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National In-patient Child and Adolescent Psychiatry Study (NICAPS)

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1 EXECUTIVE SUMMARY

1.1 Introduction

The Royal College of Psychiatrists' Research Unit was commissioned by the Department of Health as part of its Mental Health Research Initiative to investigate the characteristics and use of child and adolescent psychiatric in-patient units in England and Wales. These are highly specialised services that are a valuable, but expensive, component of child and adolescent mental health services. The National In-patient Child and Adolescent Psychiatry Study (NICAPS) was designed to generate data to inform policy decisions about future investment in, and service planning for, such units.

1.2 Methods

Starting in April 1999, NICAPS conducted a detailed review of child and adolescent mental health in-patient units. A multi-method approach was employed. The main study elements consisted of six linked sub-studies:

- 1.2.1 The identification and description of all child and adolescent in-patient units in England and Wales. This included a general survey questionnaire, censuses of bed, staff and patients and a six-month activity study of all referrals, admissions and discharges to and from in-patient units.
- 1.2.2 A detailed review of the quality of services provided by 18 of these units. Eighteen sites were visited and reviewed against a specially developed set of service standards. The reviews included on-site structured interviews with a range of professionals from each service.
- 1.2.3 A population-based, longitudinal study of the outcomes of referrals to the 18 units that were visited.
- 1.2.4 A survey of the 474 members of the Royal College of Psychiatrists' Child and Adolescent Faculty to identify issues of concern.
- 1.2.5 A survey of admissions of young people with mental disorders to general adult psychiatric wards and paediatric wards to obtain an indication of unmet need.
- 1.2.6 A survey of referring out-patient psychiatrists to obtain their view on access to in-patient services.

1.3 Main findings

1.3.1 Concerns identified by Child and Adolescent Faculty members

The main concerns expressed by members of the Faculty included: lack of emergency beds; insufficient number of beds; poor provision for severe or high risk cases; and poor liaison with other services.

1.3.2 Distribution of units

At the time of the study 80 units with 900 beds in all were identified in England and Wales. The distribution of beds per 100,000 18 and under population was higher in the South East, where 41% were funded by the NHS. These beds were largely in specialist eating disorder units and secure units. London, compared to the rest of the country, also had a higher proportion of beds, of which 27% were in the independent sector. At the lower end of the scale, Wales and the West Midlands had less than half the number of beds per 100, 000 of the 18 and under population than that found in the South East.

1.3.3 Severity of illness

A higher percentage of the in-patient population was rated as having moderate to severe problems on all the HoNOSCA scales compared to the out-patient population surveyed by the Audit Commission (1999).

1.3.4 Care and treatment

A wide range of treatments was provided in all types of units, however adolescents treated on adult wards received fewer of the treatments most commonly used in this group.

1.3.5 Staffing

Mean nurse staffing levels vary considerably. There is also great variation in the extent to which units are staffed by a full multi-disciplinary team needed to provide a range of interventions. It is striking that more than one-third of units do not employ a social worker. A high proportion of the nursing establishment is unqualified and few nurses have specialist qualifications in nursing children. This is important not only in terms of the specialist skills but also because of the availability of staff knowledgeable about child protection.

1.3.6 Referrals, admissions and discharges

For every four patients referred to in-patient units, approximately three were assessed and two admitted. Patients were commonly referred to more than one unit (either serially or in parallel) before admission was achieved.

1.3.7 Access

Patients who were admitted were generally admitted promptly. For emergencies, 60% of admissions were within 24 hours and 80% within one week. This still left a significant group for whom there was an unacceptable delay. There were also a number of patients who were refused admission due to lack of resources or the nature of their difficulties. Estimates derived from the survey of admissions of young people with mental disorders to other NHS wards also showed that the number of “inappropriate” admissions to adult general psychiatric wards and paediatric wards was likely to be around 715 in a year compared to the 2,134 estimated admissions to all CAMHS in-patient units.

1.4 Conclusions

The NICAPS results indicate that there is variation in the distribution of beds in terms of number and type (e.g. specialisation and age group) across NHS Regions in England and Wales. In particular the South East has a high concentration of beds in secure and eating disorder units, which are largely in the private sector. Variability was also found in the diversity of the disciplines on multi-disciplinary teams and among the nursing staff a lack of specialist qualifications was found. With regard to throughput, while the data showed that for many the admission is prompt there is a significant group who experience some delay. The survey of “inappropriate” admissions of young people to general adult psychiatric wards and paediatric wards also may indicate unmet need for specialist in-patient care for a considerable number of young people with severe mental health problems.

1.5 Recommendations

- 1.5.1 There needs to be population-based planning for the commissioning of in-patient CAMHS services on a regional if not supra-regional level.
- 1.5.2 Regional or national planning should be supported by each Health Authority and Primary Care Group/Trust being able to demonstrate that they have secured provision for young people who require in-patient care by robust arrangements/contracts/agreements with child and adolescent in-patient facilities.
- 1.5.3 There is a clear case for ensuring that a comprehensive range of services is commissioned for each area. This should include emergency care, general in-patient facilities and specialist services.

- 1.5.4 There is a need to ensure that emergency in-patient care is available to those who need it. There is a debate about how best this should be provided which centres on whether general units should have this as a core function or whether new units should be established.
- 1.5.5 A proportion of young people are inappropriately admitted to general adult psychiatric and paediatric wards. Where this is unavoidable, there is a need to ensure a basic level of safety, access to appropriate treatment and a high level of input from CAMHS.
- 1.5.6 Taken as a whole this study suggests that there is a need for an investment in greater numbers of CAMHS in-patient beds, and that there is a particular need to ensure the availability of beds into which emergencies can be admitted.
- 1.5.7 The percentage of nursing staff who have relevant specialist qualifications should be increased and access to specialist training improved.
- 1.5.8 Attention should be paid to ensuring that a full range of skills and disciplines is available in the multi-disciplinary teams on in-patient units.
- 1.5.9 Attention should be paid to securing staffing for the education of the 16-18 year olds in in-patient units.
- 1.5.10 There should be a strengthening of relationships between in-patient units and community CAMHS in order to ensure continuity of care. This might include outreach services from in-patient CAMHS and “inreach” services from community CAMHS into in-patient units.
- 1.5.11 There needs to be greater equity of service provision geographically. This will require an increase in in-patient resource in some parts of the country.
- 1.5.12 Liaison and transfer protocols between CAMHS and general adult psychiatric services need to be improved.
- 1.5.13 Further research should be commissioned on those referred but not admitted to in-patient CAMHS including estimates of the size of this population, their needs and outcomes following assessment.
- 1.5.14 This study focused exclusively on health facilities and so did not include facilities managed by local authorities or the independent sector which provide social care, or which are primarily for detention (e.g. local authority-managed secure units). There is a need for research to investigate mental health issues in these settings.
- 1.5.15 There is a need for further research into the characteristics and care of young people admitted to paediatric wards and general adult psychiatric wards. This should include pathways into care and the extent to which their mental health needs are met.

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2 INTRODUCTION

2.1 Background

The large majority of child and adolescent mental health services are provided in community settings. However, some children and adolescents ('young people') have problems that are so severe or complex that admission to hospital is needed for diagnosis and/or treatment. Younger children show a greater difference in pattern of mental illness from that exhibited by adults. For older adolescents this difference diminishes and "adult type" patterns become more common though differences are still evident. In addition, due to their age and developmental stage, young people are also vulnerable to exploitation by adults and may become distressed at disturbed adult behaviour. Because of these factors and the need for young people to be treated in an environment appropriate to their age and developmental stage, specialist in-patient psychiatric units (IP units) for children or adolescents have been developed.

The number of IP units and beds is relatively small, each serving a large catchment area population, often determined by history (e.g. where there was a consultant with a special interest, academic centres or the distribution of now defunct health authorities). It has been reported that the volume of NHS provision has decreased over the last decade (House of Commons Health Committee, 1997), but it is unclear whether this has been balanced by independent sector expansion. Reviewing the literature there is a striking lack of even the most basic of information concerning these low volume, high cost specialist services. Kurtz, Thornes and Wolkind (1994) identified 62 NHS IP units for young people, but were only able to obtain information from 37 of them. Services in Scotland have been considered in a consultation paper (Bryce, 1996). Summarising the current pattern of (specialist or service) provision, Kurtz *et al* (1995) have described the development of in-patient psychiatric resources for young people as haphazard and their function to be capricious. Problems continue with obtaining emergency placement (Street, 2000).

Because they are few in number and serve large areas, there has been concern that IP units can become isolated from each other, from the mainstream of medicine, and from local child and adolescent mental health services. This has raised the possibility of idiosyncratic practice, a lack of mutual audit, and a slow uptake of innovations and evidence-based practice. There has also been the fear that because IP units depend on referrals from a wide range of purchasers, that local cost pressures on purchasers may make them particularly vulnerable to cuts in provision.

This study was commissioned and designed to fill some of the major gaps that exist in our knowledge base about in-patient provision for children and adolescents with mental disorder. It aims to describe the types of patient, disorder and clinical management provided in in-patient units for young people, and in a separate report will assess the financial costs of such IP services. In addition it examines the extent to which young people with mental disorder are placed on adult general psychiatric and paediatric wards.

2.2 Policy context

There has been a large number of policy documents and initiatives which impact on IP services for young people in the past 15 years. Their impact, however, has not always been clear. Concern was raised about provision for psychiatrically disordered adolescents in *Bridges over Troubled Waters*, published by Health Advisory Service in 1986. This made recommendations that were not explicitly adopted as policy but were of some influence in setting the tone for debate. Its focus was on services for adolescents generally so its remit was not exclusively for IP units.

Following the *Health of the Nation* white paper (1992), ministers commissioned handbooks covering the five identified 'key areas' one of which was mental illness. The Handbook on Child and Adolescent

Mental Health (1995), produced by the Department of Health, the Social Services Inspectorate and the Department for Education and Employment, provides a concise statement of policy in child and adolescent mental health. The thematic review *Together we Stand* by the Health Advisory service (1995) developed this into detailed advice for commissioners. The tiered model they described was designed to assist commissioning and delivery of a comprehensive child and adolescent mental health service. It recognises four tiers of provision across all agencies and deliberately avoids the health service categories of primary, secondary and tertiary.

These are the two major current policy documents and they remain of relevance. However, there is very little indeed in either document about IP units apart from acknowledgement that a comprehensive child and adolescent mental health service must include facilities for IP care.

A multidisciplinary, multi-agency conference, hosted by the Department of Health in 1997, came to the conclusion that NHS IP units should be predominantly concerned with young people with psychiatric disorders rather than those with disruptive or anti-social behaviour. The possibility of placement in the independent sector for NHS patients has led to a clear increase in private adolescent IP unit provision, especially in the areas of eating disorders and forensic psychiatry. It has been observed that some such units only take NHS patients and have therefore become an integral element of local planning and service provision, particularly in London.

The National Service Framework for Mental Health (1999) does acknowledge to some extent the problems of the interface between the adolescent and adult psychiatric services. It states that there should be local agreement regarding age for referral to adult services and working arrangements for this (e.g. a protocol) and that when a young person needs to transfer to adult services a joint review must be undertaken to ensure effective hand-over takes place. This should be incorporated into the care plan under CPA arrangements for adult services (National Service Framework, 1999, pp 44-45).

The House of Commons Health Committee (1997) found that with respect to “Tier 4” specialist mental health services for young people (broadly equivalent to IP units):

...the current pattern of provision does not match the pattern of need; provision is patchy and inadequate...We find it unacceptable...that the DoH does not know the number or geographical distribution of beds for patients with eating disorders or the number of those beds which are designated for children and adolescents. The NHS Executive cannot begin to design, still less to implement, a strategy...if it does not collect and monitor data on current provision...it should collect (information about IP units), plan the provision of specialist services, and supervise its implementation by health authority consortia.

In addition the National Service Framework initiative on the early detection and treatment of psychosis could potentially have a major impact on adolescent in-patient services. If special services are set up for first onset psychoses, beds for these young people may no longer be required in adolescent units and the proportion of disorders treated in such units would change. In addressing this proposal there is a need to consider how best to cater for young people with a first onset of psychosis.

2.3 Service context

As well as a reduction in NHS in-patient child and adolescent psychiatric provision in recent years, there has probably been a change in its nature overall. There is little or no vestige of an older custodial model. This change has resulted in IP units as part of a continuum of care so that for example young people with chronic disabilities such as autism and general learning disability are very unlikely to have long term placements in IP units. The general philosophy of providing comprehensive, multi-modal evaluation and

treatment for young people who cannot be managed as out-patients has endured, as has the emphasis on using the in-patient environment as a therapeutic intervention in its own right (Green & Burke, 1998). However there is an apparent increasing emphasis on tailored treatments for individual young people. Although there is little research information available, units seem to have generally shifted to a shorter length of stay. This is comparable with the United States where average length of stay fell from 74 days in 1970 to 54 days in 1980 (Woolston, 1996) while the number of young people admitted has risen accordingly (Hillard, Slomowitz & Deddens, 1988). This parallels similar changes in adult psychiatry and paediatrics. Other changes include restricting admission to the more severely ill or those with complex co-morbidity, so that IP units become comparable in function to intensive care services in medicine (Blanz & Schmidt, 2000). There has also been an increased willingness to take emergency admissions, to operate for seven days in the week, and to improve working relationships with parents, referrers and other agencies.

It is likely, however, that the extent to which these changes have occurred varies from unit to unit. This has resulted in the picture of great diversity and of differing philosophies of care, admission and treatment policies, which was commented on by the Health Advisory Service (1986). This is almost certainly accompanied by corresponding differences between units in the casemix of their patients. But again the research based evidence is lacking.

A further issue where there is little empirical data is the extent to which there is overlap between the characteristics of young people admitted to NHS IP units and those admitted to other residential settings such as private IP units, adult psychiatric wards, paediatric wards, social services residential units, prison and young offenders institutions.

2.4 Research context

The recent Audit Commission survey (Children in Mind, 1999) of CAMHS focussed mainly on community services. Child and adolescent psychiatric in-patient care is a seriously under-researched area. Surveys in the past decade in England and Wales have commented on the patchiness of provision (Chesson & Chisholm, 1996; Kurtz, Thornes & Wolkind, 1994, 1995). By and large, admission to an IP unit depends on an interplay between the need for a more intensive service than out-patient/community management can provide, severity or complexity of psychiatric condition, safety for the young person, and characteristics of the young person's home which might impede treatment.

A number of, mainly American, studies have attempted to determine the factors involved in selecting young people for admission to IP units. At first sight there is discrepancy between findings to the extent that an overview by Maskey (1998) stated that there are no absolute indications for in-patient treatment. This is not nihilism but a recognition that there are multiple variables which include:

1. diagnosis (Hillard *et al*, 1988);
2. poor psychosocial functioning (Steinhausen, 1985);
3. the burden the young person's condition places on the family (Bickman, Foster & Lambert, 1996);
4. ease of access (Gutterman *et al*, 1993);
5. the clinical experience of the referrer (Morrisey *et al*, 1995);
6. the range of alternatives to in-patient care (Bickman, Foster & Lambert, 1996);
7. the availability of funding (Patrick *et al* 1993); and
8. the general backdrop of service organisation (Blanz & Schmidt, 2000).

However the data are such that this does not enable a prediction of how many young people need to be admitted to IP units in England and Wales and what clinical problems they will have.

Earlier studies on the outcome of in-patient treatment were unsurprisingly limited in the methods used. Pfeiffer and Strzelecki (1990) applied contemporary statistical methods to pooled data from 34 studies that met their selection criteria and concluded that there was fair evidence for benefit, particularly if there was careful planning of aftercare. A number of detailed findings as to which cases and which treatment methods appeared related to better outcomes has been somewhat superseded by the development of more effective treatment methods in the last 10-15 years.

In terms of evidence of effectiveness of admission there are three major studies of particular interest. In a Finnish prospective study (Sourander *et al*, 1995, 1996a,b and c, 1997, Sourander & Piha, 1998) Sourander and colleagues demonstrated improvement in half to three-quarters of young people admitted for a short stay (mean 35 days). Data from an American study suggest that, compared with adults, young people stay longer in hospital and are more expensive to treat (Patrick *et al*, 1993).

Bickman and colleagues (1995, 1996) carried out a demonstration project at Fort Bragg army base using a well-developed continuum of care model in which in-patient treatment was part of a range of psychiatric services. This study reported that a well-developed and quite expensive system of mental health care with a strong emphasis on intermediate provision (day or part-week residential) at Fort Bragg did not produce better mental health outcomes than control sites which used traditional service organisation. There are no data which delineate particular IP unit treatment effects, though four times fewer young people were admitted at Fort Bragg.

Finally, following earlier UK studies (e.g. Jaffa *et al*, 1999), a prospective multi-centre UK study involving four IP units found general improvement, particularly in symptoms, following IP unit treatment (McCabe *et al*, 1996; Rothery *et al* 1995; Wrate *et al*, 1994). A strength of the study is the detailed documentation of treatment goals and activities. Like most other studies, the least improvement was found for conduct disorder. Specific treatment effects were reported for major affective disorder and schizophrenia.

What can be gleaned from reviewing research on IP units is that we know very little about the resource in England and Wales, that admissions and therapeutic impact are hard to determine without reference to the context of other services, and that, in general, we should be optimistic about its contribution to treating severe mental health problems in the young (Blanz & Schmidt, 2000). We also know little about its cost.

2.5 National In-patient Child and Adolescent Psychiatry Study (NICAPS)

In response to this lack of data on which to base decisions concerning service provision, IP units were chosen as the focus for the Child and Adolescent element of the Department of Health's Mental Health Research Initiative. This project was developed in order to meet the Department's project brief. The main aims of the study were as follows:

- i. To identify and to describe all child and adolescent psychiatric in-patient units in England and Wales;
- ii. To carry out a detailed review of a stratified sample of 15-20 child and adolescent psychiatric in-patient units in England and Wales, including an evaluation of standards of care, and safeguards, against explicit standards;
- iii. To complete a population-based, longitudinal study of the outcome of referrals to child and adolescent in-patient units from a stratified sample of health authorities.

The Department of Health commissioned 2 additional projects to evaluate the costs of these services and to evaluate the use of the Children Act and Mental Health Act in children and adolescents. Some common data collection tools were used between the three studies, but results are reported separately.

3 METHODS

3.1 Overview

The study used a multi-method approach to collect data in each of the three elements of the study:

- i. A descriptive study of all units and their residents
- ii. A detailed review of a sample of 18 units, including an assessment against an explicit set of quality standards
- iii. A study of referrals to these units

Data were collected using questionnaires, censuses and surveys, some administered by post and some in person as part of interviews on site visits. The details of the methodology used in each section will be presented below.

The potential benefits of such an approach are well recognised (e.g. Brewer and Hunter, 1989). With particular reference to this study its advantages included the following:

- i. it allowed the choice of methods which were best suited to addressing particular questions, data sources and topic areas;
- ii. it reduced the possibility of measurement error by tailoring method to question;
- iii. it enabled us to use methods generating data facilitating ease of interpretation; and
- iv. it allowed a certain functional redundancy so that if one method failed, other complementary approaches might still succeed so generating data on all areas of interest.

There are two companion studies to this which will deliver separate reports to the Department of Health. The first covers legal and legislative issues focusing on the use of the Children Act (CA) and the Mental Health Act (MHA) for the detention and treatment of children and young people. The second is an economic evaluation of these services including cost variations between units in terms of factors such as case-mix, staffing and location. These issues will be considered in detail in the reports from these companion studies and will therefore not be addressed here.

A summary of the methodology used in this study is presented in Figure 3.1 at the end of this section.

3.2 Survey of the Child and Adolescent Faculty of the Royal College of Psychiatrists

In preparation for the main study, a survey of child and adolescent psychiatrists was conducted to obtain a prioritised list of psychiatrists' concerns relating to psychiatric in-patient units for young people. A questionnaire containing a single open question was sent to all 474 members of the Royal College of Psychiatrists' Child and Adolescent Faculty with addresses in England or Wales. The question asked was:

Briefly, what do you think are the main issues relating to child and adolescent psychiatric in-patient services?

A follow-up letter was sent to non-responders four weeks after the first forms were posted.

Content analysis was carried out on the text of the responses. First, the free text replies were broken down into component statements or "text units". Two researchers then reviewed the statements and

independently created a coding frame into which to fit these qualitative data. The two coding frames were then compared and a final version was arrived at by consensus. The researchers then independently coded the statements and any discrepancies in the coding of text units were discussed and resolved by consensus.

3.3 Identification of child and adolescent psychiatric in-patient units in England and Wales

The research team's first task was to identify all child and adolescent psychiatric in-patient units in England and Wales.

For the purpose of this study a unit is defined as a ward or unit within a service that has a specialist function. A hospital or service may have three or four units within it. One hospital, for example, has 5 specialist units within its grounds that admit young people aged 18 and under for the treatment of mental health problems.

The criteria set for inclusion in the study were as follows:

1. The study included both NHS and independent sector units.
2. There was no fixed upper age for inclusion of residents/patients, so that all individuals on child and adolescent in-patient units were included in the study. For that element of the study that focused on young people in general adult psychiatric wards we included only people under the age of 18.
3. The study focused exclusively on health facilities and so did not include facilities managed by local authorities or the independent sector which provide social care, or which are primarily for detention (e.g. local authority-managed secure units).
4. Learning disability units, addictions units and secure units were only included where they admitted young people with mental disorder (see Table 4.3).

A process of triangulation was employed to ensure that all child and adolescent psychiatric in-patient units in England and Wales were identified. The process involved checking published lists of units; contacting health authorities and the major independent sector health care providers; and contacting child and adolescent psychiatrists.

3.3.1 Published lists

At the time there were three published directories/lists available for use:

- The Directory of Child and Adolescent Mental Health Services – 1998 compiled by YoungMinds.
- The AUP Guide –Directory of NHS Adolescent Units in the South East of England.
- The published list of units surveyed by Chesson and Chisholm in 1996.

3.3.2 Contact with service providers

The search was further supplemented by directly contacting major independent health care providers who provided a list of all independent sector services for children and adolescents. NHS Executive regional directories for 1998/1999 were also obtained and details of service provision abstracted from them.

3.3.3 Information provided by child and adolescent psychiatrists

A list of child and adolescent psychiatrists was obtained from the faculty of child and adolescent psychiatry at the Royal College of Psychiatrists. 474 faculty members were contacted in writing and asked to complete and return a unit identification form that requested the name and address of any units known to them within their NHS Trusts or region. All the units identified were contacted to ensure that the details recorded were correct.

3.4 National survey of child and adolescent psychiatric in-patient units

This section describes the general unit survey, the censuses of beds, staff and patients and the six month activity study of referrals, admissions and discharges.

3.4.1 Recruitment of units

First, the lead consultants and charge nurses of each unit were sent a letter about the study. The letter provided an outline of what would be involved if a unit took part. A sample set of data collection forms were enclosed to inform the units of the type of data the research team aimed to collect. The units were asked to contact the research team to inform them of their availability to participate in the study. If a unit did not respond the research team made contact to follow up the request. At this point a key data contact person was identified for each unit who then acted as the liaison person between the unit and the NICAPS research team throughout the study.

3.4.2 Questionnaire development

The data collection tools were designed to address the key aims of the study. They were also based on the existing literature and draft service standards for child and adolescent psychiatric in-patient units. In addition we consulted with a multi-disciplinary group of professionals working in child and adolescent mental health. The tools were then edited and a final draft version was piloted in a single unit to check the appropriateness of the questions and to maximise ease of completion.

Three methods of data collection were used:

1. A general unit survey of all 80 units
2. A one day census of beds, staff and patients in the 80 units
3. A 6-month activity study of referrals to, admissions to, and discharges from the 80 units

The questionnaires designed for the purpose of data collection were sent by post to the data contact person in each unit. The purpose and content of each questionnaire is described in detail below.

3.4.2.1 Unit survey questionnaire

The purpose of this questionnaire was to collect information about the characteristics of the unit and included questions on the following topics:

- Access
- Type of treatments provided by the unit
- Physical environment (e.g. types of rooms available)
- Other services provided (e.g. day care, out-patient services)
- Educational facilities
- Full and established compliment of each unit's staff and their qualifications
- Unit costs

A senior teacher advised the team on the design of the questions needed to obtain information about educational facilities in these units.

The questions for the cost component of the questionnaire were designed by the research team at the Centre for the Economics of Mental Health (CEMH) at the Institute of Psychiatry who undertook the economic component of the study, details of which are provided in a separate report.

3.4.2.2 Census Day Questionnaires

A census of all units was conducted to describe in detail the patients residing in the unit on a particular day in the year as well as the nursing staff and beds available on that day. For this purpose two census day questionnaires were developed; the residential census day questionnaire and the bed and staff census day questionnaire. After consultation with professionals in the units, the 19th of October 1999, was chosen as the census day. The census day was chosen avoiding half-term breaks, school holidays (particularly the summer break), and Fridays due to the number of units that are only open five days a week. The census day questionnaires were then sent to the data contact person in each unit three weeks prior to the census day of October 19, 1999. The content of each questionnaire is described below:

3.4.2.2.1 Residential Census Day Questionnaire

The data contact person in each unit organised the completion of these forms by the consultant or relevant key worker for each child/young person on the in-patient list on October 19, 1999. The questionnaire was designed to include questions that would allow NICAPS to describe the characteristics of the patient population in at least the same detail as a previous national survey conducted by the Audit Commission so as to enable comparison between the two data sets (Audit Commission 1999). The study conducted by the Audit Commission informed some of the content of this questionnaire, specifically the inclusion of the Paddington Complexity Scale (Yates *et al*, 1999) and the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) (Gowers *et al*, 1999) to describe the clinical profiles of children and adolescents receiving mental health services.

Questionnaire items were included under the following sections:

- Patient information (including age, ethnicity, source of referral, place of patient at time of referral, source of funding)
- Mental Health Act and Children Act status at the time of admission
- Diagnosis
- Paddington Complexity Scale (Yates *et al*, 1999)
- Treatment
- Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) (Gowers *et al*, 1999)

Mental Health Act and Children Act status questions were included in order to describe the use of legislation in these in-patient settings, these are described in full in a companion report (the CAMHA-CAPS study). The diagnostic list was derived from the Paddington Complexity Scale and the tenth edition of the International Classification of Diseases and Related Health Problems (ICD-10, 1992).

The Paddington Complexity Scale was developed to measure both clinical and environmental complexity factors. It was included to identify psychosocial complexity factors associated with the in-patient population and to allow comparison with the Audit Commission's report on children and young people who presented to CAMHS professionals (Yates *et al*, 1999).

The HoNOSCA was designed primarily as an outcome measure of change in patient problems over time. In a previous national survey of Child and Adolescent Mental Health Services (CAMHS), the Audit Commission adopted the scale to obtain a snap shot of the range and severity of problems presenting to

CAMHS professionals. To allow for comparison between the two data sets NICAPS also used this measure in the same way. The scales cover 15 categories of problems, each with five levels of severity ranging from 0 indicating no problem to 4 indicating severe to very severe problems. The glossary for the HoNOSCA score sheet was attached to the questionnaire. A question about whether the rater had been trained to use the HoNOSCA was also included.

3.4.2.2.2 Bed and nursing staff census day questionnaire

This questionnaire was designed to collect data on bed occupancy in the units on the same census day (19th of October, 1999). The questionnaire also collected information about the nursing staff on duty on the census day (qualified or unqualified), their shift patterns over the 24-hour period, their bank/agency status and their qualifications.

3.4.3 Six-month activity questionnaire

A six-month prospective study was designed to collect information on referrals to, admissions to, and discharges from, child and adolescent in-patient units across England and Wales over a specified period that ran from the 31st July to the 31st of December 1999.

