AFT NEWSLETTER, FEB 1987, VOL 7, No 1

WHO NEEDS AN IN-PATIENT UNIT? A FAMILY/SYSTEMS PERSPECTIVE

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We in Child and Family Clinics in Lanarkshire, are one of those areas with no In-Patient units of our own. In addition, we are actually pleased that others free us by carrying this (and other) major responsibilities. Though we don't wish to run an In-Patient unit, we do need to use those in neighbouring areas.

Briefly, the Child and Family Clinics' staff of seven, plus three secretaries, provides a service to 0–16-year-olds and their families and referring agents in the Lanarkshire population of 600,000. When staffing permits, we will routinely take up to 21-year-olds. We are two psychologists short of our "minimal basic" aim of three teams of four (secretary, social worker, psychologist and psychiatrist). The three teams cover the three new social work districts from two Health Board base clinics in Coatbridge and Motherwell.

By choice and necessity we operate as integrated a service as possible based on a de-mystified flexible family systems approach—with emphasis on liaising well with other agencies. In what we hope was a freak year, our referrals jumped to nearly 600 in 1985. In the five years, 1981–5, we had about 2,000 new cases referred. As a team, stimulated by a request to do a presentation on the subject, we reviewed all cases we had considered for referral to In-Patient units in those five years.

In some 2% of these 2,000 we considered referring (or knew of referral) to specialist Psychiatric In-Patient units. Eighteen kids, that is 1% were admitted. Having no unit ourselves, we have a choice of three or four adolescent and two or three Child Psychiatry In-Patient units in neighbouring areas. We've found that these units have not admitted other Lanarkshire kids than we know of.

Of the three dozen cases we had considered for referral the vast majority of identified kids were over twelve. Over ¾ were from unbroken nuclear families. The majority were from the materially (if not emotionally) better off areas. All contained the expected urgency of one kind of risk or another. In order of frequency of leading problem, we had school refusal, conduct disorders, anorexics, odd or maladjusted kids, and (unless you are counting the parents) one or two anxious, depressed or ? psychotics. Of the dozen and a half actually admitted somewhere, school refusals and conduct disorders do not show up so much, of course!

Different units offer different things. Two thirds of our admissions went to Bangour Village Hospital Adolescent Unit, West Lothian. When referring, we are generally looking for the following features:

1. a therapeutic separation usually as a means to re-integration of the family after discharge,
2. a holding of the adolescent and the anxieties around him or her,
3. support and confrontation of adolescent and family maturational tasks with peer groups and adults, and
4. most especially, competent family work or "therapy".

Nowadays there should be no need to admit someone for assessment, except as a pseudonym for intervention. The key negotiation is of *parental* motivation and expectations.

All of the features we look for could theoretically be found in non-psychiatric residential settings. Since they are not and don't look like being available this century, psychiatric units remain an essential resource.

So what are the uses we found essential?

1. A "Thermometer"

Though we are free to focus all our skills and efforts on "out-patient" work in all its aspects, we still recognised how having a good in-patient unit in mind sometimes provides a useful mental reference point, or lever to give direction, when needed, to our "out-patient" work. This is a kind of mental thermometer! On occasions, talking over a possible referral with a member of an In-Patient unit staff acts instead as a consultation to your Out-Patient work.

2. A Threat

I have hinted at the more overt use of referral, or serious talk of it, to galvanise families to sort things out with you, and by themselves at home. Whether you intend the threat or not, you need real confidence in your strategy whichever way it goes.

