mentalwelfare commission for scotland

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STATISTICAL MONITORING

Young Person Monitoring 2015-16

OCTOBER 2016

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What we do

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

We do this by:

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

Executive Summary

This year's annual report on the monitoring of admissions of young people under the ages of 18 to non-specialist hospital wards for treatment of their mental health difficulties comes in two parts. First is a report on our routine monitoring activity that occurs throughout the year, followed by a report on an additional monitoring exercise undertaken over a period of six months, which examines in greater detail the admissions of young people to non-specialist settings.

We are pleased to report that this year admissions to non-specialist in-patient settings are at a much reduced level nationally (135 admissions involving 118 young people) when compared to last year (207 admissions involving 175 young people) and previous years. Three admissions were to paediatric wards, which are non-specialist wards for treatment of mental illness.

This year, most health board areas experienced similar or lower numbers than last year, and a small number of health boards witnessed larger reductions. We continue to see more females than males being admitted overall, with the predominant age range in both genders being 16 and 17 years old. This year, the age range of young people admitted to non-specialist settings has decreased, and we welcome the fact that no young person under the age of 12 years old was admitted to a non-specialist setting.

The predominant reason for admission, as reported last year, was self-harming and/or suicidal ideation. However, we also noted an increase in admissions of young people presenting with psychotic symptoms.

As in previous years, there continues to be an identified need for a small number of complex cases for access to specialist in-patient adolescent units that are not available within Scotland. As a result, cross-border transfers are made to specialist units in England because there are no suitable beds available in Scotland.

Scotland does not have any specialist hospital beds for young people under the age of 18 years with a learning disability, forensic needs or who require an Intensive Psychiatric Care Unit (IPCU) environment as part of their care. This lack of provision can mean that young people awaiting transfer to specialist beds in England are placed in non-specialist wards in Scotland. We are pleased to hear of the intentions to develop a national forensic mental health unit for young people over the next few years.

We continue to advocate for the need to review the availability of national hospital provision for young people with a learning disability, and also highlight the importance of the lack of service provision for young people requiring IPCU settings during their hospital stay.

Child and Adolescent Mental Health Services (CAMHS) remains a key focus area for Scottish Government, which has announced additional funding for improved mental health service provision across the country over the next few years. The Commission welcomes this investment. We look forward to seeing how this facilitates service development and the positive impact this could have on improving CAMHS access for young people. We also look forward to seeing how this might improve the services of young people admitted to hospital for assessment and treatment of their mental health needs.

The next Mental Health Strategy for Scotland is currently in development. The Commission hopes that this will continue to focus on the needs of young people in Scotland with mental disorder. In particular, the Commission hopes that the commitment made in the previous mental health strategy in relation to reducing admissions of young people to non-specialist environments (Commitment 12) will be updated and retained[1].

From our annual monitoring data, we can see that CAMHS workers continue to provide support to colleagues in non-specialist in-patient wards. This year, however, we report a decrease in the number of young people (46%) being able to access specialist CAMHS nursing support while an in-patient and a decrease in young people (38%) accessing additional age-appropriate care during their admission. Overall, specialist CAMHS support provided to young people during their admission relies heavily on the community CAMHS consultant psychiatrist. As part of our monitoring project, we were told that the impact on community CAMHS staff in supporting a young person while an in-patient can be considerable. It can result in community clinics being cancelled at a time when CAMHS services are attempting to increase accessibility of CAMH services to young people and their families in the community.

[1] Mental Health Strategy for Scotland 2012-2015. The Scottish Government. August 2012. http://www.gov.scot/resource/0039/00398762.pdf

Overall, we found that specialist CAMHS support to young people in non-specialist wards can vary considerably. We were pleased to witness the specialist CAMHS support provided by newly developed intensive treatment services or newly commissioned tier IV (most intensive provision) staff. These appear to be playing an increasingly important role in ensuring young people receive age-appropriate care while in a non-specialist setting, in addition to their roles in providing alternatives to hospital admission.

We are disappointed to see that access to age-appropriate activities for young people has reduced since last year; we had hoped to see this increase like it had in previous years.

The Commission is concerned about young people having limited access to education in some cases and about the lack of apparent consideration of this issue for many young people during their hospital stay.

The availability and promotion of advocacy to ensure young people are aware and are able to exercise their rights is an area of concern for young people in non-specialist wards. All specialist mental health units for children and young people have access to specialist advocacy services; this contrasts with the availability of advocacy to young people in non-specialist settings. The Commission will be focussing on young people's accessibility to advocacy as part of its new powers under the Mental Health (Scotland) Act 2015.

Summary of Recommendations

1. The Royal College of Psychiatrists in Scotland should review the standards developed by the Royal College of Psychiatrists in England to help adult mental health wards demonstrate their ability to provide safe and appropriate care for young people under the age of 18 years who require admission, and determine whether these standards should apply to Scottish non-specialist settings.

2. The Scottish Government, together with health boards and other key stakeholders, should review the availability of IPCU beds nationally for young people under the age of 18 in Scotland to ensure that young people requiring such provision have timely access to these environments when required.

3. Hospital managers of the regional adolescent units should review admission procedures to establish whether access to the unit can be improved for all new referrals out-of-hours and at the weekend.

4. Hospital Managers should ensure that a range of age-appropriate activities are available to a young person while they remain an in-patient. All activity planning and participation should be clearly documented in the young person's care plan. We would expect to see that the young person is involved in developing a programme of activities for their stay, which should reflect their mental health needs and interests.

5. Ward managers should ensure that when a young person's stay is longer than one week and the young person is under 16 or in formal education, their educational or learning needs are considered shortly after admission, and decisions should be made after consultation with the young person about how their needs can be supported. Learning/educational needs and any plan to support them should be clearly documented as part of the young person's treatment plan while they are in hospital and regularly reviewed.

6. Ward managers should ensure that young people are informed how to seek independent advice within 24 hours of admission (and as often as is required) and are supported in their use of advocacy services. This should be clearly documented in the young person's case notes.

Introduction

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

Each year we report on this monitoring activity and publish our findings. In previous years, we have undertaken additional monitoring exercises to explore some of the difficulties that can arise when young people are admitted to wards that are designed primarily for the needs of other age groups or different patient populations.

In recent years, the mental health of children and young people in Scotland has been a key area of focus for policy makers, and the Scottish Government has articulated the aim that Scotland be the best country in the world for a young person to grow up in. Child and Adolescent Mental Health Services (CAMHS) have been a clear focus of mental health strategy. The government has aimed to increase access of children and young people to specialist CAMHS across the country, and to reduce the admissions of children and young people to non-specialist wards to low levels.

The Royal College of Psychiatrists recently published a survey of in-patient admissions for children and young people with mental health problems across the UK[2]. Recommendations from this survey include targeted investment in community mental health services to minimise the need for admission, and nationwide development of comprehensive intensive outreach/treatment teams to undertake crisis assessment, crisis management and facilitate early discharge from hospital. They also called for planned intensive home treatment for children and young people.

In 2009 the College together with the National Mental Health Development Unit published accreditation standards to try and help adult mental health wards demonstrate their ability to provide safe and appropriate care for young people under the age of 18 who require admission but cannot be accommodated in a specialist adolescent in-patient unit (which is always to be preferred)[3].

[2] Survey of in-patient admissions for children and young people with mental health problems. Royal College of Psychiatrists. March 2015. FR/CAP/01 http://www.rcpsych.ac.uk/pdf/FR%20CAP%2001%20for%20website.pdf

[3] AIMS-SC4Y Safe and Appropriate Care for Young People on Adult Mental Health Wards. Royal College of Psychiatrists. December 2009. http://www.rcpsych.ac.uk/PDF/AIMS-SC4Y%20Standards%202009-2010.pdf

Although these standards refer to hospitals in England and to the Mental Health Act in England and Wales[4], many of the standards described would be relevant to the expectation of care provision in Scotland's non-specialist settings when a young person is admitted.

Recommendation 1: The Royal College of Psychiatrists in Scotland should review the standards developed by the Royal College of Psychiatrists in England to help adult mental health wards demonstrate their ability to provide safe and appropriate care for young people under the age of 18 years who require admission, and determine whether these standards should apply to Scottish non-specialist settings.

There has been an increased national focus on the mental health needs of children and young people in recent years. The importance of children and young people's health and health care, including mental health, is recognised in a number of Scottish Government policies and publications. Information on the Children and Adolescent Mental Health Services (CAMHS) workforce across Scotland has been collected routinely since 2006 and is now published quarterly. Overall, staffing levels have been steadily increasing from 2009 to 2016 although not in all disciplines, with some experiencing reductions in numbers in recent years[5].

The Scottish Government sets targets for health priorities, and the importance of CAMHS has been highlighted in the target for faster access to this service – an 18 week referral to treatment target for CAMHS which was due for delivery by December 2014[6].

Following additional work and engagement with heath boards and stakeholders, the Scottish Government determined that the CAMHS service standard should be set at a maximum wait of 18 weeks in 90% of patients. Unfortunately, this target has not been reached across Scotland as a whole, although some health boards have been able to do so.

