Report from visits to children and younger people who use mental health services

Report from our visits to young people using in-patient and community mental health services in Scotland 2009

mentalwelfare commission for scotland

1: Who we are and what we do

Who we are
The Mental Welfare Commission is an independent organisation working to safeguard the rights and welfare of everyone with a mental illness, learning disability or other mental disorder. Our duties are set out in mental health law.

We are made up of people who have understanding and experience of mental illness and learning disability. Some of us have a background in healthcare, social work or the law. Some of us are carers or have used mental health and learning disability services ourselves.

We believe that everyone with a mental illness, learning disability or other mental disorder should:

• be treated with dignity and respect;
• have the right to treatment that is allowed by law and fully meets professional standards;
• have the right to live free from abuse, neglect or discrimination;
• get the care and treatment that best suits his or her needs; and
• be enabled to lead as fulfilling a life as possible.

What we do
• We find out whether individual treatment is in line with the law and practices that we know work well.
• We challenge those who provide services for people with a mental illness or learning disability, to make sure they provide the highest standards of care.
• We provide advice information and guidance to people who use or provide mental health and learning disability services.
• We have a strong and influential voice in how services and policies are developed.
• We gather information about how mental health and adults with incapacity law are being applied. We use that information to promote good use of these laws across Scotland.

2: Our visits

Our duties to monitor and promote best practice in the legal, ethical and clinical aspects of care of individuals who have a mental illness, learning disability or other mental disorder are set out in Scottish mental health and incapacity law One of the key ways in which we deliver this duty is through making direct contact with people who use mental health and learning disability services. Seeing where a person lives, where he or she receives care and treatment, and hearing how he or she feels about that care and treatment, gives us an important insight into how law and policy impact on individual experience. We visit people in a range of settings throughout Scotland; at home, in hospital, or in any other setting where care and treatment is being delivered.

3: Policy context

The need for change in the way mental health services for children and young people are provided has been recognised for over eight years. In this period there have been a series of reports and policy initiatives which have made reference to or focused on child and adolescent mental health services (CAMHS) with the intention of providing direction and support for services and professionals working to meet the mental health needs of children and young people.

2003

Partnership for Care: Scotland's Health White Paper.

This white paper set out to promote a new approach to improve Scotland'sHealth and proposed a wide range of measures. It specifically stated that joint working was particularly important in improving mental health services, and that young people with mental health problems would be the first to benefit from a national approach to integrated workforce development.

SNAP Needs Assessment Report on Child and Adolescent Mental Health

This was an assessment of the mental health of Scotland's children and young people. The report suggested that mental health problems were on the increase and highlighted the need to address the continuum of mental health – from preventing mental illness through effective mental health promotion, , to supporting, treating and caring for those children and young people experiencing mental health difficulties of all ranges of complexity and severity. It concluded that funding for CAMH services was not related to the level of need, that services were overstretched, and that there was "a significant mismatch between the level of mental health need and the capacity to work with that need". It identified a clear need to invest in and enhance the capacity of services.

2004

Psychiatric In-Patient Services for Children and Young People in Scotland: A Way Forward

This report, prepared by the Child Health Support Group, recommended a phased expansion of psychiatric inpatient services to 60 inpatient places for young people focussed around the three existing sites. The report also recommended that inpatient units should implement common admission criteria.

2005

The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care

This responded to the SNAP report by setting out recommendations for implementation, and providing a self assessment tool to be used by local agencies to support service planning and continuous improvement. It recommended that those commissioning mental health services for children and young people should consider the mental health needs of all young people under 18, in keeping with the provisions of the Children (Scotland) Act 1995. With regard to specialist CAMH services it concluded that there were significant shortages in the available workforce impacting on service capacity, and it also advocated the designation of one place within each psychiatric in- patient facility for emergency admissions of young people.

Mental Health (Care and Treatment) (Scotland) Act 2003

The 2003 Act, together with the codes of practice, makes a number of specific provisions to safeguard the welfare of any child or young person under 18. It requires anyone acting under the legislation to do so on the principle of what appears best to promote the child's welfare. It imposes a duty on NHS Boards to provide sufficient services and accommodation to meet the needs of any child or young person under 18 who is admitted to hospital. The code of practice says that it would be best practice for a person under 18 to be admitted to a unit specialising in child and adolescent psychiatry, and for their doctor to be a child specialist. It also gives very clear guidance about the special considerations which should be given if a young person is admitted to a non- specialist unit.

Getting the workforce right: a strategic review of the CAMH workforce
This report examined the workforce development that would be necessary to translate national policy for CAMH services into practice. It concluded that the current workforce was established at a level "well below that necessary" to meet demands, and that significant new additional investment would be needed to meet policy aims and agreed objectives.

