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## **“Far Away from Home”: Adolescent inpatient admissions far from home, out-of-area or to adult wards: A national surveillance study.**

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Complete List of Authors:	Holland, Josephine; University of Nottingham, Mental Health and Clinical Neurosciences Roe, James; University of Nottingham, ARC East Midlands Guo, Boliang; University of Nottingham, Institute of Mental Health Dasilva-Ellimah, Morenike; University of Nottingham, Mental Health and Clinical Neurosciences Burn, Anne-Marie; University of Cambridge, Institute of Public Health Dubicka, Bernadka; University of York, Department of Child and Adolescent Psychiatry Ford, Tamsin; University of Cambridge, Department of Psychiatry Wagner, Adam; University of East Anglia; National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care East of England Nazir, Saeed; Nottinghamshire Healthcare NHS Foundation Trust James, Anthony; Oxford Health NHS Foundation Trust Morriss, Richard; University of Nottingham, Psychiatry Sayal, Kapil; University of Nottingham Faculty of Medicine and Health Sciences, Mental Health and Clinical Neurosciences
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4 **“Far Away from Home”: Adolescent inpatient admissions far from home, out-**  
5 **of-area or to adult wards: A national surveillance study.**  
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7 Josephine Holland (0000-0002-6343-8443), James Roe (0000-0002-9514-5629), Boliang Guo  
8 (0000-0002-1844-705X), Morenike Dasilva-Ellimah (0000-0002-6977-3840), Anne-Marie  
9 Burn (0000-0002-0637-2118), Bernadka Dubicka (0000-0002-8907-8589), Tamsin Ford  
10 (0000-0001-5295-4904), Adam Wagner (0000-0002-9101-3477), Saeed Nazir (0000-0002-  
11 6559-4300), Anthony James (0000-0002-2742-8328), Richard Morriss (0000-0003-2910-  
12 4121), Kapil Sayal (0000-0002-2050-4316) in collaboration with the CAPSS Scientific  
13 Committee  
14

15  
16  
17 Josephine Holland, Clinical Assistant Professor, Institute of Mental Health, School of  
18 Medicine, Mental Health and Clinical Neurosciences, University of Nottingham, NG7 2TU UK.  
19

20 James Roe, Research Fellow, National Institute for Health Research, ARC East Midlands,  
21 University of Nottingham, Nottingham, NG7 2TU UK.  
22

23 Boliang Guo, Associate Professor of Medical Statistics, Institute of Mental Health, School of  
24 Medicine, Mental Health and Clinical Neurosciences, University of Nottingham, NG7 2TU UK.  
25

26 Morenike Dasilva-Ellimah, Academic Foundation Doctor, Institute of Mental Health, School  
27 of Medicine, Mental Health and Clinical Neurosciences, University of Nottingham, NG7 2TU  
28 UK.  
29

30 Anne-Marie Burn, Senior Research Associate, National Institute for Health Research, ARC  
31 East of England, University of Cambridge, Douglas House, 18 Trumpington Road, CB2 8AH,  
32 UK.  
33

34 Bernadka Dubicka, Professor of Child and Adolescent Psychiatry, Department of Child and  
35 Adolescent Psychiatry, Hull & York Medical School, University of York, UK.  
36

37 Tamsin Ford, Professor of Child and Adolescent Psychiatry, University of Cambridge,  
38 Department of Psychiatry, University of Cambridge, Douglas House, 18 Trumpington Road,  
39 CB2 8AH, UK.  
40

41 Adam Wagner, Associate Professor in Health Economics & Prioritisation in Health & Social  
42 Care, Norwich Medical School, University of East Anglia, Norwich, NR4 7TJ, UK.  
43

44 Saeed Nazir, Consultant Child and Adolescent Psychiatrist, Hopewood Hospital, Foster Drive,  
45 Nottingham, NG5 3FL, UK.  
46

47 Anthony James, Consultant Child and Adolescent Psychiatrist, Highfield Unit, Warneford  
48 Hospital, Oxford, OX3 7JX, UK.  
49

50 Richard Morriss, Professor of Psychiatry and Community Mental Health, Institute of Mental  
51 Health, School of Medicine, Mental Health and Clinical Neurosciences, University of  
52 Nottingham, NG7 2TU UK.  
53

54 Kapil Sayal, Professor of Child and Adolescent Psychiatry, Institute of Mental Health, School  
55 of Medicine, Mental Health and Clinical Neurosciences, University of Nottingham, NG7 2TU  
56 UK.  
57  
58  
59  
60

1  
2  
3 Correspondence to: Josephine Holland; josephine.holland@nottingham.ac.uk, Institute of  
4 Mental Health, School of Medicine, Mental Health and Clinical Neurosciences, University of  
5 Nottingham, NG7 2TU UK  
6  
7  
8  
9

### 10 Contributorship statement

11  
12 The corresponding author attests that all listed authors meet authorship criteria and that no  
13 others meeting the criteria have been omitted.  
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### 29 Combined COI Statement

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37 Child and Adolescent Mental Health, has been the Chair of the Child and Adolescent Faculty  
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## **Abstract**

### **Background**

The increasing prevalence and acuity of mental disorders among children and adolescents has placed pressure on services, including inpatient care, and resulted in young people being admitted at-distance or to adult wards. Little empirical research has investigated such admissions.

### **Objective**

To determine the incidence, clinical characteristics and 6-month outcomes of 13–17-year-olds admitted at-distance (>50 miles from home or out of region) to general adolescent psychiatric wards, or to adult psychiatric wards.

### **Methods**

Surveillance over 13 months (February 2021–February 2022) using the Child and Adolescent Psychiatry Surveillance System (CAPSS) including baseline and 6-month follow-up questionnaires.