[4] Section 131A Mental Health Act 1983 http://www.legislation.gov.uk/ukpga/1983/20/section/131A/england/1992-01-01

[5] Information Services Division Scotland (07/06/2016); Child and Adolescent Mental Health Services (CAMHS) in NHSScotland: Workforce information as of 06 September 2016 https://isdscotland.scot.nhs.uk/Health-Topics/Workforce/Publications/2016-09-06/2016-09-06-CAMHS-Report.pdf

[6] Deliver faster access to mental health services by delivering 26 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) services from March 2013; reducing to 18 weeks from December 2014; and 18 weeks referral to treatment for Psychological Therapies from December 2014. The target is for at least 90% of young people to start CAMH services treatment within 18 weeks by the quarter ending March 2015. The latest figures are reported are available for 06 September 2016 https://isdscotland.scot.nhs.uk/Health-Topics/Waiting-Times/Publications/2016-09-06/2016-09-06-CAMHS-Report.pdf

In Scotland, there are three regional adolescent in-patient units provided within the National Health Service and one private hospital that provides care for young people under the age of 18 years with mental health difficulties[7]. In addition to these specialist adolescent units, the National Child Inpatient Unit based in Glasgow receives admissions of children under the age of 12 years with mental health difficulties from across Scotland.

Monitoring the admissions of children and young people to non-specialist facilities remains a priority for the Commission. We routinely collect information about the admissions of young people when they are admitted to wards for mental health care that are not the above specialist adolescent units or the National Child Inpatient Unit. We do not collect information on those admissions that are less than 24 hours in duration, are solely related to drug or alcohol intoxication or are solely for the medical treatment of self-harm. We expect to be notified of all admissions of young people to non-specialist facilities which meet our criteria, and once we have been notified about an admission, we send out a questionnaire to the consultant in charge of the young person's care (or RMO) to find out further information about the admission. We publish these findings annually.

In 2015-16, we received further information about the admission for 96% (129) of admissions, an improvement from last year's high level of 89%. As part of our monitoring process at quarterly intervals throughout the year we liaise with health boards across the country to try and ensure we have been notified about all the appropriate admissions. In this year's annual report, we are able to report for the first time on the duration of young people admissions to a non-specialist environment.

We also are able to report on an additional monitoring exercise that we undertook over a six-month period this year to gather more information about the quality of care a young person receives once they are admitted to a non-specialist setting. The findings of this exercise can be found on pages 32-49 of this report.

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

They also provide care for individuals with mental disorder who have been transferred from prison or the courts.

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

Provision of age-appropriate care for people under 18

In this part of the publication, we report on our work to examine the care and treatment of young people admitted to non-specialist mental health care over the full year period (April 2015 – March 2016). Section 23 of the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Act') places a responsibility on NHS boards to provide accommodation and services to meet the needs of persons under the age of 18 who are admitted to hospital as a consequence of mental disorder.

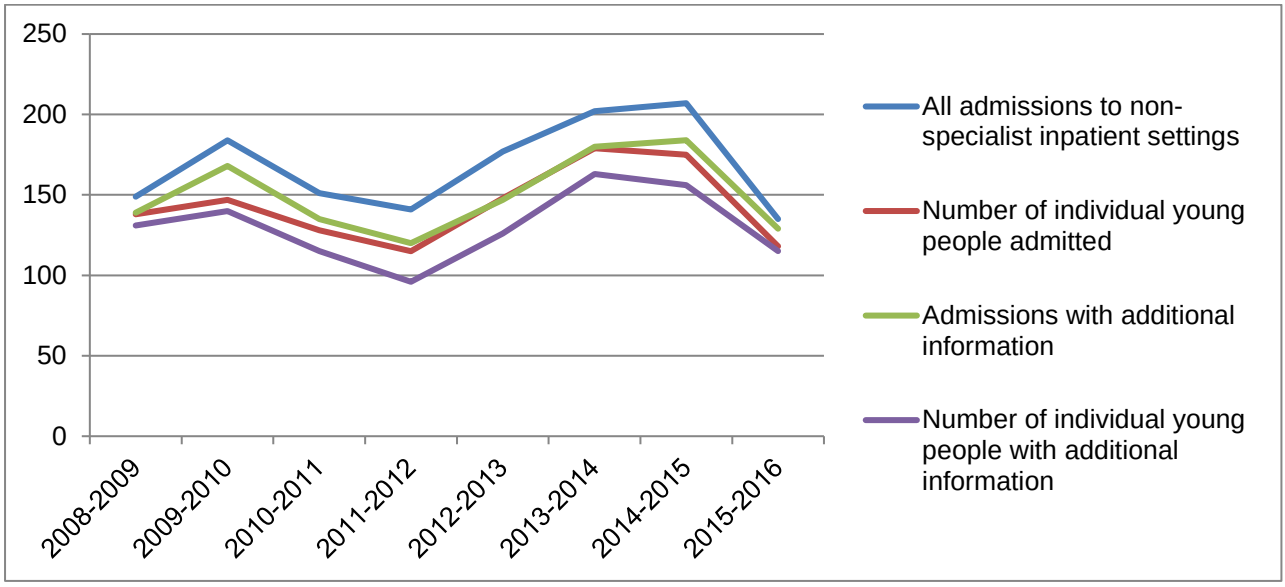
The Code of Practice to the 2003 Mental Health Act states that young people should be admitted to a non-specialist ward only in exceptional circumstances. There are a number of differences between specialist adolescent units and wards designed to treat the needs of adults with mental disorder, both in terms of staff training and experience and also in terms of the ward environment. There is a concern that the needs of a young person may not be met in a comparable way when a young person is admitted to an adult mental health ward for mental health reasons as opposed to a specialist adolescent unit. Unfortunately the demand for specialist adolescent inpatient beds in the under 18 population has been greater than supply in recent years and CAMH services across the country have been working hard both to try and reduce the number of young people admitted to non-specialist wards and to also improve their experience of care whilst an in-patient in these settings.

Young people (under 18) admitted to non-specialist facilities, by year 2008-2016

Table 1 Young people (under 18) admitted to non-specialist facilities, by year 2008-16

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

Figure 1 Young people (under 18) admitted to non-specialist facilities, by year 2008-16



Our interest in these figures

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

We noted in 2010-11 and 2011-12 that there were drops in admissions across the country, which was consistent with the Scottish Government's aspiration to reduce admissions to non-specialist settings. We were disappointed to see that in 2014-15 the number of admissions (207) was at an all-time high. However, this year we are pleased to be able to report a substantial drop in the number of admissions to 135 admissions over the course of the year, involving 118 young people. This reduction is welcome and it is hoped that this can be sustained in the future.

It is important to try and understand what factors have been important in reducing non-specialist admissions in order to try and ensure there is ongoing matching of in-patient and tier IV (most intensive) CAMH service provision to the mental health needs of Scotland's under 18 population of young people.

A number of factors influence the decision about where a young person is admitted for care of their mental health. In our additional monitoring exercise reported on later in the report, we explore the factors influencing location of admission in nationwide admissions of young people to non-specialist wards over a six-month period (1st October 2015–31st March 2016). In some cases, admission to a non-specialist ward may on balance be regarded as the best option for the child or young person. In a significant number of cases, admissions are for very short periods and an admission to a local non-specialist ward might enable contact with the family to be maintained more easily and local community services to be co-ordinated more effectively.

What has not been clear from the figures in recent years, however, was what proportion of the admissions to non-specialist settings reflected the number of cases where admission to a non-specialist ward was a positive choice as opposed to a lack of availability of a specialist adolescent bed. In recent years, we have also been concerned, as we will discuss later, about the level of specialist multi-disciplinary support available to children and young people in non-specialist wards. Across the country this appears to be very variable and our additional monitoring exercise sought to look at this issue in more detail.

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

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

Health Board	Hospital	Paediatric	Adult	Total
Ayrshire and Arran	Ailsa	0	5	5
	Ayr Clinic	0	1	1
	Crosshouse	1	14	15
Borders	Borders General/Huntlyburn house	0	7	7
Dumfries and Galloway	Dumfries and Galloway Royal Infirmary	0	1	1
	Midpark	0	4	4
Fife	Queen Margaret	0	2	2
	Whyteman's Brae	0	3	3
Forth Valley	Forth Valley Royal	1	10	11
Grampian	Dr Grays	0	5	5
	Royal Cornhill	0	10	10
Greater Glasgow and Clyde	Dykebar	0	4	4
	Gartnavel Royal	0	4	4
	Inverclyde Royal	0	2	2
	Leverndale	0	3	3
	Parkhead	0	2	2
	RHSC	1	0	1
	Royal Alexandra	0	1	1
Highland	Argyll and Bute	0	3	3
	New Craigs	0	6	6
Lanarkshire	Hairmyres	0	10	10
	Monklands	0	7	7
	Wishaw General	0	10	10
Lothian	Royal Edinburgh	0	1	1
	St Johns	0	2	2
Shetland	Gilbert Bain Hospital	0	2	2
Tayside	Carseview Centre	0	7	7
	Monroe House	0	1	1
	Ninewells	0	1	1
	Stracathro Hospital	0	3	3
Western Isles	Western Isles	0	1	1
Scotland		**3**	**132**	**135**

What we found

In 2015-16 we were notified of 135 admissions to non-specialist wards involving 118 young people. This is a large reduction from the previous two years where we were notified of 207 admissions involving 175 young people (2014-2015) and 202 admissions, involving 179 young people (2013-2014 figures) respectively.

