Child Health Support Group

Inpatient Working Group – Psychiatric Inpatient Services
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Inpatient Working Group – Psychiatric Inpatient Services for Children and Young People in Scotland: A Way Forward

December 2004
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CHAPTER ONE:
INTRODUCTION

1.1 In Spring 2003, the Child Health Support Group established a multi-disciplinary and multi-agency Child and Adolescent Mental Health Development Group to lead work to promote children and young people’s mental health in Scotland, and ensure better delivery of mental health services for those who need them. The major focus is implementation of the recommendations made in the Scottish Needs Assessment Programme (SNAP) report on Child and Adolescent Mental Health in Scotland\(^1\), published in March 2003.

1.2 The SNAP report highlighted an urgent need for investment in and expansion of psychiatric inpatient services for children and young people in Scotland. The report recommended that this issue could not be addressed adequately by individual NHS Boards and required national consideration to prevent continuing erosion of these specialist services.

1.3 At around the same time, the Mental Health (Care and Treatment) (Scotland) Act 2003 was passed. The Act includes a new duty on NHS Boards to provide services and accommodation that are suitable to meet the needs of young people under the age of 18. This provision will come into force with effect from 1st April 2005.

1.4 Psychiatric inpatient facilities are currently provided for children at one unit, in Glasgow (9 places), and for young people at three units, in Dundee, Edinburgh and Glasgow (7, 12 and 16 places respectively). As is evidenced in this report, this specialist provision is under increasing pressure and is insufficient to meet need.

1.5 Within that context, the CAMH Development Group established a short-life working group to give detailed consideration to a national strategic approach to the provision of psychiatric inpatient services for children and young people in Scotland, including a model for regional commissioning of those services. The Inpatient Working Group was established in August 2003 with clinical, nursing, teaching, social work, NHS Board and Regional Planning Group representation from across Scotland and from community and inpatient mental health services for children and young people (membership attached in Appendix 2). Its remit was to:

- Consider the optimum geographical configuration of psychiatric inpatient services for children and young people across Scotland.
- Consider the overall optimum configuration of psychiatric inpatient services for children and young people, including the need and scope for specialisation within units.
- Develop a model for regional commissioning of psychiatric inpatient provision and associated intensive outreach services for children and young people.
- Consider the function of inpatient provision within the context of a continuum of care.

1.6 The Group recognises the need for national consideration of specialist learning disability and forensic psychiatry services for children and young people in Scotland. The needs of these children and young people cannot generally be met within generic psychiatric inpatient units given the specific expertise and peer environment that they require. It was not feasible within the timescale available for the Inpatient Working Group to consider these services. We are, however, aware that a new national Forensic Mental Health Services Managed Care Network (MCN) has been established, and that a specific working group is being convened within

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that MCN to consider services for children and young people. We welcome this. Services for children and young people with a dual diagnosis of learning disability and mental illness will also require national consideration, and the Child Health Support Group proposes to address this in its future work programme.

1.7 The Inpatient Working Group’s work fits within the broader spectrum of children and young people’s mental health and the work being taken forward by the CAMH Development Group. It also links closely with the work of the Child and Adolescent Mental Health Workforce Group, which is considering workforce planning and development, not just within the inpatient sector, but across the range of sectors in which children and young people’s mental health and wellbeing is supported.

1.8 The Inpatient Working Group has met on ten occasions. Its findings and recommendations are set out in this report, which has been endorsed by the Child Health Support Group.

The way forward

1.9 The Inpatient Working Group was established as a short-life group to develop recommendations, and has now dissolved. However, developments are already in train to ensure that the recommendations presented in this report are taken forward.

1.10 The Yorkhill Division of NHS Greater Glasgow is preparing an application to NHS National Services for national designation of the 9-place children’s psychiatric inpatient unit at Yorkhill Hospital in Glasgow. Clinicians are also planning a proposal to establish a national Managed Clinical Network involving Tier 3 and 4 psychiatric services for children.

1.11 In preliminary discussions, the Chairs of the three Regional Planning Groups have indicated their support for this approach for the children’s psychiatric inpatient unit. They have also agreed that a regional approach is required to secure the future of psychiatric inpatient services for young people, with inter-regional co-operation. They have offered leadership in taking this forward. This first phase will be a cost and feasibility analysis.

1.12 Concurrently, Penumbra will be seeking the views of children and young people on the recommendations presented in this report. This work has been commissioned by the National Project for Children and Young People’s Mental Health and is linked to similar consultation with children and young people on Children and Young People’s Mental Health: A Framework for Promotion, Prevention and Care. The Regional Planning Groups will need to consider the outcomes of the Penumbra consultation with children and young people in taking implementation of this report forward.

1.13 We can be optimistic that the work put into developing this report will lead to positive change for the delivery of psychiatric inpatient service delivery, and that children, young people, families, friends and carers will in future experience the benefits.

Bruce Dickie
Chair, Inpatient Working Group

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3 Specialist services for severe, complex or persistent disorders – as defined in Together We Stand: Thematic Review of the Commissioning, Role and Management of Child and Adolescent Mental Health Services, NHS Health Advisory Service (1995)

CHAPTER TWO: CURRENT POSITION

2.1 The SNAP report states that “Current indications are that investment in and expansion of that highly specialised sector is urgently needed. Young people should be treated in the kind of developmentally appropriate settings which the specialist child & adolescent unit offers, but they are often unable to access them at present, because of the limited bed numbers”.

2.2 The National Mental Health Services Assessment similarly highlighted that “It is clear that current child and adolescent psychiatric service capacity is insufficient to meet existing need”.

Provision

2.3 The number of NHS psychiatric inpatient places for both children (up to the age of 12) and young people (from the age of 12 up to and including 17 years) has declined significantly in Scotland over the last ten years:

<table>
<thead>
<tr>
<th>Year</th>
<th>For Children</th>
<th>For Young People</th>
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<tbody>
<tr>
<td>1994</td>
<td>58</td>
<td>67</td>
</tr>
<tr>
<td>1996</td>
<td>36</td>
<td>55</td>
</tr>
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<td>1998</td>
<td>30</td>
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<td>2000</td>
<td>23</td>
<td>40</td>
</tr>
<tr>
<td>2002</td>
<td>16</td>
<td>43</td>
</tr>
<tr>
<td>2004</td>
<td>9</td>
<td>35</td>
</tr>
</tbody>
</table>

2.4 The sole remaining NHS psychiatric inpatient unit for children in Scotland is at the Royal Hospital for Sick Children, Yorkhill, in Glasgow. There are currently NHS psychiatric inpatient units for young people in Glasgow (16 places), Edinburgh (12 places) and Dundee (7 places). During the period of the Inpatient Working Group’s work, the Dundee unit was temporarily closed for several months due to staff shortages, effectively reducing the total available places for young people in Scotland to 28 for that period.

2.5 The decline in the number of NHS psychiatric inpatient places for children and young people has occurred for a number of complex reasons. Significantly, the decline has occurred during a period when a succession of needs assessment reports have indicated the need for more, rather than fewer beds. The factors that have led to this decline include:

- A significant increase in specialist community mental health services for children and young people. At a local level in some NHS Boards, this expansion has often been achieved by re-focusing investment from inpatient to community services.
- Smaller and more isolated units became unsustainable. A significant reason for this has been difficulties in retaining and recruiting staff. The expansion of community services provided alternative, often more attractive and more senior, posts for inpatient unit staff.

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• Changes in clinical practice led to some decrease in demand for inpatient provision. This is particularly the case for children below the age of 12 years.

• Only more recently has strategic regional planning started to develop. For example, in the West of Scotland, strategic decisions were made to expand the psychiatric inpatient units for children and young people in Glasgow to compensate for the closure of units in Dumfries.

• Even with the benefits of strategic planning, the larger number of inpatient units could not easily have been replaced by the expansion of more centralised units. The skilled child and adolescent mental health workforce required is still small in number. Only a small proportion of those employed in closing units would be able to relocate.

• As with many other mental health services for children and young people, the pressures of service delivery have meant that liaison and training for professionals in specialist community services have been relatively under-resourced. As a consequence, referrers have not fully understood the place of inpatient care and the circumstances meriting referral.

The independent sector

2.6 There are currently two independent inpatient services in Scotland which cater for young people. The Priory in Glasgow is a 42 bed general adult psychiatric hospital which admits patients from age 16 on an informal basis to either a general adult psychiatry or adult eating disorders unit. The Huntercombe Group has recently opened a 22 bed eating disorder inpatient unit in West Lothian, which caters for patients aged between 11 and 30 years. There is no subdivision within the unit to cater for different age groups.

Activity

2.7 Activity at the children’s unit at Yorkhill in Glasgow has remained at a steady level with some increase in use over the period since current commissioning arrangements commenced. Over the three years to December 2003, occupancy levels have averaged about 62%, but this figure conceals the actual usage of places. For the nine months between April and December 2003, average usage was approximately 8 placements – 5 inpatients and 3 day cases. For only 8% of this period did utilisation of placement capacity fall below 77% (below 7 placements). Generally, reduced occupancy reflects clinical pressures from individual cases, leading to reduced capacity for further admissions despite a technical availability of places. There is a waiting list for admission to the Yorkhill children’s unit, with at least two patients generally awaiting admission at any one time. During the financial years 2002-2004, there were only three weeks during which no children were awaiting admission.

2.8 Only partial data is available on the number of admissions of young people to mental health specialties in Scottish hospitals for 1999-2001. This is attached at Appendix 3. Though activity data is in some respects useful, the Group would stress that the number of admissions can only reflect the maximum capacity of available provision, and does not, therefore, necessarily reflect the extent of true need.
2.9 The National Inpatient Forum advises that all three of the psychiatric inpatient units for young people in Scotland are currently unable to provide sufficient places to meet demand; units are often full with waiting lists, and their capacity to deal with emergencies is very limited. A child or young person's condition can deteriorate whilst they await admission, and there is evidence that many requiring psychiatric inpatient care are admitted to:

- Adult psychiatric wards – where developmental and family needs are less likely to be met
- Paediatric wards – where mental health needs are less likely to be met
- Adult medical wards – where neither developmental nor mental health needs are likely to be met.

2.10 Recent activity for the existing 16-place Gartnavel young people's psychiatric inpatient unit in Glasgow indicates high levels of clinical observation and bed occupancy, with occupancy at 101% in 2003/04. As at September 2004, there was a six week waiting list for urgent admission to the Gartnavel unit, with no ability to accommodate planned admissions. Staff have advised that all emergency admissions are currently admitted to an adult or paediatric ward in the first instance.

2.11 Between April 2002 and March 2004 average inpatient occupancy at the Edinburgh young people's psychiatric inpatient unit was 81% (range 61.3% – 95.4%). However, as for the Yorkhill children’s unit in Glasgow, occupancy figures do not reflect the frequently reduced capacity of the unit to accept further admissions. For a significant proportion of this period, two places were funded by and designated for sole use by NHS Borders or NHS Forth Valley, and admissions could not be accepted to these places from other Boards. This arrangement has since changed. The total occupancy of the unit would have been considerably higher had these two beds been available for use by other NHS Boards. Over the same two year period, there were 65 admissions of under 18 year olds to adult psychiatry facilities in Lothian. The majority of these admissions would have been made directly to the Edinburgh young people's psychiatric inpatient unit had capacity been available.

2.12 The ability of both the Edinburgh and Dundee young people's psychiatric inpatient units to accept admissions has been significantly affected by staff shortages occurring in conjunction with clinical pressures from individual cases (e.g. those requiring intensive observation and a high staff:patient ratio). The Edinburgh young people's psychiatric inpatient unit was forced to close to all new admissions between November 2003 and January 2004 as a result of such pressures. As indicated previously, the Dundee young people's psychiatric inpatient unit was similarly forced to close temporarily to all admissions between July 2003 and January 2004. This clearly affects occupancy statistics.

2.13 Prior to the temporary closure of the young people's psychiatric inpatient unit in Dundee, occupancy was between 80% and 90%. Since January 2004, following successful recruitment of newly trained staff, occupancy levels have been approximately 70%. This has reflected the need to allow staff to gain work-based experience in caring and managing the complex and challenging needs of these patients. Occupancy is expected to increase in line with staff experience and confidence.

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5 See Appendix 6
2.14 In its 2003 annual report, the Mental Welfare Commission for Scotland noted that it “has been increasingly concerned by the shortfall in availability of age-appropriate care for young people admitted to hospital; during the past year we have been made aware of many young people receiving care in inappropriate settings”.

2.15 From October 2002, the Mental Welfare Commission asked all Primary Care NHS Trusts in Scotland to notify them of all admissions of young people under the age of 16 to adult wards, including informal admissions. In its most recent report, the Mental Welfare Commission advises that:

“Between March 2003 and April 2004, we identified 25 formal and informal admissions of young people under 16 (23 individuals: 15 girls, 8 boys) to adult mental health wards across the country. In the case of non-detained patients, we rely on medical mental health services to notify us about these admissions, and know that they do not always do so; therefore these numbers are probably an under-estimate.”