### **Findings**

Data were collected about 290 admissions (follow-up rate 99% (288/290); sample were 73% female, mean age 15.8 years). The estimated adjusted yearly incidence of at-distance admission was 13.7 to 16.9 per 100,000 13–17-year-olds. 38% were admitted >100 miles from home and 8% >200 miles. The most common diagnoses at referral were Depression (34%) and Autism Spectrum Disorder (20%); other common referral concerns included suicide risk (80%), emotional dysregulation (53%) and psychotic symptoms (22%). Over two-fifths (41%) waited  $\geq 1$  week for a bed, with 55% waiting in general hospital settings. At 6-month follow-up, 20% were still in hospital, the majority in at-distance placements.

### **Conclusions**

At-distance and adult ward admissions for <18s remains an ongoing challenge for healthcare provision and have an impact on acute hospital resource use.

### **Clinical Implications**

Long waits in non-specialist settings increase pressure across the healthcare system, highlighting the need to improve local service provision and commissioning to reflect identified clinical needs.

### **Summary box**

What is already known on this topic:

- At-distance and adult ward admissions in Child and Adolescent Mental Health Services (CAMHS) are often labelled as “inappropriate”, and national policies describe intentions to eliminate these types of admissions in the future.

What this study adds:

- Young people for whom admissions are requested on an emergency basis frequently wait a week or more for a CAMHS bed, most usually waiting in an acute hospital setting.
- Clinical risk is a main driver for these admissions, with suicide risk present in 80% and risk management requested in almost every case.
- The average length of at-distance admissions is 15 days longer than the overall average length of inpatient CAMHS admissions, with a delay to discharge in a third of cases.

Implications

- Commissioning and local service provision driven by identified needs; as well as close working with between inpatient and community teams, other specialities, social care and education is required to reduce the need for at-distance and adult ward admissions.

## **Background**

Rates of mental disorder among young people are increasing.<sup>1,2</sup> This is reflected in increases of referrals to Child and Adolescent Mental Health Services (CAMHS),<sup>3</sup> mental health crisis presentations to the Emergency Department (ED),<sup>4</sup> admissions to paediatric wards<sup>5</sup> and compulsory hospital admissions (e.g. through the use of the Mental Health Act (MHA) in England),<sup>6</sup> suggesting that the acuity of presentations is also increasing. Where a young person's mental health needs and risks have reached a level of severity and complexity that care cannot be safely provided in the community, an inpatient psychiatric admission (to a general adolescent unit, if aged 13-17 years) might be sought. If a bed in a local unit cannot be found in a timely manner, this might result in an admission to an at-distance unit. These types of admissions are a frequently discussed and controversial topic in the media and in policy statements;<sup>7,8</sup> with concerns about time spent away from family, friends, school, and local support networks during this formative phase of life. The admission of under-18s to adult psychiatric wards has also been a cause of concern.<sup>9,10</sup> Despite this, little empirical research has systematically investigated the scale, impacts and outcomes of these types of admissions in the UK or elsewhere. Surveillance studies, when compared with routinely collected administrative data, allow for the collection of detailed information such as clinical characteristics, reasons for admission and diagnosis. They also enable the collection of follow-up data about clinical and service use outcomes.

## **Objective**

To systematically gather clinical information about at-distance (far from home or out-of-region) and adult ward admissions in England over a 13-month period to investigate their incidence, clinical characteristics and 6-month outcomes.

## **Methods**

### **Study Design**

A national surveillance study in England to determine the surveillance incidence, clinical characteristics and outcomes of 13–17-year-olds who had been admitted to a: 1) general adolescent unit (GAUs; i.e. a general psychiatric ward for under-18s) at-distance from home or 2) adult psychiatric ward, during a 13-month surveillance period (1<sup>st</sup> February 2021 - 28<sup>th</sup> February 2022) as reported by Consultant Child and Adolescent Psychiatrists. [“at-distance” was defined as over 50 miles from their home address or outside their National Health Service (NHS) commissioning region area (in England this reflected ten NHS regions or “commissioning areas”) as illustrated in Appendix 1.] Case details were collected using two methods outlined below.

Surveillance data was triangulated with recorded admission numbers during the surveillance period from NHS England (the lead and central administrative organisation).

### **Ethics Approval**

This study was approved by the Royal College of Psychiatrists (RCPsych) Child and Adolescent Psychiatry Surveillance system (CAPSS) Executive Committee (August 2020). The Health Research Authority (HRA) and the Confidentiality Advisory Group (CAG) granted approval (HRA reference: 20/WM/0265, CAG reference: 20/CAG/0127).

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### **Case Notification**

#### **Strand 1 – Child and Adolescent Psychiatry Surveillance System (CAPSS)**

CAPSS is a well-established method of active surveillance to support the epidemiological study of rare mental health disorders or events amongst children and adolescents in the United Kingdom (see previous CAPSS studies e.g. Catch-U<sup>s11</sup>). Hosted by the RCPsych, Consultant Child and Adolescent Psychiatrists are encouraged to register on the CAPSS database and, each month, receive an email e-card which asks them to indicate whether they have seen an eligible case for up to two surveillance studies. For this study (called “*Far Away from Home*”), Consultants were asked if they had seen a case meeting any of the criteria below.

A 13–17-year-old admitted to:

- any adult psychiatric ward;
- a GAU over 50 miles from their home (defined by shortest road journey); or
- a GAU outside their NHS commissioning region area.