There continue to be several cases each year where young people from Scotland are transferred to specialist adolescent units in England due to a national lack of provision for the particular mental health needs of young people. In the absence of any similar unit for young people in Scotland, these will continue to be placed in specialist units in England. One such group for whom Scotland has no in-patient provision at present are those young people who have both significant mental health difficulties and forensic needs.

We are pleased to hear the news that the recent work undertaken nationally involving discussions with Scottish Government has progressed and a new medium secure forensic unit for young people under the age of 18 years is proposed to be built over the next few years. We look forward to hearing how this work progresses and monitoring the impact of this development in service provision.

A second group for whom there is currently no inpatient provision in Scotland are young people with a learning disability. The Scottish Government are committed to taking forward work to identify good models of learning disability CAMH services (commitment 10 in the Mental Health Strategy for Scotland 2012 - 2015). The NHS Information Services Division, in partnership with the Commission, Kindred and Scottish Government, have been conducting an exercise to collect data about the needs of young people with learning disabilities who may have to be placed in English units due to a lack of provision of in-patient facilities in Scotland. The report from this group is due shortly.

A third group whose inpatient requirements are not currently met fully in Scotland are those young people under the age of 18 requiring access to IPCU facilities during the course of their hospital stay. Although a proportion of these young people looked after in IPCU facilities are either in transition to secure forensic provision in England (and so will be likely to be cared for in the new secure forensic unit once it is up and running) many are not and require IPCU facilities for a short period of time during the course of their hospital admission. As a consequence these young people will be unaffected by the proposed new forensic service provision.

This year, 14 young people (11%) required IPCU facilities. From our work during the year we are aware of difficulties that can arise when a young person requires IPCU facilities; this lack of service provision can present significant difficulties for the young person and their clinical team alike. This issue appears to be especially problematic when the young person is under the age of 16 years.

We are aware of work being undertaken in the West of Scotland to explore the need for specialist IPCU facilities for young people in that region, but we understand that there is currently no work being undertaken to look at IPCU requirements nationwide in the under 18s.

Recommendation 2: The Scottish Government, together with health boards and other key stakeholders, should review the availability of IPCU beds nationally for young people under the age of 18 in Scotland to ensure that young people requiring such provision have timely access to these environments when required.

In the 2012-2015 Mental Health Strategy, the Scottish Government stated its commitment to reducing admissions of young people to adult wards to rates comparable to those achieved in the South of Scotland area. Approaches to achieve this goal have included increasing capacity of the specialist adolescent estate (Dudhope House in Tayside increased its bed capacity from 6 to 12 in 2015) and promoting the development of CAMHS intensive services to provide alternatives to admission and help reduce length of stay within adolescent units. Although this commitment was not achieved across Scotland within the time frame of the Mental Health Strategy, this year we have seen numbers of young people admitted to non-specialist wards fall. When making enquiries around the reasons behind this, the role of CAMHS intensive treatment services has been identified as a key contributory factor. We are aware that not every health board has a CAMHS intensive treatment service although we know of a number being planned. We hope that the next mental health strategy will continue to retain this goal of reducing admissions of young people to non-specialist wards.

Young people admitted to non-specialist facilities by NHS board, by year 2010-2016

Table 3 Young people admitted to non-specialist facilities by NHS board, by year 2010-2016

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

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

Our interest in these figures

It is our view that when a young person requires in-patient treatment, their individual clinical needs should be given paramount importance. When 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 with the previous year.

There continue to be differences in the configuration of CAMHS across the country with varying eligibility criteria. It had been hoped that by the end of 2015 all CAMHS in Scotland would reconfigure to provide services for children and young people up to the age of 18. However, this has not happened everywhere in Scotland and some CAMH services continue to provide mental health services only for children and young people under the age of 16 years and a proportion of young people between the ages of 16 and 18 years. This difference in service provision affects the numbers of young people admitted to non-specialist wards (see findings of additional monitoring exercise on page 38).

In April 2015, we began collecting data relating to duration of stay of young people in non-specialist settings. We wanted to see how long young people remained in non-specialist wards. We have been aware, from our monitoring activity and from our visits to young people that lengths of stay in non-specialist environments can vary considerably. We now intend to report on length of stay in each year's annual monitoring report.

What we found

Figures in Table 3 compare admissions to non-specialist in-patient mental health beds for young people up to the age of 18 years by NHS board area from 2010-11 to 2015-16. This year, we are pleased to report that all NHS board areas in Scotland have experienced admission numbers at a similar or reduced level to previous years. NHS Greater Glasgow and Clyde in particular has achieved a rather pronounced reduction in admission numbers (53% reduction from those experienced in 2014-2015).

West of Scotland

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

We have been told that greater staffing stability (especially medical staff) in Skye House and ongoing service redesign initiatives within the unit (to improve the focus of admission, plan for discharge early in admission, and help co-ordinate in-patient and out-patient CAMHS teams) have had a positive impact in the number of admissions each year and in reducing the average length of stay. This in turn has led to increased capacity in the specialist in-patient estate and therefore had an impact on admission numbers to non-specialist wards.

In addition to initiatives within the unit, we have been told that staff from all boards of the West of Scotland CAMHS network have been funded to be trained in Family-Based Treatment, an evidence based treatment for anorexia nervosa. Use of this treatment within the community is said to have led to a reduction of young people with eating disorders being treated as inpatients both within non-specialist and specialist settings.

NHS Dumfries and Galloway, NHS Lanarkshire, NHS Greater Glasgow and Clyde all now have CAMHS intensive treatment services, which are said to make an important contribution in supporting young people at risk of admission in the community and providing an alternative to hospital admission. NHS Ayrshire and Arran also intends to develop an intensive support service using Scottish Government Innovation monies, and has recently developed an acute liaison nurse post to provide a nursing mental health and risk assessment for children and young people admitted to the local Paediatric Unit due to mental health difficulties. This post also aims to liaise with CAMHS partners within NHS Ayrshire and Arran and with the regional specialist adolescent unit, Skye House in Glasgow when a young person has been admitted. This initiative has recently been reviewed and was reported to have provided significant benefit to collaborative working across services in the provision of care.

In NHS Greater Glasgow and Clyde area, the number of admissions has decreased sharply. The introduction of a bed manager post within NHS Greater Glasgow and Clyde is said to have had a positive impact in terms of facilitating admission of young people to Skye House and co-ordinating Tier IV CAMHS support to a young person in the community at risk of admission. This activity is said to have helped to postpone hospital admission until a specialist bed has become available, and thus prevent non-specialist admissions. We have been told that the bed manager role has now been extended to the five health boards that refer young people into Skye House, and it is hoped that this activity will benefit individuals in those health boards too.

East of Scotland

NHS Borders, NHS Lothian and NHS Fife all admit young people to the Young People's Unit, a 12 bedded specialist unit based in the Royal Edinburgh Hospital in Edinburgh. We have been told that there had been some issues in accessing specialist beds in the regional unit in the earlier half of the year which might have been due to staffing issues that the in-patient service encountered at the time.

These difficulties were also thought to have had an impact on the non-specialist admissions for NHS Lothian last year, and we are pleased to see that figures for Lothian have once again fallen to low numbers this year.

NHS Fife has a well-established intensive treatment service. Its admission figures have remained fairly static over the past five years, and have been lower than other health boards with comparable population sizes.

North of Scotland

The five health boards in the North of Scotland, which includes Highland (excluding Argyll and Bute), Grampian, Tayside, Shetland and Orkney, are all involved in the North of Scotland CAMHS Tier 4 Network. In the network, there are CAMHS network liaison nurses in post, with a role in providing consultation and support to professionals working with young people in the community and supporting transition in and out of the young person's unit at Dudhope House in Dundee. This is a new purpose built 12 bedded unit which opened in 2015 and has doubled the number of specialist beds available for referrals from these five health board areas from six. The reductions in non-specialist admissions in Tayside and Grampian coincided with the opening of Dudhope House. Unfortunately, there was a temporary period for several months from December 2015 when four of the new beds in the unit could not be used due to vacant staff posts within the unit. However, we are pleased to hear that the unit is now fully operational once again, and all beds available for referrers.

In NHS Highland, in addition to the work of the Network, there has been focus on improving CAMHS provision in the area. We have been told that NHS Highland is currently recruiting for three new Tier 4 nursing posts and a psychology post. We look forward to seeing how these new posts impact on non-specialist admissions in the future.

Length of stay in non-specialist wards 2015-2016

Table 4 Length of stay in non-specialist wards 2015-2016

Length of Stay*	2015-2016	%**
1-3 days	36	27
4-7 days	28	21
1-2 weeks	28	21
2-3 weeks	13	10
3-4 weeks	11	8
4 weeks+	7	5
5 weeks +	12	9
Total	135	100
Mean	15 days	
Median	8 days	
Mode	2 days	

*The Commission collects data on admissions that are 24 hours and above.
** Base =135 admissions

This is the first year that we have reported on the length of stay (LOS) of admissions of young people to non-specialist wards. The LOS is the amount of time that a young person remained in a non-specialist ward. As expected, a large proportion of admissions are three days or under (27%) and seven days and under (48%). Nevertheless, we were struck by the duration of some admissions: a small minority of young people remained in-patients in a non-specialist environment for well over two months.

