mentalwelfare commission for scotland

dignity & rights ethical tre respect ca & equality

STATISTICAL MONITORING

Young person monitoring report 2017-18

DECEMBER 2018

Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

Contents

What we do

We protect and promote the human rights of people with mental health illness, learning disabilities, dementia and related conditions.

We do this by:

- Checking if individual care and treatment are lawful and in line with good practice.
- Empowering individuals and their carers through advice, guidance, and information.
- Promoting best practice in applying mental health and incapacity law.
- Influencing legislation, policy, and service development.

Executive Summary

In this year's annual report, the number of young people under the ages of 18 admitted to non-specialist hospital wards for treatment of their mental health difficulties has risen nationally to 103 admissions involving 90 young people. Although this compares unfavourably with last year's figures of 71 admissions involving 66 young people to non-specialist wards, it remains an improvement on figures of the preceding years and contrasts with the two-year period of 2013-15 when each year over 200 admissions involving over 170 young people occurred annually in non-specialist environments across the country.

This year health board areas differ in relation to their admission figures, with some achieving continued reductions and others experiencing larger numbers than last year.

We continue to advocate for the need to address the lack of service provision for young people requiring IPCU provision during their hospital stay. Since our report in 2016-17[1] we have highlighted this issue, but thus far any work to explore the issues around specialist IPCU provision for young people across Scotland has stalled. This year once again 14 of the young people admitted to a non-specialist environment (14% of the total number of admissions) were admitted to an adult IPCU. We are aware, however, that the need for IPCU facilities in children and young people is often greater than these figures demonstrate, since some young people are not able to access IPCU facilities when required. Action 20 of the Mental Health Strategy 2017-2027 aims to "scope the required level of highly specialist mental health

[1] Young Person Monitoring 2016-2017. October 2017. https://www.mwcscot.org.uk/media/387820/young_person_monitoring_report_2016-17.pdf

inpatient services for young people, and act on its findings"[2]. In this report we recommend that specialist IPCU provision is included under this action.

Child and Adolescent Mental Health Services (CAMHS) and children's mental health and wellbeing more generally remain a key focus area for Scottish Government, and this is reflected in a number of actions within the Mental Health Strategy 2017-2027. While access to CAMHS has improved in many areas, demand has continued to increase. It is recognised that there is a need to look at the whole system supporting children and young people with mental health difficulties; not just the care provided by specialist CAMHS, but also early interventions involving less intensive levels of support with emphasis being placed on the most vulnerable young people.

We are pleased that action 19 of the Mental Health Strategy 2017-2027 takes forward a recommendation made in the Commission's Young Person's 2015-16 report[3] regarding standards relating to the care provision for young people whilst cared for in a non-specialist environment. The CAMHS Lead Clinician group has been commissioned to develop a protocol for admissions of young people to non-specialist wards (Action 19, Mental Health Strategy 2017-2027) and we have been contributing to that activity. However, we are aware that access to the regional units continues to vary across the country with some young people able to access some units out of hours and at weekends, and others not. In this report we recommend that the review of admission protocols to specialist adolescent units is included under Action 19 of the Mental Health Strategy.

It is important to highlight that under the Mental Health (Care and Treatment) (Scotland) Act 2003 Health Boards are required to provide appropriate services and accommodation for young people admitted to hospital for treatment of their mental disorder. While the number of admissions of young people to non-specialist wards is a very important aspect of care, additional crucial aspects include the environment provided for the young person while on the ward, the length of stay of the young person, and the availability of specialist care provided to the young person. It is hoped that the development of nationally agreed standards outlined in Action 19 will serve as a benchmark for future service development and a focus for CAMHS to help ensure the needs of the young person while looked after in a non-specialist environment are not overlooked. Over recent years the proportion of young people being able to access specialist CAMHS input while an inpatient in a non-specialist ward has not improved substantially. We know from our work throughout the course of the year that specialist CAMHS support available to young people in non-specialist wards can vary considerably and does not necessarily reflect the needs of the young person.

---

[2] Mental Health Strategy for Scotland 2017-2027. Published March 2017. http://www.gov.scot/Publications/2017/03/1750

[3] Young Person Monitoring 2015-2016. October 2016. http://www.mwcscot.org.uk/media/343729/young_person_monitoring_report_2015-16.pdf

Summary of Recommendations

1. Hospital managers of the regional specialist adolescent units should continue to review admission procedures to establish whether access to the units can be improved for all new referrals out of hours and at the weekend. The Scottish Government should include this activity under Action 19 of the Mental Health Strategy 2017-2027 to ensure there is a framework to support its progression.

2. The Scottish Government should include the provision of nationwide IPCU facilities for young people under the age of 18 in Scotland as part of Action 20 of its Mental Health Strategy. Work should be undertaken in partnership with the regional CAMHS Tier IV networks to address this issue. Part of this activity should be to develop mutually agreed pathways to ensure that young people requiring IPCU facilities have timely access to these environments when required.

Introduction

Section 23 of the Mental Health (Care & Treatment) (Scotland) Act 2003 places on Health Boards in Scotland a legal obligation to provide appropriate services and accommodation for young people who are under the age of 18 years and who are admitted to hospitals for treatment of their mental disorder. Since the implementation of the Act in 2005, the Mental Welfare Commission for Scotland has monitored the admissions of young people under the age of 18 years to non-specialist wards.

Every year we report on this monitoring activity and publish our findings. In some years we have also undertaken additional monitoring exercises, to explore in more detail some of the difficulties that can arise when young people are admitted to wards and some of the reasons behind young people being admitted to wards that are designed primarily for the needs of other age groups or different patient populations. Throughout the year we also try to visit young people in non-specialist wards, prioritising any young person in an IPCU or a young person under the age of 16 in a general adult ward.

For over a decade the mental health of children and young people in Scotland has been a key area of focus for Scottish Government policy. The Scottish Government has set out its aspiration that Scotland become the best country in the world in which a young person can grow up. Specialist Child and Adolescent Mental Health Services (CAMHS) have been a key focus of mental health strategy. In recent years the government has aimed to increase access of children and young people to specialist CAMHS across the country, to increase the availability of psychological therapies to children and young people and to reduce the admissions of children and young people to non-specialist wards to very low levels. Information on the specialist CAMHS workforce across Scotland has been collected routinely since 2006 and is now published quarterly. Overall CAMHS staffing levels have increased substantially since 2009, although in recent years these increases have slowed considerably[4].

The Scottish Government included a number of actions specific to CAMHS in its Mental Health Strategy 2017-2027 with the aim of promoting and protecting children's and young people's mental health and wellbeing and improving their access to timely, evidenced-based intervention and support[5]. Importantly, this includes the emphasis on the continued need to improve access to specialist CAMHS continues in addition to improvement in the prevention and early intervention services provided for children and young people. A focus on the most vulnerable children in society including those living in poverty, children in care or

[4] Information Services Division Scotland (07/06/2016); Child and Adolescent Mental Health Services (CAMHS) in NHSScotland: Workforce information as of 30 June 2018. http://www.isdscotland.org/Health-Topics/Mental-Health/Publications/2018-09-04/2018-09-04-CAMHS-Report.pdf

[5] Mental Health Straegy 2017-2027 published March 2017 http://www.gov.scot/Publications/2017/03/1750

involved with offending, and those children with a disability and/or autism is also articulated. An update of progress of these areas has now been made available[6]. Action 19 of the Strategy drew from the Commission's recommendations in a previous Young Person's Monitoring Report. The CAMHS Lead Clinician's Group has been commissioned to help develop a protocol for admissions of young people to non-specialist wards so that there are nationally agreed standards in place to help promote standards of care. The Commission has been contributing to that group, and work is underway to adapt standards developed by the Royal College of Psychiatrists in England and Wales. Given the established system in place relating to young person's monitoring at the Commission, it is planned that we will adjust our data collection to enable us to report against those standards.

It has been recognised that the demand for specialist CAMHS services has continued to grow in recent years and a recent joint report undertaken by Audit Scotland and the Accounts Commission[7] described that specialist mental health services for young people continue to be complex and fragmented, which can at times present barriers to them being able to access support. The report also describes a number of signs indicating that CAMHS are under significant pressure, with referrals to CAMHS in the past five years (since 2013-14) increasing by 22% in Scotland. The number of rejected referrals has also increased by 24% in that same timescale. In previous years Scottish Government set an 18-week referral to treatment HEAT target for CAMHS with the aim of this being delivered by December 2014[8]. Following additional work and engagement with Heath Boards and stakeholders, the Scottish Government determined that the CAMHS service standard should be set at a maximum wait of 18 weeks in 90% of patients. The Audit Scotland and Accounts Commission's report highlighted, however, that this target has never been reached across Scotland as a whole, with most recent data indicating that over 26% of young people who were accepted by CAMHS waited longer than 26 weeks[9]. Some Board areas are, however, able to reach this waiting time target although this remains the minority[10].