2006
Delivering for mental health
This delivery plan established three key commitments for CAMH services:

- Ensuring that a named mental health link person is available to every school by 2008;
- Ensuring that basic mental health training is offered to all those working with, or caring for, looked after and accommodated children and young people by 2008;
- Reducing the number of admissions of children and young people to adult beds by 50% by 2009

It also re-affirmed a commitment to implementing 'A Framework for Promotion, Prevention and Care' by 2015 with an annual increase in specialist CAMHS workforce capacity until that date.

Getting it right for every child
This cross cutting programme has core components which apply to all services for children and young people whether universal or specialist. It promotes a co-ordinated approach to identifying concerns, assessing needs, sharing information and working jointly, and planning services. It also emphasises the need to have a skilled and competent workforce in all services, both general and specialist.

2007
Looked after children and young people: we can and must do better
This report highlighted the importance of physical mental and emotional health and wellbeing in facilitating positive outcomes for looked after children and young people. It agreed that looked after children generally experience poor mental health, and identified as a clear action point that there should be a new requirement that each NHS Board ensures that the health care needs of looked after children, including mental health needs, are assessed and met.

Delivering a healthy future: an action framework for children and young people's health in Scotland.

This report was produced by the Children and Young People's Health Support Group which was asked to develop a framework to capture the key actions needed to meet the challenges for children and young people's health. It emphasised that "mental health is a key determinant of health even in childhood" and that children and young people need age appropriate care, not care based on models of service provision designed for an adult population". It also stressed the need for the CAMH workforce to expand to meet demand and highlighted the key milestone, that there should be annual increases in the CAMHS workforce capacity until 2015.

2009

Better health, better care: a national delivery plan for children and young peoples' specialist services in Scotland

This document set out the plans of the new administration in relation to health service improvement and delivery. The report recognised that CAMHS was one of the areas requiring early investment to enhance rapid service development and improvement. It reiterated the actions in *Delivering for mental health* and reinforced a commitment to delivering on the Framework for Promotion by 2015.

Audit Scotland: Overview of mental health services

This report, the first in a series of planned reports by Audit Scotland, looked at the accessibility and availability of services provided by a range of organisations, with a view to highlighting areas for improvement and priorities for future audit work. It identified long waiting times for services for children and young people and made several specific recommendations about CAMH services, including one about ensuring that CAMH services are provided up to the age of 18.

Royal College of Psychiatrists: Safe and appropriate care for young people in adult mental health wards

This is a tool for mental health professionals working with young people placed on adult wards in England and its purpose is to set standards for adult mental health wards for those occasions when young people under 18 are placed there. The guide may provide useful and practical information for adult mental health wards in Scotland, in considering what constitutes a safe environment for young people.

Taken together most of the above reports and policy documents paint a very consistent picture. Many of them emphasise that considerable numbers of children and young people have mental health problems that impact significantly on their daily lives, that specialist services need to be designed to meet these needs and that CAMH services are unable to meet current needs, far less anticipated future demands. Mental health though remains a national clinical priority, and the *Framework for promotion, prevention and care* published in 2005, remains the central reference for action relating to CAMH services. The Scottish Government has indicated it continues to expect the Framework to be implemented by the target date of 2015, with year on year increases in CAMH services until that date. A specific HEAT target for CAMH services was also announced for 2009-10, the target being to deliver faster access to services for children and young people.

4: About this visit programme

Since 2005 we have been monitoring what happens to children or young people under 18 if they are admitted to non-specialist settings, such as adult mental health or general paediatric wards, for the treatment of mental illness. We made this a priority because of the duty placed on NHS Boards to provide age appropriate services and accommodation, and because of the particular vulnerability of young people with a mental illness.. We expect to be told about non-specialist admissions, and ask the doctor responsible for the treatment of any child or young person admitted to such settings to provide us with more detailed information about how care and treatment is being provided when we are notified. We also visit all specialist children and adolescent in-patient facilities in Scotland on an annual basis, as part of our normal visiting programme.

Through our visits to specialist in-patient units and by monitoring admissions to non-specialist wards (and often by visiting young people in non-specialist wards) we have gathered a lot of detailed information about the care and treatment young people receive as in-patients. We feel that we have a reasonably accurate picture of how NHS Boards are making progress to fulfil the duty to provide age appropriate accommodation when young people are admitted to hospital, and we report on this monitoring of services each year in our annual report.
Our contact with children and young people until now has tended to be with the very small number of young people who have been hospital in-patients. We have had limited contact with children and young people who are receive mental health care and treatment in the community. We decided to find out more about how CAMH services are being provided across the country through a programme of visits to CAMH services across Scotland. Our aim was to provide a picture of how these services are developing to meet national policy priorities and perhaps more crucially, the needs of individual children and young people.

