

Experiences and impact of psychiatric inpatient admissions far away from home: a qualitative study with young people, parents/carers and healthcare professionals

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ABSTRACT

Background There are significant clinical, policy and societal concerns about the impact on young people (YP), from admission to psychiatric wards far from home. However, research evidence is scarce.

Aims To investigate the impact of at-distance admissions to general adolescent units, from the perspectives of YP, parents/carers and healthcare professionals (HCPs) including service commissioners, to inform clinical practice, service development and policy.

Method Semistructured interviews with purposive samples of YP aged 13–17 years (n=28) and parents/carers (n=19) across five large regions in England, and a national sample of HCPs (n=51), were analysed using a framework approach.

Results There was considerable agreement between YP, parents/carers and HCPs on the challenges of at-distance admissions. YP and parents/carers had limited or no involvement in decision-making processes around admission and highlighted a lack of available information about individual units. Being far from home posed challenges with maintaining home contact and practical/financial challenges for families visiting. HCPs struggled with ensuring continuity of care, particularly around maintaining access to local clinical teams and educational support. However, some YP perceived separation from their local environment as beneficial because it removed them from unhelpful environments. At-distance admissions provided respite for some families struggling to support their child.

Conclusions At-distance admissions lead to additional distress, uncertainty, compromised continuity of care and educational, financial and other practical difficulties, some of which could be better mitigated. For a minority, there are some benefits from such admissions.

Clinical implications Standardised online information, accessible prior to admission, is needed for all Child and Adolescent Mental Health Services units. Additional practical and financial burden placed on families needs greater recognition and consideration of potential sources of support. Policy changes should incorporate findings that at-distance or adult ward admissions may be preferable in certain circumstances.

WHAT IS ALREADY KNOWN ON THIS TOPIC

- ⇒ Service demand for inpatient care sometimes results in young people (YP) being admitted to units located far from their home or out-of-region.
- ⇒ National policies aim to avoid these types of admissions.
- ⇒ Little research has explored the experience and impact of these admissions from the perspectives of YP, parents/carers and healthcare professionals.

WHAT THIS STUDY ADDS

- ⇒ YP and parents/carers have limited or no involvement in the decision-making processes around admission.
- ⇒ Limited information is made available to them about the unit to which the admission is proposed.
- ⇒ Being far away presents considerable challenges with maintaining contact with home and practical/financial difficulties for families.
- ⇒ Some YP perceive being away from their local area as beneficial, removing them from unhelpful environments.
- ⇒ Clinicians struggle to transfer YP to more local units and maintain continuity of care, particularly with usual care teams and education provision.

BACKGROUND

Inpatient Child and Adolescent Mental Health Services (CAMHS) provide care and treatment for young people (YP) with severe and/or complex mental health difficulties associated with significant impairment, whose needs cannot be safely and adequately met by community CAMHS. There is variable availability of psychiatric inpatient provision across the UK and bed occupancy is very high^{1 2} leading to challenges in identifying beds, particularly in crisis/emergency situations. Consequently, many YP are admitted to units located far



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HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

- ⇒ Clarity and improved communication are needed between services and YP/families, throughout the admission process.
- ⇒ Coproduced information about inpatient units should be easily accessible to YP and families.
- ⇒ Peer support involvement at units, allowing YP and parents/carers to obtain reliable testimony about the services they will experience, could be beneficial.
- ⇒ Policymakers should consider improving the provision of support for families of YP who are admitted far from home.

from their home.³ Although there is no standard definition of an at-distance admission, the NHS England CAMHS Tier 4 report² specifically focused on bed availability within 50 miles.

Studies of psychiatric admissions identify both positive and negative impacts.^{4–8} However, significant concerns have been raised about at-distance admissions,^{2–4 9–11} which can aggravate a complex situation in which the YP and family may already feel distressed and vulnerable. At a national level, limited evidence exists about the impact of at-distance admissions.² These types of admissions have been described as ‘unacceptable’ and can increase the risk of isolation and poor clinical outcomes.¹ However, associated impacts for YP, their families and the National Health Service (NHS) remain unclear. This study aims to gain a better understanding of the impact of at-distance admissions from the perspectives of YP, parents/carers and healthcare professionals (HCPs) to provide evidence-based recommendations for service development.