---

[6] Mental Health Stategy 2017-2027: 1st Progress Report. Published 11 September 2018. https://www.gov.scot/Publications/2018/09/1102

[7] Children and Young People's Mental Health published in September 2018 by Auditor General and the Accounts Commission. http://www.audit-scotland.gov.uk/report/children-and-young-peoples-mental-health

[8] Deliver faster access to mental health services by delivering 26 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) services from March 2013; reducing to 18 weeks from December 2014; and 18 weeks referral to treatment for Psychological Therapies from December 2014. The target is for at least 90% of young people to start CAMH services treatment within 18 weeks by the quarter ending March 2015. The latest figures are reported are available for 31 March 2017 https://www.isdscotland.org/Health-Topics/Waiting-Times/Publications/2017-06-06/2017-06-06-CAMHS-Summary.pdf

[9] Children and Young People's Mental Health published in September 2018 by Auditor General and the Accounts Commission. http://www.audit-scotland.gov.uk/report/children-and-young-peoples-mental-health

[10] Information Services Division Scotland (07/06/2016); Child and Adolescent Mental Health Services (CAMHS) in NHSScotland: Workforce information as of 30 June 2018. http://www.isdscotland.org/Health-Topics/Mental-Health/Publications/2018-09-04/2018-09-04-CAMHS-Report.pdf

The Scottish Government and COSLA set up the Children and Young People's Mental Health Taskforce in 2018 chaired by Dame Denise Coia following an audit of rejected referrals to CAMHS in seven Health Boards undertaken by NHS Information Services Division and Scottish Association for Mental Health (SAMH)[11] on behalf of Scottish Government. The Taskforce aims to undertake a whole system review of CAMHS in Scotland and its preliminary recommendations were published in September 2018[12]. These respond to the findings of the ISD/SAMH rejected referrals report described above and include implementation of the recommendations made in that report: strengthening information systems to understand how services work better, creating a digital platform for young people to offer support and information discussion and combat stigma, supporting the development of a diverse workforce in wider children's services including education, communities, and primary care settings; supporting the delivery of community services to promote mental wellbeing in 5-24 year olds, promoting the awareness in young people of their rights in relation to services, and supporting the opportunities for young people to express their views on services.

The ongoing activity in relation to children's mental health services reflects the high priority placed on children's mental health and wellbeing by the Scottish Government. This priority is broad in focus given the very wide range of services involved in supporting children's wellbeing on one hand and services providing treatment for significant mental illness on the other. It will be important that focus is not lost in coming years, and initiatives are not left unfinished in favour of newer initiatives elsewhere.

Specialist child and adolescent inpatient provision remains a key feature of specialist CAMHS across the country. In Scotland, there are three regional adolescent in-patient units provided within the National Health Service and one private hospital that provides care for young people under the age of 18 with mental health difficulties[13]. In addition to these specialist adolescent units, the National Child Inpatient Unit based in Glasgow receives admissions of children under the age of 12 with mental health difficulties from across Scotland.

The Code of Practice to the Mental Health Act states that "in the event of a young patient being admitted to an adult ward, it would be best practice for the hospital

[11] Rejected Referrals Child and Adolescent Mental Health Services. Published on 29 June 2018. https://beta.gov.scot/publications/rejected-referrals-child-adolescent-mental-health-services-camhs-qualitative-quantitative/. ISD Dashboard : Information Services Division http://www.isdscotland.org/Health-Topics/Mental-Health/Child-and-Adolescent-Mental-Health/Rejected-Referrals-2018/

[12] Children and Young People's Mental Health Taskforce: Preliminary View and Recommendations for the Chair. September 2018. https://www.gov.scot/Publications/2018/09/9044

[13] NHS provision: Skye House, Stobhill Hospital, Glasgow; Young People's Unit, Royal Edinburgh Hospital, Edinburgh; Dudhope House Young People's Unit, Dundee. Private provision: Huntercombe Hospital, West Lothian.

managers to notify the Mental Welfare Commission of this to enable the Commission to monitor the general provision of age-appropriate services under the Act"[14]. Monitoring the admissions of children and young people to non-specialist facilities continues both in terms of overall numbers but also in terms of services received whilst an inpatient. We routinely collect information about the admissions of young people when they are admitted to wards for mental health care that are not in the above specialist adolescent units or the National Child Inpatient Unit. Note, however, that we do not collect information on those admissions that are less than 24 hours in duration, are solely related to drug or alcohol intoxication, or are solely for the medical treatment of self-harm. If we were to do so the number of admissions that we report on would be much higher[15].

We expect to be notified of all admissions of young people to non-specialist facilities which meet our criteria. Once we have been notified about an admission (by the ward or by medical records staff), we send out a questionnaire to the consultant in charge of the young person's care (or RMO) to find out further information about the admission. As a quality control measure we receive submissions each quarter from medical records staff of each Health Board listing all the young people who meet our criteria in order to check that we have the correct information. We publish our findings annually. In 2017-18, we received further information about the admission for 86% (89 out of 103) of admissions.

In addition to collecting information about the admissions of young people to non-specialist wards, we also visit young people in hospitals to look at how their care and treatment is provided. We do this particularly when the young person is under 16 or when we know that a young person is placed in an Intensive Psychiatric Care Unit (IPCU). IPCUs are specialist secure general adult wards that provide care for adults who are at significant risk of either harming themselves or others as a consequence of their mental health difficulties. They also provide care for adults with serious mental illness who have been transferred from prison or the courts.

[14] Code of Practise Volume 1 part 4 chapter 1 paragraph 14. https://www.gov.scot/Publications/2005/08/29100428/04324

[15] Information Services Division Scotland; Child and Adolescent Mental Health Services (CAMHS) in Scotland: Waiting Times, Service Demand and Workforce information as of 30 June 2018. http://www.isdscotland.org/Health-Topics/Mental-Health/Publications/2018-09-04/2018-09-04-CAMHS-Report.pdf

Provision of age-appropriate care for people under 18

In this part of the publication, we report on our work to examine the care and treatment of young people admitted to non-specialist mental health care over the full year period (April 2017 to March 2018).

The current Code of Practice states that young people should be admitted to a non-specialist ward only in exceptional circumstances[16]. There are a number of differences between specialist adolescent units and wards designed to treat the needs of adults with serious mental illness, both in terms of staff training and experience, and the ward environment. There is a concern that the needs of a young person may not be met in a comparable way when admitted to an adult mental health ward as opposed to a specialist adolescent unit. Unfortunately the demand for specialist adolescent inpatient beds in the under-18 population has been greater than supply in recent years, and CAMHS across the country have been working hard to try and reduce the number of young people admitted to non-specialist wards and to also improve their experience of care whilst an in-patient in these settings.

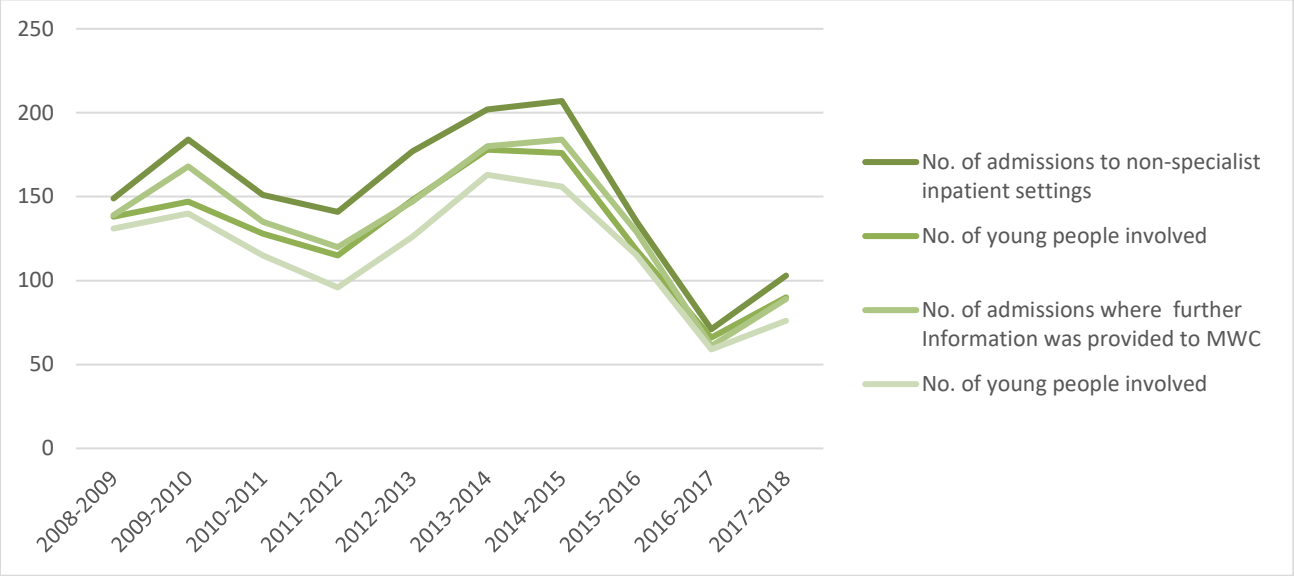
Young people (under 18) admitted to non-specialist facilities, by year 2008-18

Table 1 Young people (under 18) admitted to non-specialist facilities, by year 2008-18

	08-09	09-10	10-11	11-12	12-13	13-14	14-15	15-16	16-17	17-18
No. of admissions to non-specialist inpatient settings	149	184	151	141	177	202	207	135	71	103
No. of young people involved	138	147	128	115	148	179	175	118	66	90
No. of admissions where further information was provided to MWC	139	168	135	120	147	180	184	129	61	89
No. of young people involved	131	140	115	96	126	163	156	115	59	76

[16] Code of Practise Volume 1, chapter 1 paragraph 50. https://www2.gov.scot/Publications/2005/08/29100428/04302

Figure 1 Young people (under 18) admitted to non-specialist facilities, by year 2008-18



Our interest in these figures

Since 2005, the Commission has monitored admissions of young people to non-specialist environments and sought to confirm whether NHS boards are fulfilling their legal duties to provide age-appropriate services and accommodation. We have raised concerns about the number of admissions of young people to non-specialist environments for several years.

In 2010-11 and 2011-12 there were drops in admissions across the country, only to increase again to the highest numbers recorded in 2014-15 of 207 admissions involving 175 young people. Over the two years prior to this report a drop in the total number of admissions was seen across the country, falling to a low of 71 admissions involving 66 young people.

It is important to understand what factors have been important in reducing non-specialist admissions, in order to ensure there is ongoing matching of inpatient and Tier 4 (most intensive) CAMHS provision to the mental health needs of Scotland's of young people. It is also important to keep in mind that, in some cases, admission to a non-specialist ward may be the best option for the child or young person in a particular situation. In a significant number of cases admissions are for short periods only, and an admission to a local non-specialist ward might enable contact with the family to be maintained more easily and local community services to be co-ordinated more effectively.

