Young Persons’ Perspectives and Experiences of Specialist Tier 4 In-patient Mental Health Services in Norfolk

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The project was commissioned by Healthwatch Norfolk (funding period 1st October 2013 – 31st January 2014), and was approved by Norfolk and Suffolk Foundation Trust under the remit of service evaluation.

Project Team

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Professor Francine Cheater is Professor in Public Health and Implementation Science and Director of Research, School of Nursing Sciences, University of East Anglia. She is a nurse by professional background and an experienced health service researcher, conducting externally funded health services research and evaluation in primary, secondary and third sector settings. Professor Cheater provided overall supervision of the project.

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Introduction

The under 25’s Services in Norfolk was developed in 2012/13 as part of NSFT radical redesign. The traditional Tier 3 Child and Adolescent Mental Health Services (CAMHS) 0-18 years were redesigned into a CAMHS under 14yrs and a youth service 14-25yrs. This was in conjunction with many other changes, the development of a Tier 4 Inpatient Unit and an Intensive Support Team (IST). The Early Intervention Psychosis Service (EI) 14-35yrs, was brought under the umbrella of the combined services for youth and children.

Prior to this there had never been an adolescent inpatient unit in Norfolk. The service was set up for a number of reasons, one being the need to have a local inpatient service to aid recovery of the young people. Another factor was cost savings from out of area placements, including the costs of time and travel for the family. In the past young people needing an inpatient placement may be admitted to an adult ward in the local mental health institution, until an adolescent bed could be found somewhere in the country.

Key policies and documents that have influenced the tide of change nationally for CAMHS have been; Together We Stand 1995, Every Child Matters 2003, and the update of the Children Act 2004, The National Service Framework 2004, National Advisory Council- part of the CAMHS Review 2010 included a duty to provide an age appropriate environment under the

We conducted interviews to:

- Hear the views and experiences of professionals who are dealing with the referral process in and around Tier 4 mental health services for young people in Norfolk
- Identify the core strengths and weaknesses of current processes
- Understand the current picture of referrals into Tier 4 mental health services for this client group

We also conducted a focus group to:

- Understand the experiences of young people who had received Tier 4 mental health services
- Identify the strengths and weaknesses of the referral process from young persons’ points of view

We carried out desk research to:

- Examine statistics for young people admitted to Tier 4 services in Norfolk
- Compare current guidelines and standards with what interviewees reported was happening in practice
Context Setting: Local and National CAMHS Services

This section outlines the policy context of the local and national CAMHS services. It outlines the development of a national CAMHS service, national provision, as well as an outline of the local Tier 4 services (in-patients and intensive support team).

Development of a National CAMHS Service

In 1995, CAMHS came under the eye of the government as needing updating and offering a more consistent service across the country. Two key documents, ‘A Handbook on CAMHS’ and ‘Together We Stand’ paved the way for the development of CAMHS within a four-tiered framework for planning, commissioning and delivery (Youngminds 2013).

‘In 2003 Every Child Matters set out a framework for children’s services including children’s trusts arrangements with five outcomes. These were, being healthy, staying safe, enjoying and achieving, making a positive contribution and achieving economic well-being’ (Youngminds 2013).

In 2004 the vision put forward by National Service Framework for Children, Young People and Maternity Services has been a major driver in CAMHS methods of working, including setting national standards. They state that one part of the system cannot fully function without the other tiers and agencies themselves being in place and functional.

‘Essential ingredients; The need for highly specialist Tier 4 provision in any area is dependent upon the ‘availability, quality, range and ability of Tier 2 and 3 services along with other social care, education, youth justice services intensive support in the community.’ Multi-agency agreements and a ‘network of care is required for each locality for children and young people with severe, challenging and complex problems’ (NSF 2004:32).

National Inpatient Service Provision

The National Inpatient Child and Adolescent Psychiatry Study (NICAPS) aimed to provide a comprehensive picture of service provision across England and Wales (2001). A key issue identified was concern around the availability of beds and the provision for emergency admissions:
'The main concerns expressed by members of the Faculty included: lack of emergency beds; insufficient number of beds; poor provision for severe or high risk cases; and poor liaison with other services.' (NICAPS 2001:6)

The admission processes were also convoluted, with patients needing to be referred to multiple units before an appropriate and available bed was identified:

‘For every four patients referred to in-patient units, approximately three were assessed and two admitted. Patients were commonly referred to more than one unit (either serially or in parallel) before admission was achieved’ (NICAPS 2001:7).

