Special report: young people

mentalwelfare commission for scotland

A special report on young people in our monitoring of mental health and incapacity law

2011-12

Special report 2011-12

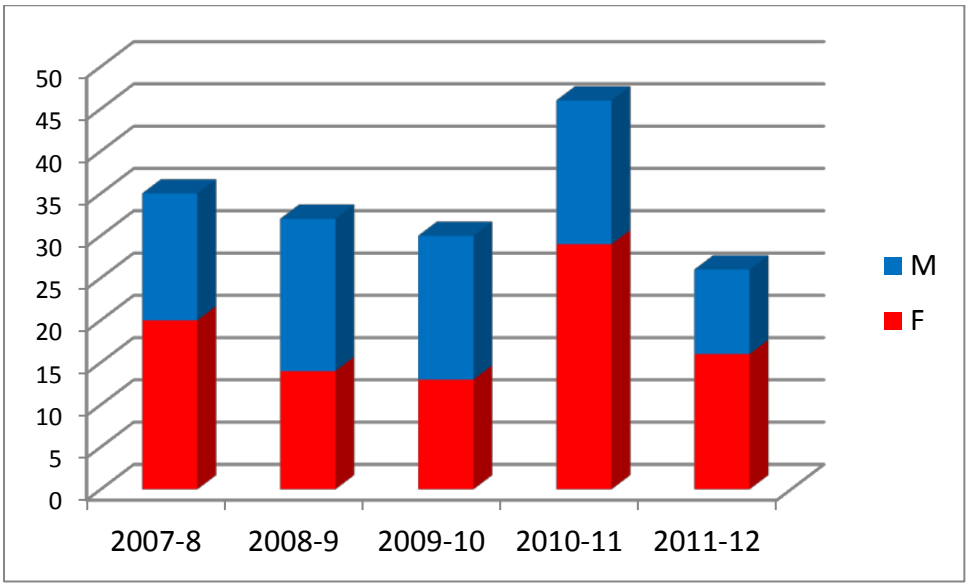
Care and treatment of children and young people under 18

A. The use of mental health legislation for young people

We have noticed some variation year by year in the use of various mental health act orders for young people. In the last two years, we have noted rises in the use of some orders. This report attempts to analyse and explain these.

1. Emergency detention

Emergency detention certificates (EDCs) for under-18s 2008-12

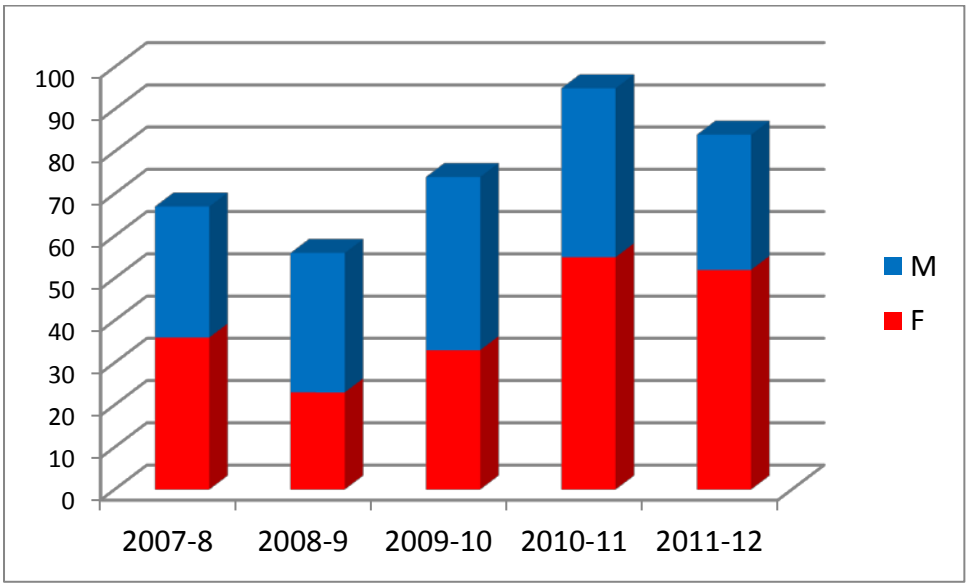


In 2010-11, we reported a sharp rise in the number of EDCs for females under the age of 18. This has not been sustained. The number of EDCs fell sharply this year. Apart from the single year's high figure, the overall trend is downward although figures for females are still higher than in 2008/9. Some NHS Boards have developed intensive home treatment services for young people. This may be having an impact.

We think last year's rise may have been a response to the publicity over two high profile and distressing suicides. Our analysis last year showed that suicidal thinking and self harm episodes were factors in most EDCs for females under 18. This year we have focussed our attention on short-term detention and compulsory treatment orders.

