Middle Articles

HOSPITAL TOPICS

New Psychiatric Inpatient Unit for Adolescents

J. D. HALDANE,* M.B., M.R.C.P.ED., D.P.M.; DONALD McINNES,† A.R.I.B.A., DIP.ARCH.ED.

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The Department of Child and Family Psychiatry at Stratheden Hospital became a full-time service in 1960, providing the psychiatric services for children, adolescents, and their parents in the County of Fife (population 320,000). The outpatient facilities include clinics in general hospital and local authority premises. The first inpatient facility was the unit for children (12 places for boys and girls under 12 years of age) opened in January 1960. The unit for adolescents, described here and opened in April 1968, was the next stage. Later the children's unit will either be extended and modernized or be rebuilt, and proposals are being considered for the building near these two units of a unit for the admission of families.

Staffing

The department staff establishment comprises two consultants, one senior registrar, two registrars, one senior clinical psychologist, and five senior social workers. The inpatient service staff comprises, in addition, one senior assistant chief male nurse, nursing and domestic staff (slightly less than 1:1 ratio), three teachers (whose salaries are paid by the local education authority), and one occupational therapist. Four secretarial staff provide the clerical/secretarial services to the whole staff. All the department staff have responsibilities in both inpatient units and other staff are appointed to the inpatient service rather than exclusively to either of the inpatient units.

Considerations in Planning

General

To facilitate the work of the staff we planned that the new unit be built near the existing children's unit, allowing for the possibility that the latter might be rebuilt on a new site. We could not discover any evidence to suggest that the close physical relationship of the two units would be to the disadvantage of either children or adolescents. As the department staff had inadequate consulting-room and office accommodation, this was to be incorporated in the new building. (If eventually the children's unit is extended, the administration/consultation section may become the physical "link" between the two inpatient units.) Sufficient open space for recreation was required. Ease and rapidity of building and the capacity for possible extension at a later date were additional factors.

Number of Places

The decision of the Board of Management for Stratheden and Associated Hospitals and the South-east (Scotland) Regional

Hospital Board that the unit should have 18 places for boys and girls was based on a review of patients referred to the department; the assessment and treatment needs of adolescents; other facilities available for residential care and treatment (children's homes, approved schools, a residential school for maladjusted adolescent boys and girls); and an assessment, so far as this was possible, of what might be the number of places most appropriate for a unit of this type.

Admission and Treatment Policy

There are wide variations in admission and treatment policy not only between different types of residential units for adolescents, but also between inpatient psychiatric hospital units for adolescents. We considered that for a time, until further experience was gained, the admission and treatment policy should be to some extent flexible and experimental. As a department providing the service to an area, we thought that, unless and until experience proved otherwise, we should try so far as possible not to limit admissions to a narrow range of diagnostic categories. We therefore expect, as in the case of the children's unit, to admit patients from all social classes—with intellectual capacity ranging from the below average to the intellectually superior—and not to exclude by virtue of diagnosis alone any of the wide range of clinical psychiatric conditions presented by patients of the age range 12-16 years. The duration of their stay will not be a matter for arbitrary decision, but will depend on the needs of each particular case. The majority will be admitted for treatment, some for assessment.

In planning this unit, an attempt has been made to consider the whole building and surrounding grounds as the framework for therapy and to provide an environment in which patients and staff will have the opportunity, in being together, gradually to evolve a pattern of living which is potentially therapeutic for the boys and girls to be admitted. We did not wish to have living, educational, and therapeutic areas so separated off from each other that clarity of function might be achieved at the cost of splitting the total therapeutic programme into disparate entities. We do not wish to separate "school" from "living" or "treatment" from "education" and "recreation," believing that these various terms describe what should be identifiable but related aspects of the total living/treatment situation. We thought it right to treat boys and girls together, offering opportunities for them to be together for the greater part of each day, while making it possible for individuals or groups of each sex to live, play, and work separately from the others when they need to. Similarly, we wished to create an environment in which staff would not be confined in their work to specific areas; where nursing staff could be with patients not only in living areas, but also in the hall, occupational therapy, and school; where teachers would not be confined to the class-

* Consultant in Charge, Department of Child and Family Psychiatry, Playfield House, Stratheden Hospital, Cupar, Fife.

† Partner in the firm of Wheeler and Sproson, Chartered Architects and Town Planning Consultants, Kirkcaldy, Fife, and Edinburgh.

rooms; and where doctors need not use only consulting-rooms for their therapeutic endeavours.

Building and Grounds

Figs. 1 and 2 show the facilities provided. The building is a single-storey structure on an extensive open site with open views, bounded on one side by a fine avenue of mature beech trees, at the southern end of the grounds of the main hospital, from which it is separated by lawns and trees. In the grounds near the unit are a large hard-surfaced playing area and room for a football/hockey pitch. The area immediately surrounding the unit is being landscaped. A shelter belt of trees will separate the unit for adolescents from the unit for families which it is hoped will one day be built, and there remains sufficient space to use the surrounding area for a variety of activities.

