Report on a Scoping Review of Intensive Psychiatric Inpatient Care Provision for Young People in Scotland

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Glossary

Child and Adolescent Mental Health Services – CAMHS

Chief Social Work Officers – CSWOs

High Dependency Units – HDU

Intensive Nursing Suite – INS

Intensive Psychiatric Care Unit – IPCU or PICU
In NHS Scotland inpatient units providing an intensive psychiatric service are known as "Intensive Psychiatric Care Unit" (IPCU). Elsewhere, including in NHS England, these wards are known as "Psychiatric Intensive Care Units" (PICUs). This review shall refer to these services as IPCUs unless referring to information that directly names them as PICUs (e.g. in documents form NHS England).

National Association of Psychiatric Intensive Care and Low Secure Units – NAPICU

National Inpatient Forum – NIF

National Secure Adolescent Inpatient Service – NSAIS

Quality Network for Psychiatric Intensive Care Units – QNPICU
Responsible Medical Officer – RMO
Scottish Intercollegiate Guidelines Network – SIGN
Young Person's Unit – YPU

Executive Summary

Currently in NHS Scotland there is no direct inpatient service provision for adolescent patients who require Intensive Psychiatric input. This means patients are often referred to, or remain cared for, in services that do not fully fit their needs. This was highlighted by the Mental Welfare Commission in their Young Person Monitoring Report (2020). Scottish Government subsequently commissioned Julie Metcalfe, Clinical Director CAMHS in NHS Greater Glasgow & Clyde, to undertake a national review of existing provision for young people under 18 years who had needs and risks that required intensive psychiatric care. This review looks at current support and provision provided across Scotland, and outlines the factors to be considered in making appropriate care settings, facilities and staff available for young people with intensive psychiatric care needs in future. This report collates the findings from a range of consultations, along with relevant data on admissions, and provides a review of relevant literature, including guidelines for IPCUs elsewhere in the UK.

As there is no dedicated IPCU provision for young people under 18 years in Scotland, individuals who require this level of care are generally either nursed in an "open" psychiatric inpatient ward or are transferred to an adult IPCU. Sometimes secure accommodation is sought to meet needs and risk in a non-NHS setting, or other solutions are found that do not completely meet need. Consultation discussions outlined the challenges (e.g. strain on nursing resource, risk of harm to other patients) of nursing a young person who required more intensive nursing support than a service could offer, as well as the difficulties of nursing a young person in an adult ward (e.g. different models of working, seclusion). Specific inpatient and social work services have been able to provide alternatives to referring to an adult IPCU unit (e.g. developing High Dependency Units), however, these options have limitations, are not appropriate for every service, or are not possible to deliver in every regional inpatient service.

Caution is required regarding the validity of data gathered for the review, as referrals and other relevant data, have not been systematically recorded across Scotland in the past. Nonetheless, collated data suggested that 44 young people were referred to adult IPCUs for the period of 2016 to 2020, and 30 of these referrals were accepted.

The review team led consultations with clinical staff from various services across NHS Scotland to determine current practice and gaps in provision for young people requiring this level of input. Consultation discussions were also held with staff from NHS Greater Glasgow & Clyde Violence Reduction Service, the new National Secure Adolescent Inpatient Service in NHS Ayrshire & Arran, and with Chief Social Work Officers from across Scotland. The report provides recommendations for the design of young person IPCU provision based on these discussions.

Ahead of designing any IPCU provision for young people, the review team recommends ensuring consultation with young people, considering the needs of

transgender and non-binary individuals, considering all issues that may lead to inequality of access, and consulting with organisations in any proposed sites. Clinical recommendations highlight the importance of using as much resource as available to facilitate young people remaining in the least restrictive service possible by intervening to meet need as early as possible, and highlights the value of ongoing multi-agency and community support in situations where admission to IPCU is required. Operationally, this review recommends the importance of a national steering group to maintain consistency (particularly if developing regional services) and training being provided by NES for staff working in Intensive Psychiatric Care settings.

Evidence gathered in the review was used to develop key (non-financial) objectives (e.g. provide age appropriate IPCU care, integrate social work links, provide access to meaningful activities), which were weighted in terms of priority. Options for IPCU provision were then considered in terms of these weighted objectives. Justification for this process was informed by the range of consultations, data gathered, and literature reviewed. The option of purpose-built regional units adjacent to existing inpatient services was the highest scoring out of this process.

Recommendations

Recommendation i) The review team wish to emphasise the importance of ensuring equality of access and recommend that an Equality Impact Assessment (EQIA) is undertaken as part of any future adolescent IPCU developments. It is crucial that steps are taken to provide for the needs of patients from different backgrounds (including BAME) and to ensure equality in relation to other protected characteristics.

Recommendation ii) Current service specifications, which were consulted for this report, do not specify standards for working with young people who are transgender or non-binary. Furthermore, a disproportionate number of young people who are LGBT+ are at risk of developing mental health problems (Plöderl & Tremblay, 2015). The review team therefore recommend that any future service providing intensive psychiatric care to young people take appropriate action to ensure comprehensive guidance is in place regarding supporting patients who are transgender or non-binary.

Recommendation iii) Referrals to an Intensive Psychiatric Care Service for young people should generally come from open adolescent inpatient psychiatrists, or be made by community child and adolescent psychiatrists in liaison with inpatient psychiatrists.

Recommendation iv) NES should provide specific training for staff in intensive psychiatric care services, to cover nursing models, multi-disciplinary models of care, management of challenging behaviour, and risk to self and others in an intensive psychiatric care setting.

Recommendation v) All least restrictive alternatives for care of a young person should be exhausted before admission to a psychiatric hospital is considered, and before admission to an Intensive Psychiatric Care Service is instigated.

Recommendation vi) Future development of IPCU provision for young people should include consultation with organisations in the local community of the proposed site(s), as well as consultation with appropriate third sector/voluntary organisations.

Recommendation vii) There should be a national steering group to allow economies of scale and consistency in service delivery if regional services are commissioned.

Recommendation viii) Liaison with young people and carers is required before commissioning of any service is implemented to consider the views of those with lived experience. It is recommended that carers/young people are involved in any design of intensive psychiatric inpatient facilities.

Recommendation ix) The planning and design of any intensive psychiatric care facility should consider the importance of a specific environment that is designed to meet patients' sensory needs in a way that will contribute to emotional regulation.

Recommendation x) IPCU service provision should be designed with violence reduction measures in mind when considering environmental and procedural planning. National Association of Psychiatric Intensive Care and Low Secure Units (NAPICU) guidelines should be instrumental in this. Violence Reduction Services should be consulted to provide training to staff working in any new intensive psychiatric care facility.

Recommendation xi) Exploration of care options with multi-agency partners as a team around the child should be in place before referral to an IPCU is made.

Recommendation xii) Even with the introduction of dedicated IPCU provision for young people, the review team anticipate there will remain a service gap for young people with a severe learning disability who are experiencing acute distress, and for whom a restrictive approach would not be appropriate. The review team wish to emphasise the importance of developing guidance for providing the correct support for these young people.

Recommendation xiii) While it is difficult to infer from available data the number of beds that would be required, the review team recommend two beds per regional site are factored in to planning for the development of future adolescent intensive psychiatric provision.

Recommendation xiv) On the basis of the findings of the review, and the outcome of the Options Appraisal, the review team suggest Regional purpose built adjacent

units would best meet the requirements for adolescent intensive psychiatric provision in Scotland.

1 Background

1.1 The need for the review

Currently in NHS Scotland there is no direct inpatient service provision for adolescent patients who require intensive psychiatric input. This means patients are often referred to, or remain cared for, in services that do not fully fit their needs. This was highlighted by the Mental Welfare Commission in their Young Person Monitoring Report (2020), and Scottish Government subsequently commissioned a national review of Intensive Psychiatric Care Unit (IPCU) capacity that:

1. Is undertaken in partnership with Child and Adolescent Mental Health Services (CAMHS) regional leads.
2. Considers both local circumstances and overall national need.
3. Makes recommendations about whether additional IPCU facilities are required.
4. Develops a national pathway for access to IPCU services when required.

The review thus scoped out and sought feedback on the current position for young people from 12 up to 18 years who require intensive psychiatric support in Scotland. This has informed the development of options on how best to meet these needs when young people require this level of intensive input. The review has been led by Julie Metcalfe, Clinical Director of CAMHS in NHSGGC.

1.2 The importance of psychiatric care at all life stages

An overwhelming amount of evidence illustrates the importance of providing appropriate psychiatric care, when required, at all stages of life. The Adult Psychiatry Morbidity Survey (2007) outlined that almost 6% of individuals age 16 and older reported having attempted to take their own lives at some point in their life. Within the UK, 18,220 individuals with mental health problems completed suicide in the ten years from 2003-2013 (National Inquiry into Suicide and Homicide, 2015) and in 2013, 6,233 suicides were recorded in individuals aged 15 and over (Office for National Statistics, 2015). Of these 6,233 people, 22% were female and 78% were male, suggesting gender differences and possible inequalities with regards to access to mental health support in the UK.

1.3 Psychiatric care for young people seen by CAMHS

The latest NHS Digital (2020) follow-up study on the mental health of children and young people in England found 20% of 17-22 year-olds were identified as having a probable mental health disorder. Similar results were found in 11-16 year-olds, where 17.6% had a probable mental health disorder, an increase from 12.6% in 2017 in this same age range (NHS Digital, 2018). This steady change mirrors findings in Scotland, where an increase in peer problems and emotional problems in adolescents has been found over time (Black and Martin, 2015).

