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Original articles

Survival in a cold climate

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Early in the 1980s I anticipated that sooner or later the Regional Adolescent Service based on the Young People's Unit in Macclesfield would ultimately have to face making a strong and if possible, an unanswerable case for survival.

Several strands contributed to my concern. One was historical. The Young People's Unit was Manchester's baby, built in 1969. After the reorganisation of the NHS in 1974, we were abruptly transferred to the Mersey Region, who already had a unit of their own in Chester. The North West Regional Health Authority followed by opening their own unit at Prestwich in north Manchester in 1979. We are still left with a lingering suspicion that we are no-one's baby, in spite of developing a good fit with the service at the Prestwich Unit. They deal with mentally ill adolescents, and we take psychologically disturbed ones manifesting serious emotional and/or conduct disorders. This recognises that no one unit can be expected to have the answer for everything.

Another strand underlying my concern was my 1990 retirement date, coupled with the recurrent failure of the Authority since 1980 to respond to our case for appointing a second consultant to share the on-call duties.

Another strand was the premises housing the YPU, built like a giant Lego set in 1969, but so insubstantial that an angry youngster could make a hole in the wall with his boot like a guided missile. The District Engineer advised us that the building would need replacing after 1990 or we would face rapidly rising maintenance costs.

Finally, there was a more subtle danger – the team and I had evolved a system to respond to the needs of disturbed adolescents with emotional and conduct disorders as appropriately as possible, but which differed in many respects from conventional practice. This has been a potential field for conflict, irrespective of the evidence from two research studies that the outcome of our in-patient treatment is very encouraging – around two-thirds remain improved for at least two years (Wells *et al*, 1978). Senior registrars, who have rotated to us since 1972 for a period of their training, seem to respond to us with intensely polarised views. Disturbed young people with conduct disorders in particular can create high levels of anxiety among staff. This can puncture the contemplative calm which is expected to emanate from the good physician. Exposure to therapeutic community methods, too, even if modified ones, can be a cultural shock to those who believe that their long, highly disciplined training in the diagnostic arts merits respect, if not awe, among lesser mortals. Our two-week induction course for all new staff cannot guarantee immunity to a feeling of exposure. If made to feel vulnerable and inadequate, not surprisingly some respond with a defensive anger and deep resentment. The majority, however, have been flexible and generous-spirited over our shortcomings, and seem to have valued their training with us, judging by their responses in a survey published in 1984 (Wells, 1984). These largely have been those doctors secure enough to question some of the basic assumptions which are so strongly developed among the medical profession, but which I venture to suggest, are not always apposite in every setting. This questioning of the tenets of their beliefs may alone contribute to a certain amount of ambivalence about us among colleagues.

These then were the strands which almost unawares could weave a pattern that could seriously endanger our future survival, when we came to be weighed in the balance with other costly units.

Broadcasting the facts

Since we opened over 20 years ago, I have published an annual report on the service, which has a wide distribution. The content is as succinct as possible, with catchy sub-titles and a not too solemn prose. There is also a section showing comparative figures for our annual workload. In 1982, it was decided to include more detailed figures about our workload. This has made it immeasurably easier for us to fight our corner, sustained by a litany of valid facts about the work we do with disturbed young people.

Promotional enterprise

Our future, of course, did not just depend on sound data, but would need, above all the full support of

our biggest consumer – general practitioners. In 1985, I wrote to all general practitioners in our District Health Authority area offering to visit and talk about our service and discuss any difficulties they might experience in using it; 57% were visited in response to their invitations. To my surprise, although we had been open for 15 years and had circulated an informative leaflet, a number of GPs were unaware of our service.

After completing the visits, a statistical analysis of referrals from visited GPs each year for four years before my visits, compared with four years afterwards, showed that referrals had doubled on the first, third and fourth years after my visits. The difference was significant. A similar analysis of unvisited GPs showed no significant change over the whole eight years.

The information gained from this operation seemed encouraging enough to repeat the exercise in four other districts. Altogether, I wrote to 217 practices and visited 81, covering 273 GPs in all. There was a valuable exchange of information, but more important was the face to face encounter. We were no longer disembodied voices on the telephone. This paid off handsomely in an entirely unpredictable way, to which I will refer later.

