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The ability of adolescent psychiatric units to accept emergency admissions: changes in England and Wales between 2000 and 2005

AIMS AND METHOD

The lead consultants of all adolescent in-patient psychiatric units in England and Wales were surveyed in 2000 and again in 2005, to determine whether they could admit young people in an emergency.

RESULTS

In 2000, 51 of 64, and in 2005, 70 of 79 units responded. Although the number of units with dedicated 'emergency admission beds' had increased from 6 to 16, 34% of the total could never admit as an emergency in 2005 and 44% could never admit out of hours. The consultants estimated that, in 2005, they turned away 72% of referrals for emergency admission. Although 87% of consultants agreed that there should be emergency access to specialist adolescent psychiatric beds, concern was expressed that services are not configured to accept emergency admissions.

CLINICAL IMPLICATIONS

This problem is unlikely to be resolved by requiring units to accept both emergency and planned admissions. These groups have very different needs. Coherent and unified commissioning is needed to achieve equity of access to emergency beds, along with separate planned admission units and a range of alternative emergency services.

Many clinicians working in community child and adolescent mental health services consider that the ability to admit a young person promptly is the most important attribute of an in-patient adolescent mental health unit (Gowers *et al*, 1991; Cotgrove, 1997; Corrigall & Mitchell, 2002). This view is echoed by the National Service Framework for Children, Young People and Maternity Services (Department of Health, 2004), which states that 'there is a particular need to ensure the availability of beds into which emergencies can be admitted'.

The number of adolescent in-patient psychiatric units has increased since the 1960s. However, there has been little national coordination of these developments. As a result, units vary widely in their admission criteria and treatment approach, as well as in their capacity to admit young people in an emergency. A survey undertaken in 1999 as part of the National In-patient Child and Adolescent Psychiatric (NICAP) Study found that only 39% of child and adolescent in-patient units could accept admissions at short notice, including out-of-hours (O'Herlihy *et al*, 2003).

This paper describes the results of a survey of the provision of emergency access to adolescent in-patient beds in 2005 and compares these with the results of a similar survey carried out in 2000. We discuss the implications of the findings for future planning of services for young people who require emergency admission.

Methods

As part of the NICAP Study in 1999 (O'Herlihy *et al*, 2003), the Royal College of Psychiatrists' Research and Training Unit developed a database listing all adolescent psychiatric in-patient units in England and Wales. This was used to conduct the 2000 survey. The 2005 survey used an updated version of the database which included new units that had opened since 1999 (Farr & O'Herlihy, 2004). All units that admitted young people between the ages of 11 and 18 years, for care funded by the National Health Service (NHS), were included in both surveys.

On both occasions, a questionnaire was sent to the named lead consultant psychiatrist in each unit. After 1 month, a reminder was sent to non-responders. The questionnaire asked about the ability of the unit to respond to requests for immediate/emergency admissions. Information was also gathered about the number of beds and the unit's catchment area. The two questionnaires used slightly different definitions of what constitutes an urgent admission. In 2000, the questionnaire referred to 'emergency' admissions and, in 2005, to 'admissions within 1 working day'; in both cases respondents were asked to state the proportions of diagnostic groups admitted in each category. The questionnaire sent in 2005 also asked lead consultants to express their opinion regarding the need for emergency access to adolescent psychiatric beds. This included an opportunity to give free-text responses.

Results

The number of adolescent psychiatric units in England and Wales increased from 64 in 2000 to 79 in 2005. We received completed questionnaires from 51 units (80% of the total) in 2000 and from 70 (89% of the total) in 2005. Of the units that responded, 80% were managed by the NHS at both time points. The size of units that responded ranged between 6 and 36 beds in 2000 (mean 12.4) and between 4 and 60 beds in 2005 (mean 14.0). Catchment area sizes also ranged widely, from 0.56 million to 5.5 million in 2000 (mean 2.0 million) and 0.2 million to 5 million in 2005 (mean 1.6 million).

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Emergency admissions

The number of units with dedicated emergency admission beds more than doubled from 6 (12% of units) in 2000 to 16 (23% of units) in 2005. However, the total number of units that could never admit a young person at short notice also increased, from 11 to 24. Even allowing for the increase in the total number of units, this meant that a higher proportion of all units were unable to accept urgent admissions at any time in 2005 than had been the case in 2000 (34% *v.* 22%). In 2005, 39 units (56% of respondents) could never admit a patient out of hours, that is between 5 p.m. and 9 a.m. or at weekends. Consistent with these findings, the consultants estimated that a mean of 24% of all young people referred for immediate admission were actually offered this. This had not changed substantially since 2000, when the mean was 28%.

Of the total number of respondents 26 units (37%) without dedicated emergency beds in 2005 reported that they had a strategy to ensure that there was alternative provision for young people who might need urgent admission. These alternatives included: adult mental health wards (16 units); paediatric wards (4 units); acute admission adolescent units (4 units); adolescent mental health units in the independent sector (2 units); and an 'outreach service' (2 units).

The reasons given for emergency admission were very similar at both time points. In 2000 the reasons were psychosis 46%, self-harm 35% and other 19%; in 2005 they were psychosis 46%, self-harm 41% and other 13%. Where specified, most of the other reasons comprised eating disorders.