Young people (under 18) admissions to non-specialist beds by bed type

Table 2 Young people (under 18) admissions to non-specialist beds by bed type

Health Board	Hospital	Paediatric	Adult	Grand Total
Ayrshire and Arran	WOODLAND VIEW		4	4
Borders	BORDERS GENERAL/HUNTLYBURN HOUSE		6	6
Dumfries and Galloway	DUMFRIES AND GALLOWAY ROYAL INFIRMARY		0	0
	MIDPARK		4	4
Fife	STRATHEDEN		1	1
	WHYTEMANS BRAE		3	3
Forth Valley	FORTH VALLEY ROYAL	1	6	7
	STIRLING COMMUNITY		1	1
Grampian	DR GRAYS		2	2
	ROYAL CORNHILL		15	15
Greater Glasgow and Clyde	GARTNAVEL ROYAL		2	2
	GLASGOW ROYAL INFIRMARY		1	1
	INVERCLYDE ROYAL		1	1
	LEVERNDALE		6	6
	MACKINNON HOUSE		4	4
	PARKHEAD		1	1
	ROYAL ALEXANDRA		0	0
	STOBHILL		1	1
Highland	ARGYLL AND BUTE		3	3
	NEW CRAIGS		2	2
Lanarkshire	HAIRMYRES		5	5
	MONKLANDS		2	2
	WISHAW GENERAL	3	12	15
Lothian	ST JOHNS		3	3
Tayside	CARSEVIEW CENTRE		6	6
	MURRAY ROYAL		5	5
	PERTH ROYAL	1	1	2
	STRATHMARTINE		1	1
Grand Total		5	98	103

What we found

In 2017-18 we were notified of 103 admissions to non-specialist wards involving 90 young people. This is a sizeable increase from last year when the figures had improved to become the lowest recorded ever (71 admissions involving 66 young people). This year's figures, however, are not as high as the worst two years when we were notified of 207 admissions involving 175 young people in 2014-15 and 202 admissions involving 179 young people in 2013-14.

This year's figures are disappointing and may reflect capacity issues within the mental health system as a whole. In the previous Mental Health Strategy of 2012-2015[17], the Scottish Government stated its commitment to reducing admissions of young people to adult wards to rates comparable to those achieved in the South of Scotland area. The figures still remain far from this ambition. Approaches to achieve this goal have included increasing capacity of the specialist adolescent estate and promoting the development of CAMHS intensive services in the community to provide alternatives to admission and help reduce length of stay within adolescent units. Although this commitment had not been achieved across Scotland in 2016-17 and 2015-16 we did see numbers of young people admitted to non-specialist wards fall substantially. Enquiries suggest that the role of CAMHS intensive treatment services has been a key contributory factor in addition to other approaches to help co-ordinate and streamline admission and discharge procedures of the specialist inpatient units, the stability of staffing within the inpatient units, and the expansion of capacity to deliver evidence-based and intensive treatment in Tier 3 CAMHS within the community.

At present Scotland has no specialist inpatient facilities that cater for young people with both significant mental health difficulties and forensic needs, young people with Learning Disability (Intellectual Disability) and/or autism, and young people who require care within an IPCU environment. Action 20 of the Mental Health Strategy 2017-2027 is a commitment to: "Scope the required level of highly specialised mental health inpatient services for young people and act on its findings." We are pleased to hear news that work in relation to the first two of these groups of young people continues to progress. NHS Ayrshire and Arran is the chosen site for the building of a National Secure CAMHS Inpatient Facility (National Secure Adolescent Inpatient Service (NSAIS)) and an options appraisal is currently underway in relation to inpatient services for young people with Learning Disability by NHS National Services Scotland. It is disappointing to learn, however, that there has been no further progress made on specialist IPCU facilities for young people in Scotland. Indeed we understand that this area of specialist mental health inpatient service is not included under Action 20 of the Mental Health Strategy. We understand that

[17] Mental Health Strategy 2012-2015. https://www2.gov.scot/resource/0039/00398762.pdf

during the early planning stages for national commissioning of NSAIS it was agreed that NSAIS would be within an NHS care pathway that included community Forensic CAMHS, adolescent IPCU (for short-term acute care), and the open regional adolescent/national child units. During this planning stage it was anticipated that the regional CAMHS networks (North, West, and East of Scotland relating to the relevant NHS specialist adolescent inpatient unit) would develop the first two, including regional IPCU provision. This model for IPCU provision was again supported when the NSAIS proposal was considered by Health Boards more recently for national designation. So far however, although we have been told that there was some initial activity by the regions to explore how the need for IPCU in each region could be met, this work has not progressed. This is disappointing given the recommendations we have made in recent years. We are aware from our work that the challenges for young people and CAMHS (both inpatient and community) in the lack of IPCU provision is significant. We are also concerned about the potential impact on the function of the planned NSAIS without specialist IPCU provision in place.

Young people admitted to non-specialist facilities by NHS board, by year 2010-18

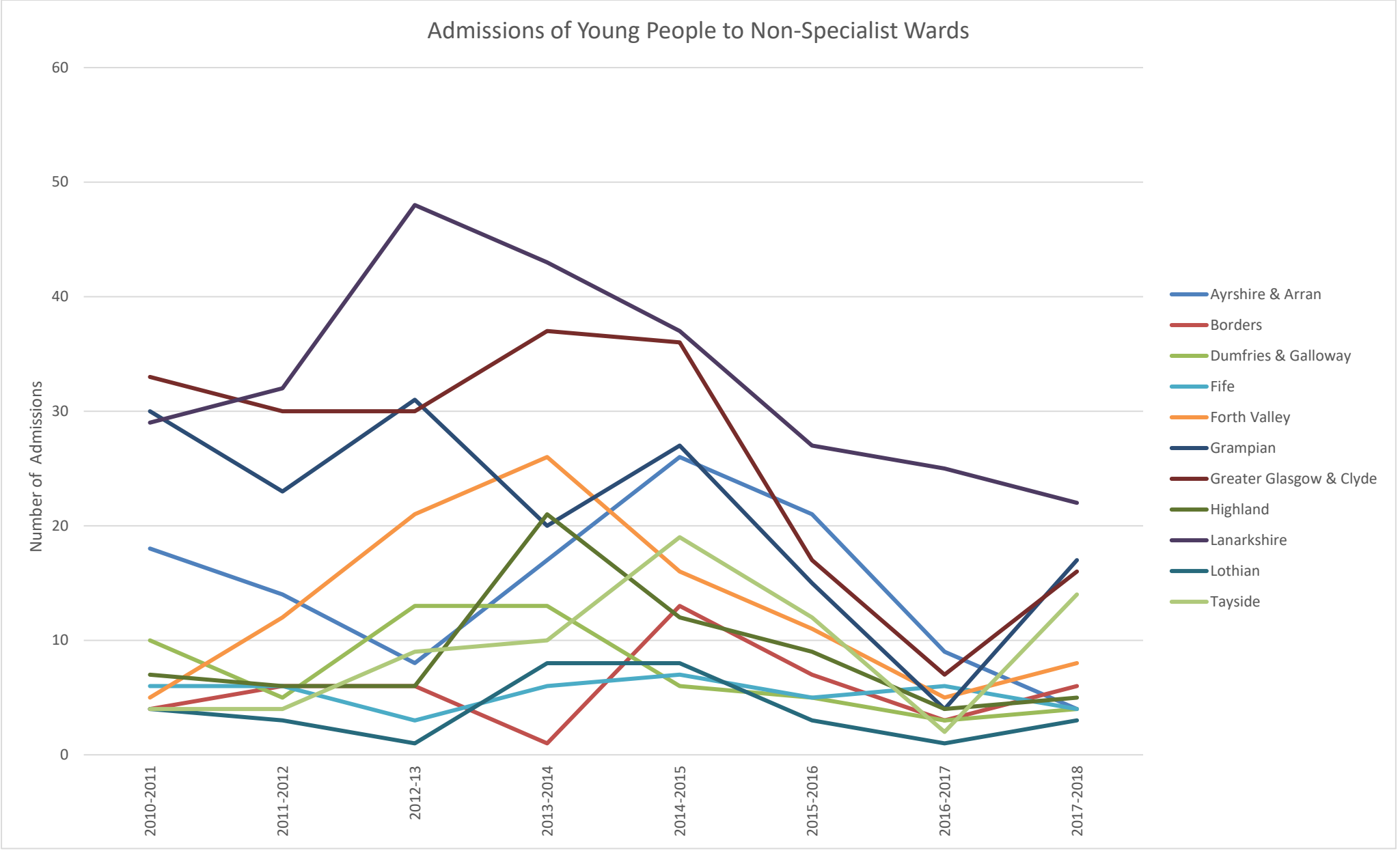
Table 3 Young people admitted to non-specialist facilities by NHS board, by year 2010-18

Health Board	2010-11		2011-12		2012-13		2013-14		2014-15		2015-16		2016-17		2017-18	
	Admissions	Young People Involved	Admissions	Young People Involved	Admissions	Young People Involved	Admissions	Young People Involved	Admissions	Young People Involved	Admissions	Young People Involved	Admissions	Young People Involved	Admissions	Young People Involved
Ayrshire & Arran	18	16	14	11	8	8	17	15	26	21	21	17	9	8	4	4
Borders	4	3	6	6	6	5	1	1	13	6	7	7	3	3	6	4
Dumfries & Galloway	10	7	5	4	13	10	13	9	6	6	5	5	3	3	4	3
Eilean Siar (Western Isles)	0	0	0	0	0	0	0	0	1	1	1	1	1	1	0	0
Fife	6	6	6	6	3	3	6	5	7	4	5	5	6	6	4	4
Forth Valley	5	5	12	10	21	19	26	25	16	15	11	9	5	5	8	8
Grampian	30	23	23	17	31	22	20	17	27	23	15	12	4	4	17	14
Greater Glasgow & Clyde	33	27	30	23	30	24	37	34	36	30	17	16	7	7	16	14
Highland	7	7	6	5	6	6	21	19	12	11	9	8	4	4	5	4
Lanarkshire*	29	25	32	27	48	40	***43	***38	37	34	27	24	25	22	22	19
Lothian	4	4	3	3	1	1	8	7	8	8	3	1	1	1	*3	*3
Orkney	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Shetland	0	0	0	0	0	0	0	0	0	0	2	2	0	0	0	0
State	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0
Tayside	4	4	4	3	9	9	10	9	19	17	12	11	2	2	14	12
Independent (Ayr Clinic)**													1	0		
Scotland	**150**	**127**	**141**	**115**	**177**	**148**	**202**	**179**	**207**	**176**	**135**	**118**	**71**	**66**	103	90

*****We were informed that one admission to NHS Lothian was an out-of-area admission from NHS Greater Glasgow and Clyde (2017-18).