METHODS

Study design

Semistructured interviews were conducted with a purposive sample of YP, parents/carers and HCPs. Participants with experience of an at-distance admission (ie, more than 50 miles away from the YP’s home address, or admission to a different NHS region) or near-home admission (ie, not at-distance) to a general adolescent unit (GAU) were interviewed to identify specific impacts of at-distance admissions compared with impacts arising from admission per se. YP and parents/carers were identified and recruited from secondary care mental health inpatient and community settings (CAMHS) in five regions of England (East Midlands, West Midlands, East of England, Greater Manchester, and Oxford and Thames Valley). HCPs were recruited nationally and were identified through (1) a linked national surveillance study using the Royal College of Psychiatrists’ Child and Adolescent Psychiatry Surveillance System (REC reference: 20/WM/0265) and (2) a snowball approach, through reporting clinicians from the linked surveillance study and local links at each recruiting site.

Study participants

YP and parents/carers

YP (aged 13–17 years) or the parent/carer of a YP with a current or recent (within last 12 months) admission to a GAU that was either at-distance (see above) or near-home.

Healthcare professionals

HCPs involved with the admission, management or care (including organisation or delivery of care) of YP who have been admitted to an inpatient psychiatric unit.

Procedures

Interviews were conducted remotely over video call or telephone, or face-to-face in CAMHS settings. Topic guides (see online supplemental files 1–4) for each participant type aimed to explore experiences around admission and gather views regarding challenges, benefits and suggestions for improvements. The topic guide was developed through collaboration with three study advisory groups, comprising YP, parents and HCPs. Interviews were conducted by seven researchers (six female, one male) between March 2021 and September 2022. Each interview lasted between 25 and 60 min.

ETHICS STATEMENT

This study was part of the ‘Far Away from Home’ study (arc-em.nihr.ac.uk/research/far-away-home). The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008. All procedures involving human subjects/patients were approved by West Midlands—South Birmingham Research Ethics Committee 20/WM/0314. Participants aged 16 years and over gave written informed consent. Participants aged 13–15 years gave written informed assent combined with written informed consent from a parent.

DATA ANALYSIS

Interviews were audio recorded and transcribed verbatim. All transcripts were coded in NVivo V.12. Transcripts were analysed using a framework approach suitable for applied policy research and facilitate the experiential focus of the research.¹² This followed five stages of framework analysis¹³: familiarisation; identifying a thematic framework; indexing; charting; and mapping and interpretation. Data were analysed deductively into six categories, each with subcategories (see online supplemental files 5 and 6). Data within each of these subcategories were then analysed thematically to produce themes within and between these categories. Six researchers (JR, JH, A-MB, EH, LW and MF) independently coded the data. Two researchers (JR and JH) independently coded an additional 10 transcripts (10%) for cross-checking. Three researchers (JR, JH and A-MB) led on the development of emerging themes and subthemes in collaboration with the other three researchers (EH, LW and MF) to reach consensus.

FINDINGS

In total, 98 people took part; participant characteristics are shown in [table 1](#).

Nine themes were generated from the analysis, relating to (a) preadmission (experiences of the admission process), (b) at-distance admission (experiences during admission) and (c) continuity of care (experiences during or following discharge).

Preadmission and admission process experience

Informed but not involved

YP and parents/carers were routinely informed about decisions but, in many cases (both at-distance and near-home admissions), had minimal involvement or influence in the decision-making processes (Q1, Q2, Q4, Q5)—see [table 2](#). This was confirmed by HCPs (Q7). Regular updates and communications from HCPs were valued by parents/carers and YP (Q3, Q6).