Most of these admissions involved young people where there was no national provision of inpatient beds for their age group and mental health needs. The length of a small number of very long admissions is reflected in the average length of stay calculated. The mean of the LOS is 15 days, while the median is shorter at 8 days. The most frequent length of stay or mode was 2 days.

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

Specialist health care for admissions of young people in non-specialist care, 2015-2016

Table 5 Specialist health care for admissions of young people in non-specialist care, 2015-2016

Specialist medical provision	Age 0-15	Age 16-17	All	*%
RMO at admission was a child and adolescent specialist	10	53	63	49
Nursing staff with experience of working with young people were available to work directly with the young person	15	44	59	46
Nursing staff with experience of working with young people were available to provide advice to ward staff	15	85	100	78
The young person had access to other age appropriate therapeutic input	10	39	49	38
None of the above	0	11	11	9
Total admissions*	**18**	**111**	**129**	**100**

***** Base=129, all admissions where further information was provided; percentages may sum to more than 100% as more than one type of specialist medical provision might be provided at any one admission

Our interest in these figures

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

Each year, we specifically want to see whether specialist child and adolescent services input is available, to ensure that appropriate care and treatment is being provided to the young person, and that relevant guidance and support is available for staff in non-specialist units who will have less experience of providing treatment and support to young people.

In the course of our visits, we have been made aware that access to specialist child and adolescent services when a young person is admitted to an adult ward varies across the country. Although we can report some improvements, overall there continue to be reports of limited access to CAMHS support during some admissions.

It is important that health boards remain focussed on the provision of appropriate care for this group of young people while in hospital, and ensure that the care and treatment provided during their stay in a non-specialist environment reflects the clinical needs of the young person.

On page 42, we report on our more detailed review of the provision of multi-disciplinary CAMHS input for young people admitted to non-specialist wards over a six-month period.

What we found

This year, there has been no improvement in the percentages of young people with specialist care input from CAMHS staff during their admission to a non-specialist unit. In fact, the figures in the table above have changed little in recent years and we continue to have concerns about this. We hope that the developments of CAMH services in many NHS board areas will increase the provision of CAMHS multi-disciplinary staff available to support the admission of a young person in a non-specialist environment in the future. In some circumstances where an admission might be of very short duration, the provision of direct specialist clinical contact might not be as important in terms of provision of care as stays of longer duration. However, even in short admissions the task of liaison, communication and co-ordination of care around discharge and discharge planning is crucial for young people presenting in crisis.

This year, the consultant in charge of a young person's care (or RMO) was a child and adolescent specialist in 63 (49%) of the 129 cases we were given additional information about. This compares with 54% of admissions (100 out of the 184 cases) in 2014-2015, 50% in 2013-2014 (91 out of 180 cases) and 52% (77 out of 147 cases) in 2012-2013. However, we are pleased to see that, in many cases specialist child and adolescent consultants continue to provide advice and support to young people during admissions. This approach greatly increases the continuity of care for young people already engaged with child and adolescent services prior to admission.

Once again, we have seen a decrease in the proportion of admissions where there has been direct input from nurses, experienced in working with children and adolescents. This year the figure is 46% (59 out of 129 cases) down from 48% in 2014-2015, 56% in 2013-14 and 58% in 2012-2013.

Additionally, the percentage of admissions where there have been nurses available with relevant CAMHS experience to provide advice to ward staff is slightly lower than last year at 78% (100 out of 129 cases), compared with 85% in 2014-2015, 80% in 2013-2014, and 76% in 2012-2013.

It is not clear whether the increased focus on the 18-week referral to treatment HEAT target for community CAMHS staff has impacted negatively on the availability of nursing staff to support non-specialist admissions of young people. We look forward to observing the impact of the increasing investment in tier IV provision that is occurring in many health board areas to see whether this will improve access to specialist nurses while a young person is an in-patient in a non-specialist ward.

This year, we report a decrease in the proportion of young people being able to access additional age-appropriate therapeutic input (38% or 49 out of 129 cases). This is a reduction from 59% last year, 51% in 2013-14 and 88% in 2012-2013.

As is the case for specialist nursing provision above the provision of age appropriate multi-disciplinary therapeutic input is an area of interest to the Commission and we will continue to monitor this closely. Findings from our additional monitoring exercise where we looked at age-appropriate therapeutic input in more detail can be found on page 45.

Social work provision for admissions of young people to non-specialist care 2015-2016

Table 6 Social work provision for admissions of young people to non-specialist care 2015-2016

Social work provision	Age 0-15	Age 16-17	All	*%
Young person was looked after and accommodated by the local authority	3	14	17	13
Young person had access to social work	13	78	91	71
Neither of the above	4	32	36	28
No information	1	1	2	2
Total*	**18**	**111**	**129**	**100**

*Total=129, based on all admissions where further information was provided to the Commission

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, there should be clear local arrangements to secure that input. There 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 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. The recent Guidance on Health Assessments for Looked after Children and Young People[8] emphasises that mental health problems for 'looked after' young people are markedly greater than for their peers in the community. This guidance has a specific section on mental and emotional health which identifies a number of factors which may impact on a looked after young person's mental health. We would assume that any 'looked after' young person admitted to a non-specialist facility should have an identified social worker.

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

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

What we found

In 2015-2016, 71% (91 out of 129 cases) of young people had access to a social worker, either at the point of admission or during their admission. This compares with 74% in 2014-15, 76% in 2013-2014, and 74% in 2012-2013.

We follow up cases where the monitoring information received about a young person's admission indicates issues concerning accessing social work input. We will continue to monitor this area in the future and follow up enquiries about individual cases when concerns about social work provision are brought to our attention.

Since April 2014, we have been asking RMOs if the young person was 'looked after and accommodated' by the local authority at the time of admission on our monitoring form.

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

Of the 129 admissions where further information was provided to the Commission, we were told that in 17 cases (13%) a young person was designated as 'looked after and accommodated' at the time of admission. This compares with 12.5% of young people last year (23 cases out of 184). Of the 17 young people this year, three were aged 15 or under and fourteen were aged 16 to 17 years.

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Supervision of young people admitted to non-specialist care 2015-2016

Table 7 Supervision of young people admitted to non-specialist care 2015-2016

Supervision arrangements	Age 0-15	Age 16-17	All	%
Transferred to an IPCU or locked ward during the admission*	2	12	14	11
Accommodated in a single room throughout the admission	15	98	113	88
Nursed under constant observation	16	82	98	76
Was this because of ward policy?	14	59	71	55
Was this following an individual assessment of the young person?	13	74	87	67
Total**	**18**	**111**	**129**	**100**

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

****Total=129, based on all admissions where further information was provided to the Commission; percentages may sum to more than 100% as more than one of the above arrangements may apply

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 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

We note that this year 14 young people (11%) out of the 129 cases where further information was provided to the Commission were cared for in an IPCU or locked ward during admission. This compares with 11% (21 cases out of 184) in 2014-2015, 9% (17 cases out of 180) in 2013-2014 and 13% (19 cases out of 147) in 2012-2013. Once again, this year a proportion of the young people concerned were under the age of 16 years (2 out of the 14 young people admitted to IPCU), which is slightly reduced from recent years where the proportion of the young people admitted to an IPCU or locked ward under the age of 16 has been around 25%. We continue to be concerned about the numbers of young people whose care necessitates the use of secure facilities but because of a lack of a specialist adolescent provision have to be cared for in an adult IPCU or locked ward environment.

Given that adult IPCUs are highly specialised environments and clinicians have raised concerns with us repeatedly about the unsuitability of an IPCU in providing secure care for young people, this lack of provision within Scotland for young people remains a concern. As mentioned previously (page 14), we support initiatives to review this issue at national level to determine how best to take these concerns forward.

We continue to monitor the use of enhanced observation levels and the use of single rooms for young people admitted to non-specialist environments. We are pleased that many health boards now have policies in place stating that young people should be cared for in a single room whilst an in-patient in a non-specialist environment, and be placed on enhanced observation levels for the duration of their stay. This year, the number of young people cared for within a single room has increased to 88% (113 out of 129 cases); this compares favourably with 81% last year, 82% in 2013-2014 and 80% in 2012-2013. We are aware from our visits that awareness and implementation of policies relating to single rooms and enhanced observation levels to promote the safeguarding of young people on non-specialist wards seems to be well established.

Other care provision for young people 2015-2016

Table 8 Other care provision for young people 2015-2016

Other provision	Age 0-15	Age 16-17	All	*%
Access to age appropriate recreational activities	8	46	54	42
Access to education was discussed	4	21	25	19
Appropriate education was provided	1	6	7	5
Access to advocacy service	11	73	84	65
Has access to specialist advocacy service	4	18	22	17
Young person has a learning disability	0	7	7	5
Total*	**18**	**111**	**129**	**100**

***Total=129, based on all admissions where further information was provided to the Commission; percentages may sum to more than 100% as more than one of the above supervision arrangements may apply

Our interest in these figures

We 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 a large proportion of admissions are for very short periods of time, and so access to appropriate recreational activities and education may not be significant for many young people. However, for longer admissions this area of service provision can be very important. We want to know if independent advocacy services are readily available, given the important role advocacy can play in ensuring that a young person's views are heard and the right that anyone with a mental disorder has in being able to access this service.
In the 2015 amendments to the 2003 Mental Health Act, health boards will have new responsibilities to demonstrate how they are discharging their legal responsibilities in relation to advocacy. The Commission will have a role in reviewing this information to ensure that independent advocacy services are available and accessible for individuals with mental disorders in each health board area.