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3 Participants were asked to exclude admissions to specialised psychiatric units such as: Eating disorder  
4 units; Learning disability/Autism units; Forensic/Secure units or Psychiatric Intensive Care Units  
5 (PICU).  
6

7 Each month, the CAPSS administrator notified study researchers of the email addresses of Consultants  
8 who had reported a case and the number of cases they had reported. Reporting Consultants were  
9 then contacted by the research team with a request to complete a baseline questionnaire about each  
10 case (with four ways to respond: via secure electronic link to an online REDCap questionnaire; secure  
11 email with a fillable pdf document; postal questionnaire; or telephone call with a researcher).  
12 Reporting Consultants were initially sent email reminders to complete the questionnaire, followed by  
13 telephone contact. For eligible cases, six months after the date of admission, the Consultant was asked  
14 to complete a follow-up questionnaire.  
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16

### 17 Strand 2 - Additional Direct Case Reporting

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19 Some Consultants who had participated in Strand 1 contacted the study team directly to report an  
20 eligible case or completed the baseline questionnaire online. For example, Consultants who held a  
21 lead role within a regional Provider Collaborative (during the course of the study, NHS policy changes  
22 were implemented to enable closer regional oversight of admissions through the establishment of 18  
23 Provider Collaboratives) were often able to use their knowledge about admissions and the data  
24 recorded by their provider collaborative to identify eligible cases.  
25  
26

27 Figure 1 shows the two strands via which Consultants reported cases to the study.  
28

29  
30 FIGURE 1 HERE

### 31 Study Questionnaires

#### 32 Baseline Questionnaire

33  
34 This was designed to be completed from information CAMHS clinicians provide on the referral form  
35 requesting an inpatient admission (NHS England Form 1). The questionnaire asked: patient's home  
36 postcode (for determining the distance between home and the admitting unit, and home NHS region);  
37 NHS number; date of admission; and demographic details including date of birth (to calculate age),  
38 sex, whether non-binary gender, and ethnicity. The questionnaire enquired about the reasons for  
39 requesting admission (including clinical diagnosis and presence of risks), whether the young person  
40 was known to services, why an at-distance or adult ward admission occurred and whether it was a  
41 planned or emergency admission, which treatments/interventions were requested from the  
42 admission, whether the admission was voluntary or compulsory (under the MHA), and where the  
43 young person had waited for their admission and for how long.  
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#### 48 Follow-up Questionnaire

49 The 6-month (from admission date) follow-up asked about the status of the young person and whether  
50 they transferred to another unit during their admission, which interventions/treatments were started  
51 as an inpatient, involvement of the community team during admission and, if applicable, date of and  
52 diagnosis at discharge and whether discharge had been delayed for any reason.  
53  
54

55 Both questionnaires also had optional free-text boxes for respondents to provide additional detail.  
56

### 57 Determining eligibility

58 To establish whether a reported case met the study criteria of being admitted more than 50 miles  
59 away from their home, distances between associated postcodes were calculated using open access  
60



1  
2  
3 online software ([www.freemaptools.com/distance-between-uk-postcodes.htm](http://www.freemaptools.com/distance-between-uk-postcodes.htm)). 'Free Map Tools'  
4 uses geographic information systems technology to determine the shortest route along a road  
5 network and has been used in previous studies.<sup>12</sup>  
6

7 To establish whether a case was admitted outside the local NHS commissioning region, the region of  
8 the home address and the admitting unit were determined and compared. The Provider Collaborative  
9 region was also similarly derived to explore the impact of this policy change.  
10

### 11 **Analysis**

12 To calculate incidence, the observed sample size was adjusted to a 12-month estimate and compared  
13 with March 2021 Office of National Statistics (ONS) census estimates of 13-17-year-olds. Adjusted  
14 rates based on the methodology used by Janssens et al.<sup>11</sup> were calculated and two assumptions were  
15 made. Assumption 1 was that the observed incidence rate also applied to half of the non-returned e-  
16 cards because Consultants with cases to report might be more likely to respond. Assumption 2 was  
17 that the observed incidence applied to all non-returned e-cards (i.e., no difference in incidence  
18 between cases that were and were not reported).  
19

20 For the quantitative data, normally distributed data were summarised with mean, standard deviation  
21 (SD), n, minimum and maximum. Skewed data were summarised by median, interquartile range (IQR),  
22 n, minimum and maximum. Categorical data were summarised using frequency (percentage). All  
23 analyses were completed using STATA 17.<sup>13</sup>  
24

25 The qualitative data provided through free-text responses were analysed using conventional content  
26 analysis as described by Hsieh and Shannon.<sup>14</sup> This involved familiarisation with the data, initial coding,  
27 grouping of codes into categories, and then combination of categories until main categories emerged.  
28

### 29 **Findings**

#### 30 **Cases**

31 Through CAPSS, 698 Consultant Child and Adolescent Psychiatrists were sent monthly e-cards. Sixty-  
32 five percent of Consultants responded to at least one e-card during the study period, with a mean  
33 monthly response rate of 46%. Figure 2 presents the flow diagram to outline how the sample of 290  
34 eligible cases was derived across the two reporting strands. Patient NHS numbers and admission dates  
35 were used to determine duplicate cases both within and between the strands. Where there was  
36 duplication, the information was reviewed and combined to ensure a single complete record for the  
37 admission. Completion rate of six-month follow-up questionnaires was very high, with data obtained  
38 about 288 (99%) cases.  
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40 As shown in Figure 3, all adult ward admissions were within region and <50 miles from home.  
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FIGURE 2 HERE

FIGURE 3 HERE

### Incidence of admissions

Table 1 shows incidence calculations, including adjusted rates, for at-distance admissions. During the surveillance period, administrative data from NHS England recorded 2025 admissions to general adolescent units, of which 534 were at-distance (personal communication). Our study captured detailed information about 279 (52.3%) of these admissions.

Table 1 Calculation of the estimated rate of at-distance and adult ward admissions (per 100,000 people aged 13-17 years per annum)

	At-distance admission	Adult ward admission
<b>Observed incidence for 13–17-year-olds (95% exact poisson CI)</b>		
Observed Cases	279	11
Estimated 12-month rate based on census data	7.8 (6.9, 8.9)	Not calculated due to low sample size
<b>Correction for non-returned notification cards</b>		
Returned*	46.3%	
No response*	53.8%	
Assumption 1 (the same incidence applied to half non-returned)	$(26.9+53.8)/46.3 =$ coefficient 1.7	Not calculated due to low sample size
Assumption 2 (the same incidence applied to all non-returned)	$100/46.3 =$ coefficient 2.2	Not calculated due to low sample size
<b>Combined coefficients</b>		
Adjusted incidence rate 1= incidence rate x correction for unreturned notification cards (assumption 1)	$7.8 \times 1.7 = 13.7$	Not calculated due to low sample size
Adjusted incidence rate 2= incidence rate x correction for unreturned notification cards (assumption 2)	$7.8 \times 2.2 = 16.9$	Not calculated due to low sample size
<b>Administrative data from NHS England (95% exact poisson CI)</b>		
Recorded number of admissions	534	259 <sup>+</sup>
Recorded incidence rate	14.8 (13.6, 16.2)	7.3 (6.5, 8.3)

\* The mean monthly response rate to e-cards was 46.33%

<sup>+</sup> NHS England recorded 259 admissions of under-18s to adult wards, however, they were unable to specify how many of these were young people referred for admission to a GAU, it is likely that some of these young people were referred for more highly specialist inpatient care.