Lack of choice

YP, parents/carers and HCPs reported a lack of options and limited alternatives to at-distance admissions. Some felt pressure

Table 1 Participant characteristics (n=98)

	Young person (n=28)	Parent (n=19)
Gender	Female=20	Female=16
Age: mean years (SD, range)	15.8 (1.07, 13–17)	49.1 (6.63, 37–62)
	13–15=7	
	16–17=21	
Ethnicity	White: English, Welsh, Scottish, Northern Irish or British=19 Non-white=9	White: English, Welsh, Scottish, Northern Irish or British=12 Non-white=7
Admission type	At-distance=21 Near home=7	At-distance=11 Near home=8
Previous admissions	Yes=10	Relationship to young person Biological parent=17
Diagnosis at admission (frequency; could have >1 diagnosis)	Neurodivergent condition=6 Mood disorders=13 Anxiety=8 Eating disorder=5 Emotional dysregulation ≤5 Psychotic disorders ≤5 Other=5	
Living arrangements	Biological mother only=6 Both parents=17 In care/not with parents/relatives ≤5 Unknown ≤5	
Healthcare professional (n=51)		
Role	Community-based consultant in child and adolescent psychiatry=19 Inpatient-based consultant in child and adolescent psychiatry=17 Mental health commissioner=4 Clinical nurse lead/senior nurse/specialist nurse=4 Private sector consultant in child and adolescent psychiatry=3 Inpatient ward manager=2 Care coordinator=1 Case manager=1	

to accept the bed offered (Q10, Q11). Many described being given the option of an informal admission, but with the caveat that refusal would result in an assessment for admission under the Mental Health Act (Q8, Q9). Some YP indicated they had agreed to a voluntary admission to demonstrate their earnestness to get help and better. Parents/carers reported that clinicians were candid about the lack of bed availability, and some recalled being warned it could take many months. One parent made a formal complaint as they thought that it was inappropriate not to know where their child was going.

Psychiatrists reported informing parents/carers that they had no idea where their child would be admitted, or even when a bed would become available (Q13). Many recognised the distress these situations caused YP and their families and reported finding such conversations upsetting. Psychiatrists expressed feeling powerless about the situation. For some, the priority of whether the YP required an admission took precedence over location (Q12).

Conversely, when near-home admissions were planned, YP often reported that they felt they were given a choice of an informal admission and felt engaged with these discussions.

Desperation and relief

Parents/carers described taking the first bed available through desperation, with some reporting relief when a bed became available (Q14). For many parents/carers, the weeks leading up to admission had been very stressful, involving a period of escalating risk. Parents/carers were relieved to have their child

somewhere safe (Q15, Q16). HCPs also reported a sense of relief from parents/carers that the YP would be in a safe place and receiving help, as parents/carers felt unable to manage their child at home (Q18, Q19). YP did not express any feelings of desperation or relief with many recalling feeling surprised at needing the admission.

HCPs explained how, due to long waiting times, families accepted an admission placement wherever a bed became available. They reported that YP often felt safer in hospital, so any admission was preferable to waiting (Q17).

At-distance admission

Information provision, expectations and reality

Despite long waits for a bed, once found, YP reported being given very little notice before admission. Some were reportedly told on the day or day before admission (Q3)—see [table 3](#). With limited time to mentally prepare for admissions, and the distances often involved, YP and parents/carers highlighted concerns around inconsistent availability of preadmission information.

Participants recalled having to carry out independent research, sourcing information online about the unit. Many YP reported feeling scared when they found out how far the unit was (Q2). Some could not find much information; however, others reported feeling reassured by information about the unit (Q1). Easily accessible online information about a unit was welcomed by participants. One parent who was sent a digital booklet about the unit found this helpful and thought the unit 'looked pleasant'.

