATRIC TREATMENT

Inpatient psychiatry units

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This is the eighth of a series of articles on treatment of child psychiatric disorders.

Inpatient child psychiatry should be seen as a mode of treatment and not a bureaucratic convenience or a form of substitute care. The kind of therapeutic work and research generated within inpatient units has taken a distinguished place in the history of mental health services for children,¹ but in the current climate there are a number of trends that quite rightly necessitate those of us working in such units to clarify and define our role in current mental health services for children. In both paediatrics and adult mental health there has been a move away from inpatient beds and towards primary care and community services. In child psychiatry a family oriented approach can make isolating the child during an admission seem paradoxical. Our units, although low on medical technology, have high needs for staffing and physical fabric, and can seem expensive.

As in any mode of treatment one can consider indications for use, mode of action, appropriate 'dosage', efficacy, and unwanted effects. I will also try and speculate a little into the future. The focus of this article is child inpatient units for children up to 14 years; adolescent psychiatry units taking children from 14 upwards have their own particular features, although many of the same points apply.

Indications for inpatient treatment

Most admissions would fall into one of these groups:

(1) Problems for which outpatient treatment is felt to be insufficient or impossible and where there is a need for the intensity, completeness, or safety of residential treatment involving nursing staff. The child's disorder is sometimes life threatening, usually severe or persistent: such as serious depression or suicidal risk, eating disorder, obsessional disorders, intractable soiling, psychotic illness, or hysterical conversion.

(2) Problems where the nature of the difficulties are unclear and residential assessment could be a valuable aid in clarifying diagnosis and needed treatment. Examples here would be some severe emotional disorders with complex family pathology, autistic-like syndromes, neuropsychiatric disorders where the balance between organic and psychological factors is unclear, and assessment of parenting, especially where there are specific concerns about risk to the child (for instance in Munchausen syndrome by proxy).

(3) Crisis situations in which psychological disorder in the child or family has reached such a pitch that caring has broken down, the child is

at risk, and the referrer highly concerned. This is the unit as 'asylum'. An important distinction has to be made here between family breakdown in the context of psychiatric treatment, and care and control issues where reception into social services care would be more appropriate.

(4) Occasionally, admission for controlled trials of drug treatment such as stimulants or supervised alteration of antipsychotic or anti-convulsant medication.

Despite calls from within the profession for more consistency,^{2,3} inpatient units have often tended to develop idiosyncratically according to local conditions and personalities. Many units will develop particular areas of expertise and thus generate referral biases. I think it is crucial for the legitimacy of these scarce (usually supra-district) resources, however, that they maintain the flexibility to respond to the full range of referrer need.

How are inpatient units therapeutic?

FAMILY ORIENTATION

Traditionally, many residential units created communities which were an 'alternative world' for the child during the course of very long admissions. The intention was for children to experience a specialised social life that would allow them to recover from a traumatic environment outside. Ordinary social expectations would often be suspended in the service of therapeutic effect. Homer Lane's 'Little Commonwealth' embodied this view, which has links with the movements within progressive and special education in the first part of the century such as Summerhill and Dartington Hall.¹ Such environments can be valuable and still exist,⁴ but on the whole not within the health service. Current psychiatric units, on the contrary, see themselves as far more integrated with the child's environment and wider service provision.⁵ This is particularly the case in relation to the family. We face two ways: inwards towards providing a specialised therapeutic environment for the child and outwards towards preparing the family from the outset for the child's return. This Janus faced position is arduous but essential to maintain. The paradox of removing children from home the better to restore them to it runs right through the way our practice is organised, and the implications of working with parents under the new UK Children Act has only strengthened our need to do this. Some children will present as adrift, effectively without a recognisable 'family': decisions here can be most difficult. We will insist that a 'home

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base' with responsible adults be identified before reconsidering admission.

THE DISLOCATION EFFECT

Children become resident for substantial lengths of time (mean length of admission in my unit is about eight weeks but many treatment admissions will extend for four months or more). This time away from family and school can have profoundly useful consequences. The children have a chance to experience themselves in a therapeutic environment. The family have a chance to recover and change without the continual pressure of the crisis. Their reintegration can be managed therapeutically.