2.16 The Commission reports that there were 106 formal detentions of under 18 year olds to adult wards in the same period. There had been 93 such detentions in the previous year.

2.17 A recent study in central Scotland identified 103 children and young people (between their 5th and 18th birthday) with early onset psychosis, giving a three-year prevalence of 6 per 100,000 general population. Half had become ill before reaching school leaving age and 80% were admitted first to an adult ward, some under the Mental Health (Scotland) Act 1984. Of 53 cases assessed in detail, only 31% were rated as having had all their needs fully met; 20% had five or more unmet needs, representing a serious failure in care. The authors of the study conclude that the results reflect the substantial under-provision of age-appropriate inpatient treatment facilities for children and young people in Scotland.
CHAPTER THREE:  
THE NEED FOR PSYCHIATRIC INPATIENT PROVISION

3.1 Intensive outreach approaches, such as those developed in Dumfries and Galloway, Fife and the Borders, are extremely valuable. They enhance the range of care that can be provided and enable greater flexibility when determining the most appropriate treatment for an individual. They also allow children and young people to remain at home and within their communities. Relative to the significantly large numbers of children and young people who are appropriately referred to specialist child and adolescent mental health services, there are few who will require inpatient care. However, there are some children and young people who, despite a fully comprehensive community mental health service, may require an intensity of treatment which can only be provided on an inpatient basis.

3.2 There are times when the best resourced community outreach teams cannot provide the level of care and supervision required by the most seriously ill children and young people. These are by definition those children and young people least able to cope with the confusion, and at times trauma, of inappropriate placement and ad hoc care packages.

3.3 Some conditions are of such severity, produce behaviour or emotions of such type or intensity, or generate disability to the child and/or their family of such a degree, that inpatient admission is essential. In general terms, the conditions which give rise to consideration of inpatient care and treatment include: psychoses such as bipolar disorder and schizophrenia (which are relatively rare in children, but of rising incidence in adolescence); severe depressive disorder; life-threatening or intractable eating disorders (which are increasing in children and young people\(^9\)); severe psychosomatic conditions; other severe disorders (such as incapacitating obsessive-compulsive disorder and intractable phobias); and a variety of conditions which may involve neurological problems such as epilepsy, or other physical disorders such as diabetes mellitus or cystic fibrosis, in association with severe emotional disorder\(^{10}\). Children under the age of 12 are more likely to be admitted for assessment where complex neurodevelopmental issues complicate emotional and/or behavioural problems.

3.4 The children and young people who are admitted to psychiatric inpatient services have complex needs, attract more than one diagnosis, and require careful attention to ensure that the impact of their illnesses across all levels of their development is minimised. An “intensive care” model of care is provided for these children and young people, who suffer from the most severe mental disorders in Scotland.

3.5 Psychiatric inpatient units with attached day units can act as resource centres offering a variety of styles of intervention to a wide surrounding area. When working with assertive community outreach services (such as those developed in Dumfries and Galloway, Fife and the Borders), highly focused interventions can be provided to meet the well-assessed, carefully considered and monitored needs of individual patients.

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\(^{10}\) *Together We Stand: The Commissioning, Role and Management of Child and Adolescent Mental Health Services*, The NHS Health Advisory Service (1995)
3.6 Inpatient and day patient facilities can not only be used to bring effective therapeutic leverage to bear on severe and otherwise intractable problems, but admission to them can also be considered as a strategic manoeuvre within more comprehensive therapeutic programmes. The staff within inpatient units have been trained to a high level of skill in dealing with the most severe disorders. These skills are valuable and can be used in consultation and training of staff in other mental health services for children and young people.

3.7 Networks of properly established assertive outreach services and well established psychiatric inpatient units are not alternative or competing models of care, but are components in a spectrum of intensive mental health care for children and young people.

Outcomes

3.8 A report prepared for the NHS Health Boards General Managers Group in 1997 discussed both the published evidence on effectiveness of treatment on an inpatient basis and reviewed the available evidence on outcome of treatment in Scottish psychiatric inpatient units for children and young people. One of the only prospective studies of inpatient treatment of young people published by that time was a collaborative study involving three Scottish units and one in England. That study demonstrated that young people treated on an inpatient basis made symptomatic improvement, and discussed the range of factors which had a bearing on treatment outcomes.

3.9 The report also considered the evidence from the then current Scottish Child and Adolescent Psychiatry Audit Study, which had recorded almost 9,000 consecutive referrals to Scottish child and adolescent mental health services. This demonstrated two very important features about the population of children and young people who were treated as inpatients. First of all, it made clear that that those young people who were admitted to psychiatric inpatient care were the most disturbed of those referred to child and adolescent mental health services. Secondly, it highlighted, as the early onset psychosis study subsequently established in some detail, that many children and young people leave inpatient care with continuing difficulties. However, taking the 371 young inpatients included in the audit as a group, the clear trend was towards improved global outcome.

3.10 More recently, the Children and Young Person’s Evaluation (CHYPIE) study of eight psychiatric inpatient units for children and young people in England has demonstrated the value of admission for children and young people and the outcomes arising from admission. The CHYPIE study is the most comprehensive study so far undertaken internationally of the process and outcomes of inpatient treatment for children and young people with health economic evaluation.

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11 Commissioning Inpatient Psychiatric Services For Children And Young People In Scotland, Dr Graham Bryce (1997) (Unpublished)


3.11 Initial indications from the CHYPIE study are that there is a real and measurable health gain from admission, with a clinically important improvement and health needs improvement across a range of domains. Examination of the process of treatment suggests that greater improvement is found with longer length of stay, when the patient develops a therapeutic alliance with his/her peers, when the patient and family hold an optimistic view of treatment, when there is better pre-admission family functioning, and when parents have a sense of control early on in the treatment process.

3.12 From a health economics perspective, children and young people are noted to use a wide range of services before and after admission, with similar cost implications. The average cost per admission is £24,000 for 116 days, with an associated cost to the family of £1,180. At follow up, 25% of patients had not been in receipt of any of the services recommended at discharge, with only 10% receiving full services recommended. Future intentions are to track the sample group over a number of years, and to investigate a range of components of treatment in more detail.

3.13 Data is not currently available on outcome comparisons between inpatient and outpatient care, and further research will be needed.
CHAPTER FOUR: DEFINING CAPACITY

4.1 The Group adopted the term “place” rather than “bed” to reflect the way in which care and treatment is provided by psychiatric inpatient units for children and young people. Children and young people should be with their families if at all possible and they are therefore supported to go home overnight wherever possible. These patients will be cared for within the unit from early morning until evening, and will require the full range of support and services provided by the unit. Even where a child or young person is not accommodated overnight, families may still use telephone support from nursing staff at night.

4.2 The CHYPIE study has shown that longer admission is associated with better outcomes, implying that giving a place up too soon can lead to poorer outcomes as measured with the Child Global Assessment Scale (CGAS)\(^\text{14}\).

Current practice and recommendations

4.3 In order to try to define the psychiatric inpatient capacity required for children and young people in Scotland, the Inpatient Working Group looked at available recommendations and current practice. Only the Royal College of Psychiatrists has published recommendations on this issue, in a report which is now some years old\(^\text{15}\). Since then, both the West of Scotland Adolescent Commissioning Consortium and NHS Lothian have recently made pragmatic decisions to increase the psychiatric inpatient capacity available for their populations of young people.

4.4 In the table below, current recommendations, practice and capacity are compared on the basis of places per 100,000 population of children and young people (using 2003 population data\(^\text{16}\)).

<table>
<thead>
<tr>
<th></th>
<th>Children</th>
<th>Young People</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Places</td>
<td>Per 100k population</td>
<td>Places</td>
</tr>
<tr>
<td>West of Scotland Planned Expansion(^\text{17})</td>
<td>–</td>
<td>–</td>
<td>24</td>
</tr>
<tr>
<td>Lothian Dedicated Places(^\text{18})</td>
<td>–</td>
<td>–</td>
<td>8</td>
</tr>
<tr>
<td>England Current Capacity(^\text{19})</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Scotland Current Capacity</td>
<td>9</td>
<td>1.3</td>
<td>35</td>
</tr>
</tbody>
</table>

\(^\text{†}\) Local population figures used for West of Scotland and Lothian respectively

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\(^{15}\) *Mental Health of the Nation: The Contribution of Psychiatry*, (Council Report CR16), Royal College of Psychiatrists (1992)


\(^{17}\) Planned expansion of psychiatric inpatient services for young people – see Appendix 4

\(^{18}\) Of the 12 places available in the Edinburgh adolescent psychiatric inpatient unit, 8 are currently designated for Lothian patients

\(^{19}\) Source: Child and Adolescent Mental Health Service Mapping 2003, Department of Health – [www.dur.ac.uk/camhs.mapping/](http://www.dur.ac.uk/camhs.mapping/)
Psychiatric inpatient services for children

4.5 The Inpatient Working Group does not recommend any further change to the size of children’s services, which are currently provided on a single site in the Department of Child & Family Psychiatry (DCFP) ward at the Royal Hospital for Sick Children, Yorkhill in Glasgow.

4.6 There is general agreement that children with psychiatric disorder are best treated within their family environment whenever possible. However, even where intensive provision is available, there are still occasions when assessment and treatment in a psychiatric inpatient unit may be in the child’s best interests.

4.7 Patterns of referral to the Yorkhill DCFP ward are by no means uniform and interpretation of referral patterns is complicated by the lack of intensive outreach and day service provision in some areas. At this stage, there is no clear case for increasing provision and the evidence from the Yorkhill DCFP ward supports the maintenance of the status quo. However, this will need to be kept under review.

Recommendation 1. The number of psychiatric inpatient places for children should be maintained and kept under review.

Psychiatric inpatient services for young people

4.8 There is no formal and accepted methodology for defining the psychiatric inpatient capacity required for children and young people. The Inpatient Working Group has therefore developed proposals for the young people’s psychiatric inpatient estate in Scotland on the basis of the model adopted by the West of Scotland Adolescent Commissioning Consortium in 200020 and using the best national data available21. The Group also made some comparison with the recommendations made by the Royal College of Psychiatrists in 1992 and with current provision in England, as identified by the Department of Health CAMHS mapping exercise. This was agreed to be the most practical approach, and had strong clinical support.

4.9 With the assistance of colleagues in NHS Information Services, the Inpatient Working Group attempted to identify the total number of admissions of 12-17 year olds to mental health specialties in Scottish hospitals by hospital and calendar year, and admissions to mental health specialties in Scottish hospitals by occupied bed days for the period 1999-2001 (presented in Appendix 3). This allowed the Group to review the number of 12-17 year olds who, given their age and need for admission, might have been considered appropriate for admission to a young people’s psychiatric inpatient unit were a place available. Converting admissions to occupied bed days22 gave some indication of the number of psychiatric inpatient places required for young people in Scotland. For the period 1999-2000, this ranged from 65 to 60, assuming 85% occupancy (since this is a recognised benchmark used in NHS planning). This suggests that at least 60 psychiatric inpatient places are required for young people up to the age of 18 in Scotland. Unfortunately, data for 2001-2002 and 2002-03 is incomplete, and cannot therefore be used in any current analysis.

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20 Described in Appendix 4
21 Presented in Appendix 3, Tables 3.1 and 3.2
22 Appendix 3, Table 3.3
4.10 The Working Group concluded very early on that the data currently collected at a national level is insufficient to give a true indication of the need and demand for psychiatric inpatient provision for young people. On one level, usage cannot exceed available provision. In addition, information is not currently collected, either at local or national level, which would tell us about the extent of unmet need – about unsuccessful referrals, or about those who are not referred at all because of a perceived lack of available places. Data issues and associated action are considered in more detail later in this report.

4.11 The Group also recognised that psychiatric inpatient services for children and young people are operating within and are affected by a very wide and evolving service context. There have been a number of changes over recent years to the way in which child and adolescent mental health services are delivered, including increasing investment in early intervention and intensive outreach approaches, which may have an impact on psychiatric inpatient services in the longer term. New and enhanced community developments may reduce the need for inpatient care, but they may also identify previously unidentified and unmet need. The impact of wider service developments will need to be monitored and reviewed on an ongoing basis. At present, no data is collected nationally on patient-based activity for non-inpatient mental health services for children and young people.

4.12 This highlights the complexities of reviewing the need and demand for inpatient services and, coupled with workforce planning issues, demonstrates the need for a long term planning and review process. Professional consensus within the Inpatient Working Group is that, on current available evidence, 60 young people’s psychiatric inpatient places represents a minimum target towards which we should aim – providing a focus on the potential provision required which has not existed on a Scotland-wide basis in recent years. However, given the issues highlighted above, there are concerns that this may be insufficient to meet need and will need to be kept under review.