In 2001, the Quality Network for Inpatient CAMHS (QNIC) was set up by the Royal College of Psychiatry. The QNIC standards evolved from a set developed to evaluate services as part of the National Inpatient Child and Adolescent Psychiatry Study (NICAPS) (O’Herlihy et al., 2001). QNIC continues to build a network of inpatient facilities and to set standards for the gold service for CAMHS and youth inpatient provision. There are currently approximately 115 adolescent inpatient units accredited by the network. Reviews take place every 2-4 years, the last one being between September 2012- June 2013.

The local inpatient unit (5 Airey Close, Lothingland, Oulton) is currently working through the application process for accreditation. The reviews include interviewing staff, young people and carers about their experiences of the unit. Results from each review cycle are published along with recommendations for improvement.

O’Herlihy et al. (2007) examined the inpatient provision in England between 1999 and 2006 which shows that the total number of units increased by 19. This led to an increase of 284 beds, from 844 to 1128; 69% of the increase in beds was the result of independent providers. This is however unlikely to reflect the current picture, following the economic downturn and the resulting cuts to services. There is currently no national data to draw upon in this regard.

**The Local In-patient Picture**

In 2010 Norfolk CAMHS Joint Commissioning Group (JCG) commissioned a needs assessment. A key issue that emerged from this was the continued lack of inpatient services (Street et al, 2010). A number of recommendations were made which have fed into the more recent radical redesign of services in Norfolk and Suffolk Mental Health Services (NSFT). Some of the highlights are:

1. To reduce the number of Psychiatrists in line with neighbouring Trusts.

2. To develop better accessibility to Tiers 2-4.

3. To support continued investment in CAMHS services that work with those who are at high risk of developing mental health problems.

4. The need for new investment to fill the gaps that exist in services.
In 2011, the CAMHS Strategy for 2011-2014 was developed by the Norfolk CAMHS Strategic Partnership. Some of the priorities proposed include:

a) A Public Information Plan, including a guide to CAMHS in Norfolk; two websites have been set up one for the CAMHS service (www.whatsthedealwith.co.uk) and one for Early Intervention Psychosis (www.memyselfandmentalhealth.org.uk).

b) Referral criteria and care pathways not widely publicised, or understood, these are to be simplified and publicised widely.

c) An adjustment of skill mix across professional groups, to reduce the number of psychiatrists, collocation of some professionals and training in a number of therapies that are in short supply for instance cognitive behaviour therapy, family therapy, and group therapy.

d) To plan and commission an outcome focussed integrated pathway for community and inpatient.

e) To develop an inpatient unit.

f) Young people’s IAPT to be developed.

The local unit at Lothingland has 8 beds, all en suite. Prior to opening, a reference group of young people with inpatient experience provided advice on the design of the unit. They have, since April 2013 had 25 admissions, with an average length of stay of 8-10 weeks. It is likely that these relatively low admission rates are in part down to the time taken to staff the unit at full strength and with the necessary skills mix.

The Intensive Support Team

The Intensive Support Team (IST) was set up at the same time as the inpatient unit. This was to assist the community teams and the T4 service, to significantly reduce the number of children and young people being admitted. This would be managed by offering intensive support at home. IST could also offer more support at time of discharge in order to reduce time on the unit. When adding the saved costs of prevented admissions and the reduction in placements, the total savings generated by the Intensive Support Team over the seven month period is £1,870,617 (IST Briefing).

Performance Data for IST  (IST Briefing)

| Referrals to IST since October 2012: | Total 60 |
| Discharges from IST back to referrer since October 2012: | Total 34 |
| Average length of support to each individual: | 12 weeks |
| Prevented admissions to inpatient services: | Total 50 |
| Reduction in Out of County Inpatient services: | Total 33% |
Figure 1: Under 25’s Services for Norfolk and Waveney

Tier 1
Universal Services
These services are accessible by all children and young people. They are delivered in settings such as children’s centres, schools and primary care by teachers, early year’s workers, GPs, school nurses, health visitors and others. The mental health role of universal services is to promote positive mental health and wellbeing and to help identify, refer on and support those children who may require input from targeted or specialist services. (Norfolk.gov)