Table 2 Preadmission theme quotations

Theme: preadmission		
Subtheme	Ref:	Quote
Informed but not involved	Q1	<i>I don't really think like I really got to decide where I went. But they did like keep be informed of like their decision-making and if anything new came about then they would like make a decision. They were like keeping me in like the know I guess. (At-distance Female YP ID: 01)</i>
	Q2	<i>So it started as an option but then by the end of the call she was like "I think it would be best if you go to hospital" and my parents agreed. And so I went along with it. (At-distance Female YP ID: 04)</i>
	Q3	<i>They was really thorough and they were kind and they'd give me several phone numbers to contact if things got a bit too much. They spoke literally about every little step that they were going to do and what they were going to involve [Name of YP] in, and she was making the decisions and the choices, and she was always honest with them and they kind of shared that respect that she was honest and they were honest. And it was great up until she went in there. (At-distance Female Parent/carer ID: 16)</i>
	Q4	<i>I don't think we had an awful lot at all but at the same time you know, we're not qualified to make those decisions necessarily (At-distance Male Parent/carer ID: 15)</i>
	Q5	<i>We very much felt in the dark. (At-distance Female Parent/carer ID: 01)</i>
	Q6	<i>I think they felt as though they'd often hear different things from different people in the team and we'd say one thing and then something else would happen. It changes so quickly and it's so unpredictable and it's so out of our control. (Community Consultant Psychiatrist ID: 07)</i>
	Q7	<i>Oh they weren't at all. They weren't. So obviously I notified them that when I detained him I put in an application for Tier 4. So they were kind of kept informed all along but they were never part of the kind of daily escalation meetings when we were thinking about you know, are we doing the right thing? Have we found a bed yet? (Community Consultant Psychiatrist ID: 01)</i>
Lack of choice	Q8	<i>The only reason I got the informal was because they practically gave me the choice do you want to be informal or sectioned. Because they weren't going to let me leave (At-distance Female YP ID: 11)</i>
	Q9	<i>Like they spoke to me about how I felt and I was honest and then it was kind of like you can either agree to go or you can go under a section. (At-distance Female YP ID: 26)</i>
	Q10	<i>There weren't really any options because I think there are so few beds it was you can go home or you can go here. (At-distance Female Parent/carer ID: 01)</i>
	Q11	<i>We were left with do this (a far away admission) or the possibility of spending another week in A&E... it almost wasn't an option by that stage. (At-distance Female Parent/carer ID: 07)</i>
	Q12	<i>The only decision making is about whether they need to be admitted or not and we do that. (Community Consultant Psychiatrist ID: 05)</i>
	Q13	<i>They have no control. We don't have any control... I often tell people... I'm afraid I don't know where you'll be going, and I wish I could tell you where you will be going... We don't have the choice, they have no choice either (Community Consultant Psychiatrist ID: 05)</i>
Desperation and relief	Q14	<i>Part of me was just relieved because she was somewhere, because she was just hell bent on hurting herself. I'd obviously done everything in my means to obviously keep her safe and I followed everything that CAMHS had obviously said and it just wasn't enough. (At-distance Female Parent/carer ID: 09)</i>
	Q15	<i>Well given like the prior couple of weeks and actually being sent home and not being equipped to handle it, we were actually relieved because we thought it's better that she's in the care of professionals who could deal with this rather than us who you know, could easily make a mistake and make things worse. (At-distance Female Parent/carer ID: 01)</i>
	Q16	<i>So we kind of, it was a bit of a shock to the system because it was so far away, but we just took it because I thought as long as they can keep her safe, best interests, we just kind of agreed for her to go in. So she went in as an informal patient. (At-distance Female Parent/carer ID: 16)</i>
	Q17	<i>You get parents who have been waiting for a bed for a long time... So I think there's always a sense of relief that a bed is found. (Inpatient Consultant Psychiatrist ID: 03)</i>
	Q18	<i>I think they were just quite relieved that he was being placed somewhere. (Clinical Nurse Lead ID: 54)</i>
	Q19	<i>...they just wanted her to be in a place of safety really. (Ward Manager ID: 51)</i>

CAMHS, Child and Adolescent Mental Health Services.

One YP received a welcome pack at the point of admission which they found helpful (Q5).

Some YP reported that they were uncertain what to expect (Q4). One described that their local CAMHS team had given them a negative impression about inpatient stays, so they felt unsure and apprehensive. For one parent, their child read poor reviews about the unit resulting in negative expectations about the admission. Conversely, one YP (near-home) knew people who had been to the unit so felt relieved to hear about their experiences.

Parents/carers and YP with previous inpatient experience expected consistency between units in terms of the admission process, structure and routine (Q6). Some were often surprised by variations, for example, rules around the use of mobile phones, therapy provision.

Keeping in touch with home

Many YP explained how being on a unit away from family felt like an unreal environment (Q11). For some, the distance was not noticeable because they were staying within a hospital. YP expressed frustration around the difficulty in maintaining contact which often led to isolation, particularly being unable to see friends (Q9). Parents/carers expressed similar difficulties keeping in touch with their child, which at times impacted their own health (Q8).