Achieving an increase

4.13 The Group recognises that any increase in the number of psychiatric inpatient places for young people raises both financial and workforce issues, particularly in terms of the capacity of existing services to recruit and train staff with the relevant skills and expertise. Service expansion will therefore need to be phased, but it needs to start now. In parallel, ongoing work will be required to review the model, taking into account:

- Improved data
- The development of intensive outreach provision across Scotland
- Further clinical developments in the management of these patients

4.14 Following approval by the West of Scotland Regional Planning Group, NHS Greater Glasgow is already planning a new build 24-place psychiatric inpatient mental health facility for young people, to replace the existing Gartnavel facility. This is expected to be in place within 4 years, and will represent an increase of 50% in capacity in the West of Scotland. This regionally-planned development is welcomed by the Inpatient Working Group.
4.15 It could be argued that some of the current lack in NHS capacity could be addressed through use of inpatient facilities provided by the independent sector. There are arguments for and against this, including the diversion of limited and valuable resources away from NHS services. Clinicians have expressed some concerns about the links of independent providers with the wider network of services that are so pivotal to continuity of care for young people. Places in the independent sector are often commissioned reactively to meet a crisis, with little consideration of continuity of care or cost effectiveness. Clinicians have also expressed concern that since there is currently no subdivision within existing independent sector facilities in Scotland to cater for different age groups, young people’s developmental needs are less likely to be addressed.

4.16 The Inpatient Working Group believes that resources should be used to provide sufficient capacity and services within the NHS to meet need. However, the Group also believes it is pragmatic for use of psychiatric inpatient facilities in the independent sector to be considered, particularly in the context of the time it will take to deliver any increase in NHS capacity. The costs of and potential for utilising existing independent sector psychiatric inpatient provision for young people should be considered at an inter-regional level.

**Recommendation 2.** Planning should commence now for a phased increase to 60 psychiatric inpatient places for young people in Scotland, with ongoing review of need and demand.
CHAPTER FIVE: LOCATION

5.1 The Inpatient Working Group agreed that inpatient units should be located in the centres of population with good access to public transport. These centres would include Glasgow, Edinburgh and Dundee, where units for children and young people are currently located.

5.2 Recruitment and retention of staff in inpatient units is difficult, and the Group believes that at present, it would be easier to recruit to an established unit that is expanding, than to a new unit in an area that has no history of psychiatric inpatient services for children and young people. The Group therefore believes that expansion of psychiatric inpatient services for young people should be developed around the existing units, rather than through new development in additional locations.

5.3 The Group noted that there are no inpatient services located in the North of Scotland. Consideration needs to be given in the longer term to how services can best be provided for young people in these areas. The Group is aware that NHS Highland has commissioned a review of current arrangements for children and young people requiring inpatient psychiatric care, which involve admission of children and young people to the general paediatric ward at Raigmore Hospital or management in community or social work settings. The outcomes of this review will clearly inform future deliberation about psychiatric inpatient provision for children and young people in the North of Scotland.

5.4 Given the demographic and geographic characteristics of the North of Scotland, accessibility must have a high priority. This should include easily accessible and regular public transport links. Part of the rehabilitation process requires that young people are able to develop independence, including the ability to travel to and from activities, and to allow parents and carers ease of access to the service for therapeutic work and visiting, whether or not they have access to a car.

Recommendation 3. Phased expansion of psychiatric inpatient services for young people should be focused around the three existing sites, with ongoing review of the need for provision in the North of Scotland.
CHAPTER SIX:
PHILOSOPHY OF CARE

6.1 The National Inpatient Forum agreed that all units should provide a safe and nurturing environment where children and young people with severe and/or complex psychiatric disorders will receive developmentally appropriate evidence-based assessment and treatment. These units should offer an integrated approach to mental and physical health difficulties, paying particular attention to issues relating to the family, and to a range of developmental, educational, cultural, social, spiritual, interpersonal, child protection and other issues. Inpatient care should be readily accessible and links between inpatient and community mental health teams should facilitate smooth transitions on admission and discharge.

6.2 This would apply equally to psychiatric inpatient services for children and young people, and is endorsed by the Inpatient Working Group.
Child Health Support Group
CHAPTER SEVEN: MODEL OF CARE

7.1 Psychiatric inpatient units need to respond quickly to referrals of children and young people who have been thoroughly assessed by referrers, and to provide a service that is flexible to manage the needs of each child or young person with a guarantee that aftercare will be prompt and comprehensive. There needs to be clarity in the expectations of families and referrers about what is being offered by the unit.

7.2 Because a child or young person is not independent, and usually lives with a family or carers, it is imperative that, when planning services, account is taken of the need for regular family work – an evidence-based therapeutic intervention which requires resources. It is also important to provide accommodation for families who have to travel a significant distance.

7.3 In order to deliver a high quality of care, a multi-disciplinary approach is required, addressing all issues that affect the wellbeing of the young person and the systems to which they belong.

7.4 For children and young people to have the highest possible standard of care, the work of the inpatient unit would start before admission and continue until after discharge, with an integrated approach involving the community team and other agencies such as social work and education. Inpatient units should be considered as part of a continuum of care. A child or young person will move between teams with differing expertise and these transitions need careful negotiation and management. It is therefore important that community teams are well resourced to ensure comprehensive pre-admission assessment and for post-discharge care to allow continued progress towards recovery.

7.5 Management of children and young people within units should be biopsychosocial, eclectic and evidence-based, arising out of diagnoses and psychological formulations.

Psychiatric inpatient services for children

7.6 The patient group served by a children’s psychiatric inpatient unit differs from the young people’s psychiatric inpatient unit population in a number of important ways. As well as children with disorders more commonly seen in adolescence or adult life, such as anorexia nervosa, psychosis, and depression, psychiatric inpatient units for children also admit some children with diagnoses that might not lead to admission of a young person. These include hyperkinetic disorders, pervasive developmental disorders, learning disabilities and conduct disorders.

7.7 The clinical needs of children admitted to psychiatric wards are complex and include a significant paediatric component. There is often a need for a collaborative approach to assessment and treatment involving paediatric investigation facilities and input from a range of paediatric specialists as well as the psychiatric team. In the Department of Child and Family Psychiatry (DCFP) ward at the Royal Hospital for Sick Children (Yorkhill), paediatric support to psychiatry has been given in exchange for psychiatric support for paediatrics.
As with young people, there must be an emphasis on home-based care for children wherever possible, and collaboration between inpatient and community services is required to support this. Whilst geographical factors can limit face-to-face collaboration, telemedicine facilities are increasingly being used to support closer liaison with services in the child’s home locality. This is a particular challenge for a single unit providing a service for the whole of Scotland.

The need for close involvement of families is particularly marked in work with younger children and requires a strong emphasis on family work in staff training. The DCFP ward at Yorkhill is fortunate in being able to offer families accommodation and a sibling crèche.

Pathways to inpatient care

The recent CHYPIE study highlighted a number of important aspects of inpatient child psychiatry. A particular concern of families was the delay experienced between first presentation to services and access to appropriate inpatient care. Children with disorders of a severity and complexity that justifies inpatient assessment or treatment are uncommon (pre-pubertal psychoses may occur in one or two children per year in Scotland and pre-pubertal anorexia nervosa is also uncommon although other childhood eating disorders may also require inpatient care). However, inpatient assessment sometimes enables clarification of complex presentations of children that are not progressing in outpatient care. Primary, secondary and tertiary services currently have little guidance on the identification of suitable cases for referral for inpatient assessment and care.

Although there is no local research at this stage, referral processes are being examined by the DCFP at Yorkhill, and there is an initial impression that the findings of the CHYPIE study are replicated. Referrers have clearly identified the value they place upon the opportunities that exist for consultation with the Yorkhill team. This can enable some children to be managed without referral and helps to define the appropriate time for referral of others.

These factors imply that future use of the children's inpatient psychiatric unit at Yorkhill would be more efficiently managed if it were seen as part of a network of intensive psychiatric care for children in Scotland. This is challenging as it would need to tie in with local patterns of service delivery across Scotland, which currently vary. Discussions are underway about the potential for a Managed Clinical Network relating to the needs of children with severe and complex conditions requiring intensive psychiatric care. This proposal was supported by participants in an Inpatient Working Group-sponsored seminar, which took place in Stirling in February 2004. The Working Group is supportive of the proposal for a Managed Clinical Network of this kind and a group of professionals is seeking to take this forward with parents’ representatives.

It is possible that better case identification will result from better collaboration within a Managed Clinical Network, but this may not necessarily lead to an increased requirement for inpatient places. It is hoped that closer working relationships with local community services will enable more children to be supported at home, with consultation from the DCFP ward at Yorkhill. Commissioning arrangements for the Yorkhill child psychiatric inpatient service will need to take into account the resources required for consultation.
Staffing

7.14 The preferred staffing profile for a children's psychiatric inpatient unit is similar to that for a young people's psychiatric inpatient unit (see below and Appendix 5), but there is a greater need for developmental therapy skills such as Speech and Language Therapy. The child psychiatry nursing team in the DCFP ward at Yorkhill benefits from a wide skill mix with input from nurses with backgrounds in mental health, child health and learning disability. It is also important to offer high quality training to inpatient staff in support of recruitment and retention. The particular circumstances of the existing children's psychiatric inpatient service at Yorkhill need to be taken into account in projecting staffing plans and there is to be further work on this as part of a bid for national designation of the service.

Recommendation 4. Tier 3 and 4 children's psychiatric services should seek to function as a Managed Clinical Network.

Psychiatric inpatient services for young people

7.15 The Inpatient Working Group asked the National Inpatient Forum to consider and make recommendations on an appropriate care model for young people's psychiatric inpatient services. On 13th February 2004, 21 professionals from children and young people's mental health services throughout Scotland met to discuss the purpose of inpatient units and how they should be configured. Psychiatry, nursing, clinical psychology, occupational therapy, dietetics, teaching and social work disciplines were represented, from Greater Glasgow, Lothian, Borders, Argyll and Clyde, Forth Valley, Fife, Tayside and Grampian regions. Further meetings were held to develop and finalise recommendations.

7.16 The National Inpatient Forum's recommendations were considered and endorsed by the Inpatient Working Group and form the basis for much of this section of the report.

Service specification

7.17 In developing a service specification, the National Inpatient Forum consulted referrers and inpatient staff about their requirements of a psychiatric inpatient service for young people. They indicated that they required:

<table>
<thead>
<tr>
<th>Referrers</th>
<th>Inpatient Staff</th>
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<tr>
<td>• Prompt access</td>
<td>• Emergency places</td>
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<tr>
<td>• Provision for short &amp; longer term, emergency and planned admissions</td>
<td>• Appropriate and well assessed referrals</td>
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<tr>
<td>• Seamlessness</td>
<td>• Prompt discharge follow-up</td>
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<td>• Flexibility</td>
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<td>• A fully-staffed multi-disciplinary team</td>
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<td></td>
<td>• Engagement in joint assessment and other work with referring teams</td>
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Physical configuration

7.18 The National Inpatient Forum considered the evidence for a range of care models and environments, and recommended that the psychiatric inpatient care environment for young people should comprise no more that 24 places on one site. Clinical practice suggests that there are difficulties in managing a large group of mentally ill young people together within a single building. It is important that all staff know about all patients within a unit, even if they are not directly responsible for their care, and this would not be feasible in larger facilities. Units should also be configured around smaller subunits, with around 8 places in each, to allow improved management of age and case mix issues. There should be a maximum 4-year age difference between patients in any one unit or sub-unit.

7.19 The treatment of young people within inpatient units can often be hampered by the unpredictability of the care environment caused by emergency admissions. The importance of emergency places is acknowledged, but these need to be provided separately from treatment areas to prevent disruption to existing and stabilising patients. It is proposed that one subunit within a psychiatric inpatient facility should be reserved for acute admissions and young people with more disturbed behaviours, so that the other parts of the unit are able to maintain a therapeutic environment for more stabilised patients. There would be step-up and step-down between the more acute emergency subunit and therapeutic treatment subunits, depending on a young person’s condition.

7.20 In some areas, up to 80% of admissions are on an emergency basis\(^{23}\), and this often results in a delay for planned admissions. The Forum believes that this could be addressed by the designation of one emergency place within each unit which must be kept free specifically for emergency admissions.

7.21 The Inpatient Working Group believes that as well as providing a better care experience for young people, this model may also support improved staff recruitment and retention, with rotation of staff between the two areas of care. Consideration should be given to piloting this model within an existing unit.

7.22 The need for good community based resources such as colleges, leisure centres, shops and parks close to the unit was also noted in order to provide for good rehabilitation before the young person is able to return home. Links with the referring or home-based CAMH teams are also vital in order to provide well-integrated continuity of care between Tier 4 and Tier 3 services\(^{24}\).

7.23 There would be benefits in Scotland’s psychiatric inpatient units for young people functioning as a Managed Clinical Network, in a similar way to the adolescent forensic psychiatry units in England. This would provide opportunities to apply a uniformity of clinical standards throughout Scotland, and allow referrers to identify appropriate and available places for admission more readily. The Inpatient Working Group believes that this should be explored.

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\(^{23}\) Based on times of high unit activity and verbal reports from clinicians

Recommendation 5. There should be no more than 24 places in any one psychiatric inpatient unit for young people.

Recommendation 6. Psychiatric inpatient units for young people should be organised in subunits of around 8 places. One of the subunits should be designated for acute admissions and those with more disturbed behaviours.

Recommendation 7. Within a 24-place psychiatric inpatient unit for young people, 1 place should be available at all times for emergency admissions.