This tool served a number of functions:

1. The referral, admission or discharge had to occur within the specified period. So for some the referral stage might only apply while for others the other two stages (admission and discharge) might also apply. To ease completion of the questionnaire it was agreed that the data should be collected on a case-by-case basis during the six-month period. This meant that if a patient was referred and then subsequently admitted staff could complete the relevant section of the form as it applied at different times within the specified period so that only one questionnaire was completed for each case.
2. The tool was also designed to conduct follow-up studies for 2 cohorts identified from the resulting data. For example items were included on the Mental Health Act and Children Act in each section to allow for the generation of a cohort of cases where this legislation applied for the CAMHA-CAPS project. The second cohort identified were cases that were referred but not admitted to the in-patient units.

The following topics were included in each of the four sections of the questionnaire:

1. **Referral section** - date; emergency status; Mental Health Act/Children Act status; who referred the patient; where the patient was at the time of the referral.
2. **Assessment section** - date; reason for not admitting if applicable.
3. **Admission section** - date; diagnosis; consent.
4. **Discharge section** - date of admission and discharge; diagnosis; abuse history; Mental Health Act/Children Act status; reason for delayed discharge if applicable; follow-up arrangements; patient's destination following discharge.

3.4.4 Non responders

For each questionnaire, all non-responders were repeatedly followed-up by phone and post from January to September 2000.

3.5 Follow-up study of those referred but not admitted to 18 units

The intention of this sub-study was to collect data from all in-patient units on those individuals who were referred but not admitted. To succeed with this sub-study, contact details on referring agents had to be obtained in relation to all referrals made to in-patient services during the six-month study period.

It rapidly became clear that this was not feasible for the majority of the units and any insistence on the delivery of these data might compromise the other elements of the study. The team therefore decided to focus resources on a smaller sample of 18 units, selected for their representativeness.

Data on referring agents was difficult to obtain and it was necessary to ask many of the 18 units to go back and check their records in order to identify the referring agents for patients that were referred but not admitted to their unit.

A further complication came from the stricture that, for ethical reasons, units had to be contacted in order to establish whether

- a) they would prefer the team to contact the referrer via the unit, or
- b) they would give the team permission to contact the referrer directly.

Some units were unable to obtain this permission (by reason of time and confidentiality) and for this reason it was not possible to pursue these cases.

This notwithstanding, a questionnaire was devised to send to those referring agents identified and consenting to participate. It provided the referrer with the following information:

- Patient information (name/initials (hand-written), gender, home post code, date of birth, date of referral)
- Period after referral
- Unit information (unit name, consultant or other staff member name, telephone number)

The questionnaire was intended to collect the following details:

- The services the patient received in the 9 months following referral
- The patient's whereabouts during this time
- Whether the patient was subject to legislation during this time

3.6 Admissions of young people with mental disorder to general adult psychiatric and paediatric wards

3.6.1 Identification of adult psychiatric and paediatric wards

A sample of nine Health Authorities in England and Wales sample was chosen to be representative of the range and mean of stratifying variables. Each of the eight English regions plus the region of Wales was represented. We considered population size, Mental Illness Needs Index (MINI) score (Glover *et al*, 1998), and ensured that Health Authorities both with and without child and adolescent psychiatric in-patient units were represented. The sample included a mix of urban/rural and socially deprived/privileged areas. The Health Authorities in which the areas were situated included as many different categories of the Office for National Statistics (ONS, 1998) "families" and "groups" as possible (families – prosperous, inner London, mining and industrial, rural, urban; groups – growth areas, inner London, coalfields, coast and country, most prosperous, ports and industry, manufacturing).

MINI scores were obtained from the Mental Illness Needs Index Programme (Glover *et al*, 1998). These scores are based on the 1991 population census data and are only available for the 1995 Health Authority (HA) boundaries. Many HAs have since changed and broadened their boundaries. In cases where two HAs in 1995 merged to form one larger HA a new MINI score was calculated. This score was obtained by multiplying the 1995 HA score by the respective populations (provided by the 1991 census data for each 1995 Health Authority) which were summed and then divided by the total population.

Table 3.1: Socio-economic characteristics of sampled Health Authorities

	Site A	Site B	Site C	Site D	Site E	Site F	Site G	Site H	Site I
Population category	Medium	Large	Small	Large	Medium	Medium	Medium	Small	Large
MINI Score	94.2	117.8	100.9	101.0	93.0	90.8	105.6	103.8	100.7
MINI category	Low	High	Medium	Medium	Low	Low	High	High	Medium
ONS Family	Prospering Areas	Inner London	Mining and Industrial Areas	Urban Centres	Rural Areas	Prospering Areas	Mining and Industrial	Urban Centres	Rural Areas
ONS Group	Growth Areas	Inner London	Coalfields	Manufacturing	Coast and Country	Most Prosperous	Ports and Industry	Manufacturing	Mixed Urban and Rural
CAMHS in-patient units within health authority boundaries?	No	No	No	No	Yes	Yes	Yes	No	Yes

ONS estimated 1996 population of health authorities Key population and vital statistics local and health authority areas (1998). Population size: Small <350,000; Medium 350,000 – 550,000; Large >550,000. ONS estimated 1996 mean population of England and Wales is 495,000; Mean population of sites A-I is 491,000, MINI score: Low <98; Medium 97-101; High >102. National mean MINI score is 100; Mean MINI score of sites A-R is 100.9.

3.6.2 The postal survey

All trusts within the nine health authorities were identified using NHS Executive Information booklets (1998/99). The adult psychiatric and paediatric wards or units in each trust were then identified by telephone. The consultant psychiatrists or paediatricians and the clinical directors of each identified unit were sent an introductory letter asking for their participation as well as a form requesting that they confirm their unit's details and to identify any other units within their trust that may have been overlooked. The sample of paediatric wards obtained by phone was also then compared with a list of all hospitals with paediatric services in the UK (supplied by the Royal College of Paediatrics and Child Health). Any units that had not been sampled were then contacted in the same manner as before to obtain their consent to participate. There was no corresponding existing adult psychiatric ward list to compare the identified units with but the College Research Unit's information base on adult mental health units was consulted. Once approval had been obtained for participation in the study, batches of forms were sent to each unit.

The adult psychiatric ward questionnaire was designed to capture the details of any individual under the age of 18 admitted to the ward and the staff's perception of the appropriateness of that admission and the potential role of an in-patient child and adolescent mental health unit. The general paediatric ward questionnaire was designed to capture the details of any individual with primary mental health problems admitted to the ward and the staff's perception of the appropriateness of that admission and the potential role of an in-patient child and adolescent mental health unit.

At the end of the study period (January 2000), the units were sent a letter informing them that the study period was over and that all completed questionnaires should be returned by the end of January. If a unit had received no relevant admissions they were asked to confirm this in writing.

3.7 Survey of referring out-patient psychiatrists

With the focus of this study being on in-patient CAMHS, it became clear that it would be helpful to obtain the views of referring out-patient psychiatrists. We therefore added a brief postal survey, asking a

representative sample of out-patient psychiatrists about their referrals to in-patient units. The sample of psychiatrists questioned were from the same nine health authorities that were identified for the 'general adult psychiatric and paediatric ward survey' described in section 3.6, sampling table 3.1.

The aim of this part of the study was to gather information regarding the number and nature of referrals made during a 6 month period. Questionnaires were designed to be filled from memory, removing the necessity to refer to records. The data therefore provides estimates rather than exact information.

Information was collected for the six months 31st July 2000 – 31st December 2000. 11 questions were asked per case, requesting patient details (gender, age, primary diagnosis, key comorbid features), referral information (amount of time spent seeking referral, how many units were approached) and information regarding admission (whether admission was granted, where to, time take to secure agreement for admission, amount of time before admitted, reason for non-admission) (see appendix 9.3.8).

3.8 The development of standards for the site visits

3.8.1 Introduction

We had two aims in developing the standards. Firstly, to generate a broad range of standards to encompass all aspects of service provision relevant to the in-patient child and adolescent psychiatric services, and secondly, to contribute towards the development of a definitive set of service standards that could be used in local service evaluations.

We intended the standards to represent 'ideal' practice and as such the level of service they described was not expected to be found universally. Any deficiencies between current practice and 'ideal' practice would indicate a potential area for intervention. The magnitude of departure from the standard and its relative importance were intended to allow interventions to be prioritised. The aim of any standards-based service evaluation would be to gradually improve the quality of services using the principles of the clinical audit cycle. We were keen that the standards we developed for this study would have potential clinical utility in this way.

A method for developing a set of “descriptors” for assessing services for people with depression has been recently described (Clinical Standards Advisory Group, 1999); this relied on consultation with stakeholder groups, a literature search and the combining of evidence with expert opinion, and we drew on this and other available methodological literature (Campbell *et al*, 1999; Brook *et al*, 1986).

3.8.2 Methods

The development involved four main elements: a literature review; consultation with an expert panel; editing and refining; and piloting in the field. We used information from the expert panel to supplement information from the literature review. This ensured that the standards covered the range of important issues, that they were up-to-date and that they took account of the views of relevant staff.

3.8.2.1 Literature review

We reviewed a wide range of publications, including health services research, best practice guidelines and consensus statements produced by professional bodies and policy and guidance from the Department of Health. We added to the results of a literature search, which included research databases and references obtained from consultation with the wide network of people involved in the project. We identified just over 600 statements relating to best practice that formed the basis of the first draft of the standards.

We classified general statements as standards, and more specific statements as criteria within these. Each standard consisted of typically four or five criterion statements. For example, a standard might state that

units are parent-friendly, and a criterion statement might state that parents may make tea, coffee or soft drinks.

3.8.2.2 Expert Panel

Each major professional group was represented in the 36 members of the expert panel (see Acknowledgements). A specialist solicitor was employed as a member of the research team and as a member of the expert panel because legal safeguards are of such importance for this patient group. We asked the experts to comment on each statement of best practice and to recommend new statements to fill any gaps in the content. We then incorporated all comments and listed any contentious or conflicting comments separately to be resolved by consensus.

3.8.2.3 Editing and pilot testing

This draft was then reduced using criteria which included: redundancy due to repetition; provenance (the evidence base for the statement); ease of measurement; achievability; local adaptability (to variations in local practice); acceptability (how agreeable practitioners might be to the statements); and relevance to the service. These criteria built on previous work (Baker and Fraser, 1995).

These standards (see Appendix 9.4) were used to inform the study generally and were also adapted into data collection tools for use on site visits. These included 7 interview schedules (see section 3.9.2.1), a checklist for documents and a checklist for the environment and facilities.

A one-day visit was arranged to pilot the standards-based schedules and checklists. Subsequent editing resulted in the final set of around 450 statements arranged as 64 standards with attaching criteria which were used in this study.

3.9 Site visits

3.9.1 Sampling of sites visited

For the visits, 18 general psychiatric in-patient units were sampled according to stratifying criteria which included: age range; 5 or 7 day opening; NHS or independently funded; their location (both in terms of geographic spread and deprivation); and ONS families and groups. These are detailed in Table 3.3.

3.9.2 Interview schedules

3.9.2.1 Adapting standards into data collection tools

The service standards were adapted into interview schedules and checklists for use in the site visits. We identified data sources and methods most appropriate for each standard. For example, to collect data on the facilities we designed a checklist to use on a tour of the premises, whereas to collect data on patient involvement in their treatment decisions we asked patients themselves in a short interview. This selection of standards kept data collection time to a minimum and enabled all visits to be conducted in one day. In all, 8 data collection tools were developed including interview schedules for the consultant psychiatrist, charge nurse, head teacher, therapists, social worker, patients, trust management, and a checklist for the site inspection. All schedules and checklists were piloted in a one day visit to a single unit.

There are problems in using service standards as a purely confirmatory tool. For example, by merely recording if a standard has been attained or not, important information about why this has happened will not be noted. Similarly, there would be no opportunity to learn about practice which is not anticipated within the structure of the standards. To help address this, reviewers recorded interviewees' comments after each standard, in addition to their routine coding of answers. Reviewers also asked about changes interviewees would like to make to improve the service the unit provided.

Table 3.2: Timetable of a typical visit

Time	Co-reviewer	CRU team member
9.30am – 10.00am	Meet at the unit, collect necessary consent forms for patient interviews	Meet at the unit, collect necessary consent forms for patient interviews
10.00am – 10.30am	Trust manager	Trust manager
10.30am – 11.30am	Consultant 1	Consultant 2
11.30am – 12.00am	Site inspection	Complete organisational diagram
12.00am – 1.00pm	Charge nurse	2 Staff nurses
1.00pm – 1.30pm	Lunch	Lunch
1.30pm – 2.00pm	Head teacher	Head teacher
2.00pm – 4.00pm	Meet patients	Meet patients
4.00pm – 4.30pm	Psychotherapist and consultant psychologist	Family therapist and occupational therapist
4.30pm	Complete “visitor’s summary” and return	Complete “visitor’s summary” and return

Sites were visited by two people, one a NICAPS team member and the other was termed a co-reviewer. All co-reviewers were working practitioners within in-patient child and adolescent services, and are listed in the Acknowledgements. Forms were sent in advance to the units for the recording of patients’ and parents’ consent to be interviewed.

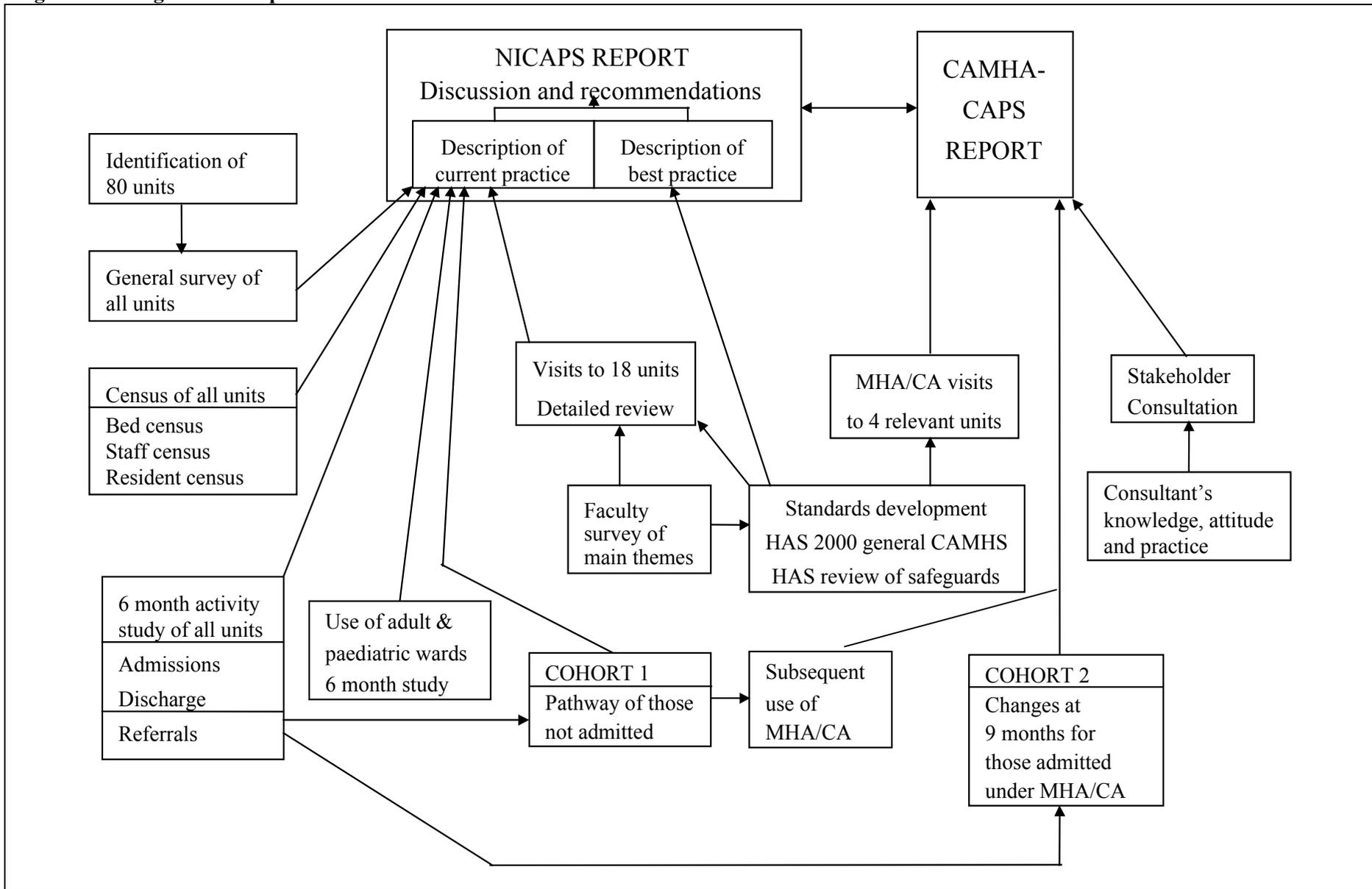
3.9.3 Sampling Table

Table 3.3: The 18 units selected for site visits

Unit	Sector	Age group	Days open	Deprivation MINI score	Family*	Group*
A	Independent	13 to 19	7 day service	92.3	Prospering Areas	Growth Areas
B	Independent	12 to 18	7 day service	92.3	Prospering Areas	Growth Areas
C	NHS	11 to 18	5 day service	105.6	Mining and Industrial Areas	Ports and Industry
D	NHS	5 to 16	7 day service	107.3	Urban centres	Manufacturing
E	NHS	8 to 16	7 day service	95.1	Rural Areas	Coast and Country
F	NHS	12 to 16	7 day service	94.3	Prospering Areas	Growth Areas
G	NHS	13 to 18	7 day service	121.7	Inner London	Inner London
H	NHS	11 to 18	7 day service	101.1	Mining and Industrial Areas	Coalfields
I	NHS	12 to 18	7 day service	100.7	Rural Areas	Mixed Urban and Rural
J		13 to 18	5 day service	99.9	Maturer Areas	Services and Education
K	NHS	13 to 18	5 (usually 7)	97.3	Prospering Areas	Growth Areas
L	NHS	0 to 12	7 day service	116.6	Inner London	Inner London
M	NHS	11 to 18	7 day service	93.5		
N	NHS	13 to 19	7 day service	109.6	Mining and Industrial Areas	Ports and Industry
O	NHS	12 to 18	7 day service	105.8	Urban Centres	Mixed Economies
P	NHS	12 to 16	5 days unless clinical need for 7	101.7	Urban Centres	Mixed Economies
Q	NHS	6 to 12	7 day service	101.0	Maturer Areas	Resort and Retirement
R	NHS	11 to 18	7 day service	105.1	Urban Centres	Mixed Economies
Average 102.4				(Average MINI score for all 81 units = 101.18)		

Note: Mini scores were obtained from the Mental Illness Needs Index Programme (Glover et al, 1998). These scores were based on the 1991 population census data and are only available for the 1995 Health Authority boundaries. Many Health Authorities have since changed and broadened their boundaries. In cases where two HA's in 1995 merged to form one larger HA a new miniscore was calculated by multiplying the 1995 HA miniscore by the respective populations (provided by the 1991 census data for each 1995 Health authority presented on the MINI table) the resulting figures were then summed and divided by the total population. * Family and Groups categories were obtained from the ONS 1996. Each of the six ONS Family categories and 10 of the Group categories are represented in the sample.

Figure 3.1: Diagram of component methods



4 RESULTS

4.1 Introduction

At the time of the study three published directories were available for use. The units listed in these directories were contacted and the details confirmed. The YoungMinds directory identified 63 child and adolescent in-patient units in England and Wales in 1998. Of the 63 identified 49 were still providing an in-patient service in April 1999. Checks revealed that some services had since closed or had changed to provide a day patient service only. These existing directories were invaluable at this key stage of the study.

The NICAPS team identified 80 child and adolescent psychiatric units, distributed across England and Wales (see Figures 4.2 and 4.3). There were 663 in-patients resident in 71 (89%) out of the 80 units on the census day in 1999.

As described in the methods section, a multi-method approach was employed to collect detailed information about child and adolescent psychiatric in-patient units in England and Wales. The results presented in this section are organised to correspond with the order in which the methods of data collection are described. The three main approaches involved the faculty survey, questionnaire surveys, and the standards-based site visit reviews.

This project has generated a large amount of data not all of which can be presented here. We have attempted to address the main aims of the report balancing the need to be comprehensive with the need for appropriate detail. This means that not all sub-group analyses (for example, by unit age range) are presented here. We will address these issues in secondary data analyses in the set of papers for publication, which we are preparing.

4.2 Survey of the Child and Adolescent Faculty of the Royal College of Psychiatrists

A survey of members of the Child and Adolescent Faculty at the Royal College of Psychiatrists was conducted to obtain a prioritised list of psychiatrists' concerns relating to in-patient child and adolescent mental health services. Of the 474 members surveyed, 274 returns were received. These responses included 29 returned with no comment, giving a total of 245 useable replies. Further investigation indicated that addresses were incorrect for about 10% of non-responders so the denominator was adjusted to 454 members, a 60% response rate.

The 245 useable replies provided 1,033 distinct statements. From these statements a total of 38 themes were derived, which then formed the basis of the coding frame. The most frequently reported themes are presented in Figure 4.1 below.

Figure 4.1: Main issues concerning child and adolescent psychiatrists

<ol style="list-style-type: none">1. Lack of emergency beds and facilities (36%)2. Insufficient number of beds (25%)3. Poor provision for severe or high risk cases (24%)4. Poor liaison with other services (20%)

The full range of themes and the frequency with which respondents identified them is reported in Appendix 9.1.

4.3 National survey of child and adolescent psychiatric in-patient units

The results presented here relate to data obtained from the survey questionnaires described previously. Data derived from these tools are presented in this section under the following headings:

1. The distribution of units across England and Wales and their characteristics
2. The characteristics of the in-patient population
3. Treatment and care provided
4. Educational provision
5. Referrals to, admissions to, and discharges from the units
6. Illustrative case studies of patients referred but not admitted to in-patient units
7. Admissions to other NHS wards
8. Access from the viewpoint of referring out-patient psychiatrists

4.3.1 Distribution and capacity of in-patient CAMHS

This section describes the distribution of units and beds across England and Wales. Each red circle in Figures 4.2 and 4.3 below represents a unit.

Figure 4.2: Location and distribution of units across England and Wales



4.3.1.1 Distribution of available beds and in-patient units

Table 4.2 describes the distribution of beds that were available for use at the time of the survey across regions and the number of in-patient units and beds available for each defined age group. There was considerable variation in the age ranges accepted by different units. It was therefore necessary to use some judgement in deciding in which category a particular unit belonged. For example, a unit that stipulated that they accept for admission children between the age of 7 and 13 falls under the Children's Unit category even though the upper age range is above 12, and units defined as Adolescent Units often admit down to the age of 11 or 12. The units themselves are not defined by age and are therefore difficult to classify in this way. Differences in the way units are classified means that the data presented here may differ from numbers presented in previous studies (such as Green and Jacobs, 1998).

Table 4.2: Estimated population of 18 and under age group based on the type of unit and number of available beds by NHS Region

Region	Estimated population based on 1991 census and mid 1999 projections for age group 18 and under	Total no. of available ¹ beds (Number of units)	Available beds per 100,000 18 and under	No of units and beds available to each age group: C = < 12; C&A = < 18; A = 12 to 18; AA ² = 14 to 18
South East	2,073,177	268 (21 units)	12.9	2 C units = 21 beds 1 C & A units = 12 beds 14 A units = 215 beds 4 AA = 20 beds
London	1,737,899	190 (15 units)	10.9	3 C units = 31 beds 1 C&A units = 8 beds 11 A units = 151 beds
Northern and Yorkshire	1,529,321	106 (12 units)	6.9	3 C unit = 15 beds 1 C & A units = 12 beds 8 A units = 79 beds
Eastern	1,288,221	74 (7 units)	5.7	1 C unit = 10 beds 5 A units = 54 beds 1 AA = 10 beds
Trent	1,220,069	60 (5 units)	4.9	1 C units = 7 beds 1 C & A units = 16 beds 3 A units = 37 beds
South & West	1,127,516	55 (6 units)	4.9	1 C & A unit = 15 beds 5 A units = 40 beds
North West	1,630,358	68 (7 units)	4.2	2 C unit = 19 beds 1 C&A units = 12 beds 3 A units = 35 beds 1 AA = 2 beds
West Midlands	1,314,750	55 (5 units)	4.2	1 C unit = 12 beds 1 C & A unit = 10 beds 3 A units = 33 beds
Wales	709,402	24 (2 units)	3.4	2 A units = 24 beds
Total	12,630,713	900 (80 units)	Total mean: 7.1	13 C units = 115 beds 7 C&A units = 85 beds 54 A units = 668 beds 6 AA = 32 beds 80 units = 900 beds

Note: For a map showing NHS Regions please refer to Appendix 9.2.

¹ Number of available beds refers to the number of beds open in the unit on the census day, occupied or unoccupied. The response rate for the actual census day was 88%, data for the remaining 12% were collected after the census day. The distribution of beds presented above is according to geographical location and not the bed's source of funding

² AA denotes: Adolescent beds in adult wards

4.3.1.1.1 New services

The number of units and beds available in child and adolescent in-patient services are continually changing. When NICAPS began in 1999 considerable change had occurred since 1998 when the

YoungMinds directory was compiled. Some of the units listed in the directory had closed or changed from an in-patient service to a day patient service.

4.3.1.1.2 Children's units

Units that fell within this category were those that predominantly admit children between the ages of 4 to 12 or 13. In total the NICAPS research team identified 13 children's units (115 available beds). There were children's units in all regions except the South West (where there was a combined child and adolescent in-patient unit) and Wales, which had no facilities for the psychiatric admission of children. There were no children's psychiatric in-patient units in the private sector. The bed numbers reported to be available (open for use) in each unit on census day ranged from 4 to 15, yielding an average of 9.3.

4.3.1.1.3 Adolescent units

The adolescent units were defined as those that predominantly admitted young people between the ages of 12 and 18. In total the NICAPS research team identified 54 such units (668 available beds) in England and Wales. There were adolescent units in all regions of England and Wales although, as Table 4.2 indicates, there was a concentration of units in London and the South East. The private/independent sector managed 30% of adolescent units and these were located largely in London and the South East.

4.3.1.1.4 Child and adolescent units

In-patient units included in this category were those that stipulated that the age group they accept for admission crossed both child and adolescent age bands. In total the research team identified 7 units (85 beds) and these were located in 7 out of the 9 regions surveyed. All of these units were managed by the NHS.

4.3.1.1.5 Adolescent beds in adult wards

Six units were identified as providing a service for adults but which also had a number of beds for young people. All six units were managed by the independent sector. The youngest age accepted for admission was 14 in four units, 16 in one and 17 in the other.

4.3.1.2 Distribution of available beds in general and specialist units

The numbers of available beds are also described in relation to the diagnostic groups that the units' beds were designated to treat. The term general psychiatric units describes units that admit a wide range of diagnostic groups whereas specialist units have beds that are allocated to the treatment of specific diagnostic groups such as eating disorder patients, or patients who require secure accommodation or forensic care. Forensic child and adolescent in-patient units treat young mentally disordered offenders who present a threat of violence to others as well as themselves. Secure units, on the other hand, primarily treat young people who present a threat to themselves but not others.