Some YP believed that the distance with their family was detrimental to their recovery. Many mentioned being able to maintain contact over FaceTime but this was viewed less favourably than in-person visits (Q9, Q10). In addition, limited access to mobile phones compounded YP's concerns about maintaining contact (Q8). YP also described having limited contact with their local clinicians when far away.

Table 3 At-distance admission theme quotations

Theme: at-distance admission		
Subtheme	Ref:	Quote
Information provision, expectations and reality	Q1	<i>Well they told me what the place was called and I decided to do some like research on it before I made a decision on whether to go or not. And to see like what it was, where it was, like what they did there. And after I did some research on it, it looked like a nice place, it looked like a decent place to go and get better (At-distance Male Young Person ID: 16)</i>
	Q2	<i>It felt like my world was like ending, just because it's so far away from my family and friends and it's like I can't get support if I'm so far away (At-distance Female Young Person ID: 29)</i>
	Q3	<i>I was thinking like oh I'm not going to be going today and then it was later that day they were like right, we've found a bed for you in [name of city], you're going. And it was like ... all of a sudden it was like right, pack your things and then I was being walked to the car, to my mum and dad. They were like 'Are you sure you're going to be safe?' And I just didn't know what was going on, like it was just like ... I don't know. (At-distance Female Young Person ID: 26)</i>
	Q4	<i>Not really, I had really no idea what it was going to be like. (At-distance Female Young Person ID: 07)</i>
	Q5	<i>I got to see like what the environment sort of looked like and how things would work with like your care team and MDT and all of that. And how leave worked and things (At-distance Female Young Person ID: 28)</i>
	Q6	<i>I thought they'd be more proactive and wanting to help the children and doing as much as they can to keep them engaged, and they just wasn't doing that. (At-distance Female Parent ID: 16)</i>
Keeping in touch with home	Q7	<i>There were times when actually I felt suicidal myself, because I thought there's no help, like I felt so lonely and frustrated... And trying to constantly phone someone just to have anything, just to see how her day's gone and hearing nothing back was just soul destroying. (At-distance Female Parent ID: 16)</i>
	Q8	<i>But it was also difficult because we weren't allowed our actual phones, we could only have them for an hour a day. (At-distance Female YP ID: 20)</i>
	Q9	<i>If I was closer to home I'd be able to see like more family and stuff like that... I don't really Facetime people, so like messaging isn't really the same as like seeing someone. I think a lot more people would visit me. (At-distance Male YP ID: 18)</i>
	Q10	<i>I don't like FaceTiming a lot of people. (At-distance Female YP ID: 01)</i>
	Q11	<i>It's like it's not a real environment, so you do kind of lose track of the outside world. Like especially when you're so far away because I've had like one visit from my family ever since I've been admitted. (At-distance Female Young Person ID: 03)</i>
	Q12	<i>The challenge there is remaining in contact with your community. But more often than not young people don't really want that... a YP who's been admitted who's got a complex social situation that they want to be escaping from for a while anyhow. (Community Consultant Psychiatrist ID: 02)</i>
Burden and impact of visiting	Q13	<i>When I was there I was furthest away from home. And everyone there was getting a lot of visits from their family but I could only see my family once a week. It was a bit difficult because I wanted to see my family but I knew that there was only two hours a week that I could. (At-distance Female YP ID: 20)</i>
	Q14	<i>It is hard for people to visit other than my immediate family since I am so far away. (At-distance Female Young Person ID: 01)</i>
	Q15	<i>It's about £178 a month in travel, like petrol costs, to go and see her. (At-distance Female Parent ID: 01)</i>
	Q16	<i>It's a horrible drive. So we ended up having to reduce it to only once a week. And that's just horrible being away from our child for the first time ever you know, at age 15. (At-distance Female Parent ID: 01)</i>
	Q17	<i>They just couldn't see her. They just couldn't afford to go and see her. And we tried all sorts of different funding streams to see if we could get some money through Social Care, we even tried charities who support families you know in difficulties. We tried all sorts to try and help but it was just awful. There's just not that support there for the families. (Community Consultant Psychiatrist ID: 52)</i>
	Q18	<i>Leave from the unit, family therapy or parental support programs are all tricky when far from home. (Commissioner ID: 02)</i>
Positive impacts	Q19	<i>If you went on local leave you're not going to see places where you've like been low or something like that. (At-distance Female YP ID: 01)</i>
	Q20	<i>When you're in hospital you're in like a bubble from the outside world. So sometimes if you're far away it can be helpful to be kind of away from everything. (At-distance Male YP ID: 18)</i>
	Q21	<i>We've definitely had cases where particularly if there's family issues or concerns around the local area for that young person, if they've had trauma there or if they've had frequent admissions to close to home areas and nothing's really changing for them, then it might be that we need to look at further away. And almost a clean, fresh start for that young person, that might be the most appropriate (Inpatient Consultant Psychiatrist ID: 12)</i>
	Q22	<i>I suppose it did help having that sort of bit of a break with her sort of being further away that I couldn't just go there in an evening. (At-distance Female Parent ID: 10)</i>

