Healthcare Improvement Scotland

mental welfare commission for scotland

Joint unannounced visit/ Safe Delivery of Care inspection

Child and Adolescent Mental Health Services (CAMHS)

National Overview Report 2026

March 2026

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Contents

Introduction

The Minister for Social Care, Mental Wellbeing and Sport committed to address the serious concerns raised by the BBC documentary (aired in February 2025) regarding the experiences of young people in Skye House in Glasgow. The Minister commissioned the Mental Welfare Commission for Scotland (the Commission) and Healthcare Improvement Scotland to carry out visits/inspections across all three young people units in Scotland and the separate children's in-patient psychiatric unit in Glasgow.

As part of this collaborative approach, Healthcare Improvement Scotland and the Commission committed to ensure that our skills, experience and resources were jointly used to deliver comprehensive, independent and robust assurance of all four units which are Tier 4 services, that is, they are highly specialised in patient settings for children and young people who require assessment and treatment for complex mental health needs.

Our first unannounced joint visit/inspection was to Melville Unit, NHS Lothian in May 2025, followed by visits to the National Child Psychiatry Inpatient Unit (Ward 4) and Skye House, NHS Greater Glasgow and Clyde in August 2025 with Dudhope Unit, NHS Tayside, being the final visit/inspection in October 2025.

Individual reports were published following each joint visit/inspection and can be found on the Commission and Healthcare Improvement Scotland websites at:

Mental Welfare Commission for Scotland

Healthcare Improvement Scotland

What did we do?

Our visits/inspection process ranged from between two to six days on site at the children and young people's units.

We engaged with 35 young people aged over 10 years and up to 17 years old.

The length of stay of the young people across all units at the time of our visit/inspection ranged from less than one week to approximately 10 months. Some of the young people were receiving care and treatment on a compulsory basis according to the Mental Health (Care and Treatment) (Scotland) Act 2003.

We 'double' read 45 health records of the young people. That is, two of our staff (nurse, psychiatrist, mental health officer) independently reviewed all records held across all four units.

We engaged with the **relatives/carers of 36 young people.**

63 of the multidisciplinary staff working directly on the units provided us with information.

We also received **feedback from 27 mental health officers** (specialist social workers).

We sought **feedback from the advocacy service provider** for each of the four children and young people's units (none of which were child specialist providers however).

We also **attended group meetings on the units** as appropriate, for example carers groups, staff groups, activity groups.

We reviewed a significant amount of information requested from each service including **policies, training records, incident records, details of staffing establishments** and so on.

We are extremely grateful to all the young people receiving care and treatment, their families, advocacy staff and mental health officers (MHOs) for engaging in this joint unannounced visit/inspection process across all four children and young people's units in Scotland. We recognise the importance of focusing on recovery whilst in hospital and the extreme busyness of staff, so we very much appreciated the level of engagement and open and honest conversations that were had.

What did we find?

Inpatient Child and Adolescent Mental Health Services (CAMHS) are regarded as Tier 4, that is, they are required to meet the needs of children and young people with the most complex, severe or persistent mental health problems.[1]

All four reports evidence a range of good practice and positive experiences of children, young people, relatives and staff (both staff working on the unit and those visiting) as well as areas for improvement.

However, different units are doing different things better and likewise regarding areas for improvement. For example, authority to treat according to the mental health act was clearly in place for all young people at Dudhope Unit and Ward 4 but not for all young people at Melville Unit or Skye House. There is therefore potential for the units to work together to learn 'what works' from each other and remove this inconsistency.

Closer collaborative working to share learning and good practice, which clearly exists, will ensure that the satisfaction ratings of those using the services (children, young people and their families) are reported as at least 'satisfied' or above. It is also the case that where young people transition from the National Child Psychiatry Inpatient Unit (Ward 4) to local regional units or other young people experience admission to more than one unit, a shared learning approach between the children and young people units will ensure that children, young people and their families experience the same consistent high quality, lawful standard of care, compassion and communication irrespective of where the young person unit is in the country.