THE ADMISSION PROCESS

We maximise the therapeutic potential of this 'dislocation' by the considerable work that goes on before the admission in assessing the family and negotiating with them and the referrer about the reason for it. Problems are clarified, general aims are set, and the responsibilities of other family members to work with the unit during admission are defined. Sometimes a formal 'contract' is produced and signed. As Bruggen *et al* have described this preadmission work can be very effective at focusing minds and sometimes obviates the necessity for admission at all.^{6,7} This is worth stressing because referrers to inpatient units (as well as families) often expect an immediate admission rather along the model of the medical ward and may feel frustrated by what are seen as obstructive preadmission procedures.

An emergency admission service is nevertheless available, and children can be assessed and admitted within a few hours when necessary. After such an admission the usual preadmission procedure will still be undertaken before a further commitment is made to keep the child for longer therapy.

THE UNIT AS PARENT

Theoretical writing on inpatient units has tended to oscillate between seeing the ward environment as a neutral background to specific treatments,⁵ or as the major therapeutic agent in itself. The ward has been developed to function therapeutically in two major ways. In the therapeutic community model, derived from pioneering work after the war in adult psychiatry, the living among other patients and staff itself, when properly supervised and explored in groups, is seen to have a major role in social learning and psychological readjustment.⁸ In a ward organised around behaviour modification (such as the 'token economy') contingencies on particular behaviours are completely controlled so as to produce specific change in that behaviour.

In its extreme form, I do not think that the therapeutic community approach is appropriate for young and disturbed children whose major lack has often been good parenting; on the other hand the behaviour modification model, while useful symptomatically, really does not address

the deeper needs of most of our children. I prefer to think of the unit as 'parent'; that is supplying for these children, albeit in an institutional context, the kind of adult behaviour that we know constitutes effective parenting. Elements of this will be: consistency of approach, good communication between the adults, clear communication of expectations and boundaries, firmness without retaliation or aggression, and the provision of appropriate privacy and time for intimate nurturing and physical care. Parenting is a complex series of skills. Most parents use at various times short range tactics aimed at rapidly modifying behaviour (the promise of a treat, a raised voice); medium range strategies involving organisation in space and time for children and communicating clear expectations; and long range goals, at the deepest level, to foster attachments and relationships. I see the unit doing likewise. We use behavioural methods in a planned way to modify specific behaviours. We recognise that the organisation and purposefulness of the environment can reduce unnecessary aggression and promote positive group dynamics. We then make space for privacy and individual nurturing that responds to the children's need for attachment and intimacy, recognising that this is often the deepest level at which they have suffered. The ward milieu remains basically 'reality orientated', and deeper levels of regression and acting out are generally expected more in the specific environment of an individual psychotherapy. The importance of peer relationships can be fostered by means of community groups and joint projects. Within such an environment, we find no need for a 'time out' room, in the behaviour modification sense, we use a supervised quiet room for children to 'cool down' when group tensions become explosive.

From the technical point of view, to preserve this kind of 'parental' stance in the face of assaults, retaliation, acting out, despair, and provocation from the children individually and more powerfully as a group, demands the highest quality of work. It dictates an organisation of the children into age orientated groups who have their own space on the unit and are worked with by a specific staff team. It demands maximum autonomy and devolved responsibility within that staff team: because the treatment is delivered essentially through individual relationships between adult and child, and these relationships are only possible for staff if they have a sense of personal responsibility for their actions within shared treatment aims.⁹ Leadership and supervision are needed from senior staff at all times.

It is thus a part of the ward's general healing function¹⁰ to generate a *reality* of parental care, both in its own functioning and by working with parents. For many of our children, the experience of this is powerful therapy in itself, quite apart from any more specific treatments offered. It is a sad irony that the psychiatric ward is just the place where one often does not feel that hum of good will and parental involvement that is such a pleasurable feature of the paediatric ward; that it is psychiatric wards of all places that have often lagged behind in

providing accommodation for parents. And yet this reflects a basic part of the problem of so many of our children, where the nature of the parental investment is low or problematic. Investment by the NHS often mirrors this neglect, and it is no coincidence that psychiatric wards are often shabby and hidden away 'around the back'. Management must be recruited effectively to counter this. It is a vital part of the treatment as the cared for environment sends a subliminal message of care to the children within it.¹¹ Bettelheim famously used the best cutlery and furnishings in his orthogenic school (even though they might not last long!) for just this reason.¹²

SPECIFIC THERAPEUTIC PROGRAMMES

The inpatient unit offers a range of more specific treatments. These will include individual child psychotherapy, behavioural programmes, medication, group work and creative work on the wards, work between parent and child, family work, and specific parent groups.¹³ The unit's school is specifically for unit children and provides educational assessment and individualised teaching.