Considering the wider context of mental health problems, The Mental Health Foundation (2019) conducted a study of young people in Scotland and found 20% of

young people feel they do not have a trusted adult that they could go to for support and advice, and 29% said that where they live has a negative impact on their mental health. This report outlined the risk factors associated with mental health disorders in this age group and stressed the importance of care that is both accessible and acceptable for this age group.

The Children and Young People's Mental Health Coalition (2015) highlighted the importance of promoting emotional health and wellbeing in an individual's childhood, as a means of positively impacting their later life, in terms of cognitive development, learning, and physical and mental health.

The mental health of children and young people is thus influenced by many factors, including any physical and neurological disabilities that may present at birth or in early childhood, as well as the social and economic circumstances in which the family lives (including homelessness, poverty, mental health difficulties or substance use in the adults who look after them, their LGBT status, and whether they are looked after outside their family of origin).

It is clear that the needs of children and young people in Scotland are best met by assessment of need at an early stage in life, with responses to these needs coming from the whole range of services in the community that contribute to children and young people's lives. The SHANARRI wellbeing indicators (Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible, and Included) provide a means of assessing children's needs across a range of domains (The Getting it Right for Every Child Team, 2017). Any additional support needs indicated through a SHANARRI assessment are best met by the agencies (statutory and third sector) involved in communities working to an integrated care plan based on Getting It Right For Every Child (GIRFEC).

This approach to meeting need applies just as much to looking after young people with major psychiatric difficulties as it does to children in early years. It is recognised that many young people who require access to intensive psychiatric care are likely to have a number of risk factors in their developmental profiles that can only be met by the approach described above. It is always best to intervene as early as possible in any developing psychiatric disorder, with the support of family and other agencies, to seek to circumvent need for the most intensive psychiatric care later in adolescence. Nonetheless, a small number of young people, usually in later adolescence, will require intensive psychiatric support for a period of time. It is also recognised that these young people will also require the support of statutory and voluntary agencies to help them move on and recover from any severe psychiatric disorder.

1.4 Intensive psychiatric care for young people

As noted above, in their 2018-2019 Young People Monitoring Report, the Mental Welfare Commission (2020) continued to recommend the current gap in IPCU service provision for adolescents be addressed. Research in terms of the efficacy of

IPCUs is limited in relation to the adolescent patient group, however, a few papers have documented the benefit of both age appropriate and intensive services.

Currently in NHS Scotland, young people under 18 years who require Intensive Psychiatric Care in an inpatient setting are often admitted to adult IPCUs, or they are cared for, sometimes with difficulty, within existing open inpatient services. Duddu et al, (2016) evaluated the use of a psychiatric inpatient service for 16 and 17 year-olds, and emphasised the importance of age appropriate psychiatric care when working with young people. They outlined several issues with regards to caring for adolescents in adult psychiatric wards, with a specific emphasis on the difference in skills required by staff to manage younger patients.

Specifically in Scotland, NHS Lothian previously redesigned their CAMH Services to develop an Intensive Treatment Service for young people up to 18 years within the community. The aim was to reduce admissions to inpatient services (Duffy and Skeldon, 2013). Although there was an increase in admissions to the young person's open ward, admissions became shorter, and findings suggested a significant reduction in admissions of young people to adult psychiatric wards. This service has successfully managed to minimise the need for placing young people in a ward not fit for their age group. It is important to recognise, however, that there are occasions where inpatient admissions of adolescents to adult mental health facilities occur as the 'least worst' option within this patient group. However, there is clear consensus that admissions for young people should be to inpatient facilities that are designed to meet their developmental needs, with a staff group trained in working with young people with psychiatric disorders.

1.5 Service specifications for Tier 4 and IPCU provision

Intensive psychiatric care is integrated into services in NHS England and can take different forms in terms of step-up/step down care pathways (NHS England, 2018). It is important to take note of the roles of the range of inpatient units to better understand the differences between these services and IPCUs so that appropriate referral pathways to and from services can be managed.

1.5.1 Levels of security in inpatient settings

The NHS England Service Specification notes Tier 4 inpatient CAMH Services "offer care at four levels to support the effective management of differing nature of risk presented by children and young people under 18". The specification outlines the variance of security levels in inpatient units, as follows:

- Medium secure units, the highest security setting that an under 18 year-old can be placed in. This is characterised by high levels of relational and procedural security, and stringent levels of physical security. Individuals placed in medium secure care will include young people who have a mental or neurodevelopmental disorder that poses a risk of harm to others, or who have committed grave crimes.

- Low secure units, young people admitted to these units are either forensic in presentation and pose a risk of harm to others, or are non-forensic but exhibit behaviour that is challenging as well as posing a risk of self-harm and being vulnerable.
- For Psychiatric Intensive Care Units levels of physical, relational, and procedural security should be similar to those in low secure units.
- For general adolescent inpatient services care is provided without the need for enhanced physical or procedural security measures.

Both low and medium secure units are set up for patients to have longer stays in the ward – as long as several months to a year in duration.

Development is currently underway for the National Secure Adolescent Inpatient Service (NSAIS), a unit which will be the first of its kind to provide medium secure care in NHS Scotland, located in NHS Ayrshire & Arran. The most recent copy of the business case indicates the Unit will open in 2022.

1.5.2 High Dependency Units

A separate NHS England specification stresses the importance of drawing a distinction between PICU and inpatient services, particularly High Dependency Units (HDUs) (NHS England, No date). The service specification outlines that HDUs are not stand alone units, but are instead areas within some CAMHS non-secure services that exist to provide care for young people whose behaviour particularly challenges the service. These units remain the clinical responsibility of the open unit in which they exist, and are not a separate service commissioned by NHS England, therefore capacity for these units varies across services.

1.5.3 Considerations for IPCUs or PICUs

The NHS England Tier 4 CAMHS PICU service specification (2018) details that patients are admitted on the grounds that they are experiencing a “short term behavioural disturbance” that requires more specialist input than what is available in open inpatient provision, and any adjacent HDUs. There is the expectation that admission should not exceed 8 weeks in duration. Recreational and educational facilities should therefore be available, and be age appropriate, but will differ to that of open wards due to the short-term nature of admissions.

The Quality Network for Psychiatric Intensive Care Units (QNPICU) (2017) produced standards that advise on the requirements for providing care in an adult PICU that are currently used in NHS Scotland. Furthermore, individual Trusts have produced additional local guidance, and Appendix I includes a flowchart of the pathway followed for admission and discharge to adult PICUs in Southern Health NHS Foundation Trust. Guidance more specific to adolescents can be found in The National Association of Psychiatric Care and Low Secure Units (NAPICU), who in 2015 published the national minimum standards for PICUs for young people. This document outlines the requirements of a PICU in terms of referrals, treatment,

discharge planning, and environmental factors. The review team recommend full consultation of this document when considering the development of an IPCU but key headings that provide insight into the individuality of this type of service when compared to previously mentioned services are discussed below.

1.5.3.1 NAPICU Admission Requirements

Key criteria and requirements that referrals should demonstrate in order to be admitted to a PICU should be clear and consistent, (as should exclusion criteria):

- Patients should be 12-18 years of age (up to the day of their 18th birthday).
- Young people referred should be exhibiting behaviour that puts either themselves or others at risk (to a degree that cannot be managed safely in an open, acute service) as a result of mental health problems or a learning disability.
- Young people referred to a PICU should be detained under the Mental Health Act Scotland (2003).

It has also been recommended to have a process in place for when a referral does not meet the criteria for admission to a PICU. A referral form currently in use for admissions to an adult IPCU in NHS Greater Glasgow and Clyde (found in Appendix II) shows the details that are required to begin the referral and admission process.

1.5.3.2 NAPICU Service recommendations

In terms of length of admission, it is recommended that the patient's treatment plan anticipate an admission of no longer than 6 weeks in a PICU. Thorough pathways should be in place that plan multidisciplinary treatment, with joint working towards a collaborative goal. Anticipatory decision making regarding the discharge location of a patient should begin from the initial referral to a PICU. This process will allow for a review process in patients where there is a likelihood of a longer stay in order to re-evaluate the treatment plan.

On top of a patient's treatment plan, the NAPICU guidelines recommend that a range of therapeutic activities should be provided for young people within a PICU; the document goes into further detail of examples of these. Facilities and ward environment should take into account the level of risk and therefore level of security in this setting, this includes observation policies. NAPICU standards recommend consultation of standards produced by SIGN (Scottish Intercollegiate Guidelines Network) for further detail on this.

2 Methods

2.1 Design

This review adopted a mixed methods approach to gathering data to inform this report. Quantitative data was sourced to inform current use of IPCUs by adolescents, and qualitative data was gathered to provide insight into clinical experiences and

recommendations from health and social care staff. Due to the large volume of transcripts from consultations, it was not possible to conduct a formal thematic analysis, however the review team have made use of a process whereby two team members coded all transcripts, identifying key issues and recommendations.

2.2 Quantitative data

Data was requested from each consulting region through use of a data template that was circulated to clinical staff and data analysts from each region. The template asked staff to complete tables indicating details of referrals to IPCU provision in their area.

2.3 Qualitative data

The review team met virtually to consult with individuals from various NHS and non-NHS organisations. This process provided input from those in a role pertinent to the use of an adolescent IPCU in NHS Scotland. A full list of individuals and organisations that were contacted can be found in Appendix III.