[1] NHS Scotland CAMHS Model (2).pdf

Areas of Good Practice

- **Introduction of new innovative roles e.g. care coordinators, physical health nurse** (Melville Unit, Skye House, Dudhope Unit)
- **All parents felt involved and included in the care planning process and were very satisfied with the care and treatment provided** (Ward 4)
- **Positive interactions observed between staff and young people** (Skye House, Melville Unit, Ward 4, Dudhope Unit)
- **Introduction of community meetings** (Melville Unit, Skye House)
- **Commitment to fill longstanding vacancies in social work** (Skye House, Dudhope Unit) **and to provide additional nursing establishment resource** (Skye House)
- **Rights respecting school and education integral and available to all patients** (Dudhope Unit)
- **Treatment in place was fully authorised by mental health law** (Ward 4, Dudhope Unit)
- **Available accessible and age specific information** (Ward 4, Dudhope Unit)
- **Development of detailed online digital resources for young people and their families** (Dudhope Unit, Ward 4, Melville Unit)

Areas for improvement

- **Culture and attitudes of some staff** (Skye House)
- **To build in discussion regarding the rights of young people to have an advance statement when they are well enough to do so, e.g. at the point of discharge planning** (Skye House, Ward 4, Dudhope Unit, Melville Unit)
- **Board wide seclusion policies need to be in place to underpin local seclusion guidance** (Ward 4, Skye House, Dudhope Unit)
- **The practical application and safe use of proportionate restraint as a last resort** (Melville Unit)
- **Timely completion of fire risk assessment improvement actions and fire safety maintenance** (Skye House, Ward 4, Dudhope Unit)
- **Safe maintenance of the care environment was an area for improvement noted across all four sites** (Ward 4, Skye House, Dudhope Unit, Melville Unit)
- **Need for robust multidisciplinary workforce models including social work, dietetics and psychology** (Skye House, Melville Unit, Dudhope Unit)
- **Timely review and implementation of lessons learned from reported incidents** (Skye House, Melville Unit).

Shaping culture and experience

We found that all the staff we spoke with across all four units shared a commitment and passion for working with young people together with their desire to support the young person's recovery.

We found that young people and their families spoke highly of the multidisciplinary teams and of the nursing staff in particular, however, this was sometimes caveated with some nursing staff being better than others within settings. The attitudes and approaches to patient care of a minority of nursing staff at Skye House were singled out as a concern and were said to impact the culture there negatively. Whilst in Ward 4, within the same health board (Greater Glasgow and Clyde), the feedback was overwhelmingly positive.

As we have stated previously, children and young people should receive holistic, person-centred care delivered by an experienced, specialist, well-resourced and supported multidisciplinary team which is inclusive of both the young person and those important to them, family members and friends.

A positive, compassionate and open culture is critically important to improve patient safety, care and experience. The King's Fund[2] confirm that "healthy cultures in NHS organisations are crucial to ensuring the delivery of high quality patient care" and the culture is shaped by both leaders and those working directly with those receiving care and treatment.

Appropriate Staffing

The commencement of the Health & Care (Staffing) (Scotland) Act 2019 means that, as of April 2024, NHS boards are legally obliged to meet legislative duties in accordance with the Act.

We found that the workforce challenges and risks associated with staffing shortfalls was a consistent theme across our visits/inspections with four requirements given to support improvement. We also highlighted the importance of ensuring that clinical leaders are provided with adequate time to lead, provide regular one to ones, and complete staff appraisals timeously. Additional themes relate to the implementation of a robust multidisciplinary workforce model to promote patient and staff safety through increased dietitian and multidisciplinary team support. The consistent application of the Common Staffing Method to inform staffing requirements and ensuring staff receive adequate protected learning time to undertake required training for their role was also raised.

Staff Vacancies

We found that where staff vacancies were filled and the range of key disciplines were actively involved in a young person's care, the delivery of and experience of treatment and care was reportedly more positive. The benefits of national funding and full resourcing at Ward 4 was acknowledged by those working there who referred to the challenges faced by colleagues elsewhere noting the potential for 'burnout' as a result. Gaps in psychiatry (Melville Unit),

[2] Improving NHS Culture | The King's Fund

psychology (Melville and Dudhope Units), waits for input with occupational therapy, psychology and dietetics (Skye House), nursing shortages (Skye House), lack of accessible social work (Dudhope Unit, Skye House) all served to impact on timely assessments, the care model provided and the experience of young people and their families. Vacancies and working with temporary staff also had a direct impact on the ability of permanent staff to do their own jobs the best that they could.