2. Short term detention

Short-term detention certificates (STDCs) for under-18s 2008-12

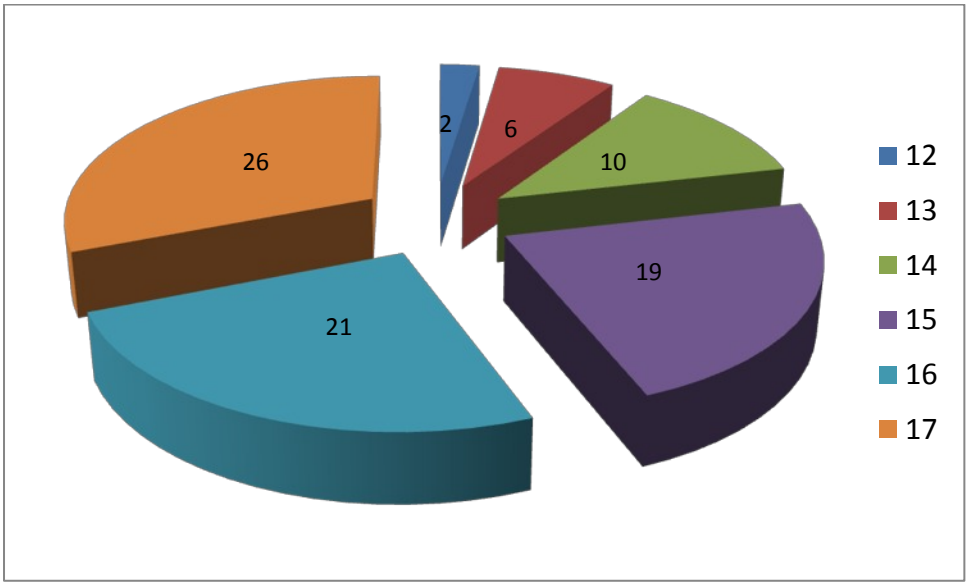


Although not as high as last year, the number of STDCs for people under 18 has remained higher than previous years. We identified 84 episodes of short-term detention in 2011-12 and conducted an analysis to find out the reasons for detention. Again, the rate is especially high for females.

Age and Gender

The youngest individuals were aged 12. Almost half were under 16.

Age distribution of young people detained on STDC 1/4/11 to 31/3/12



52 were female and 32 were male.

Location

Most were detained in hospitals in Greater Glasgow and Clyde (28) and Lothian (21). We found that 16 young people from Lanarkshire had been detained. This was relatively high, especially as Lanarkshire has a relatively low overall use of the Act.

Of the 84 episodes of short-term detention, 37 were in specialist NHS child or adolescent mental health units. A further six young people were detained in the Huntercombe Hospital, Edinburgh, an independent hospital with specialist facilities for young people with eating disorders. Some of the latter group had been receiving specialist informal treatment in that unit, but were from England originally. The remaining 39 young people were detained, at least initially, in adult mental health facilities.

As far as we could identify, only two had been in residential care before admission.

Diagnosis

From the STDCs, we found that:

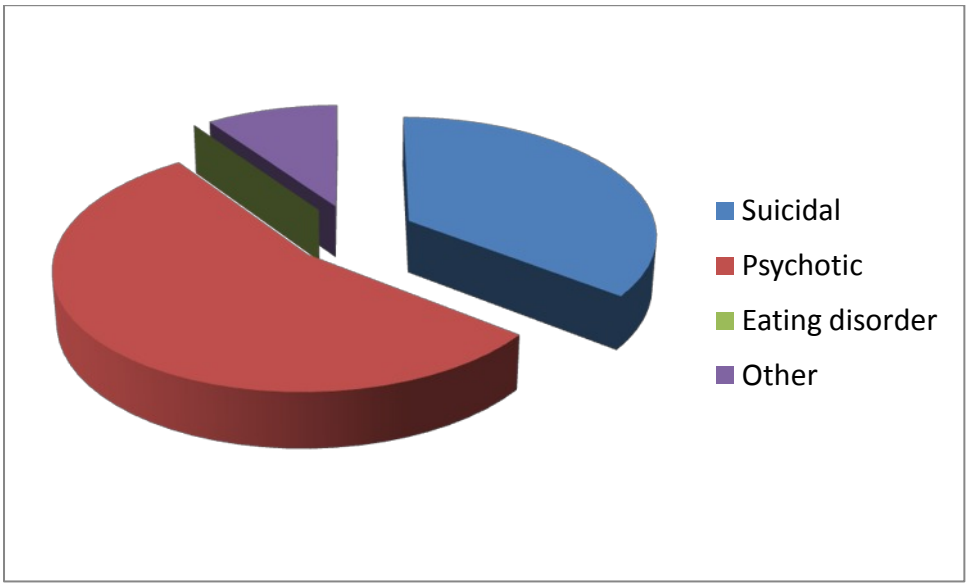
- 80 had a mental illness;
- Five had learning disability (of whom two also had a mental illness);
- Two had a personality disorder (of whom one also had a mental illness).

We examined the forms further to determine the specific diagnoses made. Given that the process of diagnosis was just beginning, it was not surprising that there were descriptions of the mental state and the individual's symptoms, but rarely a definite diagnosis stated. We identified four specific groups:

