IMJ
Official Journal of the Irish Medical Organisation

Ir Med J; June 2025; Vol 118; No. 6; P91
June 17th, 2025

Overlooked and Uncounted: Paediatric Psychiatry and Boarding in Ireland

É. Jones[1], C.S. O'Gorman[2,3], E. Barrett[1,4]

1. UCD School of Medicine, University College Dublin, Belfield, Dublin 4, Ireland.
2. Department of Paediatrics, UL School of Medicine, University of Limerick, Castletroy, Co. Limerick, Ireland.
3. Department of Paediatrics, University Hospital Limerick, St. Nessan's Road, Dooradoyle, Limerick.
4. Department of Liaison Psychiatry, CHI at Temple Street, Temple Street, Rotunda, Dublin 1.

Abstract

Aim

In Ireland, there are currently more patients requiring in-patient psychiatric care than there are beds available. As a result, doctors are left with no choice but to board patients in general medical wards. Internationally, the phenomenon of admitting psychiatric patients to a non-psychiatric setting is referred to as psychiatric boarding[1,2]. Psychiatric boarding can be defined as "when a patient presenting with a primary psychiatric condition is held in, or admitted to, a nonpsychiatric setting for a minimum of 18 hours while awaiting psychiatric care or admission to a psychiatric ward"[3].

Methods

A survey was created for this study and consisted of 3 sections; basic demographics, the nature of admissions and working diagnoses, and the clinicians perceived ability to provide adequate care to psychiatric patients. Consultant paediatricians were contacted from all 20 paediatric sites around Ireland and were requested to gather prospective data relating to admissions to their general medical wards between the 17th and 23rd of June 2024.

Results

Representatives from all 20 paediatric sites in Ireland agreed to provide data for this study. Doctors indicated that 3.8% (37) of admissions to paediatric general medical wards in this timeframe were for psychiatric reasons. Though all paediatricians surveyed had prior experience managing patients with psychiatric issues, only 15% (3) stated they felt able to provide adequate care to psychiatric patients. While 3.8% of all admissions does not seem particularly high, this number represents 37 children who are not receiving the most optimal

care possible. Several doctors who participated in this survey stressed that data collection took place during a particularly slow week highlighting the need for multiple timepoints over the period of a year to accurately assess the issue.

Discussion

To our knowledge, this is the first data examining the issue of psychiatric boarding in Ireland. The authors hope to expand this data by replicating this study over a number of timepoints in a 12-month period to determine the yearly prevalence of paediatric psychiatric boarding in Ireland.

Introduction

The prevalence of psychiatric disorders among children and adolescents is increasing with between 14% and 20% of children and adolescents experiencing a mental disorder[4]. This accounts for 13% of the global burden of disease for this age group[4,5]. Patients who present to the emergency department for psychiatric care often must wait 40% longer for care compared to those presenting for medical concerns[6]. We also know in Ireland that mental health presentations in children have increased rapidly[7,8] and that where liaison child psychiatry services exist, they are variable in what they can offer[1,9,10]. Additionally, psychiatric patients wait significantly longer for admission or transfer to specialist treatment than non-psychiatric patients[11]. For patients presenting with psychiatric complaints that may benefit from in-patient care, in the absence of medical illness the most appropriate setting may be a psychiatric ward. However, demand for psychiatric beds often exceeds supply[12] and patients are commonly admitted to non-psychiatric medical wards or housed in the emergency department while awaiting a bed in an in-patient service. This practice is referred to as psychiatric boarding[13]. Some evidence indicates that over 20% of all psychiatric patients who present to the emergency department are boarded[14], with average boarding times varying from 7 hours to 34 hours[15,16].