2.3.1 Regional Inpatient Unit discussions

There are three Open Psychiatric Units for adolescents in Scotland: Young People's Unit (Edinburgh), North of Scotland Young Person's Unit (Dundee) and Skye House (Glasgow). These units traditionally receive referrals from South East of Scotland, North of Scotland and West of Scotland respectively. The review team conducted a focus group discussion with staff from each region, to better understand the different processes that take place across the country for management of young people with a requirement for intensive psychiatric care. The consultation was opened to Senior Charge Nurses, Nursing Managers and Bed Managers of the Young People's Units, as well as Psychiatrists who worked within the Young Person's wards or the adult IPCUs that adolescents would be referred to if required and appropriate. Each of these discussions asked questions based on a pro-forma (see Appendix IV), the same questions were asked in each region.

2.3.2 National Secure Adolescent Inpatient Service discussions

A new National Adolescent Secure Service is currently being built, located in NHS Ayrshire and Arran. This will be the first of its kind for this age group in NHS Scotland. The review team consulted with the staff team involved in planning, setting up, and (in future) running this service to gain insight into developing a new service, as well as the relationship and pathways between this service and a potential IPCU for adolescents. Two separate discussions were held due to clinician availability. The regional pro-forma was adapted to reflect emphasis on issues pertinent to staff working in the Secure Service. The different discussions had slightly different pro-formas as they were further adapted to reflect the roles of the consulted staff in developing and working in the service.

2.3.3 Chief Social Work Officers (CSWOs) discussion

Social Care input is vital to informing this review of the current processes that exist between inpatient and social care services, and allowed the review team to reflect on how social work pathways would link to an IPCU setting. CSWOs across Scotland were invited to take part in a discussion, in order to gather viewpoints from local authorities in both rural and more densely populated areas.

2.3.4 Discussions with young people

Given that young people will be the patients in the type of service that this review will inform, it is obviously crucial to gather as much relevant input from young people as possible to provide a well-rounded review. This does provide challenges however: individuals who are currently accessing IPCU care in any setting may struggle to fully participate in discussions (e.g. these individuals may be experiencing disturbances, or be too unwell to take part). Advocacy services with involvement in two of the regional open wards were contacted to hold discussions on the review team's behalf and a questionnaire was developed. At the time of writing, due to COVID-19 and consequent circumstances within the wards, advocacy services have been unable to speak to patients in a capacity that would allow them to discuss the questionnaire.

2.3.5 Violence Reduction Service discussion

The review team consulted with a representative from the NHSGGC Violence Reduction Service to gain insight into the considerations that need to be taken into account in a service where there is increased risk of violence, and in relation to care planning to minimise violence.

2.3.6 NHS England consultation

Contact was made with NHS England as the review team was hoping to gain insight from NHS Trusts that have developed PICU provision for adolescents. The literature review that forms the introduction in previous sections involved the consultation of several documents and legislation that outline PICU service provision and pathways within NHS England and the rest of the UK. Positive contact was made with staff from NHS England, however, it has not been possible to formally proceed with the consultation. The review team feel that the evidence provided in this paper is sufficient to outline the processes and recommendations made by NHS England.

2.4 Ethics

This review is considered a service evaluation and audit, therefore approval to conduct the project was sought and gained from the NHSGGC CAMHS Research & Evaluation Group. Staff taking part in consultations that were recorded were asked to complete a consent form to agree to the use of the transcripts informing this review.

3 Results

3.1 Regional clinician consultation

As described earlier, clinicians from adolescent inpatient units in three different Scottish regions were consulted to gather insight of current practice on how open units operate to provide more intensive care, and what provision would be most helpful for them in an ideal situation. The following sections outline the most prominent areas of discussion relevant to the review.

3.1.1 Young person's psychiatric "open" wards

3.1.1.1 Staffing

Clinicians outlined staffing in their adolescent psychiatric inpatient service for their region. Units adopt a multidisciplinary approach to staffing but primarily are run by a core Mental Health Nursing staff team, including Clinical Support Workers/Nursing Assistants, as well as domestic and administrative staff. Multidisciplinary input includes Consultant Psychiatrists, who also fulfil Responsible Medical Officer (RMO) duties, as well as Clinical Psychologists, Family Therapists, Occupational Therapists, Dieticians, Physiotherapists, Speech and Language Therapists and Art Therapists providing a varying number of sessions across the different units. The North region also has staff working in the role of Liaison Nurses to cover the different areas within the region.

The model of care in any IPCU provision will focus on a compassionate, young person and family-centred approach to care. It will be important to access information from the young person (as possible), their caregivers, and those looking after them in health, social care, education and third sector, prior to any planned admission. All staff will be guided in their care planning by the wishes of the young person on a What Matters to Me basis and an Advanced Statement as part of their rights as a young person subject to the Mental Health Act Scotland (2003).

3.1.1.2 Service design and facilities

Service design considerations include provision of a safe and secure environment for each young person admitted. A single en-suite room would be necessary for each young person. Each room and all facilities within the IPCU would be designed with consideration of meeting the needs of the young person, in the context of a setting that is as safe and ligature-free as possible. Safety considerations would be vital in provision of leisure activities for any patient.

Young people would need access to secure outdoor space for exercise, and there should be areas within the IPCU service for leisure and activities, planned visits of family, eating meals and snacks, and mixing with peers when this is safe. Appropriate educational facilities will be a requirement for any young person who is well enough to engage in them.

Design of internal and external spaces and activities provided should be compatible with the age range concerned. All areas should be furnished in a way that minimises risk of damage to self and others in the environment.

Consideration should be given to sensory issues, and specifically sensory overload, as part of the internal design of the service.

3.1.2 Patient profile for intensive psychiatric referral

The consultations discussed the situations that would prompt an individual to be considered for a referral to a more intensive service. Reference was made to the admission requirements as outlined in NAPICU guidance. Characteristics of this included “unmanageable levels of aggression”, risk of absconding, a need for a low stimulus environment, and more intensive nursing support. In accordance with aforementioned guidance, patients must be detained under the Mental Health Act Scotland (2003).

3.1.2.1 Factors that could preclude referral to an IPCU

Factors were discussed that would preclude referral of a young person to an IPCU, and these reflect the guidance produced by NAPICU. However, staff from adolescent open wards and adult IPCUs identified that there is currently no formalised, detailed exclusion criteria for referrals. It was noted this has been considered in the past but would be a particularly complex task.

In terms of current options for a young person requiring IPCU input, factors indicative of vulnerability, such as patients under 16 years of age, those who have experienced trauma, or those with a significant learning disability, are unlikely to be accepted to an adult IPCU due to potential risk from adult patients in that ward.

When considering **age**, it is important to note that the age of young people admitted to current adult IPCU provision would likely differ if the service was set up for young people only. Concerns around admitting a younger patient (under 16) would potentially not be as prominent (although would still need to be considered on some level). An age-appropriate service would likely receive referrals for individuals who would currently be managed, with some difficulty in terms of environment, staffing and impact on self and others, in an open ward.

Those involved in the consultation expressed reluctance to admit individuals with particular **diagnoses** or conditions to an IPCU setting, even were an age appropriate IPCU available. Specifically mentioned were those with anorexia nervosa, as well as patients who have personality disorder as their sole diagnosis, or self-harm as their primary problem. It was felt the more restrictive measures of care in an IPCU would be to the detriment of such young people.

Participants noted that there can be a reluctance to admit adolescent females to an adult IPCU, especially if adults within the ward are prone to exhibiting behaviour that

is inappropriate. This reflects the importance of not only age-appropriate care, but a service that is inclusive in supporting all young people, regardless of **gender**.

Recommendation 1) The review team wish to emphasise the importance of ensuring equality of access and recommend that an Equality Impact Assessment (EQIA) is undertaken as part of any future adolescent IPCU developments. It is crucial that steps are taken to provide for the needs of patients from different backgrounds (including BAME) and to ensure equality in relation to other protected characteristics.

Recommendation 2) Current service specifications, which were consulted for this report, do not specify standards for working with young people who are transgender or non-binary. Furthermore, a disproportionate number of young people who are LGBT+ are at risk of developing mental health problems (Plöderl & Tremblay, 2015). The review team therefore recommend that any future service providing intensive psychiatric care to young people take appropriate action to ensure comprehensive guidance is in place regarding supporting patients who are transgender or non-binary.

3.1.2.2 Distinction between Secure Service and IPCU patient profiles

Discussion highlighted the need for IPCU input not to be viewed or confused with services that are characterised to be secure:

> "People get a bit confused about sometimes wanting to refer patients who just need a higher level of security as opposed to being something that can realistically add value to their care. So, we need to be really clear that it's about young people who do have a clear mental health difficulty that can be improved in some way by attending IPCU."

For more in-depth distinguishing factors between Secure Services and IPCU Services, see Section3.3, which outlines Secure Service design and admission criteria in detail.

3.1.3 Pathway

Drawing from all consultations it was clear that there is not necessarily one consistent pathway across Scotland for IPCU use by young people. There was, however, general understanding that IPCU care should be a short term treatment, and young people in particular should not remain in such a ward for any longer than necessary.

3.1.3.1 Referral

The process of referring a young person to IPCU service provision varies across different areas but also is dependent on whether the patient requires admission during an "out of hours" timeframe.

Often wards will require a referral form to be submitted to begin this process, an example used in the West of Scotland can be found in Appendix II. Other discussions indicated the difference between admitting a young person to an adult IPCU as opposed to admitting an adult; a young person's referral would be expected to be more consultant led, rather than nurse led.