** Ayr Clinic shown as independent rather than included in NHS Ayrshire and Arran figures. This admission followed a preceding admission to a non-specialist ward in Scotland. It is therefore not included in the individual data due to the young person being counted already elsewhere.

*** We were informed that one admission to NHS Lanarkshire was an out-of-area admission from NHS Greater Glasgow and Clyde (2013-14).


Admissions of Young People to Non-Specialist Wards
Number of Admissions
60
50
40
30
20
10
0
2010-2011
2011-2012
2012-13
2013-2014
2014-2015
2015-2016
2016-2017
2017-2018
Ayrshire & Arran
Borders
Dumfries & Galloway
Fife
Forth Valley
Grampian
Greater Glasgow & Clyde
Highland
Lanarkshire
Lothian
Tayside

Our interest in these figures

Reflecting the requirements of the Mental Health Act on Health Boards in relation to the provision of child inpatient care and the Act's clear principle that the child's welfare should be most important in framing service response, the Commission's view is that when a young person requires inpatient treatment their individual clinical needs should be given paramount importance. When comparing admissions to non-specialist facilities by NHS board area, we look to see whether there have been significant changes in the number of admissions within a specific area compared with the previous year.

There continue to be differences in the configuration of CAMHS across the country with varying eligibility criteria for young people for CAMHS versus Adult Mental Health depending on their age and educational status. The Scottish Government had intended that by the end of 2015 all CAMHS in Scotland would reconfigure to provide services for all children and young people up to the age of 18. However this has not happened everywhere in Scotland, and some CAMHS continue to provide mental health services for children and young people under the age of 16 years and only for young people between the ages of 16 and 18 years who are in full-time education. This difference in service configuration can affect the numbers of young people admitted to non-specialist wards. In the Commission's 2016 additional monitoring exercise[18], we learned that those young people aged between 16 and 18 who were not in full-time education, and therefore looked after ordinarily by general adult mental health teams, were unlikely to access a specialist adolescent bed when admitted to hospital due to continuity and consistency issues for the local adult psychiatric team. We know of no further changes to CAMHS eligibility criteria and populations since last year's report and so this factor will still have an impact on non-specialist admissions in some health board areas over the past year (for example Lanarkshire).

In our report two years ago we made a recommendation that hospital managers of the regional adolescent inpatient units should review admission procedures for all new referrals out of hours and at the weekend[19]. We are aware that access to beds within some adolescent units can vary depending on the location of a young person in out of hours/weekend periods. We had been told that work in relation to this question was ongoing but the difference in accessibility of young people to some specialist beds might impact on admission figures for some health board areas. Following enquiries with services we have recently been told that this work has not progressed further.

[18]Young Person Monitoring 2015-2016. October 2016.
http://www.mwcscot.org.uk/media/343729/young_person_monitoring_report_2015-16.pdf

[19] Young Person Monitoring 2015-2016. October 2016.
http://www.mwcscot.org.uk/media/343729/young_person_monitoring_report_2015-16.pdf

Recommendation 1: Hospital managers of the regional specialist adolescent units should continue to review admission procedures to establish whether access to the unit can be improved for all new referrals out of hours and at the weekend. The Scottish Government should include this activity under Action 19 of the Mental Health Strategy 2017-2027 to ensure there is a framework to support its progression.

In April 2015, we began collecting data relating to the duration of stay of young people in non-specialist settings. We wanted to see how long young people remained in non-specialist wards. We have been aware, from our monitoring activity and from our visits to young people, that lengths of stay in non-specialist environments can vary considerably.

What we found

Figures in Table 3 compare admissions to non-specialist inpatient mental health beds for young people up to the age of 18 years by NHS board area from 2010-11 to 2017-18. This year, admission numbers for each NHS board areas in Scotland have varied widely with some experiencing similar numbers to recent years (Dumfries and Galloway, Borders, and Lothian) and others experiencing higher levels once again (Tayside, Grampian, and Greater Glasgow and Clyde). What is clear from the figures is that a single year's figures are difficult to interpret and several years of data collection is required in order to be able to make conclusions about trends with confidence.

West of Scotland

Health boards involved in the West of Scotland network (NHS Dumfries and Galloway, NHS Ayrshire and Arran, NHS Greater Glasgow and Clyde, NHS Lanarkshire, and NHS Forth Valley) refer into Skye House, a 24-bedded specialist adolescent unit based in Stobhill Hospital, Glasgow.

East of Scotland

The Young People's Unit is a 12-bedded unit in the Royal Edinburgh campus in Edinburgh and receives admissions of young people from NHS Lothian, NHS Borders, and NHS Fife.

North of Scotland

The five health boards in the North of Scotland, which includes NHS Highland (excluding Argyll and Bute), NHS Grampian, NHS Tayside, NHS Shetland, and NHS Orkney, are all involved in the North of Scotland CAMHS Tier 4 Network. Dudhope House in Dundee is a purpose built 12-bed unit which opened in 2015, doubling the number of specialist beds available for these five health board areas from six.

Length of stay in non-specialist wards 2017-18

Table 4 Length of stay in non-specialist wards 2015-18

Length of Stay*	2015-16	%	2016-17	%	2017-18	%**
1-3 days	36	27%	25	35%	30	29%
4-7 days	28	21%	17	24%	23	22%
8-14 days	28	21%	8	11%	20	19%
15-21 days	13	10%	4	6%	11	11%
22-28 days	11	8%	7	10%	3	3%
29-35 days	7	5%	3	4%	2	2%
36 days or more	12	9%	7	10%	14	14%
Total	**135**	**100%**	**71**	**100%**	103	100%

Mean (days)	15		19		19	
Median (days)	8		6		6	
Mode (days)	2		3		2	

*The Commission collects data on admissions that are 24 hours and above.
** Base = 103 admissions

This is the third year that we have reported on the length of stay (LOS) of admissions of young people to non-specialist wards. The LOS is the amount of time that a young person remained in a non-specialist ward. When we calculate this data we only count days that a young person has remained in a non-specialist ward during the reporting year (so the maximum stay length could only be 365 days). As a result this data if anything may slightly under report the length of stay in a small number of admissions which have continued after 31st March 2018. We also do not count the days in a non-specialist ward once the young person turns 18. We want to capture data reflecting length of stay because we are aware from our visiting work during the year that length of stay can vary considerably for some young people, and a small but significant minority of young people are looked after for long periods of time on wards which are not designed for their needs. We believe that length of stay, together with standards of care provided while a young person is looked after in a non-specialist environment, are important quality issues to consider alongside the overall numbers of young people admitted to non-specialist wards nationally.

The majority of admissions continue to be short in length (53 admissions or 51% are for seven days and under). However, sizable numbers of young people remain inpatients in a non-specialist environment for longer periods (50 admissions or 49% last over seven days, 30 admissions or 30% last over two weeks, 19 admissions or 19% last over three, and 14 or 14% last over five weeks). Of these admissions many involved young people for whom there was no national provision of inpatient beds for their age group and mental health needs.

In longer admissions of young people to non-specialist wards, it is very important that the young person has access to a range of CAMHS specialist care relevant to their needs and provided by differing professional groups as appropriate. While a small majority of admissions are less than one week in length, this still represents a considerable amount of time for young people in a non-specialist environment, many of whom have never been in hospital before.

The length of a small number of very long admissions is reflected in the average length of stay calculated. The mean LOS is 19 days, while the median is shorter at six days. The most frequent (modal) length of stay was two days.

Specialist health care for admissions of young people in non-specialist care, 2017-18

Table 5 Specialist health care for admissions of young people in non-specialist care, 2017-18

Specialist medical provision	Age 0-15	Age 16-17	All	*%
RMO at admission was a child and adolescent specialist	12	24	36	41
Nursing staff with experience of working with young people were available to work directly with the young person	14	34	48	54
Nursing staff with experience of working with young people were available to provide advice to ward staff	21	55	76	85
The young person had access to other age appropriate therapeutic input	14	22	36	41
None of the above	0	2	2	2
Total admissions*	**21**	**68**	**89**	**100**

***** Base = 89, all admissions where further information was provided; percentages may sum to more than 100% as more than one type of specialist medical provision might be provided at any one admission.

Our interest in these figures

When a young person is admitted to a non-specialist ward, it is important that NHS boards fulfil their duties to provide appropriate services. To enable us to monitor how this duty is being fulfilled, we continue to ask RMOs to provide us with more detailed information once we have been notified of an admission. Some of the information we request is summarised in the table above.

Each year, we specifically want to see whether specialist child and adolescent services input is available, to ensure that appropriate care and treatment is being provided to the young person, and that relevant guidance and support is available for staff in non-specialist units who will have less experience of providing treatment and support to young people. In the course of our visits, we have been made aware that access to specialist child and adolescent services when a young person is admitted to an adult ward varies across the country.