To date, no research has examined the rates of psychiatric boarding in an Irish paediatric population. This is concerning as psychiatric boarding may lead to delayed provision of care, increased stress and anxiety, significant agitation, inappropriate psychopharmacological therapies, increased length of stay and worsening of symptoms[17-20]. Additionally, paediatricians report feeling uneasy providing care to children outside of their scope of practice and feel they do not currently have the necessary skills to provide care to these patients[21]. To address this gap in the literature, we set out to quantify the rates of boarding in Irish paediatric units and to examine paediatricians' perspectives of the issue.

This research group has previously established that paediatricians in Ireland, who do not have specialist psychiatry training often express their concern at the lack of skills, experience and confidence in dealing with this type of patient[22].

Clinicians internationally also question the appropriateness of medical wards for patients with mental health conditions and stress their inability to spend long periods of time with these patients given their already burdensome workload with patients within their skillset[23,24].

Materials and methods

A questionnaire was created using the online survey platform Qualtrics. The survey consisted of three sections:

1. Introductory questions establishing where the clinician works, their specialty, how many patients were admitted to their unit for any reason, and how many patients were admitted to their unit with a primary mental health complaint
2. Patient characteristics establishing basic demographics of the patient(s) admitted to their unit for mental health reasons, such as their gender and ethnicity, whether they have received a psychiatric diagnosis prior to admission, whether they have a long term-health condition, whether they have previously or are currently attending an outpatient mental health clinic, whether the clinician has consulted psychiatry and what the outcome of the consultation was, and whether the patient requires medical treatment prior to the provision of mental health care, in addition to the provision of mental health care, or not at all.
3. The final section examined clinicians' opinions and perceptions of when mental health-related admissions to general wards peak, how able they feel to provide appropriate care to these patients, how well resourced they are, what training and education they have availed of relating to paediatric psychiatry, and what training and resources do they need to provide adequate care to psychiatric patients admitted to their unit. Finally, participants were presented with a definition of psychiatric boarding and asked whether they feel if the definition is representative of what occurs in their unit and whether they feel using the proposed definition would create a shared understanding of this problem.

Paediatricians were contacted from all 20 Irish paediatric sites; and asked to provide one set of representative answers for each site following consultation with local colleagues. CHI at Temple Street, CHI at Crumlin, CHI at Tallaght, MRH Mullingar, MRH Portlaoise, St Luke's Kilkenny, Wexford General Hospital, Waterford UH, TUH Clonmel, Mercy UH, Cork UH, Kerry UH, UH Limerick, Portiuncula UH, Galway UH, Mayo UH, Sligo UH, Letterkenny UH, Cavan General Hospital and OLOL Drogheda. All who were contacted agreed to participate. Participants were asked to provide data relating to admissions for a one-week period between the 17th and 23rd of June only. Eight participants requested to answer the survey over the phone, with the rest electing to have an anonymous link emailed to them to complete

themselves. The data was extracted and analysed using IBM SPSS 29. Research ethics board approval was granted by the University College Dublin School of Medicine Research Ethics Committee.

Results

Response rate: Responses were gathered from all paediatric sites in Ireland (N=20, response rate 100%). Respondents estimated that a total of 965 patients were admitted to all units combined for any reason during the study week, with 37/965 (3.8%) admitted for psychiatry indications.

Demographics: The majority of patients admitted for psychiatric reasons were White Irish (75.5%, N=28), 1 patient was from Any Other White Background (2.7%), 1 patient was Arab (2.7%), 1 patient was other including mixed background (2.7%). Respondents indicated they were not sure of the ethnicity of the remaining 6 patients (16.2%). The majority (73%) of patients were female (N=27), 18.9% (N=7) were male and participants indicated that they were unsure of the genders of 8.1% (N=3) of participants.

Working diagnosis for boarded patients: Clinicians were able to select more than one working diagnosis. 3 indicated a working diagnosis of anxiety, 10 with depression, 10 with an eating disorder, 5 with a mood disorder, 1 with psychosis, 3 with ADHD, 4 with ASD, 2 with a conduct disorder and 11 indicated other. Some patients presented with features of more than one disorder.

