Emergency admissions to a regional adolescent unit: piloting a new service

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Adolescent in-patient units within the NHS generally provide a broad range of services to large catchment areas and populations. 'Pine Lodge' Young People's Centre in Chester has piloted a new emergency admission service which it has run in conjunction with its existing treatment service. This paper sets out to discuss the potential difficulties in providing such a service in the setting of a general purpose adolescent unit; describe the specification of the piloted emergency service; and present the results of monitoring its use and efficacy during the first six months.

For at least 30 years it has been recognised that there is a need for specialist in-patient care to be provided for adolescents with mental health problems. In the 1960s a large number of in-patient units were set up to cater for this need, but there was no consistent format for this service with individual units offering idiosyncratic operational policies (Parry-Jones, 1995). In 1986 *Bridges over Troubled Waters* (Health Advisory Service, 1986) was published which attempted to give broad guidelines on psychiatric services needed for adolescents. Much of this report is still pertinent today, but the momentum to implement change is now coming from different sources, i.e. political pressures to increase care in the community, and financial pressures from changes in service funding following the restructuring of NHS management (Jaffa, 1995).

The net result of these pressures is that adolescent units find themselves being pushed in different directions. With the trend to reduce bed numbers there is increasing demand that adolescent units should provide a 'general purpose' service (Parry-Jones, 1995). On the other hand, the most recent Health Advisory Service document, *Together We Stand* (1995) along with the Department of Health and Department for Education (1995) *A Handbook on Child and Adolescent Mental Health* suggest a four tier service, with in-patient adolescent mental health services placed in the fourth tier, along with highly specialised services such as eating disorder units, forensic units and neuropsychiatric units. However, without separate provision, district child and adolescent consultants will continue to look to their regional 'general purpose' in-patient unit to provide these specialist services. The debate on how to reconcile the need for general purpose in-patient units and the need for specialist in-patient and out-patient services, with limited resources, will continue.

At 'Pine Lodge' Young People's Centre (YPC) in Chester we have tried to maintain the role of a general purpose treatment unit, although in addition we encourage referrals of adolescents with eating disorders as we have a good success rate with this client group. However, we have resisted pressures to also provide a forensic service and neuropsychiatric service under the same roof, and support the Health Advisory Service documents (1986, 1995) suggesting that these are provided separately.

The issue of emergency admissions to adolescent in-patient units is not one covered in the above documents. Whether emergencies are dealt with locally by specialist child and adolescent mental health services using general hospitals and social services to provide emergency residential facilities, or whether this service should be provided at a tertiary level by the regional general purpose adolescent unit became an issue much debated in Merseyside during 1994. The conclusion was that an emergency service should be provided by the YPC and it is the piloting of this service which makes up the main subject of this paper.

The pressure for providing this service was purchaser driven. There was no quantitative evidence of the level of need for such a service but one or two examples of adolescents having to be admitted to adult psychiatric wards, when no beds were available at the YPC led to the request that we designate two of our 10 beds to meet the need for possible emergency admissions.

Initially, we met this request with some reluctance, believing the need for such a service was questionable. Previously, admissions were

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made on a planned basis, after an assessment of needs had been made and aims for admission agreed with the family/adolescent. Our philosophy has always been one of seeking appropriate alternatives to in-patient treatment wherever possible.

The case for an emergency service to admit adolescents who have deliberately self-harmed was the one most commonly cited, but evidence for the efficacy of this is sparse. It may be necessary to give an adolescent 'asylum' from the family (Cotgrove *et al*, 1995) but there are alternatives to an adolescent in-patient unit for this, for example, a short stay on a paediatric ward, or if long-term care away from home is needed, social services may be appropriate to provide this. However, the purchaser believed that the level of safety and psychiatric input provided by a paediatric ward was inadequate, and more appropriately provided by an adolescent unit. Particular concern was expressed about a case who needed close observation on a paediatric ward over a weekend, when neither a bed nor an assessment was available from the YPC.

Given our limited resources, we held a different view. While accepting the need to be able to admit adolescents with psychiatric illness or severe anorexia nervosa as a matter of urgency, we thought that such cases could normally be contained in the community or in extreme cases in a paediatric, medical or adult psychiatric ward until a treatment bed at the YPC became available. In addition, we feared the consequences of running both a treatment and an emergency service in a small ten-bedded unit would include: (a) disruption to the therapeutic programme, reducing treatment efficacy, (b) the potential loss of a containing, safe and secure environment, (c) longer waiting list for treatment places as a result of a reduction in treatment bed numbers by 20%, (d) the possibility that emergency referrals could queue-jump those on the waiting list, and (e) loss of planning prior to admission with the advantages of engagement and sharing in therapeutic aims which this allows for. In short, we were keen to protect the treatment philosophy of our general purpose unit.