Tier 2
Referrals to Tier 2 One Number Telephone Triage - support, signposting for early presentations. Funding stream through County Council/Social Care and Voluntary sector
Targeted services/provision-'Point 1'
These services are for children and young people (school age) who may be considered to have specific mild to moderate mental health needs and/or to be vulnerable and would benefit from effective, early, time-limited interventions. Service settings include universal settings, but the provision is aimed at identified groups, not the whole population. (Norfolk.gov)

Tier 3
Specialist Mental Health 0-25 years, including Early Intervention Psychosis
Referrals through one telephone number Access and Assessment teams, for all age population. Telephone triage and signposting, or accepted to an appropriate team. Prioritised according to urgency of referral. A clear mental health issue that requires specialist input.

IST Working with and between T3 and T4

Tier 4
Inpatient Provision
Healthwatch Norfolk Project Brief

We were tasked with collecting information that would provide a comprehensive picture of the current state of access to Tier 4 services for young people (aged 14-18) in Norfolk. The project aims were to:

- Gain insight into the experiences of young people who are users of Tier 4 services in Norfolk;
- Gain insight into the current ease of access and quality of provision of the current Tier 4 services in Norfolk;
- Develop an understanding of how Tier 4 places are agreed for young people in Norfolk.

To meet these aims, we contacted service providers, clinicians, and service users based in Norfolk, and collected qualitative interview data on their experiences of the current system of service provision.

We examined the patient pathway into and out of Tier 4 services (including the Intensive Support Team), the current picture of inpatient services for local young people, and aspects of the decision making process for placing young people into inpatient care. Figure 1 below provides an overview of the services provided for young people in Norfolk.

The data from service users and providers as well as a commissioner perspective have been synthesised below, providing a rounded impression of what the current strengths and weaknesses are in the system.
Design and Methods

This was a largely qualitative study that sought to gather and synthesise the views of a range of people who had differing experiences of the Tier 4 admission and discharge processes. We sought to recruit commissioners, case managers, clinicians and service users to talk to us about their experiences.

The report authors met weekly to discuss and monitor progress, and to ensure that any issues with the running of the project were quickly resolved. There were regular telephone meetings as well as a mid-project site meeting at a local inpatient unit between the lead author and members of Healthwatch Norfolk. The report authors also attended a Healthwatch Norfolk board meeting to present and discuss preliminary report findings.

Recruitment and sample

Commissioners and service providers

Recruitment of commissioners and clinicians was achieved through our established links with CAMHS services and healthcare professionals in Norfolk. We contacted commissioners and clinicians initially by email, and arranged a subsequent telephone interview to explore with them the issues for this report.

We conducted one-to one interviews with the team leaders of the Intensive Support Team and inpatient services, as well as two psychiatrists, and the service manager, and deputy service manager for Tier 4 services. In addition we interviewed a commissioner and case manager. Participants represented services from across Norfolk and had experienced the Tier 4 referral and admission processes from the perspective of their differing roles, providing as broad a picture as possible within the scope and time limitations of the project.

We asked interviewees to:

- Describe the current process of placing youths into Tier 4 services
- Identify the strengths of this process
- Identify the main constraints or difficulties of this process
- Describe how decisions about duration of stay are made
- Describe the issues surrounding discharge from Tier 4, and identify how decisions are made
- Identify changes that could be made to improve the current processes
Service Users

Given the time constraints for completion of the work, and the often ‘hard-to-reach’ nature of young Tier 4 service users, we adopted a multi-pronged strategy to recruitment. We advertised for participants via the youth forum for mental health, both through word of mouth and a Facebook post from the youth forum official page. We also approached service users who were at the time residents in the local inpatient service, as well as via the clinicians working in the unit who sent out letters advertising the project to recent inpatient service users. In using these approaches to recruitment we ensured that names of potential service user interviewees were not given to us directly without their consent.

Despite the varied strategies we adopted, the recruitment of young service users within the timeframe of the project was difficult. We aimed to interview 12 service users but ultimately were only able to recruit four young people to discuss their recent experiences of Tier 4 services. This sample comprised a service user focus group comprising three young people and a telephone interview with another young person (recruited via Facebook).

Interviews/focus group

The questions for the interviews and focus group were developed to explore the providers and service users’ views and experiences of the tier 4 admission process, as per the brief of this study. Questions were drafted by RS, discussed by all three members of the project team and refined. Copies of the interview schedule are provided in Appendix 1.