Recommendation 8. The young people’s psychiatric inpatient units in Scotland should seek to function as a Managed Clinical Network, with appropriate links to child and adult services.

**Day services**

7.24 Some young people do not require inpatient admission, but would, nonetheless, benefit from access to inpatient treatment programmes and resources on a day-case basis. The Group therefore believes that day places should be provided either:

- within the unit as a step-down from inpatient care, and included within the overall number of places provided by the unit; or
- as specialist disorder-specific day programmes for issues such as eating disorders or psychosis, on the same campus but not provided by the unit.

7.25 Accommodation should be provided for those young people whose homes are distant from the service, but who require access to part of an inpatient unit programme or service and cannot return home at night. This might also offer a step-down approach to discharge for those who have been admitted as inpatients.

**Recommendation 9.** Consideration should be given to the provision of accommodation for young people requiring part-time access to inpatient services and for families who live at a geographical distance from the unit.

**Specialisation**

7.26 Although originally remitted to consider the potential for specialisation within units, the Group believes that the existing generic psychiatric inpatient units for young people require a period of consolidation and stabilisation before the potential for specialisation can be considered.
The Group has noted that the need for disorder-specific units is in any case debateable, with evidence from the CHYPIE study suggesting that anorexic patients do well in generic units where they are able to mix with a range of young people with a range of disorders. Most existing disorder-specific psychiatric inpatient units are for patients with eating disorders. Clinicians advise that eating disorders represent approximately one third of the caseload in the existing generic psychiatric inpatient units for young people in Scotland, and staff have a high skill level in providing treatment and care for these cases. There is concern amongst clinicians that these skills would be lost if eating disorder patients were to be treated only in disorder-specific units, with a resultant reduction in job satisfaction and increased retention and recruitment problems.

Children with both a learning disability and mental illness can be cared for in the generic children’s psychiatric inpatient ward in Glasgow. However, clinicians working in the three generic young people’s psychiatric inpatient units advise that young people with a dual learning disability and mental illness diagnosis cannot be cared for appropriately in the existing psychiatric inpatient units for young people since they lack the necessary expertise and peer groups for effective treatment. Services for children and young people with such a dual diagnosis will be considered by the Child Health Support Group in its next work plan.

Admission criteria and protocols

Following discussion within the National Inpatient Forum, consensus has been reached between the units to standardise admission criteria and protocols across the three existing psychiatric inpatient units for young people. The agreed admission criteria are set out in Appendix 6.

Each of the existing psychiatric inpatient units for young people currently caters for different age ranges. It has been agreed that each unit should cater for young people from the age of 12 years up to their 18th birthday. This will have resource implications for those units which currently only cater for young people over the age of 16 if they are in full-time education. However, the Group believes that consistency and equitable access across Scotland is important.

Early liaison between services for young people and adult services is essential to plan for effective transition when appropriate. In some cases, transfer may take place before a young person’s 18th birthday, and in others, it may take place after. Continuity of care and a smooth transition for young people to adult services are paramount. Ideally, mental health outpatient services for children and young people should reflect the same age range as inpatient services.

There have been some concerns about emerging early onset psychosis interventions, which are being developed by adult services with a drop down to age 14. Though these interventions are welcome, close liaison between adult and young people’s services is essential to ensure that the developmental, family and treatment needs of young people are addressed.

Recommendation 10. The psychiatric inpatient units for young people should implement common admission criteria, as set out in Appendix 6.
**Recommendation 11.** Early onset psychosis services should be developed in full consultation and liaison with child and adolescent mental health services.

**Staffing**

7.33 Young people require care that is carefully planned to meet their needs, and a variety of treatment modalities is essential. Every discipline has core skills, but there are also areas of overlap between disciplines in terms of expertise and some therapeutic tasks. It is important that the team is constructed to ensure a comprehensive mix of skills and disciplines.

7.34 The skill mix should include:
- Core skills in providing a safe, therapeutic, residential, developmentally appropriate environment.
- Expertise in therapies, which may include family, group, cognitive-behavioural, psychodynamic, skill-based psychotherapies and creative therapies.
- Expertise in providing specialist pharmacological treatments.
- Therapeutic skills that provide support in eating, activities of daily living, and attainment of the maturational tasks of adolescence, building on strengths and developing resilience and independence.

7.35 The discipline mix should include:
- Psychiatry
- Nursing
- Clinical Psychology
- Occupational Therapy
- Dietetics
- Physiotherapy
- Psychotherapy
- Family Therapy
- Speech & Language Therapy
- Pharmacy
- Teaching
- Social Work
- Housekeeping & Domestic
- Administrative & Clerical

7.36 In addition, each unit requires:
- Access to good medical and paediatric services, and in particular, developmental neurology.
- Access to laboratory and other investigative services.
- Links with other disciplines (specifically, learning disability, forensic, adult psychiatry) and other agencies.

7.37 The staffing complements across the three existing psychiatric inpatient units for young people are different, partly due to their differing size, but also due to the ad-hoc way in which developments have taken place in these units over time. A suggested staffing model for young people’s units has been developed by the National Inpatient Forum, and is outlined in Appendix 5. This is based on a review of the staffing models in each of the units and taking into account a recent review of the staffing complement in the Glasgow Gartnavel unit.
7.38 The impact of staff recruitment and retention difficulties, particularly in relation to nursing staff, needs to be taken into account in establishing any staffing model. Anecdotal evidence suggests that current high staff turnover levels are related to:

- The pressures of long term working in these units given their highly specialised and intensive nature.
- Grading issues, given the highly specialised and intensive nature of this work.
- Little potential for career development.
- The attraction of CAMH community-based services, which are perceived to offer better pay and career opportunities and a more family-friendly 9-5 daily routine.

7.39 Further work is required to explore the impact of better grading, training places and the development of skills and knowledge from on-the-job experience.

7.40 In *Partnership for Care*\(^\text{25}\), the Scottish Executive gave a commitment to improve the mental health workforce for children and young people. In order to achieve this, the Scottish Executive established a multi-agency Child and Adolescent Mental Health Workforce Group, which is currently working on three themes:

- Inpatient and intensive mental health services for children and young people
- Community based specialist mental health services for children and young people
- How to build “mental health capacity” across the network of children’s services

7.41 The Child and Adolescent Mental Health Workforce Group has co-opted members of the Inpatient Working Group, and work is underway to develop a workforce model for inpatient and intensive services. This process, which draws directly on the work in this report, studies current workforce, projects workforce needed in the future, and models how that workforce can be built, offering a number of options. The Child and Adolescent Mental Health Workforce Group expects to report in Spring 2005.

**Recommendation 12.** Workforce planning for the three psychiatric inpatient units for young people should take into consideration the staffing model developed by the National Inpatient Forum (Appendix 5).

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CHAPTER EIGHT: 
STAFF TRAINING & DEVELOPMENT

8.1  An inpatient unit’s primary function is to assess and treat the most seriously mentally ill children and young people in Scotland using an intensive care model. The staff appointed enter a sub-specialty that requires a very high degree of specialist training. All aspects of care need to be supervised and in order to achieve the level of skill required, there has to be a significant investment in training and supervision. The seniority of key staff needs to be high in order to perform the clinical tasks and to train more junior staff in the specialty.

8.2  There has traditionally been a high staff turnover within psychiatric inpatient units for children and young people, and in particular, at nursing grades D and E (approximately 28% per annum in the Glasgow Gartnavel young people's psychiatric inpatient unit). This is in part due to the stressful and demanding nature of the work, and in part to the unique role of inpatient units in providing training and experience for staff who then go on to more senior posts within community child and adolescent mental health services. This has been compounded in recent years by the welcome, but relatively rapid growth of community services. As a result of the adult focus of basic professional training for nursing and some Allied Health Professions, and the unique function of inpatient units, there is a need for an ongoing robust induction and basic training programme to meet the training and development needs of junior and unqualified staff as they join and progress through the service.

8.3  Given the acute and specialist nature of psychiatric inpatient services for children and young people, there is also a need to provide “higher level” training for more experienced staff, to allow them to develop the skills and knowledge required to function as senior members of the unit teams and meet the needs of the very complex and severely ill young people to whom the units provide a service. Much of this training is highly specialised, and is both expensive and time consuming.

8.4  The Inpatient Working Group is aware that current nurse staffing profiles for inpatient units do not include adequate resources to meet the financial costs or backfill implications of necessary basic or higher level training. As a result, units struggle to meet the training and development needs of both the unit and the individual practitioners, and this has a negative impact on staff retention and recruitment. This makes it difficult to replenish and develop the pool of core clinical skills which are essential to maintain a viable unit which provides high standards of clinical care.

8.5  The Royal College of Psychiatrists requires all higher trainees in child and adolescent psychiatry to have experience in child or adolescent psychiatric inpatient units in order to complete training and obtain entry to the Specialist Register (a prerequisite for consultant appointment). In Scotland, the capacity to fulfil this important training function is currently extremely limited. Some trainees are using placements in day units as a substitute experience, but this may not provide the same level of opportunity for involvement in assessment and treatment of the most severely disturbed and most complex cases as an inpatient placement, and will not provide trainees with exposure to the full range of treatment approaches. This may impact on the ability of future consultants to refer appropriately to inpatient services.
8.6 The Group believes that future staffing profiles must include adequate workforce resource to ensure that staff can be released for training without compromising either quality or continuity of care, or placing an undue burden on the remaining staff group. Consideration should also be given to building in resource slack to address the impact of the unavoidable vacancy factor which occurs as a result of the higher turnover levels experienced in this area due to the central role of the units in providing a pool of experienced staff for future community based service developments. Service planners must obviously consider the potential impact on inpatient unit staffing of any new developments, and take this into consideration when phasing recruitment.

8.7 In Glasgow, a full-time Practice Development Nurse was appointed in the Autumn of 2002 to provide training support across mental health services for young people, with half-time dedicated input to the Gartnavel psychiatric inpatient unit for young people. There are indications that recruitment has improved, perhaps in response to this clear investment in training and development. As at October 2004, proposals are being considered within the SEAT Regional Planning Group to appoint a similar full-time training support post on a short-term 2-year basis, to help support and drive forward training within and across the Edinburgh and Dundee units. The Inpatient Working Group welcomes this proposal and notes the potential for the development of an informal training network across the psychiatric inpatient units for children and young people in Scotland.

8.8 The Inpatient Working Group was encouraged to learn that the Scottish Executive would be making some funding available over the next two years to support child and adolescent mental health workforce development, and that training for nursing staff in psychiatric inpatient units for children and young people had been highlighted as an area for priority action. The proposed funding is not recurring at this stage, and training and development therefore offers the best way to improve capacity and ensure longer term benefit from some short term investment.

**Recommendation 13.** A training network should be established across the psychiatric inpatient units for children and young people in Scotland.
CHAPTER NINE:
AGE APPROPRIATE CARE

9.1 The Inpatient Working Group has noted the requirement of the Mental Health (Care & Treatment) (Scotland) Act 2003 for NHS Boards to provide “such services and accommodation as are sufficient to meet the particular needs” of all young people up to the age of 18 years who are detained or admitted to hospital for the purposes of receiving treatment for a mental disorder. The Royal College of Psychiatrists has already recommended that young people under 16 should not be admitted to adult wards at all, and those aged 16 and 17 should be admitted only under special circumstances. The Inpatient Working Group supports this view.

9.2 The Group notes that there are some circumstances in which psychiatric admission is not the best way forward for children and young people with psychiatric disorders, and admission to a general paediatric or adult setting may be in the best interests of the child or young person. The Royal College of Psychiatrists guidelines recommend that children and young people under the age of 16 should always be admitted to hospital overnight if they present out-of-hours having self-harmed. This supports best practice in ensuring thorough assessment and connection to child and adolescent mental health services or to social work services if necessary. These children and young people are best managed in a short-stay ward in a general paediatric or adult hospital, or in a general young people’s ward if available, and psychiatric admission is not indicated. Children and young people presenting with disorders with both psychiatric and somatic components (ranging from some kinds of faecal soiling through to behavioural disturbance or psychosis associated with brain disease or severe emaciation in eating disorders) may need to be assessed and given treatment with a mental health component in a physical health setting before consideration should be given to psychiatric admission. In some cases, physical health or neurological aspects may be the initial priority for treatment, stabilisation and assessment.

9.3 Psychiatric inpatient units for young people provide treatment based on a model of care which takes account of the developmental needs of the young person, and at times, those needs may be better met in adult services. For example, those young people under the age of 18 who work, live independently from their family, are in partnerships, or are parenting children may find that adult services are more appropriate. Young people already in the care of local adult outpatient services may also benefit from a continuity of care through admission to a local adult inpatient facility should they require inpatient admission. Those approaching the age of 18 at the time of first onset of major mental illness may similarly find the resources of adult services better orientated to their needs.

9.4 The Group believes that the personal preference of a young person to be admitted to a local adult facility rather than a remote young people’s psychiatric inpatient unit must be considered and respected wherever appropriate.