Table 4.3: Regional distribution of available beds in general and specialist units and managing sector

Region	Beds in general and specialist units (% of beds managed by the NHS)							
	General psychiatric units	Eating disorder units	Forensic units	Secure units	Addictions units	Learning disability units	Paediatric and psychiatric unit	Total number of beds
South East	140 (69%)	26 (0%)	0	56 (0%)	4 (0%)	30 (0%)	12 (100%)	268 (41%)
London	140 (93%)	50 (16%)	0	0	0	0	0	190 (73%)
Northern and Yorkshire	66 (100%)	0	6 (100%)	0	0	34 (100%)	0	106 (100%)
Eastern	54 (78%)	20 (50%)	0	0	0	0	0	74 (70%)
North West	56 (100%)	2 (100%)	10 (100%)	0	0	0	0	68 (100%)
Trent	60 (100%)	0	0	0	0	0	0	60 (100%)
South West	40 (100%)	0	0	0	0	15 (100%)	0	55 (100%)
West Midlands	46 (100%)	0	0	0	9 (0%)	0	0	55 (84%)
Wales	24 (100%)	0	0	0	0	0	0	24 (100%)
Total no. of beds	626 (90%)	98 (18%)	16 (100%)	56 (0%)	13 (0%)	79 (62%)	12 (100%)	900 (73%)

Source: Bed and staff census day; see Table 5.2 footnote

Table 4.3 describes the regional distribution of general and specialist units and the percentage of units in each region that were managed by the NHS. The independent sector services were located in four out of the nine regions and were largely located in the South East region, and to a lesser degree in the London, Eastern and West Midland regions. The independent sector provided a large proportion of the specialist eating disorder beds, 40% of the learning disability beds and all of the beds in secure units, which are located in the South East region.

4.3.1.3 Regional distribution of units by number of days open

Table 4.4: 5/7 day in-patient care by region

Region	Always open 7 days a week	Always open 5 days a week	Sometimes open > 5 days a week	Total number of units
South East	18	2	1	21
London	9	3	3	15
Northern and Yorkshire	8	1	3	12
Eastern	5	1	1	7
North West	4	0	3	7
Trent	3	2	0	5
South West	3	1	2	6
West Midlands	5	0	0	5
Wales	1	0	1	2
Total	56	10	14	80

The actual response rate for this item on the general survey questionnaire was 83%; data for the remaining 17% were collected by a phone survey. The 10 units that reported being open for 5 days a week consisted of 4 adolescent units, 5 children’s units and 1 child and adolescent unit.

4.3.1.4 Emergency provision

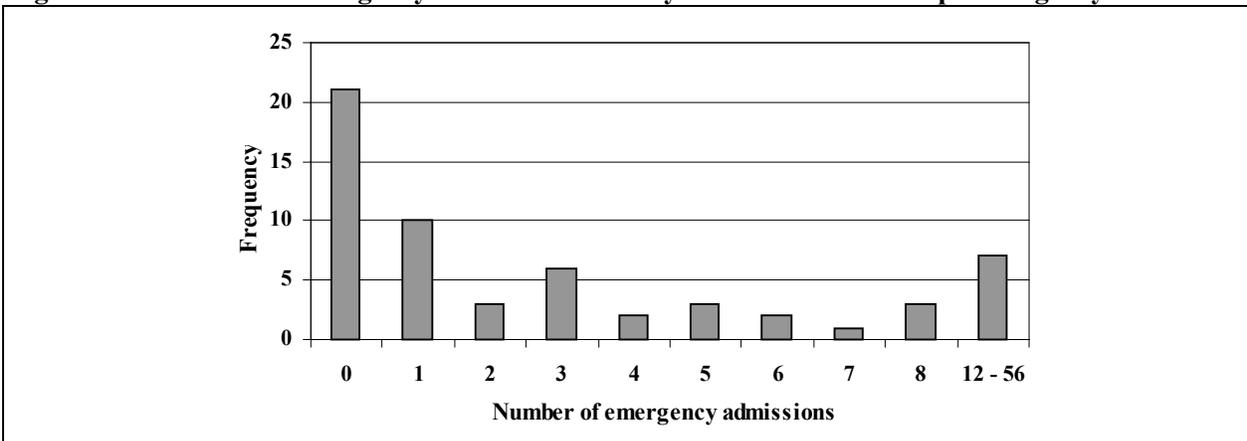
Table 4.5 below describes the distribution of units that accepted emergency referrals within 24 hours across the 9 regions. Units were asked whether they accept emergency admissions within 24 hours of referral.

Table 4.5: Regional distribution of units that accept emergency referrals within 24 hours

Region	Accept emergency referrals		Totals
	Yes	No	
South East	7	14	21
London	5	10	15
Northern and Yorkshire	5	7	12
Eastern	3	4	7
North West	4	3	7
Trent	3	2	5
South West	3	3	6
West Midlands	1	4	5
Wales	0	2	2
Total	31	49	80

The actual response rate for this item on the general survey questionnaire was 83%. Data for the remaining 17% were collected by a phone survey. 31 units (39%) reported that they accepted emergency referrals within 24 hours. Of those that accepted emergency referrals the range of emergency admissions reported for a period of a year fell between 0 and 56.

Figure 4.3: Number of emergency admissions over 1 year to units that accept emergency referrals



The large majority of those accepting emergency admissions were NHS units, and most were general psychiatric adolescent units.

Table 4.6: Type of unit accepting emergency referrals

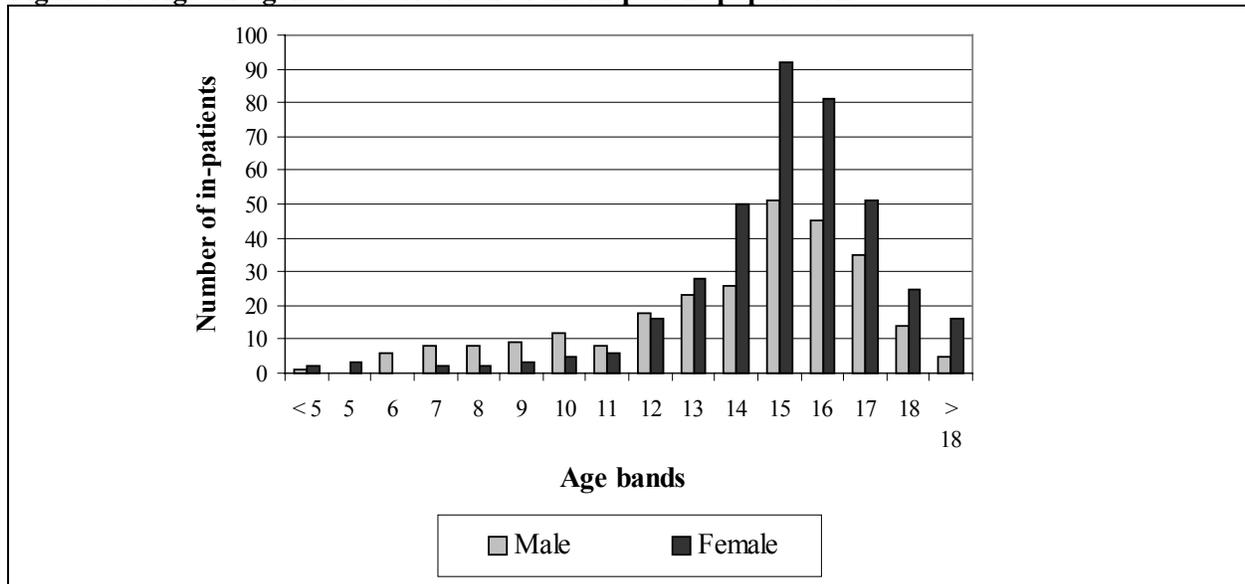
A: Units defined by age group treated	Number of units
Adolescent unit (12-18yrs)	17
Children’s Unit (5-12yrs)	5
Child and adolescent unit (5-18yrs)	3
Adolescent beds in adult wards	2
B: Units defined by specified diagnostic group treated	
General psychiatric unit	26
Addiction and eating disorder unit	1

4.3.2 General characteristics of the in-patient population

The census day data were provided by 71 (89%) of the 80 units. They returned information on 663 young people. 21 of these in-patients were over the age of 18.

4.3.2.1 Age

Figure 4.4: Age and gender distribution of the in-patient population



Males outnumbered females in the younger age groups (< 13 years), whereas females outnumbered males in the adolescent age groups.

4.3.2.2 Ethnicity

Professionals recorded their opinion about the ethnic origin of the young people resident in the units on census day. Data on ethnicity was obtained for 635 of the 642 in-patients aged 18 or under and 14.9% were described as being from ethnic minority groups. The 1991 census (ONS, 1997) reported that 5.5% of the general population in Britain did not classify themselves as white. This census also showed that the non-white population of children under 14 was 9.7% (Soni Raleigh & Balaraja, 1995). This suggests a potential over-representation of young people from ethnic minority groups in the in-patient population. From the 637 responses to the item concerning first language, it was reported that English was not the first language for 7% of the in-patient population on census day. Table 4.7 presents the percentage of in-patients from ethnic minority groups by unit type. The relative lack of in-patients from ethnic minority groups in eating disorder units is particularly striking.

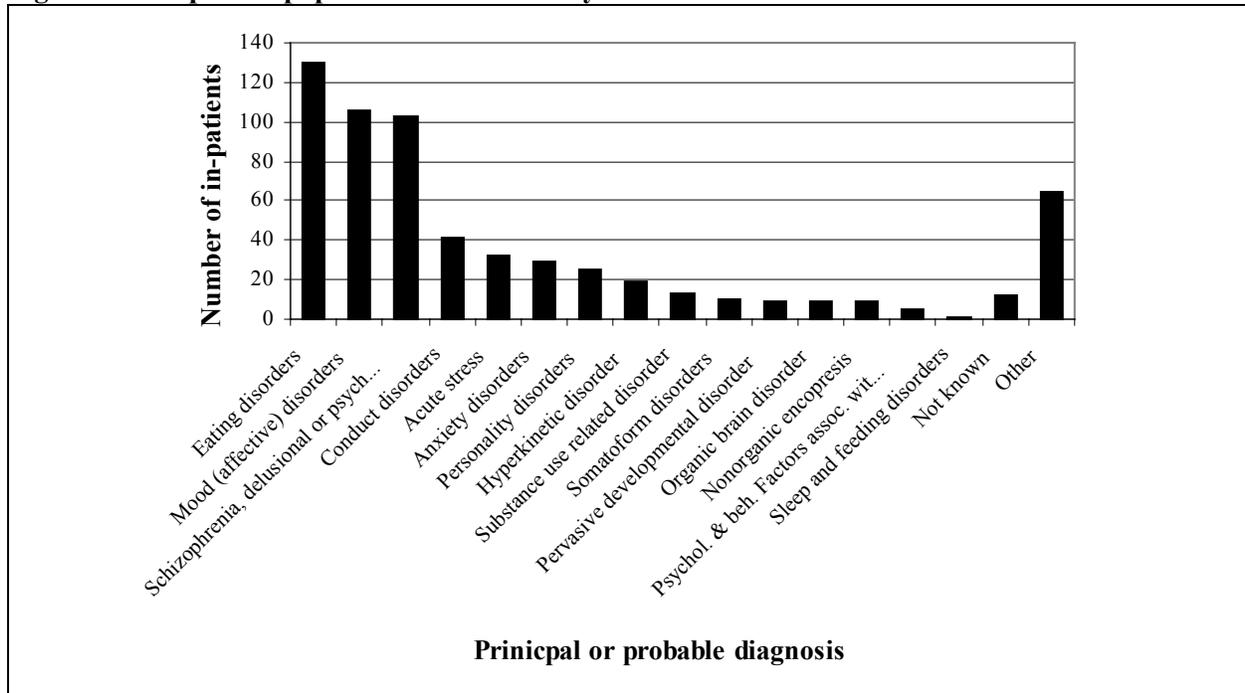
Table 4.7: Percentage of in-patients from ethnic minority groups on the census day

Type of unit	Ethnic minority in-patients (%)
General in-patient psychiatry (n=484)	15.4
Forensic and secure units (n= 44)	18.1
Eating disorder units (n=62)	0.8

4.3.2.3 Diagnosis

Figure 4.6 presents the principal or probable diagnosis of all in-patients, aged 18 or under, resident in in-patient child and adolescent psychiatric units on census day (n = 642, missing data = 25).

Figure 4.5: In-patient population on census day



Note: 'Psychol. & beh. factors assoc. wit...' is an abbreviation for 'Psychological and behavioural factors associated with physical disorders and diseases'

Figure 4.6 shows that three main diagnostic groups; eating disorders, mood (affective) disorders and schizophrenia/delusional/psychotic disorders were by some way the most common diagnoses in the in-patient units on census day. The main diagnostic groups do differ, however, according to age and gender.

Table 4.8: Main diagnostic categories by gender and age

MALES			FEMALES		
13 or under (n=91)			13 or under (n=65)		
1.	Conduct disorder (incl. Mixed CED ¹)	21 (23%)	1.	Eating disorders	21 (32%)
2.	Hyperkinetic disorder (ADHD)	12 (13%)	2.	Mood (affective) disorders	6 (9%)
3.	Mood (affective) disorders	9 (10%)	3.	Non organic encopresis/enuresis	5 (8%)
Over 13 (n=162)			Over 13 (n=287)		
1.	Schizophrenia, delusional or psychotic disorders	57 (35%)	1.	Eating disorders	95 (33%)
2.	Mood (affective) disorders	36 (22%)	2.	Mood (affective) disorders	54 (19%)
3a.	Conduct disorder	10 (6%)	3.	Schizophrenia, delusional or psychotic disorders	40 (14%)
3b.	Eating disorders	10 (6%)			

¹ CED = Conduct and Emotional Disorder

Eating disorder was by far the most common diagnostic group in females, amounting to more than the other disorders combined.

Table 4.9: Diagnosis by type of unit

PRINCIPAL OR PROBABLE DIAGNOSIS	TYPE OF UNIT		
	General psychiatric units	Eating disorder units	Forensic and secure units
Eating disorders	65 (13.7%)	60 (98%)	1 (2.3%)
Mood (affective) disorders	102 (21.4%)	1 (2%)	3 (7%)
Schizophrenia, delusional or psychotic	80 (17.8%)	0	21 (48.8%)
Conduct disorders (incl mixed CED)	37 (7.8%)	0	0
Personality disorders	12 (2.5%)	0	10 (23.2%)
Acute stress	29 (6%)	0	3 (7%)
Anxiety disorders	28 (5.8%)	0	0
Hyperkinetic disorder (ADHD)	18 (3.8%)	0	0
Somatoform disorders	7 (1.5%)	0	0
Pervasive developmental disorder	9 (1.9%)	0	0
Substance use related disorder	6 (1.3%)	0	1 (2.3%)
Organic brain disorder	9 (1.9%)	0	0
Nonorganic encopresis	9 (1.9%)	0	0
Psychological & behavioural factors associated with physical disorders	5 (1%)	0	0
Sleep and feeding disorders	1 (0.2%)	0	0
Not known	10 (2.1%)	0	1 (2.3%)
Other	49 (10.3%)	0	3 (7%)
Total number of patients in each type of unit:	476 (100%)	61 (100%)	43 (100%)

The diagnostic categories in Table 4.9 above are listed in order of their presentation in Figure 4.6. The main diagnostic groups in each type of unit are shaded. The data presented here are taken from the patient census. This table does not describe all specialist units and therefore the total number of patients is less than the total number of patients on census day (n=663). There are 83 patients not described in this table.

As mentioned above, the eating disorder diagnostic group was the most common group to be treated in child and adolescent in-patient services. This group was also prominent in general psychiatric units, with an almost equal number of patients being treated in this type of service, as there were in specialist eating disorder units.

Table 4.10: Diagnosis by age defined type of unit

PRINCIPAL OR PROBABLE DIAGNOSIS	AGE DEFINED TYPE OF UNIT			
	Adolescent units	Children's units	Child and adolescent unit	Adult ward with adolescent beds
Eating disorders	103 (22.2%)	4 (4.9%)	8	15
Mood (affective) disorders	96 (20.7%)	5 (6.0%)	2	3
Schizophrenia, delusional or psychotic	97 (20.9%)	2 (2.4%)	2	2
Conduct disorders (mixed CED)	20 (4.3%)	18 (22%)	3	0
Personality disorders	20 (4.3%)	1 (1.2%)	0	4
Acute stress	29 (6.3%)	2 (2.4%)	1	0
Anxiety disorders	18 (3.9%)	5 (6%)	5	1
Hyperkinetic disorder	5 (1%)	11 (13.4%)	3	0
Somatoform disorders	5 (1%)	0	5	0
Pervasive developmental disorder	6 (1%)	3 (3.7%)	0	0
Substance use related disorder	12 (2.6%)	0	0	1
Organic brain disorder	4 (0.9%)	4 (4.9%)	1	0
Nonorganic encopresis	0	8 (9.6%)	1	0
Psychol. & beh. Factors assoc. with phys. Disorders...	1 (0.2%)	1 (1.2%)	3	0
Sleep and feeding disorders	0	1 (1.2%)	0	0
Not known	6 (1.3%)	6 (7.3)	0	0
Other	42 (9%)	11 (13.4%)	11	0
Total number of patients in each type of unit:	464 (100%)	82 (100%)	45 (100%)	26 (100%)

¹ Mixed Conduct and Emotional Disorder

There was a much wider spread of diagnoses within the children's units compared to the adolescent units. The main diagnostic groups in children's units also differed from those in adolescent units, with conduct disorder (including mixed CED) and hyperkinetic disorder (ADHD) being the main diagnostic groups to be treated in these units.

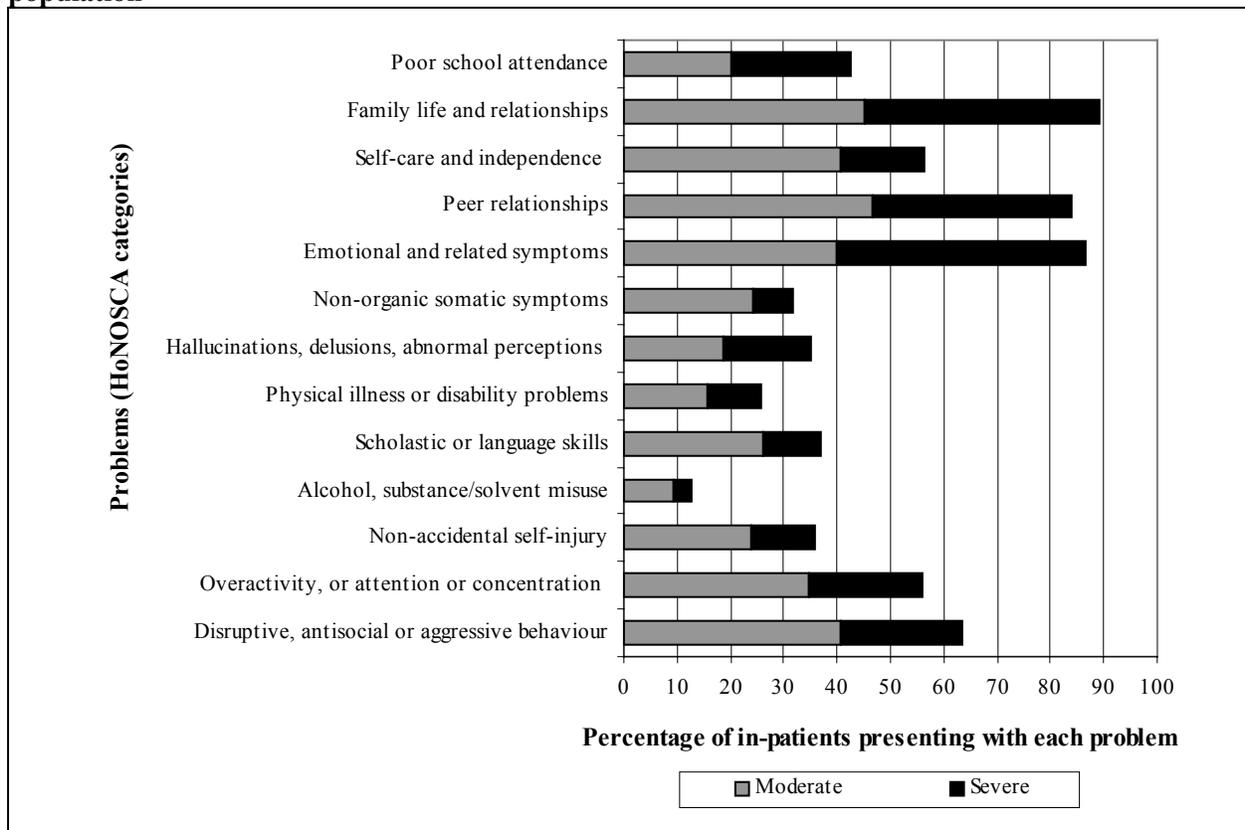
4.3.2.4 Behavioural and psychosocial factors

The following two sections report results obtained from two scales, the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) (Gowers *et al*, 1999) and the Paddington Complexity Scale (Yates *et al*, 1999). These scales were included in the residential census day questionnaire to obtain measures on the in-patient population's clinical present state and associated psychosocial factors.

4.3.2.4.1 HoNOSCA scale ratings

The Health of Nation Outcome Scales for Children and Adolescents were incorporated into the residential census day questionnaire and scores were obtained for 642 patients who were resident in 71 out of 80 units on that day.

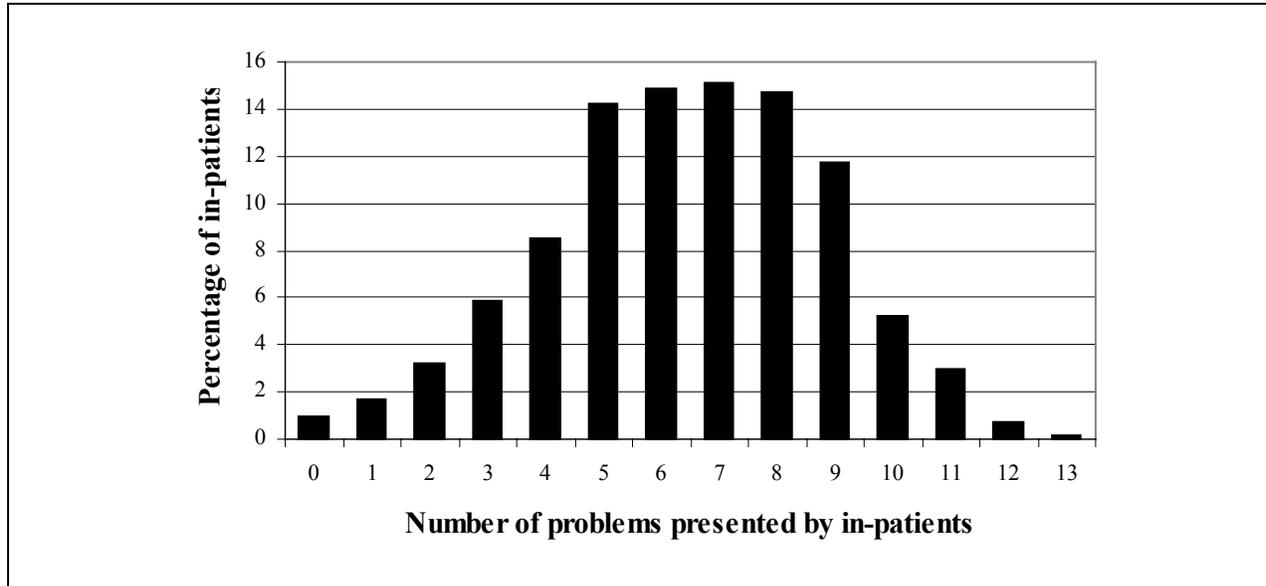
Figure 4.6: Type and severity of problems (HoNOSCA categories) presented by the in-patient population



A higher percentage of the in-patient population (IP) were rated as having moderate to severe problems on all the scales compared to the out-patient population (OP) surveyed by the Audit Commission who presented to CAMHS in general. The difference between the two populations was greatest on the self care and independence scale (approximately 33% OP vs. 57% IP had a moderate or severe rating for this problem); the hallucinations, delusions abnormal perceptions scale (approximately 11% OP vs. 35% IP); the non-accidental self injury scale (approximately 18% OP vs. 37% IP) and the emotional and related symptoms scale (approximately 70% OP vs. 87% IP). The four categories that presented most frequently were the same for both the Audit Commission's out-patient population and the NICAPS in-patient population and included the following problems:

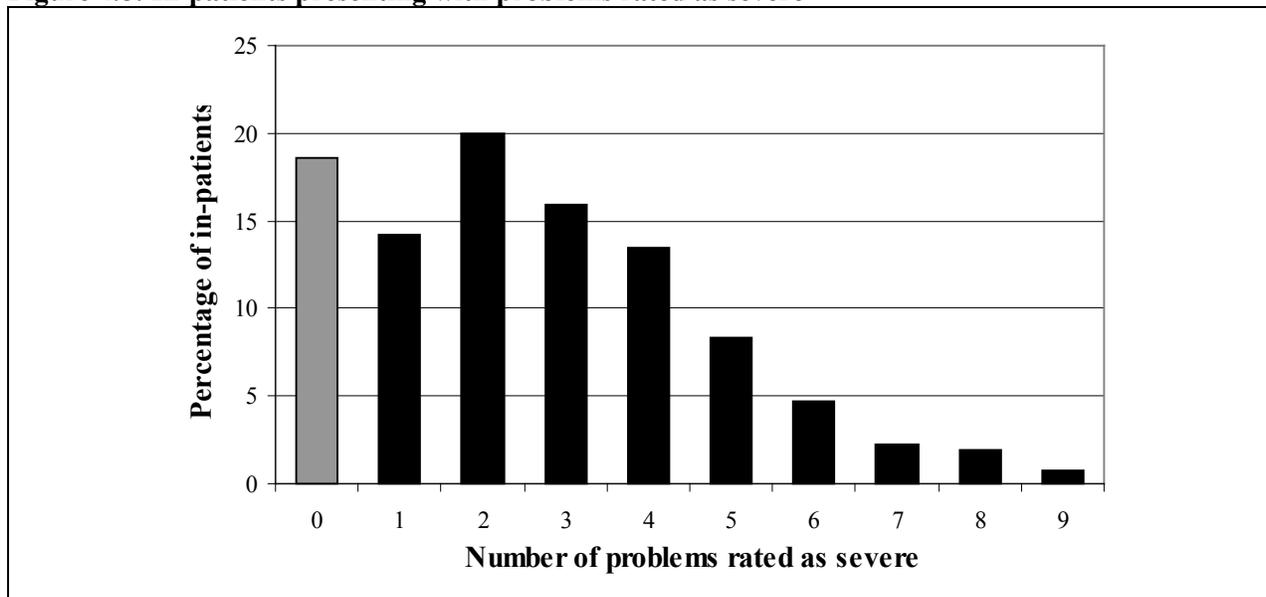
- problems with family life and relationships (approximately 80% OP vs. 89% IP)
- problems with peer relationships (approximately 67% OP Vs 84% IP)
- problems with emotional and related symptoms (as above 70% OP Vs. 87% IP)
- disruptive, antisocial or aggressive behaviour (approximately 63% OP Vs. 63% IP)

Figure 4.7: In-patients presenting with one or more category of problems from the HoNOSCA scales



The most frequent number of problems among the in-patient population was 7, this being higher than the 5 reported by the Audit Commission for young people who present to CAMHS in general. 50% of young people resident in in-patient CAMHS on census day had 7 or more categories of problems from the HoNOSCA scale.

Figure 4.8: In-patients presenting with problems rated as severe



About a third of the in-patient population had no or just one problem rated as severe. This compares to the Audit Commission’s finding that exactly half of the young people presenting to CAMHS in general

had no problems or just one problem rated as severe. Nearly two thirds of the in-patient population had 2 or more problems rated as severe and over a third had 3 or more problems.

4.3.2.4.2 *Paddington Complexity Scale*

The Paddington Complexity Scale provided information on the psychosocial factors associated with each young person using the service.

4.3.2.4.2.1 *Severity of condition*

Unit staff rated the majority of in-patients' conditions as moderate (29%) or severe (53%); the severity of the condition was reported to be extreme for 14% of the in-patient population. Comparisons between this and the Audit Commission report are not possible as the Audit Commission data is not published.

