mentalwelfare commission for scotland

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STATISTICAL MONITORING

# Young person monitoring 2012/13

## Our aim

We aim to ensure that care, treatment and support are lawful and respect the rights and promote the welfare of individuals with mental illness, learning disability and related conditions. We do this by empowering individuals and their carers and influencing and challenging service providers and policy makers.

## Why we do this

Individuals may be vulnerable because they are less able at times to safeguard their own interests. They can have restrictions placed on them in order to receive care and treatment. When this happens, we make sure it is legal and ethical.

## Who we are

We are an independent organisation set up by Parliament with a range of duties under mental health and incapacity law. We draw on our experience as health and social care staff, service users and carers.

## Our values

We believe individuals with mental illness, learning disability and related conditions should be treated with the same respect for their equality and human rights as all other citizens. They have the right to:

- be treated with dignity and respect
- ethical and lawful treatment and to live free from abuse, neglect or discrimination
- care and treatment that best suit their needs
- recovery from mental illness
- lead as fulfilling a life as possible

## What we do

Much of our work is at the complex interface between the individual's rights, the law and ethics and the care the person is receiving. We work across the continuum of health and social care.

- We find out whether individual care and treatment is in line with the law and good practice
- We challenge service providers to deliver best practice in mental health and learning disability care
- We follow up on individual cases where we have concerns and may investigate further
- We provide information, advice and guidance to individuals, carers and service providers
- We have a strong and influential voice in service policy and development
- We promote best practice in applying mental health and incapacity law to individuals' care and treatment

## Provision of age-appropriate care for people under 18

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

**Table 1: Young people (under 18) admitted to non-specialist facilities, by year 2008-2013**

| | 2008-09 | 2009-10 | 2010-11 | 2011-12 | 2012-13 |
|---|---|---|---|---|---|
| **No. of admissions to non-specialist inpatient settings** | 149 | 184 | 151 | 141 | 177 |
| **No. of young people involved** | 138 | 147 | 128 | 115 | 148 |
| **No. of admissions where further Information was provided to MWC** | 139 | 168 | 135 | 120 | 147 |
| **No. of young people involved** | 131 | 140 | 115 | 96 | 126 |

### Our interest in these figures

Monitoring the admission of young people to non-specialist settings such as adult and paediatric wards, for the treatment of mental illness, has been one of our monitoring priorities since the Mental Health (Care and Treatment) Act 2003 (the Act) came into force. We have raised concerns about the number of admissions for several years.

We are therefore disappointed this year to see that the drop in admissions across the country over 2010-11 and 2011-12, which was consistent with the Scottish Government's aspiration to reduce admissions, has not continued in 2012-13.

There has been an increased national focus on the mental health needs of children and young people over the past eight years. Information on the children and adolescent mental health services (CAMHS) workforce across Scotland has been collected routinely since 2006, and staffing levels have been steadily increasing. The Scottish Government also sets targets for health priorities, and the importance of CAMH services is highlighted in the targets for faster access to CAMHS – a 26 week

referral to treatment target for CAMHS was due for delivery by March 2013, reducing to 18 weeks by December 2014[1].

We have noted the increase in community teams in a number of areas in Scotland, and improvements in how admissions to non-specialist settings are supported by child and adolescent clinicians. We have seen this up to this year as having an impact on the numbers, and on the length of stay of young people admitted to non specialist settings.

In our monitoring of the admissions of young people under 18 across Scotland we seek to confirm whether NHS Boards are managing to fulfil their legal duty to provide age appropriate services and accommodation. We expect to be notified of all formal and informal admissions to non-specialist facilities. We ask Responsible Medical Officers (RMOs) to provide us with more detailed information once we have been notified of an admission. We have made some changes to the questionnaire we use so that we are collecting better information about the admissions.

We also now indicate that we do not require to be notified about an admission if it is related solely to alcohol or substance misuse, or has been for less than 24 hours. We have also asked NHS Boards, since 2005, to send us quarterly retrospective reports about the admission of young people to non-specialist wards. This data helps us to check if we have received all the notifications about individual admissions that we would expect. Some Boards had been doing this regularly, but others had not. We therefore wrote to each NHS Board last year to remind them that we do want to continue getting these quarterly reports, and have subsequently been receiving these more routinely.

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

[1] 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. During the quarter ending March 2013, 3,971 children and young people started treatment at CAMH services in Scotland. The initial estimates from data at an early stage of development indicate that around 96 per cent of people were seen within 26 weeks.
http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance/CAMHS

a young person is being treated in an adult IPCU, as we would want to visit any young person where care and treatment is being provided in a locked, secure environment.