We also want to know how many young people with a learning disability are admitted to non-specialist facilities. There are 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

In previous years we have been pleased to see attention being paid to ensuring that young people have access to age-appropriate recreational activities during an admission.

However, this year the proportion of admissions where a young person was described as having access to age-appropriate recreational activity has fallen to 42% (54 out of 129 cases). This is disappointing and compares with last year when the figures were 60 % (111 cases out of 184), 62% in 2013-2014 (111 out of 180 cases) and 55% (81 out of 147 cases) in 2012-2013.

Each year we ask for information about the activities that young people had access to while they were receiving care and treatment as in-patients. Many young people are reported to have access to electronic games (including their phones, Xboxes, Wiis, computer games or other equipment), and to music and DVDs. Access to physical activities, including gyms, are also mentioned for some young people. We are aware that many admissions are for relatively brief periods, but we are concerned that not enough attention is given to structuring daily activity for young people with clear documentation regarding decisions made regarding appropriate activities available to a young person (involving the young person's views) and how these can be provided. (See page 46 for findings of additional monitoring exercise.)

A lower proportion of young people were reported as having access to advocacy during admission this year: 65% (84 out of 129 cases). This compares with figures for last year of 72%, 65% in 2013-14 and 70% in 2012-2013. Of the young people who had access to advocacy during an admission, 17% (22 out of 129 cases) had access to a specialist advocacy service (for children and young people) and this compares with 29% (38 out of 184 cases) last year. This result is disappointing. We would expect advocacy support to be available and to be routinely offered to young people.

It may be that during a very brief admission there is no time to involve advocacy to support a young person. However, the findings from our monitoring project described on pages 47-48 raise concerns about the accessibility of advocacy supports during young people's admissions to non-specialist wards.

As part of our routine monitoring activity, we ask RMOs whether access to education has been discussed with the young person and, if not, to give reasons why. If education has been discussed with a young person, we ask whether education has been provided. This year, in only 5% (7) of cases was education discussed and provided. This compares with 9% of young people last year. Out of the 21 young people under the age of 16 admitted to non-specialist wards over the course of the year, in only one case was education discussed and provided to the young person. In 17 young people under the age of 16, education was neither discussed nor provided.

We know that it may not be appropriate to discuss access to education or learning if an admission is for a very short period of time or during a weekend or school holidays or when the young person is no longer in education. Sometimes a young person may be too unwell for education to be considered appropriate.

We have concerns, however, that for some young people it clearly would have been appropriate to consider issues about access to education when a young person has been admitted to a non-specialist facility. Some of the responses we receive indicate there is confusion about this issue (education not discussed because the young person is at college or not discussed because the young person refuses to attend school). We have made a specific recommendation about this issue in a previous themed visit report[9], and we remain concerned that in the absence of specialist CAMHS or social work input, staff in adult wards may not know how to access education services if this is appropriate while a young person is in hospital. As we have said in previous reports, education authorities have a duty to arrange for the education of young people who cannot attend school because of prolonged ill-health; we do think it is important that education needs are met when a young person is in an adult ward for a prolonged period.

The number of young people with a learning disability admitted to non-specialist settings this year was 7 out of 129 (5%). This compares with last year's figures of 8% (15 cases out of 184), 8% in 2013-14 and 10% in 2012-2013. We have ongoing concerns about the lack of appropriate services for young people who have significant learning disabilities and require in-patient admission. We are aware of a small number of young people who have to transfer to specialist facilities outside Scotland for this reason. In some cases, we are aware that NHS boards go to considerable lengths to try to put a specific service in place locally to meet the needs of these young people. We are aware of the work currently being undertaken at national level to review the lack of specialist CAMHS LD beds, and we hope that this will lead to the development of an appropriate service in Scotland. In the meantime, we will continue to monitor such admissions, and to visit these young people to look at how care and treatment is provided when we feel this is appropriate.

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

Age of young person by gender 2015-16

Table 9 Age of young person by gender 2015-2016

Age at last birthday (years)	Female	Male	Total
12	3		3
13	2		2
14	5	2	7
15	6	3	9
16	21	20	41
17	26	30	56
Total*	**63**	**55**	**118**

***Base=118 all individuals admitted over the year, including where no further information was supplied to the Commission

Our interest in these figures

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

What we found

In 2015-2016, there were a total of 135 admissions of young people under the age of 18 to non-specialist wards, which involved 118 young people. Since we began to gather data on the admissions of young people into non-specialist mental health beds, the Commission has identified early trends in admissions across the age range and in both females and males. In recent years, the age range of admissions to non-specialist wards continued to widen, and children under the age of 10 years were being admitted to non-specialist wards in 2014-2015 and 2013-2014. This trend has not continued this year, however, and the youngest child admitted to a non-specialist environment this year was 12 years old. We welcome this.

There continues to be a greater number of 16 and 17 year olds admitted to non-specialist wards than any other age group, and it is in this age group where there are repeat admissions this year. Unlike recent years, the 16 and 17 year olds in 2015-2016 represent a much larger proportion of the young people receiving care on a non–specialist ward: 97 out of 118 cases (82%), which compares with 69% in 2014-15, 65% in 2013-14 and 62% in 2012-13. Figures this year compare with figures of 16 and 17 year olds in the years 2008-2012 which ranged from 73%-80%.

Until recently, more young men aged 16 and 17 were admitted to non-specialist wards than young women.

However, this balance began to change in 2009-10 when the numbers became equal, and from 2012-13 more young females than males have been admitted to non-specialist units in the 16-17 age group. This year, slightly more admissions of males occurred in the 16-17 year old age group (50 males versus 47 female). More admissions of young females than males continue to occur in the 13-15 year old population and this predominance continues in the age group of 12 years and under, all of whom were female.

As in previous years, the most prominent reasons for admission reported to us in 2015-16 have been risk management in association with self-harm and suicidal ideation. This year, management of psychosis has been cited as an admission reason in more cases than before.

Conclusion

We very much welcome the substantial reduction in young people admitted to non-specialist wards for the treatment of their mental health difficulties. We hope that this will be sustained and even improved upon in the future. We have been aware, however, of the fragility of staffing in all three specialist in-patient units in recent years (especially in medical staffing), and the impact that this can have on the work of the adolescent units and also on the admissions of young people to non-specialist wards. We welcome the investment CAMH services around the country have been making in tier IV or/and intensive treatment services. We hope that these services will have responsibilities both to try and reduce the numbers of young people requiring hospital admission in a non-specialist setting and also to support the specialist care of those young people while they remain in non-specialist settings.

Additional Monitoring Exercise

In this section of the annual report, we report on an additional monitoring exercise that we undertook this year to gather further information about the admissions of young people to non-specialist wards over a six-month period.

Our interest in these figures

Our annual monitoring data provides us with information that gives us insights into the nature of admissions of young people under the age of 18 years to non-specialist wards in Scotland. The collection of this data over time has enabled us to monitor trends in admissions and the provision of care to young people in non-specialist wards.

In recent years, questions have remained about the reasons behind admissions to non-specialist wards for young people and whether this simply reflected a shortage of specialist adolescent beds available at the time of admission, or reflected more of a positive choice on the part of the young person or the clinicians looking after them to remain within a non-specialist setting. In addition to this question, we have noted the variability of provision of specialist CAMHS input into non-specialist admissions of some young people.

We wanted to gather more detailed information about the type of specialist CAMHS input provided to young people during their hospital stay.

Between October 1st 2015 and March 31st 2016, we undertook an additional monitoring exercise which ran in parallel to our usual Young Person monitoring. The results are reported on in the preceding pages of this report. For six months we undertook an additional case note review of a young person's admission which met our usual criteria, and began between the two time periods above. In addition we spoke with the RMO or consultant in charge of the young person's care to gather additional information about the young person's admission.

In this section of the report we report on the findings of this exercise.

What we found

Table 10 Admissions beginning in the six month period between 01/10/15-31/03/16

No. of notified admissions to non-specialist inpatient settings	59
No. of young people involved	57
No. of admissions where case note review was undertaken	57
No. of admissions where additional information was obtained from RMO	51

Gender	All	%*
Male	32	56
Female	25	44
Total	57	100

*Base =57 admissions where additional information was obtained.

Gender	1-15	%	16-17	%	All	%*
Male	5	45	27	59	32	56
Female	6	55	19	41	25	44
All	11	100%	46	100%	57	100
%*	**19**		**81**			**100**

*Base =57 admissions where additional information was obtained.

Over the six-month period of this additional monitoring exercise, we were notified of 59 admissions to non-specialist settings that were over 24 hours in duration and neither related to alcohol or substance intoxication alone or the medical treatment of self-harm. The 59 admissions involved 57 young people.

We were able to undertake a case note review in 57 out of the 59 admissions (97%), and to obtain further information about the admission from the RMO or consultant in charge of the young person's care in 51 cases (86%).

