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Who needs an adolescent unit?

A referrer satisfaction study

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Despite the recommendations of the Health Advisory Service report *Bridges over Troubled Waters* (1986), there has not been any dramatic growth in adolescent psychiatry as a sub-speciality. The HAS report highlighted the largely unmet special needs of this age group, the rising risk for mental illness with increasing age in adolescence, and the need for effective liaison between professional disciplines working with this age group. Nevertheless adolescent services increasingly perceive themselves as under threat from political initiatives and continue to fight their corner (e.g. Wells, 1989).

A small regional service with a relatively low turnover of cases, has a potential difficulty in maintaining a reputation throughout the region and monitoring effectively the needs and satisfaction of potential referrers. The Government White Paper *Working for Patients* requires the implementation of clinical audit, including measures of customer satisfaction, and the establishment of contracts for services, resulting in a flow of money across district boundaries with referred patients, for those services not purchased at regional level. The concept of 'customer' in adolescent psychiatry is a complex one, given that the 'patients' themselves rarely initiate contact, and the parents, where indeed the adolescent lives at home, may also not be in full agreement with the referral. Garralda & Bailey (1988) have discussed the influences within the family, determining whether referral to child and adolescent psychiatry occurs or not. In this respect, the concept of 'customer', may be expanded to include the referrer.

A recent study of general practitioners' knowledge and satisfaction with a child and family psychiatric service suggested that there was some lack of awareness of services offered (Markantonakis & Makai, 1990). An interesting finding was a belief among GPs that it was inappropriate for this service to accept referrals from agencies not related to primary medical care, presumably themselves!

The present study

The Prestwich Adolescent Unit was established in 1979 as a regional service to the North Western Regional Health Authority. It is a general purpose, seven day service for adolescent psychiatry, based in Salford Health Authority. Serving a population of $4\frac{1}{2}$ million, it offers a mix of in-patient, day-patient, out-patient and consultation/liaison work, including the treatment of mental illness.

Aims

The study aimed to address the perceived need for increased referrer awareness of the service, following changes of personnel, to clarify why potential referrers had and had not referred to the service, whether or not they were satisfied with their past contact, whether and in which circumstances they would refer in the future, and which qualities they would desire from an adolescent psychiatric unit. A final aim was to clarify the extent of interdisciplinary differences in these variables. Implicit in the study and in keeping with the spirit of audit, was a willingness to develop the service to meet the needs of the users rather than those of the established service.

Design

This paper reports a questionnaire survey of 178 past or potential referrers to the adolescent unit from six disciplines. They comprised all consultant and senior registrars in child and adolescent psychiatry in the NW region (n = 32), 20 child psychologists (8 clinical, 12 educational), 26 community child psychiatric nurses, 32 general practitioners, 38 paediatricians and 30 psychiatric social workers. The GPs comprised the 20 most recent referrers and 12 drawn at random from the five adjacent districts, the paediatricians were two from each of the 19 districts in the region, and the social workers comprised one from each district working with adolescents, plus all others who had referred in the last two years.

The questionnaire comprised 54 items, mainly of multiple choice type, with ten open-ended questions. The first section asked past referrers about their satisfaction with the service and intention to refer again and the second part asked why the remainder had not referred, and in what circumstances they might use the service in the future. The last section comprised

22 possible features of an adolescent psychiatric service and asked respondents to rate them on a 4 point scale, from not important to very important. The questionnaire was distributed by post, without other direct contact or advance warning, with a follow-up reminder after three weeks to those who failed to reply.

Findings

Of 178 questionnaires sent out, 148 were returned, a response rate of 83%. The response by profession ranged from 94% of paediatricians and 93% of child and adolescent psychiatrists to 73% of CPNs, giving a satisfactory response from each group.

Past users

Of the 148 respondents, 85 (57.4%) were past referrers, but there were marked differences between professions, the percentage of respondents from each discipline having previously referred being 87% of child psychiatrists, 87% of social workers, 67% of psychologists, 37% of CPNs, 36% of paediatricians and 35% of GPs. Each child and adolescent psychiatrist had also tended to refer more often than any other profession, and significantly so, for an admission place.