Psychiatry input: Of those who provided data relating to consultations, 97.1% (N=34) requested a consultation from psychiatry. Only 1 did not request a consultation from psychiatry (2.9%, N=1). Most of these consultations resulted in an inpatient consultation with liaison psychiatry (55.9%, N=19), 20.6% (N=7) of consultations resulted in an outpatient consultation with CAMHS, 14.7% (N=5) resulted in an inpatient consultation with CAMHS. The remaining 8.8% (N=3) indicated a different outcome. The respondents indicated that 15 patients were currently attending an outpatient mental health clinic at the time of admission, 3 patients had attended an outpatient mental health service some time prior to their admission, 11 patients were not attending an outpatient mental health clinic, 2 were on a waiting list, 6 indicated they were unsure and 2 indicated other. Most patients required medical treatment, either in concurrence to psychiatric treatment (43.2%, N=16) or prior to psychiatric treatment (18.9%, N=7). The remaining 37.8% (N=14) did not require medical treatment.

Changing epidemiology: All doctors surveyed indicated the professional opinion that there has been an increase in the number of psychiatric patients admitted to general wards (see Figure 1). All respondents indicated that they have experience treating a range of psychiatric

disorders in the past 12 months. See Table 1 for a complete breakdown of the psychiatric disorders treated by paediatricians.

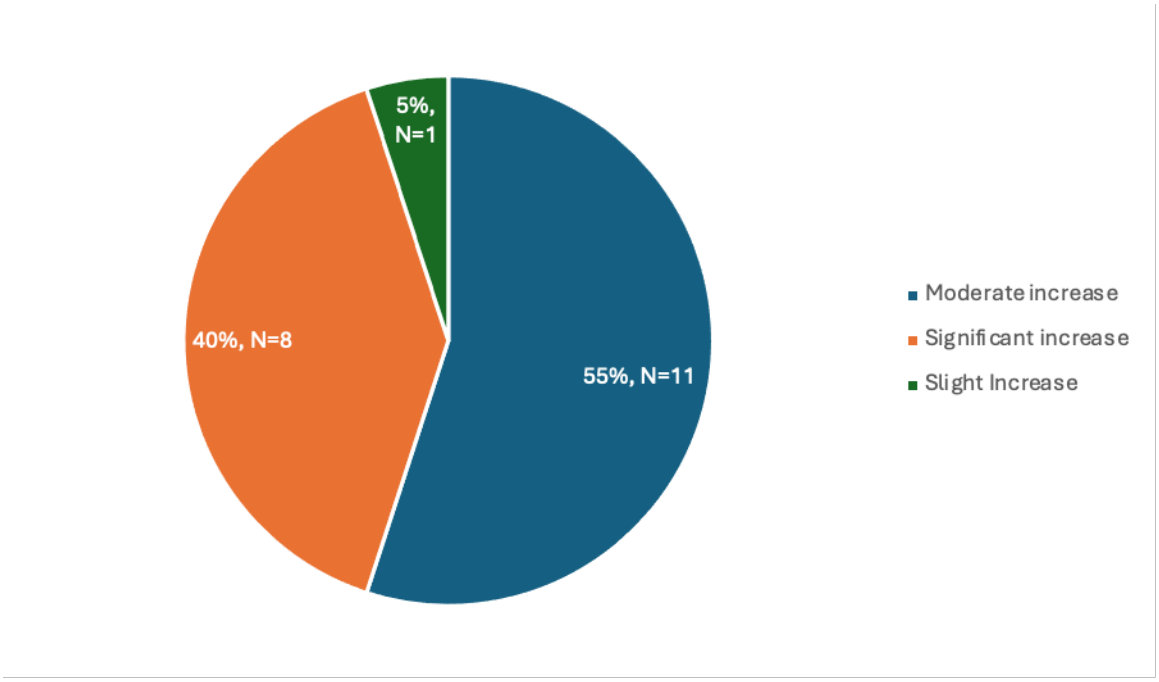

Figure 1. Perceived increase in psychiatric admissions to general wards

Table 1. Paediatricians' experience of treating mental health disorders in the past 12 months.