HCPs also shared these views, explaining that due to the distances involved it was often difficult for YP to maintain contact with their friends and family. Some HCPs noted though at times, less contact might have been beneficial for the YP (Q12).

For those admitted near-home, visiting was described by parents/carers as easy and regular. YP stated they were also able to have visits from friends, teachers and social workers. They also had the chance to experience multiple overnight leaves before going home.

Burden and impact of visiting

The distances involved with these admissions were identified as difficult for participants (Q13, Q14); YP often felt guilty about

the travel costs incurred by their parents/carers and that they could not ask parents/carers to visit when they needed their support. For example, if a YP became unwell it was difficult for a parent/carer to visit quickly.

Staff tried to make accommodations, for example, allowing parents/carers who had travelled far to stay longer. Visits from community professionals were also appreciated by YP. For some, the only person able to visit was a more distant relative who lived nearby. One YP felt isolated being the furthest from home on the ward when other patients had frequent visitors. For some, this contrasted with their experiences in the local general hospital, where parents/carers could visit every day. HCPs confirmed

that families struggled with the financial and time commitments required to visit regularly due to distances involved, with one recalling a parent who was only able to visit once or twice in a 6-month period. Another YP explained that their family had to arrange visits at specific times so that their return journey was not too late.

Some families faced additional challenges around supporting/caring for other children and securing leave from work. Train cancellations also created challenges, with a parent reporting their round trip taking 9 hours. Irregular visitations exacerbated feelings of sadness related to the separation.

Several parents/carers noted considerable costs (Q15); more expense on fuel and some had to borrow money to cover this, parents/carers considering overnight stays found hotel costs prohibitive. One parent reported covering the cost of visits until social care reimbursed them. One parent reported using most of their savings and wages on visiting and sending essentials to their child. The same parent researched online and enquired about funding for travel/accommodation but found nothing.

HCPs advocated strongly for barriers around visiting children far-from-home to be addressed to reduce burden on parents/carers. Some suggested clearer information for families to understand what financial or other support is available. However, others felt there was little practical support to offer families and minimal support was available elsewhere (Q17).

Far-away admissions made working with families challenging; particularly posing problems for parental involvement in family therapy (Q18). Involvement at in-person ward rounds was more difficult for parents/carers especially if they worked during the day and lived far away.

Positive impacts

Some YP noted benefits of at-distance admissions, being situated far away from their home environment reduced the possibility of being recognised when on local leave, thus reducing feelings/concerns of stigmatisation (Q19). YP reported distance made it easier to avoid unhelpful or 'toxic' relationships and highlighted that certain friends were not truly supportive. YP

also felt they were less likely to engage in risky or harmful behaviour. HCPs also felt that removal from the environment where the YP had become unwell could be conducive to recovery.

At-distance admissions also gave YP time to regroup and reflect on their future. Some believed that distance did not impact them and they would go far away again, if necessary. The distance away from home was also seen by some YP as favourable and empowering, allowing them more independence. In one case, their relationship with their parents/carers improved because visits enabled quality time together and to talk about things more openly.

For one set of parents/carers, the extra distance was helpful because it provided respite; feeling relief from the significant challenge of keeping their child safe (Q22). At-distance admissions were also viewed similarly by HCPs, providing a fresh start and giving YP useful 'space' (Q21). If family dynamics were viewed as part of the problem, distance contributed to resolution as families could not visit as frequently.

