PSYCHIATRIC NEEDS OF DISTURBED SOCIAL WELFARE CHILDREN AND ADOLESCENTS AND CONSULTATIVE PSYCHIATRIC PRACTICES IN SOCIAL WELFARE INSTITUTIONS

A.G. FRAZER MB ChB DPM MANZCP
PSYCHIATRIST

DEPARTMENT OF HEALTH
WELLINGTON

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INTRODUCTION

The recognition of the need for psychiatric service for the disturbed welfare child and adolescent has gained momentum in this country over the last 3 - 4 years with the opening up of a number of psychiatric adolescent units in various psychiatric hospitals and psychopaedic hospitals. With the more specialized training of the social welfare social workers to some extent there has been a disenchantment about the ability of the traditional Child Health Clinic treatment and programme to meet the need of a youngster from the social welfare population. Less satisfactory are the children who are "out of sight out of mind" so far as the community is concerned from social welfare homes and institutions and admitted to psychiatric hospitals without a childrens unit who operate a mainly custodial programme and adult orientated programme. Although child psychiatrists are familiar with the common complaints that disturbed social welfare children can display there has been very little attention paid to the work of a child psychiatrist in a residential or a non-psychiatric care establishment. This state of affairs is by no means a simple function of manpower shortage. Although it is agreed that there is a high prevalence of psychological problems amongst the delinquent and non-delinquent child welfare population the effectiveness of psychiatric consultative programmes and psychiatric treatment is by no means clear.

The paper is the result of a request by Mr I. MacKay Director General of Social Welfare for information on necessary developments in child psychiatric practices as it can be developed in Social Welfare and Health areas.

The substance of this paper is mainly from the author's experience in child psychiatry in New Zealand and overseas but it also draws heavily from many discussions with Social Welfare Workers. Statistical data was collected from "Survey of Psychiatric Hospital" July 1974 Dr I.O. Jeffery and Mr J.M. Booth, Working Party on Administrators and Functions of Child Health Clinics 1973 Mr T. Austin, Mr J. Mills and the author, National Health Statistic Centre 1971 Census on Psychiatric Patients, and a specially designed survey for this paper on Social Welfare Children in Psychiatric Hospital, Research Division, Department of Social Welfare, October 1974.

PART I

A. PSYCHIATRIC CONSULTATION IN PRACTICE AND IN THEORY

The literature abounds with subjective descriptions of consultative experiences of one type or another. Varying claims for success often rest on shaky assumptions with no mention of statistical criteria. However, New Zealand, unlike its overseas counterpart, has not yet developed to a stage where it has published a paper on consultative techniques. The movement of psychiatrists from a Health area into the Social Welfare field has been a haphazard and until recently, an unplanned development. Amongst the disciplines dealing with the work of the Social Welfare Division, the role of the psychiatrist has remained somewhat vague. Psychiatry is a comparative newcomer to a field which has primarily been the domain of education and psychology. As yet the contributions actual and potential are yet to be clearly defined but whose presumed values have been subjected to the widest imaginable limits of both acceptance and rejection.

Dr B. Nurcombe, an Australian Child Psychiatrist, in a chapter from the book "Psychiatry and the Community" describes the interview with the disturbed institutional child as a procedure which is useless and in some cases harmful. He says how can advice be given without an intimate knowledge of the child's background and the capacities and limitations of the institution and its staff; "who reads the report anyhow and how does he interpret the cautiously worded document". He points to a dismal picture of the child psychiatrist visiting the institution and placed in a back room out of harms way "seeing" patients and writing the obvious and obscure on an official report. It is thus ensured that he will make as little impact as possible on staff and children alike. A situation fostered by the unconscious collusion between staff, higher administration and the psychiatrist. Although many psychiatrists would not agree with his pessimistic outlook his eventual conclusions bear some thought, i.e. "It is far better to plan from the outset a consultation service which will operate externally with allied institutions".

Caplan 1964 in his book "Preventive Psychiatry" points out the necessity for adequate exploration of the needs of external agencies before commitment. He states where a number of agencies compete for services it is probably best to begin in a concentrated fashion where the interest is high. Taking up Caplan's points and the lessons learnt from Community psychiatry it would seem that it is often better to work through the pre-existing community networks rather than set up another facility.

As there are a number of models and styles for consultation in child psychiatry the first point to be set is whether the consultation should be external to the institution from a traditional clinic or setting, or internal to the institution in the form of psychiatric staff visiting.

Dr Berg 1973 in his article "A Psychiatrist in a Child Care Home" states that although psychiatrists are well accustomed to dealing with problems such as severe personality disturbance involving withdrawn, aggressive or destructive behaviour, soiling and wetting, marked educational backwardness and conduct disorders such as lying, stealing and running away, the problem usually presents many more difficulties for therapy as with children in the homes parents are either inadequate or absent. He comes to the conclusion that "when possible it would seem highly desirable for the child psychiatrist to treat disturbed youngsters within the context of their life in a children's home".

In various state and government agencies there has been considerable disagreement about whether children's mental health, social welfare and mental retardation should be handled together. There are also residual prejudicial feelings from adult psychiatrists who have not worked in the social welfare settings, so that many psychiatrists have been warned off from clinic work in the area of social welfare with the false view that they are not wanted and not useful. Although the child psychiatry subsection of the Australian College of Psychiatrists would not subscribe to these views some of the members of the adult section of the College do not foster liaison with the social welfare department where no child psychiatrist is available. It should also be noted that in the American journal of Psychiatry, which is the official journal of the American Psychiatric Association, an article appeared called "Psychiatry's Drift Away from Medicine" by R. Swartz 1974 who reprimanded psychiatrists for moving into the social field and stated psychiatrists should move back and adopt the medically-orientated physician-psychiatric image. Again this is an extreme view but up until recently the undergraduate training of medical students and the postgraduate training of psychiatrists in this country has ignored the social impact of psychological disorder and prevention and tended to concentrate on psychiatric disorder as a disease process.

In consideration of the possible practical aspects of internal consultation the pitfalls seem many. It has been said that each psychiatrist develops a distinctly different form of psychiatric consultation and service out of the interaction of his own personality and the unique character of the institution where he works. This may well be so but it

should be noted also that the potential consultees' enthusiasm is much more stable when based on appreciation of the consultants effectiveness rather than the immediate impact of his personality. The social workers and teachers may be unaware of the psychiatrist's role and what may be reasonably expected of him. Numerous misconceptions and illusions can occur in regard to the psychiatrist. Will he remove all responsibility from the workers' shoulders and magically right the difficulty or corollary to this and how gratifying it would be to see him flounder or fail (especially if the case worker has made a mess of things). Will he discover individual or communal weakness, faults, malpractices and open potential or actual rifts between staff factions. The psychiatrist may equally be unaware of the social structure and culture of the institution and the intricacies of managing and working within the child welfare framework. There are other traps to begin with, the psychiatrist will have to make it clear that he rejects the mantle of omnipotence the group will automatically extend to him. Therefore, there has to be a subtle avoidance of authoritarian direction and the psychiatrist has a job to contribute to this and this is not to control or infantilize his consultees. At the other extreme one must avoid the temptation to regress to being one of the boys so as to ingratiate himself and prove that psychiatrists are human after all. A number of unexpected consequences highlight the need for the psychiatrist to attend to the way their role in the welfare home becomes defined. A few visible associations in the beginning, e.g. a psychiatrist sees a boy or girl and that person is shortly afterwards sent to a psychiatric hospital - can give rise to unfortunate expectations.

Hirschowitz, a community psychiatrist at Harvard, outlined a paper at the 7th International Congress on Mental Health in 1968. He felt that frequently the consultant in these situations frequently displays "role clinging". He does this by an excessive preoccupation with the identification and treatment of disturbed children. Such diagnosis and treatment practices do not increase the "holding power" of the institutions nor do they strengthen the staffs management skill. Successful consultation should combat, not support, tendencies to respond to disturbing behaviour by prejudicial stereotyping, "self-fulfilling prophesies and needless extrusions". Social Welfare Officers who refer problem children for psychiatric assessment rarely require amplification of descriptive analytic dimensions of the problems. They often do need support or extension of their management approach. Unless the reports of the psychiatrist function as spring boards for helpful action, the welfare files are needlessly expanded by detailed descriptive reports. Sometimes, however, the psychiatrist may find himself reinforcing the observations

and judgements of the staff rather than providing new information or suggestions for specific follow-up ideas directed towards the staff who must carry on the management of the child.

Numerous theoretical options for consultation abound. Consultation may be to an individual or to a group; it may be "client centred", "consultee centred" or more diffusely organisation centred. Group consultations as Altrocchi has described combine features of group supervision, seminar teaching, sensitivity training to behaviour management and group therapy. Depending on the patient several different styles are needed on each problem. The psychiatrist who gives an opinion only and then departs while the remainder of the staff has to execute the advice, or continue to bear with the persisting problem is sure to be justly resented. Therefore, it should be noted that the patient doctor 1:1 model is seldom sufficient for the doctor to perform a useful service in a short term or long term home. The psychiatrist needs time to develop his role and his language, to be tuned in to the interdisciplinary mode around him, and to know the individuals and the style of his co-workers, as well as their special interests and skills. It seems possibly that it is in the early nurturing phase where a psychiatrist is either made or broken and it should not be assumed by the welfare staff that a psychiatrist is adequately trained in consultative techniques.

Bernstein, 1972, in a paper about psychiatric consultations in a school for the retarded summarises the basic working relationships of the psychiatrist as it could also apply to the social welfare institutions. He states, "the child psychiatrist who works in an institution needs to develop a background of relationships with other workers, and he needs to understand the cultural milieu of a school for the retarded in order to function. However, he can offer understanding of behaviour to the staff, suggestions about management, medication to modify behaviour problems, individual and group therapy either directly or indirectly and supervision or consultation with family members and other institutions. The institutional conflicts between educational, psychological and administrative approaches cannot be totally avoided. However, with practical experience rather than theoretical ideas the child psychiatrist can learn to function effectively in these situations. He has much to give professionally as he has to learn clinically".

When it comes to trying to evaluate the efficiency of the efforts we find psychiatrists have no real refined measurement to evaluate the outcome. Sometimes the ability of the psychiatrist to "provide help" refers to his ability to survive in the institutional context rather than his effectiveness. It is not possible to base efficiency or productivity on head counts, age

or readmission rates. Dr Stephenson, 1973, outlines the difficulties in a paper "Judging the effectiveness of a consultation programme to a Community Agency". Although she adopts a number of criteria she also points to pitfalls. For example, if the percentage of social welfare staff or the number of consultations are used as a criteria over a period of time this could indicate acceptance or popularity of the consultation. However, workers may have used the consultant for a variety of reasons:- to attempt to undercut their supervisors, to bring pressure to bear on administration, as a time saving helper when multiple disasters have befallen the rest of their large case load. It is generally hard to argue that the increased use of a psychiatrist by social workers necessarily reflects increased awareness of emotional problems among their clients. If another criteria is used such as referrals to an outside psychiatric resource, fall off after a consultant establishes himself in an institution, the fall off which could occur may indicate disenchantment about the ability of the traditional psychiatric clinics such as the Child Health Clinic or adult psychiatric hospital to treat this type of population, or it could mean that perhaps workers in the welfare institution feel more confident about handling disturbed youngsters knowing psychiatric back up was readily available.

Perhaps workers who have not had the experience of working in collaboration with psychologists or psychiatrists effectively might well feel why use psychiatrist in the welfare institutions. The extreme position could be stated that if only the institutional staff or social welfare social workers had a realistic work load they could do more for their clients and would not have to use psychologists or psychiatrists. Translated into clinical terms this could lead to a dangerous attitude that "anybody can do anything" which is nonsense. Even if enthusiasm for psychological testing has diminished a little in favour of social workers now spending a great deal of time doing psychotherapy and working with families, there remains a technology for each of the disciplines. The individual who has conscientiously and successfully negotiated several years of graduate training deceives himself if he denies so. The hazard of the "anybody can do anything" syndrome is double edged: on the one hand, it leads to the use of expensive specialist time that could well be performed by people with less training and on the other it leads to the assignment of people with limited training to procedures that are manifestly beyond their competence. Doctors, including psychiatrists, are no exception to this rule.

PART 1

B. BASIC CHILD AND ADOLESCENT PSYCHIATRIC FACILITIES AND THEIR RELATIONSHIP TO SOCIAL WELFARE

It is essential to understand the basic development and philosophy of child psychiatric services before planning psychiatric services for the Social Welfare Department. It is necessary to note that in many areas Hospital Boards do not understand the concepts of a child psychiatric service and, therefore, do not provide adequate child psychiatric facilities or else break away from standard concepts and re-duplicate existing facilities. Full psychiatric facilities exist at present only in Dunedin and Auckland. Other areas are developing plans for new facilities. No unified plan exists for the development at a National level as the child psychiatry clinics do not now come under Health Department control or policy since the clinics were transferred to Hospital Board control in 1973. The machinery varies for planning at the Hospital Board level but largely depends on the knowledge of members on what is called the Hospital Psychiatric Advisory Committee. However, in most Hospital Board areas the need for setting up a well thought out child psychiatric department is of low priority compared with the other medical and surgical problems Boards have to face. It may well be that with the projected re-organisation of the Health Services a more adequate delivery of service to disturbed children may result. If not, it may be that the decision not to incorporate child psychiatric facilities either into the Psychological Services of the Department of Education or into the Social Welfare Department, may have hindered the development of providing a service to disturbed children. It should be realised that unlike adult psychiatry, which has achieved adequate facilities in most areas, child psychiatry basically lacks adequate facilities in and suffers from a serious lack of trained people at the medical level. Problems in the past have been projected onto the lack of child psychiatrists to explain the deficiency of an adequate service, but this stereotyped excuse is only partly true. It must also be realised that a number of adult psychiatrists, paediatricians and general practitioners skilled in treating children can provide a reasonable "back up service" for agencies such as social welfare where child psychiatric facilities do not exist.

Two concepts are needed tobe understood in regard to the setting up of a psychiatric service for children. These concepts could equally be applied to the setting up of any other facility such as planning for new remand homes or other social welfare institutions. The concepts of "back-up services" and a

"progression of services" are important. Back up services are the alternatives that support a given setting for example, an in-patient unit would provide a back up service for a day hospital clinic which, in turn, would back up facilities for the out-patient clinic. These alternatives, provided they are not used as "dumping grounds" increase the range and flexibility of a service and prevents it being overburdened or immobilized by sheer numbers or by an attempt to provide services for which it was not well-suited.

The concept of a progression of services is useful because a significant number of children and families simply cannot have all their mental health needs met in one setting or in one discrete unit of time. The return or rehabilitation of a child or family to optimum functioning may require a sequence of interlocking services in different settings both inside and outside a department of child or family psychiatry, which progressively bring the child and his family into contact with elements of their optimum life functioning. The return of an acutely psychiatric youngster to family life and regular attendance at school through a sequence of full-time hospitalisation, partial hospitalisation, day patient care, out-patient treatment and graduated school arrangements is a classic example of a progression of services.

It should be noted that, in setting up the care facilities in child and family psychiatric services, the two principles of a "back-up service" and a "progression of services" need to be considered from a practical viewpoint. It would be impossible to set up an adequate day patient clinic without a strong out-patient clinic. It would also not be possible to set up an in-patient short-term unit for children without a viable out-patient and day clinic. Unless the various strengthening and retooling procedures are developed in the existing psychiatric services for children (for instance, the child health clinic as an out-patient clinic) then the whole venture will be a failure. Definite phases and goals for each basic care service need to be established. For instance, from 1-3 years may be needed to retool the child health clinic following the change-over to hospital control and for the setting up of a children's psychiatric day clinic. The lack of professional staff in all categories requires members to be trained in one area before they can be effectively used in another one. For example, the day hospital staff should be the "fore-runners" of the short-term in-patient unit staff. It may take up to four years for a small nucleus of staff to be trained to the level that they are capable of passing their knowledge on to new staff.

Dr W. Warren in Australian and New Zealand Journal of Psychiatry (193) 7, 303 October 1973 although he gives caution to applying different models to different countries discusses very adequately the specific needs and facilities for adolescents. He states "An in-patient unit for adolescents requires associated out-patient facilities; to sort out patients for admission, to follow them up after discharge, and to treat others outside hospital. Such a clinic for adolescents, as in the case of children, needs apart from the services of the psychiatrist adequate help from an experienced social worker and a psychologist; ideally it should be placed separately from clinics for adults and from those for younger children. Not all out-patient clinics for adolescents are associated with an in-patient unit and some novel community approaches to adolescents have been tried (Bevin and Holden, 1966), including "walk-in" clinics. It is debatable if these latter should be a medical responsibility, and if those who walk into them should be regarded as patients or as clients; probably the latter.

These in-patient and out-patient facilities together form the base for a hospital psychiatric service for adolescents. Its kind of practice has depended mainly on the interests and so the way of working of the psychiatrist in charge. Thus certain adolescent units have developed specialised therapeutic skills of a high order, but this has usually implied selection of patients suitable for the kind of regime and treatment offered there.

Psychiatric resources for adolescents, and above all manpower with practical experience of working with this age group, are everywhere limited. How should they best be deployed? To staff hospital adolescent units; to work with adolescents in the community outside, or both? While tribute can again be paid to the other kinds of service provided outside the hospital premises for disturbed teenagers by non-psychiatric persons, they are sometimes faced with most difficult and urgent mental health and social problems of management, care or treatment. Inevitably their concern then mounts, for who can be more disruptive in their acting-out behaviour than certain adolescents? Are these sorts of youngsters then best held and managed in the community? Should they be placed in a psychiatric hospital, or in some other kind of setting? There is sometimes confusion of thinking about these alternatives, and with accompanying frustration to all concerned. The hospital "adolescent unit" has not in fact provided the ready answer perhaps hoped for; that is to accommodate and to deal with all teenagers exhibiting these widely varied problems. What it has had to offer has

indeed proved invaluable but limited in scope. Thus the kinds of psychiatric service including residential care that are needed vary and are not confined only to the hospital setting. Adolescents cannot be fitted into one pigeon-hole; there has to be experiment with new kinds of psychiatric and social provisions for them.

What can be done from the psychiatric point of view? There have only been one or two small epidemiological studies of adolescents psychiatric ill-health in a community. Thus their mental health needs are not yet known, although it is suspected that as with other age groups when a psychiatric service has been set up the need for it locally will become only too apparent.