### Demographics

The demographics of the young people in our sample are shown in Table 2. Amongst the young people (n=279) admitted at-distance, of note, 12.7% of males were of black ethnicity; the comparable proportion from the NHS England triangulation data (which records young peoples' gender rather than sex) was 9.6%. Of the young people (n=11) admitted to adult wards, 72.7% were female and their mean age was 16.8 years.

Table 2 Sample demographic characteristics

Characteristics	Male sex n(%) (N=79)	Binomial Exact 95% confidence interval	Female sex n(%) (N=211)	Binomial Exact 95% confidence interval	Total n(%) (N=290)	Binomial Exact 95% confidence interval
Non Binary Gender	3 (3.8)		16 (7.6)		19 (6.6)	
<b>Age</b>						
Age 16-17 years	60 (76.0)		123 (58.3)		183 (63.1)	
<b>Ethnicity</b>						
White Ethnicity*	54 (68.4)	56.9, 78.4	166 (78.7)	72.5, 81.0	220 (75.9)	70.5, 80.7
Asian Ethnicity*	5 (6.3)	2.1, 14.2	7 (3.3)	1.3, 6.7	12 (4.1)	2.2, 7.1
Black Ethnicity*	10 (12.7)	6.2, 22.1	3 (1.4)	0.2, 4.1	13 (4.5)	2.4, 7.5
Mixed or Other Ethnicity*	4 (5.1)	1.4, 12.5	20 (9.5)	5.9, 14.3	24 (8.3)	5.4, 12.1
Ethnicity not known	6 (7.6)	2.8, 15.8	15 (7.1)	4.0, 11.5	21 (7.2)	4.5, 10.9

\* In the original questionnaire the Consultant had the opportunity to select: White, White and Black Caribbean, White and Black African, White and Asian, Any Other Mixed Background, Indian, Pakistani, Any Other Asian Background, Caribbean, African, Any Other (please write) or Ethnicity not known. However, to protect the anonymity of young people, ethnicities have been combined to avoid having cell sizes of 2 or less.

### **Clinical Characteristics**

Prior to their admission, 84.1% of the sample were known to their local CAMHS; of these, 63.5% had been known for over 6 months.

Of these admissions, 235 (81.0%) were requested as emergencies, including all the adult ward admissions, with over half (52.8%) involving the Mental Health Act. Common reasons for requesting admission included suicide risk (80.0%), emotional dysregulation (53.5%) and psychotic symptoms (22.4%). For 19.0% of the admissions, the young person had no mental health disorder diagnosis at referral, 38.3% had one diagnosis and 42.8% had two or more diagnoses. Table 3 shows the most common diagnoses at referral and discharge.

Table 3 The most common diagnoses at referral and at discharge

<b>Diagnosis</b>	<b>At referral n (%) (n=290)</b>	<b>Discharge/6-month follow-up n (%) (n=288)</b>
<b>Depression</b>	100 (34.5)	101 (35.1)
<b>Autism Spectrum Disorder</b>	59 (20.3)	64 (22.2)
<b>Psychosis</b>	45 (15.5)	39 (13.5)
<b>Eating Disorder</b>	39 (13.5)	30 (10.4)
<b>Anxiety Disorder</b>	38 (13.1)	39 (13.5)
<b>Emerging Personality Disorder/ Personality Disorder</b>	22 (7.6)	33 (11.5)
<b>Post-Traumatic Stress Disorder</b>	20 (6.9)	31 (10.8)

All diagnoses present in >5% of the sample at both referral and discharge.

### **Reasons for at-distance or adult ward admission**

The most common reasons for these admissions included a lack of local CAMHS beds (73.5% of cases) or local unit related reasons (e.g. shortage of staff, patient mix) despite bed availability (22.1%). Content analysis where respondents provided free-text information revealed three main categories.

#### *Category 1: No local bed available:*

Lack of local CAMHS bed availability was mentioned in 60 comments. Of these, 7 reported the local unit had closed, mainly due to temporary issues such as maintenance work or staffing issues but also, in one example, by the Care Quality Commission. Also, 14 comments mentioned that although the bed was within region, it was still over 50 miles away.

#### *Subcategory: No local bed with the specialist skill required:*

Seven comments reported a lack of local beds with required expertise, which mostly related to the management of eating difficulties.

*“Professionals - unit that can nasogastric feed, under restraint if needed. Unit with experience of eating disorders and disordered (non-anorexic) eating.”*

Proximity to other services was also important – two comments reported the need to be near a psychiatric intensive care unit.

*Subcategory: Young person/carer attitudes towards at-distance admission:*

Seven comments reported that young people and/or parents/carers would have preferred a local admission. One psychiatrist reported that a young person chose to be admitted to a local adult bed to avoid an at-distance admission.

*“They were keen to be local - thus admitted to a local adult bed as no adolescent bed was available.”*

*Category 2: Young person/Parent objection to local unit available:*

In instances where a local unit had been an option, six comments reported that an at-distance unit was chosen due to the young person’s and/or parent’s objection to the local unit – five reported a negative experience at the local unit and one reported knowing other young people there.