Discussions outlined that once the IPCU had been made aware of the referral request, usual practice was for staff from the IPCU to visit the patient and staff in the referring service (usually an open psychiatric ward for young people). This was to assess suitability of the patient for an adult IPCU, and to build relationships with the staff who would be supporting the patient during the duration of stay, and the patient themselves.

Recommendation 3) Referrals to an Intensive Psychiatric Care service for young people should generally come from open adolescent inpatient psychiatrists, or be made by community child and adolescent psychiatrists in liaison with inpatient psychiatrists.

3.1.3.2 Admission procedures and transfers

Discussions turned to the **procedures** that are followed when young people are admitted to IPCUs. The specifics of this can vary across regions. In terms of RMO responsibility, one region outlined that this would remain with the RMO from the Young Person's Unit. Discussion with another region outlined that this approach varies across Health Boards. RMO responsibility can fall to the IPCU consultant but with input from a CAMHS consultant, and variation from this can arise based on whether the young person was admitted from the community or from the Young Person's Unit.

There was much discussion on **transfers** and ultimately how challenging this can be. This was particularly so when considerations are made to the levels of distress that a young person is experiencing, alongside what could potentially be a long journey out of their area. The consultations reflect that there can be complications even securing appropriate transport, and with the level of risk in transferring a young person who is not compliant, it is necessary to have a contingency plan in place. This review makes specific recommendations regarding this in relation to the review team's discussions with a representative from the Violence Reduction Service in GGC (Section 3.4).

Specific to the CAMHS population, the consultation addressed the importance of keeping family involved and informed. For example, ensuring parents and guardians

have a full understanding of the reasoning of clinical staff when transferring their child to a more intensive environment. Even in instances where a transfer to an adult IPCU is deemed to be appropriate, distance between units can also be a significant barrier to access. Like many other considerations, there is a sense of a balancing act to ensure patients are only moved out of area away from their community if adult IPCU care is deemed to be absolutely necessary for the young person's care. This outlines the importance of admissions to IPCU remaining short, and that discharge planning is vital to a patient's transfer.

3.1.3.3 Discharge

The purpose of an IPCU provision is to provide short impactful nursing interventions to a person's care, anticipating the ideal length of time for any patient to be in this type of unit to be a few weeks, and as short as possible for a young person in this type of adult ward. Generally, clinicians taking part in the consultation agreed that planning for discharge should begin as soon as a young person is admitted to an adult IPCU, and even at the point of referral discussion.

Discussions outlined the importance of liaising with clinicians from the service that the young person is expected to be discharged to (usually the Young Person's Unit they were admitted from).

3.1.4 Current IPCU provision/practice

As services currently stand, consultations identified only two main formal options for adolescent patients who require an IPCU: either the young person is transferred to an adult IPCU or they remain in the Open Psychiatric Ward with additional input. It was highlighted that neither of these are ideal, as both carry risk. Caring for a young person requiring IPCU care in an Open Psychiatric Ward not only brings about significant risk to that young person, but also to the other young people in the ward. This impacts other patients both in terms of safety and in the way the environment may have to be adapted to ensure safety (for example the need for doors to be locked and items to be removed from general areas). A third, significantly less prominent option was to arrange a transfer to an adolescent IPCU in another part of the UK. As noted, in NHS England there are intensive psychiatric inpatient services for this age group. However, this also has disadvantages, not least travel and the distance from family. Admission to non-NHS secure care has also been considered for young people who require a secure environment for their care.

3.1.4.1 Adult IPCU – adolescent suitability

Admitting an adolescent patient to an adult IPCU means stepping up the level of care, clinical input, and additional nursing, but it can bring about a number of issues. One of the regional participants noted "It's providing a service to a young person that an adult IPCU isn't ideally set up for… it's a less than ideal situation".

3.1.4.1.1 Variation in ways of clinical working

Clinicians discussed that adult IPCUs are “developmentally wrong” for adolescent patients, given the lack of education facilities, and age-appropriate Occupational Therapy resource. The variation of approaches in providing clinical care to a child rather than an adult is significant.

With regards to psychiatric nursing care, staff working in IPCUs have a specific skillset that is continuously maintained by making use of core competencies of their role in such a specific nursing setting. Admitting a patient who is under the age of 18 to an adult ward (specifically a setting with intensive nursing practices), puts nursing staff in a position where they do not have the same level of competence as they would when working with an adult. “I think [Adult] IPCU nurses feel when there's a younger person in the unit that their skill set isn’t quite right for that person in the unit.”

To ease this process as much as possible, and to maintain consistent clinical responsibility, when an adolescent patient is transferred from an Open Psychiatric Ward to an adult IPCU, there is a requirement that nursing staff from the adolescent ward work with that patient in the adult IPCU. Although this is appropriate, it again is not an ideal situation, as it was discussed that there is a “difference in culture” being from two very different wards. It is also important to note that the RMO from the adolescent ward continues to provide RMO cover for adolescent patients when they reside in an adult IPCU.

Recommendation 4) NES should provide specific training for staff in intensive psychiatric care services, to cover nursing models, multi-disciplinary models of care, management of challenging behaviour, and risk to self and others in an intensive psychiatric care setting.

3.1.4.1.2 Adaptations for adolescents in an adult IPCU

For a young person to be nursed safely within an adult environment, a number of adaptations need to be made to the way of working. These can result in patients feeling isolated:

> “There's difficulties in terms of protocols for young people being in an adult environment, whether that be an open adult ward or an IPCU in that they have to be on higher level observation, and that's about limiting any damaging contact they have with adult patients, so by that criteria alone they tend to be relatively isolated and not able to access all of [the] recreational activities.”

This indicates the potential for negative impact on the wellbeing of young people who are placed in adult services, and suggests why staff do their best to support patients within an age-appropriate setting, wherever possible.

Subsequent feedback raised the additional option of an enhanced care bed adjacent to adult IPCU, with regional CAMHS unit input. This has the potential for 24/7 support to be available. It still presents the challenge of care being provided, but the young person remaining isolated.

3.1.4.2 Remaining in an open psychiatric ward

When young people who would require intensive psychiatric input cannot be admitted to an IPCU setting, staff within the open units simply do their best to manage challenging behaviour:

> "We've also got some patients here just now that would qualify for an IPCU service if it was available, and really some complex nursing that has to be adapted, along with a pharmacology that has to be looked at, in order to try and keep some of these young people safe."

At one consultation, it was noted a conversation had started about how staff might be able to work in different environments to support the different type of nursing required. This could be a potential workaround to prevent use of adult IPCUs. This was, however, a very provisional conversation, and again is reflective of the efforts staff take to accommodate patients requiring this level of support.

3.1.4.3 Existing "workarounds": Intensive Nursing Suites or High Dependency Units

As discussed in the introduction, HDUs are developed at the discretion of the Open Psychiatric Ward they are a part of. While these can be planned additions to services, NHS Lothian Young Person's Unit (YPU) has developed what is informally known as the Intensive Nursing Suite (INS), as an addition to their service, and in response to challenges caused by gaps in services.

Discussion highlighted that all would wish a patient to only remain in a service that is not age appropriate for as little time as possible. Thus, while the INS does not act to fully replace IPCU provision, it does potentially prevent adolescent patients from requiring an adult ward (see data in Section 4). Co-location also enables short visits, negating the requirement for the transfer process. Further, as clinical responsibility remains with the YPU, they have control over bed usage.

Despite being co-located, the INS is separate enough from the main ward that staff need to be pulled from YPU staffing to provide two to one support and observation to the patient residing in the INS. There were concerns around this level of seclusion for a young person, and that if this continued for any length of time that there was a

risk of the young person being "deskilled".

Recommendation 5) All least restrictive alternatives for care of a young person should be exhausted before admission to a psychiatric hospital is considered, and before admission to an Intensive Psychiatric Care Service is instigated.

3.1.5 Social care issues

Insight into current practice, workarounds, and issues are described in detail in our consultation with CSWOs (Section 3.5). In addition, the regional unit discussions indicated anecdotally that due to the number of children who are "looked after", involvement and good relationships with social work services would be vital to any service providing intensive psychiatric care:

> "When I looked at the admissions to adult wards for under sixteens so many of them were kids who were in kinship care or accommodated by local authorities whose placements have broken down."

Subsequent feedback reflected this may highlight a gap in social care services. Young people in the community who do not have their needs via access to secure social care, can end up in a position where consideration is being given to an admission to an IPCU. Further details around the relationship between IPCU and social care is outlined in Section 3.5.

3.1.6 Communication

Discussions (including those with the developers of the Secure Inpatient Service) noted the importance of communication on a national network level. Clinicians talked about the National Inpatient Forum (NIF) as being used for communication previously. Consultation discussions noted the importance of this forum, or another network specifically for CAMHS inpatient services, to allow space for information sharing.

Recommendation 6) There should be a national steering group to allow economies of scale and consistency in service delivery if regional services are commissioned.

3.2 Young person data

As noted, due to circumstances within the Young Persons' Units, advocacy services have been unable to speak to patients in a capacity that would allow them to discuss the questionnaire as planned.

The review team also contacted The Quality Network for Inpatient CAMHS (QNIC) about accessing the views of young people previously collected as part of QNIC reviews, and contacted the Young Scot Health Panel (a group used by Scottish

Government) with a view to gaining feedback on the consultation process. The review team have not been able to receive input from either organisation.

Recommendation 7) Future development of IPCU provision for young people should include consultation with organisations in the local community of the proposed site(s), as well as consultation with appropriate third sector/voluntary organisations.