9.5 At times, children and young people with psychiatric disorders will be admitted to general paediatric or adult wards, or to adult psychiatric wards, in a crisis situation and because it is

not feasible to transfer the patient to a psychiatric inpatient facility for children or young people. This may be because such facilities are remote, or because they are unable to offer a place. The Inpatient Working Group believes that admission to general wards or to adult psychiatric wards can provide a temporary place of safety and care, but must only be a short-term arrangement. Where such admissions become prolonged, the consequences can be severe, for the patient and for their family, and also for the care of other patients within a ward who may be vulnerable for a variety of reasons. From a child’s perspective, prolonged inappropriate admission to a physical ward is not only damaging in the short term, but may colour their experiences of hospital services in an unhelpful way for the future.

Care environment

9.6 The Inpatient Working Group endorses the recommendations for children’s and young people’s psychiatric inpatient care, which were developed and presented by Dr Graham Bryce in a paper to the Scottish Health Boards General Managers Group in 1997. These suggest that all NHS settings admitting children and young people with mental health difficulties should:

- **Provide an appropriate treatment environment:** As well as providing the necessary range of biological and psychological treatments, this would feature educational and occupational support and integrate the involvement of families, carers and other agencies involved in the care of the child or young person.

- **Provide an appropriate social environment:** This would promote involvement with an appropriate peer group, protect from exposure to inappropriate peer groups and offer appropriate play and recreational opportunities.

- **Take due account of developmental stage:** Amongst children and young people, mental health problems are expressed both through symptoms and through relationship or behaviour difficulties. Care, support and supervision are required, as well as treatment.

- **Recognise the significance of home, family and other carers:** Flexible arrangements must be made for family contact and links with home and the community should be maintained.

- **Consult those who use services:** The views of children, young people and families must be sought about quality of services and treatment options. Referrers and other professional users should be consulted about changes and developments in services.

9.7 The Royal College of Psychiatrists is currently considering the role of Consultants in Adolescent Psychiatry in caring for young people admitted to adult psychiatry wards and liaising with Consultants in Adult Psychiatry. NHS Boards and Regional Planning Groups will need to consider ways in which to ensure effective liaison between adolescent and adult psychiatry in these circumstances, taking into account any forthcoming recommendations from the Royal College.

**Recommendation 14.** Wherever possible, the views of older young people (aged 16 and 17) should be sought on where they wish to be treated.

**Recommendation 15.** All NHS settings admitting children and young people with mental health difficulties should meet the quality standards outlined.

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28 Commissioning Inpatient Psychiatric Services For Children And Young People In Scotland, Dr Graham Bryce (1997) (Unpublished)
CHAPTER TEN: 
INTENSIVE OUTREACH

10.1 The Inpatient Working Group discussed its remit in relation to intensive outreach on several occasions. Two forms of intensive outreach were identified, each of which the Group believes is important:
- Outreach support in the community for those not requiring or following inpatient admission
- Outreach from inpatient units to support admission and rehabilitation

10.2 The Group believes that intensive outreach approaches, which have been developed in areas where there have formerly been inpatient units or by innovative clinicians, do not replace the need for inpatient facilities. They do, however, enhance care and help young people to be integrated into their own homes and communities whenever possible. In this respect, inpatient care is part of the process towards recovery and local intensive outreach services are likely to reduce the length of admission by taking an intensive level of care into the home and working closely with parents and carers to continue the treatment programme. The need for admission may be reduced in certain cases, but clinical experience has shown that enhancement of community services identifies need in people whose difficulties have not previously come to the attention of services. These young people often have “quiet” illnesses such as Major Depressive Disorder or Obsessive Compulsive Disorder, where the behaviours associated with the illness do not impinge on others. The aims of such an approach would be to identify illness early and manage it intensively to reduce chronicity and the loss of normal development.

10.3 It was agreed that for young people to have the highest possible standard of care, the work of inpatient units should start before admission and continue until after discharge with an integrated approach involving the community team and other agencies such as Social Work and Education. Community teams, social work and education staff have a crucial role in providing integrated care, and in particular, in sustaining families and supporting improvements in functioning once specialist resources have withdrawn. Cotton\(^{29}\) cited the lack of family or support systems outside the hospital as a factor that indicated the need for higher shift ratios within psychiatric inpatient facilities for children and young people, highlighting the impact that community issues can have on the whole treatment process. The staffing profile proposed in Appendix 5 includes capacity to engage in flexible liaison with local community teams to plan and support admission and discharge.

Recommendation 16. All psychiatric inpatient units for children and young people should be resourced sufficiently to engage in flexible and effective liaison with local community teams to plan and support admission and discharge.

10.4 It was not within the Group’s remit or capacity to develop detailed recommendations relating to the provision of outreach services.

CHAPTER ELEVEN: COMMISSIONING ARRANGEMENTS

11.1 There is currently no consistency in the commissioning arrangements for children's and young people's inpatient services in Scotland. In some cases, these are informal, offering little in the way of strategic planning for a sustainable future. This situation must be reviewed if we are to prevent further erosion of these services, and to ensure that we are better able to meet the need for them.

Psychiatric inpatient services for children

11.2 The Department of Child and Family Psychiatry (DCFP) ward at Yorkhill in Glasgow is the only facility providing a psychiatric inpatient service for children under the age of 12 in Scotland. The ward is currently commissioned through the West of Scotland Paediatric Consortium and costs are underwritten solely by members of the Consortium, together with NHS Orkney and NHS Shetland. Other NHS Boards pay for use of the facility on an “unplanned activity” (UNPAC) cost per case basis.

11.3 The current commissioning arrangements originate with the closure in 1997 of the children's psychiatric inpatient unit in Dumfries, which was the only unit in Scotland providing a seven-day service. When Yorkhill became the sole psychiatric inpatient resource for children in Scotland, attempts were made to form a national consortium. In the event, NHS Grampian and NHS Highland joined the consortium but subsequently withdrew, preferring to commission care for individual children on an ad-hoc basis.

11.4 Although all NHS Boards recognise the need for a children's psychiatric inpatient resource, the current funding arrangements leave the West of Scotland Consortium and the Yorkhill Operating Division bearing all the financial risk.

11.5 Given the low volume and high cost nature of this service, the Inpatient Working Group has explored the potential for designation of the unit as a national service. Following discussion and agreement with the Chairs of the Regional Planning Groups, an application is now being prepared for the service to be commissioned through NHS National Services.

Recommendation 17. The children's psychiatric inpatient unit in Glasgow should apply for designation as a national service.

Psychiatric inpatient services for young people

11.6 The three existing psychiatric inpatient units for young people are currently commissioned and funded in different ways.

11.7 In the West of Scotland, a formal Adolescent Mental Health Inpatient Consortium was established in 2001 when the Gartnavel Unit expanded from 10 to 16 inpatient places and became operational. The annual costs of around £1.8 million are currently shared between the

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30 NHS Argyll & Clyde, NHS Ayrshire & Arran, NHS Dumfries & Galloway, NHS Forth Valley, NHS Greater Glasgow, NHS Lanarkshire
31 NHS Argyll & Clyde, NHS Ayrshire & Arran, NHS Dumfries & Galloway, NHS Forth Valley, NHS Greater Glasgow, NHS Lanarkshire
West of Scotland Boards, based on usage over a three year period. Admissions from other areas are accepted on an UNPAC cost per case basis. The Consortium meets on a six-monthly basis to discuss issues such as service development, inflationary increases, admission criteria and reasons for refusal of admissions. Although a Service Level Agreement has been agreed by the Consortium, proposals for major developments are referred to the West of Scotland Regional Planning Group for approval.

11.8 Dudhope House Adolescent Inpatient Unit in Dundee opened in 1992, and is commissioned and funded by NHS Tayside. Out of area referrals are accepted and charged to the referring NHS Board on an UNPAC cost per case basis.

11.9 The 12-place Young People’s Unit in Edinburgh opened in July 2000 and is commissioned by NHS Lothian. 8 of the 12 places are currently designated for and funded by NHS Lothian. One further place is designated for and funded by NHS Forth Valley on an annual basis. As with the Glasgow and Dundee psychiatric inpatient facilities for young people, out of area referrals are accepted and charged to the referring NHS Board on an UNPAC cost per case basis.

11.10 Clearly, any change in the circumstance of one unit, or any decision in one region, impacts on the others – local and regional decisions (or indecisions) have national implications. There was therefore general agreement within the Inpatient Working Group that the three psychiatric inpatient units for young people need to be considered as national resources, certainly for planning purposes. We know that the three units are already used (or are expected to be available for use) by NHS Boards across Scotland, and it is likely that Boards will be increasingly looking to these services in order to meet their duties under the Mental Health (Care & Treatment) (Scotland) Act 2003. In that context, the Group believes that a strategic, equitable and stable funding framework is required for all of the units.

11.11 The psychiatric inpatient services for young people were unlikely to meet the criteria for national designation, though the potential for temporary designation, for a 3-5 year period, was explored on the basis that this would support a much needed period of stabilisation whilst formal regional commissioning mechanisms were agreed and established. Ultimately, there was no support for this approach from the Chairs of the Regional Planning Groups. It was instead agreed that regional solutions should be found and formalised from the outset, within an inter-regional context. David Pigott, Chair of the West of Scotland Regional Planning Group offered to establish and lead an inter-regional planning group to take this work forward. The Inpatient Working Group warmly welcomed this response and is optimistic that this will provide an appropriate mechanism for implementation of the recommendations presented in this report.

Recommendation 18. Psychiatric inpatient services for young people in Scotland should be commissioned on a regional basis with an equitable and stable funding framework, and within a national context.

Recommendation 19. The recommendations in this report should be further developed and implemented through an inter-regional planning arrangement.
CHAPTER TWELVE: DATA AND INFORMATION

12.1 The SNAP report highlights that “the monitoring and evaluation of child and adolescent mental health services (CAMHS) has been constrained in the NHS by the lack of suitable data collection systems. ISD, the NHS Information and Statistics Division\textsuperscript{32}, is currently developing a new system for collecting mental health data”. A lack of robust data has certainly been a difficulty that the Inpatient Working Group has encountered in trying to formulate recommendations for children’s and young people’s psychiatric inpatient services.

12.2 The current inpatient psychiatric service for children and young people in Scotland is acknowledged to be under severe pressure. Good information is vital, not only to ensure that current resources are used most effectively, but also to build any case for increased capacity. To do this, we need to understand:

*Capacity*: what resources exist currently?
- Staff numbers, time and training
- Inpatient places
- Pathways in and out of inpatient care and alternatives to inpatient care
- Consistent procedures for managing scarce resource

*Activity*: how are current resources being used?
- Number of referrals
- Inpatient place usage
- Consultation

*Demand*: what additional needs are currently unmet?
- Failed/deflected referrals
- Referrals that are never made
- The way inpatient care fits within the overall care journey of patients

12.3 Routine information streams cannot currently answer all these questions, and so additional information gathering will be required to supplement existing sources. However, not all the information for quality improvement, operational management and for service planning needs to be sourced from routine data streams that are constantly collected and monitored. We believe that a “mixed economy” of information approach should be adopted, involving the use of routine data, audit/targeted data, and research data.

\textsuperscript{32} Now Information Services, NHS National Services Scotland
**12.4** A system of routine data capture is required that supports improvement in the delivery of services, rather than one that supports the delivery of services in a current mode that we already believe is substandard. National data development work is underway through the NHS National Services Scotland Improving Mental Health Information Programme. In addition, local data collection proposals will be required, keeping in mind developments at a national level.

**Recommendation 20.** The NHS National Services Scotland Improving Mental Health Information Programme should support local areas in establishing data collection mechanisms to support local service improvement and development.

**12.5** The processes of gaining support among care providers for changes to service delivery require the demonstration that current practices are not ideal. Data can be part of building the case for change. However, we need to ensure that we collect data that specifically addresses the problems being examined, always paying regard to opportunity cost (time spent gathering data is time not spent on patient care).

**12.6** Some suggested options for further work:

**Capacity**
- Service profiling to gain an understanding of where information must flow to and what those information bundles consist of – including feeder and step-down services.
- Agreement on standardised referral processing methods, preparatory to assessing why referrals fail/are rejected/deflected.

**Activity**
- Develop all-Scotland shared referral and discharge information sets and standardised care summaries.
- Audit use of psychiatric inpatient facilities for children and young people, in conjunction with all-Scotland routine data.

**Demand**
- Work to understand where “unsuccessful” referrals (i.e. those who didn’t get in) go – this requires support from community services.
- An audit of whether all admissions of children and young people to adult units are being reported to the Mental Welfare Commission for Scotland.
- An audit of whether all inappropriate admissions of children and young people to adult units are being treated as critical incidents, as is recommended by the Royal College of Psychiatrists.