4.3.2.4.2.2 *1:1 constant observation*

One fifth of the in-patient population were under 1:1 observation. The majority of this population are being treated in general psychiatric units (71%) followed by secure units (9%) and eating disorder units (8%). Most of these patients were diagnosed with an eating disorder (23%), schizophrenia, delusional or psychotic disorders (23%), mood (affective) disorders (14%), and conduct disorders (11%).

4.3.2.4.2.3 *Presence of chronic physical illness and learning disabilities*

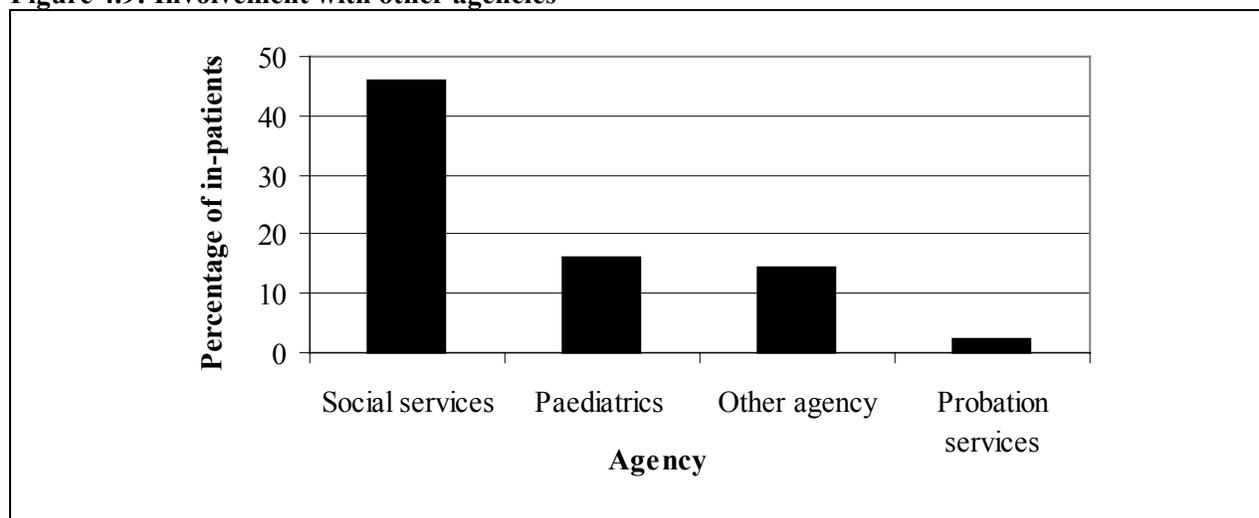
The majority of in-patients (90%) had no chronic physical illness. Staff reported that nearly a quarter of the in-patient population (23%) experienced some degree of learning disability.

4.3.2.4.2.4 *Main carers*

Both parents were reported to be the main carer for 51% of the in-patient population and one parent was the main carer for over a third (37%). 12% were looked after in local authority accommodation, similar to the 9% of young people presenting to CAMHS in general (Audit Commission, *Children in Mind*, 1999) and much higher than the 0.5% found in the general population (Department of Health, *Children looked after by Local Authorities*, July 1998).

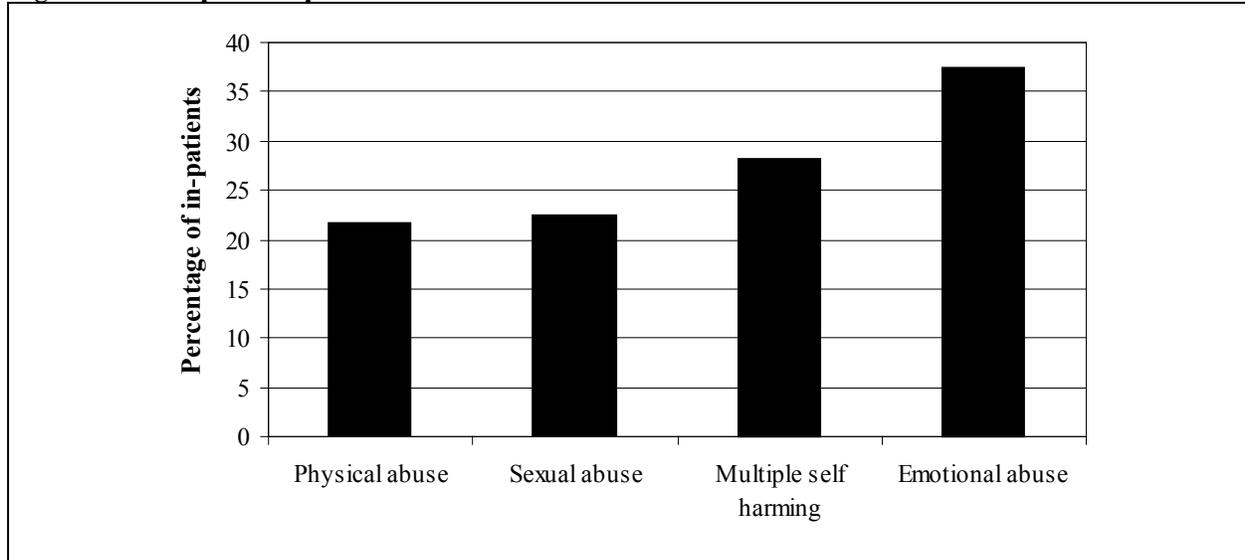
4.3.2.4.2.5 *Involvement with other agencies*

Figure 4.9: Involvement with other agencies



4.3.2.4.2.6 Previous history of abuse

Figure 4.10: Reports of previous self harm or abuse



4.3.3 Care and treatment

Information about the treatment available to young people in in-patient CAMHS was obtained from the general survey questionnaire (N = 66 units). The residential census day questionnaire (N = 661 patients) also provided information about the type of treatment patients with a specific diagnosis were receiving during their stay in the unit.

4.3.3.1 Range of treatments available

All units, regardless of their specialisation, provided a wide range of therapies. Drug therapy was available in all but two of the 66 responding units (one general psychiatric unit that specialises in treating patients with personality disorders and severely traumatised young people, and one eating disorder unit).

Table 4.11: Treatments available in general and specialist units

THERAPY PROVIDED	NUMBER OF SPECIALIST UNITS						Total units that responded (n=66)
	General psychiatric unit (n=51)	Eating disorder unit (n=6)	Forensic unit (n=2)	Secure unit (n=3)	Addictions unit (n=2)	Learning disability unit (n=2)	
Drug therapy	50 (98%)	5	2	3	2	2	64 (97%)
Cognitive therapy	44 (86%)	5	2	3	2	2	58 (88%)
Behavioural therapy	49 (96%)	2	2	2	1	2	58 (88%)
Cognitive behavioural therapy	47 (92%)	1	2	3	1	2	56 (85%)
Group therapy	49 (96%)	5	2	3	2	1	62 (94%)
Family therapy	50 (98%)	6	2	3	2	1	64 (97%)
Brief solution focused therapy	39 (76%)	6	1	1	2	2	51 (77%)
Play therapy	18 (35%)	0	0	0	0	0	18 (27%)
Parent training / counselling	46 (90%)	5	2	2	2	1	58 (88%)
Social skills training	50 (98%)	5	2	3	2	2	64 (97%)
Creative therapies	46 (90%)	5	2	3	0	2	58 (88%)
Dietetic advice	46 (90%)	6	2	2	1	1	58 (88%)
Physiotherapy	26 (51%)	4	1	1	0	1	33 (50%)
Occupational therapy	30 (59%)	1	1	3	0	2	37 (56%)
Other	26 (51%)	4	2	3	1	0	36 (55%)

Note: Data presented here are self reports from units rather than observation

4.3.3.2 Treatment in relation to patients in general and specialist units

Table 4.12: Type of treatment patients received by general and specialist units

THERAPY RECEIVED	NUMBER OF PATIENTS IN SPECIALIST UNIT							Total no. of patients receiving each treatment (n=661)
	General psychiatric unit (n=498)	Eating disorder unit (n=62)	Forensic unit (n=17)	Secure unit (n=40)	Addictions unit (n=8)	Learning disability unit (n=25)	Paediatric/psychiatric ward (n=11)	
Drug therapy	325 (65%)	27 (44%)	11 (65%)	39 (98%)	5 (63%)	16 (64%)	8 (73%)	431 (65%)
Cognitive therapy	123 (25%)	12 (19%)	4 (24%)	9 (23%)	4 (50%)	6 (24%)	1 (9%)	159 (24%)
Behavioural therapy	208 (42%)	2 (3%)	5 (29%)	3 (8%)	2 (25%)	16 (64%)	0	236 (36%)
Cognitive behavioural therapy	173 (35%)	22 (35%)	7 (41%)	26 (65%)	5 (63%)	8 (32%)	1 (9%)	242 (37%)
Group therapy	427 (86%)	55 (89%)	13 (76%)	38 (95%)	6 (75%)	11 (44%)	0	550 (83%)
Family therapy	388 (78%)	58 (94%)	12 (71%)	15 (38%)	7 (88%)	0	7 (64%)	487 (74%)
Brief solution focused therapy	107 (21%)	20 (32%)	1 (6%)	18 (45%)	4 (50%)	13 (52%)	8 (73%)	171 (26%)
Play therapy	50 (10%)	0	0	1 (3%)	1 (13%)	1 (4%)	5 (45%)	58 (9%)
Parent training / counselling	234 (47%)	35 (56%)	3 (18%)	13 (33%)	8 (100%)	3 (12%)	11 (100%)	307 (46%)
Social skills training	307 (62%)	30 (48%)	10 (59%)	31 (78%)	3 (38%)	22 (88%)	6 (55%)	409 (62%)
Creative therapies	361 (72%)	33 (53%)	10 (59%)	23 (58%)	4 (50%)	19 (76%)	11(100%)	461 (70%)
Dietetic advice	162 (33%)	61 (98%)	4 (24%)	16 (40%)	2 (25%)	20 (80%)	10 (91%)	275 (42%)
Physiotherapy	33 (7%)	23 (37%)	1 (6%)	6 (15%)	8 (100%)	16 (64%)	5 (45%)	84 (13%)
Occupational therapy	199 (40%)	10 (16%)	11 (65%)	20 (50%)	8 (100%)	19 (76%)	6 (55%)	265 (40%)
Other	167 (34%)	45 (73%)	3 (18%)	17 (43%)	6 (75%)	5 (20%)	4 (36%)	247 (37%)

Table 4.13: Treatment received in units as defined by age group

THERAPY RECEIVED	NUMBER OF PATIENTS				Total no. of patients receiving each treatment (n=491)
	Adolescent unit (n=367)	Adult ward with adolescent bed (n=6)	Child and adolescent unit (n=35)	Children's unit (n=83)	
Drug therapy	255 (69%)	4 (67%)	25 (71%)	37 (45%)	321 (66%)
Cognitive therapy	102 (29%)	0 (0%)	7 (20%)	14 (17%)	123 (24%)
Behavioural therapy	127 (35%)	0 (0%)	12 (34%)	69 (83%)	208 (42%)
Cognitive behavioural therapy	136 (37%)	0 (0%)	13 (37%)	23 (28%)	172 (35%)
Group therapy	324 (88%)	5 (83%)	23 (66%)	67 (81%)	419 (86%)
Family therapy	284 (77%)	4 (67%)	23 (66%)	71 (86%)	382 (78%)
Brief solution focused therapy	72 (20%)	5 (83%)	10 (29%)	17 (20%)	104 (21%)
Play therapy	21 (6%)	0 (0%)	1 (3%)	28 (34%)	50 (10%)
Parent training / counselling	141 (38%)	2 (33%)	22 (63%)	67 (81%)	232 (47%)
Social skills training	220 (60%)	1 (17%)	22 (63%)	60 (72%)	303 (62%)
Creative therapies	285 (78%)	4 (67%)	18 (51%)	48 (58%)	355 (73%)
Dietetic advice	123 (34%)	4 (67%)	12 (34%)	19 (23%)	158 (32%)
Physiotherapy	20 (5%)	0 (0%)	4 (11%)	8 (10%)	32 (7%)
Occupational therapy	166 (45%)	0 (0%)	0 (0%)	28 (34%)	194 (40%)
Other	130 (35%)	5 (83%)	1 (3%)	25 (30%)	161 (33%)

The range of treatments received by adolescent patients in adult wards appeared to be considerably less compared with those in the other age defined units, however a high percentage of patients in these services were reported to receive 'other' types of therapies different from the categories listed above.

Over 80% of patients in children’s units received family therapy, behavioural therapy, group therapy and the parents received parent training and counselling. A large proportion of patients in all four types of units received family therapy and group therapy. Cognitive therapy and cognitive behavioural therapy when combined were received by 66% of patients in adolescent units, 57% of patients in child and adolescent units and 45% of patients in children’s units. None of the adolescent patients in adult wards were reported to have received these forms of treatment.

4.3.3.3 Treatment in relation to patient’s diagnosis

This section focuses on treatments received in relation to the patients’ diagnoses. For ease of interpretation, treatment in relation to patients’ principal or probable diagnoses will only be reported for the three main diagnostic groups reported on the census day; eating disorders, mood (affective) disorders, and schizophrenia/delusional/psychotic disorder.

Table 4.14: Treatments received by patients diagnosed with one of three diagnostic categories

THERAPY RECEIVED	NUMBER OF PATIENTS IN EACH DIAGNOSTIC GROUP		
	Eating disorders (N = 130)	Mood (affective) disorders (N= 109)	Schizophrenia, delusional or psychotic disorders (N=107)
Drug therapy	55 (42%)	85 (78%)	103 (96%)
Cognitive therapy	48 (37%)	29 (27%)	21 (20%)
Behavioural therapy	30 (23%)	33 (30%)	35 (33%)
Cognitive behavioural therapy	54 (42%)	37 (34%)	38 (36%)
Group therapy	111 (85%)	91 (83%)	91 (85%)
Family therapy	116 (89%)	79 (72%)	72 (67%)
Brief solution focused therapy	33 (25%)	19 (17%)	19 (18%)
Play therapy	3 (2%)	8 (7%)	7 (7%)
Parent training / counselling	72 (55%)	34 (31%)	44 (41%)
Social skills training	57 (44%)	68 (62%)	69 (64%)
Creative therapies	77 (59%)	81 (74%)	74 (69%)
Dietetic advice	125 (96%)	28 (26%)	25 (23%)
Physiotherapy	26 (20%)	7 (6%)	7 (7%)
Occupational therapy	32 (25%)	43 (39%)	59 (55%)
Other	69 (53%)	41 (38%)	32 (30%)

The top three in each group or the treatments that are received by over 70% patients in each diagnostic group are shaded to ease identification.

Group therapy again was one of the main treatments common to all three main diagnostic groups. Drug therapy also appeared to be one of the main treatments provided for young people diagnosed with mood (affective) disorder or schizophrenia, delusional or psychotic disorders. This was not the case for the in-patient population as a whole where drug therapy was only received by 65% of in-patients. This also differed from the 42% of young people diagnosed with an eating disorder who received drug therapy. Family therapy also appeared to be provided for many patients in each of the three diagnostic groups as well as the in-patient population as a whole. Cognitive therapy and cognitive behavioural therapy were also common forms of treatment for all three diagnostic groups.

In section 4.3.2.3, Table 4.8, the results showed that for males aged 13 or under, the main diagnostic groups differed from those of the total population and the female population for this age group. Table 4.15 below describes information about the therapies received by males aged 13 or under who have one of the three main diagnostic categories reported for this specific group.

Table 4.15: Treatment in relation to the principal diagnosis for males under the age of 13

THERAPY RECEIVED	NUMBER OF PATIENTS IN EACH DIAGNOSTIC GROUP		
	Conduct disorder (incl. Mixed CED) (N=21)	Hyperkinetic disorder (ADHD) (N= 12)	Mood (affective) disorder (N= 9)
Drug therapy	9 (42%)	11 (92%)	7 (78%)
Cognitive therapy	3 (14%)	2 (17%)	1 (11%)
Behavioural therapy	18 (86%)	8 (67%)	4 (44%)
Cognitive behavioural therapy	5 (24%)	2 (17%)	3 (33%)
Group therapy	16 (76%)	11 (92%)	5 (56%)
Family therapy	17 (81%)	11 (92%)	9 (100%)
Brief solution focused therapy	3 (14%)	4 (36%)	9 (100%)
Play therapy	6 (29%)	3 (25%)	3 (33%)
Parent training / counselling	15 (71%)	8 (67%)	7 (78%)
Social skills training	12 (57%)	9 (75%)	7 (78%)
Creative therapies	13 (62%)	8 (67%)	5 (56%)
Dietetic advice	6 (29%)	2 (17%)	2 (22%)
Physiotherapy	1 (5%)	2 (17%)	1 (11%)
Occupational therapy	7 (33%)	1 (8%)	3 (33%)
Other	8 (38%)	1 (8%)	4 (44%)

The top three in each group or the treatments that are received by over 70% patients in each diagnostic group are shaded to ease identification.

Conduct disorder, hyperkinetic disorders and mood (affective) disorders were the most prevalent diagnoses among young in-patients aged 13 or under. Tables 14 and 15 demonstrate that group and family therapies were a popular form of treatment for a range of disorders and age groups. For those diagnosed with a conduct disorder many were receiving behavioural therapy (86%). In relation to drug therapy, it was reported that a high percentage of young children diagnosed with hyperkinetic disorders (92%), mood (affective) disorders (78%) and conduct disorder (including mixed CED) (42%) received this form of treatment.

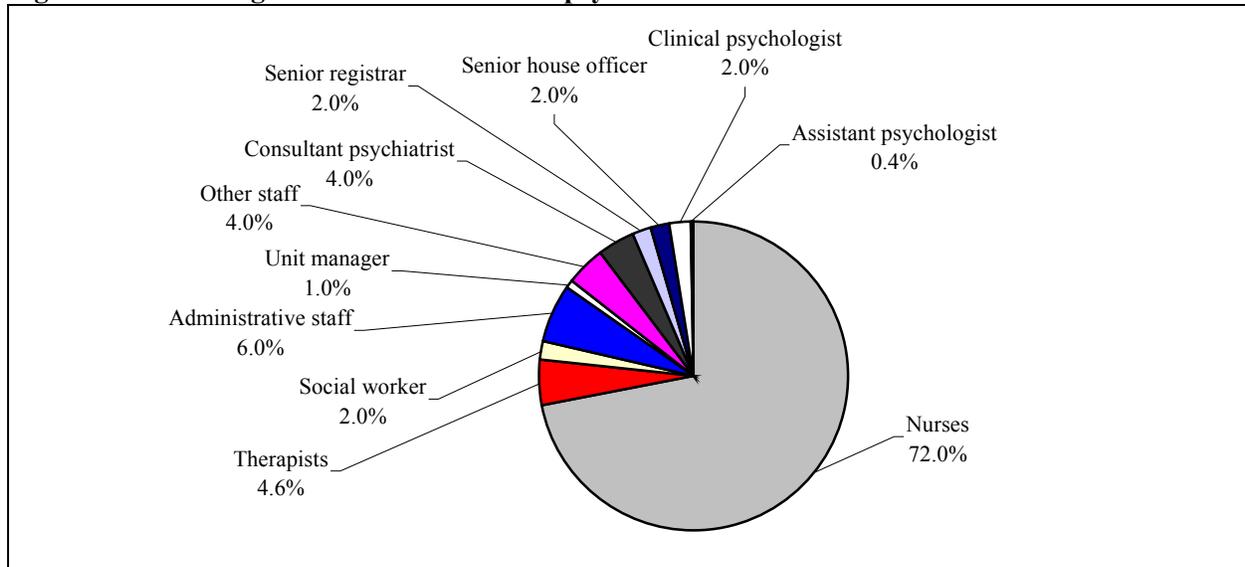
4.3.4 Staffing

Information about the staff make up of child and adolescent psychiatric units was obtained from 62 out of 80 units (78%).

4.3.4.1 Staffing levels

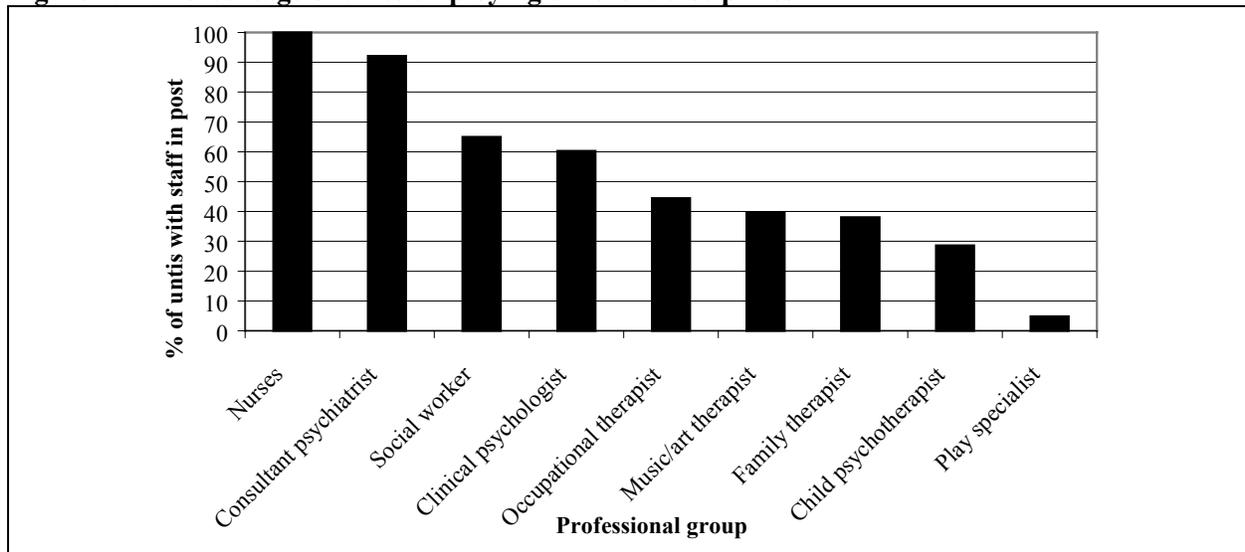
Figure 4.12 below describes staffing by professional group as a percentage of the total staff in child and adolescent in-patient units.

Figure 4.11: Staffing in child and adolescent psychiatric units



A range of professionals are involved in providing in-patient psychiatric services. Nursing staff account for by far the highest proportion of professionals working within this setting followed by medical staff, therapists, clinical psychologists, social workers, unit managers and administrative staff. Therapists comprise occupational therapists (2%), family therapists (1%), music/art therapists (0.8%), child psychotherapists (0.5%) and play specialists (0.3%).

Figure 4.12: Percentage of units employing different disciplines



Note: This figure describes only staff in post working on the unit and not those on establishment.

A consultant was in post in all but four of the responding units (three of these units were general psychiatric units and one was an eating disorder unit which reported that they had an adult psychiatrist in post). Two of the general psychiatric units had a locum in place, while the other reported that they had access to a consultant child and adolescent psychiatrist.

4.3.4.2 Multidisciplinary staffing

Table 4.16 describes the number of other disciplines that, in addition to medical and nursing staff, contribute to the multidisciplinary make-up of teams working in in-patient services. Other disciplines included are social workers; family/systemic therapists; occupational therapists; clinical psychologists;

psychodynamic psychotherapists; music therapists; art therapists; play therapists; drama therapists; cognitive therapists.

Table 4.16: Level of other disciplines in in-patient units

Number of other professional disciplines	Number of units	Type of unit
0	1	1 Adolescent learning disability service
1	6	4 General psychiatric unit 2 Addiction services
2	15	13 General psychiatric units 1 Secure unit 1 Eating disorder unit
3	17	14 General psychiatric units 2 Eating disorder units 1 Forensic unit
4	16	12 General psychiatric units 3 Eating disorder unit 1 Learning disability unit
5	4	3 General psychiatric units 1 Secure unit
6	3	2 General psychiatric units 1 Secure unit

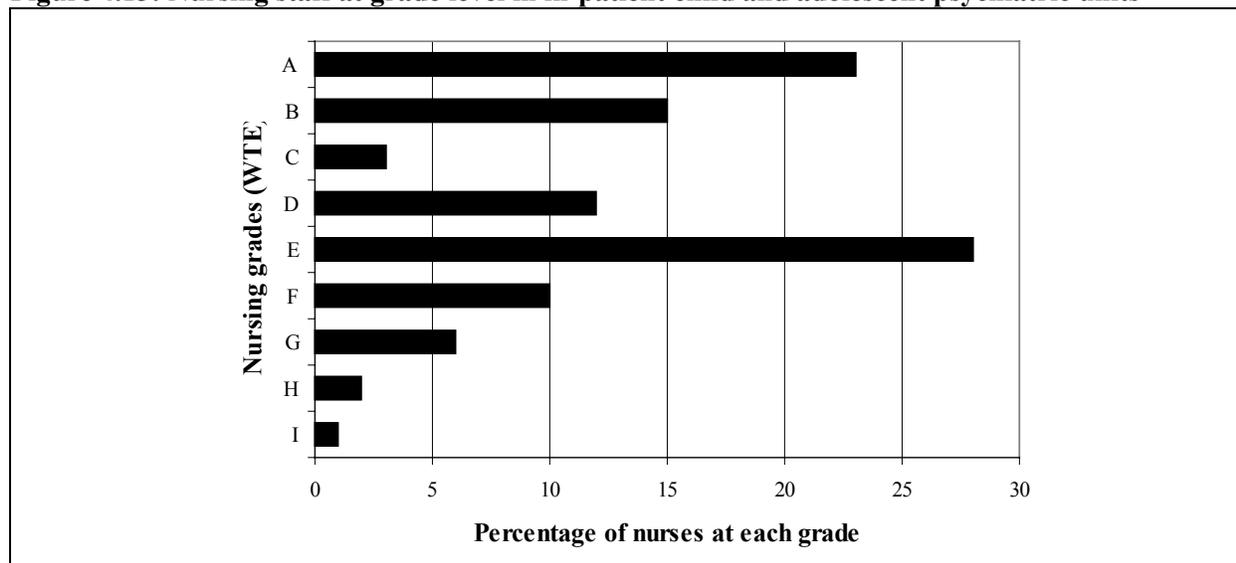
The professional make-up of unit staff ranges from having no disciplines on the team other than medicine and nursing, to having 6 other disciplines in post. The majority of units had 2 to 4 other disciplines amongst their staff and all types of units, including general psychiatric units, eating disorder units and secure and forensic units, fell within this range.

4.3.4.3 Nursing staff

Table 4.162 on the previous page showed that the nursing staff alone account for nearly three quarters of the total staff providing care and treatment in this specialised service. The qualifications held by nurses working in child and adolescent psychiatric in-patient services are described below, followed by a brief summary of the nurse to patient ratios in different types of units.

4.3.4.3.1 Nursing qualifications

Figure 4.13: Nursing staff at grade level in in-patient child and adolescent psychiatric units



Just under half (41%) of all nursing staff working in child and adolescent psychiatric units were at grade A, B or C i.e. unqualified nursing assistant status. So over half the nursing staff were qualified at grades D through to I, with the highest proportion of qualified nurses at grade E. In general psychiatric units only 34% of the nursing staff were unqualified, which was low compared to eating disorder units (44%), the two forensic units (54%) and the secure units (54%).

Table 4.17: Number of WTE qualified nurses with type of qualification

Nursing Qualifications	General psychiatric units (n=582)	Eating disorder units (n=59)	Forensic units (n=8)	Secure units (n=47)
RSCN Registered child nurse	20 (3%)	7 (12%)	0	0
RMN Registered mental health nurse	418 (72%)	16 (27%)	8 (100%)	40 (85%)
RGN Registered general nurse	57 (10%)	21 (36%)	0	1 (2%)
ENB603*	95 (16%)	2 (3%)	1 (1%)	3 (6%)
SEN State enrolled nurse	35 (6%)	3 (5%)	0	2 (4%)

Note: The categories are not mutually exclusive so totals are not presented.