3. Interagency Issues

When Bangour reviewed three years of referrals with us, they were concerned that they had assessed and turned away as "unsuitable" cases over which agencies had developed considerable desperation. We were able to reassure them that this was as helpful a service as any. The reason was that these cases were driven to Bangour by interagency issues. At that time, we were in an earlier phase of establishing ourselves with other agencies. We in CFC may have said (or at least liked to say) to these desperate agencies, "Look, your two years of intensive work would have been a loser even if you had been doing it properly; but you're certainly on a loser, and In-Patient units are not appropriate". But they would hardly have listened and certainly not thanked us for this opinion. Going along with them in referring to Bangour—who could give the most authoritative "No"—regularly enabled the situation to deflate, head in a more profitable direction and maintain friendly co-operation all round, enabling our contribution or advice to be accepted. The other agency was usually Child Guidance or Social Work. However, here's one of our own which probably should have been turned down:

Fifteen-year-old KENNY A's pleasant, middle-class, divorced mother had almost explicitly retired from parenting several years earlier, in order to read books and visit friends. So, amongst other things, Kenny was not going to his last year of schooling. The CFC social worker (with active support from the psychiatrist) was struggling to sort something out with the local GP who was determined not to let anything like contact with

social workers mar his dignity. Simultaneously, that area's Social Work Department was then being especially obtuse about most things concerning social workers in CFC. Referral to Bangour, I thought, should have helped knock this back to us, or to legal, educational or child care provision, which might have galvanised the mother or other agencies into action. However, Bangour admitted Kenny and did Mrs A's job for her during the remainder of his schooling, while Mrs A got on with her reading. Kenny later went off to technical college.

We found over a dozen of our three dozen cases were interagency problems, usually not admitted.

4. Substitute, Substitute Child Care

KENNY A was really being provided with substitute, substitute child care. Referral for admission can be more explicitly because other more appropriate residential settings have failed or are in no fit state to do the job:

KAREN B, 14, had been adopted four years earlier with her younger sister by Mr & Mrs B, a childless, middle-class couple who were very able and willing to take this late adoption. They remained willing despite lack of support until, rather too late, Karen's increasing acting out drew in CFC, then a crumbling Children's Home, and finally the local assessment centre. What should have been quite possible from a chidren's home base then needed to be taken on by Bangour.

There is another situation where the Psychiatric Unit may be really offering substitute, substitute child care. More overtly than Mrs A, but often single like her, the parent may seem too inadequate, fragile, or medically or psychiatrically ill to stand the insult of declaring their child in need of substitute child care. So the kid is admitted to a psychiatric unit instead.

We found it easy to identify these primarily interagency and/or child care cases. It helps to identify them since you have different aims and expectations with them, whether the in-patient unit turns them away or not.

5. Ordinary Referrals

And of course we use in-patient units for ordinary, appropriate referrals, severe to impossible.

One main finding helped answer several questions. It seemed useful to consider the *families* of the young people referred in terms of their Enmeshment and Disengagement.

Disengaged Families

Of our three dozen, a third were disengaged families. Only three of these were admitted, KENNY A being one. The second: another family with "retired parents" and the third: an inter-agency problem, turned away by Bangour and admitted elsewhere for a brief unproductive assessment.

Why are disengaged families referred at all? It seems that we or another agency take on what should be the family's worrying. So the agency can become enmeshed with a disengaged family as well as with enmeshed ones. A disengaged family's concern and motivation seems to arise mainly from the threat to their image.

If you disengage a family further by admitting the kid, he or she may do OK, but if you discharge them home to their family or before they are sixteen, don't be surprised to find that admission has consolidated the disengagement at home and school. Better plan for discharge after sixteen and/or to a hostel or independent living.

There is a group of families whose image is kept up while seeming to be dedicated to, if not enmeshed with, an odd or maladjusted child whom they trail around endlessly like a performing bear on a lead, determined to find someone who will agree with their view of him (usually it's a him). On consideration, I think this group belongs at the disengaged end of the spectrum as well, in which case our list contained a couple more disengaged cases admitted with similar results to the other disengaged cases. Even an admission that proves to everyone how normal these odd kids are, will not register with his parents. Their image risks being dented much more badly if they accept that their son is naughty and they need to set better limits, rather than that he has some more acceptable individual disturbance inside him.