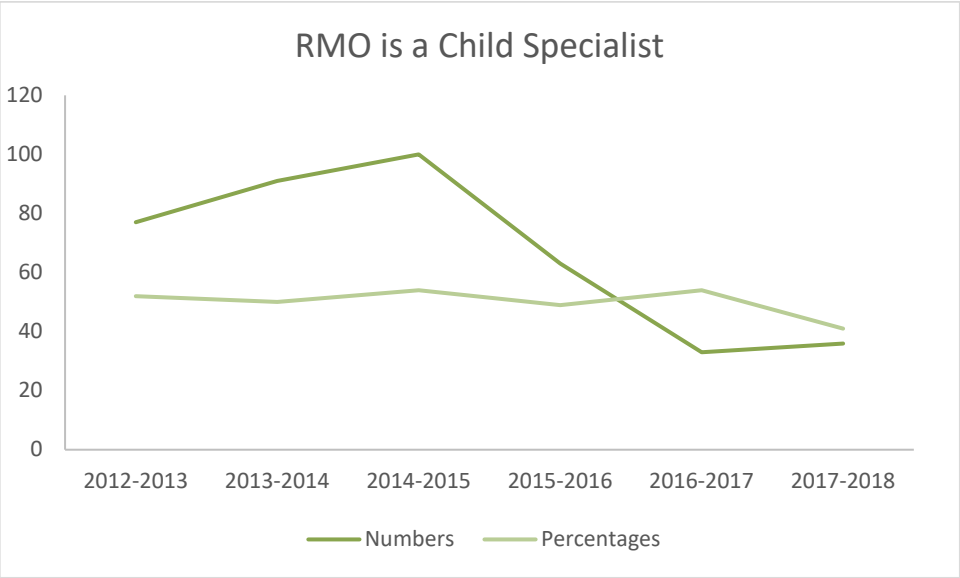
It is important that health boards remain focussed on the provision of appropriate care for this group of young people while in hospital and ensure that the care and treatment provided during their stay in a non-specialist environment reflects their clinical needs. In 2016 we drew attention in our monitoring report to the care standards that had been developed by the Royal College of Psychiatrists to establish a benchmark for care provided to young people in England and Wales while looked after in a non-specialist hospital

environment[20]. Scottish Government then included the development of admission protocol and care standards as part of its Mental Health Strategy Action 19 and commissioned the CAMHS Lead Clinician's group in Scotland to undertake this work. The Commission has been involved in supporting this work which will guide service provision nationally and provide clear standards against which care can be assessed. Any care standard which aims to help shape service design requires ongoing monitoring and audit work to become live and translate into meaningful experience on the ground. The Commission will take account of this in how we monitor admissions in future.

What we found

This year, there has been no substantial improvement in the percentages of young people with specialist care input from CAMHS staff during their admission to a non-specialist unit. The figures in the table above have changed little in recent years and we continue to have concerns about this. In some circumstances where an admission might be of very short duration, the provision of direct specialist clinical contact might not be as important as for stays of longer duration. However, even in short admissions, the task of liaison, communication, and co-ordination of care around discharge and discharge planning is crucial for young people presenting in crisis.

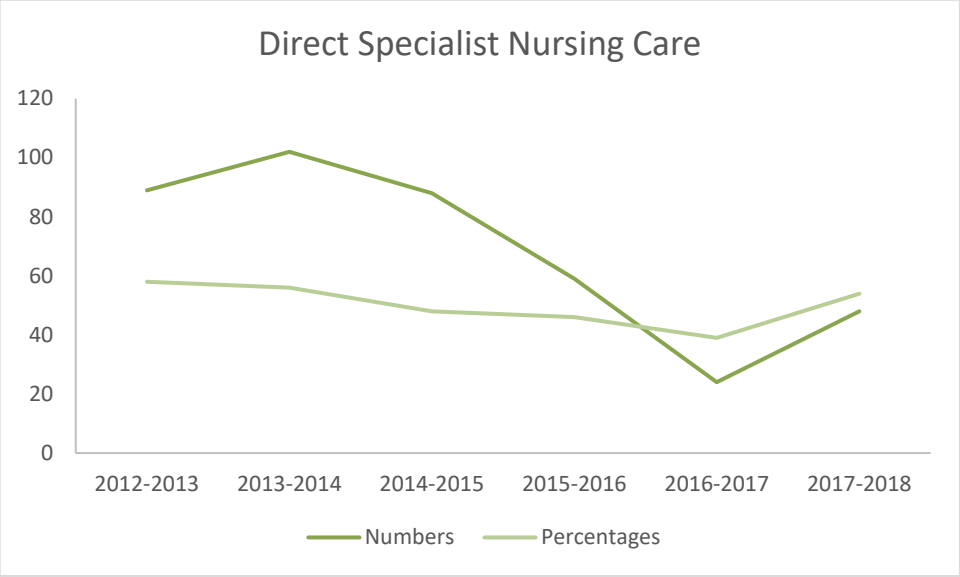
This year, the consultant in charge of a young person's care (or RMO) was a child and adolescent specialist in 36 (41%) of the 89 admissions we were given additional information about. This compares with 33 (54%) of the 61 admissions in 2016-17, 63 (49%) of the 129 cases in 2015-16, 54% of admissions (100 out of the 184 cases) in 2014-15, 50% in 2013-14 (91 out of 180 cases), and 52% (77 out of 147 cases) in 2012-13.



Data is based on the further information provided to the Commission and reported on annually.

[20] Young Person Monitoring 2015-2016. October 2016.
http://www.mwcscot.org.uk/media/343729/young_person_monitoring_report_2015-16.pdf

Once again, we have seen a large proportion of admissions where there has been no direct input from nurses experienced in working with children and adolescents. This year the figure was 48 (54%) of the 89 admissions we were given additional information about. This compares with the figure of 39% (24 out of 61 cases) in 2016-17, down from 46% (59 out of 129 cases) in 2015-16, 48% in 2014-15, 56% in 2013-14, and 58% in 2012-13. However the percentage of admissions where there have been nurses available with relevant CAMHS experience to provide advice to ward staff is slightly increased from last year at 85%, (76 out of 89 admissions we were informed about). This compares with 84% (51 out of 61 cases) in 2016-17, 78% (100 out of 129 cases) in 2015-16, 85% in 2014-15, 80% in 2013-14, and 76% in 2012-13.



Data is based on the further information provided to the Commission and reported on annually.

It is not clear whether difficulties in capacity in community CAMHS staff has impacted negatively on the availability of nursing staff to support non-specialist admissions of young people. We would have expected a higher proportion of direct input from nursing staff experienced in working with children and adolescents due to the expansion of intensive treatment services across the country. We will continue to monitor the impact of the increasing investment in intensive treatment provision that is occurring in many health board areas to see whether this will improve access to specialist nurses while a young person is an inpatient in a non-specialist ward.

This year, we report a decrease in the proportion of young people being able to access additional age-appropriate therapeutic input (36 out 89 admissions or 41%). This compares with 49% or 30 out of 61 cases in 2016-17, 38% or 49 out of 129 cases 2015-16, 59% in 2014-15, 51% in 2013-14, and 88% in 2012-13.

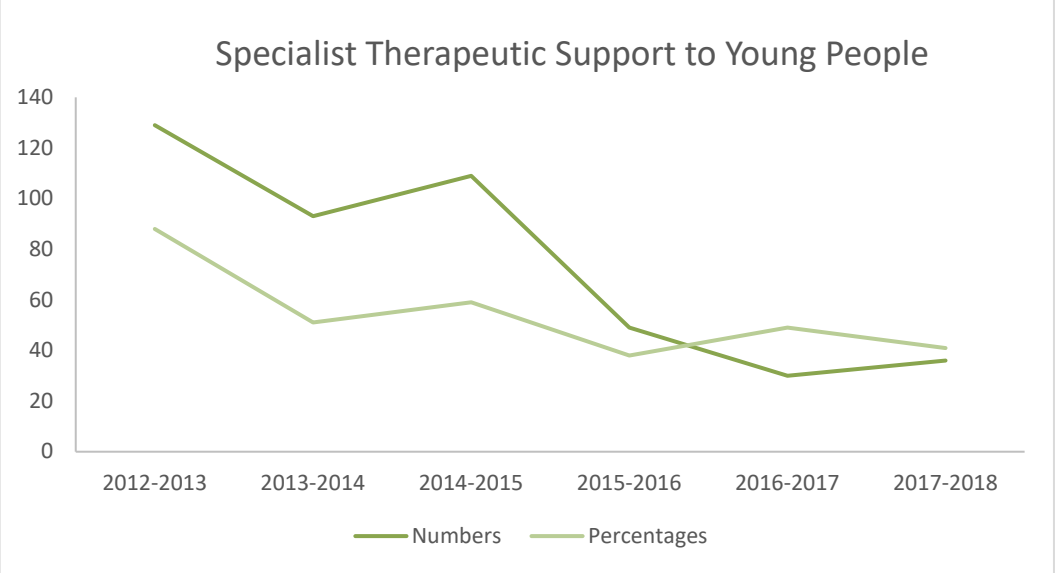
It is often not clear what factors influence whether a young person receives input from CAMHS whilst an inpatient. For those Health Boards where adult mental health services provide services for some 16-17 year olds, such young people would not be expected to

receive input from CAMHS while in hospital. Where admissions are very short or over a weekend, for example, specialist input may not be provided.

These factors do not explain many findings, however. This year, as in previous years, the provision of specialist care is inconsistent across non-specialist admissions. If we explore in more detail the 14 young people whose stay in a non-specialist environment extended beyond 35 days, six of these young people (43%) received no direct specialist nursing care during their stay, and four of these six (67%) were located in a health board where CAMHS were provided to the age of 18 years. Five out of the six young people (83%) received neither specialist therapeutic input nor direct specialist nursing provision during their stay. Not one of the six had a consultant in charge of care who was a child specialist (0%), although four were described as having a CAMHS consultant available for advice (67%).

