Thus the "political independence" of the B.B.C. is itself a political matter in a fashion that is not true of the provision of health or of any other social service.

In any case, the financial arrangements of the B.B.C. reflect the problems and objectives just described. The Corporation is not entirely dependent on the Exchequer, as it can raise revenue from licence fees. The fees are low by international standards, but their existence clearly provides some freedom of action. Again, the B.B.C. is subject to competition, both from its own and other media. Direct competition is relatively new, and its consequences have been interesting. Judgement on the content of programmes is perhaps too subjective to be useful, but there seems to be little doubt that *technical* standards have been raised by competition, and even less that the pay and conditions of the B.B.C. staff have been improved. There is equally little doubt that in the past the B.B.C. has used its monopoly powers and special relationship with the Government to protect its own position and inhibit the development of competitors, and this in ways not easily reconciled with any plausible view of the public interest: anyone who doubts this needs only to read the history of the development of wire broadcasting in Britain.

Alternative Sources of Finance

In conclusion, we can bring together some of the specific questions to which advocates of a public corporation for the National Health Service, whether or not modelled on the B.B.C., must find answers. Firstly, would they accept lay control ? If not, how would they justify doctors alone being treated as judges in their own cause (for example, in the determination of their own pay and conditions) ? Secondly, do they expect the corporation to be financed entirely from the public purse ? I do not share Enoch Powell's pessimism about the discovery of improved financial arrangements, but he is surely right in arguing that public finance must imply public responsibility: a corporation that can refer complaints only to its paymaster must expect that the paymaster will decide all the important questions. If it is accepted that the desired independence of politics demands other sources of finance, what are they to be ? There are two broad possibilities. One follows the pattern of the trading corporations (and for that matter the B.B.C.): it would make the Health Corporation wholly or partly dependent on fees provided by patients, insurance organizations, and so on (and would subject it to competition from private medicine). The other, supported by some who find private finance distasteful, would seek to alter the form of public finance by devoting a given proportion of the national product to health purposes. Thus, it is said, the Health Corporation is guaranteed an income and can plan ahead accordingly, and Parliament has done its job and need not interfere further. The argument does not stand up to serious examination. How is the share of health to be decided ? The Government provides all kinds of "good things," and the technicians responsible for each of them are all sure that their "share" of the public purse is too small. The sum of the "shares" they would all expect is larger than any Government could provide. Who but Parliament can decide where to cut ? Even if health services were the only ones to enjoy the privilege of this procedure the same questions would arise. Negotiation about the size of the health budget would be replaced by negotiation about the Corporation's share of the gross national product. Inevitably, Parliament would turn this formula back into cash, since for the politician it is the sacrifice of resources to other public or private uses that matters. We are back where we started.

We are back where we started in a broader sense. We certainly need to try to improve our arrangements for providing health services. But a Health Corporation *per se* would provide solutions for none of the problems that trouble us—and might produce some new problems of its own. It could be of value, if at all, only as a medium for the implementation of the new modes of finance and organization that remain to be found.

HOSPITAL TOPICS

Two Years' Admissions to a Regional Child Psychiatry Unit

PHILIP BARKER,* M.B., M.R.C.P.ED., D.P.M., D.C.H. ; ROSLYN JAMIESON,† M.B., CH.B.

Brit. med. J., 1967, **2**, 103–106

One of the striking changes in the psychiatric services in Britain since the inception of the National Health Service has been the establishment of many new psychiatric inpatient units for children. Most regional hospital boards now have at least one such unit operating within their area. There is nevertheless little information about the part these units play in the child psychiatry services as a whole, and the place of inpatient psychiatric treatment in children is still not clear. The subject was discussed in a memorandum of the Royal Medico-Psychological Association (1956), which recommended the provision of 20 beds for children up to 12 years of age per 500,000 population, with, in addition, one long-stay unit of 25 beds for each regional board area.

* Consultant in Child Psychiatry, Liff House Children's Unit, Royal Dundee Liff Hospital, Dundee.
† Registrar, Liff House Children's Unit, Royal Dundee Liff Hospital, Dundee.

To date, an account of the work of a regional unit catering specifically for the needs of a defined population does not seem to have been published. Yet the nature of the work done in such units must be of importance, both from the clinical point of view and for the planning of future developments in the child psychiatry field. This paper gives such an account and analyses the work of Liff House Children's Unit during its first two years of operation.