However, a number of problems in adolescents can be picked out for further consideration. The increasing number who have become dependent on soft or hard drugs calls for appropriate special measures, legal, medical and psychiatric in each country for their management and treatment. These youngsters should not be treated psychiatrically amongst other disturbed adolescents who have not been so caught up. Again those youngsters who attempt suicide, or who more often make such gestures, are a common problem admitted into a hospital medical ward for treatment. Then comes the question what psychiatric help is required for these patients? Perhaps short-term emergency psychiatric in-patient care but away from adult patients; a few beds in an annexe of the psychiatric unit for adults in a general hospital has been suggested for such teenagers. It would be important to maintain that these beds are in fact short-term and so to avoid their silting up. Disturbed adolescents are not as a rule so quickly sorted out, especially those who are deprived and without a home. Transfer to a longer-term adolescent unit can then be considered, if this would be a constructive solution to their problem. In contrast, there are a few adolescents who have chronic psychiatric ill-health resulting from psychosis, or some form of brain damage. A special long-term unit has been considered for them (R.M.P.A. 1960). Finally the special treatment and training needs of some sub-normal adolescents should not be forgotten. There has been more than one successful in-patient unit especially for them.

Some disturbed adolescents, perhaps without a settled home background and so the responsibility of the children's services, cause much concern to those responsible for them. This led, for example, to the London Borough Association (L.B.A. 1967) setting up a special Committee to consider their problems. The Report pointed out:- 'Children's Departments

are not equipped to deal with them. In the ordinary children's home they introduce a disruptive influence out of all proportion to their numbers; and they pose serious problems of placement". The Committee pressed for hospital accommodation for the psychiatric emergencies that they may present; and for a psychiatrist to be appointed to a borough with community responsibility for adolescents, but he also having charge of a few hospital beds for their emergency treatment. Again the real danger of the silting up of these beds was not considered. However, as far as is known the London Borough Association's hopes have not anywhere yet been fulfilled, but their ideas should be tested somewhere.

To turn to youngsters who offend against the law, and to the services associated with the Courts, including residential centres for their care and training, much needed psychiatric help for their assessment and treatment has grown up piece-meal over the years. It is still inadequate and could be much expanded. It is among these offending adolescents that are to be found those who present the toughest problems for psychiatric treatment because of an accompanying need for control; for a combination of psychiatric disturbance with a proclivity for acting-out and antisocial activity can be formidable. Antisocial behaviour, absconding, or both, may render untenable hospital treatment. Provision for some kind of security may then be essential if the adolescent is to be managed and so able to be treated; this is no punitive sense. Perhaps because of the ineffectiveness of a hospital to hold such an adolescent, certain 'Community Homes' have had to help themselves over these problems; a comfortable but secure suite of rooms has been built in certain of them;this in place of what was the so-called 'detention' room. In this suite an absconding youngster, for instance, and who may also be aggressive, prone to act out tensions or having been on drugs while on the run, can be cared for and psychiatrically treated - not punished - for a time under secure conditions to prevent further absconsion. Euphemistically called an "intensive care unit", there being a high staff ratio, its value has been proved, but it could unless care is taken be wrongly used in a punitive sense.

Lastly in England, the first so-called "Youth Treatment Centre" (H.M.S.O., 1971) has been established to "provide long-term care and treatment for a small minority of severely disturbed and antisocial adolescent boys and girls whose

specialised treatment needs cannot satisfactorily be met in any of the existing forms of residential provision; boys and girls whose problems are so complex and whose behaviour is so disruptive that neither children's homes, community homes, hospitals nor special schools have the facilities (including physical security) to provide them with the long-term care, control and treatment that their condition requires". The ages for admission are twelve to nineteen years and it is normally restricted to those who have been subject to a Court Order. There have been high hopes for the usefulness of this kind of provision, but it is too early to judge its efficacy."

Summary of Basic Child Psychiatry Facilities

In-patient Unit

- Emergency beds in adult psychiatric unit or paediatric beds (2-3 days).
- Short-term children's unit (up to 3 months) not in a psychiatric hospital setting.
- Medium to long-stay unit within a psychiatric hospital setting (up to 3-6 months).
- Admissions of children to adult facilities (children at risk to peer group or extremely disordered).

Out-patient Unit

- Basis for external consultation with Social Welfare Department, Education Department, Special Schools.
- Assessment, treatment and remedial unit.
- Basis for walk-in service pilot clinics.

Day Unit

- Treatment, assessment and remedial unit.

The organisation of these three units needs to consist of:

I Diagnostic unit

- Intake
- Evaluation
  - Regular
  - Emergency
  - Paediatric

II Direct out-patient unit

- Crisis-centred therapy
- Minimum visit supportive therapy
- Drug therapy
- Indirect treatment using parent as co-therapist.

III Intensive treatment service

- Selection and waiting list
  - Individual psychotherapy
  - Behaviour therapy
  - Therapeutic tutoring
  - Group psychotherapy
    - pre-school groups
    - activity groups
  - Casework with parents
  - Parent groups
  - Conjoint family therapy

IV External consultation

V Research

VI Education

Undergraduate medical and allied disciplines
Postgraduate medical and allied disciplines
External agencies and groups.

PART 2

ROLE OF THE PSYCHIATRIC HOSPITAL IN THE TREATMENT OF PSYCHIATRICALLY DISTURBED CHILDREN

A. ADMISSION PROCEDURES AND POLICY

The psychiatric hospitals have played a continuing role with the social welfare department over the years. Social Welfare children can be dealt with under the Mental Health Act, the Criminal Justice Amendment Act or as informal ordinary patients.

Under the Criminal Justice Amendment Act, collaboration is achieved between the Magistrate of a children's court, the Social Welfare social workers and the specialist team in the psychiatric hospital. A remand under the Criminal Justice Amendment Act for a set period of time is used when a child over 10 has committed a serious act that has criminal aspects and the child possibly appears to be suffering from serious psychiatric disability. This particular act is mainly used when the young person has acted extremely dangerously to himself and others. As illustrated in Table 1 - In practice it has been found that hospitals very seldom recommend return of remand patients for treatment. It is felt by psychiatric staff that hospitals do not contain facilities for their treatment or the majority of the children suffer from sociopathic conditions that previously were certifiable, prior to the latest revision of the Mental Health Act. Therefore it can be seen the Criminal Justice Amendment Act as it applies to under 16 year olds does not assure that a child is subsequently returned to hospital for treatment as the chance of this happening is between 1:10 - 1:20. Therefore, the value lies only in the providing of a magistrate with a psychiatric report on the child. As the majority of reports are prepared by psychiatrists working with adults in hospital frequently no recommendations are made or those which are made cannot be implemented. Possibly in the future with the development of remand centres for the welfare this group will be more adequately dealt with.

Table 1 - Young persons under 16 admitted to psychiatric hospitals under the Criminal Justice Amendment Act and status if re-admitted to hospital after the remand period expires.

	1972 Subsequently admitted			1973 Subsequently admitted		
	Remand	Formal	Informal	Remand	Formal	Informal
Oakley & Carrington Hospital	6	0	0	11	0	0
Kingseat Hospital	3	0	0	1	0	1
Sunnyside Hospital	2	0	0	7	0	1
Cherry Farm Hospital	0	0	0	9	1(39G1)	2
Porirua Hospital	5	0	2	6	2(39G1)	3

	Remand	Formal	Informal	Remand	Formal	Informal
Tokanui Hospital	3	0	0	4	0	1
Levin Hospital	0	0	0	0	0	0
Ngawhatu Hospital	0	0	0	0	0	0
Seaview Hospital	0	0	0	0	0	0

With admissions for treatment under the Mental Health Act 1969 to psychiatric and psychopaedic hospitals it should be noted that the act laid down new definitions of a mentally disordered patient. By altering the criteria more towards the medical aspects of the problem, the socially disordered person was not able to be certified to a psychiatric hospital. As the Criminal Justice Amendment Act is universally unpopular when it applies to young people the net result of the 1969 revision was to increase the burden on the social welfare and to put pressure on the Justice Department. Many of the older medical superintendents, although relieved of the problems of the management of sociopathic dangerous delinquents viewed this move with some reservation as it was the firm view that these young people did improve with one to two years in a psychiatric setting. However, with the adult group of sociopaths most adult psychiatrists would agree that the Justice Department was a more appropriate place to treat this type of patient and in the case of the very dangerous ones the security unit at Lake Alice Hospital. Therefore, the 1969 revision of the Mental Health Act 1969 stated the following categories:

"Mentally disordered" in relation to any person, means suffering from a psychiatric or other disorder, whether continuous or episodic, that subsequently impairs mental health so that the person belongs to one or more of the following classes, namely:

(a) mentally ill - that is, requiring care and treatment for a mental illness:

(b) mentally infirm - that is requiring care and treatment by reason of mental infirmity arising from age or deterioration of or injury to the brain:

(c) mentally subnormal - that is, suffering from subnormality of intelligence as a result of arrested or incomplete development of mind.

In regard to children it should be noted that classes (a) and (c) only apply and that no child under the age of 10 years is legally able to be certified. However, one of the problems is that it is really difficult to apply a Mental Health Act which mainly applies to adults to children's psychiatric conditions. The problem is what is mental health in children and/or what is a mentally ill child. If viewed from adult psychopathology, a

narrow viewpoint is obtained or the opposite wider view point if from a child psychiatric viewpoint. Whatever the viewpoint the certification of children is a very serious matter and most general practitioners act in good faith in providing certificates for children whom they feel should be in hospital knowing full well that the certificates do not adequately cover childhood conditions. Therefore, it is usual practice to describe the child's behaviour in the belief that the child is mentally disordered in terms of the Mental Health Act and to only certify children who if refused admittance to hospital, would expose the child or some other person to hardship or danger. Apart from the general difficulty of admitting children as formal patients to psychiatric or psychopaedic hospitals individual hospitals vary on their insistance of admitting formal or informal patients. A number of hospitals insist on the admission of disturbed young people as formal admissions as the hospital then has authority to insist that the young person stays to finish whatever treatment has been offered. It should be noted that certification of a child as a mentally subnormal person under the age of 16 is a rare occurrence and applies to only one case at present in all the hospitals as at July 1974. Approximately 25% of the 10-16 year old are certified patients (see Table 2). 85% 0-16 year old psychiatrically disturbed children in psychiatric hospitals are from social welfare department and this group contains most of the formal admissions. (see Table 3).

The third category of admission to psychiatric and psychopaedic hospital are as ordinary patients, a procedure that can be used to admit children in much the same manner as admissions to a general hospital. There is, however, provision for the medical superintendent in this case to call for a reception order in a child of over 10 if the young person refuses to co-operate in treatment or else deteriorates psychologically. This step is seldom taken and usually the unco-operative child is discharged back to the referral source with a request to certify the child if admission is wanted again. This procedure accounts for a small number of social welfare children being sent out of hospital with nowhere to go except into the social welfare short term receiving home. Policies vary from hospital to hospital on the preference to admit under the formal or ordinary patient category. Table 2 outlines this in detail.

Table 2

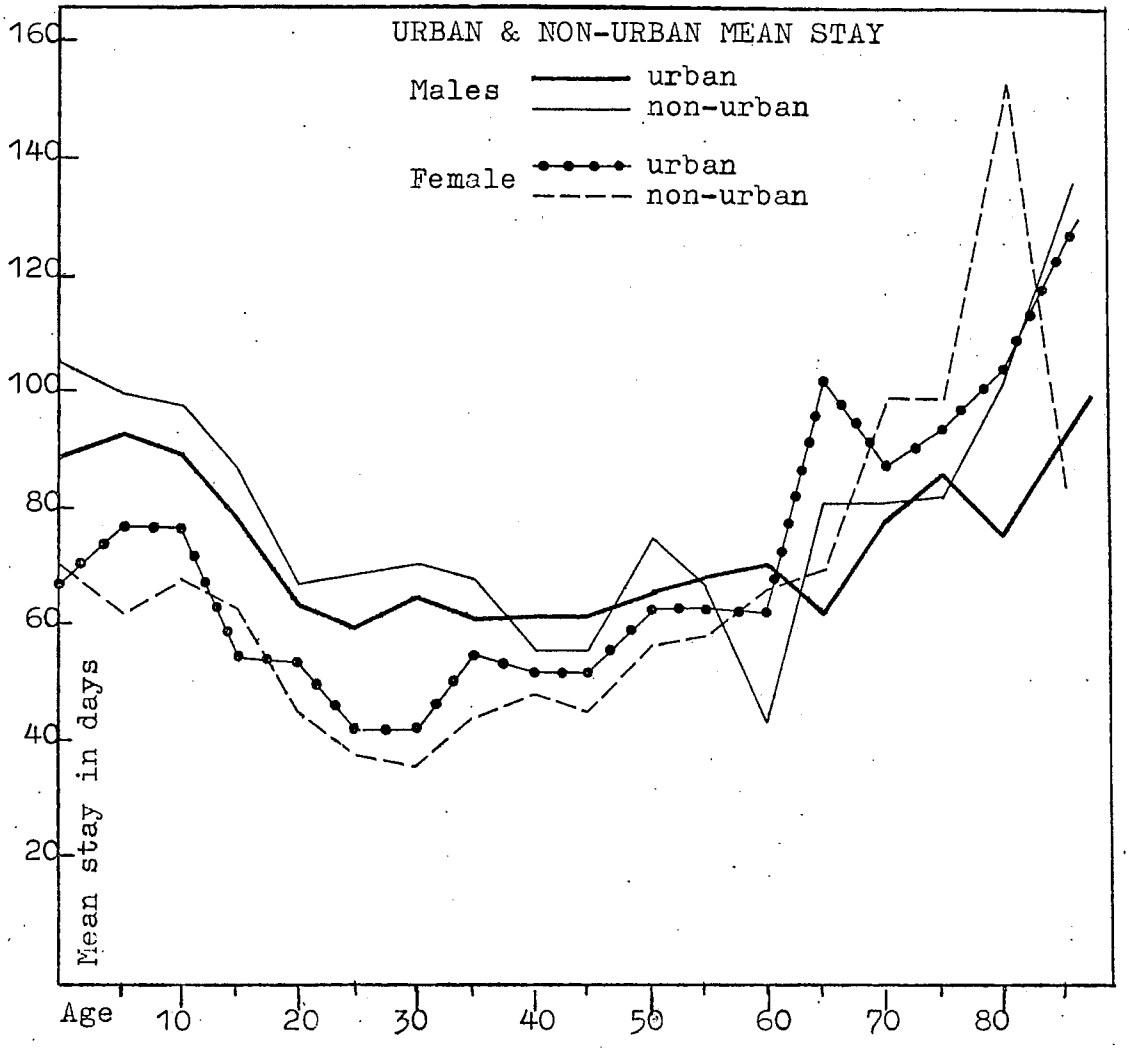
Children Admitted to a Psychiatric Hospital

(July 1974 From Survey of Patients in Psychiatric Hospitals Department of Health)

Hospital	Age Range	Informal		Formal		Special		Totals
		M	F	M	F	M	F	
Carrington	0 - 9	0	0	0	0	0	0	0
	10 - 16	2	2	0	3	0	0	7
Oakley	0 - 9	0	0	0	0	0	0	0
	10 - 16	0	0	4	3	1	0	8
Kingseat	0 - 9	0	0	0	0	0	0	0
	10 - 16	3	0	0	1	0	1	5
Tokanui	0 - 9	0	0	0	0	0	0	0
	10 - 16	4	2	2	1	1	0	10
Lake Alice	0 - 9	1	1	0	0	0	0	2
	10 - 16	21	1	0	0	0	0	22
Porirua	0 - 9	0	0	0	0	0	0	0
	10 - 16	16	4	6	1	2	0	29
Sunnyside	0 - 9	0	1	0	0	0	0	1
	10 - 16	3	7	3	0	0	0	13
Cherry Farm	0 - 9	0	0	0	0	0	0	0
	10 - 16	3	0	2	2	0	0	7
Seaview	0 - 9	0	0	0	0	0	0	0
	10 - 16	0	0	0	0	0	0	0
Grand Totals	0 - 9	1	2	0	0	0	0	3
	10 - 16	52	16	17	11	4	1	101

It can be seen from Table 2 that 104 children under the age of 16 were in psychiatric hospitals in July 1974. The subnormal children in these hospitals have not been included in these numbers. Nearly 70% of the children are admitted informally and the remainder are admitted as special patients or under certification. The mean stay for these children is of 90 days for 0 - 10 years of age and 70 days for the 10-16 year age group. See Graph 1.

Graph 1: 1971 N.H.S.C. Census on Psychiatric Patients.



B. PSYCHIATRIC FACILITIES FOR CHILDREN IN HOSPITALS

It should be realised however in Nelson, Dunedin and in Auckland, disturbed children are treated in short term units not attached to a psychiatric hospital. The Dunedin psychological department have, since 1968, been admitting on an average 60 to 70 children to its unit for short stay treatment. In Nelson a community child psychiatric service is operating which has the backup of hospital and hostel accommodation of about 10 - 12 beds. Auckland Hospital's Ward 12 Unit provides admission annually of 80 children under 16 to its unit and 30 older adolescents to the adult Ward 10 unit.

In addition a number of disturbed children are admitted to medical wards in a general hospital.

Although it is generally agreed that children admitted to a psychiatric hospital should be fairly severely disturbed this is by no means the case. As there is no formal screening of children by child psychiatrists in many areas, and as there is no significant formal screening at the Child Health Clinic level many children are unappropriately placed in hospital. Child Health Clinics only refer about six children to psychiatric hospitals per year, and of a total number of 104 children that are currently in hospital (Oct 74 DSW). However, on the other hand many children are not admitted to hospitals due to lack of specialised facilities for the children.

Table 3

Facilities for Children in Psychiatric Hospitals

Hospital	Special Ward Facilities for Children	Comments
Oakley	No	Children no longer admitted.
Carrington	No	Children admitted to adult wards. Plans are being made to start a Children's Unit in the near future.
Kingseat	No	No specific child psychiatric program. Very few children now under 16 are admitted to this hospital.
Tokanui	No	Shared facilities with the handicapped children.
Lake Alice	Yes	24 bed unit for boys in the 8 - 14 year age group. 2 teacher school. Girls admitted to female wards but join in the adolescent programme. Admits children from other areas.
Porirua	No	Children are admitted with disturbed adults; however an attempt has recently been made to form a children's unit. Children, where possible, attend the hospital school.
Sunnyside	Yes	16 bed mixed ward with teaching facilities. Does not generally admit children from other areas.
Cherry Farm	No	In 1969 this hospital had a 16 bed adolescent unit and 2 teacher school - but the unit is not at present in operation. Children admitted to adult section and admissions have dropped because of lack of children's unit.
Seaview	No	Children generally not admitted.