As part of this themed visit programme we also visited all the specialist in-patient facilities. We arranged to meet as many of the young people admitted to non-specialist wards over a three month period as possible. Where it was not possible to speak to the young person directly, we reviewed medical and nursing notes relating to the admission. Finally we arranged meetings with representatives from CAMH services and local authorities in each of the 11NHS Board areas in mainland Scotland. We interviewed 16 young people in different units across Scotland, reviewed the case files of 13 more, and interviewed staff in 11 units during our visits.

5: What we found

- **Young person's experience**

The experience the young people reported directly to us was varied, but overall positive.

<u>Privacy and dignity</u>
With regard to facilities only one person said he was not in a single room. He explained that he had been in a single room initially, but was then moved to a dorm, and speaking about this he said "it doesn't bother me". Four of the young people seen did say that although they had a single room they did not feel they had privacy in their

bedroom, and these negative responses appeared to relate to their observation status. Two young people also said they were not aware of having a safe place to keep their personal belongings, other than in the ward office. Two of the young people also said that they did not feel they had privacy in the toilet/bathroom areas. One commented specifically that staff only knocked once before entering the bathroom –"they do it so quickly you don't have a chance to say I'm in"

The majority of the young people interviewed said that they could make hot drinks or snacks when they wanted to, however six said that they could not. A further two said they could only make hot drinks. Not being able to make snacks appeared to be linked directly to eating plans which were in place. Thirteen people said they could make a private phone call when they wanted to. Of the three who said they couldn't, in one case this was because they were subject to constant observation, in another case this related to the location of the pay phone in the corridor, while the other young person did not comment further. All the young people we spoke to felt though that they were able to keep in touch with friends and family, and vice versa, but three felt that there wasn't enough privacy when they had visitors. Two stated that the only private option was to meet visitors in their bedroom.

When asked if there was anything they would want to change about the way things are organised in the unit nine said no, and seven said yes. In the latter group comments related to having increased access to bedrooms. Some young people could only access their rooms for two hours in the afternoon; others wanted the opportunity to have a bath rather than a shower. Broader comments related to the need for change in relation to "the general way patients are treated in a very restricted regime".

When asked about feeling safe in the unit thirteen said they felt safe while three said they did not. Of the three, two said they had felt threatened on the ward. Worryingly they didn't feel able to talk to anyone about their safety concerns. One explained that he would rather be with people his own age, even if this meant being further away from family and friends.

<u>Participation</u>

The new mental health legislation is underpinned by a number of principles and emphasises the importance of individual people participating as fully as possible in any decisions made about their care and treatment. The principles also say that people should be provided with information to help make participation meaningful.

We asked the young people questions about their involvement in care planning generally and in decisions about their care and treatment. Eight of them had seen their care plans and six felt they were involved meaningfully in discussions about their care and treatment. Eight young people had not seen a care plan, and two of this group felt they had not been involved in discussions about their care and treatment. Although the other six had also not had sight of their care plan, they all commented that they had been involved to varying degrees in discussions about their care and treatment.

"I get involved in ward meetings but there are six people around me sometimes so I just nod my head".

Fourteen out of the sixteen young people said that they felt "they were listened to".

All sixteen young people we spoke to confirmed that they were receiving medication for their mental illness. Twelve confirmed that the reasons for prescribing this medication had been discussed with them and they had agreed to take the medication accordingly. The other four did not recall anyone explaining the reasons why medication had been prescribed, but, they all confirmed that they had agreed to take the medication. Six young people confirmed that they knew what the plans were for their future care. One of the respondents described his future care plan as "to sign myself out". The others did not know of future care plans.

Contact with staff

Experiences of accessing staff in the units varied. Some young people told us that they had weekly key worker sessions, others said they could access their key worker "any time" and others whenever their named nurse was on shift. Twelve out of the sixteen young people clearly stated that staff treated them with respect. Two others described this as "variable" "some are helpful, some are very punitive". One young person commented that she did not think staff treated her with respect at all- "I don't think any of them like me". One of the young people interviewed had been in a residential care setting and subject to supervision requirements prior to admission. This young person described the transfer to a specialist young person's inpatient unit as a very positive move.