	Frequency	Percentage of Sample
Anxiety	20	100%
Deliberate self-harm	20	100%
Mood disorders	20	100%
Eating disorders	20	100%
ADHD	20	100%
ASD	20	100%
Depression	18	90%
Tic/Tourette disorder	16	80%
Conduct disorders	15	75%

Somatoform disorder	14	70%
Psychosis	10	50%
Other	3	15%

Ability to provide adequate care: Most paediatricians reported that they feel unable to provide appropriate care to paediatric patients with mental health difficulties. See Figure 2 for a breakdown of paediatricians' perceptions of their ability to provide care to this cohort.

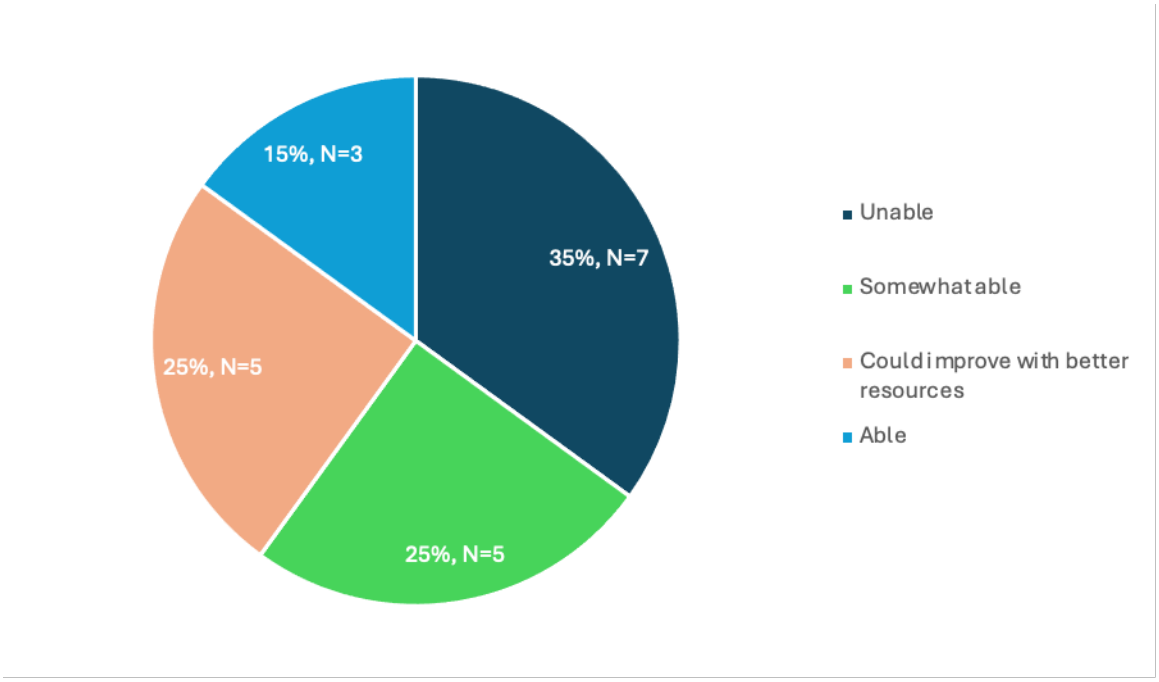

Figure 2. Percentage of paediatricians who feel able to provide appropriate care to patients with mental health difficulties.

Training needs: The doctors surveyed were overwhelmingly supportive of undertaking additional training to support their care of psychiatric patients. However, many respondents indicated that they currently do not have the time or resources to complete such training.