**Recommendation 21.** Action should be taken by the NHS National Services Scotland Improving Mental Health Information Programme to ensure that data on capacity, activity and demand is collected to support service planning and development in the medium to long term.
# APPENDIX 1: SUMMARY OF RECOMMENDATIONS

## Capacity and location

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendation 1.</td>
<td>The number of psychiatric inpatient places for children should be maintained and kept under review.</td>
</tr>
<tr>
<td>Recommendation 2.</td>
<td>Planning should commence now for a phased increase to 60 psychiatric inpatient places for young people in Scotland, with ongoing review of need and demand.</td>
</tr>
<tr>
<td>Recommendation 3.</td>
<td>Phased expansion of psychiatric inpatient services for young people should be focused around the three existing sites, with ongoing review of the need for provision in the North of Scotland.</td>
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## Model of care

<table>
<thead>
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<th>Recommendation</th>
<th>Description</th>
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<tr>
<td>Recommendation 4.</td>
<td>Tier 3 and 4 children's psychiatric services should seek to function as a Managed Clinical Network.</td>
</tr>
<tr>
<td>Recommendation 5.</td>
<td>The young people's psychiatric inpatient units in Scotland should seek to function as a Managed Clinical Network, with appropriate links to child and adult services.</td>
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<tr>
<td>Recommendation 6.</td>
<td>There should be no more than 24 places in any one psychiatric inpatient unit for young people.</td>
</tr>
<tr>
<td>Recommendation 7.</td>
<td>Psychiatric inpatient units for young people should be organised in subunits of around 8 places. One of the subunits should be designated for acute admissions and those with more disturbed behaviours.</td>
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<tr>
<td>Recommendation 8.</td>
<td>Within a 24-place psychiatric inpatient unit for young people, 1 place should be available at all times for emergency admissions.</td>
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<tr>
<td>Recommendation 9.</td>
<td>Consideration should be given to the provision of accommodation for young people requiring part-time access to inpatient services and for families who live at a geographical distance from the unit.</td>
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<tr>
<td>Recommendation 10.</td>
<td>The psychiatric inpatient units for young people should implement common admission criteria, as set out in Appendix 6.</td>
</tr>
<tr>
<td>Recommendation 11.</td>
<td>Early onset psychosis services should be developed in full consultation and liaison with child and adolescent mental health services.</td>
</tr>
<tr>
<td>Recommendation 12.</td>
<td>Workforce planning for the three psychiatric inpatient units for young people should take into consideration the staffing model developed by the National Inpatient Forum (Appendix 5).</td>
</tr>
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</table>
Staff training & development

Recommendation 13. A training network should be established across the psychiatric inpatient units for children and young people in Scotland.

Age appropriate care

Recommendation 14. Wherever possible, the views of older young people (aged 16 and 17) should be sought on where they wish to be treated.

Recommendation 15. All NHS settings admitting children and young people with mental health difficulties should meet the quality standards outlined.

Intensive outreach

Recommendation 16. All psychiatric inpatient units for children and young people should be resourced sufficiently to engage in flexible and effective liaison with local community teams to plan and support admission and discharge.

Commissioning arrangements

Recommendation 17. The children’s psychiatric inpatient unit in Glasgow should apply for designation as a national service.

Recommendation 18. Psychiatric inpatient services for young people in Scotland should be commissioned on a regional basis with an equitable and stable funding framework, and within a national context.

Recommendation 19. The recommendations in this report should be further developed and implemented through an inter-regional planning arrangement.

Data and information

Recommendation 20. The NHS National Services Scotland Improving Mental Health Information Programme should support local areas in establishing data collection mechanisms to support local service improvement and development.

Recommendation 21. Action should be taken by the NHS National Services Scotland Improving Mental Health Information Programme to ensure that data on capacity, activity and demand is collected to support service planning and development in the medium to long term.
APPENDIX 2:
INPATIENT WORKING GROUP MEMBERSHIP

Bruce Dickie (Chair)  Strategy & Performance Manager, NHS Tayside
Sally Amor  Child Health Commissioner, NHS Highland
Roderick Beasley  Consultant Child & Adolescent Psychiatrist, NHS Highland
Linda Brown  Assistant Co-ordinator, Hospital Education Service, Glasgow
David Carson  Head of Financial Performance Management, NHS Tayside
Charles Clark  Child Health Commissioner, NHS Lanarkshire
Sandra Davies  Consultant Child & Adolescent Psychiatrist and Chair, Child & Adolescent Section, Royal College of Psychiatrists Scottish Division
Kevin Dawson  Service Manager, Adult Mental Health, NHS Grampian – representing the North of Scotland Regional Planning Group
Louise Duffy  Clinical Psychologist, NHS Lothian (from July 2004)
Heather Gardiner  Consultant Child & Adolescent Psychiatrist, NHS Greater Glasgow and Chair, National Child & Adolescent Inpatient Forum
Robin Glaze  Consultant Child & Adolescent Psychiatrist, NHS Lothian (until July 2004)
Mary Hattie  Organisational Development Advisor for Child & Adolescent Mental Health Services, NHS Greater Glasgow
Tony House  Community Psychiatric Nurse, NHS Borders
Annie Ingram  Regional Planning & Workforce Co-ordinator, North of Scotland Regional Planning Group
Derek Lindsay  Director of Finance, NHS Ayrshire & Arran – representing West of Scotland Regional Planning Group
Michael Morton  Consultant Child & Adolescent Psychiatrist, NHS Greater Glasgow
Kathy O’Neill  General Manager, NHS Forth Valley – representing South East & Tayside Regional Planning Group
Alastair Philp  Programme Principal, Improving Mental Health Information Programme, NHS National Services Scotland: Information Services
Ian Pullen  Principal Medical Officer, Scottish Executive Health Department
Christine Smith  Consultant Child & Adolescent Psychiatrist, NHS Tayside
Lindsey Wright  Scottish Executive Health Department, Women & Children’s Unit
APPENDIX 3:
NATIONAL ADMISSIONS DATA

Table 3.1 Admissions to mental health specialties in Scottish hospitals by occupied bed days, hospital and calendar year aged 12-17 (inclusive), excluding all admissions to the specialty “learning disabilities”

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</table>
1 Occupied bed days is an estimation of the number of days 1 bed would be occupied per year
   a) any patients admitted and discharged on the same day are counted as occupying 1 bed day
   b) the difference between the date of admission and date of discharge in all other cases is not inclusive (i.e. admission on
      1 day and discharged the following day equates to 1 bed day, not 2)
   c) if there is no date of discharge on a record, it is assumed the patient is still resident, so bed days are calculated to the end
      of that financial year

2 Age as at 30th June for each year (i.e figures for 1999 relate to patients aged 12-17 at 30th June 1999)

Source: SMR04, as at 31/07/04
Ref: IR2004-02450, Information Services
Table 3.2  Admissions to mental health specialties in Scottish hospitals by hospital and calendar year aged 12-17 (inclusive) at time of admission, excluding all admissions to the specialty “learning disabilities”

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<tr>
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<td>Mental Health &amp; Long Stay Geriatric Services, Falkirk Royal Infirmary</td>
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## Average Length of Stay of Patients by Facility

<table>
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<th>Facility</th>
<th>1999 Patients</th>
<th>1999 Episodes</th>
<th>1999 Average Length of Stay (days)(^1)</th>
<th>2000 Patients</th>
<th>2000 Episodes</th>
<th>2000 Average Length of Stay (days)(^1)</th>
<th>2001(^p) Patients</th>
<th>2001(^p) Episodes</th>
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<td>Blythswood House (Residential Rehab)</td>
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<td>Stobhill Hospital</td>
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</tbody>
</table>

\(^p\) Provisional (data for 2001, very incomplete for Lothian, Lanarkshire and Forth Valley Health Boards)

\(^1\) Excludes residents as they have no discharge date and therefore no length of stay can be assigned

\(^2\) Average length of stay=total length of stay/total number of episodes

Note: This is based on small numbers therefore care should be taken using these figures

Source: SMR04, as at 31/07/04
Ref: IR2004-02450, Information Services
Table 3.3  Admissions to mental health specialties in Scottish hospitals by occupied bed days\(^1\) and calendar year aged\(^2\) 12-17 (inclusive), excluding all admissions to the specialty “learning disabilities”

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Bed days</th>
<th>No. of beds required if assume 85% full</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>20,593</td>
<td>66</td>
</tr>
<tr>
<td>1998</td>
<td>18,005</td>
<td>58</td>
</tr>
<tr>
<td>1999</td>
<td>20,366</td>
<td>65</td>
</tr>
<tr>
<td>2000</td>
<td>18,717</td>
<td>60</td>
</tr>
</tbody>
</table>

\(^1\) Occupied bed days is an estimation of the number of days 1 bed would be occupied per year
  a) any patients admitted and discharged on the same day are counted as occupying 1 bed day
  b) the difference between the date of admission and date of discharge in all other cases is not inclusive (i.e. admission on 1 day and discharged the following day equates to 1 bed day, not 2)
  c) if there is no date of discharge on a record, it is assumed the patient is still resident, so bed days are calculated to the end of that calendar year

\(^2\) Age as at 30th June for each year (i.e figures for 1999 relate to patients aged 12-17 at 30th June 1999)

Source: SMR04, as at 31/07/04
Ref: IR2004-02450, Information Services
APPENDIX 4:
THE WEST OF SCOTLAND ADOLESCENT BED MODEL

In 2000, with the impending closure of the Ladyfield Adolescent Unit in Dumfries, a working party of clinicians and managers produced a report\(^{33}\), which included recommendations for the service model, staffing profile and number of inpatient places required for the Gartnavel Adolescent Unit if it were to remain as the only unit serving the West of Scotland. This report was accepted by the West of Scotland NHS Boards as the basis for future service planning for this group.

In arriving at their recommendations on the number of inpatient places required, the working party undertook an analysis of SMR04 data for 1993-1999. Included in the analysis were all young people between the age of 12 and 17 years inclusive who were admitted to a psychiatric facility and resident in one of the 6 West of Scotland NHS Boards. Data for the last year (1998-1999) was incomplete and therefore excluded from the final analysis. Between 1993 and 1998, the total occupied bed days were as shown in table 1.

Table 1

<table>
<thead>
<tr>
<th>Year</th>
<th>Total occupied bed days</th>
<th>Occupied beds @ 85% occupancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993/94</td>
<td>5,766</td>
<td>19</td>
</tr>
<tr>
<td>1994/95</td>
<td>7,679</td>
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<tr>
<td>1995/96</td>
<td>8,812</td>
<td>28</td>
</tr>
<tr>
<td>1996/97</td>
<td>7,638</td>
<td>25</td>
</tr>
<tr>
<td>1997/98</td>
<td>7,878</td>
<td>25</td>
</tr>
</tbody>
</table>

Occupied beds have been shown as 85%, which is an acceptable level for an admission unit.

In 1997/98, there were 132 individual young people admitted to hospital, 48 to a young people’s psychiatry unit, 3 to a child psychiatry unit, but the majority to an adult psychiatry unit. About half of those admitted to an adult unit stayed less than one week, but 41 stayed for an average of 50 days. (See table below.) Although the majority of those admitted to adult psychiatry wards were aged 17, almost half were younger.

<table>
<thead>
<tr>
<th></th>
<th>Stay &lt; = 7 days</th>
<th>Stay &gt; 7 days</th>
<th>All stays</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Total stay</td>
<td>Number</td>
</tr>
<tr>
<td>Child psychiatry</td>
<td>2</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Adolescent psychiatry</td>
<td>8</td>
<td>29</td>
<td>40</td>
</tr>
<tr>
<td>General psychiatry</td>
<td>38</td>
<td>127</td>
<td>41</td>
</tr>
<tr>
<td>Total</td>
<td>48</td>
<td>162</td>
<td>84</td>
</tr>
</tbody>
</table>

In considering admissions to adult places, the following were excluded from the West of Scotland calculations:

- Young people with a length of stay of fewer than 7 days. (Clinicians believed that only a small percentage of these young people would have been admitted to the Adolescent Unit had a place been available.)
- Young people with learning disability (additional provision would be required for this group).
- Young people with a primary diagnosis of drug or alcohol problems.

Based on this information, the West of Scotland working party recommended that the minimum adolescent psychiatric inpatient provision required to provide a sustainable service for the population of 2.6 million residing within the West of Scotland NHS Boards would be 24 places, assuming 85% occupancy. This recommendation was based on a model of service which included day programmes with the capacity to provide step down day provision to minimise length of stay. It was also based on the need for a feasible solution in the current financial and workforce climate.

The West of Scotland figures are based on historical data up to 1998. The experience of the Inpatient Working Group is that the requirement for inpatient places has not reduced in the last 6 years. Occupancy rates within the existing 16-place West of Scotland unit have consistently remained in excess of 100%, with a continuing pattern of admissions of young people to adult wards across the West of Scotland.

It is worth noting that the small number of West of Scotland 17 year olds in adolescent psychiatry provision during the period (5) reflected admission criteria at that time which restricted admissions to young people before their 16th birthday or 16 and over if in full-time secondary education. This does not, therefore, recognise the requirements since introduced through section 23 of the Mental Health (Care and Treatment) (Scotland) Act 2003 for age appropriate facilities to be provided for all young people up to the age of 18. This suggests that additional capacity will be required.
APPENDIX 5:
YOUNG PEOPLE’S UNIT STAFFING PROFILE

Introduction
The Royal College of Psychiatrists Guidance for the Staffing of Child and Adolescent Inpatient Units (1999) is currently being revised. The Scottish National Inpatient Forum was asked by the Chair of the Executive Committee of the Scottish Section of the Child and Adolescent Faculty of the Royal College of Psychiatrists to contribute to the revision process. Some of the recommendations submitted by the Forum to the Royal College are presented below. They are based on the original Guidance, experience from clinicians who have had experience of a team where the Guidance was applied in part, and experience from clinicians who work in very under-staffed teams. The needs of young people underpinned the discussions. Because Scotland has a smaller population in relation to geographical size than the regions in England, this was taken into account. Rehabilitation, liaison with community services and outreach were discussed and informed the staffing model.