Of the 57 young people, 32 admissions (56%) were of males and 25 of females (44%). The majority of admissions (46) related to young people aged 16 and 17 years old (81%). This reflects a similar proportion of young people of similar age in the annual report (82%). Once again we found a slight predominance of males in the 16-17 year old age group (59% male, 41% female).

Primary Reason for admission

Table 11 Primary reason for admission

	All	%*
Low mood/suicidal ideation/deliberate self-harm	28	49
Psychosis	15	26
Eating Disorder	2	4
Other (psychosocial crisis, violence)	12	21
Total	**57**	**100**

*Base =57 admissions where further information was obtained

We were interested in the primary reason behind admission for these young people. In almost half of the cases, the young person had been admitted either after a suicide or self-harm attempt and retained for further assessment of their mental health, or the young person had presented to services and had been assessed as being at high risk of attempted suicide or self-harm and required further assessment.

In 26% of cases, the young person was admitted due to concerns relating to possible or actual psychosis. In a sizeable minority (21%), the young person was admitted due to psychosocial crisis and their living situation in the community was unable to maintain a safe environment for the young person. In these cases, the young person was admitted primarily to provide them with a place of safety until they could be returned to the community safely.

Table 12 Living situation at time of admission

	All	%*
Family home	43	75
Foster/kinship/residential care	8	14
Homeless/staying with friends/own tenancy	6	11
Total	**57**	**100**

*Base =57 admissions where additional information was obtained.

During this monitoring project, we were struck by the number of young people who had been admitted to non-specialist wards and were not living within a family home at the time of admission. Fourteen per cent of young people (8 out of the 59 cases) were living in either a foster or kinship placement or were looked after in residential local authority accommodation. Of the six young people identified as living a residential unit prior to admission, four were from one health board. This appears to represent disproportionate admission activity for the health board concerned, and we will continue to monitor this situation closely in the future.

Table 13 Looked After and Accommodated Young People

	All	%*
Yes	12	21
No	44	77
Null	1	2
Total	**57**	**100**

*Base= 57 admissions where additional information was obtained.

Of the children and young people who were admitted during this six-month period, 21% were identified as being 'looked after and accommodated' by the local authority. This reflects a slightly higher proportion of young people than in our annual report (13%).

Table 14 Ward type

Ward type	All	%*		Single room	% in single rooms by ward type**
General adult psychiatric ward	47	82		46	98
Paediatric ward/medical ward	6	11		4	67
IPCU	4	7		4	100
Total	**57**	**100**		**54****	**95**

*Base=57 admissions where additional information was obtained.

** Information on room type was not available for 3 young people

Of the 57 admissions we obtained additional information about, 82% were admitted to a general adult psychiatric ward (47 out of 57 cases). Seven per cent (4 out of 57 cases) were looked after in an IPCU and 11% (6 out of 57 cases) of young people were looked after in either a paediatric or a general medical ward. All the young people admitted to an IPCU were provided with a single room. Ninety eight per cent of those young people placed in a general adult ward were provided with a single room. Sixty seven per cent of those nursed in a medical or paediatric ward were placed in a single room.

Table 15 Type of admission

Planned/ crisis admission	All	%*	In office hours	Out of hours & weekends	NK
Planned	6	11	5	0	1
Crisis	51	89	21	27	3
Total	**57**	**100**	**26**	**27**	**4**

*Base=57 admissions where further information was obtained.

When we looked at whether the admissions to non-specialist setting had been planned or had occurred in the context of a crisis or urgent clinical situation, we were surprised at the number of crisis admissions that occurred within office hours (21 out of 51 cases or 41%).

When we looked at details of these admissions further, they often reflected young people who were admitted as an emergency from out-patient clinics or from assessment undertaken by CAMHS out-patient teams in the community. All of the planned admissions to non-specialist wards occurred during office hours.

Ninety per cent of the total admissions were crisis admissions (51 out of 57 cases) and 27 out of these 51 admissions (53%) occurred out of hours and at weekends.

Table 16 Legal status at time of admission

	All	**%***
Informal	40	70
Detained on EDC	5	9
Detained on STDC	10	18
Detained on CTO/CPSA	3	5
All	**57****	**100**

*Base=57 admissions where further information was obtained.
** Numbers may add up to >57 if individuals are detained on more than one order.

Table 17 New detention episode during while inpatient

	All	**%****
Detained on EDC	2	4
Detained on STDC	9	16
ALL	**11**	**19**
Never detained throughout admission episode	30	53*

**Base=11 admissions detained while an in-patient

We were interested in the numbers of young people who were detained during the course of their admission. At the time of admission, 30% (18) of young people were compulsorily admitted under the provisions of the Mental Health Act. Seventy per cent of young people were admitted voluntarily. Some young people however were admitted and then detained during their admission, or detained at the time of admission and then experienced further new episodes of detention during the in-patient stay in a non-specialist setting.

Only 53% (30 out of 57 cases) remained informal throughout the course of their admission. The remainder experienced either one or two discrete episodes of detention. These numbers of young people subject to formal detention appear high. This may well reflect the severity of the difficulties with which the young people were presenting, and demonstrate that the decision to admit young people to non-specialist settings was reserved only to those with the most pressing difficulties.

We believe that this proportion of young people subject to detention underscores the importance of young people being provided with age-appropriate services.
The Mental Health Act has a number of principles which clinicians must take account in their use of the Act.

One of these principles in the principle of ‘reciprocity’, which can be understood as: where society imposes an obligation on an individual to comply with a programme of treatment of care, a parallel obligation is imposed on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion.

We have previously described the responsibilities of health boards under the Act to provide young people under the age of 18 years appropriate services and accommodation when they are admitted to hospital.

This requirement is particularly underlined in those young people subject to detention in hospital where the principle of reciprocity further emphasises the responsibility of health boards to provide the young people with age-appropriate services.

Table 18 Location of young person prior to admission

	All	%*
Community	47	82
Inpatient on medical/paediatric ward	7	12
Inpatient in GAP/IPCU	2	4
Inpatient in specialist adolescent unit	1	2
All	**57**	**100**

*Base=57 admissions where further information was obtained.

We were interested to find out the location of the young person just prior to admission to the non-specialist setting. The vast majority of young people were living in the community just prior to admission (82%). Twelve per cent of young people were transferred from a paediatric or medical ward after having received medical treatment there, and 6% of young people were either transferred from another non-specialist setting (4%) or from a specialist adolescent unit (2%).

Table 19 Reasons behind admission to non-specialist ward

	All	%*
No specialist beds available	29	51
Under care of General Adult Psychiatry	10	18
Requiring IPCU/locked ward	4	7
Short admission required	12	21
Individual and/or family preference only	2	4
All	**57**	**100****

*Base=57 admissions where additional information was obtained.

**Total may appear as >100% as percentages are rounded to nearest whole figure.

From our work throughout the year, we are aware that a number of factors influence where a young person is admitted once they are assessed as requiring in-patient care. Sometimes the factors influencing that decision are simple and straightforward, and sometimes there are a number of factors which require consideration and reflection in determining what setting best meets the needs of a young person.

When we explored the reasons why a young person had been admitted to a non-specialist setting rather than a specialist adolescent ward, we found that in approximately half of the young people the reasons given for their placement related solely or predominantly to the fact that there were no specialist beds available at the time of admission (51%).
During our enquiries we were told that not all regional specialist adolescent units allow admission of young people from out-with the heath board area in which the adolescent unit is placed out-of-hours (and at weekends). We think this arrangement should be reviewed to enable greater access of young people to regional adolescent beds.

Recommendation 3: Hospital managers of the regional adolescent units should review admission procedures to establish whether access to the unit can be improved for all new referrals out-of-hours and at the weekend.

For a small proportion of young people (7%, 4 out of 57 cases) who could not be looked after on an open ward, IPCU admission was the only resource in Scotland that approximated to their needs. Although this was often far from ideal (especially in the small population of younger people under the age 16 years), there was no alternative to admission to this environment.

In the remaining admissions we looked at, a number of factors had greater or lesser significance: the location of the health board and the distance to the relevant regional adolescent inpatient unit; the availability of an adolescent specialist bed; the young person's presenting difficulties and the estimated duration of their need for an inpatient stay; and the configuration of mental health services in the 16-18 age group of the health board.

In approximately a fifth of cases (21%, 12 out of 57 cases), it was either clear at the time of admission that only a short crisis admission was required to help stabilise the presenting difficulties (some cases had no clear mental disorder requiring inpatient care but the young person had nowhere to stay due to crisis), or a young person had been admitted for management of the medical consequences of their self-harm and a longer stay in the medical/paediatric ward had enabled additional assessment to be undertaken of their mental state such that further admission or transfer to a specialist bed was not required. This was especially the case in health boards located further away from the regional adolescent in-patient unit. In these latter cases, transfer to another hospital was thought unnecessary.

For a sizeable minority of young people (18%, 10 out of 57 cases), the configuration of services in their health board area meant that they would ordinarily be looked after by General Adult Psychiatry services rather than CAMHS, whose remit extended only to those young people up to the age of 18 who were in full-time education. (This contrasts with other CAMH services in the country which look after all young people up to the age of 18 years irrespective of educational status.)