Similarly of the 89 admissions that we obtained additional information about, 32 received neither direct nursing support nor specialist therapeutic input (32 out of 89 admissions, 36%). Of these 32 admissions, eight lasted between one and three days (eight out of 32, 25%), seven lasted between four and seven days (seven out of 32, 22%), seven lasted between eight and 14 days (seven out of 32, 22%), five lasted between 15-21 days (five out of 32 admissions 16%), and five lasted longer than 35 days (five out of 32, 16%). On the face of it these examples demonstrate inconsistencies in specialist CAMHS provision available to support a young person's care whilst in a non-specialist environment. It is not clear whether this data reflects the clinical needs of the young person or constraints within services to provide such input.

The provision of age appropriate multi-disciplinary therapeutic input for young people remains an area of interest to the Commission and we will continue to monitor this closely, both in terms of our monitoring activities and also in terms of our visits to young people in non-specialist wards.



Data is based on the further information provided to the Commission and reported on annually.

Social work provision for admissions of young people to non-specialist care, 2017-18

Table 6 Social work provision for admissions of young people to non-specialist care, 2017-18

Social work provision	Age 0-15	Age 16-17	All	*%
Young person was looked after and accommodated by the local authority	5	9	14	16
No information	1	4	5	6
Young person had access to social work	14	43	57	64
No information	1	3	4	5
Total*	**24**	**73**	**89**	**100**

*Total = 89, based on all admissions where further information was provided to the Commission.

Our interest in these figures

Many young people admitted to a non-specialist facility will have had no prior involvement with social work services, but our expectation would be that if social work input is felt to be necessary at the time when an admission is being considered, or after admission, there should be clear local arrangements to secure that input.

We have an interest in the provision of services to looked after children. A young person is described as being 'looked after and accommodated' if, under the provisions of the Children (Scotland) Act 1995, they are under the care of their local authority and either subject to a supervision requirement and looked after at home, or looked after away from home in foster or kinship care, a residential care home, a residential school, or secure young people unit.

There is evidence that such children generally experience poorer mental health and there is now a national requirement that NHS boards ensure that the health care needs of looked after children are assessed and met, including mental health needs[21]. The Guidance on Health Assessments for Looked after Children and Young People[22] emphasises that mental health problems for looked after young people are markedly greater than for their peers in the community. In the recent Mental Health Strategy 2017-2027[23] Action 5 addresses particular issues "for young people on the edges of and in secure care" and seeks to ensure mental health needs are considered in the pathway of care for these children and young people. We have been collecting information about young person's admissions to non-

[21] Action 15 Looked After Children and Young people: We can and must do better. January 2007 https://www2.gov.scot/resource/doc/162790/0044282.pdf

[22] The Scottish Government (28 April 2009) CEL16 http://www.sehd.scot.nhs.uk/mels/CEL2009_16.pdf

The Scottish Government (2014) *Guidance on Health Assessments for Looked After Children and Young People in Scotland* http://www.gov.scot/Resource/0045/00450743.pdf

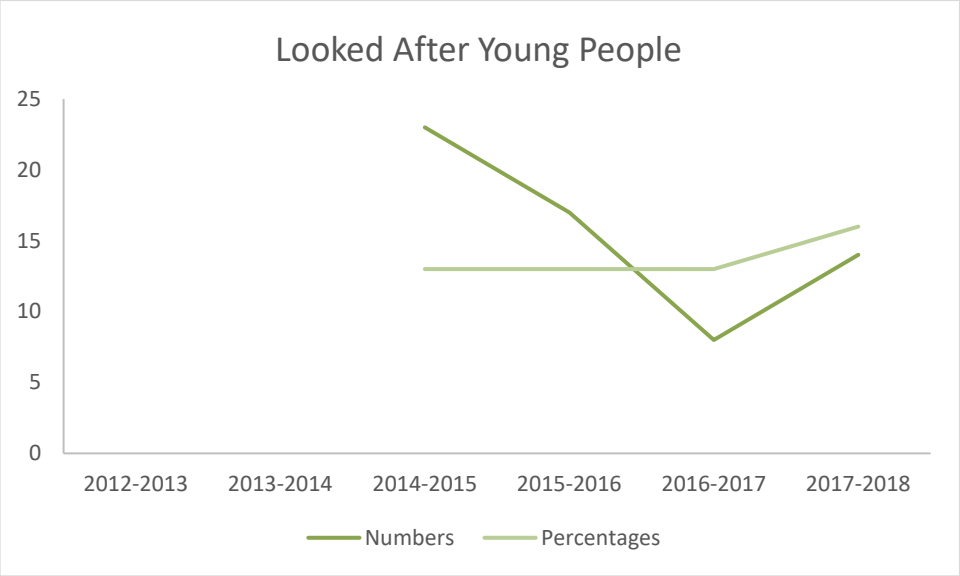
[23] Mental Health Strategy. March 2017. http://www.gov.scot/Publications/2017/03/1750

specialist wards and whether they are ‘looked after and accommodated’ since 2014. We would assume that any looked after young person admitted to a non-specialist facility should have an identified social worker.

What we found

In 2017-18, 57 or 64% of the 89 admissions that we were given additional information about had access to a social worker. This compares with 77% (47 out of 61 cases) of young people in 2016-17, 71% (91 out of 129 cases) of young people in 2015-16, 74% in 2014-15, 76% in 2013-14, and 74% in 2012-13.

This year of the 89 admissions where further information was provided to the Commission, we were told that in 14 (16%) of cases that these young people were ‘looked after and accommodated’. This compares with 13% (eight out of 61 cases) in 2016-17, 13% (17 out of 129 cases) in 2015-16, and 13% of young people in 2014-15 (23 cases out of 184). Of the 14 young people this year, five were aged 15 or under and nine were aged 16 to 17 years.



Data is based on the further information provided to the Commission and reported on annually. Data not collected prior to 2014.

When we looked at the admissions of young people who are ‘looked after and accommodated’ we found that a high proportion of these admissions involved IPCU facilities (seven admissions out of 14, 50%). This is a much higher percentage than those young people who were not looked after. Also, four of the 14 admissions involving young people who were looked after involved young people who had an identified learning disability. Four of the 14 admissions (29%) lasted longer than five weeks and eight (57%) lasted more than a week.

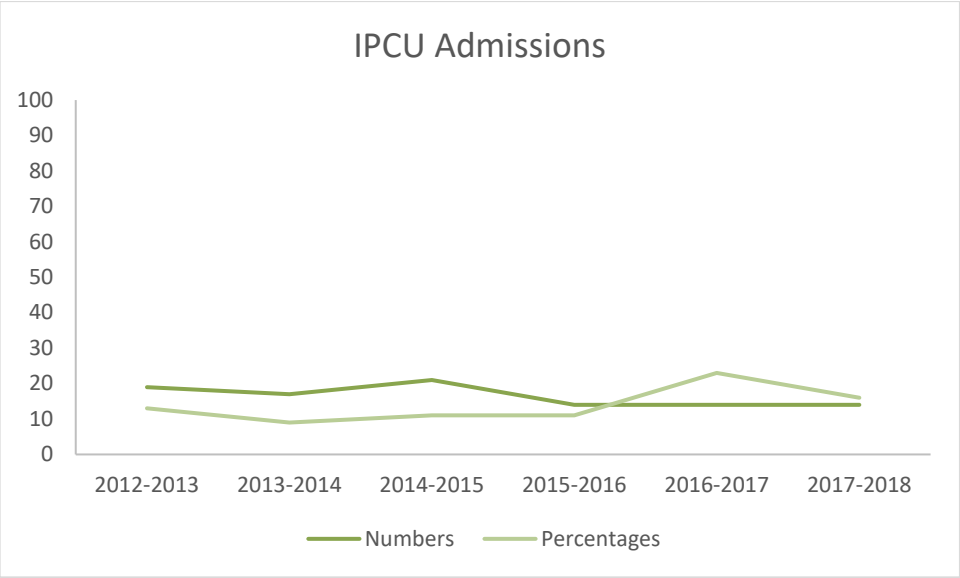
Supervision of young people admitted to non-specialist care, 2017-18

Table 7 Supervision of young people admitted to non-specialist care, 2017-18

Supervision arrangements	Age 0-15	Age 16-17	All	%**
Transferred to an IPCU or locked ward during the admission*	5	9	14	16
Accommodated in a single room throughout the admission	16	52	68	76
Nursed under constant observation	14	42	56	63
Constant observation because of ward policy	12	28	40	45
Constant observation following an individual assessment of the young person	16	47	63	71
Total**	**21**	**68**	**89**	**100**

***This is taken from information recorded on the forms.

****Total = 89, based on all admissions where further information was provided to the Commission; percentages may sum to more than 100% as more than one of the above arrangements may apply.



Data is based on the further information provided to the Commission and reported on annually.

Our interest in these figures

We ask for specific information about the supervision arrangements for young people admitted to non-specialist facilities to enable us to monitor whether the need for heightened observation is being carefully considered. We will try to arrange a visit if the young person is particularly vulnerable, to look at the care and support arrangements in place.

What we found

This year 14 of the 89 admissions (16%) where further information was supplied to the Commission were cared for in an IPCU or locked ward during admission. This contrasts with 14 young people (23%) last year, 14 in 2015-16 (11% of 129 cases), 21 (11% of 184

admissions) in 2014-15, 17 (9% of 180 admissions) in 2013-14 and 19 (13% of 147 admissions) in 2012-13. The actual number of young people requiring IPCU facilities this year is comparable with previous years. Five out of the 14 young people admitted to an IPCU were under the age of 16. This is similar to previous years, when the proportion of the young people admitted to an IPCU or locked ward under the age of 16 has been around 25%.