Seniority
The seniority of the posts is pivotal to providing effective care for young people with the most severe psychiatric disorders in Scotland. Young people’s psychiatric inpatient units function as intensive care environments and the model of staffing has been chosen to reflect this much in the same way as medical or surgical intensive care units.

Medical Staff
Consultant Psychiatrists
In keeping with guidance from the Royal College of Psychiatrists, there should be one Consultant Psychiatrist for every 8-10 patients. Admission to hospital is a medical decision. Psychiatrists assess all referrals, although they generally include other team members in this. It is important to know when it is advisable not to admit and for the Consultant Psychiatrist to discuss with a referrer whether or not to proceed with an assessment.

The Consultant Psychiatrist in the team has legal responsibilities firstly as the Responsible Medical Officer for the patients and as an Approved Medical Practitioner for Mental Health Act work, both in terms of the 1984 and 2003 Acts. The Psychiatrist will provide clinical leadership to the team, and his or her experience in therapeutic skills is a foundation for teaching and training of the staff in a specialist environment. The training of Psychiatrists who wish to work in inpatient units is circumscribed and laid out by the Royal College of Psychiatrists. This system of supervised and monitored training is unique to Psychiatrists among the disciplines employed in psychiatric inpatient units for young people.

The Psychiatrist is very heavily involved in family assessment and therapy. In addition, a child’s parents or carers will expect to see the Consultant regularly and often at short notice. The Psychiatrist has a duty to have an overview of cases, knowing what is happening to each one and knowing how to integrate the care. It is expected that Scotland’s psychiatric inpatient units for young people will function eventually as a Managed Clinical Network, applying a uniformity of clinical
standards throughout Scotland. Consultant Psychiatrists will have a pivotal role in setting this up and maintaining it, and will be expected to promote research and audit in the units. All Psychiatrists receive training in research and audit and will be in an ideal position to ensure that this takes place. Consultant Psychiatrists will be expected to sit on committees that are relevant to the development of psychiatric services for young people.

Staff Grade Psychiatrists

Staff Grade Psychiatrists are pivotal to the running of an efficient unit. They undertake the day to day management of cases, mental and physical state assessments, ensuring case notes are kept up to date, that prescribing is maintained and that care is integrated with other disciplines. It is to be expected that a Staff Grade would progress to the position of Associate Specialist over time.

Nursing

Nurses play a unique role in the life of psychiatric inpatient units for young people. They provide continuity of care and generally are responsible for the day to day case management of young people in what is a highly specialised, “intensive care” role. Nurses are with the young people and are responsible for maintaining a therapeutic environment 24 hours a day. They are *in loco parentis* during the young person’s stay.

Nurses working in an inpatient setting are trained professionals and require high levels of generic skills in care planning, mental health assessment and clinical observation. It is necessary that some have training in general and paediatric nursing in order to provide the skilled physical care of complex young people with significant physical morbidity. Specific training in child and adolescent mental health needs to take place once in post as it is unusual to employ nurses who already have this experience.

Nurses participate in assessment and formulation work and become involved in family, group and individual work. It is important that there are enough nurses available to undertake these therapies and manage the environment, and that there is adequate time and funding for training and carrying out these duties. Nurses are responsible for the delivery of all medications and physical treatments and carry specific responsibilities with regards to the Mental Health (Scotland) Acts of 1984 and 2003. In an inpatient setting, a key worker/named nurse also has the task of liaising effectively with wider systems such as schools, colleges, social work and other health and non-health agencies. These nurses will often be the people who undertake preparatory work prior to admission and carry out rehabilitation and preparation for discharge.

The staffing numbers and seniority need to reflect the intensity of the work and the case dependency of the patients (Royal College of Psychiatrists 1999). Currently, all units have D and E Grade nurses and some nursing/care assistants doing the daily work in shift patterns that include nights and weekends. Community Nurse Therapists are employed at G Grade because it is felt that this level of seniority is required for the post and more junior grades are not considered experienced enough to case manage. Within inpatient units, assessment and therapy may be continued by a D or E Grade nurse who will require the support and supervision of more senior nurses. It is recommended that consideration is given to employing G Grade Nurse Therapists within the inpatient units.
The most senior nurse should be H Grade in a managerial role to include supervision of G Grade staff, appraisals of senior staff, and planning of effective development strategies. The role of one G Grade post carries responsibility for the day to day management of the unit including supervision of nurses and clinical work. A second G Grade Nurse Therapist will be involved in leading the clinical work of nurses and in training and supervision. This should be supplemented by F Grade charge nurses who will have specific managerial responsibilities to support the G Grades and clinical responsibilities within the ward. The majority of the day to day work is undertaken by E Grade nurses who develop the skills to work directly with the young people. The E Grade nurse is usually the key worker/named nurse for a young person during the admission and will become involved in family and group work. D Grade staff are usually new to child and adolescent mental health work, and will only be given responsibilities as their skills develop.

Usually, units will employ nursing assistants or support workers who carry responsibility for the physical environment and in being responsible adults who are not involved in therapy interventions and provide a normalising presence in their interactions with young people.

Recruitment and retention of nursing staff depends on many factors including job satisfaction, opportunities to practice therapeutically, adequate training funding and personal development planning, and a respectful understanding of the abilities and roles they fulfil within a multi-disciplinary team. In an intensive and potentially exhausting job they need backup at times of particularly intensive clinical activity. Nurses need to see that there are opportunities for promotion within the service without looking elsewhere. Young people’s psychiatric inpatient units are wonderful training environments that provide invaluable experience for staff developing expertise in child and adolescent psychiatry. Increases in the size of outpatient teams, where staff work family-friendly hours, has led to the major career structure and opportunities in child and adolescent mental health services being in the outpatient teams and a consequent loss of inpatient nurses to these posts. The seniority and numbers recommended in this report attempt to address these issues and help to solve a serious recruitment and retention problem. It will allow the inpatient G Grade Nurse Therapist and other nursing staff to do rehabilitation, outreach, and will facilitate home-based care.

Clinical Psychology

The Clinical Psychologist in a young people’s psychiatric inpatient unit plays a vital role in the assessment and formulation of each admission. Guided by findings from psychology research, the Psychologist has a responsibility to ensure that treatment decisions are based on a thorough understanding of the history and presentation of each young person’s difficulties.

The Psychologist makes a large contribution to the treatment of young people using evidence-based interventions in individual, group and family-based settings, and in supervised or joint work with other disciplines or by consultation in case discussions and team meetings. The tasks of monitoring and evaluating treatment effectiveness are central to the training of Clinical Psychologists, who therefore often organise and oversee the process of treatment evaluation in inpatient units, using the information collected to direct the work of the unit and to contribute to treatment outcome research. Psychologists offer training, keeping staff up to date with research findings and the evidence base on therapeutic interventions. Teaching and supervision of Clinical Psychology trainees is a requirement of all qualified Clinical Psychologists.
As a senior member of the multi-disciplinary team the Clinical Psychologist has a role in the general management of the unit, contributing to decisions about the overall treatment philosophy, operational policy and staff recruitment.

**Social Work**

Social Workers based within psychiatry settings for children and young people all hold a professional award (usually a post graduate Diploma in Social Work) and are usually funded and seconded by a local authority. Almost all will have previously worked for several years within a more generic setting, gaining an insight into how the functioning of children and young people is influenced by both individual and external factors. Social Workers bring expertise in the field of child protection to the multi-disciplinary inpatient team, and are able to assist colleagues in balancing the complex issues around mental ill health, family functioning and childcare. They also liaise with colleagues and relevant agencies to encourage a comprehensive understanding of wider issues that affect the child or young person’s current presentation – and those that may influence treatment outcomes following discharge. They are key players when the child or young person is in transition, having a working knowledge of both care in the community and inpatient settings.

Social Workers may be Mental Health Officers and undertake associated duties in relation to children and young people who require detention under mental health legislation. The new Mental Health (Care and Treatment) (Scotland) Act 2003 places additional responsibilities on Mental Health Officers, including undertaking of developmental assessments of need. Social Workers also provide practical solutions to problems that can place families under stress and lead to social exclusion as well as undertaking individual work with the children and young people.

The National Inpatient Child and Adolescent Psychiatry Study (NICAPS) emphasises both the important role of Social Workers within the multi-disciplinary team and in ensuring that a full range of skills, as well as disciplines, are available within units. All Social Workers are now required to evidence continuing professional development to maintain professional registration. Many working within these psychiatric inpatient settings undertake additional training and qualifications relevant to their specialist post – for example in family-based interventions.

**Teaching**

Like Social Workers, teaching staff are not employed by the health service, but are vital for the safe and efficient running of the unit. Teachers in Hospital Education Services all hold graduate and post graduate Diplomas in Education. They are employed by local authority education departments. In addition to their primary education or specialist secondary subject skills, teachers receive continuous professional development in their own academic area, and in aspects of child and adolescent psychiatry.

Teaching staff should be dedicated to child and adolescent mental health teams. For every 8 places within a psychiatric inpatient unit, there should be at least one full-time teacher with at least one other whole time equivalent post comprising subject specialists at secondary stage.
In addition to providing the curriculum education for patients in liaison with the pupil's mainstream school, teaching staff advise clinical staff on the educational elements of treatment, liaise with schools, further education establishments and other child and adolescent mental health outpatient staff and teachers. They are involved in inter-disciplinary work in assessment and planning for an individual's treatment programme. They should be involved in admission planning and are pivotal in the discharge process.

**Dietetics**

Dieticians have an essential role to play within any psychiatric inpatient unit for young people which admits patients with eating disorders. They oversee the nutritional treatment and therapy of each patient and communicate with and support staff and family. Nutrition therapy has been acknowledged and well documented as an integral part of the comprehensive treatment of anorexia and bulimia nervosa.

Dieticians are able to ensure the safe re-feeding of starved patients, regular essential weight gain, allowing cognitive work to begin. Dieticians go on to have a large role in helping patients challenge their distorted thinking. The Dietician gives support and training to the multi-disciplinary team with what is a difficult and challenging disease.

Some other patients within inpatient units are prescribed medication which increase appetite and cause weight gain. Dieticians are trained in communicating the science of nutrition and therefore have a role to play in advising all inpatients on their dietary intake, especially in light of growing obesity and healthy eating initiatives and developments in the science of nutrition within mental health.

**Occupational Therapy**

Occupational Therapists have a very specific role in developmentally appropriate assessment of the young person's premorbid skills and in tailoring a programme to help them regain lost skills and develop new skills for living. Occupational Therapists do intensive work with young people as they start to recover from the acute stage of their illness. Occupational Therapists are pivotal in the running of the group programme of the unit. They do community-based work in order to prepare young people for and to give them the skills they require to be reintegrated into the community. This needs to be flexible in terms of working hours and would involve joint working with other disciplines.

**Speech and Language Therapy**

Access to Speech and Language Therapy is very important for the assessment of autistic spectrum and communication disorders, schizophrenia and feeding or eating disorders. These issues often go unrecognised, especially when there is co-morbidity between communication or autistic spectrum disorders and other disorders such as schizophrenia, depression and eating disorders.
Physiotherapy

Young people are known to have poor diets and a lack of exercise and this is especially so for mentally ill young people. In addition, many psychotropic medications cause weight gain and mental illness itself can cause lack of energy, inertia and listlessness. The benefits of exercise are evidence based (Fox 1997). Young people with anorexia nervosa have bone loss, frequently over-exercise and need rest with attention being paid to muscle tone to reduce the chances of further complications. Access to physiotherapy is fundamentally important to provide specialist programmes in improving such areas as body awareness, strengthening and toning, stretching, cardiovascular exercise etc. Physiotherapists are also able to develop links to leisure centres for continuing healthy lifestyles following discharge.

Psychotherapy

Psychotherapists provide a valuable contribution to the multi-disciplinary assessment team. They play an important part in understanding the young person’s internal emotional world and how that impacts on their presentation and behaviour. They are also able to provide assessment of young people’s suitability for psychotherapy which might be part of the follow up treatment.

Child and Adolescent Psychotherapists are trained in thinking about and understanding complex and conflicting emotions and situations. The task of a psychiatric inpatient unit is very complex and staff may be influenced by conflicts generated by the combination of the small group of highly disturbed individuals found in an inpatient population. Very unwell or disturbed young people generate emotions in staff that are very profound. This can be reflected in high stress levels within the staff group. This may lead to difficulty in achieving and implementing an agreed care plan. These issues need to be resolved in a safe way without loss of face to staff members or disruption to team functioning. The availability of a Psychotherapist provides an opportunity to reflect on these dynamic processes, and this leads to improved multidisciplinary staff support and supervision as well as a dynamic understanding of difficult patients.

