Acute in-patient psychiatric care for young people with severe mental illness

Recommendations for commissioners, child and adolescent psychiatrists and general psychiatrists

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Membership of the working party

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Executive summary

This document has been produced by a working group of the Faculties of Child and Adolescent Psychiatry and General and Community Psychiatry. It makes recommendations about how services should be provided and commissioned for the acute care of young people with serious mental illness.

There is widespread recognition that the care of young people presenting with acute, severe mental illness is often unsatisfactory. This can involve a lack of any suitable bed, undue delay, or an inappropriate admission to an adult or paediatric bed. In fact, in England and Wales, some 600 young people are inappropriately placed each year on adult or paediatric wards.

The report notes that the principles of specialist provision for adolescents with serious mental illness should include: prompt admission; a suitably safe and appropriately staffed ward environment (which conforms to the agreed standards); geographical proximity to the family home (enabling frequent visits and appropriate family interventions); and minimisation of health and safety risks from other patients and availability of drugs and alcohol.

The key recommendations are that:

- young people aged under 16 years should not be admitted to adult psychiatric wards
- those aged 16 or 17 years can be considered for admission to adult psychiatric wards when:
  - no suitable specialist adolescent psychiatric bed is available
  - they have severe mental illness
  - acceptable standards of care are met
- health commissioners need to develop appropriate services
- inappropriate admissions should be considered as a sign of inadequate resources and treated as an untoward or critical incident.

The report concludes that significant investment and development are needed to provide acute in-patient and community services for adolescents with severe mental illness in line with Government priorities.

Introduction

This document has been produced by a working group of the Faculties of Child and Adolescent Psychiatry and General and Community Psychiatry. It recommends how services should be provided and commissioned for the acute care of young people with serious mental illness. However, it does not consider the additional needs of young people with significant learning disability.

There is widespread recognition that the acute care of young people presenting with severe mental illness is often unsatisfactory (Audit Commission, 1999; Street, 2000). When in-patient admission is required, there are times when no beds are available in an adolescent psychiatric unit or the facilities are located too far away for easy family access. Furthermore, some adolescent units have admissions procedures and timescales which may not be appropriate for the treatment of acute serious mental illness.

In other cases, young people are placed for varying periods of time on adult wards which, as they exist today, are unacceptable facilities for young adolescent admissions (under 16 years) because of health and safety risks arising from current staffing ratios and patient mix. This is particularly so in inner-city areas with high levels of social deprivation and widespread substance misuse. Additionally, young people are placed on paediatric wards without appropriate nursing or therapy support. In England and Wales, some 600 young people are inappropriately placed each year on adult or paediatric wards (O'Herlihy *et al*, 2001). Finally, the lack of a suitable bed may keep the young person with acute severe mental illness with their family, thereby placing them, their family and other professionals at risk.

Concerns are being expressed by community child and adolescent psychiatrists who are undertaking, or are being pressured to undertake, on-call responsibilities without the resources necessary to manage acute mental illness in such a vulnerable group (Royal College of Psychiatrists, 1999; Worrall & O'Herlihy, 2001).

The lack of adequate resources can be attributed to:

- a 50% reduction in National Health Service (NHS) provision of adolescent in-patient psychiatric beds, added to the inadequate baseline provision of beds which has been recognised over the past two decades
- increasing pressure on adult psychiatric beds
- a worsening in the environment of adult psychiatric wards
- an increase in morbidity in the child and adolescent population (Office for National Statistics, 1999).

Service principles

Adolescence is a time of rapid developmental change. In addition to physical, intellectual, emotional and social development, adolescents are also managing the transition from the world of the child and family to that of the independence of adulthood. All these factors mean that a specialist adolescent mental health service should have expertise in:

- the assessment, management and treatment of severe mental illness
- adolescent development
- working in partnership with family, educational and social welfare systems.

Provision for those young people who require in-patient care should include:

- prompt admission
- a suitably safe and appropriately staffed ward environment which conforms to agreed quality standards (http://www.rcpsych.ac.uk/cru/qnic.htm)
- geographical proximity to family allowing frequent contact and appropriate family interventions
- minimisation of health and safety risks from:
  - other patients
  - availability of drugs and alcohol.

Recommendations

1 Health commissioners must give immediate priority to the development of sufficient, specialist, age-appropriate services for adolescents with severe mental illness, capable of delivering evidence-based assessment and treatment in combination with specific therapies to address the developmental and family issues (Department of Health, 1998). The goal is to prevent the inappropriate admission of young people to adult psychiatric or paediatric beds. A child and adolescent mental health service cannot be considered safe or adequately resourced if it does not have guaranteed access to specialist adolescent in-patient facilities offering same-day admission for patients with symptoms of acute severe mental illness.

2 Health commissioners will need to ensure that:
- appropriate provision is available which addresses the particular challenges (arising from social deprivation or geographical isolation) that some geographical areas will face in meeting these recommendations
- a timescale of 3 to 5 years should be set for such plans to be implemented.

3 Young people aged under 16 years should not be admitted to adult psychiatric wards.

4 It is recognised that it is a clinician's overriding duty to act in the best interests of his or her patients. This requires the identification and use of the best psychiatric care available. In some circumstances this may be an inappropriate admission to a ward that does not have acceptable standards of care or safety. If such an admission occurs, it demonstrates that inadequate resources are available for the treatment of acute severe mental illness in young people and it should be considered a critical or untoward incident, triggering a management review.

5 Those aged 16 or 17 years should be considered for admission to adult psychiatric wards for assessment or treatment only when:
- no suitable specialist adolescent psychiatric bed is available
- they have or are likely to have serious mental illness
- acceptable standards of care are met
- child and adolescent psychiatric consultation and advice is available throughout the admission.

6 Child and adolescent and adult psychiatry services must collaborate in the care of this vulnerable group of patients.

7 Availability of specialist child and adolescent mental health advice: in areas where child and adolescent mental health on-call services are

provided, because of adequate resources and workforce, child and adolescent psychiatrists-in-training will, where possible, provide the first-on-call cover, with supervision from consultant child and adolescent psychiatrists. Where child and adolescent psychiatrists-in-training are not available, the first-on-call may be provided by the first-on-call psychiatric senior house officer, with the same supervision from consultant child and adolescent psychiatrists. It should not be expected that consultants will provide first-on-call cover.

8 Child and adolescent psychiatrists, general psychiatrists, paediatricians and other agencies share concern about the availability of on-call services for child and adolescent patients. Furthermore, the Faculties of Child and Adolescent Psychiatry and General and Community Psychiatry recognise that the above recommendations are an important part of establishing child and adolescent mental health on-call services. However, the Faculties also make clear that many other issues, such as workforce, in-patient resources and investment, must be addressed before these aspirations can be realised.

The National Service Framework and the Children's Taskforce

Significant investment and development are needed to provide acute in-patient and community services for adolescents with severe mental illness in line with Government priorities (Department of Health, 1998). It is essential that these issues are key considerations for the Children's Taskforce. The National Service Framework offers a unique opportunity for children's services. This must address the staffing and resources required and consider the questions of training and the need for research and development funding, with particular regard to service outcomes and interventions.

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