Early warning

My gut feeling early in the '80s that we were in for a desperate struggle was triggered in 1980 just before I left for almost a year to go to Australia, when an attempt was made to dispose of the land surrounding the unit. Housing estates were spreading like mushrooms all round us but I was able to stave off too close an encroachment by persuading the Authority that seriously disturbed adolescents were a risk, and needed a *cordon sanitaire* around them both as a buffer zone and as an area where they could let off steam with sporting activities. A compromise was reached whereby a new hospice rather than housing, with its own need to overlook a pleasant area of green, would be built on one corner of our plot.

A bid to move us

The first round in the real struggle came in 1987. Our neighbouring adolescent unit in Chester was moved to smaller premises and their beds reduced from 20 to 10 in 1986. The following year Warrington District Health Authority complained that the reduction of beds in Chester limited their use of them, and asked if the Young People's Unit could be relocated nearer to Warrington. I was able to demonstrate that access to us was not the problem; our data base revealed that the five year referral rates from general practitioners in Warrington district was well below the average for all districts. Warrington's difficulty was met by my visiting GPs in their district, and developing a working relationship with the new child guidance colleague from there. Since then referrals from that district have greatly increased.

Preliminary skirmishing

The following year I stage-managed a meeting between representatives from the two RHAs and our own DHA, to try to establish whether or not they wished our service to continue and if so on what basis. Not unexpectedly, the two RHAs were non-committal. Sensing perhaps that they were being overtaken by events, Mersey RHA called a meeting for child and adolescent psychiatrists and others, to propose that instead of three units – one in Chester, one in Macclesfield, and a new one for psychotics in north Liverpool, the unit in Macclesfield should be relocated north of the Mersey. Our administration and I put forward a strong case against this, which was fully supported by the meeting. The RHA then proposed a new working party, rather pre-empting the outcome by announcing that capital was available to build the new unit north of the Mersey, but not the revenue to run it. One simplistic solution suggested would be to close us, and appropriate our revenue. Significantly, my colleague from the other Mersey adolescent unit was appointed to the working party, but I was not.

A case for closure?

One dismissive view of the working party was that we on the YPU were treating what were felt to be "social cases". This view held that social cases requiring treatment could be treated much less expensively on site in their Social Service establishments by an NHS community team, a plausible notion quickly seized upon by the Regional administration, and indeed shared by many of our colleagues. This is not an easy argument to refute, since there are many NHS teams – including I might add, our own – doing valuable work of that kind in the community.

In practice, however, there can be considerable problems in working *solely* in this way. They are summarised below.

(a) If you select one individual for special treatment in a Social Services establishment full of very needy kids, it can create pandemonium. All the residents begin to compete for the extra attention, and in the end you may be creating more difficulties for the staff not less. A great deal of resistance may soon thwart the good intentions of the outside therapist.

(b) Social Services do not purport to provide our kind of treatment. Nevertheless although therapy of course does take place, Social Services are primarily in the business of social care. Shortages of staff, a

high turnover, and an uneven spread of skills, can limit the effectiveness of prescribed therapeutic programmes in that setting.

(c) Although out-patient treatment of the majority of adolescents in the community seems to be effective, treatment of *some* adolescents in this way by periodic treatment sessions may be quite insufficient, and so very wasteful. For a minority, residential treatment on a specialised unit enables treatment to be given with the necessary intensity and immediacy. Both are missing when the patient is only seen once a week, for example. Furthermore, research is needed to demonstrate whether or not treatment in the community is a viable alternative in every case.

(d) Residential treatment can provide a very powerful therapeutic tool in that you can utilise the therapeutic potential of both small and large groups. The continuity of *out-patient* groups on the other hand is frequently disrupted by defaulters.

(e) Practically all the districts we serve already have community teams functioning, yet they still make tertiary referrals to us for admission. Why is this so, if treatment in the community is the complete answer?

There was a danger that these objections could be conveniently ignored in the interests of achieving a long desired goal – with which no-one in our region would disagree – of providing a unit for psychotics. If the price was to sacrifice our unit which at present is the only one in the North West specialising in treating the largest consumer group – emotional and conducts disorders comprise about 90% of the disturbed adolescent population at large – then the price in my view would be too high.