To help create the atmosphere of a modern domestic building the walls are finished in a crisp white roughcast (similar to that used on many houses in this part of Scotland); the roof is of grey-textured slates, in harmony with other buildings, and the different elements of the building have been unified by a pitched roof. In hall and classrooms the line of the internal ceiling follows the steep monopitch of the roof, and laminated timber beams and timber ceilings add visual interest as well as helping the acoustics. Elsewhere in the ceilings of the circulation areas acoustic tiles have been used. The architects have designed much of the furniture and fittings and have participated in the selection of furniture and furnishings. We hope thereby to have achieved a sense of unity and consistency throughout the building, while preserving a range of shapes and proportions which vary from the stimulating to the reassuring, and to have achieved an environment which is domestic rather than institutional in character.

FIG. 1.—Photograph of adolescent psychiatric unit.

FIG. 2.—Plan of adolescent psychiatric unit.

We hope that the building is an effective expression of our wish to provide for both group and individual activities; for openness of communication with due allowance for privacy; and for therapeutic, educational, and recreational activities (which are so closely interrelated).

We have attempted to plan and equip the various rooms so that they can be used for a variety of functions—for example, the hall has gymnastic and recreational equipment and a demountable stage, as well as facilities for films and lectures. The living areas, general-purpose room (girls), kitchen, and occupational therapy room will offer scope for domestic/household activities. The classrooms, quiet room, occupational therapy room, and general-purpose room (boys) have equipment for formal schoolroom work, technical and commercial studies, hobbies, craft work, and art.

There is within the unit no central or focal point, no room or area which is unequivocally the one part of the building around which other activities revolve, or in which the main activities take place. This is not owing to a failure to recognize the need for such a focal point. It was considered that having regard to the provisional treatment policy which had been evolved, no room or area should be given such special emphasis or prominence as to imply or suggest that it should be the most important part of the building. Just as it was considered that most of the rooms should be multipurpose, allowing flexibility of use and function by both patients and staff, so it was considered that both patients and staff, in their working and living together, should be able to choose, depending on the needs at the particular time, which room(s) or area(s) to use for different purposes.

There is no central observation point, no central nurses station. Clearly, the absence of such a room reduces the range of observation which can be undertaken by any one nurse, thus placing a considerable responsibility on staff who are required to be aware of patients' movements within the building. But it was decided to accept the risks inherent in this rather than create a more institutional type of situation in which dormitories or sitting-rooms would be under observation by staff.

Experience may prove us mistaken, but it was our opinion that to have a focal point and central observation station for nursing staff might have value in terms of economy of staff, but would not be appropriate to the particular kind of therapeutic milieu which we hoped would develop.

Some Problems

The administration/consultation section contains both the department's headquarters and the consulting-rooms for the unit for adolescents. It was considered that these rooms, together with others in the unit itself, would offer sufficient facilities for individual and group therapy. This may prove to be unrealistic.

We wished the building to have a sense of light and space: only time will show whether the type and area of glass is a realistic compromise between this aim and the risk of breakage.

Wall surfaces have been finished in plaster, except in the hall, where grey facing bricks form the internal finish. We do not know whether these surfaces will withstand the rough usage which may be expected.

Economy of installation and the existence of the main hospital's plant were the factors which decided that heating should be by low-pressure hot water supplied through a calorifier fed by steam from the main hospital's plant. Under-floor or ceiling heating might have reduced the disadvantages, both aesthetic and practical, of pipes and radiators.

Conclusion

This brief communication, which describes a new inpatient unit for the psychiatric treatment of adolescents, can indicate only some of the principles considered in its planning and suggest a few of the problems. It will be some years before these principles and the building which has been developed from them can be adequately tested. We hope that a later report on success and failure may be of some help to others planning similar units.

A Century of Asthma Deaths in Young People

F. E. SPEIZER,* M.D.; R. DOLL,† M.D., F.R.C.P., F.R.S.

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To appreciate properly the significance of the recent increase in the mortality attributed to asthma it is desirable, as Robbins (1968) points out, to examine its historical setting. This, according to Alexander (1963), consists of a long period in which death in an attack was almost unknown, a period of 25 years in which death occurred with increasing frequency, and a period of a few years in which the annual number of deaths declined abruptly. In support of this conclusion he referred to an aphorism of William Osler that "the asthmatic pants into old age" and to extracts from nineteenth-century textbooks, case reports from the first half of the twentieth century, and crude mortality rates at all ages from the late 1930s onwards.

Long-term comparisons of this type, however, are hazardous. In adult life asthma is commonly associated with other respiratory conditions, and the many changes in the rules for classifying causes of death, apart from possible changes in

nomenclature and the accuracy of diagnosis, led Speizer, Doll, and Heaf (1968) to limit their comparison of mortality rates to ages 5 to 34 years and to a period of 15 years during which the sixth and seventh revisions of the international classification of causes of death had been used.

In the present note we have extended the comparison of mortality rates at these ages to include data over one hundred years. Because of the small numbers of deaths we have grouped the data and calculated average annual death rates for consecutive periods of five years. Data for the periods covered by the first and second world wars have been omitted because of the disturbance caused by the selection of young people into the armed Forces. Before 1911 deaths attributed to emphysema were intermittently coded with asthma, but this has been ignored. The number of deaths attributed to emphysema (when this was specified separately) was never more than 10% of the total attributed to both conditions at these ages; in all subsequent years emphysema was classified separately. Since 1910 there have been several other major alterations of coding and classification procedure, and each decade saw the introduction of some change. The most important occurred in 1940, when

* U.S. Public Health Service Special Fellow, Medical Research Council's Statistical Research Unit, London W.C.1.

† Director, Medical Research Council's Statistical Research Unit, London W.C.1.