Recommendation 8) Liaison with young people and carers is required before commissioning of any service is implemented to consider the views of those with lived experience. It is recommended that carers/young people are involved in any design of intensive psychiatric inpatient facilities.

3.3 National Secure Adolescent Inpatient Service

As indicated previously, three staff members involved in the setup and development of the National Secure Adolescent Inpatient Service (NSAIS) were consulted to provide insight into their own service, and the anticipated relationship between the NSAIS and current services, as well as any future young person IPCU provision. The most recent business case document (North Ayrshire and Arran Health and Social Care Partnership, 2019) provides a fuller picture of what the service will offer.

Consultations identified the NSAIS will be a 12-bed unit for individuals from the age of 12 to 18 years. Staffing will include psychiatrists, psychologists, nurses, nursing assistants, occupational therapists, occupational therapy assistants, speech and language therapists, dieticians and social workers as well as input from physiotherapists, art and music therapists and an advocacy service. Facilities include a seclusion suite and a fully operational school, which will be set up to provide 30 hours of education per week to patients, in accordance with North Ayrshire Council Policy.

3.3.1 Admission criteria

In terms of security, the NSAIS is expected to provide a medium secure physical environment, with procedural levels of security sitting somewhere between low and medium levels (implications of different levels of security are outlined by Crichton, 2009). Discussions recommended the importance of admission criteria to ensure individuals who access the service fully require this level of 24-hour psychiatric care and security.

> “A lot of young people, although they're distressed, don't need 24-hour nursing care. They need 24-hour care, but they don't need a specialist mental health nurse.”

A secure service would differ from an IPCU as it would offer more long-term care, rather than short intensive treatment. There would also be patients who have more serious levels of offences than would be expected to be in an IPCU.

Provisional criteria for admission to the NSAIS therefore is that patients would require help for a treatable mental illness (rather than distress), who are detained under the Mental Health Act Scotland (2003) and pose a risk that requires the level of security offered by a Secure Inpatient Service.

3.3.2 NSAIS Pathway

The NSAIS will not facilitate out of hours or emergency admissions and noted that referrals would be expected to be from other NHS Services. Procedure following referral would therefore be to assess the patient in their current NHS service (usually an inpatient ward). This process will include input from the patient and their family/carer, as well as members of the referring staff team. If the referral is not appropriate for the NSAIS, the team will offer guidance on how to manage the individual in their current setting. There is also guidance drawn up on a dispute resolution process to follow if required in these situations.

Although anticipated that the NSAIS will accommodate young people for longer term admissions, staff stressed that planning for discharge will begin as soon as the individual is assessed and accepted for admission. The team anticipated that a barrier to admission could be the beds not being available, therefore planning for placements after discharge is crucial to this process.

3.3.3 Relationship with IPCU

Currently, if a young person requires an increased level of security that their open psychiatric ward cannot facilitate, then they would potentially be admitted to an adult IPCU. This way of working has its drawbacks, as it offers a short-term solution, but in a service that is not age appropriate. With the development of the NSAIS, there will be the opportunity for a more appropriate longer-term solution to meet patients' needs.

There was a discussion of where an adolescent IPCU would then fit in. There was suggestion of a young person IPCU acting as part of a stepped approach. For example, an IPCU might be a suitable environment for a young person to be referred and assessed from, particularly if the IPCU facilitated out of hours or emergency admissions. Discussion with colleagues from the NSAIS indicated they felt it would be appropriate for a young persons' IPCU to be built adjacent to the NSAIS.

3.4 Discussion with Violence Reduction Service

This meeting was valuable to discuss recommendations with someone who has specific extensive knowledge and experience of reducing and managing high levels of violence risk in patients.

The Violence Reduction Service resource in NHSGGC works across all patient groups, and is split between providing training and clinical input. Training follows a public health approach aimed at minimising stress and distressed behaviour at a primary level, but also providing strategies at both secondary and tertiary levels. Clinically, the team provides behaviour and safety planning. Upon receiving a referral, the team spend time within the referring clinical service working with that staff team and patients. This health board wide way of working allows the Violence Reduction Service to continue working with a patient if they are moved to different units.

Specific to adolescents, there were several recommendations from this discussion the review team felt important to highlight, these are included in the following sections.

3.4.1 Activities should reflect what is appropriate and interesting to young people

At a primary level there was discussion that providing activities to reduce boredom is key to reducing the escalation of violence, aggression and self-harm. Emphasis was placed on the importance of ensuring activities are relevant to the adolescent patient group and not just what staff think is interesting. For example, open green spaces are important, but what is vital for adolescents is the opportunity to make use of this space for physical activity, rather than somewhere to sit and look at a garden. Using outdoor gym equipment in these areas, such as cross trainers, was suggested.

Recommendation 9) The planning and design of any intensive psychiatric care facility should consider the importance of a specific environment that is designed to meet patients' sensory needs in a way that will contribute to emotional regulation.

3.4.2 Recognise the value in peer support in an adolescent patient group

Young people often rely on peer support in the form of socialising, often communicating via their phones. However in secure environments patients can be separated from their belongings due to other risk issues.

A lack of socialisation can have a negative impact on the young person. With this in mind, it is vital to ensure that support is in place to provide any reassurance that the patients may seek out from their peer group in this way. It is also important to consider the value of open social spaces in the ward to provide opportunities for patients to engage with others, so peer support can occur more organically. "Discharge messages" from patients who have left the ward can promote feelings of hope for remaining patients and reduce risk of agitation.

3.4.3 Use technology to maintain communication with family

Maintaining contact with family is important due to the developmental need of adolescents. Particularly during the current COVID -19 pandemic, technology (video conferencing) can serve as an alternative when family visits are restricted. It is vital to ensure future provision is equipped with WiFi that can be used for this purpose. It is also important to gather information from families to inform safety planning. Validating the importance of a family member's input to this process will not only be helpful to care planning, but will also enhance the relationship that family members have with the ward.

3.4.4 Importance of relationship between staff and patients

The consultation confirmed the importance of engaging patients in the process of being admitted to hospital and recommended considering the "Safewards Model" as a way of building trusting relationships between staff and patients (Bowers, 2014). The discussion also emphasised the importance of staff who are able to mitigate giving bad news and the value of having these types of discussions in a manner that minimises distress.

3.4.4.1 Adult IPCU Clinical Exchange Group

The Clinical Exchange Group, established as a result of the Scottish Patient Safety Programme, is a NHSGGC based group with representatives from adult IPCUs, which aims to promote patient safety by reducing restrictive practice. The group is used to review complex cases, allows information and practice sharing sessions and is used as a platform for ensuring consistent ways of working across similar services. Future IPCU Services should be aware of this model for exchanging good practice.

3.4.5 Importance of management of individual levels of risk

When working with detained individuals where methods of restraint may be necessary, it is important for any approach to be the least restrictive possible. Managing individualised levels of risk must therefore take into account different risk factors: size of patients, previous trauma (e.g. to avoid triggers of abuse). Further details around managing individual levels of risk are detailed by NAPICU (2015).

3.4.6 Importance of planning when transferring patients between services

Risk management is vital in a process such as transporting patients who are detained and have the potential to become distressed. Specific recommendations were discussed for this process including the importance of having a management plan in place while recognising that this may need to be altered depending on the age of patient; notifying police in advance of the planned route of transfer; considering the type of vehicle (it was suggested that black cabs are often more suitable than ambulances); and knowing options for restraint that are appropriate. There are currently no formalised clinical governance guidelines for transporting patients.

Overall, the consultation with the Violence Reduction Service characterised that any service that requires violence reduction measures in place should ensure staff are trained in a values based approach that is the least restrictive possible for patients. Individual risk factors are vital to consider when completing risk assessments across all levels of secure care. There should be a process in place to ensure that these ways of working are being implemented and evidenced in practice.

Recommendation 10) IPCU service provision should be designed with violence reduction measures in mind when considering environmental and procedural planning. National Association of Psychiatric Intensive Care and Low Secure Units (NAPICU) guidelines should be instrumental in this. Violence Reduction Services should be consulted to provide training to staff working in any new intensive psychiatric care facility.

3.5 Discussion with Chief Social Work Officers

This consultation was useful for the review team to gain a sense of the involvement of social work when a young person is admitted to an inpatient psychiatric service, including IPCU provision.

3.5.1.1 Variation in Social Work involvement

There is real variation in the level of social work care that a young person receives. The discussion estimated that around 80% of patients requiring intensive psychiatric care will likely already have a named social worker assigned to them (known to be lower in specific illnesses like eating disorders), but not all of these individuals will have a package of care in place. There is no set “pathway” as such for social work involvement as this usually occurs on a case by case basis, and if admissions are running smoothly, there may be no requirement for social work during the admission. Indeed, social workers may only be notified of a patient's stay in hospital when they receive an invite to attend a discharge meeting. This variation can also lead to challenges – if social work input is required for a young person who is completely new to the service, then social work staff have no background information and often have to start from scratch to build a case file, which is not ideal at a potential time of crisis.

3.5.1.2 Requirement for a multi-agency, collaborative approach

The CSWOs in the discussion identified the need for a multidisciplinary approach when working with young people who require intensive psychiatric input. As mentioned briefly above, social work is often consulted only regarding specific patients, however it was noted that it can be helpful for social work to have a more general presence in inpatient services.

Recommendation 11) Exploration of care options with multi-agency partners as a team around the child should be in place before referral to an IPCU is made.