A case for survival

I reasoned that if the region were to close us (moving us would mean that most of our skills developed in dealing with emotional and conduct disorders would be lost, and in any case would be of less utility in treating psychotics) the decision should at least be an informed one. There was widespread ignorance about what we did, and not a little mythology about our being "highly selective". A number of senior administrators from both regions and our district were therefore individually entertained to a carefully designed programme, with slides and information about our approach and our research findings. In an analysis of 1,000 referrals, I was able to show that we were unable to offer treatment in only 4% – half of whom were outside our age range – scarcely deserving the epithet "highly selective" (Wells, 1989).

Towards the end of 1988, the regional working party made a recommendation which reiterated the findings of at least four previous working parties, that a new unit north of the Mersey for psychotic adolescents should be built. No recommendation was made as to how this might be achieved, but an influential member of the group warned me that we were "in for a difficult time". Clearly the decision as to how to procure the revenue resources to run this new unit was to be left to the Regional Health Authority itself.

It was clear to me that merely stating our case would not be enough, particularly if, as I suspected, a kind of administrative tunnel vision would not even look at it. My early visits to general practitioners over a wide area from 1985 to 1988 then came into their own. I wrote to all who were heavy consumers, many of whom had been visited, warning them that our service might close. I asked them to write to the Regional Chairman if they objected to closure, and requested copies of their letters be sent to me. Similar letters were written to child and adolescent psychiatrists both in the two regions and elsewhere in the UK and abroad, and to senior people in Social Services and education. Over a period of two or three months early in 1989 a large volume of letters from a considerable number of professional people landed daily on the Chairman's doormat. The response was overwhelming and enormously encouraging to the team and I. However, although this might effect a stay of execution, I was convinced that more was needed if we were to survive.

Political dimension

I next met our member of parliament, Nicholas Winterton, fully briefed him, and quietly let it be known to the Regional Chairman that he had given me the addresses of 25 MPs, whose constituents would be affected by our closure, and to whom I would not hesitate to write if we were closed.

I next wrote to Roger Freeman, then the newly appointed Junior Health Minister, who had been recorded in an interview as expressing a wish to familiarise himself with problems facing the mental health services as quickly as possible. I suggested we could show him a service for adolescents which might be of interest to him. I did not, however, share with him my anxiety about our future.

To our surprise and pleasure he responded, and visited our MP, in September 1989 accompanied with members of the District and Regional Health Authorities. He was given my now well-worn slide show, and interviewed a panel of kids. He made a number of very quotable comments about us which duly found their way into the local press, and which I am confident soon landed on the Regional Chairman's desk.

These tactics gained us just enough time to exploit the newly published white paper on the future of the NHS. A series of meetings at the Regional Health Authority was held from December 1989 to make a firm decision about future adolescent services. I was able to tell the group that all we wanted for the YPU

was for the region to fund us until March 1991, after which, like everyone else in the NHS we would expect to be funded by the number of patients with price tags we could attract. The overwhelming simplicity of this solution brought relieved and unanimous support, and we were at least for the time being anyway, high and dry.

Demonstrating our market

Of course our survival is by no means assured yet. During 1990, I wrote once again to all our GP, child psychiatry and Social Service customers in the 25 districts who make referrals to us, asking them to write to their District Directors of Public Health, with copies to me if they wished districts to make contracts with us for continued services. Practically all have now done so, and most in positive terms. Our market survey gave our District confidence to risk allowing us to push out the boat after March 1991, to find out if we really are going to be financially solvent.

Survival skills

In this paper I have emphasised that the most pressing need for those of us working in the NHS with young people at present and for the near future is to *survive*. Survival calls upon special skills. All of us need to develop them if our services are to continue, let alone continue with little damage. Many multidisciplinary teams at present are suffering from symptoms which suggest burnout and so are in no fit state to resits administrative initiatives. One hears alarming stories of colleagues returning from leave to find their units are to close within weeks. If we believe in our service, whether it is residential, solely in the community, or a combination of both, it is essential to think through a well prepared strategy to counter these powerful assaults. If we do not anticipate them, we will be wide open to manipulation by an increasingly powerful and politicised administration. Strategies need to be devised for preserving those parts of the service which are extremely vulnerable because they are expensive, but which cannot be provided as effectively in any other way.