Table 2. Teaching opportunities paediatricians indicated would be useful

	Frequency	Percentage of Sample
Joint training initiatives	8	40%
CPD courses	7	35%

Psychiatry clinic exposure for paediatric trainees	7	35%
Joint paediatric-child psychiatry teaching sessions in post-graduate	7	35%
Optional psychiatry training as part of Higher Specialist Training	6	30%
Paediatric clinic exposure for psychiatric trainees	6	30%
Balint reflective groups	6	30%
Mental health grand rounds teaching	5	25%
Tutorials/Seminars	5	25%
Child and adolescent psychiatry trainees undertaking training in paediatric medicine	5	25%
Undergraduate electives in child and adolescent mental health	4	20%
Joint paediatric-child psychiatry teaching sessions in undergraduate	4	20%
Journal clubs	2	10%
Other	10	50%

Familiarity with Psychiatric Boarding: When asked whether they are familiar with the term psychiatric boarding, most said no (50%, N=10) or not sure (15%, N=3), with only 15% (N=3) indicating they are familiar. When presented with our definition of psychiatric boarding and asked whether they feel the definition is representative of what happens in their hospital, 90% (N=18) said yes and 5% (N=1) said no. When they were asked whether using this definition would be beneficial in creating a shared understanding of this issue, 75% (N=15) said yes and 20% (N=4) said no. One participant (5%) did not answer.

Discussion

This study is the first to examine the prevalence of psychiatric boarding in Irish paediatric units. In fact, this study appears to be the first to examine psychiatric boarding in Ireland. It is important to note the lack of an agreed term to describe this phenomenon in Ireland—has this contributed to the lack of capture of this data? Is this an unseen and under- reported cohort? Importantly, this study has described that in a one-week period (between the 17th

and the 23rd of June 2024) almost 4% (3.83%) of all children who were admitted to paediatric units in Ireland were admitted for psychiatric reasons in lieu of a psychiatric ward. While this number does not seem particularly high, it is important to note that this number represents 37 sick children who may not be receiving the most appropriate care due to the lack of psychiatric beds available in Ireland and variations in child psychiatry services across Ireland. With that being said, 3.83% is significantly lower than the up to 20% reported in the literature[14]. However, all 8 participants who responded to the survey over the phone stressed that it was a particularly quiet week, with 1 doctor stating: "some weeks almost half our ward is filled with suicidal children". Another participant remarked that if the survey was conducted in October or late spring the rates of admission would be drastically higher. It would be premature to conclude whether 3.83% of admissions is high, low, or expectant without further data collected across multiple timepoints. The authors intend to use this research as the first time-point in at a series of time-points to gain a more accurate understanding of the prevalence of psychiatric boarding in Ireland.

Worryingly, all doctors in this sample indicated a rise in the number of children with mental health difficulties being admitted to general wards suggesting an increase in the number of children with mental disorders, and no increase in the number of available psychiatric beds or standardisation and optimisation of child psychiatry service delivery across the country. Despite all paediatricians reporting experience in treating psychiatric disorders in the past 12 months, only 15% of our sample respondents feel able to provide adequate care to these patients, but are open to the prospect of undertaking additional training to support the care of an increasing cohort of patients they previously did not manage.

Definitions of psychiatric boarding vary greatly between authors and geographic location. The Joint Commission, an American based healthcare company define boarding as keeping a patient in a temporary location for four hours[16]. However, this definition is not specific to psychiatric patients, but for any patient who awaits admission to their appropriate ward. Misek, DeBarba and Brill define psychiatric boarding as the practice of holding a patient in a non-psychiatric setting for longer than six hours post medical clearance[25]. Authors in England and elsewhere define the concept as inappropriately admitting psychiatric patients to general medical wards[26,27]. To adequately examine and quantify the prevalence of this issue, a standardised definition is needed, particularly one that is more appropriate to an Irish context. Hence, the authors have proposed the following definition of psychiatric boarding:

Psychiatric boarding occurs when a patient presenting with a primary psychiatric condition is held or admitted to a non-psychiatric setting for a minimum of 18 hours while awaiting psychiatric care or admission to a psychiatric ward.