The Unit

Liff House is the children's unit of Royal Dundee Liff Hospital, the psychiatric hospital for the Dundee area. Unlike its parent hospital, Liff House is a regional unit, admitting patients from the whole area covered by the Eastern Regional Hospital Board. During the two years under review only three

patients were admitted from outside the region. We believe, moreover, that during this period no children in the relevant age range from the region were admitted to any other psychiatric unit.

Liff House contains 10 beds for the treatment of children up to the age of 12. As the population served is about 500,000 this provision thus falls well below that recommended by the Royal Medico-Psychological Association. During the latter part of the period under review a few day patients (additional to the inpatient complement) were treated. These never numbered more than three, and were children who previously had been inpatients.

Staff

There are 10 nursing staff: ward sister, male charge nurse, a male and a female staff nurse, and six assistant nurses. The nurses work permanently in the unit and are not transferred from or to the adult hospital. There are also a full-time teacher (on the staff of the Angus Education Authority) and a half-time occupational therapist. The psychiatric staff is made up of a consultant, a senior registrar, and a registrar, but these are also responsible for running the regional outpatient child psychiatry service and thus work only part-time in Liff House itself. The services of two psychiatric social workers and a psychologist are similarly provided part-time. This enables the same psychiatric social workers to carry out casework with the families of patients during both inpatient and outpatient treatment.

The unit is housed in a large converted house. On the ground floor are a dayroom, a classroom, two playrooms (one with a one-way screen for teaching purposes), dining-room, kitchen, and offices. On the first floor are bedrooms, night nurse's station, and an occupational therapy room. There is also a large garden, fenced off and secluded from the main hospital grounds, into which the children are not allowed to go unaccompanied.

Visiting is unrestricted outside school hours. As their condition improves the children usually start spending week-ends at home; these are lengthened as discharge approaches.

Admission Policy

The main indications which have led to admission of children for *treatment* have been, on the one hand, severely disturbed behaviour in the child such as would make management elsewhere difficult or dangerous, and, on the other hand, the existence of very unfavourable environmental circumstances making effective treatment difficult or impossible while the child remains at home.

Disturbed behaviour necessitating admission has included withdrawn and bizarre psychotic behaviour, actively aggressive and antisocial behaviour, persistent refusal to go to school which has not responded to outpatient therapy, states of severe depression, severe hyperkinesis, habit disorders (notably some cases of encopresis), and serious episodes of running away from home.

The *adverse environmental factors* which were sometimes decisive in causing inpatient care to be recommended were almost invariably concerned with the emotional climate in the child's home. Rejecting and hostile or anxious and over-protective attitudes were most common. The unfavourable situation had often existed for a long time, the child's disturbed behaviour having the effect of increasing the intensity of the adverse parental reaction, which in turn increased the degree of the child's disturbance.

Some children were admitted primarily for *diagnosis* rather than for treatment. The diagnostic work of a children's psychiatric inpatient unit has been lucidly described by Rogers (1965).

Treatment Methods

The unit is organized with a view to providing a therapeutic milieu suited to the particular needs of the children in it. The progress of the children is discussed at weekly staff meetings at which future treatment plans for each child are formulated. A day's activities may include occupational therapy, periods of school work, physical education and games in the hospital recreation hall, a visit to the swimming-baths in Dundee, and a variety of other activities. There are also periods of free play. The general aim is to create a warm, accepting emotional climate. In this context definite, though relatively few, limits are set and the environment and handling of each child are adjusted according to his apparent needs.

The place of individual psychotherapy varies from case to case, but normally each child is seen at least once a week on his own by one of the psychiatric staff. Some are seen more often than this. Drug therapy has been limited to anti-convulsant treatment for epileptic children, night sedation in a few cases, and the occasional use of phenothiazine tranquillizers and of antidepressants, notably amitriptyline.

Two Years' Admissions

This analysis covers all the children admitted to Liff House during the two years since its opening on 12 May 1964. Of 55 patients admitted 37 (67%) were boys and 18 (33%) girls. The mean age on admission was 8.3 years and the age range 4 to 12 years. The areas from which the children were admitted were: City of Dundee 30 (54%), Perthshire 11 (20%), Angus 11 (20%), and Aberdeen 3 (6%).

Only the three children from Aberdeen came from outside the regional hospital board area. They are included in the analysis for the sake of completeness, but where relevant are identified separately.