Contact with family

We asked young people whether they were able to keep in touch with families, and they all said they could. Visiting policies within the specialist units varied. Most units have core visiting times, but offer flexibility to families if required and actively encourage family contact and involvement. At the time of the visit one unit was offering rather restricted visiting times, however following discussions with us this policy is now under review. Units report that financial support is available for families on benefits to visit, especially if they have to travel a distance and one unit does have overnight facilities for parents visiting from distant parts of the catchment area. Involvement of families in family therapy is provided for the majority of services. Where this is not clinically indicated, family support is provided by nursing and medical staff. This can take the form of face to face meetings and telephone contact, especially when young people are spending time at home.

Recommendation

When a young person is admitted to hospital information should be provided in a way the young person can understand, including an introductory booklet about the unit, about facilities and modes of treatment, with information also being provided throughout their stay about medication, treatments offered, observation levels, and care plans.

- **Access to education and age appropriate activities.**

Education law in Scotland states that every child has a right to school education, and places a duty on education authorities to make special arrangements for children and young people where they are unable to attend school. Support to remain engaged in education is vitally important in reducing the long-term impact of mental illness on young people.

All specialist in-patient units have education provision on site. During our visits we looked at arrangements where a young person was admitted to a non-specialist ward. Many of these admissions are for such short periods of time that the need to make arrangements for education does not arise and many of the young people admitted are over school leaving age and have left school. Where a young person was still at school, access to education was an area of difficulty, even where the non-specialist ward was a designated ward for the admission of young people. It was clear from the information gathered that limited access to education was available for some young people, with their own school providing work when the school had been contacted. Staff working in non-specialist wards, however, often did not know how arrangements should be made to ensure the provision of appropriate education.

Where a young person was admitted to a non-specialist ward all wards reported difficulty providing age appropriate activities, even where the NHS Board had identified a designated ward to be used for young person's admissions. One ward had recently secured funding to develop activities for young people, and one ward had used the occupational therapy service to provide art work for a young person during admission. Several wards identified issues with adults watching television programmes or DVDs on the ward which were not appropriate for a young person. This meant that the young person's access to TV and recreation was limited.

Recommendation
Local arrangements should be in place to ensure that education authorities are contacted to make appropriate arrangements when a young person is admitted to a non-specialist ward and where this is likely to impact on their education.

- **Access to advocacy**

The UN Convention on the Rights of the Child requires that children and young people must be given an opportunity to express views on all matters affecting them. The 2003 Act gives every person with a mental illness or learning disability, including children and young people, the right to access independent advocacy. The act also requires that local authorities and NHS Boards make sure that independent advocacy services are available locally and that information about services is provided so that the services can be readily accessed. The code of practice also notes that the right of access to independent advocacy is for every patient and is not limited to those who are best able to articulate their needs. People may need support and advice from staff to encourage them to access advocacy. We regard independent advocacy as vitally important, particularly in relation to children and young people in hospital who are potentially vulnerable to having their views ignored.

During these visits the availability of independent advocacy services was discussed at each of the meetings with CAMH services. Advocacy services appear to be readily available within the specialist in-patient units, and we were pleased to see that several NHS Board and local authority areas have specialist advocacy services for young people in place, or in the process of being developed. We would expect that where a specialist service is in place an advocacy worker would be more familiar with specific issues about children's rights and have particular skills and experience in relation to engaging with young people. In one area the development of collective advocacy for young people has been tried, although it has proved to be difficult to engage young people with this provision. In most other areas children and young people access

generic advocacy services. In one local authority area we were told that there is no independent advocacy service for young people, but that children's' rights officers who are employed by the local authority provide advocacy support. This does raise an issue about whether there is a conflict of interest in such a situation, even if structurally a children's' rights service is not part of the operational service system in a local authority.

With regard to what young people told us themselves, four people confirmed that they had accessed advocacy services. Others mentioned seeing leaflets, one person said that they had heard of it but did not really understand what this service provided and others had "never heard of it". One understood about advocacy and how to access it, but said he had not felt the need to use the service.

Recommendation
NHS Boards and local authorities should review the provision of independent advocacy services and the format of information about advocacy services available to children and young people. As part of this review, consideration should be given as as to whether a specialist service may be appropriate in their area.

- **Staffing levels and staff training**

Within the specialist CAMHS units nurse staffing ratios are generally good.. The multidisciplinary teams within these units also include a wide range of skills, including clinical psychology, dietetics, occupational therapy, family therapy, social work and teaching staff. Some units also had psychotherapy services as part of the core multidisciplinary team. However, the level of clinical need can be very high within the units as there are no intensive psychiatric care unit beds for young people in Scotland. As a result, staff may be nursing individuals with complex needs and particularly challenging behaviours in these services.