Family Therapy

Every unit must have a registered Family Therapist to undertake family work and/or therapy with parents/carers and siblings. This is evidence-based for major ICD10 Axis 1 psychiatric disorders (De Jesus Mari and Streiner 1994; Eisler et al 1997) and very important for psychiatric inpatient units for children and young people (Lask and Maynerd 1998). The CHYPIE study (2003) has shown that when parents engage and work well, progress following discharge is improved, as measured by the CGAS (Shaffer et al 1983). The types of cases admitted are complex and a very high level of expertise is required for family therapy. A qualified Family Therapist would provide skilled family therapy, training and supervision and a systemic view of young people admitted and the dynamics generated within the unit.
Creative Therapies

Young people have very individual ways of expressing themselves including the use of language, music, art and drama. Most therapies are language based and require patients to use words to express feelings. Not all people find this easy, and it is important that a range of modalities can be used to assist expression and resolution of difficulties. Creative Therapists are trained in using artistic approaches to assessment and treatment. Access to these approaches greatly enhances the work of units.

Housekeeping and Catering Staff

The National Inpatient Forum agreed that domestic staff need to be integral to the team. The same members of staff should be there each day and become familiar to the young people. This will lead to young people feeling that their physical environment is being cared for by trusted, consistent staff. When estimating the numbers of domestic staff, it is important to remember that this will be dependant on the size and configuration of the building and numbers may need to be adjusted accordingly.

Catering in psychiatric inpatient units for young people is vital as the young people need properly planned and prepared food to allow for growth and development, treatment of eating disorders, healthy eating for those on appetite stimulating medications, and more generally to appeal to the young person’s palate. A unit cook or cooks would liaise with the Dietician to provide good nourishment for patients. It is recommended that consideration is given to each unit employing catering staff in order to prepare food on site for lunch and evening meals.

Administrative and Clerical Staff

The work of the team is dependant on high quality secretarial and other administrative staff. It is a false economy to reduce this input. Case notes and other information resources to support joined-up care (shared care records, integrated care plans, assessments, transfer documents and discharge plans) must be kept up to date with entries complete, clear, typed when necessary, and filed promptly. Where electronic systems exist, they must be properly supported with clear responsibility for entering and retrieving information. Telephone contact from other professionals must be processed promptly and clinicians should not be required to spend time performing administrative tasks that could be undertaken by a member of administrative staff.

Research Assistants

Specialist inpatient services are very difficult to research (Green and Jacobs 1998). They treat relatively small numbers of people with rare disorders and are expensive to operate. In order to ensure that the best evidence is adopted, it is important to be up to date on the literature and to be contributing to that literature. A culture of research will lead to this, and research assistants are required to support senior clinicians in this. Each of the existing psychiatric inpatient units for young people in Scotland is in an academic site with local child and adolescent academic posts in psychiatry and other disciplines.
In the past, Scotland has been a leader in research, with the multicentre study (Wrate et al 1994) being widely published and cited in inpatient literature. With the reduction of units and staffing, this has not been possible in recent times, and the most important recent study (CHYPIE) has been focused on centres in England. There is a dearth of evidence for inpatient child and adolescent interventions, although empirically, clinicians see the benefit of admission on a daily basis. Clinical governance is vital, but without good research, is not possible. We do not believe that we can continue to rely on “others” to do research and need to be involved in collecting the evidence. Each of the inpatient units is associated with an academic centre, and research must be part of the culture in each of the units.

Models and Numbers

Staffing profiles have been presented (below) which have been discussed by the National Inpatient Forum. The multi-disciplinary team staffing levels proposed would be required by any 8 place unit to provide comprehensive care. It is likely that a larger unit would provide some economies of scale especially in senior and managerial roles so the numbers would not need to be increased pro-rata. The day-to-day work of a unit is provided by nurses and the nursing profile has therefore been compiled in a separate table. The staff numbers we have itemised below represent a model of care where staff are developing and maintaining skills by training in up-to-date evidence-based therapeutic modalities, as well as providing an integrated pathway of care for patients from referral to reintegration into the community. This includes assessment prior to admission, work with the referring team and family leading up to admission, all aspects of care whilst an inpatient and home-based work while the young person is reintegrated into his or her family and community. The dependency of the patients with an intensive care type of approach and need for high observation levels with intensive treatment approaches have been taken into account.

<table>
<thead>
<tr>
<th>Recommended staffing numbers for 8 places (excluding nursing)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Clinical Psychologists</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Dieticians</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Occupational Therapists</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Speech &amp; Language Therapists</td>
</tr>
<tr>
<td>Physiotherapists</td>
</tr>
<tr>
<td>Pharmacists</td>
</tr>
<tr>
<td>Psychotherapists</td>
</tr>
<tr>
<td>Family Therapists</td>
</tr>
<tr>
<td>Creative Therapists</td>
</tr>
<tr>
<td>(Art, Music, Drama)</td>
</tr>
<tr>
<td>Social Workers</td>
</tr>
</tbody>
</table>
Inpatient Working Group – Psychiatric Inpatient Services

Teachers  To meet national standards  2
Housekeeping  Housekeeper  0.5
  Cleaning staff  1
  Kitchen staff  To be determined
A&C  Secretaries  1
  Ward Clerical  1
Research and audit  Research assistant  0.5
  Assistant Psychologist  0.5
Teaching and Training  Practice Development Professional  0.5

In addition to these substantive staff, there will be trainees and other staff in the units. Trainees include Senior House Officers (SHOs) (essential and requiring funding and approval by the Royal College of Psychiatrists), Specialist Registrars (SpRs) (also requiring approval by the Royal College of Psychiatrists), Clinical Psychologists, Allied Health Professionals, and students of any discipline.

Nursing staff

The Royal College of Psychiatrists has worked out a formula for numbers (1999). Nursing staff numbers also need to reflect the rapid turnover of nursing staff, training, supervision, study leave and the need for peer support.

Royal College of Psychiatrists formula – ward staff to patient shift ratios:

<table>
<thead>
<tr>
<th>Nature of shift activity</th>
<th>‘Low’ case dependency</th>
<th>‘High’ case dependency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Night-time</td>
<td>2 staff (plus additional on-call for emergency)</td>
<td>1:3</td>
</tr>
<tr>
<td>Basic observation and maintenance of safety</td>
<td>1:3/1:4</td>
<td>1:2/1:3</td>
</tr>
<tr>
<td>Low intensity occupational activities</td>
<td>1:3 (Note – some patients may find low intensity activities highly demanding)</td>
<td>1:2</td>
</tr>
<tr>
<td>Active therapeutic programming times</td>
<td>1:3</td>
<td>1:2</td>
</tr>
<tr>
<td>Emergency/intensive care</td>
<td>1:2</td>
<td>1:1</td>
</tr>
</tbody>
</table>

Recommended nursing numbers per 8 places

- H or I Grade Clinical Manager  1
- G Grades – a Managerial and a Nurse Therapist post  2
- F Grades  3
- E Grades  14
- D Grades (learning the specialism)  7
- B Grades/clinical support workers  6
- Formula for total nursing numbers:  4 per unit place
This staffing model would allow a unit to be safely staffed with the possibility that 4-5 young people require constant observation, and without jeopardising the necessary outreach work which supports young people prior to admission and in the process of leaving. The process of reintegration to education, work, social settings, family and community activities, should be an ongoing part of the treatment process. It would be possible to deploy staff in these activities and liaise with local child and adolescent mental health services where the geographical distance means extra time is required. This would improve equality of access and service provision.

This model would also allow for intensive support in the community or other hospitals over a 24-hour period using a combination of staff, where such input is required. The role of one G Grade post would be as ward manager and lead nurse for the psychiatric inpatient unit, but the 2nd G Grade post would be as a Nurse Therapist and to co-ordinate the outreach service (in conjunction with the Ward Manager). Other members of the multidisciplinary team would also play an important part in providing outreach services, e.g. Social Workers. This model would allow internal rotation of staff at each grade, thus aiding job satisfaction and recruitment and retention of staff. It also takes into account the potential changes to the profile of those admitted to psychiatric inpatient units for young people following introduction of the Mental Health (Care and Treatment) (Scotland) Act 2003.

Bibliography

De Jesus Mari, J and Streiner, D L (1994) An overview of family interventions and relapse in schizophrenia: Metaanalysis of research findings. Psychological Medicine, 24: 525-578


HAS Child and Adolescent Mental Health Services, Together We Stand (1995) London HMSO


National Inpatient Unit Forum
September 2004
APPENDIX 6: ADMISSION CRITERIA

The following guidelines for generic psychiatric inpatient units for young people have been developed and agreed by the National Inpatient Forum.

Admission criteria

The purpose of a psychiatric inpatient unit for young people is to offer inpatient assessment and management to young people with severe and/or complex psychiatric disorders and when outpatient or day-patient care has ceased to be able to meet the needs of that young person. It must be better to admit to hospital than not to admit to hospital and a young person's psychiatric inpatient unit cannot replace good quality social work services or fill the gap in local child and adolescent mental health services.

The age range is 12 – 17 years inclusive. Consideration will be given on a case by case basis to young people aged 11 years if they have left primary school. Young people who may become 18 in the unit will have a transfer plan negotiated with the referring team in the months preceding their birthday, but may need to stay in until the final year of school has been completed.

Referral should always be made by a Consultant Child and Adolescent Psychiatrist. If another team member wishes to make a referral then the Consultant Child and Adolescent Psychiatrist must have been consulted. If a Consultant Paediatrician or other consultant wishes to refer this should be discussed with the local child and adolescent psychiatry team.

Admission may take place in situations where:

1. A mental disorder in a young person has led to a significant risk of suicide or significant harm may ensue if admission does not take place.

2. A young person is suffering from a severe ICD10 Axis 1 disorder (including psychotic disorder, affective disorder, eating disorder, obsessive compulsive disorder, neuropsychiatric disorders, psychosomatic disorders, and disorders of development including pervasive developmental disorders).

3. A young person's development has been disrupted by adverse experience and it is deemed that an inpatient assessment would add to the understanding in management of that case.

4. The complexity of a young person's presentation causes difficulty in reaching a diagnosis and an inpatient assessment would prove valuable.

5. Other young people may be considered where negotiation between the outpatient and inpatient consultants has led to an understanding that an inpatient assessment is required.
The needs of patients would be considered on a case-by-case basis but the following would make admission unlikely:

1. The level of dangerousness presented by the young person would put staff and patients at risk or the patient would require a locked environment. This category requires its own specialist provision and it needs to be noted that this is not currently available in Scotland.

2. Drugs and/or alcohol are the sole condition causing the disturbance to the young person. This category requires its own specialist provision and it needs to be noted that this is not currently available in Scotland.

3. The young person is affected by moderate or severe learning disability whether congenital or acquired. The staff of the current young people’s psychiatric inpatient service are not trained or accredited in the management of significant learning disabilities and would not be able to meet the needs of this group of people without further training and the commissioning of extra places. This category requires its own specialist provision and it needs to be noted that this is not currently available in Scotland.

4. A particular mix of cases may, on occasion, preclude admission. Admitting a particular patient may cause problems for the wellbeing of the other patients within the unit or alternatively the other patients within the unit would cause problems for the wellbeing of the young person being referred.

5. The young person presents with deliberate self harm behaviours in the absence of a major psychiatric disorder or clear suicidal intent. There is evidence that this group of patients does badly if admitted to hospital and requires particular therapeutic interventions in the community.

Psychiatric inpatient units for young people will provide consultation and advice following consultant discussion to outpatient teams nationally. Second opinions will be available for young people and families where indicated.

National Inpatient Forum
September 2004
APPENDIX 7: NATIONAL INPATIENT FORUM

The National Child and Adolescent Inpatient Forum was formed in September 2001. Clinicians from the inpatient units had previously been meeting three times a year for peer support, working towards developing national standards of care, discussing difficult cases and looking at the literature and the latest evidence informing practice. There was also increasing concern about the need for a national strategy in order to adopt a recognisable identity and make a case to commissioners for better services.

When the Fife Playfield House unit stopped admitting patients in the summer of 2002, the group felt that it would be appropriate to formalise the National Child and Adolescent Inpatient Unit Forum. A Chair and Secretary were elected and meetings were established on a more formal basis. The regular membership of the Forum consists of professionals of all disciplines and agencies who work with inpatient units. From time to time, special meetings are convened to include professionals from community teams, as they are involved in the preparation of young people and their families for admission and for the rehabilitation and discharge processes.

The Forum now meets for a full day every 3-4 months, with business in the morning and peer support and education in the afternoon. The Chair of the Forum sits as a co-opted member on the Executive Committee of the Scottish Section of the Child and Adolescent Faculty of the Royal College of Psychiatrists.

Staff from the psychiatric inpatient units for children in England and Scotland have a regular meeting organised by CHIPSIG (Child Inpatient Special Interest Group). Staff from the children’s psychiatric inpatient unit at Yorkhill in Glasgow have only limited involvement with the National Inpatient Forum.