We ask for monitoring information each time we are notified about the admission of a young person to a non-specialist in-patient unit. In 2012-13 we received further information about 84% of these admissions (a total of 148 admissions). In the majority of cases the information is eventually provided, but this year we have received no responses in relation to 11 admissions, involving 9 young people[2]. Sometimes we find that there has been confusion about which psychiatrist is responsible for a young person's care and treatment during an admission, and this prevents us receiving information. We will look at how we chase up information this year, to reduce the number of admissions we are told about, but about which we receive no further monitoring information.

### What we found

The figures in the table above show that in 2012-13 we were notified of 177 admissions, involving 148 young people. These figures compare with 141 admissions, involving 115 young people, in 2011-12, and 151 admissions involving 128 young people in 2010-11.

As mentioned in previous reports we had anticipated that NHS Boards would experience difficulties meeting a commitment to reduce admissions of young people to non-specialist wards. We were concerned about the significant increase in admissions in 2009-10. However we were pleased to see decreases in 2010-11 and 2011-12. This trend has not continued in 2012-13. The total number of admissions has increased again, by 26%, and the number of young people involved has increased by 29%.

We continue to be concerned about the number of repeat admissions, that is, the small number of young people who are admitted to a non-specialist ward on several different occasions. The number of repeat admissions has risen slightly and 20 young people were admitted two or more times during the year, with one person admitted four times, and seven young people admitted three times. We look closely at the reasons for re-admission and at the information we get about arrangements to provide support on discharge. We had some follow up contact with services about most of the young people re-admitted to hospital during the year. We will be looking at this group of young people again this year to see how we might follow this issue up.

We have been aware in 2012-13 of a small number of very complex cases where a young person was admitted to an adult ward, and where the provision of appropriate

[2] For the majority of admissions information is received at MWC very soon after admission, for 30 admissions data came in over the following weeks or even months, at the time of writing this report no detailed information had as yet been received on 11 admissions involving 9 young people.

services was proving to be challenging. Young people in this group were often looked after and accommodated in residential care prior to admission, or were experiencing serious and complex issues at home, and were often at significant risk of harming themselves and/or others.

- In four cases the young person was transferred to specialist units in England.
- In one case a cross border transfer had been arranged, but a tribunal granted an appeal against the transfer.
- In one case a transfer to England had been agreed as appropriate, but then the home NHS Board decided it could make special arrangements to provide a very intensive care and treatment package to allow the young person to return to their home area.

We are aware of several cases where plans were being made to transfer young people from secure care accommodation to specialist units in England, but where there have been difficulties arranging transfers because of difficulties identifying a suitable in-patient bed in Scotland where the young person could be placed on an interim basis before transfer. There is a process to look at the lack of specialist secure in-patient care for young people in Scotland. But in the absence of any unit for young people in Scotland, young people continue to be placed in specialist units in England. We know that a national working group is currently looking at this issue, and we would look forward to seeing some progress made in addressing this concern.

We are also planning joint visits with the Care Inspectorate later this year. We will go to the five secure accommodation units for young people in Scotland. In these visits we will be looking at how services are being provided to meet the needs of young people with an identified mental health problem, and speaking with young people about the specialist care and treatment they have received.

**Table 2: Young people admitted to non-specialist facilities by NHS Board, by year 2010 to 2013**

| Health Board | 2010 - 2011 | | 2011 - 2012 | | 2012-13 | |
|---|---|---|---|---|---|---|
| | Admissions | Young People Involved | Admissions | Young People Involved | Admissions | Young People Involved |
| Ayrshire and Arran | 18 | 16 | 14 | 11 | 8 | 8 |
| Borders | 4 | 3 | 6 | 6 | 6 | 5 |
| Dumfries and Galloway | 10 | 7 | 5 | 4 | 13 | 10 |
| Eilean Siar | 0 | 0 | 0 | 0 | 0 | 0 |
| Fife | 6 | 6 | 6 | 6 | 3 | 3 |
| Forth Valley | 5 | 5 | 12 | 10 | 21 | 19 |
| Grampian | 30 | 23 | 23 | 17 | 31 | 22 |
| Greater Glasgow and Clyde | 34 | 28 | 30 | 23 | 30 | 24 |
| Highland | 7 | 7 | 6 | 5 | 6 | 6 |
| Lanarkshire | 29 | 25 | 32 | 27 | 48 | 40 |
| Lothian | 4 | 4 | 3 | 3 | 1 | 1 |
| Orkney | 0 | 0 | 0 | 0 | 0 | 0 |
| Shetland | 0 | 0 | 0 | 0 | 0 | 0 |
| State | 0 | 0 | 0 | 0 | 1 | 1 |
| Tayside | 4 | 4 | 4 | 3 | 9 | 9 |
| **Scotland** | **151** | **128** | **141** | **115** | **177** | **148** |