For example, having social workers attending relevant ward team meetings not only helps to build relationships with nursing staff, the consulting CSWOs expressed there are always problems to solve across services. The discussion expressed that there are anxieties from staff working across all services to support young people who require intensive psychiatric care, whether that be around forensic or CAMHS risk, and increased joint working from different agencies helps to share knowledge and provide reassurance. Joint working and pathways were suggested as being helpful to provide aftercare and ease transitioning processes for young people moving from child to adult services, in sharing information about other services that take referrals (e.g. admission criteria) and also in placing greater emphasis on care and compassion.

3.5.1.2.1 Example of good practice/specific workaround

The review team's attention was drawn to an example where current resources were used to support young people who required intensive psychiatric care in the community. In a more rural area, social work is making use of residential provisions for two to three young people and providing nursing and multi-agency input. Although this has been a move away from the traditional system, this provision has had a positive impact, and in one example has allowed children who previously had been in and out of hospital to now be in a position to safely access mainstream education. This model is particularly beneficial for services in more rural areas to access this level off care without young people being removed from their community.

The CSWOs reflected that this provision has been resource-intensive to set up, and that there is a need for staff in other residential services to receive specific training in mental health, in order to feel confident enough in their competence to deliver care in this way. Based on this use of resources, it is worth considering the current variability of intensive psychiatric care provision options.

3.5.1.3 Recommendations for the future, and potential gaps in service provision

Consulting CSWOs illustrated the benefit of a national resource in terms of concentration of specialist skills and therefore access to specialist care. However consultees felt there were drawbacks in terms of a national service model as this would mean that staff who have these skills would all be located in one place without an easy opportunity to spread knowledge to other parts of the country. A national unit would also mean that for patients not living in the area of the unit, there would be movement away from their support network in the form of friends and family, whereas a more regional approach would allow patients to remain close to local resources and community aftercare, allowing for better integration of services.

Discussion with CSWOs outlined some current gaps in service provision, for example, there was concern of young people being admitted to services that were not appropriate for them, as there is no other place for them to go. An individual presenting as a complex case with a high degree of risk can be referred to a secure

service provision, whether a non-NHS secure unit or the developing NHS secure inpatient service, which may not be fully appropriate for their needs.

Other issues that were identified would not necessarily be solved by the development of a traditional adolescent IPCU. For example, young people with a learning disability would continue to have no direct provision available. The CSWOs also recognised that some young people who are experiencing episodic distress may not meet the criteria to be admitted to an IPCU if their illness is such that they do not cope well with restrictive measures, and other options would ideally need to be in place for these young people.

Recommendation 12) Even with the introduction of dedicated IPCU provision for young people, the review team anticipate there will remain a service gap for young people with a severe learning disability who are experiencing acute distress, and for whom a restrictive approach would not be appropriate. The review team wish to emphasise the importance of developing guidance for providing the correct support for these young people.

4 Adolescent IPCU Admission data –For the period of 2016 -2020

4.1 Admissions to Adult IPCU Provision

Table 1 indicates the number of admissions of young people to Adult IPCUs for the period of 2016 to 2020 (for the second half of 2020, data was only available from the North of Scotland).

Table 1: Adolescent Admissions to Adult IPCUs.

Region of IPCU	Accepted Adolescent Admissions to Adult IPCUs	Adolescent Referrals to Adult IPCUs that were not accepted
North	17*****	10
South East	2	2
West	11	2

***Five of these were identified as not requiring the level of security of an IPCU, and were mostly due to bed shortages. One of these was a Tayside patient who was admitted to an IPCU in a different region.**

Although numbers in Table 1 are small they are likely to underestimate the true number of patients who require this intensive level of care. As mentioned in previous sections, some patients who require IPCU are instead nursed in the open ward if an adult ward is deemed to be inappropriate. These patients are not accounted for in this table.

4.2 Demographics

4.2.1 Age

Data indicating the ages of patients at the time of their admission was available for 27 of the 30 referrals of young people accepted to adult IPCU provision. Of these admissions, patients ranged from 15 to 17 years of age, four of these admissions were patients who were 15 years old.

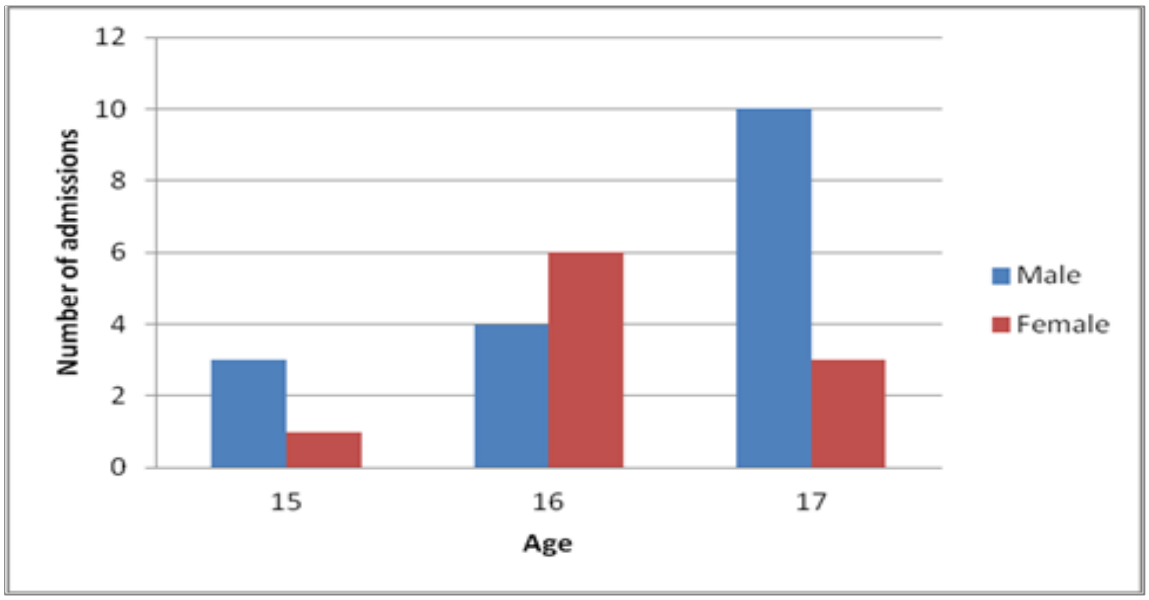
4.2.2 Gender

Data gathered on gender of patients who were admitted to adult IPCU provision is listed in Table 2. Figure 1 shows a breakdown of admissions by patient age and by gender

Table 2: Breakdown of admissions of adolescents to adult IPCUs according to gender.

Gender	Number of admissions of young people to adult IPCU
Male	17
Female	10
Data does not specify	3

Figure 1: Admissions of patients to adult IPCU by age and gender.



Of the 17 male admissions, three were 15 years old, four were 16 years old and ten were 17 years old.

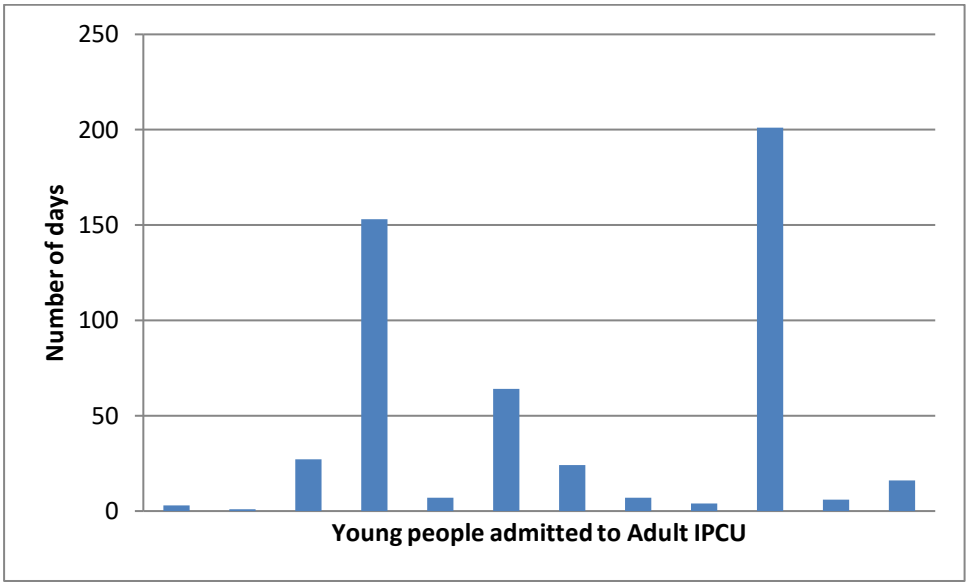
Of the 10 female admissions, one was 15 years old, six were 16 years old and three were 17 years old.

4.2.3 Duration of Admission

Data on duration of admission was available for 12 of the admissions of young people to IPCU (see Figure 2). Admission length ranged from 1 day to 201 days, mean length was 42.75 days, median length was 11.5. This indicates that the

majority of admissions only last a few weeks or even days, however, occasionally admissions will last for a number of months.

Figure 2: Duration of admission for young people admitted to an adult IPCU.



4.3 Diagnoses and presenting problems

Based on information gathered from the North and West of Scotland regions, Table 3 shows the diagnoses of young people who were admitted to IPCU.

Table 3: Summary of Diagnoses of Young People admitted to Adult IPCU provision.