It can thus be seen that the psychiatric hospitals are to some extent underutilized when it comes to treating the under 16 year old group except where specialized facilities exist. This state of affairs is probably desirable provided the hospital do contain treatment programmes rather than just provide custodial treatment.

2. C. CRITERIA FOR PSYCHIATRIC HOSPITALIZATION OF CHILDREN

There is an enormous gap between those children who would benefit from in-patient psychiatric treatment and those who are in need of them and those who seek and obtain them. While this is so it can be seen that only two of the psychiatric hospitals do have specific facilities for the younger age group. Although adult facilities in hospital have improved vastly over the last 10 - 15 years nevertheless some of the effects of the hospital need to be considered particularly where children have to be admitted in with adults. It is usually found that a fantastically small amount of daily co tact is spent with the child and individual staff members in particular the doctors. Many effects of the depersonalization, segregation, incorrect labelling have an effect on subsequent personal and social development. However, in hospital with children and adolescent units patient care is usually re-organised so as to encourage the development of supportive relationships between the children and the adult staff. Even in these units it should be realised that professional training in the management of the disturbed child or experience in residential care by the nursing staff is not part of the training of the nursing staff at a graduate or post-graduate level. Frequently personal maturity and a strong desire to work with children outweighs lack of professional training or direct relevant experience.

While leaders of psychiatric opinion indicate that additional residential treatment facilities for disturbed adolescents are required they do not mention specific criteria for hospitalization. One author mentions (Beckett) that adolescents are usually referred for in-patient treatment because they show behaviour that "adult society considers boisterous, aggressive or violent". Under these criteria alone, most teenagers at sometime during their emotional growth would qualify for residential treatment.

In-patient treatment is sometimes recommended as a necessary measure to separate the emotionally ill adolescent from a disturbed family environment. If the disturbed adolescent does have the ability, even partially to control and to channel his impulses, or if he is capable of using meaningful relationship to provide him with emotional support, his separation from a disruptive family environment will lead to greater emotional growth if he is placed in a boarding

school, a foster home, hostel or with friends or relatives. In these more normal social settings the environmental expectations for continued adolescent maturation would be maintained. The moderately competent adolescent is generally able to cope with the separation experience and can muster his personal and emotional capacities to struggle and further grow. The admission of this type of adolescent to an in-patient unit is wrong as the unit provides too much support and removes the necessary growth impetus of separation.

In-patient residential psychiatric placement has been suggested for its "punishment" effect. Punishment and residential treatment are almost directly contradictory in treatment purpose. Meaningful punishment to be emotionally productive, must cause personal anxiety which leads to emotional change and personality growth. If a disturbed adolescent is so lacking in individual personality strength that does in fact require residential treatment, by definition he also lacks personality capability to profit by a meaningful punishment experience. If he is so deficient in personal strength and in relationship capabilities that he requires in-patient treatment, the emotional pain and the anxiety caused by punishment will further overwhelm his minimal emotional resources. If the disturbed adolescent has sufficient personality strength and relationship capabilities so that punishment can be used as a meaningful growth experience, a residential placement would be a stunting treatment approach for a teenager. For the more competent young man or young woman there are social and legal agencies available offering "punishment" at all levels of sophistication all planned to arouse enough personal anxiety in the adolescent that he may change and grow.

Too frequently, however, adolescents are still placed in residential psychiatric settings "to bring them to their senses". Too often well intentioned parents prefer to place the anti-social adolescent in their family in a residential treatment unit rather than help him to face the consequences and the responsibilities of his socially unproductive behaviour. Though such placement may temporarily remove the threat of social disgrace or of severe legal retribution, the placement of an otherwise emotionally competent adolescent in a treatment institution for purposes of punishment under guise of treatment may produce profound permanent emotional crippling. The psychiatrist may collude with this situation and therefore misuse psychiatry.

If an adolescent is placed in a residential psychiatric treatment unit largely because his ideas and his opinions are counter to those of his family or his society, this residential

treatment programmeis being used to crush individuality and to counteract independence against the natural growth process. If residential psychiatric placement is used to force the teenager back into a parental pattern the treatment facility is working contrary to the natural adolescent emancipation. If the teenager has sufficient personality strength to handle inner anxieties and to use his drives towards emancipation, he has the personal capability to use the training and control provided by normally available social agencies such as schools, churches, adolescent peer organisations and legal agencies. It is not the therapeutic function of a residential psychiatric treatment programme to force the ideas of parents and of the society on the emancipating adolescent. Residential psychiatric treatment units should not accept adolescent patients for "treatment" merely because the adolescent boy or girl has decided to marry, to leave school or to move away from home against the parental wishes. Only where such behaviour is part of a pattern of disorganisation disrupture, or infantile reactions by an adolescent who cannot handle his tension and who cannot face the reasonable expectations of society, only then should residential treatment be considered as one possible means of providing external strength and direction which may be required for the teenager at that time.

Therefore in-patient treatment is one of the most powerful tools in the psychiatric arnamentarium. Since hospital treatment provides the maximum external support and direction with the minimum necessary patient co-operation, this treatment must be directed specifically towards those adolescents who lack both personality strength to control their own tensions and relationship capability to compensate for their weaknesses. Where a disturbed adolescent meets these two basic criteria, in-patient treatment may be a therapeutic procedure of choice and may be necessary for his continued growth. It must be realised that this discussion is on the correct theoretical position to take on the criteria for admission in reasonably favourable circumstances. However, the decisions to admit/an emotionally disturbed adolescent who does not consider that he is mentally sick to a psychiatric hospital without facilities is extremely difficult to make. Very often when the child needs special psychiatric skills they cannot be given.

D. THE PROBLEM OF LABELLING AND MISDIAGNOSIS:

It should also be noted that there is an increasing tendency to label all delinquent youngsters as "emotionally disturbed" and/or "brain damaged". In this respect some hospitals and doctors misinterpret abnormal EEG reading minimal brain damage when in fact there is no equivocal sign of minimal brain damage. Some 60% of disturbed children show an "abnormal" E.E.G. This tendency of labelling tends to dump all delinquent behaviour into "psychiatric disease". In a subtle way, this implies sickness, helplessness, something impersonal over which the person has no control. In effect this position makes the youngster and his parents or Welfare Social Worker respond as if the process were, in fact, hopeless and irreversible. The concept of illness may, therefore, be a ready rationalisation for delinquent behaviour. Psychiatrists cannot be expected to resolve all acting out behaviour. The effect of labelling children as psychiatric patients is seen more so when a child enters a psychiatric hospital or a formal psychiatric out-patient clinic. Unselected referrals to psychiatric hospitals give rise to a phenomenon which is repeatedly seen in each welfare area of having children return to welfare care from the psychiatric hospital with unresolved aggressive behaviour patterns and anger at being labelled sick and helpless. The parents of these children and welfare social workers also tend to respond with disappointment and anger over the absence of beneficial results. Some hospitals such as the Adolescent Unit at Sunnyside hospital make an attempt to treat children who are emotionally sick, drawing a line at not taking in delinquent children. To some extent this causes problems also as the delinquent should not be viewed as if delinquency was a unitary phenomenon. Juvenile delinquents are no more the same than are "coronary or tuberculosis patients". There may be single factors versus an interlocking maze of aetiological factors. As shown all the Child Health Clinics only act as a screening clinic for about 6 - 7 children admitted to hospital per year and the rest of the children are admitted from a variety of sources it can be said that there is no real formal screening of welfare children to hospital and, therefore, at times cases do not get to hospital that should or cases get admitted that should not. This situation may well improve when assessment centres for welfare children develop. It also could be debatable that disturbed welfare children should not be treated in psychiatric hospitals except in exceptional circumstances.

E. SOCIAL WELFARE CHILDREN IN PSYCHIATRIC HOSPITALS

Table 4 outlines the social welfare districts and social welfare institutions who have admitted disturbed children to psychiatric hospitals.

Table 4

Social Welfare children 0 - 16 years currently resident (Oct 74 DSW) in psychiatric or psychopaedic hospitals.

District admitted from	State Wards	Non-State Wards
Auckland	5	4
Blenheim	0	0
Christchurch (including Kingslea)	12	3
Dunedin	4	2
Gisborne	1	0
Greymouth	0	0
Hamilton	6	-
Hastings	1	3
Invercargill	1	1
Kaitaia	0	0
Lower Hutt	5	6
Masterton	1	1
Napier	1	1
Nelson	2	0
New Plymouth	0	0
Otahuhu	8	0
Paeroa	0	0
Palmerston North	13	8
Pukekohe	3	2
Rotorua	0	3
Takapuna	0	1
Taumaruni	0	1
Tauranga	0	2
Timaru	0	2
Wairoa	0	0
Wanganui	7	6
Wellington	13	0
Whakatane	0	0
Whangarei	0	0
Total	83	46

Grand Total = 129

Out of this grand total 44 children were admitted to a subnormal hospital (psychopaedic) and 85 were admitted to psychiatric hospitals. Not included in these figures, so that table 2 and table 4 could be compared, were 16 children over the age of 16 years. Therefore, when table 2 and 4 are compared bearing in mind one survey was done in July 1974 and the other in October 1974 it can be seen that something in the vicinity of 80-85% of children 0 - 16 in psychiatric hospitals are social welfare children.

Table 5 also reinforces the fact that there is a considerable turnover of social welfare children in psychiatric and psychopaedic hospitals.

Table 5

State Wards 0 - 16 who have been resident in psychiatric or psychopaedic hospitals over the last two years but are not currently resident (Oct 74 DSW).

District or Institution admitted from	Number of children
Auckland	8
Blenheim	0
Christchurch	10
Dunedin	47
Gisborne	3
Greymouth	1
Hamilton	0
Hastings	1
Invercargill	7
Kaitaia	0
Lower Hutt	5
Masterton	4
Napier	1
Nelson	4
New Plymouth	5
Otahuhu	3
Paeroa	3
Palmerston North	16
Pukekohe	5
Rotorua	7
Takapuna	3
Taumarunui	1
Tauranga	0
Timaru	3
Wairoa	5
Wanganui	52
Wellington	1
Whakatane	1
Whangarei	2

(Table 5 - continued)

Hokio Boys School	2
Holdsworth School	1
Kingslea Training Centre	16
Kohitere Training Centre	9
Weymouth Training Centre	0
Fareham House School	0
Total	214

The average length of stay of these children in the 10 - 16 year old age range was consistent with the national average of 70 days (see graph 1). However, it also appears that in the over 16 year old group and if the patient is a certified state ward a stay of up to one year or more is usual in some psychiatric hospitals.

A number of welfare children are on waiting lists for more appropriate placement in psychopaedic hospitals. Out of 35 patients some 7 cases (Oct 74 DSW) are sufficiently urgent that if placement is not forthcoming it is considered that the child is at risk, that there is some potential danger to the child or else the child is of danger to some other person in the living situation. Although this group may seem small a significant number of children over the last three years have been tragically killed by a parent or parent substitute.

It also appears from the returns from the Oct 74 survey for this report and impressions of the author that most districts feel psychiatric treatment facilities remain limited, insufficient and often ineffective. Even in areas where specific child psychiatric units exist admission policies eventually evolve which exclude social welfare children. It is ironical that this does happen as most child psychiatric units in a hospital eventually start with social welfare children and if it was not for these children the units would never have got off the ground. As the unit becomes known it attracts more children and it seems somehow the social welfare child is less attractive to admit or treat. It should also be noted that in spite of the lack of psychiatric treatment methods frequently the social welfare institutions are asked to take the psychiatric treatment failures from the psychiatric hospitals. Many of these children react badly to the structured welfare institution and often request transfer back to hospital. Some children fear readmission back to psychiatric hospital because of past treatment methods with injections and physical methods of treatment and punishment. In a number of situations encountered by the author children who run away from the psychiatric hospital have been refused readmission by the hospital

inspite of the fact that treatment is still indicated. In these cases often the short term home is frequently asked to cope with very difficult situations. Many children are discharged from hospital without a liaison with the social welfare workers. Frequently these children cause specific difficulties in rehabilitation. Miss P.A. Baines, Housemistress, at Kingslea Training Centre summarizes her view on the psychiatric disturbed child in the institution.

"The placement of young adolescents in psychiatric clinics prior to admission to training centres appears to make their rehabilitation more difficult. Particularly the younger teenagers (13 - 15 years) report being distressed by what they have seen and experienced and show a tendency to act out the bizarre and abnormal behavioural patterns they have witnessed. In view of this, we would feel in principle that the psychiatric clinics on the whole do not offer these young people a realistic, therapeutic experience.

Nevertheless there is always a small group of girls within the institution (6 - 10 girls at any one time) who do not gain maximum benefit from the present institutions structure. These girls are usually emotionally disturbed (but not psychotic, some may be pre-psychotic) rather than delinquent, with self-destructive modes of attempting to cope. They find large institutions stressful and usually have a low rank in the peer hierarchy. There appear to be no therapeutic facilities at present available in New Zealand for these children.

We feel that if such facilities were made available the unit should definitely be separate from the mental hospital - i.e. not in the same grounds".

2. F. THE LACK OF INTEREST OF PSYCHIATRISTS IN THE TREATMENT OF DISTURBED WELFARE CHILDREN

In 1972, a questionnaire was sent to 150 college members of the Australian and New Zealand College of Psychiatry. The representative sample of college opinion was reported by Hook, ANZ Journal of Psychiatry, Vol.7, No.2, 1973. (See Figure I). "The Australasian psychiatrist clearly sees himself as interested predominantly in the treatment of neurosis and psychosis. Does this interest correspond to the needs and expectations of the community? Is it a real problem that there is a relative lack of interest in certain areas such as delinquency, forensic psychiatry, alcoholism, and geriatric psychiatry? Is aversion to treating mental retardation a reflection of inadequate training in this area or pessimism about what can be achieved? Is it good enough that only about 25% of psychiatrists give work with children at least a third preference and nearly as many again prefer not to work with children at all?"

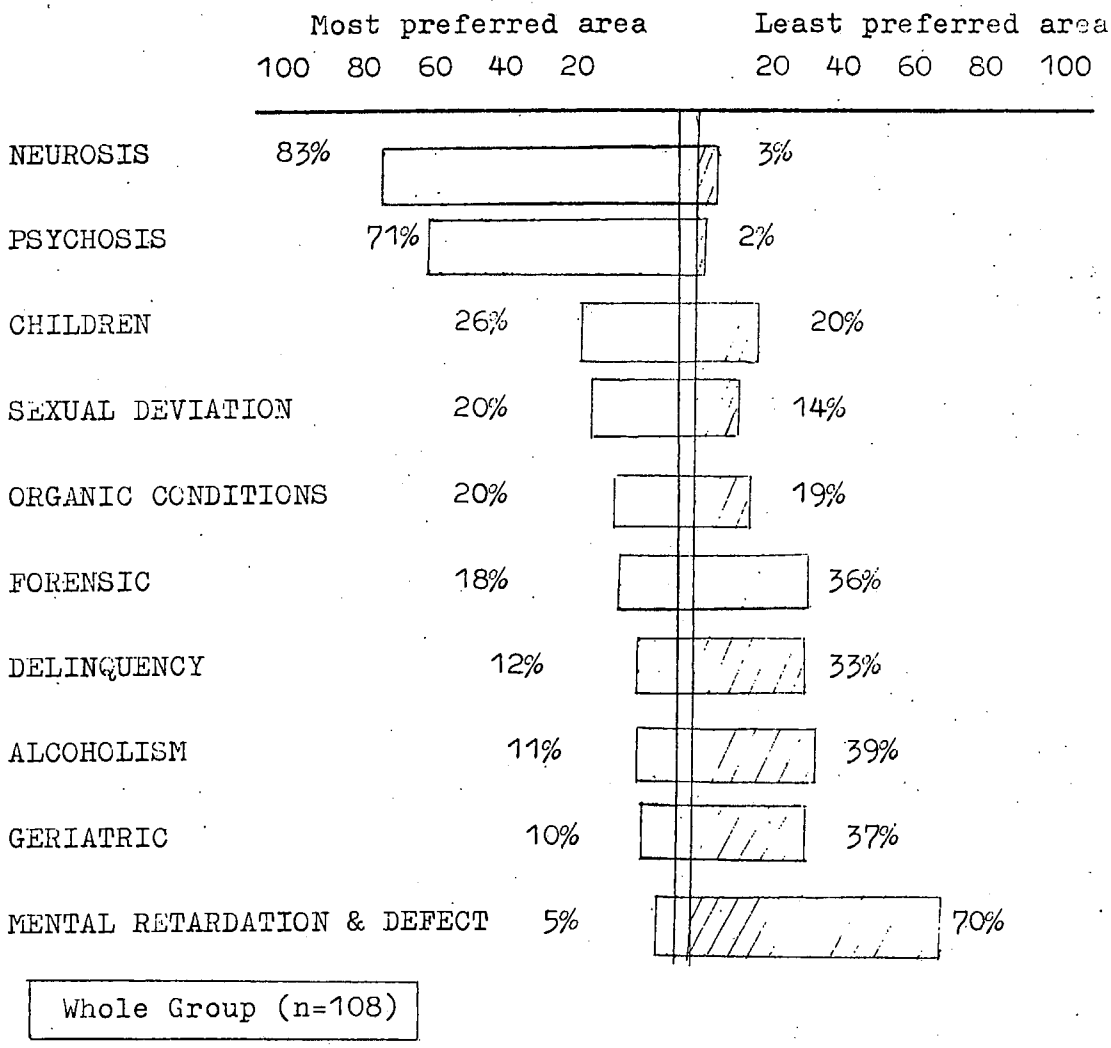
Therefore, it seems only a small number of psychiatrists available in New Zealand are able to or wish to work with children or delinquents. It may well be that a situation could arise whereby an area is fully staffed with psychiatric staff but are not able to supply the needs of children who are psychiatrically disturbed. Basically this situation should not arise if the hospital insist that 1 in 3 of their recruited psychiatrists have experience in dealing with children and adolescents or are child psychiatrists. However, at present it seems that hospitals do not balance the staff interests and expertise and virtually take any psychiatrist they can get.