The interviews and focus group were digitally recorded (with participants’ consent), transcribed verbatim in full, and subjected to thematic content analysis. Data from clinicians, commissioners and service users were compared and contrasted, with the output being a synthesis of experiences of the care pathway into and out of Tier 4 services, pinpointing key areas in need of attention.

Desk research was also conducted to review recent policies, current standards and guidelines. This was used to provide the context for the current study, as highlighted in a previous section.
Findings from interviews conducted with staff, service users, and commissioners

The following sections synthesise the views and experiences of commissioners, clinical staff and service users regarding Tier 4 services for young people in Norfolk. The selective quotes from the interviews or focus group are used to illustrate the key issues, and allow the participants’ own words to be heard. The three subgroups of participants who provided data for this report are ‘commissioner’ (a commissioner), ‘clinicians’ (two team leaders, two psychiatrists, a case manager, a service manager and deputy service manager), and ‘service users’ (four young people with current or recent experience of being placed into Tier 4 in-patient services). We have labelled quotes as to which subgroup they came from, and in order to preserve anonymity we have not included any more personal identifiers.

A flow chart depicting the theme development stemming from the interviews is provided in Appendix 2.

How are decisions to place young people into Tier 4 services made?

The process of placing young people into a Tier 4 service is based on national provision of places, with decisions made to refer to Tier 4 made by local clinical teams. Delivery and provision of services is no longer locally determined, it is now a system based on national delivery. This has in the past year been implemented into the contracted funding of treatments for young people. Any young person who requires a Tier 4 service would have to be accessing and referred from a Tier 3 service.

This “ensures that all the other options have been exhausted before we admit to a bed… what we don’t want is children going into services without the space being managed, or could be potentially managed in the community by community health teams” (Commissioner)

Both commissioner and clinicians concurred that the most potent variable in the decision-making process is that of risk. To be considered for admission to Tier 4, Service users already within Tier 3 services:

How are decisions made to place young people into Tier 4 services?

Key points:

- Perceived levels of risk is the key deciding factor as to whether a young person is referred to Tier 4 services
- Managing this level of risk can at times lead to inappropriate referrals and admissions
- Scarcity of community resources contribute to an increased number of these admissions as clinicians seek to balance the risk
“Would have quite high risk around their behaviours and needs – so we’re talking about the severe and very severe criteria of the care programme approach” (Clinician).

Once Tier 3 services felt that the level of risk to self or others was severe, liaison with commissioners and Tier 4 commences:

“Assuming that we [Tier 4] agree it was appropriate, they then need to fill out the funding form, which goes to the commissioners. The commissioners then agree that that’s an appropriate placement and send the form to us once it’s signed off. And at that point, the young person can come in” (Clinician).

This is not necessarily a smooth process, however. One of the key words in the above quote is ‘appropriate’. Many participants spoke of the difficulties that both Tier 3 and 4 services sometimes have in deeming what is ‘appropriate’ for admission to in-patient services, especially as

“*We don’t want children going into services without the space being managed, or could be potentially managed in the community by Community Health Teams*” (Commissioner).

This in turn could lead to the young person being admitted to a unit which is not set up to meet their specific needs, either due to the current staff skill mix, or the range of other diagnoses that current service users may have there. Participants did state that it is however common that young people are

“*Being admitted to a wrong unit, which can then not just impact on that young person, it can impact on the other young people in the unit*” (Clinician).

The difficulty for clinicians and commissioners to judge is whether this perceived level of risk warrants admission to a particular unit or not. As the previous quotes indicate, if the risk is not actually as severe as initially thought, perhaps an ‘inappropriate admission’ is initiated, when continued community treatment may have been more appropriate. However, it’s also possible that the level of risk is too great for units to take on in case they:

“*Impact on the unit, the safety of the patients, the safety of the staff…a big thing for me would actually be risk assessing to make sure that the person was safe to come to this unit*” (Clinician).

Clinicians have measures at their disposal to help judge levels of risk in relation to Tier 4 admission:

“*We’ve developed our own assessment tool that actually gives us a scoring around risk…quite a holistic assessment. So we won’t just focus on mental health, we’ll also focus on the socioeconomic needs for that young person, education, the whole theme of everything that’s going on around their lives*” (clinician).
However, the likelihood of admitting young people to in-patient services when they could perhaps continue to be treated in the community increases in connection with a growing pressure on increasingly scarce community resources:

“You’re going to be more likely to admit someone if you can’t – if your community team is under pressure. You haven’t got the resources that you had say, a year ago because they’ve been cut” (Clinician).