*“Patient associates the nearest GAU with a traumatic memory of witnessing a peer’s tragic death on the ward. Alternative hospitals in the area did not have a bed available.”*

There were also two reports of young people or their parents requesting a particular unit. One was due to the young person’s familiarity with the unit’s staff and the other because the young person’s parents were temporarily living elsewhere.

*“Transferred from a unit closer to home as the patient’s family were temporarily staying locally so this unit was closer for them to visit than their home address.”*

*Category 3: Exceptionally acute need for a bed:*

A total of 14 comments mentioned a young person being admitted to the first available bed due to the acuity of their presentation. Consultants referred to young people deteriorating in the community (n=6), deteriorating on a paediatric ward (n=1) or requiring intense input (n=2) or crisis management (n=5). One Consultant reported that a young person was initially due to be admitted locally but was sent to an at-distance unit instead as the urgency increased:

*“They had no choice over the matter, given the acuity of presentation.”*

*“Escalating challenging behaviours on a paediatric ward, difficult to contain, police called around five times to the ward, needed quick admission.”*

### **Location and length of wait for a bed**

Over a fifth (23.5%) of the young people waited over 10 days for a bed (longest waiting time Consultants could select in the questionnaire). A further 17.6% of the young people waited for 7-10 days. 9.0% of young people experienced a wait of less than a day for a bed.

The majority of these young people waited in general hospital settings (40.0% paediatric ward, 7.9% adult medical ward and 7.2% Emergency department). One in ten (10.7%) had to wait in Section 136 suites, a specialist holding suite usually located at an adult psychiatric hospital, designed to hold people for no longer than 24 hours whilst awaiting a Mental Health Act assessment.

### **Nature and course of admission**

#### Distance

1  
2  
3 Amongst those admitted to GAUs (n=279) 54.5% were between 50-100 miles from home, 22.2% 100-  
4 150 miles, 9.7% 150-200 miles and 7.9% more than 200 miles. All the adult ward admissions were  
5 within area and <50 miles from home.  
6

#### 7 Length of stay and care received

8  
9 The median length of stay was 75 days (interquartile range 34-142 days) for the whole sample, 36 days  
10 for those admitted to adult wards and 76 for those admitted at-distance.  
11

12 At the point of referral, the most common types of care requested from the admission were risk  
13 reduction/management (97.6%) and assessment/monitoring (95.5%); less commonly requested were  
14 psychological therapy (65.5%), occupational therapy (45.5%) and family therapy (40.0%). When  
15 received care was recorded at follow-up, 99.0% had received assessment/monitoring, 96.9% risk  
16 reduction/management, 77.5% medication initiated (with 85.4% receiving reviews of medication),  
17 76.3% psychological therapy, 64.5% occupational therapy and 52.3% family therapy.  
18  
19

#### 20 Transfers

21  
22 Just under a fifth (19.0%) of young people were known to have transferred to another ward during  
23 their admission (36.4% of those admitted to adult wards and 18.3% of those admitted at-distance).  
24 Among the sample, 23 (7.9%) were transferred to a GAU within their commissioning region (known as  
25 repatriated). For those who were transferred (n=55), the median duration of the stay on their initial  
26 ward was 38.5 days. Of those who had transferred unit, 27.3% went to another GAU more than 50  
27 miles from their home (i.e. they experienced two at-distance placements during the course of the  
28 same admission), 5.5% went to an adult psychiatric ward, 7.3% went to a low secure unit and 16.4%  
29 to a Psychiatric Intensive Care Unit.  
30  
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#### 32 Discharge and delays to discharge

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34 For 93.4% of the sample, clinicians from their local CAMHS team attended at least one ward meeting  
35 whilst they were an inpatient, mainly through video call (92.2%). For 87.5%, their local CAMHS team  
36 attended a discharge meeting, again most commonly through video call (94.4%).  
37

38 At 6 months after the admission date given, 59 (20.3%) of the young people were still in hospital; less  
39 than 5\* young people were still on an adult ward (\*exact number withheld to protect anonymity) but  
40 71.2% of the young people in hospital at 6 months were still placed in a hospital which was at-distance.  
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42

43 Discharge was reported as being delayed for 34.1% of the sample. The most common reasons were  
44 distance from home limiting in-reach from the local CAMHS team (18.5%), and distance from home  
45 causing difficulty organising local social care support (17.1%). When asked to list 'other' reasons,  
46 twenty "other reasons" were noted, with two main categories that reflected 'social circumstances'  
47 and 'patient factors'.  
48

#### 49 *Category 1: Social circumstances:*

50  
51 This occurred in 13 comments, five mentioning that the young person did not have a suitable discharge  
52 destination. One comment reported that the young person's care home refused to take the young  
53 person back.  
54

55  
56 Four comments related to issues with the young person's family, such as breakdown in the familial  
57 relationship and parental anxiety surrounding discharge. In addition, a couple of comments reported  
58 that the young person was waiting for a suitable provision to be able to admit them.  
59

60 *"No accommodation. Care home handed in their notice at discharge."*

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3 *"... complex family issues complicating pursuing alternative accommodation."*  
4

5 *Category 2: Patient factors:*  
6

7 Four comments mentioned that the discharge was delayed due to patient factors, all related to  
8 complexity or deterioration in the young person's clinical condition.  
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10 *"delayed discharge due to needing more intensive community package of care."*  
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## Discussion

The findings from this unique national surveillance study show that most at-distance and adult mental health ward admissions for 13-17-year-olds are emergency admissions for young people who have been detained under the Mental Health Act. Sample characteristics highlighted a predominance of female and older adolescents, with many having co-morbid mental health diagnoses, and high risks, most notably suicide risk (80% of cases). The salience of risk associated with these presentations is highlighted by risk reduction being the most frequently requested intervention at admission, requested almost universally.

The most commonly reported diagnosis at admission was Depression, suggesting that treatment-resistant or complex depression is an important driver for requesting inpatient care. Over a fifth of young people captured in our study at baseline and at follow up had a diagnosis of Autism Spectrum Disorder (ASD). Specific policies such as Care, Education and Treatment reviews (CETRs) were developed to help young people with ASD avoid hospital admission wherever possible and minimise length of stay;<sup>15, 16</sup> however, as shown by these findings, autistic young people are still requiring admission and staying for an extended period. Our study however did not enquire whether these initiatives had been implemented for these young people, and this will be important to capture in future work.