A very potent incentive for recruitment of child psychiatrists would be a well designed and suitable in-patient unit. It is the author's opinion that unless a child psychiatric unit is functioning, child psychiatrists at the senior registrar level or at junior consultant level will not be prepared to gamble their prospects in the U.K. for a less developed unit in New Zealand. Therefore, the only interest from overseas child psychiatrists is at the semi-retired age group or from a chance association whereby the spouse of a child psychiatrist decides to come to New Zealand. It seems that more effective pressure could be brought on the New Zealand doctor graduate with provision of training bursaries in child psychiatry. Also possibly relevant to the New Zealand situation is the U.K. training scheme for child psychiatrists whereby married women doctors are re-trained as child psychiatrists.

There is no easy answer to the shortage of trained people at all levels. Although the situation will improve in regard to numbers of child psychiatrists, basic problems might exist

if areas of responsibilities are not worked out between formal child psychiatric clinics and welfare institutions.

FIG. 1: PSYCHIATRISTS' PREFERENCES FOR VARIOUS AREAS OR WORK



2. G. SUMMARY OF THE ROLE OF THE PSYCHIATRIC HOSPITAL AND THE DISTURBED 0 - 16 YEAR OLD

Patients of this age group have been referred over the years rather haphazardly to psychiatric hospitals. They have largely been left out of account as an age group when psychiatric facilities have been planned and have tended to be admitted to psychiatric wards for adults. Apart from some adolescents with overt psychiatric illnesses, admission to a psychiatric ward among adults, on the whole, is now considered unsuitable and so if possible avoided.

Although the 104 children in residence in Oct 74 is small it seems that disproportionately represented amongst this group is the welfare children that form 85% of the population. Most of these welfare children are in hospitals that do not contain specific treatment programmes so that treatment is largely custodial. Where a hospital does provide facilities a need soon arises and becomes so great that social welfare cases generally get excluded. The development of more psychiatric units for children while desirable will, therefore, probably not cope better for the welfare children than at present. It appears while psychiatrists do display a lack of interest in the child psychiatry field many of the psychiatrists would be capable of supervising an in-patient unit. However, the deficient areas for the psychiatrists with welfare patients seems to be in consultative techniques and therapeutic utlization of juvenile court and social welfare placement of children. It therefore may well be with a joint effort of responsibility between hospitals and welfare satisfactory adolescent in-patient units could be in operation in a short period of time. These units would then be able to provide a back up facility for the children and families that cannot have all their mental health needs met under the Social Welfare Department. It is the lack of back up either at a child psychiatric clinic or at the in-patient unit level that is seriously lacking to the social welfare worker. So far there is no basic acceptance of the fact that hospital psychiatrists donate some time and effort into evolving patterns of liaison and consultation with the social welfare departments.

It seems to the author that suitable psychiatric services for youth have to be thought out anew. At this point in time plans for psychiatric care for adolescent patients are by no means so far advanced. Particularly with this age group the mental health service for youth cannot be considered in isolation like it is today. It is bound up with the other

kind of service provided for their benefit whether for instance social, educational or judical. The basic mental health services are fully developed in (part 1) a previous paper. A better organised and more comprehensive service for adolescents is required.

PART 3

THE SUBNORMAL (PSYCHOPAEDIC) HOSPITAL AND THE WELFARE CHILD

Considerable discussion over the last two years has been devoted to the services for the mentally handicapped. With the Royal Commission of Inquiry finding 1973 and with the Health Department Accommodation study on patients in psychiatric (and subnormal) Hospitals and with various other reports, the area of subnormal care is under review.

In July 1974, there were 4,312 patients with the diagnosis of mental subnormality in the psychiatric hospital. Some 897 of these were in the 0 - 14 year old range (20.8%). The number of subnormal state wards in these hospitals are small (5%) and there are probably as many subnormal state wards outside the hospital as in them. Admission policies for each hospital vary but there is a general reluctance with each hospital to admit state ward children who are frequently long-term problems. Parents of subnormal children also find the same problems as the Welfare Social Workers do in regard to state wards and this has led a very small number of parents to abandon their child in hospital and refuse to take the child home. In this type of case, the hospital involves the Social Welfare Department who takes over guardianship. Some eight subnormal children on the waiting list for subnormal hospitals, have been killed by one or other parent over the last three years.

PART 4

THE ROLE OF THE CHILD HEALTH CLINICS IN REGARD TO CONSULTATIVE PRACTICES WITH SOCIAL WELFARE WORKERS AND CLIENTS

Child psychiatric services of varying levels of sophistications are at present provided by Child Health Clinics at Whangarei, Auckland, Hamilton, Palmerston North, Wellington and Christchurch. Towards the late 1950's and early 1960's the Child Health Clinics began as a means of assisting with problems of physical health, but they have all found that the bulk of their work has been in child and family guidance. Originally the Child Health Clinics were administered by the Health Department, however, they were passed to hospital board control in 1973 in line with the general concept of unified control for all treatment services. All the six Child Health Clinics offer an out-patient psychiatric service only on an 8am to 5pm basis five day week. Each clinic operates with a multi-discipline staff with a Director who is usually a child psychiatrist or a paediatrician. The Clinics provide a diagnostic and therapeutic service for school-aged children and their families. After initial assessment and appropriate investigation a programme of therapy for the child and family is carried out. Most clinics hold a weekly or fortnightly case conference where cases are discussed or it is used to meet and discuss cases with other outside professional workers who may be involved with the child or family. For many years the Child Health Clinics have formed the basis for child psychiatric services and have provided an extremely useful and at one time a unique service. However it should be realised that in its present form the Child Health Clinic only forms part of a comprehensive child psychiatric service which should also include wider varieties of services in the clinic and in facilities such as the use of day-patient units and in-patient treatment units. Because of the increasing sophistication of Social Welfare Social Workers and as they have the same basic training as the Social Workers in the Child Health Clinic and as there has been no dramatic change in Child Health Clinics functioning in most areas it is felt by many Social Welfare Social Workers that little value could be obtained by referring cases to the Child Health Clinic. In addition fairly valid criticism has been levelled at the Child Health Clinics in that they are poorly orientated in terms of identifying patients or providing a preventive service. It is generally felt that most clinics therefore do not make realistic recommendations for the Social Welfare Social Worker to execute the advice or bear with the problem and this situation

tends to build up antagonism. Many clinics have not established or have hindered the development of a working relationship with the social welfare social workers in working with their clients. Although the Child Health Clinics are basically very much better off for staffing and work loads when compared with Social Welfare case loads certain bottle-necks occur when it comes to the use of Child Health Clinic time by the Social Welfare Workers. Most clinics have waiting lists either in terms of numbers or in terms of an actual delay in seeing cases. In addition, within the clinics there is an actual delaying procedure due to a shortage of child psychiatric time. Therefore, except in emergencies Child Health Clinics do not take on cases till a child psychiatrist or a paediatrician can see the case soon after initial contact has been made by other Clinic Workers.

As referrals from the Social Welfare do arise irregularly, haphazardly and often as an emergency frequently information is not at hand or typed and, therefore, the more orderly general practitioner or psychological service referral is usually preferred. In fact over the years the clinics have retained the Medical orientation and general receive 80 - 90% of their referrals from general practitioners. In some clinics such as Wellington at one stage direct psychologists' referrals were not accepted. It should be noted also that the problem of non-medical referrals to a clinic is an unexplored problem in a hospital area and a number of psychiatric units such as Wellington's Unit will not accept direct welfare referrals. Many other administrative practices and rigidities occur and in the opinion of the Health Department Working Party on Child Health Clinics it was felt all clinics were under-utilized where it came to making use of the clinics for social welfare cases or for the basic ongoing training of Social Welfare Social Workers to increase their skills in management of child psychiatry problems. The under-utilization of the clinics is reflected in the sophisticated statistics the clinics collect. For instance, it can be seen from Table I that for all the Child Health Clinics they saw a total of 1419 new cases in the year ending 1972. Out of this number 195 children were referred by Social Welfare agencies. Also it should be noted in Table 2 that Child Health Clinics do not act as screening centres for children who are admitted to psychiatric or psychopaedic hospitals. In a recent survey of patients in psychiatric hospitals July 1974 Department of Health by Dr I.J. Jeffery and Mr J.M. Booth they state that just under 1,000 children between the age of 0 - 14 are in psychiatric and

psychopaedic hospitals. They also made relevant comment by the use of statistics on the percentage who should be in alternative forms of accommodation. A large number of Welfare children are amongst this group and the conclusion must be that the children are admitted to hospital in the majority of cases unassessed by the Child Health Clinic facilities.

In actual pratice the Child Health Clinics are bypassed or not consulted and in areas where the adult psychiatric departments are co-operative. Referrals to adult psychiatric clinics are seen for assessment and disposal only and in general only the occasional case is taken on for treatment.

Miss Avery Jack in Chapter 13 in "Issues in New Zealand Special Education" 1972 speaks from her experience where she feels Child Health Clinic diagnostic procedures should be more flexible. The child and his parents are too frequently put through a standard series of interviews, examinations and conferences where the type of treatment needed is fairly obvious without them. She also refers to the writing of Furman in the U.K. which applies also to Child Health Clinics - "Clinics have become too much concerned with psychopathology and psychotherapy and they should extend their concern to cover any sort of service which will restore equilibrium to this client and the family". This could mean looking beyond the clinic team or assisting some other agency such as the Social Welfare divisions to carry responsibility for the family. It could also mean the clinic taking a much greater part in the child's life than the customary one a week. The future of the Child Health Clinics is uncertain except that the die has been cast in the direction of the hospital boards and the likely re-development in the future of regional hospital authorities. Although, in theory, medical services are becoming more community orientated, it is unlikely that anyone sees a hospital as a place from which to seek help with social problems. Had the die been cast in the direction in the Social Welfare Department in that environment the Child Health Clinic would have been close to the community, not only receiving earlier referrals, but also fulfilling an educational role for workers in the Social Welfare Service.

TABLE 6

CHILD HEALTH CLINICS - CHILD WELFARE CASES 1968 - 1972

Year 1972

	Clinics*						Totals
	* 01	02	03	04	05	06	
State Ward	3	8	9	10	11	7	48
Supervision	1	9	5	23	15	26	79
Preventive supervision	4	5	12	10	10	5	46
Child boarded out	-	3	2	-	1	2	8
Court adjournment	-	2	2	-	-	5	9
Section 12 Child Welfare Act	-	-	-	1	2	2	5
Other	-	4	17	2	4	-	27
Not applicable	85	257	206	150	315	184	1197
Totals	93	288	253	196	358	231	1419
Blanks	4	23	12	2	1	1	43

Year 1971

	* 01	02	03	04	05	06	Totals
State Ward	-	2	9	6	9	9	35
Supervision	-	6	18	19	7	13	63
Preventive Supervision	1	7	9	20	19	4	60
Child boarded out	1	5	4	-	3	2	15
Court adjournment	1	4	3	-	2	2	12
Section 12 Child Welfare Act	-	-	-	2	1	-	3
Other	2	6	16	-	7	6	37
Not applicable	65	255	216	118	286	156	1096
Totals	70	285	275	165	334	192	1321
Blanks	1	2	35	2	7	2	49

Year 1970

	* 01	02	03	04	05	06	Totals
State Ward	-	-	13	4	4	16	37
Supervision	-	-	16	5	4	3	28
Prevention supervision	2	-	13	8	2	1	26
Child boarded out	2	-	2	-	2	1	7
Court adjournment	-	-	11	-	1	6	18
Section 12 Child Welfare Act	-	-	-	1	-	-	1
Other	-	-	4	-	-	30	34
Not applicable	58	-	216	91	198	170	733
Totals	62	-	275	109	211	227	884
Blanks	-	-	1	1	3	-	5

Year 1969

	* 01	02	03	04	05	06	Totals
State Ward	3	14	7	8	7	8	47
Supervision	2	3	6	6	4	7	28
Preventive Supervision	-	2	10	3	8	-	23
Child boarded out	-	3	4	1	2	1	11
Court Adjournment	1	4	4	1	-	6	16
Section 12 Child Welfare Act	-	-	1	1	-	1	3
Other	-	10	6	1	2	25	44
Not applicable	70	237	174	111	152	130	874
Totals	76	273	212	132	175	178	1046
Blanks							

Year 1968

	* 01	02	03	04	05	06	Totals
State Ward	3	15	-	10	7	12	47
Supervision	8	4	2	14	10	4	42
Preventive supervision	-	3	6	4	7	3	23
Child boarded out	1	1	1	2	1	1	7
Court adjournment	-	5	-	1	6	10	22
Section 12 Child Welfare Act	-	-	-	-	2	1	3
Other	6	6	-	1	2	10	25
Not applicable	66	268	99	127	175	121	856
Totals	84	302	108	159	210	162	1025
Blanks	-	-	1	-	4	-	5

*Code

01 Whangarei
02 Auckland
03 Palmerston North
04 Wellington

TABLE 7

FROM ALL REFERRALS TO ALL CHILD HEALTH CLINICS

State at Closing referred to

	Psychiatric Hospital	Psychopaedic Hospital
1968	5	6
1969	8	4
1970	-	-
1971	2	-
1972	6	4
	21	14

PART 5

RESIDENTIAL HOMES AND DISTURBED ADOLESCENT

INTRODUCTION

Girls homes in Auckland, Hamilton, Palmerston North, Wellington, Christchurch and Dunedin provide for girls between 13 - 17 years of age group who are difficult, disturbed, delinquent, and for the care of young children in times of an emergency. They also serve as a classification and remand facility. Boys Homes in Auckland, Hamilton, Lower Hutt, Christchurch and Dunedin provide for boys aged 8 to 18 years. Boys are admitted on remand from courts, for observation and assessment, in times of emergency and for short term training. If the reception centres and the hostels are included, there are a total of 16 short term institutions at present containing just over 400 beds. The turnover of children per year varies but is immense, in one area in excess of 900 children, whereas a similar institution in another area turns over 250 to 300 children. By definition the population defined by the short term homes would be expected to contain in excess of the general population norm of children under 16 showing 7-12% emotional disturbance. It is the opinion of many of the workers in the short term home that a figure of 20-25% of moderate to serious psychiatric disturbance is present in the children in the short term homes. It should be noted that although delinquency is not equated with psychiatric disturbance, a small percentage of delinquents show psychiatric disturbance.

The role of the short term home has yet to be defined adequately but the emphasis is on providing if possible short term training. From a child psychiatry point of view it could be said that what in fact the short term homes provide is an emergency or a crisis service. However, the problem is how does one recognise a psychiatric emergency or crisis, and what is the point where "normal" problems of growth escalate into a serious family crisis. Apart from admitting the obvious psychiatric problems of children to hospital for example, attempts at suicide, obvious psychotic behaviour, none of the child health clinics or child psychiatric units are able to cope with crisis orientated problems. In fact it would be most inappropriate for a hospital orientated unit to attempt to deal with the present population in the short term home, as in this area, because of the complexity of the social aspects, a hospital team usually shows little motivation beyond the desire for a quick solution. It must also be realised that most of the traditional child health clinics in this country provide

basically long term intensive casework or therapy and have not attempted to enter the area of short term therapy. This technique is used overseas; however, there has been a healthy awakening of interest in the crisis intervention area by social workers in all areas. This short term therapy with parents and their children poses special technical problems for the social worker and are outlined well in a number of publications including "Children and their Parents in Brief Therapy" - Carter, and "The Treatment of Families in Crisis" Longsley and Kaplan. Therefore, from the overall psychiatric administrators point of view the present problem in relation to the short term homes is that most psychiatrists in general are deficient in the use of short term crisis orientated techniques and the short term homes are not to utilize this technique also and yet the homes are constantly bombarded with children with psychiatric crisis orientated problems. The present problems of the mixing of severely emotionally disturbed children with the children who show their disturbance basically in a social area will continue into the future, unless basically a screening process is set up or a joint venture between the Department of Social Welfare, Department of Education and Department of Health. The realisation that the short term welfare home is basically, in addition to other functions, a psychiatric emergency service has not been given sufficient recognition. There has been very little deliberate planning of the use of psychiatric time between the social welfare areas and the hospital. It is hoped that at times the hospital psychiatric advisory committees will seek opinions from the social welfare department rather than the thoughts of the committee doctor who may not wish to represent the views of the social welfare in planning new child psychiatric services. However, this argument may also work the other way when a new service for the welfare is planned. Perhaps the reorganisation of the Health Services may overcome this difficulty.

In a recent paper "The upbringing of other people's children: Implication of research and for research 1974" Jack Tizzard outlined a paragraph called "Who gets residential care and who provides it?" - these comments could equally be applied to the New Zealand situation: "Nothing in the planning of residential care is very rational. As we all know, the same deprived, handicapped or maladjusted child might well stay in his own home, with or without what is believed to be appropriate treatment, or go to a children's home, or to a special boarding home, or to a special day school or a residential school, to an approved school, or even to a hospital unit. The actual placement of individual children thought to be

in need of special care or special educational treatment is highly irrational and idiosyncratic. In part of course this is because of an alleged shortage in all forms of provision; but I very much doubt whether even doubling the amount of provision would solve many of the problems of child care, since by a corollary to Parkinson's Law the places would all be taken up, the waiting lists would remain as long and the fundamental question as to what is best for children would remain."

5A. MIRAMAR GIRLS HOME PSYCHIATRIC SURVEY 1971 - 1974

From the beginning of 1971 to the end of 1973 the author collected statistical data on 180 consecutive cases referred to him for child psychiatric assessment. The referrals were initiated by the home staff or by the field workers from the Child's home district, a small percentage was referred after a multidisciplines case conference. The number by no means indicates a screening of the population entering the girls home for psychiatric disorder, but would generally represent the most seriously disturbed girl.