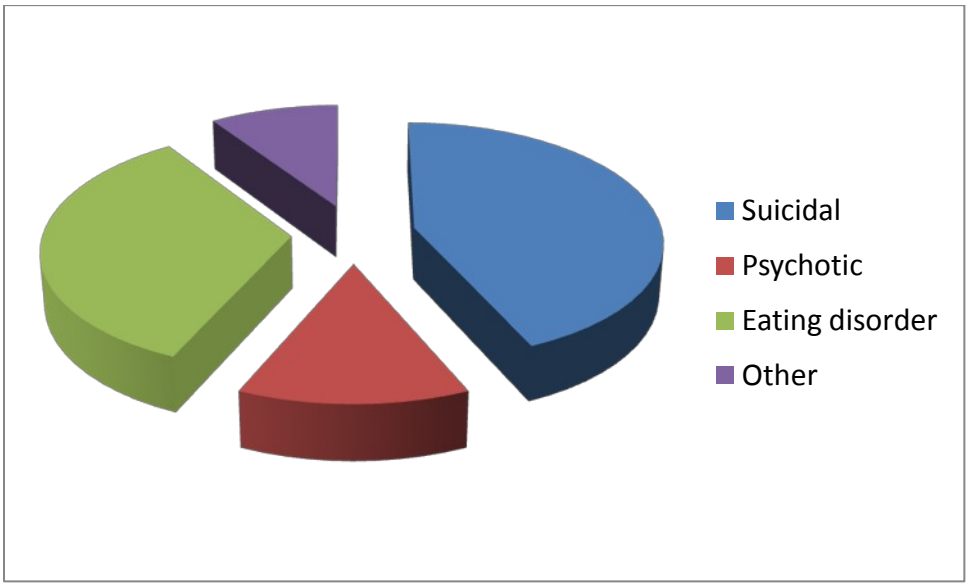
- Suicidal ideas/self harm. This appeared to be the primary reason for detention in 34 of the 84 young people. Most of these appeared to have a primary mood disorder or a reaction to traumatic events.
- Psychotic symptoms. A further 24 young people were detained primarily because of apparent psychosis.
- Eating disorders. Eighteen (all female) were detained because of an eating disorder. Some also had significant depressive symptoms. We have given guidance on using the Act instead of relying on parental consent for those under the age of 16. It may be that this has resulted in changes in policy in some units. We have also warned against using coercion rather than formal measures.
- Others. There were eight other young people detained because of behavioural problems. These were associated with learning disability or other developmental disorders (e.g. autistic spectrum disorder). Two individuals had severely disabling symptoms of obsessive-compulsive disorder.

There were gender differences in these diagnostic groups. Young males were much more likely to be detained because of psychosis. Eating disorders were prominent in young females. Suicide risk was high in both groups, especially young females.

Reasons for STDC for young males 1/4/11 to 31/3/12



Reasons for STDC for young females 1/4/11 to 31/3/12



We looked for evidence that illegal drug use was a significant factor in compulsory admissions. Illegal drug use was recorded on the forms as a factor for only seven (five male and two female) of the young people detained.

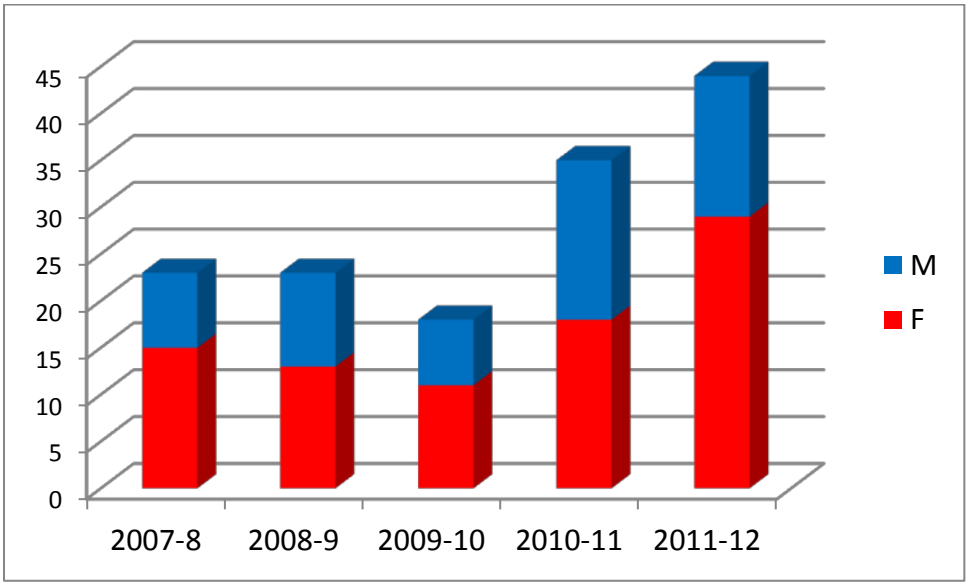
Conclusions

The use of STDCs for females under the age of 18 has been high for the past two years. The likely reasons are:

- Continued concerns over suicide risk especially following publicity over two distressing suicides, and
- A greater tendency to use STDCs for people with eating disorders rather than using coercion or relying on parental consent.

3. Compulsory treatment orders

Compulsory treatment orders (CTOs) for under 18s 2008-12



Figures provided by the mental health tribunal

The number of new CTOs for young people has risen markedly over the past two years. We were able to identify the individuals in 37 of the 44 cases reported by the Tribunal and looked into their cases in greater detail.

The 37 CTOs were for 36 individuals (one person was subject to a CTO twice during the year). All but one order authorised detention in hospital. Only nine of the sample were male and usually had diagnoses of psychosis. Of the 27 females, 12 had eating disorders. Most of the others had depressive disorders; self harm or suicide risk being a major feature. We found four young people who had learning disability. All had an additional diagnosis of either a psychotic illness or autistic spectrum disorder.

Thirty two individuals were living with one or both parents. Two were in residential care and one was in foster care. One young person was homeless before admission. Four individuals with mental illness were in an adult psychiatric environment at the time of CTO being granted 2 of these were private low secure facilities. Ten individuals had at least one previous admission to psychiatric services.