Tier 3 services have been faced with numerous cuts –

“Because CCG’s have targets to meet…we’re seeing kids going into Tier 4 that perhaps may not have done if Tier 3 services were more robustly supported” (Commissioner).

The lack of round the clock community care also places undue strain on the admission process, as clinicians become faced with leaving their most vulnerable patients unsupported over the weekend:

“I think sometimes you get to a point on a Friday afternoon, if the risk hasn’t reduced in any way and your facing 48, 72 hours with no additional support and the families are looking at you, you think, what are we going to do tomorrow if she does X, Y, or Z? I think that’s another big problem with the system…I think you’re much more likely to admit [to inpatients] at that point” (Clinician).

What are the issues when trying to access Tier 4 services?

The key principle underpinning Tier 4 services is “if a kid needs a bed, a kid needs a bed” (Commissioner), and there is also an expectation that “there’s no barriers to anybody receiving the treatment they should have” (Commissioner). The previous section has also highlighted that Tier 4 admissions are initiated because the young person involved is considered to be too high a risk to stay under the care of community teams. Holding these points in mind, the following experiences of clinicians and service users differ somewhat from these expectations.

Clinicians consistently spoke to us about a lack of beds for young people, both on a local and national level:

“We frequently have difficulties finding a bed...most units are actually just full, and the ones – obviously the patients that generally need admission are those presenting with lots of behavioural and high risks, and because units are all full, they’ve got very complex cases on them already…so they can’t admit anyone else” (Clinician).

This situation was echoed throughout the clinician interviews, with it not being uncommon for senior clinicians to spend a week or more searching for ‘emergency’ beds for their patients:

“I think it’s increasingly common…you’re phoning masses of units to try and find a bed, and then are looking at miles away simply because there is no capacity in the system at the moment. And it’s something the commissioners are aware of. In fact the
commissioners are meant to take responsibility for finding beds but they can’t compel units to take people” (Clinician).

Partly, this lack of beds has been attributed to a surge in demand caused by the increasing pressure and cuts to community services, described in the previous section. Clinicians also identified the increased number of the aforementioned ‘inappropriate admissions’ as putting strain on the number of beds available. Finally, low staffing levels on in-patient units has led to referrals being refused due to concerns about maintaining safety on the unit:

“I want the unit to be working at full capacity, but for me, at the moment it’s just not safe to do that, for the patients, the staff, the whole sort of package really” (Clinician).

This time-consuming process, in which clinicians spend large proportions of their time phoning and faxing other units with what seemed to be minimal confidence of actually admitting their patients was described as an inherent problem with the current system of referrals:

“[a previous referral] was my time and four members of my team. We were all doing it. So we were just working down a list of units, and I was phoning the commissioner as well…it takes an enormous amount of time” (Clinician).

“A very clunky system. It doesn’t work with the patients’ needs in mind, I don’t think” (Clinician).

Whilst this is happening, clinicians are also having to manage the high levels of risk in the community, as they wait for a suitable bed to become available. Clinicians have described having to improvising care packages with the service user and their family as they wait for a bed:

“It does mean we have had some young people that couldn’t be admitted because there are no beds. We have managed to keep them at home, and probably taking some more risks that we’d like” (Clinician).
Service users in the focus group concurred that this system, in which they themselves (and their families) were often left waiting for days, not knowing when or where they would be going had detrimental effects on them:

“I was sort of in between doctors and hospitals all the time in that period. But my dad wasn’t [happy] – he was quite upset about how long it took” (Service user).

Because of the unpredictability of where and when beds become available for young people in need of in-patient admission, our service user participants reported feeling under-prepared for admission to the unit, and unsure of what to expect. Service user participants requested more information and communication about what to expect prior to admission, as well as more substantial information upon admission to help them acclimatise to their new setting:

“I think if it was just a bit more organised then – because I was told on the day. If I was told like a week before and then I got the chance to come here and then meet everyone before I came and then come back a week later, because then I would know my way around, and some people and some of the staff” (Service user).