Some 750-800 new admissions were admitted during the period of study and out of this number 180 girls were seen for psychiatric assessment. The author had a lengthy interview with each girl and in some cases this was followed up by a joint family interview. Most girls were seen twice but some several times. Consultative procedures followed as outlined in the Part I paper. In relevant cases psychological assessment was carried out by Mr E. Maurer, Senior Psychologist, Wellington Department of Education. Additional assessment included EEG assessments and other specialist referral where necessary. Observational data includes group, sport and work and school observation reported by various staff members. Each girl was examined medically by the visiting practitioner to the home and by the venerologist at the hospital when referred. Out of the general population in the home it should be noted that some 75% of the adolescents admitted had no status with the Social Welfare Department prior to admission to the girls home. Less than 20% of cases are state wards unlike the Epuni Boys Home which contains excess of 50%. Some 60-70% of the population are non-European in origin but this percentage seems to vary from time to time. The girl's home receives girls from a wide area and in my experience from a wider area than its delineated boundaries. Thus the author has seen girls from Auckland and others from Nelson and Christchurch. This is understandable in that Miramar Girls Home sends girls to National Social Welfare institutions and also the home is the only one in the country which has a regular consultative psychiatrist and psychologist team. It is also the only home that conducts a multidiscipline team approach involving a type of case conference approach.

(a) RESULTS

(i) Factors in the Family

Table 8 Ages of 180 cases assessed

Years of Age	Number
8	1
9	2
10	1
11	0
12	10
13	27
14	68
15	52
16	19

It should be noted that very few children under the age of 12 are referred but the younger ages are frequently seen as outpatients (not included in this study). National Child Health Clinic Data indicates that they deal with 6-10% of cases in the 13-16 year old age range.

Table 9 Number of Siblings in referred Adolescents Family

Family Size	No. of Families	Percentage of total
1	1	0.5
2	30	16.7
3	42	23.3
4	22	12.2
5	26	14.4
6	15	8.3
7	13	7.2
8	10	5.8
9	6	3.3
10	6	3.3
11	3	1.7
12	2	1.1
13	3	1.7
14	0	0
15	0	0
16	1	0.5

Amongst the referred sample it is noted that the children come from an average family size of 4.6 children.

Table 10

Birth order of child under study	Number
1	44
2	71
3	37
4	14
5	3
6	5
7	2
8	1
9	1
10	0
11	0
12	0
13	2

There have been a number of studies in the literature on birth order which has shown that it is extremely difficult to interpret. It is not possible to interpret this data as many other aetiological factors operate in causing emotional disturbance. However, when this data on size of family and birth order are compared with National Child Health Clinic Data it can be seen that the welfare families are significantly larger but both show a high rate of referral amongst the first and second born child.

Table 11 Broken Homes

	Separation	Death M	Death F
No.	59	11	7

Total 77

Table 12 Absent parent from child's family

	F	M	Both
No.	53	15	9

Total 77

Table 13 Significant Medical problems in parents or siblings

	M	F	Siblings
Medical	4	13	8
Alcoholism	6	5	0

Table 14 Parents or other siblings who are or have been under psychiatric care

	M	F	Siblings
Inpatient	8	5	13
Outpatient	4	2	5

The incidence of 20-25% of homes broken by death separation and divorce is similar to the national average that 25% of young offenders come from broken homes. It should also be noted in tables 11, 12 and 13 the high incidence of added stress in the families studied including medical illness in the parents and/or siblings, and alcoholism. Table 14 indicates a small percentage of parents (9%) who have been under psychiatric treatment. Often in the case history grandparents or near relatives have had psychiatric disorder. Most of the families studied did show ingredients of what is commonly associated with family disorganisation. Whether the group studied differs from the remainder of the girls admitted to Miramar Girls Home in regard to family structure remains to be seen. However, the Miramar group certainly differs from families attending Child Health Clinics. Multiproblem families are not a feature of child health clinic families nor are serious psychiatric disorders needing inpatient care seen in the parents. The majority of psychiatric disorder seen in the parents in Child Health Clinic samples point to neurotic disorders rather than the psychotic disorders.

While this data is rather primitive a number of clinical impressions can be stated. The cases seen did not line up to the stereotype frequently given to welfare children by psychiatrists who never work with welfare children i.e. a child from the lowest social strata with disadvantaged value systems and ways of thinking and with social habits they acquire from their families - regarded as not suitable for "treatment". This group was the exception rather than the rule in the 180 cases and surveyed and if this type of problem arose it is not a question of "treatment" being unsuitable but how to make treatment suitable for these different families.

Virtually all families showed some form of disequilibrium as already stated. The absence of the father figure either due to broken homes or absence due to withdrawal in the family for various reasons seemed a common feature. Many of the adolescents were first or second born and there was possibly little peer group pressure to conform. There were a few fathers who could be regarded as brutal whether drunk or otherwise but generally the stern father was absent. Where the stable father did exist

frequently the wife seemed to aggravate the problem by being rigid, authoritarian or overprotective. This at times seemed to lead to fostering of delinquent elements. In the absent father situation it seemed that a number of mothers wanted "to take his place" and it may have been better for the mother to retain her feminine identity. In the group of psychotic girls frequently a highly disturbed symbiotic bond between the mother and daughter was seen. It also appears that a number of parents expose their children to adult psychopathology of one sort or other. The range of this behaviour is wide. In addition specific problems due to personality problems in a parent occur in a small proportion of cases; for instance, five cases of father daughter incest, near relative incest 4, were alleged. A lack of stability in relationships and in placements seemed to be a common feature. Early prolonged neglect of the child by the family was not a significant feature but when it did happen it was difficult to help a child who had sunk into a "fatalistic" passive attitude with a lack of interest in anything. The same end result seems to occur in the children exposed to alternating periods of emotional warmth and of being cast out socially in the cold. Whilst these are merely disruptive historical events that seemed to regularly occur in the families of the adolescents it should be stressed that it should not be assumed that they have direct aetiological significance. Many subtle parent behaviours (for example, scapegoating, withdrawal of affection, transient depressive affect) may not be retrievable because of denial or repression of the behaviour by the child or parent.

(ii) Factors in the Child

Not all emotional disorder can be attributed to society and the family, but can also be traced back to the child himself. However, unlike the adolescents studied at Epuni Boys Home the organic aspects seemed less frequent. However, several cases were documented in which epilepsy or a medical condition were diagnosed and treatment instigated but really too late to reduce the accumulated disorder. Neurological or maturational aspects causing severe or specific learning disorders were seen in only three cases. Although frequently the adolescents show academic difficulties with the emotional disorder, they do not show the gross academic retardation of their male counterpart. Mental subnormality is not a feature.

Table 15 Intelligence (tested or estimated) 180 cases

Above	Average	Below	Subnormal (below IQ 70)
4	169	5	2

Table 16. EEG Results (28 cases referred)

Nonspecific abnormalities	lateralizing R	L	Epileptic Activity associated with Clinical Epilepsy	Normal
16	4	2	3	5

Anti-epileptic drugs were used in 20 cases with EEG disorder either to control epilepsy, improve frustration tolerance or to improve attention spans. The diagnosis of temporal lobe epilepsy was not made unless there were clinical concomitants. Although this condition is overdiagnosed if an EEG result is taken on its own, it is just as easy to overlook it, as a cyclical depressive condition alternating with periods of extreme aggression is often a case of temporal lobe epilepsy. A small number of depressed girls did have this condition as a second diagnosis (4).

Illicit drug usuage occurred in two cases and most of the adolescents are not prepared to use illicit drugs where available. However, a small percentage are underage drinkers.

Many of the adolescents seemed to have disturbance in self image and have a deep feeling of failure and a lack of sense of self worth. Many of these adolescents, who have a very low opinion of themselves, and who, besides this, have not had the benefit of parental identification (or substitute) are fascinated by the "strong figures" of delinquents (or the gang). At times the attraction of the gang and the "good life" seemed to be the only reason apparent for a short but torrid history of antisocial behaviour. Some of these girls were from families with considerable socio-economic status and expressed their disturbance in terms of the protest movement of a few years ago rather than by gang involvement. In general the adolescents seen in the girls home have reached biological maturity in regard to sexuality and many of them seem to be prematurely initiated into adult sex behaviour, arrived at the achievement of status. Sexual reaction in general is not necessarily indicative of strong impulsives or urges but more related to sexual exploitation. Sex is often the preferred vehicle of ego inflation for the boy or girl as individuals or in gangs. As veneral disease is not that uncommon in the girls each girl is tested for this condition by a specialist physician who reports that 85% of the general population of the home had sexual activity. Girls admitted on warrant who have a history of gang involvement have veneral disease of between 50-60% and girls with peripheral

Gang involvement or no gang involvement 25%. Girls admitted by the Social Welfare Department have a 10% incidence of veneral disease. Salpingitis is a major complication of veneral disease and contributes to a number of cases admitted to the local hospital. Were it not for this complication the 4 - 5 extra nuptual pregnancies seen per year would be higher. It is not surprising that sexual conflicts and sexual identity problems were seen in a high percentage of girls. Confusion about sex gender was not common. However, more serious conflicts were caused by adult sexual exploitation rather than by the peer group. As mentioned these include father daughter incest and the more perverse assaults on children.

Table 17 Sexual Assaults actual or alleged

	No.
Father daughter incest	5
Sexual assault by stepfather	3
Sexual assault by defacto	2
Accusation of sexual assault by father	2
Accusation of sexual assault by foster parent	1
Sexual assault by mother's friend	1

These figures are probably an underestimation as denial and repression again operate in the child or the parents. On the other hand the frequency of reported rape in the case histories by gang or individual seems excessively high and may involve fantasy type thinking.

Suicidal attempts prior to admission to the home and bringing the adolescent to medical attention occured in 19 cases. Most cases involved overdosage of medication usually from their parents supply. 1 - 2 girls were seen who seriously mutilated themselves with sharp objects while in the home. Threats of suicide are not that uncommon by some depressed girls and this constitutes a major worry for staff. Whilst the closed part of the institution removes some of the means of suicide it actually tends to increase the risk of suicide by other means. The author has seen in another short term home an attempted suicide (nearly successful) by hanging and attempts to choke by forcing objects down the throat. Recent threats at suicide include threats to fling themselves off the upstairs balcony. Often it is necessary to cope for various reasons with adolescents who make threats of suicide as there is often not sufficient leverage to implement a placement of the young person in a psychiatric setting if it existed. This is an area where psychiatric consultation is important in elaborating whether the suicidal behaviour is a real symptom and if so how firmly anchored or whether the crisis

is a result of defective personality structure without specific symptomatology or due to the environmental factors in the home. Usually the behaviour can be treated effectively within the home, but homes without psychiatric consultation should not attempt to do so. Since adolescent suicides do occur, one must take either a threat or an attempt as serious.

Most of the symptoms that the girls show are not generally due to a circumscribed cause. Even though at times the symptomatology appears to be clear cut it seems also some of the symptoms seem to represent extreme variations from the norm. This means that the genetic part of the aetiology is based on multifactorial inheritance and that the exogenous part of the causation consists of a great number of unspecific noxious agents. It appears to the author that the genetic part of the aetiology in a number of girls seems to be loaded. Not only as reflected in table 13 and 14 near relatives have psychiatric disorder but there seems also a high incidence in the grandparents. Whether or not this is a true reflection of the genetic part of the aetiology. For instance the cases of four generation incest families at the Girls Home and Epuni Boys Home could probably not be put down to a genetic effect.

Whilst not wanting a dissertation on the problems of adolescent turmoil or disorder and the so called generation gap, a careful approach was called for as often early psychosis presented as turmoil. It is probably better for a social worker to overdiagnose adolescent turmoil and refer for an opinion than to miss a case of early psychosis. Early psychosis occurs not infrequently in the home and although clinically easy to diagnose it produces a profound effect on the peer group in the home. The peer group are either frightened of the inappropriate reactions of their girls or adopt an overprotective reaction. In both reactions the girls maintain the sick adolescent is mad. This occurs with the very early cases of psychosis where a girl is in a borderline state between normality and psychosis. The frank psychotic adolescent is very obvious and extremely anxiety provoking to the staff. It is a sad fact that the girls home is frequently asked to deal with this type of case. The psychotic adolescent rarely occurs in the Epuni Boys Home and is over-reacted to so much by the peer group that the child has to be kept in seclusion for its own safety. Basically the boys seem to have little tolerance for mental illness and disability and have a fear of going "mental".

(b) Reasons for referral for psychiatric assessment

Referrals were generally initiated by the Social Welfare Social Worker or staff at the Girls Home and were generally made on the basis of the type of behaviour that the girl showed that precipitated the admission to the home. Generally the behaviour stated did not differ much from the total population in type but did differ in terms of frequency and intensity. However, in addition to the general symptoms of antisocial behaviour a number of cases were quite rightly referred for assessment almost automatically for instance those involving serious assault, arson or bizzare behaviour. Often cases were referred when the background did not explain adequately the reasons for the antisocial behaviour that the girl showed. A history of previous psychiatric treatment or assessment did not preclude a further assessment, but increased the likelihood of referral.

Table 18 Previous psychiatric care

Source	No.
Child Health Clinics	19
Psychiatric Hospital	16
Psychiatrists (OPD)	13
General Practitioners known to be involved	18
Neurologists	2
Total =	68

Some 68 out of a total of 180 cases were brought to the various health agencies that attempt to deal with behaviour problems. Because of medical ethics and other problems not related to these aspects Social Welfare Social Workers experience great difficulties in obtaining background medical information. Generally however Child Health Clinics supply adequate information on request.

Many other agencies help disturbed children but this survey did not cover this aspect. Because of lack of detailed case reports it was not known exactly how many adolescents received a psychological assessment prior to admission. The author's experience would suggest as an estimate 10% for his sample and about 5% for the total population in the Girls home.

It would probably be expected that only a small number of girls had previous assessments but table 11 indicates this is not so. In fact the situation points to ways in which the homes are being used by health agencies. The 16 adolescents discharged bypsychiatric hospitals were discharged because the hospital could no longer cope. The phenomena

is well known to the girls home as the annual clean out of a psychiatric hospital. Other cases show the inability of outpatient clinics, Child Health clinics to cope and that these clinics seem to dump cases on the girls home rather than into the health areas. However, a number of girls who have had psychiatric inpatient treatment have progressed well. Just as psychiatric treatment can be misused (see Part I) so may residential treatment for coping with psychiatric problems.

Other reasons for referral for psychiatric assessment in the home include poor adjustment in a sense of misbehaviour in the girls home and girls school. For this misbehaving group advice was sought regarding further management or possibly transfer to a more appropriate setting.

Other reasons included administrative decisions regarding suitability of transfer to National institutions or to foster or family homes or on rehabilitation. This area was looked at to avoid psychiatry being a rubber stamp of approval for a National institution.

A small number were referred because of specific medical problems such as epilepsy. Although this survey does not discuss the outpatient referrals from Social Welfare workers the effectiveness of a consultative programme and the trends can often be judged. The extreme rate of referral from the homes and as outpatients appear to the author tobe due to the high number of severely psychiatric disturbed youngsters who are under the Welfare. It is not necessarily a case of Welfare Social Workers becoming more aware of emotional problems, but a case of not being able to avoid them. There is also disenchantment about the ability of traditional psychiatric treatment and programmes to meet the needs of the type of population under the Department of Social Welfare. However, on occasions it must be admitted that there are a number of reasons at times why a number of social workers do over refer, for instance to undercut their supervisors, to bring pressure on administration, as a time saving helper when multiple disasters have befallen the rest of the large case load of a Social Welfare Social Worker. Other problems of a similar nature are outlined in part I of this survey.

c)<u>Diagnosis</u>

Although steering away from using psychiatric diagnostic labels in reports to various agencies where possible the author recorded a psychiatric diagnosis in his own records. The diagnosis was based on the International Classification of diseases eighth revision. It follows the same diagnostic criteria as used in Child Health Clinics through out this country. Therefore, the diagnostic categories obtained can

be related to National Child Health Clinic data.

The major categories fall into the various subdivisions of the classification

Adaptation Reactions - a category used for disorders which are somewhat outside normal limits of normal variation but in which there is no significant distortion of the general development.

Developmental disorders - a category reserved for specific delays in development or abnormalities of developmentawhich are related to biological maturation and which are not secondary to any other psychiatric syndrome.

Conduct Disorder - a category used for abnormal behaviour which gives rise to social disapproval but which is neither part of any other psychiatric condition nor associated with personality disorder. This category includes some types of legally defined delinquency and is a type of socialogical delinquency representing group endorsement of antisocial behaviour in the relative absence of individual disturbance. It also includes non-delinquent disorders of conduct (e.g. fighting, bullying, destructive behaviour, cruelty to animals). The mere fact that a child committed a delinquent act is not sufficient for the diagnosis of conduct disorder. It is necessary that the behaviour be abnormal in its socio-cultural context. This may be judged by the frequency, severity, and type of behaviour and its association with other symptoms.

Neurotic Disorder - this category is to be used for disorders in which there is an abnormality of the emotions which is not accompanied by marked personality disorder or loss of reality sense (as in psychosis). The chief characteristic is anxiety, which may be directly felt and expressed or which may be unconsciously and automatically controlled by utilization of various psychological defences such as depression, conversions, disassociation, phobic formation, obsessions and compulsions.

In children neurotic suffering the common symptoms of the adult neurosis is not present in the child to the same extent; and that whatever the amount of suffering may be it is equally divided between the child and parents. In some instances it is only the reaction of the parents to the symptom that brings home to the child, secondarily, that he suffers from a symptom. In some cases children at a certain age show indifference towards his symptom while the adult environment suffers badly on its account. Neurotic display of aggression and destructiveness, as they occur in the initial stages of an obsessional neurosis, are most disturbing symptoms to the family; the child rather

indulges in them. Frequently delinquency masquerades as the acting out of a neurosis in an adolescent. Neurotic depressions are a common cause of acting delinquent behaviour.

Personality Disorder - this category is for children with relatively fixed abnormalities of personality, of whatever kind, appearing as the main pathological feature. Relatively fixed sexual deviations which are abnormal in relation to the child's level of development are included in this category.

Two other personality disorders are often seen in children and adolescents are the passive aggressive personalities and varieties of the sociopathic personality disturbance. The dynamics of the passive aggressive personality functioning emerge usually as academic under-achievement. The differentiation between sociopathic and symptomatic delinquency is evident in the child's behaviour; for example, repetitive and poorly controlled aggressive outbursts more frequently indicate asocial orientation than a symptomatic effort to resolve neurotic conflict. Delinquent behaviour arising specifically as a depressive equivalent can usually be distinguished from sociopathy by its precipitous onset in the wake of demonstrable object loss and in the absence of previous antisocial tendencies. The more a delinquent youngster demonstrates lack of remorse, lack of personal loyalties, and disinclinication to precede action with thought and the greater his display of shallow interpersonal relatedness, underdeveloped affectional needs, incapacity to delay impulses, limited time perspective and intolerance for anxiety or frustration - the more likely is that his delinquency is a concomitant of sociopathic personality formation. Conversely, the less prominently he manifests such personality characteristics, especially when neurotic concerns and parental fostering adequate to account for his antisocial behaviour are in evidence, the more probable his delinquency is symptomatic in nature and should be coded under the appropriate category. Where schizophrenia, mental retardation or organic brain dysfunction appears to be primarily responsible for the antisocial behaviour it should be coded elsewhere.