Our findings of a greater proportion of female young people and older adolescents in this sample are consistent with recent community-based studies investigating the prevalence of mental disorders in the wider population.<sup>17</sup> In our study, however, there was an over-representation of males of Black ethnicity compared with the general population, which is concerning. This finding is in keeping with government reports showing an over-representation of Black young people detained under the MHA.<sup>18</sup> However, since our study has a relatively small sample size, this finding should be interpreted with caution. In addition, our study did not collect data about local admissions, it is not possible to conclude whether this represents a bias towards males of Black ethnicity being more likely to be admitted generally, or specifically at-distance. Routine ethnic minority monitoring of admissions by NHS England may help to further investigate this possibility.

In mental health access standards, there is an expectation that those requiring urgent or emergency care should receive this within 24 hours.<sup>19</sup> However, despite 80% of these admissions being requested as an emergency, our study found that over 40% of young people waited for a week or more for a bed, with many waiting in general hospital settings, particularly paediatric wards. These findings fit with surveys of paediatric doctors in the UK who reported that mental health admissions to paediatric wards make up more than a quarter of their admissions.<sup>5</sup> Such points of 'cross-over' can create tension between staff working in general hospital and mental health settings – collaborative working across services and agencies is likely to be fruitful and may prevent risk escalation during this period. Future commissioning of paediatric and CAMHS beds should take this into account.

The median length of stay of the admissions in this study was 75 days; for those admitted at-distance this was 76 days, which was two weeks longer than previous figures of the average length of CAMHS admission of 61 days.<sup>20</sup> Over a fifth of the young people in our study were still in hospital after 6 months. This is a very long time in a person's life, away from friends, family, school and usual daily activities at a seminal stage of development. The "Getting It Right First Time" report<sup>21</sup> found that length of stay in CAMHS was less than 60 days in only 39% of cases. Since our study focused on at-distance admissions, this suggests that many at-distance admissions are longer than local admissions, which was further corroborated by responding Consultants who reported that discharge



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3 was delayed in a third of cases. This is very likely to result in higher NHS costs and may result in  
4 greater costs more widely if reintegration is more difficult for the young person (e.g. being away  
5 from school for such a long time).  
6

7 Our study has several strengths. The use of a national surveillance system ensured that cases were  
8 identified across the country and that the sample was representative across England. The  
9 triangulation with administrative data from NHS England showed that our study collected detailed  
10 clinical and contextual data on over half of the at-distance admissions during the surveillance period.  
11 The 99% follow-up completion rate ensured comprehensive capture of 6-month clinical outcome  
12 data for these young people, which is not easily possible with administrative data. However,  
13 limitations of our study included modest monthly response rates (46%). Some responding  
14 Consultants explained that their unit received so many at-distance admissions that they did not have  
15 time to complete questionnaires about each case therefore, our understanding of the admissions to  
16 these units was not as comprehensive. The low reporting of adult ward admissions was likely  
17 affected by the fact that General Adult Psychiatrists who looked after the young people on the wards  
18 would not have been within the CAPSS database. Another limitation was the voluntary nature of  
19 participation among Consultants, with the possibility that Consultants with strong opinions about  
20 these types of admissions, positive or negative, were perhaps more likely to respond.  
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### 25 **Clinical Implications**

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27 As shown by the findings of this investigation, at-distance and adult ward admissions continue to  
28 affect many under-18s requiring psychiatric inpatient admission. Provider collaboratives within each  
29 region, once fully established, aim to change this, allowing more regional clinical oversight of  
30 admissions; however, more time is needed to assess the impact of this change.  
31

32 These admissions are mainly emergencies and driven by risks which cannot currently be safely  
33 managed in community settings. The majority of this sample was known to CAMHS prior to referral,  
34 usually for over 6 months, suggesting that more needs to be done to identify and manage escalating  
35 risk at earlier stages to prevent it reaching the level for requiring admission.  
36  
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38 The high proportion of young people with ASD in this sample are concerning. Previous studies have  
39 shown that young people with ASD can present to emergency departments with higher acuity than  
40 those without ASD, particularly with acute behavioural disturbance<sup>22</sup>. Despite the implementation  
41 of measures to reduce admissions in this group it seems current care provision is not meeting their  
42 needs, with many additional barriers to mental health support for these young people<sup>23</sup>.  
43

44 Young people are spending significant amounts of time waiting for an available psychiatric bed even  
45 after the decision to admit has been made. Acute hospital beds are often having to provide a safe  
46 'holding' place in the interim. However, since the aim is for all CAMHS admissions to be as short as  
47 possible, such interim placements could be used more effectively by commencing assessment and  
48 treatment processes within them. To implement this, intensive involvement of CAMHS staff with the  
49 young person in the general hospital is needed, alongside support and training for those who work  
50 in the place where the young person is waiting. To achieve this, more joint service commissioning  
51 and planning across CAMHS and Paediatric services is essential.  
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### 55 **Acknowledgements**

56  
57 We thank the Child and Adolescent Psychiatry Surveillance System for facilitating the data collection,  
58 and the reporting psychiatrists, particularly those who reported cases and completed the  
59 questionnaires. The views, opinions and/or conclusions expressed by the author(s) are their own and  
60

do not necessarily reflect the views, opinions and/or conclusions of the Child and Adolescent Psychiatry Surveillance System or its constituent partners. A special thanks to the 3 advisory panels for this study: professionals, young people and parents who have generously contributed their time regularly throughout.