Staff training is given a high priority and as well as access to support and advice from colleagues within the multidisciplinary team we found staff access a wide range of training opportunities, from the national programme of New to CAMHS training through to specialist training in family therapy, Dialectical Behaviour Therapy and Eye Movement Desensitivisation and Reprocessing resulting in staff feeling skilled and confident in their ability to work effectively. This is in direct contrast to the situation within the non-specialist wards which we looked at.

We visited 12 non-specialist wards which had admitted young people during the previous year. Of these, three were designated as wards which young people would be admitted to when required. Between them these designated wards had admitted 14 young people during the year. The other 9 wards had one or two admissions each. Surprisingly, none of the staff in the non-specialist wards, including the designated wards, had undergone any training to equip them to meet the specialist needs of young people. One of the designated wards had previously had a nurse with specialist training which they had found enormously helpful, this individual has since left and there are no plans to replace her with another CAMH trained nurse.

Within the non-specialist wards access to specialist CAMH services varied greatly across the country. Some areas reported being well supported by the CAMH service which provided a consultant as RMO and who attended case conferences. Other units reported that they could access up to three direct contacts a week with members of the CAMHS team for the young person and had readily available telephone support. However, some units reported inadequate levels of access to CAMH services including having access to telephone support only and experiencing delays in obtaining a response from CAMH services. There was no evidence that access to CAMH services was better within designated wards than in other non-specialist facilities.

Given the lack of specialist training within the staff group caring for these young people it is important that there are systems in place to ensure that specialist advice and supervision is readily available to all wards where young people are admitted.

Several health board areas have taken a decision to identify a specific adult ward to which a young person would be admitted if in-patient treatment is necessary and has to be provided in a non-specialist facility. Several other health boards have aspirations to introduce this arrangement. We support this model of working, however our experience is that designated wards have not as yet made use of the opportunities to develop closer liaison with CAMH services and designated status has not improved access to education for the young person or the provision of targeted training and support for nursing staff to enable them to develop skills in working with young people.

Recommendation
To maximise the potential benefits of designating beds in adult wards for care and treatment of younger people NHS Boards must ensure there are systems in place to ensure ready access to support from CAMH services, clear protocols for joint working and the provision of specialist training opportunities for staff, such as that provided by the New to CAMHS training programme.

- **Admission, discharge criteria and models of care**

Concerns about admission criteria were raised at several meetings that we had with CAMHS staff during this programme. Staff were also concerned about discharge planning and continuity and consistency of care. Services are aware that work to standardise admission criteria and models of care across all regional in-patient units is being undertaken and this was generally welcomed and seen as overdue.

When we visited none of the NHS specialist units were able to produce a set of written admission criteria or an admission policy. It appears that decisions are made on a case by case basis following assessment by members of the multidisciplinary team. Whilst this has the benefit of enabling admission of complex cases for assessment there is considerable merit to having clear admission criteria which is understood by referrers.

We were told on a number of occasions that a young person who was being, or had been, treated on an adult ward, had not been referred to the regional specialist unit because staff believed the referral would be unsuccessful. This appeared to be based

on a mix of past experience and a lack of transparency about both the referral criteria and admission policy.

Each of these specialist NHS units had a waiting list . Units were however unable to provide accurate information on waiting times for admission.

Admissions

Twenty-five of the young people whose care we examined had been assessed by CAMH services before admission. All of those admitted to the specialist unit had been assessed prior to admission.

The length of time between the decision to admit a young person and a bed becoming available varied considerably according to the setting. 32 case files recorded that this period was less than seven days. For those admitted to an adult ward, most were admitted within two days of the decision to admit, but two-thirds had not had a CAMHS assessment. While a majority of those admitted to a specialist unit were admitted within one week of the decision to admit, a smaller number waited between two weeks, and, in one case, five months.

It may be that the "necessary" relative delay in admission to the specialist units (to allow full CAMHS assessment) compounds the low expectation of referral outcome that we encountered in some non-specialist settings, and this again highlights the need to for services to put standardised admission policies in place.

More than one third of the young people we visited had had previous admissions to hospital for care and treatment in relation to their mental health needs.

For some of these young people admission patterns reflected recurrent crises, often accompanied by self-harming behaviours, in circumstances where appropriate emergency social care accommodation might have been a more appropriate alternative to hospital admission. At some of our meetings CAMHS teams reported a need for appropriate emergency social care. In other cases, this reflected the challenge of caring for a young person with a particularly complex or treatment resistant mental illness, and sometimes highlighted the difficulty in accessing an appropriate setting for a young person with particular complex needs.