Psychosis - several types exist but the common type met within adolescents include a progressive disintegration of personality of an acute or insidious type. When fully developed the subtypes are clearly recognised as in the adult type. A number of prodromal indices may be experienced

before the onset of schizophrenia. These prodromal indices usually take the form of either a withdrawn schizoid adolescent adjustment or a stormy youth characterized by antisocial behaviour.

Table 19

Diagnosis		Number
Adaptation Reaction		2
Developmental Disorder		2
Neurotic Disorder -	severe "acting out"	18
	moderate "acting out"	10
	depressed	23
	hysterical	13
	cyclical depressive	8
	obsessional	1
	anorexia nervosa	1
Conduct Disorder		40
Personality Disorder -	deprivation syndrome	10
	passive aggressive	1
	sociopathic	5
	schizoid	5
	sexual deviation	2
Epileptic -	minor	2
	Grand Mal	4
	temporal lobe	17
	post traumatic	6
Psychotic -	symbiotic	2
	prepsychotic	10
	psychotic	7
Other		1
	Total	180

In actual fact the group comprised of all kinds of diagnostic groupings from phase crises to severe psychoses and from mere oppositional behaviour in the family to attempted murder.

Psychiatric Impairment - although the author's study is a pilot study it should be noted that a useful measure of psychiatric impairment exists. This is the Langer Scale based on work done in the midtown Manhattan Study. It has been used in Australia and the results compared with four major United States surveys. It is of interest to note the results of the Canberra Mental Health Services (B.L. Hennessy and W.O. Bruen Australian and N.Z. Journal of Psychiatry 1973 7 pp55-59).

Table 20 Langer Scale Results (age range 13-18 years)

	No.	%not disturbed	% borderline	% disturbed
Adolescents in Community	136	74.2	21.4	4.3
Adolescents patients	70	32.9	28.6	38.6

It is the author's opinion that similar results of psychiatric impairment would be indicated if the general population of girls at the home was assessed with the Langer scale. The 180 cases screened in the present survey were generally the most difficult problem cases and probably does not give a true incidence of psychiatric impairment.

Further statistical analysis of data could well show an interesting phenomena, however, it is at present beyond the scope of the paper. It seems that the disturbed girls admitted to Miramar girls home occupy a mid position between those adolescents treated in a Child Health Clinic and those treated in a psychiatric hospital. Child Health Clinics see a large number of cases of a milder kind suffering from adaptation reactions, developmental disorders or mild behaviour disorders. The psychiatric hospitals see children with severe character or behaviour disorders or epileptic children often associated with retardation. Even the two inpatient psychiatric units in hospital do not seem to cope with the Miramar girls home type of population and they tend to mirror the Child Health Clinic "quick cure" type of population. In actual fact the girls home is an unique twenty-four hour service that copes with a number of disturbed adolescents who are under fairly severe life stresses or crises. The medical and other formal agencies even if they exist are not accessible to most of these adolescents even if they would use them which is doubtful. A small number of adolescents still show the stigma of previous psychiatric care.

Drug Use - the author adopts a conservative approach to the use of drugs and feels that psychiatric drugs can be misused more than properly prescribed. Minor tranquillisers are especially avoided and the major tranquillisers are only used in cases of psychosis. There is one exception in the use of major tranquillisers to break a vicious circle or so called chain reaction. The drug in this case is used only short term. When drugs are used the antidepressant drugs are generally the drugs of choice particularly with the adolescent who is liable to endogenous mood changes. Anti-epileptic drugs are often given to adolescents with learning and behaviour problems but without a history of convulsive disorder. Although most cases represent developmental deviations rather than organic disorder the drugs used in selected cases tend to improve attention span, short term memory and reduce temper and aggressive behaviour. As most anti-epileptic drugs are toxic products the author limits the prescribing only to Nydrane or Tegretol. A number of other conditions exist where drug therapy is specific. Night time sedation is not used widely. Analysis of the prescribing indicates that psychiatric drugs are not used widely and drugs are more likely to be prescribed for medical problems than for a psychiatric condition.

Table 21

Drug Use Total Population 180

	Anti-Epileptic	Antidepressant	Tranquilliser	Combined Medication
No.	20	13	4	2

Total number of cases on medication = 39

Psychiatric drug usage in a selective way has shown to be effective when combined with other ways of managing a girl. In general the girl has to be prepared fairly well as there appears to be a universal dislike for drugs by adolescents.

Usually drug useage is short term and provided the girl stays long enough in the girls home drugs are usually phased out. However, occasionally long term use of drugs are indicated or a girl is discharged soon after a girl has started drug treatment. This situation can create problems with follow up treatment. There is a considerable need for establishing better clerical services within the girls home.

Conclusions - It is possible to integrate a psychiatric service into a non psychiatric residential unit such as Miramar Girls Home. Although a large number of girls do seem to have emotional disturbance of varying severity not all will need long term intensive psychiatric treatment. Many of the girls will need diagnostic study and short term therapy and practically all will need some rehabilitative service. The potential of the home is frequently underestimated and it is often not realised that the home acts as a crisis adolescent service for social and psychiatric casualties. More effective use of the home seems to be appearing to develop however screening of admissions to avoid admitting severe psychiatric problems, girls who would not benefit from an intensive group situation or cases admitted for holding only.

PART 5 B. THE EPUNI BOYS HOME SURVEY 1971 - 1974

Like Miramar Girls Home, Epuni Boys Home acts as a collecting point for the community adolescents whose behaviour for various reasons is difficult to control by the community. Some of these adolescents remain in the community because of persistence of the parents and others and because other alternatives exist. However a number are placed in Epuni Boys Home for assessment or for protection of the community from the individual but also for training and rehabilitation of the individual. It should be noted as in a previous paper that there is no formal screening and filtering of adolescents to appropriate services if they existed and that Epuni like other short term residential units acts as a crisis service.

Epuni Boys Home admits adolescents from an extremely wide area of the North Island and from the upper part of the South Island. The area basically falls short of the Hamilton Boys Home and the Christchurch Boys Home areas. Admissions frequently come from other areas because of the facilities that the home is able to provide. Forty six beds turn over annually about 250 admissions.

The function of the institution appears at times to be misunderstood or at times the short term residential homes seem to be considered with the long term institutions and the results of treatment considered poor. If the potential was realized possibly the quantity and quality of the staff might be improved. In spite of the difficulties the home has, it has always impressed the author, that a number of adolescents receive and are provided with a number of positive social experiences. Evaluation of results of the discharged adolescents is a difficult area.

A number of overseas attempts have tried to provide the answer. Are existing corrective schemes for juvenile delinquents aggravating the problem of delinquency? In an article by Dr M.D. Clayson (Medical News August 16, 1968) of the Department of Psychiatry, Cornell University, New York, he has been led to the conclusion that even well considered programmes now in use (also those in psychiatric units or hospitals) may in important ways be more debilitating than rehabilitating in net effect. The experiment he conducted at the National Training School for boys, a reformatory in Washington D.C. for youths convicted of federal crimes is worth quoting at length. It is interesting to note the means also of evaluating the programme.

"Two groups of boys were used during the project: an experimental group of 45, and a control group of 40. A second, non-institutional control group of 93 boys, representing a similar cross-section of age and abilities was drawn from a local high school.

As the project was conceived as a supplement to, and not a substitute for, normal institutional procedures, both the experimental and control groups participated in all regular institutional programmes.

Three special programmes, however, were tried with the experimental group. These were an activity programme, in which the boys were given additional opportunities to use the institute's recreational facilities; a group programme, involving group discussion of problems connected with any aspect of institution life; and a programme of informal interviews between boys and their counsellors.

These special programmes sought to deal directly with such critical problems as insecurity, excessive hostility, anxiety, disturbed interpersonal relationships, low self-esteem, faulty identifications, and lack of motivation.

By keeping each boy involved in continual and diversified activities, "boredom and idleness were in great part alleviated, reducing tension and increasing the probability of more constructive focusing of energy", Dr Clayson reported.

As a means of evaluating how these programmes were affecting concept formation, a semantic differential analysis was employed to appraise pre and post-test meanings of 21 experimental concepts.

As well as me and sin these included mother, father, teacher, policeman, boy, trouble, fear, sickness, fighting, religion, work, earn, sex, girl, white, negro, time, friend and laughing. These concepts were especially designed to explore areas of authority, self, responsibility, fear and sex.

Using Osgood's techniques (1957), each concept was evaluated on eighteen dimensions by each boy in all three groups before and after the test period of six months.

Each dimension was defined by judgments of polar adjectives on a seven-position scale (e.g. Dimension I: good - 1,2,3,4,5,6, 7 - bad). The adjectives were divided into three identified as evaluative (e.g. good/bad) potency (e.g. thick/thin), and activity (e.g. fast/slow).

In the pre-experimental test the two groups of boys showed parallel orientation, though this was different from the orientation of the high school control group, who showed a higher degree of anxiety tolerance and judgmental ease (by greater use of the extreme positions 1 and 7 on the scale: the higher the use of the central, inconclusive position 4, the lower the

anxiety tolerance of the individual).

At the end of the six months, the conceptual values of the boys in the experimental group had changed considerably and showed far more parallels than before with the values of the high school group (i.e. they had gained increased anxiety tolerance and judgmental ease). This was just as had been hoped.

However, the institutional control group on re-test showed far lower anxiety tolerance and judgmental ease than they had done six months previously.

In other words, the normal programme and condition of the institution had lowered their ability to adapt to society in a constructive fashion."

Although it must be realized the author's viewpoint of the short term is that of a crisis orientated service it was felt that possibly the viewpoint might not be shared by the Social Welfare Social Workers. The ideas were discussed with various social workers and it was felt that to view the short term institution as a crisis service was both interesting and useful. Mr J. Comber Assistant Principal, Epuni Boys' Home, an experienced social worker, in consultation with Mr M. Howe, Principal, outlined a number of aspects of utilizing a crisis approach in addition to the basic programme of the home. It is the author's opinion that the factors outlined in Mr Comber's papers are far more important than a basic discussion on whether a home should run an institutional programme, a sports orientated programme, group or school programme. However, this aspect is important but the solutions to the problems are more obvious, once the basic philosophy of the short term home is set by each manager.

When discussing the use of the home as a crisis service Mr Comber states: "It would be fair to state that most children are admitted from a 'crisis' situation e.g. remanded from children's court; taken into custody on the basis of Police or Social Welfare warrant, breakdown of foster home placement; in general, where behaviour symptoms are such that the community demands the temporary removal of the child.

It is equally important to realise that the element of 'crisis' does not disappear when the child is admitted to the short term institution. Rather, he enters another 'crisis'. He is removed from significant, meaningful figures (parents, siblings, peer group); he is admitted to a situation which is structured and authoritative, where demands will be made on him which he may never have experienced before. His freedom is to a large extent curtailed and he might well face an initial three day period confined to a secure situation. These are but a few of the more obvious factors which add to a crisis. There must of course be many more which are related

to the child as a unique personality from a particular background and environment.

It is my opinion that staff in the residential situations should be constantly aware of the element of crisis. Most importantly, staff should be alert enough to capitalize on the situation in such a way that it contributes to the learning and social experiences of the child."

A number of case work implications of a crisis situation in the short term residential setting were also discussed in the same paper.

"Crisis oriented work rests on the premise of quick and effective intervention during the state of crisis. It is at this stage that the ego is most fluid and therefore susceptible to the influence of significant others (social workers/residential staff).

Successful 'crisis' work demands that the caseworker appreciate:

(a) the nature of the crisis
(b) the relevant precipitating stress
(c) the need to have the client/child experience an immediate sense of hope, reassurance and warm acceptance by the caseworker to give a reduction of tension/anxiety.
(d) need to commence immediate problem solving: aim at short term goals, mutually defined - goals to be defined according to the client's present situation i.e. realistic - taking into account his temporary removal from the community.

The above points presuppose that the residential caseworker is fully acquainted with the child's background/social history, factors which precipitated admission etc.

I believe that therapeutic use of crisis situations in the short term residential setting should not only involve residential staff. The child's social worker within the district must be involved for it is presumed he will be working with the family while the child is in care. The family itself is inevitably involved therefore. This demands that contact between district and institution is consistent - local office social workers should visit the child, discuss problems, progress and options with the institutional staff. They must provide incentives, aims - ensure that both family and child are aware of each others situation. Where appropriate, I would like to see the residential setting itself utilized as a situation where parent and child receive the benefit of joint/group counselling by their social worker; or by outside resources such as visiting psychologists or psychiatrists.

Should the institution be fortunate enough to have the services of a counsellor, he must play a vital part. I

visualize his role as one which could be extended beyond the confines of the residential setting itself. For example, when involved in a trusting relationship with a child, he might well be the most appropriate person to follow up any positive movement with the child's family. After all, it is he who is sharing with the child, all the positive and negative influences of a community - of a particular life style within a defined situation. There are obvious difficulties of course. The fact that most contributing districts are so distant precludes regular visiting by many social workers; the extension of the counsellors role to the child's home should not be automatic, rather part of a casework plan agreed upon by counsellor and social worker.

The few points I make however are an attempt to provide a perspective whereby the most positive and therapeutic use is made of an inevitable situation."

A number of Mr Comber's points could be developed and explored further. For three months however a number of these ideas were tested out at the Epuni Boys Home by making use of a student from the Diploma of Social Science Course as a full-time counsellor. This role was complimentary to the author's role and basically it defined potentialities for the use of the assistant master as full-time counsellor or to appoint an additional person as a counsellor. Miramar Girls Home have also used a Social Science Student as a counsellor and this too has been of value. Miramar developed later an additional variation on this programme resulting in the Social Welfare Senior Social Worker, Miss A. Corcoran, providing very close contact with the home both inside and out and Mr J. Robinson, Social Worker, involved very closely in a counselling role with a number of clients. In addition the assistant manager at the Girls Home has also been involved as a counsellor. It is the opinion of all the assistant managers the author has worked with in both institutions that they could work more effectively if they did not also act as part-time secretary, receptionist and the odd job man. The development of the various arrangements at Miramar or at Epuni attempt to sustain an active interest with the adolescent and maintain some contact with the outside world. For various reasons the social workers generally are not available to continue contacts when a child is admitted. The transfer of care is an important aspect particularly at the moment of discharge from the home and this is where the adolescent offender stands in most need of the help and support of the caseworker who knows him.

Although there is a certain amount of vested guardianship in the residential home it does seem to the author that the

adolescent frequently does need a personal guardian, spokesman. So many children are lost in a sense in the institution, but fortunately not "out of sight". At Epuni, the manager and the assistant manager do fulfill these functions but there is a limit to the stresses and good will to which people can be subjected. It is the author's opinion that a counsellor in the short term residential home will supplement and aid the role of the manager and assistant manager and to some extent enable the caseworker to concentrate on more effective rehabilitation.

The results of the use of a counsellor at Epuni Boys' Home suggest that the counsellor can screen all admissions but can work in a 1:1 relationship on a regular basis with 10 and superficially with up to 20 adolescents. The assistant manager was still felt necessary to develop staff training and to work in with the counsellor. It was suggested that if a counsellor was appointed he would have a Social Science Diploma and have the same salary scale as the assistant manager.

It should be noted, however, after a great deal of time and effort is spent talking to boys and looking into family problems only to have the effects counteracted by premature discharge or inability to put forward a case for an earlier discharge. Often also a breach of discipline and its 'punishment' can cut across the counselling approach. It is suggested by the author that a counsellor should not be too involved with in depth therapy but should concentrate where therapy is needed on a crisis orientated programme. A certain amount of balance is needed as basically a group orientated millieu programme is needed which involves techniques of education training, psychological training and sports and physical educational training.

It is considered essential to running a successful programme that an adequate number of trained residential staff are needed. In Epuni Boys' Home staff to pupil ratios have been watered down so that an ideal ration of 1:8 is never achieved. The author has worked in in-patient units where this ratio has been met and it is found that this magical ratio does not solve all the problems in the institution. Much of the quality of work done will follow from sound staff morale and a sense of professional identity. Granted low morale can come from staffing crisis problems but the main problem seems to the author more complicated than this. Morale cannot for long be sustained on good personal and social relationships, it must also be based on mutual professional respect in relationship to the task to be done.

This seems to be true of all levels of workers in the institution and must exist equally in all areas. There have been fluctuations from time to time in staff morale at the Epuni Boys' Home and a noticeable tendency seems to be to scapegoat the manager and assistant manager for the difficulties. This tends to shift the focus away from the true problems. The main problem is at the Housemaster and Assistant level whereby basically people filling these positions who may have had no experience in the residential field are asked to look after some of the most difficult children in the area. People who hold these positions are usually not attracted by the salary scale nor by the prospects of obtaining training in residential work. So far no preservice training scheme exists for the residential worker.

The institution in a state of crisis due to staffing problems is hardly in a position to instigate staff training programmes within the institutions and from without. The devotion or genuineness of the staff at the Boys' Home is not in question but, as Bettelheim states in his book "Love is Not Enough", training for the staff is not to turn the worker into a lay therapist but basically to teach techniques of management of surface behaviour, to use environmental manipulation and supportive treatment. The manager or assistant manager involved in staff training will deal with organising the work settings of each worker and in coping with staff/pupil or staff/staff reactions where they arise. This leads to at times clarification and facilitating the performance and essential roles of each worker.

Obviously a programme of staff training is in operation even if frustrated in its efforts. However, most of the staff would agree that more could be done if the staff were chosen well and given an adequate orientation training to delineate their responsibilities and then given appropriate supervision in the residential home situation.

Whatever the atmosphere or millieu created; a home such as Epuni Boys' Home or Miramar Girls' Home has two basic functions to fulfill, that is assessment and short-term therapy. It is not proposed to discuss the remand custodial function in detail nor to discuss why it is not possible to find or use alternatives to short-term institutional care. However, it must be noted that at times adolescents are inappropriately admitted, but this difficulty has improved considerably due to liaison between the Home and district offices.