We remain concerned about the numbers of young people whose care necessitates the use of secure facilities and, because of a lack of a specialist adolescent provision, have to be cared for in an adult IPCU or locked ward environment. We are also concerned that, because of the lack of any IPCU beds in Scotland for the under-18 population, some young people have to be cared for with significant restrictions in place in an attempt to manage risk on an open ward; a situation which may prove to be unsuitable for the young person and the other patients on the ward. The figures shown are likely to underrepresent the number of young people whose care needs indicate the need for IPCU facilities. We are aware of cases where an IPCU environment was indicated by the young person's needs but access to one was not possible. As a result the figures reflect the number of young people who were able to access an IPCU, not the number of young people whose care needs indicated one. This contrasts with adult services where the range of routine facilities available include both open ward and IPCU facilities. Concerns continue to be expressed to us by clinicians regarding this situation.

Adult IPCU facilities are specialised environments designed to help care for adults when they are very unwell and present with high levels of risk either to themselves or others. Adult IPCU facilities are also used routinely to provide care for adults who are in the criminal justice system due to the security of the environment. The lack of specialist adolescent IPCU service provision and the lack of clear pathways around access to adult IPCU facilities can add significant difficulties for the young person and their clinical team when a bed for the young person within a secure hospital environment is required. Issues around difficulty accessing IPCU facilities adds complication at a time when there is often clinical urgency and challenge anyway about the availability of appropriate care for the young person. Clinicians have told us that the issue of young people experiencing difficulty in accessing IPCU facilities appears to be especially problematic when the young person is under the age of 16 or if the patient is female. Concerns about the young person's vulnerability in an IPCU can be heightened when a young person is under 16 years of age.

We are aware that this issue of young people being able to access IPCU facilities has arisen in the past at various different strategic levels. Most recently, during the early planning stage of the National Secure Adolescent Service, the lack of adolescent IPCU provision in Scotland was raised and we have been told that it was agreed that the issue of IPCU access for the under 18s would be addressed regionally. It remains a concern therefore to learn that there has been no substantial movement in the area. At the most recent CAMHS Lead Clinicians Group in October 2018 the matter was raised by the Commission and we were told that, other than initial scoping exercises which indicated that

there were insufficient numbers to merit a separate unit for each region, there has been no forward movement on the issue. Additionally no work has been undertaken to explore the development of agreed pathways for accessing IPCU provision for young people in Scotland. Action 20 of Scottish Government's current Mental Health Strategy states the ambition to "scope the required level of specialist mental health inpatient services for young people in Scotland and act on its findings." Thus far the focus has been on exploring the need for Medium Secure Forensic Facilities as part of the National Secure Adolescent Service and inpatient services for young people with Learning Disability. We are concerned that without further support the issue around the lack of IPCU provision for young people will remain unresolved.

Recommendation 2: The Scottish Government should include the provision of nationwide IPCU facilities for young people under the age of 18 in Scotland as part of Action 20 of its Mental Health Strategy. Work should be undertaken in partnership with the regional CAMHS Tier IV networks to address this issue. Part of this activity should be to develop mutually agreed pathways to ensure that young people requiring IPCU facilities have timely access to these environments when required.

We continue to monitor the use of enhanced observation levels and the use of single rooms for young people admitted to non-specialist environments. We are aware of many health boards having policies in place stating that young people should be cared for in a single room whilst an inpatient in a non-specialist environment, and be placed on enhanced observation levels for the duration of their stay. This year, the number of young people cared for within a single room is 76% (68 out of 89 cases) which is comparable to figures in recent years. We are aware from our visits that awareness and implementation of policies relating to single rooms and enhanced observation levels to promote the safeguarding of young people on non-specialist wards seems to be well established.

Other care provision for young people, 2017-18

Table 8 Other care provision for young people, 2017-18

Other provision	Age 0-15	Age 16-17	All	*%
Access to age-appropriate recreational activities	12	33	45	49
Educational materials were provided	0	1	1	1
Access to advocacy service	10	50	60	67
Has access to specialist advocacy service	3	13	16	18
Young person has a learning disability	2	5	7	8
Total*	**21**	**68**	**89**	**100**

*Total=89, based on all admissions where further information was provided to the Commission; percentages may sum to more than 100% as more than one of the above supervision arrangements may apply.

Our interest in these figures

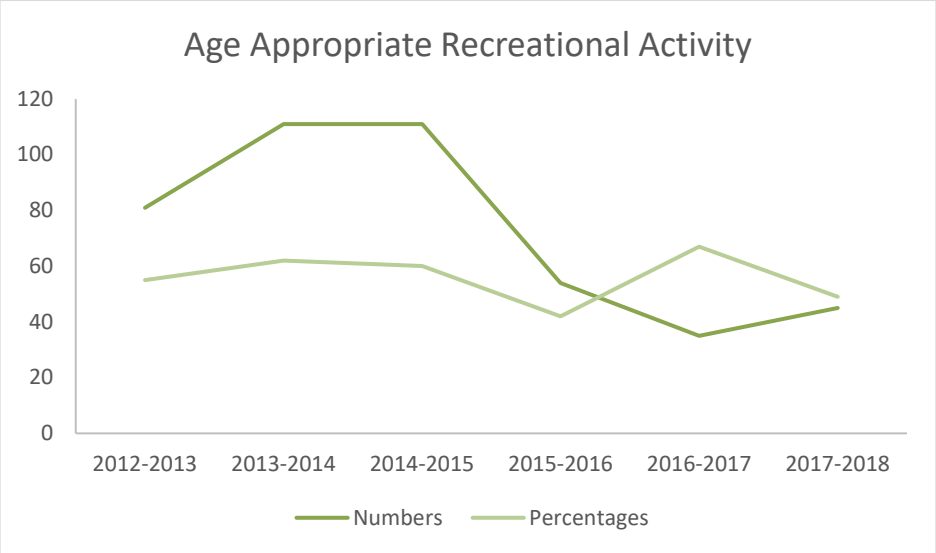
We are aware that a large proportion of admissions are for very short periods of time, and so access to appropriate recreational activities and education may not be significant for many young people. However, for longer admissions this area of service provision can be very important. We want to know if independent advocacy services are readily available, given the important role advocacy can play in ensuring that a young person's views are heard and the right that anyone with significant mental illness has in being able to access this service.

As a result of the 2015 amendments to the 2003 Mental Health Act, health boards have new responsibilities to demonstrate how they are discharging their legal responsibilities in relation to advocacy. The Commission has a role in reviewing this information to ensure that independent advocacy services are available and accessible for individuals with significant mental illness in each health board area.

We also want to know how many young people with a learning disability are admitted to non-specialist facilities. As mentioned earlier in this report there are ongoing concerns about the lack of appropriate services for young people who have significant learning disabilities and require inpatient admission for assessment and/or treatment, particularly where there are significant problems with challenging behaviour.

What we found

This year the proportion of admissions where a young person was described as having access to age-appropriate recreational activity unfortunately has dropped to 49% (45 out of 89 cases). This compares to 67% (35 out of 61 cases) in 2016-17, 42% (54 out of 129 cases) in 2015-16, 60% (111 cases out of 184) in 2014-15, 62% in 2013-14 (111 out of 180 cases), and 55% (81 out of 147 cases) in 2012-13.



Data is based on the further information provided to the Commission and reported on annually.

Each year we ask for information about the activities that young people had access to while they were receiving care and treatment as inpatients. Many young people are reported to have access to electronic games (including their phones, Xboxes or other equipment), and to music and DVDs. Access to physical activities, including gyms, is also mentioned for some young people. Interestingly, unlike in some specialist adolescent units, young people in non-specialist hospital wards are often allowed to keep their mobile phones. Whilst this provides them with possibilities of accessing music and games more easily it does raise concerns of the young person accessing inappropriate social media at times which may be unhelpful during times of crisis. From previous reports we have suggested that, even when admitted for a relatively short space of time, staff should give enough attention to structuring daily activity for young people with clear documentation regarding appropriate activities available to a young person (taking account of the young person's views) and how these can be provided[24].

Once again a majority of young people were reported as having access to advocacy during admission this year: 67% (60 cases out of 89 in which additional information was gathered) which compares with 61% (37 out of 61 cases) in 2016-17, 65% (84 out of 129 cases) in 2015-16, 72% in 2014-15, 65% in 2013-14, and 70% in 2012-13. Of the young people who had access to advocacy during an admission, 18% (16 out of 89 cases) had access to specialist advocacy services which compares with 20% (12 out of 61 cases) in 2016-17, 17% (22 out of 129 cases) in 2015-16, and 29% (38 out of 184 cases) in 2014-15. This result remains disappointing. We expect advocacy support to be available and to be routinely offered to young people. It may be that during a very brief admission there is no time to involve advocacy to support a young person. However, the findings from our monitoring project described in 2016 raised concerns about the accessibility of advocacy supports during young people's admissions to non-specialist wards[25].