The reason most commonly given for admission to adult ward was "no adolescent beds available". In a small number of cases, the local NHS Board policy is to treat any young person over the age of 16 and not in full time education, in adult services. In one case, the parents did not want their child admitted to the adolescent unit because of the distance. Our wider monitoring work has identified this as an issue in other cases.

Care plans were evident in 32 of the case records we reviewed. However the quality and detail of these varied widely, as did review dates. In a further two cases care plans were not applicable as discharge took place within 11 hours. In most cases there was clear evidence of participation by the young person or of efforts to engage him or her in the care and treatment planning process. No particular model appeared to be used in any setting, but, in the non-specialist units review meetings tended to involve medical and nursing staff only. In the specialist units, reviews were more likely

to be multi-disciplinary and multi-agency, with input from, for example, parents, psychology, pharmacy and social work.

All the young people we saw had contact with relevant professionals involved in their care at least once a week. The nature of the contact, for example whether this was one to one or in meetings was not always clear from records. For around two thirds of young people, there were no documented family sessions. Documented family sessions most often took place when the young person was in a specialist unit. In a small number of cases, letters could be found inviting family to sessions but, no documentation could be found to confirm they had actually taken place.

We found no issues were with access to psychology, apart from for one young person whose care had been transferred to adult services at the age of 16, and who could not access psychology services.

The level of involvement of community CAMHS and local social work services varied widely. Some units make considerable efforts to overcome the challenge of serving a wide geographical area, for example using teleconferencing to involve community partners from the young person's home area.

For 16 of the young people whose care we looked at, there was no evidence on file to suggest that local CAMH Services remained involved in the young person's care during admission to hospital (one young person aged 17 had been discharged from CAMHS to Adult services at the age of 16).

Eighteen young people had social workers or mental health officers (MHO) allocated to their case. Of those who were detained under mental health legislation, half had both a Mental Health Officer and Social Worker. Seven out of 21 young people who were informal had allocated social workers.

Access to local social work services varies greatly between local authorities, and, especially where distances involved are great, MHO duties are often picked up by unit social workers. While this is a reasonable arrangement, it would be good practice for there to be an officer within the young person's local social work department, identified from the outset, to ensure appropriate involvement in discharge planning and access to services, without delay, when care of the young person returns to local services.

The length of each young person's admission to in-patient care varied greatly. Although most admissions were less than six months in duration, one specialist unit reported that half of the young people in the unit had been there more than one year. From the records we examined it was difficult to find any systematic process for agreeing the goals of individual admission between the in-patient unit, the local CAMHS team, the young person and his or her family. Community CAMH services identified this as a concern, particularly when a young person stayed in the specialist unit for a very long period of time and especially if they had another patient who was, in their opinion, in greater need of in-patient care.

Discharge planning

We found evidence on file of clear discharge care planning, or at least tentative plans, for only eight of the individuals we visited. No discharge planning protocols were in evidence. As there will always be multiple teams and agencies involved when a young person has been admitted to a regional specialist unit, it is a matter of some concern that there did not appear to be robust systems in place to ensure that all necessary parties were identified and able to be brought into discharge planning from the earliest agreed stage. As discussed above, the geographical distance may be an issue for bringing parties together, which highlights the need for agreed roles, responsibilities and effective communication.

Recommendation

There is a need to agree clear and consistent admission and discharge criteria for all the specialist in-patient facilities, and to circulate these widely to ensure equity of access to specialist in-patient facilities across Scotland. The National In-patient Forum has started a piece of work to develop agreed and consistent criteria for the three in-patient units, for admissions and discharge planning, and we would hope that this work is completed in the near future.

- **Sixteen and seventeen year olds**

The 2005 report, 'The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care', clearly recommended that those commissioning services for young people should consider the needs of all young people up to the age of 18. The Mental Health (Care & Treatment) (Scotland) Act 2003 also places a duty on NHS Boards to make age appropriate mental health treatment available, and provide sufficient services and accommodation to meet the needs of any child or young person under 18 who is admitted to hospital. The recent Audit Scotland report, 'Overview of Mental Health Services' also commented that a number of NHS Boards had still not implemented the recommendation from the framework report.

In the meetings with CAMH services which were arranged as part of this themed visit we asked about the operational criteria for referrals to CAMH services for young people aged 16-17. It was clear from these discussions and from copies of referral criteria we had asked services to provide us with, that arrangements continue to vary across Scotland. In two NHS Board areas CAMH service provision is only available up to the person's 16th birthday. In seven NHS Boards a service is provided up to 18th birthday (and sometimes beyond) In the rest of the health board areas a service is available in all or part of the area up to 18th birthday if still in full time education

Recommendation

Different arrangements within different NHS Board areas disadvantage many young people across the country. All NHS Boards should provide CAMH services to young people up to their 18th birthday, unless clinical need indicates otherwise in a particular case.