This proposed definition has a longer waiting period before it should be considered boarding. This is to acknowledge the fact that patients in Irish emergency departments incur an average wait time of almost 12 hours which is significantly longer than other healthcare systems[28].

Additionally, the proposed definition is longer as many services such as Child and Adolescent Mental Health Services (CAMHS) often do not have an out of hours or weekend service available, increasing the time a patient must wait to receive specialist care.

As with all research, this study has limitations. This study is an initial attempt to create a network to support data capture for this unseen cohort; and in this report data was only gathered for a one-week period. Future research aims to replicate this study in several time-points to gain a more generalisable description of this issue. Another key limitation of this study is the fact that only data were gathered on patients admitted to general paediatrics wards. This approach excludes patients that were boarded in the emergency department and discharged to outpatient mental health services. Future research should examine the rates of this issue in both general paediatric wards and emergency departments to determine truest prevalence of psychiatric boarding possible.

Acknowledgements

The authors would like to extend their deepest thanks to the doctors who took the time to answer our survey and advance our understanding of psychiatric boarding; M. Azam, E. Roche, F. Sharif, N. van der Spek, R. Barry, P. Curran, P. Gallagher, S. Glackin, M. Grace, M. Khan, J. Lucey, D. Mullane, D. Oyekwere, N. Oketah, E. Reade, S. Richardson, H. Stokes, H. Thomas, D. Waldron and O. Walshe.

We also extend our thanks to the UCD School of Medicine SSRA program for facilitating this research internship.

Declarations of Conflicts of Interest:

None declared.

Corresponding author:
Eamon Jones,
UCD School of Medicine,
University College Dublin,
Belfield,
Dublin 4,
Ireland.
E-Mail: eamon.jones@ucdconnect.ie

References:

1. McNicholas F, Parker S, Barrett E. A snapshot in time: a 1-month review of all referrals to paediatric liaison psychiatry services in Dublin following emergency department presentation. *Irish Journal of Psychological Medicine.* 2021; 378–386.
2. Simpson SA, Joesch JM, West II, Pasic J. Who's boarding in the psychiatric emergency service? *Western Journal of Emergency Medicine* 2014; **15**: 669–674.
3. Jones É, O'Gorman C, McNicholas F, Barrett E. Psychiatric boarding: what is it, how do we recognise it, and what are the implications? *Irish Journal of Psychological Medicine*. 2024;1–2.
4. World Health Organisation. Mental Health of Adolescents. 2021. https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health.
5. Davie M. Doing more for mental health. *Arch Dis Child Educ Pract Ed* 2016; **101**: 77–81.
6. Slade EP, Dixon LB, Semmel S. Trends in the Duration of Emergency Department Visits, 2001–2006. *Psychiatric Services.* 2010; **61**.
7. Ansari H, Santiago-Jiménez M, Saab H, De Souza CM. 4.2 Comorbidities and Service Utilization In Paediatric Consultation-Liaison Psychiatry In-Patients. *Journal Of The American Academy Of Child And Adolescent Psychiatry* 2018, **57**(10).
8. Lynch F, Kehoe C, MacMahon S, McCarra E, McKenna R, D'Alton A *et al.* Paediatric Consultation Liaison Psychiatry Services (PCLPS) -what are they actually doing? *Ir Med J* 2017; **110**: 652.
9. McNicholas F. Child & adolescent emergency mental health crisis: a neglected cohort. *Lenus The Irish Healthcare Repository* 2018.
10. Doherty AM, Plunkett R, McEvoy K, Kelleher E, Clancy M, Barrett E *et al.* Consultation-Liaison Psychiatry Services in Ireland: A National Cross-Sectional Study. *Front Psychiatry* 2021; **12**. doi:10.3389/fpsyt.2021.748224.
11. Nicks BA, Manthey DM. The Impact of Psychiatric Patient Boarding in Emergency Departments. *Emerg Med Int* 2012; **2012**: 1–5.
12. Lynch S, McDonnell T, Leahy D, Gavin B, McNicholas F. Prevalence of mental health disorders in children and adolescents in the Republic of Ireland: A systematic review. Ir J Psychol Med. 2023; **40**: 51–62.
13. Mansbach JM, Wharff E, Austin ; S Bryn, Ginnis K, Woods ER. Which Psychiatric Patients Board on the Medical Service? 2003. http://publications.aap.org/pediatrics/article-pdf/111/6/e693/1011123/pe060300e693.pdf.
14. Nolan JM, Fee C, Cooper BA, Rankin SH, Blegen MA. Psychiatric boarding incidence, duration, and associated factors in united states emergency departments. *J Emerg Nurs* 2015; **41**: 57–64.
15. Weiss AP, Chang G, Rauch SL, Smallwood JA, Schechter M, Kosowsky J *et al.* Patient and practice-related determinants of emergency department length of stay for patients with psychiatric illness. *Ann Emerg Med* 2012; **60**. doi:10.1016/j.annemergmed.2012.01.037.