An important area of current development is in 'focal treatment planning'.¹⁴⁻¹⁶ Goals are carefully defined before admission, treatments designed to accomplish these goals, and progress reviewed. This planning aims to avoid interminable treatment and therapeutic 'drift' by setting out achievable and measurable goals. In the Booth Hall unit, much work focuses around a number of assessment and treatment programmes—for instance a parenting programme, a programme for autistic-like social impairments, and a programme for over activity disorders. These programmes organise the staff into specific patterns of assessment and care, and because of their uniformity make research into treatment delivery and outcome much easier. They also present a clear service to referrers that can be costed. For children whose needs fall outside these programmes, the care plan will be individualised, but the goal orientation and monitoring is the same.

Unwanted effects of inpatient treatment

Like any powerful therapy, inpatient treatment can have unwanted effects.

It may be prescribed in the wrong situation, and this is usually the result of inadequate preadmission assessment. The admission of a child of instance may simply collude with a scapegoating rejection by the family. Removal of a child from a local school for admission may take away the only source of real continuity and esteem that he or she has. The treatment may be continued too long and child and family may become demoralised or the child resigned to the institution or the sick role.

The dynamics of a unit can become unhelpful in a number of ways. Especially working with deprived groups, there is a tendency to become introverted and self contained, preoccupied with 'rescuing' children from an environment that is increasingly seen to be

harsh and uncaring. Attitudes can drift into 'parent blaming' (P S Penfold, presentation to 9th Congress of the European Society for Child and Adolescent Psychiatry, London 1991), longer admissions, and anxious over protection of the children; in effect a substitute care. We work against this tendency by the involvement of ward staff in community visiting and home visits, and the active engagement of families into treatment along side the child. Of course, the reality is often appalling. We have to recognise the powerful feelings that these children evoke in us, the pain their predicament can provoke, and most of all, the limitations of what we can sometimes do. A well functioning team can be very helpful here: listening to each other's distress and clarifying issues. A team functioning poorly will often not recognise that it is mirroring the child or family psychopathology in its own process, and the despair is compounded. Main's classic paper describes this well.¹⁷

A second, related, way that the treatment can go wrong is in the therapeutic drift that comes from a unclear goals or a difficulty in appropriately placing children who cannot return to their families, at a time when social services resources are diminishing.

Thirdly the 'parental care' of the unit can fail under stress: demoralisation and disintegration of care set in, the emphasis switch from care and treatment to custodial control, and the fabric of the unit deteriorate. Here the stage is set for the excesses of institutional abuse that have recently been well publicised in residential environments. Prevention lies in good staff recruitment, and adequate leadership, supervision and support from experienced staff. There is no substitute for that human provision.

Finally inpatient units can sometimes be degraded along with their patients, seen as places of 'last resort', and become over loaded with 'impossible' intractable problems. This obviously promotes demoralisation. The answer lies in patient selection, and a more active approach to the use of intensive treatment earlier in the course of psychopathology. The inpatient unit should not be seen as the end of the line, but rather an 'intensive therapy unit' where work can be undertaken at any stage in the development of psychiatric disorder.

How effective is inpatient treatment?

A number of studies have looked at the efficacy of inpatient treatment.¹⁸⁻²² There have been great methodological problems in patient selection, comparison treatment groups, and the measurements of outcome, and there has not yet been a prospective randomised study of inpatient compared with community care for a particular disorder, although one is now being planned in the UK. In general, studies show beneficial treatment effects, particularly (hardly a surprise) with less severe disorders, and when there is specialised treatment programming and good aftercare. One provocative finding suggests that the length of admission has only a modest relationship to outcome.²⁰ This kind of result

has led to suggestions of standard admission lengths for all patients.¹³ This is rigid, and many severely damaged children undoubtedly benefit from longer admissions, but cost/benefit analysis for longer stays is bound to become an increasing concern.