*ENB603 is the English National Board 603 course for child, adolescent and family mental health.

The majority of qualified nurses in three out of the four types of units are registered mental health nurses (RMNs). In eating disorder units, however, the most common qualification held by nurses is the registered general nursing qualification RGN, followed by the RMN. Only a small percentage of nurses in each type of unit held an ENB 603 qualification.

4.3.4.3.2 Nurse:patient ratio on census day

Error! Reference source not found. below describes the average number of nurses per patient over a 24-hour period. The ratios were derived by dividing the mean number of nurses on day or night shift over a 24 hour period on census day for each group of units by the mean number of patients on the census day.

Table 4.18: Nurse:patient ratios over 24 hours on census day

Type of unit	Nurse:patient ratios (S.D.)	
	Day shifts ¹	Night shift
Forensic/secure (n=4)	1.38 (0.34)	0.37 (0.29)
General psychiatric units (n=55) ²	1.25 (0.81)	0.30 (0.26)
Eating disorder units (n=7)	0.84 (0.40)	0.21 (0.18)
Others (n=3)	1.22 (0.35)	0.28 (0.19)

¹The figure given is for the two day shifts combined. The mean ratio of nurses to patient during the day-time is approximately half of this.

²General child, adolescent and child and adolescent units combined

4.3.5 Educational provision

The general survey questionnaire, sent out to all 80 units, included questions about the educational provision within in-patient services. The results presented here refer to educational provision in the 66 units (response rate 83%) that answered the relevant questions.

63 (94%) responding units reported that they provided an educational facility or had on site access to an educational facility i.e. off premises but on site. The three units that reported not to have an educational facility were primarily adult wards with a licence to treat young people under the age of 18.

4.3.5.1 Teaching staff

All the units were asked how many WTE teachers are normally active in the educational facility. Unfortunately data was missing for 23 units and not applicable for 3 units out of the 66 responding units. The number of full time teachers reported to be normally active in the educational facility was varied. The majority of units (31 units) had 1 to 3 WTE full time teachers while the remaining 9 responding units had between 4 to 10 WTE full time teachers working in the educational facility on the unit. There was no obvious relationship between the type of unit and number of WTE full time teachers.

4.3.5.2 Educational resources

35 out of 62 (56%) units reported that they only have educational resources to cover national curriculum areas that they prioritise and teach, while the remaining 44% had the resources to cover all national curriculum areas.

4.3.5.2.1 Range of secondary level specialist subjects

For young people who had entered secondary school level, units were asked to detail the subjects taught by specialist teachers trained to teach at secondary level. This questionnaire item was only applicable to 56 units, of which 11 units reported the item as not applicable and 2 did not provide any data. The total number of units, excluding children's units, to complete this item was 43.

The number of specialist subjects the teachers in each unit were trained to teach at secondary school level ranged from 2 to 16 with a mean of 8.6. The distribution, however, is not normal and exhibits two peaks. The peaks included two clusters of units: 14 units reported to have specialist subject teachers for 4 to 7 specialist subjects while a second cluster of 17 units reported that they have specialist teachers for 10 to 12 specialist subjects.

4.3.5.3 Educational resources for key stages

All the units reported that they had the educational resources to cover key stages appropriate to the age group being treated in the units.

4.3.6 Referrals, admissions and discharges

This section describes the throughput of patients for the 62 (78%) units that returned information about referrals, admissions and discharges over a specified study period of six months in 1999 (1st of July to the 31st of December 1999). This study did not follow a cohort of patients through to conclusion but simply captured the number of referrals, admissions and discharges that occurred over a six-month period. So in some cases a patient may have been referred, admitted and discharged within the study period but for many only one of these events (referral, admission or discharge) occurred.

4.3.6.1 Referrals

During the specified six-month period the 62 units received a total of 1,517 referrals. The average number of referrals received by a unit was 25 (standard deviation 16; range 2 to 73 referrals).

4.3.6.1.1 Referred population: request for emergency assessment

This questionnaire item was completed for 1,486 referrals, of which 334 (22%) cases were requests for an emergency assessment or admission within 24 hours. Within the six-month time band a total of 168 such referrals were admitted. The period of time that passed between the point of an emergency referral and an admission ranged from within 24 hours to 4 months. 101 emergency referrals (60%) were admitted within 24 hours, 34 (20%) within a week, 11 (6.5%) between 1 to 2 weeks of the referral and longer than two weeks for the remaining 19 (11.3%) emergency referrals.

4.3.6.1.2 Referred population: Children Act or Mental Health Act status

At the point of referral 160 (11%) of the 1,444 referrals for whom this information was available, were reported to be subject to an order of the Children Act or the Mental Health Act. Detailed information on in-patients with a Children Act or Mental Health Act status is given in the partner CAMHA-CAPS report.

4.3.6.1.3 Referred population: source of referrals

The main source of referrals came from child and adolescent psychiatrists who referred more than 60% of the cases to in-patient units. This was followed by referrers from other child and adolescent mental health services or child clinical psychologists (9%) and general practitioners, who accounted for 5% of the recorded referrals. The remaining 16% of referrals were made by a range of 8 other professional groups including paediatricians (community and acute) (5%); social services (5%); adult psychiatrists (4%); educational services (0.7%); self/parent or guardian (0.9%); accident and emergencies (0.5%); youth justice system (0.3%); other (5%) and missing data 4.6%.

4.3.6.1.4 Referred population: assessment and admission

963 (63%) of the referrals made were assessed during the same six-month period and 546 (36%) referrals were admitted during the same period. These data do not represent all admissions to result from a referral during the study period, as referrals were not followed through to their conclusion.

4.3.6.2 Assessments

Over the six-month period the 62 responding child and adolescent in-patient units assessed 1,131 cases.

4.3.6.2.1 Assessment population: reasons for non-admission

A large number of reasons, 662 in total (reasons were not mutually exclusive), were reported for not admitting 500 patients to the units they were referred to. The questionnaire item provided 14 categories of reasons for not admitting patients. However the category 'other' was recorded for 307 responses. It was therefore subjected to a content analysis and was re-categorised. Reasons applying to 15 or less cases are not reported. A small proportion of these assessments may have been subsequently admitted. This is because admission may have occurred after the end of the study period.

Figure 4.14: Summary of units' throughput over six months

<ul style="list-style-type: none">◆ REFERRALS = 1,517<ul style="list-style-type: none">◆ Emergency referrals = 334 (22%) requests for an emergency assessment or admission within 24 hours.◆ ASSESSMENTS = 1,131◆ ADMISSIONS = 827◆ DISCHARGES = 783
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Figure 4.15: Main reasons for not admitting patients (number & % of cases)

<ol style="list-style-type: none">1. Admission was not necessary (181 cases, 36%)<ul style="list-style-type: none">➤ <i>This was reported for cases where there was no psychiatric disorder, or when out-patient, day-patient or other care by social services or education was recommended</i>2. Patient or family refused admission (117 cases, 23%)3. Inappropriate for current casemix (95 cases, 19%)<ul style="list-style-type: none">➤ <i>This category includes 18 cases that were viewed as too violent and 12 cases where the patient had a forensic history.</i>4. Placed on a waiting list or delay in admission (48 cases, 9.6%)5. Insufficient resources to safely admit (39 cases, 7.8%)

4.3.6.2.2 Assessment population: length of wait for admissions

A time delay between assessment and admission may be planned to explore possible out-patient care. However, the length of wait between the date of assessment and admission for patients assessed and admitted during the specified period (585 cases) ranged from 0 to 279 days. 210 (36%) of these cases were assessed and admitted on the same day and another 31 (5%) cases were admitted the next day. 85% had a waiting time of less than a month between assessment and admission.

4.3.6.3 Admissions

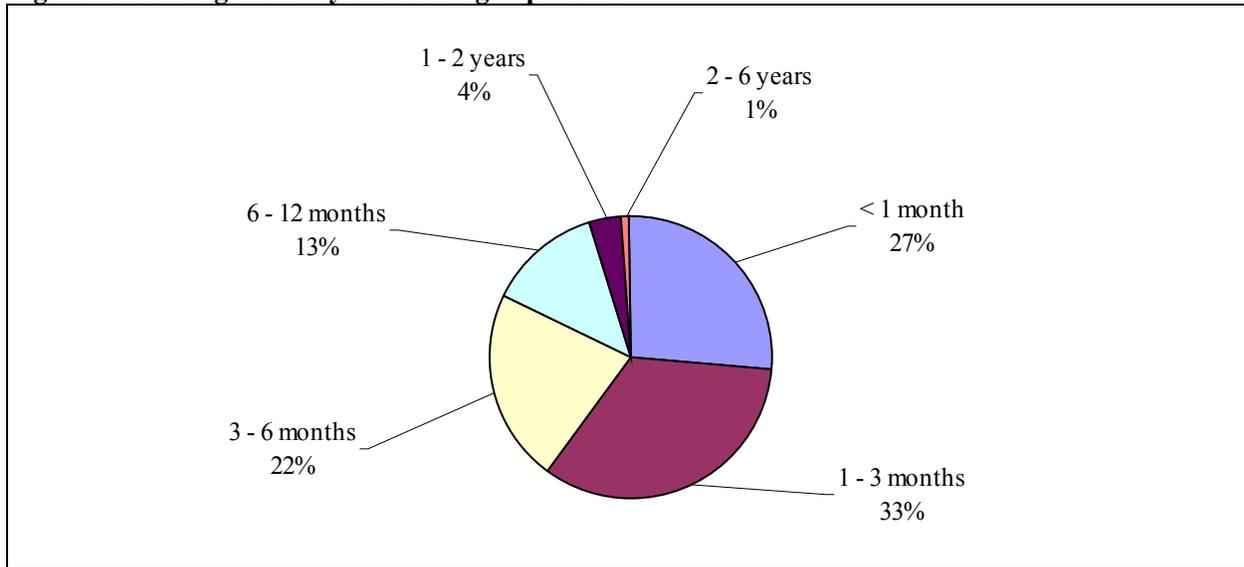
Irrespective of the date of referral (e.g. referral before the start date of the study period), 827 admissions occurred over the six-month period. Some of these may have been multiple admissions of the same patients.

4.3.6.4 Discharges

Over the six-month study period 783 discharges occurred in the 62 responding units.

4.3.6.4.1 Discharged population: length of stay

Figure 4.16: Length of stay of discharged patients



The mean length of stay for cases discharged during the study period was 115 days (3.7 months) with a standard deviation of 181 days (5.9 months) and a range of 0 to 2,194 days. The range, excluding the 6 (1%) long stay in-patients (2 to 6 years), fell between 0 to 717 days (23 months) with a mean length of stay of 103 days (3.3 months) and a standard deviation of 108.38 days (3.5 months).

The 6 long stay patients (2 to 6 years) were over 18 at the time of discharge and were in-patients in two types of specialist units; 5 were resident in a secure adolescent unit and 1 in a learning disability psychiatric unit. Delay in discharge due to difficulty arranging local follow up or community support was reported for 4 of these cases. These 4 cases were discharged to low and medium secure units.

Specifically for general psychiatric units the mean length of stay was 104 days with a standard deviation of 106 days and the range was from 0 to 680 days, 4% stayed between 1 to 2 years. There was a significant association between diagnosis and length of stay in general psychiatric units (Fisher's Exact Value = 97.79, p-value < 0.001). However, this association was not strong (Cramer's V = 0.218, p-value < 0.001).

4.3.6.4.2 Delayed discharge

This questionnaire item was completed for 752 discharges. In total 121 (16%) of these discharges were reported to have been delayed, the reasons given for why a discharge was delayed is described in Table 4.20 below.

Table 4.19: Reason for delay at discharge

Reason given	Number of discharges delayed
Difficulty arranging local follow-up / community support	48 (35.6%)
Provision of educational support	34 (25.2%)
Delays in agreement / funding of residential placement	31 (23.1%)
Family refuse	16 (11.3%)
Other	41 (30.8%)

The reasons listed are not mutually exclusive, so more than one may apply to a discharged case.

4.3.6.4.3 Follow-up arrangements

This item was completed for 774 discharges.

Table 4.20: Follow-up arrangements

Arrangement	Number of discharges
Referred back to referrer	418 (54%)
Follow-up provided by unit	152 (19.4%)
Referral to other agency	83 (10.6%)
Other	121 (15.6%)
Total	774 (100%)

4.3.6.4.4 Destination following discharge

This item was completed for 773 discharges. The majority of patients (76.9%) were discharged to the family home. The remaining discharges, apart from those reported under the 'other' category, were discharged to a non-hospital residential unit (5.9%), residential schools (1.8%) or foster care home (3.4%).

4.4 Follow-up study of those referred but not admitted to 18 units

As discussed above, the 18 units selected for the site visits were also the basis of the follow-up study of patients referred but not admitted to in-patient child and adolescent units. Of the 18 units surveyed, three were either not willing or not able (by reason of resource or ethical concerns) to provide referrer information for cases of those referred but not admitted.

The 15 units, which supplied these data, reported that 205 cases of patients were referred but not admitted. Two of the units reported that all patients referred to them in the study period were admitted. 10 units provided information on the referring agents for each relevant case. Further data collection in this element of the study was problematic. It was not possible to contact the referrer in over half the cases referred but not admitted, due to the lack of either contact details or consent to do so. This led to a situation where only 70 questionnaires were sent out to referrers, of which 49 questionnaires were returned.

This means that the data obtained in this element of the study are likely to be subject to substantial and unquantifiable non-response bias. This results in major limitations in the interpretation and generalisability of the results. In particular it is not possible to generate population-based estimates of the rate, relative frequency and impact of those referred but not admitted. However this is not to say that the data are without some usefulness. As in much of the study, the evidence base is at a very early stage and is sparse. In such circumstances it can be useful to illustrate processes and pathways through care. This can form the basis for further empirical study in terms of parameter estimation for sample size calculations and by hypothesis generation. In the following sections the data obtained from this study will be considered in this light.

4.4.1 Null returns

The reasons given for forms being sent back with no information included:

- The recipients of the form reported to have no knowledge of the young person in question
- The people involved in the case had since left the department
- The young person had since left the NHS Trust in question
- The young person had since left the consultant's list
- The young person had had no further consultations with the referrer or elsewhere regarding their mental health

4.4.2 Emerging themes

Content analysis was applied to the returned forms in order to identify common themes in the outcome of those young people not admitted. The six main themes are presented in Figure 4.17. Individuals may have experienced more than one of these outcomes.

Figure 4.17: Outcomes following non admission

1. Contact with social services (*9 cases*)
2. Contact with psychiatric out patient clinic or community services (*9 cases*)
3. Input from educational services (*6 cases*)
4. Patients admitted to another CAMHS in-patient unit (*8 cases*)
5. Patients subsequently admitted to the unit that first refused admission (*2 cases*)
6. Use of the Mental Health Act (*6 cases*)

4.4.2.1 Six case vignettes

These cases were selected as indicative of the trajectories through services set out above. Cases 1, 2 and 3 clearly focus more on the first three themes and cases 4, 5, and 6 on the last three.

Case 1

A was aged 16 at the time of the unsuccessful referral. The reasons given for non-admission were that the ‘patient or family refused admission’ and that there was ‘no definite home base’. A was subsequently placed with his father away from his mentally ill mother and has been in contact with local social services. Mother and son had previously developed a violent relationship, culminating in mother setting fire to herself in front of A. At referral A was depressed, socially withdrawn, not attending school or leaving the flat. Diagnosis: anxiety disorder, profound emotional abuse and psychological trauma.

Case 2

B was 16 years old at the time of the unsuccessful referral. He refused admission to an adolescent in-patient unit and was then seen in a specialist NHS paediatric unit for assessment of a developmental disorder. He had also been seen by private psychologists and was attending a special school unit provided by his Local Authority. He remained at home and was seen by out-patient and community CAMHS.

Diagnosis: affective disorder and pervasive developmental disorder

Case 3

C was 13 years old at the time of referral. She had been diagnosed with schizophrenia/psychosis and learning disability. The level of her learning disability was unclear, with an IQ between 30 and 70 (her elective mutism compromised assessment). Her original referral was rejected by an adolescent in-patient unit because her learning disability was felt to be incompatible with the unit’s milieu – it was felt that her age/maturity made her inappropriate for an adolescent setting. She was then placed as a day patient in a children’s unit. However, following increased severity of disturbance, diagnostic complexity and difficulties in management she required admission to a 7 day unit. Epilepsy was diagnosed and C was transferred to a paediatric unit specialising in this disorder. Staff there found her difficult to manage and she was transferred to another psychiatric in-patient adolescent unit. Later she was transferred back as a day patient on the adolescent unit which had initially not accepted her. The complexity of C’s learning disability, psychosis, epilepsy and problems nursing her have been a real problem in finding a suitable place.

Case 4:

D, diagnosed with schizophrenia, was 16 years old at the time of referral, and a resident with rehabilitation services. A referral to an in-patient unit was refused (without assessment), and D was admitted to an adult in-patient ward. The current RMO notes that "it has been difficult to find services for D. He has been resident in an adult psychiatry ward for 17 months under Section 3. No adolescent service would work with him. The adult rehabilitation team has accepted him, but he remains an in-patient. We are having to get a variance in the registration of the rehabilitation hostel to enable us to house a minor."

Case 5:

E was 17 years old at the time of referral and was diagnosed as having a personality disorder, an eating disorder and a mood disorder. She had a history of sexual abuse and self harm. E was a resident in an adult in-patient ward at the time of referral, and was refused admission to an adolescent unit. E subsequently required admission to a secure in-patient unit.

Case 6:

F was 17 years old at the time of referral, and was diagnosed as having schizophrenia. F was admitted as an in-patient to a secure adolescent unit during the acute phase of his illness. An attempt to refer F to an open in-patient unit failed, and F remained at the secure unit until discharged into the care of an adult CMHT 8 months later. The referrer noted: "This patient was admitted to (a secure adolescent in-patient unit) in the acute stage of this illness (Dec 98). We then referred him to his local NHS unit once he had stabilised (Jul 99) but he was not offered admission. Consequently we continued treatment at (the same secure unit) until he was eventually discharged home (May 2000)"

4.5 Admissions of young people with mental disorder to general adult psychiatric and paediatric wards

We carried out two brief sub-studies in order to attempt to quantify the number of young people under the age of 18 with primary mental health problems admitted to paediatric wards and adult general psychiatric wards for the treatment of mental health problems. The data from this part of the study are presented here.

4.5.1 Admissions to adult psychiatric wards

In total, 31 general adult psychiatric wards were identified in the 9 Health Authorities studied. The lead clinician in each ward was asked to complete a brief questionnaire and report whether, in their opinion, the admission to a general adult psychiatric ward was appropriate. Responses were obtained from all 31 wards. 13 wards reported that during the 6-month period they had had no admissions of people under the age of 18. From the remaining 18 wards, the survey identified 43 people under the age of 18 admitted to adult general psychiatric wards. Of those admitted 26 (60%) admissions were reported to be 'inappropriate'. The two main reasons given for not transferring or admitting these patients to a more appropriate setting were:

- the non availability of an appropriate facility (15 cases); and
- the appropriate facility was either full or would not accept the patient (10 cases).

4.5.1.1 ‘Inappropriate’ admissions

This group included 14 males and 12 females aged between 15 and 17 years. Five cases (19%) were aged 15, 7 cases (27%) were aged 16 years, and 13 cases (50%) were 17 years old. 6 were subject to the Mental Health Act or the Children Act.

4.5.1.2 ‘Appropriate’ admissions

This group included 9 males and 6 females. 4 were aged 16 and the remainder were 17 years old. 4 were subject to the Mental Health Act or the Children Act.

The principal or probable primary diagnoses of those admitted to general adult psychiatric wards is presented in Table 4.21 below.

Table 4.21: Principal or probable diagnosis

	Inappropriately admitted	Appropriately Admitted
Diagnosis	Total	Total
Substance use related disorder	3	3
Schizophrenia, delusional or psychotic disorder	4	4
Mood/affective disorder	4	0
Acute stress reaction/adjustment disorder	2	2
Personality disorder	3	3
Other categories		
Substance use related disorder and schizophrenia, delusional and psychotic disorder	1	0
Substance use related disorder and mood affective disorder and organic brain disorder	2	0
Substance use related disorder and personality disorder	1	0
Schizophrenia, delusional and psychotic and mood affective disorder	2	0
Acute stress reaction/adjustment disorder and conduct disorder	1	0
Obsessive compulsive disorder	1	0
Attention seeking behaviour - no evidence of mental illness	1	0
Admitted following bizarre actions and physically aggressive, showed no evidence of mental illness	1	0
Mental & behavioural disorders due to multiple drug use & use of other psychoactive substances	0	1
Mood affective disorder, acute stress reaction or adjustment disorder	0	2
Total	26	15

4.5.1.3 Length of stay

For the population as a whole the length of stay in adult psychiatric wards ranged from 0 to 57 days, with one extreme value at 156 days. The mean length of stay was 20 days (s.d. 26 days). For those whose admission was viewed as ‘inappropriate’ the length of stay ranged from 0 to 34 days with a mean of 13 days (s.d. 11.5 days).

4.5.1.4 Estimate of the number of ‘inappropriate’ admissions to adult psychiatric wards in England and Wales

In summary, a response was obtained from all 31 wards; 13 reported no admissions and the remaining 18 reported 43 relevant cases of which 26 were viewed as ‘inappropriate’. The survey identified 26 ‘inappropriate’ admissions in 31 adult wards in the 9 health authorities sampled, yielding an average of 0.84 ‘inappropriate’ admissions per adult ward. Thus 26 ‘inappropriate’ admissions occurred over a six-

month period in 9 health authorities with a combined 18 and under population of 1,132,335 (based on mid-1999 projections of the 1991 census). The rate of ‘inappropriate’ admissions to adult general psychiatric wards was therefore 4.6 per 100,000 18 and under per year. Applying this to the total 18 and under population in England and Wales (12,630,713), the estimated number of ‘inappropriate’ admissions to general adult psychiatric wards of people in this age group was 581.

4.5.2 Admissions to paediatric wards for treatment or care of mental illness

In addition to adult general psychiatric wards we also studied admissions to paediatric wards for the treatment or care of mental illness over a 6-month period. The lead clinician in each ward surveyed was asked to complete a brief questionnaire and report on whether in their opinion the admission of the patient to a paediatric ward was ‘appropriate’. We identified 21 paediatric wards in the 9 health authorities and 16 wards responded. 10 wards reported no relevant admissions during the study period; the remaining responding wards reported 11 relevant cases of young people being admitted to the ward for the treatment of mental illness. Of those admitted, 6 (56%) were reported to be ‘inappropriate’ for that setting. The two main reasons given for not transferring or admitting the patients to a more appropriate setting were:

- the non-availability of an appropriate facility (5 cases), and
- the appropriate facility was either full or would not accept the patient (1 case).

4.5.2.1 ‘Inappropriate’ admissions

This group included 5 females and 1 male aged between 8 and 14 years. 2 of the patients ‘inappropriately’ admitted had Mental Health Act or Children Act status.

4.5.2.2 ‘Appropriate’ admissions

In this group there were 3 females and 2 males aged between 13 and 16 years and of one patient aged 3 years old. None were subject to the Mental Health Act or the Children Act.

The principal or probable primary diagnosis of the admitted to paediatric wards is presented in Table 4.22 below.

Table 4.22: Principal or probable diagnosis of those admitted to paediatric wards

	Inappropriately placed	Appropriately Placed
Diagnosis	Total	Total
Schizophrenia, delusional or psychotic disorder	1	0
Mood affective disorder	1	0
Eating disorders	1	1
Pervasive development disorder	0	1
Anxiety disorders	0	1
Psychological and behavioural factors associated with physical disorders and diseases	0	1
Other categories	3	2
Total	6	5

The length of stay ranged from 1 to 56 days. As is usual with such data the distribution was skewed so for 9 out of the 11 patients the length of stay was under 14 days, while the remaining 3 cases stayed on a paediatric ward for 25, 28 and 56 days respectively (mean 13 days; s.d. 17). For those whose admission was viewed to be ‘inappropriate’ the length of stay ranged from 1 to 9 days with the exception of one case, who was on the ward for 28 days.

4.5.2.3 Estimate of the number of ‘inappropriate’ admissions to paediatric wards in England and Wales

In summary, a response was obtained from 16 out of the 21 wards identified. The 16 responding wards identified 11 relevant cases of which 6 were viewed as ‘inappropriate’. The survey therefore identified 6 ‘inappropriate’ admissions in 16 paediatric wards in the 9 health authorities sampled, yielding an average of 0.38 ‘inappropriate’ admissions per ward. To adjust for the 5 non-responding wards missing data was substituted with the mean rate of 0.38, yielding a total of 7.9 ‘inappropriate’ admissions. Thus an estimated 7.9 ‘inappropriate’ admissions occurred over a six-month period in 9 health authorities with a combined 18 and under population of 1,132,335 (based on the 1991 census with mid-1999 projections). The rate of ‘inappropriate’ admissions to paediatric wards is therefore 1.4 per 100,000 18 and under per year. Applying this rate to the total population of 18 and under in England and Wales (12,630,713), the estimate of the number of ‘inappropriate’ admissions to paediatric wards for the treatment of mental disorder is 177 per year. Given the non-response detailed above it is also sensible to carry out a “worst case scenario” analysis, assuming that there were no cases of ‘inappropriate’ admission in non-responders. Applying the rate derived in this way yields an estimate of 134 such ‘inappropriate’ admissions per year.

4.6 Access from the viewpoint of out-patient psychiatrists

As a supplement to the core NICAPS study the project group decided that it would be of use to seek the views of referring out-patient child and adolescent psychiatrists. We therefore sent a brief questionnaire to all out-patient child and adolescent psychiatrists in our representative sample of nine health authorities.

A total of 37 out-patient psychiatrists were identified in the nine health authorities. Of these, 30 returned their questionnaires, a response rate of 81%. The number of cases referred ranged from none to seven. The number of referrals made by each psychiatrist is shown in Figure 4.18.