We were aware that other adolescent units have tried running emergency beds and admissions within 24 hours. However, we had reports from one unit that the emergency beds often remained full and therefore unavailable, and from another unit that they had to withdraw their 24-hour response time as the service was being misused by referrers.

Among our referrers, there were mixed views. Some believed that all emergencies could be contained within district services, while others expressed the view that there was a need for a regional emergency admission service. Few thought this should be provided within existing resources, fearing that such service would detract from an already stretched regional in-patient treatment service. (Chester YPC with 10 beds is the only NHS adolescent in-patient resource serving a catchment area population of approximately 2.5 million.) The result of this debate, with the mixed views expressed, was to try it and see! We agreed to pilot the scheme for six months while closely monitoring its use.

Service specification

We designed an operational policy aimed at balancing the need for an effective service, while reducing the risk of some of the negative consequences of running an emergency admission service alongside our in-patient treatment service.

The service is available seven days a week on a 24-hour basis. Referrals for emergency admission are assessed within 24 hours by a senior member of the YPC staff. The population served is adolescents aged 13–18 years inclusive and referrals are accepted from district child and family psychiatric services working within the six health authorities making up the former Mersey Region (population 2.5 million). We only accept referrals after the local services have made their own assessment and consider emergency admission appropriate. We then carry out our assessment in the locality of the referral in collaboration with a member of the local child and family team so they can retain responsibility and continue their involvement if the adolescent is not admitted.

The problems appropriate for emergency admission are defined as those adolescents suffering with an acute psychiatric disturbance, including psychosis or life-threatening behaviour, where it is unsafe to continue management in the community. In order to maintain the availability of emergency beds a maximum time of three weeks is placed on each admission. If a longer placement for treatment is needed, then a transfer to one of the treatment beds takes place when available. Weekly meetings to review the case are organised to which the referrer is encouraged to attend and other relevant professionals invited. During their admission the adolescent joins the general therapeutic programme within the centre which includes group therapy, art and drama therapy, social and living skills programmes, education sessions, etc. However, the main emphasis in such a short admission is to offer a containing, safe environment and make an assessment for future therapeutic needs.

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The study

The aim of this study was to monitor the activity of the emergency service and review its efficacy.

Basic demographic and clinical information was collected from the referrer using a standardised form at the time of the initial telephone referral. Further clinical information was gathered from our assessment. The YPC staff team audit the emergency referrals in a monthly team meeting. Discussion of each case includes rating the appropriateness of the referral and consideration of alternatives to admission to the YPC. One month after an emergency referral, a questionnaire is sent to the referrer seeking their views of the service provided.

Findings

In the first six months of this service we received 21 referrals. These referrals came from five of the six districts with whom we have contracts (see Table 1). Seventeen assessments were carried out. Three of those initially referred as emergencies were agreed on further discussion with the referrer not to be treated as an emergency, and one arranged assessment was cancelled at the last minute by the family. Fourteen of the 17 referrals were assessed within 24 hours, two were delayed because there were no beds and one was an in-patient on a paediatric ward and it was agreed to delay our assessment until she was medically stable. There were eight admissions.

The reasons for non-admission following an emergency assessment were as follows:

(a) It was agreed between referrer and the YPC that emergency admission was not appropriate after all (*n*=4).
(b) It was agreed with the referrer that admission would be appropriate, but the client or their family were refusing admission and there were not sufficient grounds for compulsory admission (*n*=3).
(c) Referrals were received when both emergency beds were occupied and so immediate admission was not possible (*n*=2).

Table 1. Referrals by district (February to July 1995)

District	Number	Assessments	Admissions
Liverpool (including South Sefton)	8	5	1
S. Cheshire	7	6	4
N. Cheshire	3	3	1
Southport (North Sefton)	2	2	1
Wirral	1	1	1
St Helens & Knowsley	0	0	0
TOTAL	21	17	8

Admission was never refused by the YPC as long as the referrer remained convinced that this was appropriate, and a bed was available.

Duration of admission

The duration of admission ranged from one and a half to three weeks.

Bed occupancy

Mean bed occupancy was approximately 35%. The total period when both beds were occupied was three weeks out of 26.

Outcome of admission (n=8)

Five were discharged back to the care of their referrer, two were admitted into treatment beds at the YPC, and one was offered further in-patient treatment at the YPC, but then moved away from the area.

Qualitative measures

Reason for emergency referral In 17 of the 21 referrals the request for an emergency admission was because of a risk of deliberate self-harm. For three there was some evidence of psychosis, with associated fears for the safety of the adolescent. For the remaining one, the referral was made by the district service on the instigation of the child's mother, who was extremely anxious. In all cases there were additional complicating factors, for example, family difficulties, relationship problems and history of abuse.