Assessment

Depends at first on the gathered detailed information about the adolescent's offence and all the events that surround it - the response of the family, previous treatment record of the family or family members; school records and results of previous help or specialist reports. This type of information is necessary to clarify a number of points and problems that might arise in the management of the adolescent in the home. While this statement is obvious it is not always appreciated that it is necessary to know a lot about the general tendencies or presenting symptoms of a delinquent adolescent rather than a report on admission that has made a study in depth. This initial information if adequate and used properly can short circuit up to a month's stay in a home according to the author's experience. For example, if it is not known about the youngster's defensive structure, the stage of development and various shifts of symptoms and possibility of reversal and other factors, the staff have to use a trial and error approach rather than test out previous difficulties. Although it is admitted that it is a demanding procedure by the Social Welfare Social Worker to gather this information in a relatively short period, it should be noted that a refusal to admit an adolescent because of lack of information may reduce the ability to use the therapeutic potential of the crisis. When it comes to specialist assessment, whether by a psychiatrist or a psychologist, the basic admission data is necessary to expand the diagnostic study to a much more extensive assessment. At times, the visiting specialist works with minimal case work data and, if so, it should be realised that the value of the report is reduced.

Assessment is really more than just the collecting of pieces of paper whereby each worker amplifies the dimensions of the problem. It should really be a guideline for helpful action. This is referred to in the Epuni Boys' Home staff training pamphlet.

"In general, to provide relevant 'feedback' or information to the home district of the boy concerned. This information should prove useful to the district in a number of ways:

(a) It might provide the district with an indication as to where a boy might be most appropriately placed.

(b) Because we are able to observe a boy consistently for a prolonged period of time, we should be able to provide intelligent comment on various important

aspects of his social functioning, e.g. social relationships; attitude to authority; observable behaviour; control of emotions; reaction to incentives; discipline, etc., insight into his own situation/problems; attitude to family, community, etc.; abilities and attitudes in respect of school, recreational interests and other skills.

(c) Should the boy return to the community, such information should prove a valuable aid to his social worker, who will be involved in a continuing relationship with him.

When one considers that the content of these reports could be instrumental in affecting a boy's life, it becomes obvious that the author of such reports has a considerable responsibility. The task should be much more than a tiresome chore; rather, it should provide an intelligent and thoughtful summary of a particular boy's reaction to the total programme within the Boys' Home."

Considering thet the adolescent is in a somewhat artificial situation, provided the staff reports are not too 'judgmental' or 'diagnostic', the assessment that can be provided by suitably trained staff is of immense value. The report writing and supervision of staff members has always been a problem and at times, due to lack of staff report writing, has to be abandoned.

In regard to specialist assessment, the situation is even more artificial in that the psychologist or psychiatrist is seeing an even smaller segment of the adolescent's behaviour. Nevertheless, this is the typical clinical situation and in a more formal setting the specialist would have gained information from the parents and others in addition to the child. Therefore, if the parents of the child are not available or if the specialist considers that he has reliable information on previous assessments of the family, then he makes use heavily of other people's reports and his clinical assessment of the child. (Part I on Consultative Techniques goes into this aspect more fully and this applies to the visiting psychologist or child psychiatrist).

For the child psychiatrist the assessment function seems to be directed at a number of levels, at first a formulation and diagnosis, consultative processes and a screening of costs. Therefore, at the end of assessment of a number of disturbed adolescents, the child psychiatrist is left with a small number of children who seem to be disturbed children who need more specific or more intensive 'treatment' approaches. This small group falls into a number of categories:

1. Those adolescents who are clearly disturbed but would not benefit from out-patient or in-patient treatment.
2. Those adolescents who, though initially unmotivated, can make use of psychotherapy once they get involved.
3. Those who are immediately motivated for psychotherapy.
4. Those who need in-patient psychiatric help on an informal or formal basis (See part 2, page 14).

With regard to assessment for suitability for placement of an adolescent in another social welfare institution, it is felt, if possible, the psychiatrist should avoid making a direct recommendation for placement. At times, this is sometimes necessary but, if so, the report should be considered with other reports and should not be regarded as the final rubber stamp of approval. Assessment in terms of giving a prognosis on every case is a dangerous procedure and it should be limited to only a small number of cases that fit into a number of diagnostic categories. A diagnosis in terms of a label is not helpful in general and a formulation of the case by the child psychiatrist is better.

The psychological assessment of an adolescent in the Boys' Home has traditionally been carried out by a psychologist who has been trained from the viewpoint of education. As well as psychometric testing the psychologist is able to provide an overall assessment of personality growth. The role of the psychologist and child psychiatrist are complementary to broaden the scope of assessment of the adolescent. The psychologist ties in with the school in an advisory way as previously stated and in also providing an overall educational assessment where required. In the Boys' Home, much more than in the Girls' Home, an increase of psychologist time is necessary. This is because of the higher rates of associated educational problems in adolescents with conduct disorders.

The general educational assessment by the two teachers in the Epuni Boys' Home is another area that has developed and strengthened the assessment over the years. The school is also part of the treatment milieu and it provides early remedial work with the adolescents and in some cases provides the first positive educational experience for the adolescent. With balance it seems possible to integrate a school programme within the residential institution. The school consists

of a senior teacher, Mr C.D. Kelsey, and a scale B teacher Miss J. Noble, and a part-time remedial teacher, Mrs C.A. McCausland. This school seems to have piloted a very successful programme considering they are dealing with staff pupil ratios of 1:15 at times.

The school will not provide an assessment of every child in the boys' home. (See table below).

Epuni Boys' Home (February 1974 - October 1974)

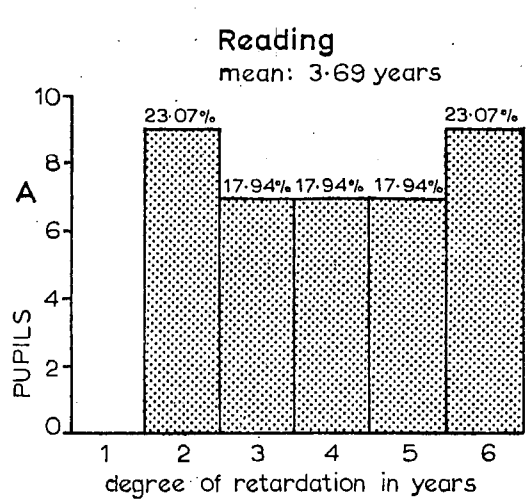
Table 22

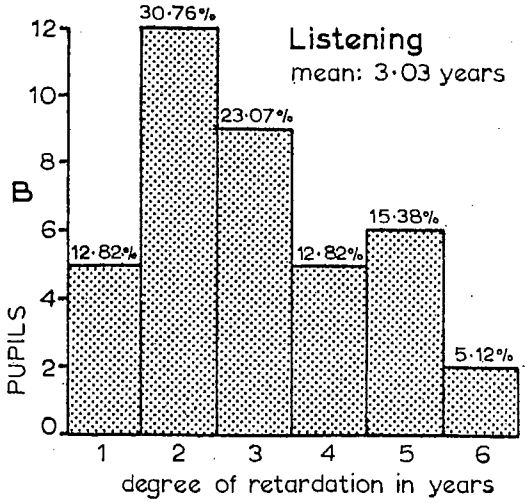
% Working Boys who have left school	% attending the Boys' Home school.	% attending outside school	% school age but not attending the Boys' Home school
9%	56%	5%	30%

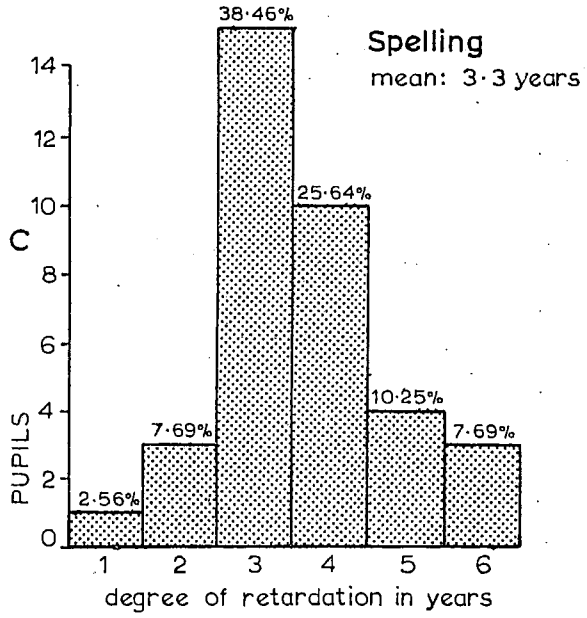
Not all the adolescents who are school pupils can be catered for in the Boys' Home school at present. Virtually without exception, the boys going to school need help with language problems, basic amputational skills and in social and moral development. The effective teaching of children who evidence a wide behaviour and academic deficiency demands complete individualisation of skill instruction as well as a very thorough knowledge of testing, analysis of test results and a very high degree of teaching skill, tables 23-26 indicate the sample tested and the retest figures after short-term remedial work.

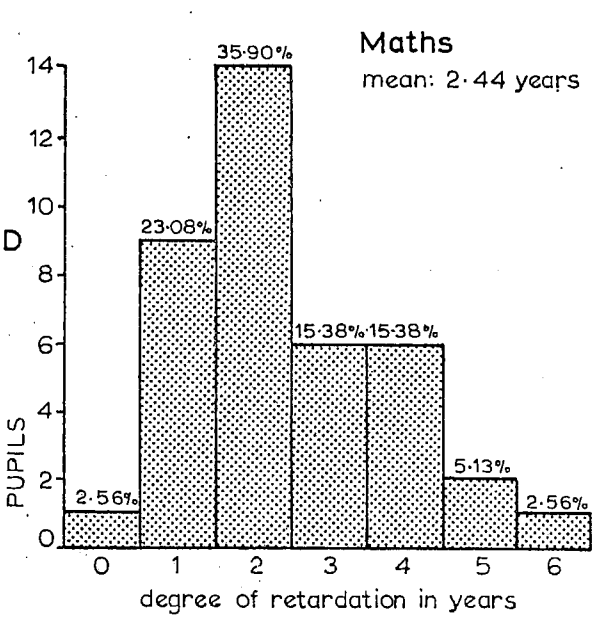
Table 23. EPUNI BOYS HOME SCHOOL

Degree of retardation based on chronological age









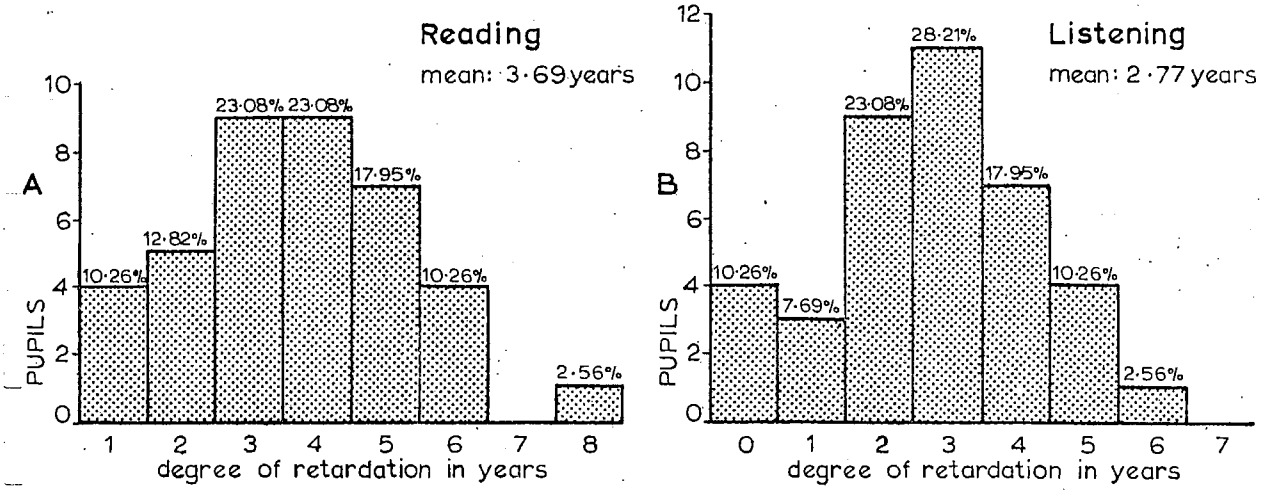
Sample: 39 Ages from 10–15 years

These test results do not represent all boys who were tested.

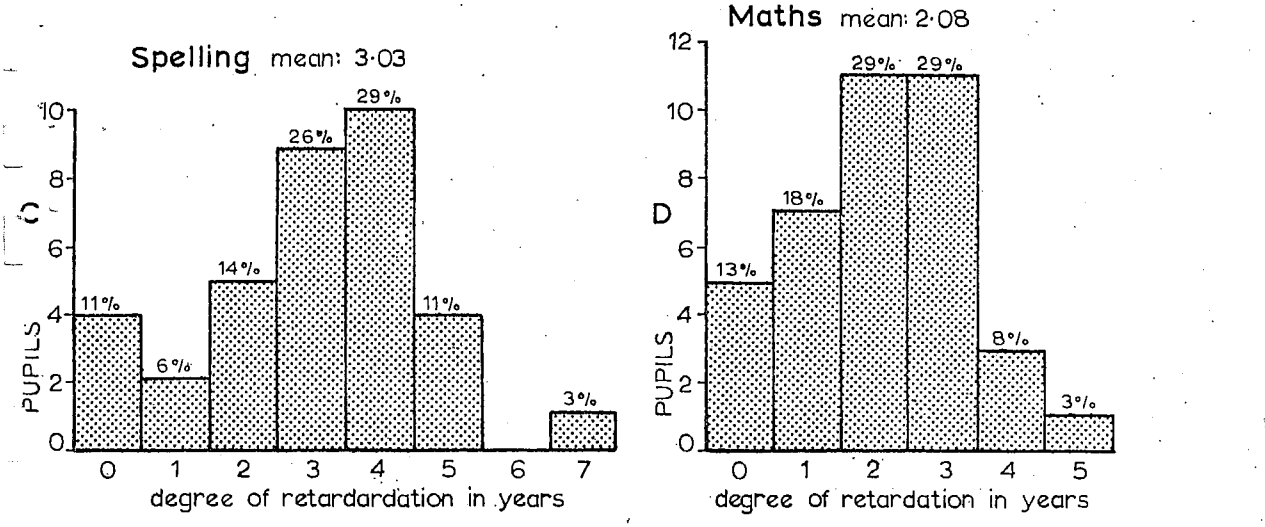
Only those boys who were completely tested have been included.

Table 24. EPUNI BOYS HOME SCHOOL

Degree of retardation based on mental age



Sample: 39 Ages from 10—15 years

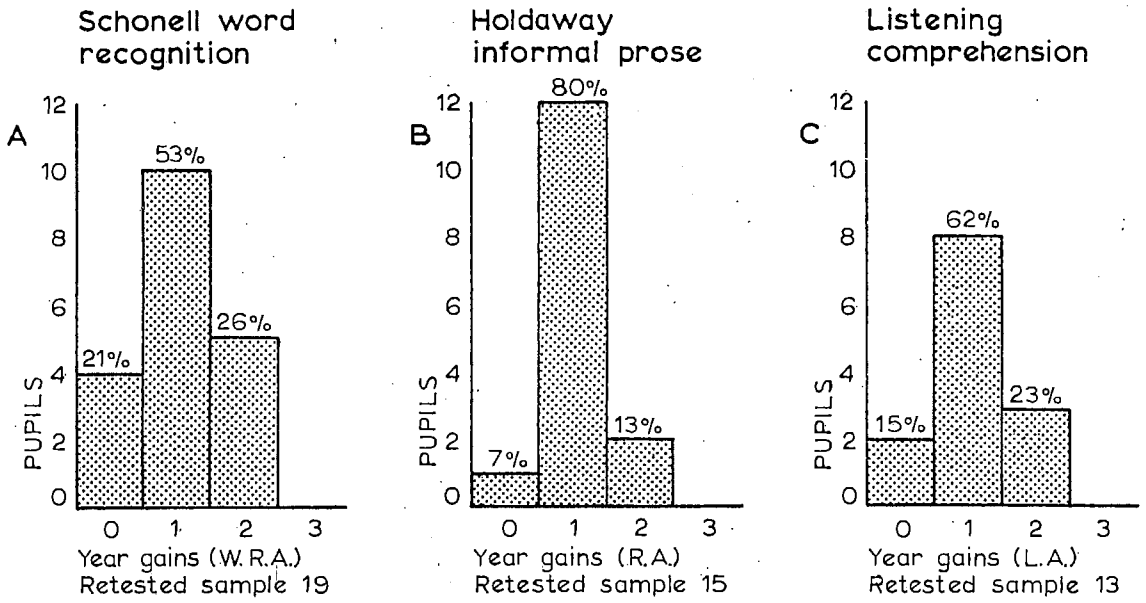


Sample: 35 only Ages from 10—15 years

Sample: 38 only Ages from 10—15 years

Table 25 EPUNI BOYS HOME SCHOOL—RETESTS

(Conducted 1—3 months after initial testing)



Those children who appear under the 0 year gains have made progress in attitudes and some skills, but not enough to measure 1 year or more gains on the present tests.

The teachers are in an excellent position to discuss the problems of a particular adolescent with other staff or outside teachers. At times, a prescription for the teacher's reaction to the adolescents behaviour needs to be supplied by the psychologist or psychiatrist. The teacher to do assessment work has a fair burden of action as he has to keep a complete record on learning disabilities, organise a series of reports, including test results, rating scales, sociograms, annecdotal records and personal impressions.

The final area of assessment is in the medical assessment of the adolescent. This area enables early screening of children for physical problems and treatment, if necessary. All the adolescents go through this process. However, where this process falls down is in the non-availability of the previous medical history. For instance, it might be possible to examine an adolescent and give a clear bill of health on an adolescent who has a history of rheumatic fever. Where possible, data on birth history, family history of physical and psychiatric illness, past history of illness or trauma is needed. It is not always possible to obtain accurate data from the adolescent. If this data was available it would be possible to reduce a number of requests for visiting specialist time (for example, diagnosis on treatment of epileptic children).