Figure 4.18: Number of referrals made by out-patient psychiatrists to in-patient services 31st July 2000 – 31st Dec 2000

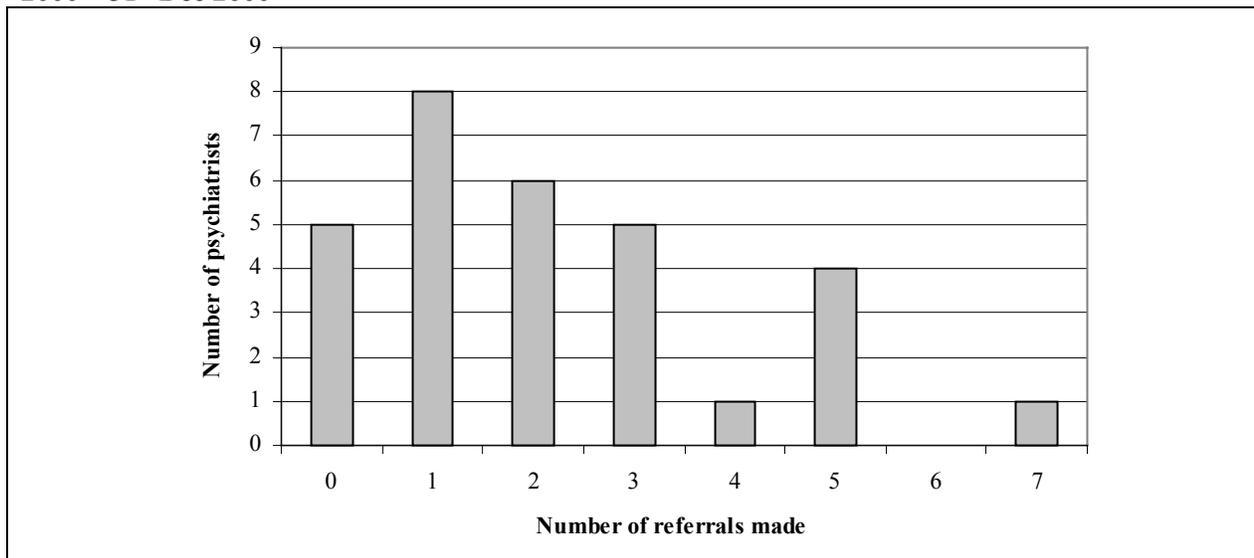
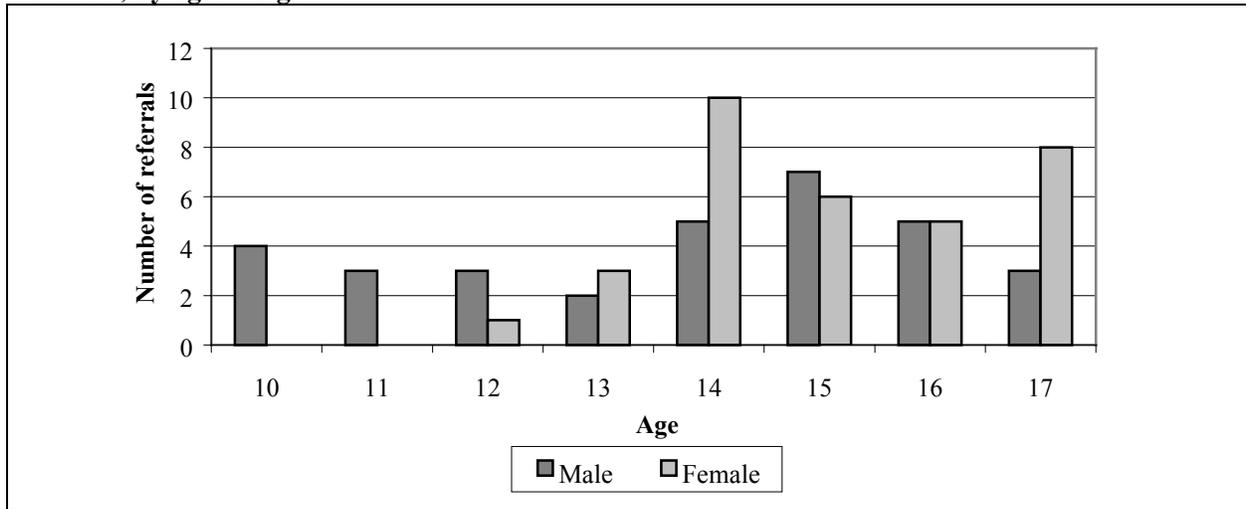


Figure 4.19: Referrals made by out-patient psychiatrists to in-patient services 31st Jul 2000 – 31st Dec 2000, by age and gender



There were a total of 66 referrals made by the 30 responders. This referral population contained fairly equal numbers of males and females (34 females, 32 males).

The average amount of time spent seeking referral was 3.5 hours, with the range of hours spent seeking referral from ‘no time at all’ to 24 hours. This item was completed by 65 of the 66 responders.

44 (67%) patients out of 66 were granted admission..

Figure 4.20: Number of units approached

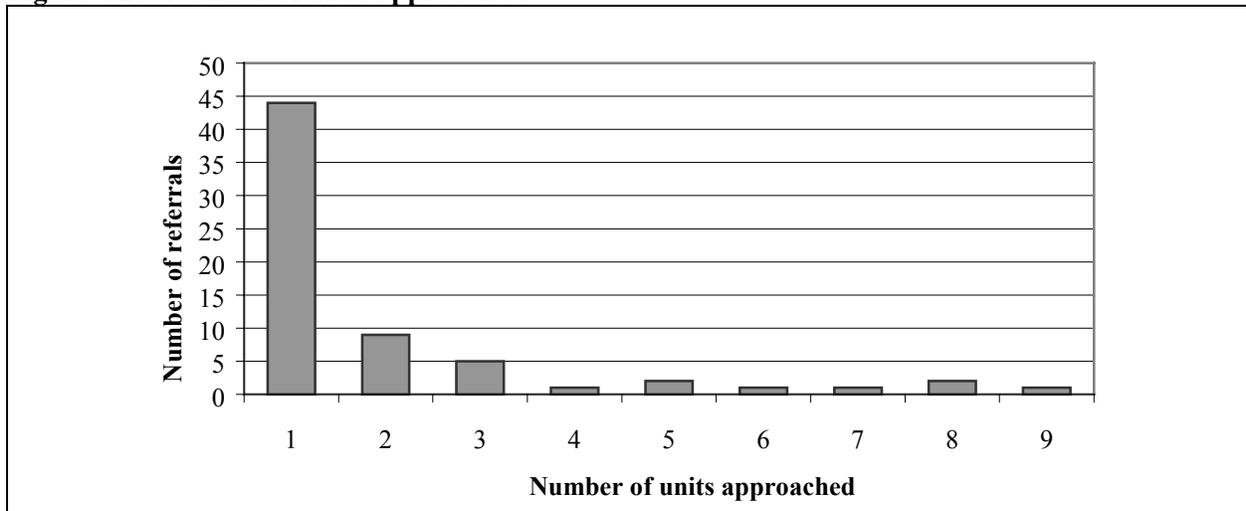


Figure 4.20 shows how many units were approached for each referral. The average number of units approached for each referral was 1.9, this number varying between 1 and 9. Referrers approached one unit only for 44 of the 66 cases reported.

4.6.1 Admitted population

Table 4.23: Amount of time spent seeking admission for those who were admitted (n=43)

No. hours	0.5	1	1.5	2	2.5	3	3.5	4	4.5	5	6	8	10	12	15	24
Frequency	3	14	2	8	0	2	1	3	0	2	2	1	2	1	1	1

Note: This item was completed for 43 out of 44 patients

The average amount of time spent seeking admission for those patients who were subsequently admitted was 3.7 hours. For 37 out of 43 responses, 2 hours or less were spent seeking referral. The amount of time spent ranged from half an hour to 24 hours.

Table 4.24: Number of units approached for those who were admitted (n=44)

Number of units	1	2	3	5	6	7	9
Frequency	29	6	4	2	1	1	1

The average number of units approached for those patients who were subsequently admitted was 1.9. In 29 cases out of 44 there was only one unit approached. The number of units approached ranged from 1 to 9.

Table 4.25: Length of time before admitted (n=43)

No. days	0	1	2	3	4	5	6	7	10	13	14	21-40	41-60	61-80	81-100	101-120
Frequency	5	3	2	1	3	1	3	6	2	1	3	6	3	2	1	1

Note: This item was completed for 43 out of 44 patients

The average length of time before admission was 19.5 days, ranging from under 1 day to 120 (see Table 4.25).

4.6.2 Non-admitted population

Table 4.26: Amount of time spent seeking admission for those who were not admitted (n=22)

No. hours	0	0.5	1	2	3	4	4.5	5	6	8
Frequency	1	3	4	1	4	3	1	1	1	3

The number of hours spent seeking admission for those patients who did not gain it ranged from under 1 hour to 8 hours. The average number of hours spent was 3.2.

Table 4.27: Number of units approached for those patients who were not admitted (n=22)

No. units	1	2	3	4	8
Frequency	15	3	1	1	2

The average number of units approached by referrers on behalf of patients who did not gain admission was 2.0. This number varied from 1 unit to 8 units. Only one unit was approached in 15 out of 19 cases.

4.7 Site visits

The 18 units visited are detailed in Table 3.3. It is difficult to present these data in summary form since the findings and the potential implications of the assessment are to a large extent unit-specific. However there is likely to be substantial potential value in public health and policy terms in presenting and discussing such summary data. This is especially true given the nature of the units (high cost low volume) and the representativeness of the units studied. It must be remembered that the standards used to evaluate these services are statements of best practice. It was not expected that any unit would entirely fulfil every single one.

In this section of the report the number of each standard is given in brackets after each section title in the results below. This allows reference to be made to the detailed standards, which are presented in full in Appendix 9.1. Additional questions that are not listed in the standards are coded 'A'.

The response rate for each standards-based item varied between 70-100%. Results describe the number of units or the number of responders that achieved a particular standard. To aid comprehensibility, and taking into account the relatively small number of units, they are given either as fractions such as “half” or “about half”, or as adjectives, “few” describes about 5-15% and “most” describes about 85-95%.

4.7.1 Environment and facilities

Proximity of units to adult units (Standard 1)

All units were separate from adult psychiatric units. However, a quarter were next to or close to an adult unit. One of these was located between an addiction ward and an adult psychiatric ward.

Design and facilities (Standard 2)

Three quarters of the units were assessed as clean, comfortable and having a warm and welcoming atmosphere. The other units partly met this standard and only one unit failed it.

Most units contained a large room for family interviews. One did not and one partly met this standard. All units contained small rooms for individual interviews. Most units had a designated waiting area. Two did not and one partly met this standard.

Only a half of the units that provided services for younger children had waiting rooms, which contained suitable play and reading material. However, all those who provided services for younger children provided play material for recreational purposes and as a diagnostic and therapeutic tool.

Half the units had a place for seclusion as needed as part of an agreed therapeutic plan. In a half of those units who had a seclusion facility, staff reported that the designated room was not designed and arranged so as to minimise risk of injury.

Confidential case material, for example patient notes, was mostly kept in locked cabinets or locked offices, but was also stored in busy nurses' offices which were not locked when occupied.

In all units drugs were kept in a secure place with the dispensary book.

Most units had adequate spaces for educational activities. Two units did not meet this standard and two partly met it.

Patient privacy and dignity (Standard 3)

In all, 58 patients were interviewed during the site visits. Two thirds of patients interviewed reported having been given the option of a single bedroom. All patients reported that they could bathe and wash in privacy and in areas separate from the opposite sex.

Most patients reported they could go out when they wanted to. Some patients explained this was subject to staff being available to accompany them. One patient reported that this was subject to their good behaviour.

Most units had a specific room for physical examination and minor medical procedures. Three units did not have this facility. Three quarters of patients reported that there were suitably located quiet rooms available. All but two of the 18 units had private rooms for meeting relatives and friends.

Two thirds of patients reported they had access to a telephone. The site inspection found all units to have a telephone for the use of residents, mostly payphones. However two of the 18 units did not have a telephone that patients could use easily. In about half of the units the phones were not located in a private place. In about a quarter they were located in a partly private place.

Most units had arrangements for the safe-keeping of patients' property. Most units had arrangements for the safe-keeping of staff property although two units did not.

Three quarters of the units reported that they had facilities to manage those who are threatening, or sexually harassing, such as segregation or the use of a high level of supervision. About half the units had facilities to manage those who were severely overactive, such as low stimulation environments. About a half of the units had facilities to manage those who were self-harming, such as high level supervision in areas where there were clear lines of sight to enable staff to monitor patients.

Age-appropriate security (Standard 4)

Most units had appropriate security within the unit (eg lockable doors). Two thirds of the units had appropriate external security to prevent unwanted visitors. However, one third of units did not. One unit reported that they had a problem with adult psychiatric patients coming into the ward and drug "rehab" patients in the car park.

Patients and the ward environment (Standard 5)

Two thirds of the patients reported that the decoration and furniture in the unit looked fine. Of the third that did not, several said the unit looked dull and boring and needed new furniture. Most patients found the unit comfortable to stay in. Most patients felt encouraged to personalise their bedroom spaces. All patients were permitted to have personal audio equipment.

Emergency equipment and procedures (Standard 6)

In two thirds of the units reviewers found a written procedure on display for evacuation in case of fire. In four of the units the reviewer did not know if a procedure was on display and in one unit it was reported that there was none. Most units did not have panic buttons for staff or patients to raise an alarm in an emergency. Most units reported there was an identified duty doctor available at all times. Some units complained that they were not necessarily close by.

4.7.2 Staffing

Training needs assessment (Standard 12)

About three quarters of nurses reported their training needs had been assessed in the previous year. Two thirds of therapists and half the social workers had also had these needs assessed. However, about two thirds of psychiatrists reported they had not had their training needs assessed in the previous year.

Training and education (Standard 13)

Three quarters of the nurses and a third of teachers interviewed had not had training on touching and sexual attraction between staff and young people. Most nurses and teachers had received training on child welfare and child protection issues. Nine of the 50 nurses who responded to this question reported they had not had this training. About three quarters of nurses and teachers reported they had received training on the management of imminent and actual violence, breakaway techniques and restraint measures. About one quarter reported they had not received this training.

Multi-disciplinary team working (Standard 10)

Most staff reported that they attended regular multidisciplinary team meetings and that these covered clinical matters. Policy and administration were reported to be covered in a separate monthly meeting. In about a quarter of the units these meetings were reported to be attended by line managers or nursing staff and not by other members of the multidisciplinary team.

Most staff reported that they were happy working in their unit. Most staff reported that there were clear procedures in place for managing complaints and also felt that there was a forum where they were able to

express any concerns. Most therapists were clear about their role in the assessment and treatment process.

Access to training budgets (Standard 11)

About half the staff reported that there was a defined training budget that related to the various disciplines in the team. Just over a half of the staff interviewed reported that they knew how to access a defined training budget for their discipline and how to access funds from external consortia. All the staff interviewed reported that that they knew how to access in-house training and knew of a clear procedure to do so.

Decisions about staff training need (Standard 12)

Most managers interviewed reported that the Trust supplied training material on how to supervise and conduct appraisals. Most ward managers at nursing levels G and H had received training in management and team leadership. All the therapists reported that they held relevant qualifications. About half of the staff had access to the Internet. These were largely psychiatrists and teachers. Nurses had poor access.

Most of the nursing staff reported that induction training was provided for new permanent staff. The teaching staff however reported that this was not the case. Just over half of the teachers interviewed reported that they used temporary teaching staff and that the necessary induction training was provided.

Staff support (Standard 15)

Most staff reported that they received regular supervision and had access to a support system.

‘What changes would you make to improve the service the unit provides?’ (Standard ‘A’)

Staff were asked, ‘What changes would you make to improve the service the unit provides?’ The most frequent theme to emerge was enhancement of staffing and service provision. Details of this are presented in Table 4.28.

Table 4.28: Responses to the question ‘What changes would you make to improve the service the unit provides?’

Comment	Number of people	Number of units
More staffing generally	27	13
More therapists (inc psychotherapists, art, drama)	45	20
More (trained) nursing staff	17	13
More social work(ers)	14	10
More outreach work	13	10
More psychology/ists	12	9
More teaching staff	8	7
More consultant psychiatrists	6	5

4.7.3 Access, admission and discharge

Provision and procedures ensure that in-patient care is available to all those who would need it (Standard 18)

A half of the psychiatrists and social workers interviewed believed that children are admitted inappropriately to their unit because of deficits in other local services. These ‘inappropriate’ admissions were reported as mostly numbering 1-5 cases per year.

Average waiting time from referral to admission to the unit was reported by psychiatrists as being just over 1 month (min 0 months, max 4 months). Psychiatrists reported an average waiting list size of 4 patients (min 0, max 10). Half the psychiatrists reported that some patients who should be admitted were refused admission due to lack of bed availability. These psychiatrists reported an average number of patients refused admission for this reason as 4 per year (min 1, max 9).

Assessment and treatment are offered without unacceptable delay (19)

Most psychiatrists reported that those at risk or with more severe conditions were given priority with assessment. The majority of psychiatrists did not use any standard tool or inventory when conducting risk assessments.

There is equity of access to in-patient units in relation to ethnic origin, social status, disability, physical health and location of residence (Standard 20)

Most staff said that their unit was culturally sensitive, and could for example offer a special menu when needed. Staff from a few units mentioned that this question was answered theoretically due to the very low number of referrals from ethnic minority groups.

Most nurses reported that advocacy services were easily available. Most social workers responded either 'yes' or, 'partly' to this item. Site inspections found that advocacy services were easily available in half the units. Just over half of nurses, social workers and site inspectors reported that interpreters were easily available. However, two thirds of the units had not used an interpreter in the previous year.

Just over half of nurses and social workers said that their unit could meet the needs of those with a physical disability adequately. Site inspections found that half of the units had doors of sufficient width to allow wheelchair access, and that the toilet facilities met the needs of people with physical disabilities in half of the units. Two thirds of units were found to have parking facilities that met the needs of people with physical disabilities. Just under half of units had ramps for people with physical disability. Over half had a place where access for those with physical disabilities was restricted.

Over half of staff reported that where necessary special arrangements could be made for families who needed to stay overnight (e.g. in a nearby hotel).

Units are parent-friendly (Standard 21)

Over half of therapists and social workers said that parents were supported and encouraged to participate in their child's care. Only two of the four children's units could admit parents with the child when appropriate. When on the ward, parents had the opportunity to make themselves tea, coffee or soft drinks at the unit. They also had privacy when they needed it, for example there was a family room where parents could meet their children.

Before discharge, decisions are made about meeting any continuing needs (Standard 23)

According to psychiatrists, there were difficulties in discharging patients due to limitations in community based services. Psychiatrists reported that such difficulties affected an average of 7 cases per year (min 1 case, max 40 cases). Delays were widely attributed to social services and education services.

According to both psychiatrists and social workers, most units informed the patient's general practitioner and involved local services prior to discharge. It was also reported that a discharge planning meeting was held for all in-patients. All social workers reported that patients and parents knew the names of workers involved in follow-up after their discharge. Most psychiatrists and social workers reported that patients and parents know before discharge the dates and times of appointments with the workers involved in their care after their discharge.

Most psychiatrists and social workers reported that ongoing care planning with the relevant social services departments was arranged for "looked after" patients. Most teachers and social workers reported that plans for ongoing education were specifically arranged.

4.7.4 Care and treatment

Range of treatments available (Standard 25)

In just over half of the units' staff reported that they were limited in the range of treatments they provided due to therapist and staff availability. The range of therapies mentioned to be lacking included family therapy, CBT skills, individual psychotherapy and occupational, art and drama therapy.

Evidence-based treatment (Standard 26)

About half of the nurses interviewed felt they knew enough about the treatments they provided.

About two thirds of staff interviewed reported they had access to good quality information about the evidence behind the treatment they provided.

Most psychiatrists reported that they would like to know more about the evidence behind some treatments. These included: newer anti-psychotic medications, CBT, REM therapy applications, family therapy, eye movement treatment in PTSD, treatment for PTSD for adolescents, treatment of personality disorder, dialectical behavioral therapy, and solution focussed therapies.

Access to other services (Standard 27)

Most psychiatrists reported that they had good links with general and community paediatric services. They reported using junior doctors to meet the physical health needs of patients in the unit. Consultants from about half of the units, and all of the adolescent units, reported either that they did not have good links with adult mental health services or that they only partly met this standard.

Consultants from about two-thirds of the units reported that they had good links with forensic mental health services. Consultants from about two-thirds of the units reported they had good links with paediatric neurological services. Consultants from about half of the units reported good links with substance and alcohol misuse services. Again, consultants from about half the units reported good links with learning disability services.

All consultants reported good links with laboratory services. Most consultants reported good links with accident and emergency services. Most consultants reported having good access to other practitioners able to provide a second opinion. Consultants in about a third of the units reported not having good links with general practitioner services.

Care planning (Standard 28)

All units reported that all patients had a written management or care plan. Most patients reported they knew they had a written care plan and most patients reported they had been involved in developing it. Most patients reported they had not been given a copy of their care plan.

All teachers and most therapists reported they were involved to some degree in the development and review of the plan. All consultants reported that the management plans were reviewed at regular intervals.

When a care order was in place, most consultants reported that the local authority fulfilled the role of a parent, for example they attended review meetings and were able to give consent where necessary.

Meetings with the key worker (Standard 29)

Most staff reported that there were regular meetings planned for all patients and their parents with the key worker. Most staff reported that parents were invited to review meetings. On average, staff reported that these took place every 3.5 weeks. Most patients reported they had weekly meetings with their key worker.

Communication with the patient's family and local services (Standard 30)

About half of consultants reported they contacted patients' local GP on referral or admission and discharge only. About a half reported contacting them following case conferences and review meetings. About half the consultants reported contacting patients' local CAMHS following case conferences and review meetings. Others reported contacting them either weekly, monthly or at referral or admission and discharge only. About a half of consultants reported contacting patients' local social services departments following case conferences and review meetings, when necessary. Others reported contacting them from weekly to monthly.

Use of drugs and relevant guidelines (Standard 31)

About two thirds of nurses reported they used rapid tranquillisation, but a third reported that they did not have written guidelines for this.

School work (Standard 32)

All teachers reported that all patients under the age of 16 received educational input. Most patients over 16 years were receiving some kind of educational input. Those that were not were generally too unwell to attend. Most teachers reported that there was adequate time provided for the education of patients. All teachers reported that each patient had a formal assessment of their educational needs.

All teachers reported that they liaised with the patient's own school where possible to maintain progress with the topics or lessons being covered. All teachers reported that educational outings were provided and that educational videos, textbooks and games were used.

Two thirds of the teachers reported that patients had access to local school facilities as required. One third reported that these were not available. Most teachers reported that there were opportunities for patients to take exams. Teachers from one unit reported that this was not possible. Most teachers reported they had a good working relationship with patients' parents.

4.7.5 Information, consent and confidentiality

Patient access to information (Standard 33)

About half of the units had a poor or very poor range of leaflets and posters on display. Many units did, however, have copies of 'The Patient's Charter: Services for Children and Young People' on display.

Key working (Standard 34)

According to nurses and social workers, most patients had a key worker. Staff reported that patients' views were nearly always taken into account if they were not satisfied with their key worker. There was a high variation between units of proportions of patients who had a named social worker local to the unit.

Patient knowledge of staff names (Standard 35)

All patients knew the name of their key worker or primary nurse. In two thirds of units, staff did not wear name badges. Most units did not have a board on display with the names and photographs of staff. Most patients knew who the named nurse was and that there were procedures for letting the patient know at handover between shifts.

Information before admission (Standard 36)

Most patients reported that they knew about the unit and the services offered before being admitted.

Patient involvement in treatment decisions (Standard 37)

Almost all patients reported that someone had spoken to them about the treatment they were receiving, for example what it was and how it could help them. Over half of patients reported that they were not provided with written information about their problems or treatment plan.

Most staff reported that written information about treatments was provided, for example a leaflet, although there was high variability in responses. Most staff reported that they did not normally provide patients and parents with written information about their problems or condition.

Almost all patients reported staff had explained to them what kind of problems they thought he/she had. Almost all patients reported that they could discuss their problems and treatment as much they needed.

Almost all patients reported they had not been offered a choice of treatments. Psychiatrists explained that a choice of treatments was not generally offered to patients or parents. It was thought that this was mostly not applicable, and that in many instances advice on a particular treatment was needed.

Access to health records (Standard 38)

Most patients were not informed of their rights to see the health record and the limitations on those rights. Most psychiatrists in adolescent units reported that they would normally show a patient over 16 their health record if they asked to see it. Psychiatrists also reported that the consent of a competent child or young person was always obtained before disclosing case material to parents.

Confidentiality (Standard 39)

All psychiatrists and most patients reported that confidentiality and its limits were explained. It was usually made clear to patients that this is extended beyond the clinical team only if the quality of their care and/or the safety of another depends on this and then only to those who need to know.

Consent (Standard 40)

Consent was mostly verbal and three quarters of patients reported that someone had asked them if they had agreed to the treatment. A quarter of patients said that they had not been asked. About half of the staff reported that consent was not necessarily obtained by a person capable of performing the relevant procedure.

4.7.6 Rights, safeguards and child protection

Restriction of liberty (Standard 43)

Most staff reported that they understood the definition of restriction of liberty, the circumstances in which it might be used, and the distinction from “time out”. Most restrictions of liberty were reported to be recorded in the patients’ notes, including indications for use, the type of restriction, its duration, and the name of the person who authorised its use. Most units reported the running total number of hours of restricted liberty in each case was monitored.

Patient rights (Standard 44)

Staff from all units reported there were opportunities for children and young people to play with and meet others of a similar age, within the limits of the unit program. Staff from all units reported there was a choice of food that suited all dietary needs.

Almost all units had an area outside for patients' recreation. Staff from most units reported they were sensitive to the needs of different ages, for example bed times were varied, and age appropriate toys were provided for children. All patients reported they could ask to see the doctor on their own (i.e. without other nursing staff or family present). In most units patients could ask to see a doctor of the gender of their choice. Almost all patients reported the unit staff polite and friendly.

Patient complaints (Standard 45)

Complaints procedures were generally publicised although there were mostly no suggestion boxes for patients to use.

Control and discipline (Standard 46)

Four units reported that the “grounding” of patients was sometimes enforced by refusing them leave from the unit. Most units sent patients home for short periods as a disciplinary measure and in most units the availability of alternative accommodation, such as a patient's home, was a condition for admission. This underlined the nature of the unit as a treatment resource rather than a home.

Physical restraint (Standard 47)

All staff reported that the circumstances and justification for using any physical restraint was recorded immediately.

Legal advice for staff (Standard 48)

Staff from all units reported that legal advice was available to them when needed, although there was some variation within units. Most units did not give patients a copy of 'The Patient's Charter: services children and young people'.

Awareness of legal status (Standard 49)

All nurses reported that the child protection status or Mental Health Act or Children Act status of patients was known to them.

Child protection (Standard 50)

Most staff said they knew who the named professionals were, designated by the Trust to be responsible for ensuring child protection supervision. Most staff reported that local Area Committee for the Protection of Children (ACPC) guidelines, *Working Together under the Children Act, Clarification of Arrangements, Medical Responsibilities and Guidance to Senior Nurses* were available and accessible.

Induction training of staff was reported to include child protection policies and procedures. Almost all staff reported they had access to the local Area Committee for the Protection of Children (e.g. for the development of procedures and better practices in child protection). Most staff reported that induction training included the reporting of violent incidents.

Allegations of abuse (Standard 51)

All staff explained that if significant abuse of a patient, of any kind, was suspected by a member of staff then the trust management would be informed. Eight units reported that social services would be informed, six units would inform the police and one the Home Office. Most staff explained that any alleged abuser would be suspended. Almost all staff reported that there was guidance on dealing with allegations of abuse against staff which had been endorsed by the trust. Staff from most units reported that there had been no staff subject to any legal action in the past year regarding the service at the unit.

Children accommodated (Standard 52)

Most staff reported that the trust informs the responsible SSD when a child was admitted for a consecutive period of 3 months or more, and when such a child leaves the ward.

Local authority's role with longer staying patients (Standard 53)

Staff from almost all units reported that the local authority promoted contact between longer staying patients and their family in some way.

4.7.7 Audit and policy**All available information is used to evaluate the performance of the unit (Standard 54)**

All staff reported that there was a system in place for the reporting of violent incidents. More than half of psychiatrists reported that their unit had an agreed definition of 'violence'.

Over half of staff reported having been involved in clinical audit in the past year.

About half of staff regularly used outcome measures (i.e. any instrument to measure patients' symptoms or problems, such as HoNOSCA). There were 4 units where staff used no routine outcome measures. Half the staff reported that their unit used a computer database to manage patient information such as prescribing, diagnosis, admissions and discharges.

Most staff reported that they have a system in place for the reporting of incidents involving the use of physical restraint. The remaining respondents were unsure about whether such a system was in place. All trust/CAMHS managers reported that the trust monitored and investigated (if necessary) patterns of frequent use of physical restraint. Most trust/CAMHS managers reported that the trust monitored and investigated (if necessary) patterns of patients absconding. Most staff reported that there was a system in place for the reporting of incidents involving patients absconding. Half of staff reported that there were arrangements so that patients who run away could be interviewed by a person not connected with the unit (e.g. the police).

More than half of trust/CAMHS managers formally evaluated their unit's service in some way.