We welcome the recruitment plans we were advised of, not only to fill vacancies, some long standing, but also to significantly expand the workforce at Skye House and we will continue to follow up.

Staff Training

As of 1 April 2024, NHS boards have a duty under the Health and Care (Staffing) (Scotland) Act 2019, to ensure staff have the required training to undertake their role and have adequate time and resources to undertake the required training. A total of four requirements were issued across three sites (Melville and Dudhope Units and Ward 4) in relation to staff training.

Three of these requirements related to low compliance rates with staff training in immediate life support.

The Quality Network for Inpatient (CAMHS) Standards for Services (Royal College of Psychiatrists) standard (2.3.3) documents that all medical and registered nursing staff that administer rapid tranquillisation should complete immediate life support training or a local equivalent. Immediate life support training teaches more advanced skills than basic life support training including airway management.

We have raised the low compliance rates in Dudhope Unit, Melville Unit and Ward 4 with NHS Tayside, NHS Lothian and NHS Greater Glasgow and Clyde to highlight the need to ensure that staff are appropriately qualified to care for, recognise and respond appropriately in emergency situations to a child whose physical health is deteriorating.

NHS boards also play a crucial role in child protection and adult support and protection. The need to ensure all staff have completed appropriate levels of this training relevant to their roles resulted in two requirements (Dudhope Unit and Skye House). Child protection and adult support and protection is further discussed below.

Two requirements were also made in relation to staff training and the use of physical restraint (Dudhope and Melville Units). The use of physical restraint is discussed below.

Training staff receive in relation to the prevention of self-harm was raised with senior managers. The National Institute for Health and Care Excellence (NICE) defines self-harm as intentional self-poisoning or injury, irrespective of the apparent purpose. Scotland's Self Harm Strategy and Action Plan (2023-27) highlights that self-harm is complex and varies widely from individual to individual and can serve a variety of functions. These can include a form of self-punishment, compulsive or

habitual behaviour and distraction from distressing emotions. It also documents that self-harm can enable people to regulate emotion, provide release or comfort and restore calm.

We observed a significant amount of incident reports in relation to self-harm, including the use of restraint to prevent or stop self-harm. We were advised that although there is in-house training that suicide and self-harm prevention training is not currently part of mandatory training for staff in either the Melville Unit or Skye House.

Child protection and adult support and protection

Although staff we spoke with confirmed that they had undertaken child protection and adult support and protection training, it was not always clear that understanding of types of harm and witnessing harm would lead to reporting via protection routes. Explicit understanding of the overlap of child protection and adult support and protection for some of the young people in the units was also not evidenced. Worryingly some staff reported witnessing unacceptable staff attitudes towards young people but explained this away in terms of 'burnout' instead of challenging this.

It is important that those visiting children and young people units (MHOs, advocacy) and all staff on site are aware of their child protection and adult support and protection reporting responsibilities. Child protection and adult support and protection is everyone's business, and this extends to health settings.

Multidisciplinary Team Working

It is essential that multidisciplinary teams respect the value of each other's contributions and whilst we found this to generally be the case, there were reports that the medical model of psychiatry, at times, seemed to assume lead at the expense of a holistic approach (Melville Unit, Skye House). The team dynamics at the Melville Unit were particularly concerning and longstanding. We are clear that urgent action must be taken now and have followed up on the actions NHS Lothian have advised us that they intend to take. On the other hand, the multidisciplinary team at Dudhope was high functioning, with staff across disciplines willing and able to challenge each other and express different views, knowing these would be heard and a shared position reached focussing on the young person.