## Our interest in these figures

Our view is that when a young person needs in-patient treatment their individual clinical needs should be paramount. In comparing admissions to non-specialist facilities by NHS Board area we are looking to see whether there have been

significant changes in the number of admissions within a specific area compared to figures from the previous year. In this year's figures we are also identifying not only the number of admissions in each area but the number of young people involved,.

The 2003 Act is clear that the specific duty on NHS Boards to provide sufficient services for young people continues to their 18th birthday. We are aware that child and adolescent services (CAMHS) are configured differently across areas, with varying eligibility criteria. We highlighted this issue in our published report on our themed visit to look at CAMHS (2009)[3]; we recommended that all NHS Boards should provide a CAMHS to a young person up to their 18th birthday, unless clinical need indicates otherwise in a particular case. We are aware that Boards who do not currently have CAMHS up to age 18 are striving to do so by 2015. We are also aware that CAMH services are making strenuous efforts to admit under-16s to specialist facilities, and that work has been in progress nationally to develop agreed criteria for the admission to and discharge from specialist in-patient units.

### What we found

Figures in the table above compare admissions in 2010-11, 2011-12 and 2012-13 by NHS Board area. In five NHS Board areas admission numbers notably increased last year, in three areas they have decreased, and in the other areas the number of admissions has been static. There was one admission to the State Hospital of a young person awaiting transfer to an age appropriate facility in England.

We were pleased to note the continued support of CAMHS clinicians to their colleagues in non-specialist areas during young people's admissions across all areas in Scotland. We also welcome the reductions in admissions in three areas, in NHS Ayrshire and Arran, NHS Fife, and NHS Lothian.

It was good to note that NHS Lothian decreased admissions to one. The young person was in the 12 to 15 age range and was transferred to the CAMHS inpatient unit under the Mental Health (Care and Treatment) (Scotland) Act 2003 within one day. We acknowledge the review of the in-patient journey for young people in NHS Lothian alongside an increase in community teams. The impact of the review of CAMHS and admissions to non specialist areas, which we saw and commented on in the last two annual reports, has clearly been sustained.

It is also encouraging to note the continued trend down in admissions in NHS Ayrshire and Arran, where there were eight admissions last year compared to 14 in 2011/12 and 18 in 2010-11. This would seem to provide evidence of the effectiveness of strategies they were developing with local authority partners to support young people without hospital admission, and to enhance community supports for young people in crisis, including young people who were self-harming in

[3] 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

the context of alcohol or drug misuse. In NHS Fife we are also pleased to see that the number of admissions has now fallen to three for 2012-13, and that admission figures there have either fallen or stayed level over the past six years.

In the NHS Greater Glasgow and Clyde area the number of admissions in 2012-13 is exactly the same as in 2011-12. We know that changes have been introduced there which were intended to provide more effective support and to avoid need for admission, with for example an intensive home treatment service. We also know of the work being done focussing on length of stay and the treatment model, to improve access to the regional in patient unit, including opening two beds for emergency admissions. We understand there will be challenges keeping emergency admission beds for that purpose but we hope that the changes being introduced will impact on admissions over a period of time.

We noted an increase in admissions and the number of young people involved in NHS Dumfries and Galloway, Forth Valley, Grampian, Lanarkshire and Tayside.

In NHS Lanarkshire and NHS Forth Valley self harm and suicidal ideation and planning were the most common reasons for admission given on returned monitoring forms, this was for around half of the admissions. In five cases we were informed that alcohol or substance misuse played a part in events. We were concerned about the increase in admissions but in all circumstances they appeared to be appropriate to the risk of harm to the young people involved. We are aware that NHS Lanarkshire CAMHS now offer a service young people up to the age of 18 if they are still in mainstream education and that NHS Forth Valley CAMHS continue to offer a service to young people up to their 19$^{th}$ birthday.

