

Convergence with previous evidence shows that our findings are more generally relevant than just to our sample. Where they depart most from current knowledge and assumptions is by showing how clinical communication can deliver or deny trust, care, and respect and by showing that aspects of communication believed to be ends in themselves should be considered from the perspective of the function that they have for patients. Testing and elaborating our analysis will help to focus communication research and teaching on what patients need rather than on what professionals think they need.

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## Inappropriate admission of young people with mental disorder to adult psychiatric wards and paediatric wards: cross sectional study of six months' activity

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Child and adolescent psychiatric inpatient wards were established because young people with mental illness are often poorly served by admission to general psychiatric wards, owing to needs that differ from those adults, different skills needed by staff, and difficulty ensuring young people's safety.<sup>1</sup> The admission of young people with mental illness to paediatric wards also raises concerns about safety and the skills of staff. We estimated the number of inappropriate admissions of young people with mental disorder to adult psychiatric wards and paediatric wards.

### Participants, methods, and results

We chose nine health authorities representative of England and Wales in terms of location, population size, deprivation, and provision of child and adolescent psychiatric wards (see table on [bmj.com](http://bmj.com)). These health authorities served 1.13 million people aged under 18, representing 9% of the population of England and Wales (1999 projections of 1991 census).

We identified all adult psychiatric wards and paediatric wards. Consultant general psychiatrists and paediatricians completed a questionnaire for each

eligible patient (patients aged under 18 on general psychiatric wards and patients on paediatric wards for treatment of mental illness not solely for medical treatment of self harm) admitted between 1 July and 31 December 1999.


All 31 adult psychiatric wards replied, yielding 43 eligible admissions (23 male). Five were aged 15, and the remainder were 16 or 17. Sixteen of the 21 paediatric wards replied, with 11 eligible admissions (three male, one aged 3 and the others 8-16). The table presents the numbers and projected rates of admissions.

The consultants rated whether each eligible admission was appropriate and, if not, why the patient had not been admitted to a more appropriate unit. Twenty six (60%) adult psychiatric admissions and six (55%) paediatric admissions were deemed "inappropriate." The main reasons for these admissions were

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Numbers and rates of admissions of young people with mental disorder to general adult psychiatric wards and paediatric wards in England and Wales

Study group	No of admissions in six month study period	Median (interquartile range) length of stay in days	Annual admission rate per 100 000 under 18s (95% CI)	Projected annual No of admissions (95% CI)
General adult psychiatric wards	43	12 (5 to 28)	7.6 (5.3 to 10.0)	955 (666 to 1266)
Paediatric wards	11	6 (2 to 25)	1.9 (0.8 to 3.1)	244 (103 to 398)

non-provision of an appropriate facility (n = 25) or the appropriate facility being full or refusing the patient (n = 12).

## Comment

According to our projections, substantial numbers of young people with mental disorder are admitted to adult psychiatric wards (955, 95% confidence interval 666 to 1266, per year) and paediatric wards (244, 103 to 398). Over a half of these admissions would be to an inappropriate ward.

Although our study population represents 9% of under 18s in England and Wales, the number of admissions was low, so extrapolations must be viewed cautiously. The validity of the estimates depends on the representativeness of the health authorities sampled, so we took care to attempt to ensure this. Five (24%) out of the 21 eligible paediatric units did not reply. We assumed no eligible admissions to non-responding wards; our data are thus a minimum estimate.

This study quantifies the use of non-specialist wards for young people with mental disorder. Around 2100 young people are admitted to specialist child and adolescent mental health units each year,<sup>2</sup> so more than a third of all young people admitted for a mental illness are admitted to general psychiatric wards and paediatric wards. Young people may have poor experiences in general psychiatric wards.<sup>1</sup> Levels of disturbance are high, assaults are common, and patients feel unsafe.<sup>3,4</sup> On paediatric wards, adolescents with challenging behaviour raise concerns that staff are not trained to manage them safely; also specialist mental health skills are rare.

Our findings indicate an absolute lack of capacity in child and adolescent inpatient psychiatric units in England and Wales. This is consistent with the views of child and adolescent psychiatrists.<sup>5</sup> Aggravating factors may include uneven geographical distribution and units that do not accept emergency admissions.<sup>2</sup> If these admissions to general psychiatric and paediatric wards are to continue, then skills need to be developed in units receiving these vulnerable young people. If the admissions are to be avoided, further investment in specialist inpatient care, the formulation of alternatives to admission, or both will be needed.

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