HCPs reported far-away admissions as a strong component in the recovery of some YP; YP occasionally expressed a preference for being further away from home. One clinician explained how sometimes when there have been safeguarding issues at home, for instance, if a YP has been involved in gangs, drug trafficking or had other safeguarding issues, an at-distance admission can be preferable. Another clinician explained that for YP with trauma, or difficulties with relationships at home, an at-distance admission can provide a fresh start (Q21).

Continuity of care

Home leave

Opportunities for YP to have home leave (either during the day or overnight) were limited due to distances involved. As a result, YP reported feeling daunted by the prospect of being discharged without first experiencing periods of home leave. One YP explained how their parent had to learn to drive to facilitate home visits. Another YP had concerns that if they were

Table 4 Continuity of care theme quotations

Theme: continuity of care		
Subtheme	Ref:	Quote
Home leave	Q1	<i>Because if my home leaves aren't going well, like for example if I was at [name of unit far away from home] and my home leaves were going bad, like almost every time, then like it would have been a nightmare having to bring me back at the time. (Female YP ID: 28)</i>
	Q2	<i>What we quite like to do is gradually increase home leave. So we might start off with just some local leave and then a couple of hours home. And then overnight two nights, etc. But if someone's a few hours' drive away then it doesn't make that possible. So it can mean that home leave can be affected as well. (Clinical Nurse Lead ID: 34)</i>
	Q3	<i>We have to really consider ... I can't send them just for a few hours, even for day leave, I need to really think that okay, how do I even send ... I need to wait for them to at least manage for two nights or one night leave. I can't even send them for the day leave or one overnight, that's really tricky. (Case Manager ID: 41)</i>
Continuity of care/returning home	Q4	<i>It is because again they can't go to school in the morning and then be picked up by mum and dad and driven back to the unit, which you know if they're that far away it's not possible is it? (Community Consultant Psychiatrist ID: 14)</i>
	Q5	<i>Unfortunately, that kind of institutionalised element creeps in sometimes fairly quickly for some of these young people. (Clinical Nurse Specialist ID: 32)</i>
	Q6	<i>It might even be with Social Care not just CAMHS within your area and so the communication and the kind of risk handing over and all of those things just become a little bit easier and a bit more cohesive if you're on the same team. And it can just be a bit more joined-up. And it was just quite segregated and separate because I've never met those team members before. So it felt yeah, it just didn't feel as cohesive as it could have done. (Clinical Nurse Lead ID: 21)</i>
	Q7	<i>Yeah they're not very good. There's like no communication at all. (Female YP ID: 06)</i>
	Q8	<i>I had a meeting with my mental health coordinator last week and I've had one with her today. I'm staying in contact with college because I know that I'll be back there soon. (Female YP ID: 01)</i>

CAMHS, Child and Adolescent Mental Health Services.

to experience any difficulties with their mental health while at home, they may struggle to return to the unit (Q1)—see table 4.

HCPs also highlighted challenges around organising leave, resulting in feelings of frustration for YP and sometimes even exacerbating their mental health difficulties because of long distances and limited flexibility (Q2, Q3).

Discharge planning and returning home

For near-home admissions, some were able to access their school or college work through this being brought in by their parents/carers. Support for the transition period back home was harder if the admission was far away. YP explained how, after improving, they could not easily attend their usual school (Q4). Due to difficulties in communication with their usual school while in the unit, many YP indicated missing a lot of school. They explained finding reintegration into school difficult and needing reduced timetables and 1:1 sessions to try to catch up. For some YP, schools showed understanding about their difficulties and one YP was able to access their work remotely. However, overall, additional support was not provided for those far from home (Q7). HCPs noted that YP rejoining/starting school or college later than peers could adversely impact reintegration.

Poor communication between agencies created uncertainties, prolonging discharge. Some reported how the long wait for a placement was stressful. Conversely, some YP remained in contact with their care coordinator from their local team while in hospital, and others found their schools and colleges were accommodating (Q8). HCPs often recognised the distances involved could lead to challenges linking up with local social care services (Q6).

Some HCPs suggested that separation from usual peer groups combined with being exposed to other patients could be detrimental to the YP. They believed that the prolonged separation from the child's home environment often led to a loss of confidence in their own home setting or exacerbated the risk of institutionalisation (Q5).