16. The Joint Commission. Patient Flow Through the Emergency Department. Illinois: TJC; 2012. https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_report_issue_4.pdf.
17. Smith JL, De Nadai AS, Petrila J, Storch EA. Factors Associated With Length of Stay in Emergency Departments for Pediatric Patients With Psychiatric Problems. 2019. www.pec-online.com.
18. Campbell M, Pierce J. A retrospective analysis of boarding times for adolescents in psychiatric crisis. *Soc Work Health Care* 2018; **57**: 393–405.
19. Brathwaite D, Strain A, Waller AE, Weinberger M, Stearns SC. The effect of increased emergency department demand on throughput times and disposition status for pediatric psychiatric patients. *American Journal of Emergency Medicine* 2023; **64**: 174–183.
20. Vázquez-Vázquez A, Smith A, Gibson F, Roberts H, Mathews G, Ward JL *et al.* Admissions to paediatric medical wards with a primary mental health diagnosis: a systematic review of the literature. *Arch Dis Child* 2024; **0**: 1–10.
21. Oketah N, Sewell V, Barrett E. '99 voices, one story – supporting mental health in paediatric patients' a national survey of paediatric trainees. 2019. doi:10.1136/archdischild-2019-epa.598.
22. Oketah N, Sewell V, Barrett E. Knowledge and Training Needs of Paediatric Trainees in Mental Health. *Ir Med J* 2021; **114**: 294–302.
23. Buckley S. Caring for those with mental health conditions on a children's ward. *British Journal of Nursing* 2010; **19**: 1226–1230.
24. Wu WL, Chen SL. Nurses' perceptions on and experiences in conflict situations when caring for adolescents with anorexia nervosa: A qualitative study. *Int J Ment Health Nurs* 2021; **30**: 1386–1394.
25. Misek RK, DeBarba AE, Brill A. Predictors of psychiatric boarding in the emergency department. *Western Journal of Emergency Medicine* 2015; **16**: 71–75.
26. Worrall A, O'herlihy A, Banerjee S, Jaffa T, Lelliott P, Hill P *et al.* Inappropriate admission of young people with mental disorder to adult psychiatric wards and paediatric wards: cross sectional study of six months' activity. *BMJ* 2004; **328**. doi:10.1136/bmj.38058.605787.AE.
27. Hudson LD, Vázquez-Vázquez A, Gibson F, Phillips K, Mathews G, Roberts H *et al.* Mental Health Admissions to Paediatric Wards Study (MAPS): protocol of a prospective study of mental health admissions to paediatric wards in England using surveillance and qualitative methods. *BMJ Paediatr Open* 2024; **8**: 2186.
28. Health Service Executive. Weekly Urgent and Emergency Care Report: Week Ending April 21st 2024. https://assets.hse.ie/media/documents/Weekly_Urgent_and_Emergency_Care_Performance_Update_-_23_04_2024.pdf (accessed 12 Jun2024).