Diagnoses:
Psychosis (including drug induced)
Developmental Trauma (and acute stress)
Depression
Paranoid Schizophrenia
EUPD*

*All individuals with EUPD were admitted due to bed shortages

Table 4 notes the presenting problems that staff have indicated are the reason that a young person was admitted to an adult IPCU provision throughout Scotland.

Table 4: Summary of Presenting Problems of Young People admitted to Adult IPCUs.

Presenting Problems:
Aggression (towards staff, property, and/or community)
Suicidal
(Significant) Violent risk towards staff and patients
Risk to staff due to psychosis and delusions
Prison Order
Absconsion
Mania symptoms, delusions and/or aggression due to psychosis
Risk to self (due to paranoid schizophrenia)

5 Conclusions

To conclude, staff currently working in services providing intensive levels of psychiatric care to young people are working extremely hard to adapt their practice and manage situations as safely as possibly. However, based on findings from this review, dedicated IPCU provision for young people is a necessary requirement to provide quality care moving forward.

Qualitative data (although as mentioned previously this is not recorded systemically and therefore caution must be taken) combined with the experience of NHS staff, outline that while young people can sometimes be transferred to an adult IPCU, those who are not accepted are managed within open wards. Staff experiences indicate the challenges that this brings, and the negative impact this can have on the wellbeing of the young person concerned, as well as on the other young people in the open unit. Those who are transferred to an adult IPCU often face seclusion to ensure safety from other patients, and do not have the same access to age-appropriate services (e.g. education, age-appropriate occupational therapy input). Based on the findings of this review, neither of these options appear fit for purpose.

Location is a key debating point for any new IPCU provision, particularly when considering the appropriateness of national or regional units. Discussions made clear the importance of considering the negative impact of removing a young person from their local region and community to receive further inpatient care, and suggested this should be minimised if possible. Also discussed was the challenge of transferring a patient, who is likely to be distressed, between services. Staff noted this can be challenging even between units on the same site, but factoring in travelling long distances, in appropriate vehicles, requires significant planning.

Location in terms of adjacencies to existing units is also an important aspect of the options appraisal. Appropriate adjacent inpatient units could provide staffing support, however it will be crucial to plan this in a way that is manageable for all units. Staffing required for an IPCU for young people requires specialised training and consultations highlighted the requirement for any staff working in this setting to be trained fully and given opportunity to maintain skills. In the likelihood of a new provision facilitating an out-of-hours service, consideration must be given to ensure appropriate consultant psychiatrist cover for this.

The number of beds required for this provision (whether in different regional settings, or a national unit) is difficult to infer from the data. Staff recognised that although quantitative data indicate a low number of admissions to IPCU, having to manage multiple patients who require IPCU over the same period of time is not unheard of. Although IPCU provision is intended to provide short term intensive input (a few weeks), occasionally patients can require a longer admission.

Consultations also considered where an IPCU would fit in current service structure. Primarily there would likely be a “Step up and Down” approach between IPCU and Open Young People’s Units. With the development of the new National Secure Adolescent Inpatient Unit, IPCU could also act as a “bridge” between this service and Open Young People’s Units.

5.1 Options Appraisal

The objectives identified in the options appraisal were developed drawing from the background literature and findings, as described in Sections 1 & 3. They were discussed within the review team and refined to take account of clinical considerations, and the priorities of young people and their families, as well as professional staff within the wider health and care system involved in supporting young people who require intensive psychiatric care. A weighting was assigned to each objective to indicative the relative importance for adolescent IPCU provision. The scoring was undertaken by two of the review team, again drawing on the findings of the review, including Section 4, but also the extensive clinical experience of the review lead. The options appraisal is thus not an “absolute” scientific measurement but rather an informed view. The thinking behind the weighting and scoring is described below.

- Provide age appropriate IPCU care - The Mental Welfare Commission have identified gaps in IPCU provision for young people: age appropriateness is therefore crucial to any future provision.
- Intensive (adolescent trained) nursing – This objective reflects the pressures in recruiting, training, and retaining nursing staff with adolescent intensive psychiatric experience, and that this requires different skills to nursing adults, and to nursing adolescents in open units. Adjacency to existing units may enable sharing staff across inpatient services and supports maintaining staff skill levels when patient demand is lower, although considerations must be taken to ensure existing units are staffed at a level that can support this.
- Full Multidisciplinary Team (MDT) staffing complement - Recognising pressures in recruiting, training, and retaining specialist MDT staff, with variation of scoring across options reflecting viability of potentially low part-time staffing given number of patients/beds vs adjacency to existing units with potential to share staff across. This includes considerations around out of hours staffing, consultant cover and job planning.
- Sufficient beds to meet likely demand - Available data indicates relatively low demand over any 12 month period, but with potential for peaks in demand that may exceed any new dedicated provision. Adjacent provision could support some flex across new IPCU provision and existing open units.
- SW support integrated & local SW links - National provision less likely to be able than regional provision to maintain strong links into social work services of the young person's home locality.

- Equality of access (travel minimised, gender appropriate) - Regional provision reduces impact of travel (for patient transfer and family access). Purpose built facilities reduce negative impact of vulnerable young people being exposed to risks from older patients.
- Family input integrated - Acknowledging that any intensive psychiatric care should use a family-centred approach, including planned visits of family/caregivers, and gathering information from families to inform safety planning, which can also enhance family members' relationship with the ward.
- Facilities are safe and appropriately secure - By the nature of their mental health care needs, young people referred are likely to present risk to themselves or others to a degree that cannot be managed safely in an open unit. Purpose built facilities are thus preferable.
- Fit for purpose: safe, secure, young people friendly, trauma informed care. IPCU provision must be designed in such a way that it is an environment in which young people can be comfortable, safe and secure. A low-stimulus environment to meet sensory needs would also be a requirement. Décor and facilities should be designed with young people at the centre.
- Access to meaningful activities (education, green space, exercise, arts) - Access to meaningful activities will be a requirement for any young person who is well enough to engage in them. While the expectation is admission to an IPCU should be short, recreational and educational facilities should be available and age appropriate. Being adjacent to an open unit could mean a broader range of activities.
- Capacity to adapt in case of emergency (fire, staff illness). Business continuity must be safely maintained in emergency situations.

Table 5 provides an overview of the options appraisal, including scoring and weighting of non-financial objectives in relation to options for adolescent IPCU provision. Option 1 (Regional purpose built adjacent units) score most highly. It should be stressed that this does not include economic considerations.

Recommendation 13) While it is difficult to infer from available data the number of beds that would be required, the review team recommend two beds per regional site are factored in to planning for the development of future adolescent intensive psychiatric provision.

Recommendation 14) On the basis of the findings of the review, and the outcome of the Options Appraisal, the review team suggest Regional purpose built adjacent units would best meet the requirements for adolescent intensive psychiatric provision in Scotland.

Table 5: Scoring and weighting of non-financial objectives in relation to options for Adolescent IPCU provision.

Objectives	Weight (W)	Option 1 Regional purpose built adjacent units		Option 2 National purpose built adjacent unit		Option 3 National stand-alone unit		Option 4 Regional community care		Option 5 Current provision	
		Score	Score x W	Score	Score x W	Score	Score x W	Score	Score x W	Score	Score x W
Provide age appropriate IPCU care	5	10	50	10	50	10	50	8	40	2	10
Intensive nursing (adolescent trained)	5	7	35	8	40	8	40	5	25	1	5
Full MDT staffing complement	5	6	30	8	40	8	40	7	35	5	25
Sufficient beds to meet likely demand	4	8	32	8	32	7	28	4	16	1	5
SW support integrated & local SW links	3	8	24	3	9	3	9	8	24	7	21
Equality of access (travel minimised, gender appropriate)	3	7	21	7	21	7	21	9	27	2	6
Family input integrated	4	8	32	7	28	7	28	9	36	5	20
Facilities are safe and appropriately secure	4	9	36	9	36	9	36	2	8	4	16
Fit for purpose: safe, secure, young people friendly, trauma informed care	4	8	32	8	32	8	32	5	20	3	12
Access to meaningful activities (education, green space, exercise, arts)	4	9	36	9	36	8	32	2	8	2	8
Capacity to adapt in case of emergency (fire, staff illness)	3	8	24	8	24	2	6	2	6	6	18
Totals		**88**	**352**	**85**	**348**	**77**	**322**	**61**	**245**	**38**	**146**