YPC staff's rating of appropriateness of emergency referral The appropriateness of the emergency referral was rated after team discussion at our monthly service review, according to a rating scale of 0–5, where 0 is not appropriate and 5 is very appropriate. Only four of the 21 referrals rated 3 or above for appropriateness. In our opinion, with the benefit (and luxury) of hindsight, 14 of the 21 would have been more appropriately dealt with elsewhere, for example, with intensive out-patient work or in social services care if it was available. However, in several of these cases it was clear that the YPC service was more accessible than the alternatives. In 11 cases we thought referral for an assessment for longer-term treatment at the YPC would have been appropriate, but we did not think this was urgent or an emergency.

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Benefits to the client and the referrer

This information was gathered by feedback from the referrer and from the YPC team at the service review meeting. By and large, three possible benefits to the client and the referrer emerged: the offer of safety to the client if they were admitted; a second opinion, including recommendations for future management, within 24 hours; and immediate support for the referrer in managing anxiety-provoking cases.

Feedback from referrer

Sixty-five per cent (11 out of 17 assessments) of our questionnaires to referrers were returned. General themes from the responses suggest the following aspects of our service are good: ease of making emergency referral (n=11); YPC speed of action (n=11); and communication of information from the YPC with regard to the case (n=10).

In terms of overall satisfaction of the outcome of the emergency assessment and admission the comments were more mixed. Six were satisfied with the outcome, three were not satisfied and two were unsure. Of those that were admitted it appears that those referrers who attended at least one of our weekly reviews were generally satisfied with the outcome (4 out of 5), whereas the one who did not attend was not satisfied. However, these numbers are too small to draw clear conclusions from this data.

Effect of emergency admissions on treatment cases

Undoubtedly emergency admissions can be disruptive to the YPC's regular therapeutic programme. However, our planning to reduce this disruption to a minimum was effective and generally emergency admissions were infrequent enough to be only a little more disruptive than a planned admission.

We have continued to keep our waiting list down over the six months, despite an effective loss in beds, by increasing our turnover in planned admissions. This may have resulted in some youngsters being discharged sooner than would be ideal, but the effects on long-term outcome are unknown. It is likely that some referrals who previously may have been admitted to a treatment bed are being picked up by the emergency service, thus reducing the demand on the treatment beds.

Comment

Overall, the results we have from the analysis of this new service are mixed. The less positive aspects will be discussed first.

In the first two months of the service we received 12 referrals and admitted five. The effects of this on both staff and residents at the YPC was quite disruptive, at times reducing the sense of safety and containment which is vital in a therapeutic residential service. However, in the following four months we only received a further nine referrals with just three admissions, which was less disruptive. This latter pattern has continued in the months following the pilot study.

The fact that YPC staff only considered four out of the 21 referrals were appropriate for an emergency admission, and that some 14 of these referrals could have been dealt with better elsewhere by existing services, raises some serious questions. In some cases, there is a significant difference in the YPC staff's assessment of need and the assessment of the professionals in the district service. It may, therefore, be worthwhile developing a standardised assessment, including a risk assessment, in collaboration between the YPC and district services in an attempt to bridge this gap. It also raises the question of the ease (or lack of it) of emergency access to other resources, such as social services care and intensive out-patient therapy, when resources are limited. Other alternatives to in-patient admission, such as day units, are virtually non-existent throughout most of the region.

The relatively infrequent use of the service during the last four months of the pilot, draws into question the cost-effectiveness of keeping two beds available and largely empty (65% of the time) when there are only 10 beds serving all the in-patient needs of the six districts in the former Mersey Region.

However, in addition to the YPC being able to admit genuine emergencies, there are some very positive aspects to the service which we had not fully anticipated.

We are 'there' and available, even if not used. In itself, that can provide a feeling of containment and support for professionals working in district services, knowing that they have usually got the option of an immediate admission to the YPC if their most difficult cases develop into crises. In this sense we act as an 'insurance policy', hopefully rarely called upon, but reassuring to have.

The service is able to offer a very rapid second opinion. Professionals working in district services can at times feel quite isolated and to have access to an experienced clinician for an urgent second opinion can be very helpful with some of the most difficult cases.

As a result of this pilot, despite our reservations, we recommended to the purchaser that we continue to provide our emergency service for a further six months, and then jointly review our

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findings again. Although we thought the majority of referrals to the service did not require emergency admission, they were all, without exception, worrying cases. In most instances the referrer found our service helpful.

In terms of our unit philosophy, we have been able to continue to provide the general purpose treatment service as well as the new emergency service without either being significantly compromised.

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