The most frequent reason for referral was specialisation in the adolescent age range; 33% of referrers mentioned wanting help for a specific disorder and by far the most frequent were psychotic and eating disorders (10 and 13 responses respectively).

Satisfaction

The handling of past referral(s) was rated "completely satisfactory", or "in the main" satisfactory by 86.6% of past referrers (n = 71). Only one (a GP) rated this "not at all" satisfactory. There were no significant differences between professions. Minor levels of dissatisfaction concerned lack of awareness or understanding of the nature of services offered, or poor communication.

Were the patients outcomes satisfactory? Perhaps surprisingly 78.7% answered "yes" or "in the main". Quite probably respondents took into account the likely prognosis in a given case, although of eight replies saying the outcomes were "not at all" satisfactory, five gave reasons within the patient or family, rather than criticisms of the service, by way of explanation. When child and adolescent psychiatrists ratings were compared with all others, the psychiatrists were significantly more satisfied with the outcome ($P < 0.05$).

Two-thirds of past referrers said they would definitely refer in the future, with a further 20% saying they probably would. Only one (the same disgruntled GP) said he definitely would not. Here there was an inter-professional difference, with 96% of child and adolescent psychiatrists saying they would definitely refer again. The greater intention to refer in the future compared with all other disciplines pooled was significant ($P < 0.01$). Where a reason was given for intending to refer (70 past users), the most frequent reasons given were a need for in-patient treatment, which could not be met elsewhere, treatment for anorexia nervosa and psychotic disorders, or second opinions.

Past non-users

Sixty-three respondents said they had never referred in the past, of whom 29 said they were unfamiliar with the service and 14 said it was too far away; 22 said they had no suitable patients (predominantly GPs, paediatricians and CPNs). Most importantly, when asked directly, not one respondent claimed that in-patient treatment was not required for adolescent psychiatric disorder, while only five identified adequate alternative beds within the region (two paediatricians, two GPs and one psychiatrist). Only nine replies (four of them GPs) believed a district should manage all cases without recourse to a regional service.

Of past non-users, 29% said they would definitely or probably refer in the future. Not surprisingly, these were generally those previously unaware of the service. The most frequently volunteered circumstances were for in-patient treatment in general and the treatment of psychosis in particular.

Only seven replies said they definitely would not refer and these, together with those unlikely to refer, frequently cited (14 replies) a policy of referral to the district child and adolescent psychiatrist first. This suggested that the other disciplines saw the need for referral, but viewed the judgement as best made by the specialists in the field. (This view of our operating as a tertiary referral service was especially prevalent amongst GPs and paediatricians).

What would you most value from an adolescent psychiatry service?

Table I shows the 22 items and their ranking in importance, for all respondents and for each discipline (n = 148, past referrers and non-referrers combined). Overall, the most valued items related to communication/liaison, and prompt, although not necessarily 24-hour, response to emergencies, particularly with provision of in-patient beds. An admission facility was rated "very important" by 69.1% of respondents. An ability to manage severe psychiatric illness was rated very highly (69% "very important" for psychosis, 43% for eating disorders). Those items loosely classified as "social" were not rated important in this context.

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TABLE I
Ranking in order by preference of 22 features of an adolescent psychiatry service by discipline

	All	*Child & Adolescent Psychiatrists*	*Psychologists*	*CPNs*	*GPs*	*Paediatricians*	*Social workers*
Out of hours service	16			9			
Prompt response to emergency referrals	1	3	4	2	1	2	2=
Domiciliary service	20						
Opportunity to discuss cases by phone	5	2	5	5	3	6	7
Day patient places	19						
Fully staffed unit school	14	10	7=				
Service for eating disorders	9	8	10	8		9	
Service for adolescent psychosis	4	4	3	6	4	3	2=
Treatment for conduct disorders	18				9=		9**
Respite for social reasons	22						
Service for sex abuse victims	15				5		8*
Management of school attendance disorders	21						
Neuropsychiatric assessment	11	9		10			
Treatment for older adolescents (16–17)	6	6	6	3=		8	5
Treatment for young adults (18–19)	12						10
Advice or opinions	7	7	2	7		5	6
Out-patient treatment	17				9=		
In-patient beds	3	1	7=	3=	6	4	4‡
Prompt informative communication	2	5	1	1	2	7	1
Family therapy service	13		9		7=		
Effective liaison with paediatrics	8				7=	1	
Effective liaison with adult psychiatry	10					10	