We looked at the three main diagnostic groups: learning disability, eating disorders and other mental illness

Learning disability

All four individuals with learning disability had an additional diagnosis of mental illness. Two also had drug/alcohol misuse with criminal charges as a result. Two had an additional diagnosis of autistic spectrum disorder. One individual was placed on a CTO to facilitate transfer to a specialist resource in England.

Eating disorders

Of the 12 individuals with eating disorders,

- All were treated in a specialist facility at time of detention although one had initially been admitted to an adult psychiatric ward.
- Nine were receiving artificial nutrition. In eight cases, this was authorised by an independent opinion. The other individual gave consent.
- Six had at least one previous episode of detention on a CTO (including interim orders).
- Three had an additional diagnosis of depression or post-traumatic stress.
- Eight are still on a CTO at the time of writing- 1st July 2012.

Mental illness

Of the seven males,

- Six had a diagnosis of psychosis (2 with additional autistic spectrum disorder). One had obsessive-compulsive disorder. Two also had significant difficulties with drug or alcohol misuse
- Two were transferred to a specialist young persons' forensic unit in England
- One was initially in custody in a young offenders institution and moved to a private low secure facility on a transfer for treatment direction prior to a CTO being sought.

The 13 females tended to have more complex needs with multiple diagnoses.

- Eleven of the 13 individuals had a diagnosis of depression,
- One had a history of significant drug and alcohol misuse which had resulted in her spending a night in prison.
- Four had an additional diagnosis of psychosis,
- Two had personality disorder,
- Additional diagnosis included post-traumatic stress disorder, obsessive-compulsive disorder and bipolar disorder.
- Suicide risk was a factor in 10 of the 13 admissions of females but not in any of the male admissions.

By 1st July 2012, 17 of the orders had been revoked. The increased complexity in female presentations was also reflected in the numbers who remained on orders. We

found that 15 females were still on a CTO, including eight with eating disorders. Only 2 males were still on a CTO.

Conclusions

The increased use of CTOs for the under 18s was mainly in young females. Girls with eating disorders or complex presentations with mental illness were subject to the order for longer. Young people who needed secure accommodation were transferred to England. The Scottish Government should take account of these findings when considering strategic approaches to young people with complex mental health problems.

B. Provision of age-appropriate care for people under 18

Here, we report on our work to examine the care and treatment of young people admitted to non-specialist mental health care. Section 23 of the 2003 Act places a responsibility on NHS Boards to provide accommodation and services to meet the needs of persons under the age of 18. There is a risk that this will not happen if a young person is admitted to an adult mental health ward.

Young people (under 18) admitted to non-specialist facilities, 1 April 2011 to 31 March 2012

	2008-09	2009-10	2010-11	2011-12
No. of admissions to non-specialist inpatient settings	149	184	151	141
No. of young people involved	138	147	128	115
No. of admissions where further Information was provided to MWC	139	168	135	120
No. of young people involved	131	140	115	96

Our interest in these figures

Monitoring the admission of young people to non-specialist settings such as adult and paediatric wards, for the treatment of mental illness, has been one of our monitoring priorities since the Mental Health (Care and Treatment) Act 2003 came into force. We have raised concerns about the number of admissions for several years. We are therefore pleased this year to see a continuing drop in admissions across the country. This is consistent with the Scottish Government's aspiration to reduce admissions.

There has been an increased national focus on the mental health needs of children and young people over the past seven years. Information on the CAMHS workforce across Scotland has been collected routinely since 2006, and staffing levels have been steadily increasing. The Scottish Government also sets targets for health priorities, and the importance of CAMH services is highlighted in the targets for faster access to CAMHS – a 26 week referral to treatment target for CAMHS is due for delivery by March 2013, reducing to 18 weeks by December 2014. We have noted the increase in community teams in a number of areas in Scotland, and improvements in how admissions to non-specialist settings are supported by child and adolescent clinicians. We see this as having an impact on the numbers, and on the length of stay of young people admitted to non specialist settings.

In our monitoring of the admissions of young people under 18 across Scotland we seek to confirm whether NHS Boards are managing to fulfil their legal duty to provide age appropriate services and accommodation. We expect to be notified of all formal and informal admissions to non-specialist facilities. We ask Responsible Medical Officers (RMOs) to provide us with more detailed information once we have been notified of an admission. We will be making some changes to the questionnaire we use so that we are collecting better information about the admission. We have also asked health boards, since 2005, to send us quarterly retrospective reports about the admission of young people to non-specialist wards. This data helps us to check if we have received all the notifications about individual admissions that we would expect. Some health boards have been doing this regularly, but others have not. We will therefore be writing to each health board to remind them that we do want to continue getting these quarterly reports.

Monitoring admissions of children and young people to non-specialist facilities will remain a priority for us in the coming year. We will visit hospitals to look at how care and treatment is being provided, when the young person is under 16, or when we know that a young person is in an IPCU (intensive psychiatric care unit). We are aware that we may be notified about an admission to an adult assessment ward, but that we may not be notified about any transfer to an IPCU facility within the same hospital after admission. We are looking at how we can identify when a young person is being treated in an adult IPCU, as we would want to visit any young person in such a unit, where care and treatment is being provided in a locked, secure environment.