As a consequence, in those health boards areas where CAMHS looks after young people in full-time education up to the age of 18, when young people were admitted to non-specialist wards and came under the care of General Adult Psychiatry, we were told that transfer to specialist beds in an adolescent unit was not sought in order to provide consistency of care for the young person with the local adult mental health service. In the future, when all CAMHS services will have a similar age range in Scotland and provide mental health services to all young people up to the age of 18 years regardless of education status, this group of young people currently looked after by adult services will be looked after by CAMH services, and is likely to create a larger demand on specialist adolescent beds in their regional inpatient unit than is currently the case.

Finally, in our review of admissions we found a small proportion of cases (4%, 2 out of 57 cases) where it was clearly the young person's or their family's preference that they be cared for in a ward close to their home that was the primary deciding factor. This feature was a contributing - but not primary - factor in a number of other cases we looked at. Many young people and their families live far away from the regional adolescent in-patient unit, and this distance appears to be a factor influencing some young people, their families and also the health professionals looking after the young person, particularly in cases where a reasonably short admission is thought only to be required, or continued intense contact or work with the family as a whole is a priority in a young person's treatment.

Table 20 Alternatives to admission explored

	All	**%***
NULL/no alternatives documented	15	26
Inpatient assessment/treatment required	15	26
Requiring secure inpatient care e.g. IPCU facility	4	7
High risk of self-harm	11	19
Family/residential unit unable to manage levels of distress/aggression	6	11
Attempted to discharge but represented/refused community care	6	11
All	**57**	**100%**

*Base=57 admissions where additional information was obtained.

We looked at whether alternatives to in-patient admission were documented as being explored at the time of admission. In 26% of cases, there was no documentation that alternatives were sought.

In 11% of cases, assessing clinicians had tried to discharge a young person home, but this was documented as either being refused when attempted or the young person re-presented to hospital several hours later.

In 11% of cases, the levels of aggression or distress was said to be too high for the families or residential units looking after the young person to be able to manage. In a proportion of the young people living in residential units, it was not always clear that mental health difficulties were the primary factor behind presenting behavioural difficulties.
However, the young person's behaviour was said to be too difficult for the residential unit to manage, and transfer to secure care within an appropriate time frame was not available.

When we looked at the numbers of young people placed on a waiting list for a specialist adolescent bed, we found that out of the 57 young people we reviewed, 20 were documented as having been placed on a waiting list. Of these 20, 13 (65%) were transferred.

Eight young people waited less than three days, two young people waited between four and seven days and two young people waited between one and two weeks before transfer. When we looked at those seven young people who were placed on a waiting list but did not transfer, in two cases the further assessment provided while awaiting transfer indicated that transfer was not required.

In two young people, their difficulties necessitated transfer to an IPCU and two other young people either refused to go to the regional unit or their families did.

Of the 37 patients who were never placed on a waiting list for transfer to a specialist adolescent unit, ten were looked after by General Adult Psychiatry, four required IPCU care, 17 required only a crisis admission that was thought to be able to be provided in the non-specialist setting, and two patients preferred to remain in the non-specialist ward for reasons of distance.

When we looked at where young people went to following admission in a non-specialist setting, of the 57 young people who were admitted to non-specialist settings, 13 transferred to an adolescent specialist unit, two transferred to another non-specialist setting or were transferred across the border into England, two remained an in-patient in the non-specialist setting at the time of the end of the study, and 40 were discharged into the community. Thirty two young people returned home to either the family or to foster carers, six were returned to either residential or secure local authority care, and two young people went to stay with relatives or friends. Of the six young people returned to local authority care, three were placed in secure care (none were admitted to hospital from local authority secure care provision).

Duration of admission in a non-specialist setting

Table 21 Duration of admission in a non-specialist setting

Length of stay (LOS)*	All	%***
1-3 days	23	40
4-7 days	14	25
1-2 weeks	7	12
2-3 weeks	4	7
3-4 weeks	5	9
5 weeks +	4**	7
	57	**100**

*The Commission does not collect data on those admissions less than 24 hours in duration.
** 2 of the 4 young people were still inpatients at the time of the end of the study. They have been given a discharge date of 31/3/16 but in fact their duration of stay in a non-specialist ward would be longer in reality.
*** Base=57 admissions where additional information was obtained.

The mean length of admission for young people over this six-month period was 11 days. The median was 5 days and the mode 2 days. In this sample, 20 young people (35%) were in-patients in a non-specialist setting for over a week.

Table 22 Number of Inpatient admissions in previous 12 months*

	ALL	%**
0	44	77
1	7	12
2	2	4
3	1	2
NULL	3	5
All	**57**	**100%**

*Excluding A&E presentations of which some young people had many.
** Base=57admissions where additional information was obtained.

We found that for the majority of young people whose cases we reviewed, this would have been their first hospital admission for the treatment of mental health difficulties. This is important for ward staff to bear in mind, and ensure that young people are thoroughly introduced to the ward environment and orientated into both ward and hospital processes and routines. The importance of young people being aware of their rights is crucial, as is the consideration given by staff to the impact on young people when levels of activity within the adult ward environment are unsettled and high.

Table 23 Enhanced Observations during admission

	All	**%****
Yes*	46	81
No	10	18
Null	1	2
All	**57**	**100**

*Enhanced observations could vary depending on risk or be applied as part of a policy for security of young people in non-specialist environments.
**Base=57 admissions where additional information was obtained.

As we found in our annual report, most young people when placed in non-specialist ward settings are placed on enhanced observations levels for either the entirety of their stay or for part of the stay, depending on ward policy and the assessment of risk of the young person within the ward environment. Those young people who were never placed on enhanced observations during their stay were mostly over 16 years (9 out of 10), and were placed in general adult psychiatry wards (7 out of 10).

An area of care we particularly wanted to explore in this monitoring exercise was the availability of multi-disciplinary CAMHS input into a young person's care while they remain in a non-specialist setting. Specialist adolescent units have a range of professionals (child and adolescent psychiatrists and nursing staff, psychologists, family therapists, speech and language therapists, occupational therapists and specialist dieticians) available to assess and support a young person during their stay.

From our annual monitoring over the years, we have been aware that child and adolescent psychiatrists tend to provide the main and sometimes sole contribution of CAMHS input into a young person's stay in a non-specialist setting.

As mentioned earlier in this report, some CAMH services across the country are now developing posts involving non-medical staff, whose role will include the support and care of young people while admitted within a non-specialist setting. It is hoped this service development will continue to improve the quality of care provision for young people in the coming years.

Table 24 CAMHS consultant reviews

	All	%*
No CAMHS contact because under care of GAP	10	18
No CAMHS RMO review because care of GAP prior to transfer to Specialist unit	1	2
No CAMHS consultant review Discharge by GAP	4	7
Weekly CAMHS consultant review	3	5
2-3 times week	17	30
Daily	22	39
All	**57**	**100%**

*Base=57 admissions where we obtained further information.

When we looked at the contribution Community CAMHS consultants make to a young person's care when admitted to a non-specialist environment, it was clear that this professional group provide the largest proportion of specialist CAMHS input for these young people. Ten (18%) young people in our exercise were located in health boards where their care was provided by General Adult Psychiatry (GAP). As a result, they received no CAMHS input into their care from any CAMHS professional group including consultant child and adolescent psychiatrists.

In 9% (5 out of 57 cases) the young person was admitted and either transferred away to a non-specialist environment or discharged prior to being seen by a CAMHS consultant. These cases related to young people admitted out-of-hours or at the weekends when there were no CAMHS consultants on call. For the remaining 42 young people, CAMHS consultant input ranged from once a week to daily review, and this comprised face-to-face individual reviews on the ward. For the young people who stayed longer in the non-specialist environment, the frequency of CAMHS consultant review varied depending on clinical need, and was often supplemented by telephone calls with the ward for updates and advice.

When we spoke with community CAMHS consultants, many of them told us that supporting a young person's admission to a non-specialist setting would often result in a significant impact on their clinical work in the community. Many psychiatrists told us that clinics had to be cancelled in order to provide support to the young person on the ward. Some consultants told us that other CAMHS colleagues experienced similar impact on their community work when they were required to support a young person in hospital.

Some consultants told us that the frequency of admissions in their area had necessitated a revision of their job plans to formally take account of the significant input that providing support for a young person admitted to a non-specialist ward could entail.

Although regional adolescent in-patient units have told us that they continue to try and improve the referral process for community CAMHS clinicians and many clinicians told us that their experience of referral had improved, the CAMHS consultants told us they could find this process time-consuming and problematic at times. At a time when community CAMHS clinicians are working to try and improve access of young people in the community to CAMHS, the impact of cancelling clinics in community CAMHS as a result of providing support to a young person who has been admitted to hospital can be considerable.

Table 25 CAMHS nursing reviews

	All	**%****
No reviews*	26	46
Every two or three weeks	2	4
Once a week	7	12
Every 2-3 days	7	12
Daily	15	26
All	**57**	**100**

*10 young people under care of GAP and received no CAMHS input.
**Base=57 admissions where further information was obtained.