4.7.8 Location within a public health context

The Health Authority has a recent written strategy, developed in consultation with all relevant parties, which addresses the provision of child and adolescent services (Standard 60)

Just under half of the psychiatrists had been consulted as part of any process of commissioning in-patient services.

The in-patient unit contributes to effective multi-disciplinary and multi-agency working, between health, education, social services (Standard 62)

Just over half the psychiatrists reported there being a social services link worker to help communication with the unit's local social services. All social workers interviewed (11 units) reported that staff from the patient's local social services were encouraged to attend the unit.

The development of the unit's admission criteria was mostly carried out by senior staff within the unit and trust management.

The in-patient unit liaises effectively within the Health Service and has a good working relationship between disciplines, departments and levels of care (Standard 63)

Just over half of psychiatrists reported that they did not provide any consultation or liaison service to their unit's local paediatric service.

4.7.9 Additional Questions

Staff were asked 'What changes would you make to improve the service the unit provides?' (Standard 'A')

The most common theme to emerge was **staffing/provision**, as detailed earlier, in the 'Staff' section.

Other responses that stood out for their seriousness

- *'Nursing students aren't police checked – found 2 with criminal records not disclosed'*
- *'Security can be a problem with adult psychiatric patients coming into the unit and stealing books or selling drugs'*
- *'Adult patients walk in fairly regularly and sell drugs'*
- *'Asbestos in building'*

Other generally required improvements identified

- More skills training for patients
- More preparation of patients for discharge into the community
- Better follow-up after discharge
- Buildings: size, lack of there having been purpose built, specialist rooms, location
- More involvement of parents, including their being able to stay overnight
- Quality of food and the child friendliness of food
- Many units that open for 5 days a week felt the need to be open for 7 days a week
- Increased ethnic minority intake and awareness

5 DISCUSSION

5.1 Overview

This is a unique study. It is the first attempt to provide a national snapshot of the provision and activities of child and adolescent in-patient units. In the introduction to this report we referred to the identified lack of the simplest sort of data (e.g. number and type of units, referral activity and bed use, diagnostic data on patients). The main value of this report is that it starts to fill in these gaps in basic knowledge. The majority of the data that we have presented in the results sections of this report are simple descriptions of the nature and activities of in-patient units, and as such do not require complex explanation and discussion. In the following sections we will therefore summarise and briefly expand on some of the main findings, which have relevance for those planning, purchasing, providing and in particular receiving such services.

5.2 Limitations of the study

We adopted a multi-methods approach in order to attempt to address the main issues and questions detailed in the research brief. In a project with such multiple aims some elements of the project will always be more successful than others, and this was certainly the case with the NICAPS project. Our over-riding principle during the project was to focus our resources on those areas where there was the greatest priority for good quality evidence, while attempting to ensure that we were collecting data that would enable a comprehensive overview of the services provided. In this section we will focus on some of the main limitations of this study.

Things change and services develop. The initial identification of units was conducted in 1999, and since this time some units have opened and some have closed. Details of such changes are available from the Royal College of Psychiatrists' Research Unit (CRU) which has maintained an up-to-date list for its quality improvement initiative in in-patient CAMHS. A national directory of in-patient CAMHS, updated in May 2001, can also be found in Appendix 9.2. While there have been changes they are however relatively minor and are very unlikely to have significantly affected the usefulness of the data presented here.

One paramount consideration in this study was to maximise the response rate for information describing basic unit characteristics from the general surveys and the censuses. We achieved high response rates for such items, typically between 80% and 100%. However, we need to acknowledge the possibility of non-response bias having entered error into our parameter estimates. We were able to ascertain from our various telephone enquiries that these non-responding units were not particularly unusual, so although there is a possibility of selection bias, its effect on our results is likely in general terms to be minimal.

One element of the study, which was not completed, was the investigation of pathways through care followed by children and young people who were referred but not admitted to these units. We have described the difficulties that we encountered above and it was not possible to redesign this element within the study timeframe and resources in order to generate definitive population-based data. However, the questions raised are of major importance and we have concluded that a separate specifically tailored cohort study with simultaneous controls would need to be commissioned in order to meet this information need. The data that we have presented here should be of use in designing such a study.

It would have been useful to have been able to have used a larger sample for the study of 'inappropriate' admissions to adult general psychiatric wards and paediatric wards. However, the population covered by this element of the study did amount to approximately 10% of the 18 and under population in England

and Wales. A larger base population would have enabled us to be more confident about our predictions for potential unmet need in this area. In addition there are clearly other places where there might be 'inappropriate' admissions of this population (e.g. social services secure accommodation or special educational provision) that we did not survey. Our estimates therefore need to be considered critically given the (albeit small) possibility that the wards we surveyed were non-representative in some way and the relatively wide confidence intervals that our estimates will necessarily have. We would however suggest that our estimates can be taken as an indication of unmet need in health if not social service or educational settings.

The detailed site visit element of the study focussed on only 18 units. While these were purposively sampled to attempt to ensure they represented services more generally and they represented about a quarter of all the units in England and Wales, there is the possibility that they might have been unrepresentative of all units, so limiting generalisability. It is also a distinct possibility that in a one-day visit we may have missed some examples of good practice. Also the standards themselves are open to question. We developed them in a collaborative way and aimed for them to be comprehensive in their scope. We acknowledge that there are areas of performance, which are not best addressed by a standards-based approach and that areas of importance may have been missed in our approach. However we did supplement this element of the study with open questions to attempt to address this potential source of error. At the least this part of the study provides a methodology and data with which to debate what determines a good quality service and how to assess this.

The categorisation of age groups is an issue that has caused much comment. Our aim was to divide, in general terms, children's units from adolescent units from mixed units. Our classification of units is essentially pragmatic and acknowledges that age is not the only issue in making this distinction.

5.3 Faculty survey

This was a simple information gathering exercise to attempt to place NICAPS in context and to generate issues for investigation. The single open question proved a surprisingly effective method of obtaining psychiatrists' views and is indicative of the high level of co-operation we received in all parts of the study. The alternative of providing categorised response options might have influenced or constrained respondents replies.

There are some limitations to the study. Firstly, the response rate was only 60%. We do not therefore claim the results to be representative, but rather illustrative of the range of issues relevant to faculty members. Secondly, the frequency of the responses was dependent upon post hoc coding and so there is an element of the opinion of the research team in the coding system. Thirdly, the most important comments may not necessarily have been the most often reported. Finally, and potentially most importantly, this was a uni-disciplinary enquiry in a multi-disciplinary and multi-agency service. This will have limited the viewpoint of responses. This method was used because of the ease of availability of the sampling frame to the CRU. The impact of this may be mitigated by the fact that the other elements of the study are explicitly multi-disciplinary.

It is perhaps unsurprising that the main concerns expressed by faculty members were focussed on perceived difficulties in achieving admission, particularly for emergency or high risk cases. This raises questions both about the level of in-patient resource and the range of service provided. It could be argued that there is a need both for acute, emergency provision and also for longer stay provision offering a somewhat different profile of treatment for less acute cases, and that it may not be achievable to combine these functions in one unit. There might, in addition, be a case for reducing the need for both through increased targeting of resources on outreach and bridging the gap between community and in-patient units. Some English Regions have chosen to use the recent tier 4 modernisation fund allocation in this

way and it will be interesting to see the evaluations of such developments. Parallels may also be drawn with the assertive outreach developments in adult psychiatry

5.3.1.1 Emergency beds and facilities

Provision of emergency facilities was the most frequently reported theme among the psychiatrists surveyed. Respondents who raised this theme commonly expressed concerns about the admission of young people in crisis to paediatric or adult psychiatric wards. Statements typically referred to the 'need for emergency beds' and the 'lack of emergency admission services'. Gowers *et al* (1991) reported a high degree of agreement across disciplines for the need for prompt response to referral including emergency beds and effective communication. The lack of quantifiable estimates of need for emergency services has been highlighted as an important related problem (Cotgrove, 1997). This is particularly pertinent in the light of the recent finding that over one third of trusts felt they could not respond effectively to young people presenting in a crisis (Audit Commission, 1999).

5.3.1.2 Numbers of beds

Some respondents referred to the fact that there were no child and adolescent psychiatric in-patient services available in their area. They reported that patients were often accommodated in either paediatric wards or adult psychiatric wards until they could be placed out of area or were well enough to return home.

Provision for adolescents appears to be a particular concern (HAS, 1986). The Audit Commission has reported that 1 in 5 Health Authorities are 'unclear' about the age ranges covered by their services, while 1 in 3 commission services only for those up to age 16. They concluded that, 'despite several specific reviews of adolescent care, services for young people remain patchy'.

5.3.1.3 Liaison with other services

Respondents commented that effective communication between local services is important to 'ensure timely admissions and discharge with effective follow-up'. Others reported difficulties they had experienced establishing joint working with other agencies and locally based services. Problems integrating with local services were attributed to the fact that 'most units are regionally focused'.

Previous reports have highlighted problems of joint working (HAS, 1986; HAS, 1995; Audit Commission, 1999). The Audit Commission commented specifically on the difficulties when several Health Authorities fund a unit (Audit Commission, 1999).

5.3.1.4 Provision for severe or high risk cases

Respondents were concerned about the inadequate provision for those who are severely ill and in need of secure accommodation. Statements that typify this concern include 'units are unable to admit seriously disturbed young people', and, 'there is a need for more forensic services or secure and semi-secure services'. It is likely that at least some young people admitted to adult psychiatric wards are those with severe psychiatric illnesses whose needs cannot be met by in-patient child and adolescent mental health services. One respondent commented that in-patient services only offer a 'modified residential provision of Tier 3 services' and that 'they do not cater for the urgent placement of very disturbed or forensic patients'.

A fifth of respondents identified a need to increase the range of specialised units catering for severe or high-risk cases. In particular, specialist units for 'acute psychiatric' conditions were reported to be lacking as were facilities for children with conduct disorder and children with psychiatric problems and learning difficulties. Concern about lack of provision for severe or high-risk patients and the lack of specialist services had not been specifically identified in previous reports.

A joint working group of the Adult and Child and Adolescent Faculties of the Royal College of Psychiatrists is considering the problem of admission of young people to adult psychiatric wards. This

issue relates to all three of the most common themes reported in this survey. There may therefore be no simple solution because two of the themes, the absolute lack of beds and the lack of specialist provision, relate to resources. The third, communication between local agencies, might be more amenable to short-term action.

5.4 National survey of child and adolescent psychiatrists

5.4.1 Distribution of units

One of the most striking results of this study was the marked geographical variability in units with very limited availability in Wales and parts of England compared with a concentration of services in London and the South East. Over half the beds in the South East were in the private sector, often offering specialist services. It is not clear that need determines this geographic distribution. This means that there is likely to be a flow of patients from areas with need but no resource to the areas where there is provision. The implications of this in terms of continuity of care, liaison with local services, aftercare, ownership of services and accessibility for families and friends are clear. These data illustrate the challenges in terms of public health planning and service provision for these areas with and without in-patient units. They also demonstrate some of the problems that may accrue when there is a lack of public health planning and a reliance on the independent sector for the provision of core health services.

5.4.2 Capacity of units

5.4.2.1 General units

The nature and level of provision is in continual flux with the trend having been for a reduction in general in-patient beds and an increase of specialist services in the private sector. At the time of the study there had been a clear decrease in the number of children's units compared with those identified in the YoungMinds directory and by Jacobs and Green (1998) some years earlier.

5.4.2.2 Specialist units

One of the main findings here is how few specialist units/beds there are in anything other than eating disorders. If need outstrips provision as is suggested by the faculty survey then this will result in limited availability and poor accessibility for many parts of the country. With respect to patients with eating disorders it is striking that a large proportion of general beds are taken up by this group so that the number of eating disordered individuals in specialist eating disorder units is the same as that in general units. One would hope that those in eating disorder units are the patients who most need this specialist resource although it seems equally likely that it is other factors, such as geography, which determine this.

5.4.2.3 Days open

Most units could open 7 days per week if the resources were available to them; the question which therefore arises is should they. The model of 5-day opening is more akin to specialist education provision rather than a health (especially an emergency health) paradigm. The decision to operate a 5-day service brings into question the sorts of treatment and care that are made impossible where units cannot stay open and the relation of this to clinical need. Groups where there might be particular concerns include patients who are very disturbed, suicidal, or require constant specialist child and adolescent psychiatric nursing. If patients cannot go home then these individuals would presumably need to be admitted to 7-day units, often in distant areas. One unit that was visited had been required to reduce their service from a 7 to 5 days and therefore had to locate young people on adult psychiatric wards at weekends. It might be that a large proportion of those patients who can manage on a 5-day per week basis could equally attend as day patients, where travel times allowed this.

5.4.3 Emergency provision

Emergency provision depends not only on a unit in principal being willing to admit emergencies but also that unit in practice having beds available to accept emergency referrals. Emergency provision is a contentious area. It is increasingly accepted that patients should be able to be admitted as an emergency and there are reports of negative situations when this is not possible. Those referred as an emergency will include those with acute and severe mental disorder such as acute and severe psychosis, but also a group who are causing services and carers great anxiety through their behaviour. This second group will often merit emergency assessment of one sort or another but arguments occur as to whether a psychiatric admission is the best course of action. It certainly relieves the anxiety of those in the community but may not in the long run do much for the patient. This raises questions concerning the expectations and use of in-patient units with respect to emergency work and their place in the interagency work being carried out with these groups of individuals in the community.

A comparison with the pattern of established and emerging general adult psychiatric services is of some interest. Adult psychiatry has a variety of in-patient (e.g. general wards, rehabilitation, continuing care, addiction units, forensic services) and community provision (e.g. assertive outreach teams, crisis services, 24 hour staffed accommodation), while child and adolescent services have mostly been provided by a single team or unit. A strong argument can be made for the need for a similar specialisation for children and adolescents as there is for adults.

The relatively low volume of these services means that there is a need for co-ordinated service planning including ways of achieving the optimum balance of units (e.g. general versus specialist) while ensuring accessibility. Up to now services have developed in a more or less piecemeal fashion and there has been little regional or national planning. In particular, the drivers of independent sector provision are likely to be financial rather than an attempt to provide a comprehensive service. The NICAPS data provide support for a more measured and coherent approach to service planning and provision. With the changes in purchasing health services that are consequent to the establishment of Primary Care Trusts (PCTs), there is likely to be particular value in developing a national plan with regional implementation for in-patient child and adolescent mental health services. An implication of this would be to separate the purchasing of such services from local community services, perhaps on a regional basis as with forensic mental health services. Perhaps there is now recognition of the need for this.

The 39% of units that accept emergency referrals (mostly general units in the NHS) are distributed geographically in a pattern not dissimilar to that seen for the total population of in-patient units. Ideally this would reflect a degree of co-ordination and differentiation of function between units as suggested above. Information is not available concerning to what extent this is actually the case.

5.4.4 General characteristics of in-patient population

The HoNOSCA and Paddington Complexity Scale scores demonstrate the high levels of severity and complexity of mental disorder encountered in residents of child and adolescent in-patient units (potential difficulties in the scoring of HoNOSCA notwithstanding). As expected these were higher than those reported by the Audit Commission for users of community services.

At the time of writing, no value was available for the proportion of ethnic minorities in the general population 18 and under. We cannot therefore calculate whether there is an excess of young people from ethnic minority backgrounds admitted to in-patient units. Our data do suggest that these groups may be over-represented in the detained population and in forensic and secure settings. In this these data have similarities with general adult and forensic mental health populations.

The analysis by diagnosis, with over half of in-patients suffering from mood disorders, psychosis or eating disorders, does suggest that the scarce in-patient resource is being used for those with severe

psychiatric illness. Also, given the rapid increase in hyperkinetic referrals to community services, that these should be well represented in the in-patient population. It is perhaps worthy of comment that encopresis is a relatively common reason for admission to a children's in-patient psychiatric unit. The general picture for children's units is of a wider range of diagnoses to be represented. This has implications for the running of such units and the range of assessment and treatment skills required.

5.4.5 Care and treatment

5.4.5.1 Treatment

The general picture is encouraging, with a wide range of treatments available across units. That being said, there are some particular findings worthy of comment. The relative lack of therapies available to adolescents on adult wards is concerning and perhaps a further indication of the unsatisfactory nature of such arrangements.

The data suggest that there is a relative lack of family therapy on the secure and learning disability units. This may well be a function of availability of expertise and the distance of families from the units. In either case it is of concern to see that the distribution of the units may lead to the de facto unavailability of potentially beneficial therapeutic options.

Differences also exist in the use of drug therapy. 42% of young people diagnosed with an eating disorder receive drug therapy. At first sight this might seem curious, as there is no drug treatment for anorexia nervosa. However, this is probably explained by some of the patients having bulimia for which Selective Serotonin Reuptake Inhibitors (SSRIs) are a recognised treatment and also by the high prevalence of comorbidity with illness' treatable with drugs such as depressive illness.

The figures for cognitive and cognitive behaviour therapies may be misleading as in practice, the two terms seem to be used rather interchangeably and it probably is more useful to combine them together for the purposes of this study. What is nonetheless clear is that these therapies are widely used with the child and adolescent in-patient population.

5.4.5.2 Access to other services

The finding that consultants from about half of the units, and from all adolescent units, reported they did not have good links with adult mental health services is of concern since this is likely to impact on the quality of care provided:

- at the stage of transition to adult psychiatric services
- for those where there is argument about where they would be best managed
- where access is needed to specialist opinions

The same issues apply to those units reporting poor quality links with substance misuse services and services for people with learning disability. This may be of particular importance given the reports that these may be groups that are particularly poorly served.

5.4.5.3 Educational provision

With respect to educational provision one point raised was whether adult wards with adolescent beds should have a licence to treat young people if they do not provide any education. We would contend not.

There is a large degree of variability between units in terms of educational provision. While some of this may be accounted for by variations in age or length of stay, it is likely that there is also a degree of variability due to local and historical factors, which are presumably unrelated to the educational needs of the patients. A particular difficulty arises over those patients who are above school leaving age and for whom there is not the same statutory responsibility for educational provision. This seems to be a widespread problem and one that could do with attention at central government level (Department of

Health and Department for Education and Employment) rather than being played out over each individual in-patient unit.

5.4.5.4 Communication with the patient's family and local services

The finding that some in-patient teams had a fairly low level of contact with patients' local CAMHS brings into the question the adequacy of arrangements for joint working and for the seamless transfer of information.

5.4.5.5 Use of drugs and relevant guidelines

The reports of a lack of guidelines for the use of rapid tranquillisation on some units is of concern and one where fairly simple sharing and local adaptation of materials from other units may be of particular value.

5.4.6 Environment and facilities

The need for all units (where seclusion is used) to have clear seclusion policies, and for the areas in which seclusion is delivered to be designed in such a way as to minimise the risk of harm to patients and staff is self-evident. It was therefore of concern that there were wards that reported themselves to be deficient in these areas.

The issue of availability of a private place from which to phone is also an important one since it covers not only privacy but also the ability to tell someone if a patient feels he or she is being treated badly.

5.4.7 Staffing

The central role of nursing in the staffing of these units is clear. 72% of the staff of the in-patient units are nurses. This underlines the importance of the current recruitment and retention difficulties experienced in in-patient child and adolescent psychiatry for nurses. This may be related to an absolute shortage of nurses and also within child and adolescent psychiatry, to the availability of community nursing posts, at the same or higher grade.

It is also of concern that few of the nursing staff had the specialist qualification in child and adolescent psychiatric nursing, the ENB603. This is important not only in terms of the specialist skills and the consequent quality of service but also because some nurses interviewed have linked this to reduction of sick leave and burnout. It is also of note that there are very few nurses on these units who have the specialist RSCN qualification in nursing children.

It could be argued that the considerable use of untrained nursing staff (grades A-C) represents either an example of the use of skills mix so as to maximise the efficient use of scarce trained nurses, or alternatively a pragmatic but problematic solution to the nursing shortage which results in patients being cared for by insufficiently trained staff, and there being excessive stress on the trained staff actually in post. We are not in a position, on the basis of the information available, to know to what extent the use of untrained staff is a problem and to what extent it is a solution.

After nurses, the next most numerous professional group is doctors. Indeed, despite the high profile of the multidisciplinary team, 80% of the staff of the units (including administrative staff), were either doctors or nurses.

There is great variability in the make up of the units' multi-disciplinary teams (MDTs) and this does not appear to be determined by the type of unit. This suggests that there may be an unhelpful variation in the services provided between units, and warrants further consideration. It is of concern that over one third of units do not have a social worker (SW) given the complexity of problems found in the patient population. The findings of the site visits suggest that availability of suitably trained multidisciplinary staff, or rather the lack of them, is a major limitation on the treatments available in the in-patient context.

5.4.8 Referrals, admissions and discharges

A summary of the estimated numbers of referrals, assessments, admissions and discharges to and from in-patient child and adolescent psychiatric units in England and Wales is presented in Figure 5.1,

Figure 5.1: Estimates of the numbers of referrals, assessments, admissions and discharges to and from in-patient child and adolescent psychiatric units in England and Wales

<p>REFERRALS 62 units 1,517 referrals over six-months Average number of referrals per unit 24.48</p> <p>Applied to all 80 units the estimated total number of referrals:</p> <ul style="list-style-type: none">➤ 6 months 1,957➤ 1 year 3,915 <p>ASSESSMENTS 62 units 1,131 assessments over six-months Average number of assessments per unit 18.24</p> <p>Applied to all 80 units the estimated total number of assessments:</p> <ul style="list-style-type: none">➤ 6 months 1,459➤ 1 year 2,919 <p>ADMISSIONS 62 units 827 admissions over six-months Average number of admissions per unit 13.24</p> <p>Applied to all 80 units the estimated total number of admissions:</p> <ul style="list-style-type: none">➤ 6 months 1,067➤ 1 year 2,134 <p>DISCHARGES 62 units 783 discharges over six-months Average number of discharges per unit 12.63</p> <p>Applied to all 80 units the estimated total number of discharges:</p> <ul style="list-style-type: none">➤ 6 months 1,010➤ 1 year 2,021

5.4.8.1 Access, admission and discharge

Roughly speaking, for every 4 patients referred, 3 are assessed and 2 admitted. We do not know how many patients are referred to more than one unit simultaneously and the effect of this on the “referred but not admitted” figures. The survey of referring out-patient psychiatrists suggests that on average, two units are approached for each case. Such a proportion would account for a considerable proportion of the discrepancy between figures for referral, assessment and admission.

Over half of those referred but not admitted were not admitted either because the patient and/or family decided against this course of action or because admission was felt, by those carrying out the assessment, to be unnecessary. A little over a third were placed on a waiting list or were refused admission. This was attributed to consideration of patients already on the unit, or because admission was judged to pose an unacceptable risk e.g. given the level of violence demonstrated by the patient or the level of staff available on the unit at that time.

36% of admissions were on the day of assessment and 85% were within one month of assessment. For emergency admissions, 60% were within 24 hours of referral and 80% within one week. Thus although there are clearly some cases with long waits for admission, and there is further room for improvement in this regard, the results suggest that those admitted usually have not had an unacceptable wait. What may be a cause for major concern may be those who are referred but refused admission. Although, as suggested above, the difference between the figures for referrals and admissions is likely to be in part attributable to a mean of two units contacted for each case referred, this is not the whole picture. Some of these cases are likely to be suffering the effects of a shortage of appropriate placements and indeed half the psychiatrists reported that patients who should be admitted are refused admission due to lack of bed availability. These psychiatrists reported average number of patients refused admission for this reason as 4 (min 1, max 9). This amounts to 320 patients nation-wide; while there may be duplication of individuals between units this is still a considerable number where services appear to be being refused because of inadequate resourcing in terms of beds. What happens to these patients is a matter for further investigation, but might involve sub-optimal treatment at home or 'inappropriate' admission to paediatric or general psychiatry wards

That said, half of the psychiatrists and social workers interviewed believed that children were admitted inappropriately to their unit because of deficits in other local services. These 'inappropriate' admissions were reported as mostly numbering 1-5 cases per year or between 80-400 'inappropriate' admissions to all IP units per year. If local services were constructed in such a way as to enable these young people to be managed in the community or in other local settings then at least some of these admissions might be avoided. For such cases, as well as for some of those refused admission, it is likely that there is no simple answer but rather a need for multi-agency collaboration in assessing and managing risk and providing the optimum package of care and treatment.

Standard 23 stated that 'before discharge, decisions are made about meeting any continuing needs'. According to psychiatrists, there were difficulties in discharging patients due to limitations in receiving community-based services. Psychiatrists reported that such difficulties affect an average of 7 cases per year (min 1 case, max 40 cases). Again if local services were constructed in such a way as to enable them to take over the care of these individuals in the community or in other local settings then at least some of these delayed discharges might be avoided, consequently increasing the relative availability of in-patient beds.

5.4.8.2 Follow up arrangements

There is a dilemma in how best to follow up those discharged from in-patient units. The unit or staff from the unit may well be best placed to do it from the point of view of the relationships developed, knowledge of the case, and sometimes expertise in the case of specialist units. But problems of geography, the perception of undermining of local services and clarity of responsibility for care among others complicate matters. There is also the possibility of a two-tier service with those living in the area local to the unit being followed up by the unit while those admitted from distant areas are denied this. There is also the issue of whether in-patient units have the resource to follow cases into the community without it impacting negatively on the care provided for in-patients. More than half those discharged from the units are referred back to local services and only a minority are followed up by the staff of the in-patient units.

5.4.8.3 Admissions to other NHS wards

There is a need to exercise caution in the interpretation of the data from this element of the study. We estimated that there were approximately 581 'inappropriate' admissions of people under the age of 18 to general adult psychiatric wards and between 134 and 177 to paediatric wards over a period of a year. Clearly much depends on the definition of 'inappropriate' used by the lead clinicians on the wards surveyed. Several factors lend support to the validity of the findings. First the respondents were experienced practitioners, second we did not assume that all admissions to paediatric and general adult psychiatric wards were 'inappropriate'. Third, the clinicians in their assessments demonstrated an ability to discriminate between 'appropriate' and 'inappropriate' admissions. Fourth the study was prospective

allowing them to consider each case according to the criteria of the study. Taken as a whole our estimate of the number of 'inappropriate' admissions to other units was just over a third (36%) of the 2,134 estimated admissions to child and adolescent in-patient units.

5.5 Discussion day

5.5.1 Practitioner consultation exercise

5.5.1.1 Rationale and method

Given the nature of this project and the data obtained from it we were very keen to enable as high a degree as possible of practitioner involvement in the interpretation of the results of this study within its tight time constraints. We therefore convened a one-day conference in collaboration with the Child In-patient Special Interest Group (CHIPSIG) of the Faculty of Child and Adolescent Psychiatry of the Royal College of Psychiatrists. About 110 people attended this conference. While we termed it a practitioner conference it also included representatives of user and carer groups, service managers and service planners as well as all elements of the multi-disciplinary teams working in general and specialist in-patient units for children and adolescents with mental health problems.

The day was split into three parts; first preliminary data from all elements of the study were presented to the whole group. The participants were then split into eight facilitated groups, balanced by professional group and role. Eight key themes from the research had been identified for discussion, these were:

- Environmental Safety
- Staffing
- Access to in-patient care for emergency referrals and severe or high risk cases
- Access to psychological therapies
- Information and consent
- Rights and Safeguards
- Links with Adult Psychiatric Services
- Level of Provision

Each of the groups were given the task of considering two of the themes in detail and also making any points that they wished to on the remaining six. The groups were particularly encouraged to consider the conclusions and the practical implications of the data presented drawing on their own expertise and experience. Finally the group facilitators synthesised the group responses and fed them back in turn at a plenary session where they were discussed and debated further.

The following sections present a summary of the key points on each theme.

5.5.1.1.1 Environmental Safety

Concerns were raised about the safety (in terms of built environment, other patients, staff skills and supervision) of young people with primary mental health problems being admitted to general adult psychiatric wards and paediatric wards.