What we found

The figures in the table above show that in 2011-12 we were notified of 141 admissions, involving 115 young people. These figures compare with 151 admissions, involving 128 young people, in 2010-11.

As mentioned in previous reports we had anticipated that NHS Boards would experience difficulties meeting a commitment to reduce admissions of young people

to non-specialist wards. We were concerned about the significant increase in admissions in 2009-10. However we were pleased to see a decrease in 2010-11 of 18 %. This trend has continued in 2011-12. The total number of admissions has dropped again, by 6% 6.6 or 7%, from 151 to 141, and the number of young people involved has dropped by 11%, from 128 to 114. We continue to be concerned though about the number of repeat admissions, that is about the small number of young people who are admitted to a non-specialist ward on several different occasions. The number of repeat admissions has risen this year, and we will be looking at this to see how we might follow this issue up this coming year.

Young people admitted to non-specialist facilities by NHS Board between April 2011 and March 2012

	2010 - 2011		2011 - 2012	
Health Board	Admissions	Young People Involved	Admissions	Young People Involved
Ayrshire and Arran	18	16	14	11
Borders	4	3	6	6
Dumfries and Galloway (HB)	10	7	5	4
Eilean Siar	0	0	0	0
Fife (HB)	6	6	6	6
Forth Valley	5	5	12	10
Grampian	30	23	23	17
Greater Glasgow and Clyde	34	28	30	23
Highland (HB)	7	7	6	5
Lanarkshire	29	25	32	27
Lothian	4	4	3	3
Orkney	0	0	0	0
Shetland	0	0	0	0
State	0	0	0	0
Tayside	4	4	4	3
Scotland	**151**	**128**	**141**	**115**

Our interest in these figures

Our view is that when a young person needs in-patient treatment their individual clinical needs should be paramount. In comparing admissions to non-specialist facilities by NHS Board area we are looking to see whether there have been significant changes in the number of admissions within a specific area compared to figures from the previous year. In this year's figures we are also identifying not only the number of admissions in each area but the number of young people involved,.

The 2003 Act is clear that the specific duty on NHS Boards to provide sufficient services for young people continues to their 18th birthday. We are aware that child and adolescent (CAMH) services are configured differently across areas, with varying eligibility criteria. We highlighted this issue in our published report on our themed visit to look at CAMH services (2009); we recommended that all Health Boards should provide a CAMH service to a young person up to their 18th birthday, unless clinical need indicate otherwise in a particular case. We are also aware that CAMH services are making strenuous efforts to admit under-16s to specialist facilities, and that work has been in progress nationally to develop agreed criteria for the admission to and discharge from specialist in-patient units. We would hope that when these admission criteria are bedded in this will impact on the numbers of admissions to non-specialist facilities.

What we found

Figures in the table above compare admissions in 2010/11 and 2011/12 by NHS Board area. In the majority of areas the number of admissions has been static or has reduced slightly. In three areas, NHS Borders, Forth Valley, and Lanarkshire, there has been an increase in both the numbers of admissions, and the number of young people involved.

In NHS Lothian there was a significant decrease from 16 admissions to 4 from 2009/10 to 2010/11. There have been 3 admissions to adult beds in 2011/12, and all of the young people involved were 16 or 17. One admission was a planned transfer to the specialist Brain Injury Unit supported by liaison with CAMHS. One admission, to a medical ward, was for a young person requiring medical treatment following a suicide attempt, and this person was transferred to the CAMHS inpatient unit when medically fit. The third young person was admitted to IPCU and transferred to the CAMHS inpatient unit after 3 days. We were aware last year that the in-patient unit for young people in NHS Lothian had reviewed how a young person's journey through the service was supported and managed, alongside an increase in community teams. The impact of the review of CAMHS services on admissions to non specialist areas, which we saw and commented on last year, has clearly been sustained.

In Ayrshire and Arran there had been a marked drop in the number of young people admitted to adult wards, from 40 in 2009/10, to 18 in 2010/11. There has been a

further slight decrease in admissions there in 2011/12, with 14 admissions involving 11 young people. We know that NHS Ayrshire and Arran had been concerned about the relatively high number of young people in their area who were being admitted to adult wards, and had been looking to enhance community supports for young people in crisis, and we would continue to encourage this work. The issue of self-harming ideation/actions in the context of alcohol or drug misuse, continues to cause concern, and again we encourage them to take forward work in this area with local authority partners.

Following a significant increase in admissions in the NHS Grampian area in 2010/11, the number of admissions and young people involved reduced in 2011-12, from 30 admissions (23 young people) in 2010/11, to 23 admissions (17 young people) in 2011/12. Last year we noted that considerable efforts were being made to provide age appropriate services within the adult wards in Grampian. NHS Grampian has designated a specific adult admission ward for admissions of young people, and has established a dedicated nursing team within that ward to provide nursing care to young people who have been admitted. A CAMHS psychiatrist will always be the RMO, and other CAMHS professionals are providing significant input into the ward. We welcome these local responses, and having visited a number of the young people admitted to adult wards in Grampian in 2011/12 we think that the arrangements are helping to ensure that the specific needs of young people who are in an adult ward are addressed. We also know that the work to develop a new regional young persons' unit in the north east of Scotland is progressing. We hope that work to build this unit will start soon, as this will improve access to specialist in-patient care for young people from the NHS Grampian area.