Opinions of lead consultants regarding emergency admissions

It was the opinion of 61 lead consultants (87%) that the NHS should provide or commission 24-hour (emergency) access to specialist adolescent in-patient mental health services. Free-text comments reflected a range of views. Some consultants thought that emergency admission beds should be provided separately from other in-patient services and should include intensive care facilities. Others highlighted the practical problems associated with emergency provision, including difficulties posed by recruitment and retention of staff. Some expressed concerns that a system that bypassed the usual pre-admission assessment process might be misused by those making referrals and that it might lead, for example, to the inappropriate admission of young people with behavioural problems but without mental illness.

Although this was a minority view, several consultants questioned the need for emergency admissions and suggested that all admissions should be planned, or that crises should be managed in the community with crisis intervention teams. A number of consultants, whose units did not offer emergency admissions, thought that such admissions were needed only rarely in practice. They suggested that social care issues were usually behind requests for urgent admission and that these cases were better dealt with by other agencies.

Discussion

The change in the definition of an urgent admission in the two surveys, from 'the ability to admit emergencies' in 2000 to 'the ability to admit within 1 working day' in 2005, might have had some effect on the results. However, it would not have influenced the broad finding that, 1 year after the publication of the National Service Framework, the great majority of adolescent psychiatric units in England and Wales still could not guarantee to offer 24-hour emergency admission. Consistent with this, the lead consultants who responded to the survey estimated that three-quarters of young people referred for urgent admission are turned away.

The majority of lead consultants in in-patient adolescent units think that emergency beds are required. However, others question this, pointing out the risks of unplanned admissions and suggesting that alternative types of provision might better meet the needs of some young people who are referred in this way. These alternatives include other forms of in-patient service such as adult psychiatric and paediatric wards. There is good evidence that a large number of young people with primary mental health diagnoses do get admitted to such wards (Gowers *et al*, 2001; Worrall *et al*, 2004). Other alternatives to emergency admission to an adolescent psychiatric unit may be admission to units managed by social services and community-based outreach teams. The truth is, probably, that all of these types of service are required. The challenge is to make this range of provision available locally, across England and Wales.

Units which cater for both emergency and planned admissions face the problem that these two groups of young people often have very different needs. For example, a young person admitted acutely with a psychotic disorder might require containment in a low-stimulus environment, where treatment decisions are made on their behalf. In contrast, a young person with an eating disorder, or with serious self-harming behaviour, is likely to require an intensive structured therapeutic programme and may be required to assume high levels of motivation and responsibility for the therapeutic process.

We therefore propose that a comprehensive, local service requires adequate and separate provision of acute and planned in-patient services (Gowers & Cotgrove, 2003). This would allow for young people in crisis to be managed safely by admitting them to a dedicated acute unit. Separate in-patient services would be needed for the planned admission of those who are able to take higher levels of responsibility for their involvement in the therapeutic work. This model has been successfully adopted in some areas, for example in parts of London and Birmingham, but is absent in most of the other parts of the country. Equity of access to emergency beds, their separation from planned admission units and the provision of the range of alternative emergency services can only be achieved by a coherent and unified process for the commissioning of adolescent Tier 4 child and adolescent mental health services.

The evidence from research about outcomes of in-patient care sounds a note of caution. Better outcomes

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are achieved when young people and their families are engaged with the service and motivated to take part in the treatment offered, and when the admission is planned (Green *et al*, 2001). These conditions are difficult to fulfil for an emergency admission. It is important therefore that unplanned admissions do not become the norm in adolescent psychiatry, as they are in adult mental health services in the UK.

In conclusion, despite an increase in dedicated emergency admission beds there has been little change in the capacity of adolescent units across England and Wales to admit young people in an emergency. The majority of young people assessed to require immediate admission do not receive it. We argue that the solution should be the provision of specialist acute admission units for young people.

Declaration of interest

None.

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Olanzapine and risperidone prescriptions for people with dementia in care

AIMS AND METHOD

To determine what has happened to care home residents with dementia who were on risperidone or olanzapine prior to the Committee on the Safety of Medicines (CSM) guidance, and to compare with a previous audit of the practice within a community mental health team (CMHT) for older people. Residents with dementia were identified from 10 randomly selected care homes in Leicestershire, and prescriptions before and 9 months after the CSM guidance were assessed. Carers were interviewed to determine who was reviewing residents and how often a review occurred.

RESULTS

In total, 330 residents' medication charts were assessed; 164 (50%) had documentation which identified them as having a dementia; 75 of these residents with dementia (46%) were on an antipsychotic at some time during the audit period. Before CSM advice 69% (37 out of 54) of the antipsychotics prescribed to residents with dementia were either risperidone or olanzapine; this reduced to 39% (19 out of 49) after the CSM advice. Out of those who continued on risperidone or olanzapine, the majority were under GP care only (15 out of 19) and overwhelmingly seen on an as-required basis and infrequently. In two-thirds of cases the prescriptions for antipsychotics were for behavioural and psychological symptoms of dementia. Compared with the CMHT for older people, primary care was less successful at withdrawing risperidone or olanzapine.

CLINICAL IMPLICATIONS

Further research is needed to clarify what approach would be most acceptable and cost-effective to assist British GPs in the management of this patient population.

At some point during their illness 90% of patients with dementia develop a behavioural disturbance (Ballard & Oyebode, 1995). These behavioural and psychological signs and symptoms of dementia (Finkel *et al*, 1996) are varied in presentation and aetiology, and encompass three syndromes, two behavioural (overactivity and