In 16 (29%) cases admission was only for diagnosis. The other 39 (71%) were either admitted for treatment or were kept in for treatment after being initially admitted for diagnosis. Of the three children from outside the region two were admitted only for diagnostic observation; the third was transferred from Liff House to a newly opened unit in his own area for continued treatment.

Source of Referral.—Normally, children are admitted only after having been assessed as outpatients. The decision whether to admit is thus made by the child psychiatric staff, not by the person referring the child. The source of the original referral to the child psychiatric service is shown in Table I. It will be seen that only one-fifth of the referrals came direct from family doctors.

TABLE I.—*Source of Original Referral to Dundee Child Psychiatry Service*

General practitioner	12 (22%)	Other medical specialist	4 (7%)
Paediatrician	12 (22%)	Local health authority	6 (11%)
Child guidance services	11 (20%)	Children's officer	2
Other psychiatrist	7 (13%)	Procurator fiscal	1

Diagnosis.—Table II shows the diagnostic categories. The system of classification is similar to that proposed by Rutter (1965), though we have avoided a "mixed" group by placing children in either the "conduct disorder" or the "neurosis" group, according to which symptoms predominated at the

TABLE II.—*Main Diagnosis in 55 Cases*

Conduct disorder (includes 2 epileptics)	26 (47%)
Neurosis (school refusal 5; anxiety state without school refusal 2; hysteria 2; neurotic depression 1)	10 (18%)
Habit disorders (encopresis)	7 (13%)
Psychosis (organic in 2 cases)	6 (11%)
Miscellaneous (mental subnormality 2; primary educational problems 2; epilepsy 1; psychosomatic condition 1)	6 (11%)

time of admission, even if mixed symptoms were present. In other cases of multiple diagnosis the predominant condition at the time of admission has been recorded. In two of the epileptic children the conduct disorder seemed not due predominantly to the epilepsy, but in the third child admission was necessitated by rapidly increasing frequency of fits with a simultaneously worsened behaviour disorder.

Social Background.—Table III shows the social class in each case, based on the occupation of the father or, in the absence of a father, on that of the mother. For comparison the social class distribution in the region is shown, based upon the 10% sample of those in gainful employment (1961 census); this is the most nearly comparable control group that is available.

TABLE III.—*Social Class*

Social Class	Unit Admissions		Working Population of Catchment Area (Angus, Dundee, Perth and Kinross)	
	No.	%	No.	%
I	0	0	4,830	2·3
II	5	9·1	33,500	16·1
III	19	34·54	95,300	46
IV	24	43·64	56,430	27
V	7	12·72	16,960	8·1
Total	55	100	207,020	99·7*

* 0·3 unclassified.

Only 34 (62%) of the children were living with both natural parents; 14 (25%) were living with one natural parent and seven (13%) with neither. Of the latter seven, six were in the care of local authorities and one was adopted.

Intelligence Quotients.—The distribution of intelligence quotients (I.Q.s) among the children was: below 90 in 16 (29%), 90–110 in 21 (38%), and over 110 in 10 (18%). The remaining eight, whose I.Q.s were not assessed, include some who were functioning at a retarded level but whose severely disturbed behaviour was such that they could not co-operate in intelligence-testing in such a way as to produce a clinically useful result.

Length of Stay.—In the cases of the 52 children who had been discharged from inpatient care at the time of writing the mean duration of stay was 19.5 weeks; if day-patient attendance is also taken into account the mean stay (for 51, since one who had been discharged from inpatient care was still a day-patient) was 21.2 weeks. As shown in Table IV, these mean figures conceal wide variations in duration of stay. In

TABLE IV.—*Length of Stay (Weeks)*

	0–10	11–20	21–30	31–40	41–50	51–60	60+
Inpatients only ..	17	21	4	2	4	2	2
Total stay	17	20	4	1	4	–	5

Median total stay = 14 weeks.

the group admitted for diagnosis the mean duration of stay was 5.4 weeks, whereas in the "treatment" group it was 25.8 weeks, or 31.5 weeks if subsequent day-patient attendance is included. Only three children, including a pair of twins,

TABLE V.—*Placement on Discharge*

	Assessment	Treatment	Total
Home	6	17	23
Home and special class	1	8	9
Home and occupation centre	1	2	3
Home and special school	0	1	1
Residential school for maladjusted children	2	3	5
Children's home	3	2	5
Boarding school	1	1	2
Foster home	2	0	2
Adolescent unit	0	1	1
Other inpatient unit	0	1	1
Total	16	36	52

Total discharged home: 36 (67%).

were taken home by their parents against medical advice. All three were suffering from encopresis.