We are pleased to note the reductions in admissions in Glasgow and Dumfries and Galloway. We hope they continue to develop alternatives to admission, and services to facilitate discharge, in both areas. We are also pleased to note the small reduction in admissions in NHS Highland.

We have looked more closely at the figures for the three health board areas where admissions rose in 2011/12. In NHS Borders the increase has been in the 16/17 year old age group. Five of their 6 admissions involved 17 year olds, four of whom were male. Admissions were fairly short, and mainly involved young people experiencing psychotic symptoms, or who had self harmed. In NHS Forth Valley the marked increase in reported admissions would appear to be because we were notified about admissions to the paediatric ward, which had not been consistently happening in previous years. This had been discussed with services at the end of year meetings with boards. The increase in admissions within NHS Lanarkshire is again mainly in the 16/17 year age group. Reasons for admission varied with 14 admissions being due to self harm and/or suicidal ideation. This high number may have been influenced by reporting in the national press throughout the year about the suicides of two young girls in the Glasgow area.

The monitoring questionnaire we send out when we are notified about the admission of a young person to a non-specialist ward now includes a question about whether the young person is on the waiting list for a specialist bed. In 2011/12 we were notified that 15 young people were on a waiting list. This is the first time we have collected this information for a full year, so we cannot comment on any trends about waiting lists for specialist beds. We will be looking at this information next year though, to see if there are any emerging patterns, and if young people in particular health board areas are more likely to be on a waiting list for a specialist bed.

We are also aware that a small number of young people are transferred to independent hospital facilities in Scotland, having been admitted to non-specialist NHS wards. There is one independent hospital with specialist facilities for young people with eating disorders, but other independent sector facilities are not registered as providing specialist care and treatment for young people. We will be monitoring such admissions, as we feel it is equally important that there is appropriate CAMHS input when a young person is in an independent hospital as when they are in an NHS facility.

Specialist health care for admissions of young people in non-specialist care, 1 April 2011 to 31 March 2012

Specialist medical provision	Age 0-15	Age 16-17	All	Young people (base=120) %
RMO at admission was a child and adolescent specialist	20	34	54	**45%**
Nursing staff with experience of working with young people were available to work directly with the young person	26	39	65	**54%**
Nursing staff with experience of working with young people were available to provide advice to ward staff	27	65	92	**77%**
The young person had access to other age appropriate therapeutic input	16	43	59	**49%**
None of the above	0	14	14	**12%**

** Percentages in the final column are based on all admissions where further information was provided to the Commission =120*

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, and some of the information we request is summarised in the table above.

We specifically want to see whether specialist CAMH service 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 CAMH services when a young person is admitted to an adult ward varies across the country. Although we can report some improvement overall there continue to be reports of limited access to CAMHs support during admissions to some adult wards.

What we found

In 45% of admissions the RMO at the point of admission was a child and adolescent specialist. This is consistent with the previous year. We saw an increase in the direct input from experienced nurses working in the field, up to 54% from 44% the previous yearand a 4% increase in the availability of nurses with relevant experience to provide advice to ward staff. This demonstrates a continued increase in nursing availability in both instances in recent years which we welcome.

The number of cases where the RMO at admission is a child and adolescent specialist has fallen slightly from last year although the overall percentage remains the same. We are pleased to see that in many cases specialist child and adolescent consultants continue to provide advice and support during admissions. We expect that as increases to CAMHS workforce numbers occur that CAMHS clinicians will be more available to support non specialist services.

Social work provision for admissions of young people to non-specialist care, 1 April 2011 to 31 March 2012

Social work provision	Age 0-15	Age 16-17	All	% of young people
Young person has an allocated social worker	21	48	69	**58%**
If no allocated social worker, had access to a social worker.	7	26	33	**28%**
Neither of the above	2	14	16	**13%**

Percentages in the final column are based on all admissions where further information was provided to the Commission =120

Our interest in these figures

We receive information on monitoring forms about social work input. Many young people admitted to a non-specialist facility will have had no prior involvement with social work, 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, then there should be clear local arrangements to secure that input. There certainly is a very clear emphasis in national policy, for children's services and for adult care, on co-operation and good joint working between health and social work.

We also have an interest in the provision of services to "looked after" children. 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. We would assume though that any looked after young person admitted to a non-specialist facility will have an identified social worker.

What we found

Compared to the figures for previous years a significantly higher proportion of young people had an allocated social worker at the time of admission in 2010/11, and this has been maintained in 2011/12 -58% of young people already had an allocated social worker at admission. A smaller percentage of young people, who had no social worker prior to admission, had access to a social worker after admission -

28%, compared to 31% in 2010/11. The number of young people who did not have an allocated worker, and were reported as having no access to a social worker, has risen from 10 (7%) in 2010/11 to 16 (13%) in 2011/12. This is disappointing and surprising, because of the policy emphasis on developing more integrated approaches to providing care and support to meet the needs of young people. We will continue to monitor this to see if this seems to be a trend, and to consider if we need to follow this issue up in relation to individual cases.