Significant differences χ^2 test.
Child and adolescent psychiatrists value < the rest
*$P<0.01$
**$P<0.001$
Child psychiatrists value > the rest
‡$P<0.001$

There was remarkable agreement across disciplines, with the top five overall rated items featuring in all the top 10s, the major significant across-group findings being the importance paediatricians give to liaison with themselves and child and adolescent psychiatrists give to in-patient beds on the one hand, and child psychiatrists' relatively low rating for sex abuse and conduct disorder services. The opportunity to list additional services required, or make other comments yielded much the same message, with 19 requests for further information about the service provided.

Comment

This modest survey reveals a great deal about six disciplines' awareness of and satisfaction with a particular regional adolescent service, but also what they require from adolescent psychiatry in general. The level of response alone might well be taken as confirmation of the importance attached to such a service. Regarding the specific service, respondents were generally satisfied and fully intended to refer in the future, after the establishment of the 'open health market', although there were requests for improved communication about the service and over specific patient management.

Respondents rated the need for a regional adolescent psychiatric service very highly indeed and their desires are remarkably consistent across disciplines. There was no confirmation of the notion that those in primary care do not wish their patients to see a psychiatrist, as has been reported elsewhere (Wilkinson, 1988). They want a prompt, comprehensive service for adolescents with mental illness, within which in-patient beds are perceived to be essential, together with effective consultation and liaison. A number of referrers are happy for the district child and adolescent psychiatrists to determine the need to refer on an individual case to the regional service. This view is matched by our current referral pattern, within which 40% of referrals come from the district specialists.

One could thus see the views of child and adolescent psychiatrists as the most vital. It is therefore of great significance that they are the most satisfied, the most intending to refer, and the most perceptive of the need for in-patient adolescent beds. In short, they are aware of the limitations of their own district-based facilities for managing severe adolescent disorder.

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Usage of professional time: a case by case analysis

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The study

Child and adolescent psychiatric services receive referrals from a variety of sources in addition to traditional medical channels. It is unknown whether this practice has implications in patterns of usage of time. Our hypothesis was that referrals from non-medical sources were likely to be more time-consuming than those from medical colleagues.

Diagnostic related groups (DRGs) have been proposed for some specialities as being a possible way of simplifying the complex task of monitoring and quantifying resources needed for the management of disorders. Their usefulness in child and adolescent psychiatric services is currently doubtful and unproven (Parry-Jones, 1990). Our hypothesis was that narrower groups than those previously used may be helpful in predicting workload.

This paper was first presented as a short paper at the Annual Residential Meeting of the Child and Adolescent Psychiatry Section of The Royal College of Psychiatrists held in Glasgow in September 1990.

All new referrals received between 1 February 1990 and 31 May 1990 by a sub-regional (serving six health districts) in-patient adolescent unit were entered into the study. This unit also provides a supra-district out-patient and day patient service to young people aged between 13 and 19 years. The philosophy and style of working is multidisciplinary with an out-patient team consisting of two consultant psychiatrists, one senior registrar, one senior clerical medical officer (psychiatry), one principal psychologist and one senior social worker.

Following referral and allocation to a member of the team, all professional activity directly related to the case was timed and logged under one of six headings: direct contact with patient; direct contact with relatives; case management; administration; travel; lost. This was recorded on a front sheet attached to the notes to ensure greatest reliability. This recording was continued until 31 July 1990 (i.e. six months after inception of the study).

Also recorded for each referral were age and sex of young person, discipline of referrer, health district of origin and ICD-9 diagnoses (World Health