The ward environment (built, staff and patients) was identified as a major facilitator or limitation to the admission of individuals who might benefit from in-patient care. The need for and value of user and provider input into the design of new facilities and the renovation of old ones was stressed. Safety was felt to be an amalgam of adequate staffing, mechanical aids such as alarm buzzers as well as careful risk assessment with the resources and skills to implement management plans.

The concerns about inadequate procedures and premises in some units where seclusion is used was seen as being of strong concern and a priority for attention in order to attempt to assure the safety of patients and staff.

5.5.1.1.2 Staffing

Participants were sure that some of the issues raised in the study were a function of the national shortage of specially trained child and adolescent mental health nurses where the pool of potential recruits is relatively small. A main contributor to this was identified as the private sector, which was perceived as draining staff from NHS facilities while not training new staff. Concerns were raised that the skilled staff grades available on in-patient units meant that skilled staff were often forced to move into community services to pursue promotion and better remuneration. With respect to medical staffing there were concerns about a lack of consultants to train new specialist registrars; the need for specialist on-call rotas;

Recommendations included:

1. increasing and improving supervision and the staff-patient ratio to prevent burnout;
2. that the staff-patient ration should be more like the ratio in paediatric wards rather than that in general adult psychiatric wards
3. the inclusion of an option to train on a child and adolescent in-patient unit as part of general mental health nursing training;
4. enhancing career opportunities for in-patient nurses;
5. encouragement of greater numbers to train for the ENB 603 qualification;
6. enabling access to ENB 603 training;
7. purchasing general health care (e.g. from GPs, paediatric consultants) to enhance medical input; the need more social workers;
8. the need for more post 16 years teachers with appropriate specialist skills.

5.5.1.1.3 Access to in-patient care for emergency referrals and severe or high risk cases

This was generally accepted to be a major challenge where current services in many cases could be said to be failing young people amongst the most in need of help. The definition of what constitutes an emergency is likely to vary between professional groups and between agencies (e.g. acute psychosis, severe eating disorders, the need for containment, risk of violence or self harm). Concerns were raised that one group's emergency admission might be another group's 'just another placement' to contain anxiety and would lead to the admission of 'hard to move on' patients. The fundamental question appeared to be should the admission of emergency referrals be a core function of general child and adolescent in-patient units. A second allied question was whether such units should be directly available in all regions. The balance of opinion tended towards a positive answer to both these questions.

Some participants strongly felt that there was a tendency in some units to want to do psychotherapeutic work or a concentration on the ward milieu, which is a different ethos from most adult general psychiatry units. Emergency admissions do not fit well with this model and may be perceived to have a disruptive impact. Concerns were raised that units were not set up to deal with admissions out of hours and that these caused major disruption.

What happened to emergencies that were not admitted to child and adolescent psychiatric in-patient units was a cause for major concern, with fears that they ended up being admitted to services that did not have appropriate training and understanding. There was a consensus that there needed to be a process of establishing new emergency assessment units and/or modifying existing units and their procedures. The fundamental obstacle to this appeared to be that this course of action would not be resource neutral and would require additional investment.

Emergency admission was generally seen as a 'last resort' with strenuous efforts having been made to prevent the admission. Developments in general adult psychiatry such as inter-agency crisis intervention teams or assertive outreach were discussed and one option would be for generic community teams to be enhanced in order to be able to take on such a role. The establishment of separate services might not be the best use of resources given the relatively low frequency of need compared with general adult services. Any development will require an agreed joint vision with appropriate training and resources. Again the value of regional commissioning of such services in the context of a national plan was stressed.

5.5.1.1.4 Access to psychological therapies

The central importance of psychological therapies in in-patient care was supported by all. An important element in the delivery of such interventions was held to be that it was a matter of the skills that staff had and the time to be able to use them rather than a matter of specific disciplines. The nursing profession is at the core of care provision in in-patient CAMHS, and they are a resource that provides much of the therapeutic input to units. Supporting the development of psychotherapeutic skills in nursing staff, enabling their deployment and rewarding people for this enhanced role was seen as a potential way to improve quality of care and encourage the retention of skilled staff.

5.5.1.1.5 Information and consent

The fundamental need for the information given to patients to be age-appropriate was stressed. This might require that nurses read written documents to young people and assess the extent to which the information has been understood. User involvement in the drafting and testing of materials is likely to be of benefit. There is the potential for the sharing of resources so that each unit does not have to 'reinvent the wheel'; the Internet and quality improvement networks such as QNIC were identified as ways to disseminate and develop such materials. The giving of information should be seen as an integral part of the care plan rather than as a peripheral activity. The sharing of information with and from other agencies and with patients and their families was also raised as an issue requiring the formulation of local, regional and national policies given the large catchment areas served by these units.

With respect to consent the main issues revolved around what procedures or activities require consent on in-patient units and how such consent should be obtained. The balance of difficulties and benefits in obtaining written and verbal consent were discussed along with any role which parents might have if the young person were capable of giving consent. One area where there was discussion was the extent to which parental or young person consent on admission could be considered a blanket consent to any management strategy during the admission. To what extent should consent be renegotiated with parents and children at each stage in the development of the treatment plan?

On balance it was felt that informed consent involved constant negotiation and re-negotiation in an ongoing process involving both parents and children since they can both change their minds. When explained, a general consent for the ward programme is likely to be possible. This might be supplemented by specific consent to specific treatments in regularly reviewed care plans with signatures, both parental and the young person's where possible.

5.5.1.1.6 Rights and Safeguards

One enduring point developed was the idea that patients had more rights and safeguards when they were detained under the Mental Health Act 1983 than when they were informal patients. The impact of this was held to be able to assure the quality of care provided for all on the unit not just those detained under the Mental Health Act. The Care Programme Approach was identified as one method to achieve this with the explicit negotiation and careful recording of all discussions and decisions concerning treatment and aftercare.

The issue of rights was seen as complex. It will primarily involve the rights of patients and parents with respect to the activities of the unit. However the rights of staff and the rights of other young people on

the ward and how these might be compromised by another patient's actions also need to be part of the consideration of rights and responsibilities. With respect to the responsibilities of staff, patients and parents the balance between coercion and willing participation in activities was seen as of importance given the role of the milieu and the ward programme in the treatment provided by a ward.

The important role of specific advocacy services for young people in in-patient units was affirmed. Such services need to be easily accessible and need to provide age-appropriate services. Parents may be unable, unwilling or unsuited to fulfilling this role. The difficulty in achieving this in some areas was presented along with examples of high quality services provided by external agencies such as MIND.

5.5.1.1.7 Links with Adult Psychiatric Services

There was an acknowledgement that general adult mental health services were under pressure from the workload presented by adolescents with severe mental illness. There was also concern that the care provided is likely to be sub-optimal due to a general lack of understanding of issues and evidence in adolescent mental health. While the relationship with general adult mental health services was seen as particularly important and problematic there was a strong acknowledgement that in-patient CAMHS also work with different networks (such as social services, child protection, education) and these relationships also require attention.

Structural difficulties may occur when CAMHS and adult services are part of different Trusts. There are also cross professional disagreements with no clear definition of what defines 'an adult' and at what age (e.g. some services cut off at 16, some not till age 21). Nurses reported better links than did other professionals. Links with specialist mental health services such as those for people with eating disorders may be better since both services share an understanding of the specific disorder.

A consistent concern was for the health and safety of adolescents admitted to general adult units. Adult criteria for risk assessment may be different to that needed for adolescents.

Specific solutions suggested to attempt to address these issues included:

- more joint teaching between the services;
- joint research;
- the development of formal liaison or outreach posts to work with young people placed on adult wards;
- contacting adult services when a patient reaches 16 to develop links and plan for transfer;
- more use of the formal CPA in CAMHS;
- making child and adolescent mental health part of nurse training rather than an elective placement; and
- developing extra capacity to prevent 'inappropriate' admissions to adult wards.

5.5.1.1.8 Level of Provision

The data suggest that in-patient units run at a close to full capacity and there were substantial numbers of young people inappropriately placed on general adult and paediatric wards. There was consensus that there was currently too little capacity in in-patient CAMHS. This appeared to be the case for general services, for emergency services and for specific services (e.g. forensic, younger children).

The variability of services provided was also felt to be unacceptable and not explained by need. This was true for the geographical variation in provision, the nature of provision (e.g. 5 day versus 7 day) and the entry criteria into services. Services that are national or regional appear to have grown without any rational planning resulting in inequalities in the access to care of young people with severe and complex mental disorder. Geographical inequality does not necessarily mean too many beds in areas but instead

not enough in others. This problem may well have been impacted upon by the closure of children's homes. Provision is not just about bed numbers but also access to a range of services including emergency admission. The geographical spread of units may be counter-therapeutic since distance to provision may inhibit working with the 'whole' family and planning discharge effectively. Coupled with this is a lack of national clarity about the expectations of an adolescent unit and the services it should provide. The need for regional planning and provision was supported with the need to take the current ad hoc provision and to rationalise it up into a coherent matrix of service provision. Current health authorities and trusts are too small to plan these services as will be Primary Care Trusts (PCTs).

Such a set of developments will require the building of capacity in staff of all disciplines. The two options, which might be used to achieve this, would be to take an incremental approach gradually developing more units or greater capacity and function (e.g. for emergencies) in existing units depending on current regional provision. The second way would be to decide on a step change in provision as was adopted when medium secure units were introduced. It was felt that either would require new investment and a central vision since the extra capacity and function needed would not be achieved by increasing existing unit's efficiency or by developing community alternatives to admission. Improving community services was agreed to be very important but it was felt likely that this would lead to increased demand by tapping the worryingly large pool of unmet need for child and adolescent mental health services of all types in the community.

6 CONCLUSIONS

1. There is a high degree of concern amongst CAMHS psychiatrists regarding difficulty in achieving admission, particularly for high risk and emergency cases to CAMHS in-patient units.
2. There is marked variability in the location and availability of units with a concentration of beds in London and the South East and a very limited availability in other regions such as Wales.
3. Over half of the beds in the South East are in the private sector and in specialist provision.
4. Children and adolescents on in-patient units are generally suffering from severe mental illness and have a high degree of clinical complexity.
5. There is a wide range of treatments available across units. Adolescents treated on adult units receive fewer of the treatments most commonly used in this age group.
6. Few of the nursing staff on in-patient units have relevant specialist qualifications.
7. There is great variability in the diversity of disciplines represented on the multi-disciplinary teams.
8. For every four patients referred to in-patient units, approximately three are assessed and two admitted. Patients are commonly referred to more than one unit (either serially or in parallel) before admission is achieved.
9. Patients who are admitted are generally admitted promptly. For emergencies, 60% of admissions are within 24 hours and 80% within one week. This still leaves a significant group for whom there is an unacceptable delay.
10. It is of concern that there are patients who are refused admission due to lack of resource and the nature of the patients' difficulties.
11. A number of patients may be admitted inappropriately to CAMHS in-patient units or their discharge delayed due to gaps in community resources.
12. Our estimate of the number of 'inappropriate' admissions to adult psychiatric wards and general paediatric wards is that there are likely to be around 758 each year compared to 2,134 estimated admissions to all CAMHS in-patient units.
13. Taken as a whole our data suggest that there is a need for more emergency in-patient CAMHS beds.

7 RECOMMENDATIONS

7.1 Recommendations

- 7.1.1 There needs to be population based planning for the commissioning of in-patient CAMHS services on a regional if not supra-regional level.
- 7.1.2 Regional or national planning should be supported by each Health Authority and Primary Care Group/Trust being able to demonstrate that they have secured provision for young people who require in-patient care by robust arrangements/contracts/agreements with child and adolescent in-patient facilities.
- 7.1.3 There is a clear case for ensuring that a comprehensive range of services are commissioned for each area. This should include emergency care, general in-patient facilities and specialist services.
- 7.1.4 There is a need to ensure that emergency in-patient care is available to those who need it. There is a debate about how best this should be provided which centres on whether general units should have this as a core function or whether new units should be established.
- 7.1.5 A proportion of young people are inappropriately admitted to general adult psychiatric and paediatric wards. Where this is unavoidable, there is a need to ensure a basic level of safety, access to appropriate treatment and a high level of input from CAMHS.
- 7.1.6 Taken as a whole this study suggests that there is a need for an investment in greater numbers of CAMHS in-patient beds, and that there is a particularly need to ensure the availability of beds into which emergencies can be admitted.
- 7.1.7 The percentage of nursing staff who have relevant specialist qualifications should be increased and access to specialist training improved.
- 7.1.8 Attention should be paid to ensuring that a full range of skills and disciplines are available in the multi-disciplinary teams on in-patient units.
- 7.1.9 Attention should be paid to securing staffing for the education of the 16-18 year olds in in-patient units.
- 7.1.10 There should be a strengthening of relationships between in-patient units and community CAMHS in order to ensure continuity of care. This might include outreach services from in-patient CAMHS and “inreach” services from community CAMHS into in-patient units.
- 7.1.11 There needs to be greater equity of service provision geographically. This will require an increase in in-patient resource in some parts of the country.
- 7.1.12 Liaison and transfer protocols between CAMHS and general adult psychiatric services need to be improved.
- 7.1.13 Further research should be commissioned on those referred but not admitted to in-patient CAMHS including estimates of the size of this population, their needs and outcomes following assessment
- 7.1.14 This study focused exclusively on health facilities and so did not include facilities managed by local authorities or the independent sector which provide social care, or which are primarily for detention (eg local authority-managed secure units). There is a need for research to investigate mental health issues in these settings.
- 7.1.15 There is a need for further research into the characteristics and care of young people admitted to paediatric wards and general adult psychiatric wards. This should include pathways into care and the extent to which their mental health needs are met.

8 REFERENCES

- Audit Commission: National report (1999)** Children in mind: Child and adolescent mental health services.
- Baker, R. & Fraser, R.C. (1995)** Development of review criteria: Linking guidelines and assessment of quality. *British Medical Journal*, **311**, 370-3.
- Bickman, L. (1996)** A continuum of care - more is not always better. *American Psychologist*, **51**, 689-701.
- Bickman, L., Guthrie, P.R., Foster, E.M., Lambert, E.W., Summerfelt, W.T., Breda, C.S. & Heflinger, C.A. (1995)** *Evaluating managed mental health services: The Fort Bragg experiment*. New York: Plenum Press.
- Bickman, L., Foster, M. & Lambert, E.W. (1996)** Who gets hospitalized in a continuum of care? *Journal of the American Academy of Child and Adolescent Psychiatry*, **35**, 74-80.
- Blanz, B. & Schmidt, M. (2000)** Preconditions and outcome of inpatient treatment in child and adolescent psychiatry. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, **41**, 703-712.
- Brewer, J. & Hunter, A. (1989)** *Multimethod Research; a synthesis of styles*. Newbury Park and London: Sage.
- Brook, R.H., Chassin, M.R., Fink, A., et al (1986)** A method for the detailed assessment of the appropriateness of medical technologies. *International Journal of Technology Assessment in Health Care*, **2**, 53-63.
- Bryce, G. (1996)** *A report on the commissioning of child and adolescent mental health services*. Greater Glasgow Health Board: Unpublished Report.
- Campbell, S.M., Rowland, M.O., Shekelle, P.G., Cantrill, J.A., Buetow, S.A. & Cragg, D.K. (1999)** Development of review criteria for assessing the quality of management of stable angina, adult asthma, and non-insulin dependent diabetes mellitus in general practice. *Quality in Health Care*, **8**, 6-15.
- Caviston, P. (1998)** AUP Guide: Directory of NHS Adolescent Units in SE England.
- Chesson, R. & Chisholm, D. (eds) (1996)** *Child and Psychiatric units: At the Crossroads*. London: Jessica Kingsley.
- Children Act 1989**. London: HMSO.
- Clinical Standards Advisory Group (1999)** *Services for Patients with Depression*. London: Department of Health
- Cotgrove, A. (1997)** Emergency admissions to a regional adolescent unit: piloting a new service. *Psychiatric Bulletin*, **21**, 604-608.
- Department of Health (1992)** *Health of the Nation White Paper*. London: Department of Health.
- Department of Health (1995)** *Health of the nation: A handbook on child & adolescent mental health services*. London: HMSO.
- Department of Health (1996)** *The Patient's Charter: Services for Children and Young People*. London:
- Department of Health (1998)** *Children looked after by Local Authorities*. London: Department of Health.
- Department of Health (1999)** *A National Service Framework for Mental Health: Modern Standards and Service Models*. London: HMSO.
- Department of Health.
- Diamond, C. & Goldberg, D. (1999)** On admitting psychotic adolescents to hospital: Time to review the admission process. *Child Psychology and Psychiatry Review*, **4**, 16-19.

- Glover G.R., Robin E., Emami J. & Arabscheibani G.R. (1998)** A needs index for mental health care. *Social Psychiatry and Psychiatric Epidemiology*, **33**, 89-96.
- Gowers, S.G., Harrington, R.C., Whitton, A., Lelliott, P., Beevor, A., Wing, J. & Jezzard, R. (1999)** Brief scale for measuring the outcomes of emotional and behavioural disorders in children. Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA). *The British Journal of Psychiatry*, **174**, 413-417.
- Gowers, S.G., Symington, R.E. & Entwistle, K. (1991)** Who needs an Adolescent Unit? A referrer satisfaction study. *Psychiatric Bulletin*, **15**, 537-540.
- Green, J. & Burke, M. (1998)** The ward as a therapeutic agent. In J. Green & B. Jacobs (Eds) *In-patient Child Psychiatry. Modern Practice, Research and the Future*. (pp 93-109) London: Routledge.
- Green, J.M. & Jacobs, B. (eds) (1998)** In-patient Child Psychiatry: Modern practice, research and the future. London: Routledge.
- Gutterman, E.M., Markowitz, J.S., LeConte, J.S. & Beier, J. (1993)** Determinants for hospitalization from an emergency mental health service. *Journal of the American Academy of Child and Adolescent Psychiatry*, **32**, 114-122.
- Hillard, J.R., Slomowitz, M. & Deddens, J. (1988)** Determinants of emergency psychiatric admission for adolescents and adults. *American Journal of Psychiatry*, **145**, 1416-1419.
- House of Commons Health Committee (1997)** Child and Adolescent Health Services 4th Report. London: HMSO.
- Jacobs, B. & Green, J. M. (1998)** Inpatient Child Psychiatry -Adapting for the Future. *YoungMinds*, **36**, 14 - 16.
- Jaffa, T. & Stott, C. (1999)** Do inpatients on adolescent units recover? A study of outcome and acceptability of treatment. *European Child & Adolescent Psychiatry*, **8**, 292-300.
- Kunze, H. & Priebe, S. (1998)** Assessing the quality of psychiatric hospital care: A German approach. *Psychiatric Services*, **49**, 794-796.
- Kurtz, Z., Thornes, R. & Wolkind, S. (1994)** *Services for the mental health of children and young people in England: a national review*. London: South Thames Regional Health Authority.
- Kurtz, Z., Thornes, R. & Wolkind S (1995)** *Services for the mental health of children and young people in England: an assessment of need and unmet need*. Department of Health: London.
- Maskey, S. (1998)** The process of admission. In J.Green & B. Jacobs (Eds) *In-patient Child Psychiatry. Modern Practice, Research and the Future*. (pp39-50) London: Routledge.
- McCabe, R., Rothery, D, Wrate, R., Aspin, J. & Bryce, J. (1996)** Diagnosis in adolescent inpatients: Diagnostic confidence and comparison of diagnoses using ICD-9 and DSM-III. *European Child and Adolescent Psychiatry*, **5**, 147-154.
- McCulloch, A., Muijen, M. & Harper, H, (2000)** New Developments in Mental Health Policy in the United Kingdom. *International Journal of Law and Psychiatry*, **23**, 261-276.
- Mental Health Act 1983**. London: HMSO.
- Morrisey, R., Dicker, R., Abikoff, H., Alvir, J., DeMarco, A. & Koplewicz, H. (1995)** Hospitalising the suicidal adolescent: an empirical investigation of decision making criteria. *Journal of the American Academy of Child and Adolescent Psychiatry*, **34**, 902-911.
- NHS Executive (1999)** *Anglia and Oxford Directory*. NHS Executive.
- NHS Executive (1999)** *North Thames Directory*. NHS Executive
- NHS Executive (1999)** *Northern and Yorkshire Directory*. NHS Executive.
- NHS Executive (1999)** *South Thames Directory*. NHS Executive.
- NHS Executive (1999)** *South and West Directory*. NHS Executive
- NHS Executive (1999)** *Trent Directory*. NHS Executive.

- NHS Health Advisory Service (1986)** *Bridges over Troubled Waters: A report from the NHS Health Advisory Service on services for disturbed adolescents*. London: HMSO.
- NHS Health Advisory Service (1995)** *Child and Adolescent Mental Health Services: Together we stand*. London: HMSO.
- ONS (1997)** 1991 Census Key Statistics for New Health Areas England and Wales. London: HMSO.
- ONS (1998)** Key population and vital statistics local and health authority areas. London: HMSO.
- Patrick, C., Padgett, D.K., Burns, B.J., Schlesinger, H.J. & Cohen, J. (1993)** Use of inpatient services by a national population: Do benefits make a difference? *Journal of the American Academy of Child and Adolescent Psychiatry*, **32**, 144-152.
- Pfeiffer, S.I. & Strzelecki, S.C. (1990)** Inpatient psychiatric treatment of children and adolescents: a review of outcome studies. *Journal of the American Academy of Child and Adolescent Psychiatry*, **29**, 847-853.
- Rothery, D., Wrate, R., McCabe, R., Aspin, J. & Bryce, G. (1995)** Treatment goal planning: Outcome findings of a British prospective multi-centre study of adolescent inpatient units. *European Child and Adolescent Psychiatry*, **4**, 209-221.
- Soni Raleigh, V. & Balaraja, R. (1995)** The health of infants and children among ethnic minorities. In *The Health of Our Children (ed B Botting), OPCS Decennial Supplement, series DS no. 11*, 82-94. London: HMSO.
- Sourander, A., Helkkilä, T., Leijala, H., Heinisuo, A.M., Helenius, H. & Piha, J. (1995)** Follow-up of short-term child psychiatric inpatient treatment. *Nordic Journal of Psychiatry*, **49**, 95-101.
- Sourander, A., Helenius, H., Leijala, H., Heikkälä, T., Bergroth, L. & Piha, J. (1996a)** Predictors of outcome of short-term child psychiatric inpatient treatment. *European Child and Adolescent Psychiatry*, **5**, 75-82.
- Sourander, A., Helenius, H. & Piha, J. (1996b)** Outcome of short-term child psychiatric hospitalization: Teacher evaluation at 5 month and 12 month follow-up. *European Child and Adolescent Psychiatry*, **5**, 204-211.
- Sourander, A., Leijala, H., Lehtilä, A., Kanerva, A., Helenius, H. & Piha, J. (1996c)** Short-term child psychiatric inpatient treatment: Place of residence as one year outcome measure. *European Child and Adolescent Psychiatry*, **5**, 38-43.
- Sourander, A., Hukkanen, R. & Piha, J. (1997)** Mental health among children in children's homes and in psychiatric hospital. *Psychiatria Fennica*, **28**, 183-191.
- Sourander, A. & Piha, J. (1998)** Three year follow-up of child psychiatric inpatient treatment. *European Child and Adolescent Psychiatry*, **7**, 153-162.
- Steinhausen, H-C. (1985)** Eine Skala zur Beurteilung psychisch gestörter Kinder und Jugendlicher. *Zeitschrift für Kinder und Jugendpsychiatrie*, **13**, 230-240.
- Street, C. (2000)** Whose crisis? Responding to children and young people in an emergency. *Young Minds Magazine*, **49**, 14-18.
- Woolston, J.L. (1996)** Psychiatric inpatient services. In M. Lewis (Ed) *Child and Adolescent Psychiatry* (pp 890-894). Baltimore: Williams & Wilkins.
- World Health Organisation (1992)** *The tenth edition of the International Classification of Diseases and Related Health Problems (ICD-10)*. Geneva: WHO
- Wrate, R., Rothery, D.J., McCabe, R.J.R., Aspin, J. & Bryce, G. (1994)** A prospective multi-centre study of admissions to adolescent psychiatry inpatient units. *Journal of Adolescence*, **17**, 221-237.
- Yates P., Garralda M.E & Higginson I (1999)** Paddington Complexity Scale and Health of the Nation Outcome Scales for Children and Adolescents. *British Journal of Psychiatry*, **174**, 417-423.
- YoungMinds (1998)** *Directory of Child and Adolescent Mental Health Services*. YoungMinds, London.

9 APPENDIX

9.1 Psychiatrists' views of in-patient CAMHS: A survey of members of the child and adolescent faculty of the Royal College of Psychiatrists

Table 9.1: Range of themes and frequency of psychiatrists who identified them.

Rank	Theme code	Sub theme	Frequency (%)
1	3.2	Lack of beds and facilities for emergency admissions	89(36%)
2	6.4	Lack of beds	61(25%)
3	4.4	Failure to provide for severe cases and certain groups (for example, high risk patients)	58(24%)
4	5.1	Insufficient liaison with the patient's local services	50(20%)
5	2.1	Poor geographical proximity	45(18%)
6	4.5	Need for increased range of specialist services	41(17%)
6	4.1	Selective referral or admission criteria - units are too selective	41(17%)
7	6.1	General poor planning of services – geographic distribution of services	40(16%)
8	2.2	Long waits for admission and difficulties with the process of finding a bed	35(14%)
9	6.2	Funding problems – securing funds, funding from one agency can disrupt interagency working.	32(13%)
10	4.3	Unclear where conduct disorder and “social admissions” should be managed	30(12%)
11	1.1	Problems recruiting nursing and multidisciplinary staff	27(11%)
13	6.7	Need for standards and guidelines – National variation in quality of services	25
14	1.2	Need for training – maintaining a high level of skill including therapeutic skills	23
15	7.3	General problems with treatment – Need for a wider range of treatments	22
16	7.2	Problems with patient's length of stay – impact of inadequate local services	20
17	7.7	Managing patients in other settings	20
18	4.2	Problems managing a diverse casemix	17
19	5.3	Poor integration of in-patient services with out-patient services	16
20	3.1	Unacceptable delay (or response to) for emergency admissions	15
21	7.1	There is a need to show clinical effectiveness- (of inpatient care over outpatient care	13
22	6.6	Poor quality surrounding services increase pressure on in-patient units	14
23	6.8	The service is costly and benefits are not always clear	13
24	5.4	Poor multi-agency working in general	11
25	8.2	Other legal	6
26	6.9	Request for setting up outreach services	11
27	5.2	Poor linking of adolescent with adult services	9
28	6.5	Poor physical environment and facilities	7
29	7.4	Education is not adequately provided	8
30	7.8	Problems with assessment and admission procedures	5
31	7.5	Poor discharge planning and follow-up	6
32	7.6	Difficulties with the management of aggressive patients	7
33	1.3	Problems with retaining and supporting staff	3
34	2.3	Unclear referral procedures	2
35	8.1	The threshold at which compulsory admission and treatment are needed is not clear	1

36	8.0	Thresholds for use of the Mental Health Act Vs Children's Act, if child opposes treatment plan/admission.	2
37	8.2		6

9.2 NICAPS directory

9.3 Data collection tools

9.3.1 6 month activity study questionnaire – referrals, assessments, admissions and discharges

9.3.2 Residential census day questionnaire

9.3.3 Bed and staff census day questionnaire

9.3.4 Unit survey questionnaire

9.3.5 Admissions to adult psychiatric wards questionnaire

9.3.6 Admissions to general paediatric wards questionnaire

9.3.7 9 month follow up of those referred but not admitted questionnaire

9.3.8 Survey of referring out-patient psychiatrists questionnaire

9.4 Standards for child and adolescent psychiatric in-patient services