Supervision of young people admitted to non-specialist care, 1 April 2011 to 31 March 2012

Supervision arrangements	Age 0-15	Age 16-17	All	% of admissions
Transferred to an IPCU or locked ward during the admission*	4	18	22	18%
Accommodated in a single room throughout the admission	31	73	104	87%
Nursed under constant observation	28	60	88	73%

Percentages in the final column are based on all admissions where further information was provided to the Commission =120

**This is only the number reported to us when we sent out the questionnaire. There may have been more transfers then this.*

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 also use this information to help us decide if we want to arrange to visit a young person. We will arrange a visit if the young person is particularly vulnerable, to look at the care and support arrangements in place.

What we found

The total number of young people transferred to IPCU remained static, although this represented a slightly greater percentage of the total number of admissions; 18% compared to 16% in 2010/11. However the number of 0-15 year olds transferred to an IPCU or locked ward reduced from 6 to 4.

1 young person was admitted, under a transfer for treatment directive, to a forensic low secure facility. There was good liaison with the forensic CAMHS team and the young person was subsequently transferred to a CAMHS inpatient unit.

The percentage of young people accommodated in single rooms has increased from 82% last year to 87% this year. The numbers and percentage of individuals nursed under constant observations has decreased to 73% this year, from 76% in 2010-11.

We have previously commented on young peoples' experience of being on constant observations in a single room as lonely and boring, and on the need to ensure that, where this is necessary, efforts are in place to mitigate against these adverse consequences. The following vignettes illustrate the difference which good risk assessment and management can make to a young person's experience of care.

Two vignettes about supervision

1.

Ms N is a 13 year old girl with insulin dependent diabetes. She had become depressed, had expressed suicidal ideas, was no longer adhering to her treatment and had threatened to take an overdose of her insulin. Her diabetic control was now sub-optimal, and efforts were being made to re-stabilise this.
Admission to hospital was thought necessary for assessment and treatment of her depression. There was no bed available in the regional adolescent unit, and admission to the paediatric ward, with her CAMHS consultant as RMO was felt more appropriate than admission to the adult psychiatric ward.

In the event she refused to agree to come into hospital and was admitted on a STDC. She was assessed as requiring constant observation because of the self-harm risk. Because she was detained, local protocol meant that this enhanced observation would be provided by an RMN at all times.

We visited, and noticed that she was being cared for in a side-room, with a one-one observation in place, the nurse on duty being an older male nurse. He told us he was a bank nurse with no CAMHS experience, and had not had any direct contact with the CAMHS team before starting his shifts with Ms N.

Ms N told us she felt very uncomfortable being constantly in such close proximity, generally without any wider company, with a much older man she did not know, who she said "just watches me" and who did not seem to be relaxed about engaging in conversation or activities, as some of the RMNs did. There was an adolescent group, and a school on the ward, and both of these had activities going on, under the supervision of staff. She would have liked to join in with this group, but she was embarrassed about having to have her observing nurse present. Staff had not had authority from the CAMHS RMO to relax this requirement, although they felt it was inconsistent with her being allowed off the ward in the care of her mother or her father.

In the event, transfer to a YPU was possible later that day, but we raised issues with RMO about the need for a careful risk assessed approach to measures which are so restrictive, and about measures taken being appropriate and consistent. We feel

there is a need to look at who is delivering constant observation, to ensure nursing staff acting in this role have the necessary skills and experience. When a young person is being cared for outwith a specialist unit, they should be excluded to the least possible extent from their peer group, and activities from which they might benefit.

2.

A young person aged 14 was detained on adult general ward. He was very unhappy because he was being cared for on 1:1 constant observations, and was not allowed to associate with any other patients. He complained that some of the nurses observing him did not interact with him in any way, and sat at the doorway, facing away from him. His main complaint though was how isolating he found it to not be allowed any association with any other patients. It meant he had to spend almost all of his time in his room, including having his meals there, as he did not access the sitting room or dining room, unless the former was empty. He said it felt like he was being punished.

He had previously had an admission, just a few weeks previously, to a nearby adult general ward. There he had also been on 1:1 constant observation, but had been allowed to mix with certain other patients , and join in activities with these other patients, under dedicated staff supervision. He had much preferred this, and said the company and mutual support from within the patient group had helped him cope better with his distress at being in hospital.

His mother said she had had confidence that staff in the first placement had clearly identified those patients with whom he should and should not be able to mix, and that even with the former group, staff were always present and intervened effectively if either the content or language of any conversation became inappropriate.

Staff on the current placement acknowledged that there had been no risk assessment of the current patient mix, in relation to any risk they might present to this young person, and that actually currently they had no patients who on either history or current presentation, would be likely to present any risk, or inappropriateness to the young person. In part they had taken the decisions based on a local policy which seemed to be folklore- no one had seen it or could produce it – and which they thought was based on an (erroneous) interpretation of MWC guidance in this matter.

Other care provision for young people, 1 April 2011 to 31 March 2012

Other provision	Age 0-15	Age 16-17	All	% of all admissions
Access to age appropriate recreational activities	19	55	74	**62%**
Access to education was discussed	9	26	35	**29%**
Access to advocacy service	20	75	95	**79%**
Young person has a learning disability	3	9	12	**10%**

Percentages in the final column are based on all admissions where further information was provided to the Commission =120

Our interest in these figures

We ask for further information about access to other provisions to give us a clearer picture of how NHS Boards are fulfilling their duty to provide age appropriate services.

We are aware that because a large proportion of admissions are for very short periods of time access to appropriate recreational activities and education may not be significant for many young people. We want to know if independent advocacy services are readily available, given the important role advocacy can play in ensuring that any patient's views are heard.