When we looked at the provision of specialist CAMHS nursing input in the 57 young people admitted to non-specialist wards over the six-month period, we found that in 15 out of 57 cases (26%) daily CAMHS nursing was provided directly with the young person. Although this was in the main provided to young people admitted for short periods, in three of these 15 admissions, length of stay of admissions was between one and three weeks.
In the seven young people who received CAMHS nursing input every 2-3 days, again a number of these admissions were short in duration. However, in the case of four admissions, young people were documented as being reviewed by a CAMHS nurse every 2-3 days and their length of stay was 2-3 weeks or even longer.

From the information provided in the case notes it appears that nurses working either within intensive home treatment teams or tier IV nurses provided the majority of this support to young people in non-specialist wards. When we looked at those cases where there was no specialist nursing input (26 out of 57 cases, 46%), ten young people were looked after by General Adult Psychiatry and received no input from CAMHS, and of the remaining 16 cases, most were short admissions. However, in two of the cases, the length of stay of the young person was over five weeks in length, yet they received no specialist CAMHS nursing input.

A similar situation was found in two admissions that lasted between two and four weeks in duration. This lack of nursing provision was also evident in the five cases where CAMHS nursing was provided either weekly or less frequently – in two of these cases admission length was over four weeks in duration. Therefore, it would seem that specialist CAMHS nursing input continues to vary significantly across the country.

Table 26 Psychologist Input

	All	%**
Daily	1	2
Every 2-3 days	3	5
Weekly	4	7
Less than once a month	1	2
No reviews*	48	84
All	**57**	**100**

*10 young people under care of GAP

**Base=57 admissions where we obtained further information.

Support from a CAMHS psychologist for young people admitted to a non-specialist ward was infrequent. In the majority of cases (48 out of 57 cases), there was no child psychology provision. CAMHS occupational therapy (OT) involvement was seen in only two out of the 57 cases only and speech and language therapy (SLT) was documented as being involved in the care of two young people only. In these cases where psychology or OT or SLT input was provided, nearly all of these young people had received input from these professionals whilst being treated in the community before admission. In some young people, a psychologist or an OT might have been the young person's keyworker in the community and this contact continued after admission.

Overall, it appears that the provision of multidisciplinary support for young people in hospital in non-specialist settings continues to be very variable. In services which have developed/are developing intensive treatment teams or tier IV nursing posts the provision of nursing into young people's care has improved. However not all Health Boards have developed/are planning to develop these services. Overall it was difficult to demonstrate that specialist CAMHS provision for young people while they were inpatients was always based on the needs of the young person. We very much welcome the investment in tier IV /IHTT staff that some Boards are making and hope this increased service provision will increase the multidisciplinary care provided while a young person is an inpatient in non-specialist setting.

When discussing therapeutic care provided to young people in non-specialist wards, it is important not to leave this subject without recognising the important therapeutic work that is undertaken with the young people by ward staff. During our monitoring exercise, we noted that many consultant adult psychiatrists routinely reviewed young people on a weekly basis, in addition to the reviews undertaken by the CAMHS consultant.

Young people might also be discussed at the weekly ward round by the adult team, and the ward junior psychiatrist was often responsible for undertaking reviews and providing day to day medical care for the young person. Additionally, we saw evidence of ward nurses undertaking therapeutic work with young people in relation to their mental health as part of their daily one-to-one meetings.

Ward staff were also important contacts for families and carers of young people. While many of these staff had no particular training or experience in working with children and young people, we are aware of some initiatives around the country where tier IV CAMHS staff are providing training to ward staff of their local general adult wards as a means of supporting staff who provide care to young people when admitted. We very much welcome these developments.

Social Work involvement with the young people we studied was variable. In the young people who were detained all were appointed a mental health officer. In the cases we reviewed where young people were homeless prior to admission or were 'looked after and accommodated' by the local authority, there was often evidence of considerable work undertaken by social workers in liaising with the ward and trying to locate resources for the young person in the community after discharge.

In our annual report this year, we reported that the provision of age-appropriate activities while a young person was staying on the ward can be very variable and rely heavily on the young person accessing recreation via their mobile phone. During this monitoring exercise, when looking at young people's case notes we found it very difficult to identify how most young people spent their time on the ward. Although some young people might be too unwell to access recreational activities, we saw no evidence of care plans included in a young person's case notes which addressed the issue of daily activities. In many case notes (21 out of 57 cases) there was no or almost no mention of a young person's activities throughout the day and the duration of admission in these cases ranged from two days through to nearly six weeks.

We found no evidence of young people being able to access activities that were restricted in age group. We found many references to the young person engaged in informal activities on the ward such as chatting with other patients or the nurses, watching TV and enjoying walks in the grounds. We also noted many examples of young people undertaking informal activities on their own or with their family or carers.

Recommendation 4: Hospital managers should ensure that a range of age appropriate activities are available to a young person while they remain an inpatient. All activity planning and participation should be clearly documented in the young person's care plan. We would expect to see that the young person is involved in developing a programme of activities for their stay, which should reflect their mental health needs and interests.

As in our annual report, we found education was discussed with young people in only a small proportion of cases. Of the 57 cases we reviewed, education was documented as being discussed in only eight cases (14%) and provided for in two (4%). Eleven of the 57 young people were under the age of 16. None of the forty six 16-17 years olds were provided with education during their hospital admission.

Recommendation 5: Ward managers should ensure that when a young person's stay is longer than one week and the young person is under 16 years or in formal education, their educational or learning needs are considered shortly after admission, and decisions should be made after consultation with the young person about how their needs can be supported. Learning/educational needs and any plan to support them should be clearly documented as part of the young person's treatment plan while they are in hospital and regularly reviewed.

When undertaking this monitoring exercise, we were struck by the numbers of reports of actual or threatened violence on the part of the young person. This feature was evident in reasons behind admission in some cases and also in the number of incidents reported to have occurred while a young person was looked after in a non-specialist environment. We are familiar with concerns expressed about the vulnerability of young people in non-specialist settings but were surprised by the incidence of the reports of violence and aggression in the young people whose case notes we reviewed. In our review, we found that 20 young people out of the 57 cases where we obtained additional information were involved in incidents while on the ward (35% of the young people). Of these, 15 (26% of the 57) were involved in violent or aggressive incidents directed towards staff, two young people (4% of the 57) were involved in incidents relating to self-injury, and three (5%) young people made attempts to abscond from the ward. This feature of some young people's difficulties would seem to underline the importance of the availability of IPCU beds for those young people whose difficulties mean that they cannot be nursed in an open ward.

From our monitoring exercise, we were impressed by the documentation of the levels of involvement of the young person and their carers/family in the young person's care while an in-patient.

Fifty six of the 57 young people (98%) were clearly documented as being involved in discussions about their care, and a young person's carer or parents were involved in 49 out of the 57 young people reviewed (86%). Carer contact included discussions by telephone (33 out of the 49, 67%), face-to-face discussion with the CAMHS consultant (35 out of the 49, 71%), face-to-face discussion with other members of CAMHS staff (13 out of 49, 27%) and face-to-face discussions with ward staff in 26 out of the 49 young people (53%). Parents and carers were documented as being involved in the weekly adult ward rounds on occasion.

When we looked at the role of advocacy in young people's care in non-specialist settings, we were disappointed to see very low levels of documented activity.

In our annual reports for a number of years, clinicians have told us that access to advocacy is available to a reasonably large number of young people in non-specialist settings. In this year's annual figures, 65% of young people were described as having access to advocacy services, 17% of which were said to be specialist advocacy for children and young people.

However, from this monitoring exercise we found that in only four cases was there documentation that advocacy had been discussed with young people and in only three young people was there any documentation of advocacy taking an active role in a young person's care.

In those young people detained under the Mental Health Act it is the role of the MHO to alert a young person to their right to advocacy. Despite this, we saw little documented evidence of advocacy involvement and many young people had no access to specialist children's advocacy services that are familiar with the particular issues affecting children and young people and their rights. This contrasts with the situation in the specialist adolescent in-patient units all of which have access to specialist advocacy services for young people staying there.

Recommendation 6: Ward managers should ensure that young people are informed how to seek independent advice within 24 hours of admission (and as often as is required) and supported in their use of advocacy services. This should be clearly documented in the young person's case notes.

Conclusion

This additional monitoring exercise provided information about young people's care in non-specialist settings that was not possible via our routine monitoring. We have been able to gain a more complete understanding about some of the issues relating to the deciding factors of whether a young person is admitted to a specialist child or adolescent unit or to a non-specialist setting. The Commission continues to support the view that a specialist child or adolescent mental health unit would normally be the preferred environment for a young person requiring in-patient care.

We hope that continued development of community-based CAMH services (including intensive treatment services) will help reduce the demand for admissions of young people to hospital and to non-specialist wards in particular. Providing alternatives to admission appears important in admissions involving young people presenting in crisis who do not require longer in-patient stays for treatment.

We were pleased to see some of the levels of specialist CAMHS care provided for some young people within non-specialist settings. However, we are aware that the provision of age appropriate care for young people in non-specialist settings can vary a great deal across the country, and does not always reflect a young person's mental health needs. Our future visits to young people will be informed by our findings relating to young people's access to specialist CAMHS, access to advocacy, education/learning and daily activities. We will continue to try and visit young people under the age of 16 years while in-patients in non-specialist settings and young people under the age of 18 in IPCUs as standard practice, and visit young people under the age of 18 years when we have concerns.


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