DISCUSSION

This novel study demonstrates consistency and agreement between YP, parents/carers and HCPs on several challenges and negative consequences arising from at-distance admissions. These admissions were often necessary because of the urgency of the clinical situation and neither the admission nor the negative impacts could be completely avoidable. Some potential negative impacts were mitigated by good practice at some units, and others could be through more consistent practice and policy recommendations. For example, clearer information for families to understand what financial or other support is available could mitigate financial impacts.

However, there were also some clear examples of beneficial aspects. At-distance admissions are not by default negative; rather, it is about matching appropriately the right service for the YP's needs as well as access to particular interventions.¹⁴ More active involvement of the YP and family members in the admission process, perhaps offering an element of choice if feasible, might assist in shifting the benefit:risk balance of at-distance admissions.

Our findings extend on previous research exploring YP's general experiences of psychiatric admissions, highlighting the lack of information provision⁷ and feelings of confinement and powerlessness as a result of rigid routines.^{4 5} We identified the importance that both parents/carers and YP place on regular, consistent and clear communication throughout the referral/

preadmission process.⁷ Readily available practical information about the location and routines of a unit alongside visual images of the unit appearance and visiting information could help alleviate potential fears and concerns.

Our study also highlights that admissions can facilitate independence and growth⁴ but that the erosion of support networks is a clear negative aspect of at-distance admissions.¹⁵ We have also demonstrated challenges surrounding the discharge process in which despite an emphasis on inpatient care aiming to maintain links between YP and families, friends and education,¹⁰ these are much more difficult to maintain at-distance.

Strengths and limitations

The national geographical spread of participants (five large regions across England), family backgrounds, clinical diversity and range (professional disciplines, national sample) of HCPs allowed for a wide range of experiences to be captured. The study involved a large sample (n=98) of YP, family members and HCPs exploring different perspectives of the whole admission process, from preadmission, inpatient stay to discharge. Given that this is often an involuntary, distressing and urgent process where one would not necessarily expect consensus, there was a considerable amount of consistency between the views of YP, family members and HCPs, suggesting that the main issues and challenges have been robustly identified by this study.

However, due to our efforts to interview YP and parents/carers with current or recent admission experiences, participants were largely identified by HCPs in inpatient rather than community settings. Furthermore, most YP were interviewed while still in hospital, thus impacting on their potential to reflect in detail on their whole admission experience, particularly around returning home. Although most YP and parent/carer participants were white British and female (reflective of the wider CAMHS inpatient population), some participants were male or non-binary, some from single-parent families or were looked-after children, and some from other ethnic backgrounds, capturing a rich diverse range of experiences.

CLINICAL IMPLICATIONS

The findings from this study have several implications for clinical practice. Perceptions of being informed about, but not explicitly involved in, the admission decision-making processes suggest more clarity and improved communication is needed between services and YP/families, throughout the admission process. This might help inform who might benefit from being at-distance or who might need transferring nearer home before discharge, as well as ensuring that information, finance and other practical needs are better met. Family difficulties should be addressed as much as possible during the admission, as most YP will return to their local area when discharged.

Our findings underscore the importance of information provision for YP and families, particularly easily accessible information online. This information, and how it is shared, should be coproduced. The powerless nature of these admissions as felt by all stakeholders, together with the apparent lack of support and advocacy for parents/carers forcing them to be proactive and push for information, highlights the need for units to have information resources to share as soon as the admission is confirmed. Additionally, the provision of peer support involvement at units, allowing YP and parents/carers to obtain reliable testimony about the services they will experience, could be beneficial.

The additional burden at-distance admissions have on families suggests a call for an explicit national policy around support

provision for families. Additional flexibility may therefore need to be considered by all units with additional funding implemented for travel, accommodation and childcare costs reflected in the costs of these admissions.

CONCLUSION

This study provides evidence that at-distance admissions can exacerbate the distress and uncertainty for YP and parents/carers at an already difficult time, limiting contact with support networks and usual education. However, we have also identified some potential benefits. Admission processes should incorporate YP's and parents'/carers' opinions. Ideally, choice should exist to provide local or at-distance admissions, whichever would be most beneficial depending on individual circumstances.

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