Placement on Discharge.—Table V shows the placement of the 52 discharged children. Thirty-six (67%) were discharged to live at home (this excludes those who went to boarding school), and of the remainder four had been in children's homes at the time of admission. The "special classes" referred to are day classes for maladjusted children; such classes are run by two of the local authorities in the area.

Discussion

During the two-year period under review 345 new outpatients were seen in the Dundee child psychiatry service. Thus the percentage admission rate (excluding the three cases from Aberdeen) was 15%. However, only 244 of the new outpatients were aged under 12, and the admission rate in this group was 21%. This figure is deceptively high, however, in that a number of children were referred from more distant parts of the region specifically because there was felt to be a need for inpatient care. Less seriously disturbed children from these areas are not often seen in our outpatient clinic, but no doubt would be referred if a children's outpatient service were operated in these peripheral areas. If children from Dundee only are considered, the admission rate is 17% of the total of those under 12 seen in the child psychiatry service in the period. If only Dundee children admitted for *treatment* are considered the figure is 11.5%.

The figures for admission to the unit are difficult to interpret for several reasons. On the one hand there has always been a waiting-list for admission, while on the other there has often been considerable delay in securing admission to residential institutions (notably schools for maladjusted children) of those not suitable for discharge home.

A further difficulty is that there are no generally accepted criteria for admission of children for inpatient psychiatric care, and ours are inevitably personal ones. In the past the great shortage of beds has forced child psychiatrists to make minimal use of inpatient treatment. Consequently they have tended to develop techniques of treatment and diagnosis not involving admission to hospital. This situation is now changing as the number of inpatient places increases, and as a result there may well be a marked change in the pattern of child psychiatric practice. Our experience is that inpatient care can greatly assist both in making diagnostic assessments in difficult cases and in treatment. The effectiveness of living for a period in a therapeutic environment should often be greater than that of purely outpatient psychotherapy, and in practice it seems to be so.

The proportion of children admitted out of the total seen may appear high, but it is lower than the 22.5% reported by Davies (1964) for a unit in some ways similar to ours, though not strictly a regional one. This unit had a considerably higher admission rate to its 12 beds (75 patients in one year) and a much shorter average duration of stay (33 days). This contrast emphasizes the diversity of practice in this field and the need for further studies and reports from different units.

Almost all the children admitted for treatment improved while in the unit, but of course very often the real test comes after discharge. It is too early to draw any conclusions about even the medium-term outlook, but all the patients are being followed up, and it is hoped to publish the results in due course.

Summary

Two years' admissions to a regional child psychiatric inpatient unit containing 10 places are reviewed, and the organization of the unit is briefly described. Total admissions numbered 55 (37 boys and 18 girls). In 39 cases admission was for

treatment, in 16 for diagnostic observation. The mean length of stay was 21.2 weeks, but the period of stay varied widely, the maximum being 75 weeks. A wide range of diagnostic categories was included in the admissions ; the biggest single group was of children suffering from conduct disorders.

Admission plays an important part in both diagnosis and treatment, about one-fifth of the outpatients in the relevant age group being admitted. Inpatient care is likely to assume increasing importance in child psychiatric practice.

We are grateful to Professor I. R. C. Batchelor for his advice during the preparation of this paper.

REFERENCES

Davies, G. L. (1964). *Lancet*, **2**, 955.
Rogers, W. J. B. (1965). In *Modern Perspectives in Child Psychiatry*, edited by J. G. Howells, p. 543. Edinburgh.
Royal Medico-Psychological Association (1956). *In-patient Accommodation for Child and Adolescent Psychiatric Patients*. London.
Rutter, M. (1965). *J. Child Psychol.*, **6**, 71.

CONFERENCES AND MEETINGS

Teenage Drug-taking

[FROM A SPECIAL CORRESPONDENT]

A symposium on teenage drug-taking was held at Whitchurch Hospital, Cardiff, on 23 March, organized by the Cardiff Division of the B.M.A. The mixed invited audience included consultant psychiatrists concerned in the treatment of the teenage group, with their supporting staff of social workers and nurses, and general practitioners, police officers, public health workers, and officers from the probation service and educational services were also present.