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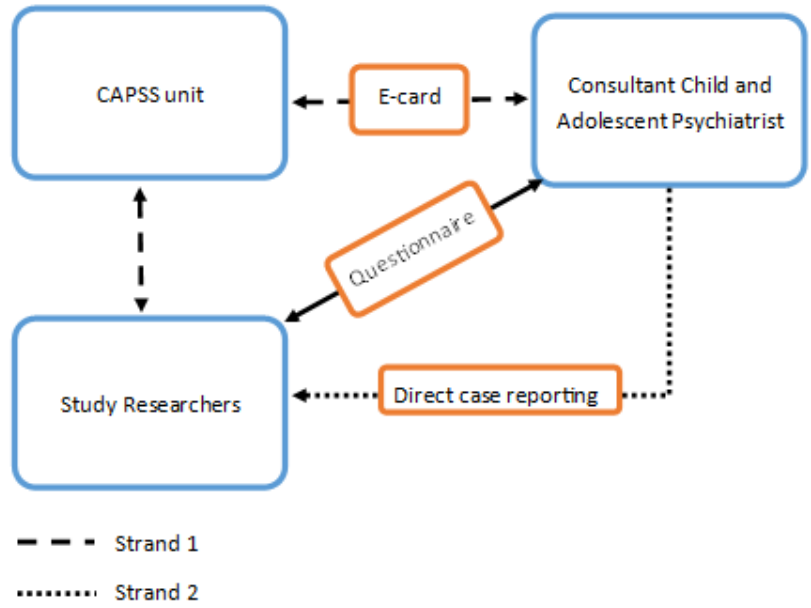
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3 Figure Captions  
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5 Figure 1 The two strands of case reporting used in the study. Consultants were able to report cases  
6 prompted by the Child and Adolescent Psychiatry Surveillance System (CAPSS) or directly to the  
7 research team.  
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9 Figure 2 A flow diagram of how the sample of 290 eligible cases was derived across the two  
10 reporting strands.  
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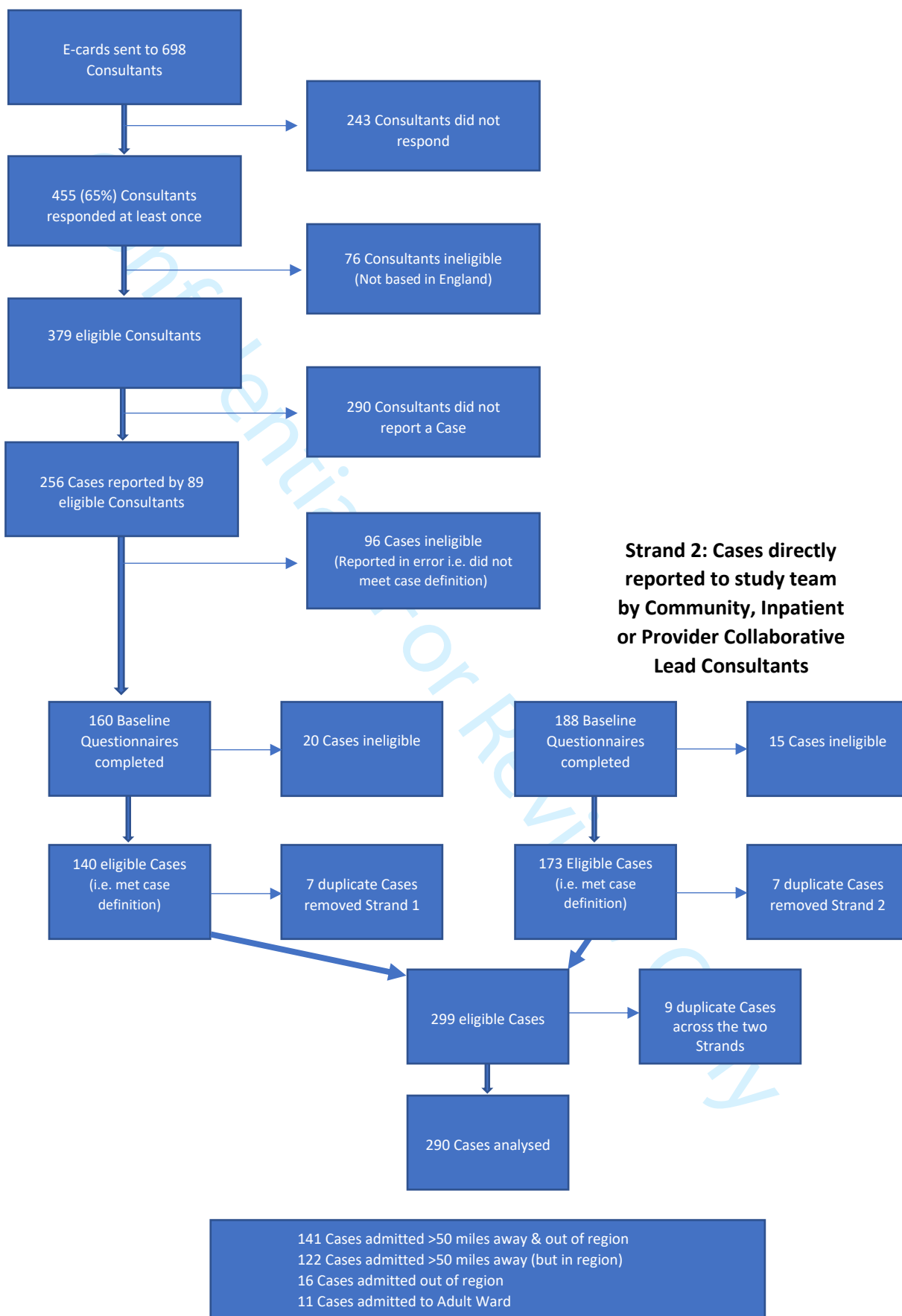
12 Figure 3 Overlap of eligible cases (n=290) by type of admission. During the course of the study, policy  
13 changes were implemented to enable regional oversight of admissions through the establishment of  
14 18 lead Provider Collaboratives. When the sample was recategorised according to Provider  
15 Collaboratives, there were a few differences due to the differences in geographical boundaries and  
16 the ability of Provider Collaboratives to use units outside of their NHS Region. For example, whereas  
17 157 young people were admitted out-of-region, 162 were admitted outside their Provider  
18 Collaborative. These findings suggest that during the period of study surveillance the introduction of  
19 Provider Collaboratives did not appear to reduce the number of admissions out-of-area; however, it  
20 should be noted that many Provider Collaboratives were not fully established during the surveillance  
21 period (February 2021-February 2022).  
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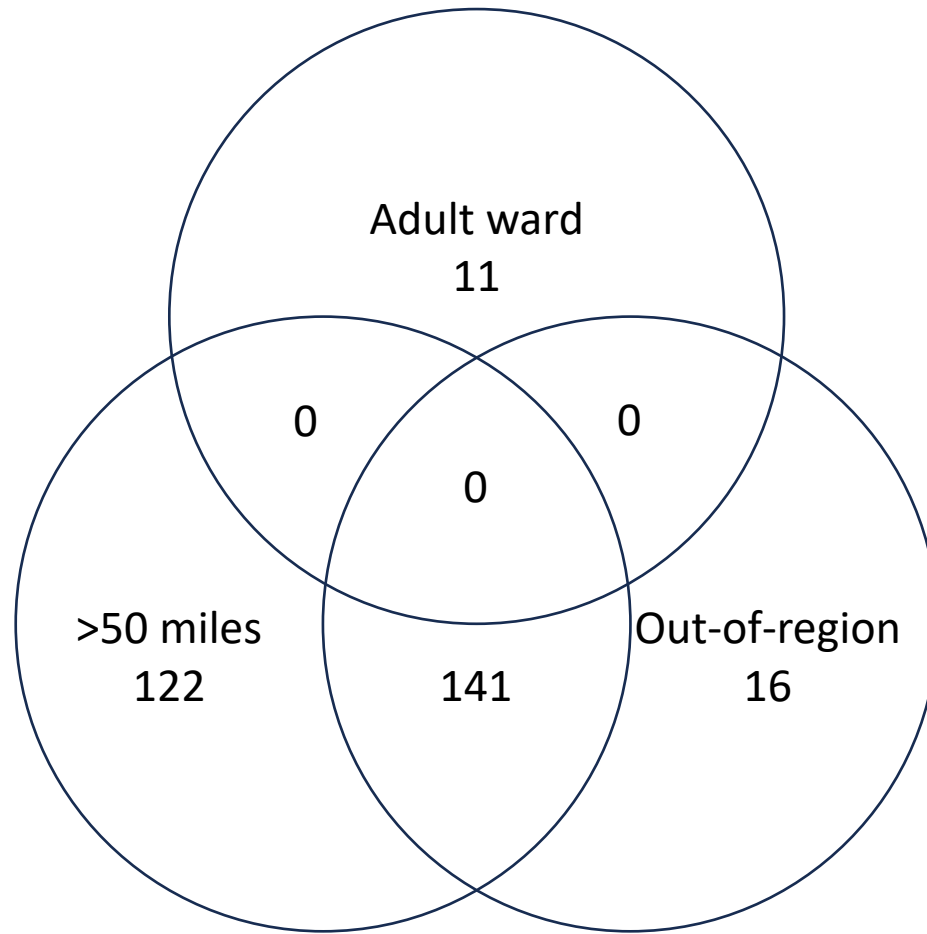