Conclusions

The child psychiatry team has little in the way of technology to fall back on to effect cures. Medication has its place, but by and large the efficacy of our treatment relies on a psychological momentum generated and sustained within the staff group, the group of children and their families. The power, but also sometimes the weakness, of inpatient treatment lies in the size and intensity of this group process. Like any treatment it has drawbacks, but if these are recognised and the treatment prescribed appropriately, it can work powerful change. For obvious reasons the unit is an excellent source of training and teaching (at any one time the Booth Hall unit is training five psychiatric social work students, one psychology student, four training psychiatrists, and several learning nurses). It is potentially an excellent environment for the development and evaluation of new treatments and for scientific research; particularly, it is a place where children's behaviour can be precisely observed, as part of assessment and during treatment. Prospering in the future will depend on sensitivity to changing needs in referrers, and the recognition of the superiority of this mode of assessment and treatment, in some situations, over less intensive home oriented treatments. At its best a well functioning inpatient unit can have an effect on child mental health in a region which is considerably beyond the actual number of children who pass through it. Partly this will occur through research and training, but there is

also an indefinable sense of it 'being there' as a resource and support for other professionals.

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- 1 Wardle CJ. 20th Century influences on the development in Britain of services for child and adolescent psychiatry. *Br J Psychiatry* 1991;159:53-68.
- 2 Wrate RM, Wolkind S. Child and adolescent psychiatry in-patient units. *Psychiatric Bulletin* 1991;15:36.
- 3 Health Advisory Service Report on Services for Disturbed Adolescents. *Bridges over troubled waters*. London: HMSO, 1986.
- 4 Rose M. *Healing hurts minds: the Peper Harrow experience*. London: Tavistock/Routledge, 1990.
- 5 Hersov L, Bentovim A. Inpatient and day-hospital units. In: Rutter M, Hersov L, eds. *Child and adolescent psychiatry, modern approaches*. Oxford: Blackwell Scientific Publications, 1985:766-80.
- 6 Bruggen P, Byng-Hall J, Pitt-Aitkens T. The reason for admission as a focus of work for an adolescent unit. *Br J Psychiatry* 1973;123:319-29.
- 7 Bruggen P, O'Brian C. *Helping families. Systems, residential and agency responsibility*. London: Faber and Faber, 1987.
- 8 Kennard D. *An introduction to therapeutic communities*. London: Routledge and Kegan Paul, 1983.
- 9 Menzies-Lyth I. *Containing anxiety in institutions: selected essays*. Vol 1. London: Free Association Books, 1979.
- 10 Frank J. *Persuasion and healing*. Baltimore: Johns Hopkins Press, 1973.
- 11 Cotton NS, Geraty RG. Therapeutic space design in an inpatient unit. *Am J Orthopsychiatry* 1984;54:624-36.
- 12 Bettelheim B. *The Empty fortress*. New York: Free Press, 1973.
- 13 Ney PG, Mulvihill DL. *Child psychiatry treatment: a practical guide*. London: Croom Helm, 1985.
- 14 Harper G. Focal inpatient treatment planning. *J Am Acad Child Adolesc Psychiatry* 1989;28:38-7.
- 15 Nurcombe B. Goal directed treatment planning and the principles of brief hospitalisation. *J Am Acad Child Adolesc Psychiatry* 1989;28:26-30.
- 16 Woolston JL. Transactional risk model for short and intermediate term psychiatric inpatient treatment of children. *J Am Acad Child Adolesc Psychiatry* 1989;28:38-41.
- 17 Main TE. The ailment. *Br J Med Psychol* 1957;30:129-45.
- 18 Pfeiffer SI, Strzelecki SC. Inpatient psychiatric treatment of children and adolescents: a review of outcome studies. *J Am Acad Child Adolesc Psychiatry* 1990;29:847-53.
- 19 Pfeiffer SI. Follow up of children and adolescents treated in psychiatric facilities: a methodology review. *The Psychiatric Hospital* 1989;20:15-20.
- 20 Blotchy MJ, Dimperio TL, Gossett JT. The follow up of children treated in psychiatric hospitals: a review of studies. *Am J Psychiatry* 1984;141:1499-507.
- 21 Windsberg BG, Bialer I, Cukupietz, Botti E, Balka EB. Home versus hospital care of children with behaviour disorders. *Arch Gen Psychiatry* 1980;37:413-8.
- 22 Kazdin AE. Hospitalisation of anti-social children: clinical cause, follow-up status, and predictors of outcome. *Behav Res Ther* 1989;11:1-67.