Opening the morning session, Dr. W. POWELL PHILLIPS (Medical Officer of Health for the City of Cardiff) suggested that the task which the symposium was setting itself was an extremely difficult one. He saw the contemporary need as being an objective appraisal of the size of the problem. In trying to determine what was to be done, the symposium members were all having to face the difficulty of placing themselves in the youngsters' situation. This was not only the problem for the day, but the one which each person who had any contact with the treatment of the adolescent experienced at all times.

Dr. Powell Phillips suggested that in Wales the known number of heroin addicts did not exceed four or five out of the total in the United Kingdom of over 1,000. In a recent survey by his department the view had been expressed that of the under-15-year age group some 1% of children had experimented with drugs. In the grammar schools of Cardiff the possible proportion might be between 5 and 8%.

Three Problems

Dr. MYRDDIN EVANS and Dr. AVRIL WEEKS suggested that three interrelated problems were presented to anyone involved in the management of these patients. These were the complexity of the normal adolescent situation ; the considerable difficulty in achieving sympathetic identification ; and the need to recognize a depressive component in the majority of patients.

Though their experience was limited, they suggested that a proportion of the vulnerable section of the teenage population took to drug-taking and its associated activities either as an "acting out" of their problems or as a dangerous form of self-treatment. One answer for this vulnerable group was to control the access to drugs. Another would be to provide adequate counselling services for the young so that an alternative form of help was available to them at critical times.

Cannabis

Dr. J. MITCHELL presented a paper written by Dr. J. D. P. Graham on the pharmacology of cannabis.

He pointed out that there was a dearth of reputable scientific information on cannabis or its active principles. He indicated the world-wide use of the material and commented that there was no record of any person having died of the acute effects of hashish.

Dr. Mitchell went on to describe the variable effects of cannabis in man as illustrated by the incidence of dependence throughout the world. He emphasized the tendency for group cults and rituals to develop. Though cannabis could not be regarded in a strictly logical way as a dangerous drug, he pointed out that hashish potentiated the effects of amphetamines, barbiturates, and alcohol. However, as it was a stepping-stone to the use of the more truly addictive drugs he supported the continuation of restrictions on cannabis and suggested that control should include compulsory notification of known users.

Minority of Drug-takers

The first afternoon session was under the chairmanship of Dr. R. T. BEVAN, of the Welsh Board of Health. Introducing the speakers for the session he underlined the need to remember that drug-taking teenagers were in the minority and questioned the validity of recent publicity.

The first speaker of the afternoon was Mr. H. B. SPEAR (H.M. Deputy Chief Inspector (Dangerous Drugs) of the Home Office). He felt that the publicity had served its purpose, the community having ignored the warning signs for long enough.

He suggested that one of his tasks was to dispose of some of the folklore surrounding the facts and warned that no community was immune to the spread of narcotic addiction. Heroin addiction was increasing at an alarming rate and in particular in the younger age groups. He did not think that a ban on the drug would be effective and he expressed concern as to whether control could be sufficiently exercised. The community should be realistic, said Mr. Spear. There was a limit to what the enforcement services could do.

Mr. A. C. L. HASWELL (Principal Probation Officer in the City of Cardiff) then presented a paper on "Casework in the Probation Setting." He emphasized that, while the basic precepts of case work were the same in all agencies, the probation service was unique in that the client did not seek the relationship. The Court defined the conditions and determined the period of the relationship. This led to the difficulties arising from initial resentment and the disadvantage of a prescribed time limit.

Every probation officer knew of clients who would not respond to case-work, said Mr. Haswell, and he suggested that drug-takers might be in this category. He felt that case-work was quite useless in the case of the true addict on "hard" drugs. His own case load contained very few drug-takers and these mainly showed a spasmodic drug-taking pattern in pursuit of aimless "kicks."

Dr. J. P. SPILLANE (Physician Superintendent of Whitchurch Hospital) chaired the next discussion. He said that he tended to regard the teenage drug problem as a function of the easy availability of some drugs.

He emphasized the difficulty of diagnostic classification in this age group. Some 200 adolescents were admitted annually to adult psychiatric hospitals in Wales with various disorders. He postulated increasing difficulty in meeting the demands for treatment, and suggested that the conventional hospital had little to offer the more obviously disturbed adolescent.

Dr. IDRIS JONES (Chairman of the Cardiff Division of the B.M.A.) in summing up the proceedings said that he had been impressed by the wide range of the papers and considered that the opportunity to discuss the issues had been of great value.