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**Strand 1: Child and Adolescent Psychiatry Surveillance system**





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Appendix 1

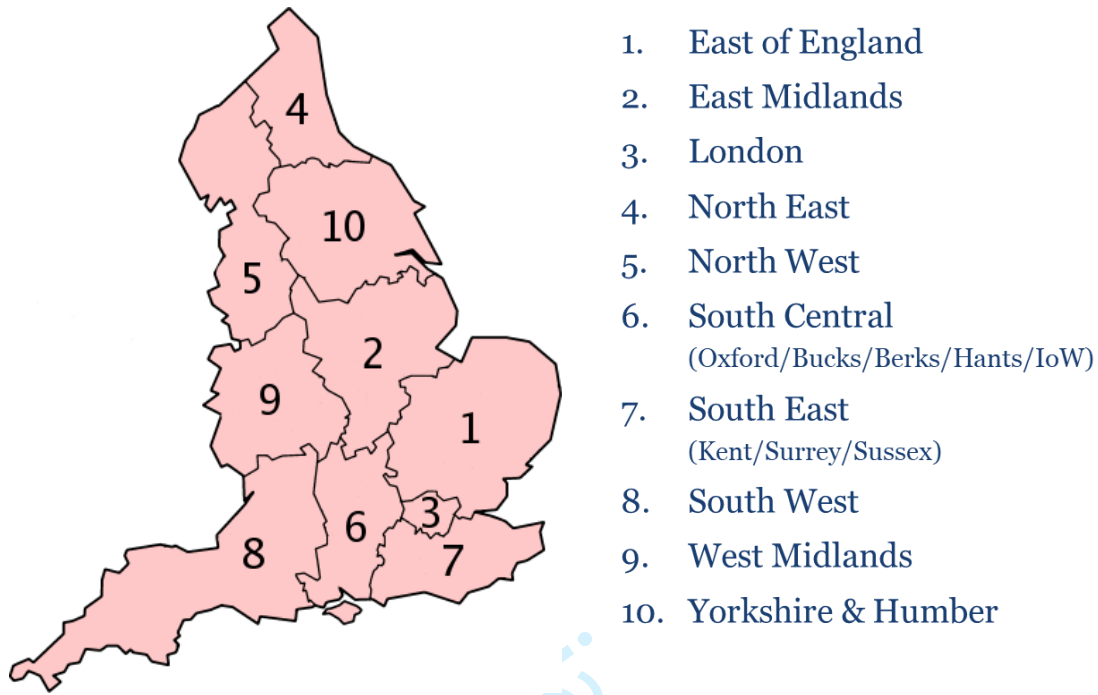


Figure 4 A map of the 10 NHS regions in England

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