“It would be nice to know like some of the staff a little bit, just a bit more. Not throwing you in at the deep end as much when you arrive” (Service user).

These concerns appear particularly evident when service users spoke of being faced with admissions in units that were a considerable distance from their family home, which presented the young person with an additional level of anxiety about the process. Our service user participants spoke of how this prospect would lead to them refusing to be admitted so far away, and ultimately needing to be sectioned under the Mental Health Act to enable admission:

“There was like talks about hospital, like going to London or something, and I was like, “I’m not going.” so then my worker got quite concerned. She was like “Well, if you’re going to refuse to go then I’ll have to get the Mental Health Act involved…and then it got to the day and I got sectioned” (Service user).

However, long distance placements, whilst anxiety-provoking for the service users, do provide the opportunity for service users to receive the specialist care they need, rather than attend a local unit that may not be set up to achieve the best outcomes for them.

“If that child requires a specific service that can be offered in North Essex, for instance, it doesn’t matter where that child comes from; if the patient and the family and everybody else thinks that that’s the best place for the kid, they can come then” (Commissioner).

What happens once service users have been admitted to treatment?

Our service user participants reported to us that once they were admitted to an in-patient unit, the lack of preparation that was discussed in the previous section seems to be followed by a
lack of information about the ward, and wished to have some information on the unit and its staff either prior to, or at the point of admission.

“I thought it’ll just be like eating disorders, but then like it turns out there was quite a lot of like other mental health issues. But they didn’t tell me like how distressed some of the people would be” (Service user).

“They didn’t really give me any information, so I spent the whole weekend worrying about what it would be like” (Service user).

Service users also said that they experienced feelings of isolation whilst on the unit. This included complaints regarding the décor and ‘dull and clinical’ feel of units, but mainly focussed on the lack of access to technology to help stay in touch with their friends and families. Some of this was down to the infrastructure of the unit, such as poor wifi access:

“We have laptops but the wifi isn’t very good because only one person can use it at a time, if someone else is on a laptop as well, it tends to crash”.

But this isolation was also enhanced by the rules of the unit, which restrict the use of technology with cameras built in. According to our participants, this rule not only made it hard to stay in touch with family and friends, but also restricted social interaction between patients on the unit:

“If we brought our laptops or tablets or whatever then they have to be kept in our boxes which are locked up and then we have to ask for them. And then we’re only allowed to use them in our rooms, which is a bit rubbish. It’s mainly because they’ve got cameras in them. But … we put tape on our cameras so we couldn’t take pictures, but we still weren’t allowed them out. Which isn’t that fair because like if we want to be in the living room but still be on the ipod, we can’t be. So you’re either being really unsociable in your room or just bored in the living room” (Service user).

Once service users had been admitted to in-patient treatment, however, the systemic problems that were evident in the referral and pre-admission process seem to dissipate. Once admitted,
service users’ treatment is individualised, and duration of in-patient stay is very much down to their personal progress during treatment.

“There’s no definitive ‘you must be in and out in a certain period of time’, every child is different…it has to be an individual pathway” (Commissioner).

Once in-patient treatment commences, an assessment takes place in which the child’s needs and likely duration of stay is determined. The CAMHS case manager and care co-ordinator monitors progress and determines if the provider is on track in delivering the goals of treatment. However, there is an understanding that treatment is not always linear, and that a degree of flexibility is required.

“We’d also understand through that process, any hiccups, because no treatment’s perfect. The child could be completely engaging and then, all of a sudden, for some adverse reason, become unwell again and not engage. So we have to manage that on an individual basis” (Commissioner).

This process of individual monitoring and advance discharge planning appears to contrast with the difficulties experienced by professionals during the referral and admission process. The discharge process is often a stepped one, in which the service user leaves the unit for increasing periods of time until suitable progress is made and discharge plans fully formed. This process works well:

“We see them become well, and then we move them out and back into their family unit, and then support them again by Tier 3 services. And that way, the pathway’s smooth, there’s no delay in discharge…health and social care are all managed prior to discharge” (Commissioner).

The one hurdle to completely smooth discharge planning and delivery is however based upon the proximity of the in-patient unit to the service users’ family. Although the previous section highlighted that national placements may provide more specialised care for the service user, when the unit is a distance away from the familial home, this stepped approach of home leave can be made more difficult, and communication between in-patient and community teams is not as fluid as it is when the Tier 4 services are communicating with their local community clinicians:

“[the difficulties with agreeing a discharge plan] may be just because of the distance between providers. It’s hard to communicate a care plan. It’s hard to have that reassurance” (Clinician).