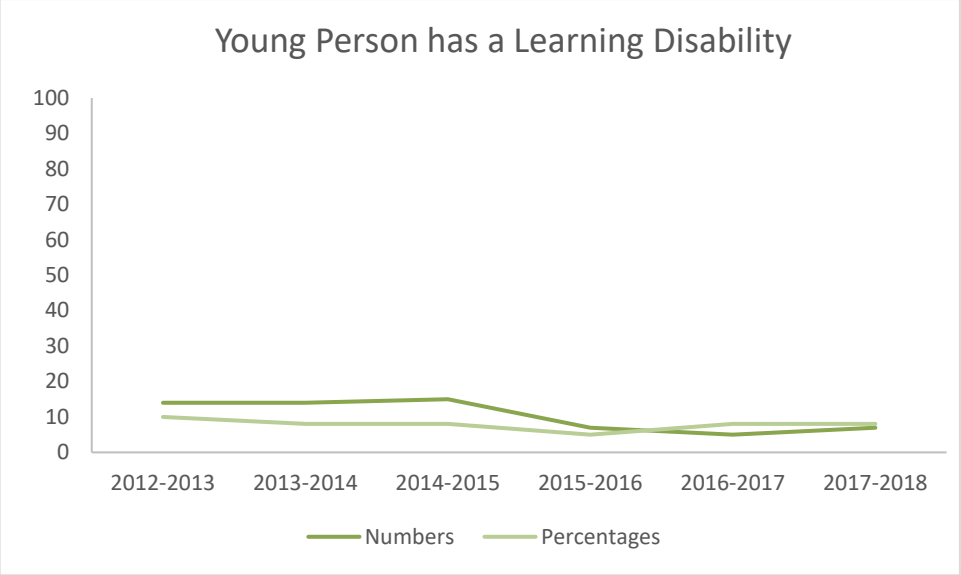
As part of our routine monitoring activity, we ask RMOs whether access to education has been discussed with the young person and, if not, to give reasons why. If education has been discussed with a young person, we ask whether education has been provided. This year 16 of the 89 admissions that we gained additional information about had education discussed during their inpatient stay (18%) which contrasts with 16 of the 61 (26%) in 2016-17. Five per cent of cases had education discussed and provided in 2015-16 figures with the figure 9% of young people in 2014-15. Only one young person was, however, provided with educational materials during their stay this year. The remainder were described as being too unwell, the admission too short, or the younger person was no longer in education or had not been in education due to their difficulties. We know that it may not be appropriate to discuss access to education or learning if an admission is for a very short period of time, during a weekend or school holidays, or when the young person is no longer

[24] Young Person Monitoring 2015-2016. October 2016.
http://www.mwcscot.org.uk/media/343729/young_person_monitoring_report_2015-16.pdf
[25] Young Person Monitoring 2015-2016. October 2016.
http://www.mwcscot.org.uk/media/343729/young_person_monitoring_report_2015-16.pdf

in education. Sometimes a young person may be too unwell for education to be considered appropriate. Young people accessing education remains a fragile area of service provision, however, when a young person has been admitted to a non-specialist facility. Some of the responses we receive indicate there is confusion about this issue and we have made a specific recommendation about this issue in a previous themed visit report[26]. We remain concerned that in the absence of specialist CAMHS or social work input, staff in adult wards may not know how to access education services, if this is appropriate, while a young person is in hospital. As we have said in previous reports, education authorities have a duty to arrange for the education of young people who cannot attend school because of prolonged ill-health; we do think it is important that education needs are met when a young person is in an adult ward for a prolonged period.

The number of admissions to non-specialist settings where additional information was obtained and the young people had a learning disability this year was seven out of 89 admissions (8%). This compares with previous year's figures of five out of 61 admissions (8%), seven out of 129 (5%) in 2015-16, 8% (15 admissions out of 184) in 2014-15, 8% in 2013-14, and 10% in 2012-13. Of the seven admissions this year only two (29%) were for less than seven days, four were more than 14 days (57%), and two for more than five weeks (29%). Of the seven admissions, two were looked after in an IPCU during their stay (29%). We have ongoing concerns about the lack of appropriate services for young people who have significant learning disabilities and require inpatient admission. We are aware of a small number of young people who have to transfer to specialist facilities outside Scotland for this reason. In some cases, we are aware that NHS boards go to considerable lengths to try to put a specific service in place locally to meet the needs of these young people. Work is currently being undertaken at national level to review the lack of specialist CAMHS learning disability beds, and we hope that this will lead to the development of an appropriate service in Scotland. In the meantime we will continue to monitor such admissions and to visit these young people to look at how care and treatment are provided when we feel this is appropriate.

[26] Visits to young people who use mental health services: Report from our visits to1 young people using in-patient and community mental health services in Scotland 2009 (2010)
http://www.mwcscot.org.uk/media/53171/CAMHS_report_2010.pdf



Data is based on the further information provided to the Commission and reported on annually.

Age of young person, by gender 2015-18

Table 9 Age of young person, by gender

	2015-16			2016-17			2017-18		
Age at last birthday (years)	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**
12 and under	3	0	3	3	0	3	1	1	2
13	2	0	2	1	1	2	1	0	1
14	5	2	7	1	0	1	7	3	10
15	6	3	9	2	4	6	9	3	12
16	21	20	41	10	6	16	12	12	24
17	26	30	56	20	18	38	21	20	41
Total*	**63**	**55**	**118**	**37**	**29**	**66**	**51**	**39**	**90**

***Base= all individuals admitted over the year, including where no further information was supplied to the Commission

Figure 2 Young people admitted by gender (number of individuals), by year 2008-18

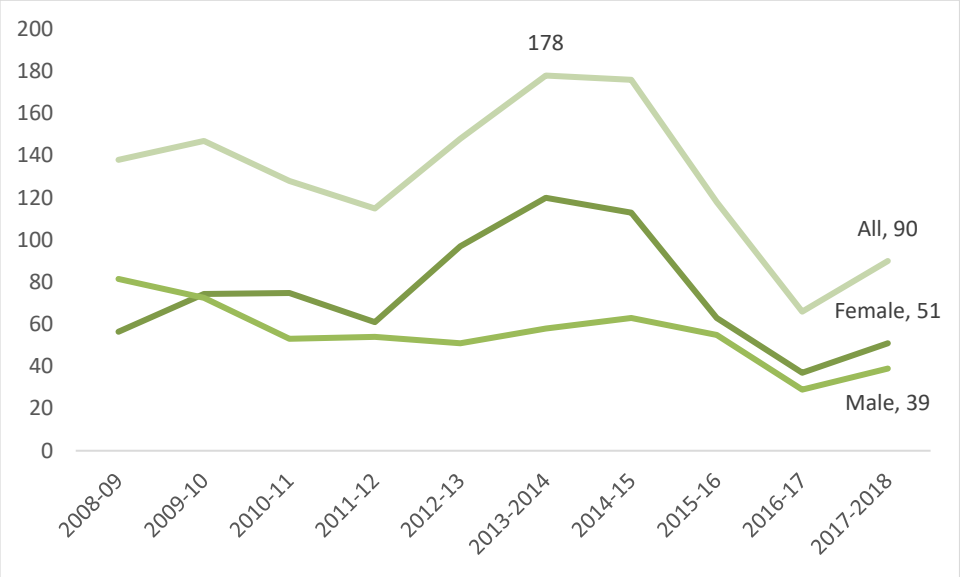
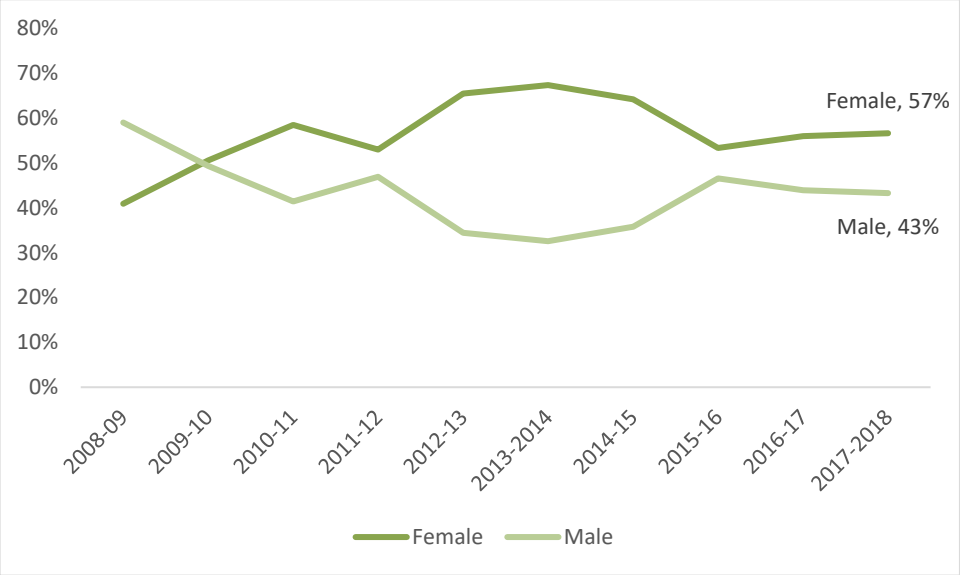


Figure 3 Young people admitted by gender (%), by year 2008-18



Our interest in these figures

We are interested in the age and gender of young people admitted to non-specialist settings and any trends that develop over time. Locally services need to consider arrangements to meet the need and any specific issues related to a young person's age and/or gender.

What we found

In 2017-18 there were a total of 103 admissions of young people under the age of 18 to non-specialist wards, which involved 90 people. Since we began to gather data on the admissions of young people into non-specialist mental health beds, the Commission has identified early trends in admissions across the age range and in both females and males. In recent years the age range of admissions to non-specialist wards continued to expand, and children under the age of 10 were being admitted to non-specialist wards in 2014-15 and 2013-14. Last year the trend did not continue, but this year once again an admission of a child under the age of 12 occurred to a non-specialist environment.

In 2017-18 the proportion of 16 and 17-year-old young people admitted was 65 out of 90 young people (72%), and compares with 54 out of 66 (82%) of the admissions in 2016-17, 82% in 2015-16 (97 out of 118 cases), 69% in 2014-15, 65% in 2013-14, and 62% in 2012-13.

Conclusion

This year's report documents less positive results than last year in terms of overall numbers of admissions but still represents an improvement overall from previous years; albeit with the caveat that there is variation from Health Board to Health Board. We welcome the ongoing commitment from Scottish Government to scope the inpatient provision for young people with forensic needs and young people with a learning disability and/or autism, but remain concerned at the lack of progress in the exploration of access to IPCU beds for young people during the course of their inpatient stay. We are also concerned about the ongoing level of services provided to young people while they are inpatients in a non-specialist environment. We hope that nationally agreed standards developed under Action 20 of the Mental Health Strategy will help support provision of consistent and appropriate levels of service.


npm
national
preventive
mechanism

Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE
Tel: 0131 313 8777
Fax: 0131 313 8778
Service user and carer
freephone: 0800 389 6809
enquiries@mwcscot.org.uk
www.mwcscot.org.uk