Providing you select the appropriate groups – and in my view it is unprofessional not to do so (Wells, 1986) – there are a group of teenagers who will *not* have their needs met effectively, nor will their families be able to survive, *except* through a brief separation, and treatment of their youngster in a residential setting where treatment can be provided with sufficient immediacy and intensity. This will give the families a badly needed respite, and time to offer them family therapy in the hope of restoring the family intact. The fact that this group of young people is very seriously disturbed may be ignored by administrators, because they are a relatively small population, and because it is politically and financially expedient to do so. This paper, although addressing the issues of the survival of teams, is really about the survival of many young people.

Tips on how to survive

I have outlined some strategies to preserve the residential element of our own service. These include:

- a system which attempts to ensure that only those young people are accepted to occupy beds who are likely to use the unit effectively.
- After a three week assessment period, we then negotiate a therapeutic contract with the young person and his family, about change, and about what controls they will permit staff to use, should they prove necessary.

Our policy also includes:

- a comprehensive data base and an annual report on how our resources have been used
- an active, market strategy that involves visiting GPs on a large scale
- a schedule of inviting key administrators one at a time, to half a day's programme on the Young People's Unit, to brief them on how our service works
- an ongoing follow-up research project
- a carefully thought through campaign requesting our consumers to individually petition the Regional Health Authority if they wanted our service to continue.
- an orchestrated political component so that the Authority would be aware that closure could not happen without political repercussions
- consultation with staff at every stage.

Three years ago, given my forthcoming retirement, our building needing replacement, and widespread muddled thinking about what we do, I would not have placed any bets on our survival. Although the team is not yet in any way certain about our future, anymore than anyone else is about theirs, I think our strategy has proved roadworthy and hopefully may repay study.

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Use of Section 5(2) in clinical practice

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The Mental Health Act (1983) came into being eight years ago but few studies into its use have been reported (West, 1987; Sackett, 1987). The Act provided for the setting up of the Mental Health Act Commission to safeguard the interests of detained patients and to monitor the use of the Act. The Commission visits ordinary psychiatric hospitals on an annual basis and writes a report of the visit. The Commission also submits a Biennial Report to Parliament. These reports address important issues but do not provide detailed information on the use of the various sections of the Act in differing hospitals.

There is a need to have some understanding of the pattern of use of the Act within particular hospitals and it is also desirable to have some notion of the relative use of the Act between hospitals. The use of the Act can legitimately be the focus of medical audit (Garden *et al*, 1989). Indeed, there has been a recent report of an audit of the use of Section 5(2) in a psychiatric unit in Mid-Glamorgan (Joyce *et al*, 1991).

The aim of our study was to examine the use of Section 5(2) of the Act within a particular hospital. Section 5(2) is an order which empowers the emergency detention of a patient who is already in hospital as a voluntary patient, but who wishes to leave. If a doctor believes that an application should be made for compulsory admission under the Act, all that is required is a single medical recommendation by the doctor in charge of the patient's care or by another doctor working in the same hospital and nominated by the doctor in charge. It is usual to consider a change to Section 2 or 3 as soon as possible. The patient may be detained in hospital for a period of 72 hours from the time a report is furnished to the managers (HMSO, 1990).

The study

The study was carried out in a psychiatric hospital serving a population of about 100,000 including adult and psychogeriatric patients. The demographic characteristics of the population base may have varied somewhat in the period studied due to changes in boundaries and catchment areas served. Data on all compulsory admissions and treatments from January 1984–December 1990 inclusive were available in the Medical Records Department. The original section papers of patients detained under Section 5(2) were scrutinised and the following information was gathered: times of day, day of week and month when the Section was implemented; grade of doctor making the recommendation for detention; reasons given for detention; outcome of the Section; number of consecutive Section 5(2)s; transfers to other hospitals under Section 5(2).

Findings

There were 2,614 in-patients during the study period of whom 784 (30%) were detained under the Act. There were 189 (7.2%) detentions under Section 5(2); this constituted 24% of all detained patients. This was composed of 110 (58.2%) females and 79 (41.8%) males. On average, two patients were detained on Section 5(2) each month and there was no difference between implementations of Section 5(2) for any month of the year. There was no evidence of detentions under Section 5(2) being more common