Family Involvement

Experiences of families and those important to the young person were very mixed across and within some settings. Some relatives felt very involved and included, others did not receive information at the right time, others explained the lack of consistency across staff, explaining that some staff were really good but with the caveat that it depended on who they spoke to (this extended to both temporary and permanent staff) and some having to invoke complaints procedures to ensure respect for their role. Only the small group of parents at Ward 4 all

described being very satisfied with the service they and their young person received (the top score of the sliding scale) and were all uniformly positive in their feedback. It was clear that having a dedicated carer support worker made a difference at Dudhope and the introduction of a carer support group at Skye House in August 2025 will also hopefully make an impact. This is particularly necessary as very few parents/carers that we spoke with had been made aware of their right to an adult carer support plan or a young carer statement. Whilst it was explained to us that this was the role of the local authority, we would expect that children and young people's units would be aware of the rights of carers and young carers and direct families accordingly.

Mental Health Officers (MHOs)

Mental health officers (MHOs) have statutory powers under the Mental Health Act to support the care and treatment of people whose mental health condition may require the protection afforded by legislation. They are the authors of social circumstances reports (SCR) (section 231 Mental Health Act), a critical process and tool to assess, encourage participation of relevant others and consider future care planning.

The Commission's good practice guidance is clear that an SCR should be prioritised for children and young people up to aged 18 years. However, there was a consistent theme of missing SCRs and the reports not being completed because of caseloads and reported competing work demands on MHOs (Melville Unit, Skye House and Dudhope Unit). National standards for MHO services[3] are clear that MHOs require to fulfil their statutory duties under the legislation and managers require to enable this. It is important to note that this lack of statutory SCR provision extends beyond the four children and young people's units in Scotland as highlighted in the Commission' s Mental Health Act monitoring report. SCRs were missing in respect of 47% of all short-term detentions across Scotland in 2024-25.

Mental Health Act

The Mental Health (Care and Treatment) (Scotland) Act 2003 provides the authority for compulsory treatment of individuals under strict circumstances and describes important safeguards for individuals as to how medical treatment, such as medication, nasogastric tube feeding (NGT) and electroconvulsive therapy (ECT) may be lawfully authorised. Part 16 of the 2003 Mental Health Act describes these requirements which seek to ensure that the rights of patients are sufficiently upheld and protected at a time when they are unwell and may be unwilling to receive treatment or be admitted to hospital on a voluntary basis.

Lawful practice and understanding of roles and responsibilities around Part 16 was embedded at Ward 4 and Dudhope Unit but not yet at Melville Unit or Skye House. Mental health legislation is in place to protect the rights of young people, it is unlawful to receive treatment without mandatory safeguards, including second medical opinions where indicated.

[3] https://www.gov.scot/publications/national-standards-mental-health-officer-services/

To remove a person's liberty and enforce treatment is a significant intervention and violation of human rights without the requisite law being in place to authorise this. There is evidence that this can be done lawfully in practice therefore learning from other children and young people settings where there is managerial oversight and audits require to be undertaken at Skye House and Melville Unit to ensure this.

Anyone has a right to make an advance statement. Section 275 and 276 of the Mental Health Act enable a person to do so. We found that no discussion had taken place with any young person on this right at any setting we visited/inspected.

It is the responsibility of all services to promote the rights of individuals and we have recommended that **all** Scotland's children and young people's units build the offer of an advance statement into practice when the person is well, as part of discharge planning. It is not solely the responsibility of community services to do so as intimated by some of the staff we met, neither are advance statements only for adults.

Scotland's mental health law confirms the important role of independent advocacy services in supporting people to access their rights. We welcomed the fact that the advocacy services we met with consistently reported that staff from all of the children and young people's units were accommodating, they were promoting advocacy activity and facilitating access to advocacy.

Restraint

The practice of restraint should be informed by human rights law and where there is no other option, restraint should be the minimum required for the assessed risk and applied for the minimum possible time. Restraint practice was a particular focus for improvement at the Melville Unit. We therefore welcomed NHS Lothian's quality improvement initiative to aim to reduce the use of restraint required when administering nutrition by artificial means and look forward to the impact on patient care as a result.

Staff training in the use of restraint is critically important and this led to two requirements being made across two visits (Melville and Dudhope Units) to support improvement.

The matter of consistency of the recording of restraint, both numbers of restraints and the details of the actual restraint, was a significant issue highlighted throughout our visits/inspections.