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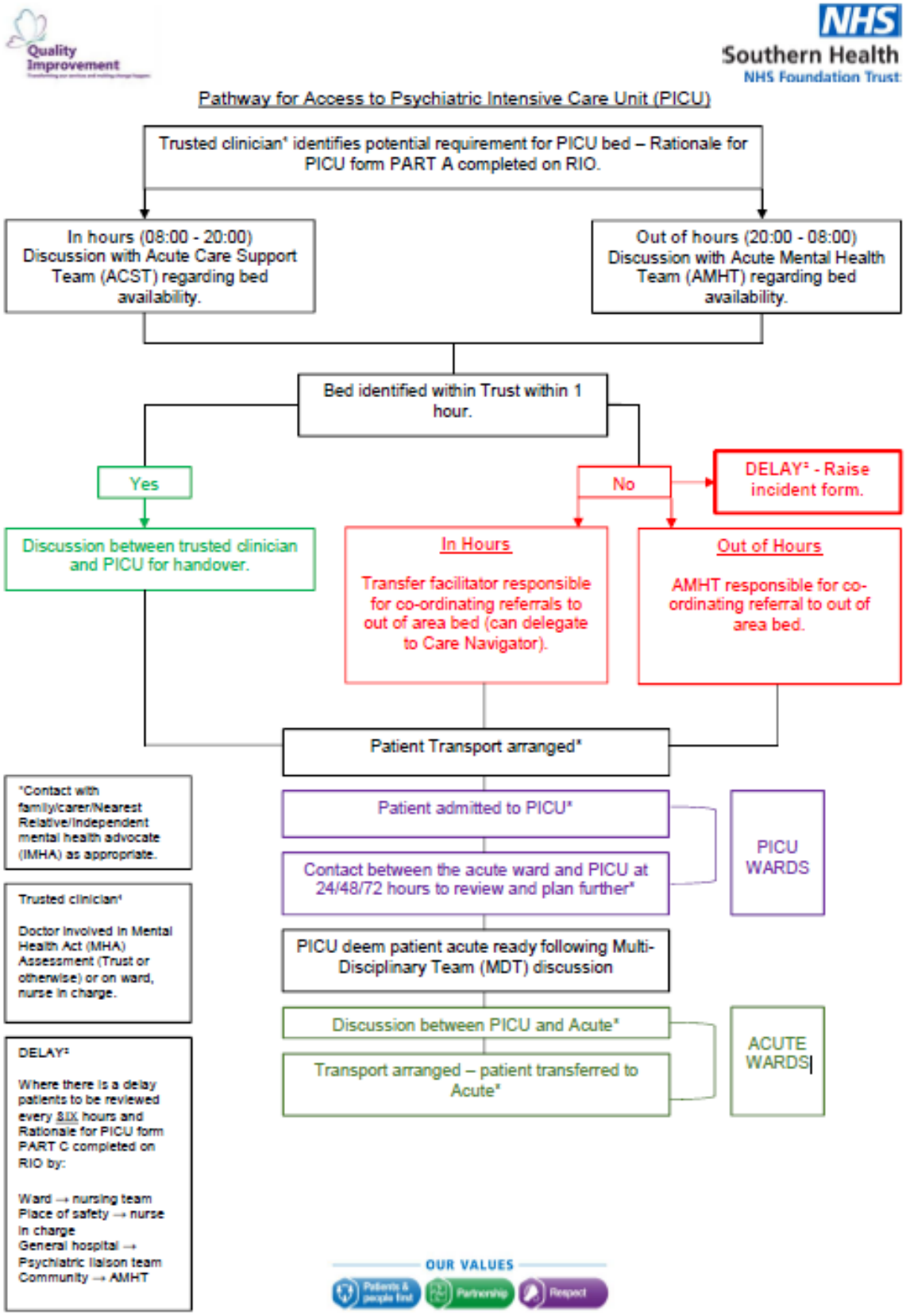
Appendix I. Pathway for Access to Psychiatric Intensive Care Unit Flowchart



IPCU GRH REFERRAL

Referring area to complete before contacting IPCU

Date:……

Have you referred to another IPCU? Yes / No

If yes Give reason why referral Declined:……....

Patient Name	CHI	MHA status/AWI Status
Locality Ward	**Referrers Name**	**Expiry of detention**
Advance statement	**Specified Person**	**Consultant**

Reason for referral and MDT opinion (including diagnosis or working diagnosis)

Expectation of stay

Define Current risk

Aggression? Describe type/frequency/ any injury
Self Harm? Describe method and frequency
Absconding with associated risk?- describe how often/intent/risk
Vulnerability/Disinhibit ion ? Describe behaviour and frequency
Any Physical Health Needs?

Please tick Interventions tried		Current Medication	Dose	Frequency
Observation				
PRN Medication				
Psychological Input				
Behavioural Strategies				
Medication Review				
Other?				

Effectiveness of Interventions

What Worked? If Interventions above not used give reason why?

Now Contact IPCU- 211-3601

Appendix II. Referral form for an adult Intensive Psychiatric Care Unit

Member of IPCU staff Taking referral…….

IPCU MDT discussion	
Please circle Admit? Yes No	
Detail Expectations of stay and conditions of return	
For all Admissions please confirm the below:	
Approximate time of admission	
Mode of transport	
Location of MHA papers	
Security of home/Location of keys	
Location of Children/pets	
Access to clothing and essentials	
Access to Money	
Next Of Kin informed of admission by	
If admission declined please give reason why, advice offered and re-referral	

IPCU Staff signature (print and sign)……..

Referring staff signature (print and sign)……

GRH IPCU v1.0

Appendix III. List of Health & Social Care staff consulted for review

Organisation	Service	Member of Staff
NHS Ayrshire and Arran	National Secure Adolescent Inpatient Service	Eileen Bray
		Stuart MacKenzie
		Dr Helen Smith
NHS Greater Glasgow and Clyde	Adult IPCU	Dr Lucy Carrick
	CAMHS Inpatient Unit	Andrea Blair
		Dr Anoop Devasahayam
		Jacqueline Hardie
		Dr Laxmi Kathuria
		Hilary Smith
	Specialist Children's Services	Julie Metcalfe
	Violence Reduction Service	John Gilmour
NHS Lothian	Adult IPCU	Dr Jane Cheeseman
	CAMHS Inpatient Unit	Dr Kevin Brown
		Margaret Monan
		Barry Muirhead
		Dr Ereni Skouta
		Jenny White
NHS North of Scotland Network	CAMHS Inpatient Unit	Susan Hynes
		Dr Kandarp Joshi
		Lynne Taylor
Edinburgh Council		Jackie Irvine
Dumfries and Galloway Council		Stephen Morgan
Highland Council		Karen Ralston

Appendix IV. Proforma used to guide discussions and data collection.

Review of Adolescent Intensive Psychiatric Care Units (IPCU) in Scotland – NHS Scotland Regional Consultation Pro forma

Introduction

- Current Inpatient Units
    - *Please tell us about the inpatient service you work in and your role within that.*
    - *What age are your patients?*
    - *How many beds in the unit?*
    - *What mix of professionals currently work in your inpatient service?*

Care Pathway

- Referral
    - *What would prompt your decision to refer a patient to a more intensive unit?*
    - *What organisations can make a referral? (Where do referrals come from?)*
- Admission
    - *What criteria do patients need to meet to be admitted to an IPCU?*
    - *Once a referral is accepted, what's the process for new admissions?*
    - *What needs to be considered in relation to transferring patients to an IPCU?*
- Barriers to admission
    - *What would exclude a patient from being admitted?*
    - *What happens when a patient is not suitable for an IPCU? Or if a bed can't be found?*
    - *Are there any other barriers to patients accessing an IPCU if they require it?*
- Discharge
    - *When does planning for discharge begin?*
    - *What is the pathway for discharge?*
    - *What type of barriers could prevent patients from being discharged?*

Current Adolescent IPCU Options

- IPCU Service Options in your region
    - *Currently in your region, what are the options for a patient who requires more intensive psychiatric care?*
    - *How well does this match the need for adolescent intensive psychiatric care?*
- Staffing
    - *What staff disciplines are present in the IPCU in your region?*
    - *What mix of staff would you want to see within an adolescent IPCU?*
- Patient Management
    - *Are there any patient management issues specific to adolescents who require intensive psychiatric care? (E.g. restraint procedures, risk assessment, observation)*
    - *What guidelines would you refer to for this? (Are these sufficient?)*

  - *How well are these issues currently provided for in your region?*
- Interventions/Facilities
  - *What facilities need to be in place for adolescents who require intensive care? (e.g. access to schooling, anything treatment specific?)*
  - *What else could be provided to facilitate their care? (e.g. violence reduction options; meaningful activities)*
  - *How well are these facilities currently provided in your region?*

Relationships across Services

  - *How do intensive care services and CAMHS/Community Services communicate generally?*
  - *How do you maintain communication with intensive psychiatric care services regarding specific patients?*
  - *How do you intensive care services and CAMHS/Community Services communicate with social work regarding specific patients?*
- National Secure Adolescent Inpatient Service
  - *What do you anticipate the relationship being between your service and the new National Secure Adolescent Inpatient Service?*

Future Adolescent IPCU Options

- Current unmet need (if not already covered in above discussion)
  - *What is lacking in current adolescent intensive psychiatric provision?*
  - *What are the key unmet needs?*
- Future options
  - *Would it be possible to adapt current services to meet need?*
  - *What would be the preferred option in your region? (e.g. current arrangement / adapt beds in an adult IPCU / have a dedicated unit adjacent to an adult IPCU/ have a dedicated unit adjacent to an adolescent inpatient unit/ other)*
  - *What are the benefits of your preferred option?*
  - *What are the disadvantages of your preferred option?*
    (On patient care? / On staff? / On families?)
  - *What clinical considerations need to be taken into account for these options?*

Activity data

- Admissions to open inpatient adolescent psychiatric units by Health Board?
- Duration of stay of patients in these units
- Referral/Admission rate – *(How many are referred vs accepted and admitted) to open units but also to IPCU services from open units*

Patient Profile (for patients requiring intensive psychiatric care)

- Diagnosis/Conditions - *Prevalence of conditions existing in patients in the wards*
- Age of patients admitted
- Level of deprivation – *(SIMD)*
- Location – *Admitted from/Discharged to*
- Detention Status – *How many patients were informal/detained*
- Patients placed on observation – *And varying levels of this?*

Staffing Data

- Core Team – *Nursing and Medical Staff required to run the ward? Number of sessions? Daily staffing levels per shift?*
- Allied Health Professionals/MDT – *Clinical Psychology, Occupational Therapy, SLT input etc. Number of sessions?*

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