There has been a considerable increase in admission numbers in NHS Dumfries and Galloway. We are aware that adult inpatient services in NHS Dumfries and Galloway are now in a newly built facility and that the physical environment there will have more potential for providing safer and less inappropriate care for young people. The new unit will allow CAMHS and general adult psychiatry staff to work together to arrange admissions for young people who might otherwise have not been admitted when a period of in-patient care and treatment would have been appropriate, and to look at providing a more local response when this is in the best interests of the young person. We will be following this up though with NHS Dumfries and Galloway

In NHS Tayside there were nine admissions in 2012-13, compared to three the previous year. In two cases the young person was transferred to a specialist unit when a bed was available, and in the other cases we looked at the information provided about the reasons for admission. Four admissions related to self harm and/or suicidal ideation, and in the other cases there were either established illnesses, with concerns about a deterioration, for example a recurrence of psychotic symptoms, or there were concerns about an emerging illness. We did not feel any of the admissions were inappropriate. We are aware that work has now started on the

new young person's unit in Dundee. When this is completed, 12 beds will be available for the NHS Boards in the north of Scotland who are part of the regional network. We know that young people have been contributing to the design of this new unit, and we would hope the eventual increase in specialist beds will reduce the number of in-patient admissions to adult wards.

In NHS Grampian the number of admissions increased by eight last year, to the same level as in 2010-11. As in the other areas where there was an increase in admissions we have looked closely at the information about the reasons for admission. We know that ten of these admissions involved three young people who came into hospital three or four times.

In 13 cases issues about the risk of suicide were identified and in a number of these cases there had been a significant suicide attempt, and there were concerns about ongoing risks involving planning further attempts. Six young people already had an identified illness and their mental health was deteriorating, with the young person often experiencing distressing symptoms. One young person had an eating disorder, and was physically very unwell, and two young people were transferred to a specialist unit after admission. In reviewing the information on each young person we did not feel that any of the admissions were inappropriate.

We said last year that we could see that considerable efforts were made to provide age appropriate input within adult wards in NHS Grampian when a young person was admitted. This has been maintained, and in each case a CAMHS psychiatrist was the responsible doctor, and there was often very intensive input from other CAMHS professionals, including nurses, psychologists, and OTs.

We note that one admission in NHS Grampian involved a young person from an island NHS Board area, and one of the outcomes of this admission is that positive discussions between workers in the two areas have taken place to develop an integrated care pathway for access to tier 4 CAMHS services for young people in island areas.

**Table 3: Specialist health care for admissions of young people in non-specialist care, 2012-13**

| Specialist medical provision | Age 0-15 | Age 16-17 | All | *% |
|---|---|---|---|---|
| RMO at admission was a child and adolescent specialist | 32 | 45 | 77 | 52 |
| Nursing staff with experience of working with young people were available to work directly with the young person | 34 | 51 | 85 | 58 |
| Nursing staff with experience of working with young people were available to provide advice to ward staff | 38 | 73 | 111 | 76 |
| The young person had access to other age appropriate therapeutic input | 31 | 98 | 129 | 88 |
| None of the above | 4 | 13 | 17 | 12 |
| **Total admissions*** | **49** | **98** | **147** | **100%** |

** Base=147, 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, and some of the information we request is summarised in the table above.

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

In the course of our visits we have been made aware that access to specialist CAMH services when a young person is admitted to an adult ward varies across the country. Although we can report some improvement overall as we commented last year there continue to be reports of limited access to CAMHs support during admissions to some adult wards.

## What we found

We were pleased to note a 7% increase in the percentage of cases where the RMO at the point of admission was a child and adolescent specialist (an increase in numbers from 54 to 77). We are pleased to see that in many cases specialist child and adolescent consultants continue to provide advice and support during admissions. We are encouraged by this increase which in part will be due to the increase in CAMHS workforce numbers which in turn will hopefully result in CAMHS clinicians being more available to support non specialist services.

We saw an increase in the direct input from experienced nurses working in the field, up to 58% from 54% the previous year but a very slight decrease in the availability of nurses with relevant experience to provide advice to ward staff. Overall this demonstrates a continued increase in nursing availability in recent years which we welcome.

### Table 4: Social work provision for admissions of young people to non-specialist care 2012-13

| Social work provision | Age 0-15 | Age 16-17 | All | *% |
|---|---|---|---|---|
| Young person had an allocated social worker | 31 | 46 | 77 | 52 |
| If no allocated social worker, had access to a social worker | 5 | 58 | 33 | 22 |
| Neither of the above | 9 | 15 | 24 | 16 |
| No information | 4 | 9 | 13 | 9 |
| **Total*** | **49** | **98** | **147** | **100%** |

**Total=147, 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, then there should be clear local arrangements to secure that input. There certainly is a very clear emphasis in national policy, for children's services and for adult care, on co-operation and good joint working between health and social work.