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

What we found

The information provided indicates a significantly higher proportion of young people having access to age appropriate activities than in 2010/11 (62% compared to 44%), and almost the same proportion having access to advocacy services (79% compared to 81%) We welcome the availability of advocacy, although it is still concerning if all young people are not reported as having access to advocacy during their admission. We are also pleased to see that more attention appears to being paid to ensuring that young people have access to age appropriate recreational activities during an admission, and where beds have been designated in specific adult wards for the admission of young people we have seen examples of considerable attention being paid to providing age appropriate activities.

From the information provided access to education was discussed less frequently in 2011/12 than in the previous year (in 35 cases as opposed to 48 cases in 2010/11) It may not have been appropriate to discuss access to education if an admission was for a very short period of time. We have concerns though that in certain situations it clearly would have been appropriate to consider issues about access to education, when a young person was in a non-specialist facility. We have made a specific recommendation about this issue in a previous themed visit report, and we remain concerned that in the absence of specialist CAMHS or social work input staff in adult wards will not know how to access education services if this is appropriate while a young person is in hospital. We have also started to ask for more specific details about how this issue is being addressed in our monitoring forms so that we will be gathering better and more consistent information about education provision in the future.

There has been a small increase in the number of young people with a learning disability admitted to non-specialist facilities, up from 10 in 2010/11 to 12 in 2011/12.

As we have said above we have ongoing concerns about the lack of appropriate services for young people who have significant learning disabilities and require in-patient admission, and we are aware of a small number of young people who have to transfer to specialist facilities outwith Scotland for this reason. In some cases we are aware that health boards go to considerable lengths to try to put a specific service in place locally to meet the needs of young people in this situation. We will continue to monitor such admissions, and to visit to look at how care and treatment is provided when we feel this is appropriate.

Vignette about education provision.

Andrew is 15 years old and has been diagnosed as having a psychotic illness. He had been in contact with his local CAMH service for six months, before he became acutely unwell, and was admitted to an adult ward.

Before this admission Andrew had been missing much of his schooling. This had been discussed at multi-disciplinary reviews within the CAMH service, which his guidance teacher had attended, and options for his education were being looked at, including home tuition and attending a special pupil support service in one particular school. After he was admitted to the adult ward an arrangement was made for him to attend a special day unit which provides education for children in hospital or who are not able to attend school for medically related reasons. When the Commission visited him in the adult ward he was going to this unit from Monday to Friday.

We were pleased to see that education provision was considered, and that arrangements were made for education in this case. This may well not have happened though if education provision was not being discussed before Andrew's admission to hospital. When a young person is admitted to an adult ward it would be unusual for staff in that ward to be aware of arrangements which can be made for the provision of education off site, outwith schools. It would also be rare for staff to know who to contact in an education authority to discuss the provision of education for any young person who may be an in-patient for a lengthy period.

Education authorities have a clear duty to arrange for the education of young people who cannot attend school because of prolonged ill-health. When a young person is admitted to an adult ward for a period of time which will affect their education we think it is very important that their education needs are being looked at and met. In Andrew's case this was happening, and we would want to see clear arrangements in place across all health boards, to make sure that education authorities are involved in looking at how any young person in an adult ward for a prolonged period can access education.

Age of young person by gender, 1 April 2011 to 31 March 2012

Age in years at last birthday	Gender		Total
	F	M	
12	1	1	2
13	4	0	4
14	4	7	11
15	10	4	14
16	23	10	33
17	19	32	51
Total	**61**	**53**	**115**

This is based on the number of young people admitted in the period, including where no further information was supplied to the Commission. 115

Our interest in these figures

Monitoring the admission of young people to non-specialist settings such as adult and paediatric wards for the treatment of mental illness has been a priority for us since the 2003 Act came into force, and will remain a priority. We are interested in the figures for the age and gender of young people admitted, because they can indicate whether there are any trends evident over a period of time, with regard to the admission of young people. They can suggest where services should be giving careful thought to arrangements in place to meet needs, or where there may be specific issues to address.

What we found

The data on the admission of young people to non-specialist wards had shown in previous years that mental health services were treating young men and young women differently, with the number of admissions for young men going up, while admissions of young women was decreasing. We have previously looked at some possible reasons for this, suggesting that young women may be more likely to be admitted on an arranged basis, often for treatment of eating disorders, whereas young men may be more likely to need urgent admission for other mental health problems, when arranging a specialist placement is more difficult. We also suggested that there may be a tendency to regard 17 year old males as less suitable for an adolescent mental health ward.

Again this year, as was the case in previous years there were more 17 year olds admitted than any other age group, with 73% of admissions involving young people aged 16 to 17, up slightly from 70% last year The trend, up to 2009/10, was for the number of female admissions to non-specialist facilities to fall and the number of male admissions to rise, particularly in the 17 year old age group. This trend was not observed 2009/10, when there were almost equal numbers of male and female admission for 16 and 17 year olds. In 2010/11 however the pattern we had been observing was observed again, with a drop in the number of admissions of females aged 15, 16 and 17, and an increase in the numbers of young males within the same age groups. This year we found that the female admissions in the 15 and 16 year old age groups remained stable, with a marked drop in the admission of 17 year olds. We remain concerned about the position of the older adolescent males, and will continue to monitor the situation, to try to identify whether there are any particular barriers to admission to specialist in-patient care.