- **In-patient provision for young people with complex needs**

Services for young people with a learning disability
This themed visit did not focus on services for young people with a learning disability, but because meetings were arranged with all the mainland CAMH services the opportunity was taken to ask about services in place for young people with a mental illness combined with learning disability. In all areas now some form of dedicated community service is provided, but it is recognised that in all parts of Scotland the service is limited, and services are very rarely multi disciplinary. We were also advised of significant issues about the lack of specialist in-patient facilities for this group of young people.
This sometimes results in admissions of a young person with a learning disability to a general adult ward, where they are potentially even more disadvantaged by the absence of specialist skills or to an adult learning disability ward., We know of a small number of highly intensive "bespoke" packages in place for individual young people in some of these other settings. In some cases specialist placement outside Scotland is sought.

Services for young people with a history or risk of violence or sexual offending
There are currently no adolescent IPCU beds in Scotland, nor any forensic in-patient service. Young people who have a mental disorder and who require treatment in a secure setting, because of risk to self or others, are either transferred to an adult IPCU, or to low or medium secure adolescent units outwith Scotland.

In an adult IPCU these young people are invariably cared for under enhanced observation, and often with a very significant degree of isolation, because of very real concerns about their vulnerability within this particular adult setting. This often means young people are excluded from therapeutic and diverting activities. For any young person subject to an assessment order or treatment order, or any other mental health section of the Criminal Procedure (Scotland) Act 1995, there is no legal mechanism which would allow for transfer to a service outside Scotland. At present there is no secure age-appropriate service for them.

This raises significant issues about estrangement from family and community of origin, where it results in a child being detained for a significant time far from home, which may impact negatively on outcome. Additionally the young person may be educationally disadvantaged because of non-compatible education and examination systems.

Across Scotland community CAMHS teams have limited specialist learning disability or forensic provision. In Greater Glasgow and Clyde there is a team in both specialties, elsewhere development of CAMH services for people with learning disability is ahead of specialist forensic services. All are still mainly single practitioner rather than multidisciplinary teams.

Recommendation
There are no in-patient beds to meet the needs of young people with learning disabilities or of young people who require treatment in IPCU units. We recommend that regional commissioning groups give consideration to providing appropriate facilities in Scotland.

- **Legal issues**

Specialist units for young people detained under mental health law
There are only a small number of inpatient units for children and young people in Scotland. Levels of detention varied between units we visited. In one unit all but 1 patients were detained, in another a quarter of patients were detained while one unit that specialises in eating disorders had no detentions at all.

Where young people were receiving care and treatment on an informal basis, they had generally been informed of their rights as voluntary patients. Some of the voluntary patients reported that they had been physically stopped from doing something they wanted to do but staff had talked to them afterwards and explained why they had intervened. Where young people had been detained and reported that they had been physically stopped by staff from doing something they wanted to do they advised that no one took time to explain and talk to them afterwards.

All units provide verbal and written information to young people about the unit and their legal rights if they are detained. We found documented evidence of this in all but a small minority of cases we looked at. Young people within specialist units also all have access to specialist advocacy services.

At the time of our visit half of the units were locked, meaning young people couldn't leave without staff intervention. One unit had a policy of never locking the door, all other units did have a policy in place for when the door is locked.

- **Consent**

Consent to treatment was recorded in approximately a third of the case notes of young people who were in hospital on an informal basis. In two cases, parental authority was being appropriately used. Covert medication was not being used within any of the units when we visited.

- **Restraint**

In less than a third of the cases we looked at the young person had been subject to restraint. The main reasons for this related to aggressive behaviour, attempts to abscond and parenteral feeding. All but two of these incidents were managed under the authority of the 2003 Act. All the units have a restraint policy in place and provide training on restraint for nursing staff. One unit has been asked to review their policy and training in light of issues raised by us during the visit.

The use of seclusion is very rare in young people's units. However, during our visit one young person was being nursed separately from the other residents due to the level of risk to others that could result from his behaviour. This was a temporary situation while a more appropriate placement was being sought and there was a clear risk assessment and care plan in place for this.

All units report that they may carry out searches of a young person's s room and their bags on admission or return to the unit based on individual risk assessments. Several of the staff we spoke to were unclear under what authority this was carried out and

were unaware of the provisions for safety and security under section 286 of the 2003 Act.

We also found that young people admitted to non-specialist wards didn't have access to specialist advocacy services.