We have an interest in the provision of services to "looked after" children. There is evidence that such children generally experience poorer mental health and there is now a national requirement that NHS Boards ensure that the health care needs of looked after children are assessed and met, including mental health needs. We would assume though that any looked after young person admitted to a non-specialist facility will have an identified social worker.

### What we found

In the previous two years, in 2010-11 and 2011-12, we noted that a significantly higher proportion of young people had an allocated social worker at the time of admission compared with earlier years. In both those years 58% of young people had an allocated social worker at the point when they were admitted, and almost 30% had access to a social worker if they had no allocated worker.

In 2012-13 there has been a reduction in the proportion of young people who were reported as having a social worker when admitted (52%), or as having access to a worker during admission (22%). This is disappointing and surprising, because of the policy emphasis on developing more integrated approaches to providing care and support to meet the needs of young people.

Where the monitoring information we received after the admission of a young person indicated that there were issues about arranging for input from social work we follow these cases up.  We will continue to monitor this issue and to make follow up enquiries about individual cases when concerns about social work provision are brought to our attention.

**Table 5: Supervision of young people admitted to non-specialist care 2012-13**

| Supervision arrangements | Age 0-15 | Age 16-17 | All | % |
|---|---|---|---|---|
| Transferred to an IPCU or locked ward during the admission* | 5 | 14 | 19 | 13 |
| Accommodated in a single room throughout the admission | 41 | 77 | 118 | 80 |
| Nursed under constant observation | 36 | 59 | 95 | 65 |
| **Total**** | **49** | **98** | **147** | **100** |

**This is taken from information recorded on the forms.*
***Total=147, 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 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

The percentage of young people's admissions transferred to IPCU had decreased by 5% ( 22 to 19 admissions) since 2011-12 However the number of 0-15 year old admissions transferred to an IPCU or locked ward increased from four to five.

There was one young person admitted to the State Hospital whilst awaiting a cross border transfer to an appropriate CAMHS facility in England. During the State Hospital admission there was liaison with the home area CAMHS team and the young person was subsequently transferred to an appropriate CAMHS inpatient unit after five months. The length of stay was prolonged due to an appeal against transfer. The Commission visited this young person during their stay in the State Hospital and found that as far as possible within the environment age appropriate education and recreation was being provided.

We have previously commented on young peoples' experience of being on constant observations in a single room as lonely and boring, and on the need to ensure that, where this is necessary, efforts are in place to mitigate against these adverse consequences. This year we can report the percentage of young people accommodated in single rooms has decreased from 87% last year to 80%. The percentage of admissions nursed under constant observations has also decreased to 65% this year, from 73% in 2011-12.

### Table 6: Other care provision for young people 2012-13

| Other provision | Age 0-15 | Age 16-17 | All | *% |
|---|---|---|---|---|
| Access to age appropriate recreational activities | 27 | 54 | 81 | 55 |
| Access to education was discussed | 19 | 29 | 48 | 33 |
| Access to advocacy service | 31 | 72 | 103 | 70 |
| Young person has a learning disability | 8 | 6 | 14 | 10 |
| **Total*** | **49** | **98** | **147** | **100%** |

**Total=147, 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 because a large proportion of admissions are for very short periods of time access to appropriate recreational activities and education may not be significant for many young people. We want to know if independent advocacy services are readily available, given the important role advocacy can play in ensuring that any patient's views are heard.

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

### What we found

The information provided indicates that a slightly higher number of young people's admissions were reported to have access to age appropriate activities in this year (81) than last year (74) although the proportion has fallen from 62% to 55%, because of the overall increase in the number of young people admitted. Similarly with advocacy services a slightly higher number of young people (103) were reported as having access to advocacy during admission this year, although the percentage has fallen from 2011-12 (from 79% to 70%) because of the increase in the overall number of young people admitted. We welcome the availability of advocacy. We remain concerned if all young people are not reported as having access to advocacy during their admission. We have said in previous years that we have been pleased to

see that more attention appeared to be being paid to ensuring that young people have access to age appropriate recreational activities during an admission, and it is disappointing to see that there are a significant number of admissions where we are being told that age appropriate recreational activities were not available. We are aware that many admissions are for relatively brief periods but we feel that more attention can be paid to the issue of access to appropriate recreational activities. We do see that where beds have been designated in specific adult wards for the admission of young people, and where specialist CAMHS staff including nurses and OTs are involved with the young person, there are examples of considerable attention being paid to providing age appropriate activities.