Summary of key issues

Table 1 summarises the key themes that have emerged from the interviews that were undertook for this report. The themes are presented in relation to the following phases of
service provision: (i) the decision making process behind Tier 4 admission, (ii) the ease of access to Tier 4 services, and (iii) the process once admitted to Tier 4 services.

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<th>Description of theme</th>
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<td>Treatment in, and discharge from Tier 4</td>
<td>Lack of information</td>
<td>Young people described a lack of information about the unit upon admission</td>
</tr>
<tr>
<td></td>
<td>Isolation</td>
<td>Young people spoke of feeling socially isolated whilst in Tier 4 services</td>
</tr>
<tr>
<td></td>
<td>Individualised care</td>
<td>Once admitted, duration of stay is based on individual progress whilst in treatment</td>
</tr>
<tr>
<td></td>
<td>Proximity</td>
<td>Communication regarding discharge planning hampered if Tier 3 and 4 services are geographically far apart</td>
</tr>
</tbody>
</table>
Suggestions for improvement arising from this report

This section provides suggestions for addressing some of the issues identified in this report. It is of note that a number of the key issues highlighted in the NICAPSA study (2001) referred to in the context section of this report are still evident today, 13 years later. This includes the lack of provision of available beds, and a clunky, non-user-friendly referral process and admission system. We should also note that the local inpatient unit is currently aiming for accreditation to QNIC standards. Of particular relevance here would be an increased emphasis on providing information for service users at access, admission, and discharge. This was repeatedly highlighted as not satisfactory by our service user participants, and would need to be addressed prior to any submission for accreditation.

During our interviews, we also gave participants the opportunity to suggest improvements that could be made to the current system of Tier 4 services. What immediately follows is a selection of ideas that were put forward by participants.

“I think that we should be able to have a service that a young person can self-refer to, or a GP professional self-referral through to, and once they’ve gone through a really good assessment of the needs for them at that time, a package of support should be available for them where they have a virtual team created around them. So there’s no more journeying for them from one service to another, from one team to another to another, with a semblance of care planning. I think it should be around services coming to them, and that should be completely multi-agency and multi-disciplinary.” (Clinician)

“If I’ve got somebody that I need to admit, for whatever reason, I want to make one phone call and say, “I’ve got this individual,” and then for them to access the bed. So that there’s some central point that knows where the beds are and will facilitate that happening, and so I’m not having to make fifteen different phone calls to fifteen individual units, and fax off clinical information to fifteen different places, to be told no each time. And I think that would be much better for the family because you could say almost immediately, okay, there’s a bed here, off you go.” (Clinician)

“I think a lot of it is about us being able to be creative. So at the moment we’re trying to get a pilot up and running to allow our crisis workers to buy packages of care from a local partner agency. But the difficulty is that organisations don’t work in that way. So it’s very hard for us to buy the care that the young person needs. Often they don’t need a doctor or a hospital; they just need some support, some social care. So I think those links across social and health are particularly important.” (Clinician)
“I think it’d be better if we got to have the chance to like meet the people at – who were here before we start staying here. Because otherwise it’s just like you go to a place one day and then everyone you know just leaves you and then you’re just surrounded by loads of strangers who you don’t really know. And then you’re told that you have to stay here and sleep here.” (Service User)

“It’s just little things like some pictures on the wall. Like in here, there isn’t much art at all…and if it was a bit more colourful as well. Because everything is a bit like dull…a bit clinical.” (Service User)

Considering the implications of the interviews for the current study, we have detailed a number of suggestions to address core issues raised by interviewees. These are as follows:

a) For in-patient units to update their website, with easy to access information on policies and things to expect whilst on the unit. A virtual (website) tour and introduction to staff would also help prepare young people for admission.

b) Upon admission to an in-patient unit, for young people to be given a ‘treatment folder’ in which clear information about unit boundaries and procedures is documented. This folder could also contain copies of individual care plans, goal setting etc.

c) CAMHS is a specialist setting and requires staff with the relevant specialist skills and training, not just in mental health, but also in working with young people. Local training in Tiers 1-4 of CAMHS for all professions, delivered by specialist trainers should be considered.

