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Commentary (on: Calton & Arcelus, Adolescent units: a need for change?)

It is often said that you can't hold back progress. For those who work with troubled teenagers, much therapeutic time is taken up helping them cope with the daunting developmental challenges of adolescence. A 14-year-old boy with anorexia nervosa told me recently that life felt like an escalator that was taking him inexorably upwards and onwards. 'On an escalator, you can't usually see what's beyond the top, as it's out of sight,' he told me, adding: 'At least on an escalator there's a big red button you can press in an emergency and stop it – and then someone will come and help you.' Not though in life, and evidently not in the NHS!

In a description of the work of a sub-regional adolescent unit, Calton and Arcelus (2003, this issue) have reviewed the work of 14 months and highlighted the challenges facing the service (and other general-purpose units). In the face of a rapidly-changing NHS, like the troubled teenager, the unit lacks confidence in knowing whether it is doing a good enough job. There is a sense of its feeling ineffective, with some difficult patients being transferred out and a notion that another, more specialised service might do better.

The paper also reveals a feeling of lack of control over the unit's practice. This is a report of what came through the door rather than a description of the disorders the service chose to admit and the basis under which it decided to treat them. The main findings are that the unit admitted a good number of young people with serious mental health problems in the time period, that more than a quarter were admitted under a section of the Mental Health Act 1983 and that a similar number presented with high levels of violence. Five (8.9%) were subsequently admitted to adult intensive care.

The authors conclude that the clinical needs of different diagnostic groups might not best be met by admission to the same general-purpose unit. Without information on clinical outcomes, we cannot be sure on this point, but if the staff doubt their effectiveness and a sizeable number of patients are sufficiently disengaged with treatment that they need to be transferred out or display violence, this conclusion seems plausible. One wonders about staff morale and its impact on therapeutic effectiveness.

It is certainly a time of rapid change for adolescent in-patient services. Historically, these units developed in a haphazard, unplanned way with individual styles and philosophies largely dependent on the driving force of a charismatic leader. Some ran as modified therapeutic communities, some focused on conduct disorder and others specialised in the treatment of mental illness. Although many of these units were nominated as specialist services funded through regional health authorities, it was really after the publication of *Together We Stand* (Health Advisory Service, 1995) that they were designated as the fourth tier of comprehensive child and adolescent mental health services (CAMHS) for a defined community. As well as serving their patients (increasingly clients), they were more clearly identified to serve their constituent tier 2 and 3 CAMHS; the advent of audit and outcome measures demanding increasing accountability. More recently, the dissolution of regional health authorities has made services dependent on local commissioning. Although the strategic health authorities have a role in advising on priority setting, primary care trusts hold the budgets. The extent to which zonal or lead commissioning structures will be effective in facilitating in-patient service development (and specialisation) is, as yet, unclear.

The series of publications from the National In-patient Child and Adolescent Psychiatry Study (NICAPS) (O'Herlihy *et al*, in press; Beecham *et al*, in press) and the forthcoming launch of the Children's National Service Framework are likely, however, to cast a spotlight once again on tier 4 service provision.

So what should services do? The NICAPS survey and the epidemiology of adolescent mental disorder leave little doubt of a gross under-provision of tier 4 in-patient beds. In the Thorneywood Unit's catchment area, how many young people with psychosis, depression, eating disorders, self-harm, drug and alcohol misuse, adjustment disorder, etc. are there who might benefit from an in-patient assessment or treatment at any time if the service was appropriately therapeutic? Almost certainly many times the number of available beds. Surely this provides an opportunity for a service to wield greater control of admissions. In a rationed service, the issue is surely one of *which* young people are selected for admission rather than *whether* selection should operate. Adolescent services then need to justify that their selection policy chooses those of sufficient severity, that the length of stay can be justified and that the clinical outcomes and user satisfaction levels are acceptable. If service commissioners then become aware that another patient group's needs are not being met, they may need to commission an additional service.

For adolescent unit providers, the message I took from this paper is 'seize control'. Otherwise, who will want to be an adolescent in-patient psychiatrist any more than a general adult psychiatrist (Colgan, 2002) and which patients will benefit from these expensive resources?

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