The information provided indicates that access to education was discussed in relation to both a higher number and a higher percentage of young people this year (2012-13 =48, 33% ; 2011-12=35, 29%). We know that it may not be appropriate to discuss access to education if an admission is for a very short period of time. We have concerns though that in certain situations it clearly would have been appropriate to consider issues about access to education, when a young person was in a non-specialist facility. We have made a specific recommendation about this issue in a previous themed visit report[4], and we remain concerned that in the absence of specialist CAMHS or social work input staff in adult wards will not know how to access education services if this is appropriate while a young person is in hospital. We are now starting to get more specific details about how this issue is being addressed in our monitoring forms so that we will be gathering better and more consistent information about education provision in the future.

There has been a small increase in the number of young people with a learning disability admitted to non-specialist facilities, up from 12 in 2011-12 to 14 in 2012-13.

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

### Education provision

We have produced a short case study to give an example of education provision.

*Marie is 16 years old, and was admitted to an adult ward after she had taken an overdose. Marie continued to say that she was thinking about harming herself, and*

[4] 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

*she was referred for a placement to a specialist young person's unit. The Commission was advised that she was probably going to have to remain in the adult ward for several months, until a bed was available in the young person's unit, so we arranged to visit to talk to Marie about the care and treatment she was receiving in the adult ward in the meantime.*

*When we visited and spoke to Marie she was very positive about the treatment she was receiving. Specialist CAMHS staff were visiting her in the ward regularily, she felt staff in the ward listened to her, and that she was fully involved in decisions about her treatment. It was also clear that there had been a lot of discussion about her education, with both Marie and her school. On the day we visited she had been to school that morning to sit an assessment which was part of her higher coursework, and arrangements had been made for her to sit her higher grade examinations when these started. Staff were supporting her to begin the process of integrating back into school, visiting school and meeting friends, and talking to guidance teachers, and plans for her next year at school were being looked at with Marie.*

*We said last year that when a young person is admitted to an adult ward it is often unusual for staff in that ward to know who to contact in an education authority to discuss the provision of education for any young person who may be an in-patient for a lengthy period. We were pleased to see that Marie's education needs were being addressed and we feel it was important that the CAMHS staff who worked with Marie in the adult ward had the links with school and were able to make sure that she was supported to complete some of her school coursework as an in-patient.*

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

### Table 7: Age of young person by gender 2012-13

| Age at last birthday (years) | Female | Male | Total |
|---|---|---|---|
| 11 | 1 | 1 | 2 |
| 12 | 0 | 1 | 1 |
| 13 | 6 | 2 | 8 |
| 14 | 13 | 3 | 16 |
| 15 | 19 | 9 | 29 |
| 16 | 28 | 19 | 47 |
| 17 | 30 | 16 | 46 |
| **Total*** | **97** | **51** | **149** |

**Base=148, 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 figures for the age and gender of young people admitted, because they can indicate whether there are any trends evident over a period of time, with regard to the admission of young people. They can suggest where services should be giving careful thought to arrangements in place to meet needs, or where there may be specific issues to address.

### What we found

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

The trend, up to 2009-10, was for the number of female admissions to non-specialist facilities to fall and the number of male admissions to rise, particularly in the 17 year old age group. This trend was not observed 2009-10, when there were almost equal

numbers of male and female admission for 16 and 17 year olds. In 2010-11 the pattern we had been observing was observed again with a drop in female admissions and an increase in male admissions. This however, is clearly different this year as we note a marked change in female admissions which have risen to 97 individuals from 61 in 2011-12 whereas male admissions have remained fairly consistent having fallen slightly from 53 individuals in 2011-12 to 51 this year.

As was the case in previous years there were more 16 and17 year olds admitted than of any other age group (2012-13 = 93 individuals, 63% of all young persons admitted). It is of interest to note that female admissions for 17 year olds have increased from 19 last year to 30 this year and male admissions in the same age group have decreased to 16 admissions from 32 in 2011-12

We cannot say with any certainty what has caused such a significant shift in the gender ratios of older adolescent admissions but we are aware of the most prominent reasons for admission being self harm and suicidal ideation. We remain concerned about the position of the older adolescents and will continue to monitor the situation, to try to identify whether there are any particular barriers to admission to specialist in-patient care.

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