d) To address the ‘clunky’ referral process, we suggest that there should be a frequently updated list of units of who are currently accepting emergency admissions.

e) We also suggest the streamlining of the referral process, with a centralised form, to avoid multiple forms needing to be completed for multiple units.

f) The lack of 24/7 community care is, according to our participants, linked with emergency admissions which might not always be appropriate. We suggest a review of the current capacity of community services, and if warranted, a strengthening of community resources.

g) We suggest that services explore ways of enabling service users to continue to engage and stay connected with family and friends via the use of technology, whilst managing any safeguarding or risk-related issues.

h) The décor of a unit contributes to how service users relate to their experience there. We suggest service users are consulted about ways to enhance the ‘feel’ of the unit they are on.
References

Anderson Y. et al. (2009) New Ways of Working in CAMHS. Cernis


Royal College Research Unit (2001) National In-Patient Child and Adolescent Psychiatry Study.

Royal College of Psychiatry (2013) Building and Sustaining Specialist CAMHS to Improve Outcomes for Children and Young People.


Appendix 1: Interview schedules

Young person interviews

+ Introduction to scope of the project, tier 4 services etc

+ Can you tell us about the inpatient unit you were admitted to?
  - When was it that you were admitted there?
  - How long were you there for, prior to discharge?

+ What are your overall feelings about the process of referring and admitting you to these services?
  - Did you have any input into decisions around being admitted to inpatient services?
  - How involved were your family in decisions?
  - Were there any difficulties, or things that went wrong?

+ What do you think could be improved about the system that you experienced?

+ What were the good points about the process or system that you experienced?

+ How did you experience the discharge process? Do you feel that you had the support you needed?
  - How far in advance was your discharge planned?
  - How much input did you have into this process?
  - How much was your family involved in these decisions?
  - Were there any difficulties, or things that went wrong?
  - Overall, how would you assess that experience?

+ Are there any other points that you would like to make about your experiences into and out of these services?
Clinician Interview

+ Introduction to scope of the project, tier 4 services etc

+ To the best of your understanding, could you describe the current process of placing youths into tier 4 services?
  - What factors are involved in the decision making process?
  - In your experience, what are the strengths of this process?
  - In your experience, what are the main constraints or difficulties of this process?

+ How are decisions about duration of stay made?
  - What influences these decisions?
  - Could you provide an example of when this process has really worked well?

+ Could you provide an example of when this process has failed, or worked poorly?

+ In an ideal world, what would this process look like? What factors would ideally inform the decision making process?

+ Is there anything else you feel it is important to mention about access to Tier 4 services for young people?
Commissioner interview

+ Introduction to scope of the project, tier 4 services etc

+ To the best of your understanding, could you describe the current process of placing youths into tier 4 services?

- What factors are involved in the decision making process?
- In your experience, what are the strengths of this process?
- In your experience, what are the main constraints or difficulties of this process?

+ Could you describe how these placements are currently funded?

+ What are the improvements that are needed to the funding process?

+ How are decisions about duration of stay made?

- What influences these decisions?
- Could you provide an example of when this process has really worked well?

+ Could you provide an example of when this process has failed, or worked poorly?

+ In an ideal world, what would this process look like? What factors would ideally inform the decision making process?

+ Is there anything else you feel it is important to mention about access to Tier 4 services for young people?
Appendix 2: Flowchart of the development of core themes from interviews regarding [decision making], [ease of access], and the [process out of Tier 4]

- **Risk: Key to decision making process**
  - Lacking resources to manage it
  - Inappropriate admissions
    - No 24/7 community care
    - Used to be treated in tier 3
  - Duration of stay = individual process
    - A more joined up process than referrals

- **Lack of beds**
  - Primary reason for admission
  - Filling up beds

- **Lack of staff**
  - Improvised care
    - Week-long searches for ‘emergency’ beds

- **Discharge is planned and stepped**
  - Problems with family visits
  - Problems with local team liaison

- **Risk: Key to decision making process**
  - Inappropriate admissions
    - No 24/7 community care
    - Used to be treated in tier 3

- **Nationally**
  - Improvised care
    - Week-long searches for ‘emergency’ beds
  - Time wasting

- **Long distance placements**
  - Problems with local team liaison
  - A more joined up process than referrals
  - Discharge is planned and stepped