
 SAM POSITION STATEMENT

Adolescent Inpatient Units: A Position Statement of the Society for Adolescent Medicine

Position

It is imperative that appropriate care of hospitalized adolescents be included in the planning of health care services at local, regional, and national levels. The Society for Adolescent Medicine advocates the continuation and establishment of adolescent medicine inpatient units in both pediatric and general hospitals as an optimal approach to the delivery of developmentally appropriate health care to hospitalized adolescents. Such units should be geared to meeting the psychosocial needs of adolescents and the training needs of health professional students. In those hospitals in which there are too few admissions of adolescents to warrant a separate adolescent unit, a multidisciplinary team of health care professionals with expertise in adolescent health should set guidelines and policies for, as well as provide consultative services to, hospitalized adolescents. Whenever possible, teenagers admitted to such hospitals should be placed with other teens, rather than with older adults or infants or young children.

Commentary

Adolescent inpatient units were first established in the 1950s and 1960s as a way of providing optimal, developmentally appropriate care for hospitalized adolescents. In the 1970s, several organizations, including the Society for Adolescent Medicine, American Academy of Pediatrics, and Association for the Care of Children's Health, developed guidelines for the establishment of adolescent units (1-3). These early guidelines emphasized that the segregation of adolescent patients is called for primarily on psychological grounds; that the required facilities may necessitate an initial increase in funding; that the clustering of teenagers in a separate area provides unique clinical, behavioral, and educational oppor-

tunities and challenges; and that the patient mix in such units allows for variability based on each hospital's needs (4).

It is estimated that there are currently 40-60 adolescent units in North America, with several additional units in Europe, Asia, South America, and Australia. As noted in a recent report, units range in size from 6-35 beds, with most having 11-20 beds (4). The units generally have lower age limits of 10-13 years and upper limits of 17-24 years. Most admissions are for medical or surgical conditions, with smaller numbers for gynecologic or psychiatric care.

Adolescent units are designed to meet the unique developmental and psychosocial needs of teenagers (5-11). Specified areas for a dayroom, classroom, and/or conference room, generally supervised by child life specialists and teachers, allow for mobility, recreation, socializing, and continued schooling. Nursing, medical, and ancillary staff are trained to provide adolescents with as much autonomy as possible, while social workers, psychologists and psychiatrists are available to help adolescents manage the psychological stresses of hospitalization (12-16). Adolescent patients with psychosocial issues too complex for general medical services or medical concerns too pressing for psychiatry services often are best managed on multidisciplinary adolescent units. Examples include patients with severe eating disorders, medical complications of suicide attempts, substance abuse, and pelvic inflammatory disease (17-22).

In recent years, some adolescent units have been downsized or eliminated because of financial pressures. Hospital administrators cite inadequate staff, declining occupancy rates, and mismatch between available beds and patient age or gender. Further, there remains a continued tension between the need for adolescent units and the desire of some specialists to create or maintain disease or organ-specific inpa-

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tient units. These tensions have increased with the advancing technologies associated with the care of particular illnesses such as malignancies or cardiac dysfunction. Whether the psychosocial advantages of the adolescent setting outweigh the medical advantages of the subspecialty setting must be judged on an individual basis.

Despite the financial reservations expressed by some hospital administrators, most hospitals have noted specific benefits associated with having an adolescent unit (4). In addition to the improved care available to adolescent patients, residency training programs, especially in pediatrics, are enhanced by the educational opportunities presented by a concentration of adolescent patients and specialists in one location. Nursing staff receive necessary backing in handling a difficult age group, leading to a more satisfying work experience. Attending physicians and fellows interested in studying the health needs of adolescents find new educational and research opportunities. Non-hospital-based physicians are more likely to admit their adolescent patients to the hospital with an adolescent unit in those communities where hospitals compete for market share. Finally, hospitals may market specific and unique adolescent services to teenagers, parents, and admitting physicians. Ultimately, each of these advantages accrues to the benefit of the institution and enhances the argument for the continuation of these units in times of health care reform.

There are nearly five million admissions per year of adolescents and young adults, ages 10–24 years, to short-stay hospitals in the United States (23). With fewer than 100 adolescent units, and many adolescent patients admitted to obstetric units, it is clear that most hospitalized adolescents do not have the opportunity to benefit from the advantages of an adolescent unit. To meet the developmental and psychosocial needs of these adolescents, we suggest the development of "adolescent units without walls." Adolescents can be preferentially admitted to those units with staff interested in adolescent health care, and these staff can form a multidisciplinary team who can set policies for, and provide specialized services to, adolescents admitted to general medical, pediatric, psychiatric, surgical, and obstetric units. In this way, developmentally appropriate care can be offered to those adolescents admitted to hospitals where there are too few adolescents to warrant development of a separate adolescent unit.

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