It is hoped that not only assessment of a disturbed adolescent will have some benefit but also this may lead to more recognition and prevention of the educational, medical, psychiatric and social aspects of the problem.

The psychiatric aspects of the problem are outlined from a survey of patients seen by the author for psychiatric assessment from the beginning of 1971 to the end of 1973. Similar assessments and interviews were given as in the Miramar Girls' Home survey except that interview time for new cases was based on hour interviews rather than 1½ hours.

Results:

a) The Families:

Evidence to date indicates family life to be the most important determinant in delinquent behaviour. The family in general needs fairly careful assessment prior to the admission of the adolescent to the home. Virtually all the families are seen by the field social workers and usually a good analysis of the major contributing factors to the adolescents symptoms are elicited. In a number of cases some of the families are seen by the author for a diagnostic family interview. This procedure is usually aimed at looking at the more subtle and less obvious family psychopathology. One of the most important aspects of family assessment and short term work often passes almost unnoticed as a feature of work of the Home staff. This is the question of how is a family of a delinquent adolescent going to receive him if he is able to return home. The Principal and Assistant Principal have considerable contact with the parents of the boys and are often able to test out what might happen. For instance some families are barely able to accept the advances of the staff and avoid a frank and friendly discussion and they continue to be gripped by a deep anxiety. While other families do make an attempt to cope with the problem and try and make it known to their child that they will finally be accepted in the family to the same degree as their siblings. However, in the author's opinion the adolescent needs to make his peace with the parents first and it should not be left to happen but ideally should involve the adolescents social worker or whoever is going to follow the return of the adolescent to the family. It must be remembered that even in the most "ideal" family of the adolescent in Epuni Boys' Home they contain still a large amount of mistrust and suspicion still, the same attitudes that forced the delinquent to become the black sheep of the family. Unfortunately some of the most rewarding and skillful work of the staff is unable to be done as so many of the families from which the child is admitted are unsuitable for even providing the basic needs for a child. In addition some of the families are not accessible because of distance. In contrast to the Girls' Home survey the Boys' Home families seem to contain some very adverse features for good personality growth. It should be noted that the type of family in the survey is not one that is necessarily associated with poverty. The low socioeconomic family certainly features more so than in the Girls' Home survey but this is not always

so. Most of the families seen are unstable and disorganised. Tables 30-32 gives a rough index of the disorganisation but perhaps more important are the unstable child rearing practices, in a home whose activities are usually impulse determined and where consistency is totally absent. Many of the children are thus predisposed to acting out and impulse disorders. In a much higher proportion than in the girls these adolescents seem to exhibit low frustration tolerance, impulsivity and unreliable controls, aggressiveness and a poor sense of identity. In others the adolescents seem to be precipitated into a situation where they grow up fast and adopt a premature pseudo toughness and a defensive way of coping with life. Common in the families are marked in consistencies of disciplining practices. This seems to lead to difficulties in the adolescent's relationships with authority figures. When an act results in retribution in one instance and not in another, authority comes to be seen as "capricious and punitive". Often the punishment given in the past does seem excessive and verging into the child abuse spectrum especially when an adolescent still carries physical scars of past injury. In these cases aggression frequently breeds agression and the characteristic picture of a child who has the life style of a spontaneous violent discharge of emotion frequently appears especially when the adolescent is placed in a position of powerlessness in the institution. In fact aggression due to causes such as these outlined are a source of a major worry within the staff. Many forms are simply due to the adolescent seeking ego enhancing experiences amongst his peers. The more severe and bizarre forms of aggression often seen in some forms of psychiatric disorder have not been seen or only rarely at the Boys' Home. (See page 83). There is a mistaken impression that many forms of aggression are due to organic deficits and that an EEG will diagnose this condition. This is not so and an EEG will not differentiate between a developmental condition or an organic one. As already mentioned a number of the adolescents are reared under conditions that cause poor impulse control and some degree of developmental immaturity would be expected in emotional control or EEG disorder.

Table 27 Ages of 250 adolescents assessed.

Years of Age	Number
8	1
9	3
10	11
11	17
12	27
13	56
14	89
15	37
16	9

35% of families studied were European the remainder consisted of Maori, Islanders or mixed mariages. A significant proportion of European families came from minority groups and from immigrant families.

Table 28 Number of Siblings in referred Adolescents Family

Family size	No. of Families	Percentage of Total
1	7	2.8
2	25	10.0
3	32	13.3
4	46	18.4
5	36	14.7
6	27	10.8
7	29	11.6
8	16	6.4
9	11	4.4
10	7	2.8
11	7	2.8
12	4	1.6
13	1	0.4
14	1	0.4
15	0	0.0
16	1	0.4

Amongst the referred sample it is noted that the adolescents came from an average family size of 5.4 children.

Table 29

Birth order of child under study	Number
1	49
2	69
3	46
4	45
5	19
6	10
7	5
8	2
9	3
10	0
11	2

There seems to be a much more even spread of referrals from the Miramar Girls' Home survey which shows a predominance of first and second born children. There also seems to be a higher number of admissions of children from the same family when the children reach the adolescent age.

Table 30 Broken Homes

	Separation	Death M	Death F
No.	79	15	20

Total 114

Table 31 Absent parent from child's family

	F	M	Both
No.	63	24	27

Table 32 Significant medical problem in parents or siblings

	M	F	Siblings
Medical	21	18	12
Alcoholism	15	35	1

Table 33 Parents or other siblings who are or have been under psychiatric care

	M	F	Siblings
Inpatient	11	5	9
Outpatient	10	5	3

Table 34

Legal Adoptions	22 cases

A number of Maori children who were not legally adopted were not included in these figures. The figure of 22 adopted children is similar to the percentage of cases seen in child health clinics and it is slightly above the national average.

23 children were living with the fosterparents or in family homes prior to admission to the Home.

The incidence of 56% of broken families by death, separation or divorce is higher than the 23.4% of a similar sample at the Girls' Home. Tables 30 - 34 indicate further areas of stress on the families which add to the disorganisation of these multiproblem families. A large number of families seem to be one parent families where the mother looks after the children through a succession of unstable father figures. Even in the "intact" family the typical family structure, compared with the Miramar group, seemed to be much more disorganised in a general way than in specific ways. However, some of the family characteristics described in the Miramar survey are also seen in the Epuni group. Epuni Boys' Home admit a higher proportion of state ward children than Miramar and amongst this group are children exposed to various deprivation experiences and/or subject to multiply erratic nurturing figures, impermanence and unpredictability. Many parents seem to have disengaged from their responsibility for bringing up their children nor do they continue to make any contact whatsoever with their children. In actual fact all varieties of psychopathology are represented in the families seen. However, there does seem to be an overemphasis on families that produce children with conduct disorders. These are the families that fall down in the socialization of their children. In a sense these families do not need detailed study in diagnostic family interviews as the major defects and reasons for disorganisation are fairly obvious to most workers. More subtle and less obvious in these families seems to be the breakdown in communication or poor communication

skills between parents and child. Virtually all aspects and types are seen but not uncommonly another factor works where the sibling subsystem tends to encourage expression of opposition to parental control. During the author's 4½ years experience in work in the Homes he has seen many children from the same family in the Home. Often there does seem to be a power structure and an equilibrium process in the family where the delinquent role of a child seems to be re-allocated to another sibling once the first one leaves the family. The finer points are not surveyed in this study but there are other problems in the families that could have been tabulated such as parents with criminal records, cousins in trouble, sisters with extra-nuptual pregnancies and so forth. It is probably true for a small proportion it can be said that some of the families seen are a true breeding ground for criminal behaviour.

b) The Adolescents:

Many of the adolescents seen seem to be poor in communication skills. Some were unable to communicate their thoughts, feelings and observations. Some of the adolescents appear to have not learnt some of the basic rules which regulate communication. This process seems to have impaired learning and socialization in many cases and probably is traceable back to the parent child relationship. To some extent it would be easy to misdiagnose a number of children as having an affectionless psychopathic state. Other factors operate also including intelligence and specific learning disabilities.

Table 35 Intelligence (tested or estimated) 250 cases

Above	Average	Below	Subnormal (Below IQ 70)
14	158	59	19

Less than 3% of the Girls' Home adolescents are below average intelligence whereas with the Boys' Home group some 23.4% are below average intelligence. The 7.6% of the group falling into the subnormal group are an extremely difficult group to deal with and cater for as basically the programme in the home is set for a child of normal or near normal intelligence. The subnormal child is poorly tolerated by the boys in the Boys' Home. A number of admissions to the Home

have specific learning disabilities as already discussed in the general part of this paper. Specific learning disabilities are a rare feature of the Girls' Home group who seem to have more learning inhibitions based on emotional disorder.

Table 36 EEG Results (76 cases referred)

Non specific abnormality	lateralizing R	lateralizing L	Epileptic Activity associated with clinical signs	Normal
45	16	0	9	6

The EEG is of diagnostic value in cases of learning problems where the possibility of seizure activity is under consideration. Unlike adults, with children there is no real correlation between EEG abnormalities of a nonspecific or lateralizing kind and certain intellectual and academic variables. However, some of the adolescents with these abnormalities show short attention spans and low tolerance to frustration which in some cases responds to broad spectrum antiepileptic drugs. The EEG in most cases is expressed in a nonspecific abnormality (see table 36 and table 16 page 48) however a small number do have a more significant abnormality in terms of unilateral abnormalities or paroxysmal disorder suggestive of epilepsy. Anti-epileptic drugs were used in 37 cases with moderate to good results. Most studies have found EEG abnormalities in 65% of children with learning and behaviour problems but without a history of convulsive disorder. There is also a lack of real agreement in the literature on what an abnormal record is and what correction should be made for age. The overall incidence of EEG abnormalities in the general population of children is usually stated at about 12%. The proportion of EEG abnormalities amongst children with behaviour disorders diminishes as age increases, a fact suggesting the earlier abnormalities were manifestation of immaturity. Therefore, the use of the EEG as a diagnostic procedure should be selective and medication only used in a small number of cases where indicated. Most of the cases were physically fit but a few did have a number of minor defects or abnormality due to accident. Three cases had loss of an eye on one side from accident and five cases had loss of vision to an eye caused by an old perforating injury. Enuresis occurs in a high proportion of cases and thirteen cases were treated with medication. Enuresis seems more related

to developmental abnormality or neurological immaturity than to defects in social training. Other expressions of developmental disorders occur as learning disabilities. Unlike the Girls' Home veneral disease is not a problem in the Boys' Home. No cases were recorded, and it should be noted that due to the nature of veneral disease in a male the male is more likely to seek treatment than the female when symptomatic. To some extent the sexual delinquency problems seem much less with the Boys' Home group than the Girls' Home group. However, some of the more disordered sexual behaviour does present (see table 37).

Table 37 Sexual disorder

Attempted rape	5
Homosexual behaviour	4
Indecent assault	4
Indecent exposure	4
Theft of womens' clothing	9

c)Reasons for referral:

Were very much as in the Miramar Girls' Home survey. Suicidal attempts were less common in the Boys' group and referral for assessment of aggressive behaviour more common than in the Girls' Home group. Some of the aggressive behaviour was extreme with serious assaults on children causing injury, (five cases) attempted murder of a parent (three cases of which one boy stabbed his mother in the neck). In some cases it was in fact the parent or defacto that was the aggressor, with serious assault on a child (five cases) assault resulting in criminal charges (three cases). In some cases punishment appreared to enter the child abuse area whereby some cases still carry around scars from previous abuse.

The type of symptoms that an adolescent shows that results in admission to the Boys' Home frequently is not a very good indicator of whether a child is disturbed in a psychiatric way or not.

Table 38 indicates that a considerable number of the 250 cases seen have had some contact with psychiatrists or have had inpatient psychiatric treatment. The child health clinics involved were Palmerston and Wellington. Other out-patient psychiatric clinics included Nelson, Hastings and Wanganui. The psychiatric hospitals included Lake Alice and Porirua Hospitals.

Table 38 Previous psychiatric care or counselling

Child Health Clinics	31
Psychiatric Hospitals	13
Out-patient Psychiatric Clinic	26
Practitioner known to be involved	7
Paediatric out-patients	1
Psychological Services	72
School Guidance Counsellors	8
Church Voluntary Agency	6
Total	= 164

Disturbed adolescents unlike adults do not seek help through their practitioner. Adolescents with behaviour disorders rightly do not consider themselves as mentally sick and many of the referrals to psychiatrists are initiated by non-medical professional workers. In most cases a number of agencies and departments struggle inappropriately with a disturbed adolescent who needs a particular type of treatment which is not available and admission to Epuni Boys' Home is the end of the line. This is reflected in the case studies of the children under study as frequently presenting symptoms have been present for many years before an adolescent reaches

Epuni Boys' Home. The reasons for failure and lack of "holding power" of the various agencies istouched on in the theoretical section (on page 6 onwards). However, even Epuni Boys' Home experiencies the same difficulty as various referral agencies as at times there is a build up of a type of case that has five to six admissions to the home without possibilities of palcement elsewhere.

(d) Diagnosis:

Table 39 All categories of psychiatric diagnosis seem to be represented in the sample.

Adaptation disorder	3
Hyperkinetic disorder	1
Neurotic Disorder	
a) Severe acting out	20
b) Moderate acting out	7
c) Neurotic depression	24
Conduct Disorder	104
Personality Disorder	
a) Deprivation syndrome	24
b) Passive aggressive	6
c) Sociopathic	30
d) Schizoid	2
e) Sexual deviation	7
Epileptic	
a) Minor	2
b) Grand mal	1
c) temporal lobe	2
d) post traumatic	2
Other	
a) Organic brain syndrome	6
b) Toxic state from petrol sniffing	2

Total = 250

The diagnostic categories follow the ICD classification as used in New Zealand. The categories in general were not used in the assessment reports for sometimes a psychiatric label can have unforeseen consequences. For further details of the diagnostic categories see pages 53 - 55.

Tabke 40

Comparison of diagnostic categories between the Girls' Home sample (180) and the Boys' Home sample (250).

	% girls diagnosed		% boys diagnosed	
1. Adaptation	1.1		1.2	
2. Developmental Disorder (including hyperkinesis)	1.1		0.4	
3. Neurotic				
a) Severe acting out	10.0		8.0	
b) moderate acting out	5.56		2.8	
c) hysterical	12.78		0.0	
d) depressive	7.22	40.6	9.6	20.4
e) obsessive	4.44		0.0	
f) anorexia	0.56		0.0	
4. Conduct Disorder	22.2		41.6	
5. Personality Disorder				
a) deprivation syndrome	5.56		9.6	
b) Passive aggression	0.56		2.4	
c) sociopathic	2.78	12.78	12.0	27.6
d) schizoid	2.78		0.8	
e) sexual deviation	1.1		2.8	
6. Epileptic				
a) minor	1.1		0.8	
b) Grand Mal	2.2		0.4	
c) temporal lobe	9.44		0.8	
d) post traumatic	3.33		0.8	
7. Psychotic				
a) symbiotic	1.1		0	
b) pre-psychotic	5.56		1.2	
c) psychotic	3.89		1.6	
8. Other	0.56		2.4	

Some fairly serious psychiatric disorder is seen in both the Miramar and Epuni group. In some cases the psychiatric hospitals have discharged an adolescent into welfare care with the hope that the short term home may provide the rehabilitation that the hospital are unable to provide. From 4 to 6 cases from each institution are sent to psychiatric hospitals under certification. Many cases would be better treated in adolescent units if they existed.

Although treatment methods will not be outlined the use of medication within the short term home is discussed. It would be possible to tranquillize an aggressive adolescent into a zombie state and the potential for the overuse and

improper use of drugs in a short term home is great. It is not possible to get away from the medically prescribed drugs within the institution as frequently cases are admitted already on medication. With others there are medical aspects that justify reasonable use of drugs. In actual fact the use of medication in the author's sample was higher than expected.

Table Use of Medication

Antiepileptic Drugs	Antidepressant Drugs	Tranquillisers Major	Tranquillisers Minor	Medication for Enuresis
37	16	18	4	13

Total = 88

The author's position is that if an adolescent needs tranquillisers to contract aggression in himself to make him 'safe' then it is debateable whether he should be in a non-medical setting. Occasionally the short term use of a tranquilliser is necessary to break a vicious cycle of behaviour. Minor tranquillisers should probably not be used because of the tendency to psychological dependency. Both minor and major tranquillisers impair learning ability in children and adolescents. Most adolescents tolerate tranquillisers very badly and on discharge soon take themselves off the medication. Short term use of antidepressant medication is helpful and usually tolerated well with adolescents with depressive conditions and/or adolescents with profound mood changes. The use of medication in the home brings in another dimension of treatment into the home but is justified if sufficient Home staff are able to be trained in basic nursing procedures and aware of certain side effects of the drugs. One of the main problems is to co-ordinate the continuation of medication and oversight where necessary when an adolescent is discharged from hospital.

The use of illicit drugs was not a feature of the Home group during the period surveyed. Some 4 cases are known to have taken drugs and one adolescent jumped in a river when under the influence of illicit drugs. No cases used the intravenous drugs (one case in the Miramar Girls' Home survey did.) The main drug of use seems to be alcohol.

Conclusions:

Although no doubt the data collected could be greatly improved with careful recording of other factors and techniques no amount of statistical data will give rise to a hypothesis as to why some childrens' controls breakdown, how some defend themselves so successfully against adults in their lives and what can be done to prevent and treat childhood disorganization. It can be seen from the cases assessed in both institutions that both Homes are dealing with a wide range of disturbed behaviour and not just delinquent behaviour. Even with delinquency some severe cases are manifestations of very disturbed behaviour. The long term psychological implications of delinquent behaviour patterns have clearly emerged in a number of studies including Robin's (1966) work 'Deviant Children Grown-up'. In this thirty year follow-up of 524 Child Guidance Clinic patients initially seen at a median age of 13 the primary neurotic children were found as adults to resemble closely the 100 control subjects, whereas the primary antisocial children were notable as adults for their high frequency of arrests, alcoholism, divorce, poor job histories, child neglect, dependency on social agencies and psychiatric hospitalization. Robins emphasised the role of antisocial behaviour in causing the adult sociopathic disorder. It should be noted that in 12% of the Epuni sample sociopathic traits seem to be already established. The importance of the short term home in the treatment and assessment of early delinquent and disturbed adolescent in short circuiting the presage progression to serious delinquency cannot be stressed too much.