Enmeshed Families

Two-thirds of our three dozen were enmeshed, with the typical psychiatric diagnoses for what constitute the adolescent's forlorn attempts to cope. Psychiatric admission is basically a therapeutic separation, so it is not surprising that most cases referred or admitted are enmeshed enough to warrant this.

Enmeshment is less pathological in families with younger children. This, along with the other reasons for avoiding unnecessary residential admission and family separations with younger children, helps explain why we prefer to work with them in other ways than In-Patient admissions.

Enmeshment cuts across behavioural and diagnostic categories and can provide a more subtle measure. A simple clinical or empirical rating of severity of enmeshment (mild, moderate or severe) gives a measure of the family's likelihood of motivation and ability to use the admission. It follows that this rating also correlates with success or failure—especially distinguishing those successes that last after discharge from those that don't. Put another way, the more enmeshed the family is, the more skilful your negotiation and grip has to be to get going on the work, and the more powerful your family work has to be to get good results to last after discharge. Thus:

KATE C, 14 was an anorexic in a moderately enmeshed family. She eventually danced in fishnet tights at the Xmas Pantomime and went from strength to strength with her family afterwards. In comparison:

KEVIN D, 17, was desperately anorexic in a desperately enmeshed family. After the failure of sterling efforts to hold him and maintain progress, including plans to get the rest of the grown-up family to disable the mother, they all continued as before. And:

KEITH E, 14, violent and obsessional, did well while separated from a similarly severely enmeshed family, but little changed at home. Three years later, precisely the same crisis scenario recurred. He is just about doing OK now in a local social work day unit hostel.

Two families we rated as mildly enmeshed (or normally engaged):

KAREN B,'s adoptive family (already mentioned) and the parents of a girl who developed florid psychotic symptoms of schizophrenia at ten-years-old. Now fourteen, on medication, she is at a special school.

Finally, three comments:

1. We have to ask the question: for families where Psychiatric In-Patient units work really well, if you tried hard enough, would Out-Patient treatment work well enough?
2. From our various experiences of departments where In-Patient units and Out-Patient units live side-by-side we see factors that govern admissions that over-ride those to do with the case or even inter-agency issues. These arise from the enmeshment of Out-Patient and In-Patient staff with their In-Patient unit and its related systems. For example, the huge imbalance of meetings in favour of the In-Patient unit, concerns with the composition of the current In-Patient group, morale of nurses, pressure to keep beds filled, and so on. Since we cannot see how these factors can be "isolated" the best way to do a study of admissions to In-Patient units is to do it in an area like ours. In other words, you can only do research on admissions when you don't have an In-Patient unit!
3. Who needs an In-Patient unit? I did—to be trained in! Or did I?

TOWER OF BABBLE

Following Bryan Lask's suggestion at the 1986 Plenary Address for a regular competition for examples of what he called "cybernetico-epistobabble", the Newsletter is happy to oblige—subject to lawsuits, old professional scores being settled, etc, via this column!

Called simply "Tower of Babble" we invite AFT members to submit examples where language is used to mystify and confuse than to enlighten. Examples welcomed, *real* or *imagined*, of positive connotations, paradoxical injunctions, prescriptions, etc, that are so over the top and absurd even Carl Whitacker would hesitate using them! These need not be confined *only* tc clinical settings—so Sir William Armstrong's "Economical with the Truth" would qualify.

Book tokens—for modest sums (Steve Dorner, relax!)—for all printed "Babble".

Newsletter offers this opener:—

"As family therapists, there are several jumps that can be made. First of all, a therapist can jump from the paradigm of substance to that of pattern. This places him in the context of cybernetic epistemology. Once there, the family therapist can embody the complementary gestalt of simple cybernetics and cybernetics of cybernetics. He will then be able to jump back and forth between these orders of recursion. With this full view, a family therapist can approach the complexity and elegance of autonomous and interconnected patterns of life".

Brad Keeney
"Aesthetics of Change"