- **Other issues**

Services for looked after children

We are aware of past cases where there have been disputes between NHS Boards about responsibility for providing CAMH services to looked after children and young people who are accommodated outwith their home area . We therefore asked some questions about provision for looked after children and young people at the CAMH service meetings.

We found that in each NHS Board area there have been developments in providing services to looked-after children and some form of dedicated service is now in place. This can range from a fully dedicated multi-disciplinary team to services which provide consultation and advice or training to carers working with looked after children. CAMH services though are concerned about the equity of provision for children and young people who are accommodated outwith their home NHS Board and local authority areas. It was clear from discussions about this issue that approaches to providing services to this group vary widely across the country. This is in spite of the fact that guidance was published in March 2004 which set out procedures for establishing the responsible commissioner for an individual's care within the NHS (NHS HDL (2004)15: Guidance on Establishing the responsible Commissioner). This guidance clearly says no treatment should be refused or delayed due to uncertainty or ambiguity over who is responsible for funding an individual's health care. It includes a specific section on looked after children, again emphasising that any changes in health care commissioning responsibilities must not be allowed to disrupt the provision of timely care and treatment. We are concerned that, based on those individual cases we have been made aware of and discussions with CAMH services across Scotland, looked-after and accommodated young people may not be receiving timely access to care and treatment.

Services for people who self harm

In all NHS Board areas we found a focus on developing services for young people who self harm. We heard about several Choose Life initiatives, about the development of local protocols and about areas where very positive links with primary care have been established. One common theme was the need in many areas to ensure that accident and emergency staff are aware of local protocols so they can make appropriate referrals to CAMHS when a young person has been seen at A&E.

Service development plans

We were advised at each of our meetings with CAMH services that very detailed service development plans are now in place. These plans identify gaps in service provision and contain proposals for enhancing the specialist services. We received copies of these plans either before or at the meetings arranged. There is obviously a

very significant issue about how resources will be allocated to implement these service development plans, many of which will be based on the recommendations of the 2005 framework report.

Notification of admission of children or young people to non-specialist wards
It was clear in discussion at the CAMH meetings that the MWC may not be receiving all the notifications we expect to get, when a young person is admitted to a non-specialist in-patient unit. It was also clear that on occasions some general adult psychiatrists are under the impression that the MWC has issued guidance to say that no young person under 18 should be admitted to a non-specialist unit.

Recommendations
NHS Boards must ensure that looked after and accommodated young people placed outwith their home health board and local authority areas receive CAMHS input whenever this is necessary

The MWC will revise and re-issue our guidance re admissions to non-specialist wards, and notifications; review monitoring information we request; and review how we undertake our monitoring duties generally as they relate to children and young people.

6: Our key recommendations

When a young person is admitted to hospital information should be provided in a way the young person can understand, including an introductory booklet about the unit, about facilities and modes of treatment, with information also being provided throughout their stay about medication, treatments offered, observation levels, and care plans.

Local arrangements should be in place to ensure that education authorities are contacted to make appropriate arrangements when a young person is admitted to a non-specialist ward and where this is likely to impact on their education.

NHS Boards and local authorities should review the provision of independent advocacy services and the format of information about advocacy services available to children and young people. As part of this review, consideration should be given as to whether a specialist service may be appropriate in their area.

To maximise the potential benefits of designating beds in adult wards for care and treatment of younger people NHS Boards must ensure there are systems in place to ensure ready access to support from CAMH services, clear protocols for joint working and the provision of specialist training opportunities for staff, such as that provided by the New to CAMHS training programme.

There is a need to agree clear and consistent admission and discharge criteria for all the specialist in-patient facilities, and to circulate these widely to ensure

equity of access to specialist in-patient facilities across Scotland. The National In-patient Forum has started a piece of work to develop agreed and consistent criteria for the three in-patient units, for admissions and discharge planning, and we would hope that this work is completed in the near future.

Different arrangements within different NHS Board areas disadvantage many young people across the country. All NHS Boards should provide CAMH services to young people up to their 18th birthday, unless clinical need indicates otherwise in a particular case.

There are no in-patient beds to meet the needs of young people with learning disabilities or of young people who require treatment in IPCU units. We recommend that regional commissioning groups give consideration to providing appropriate facilities in Scotland.

NHS Boards must ensure that looked after and accommodated young people placed outwith their home health board and local authority areas receive CAMHS input whenever this is necessary

The MWC will revise and re-issue our guidance re admissions to non-specialist wards, and notifications; review monitoring information we request; and review how we undertake our monitoring duties generally as they relate to children and young people.