The Scottish Government has since asked the Commission to undertake national monitoring and reporting on the use of restrictive practices in inpatient mental health units across Scotland. This was a recommendation in the Scottish Mental Health Law Review published in 2022.

In 2026 the Commission will work with Health boards to improve and standardise the collection of data relating to the use of restrictive practices with a view to gathering this data nationally and reporting on this as requested.

Mealtime support and nasogastric tube feeding (NGT)

Scottish Child and Adolescent Mental Health Services have reported an unprecedented increase in the number and severity of young people presenting with eating disorders since the start of the COVID 19 pandemic. There are a range of guidelines from the Royal College of Psychiatrists, the Mental Welfare Commission, the Scottish Intercollegiate Guidelines Network (SIGN) to inform practice noting that some people may resist weight gain by any means and compulsory treatment under the relevant legislation may be necessary where the level of malnutrition is life threatening. This may require insertion of a nasogastric tube (NGT) against the patient's will, by staff trained in restraint techniques to enable the administration of nutrition.

Across Skye House, Dudhope and Melville Units, approaches to NGT feeding under restraint and mealtime support varied (as did recording), though all were reportedly guided by national legislation and best practice frameworks. Mealtime support was clearly a pressure area and there required to be sufficient staff resource to manage this without impacting on other planned interventions. We heard from some families, however, that they felt they were used at meal times to address gaps in staffing (Skye House) and many staff and young people (across all of the three children and young people units referred to) reflected on the fact that significant staff resource was directed towards those with eating disorders leaving other patients' care with less staff time.

All three units (Skye House, Dudhope and Melville) aimed to provide NGT feeds in a private area, but where a young person struggled, and staff had difficulty moving them safely, NG feeds may have been given in a communal area. When this was required, staff moved the other young people to other areas of the ward and would screen the young person to ensure their privacy and dignity. The impact on the young person and other young people on the ward in these circumstances cannot be overstated.

Restrictive practice

The Commission's good practice guidance on Specified Persons[4] is clear that people who are in hospital should be able to keep contact with friends and family throughout their stay, and should, if appropriate, be able to carry on with their lives in as usual a manner as possible.

We found that all young people were able to keep in contact with people important to them if they wished. We also noted how difficult it is for those parents whose young people ask not to keep in contact and remind that staff require to be sensitive to this (which we found to be the case).

Restrictions can be imposed, for example, it is possible to use section 284 of the Mental Health Act and associated regulations to intervene in the use of a mobile phone where this is assessed and deemed as necessary by the responsible medical officer. We are aware of the difficult decisions that have to be made to balance free communication with privacy and ensuring safety, particularly with regards social media but we are concerned where blanket policies underpin this, such as that

[4] Specified persons good practice guide

found only at Skye House. We were also concerned to note that young people were subject to seclusion, and while locally drafted guidance may have been produced, there was no supporting board agreed seclusion policy in NHS Tayside or NHS Greater Glasgow and Clyde. Recommendations were therefore made to address this.

Activity and education

Activities provide structure, opportunities for new learning and engagement. They can improve mood and combat boredom which might otherwise lead to negative behaviours or, as some young people told us, preoccupation with their thoughts.

Once again, we found an inconsistent picture across the four units. An activity culture was very evident in Ward 4 and at Dudhope Unit. Dudhope also has a well-maintained courtyard garden where staff facilitated young people to go outside to the open grounds, including wooded areas. However, both Skye House, despite having a welcome indoor gymnasium and outdoor multi use games area, and Melville Unit were found to be lacking in the range of activities available, particularly in the evenings and at weekends (confirmed by young people, their parents and our observations).

Two requirements were given to support improvements to ensure meaningful activity is consistently provided, including evenings and weekends. One of these requirements also supported ensuring the completion of activity plans and that they are updated within care plans.

Despite the fundamental right to education, those attending Skye House had differing levels of access to education based on the local authority they lived in (postcode lottery), unlike Melville and Dudhope Units where we were told access was readily available to the young people if they were well enough and willing to attend. Families and young people were aware of their differential rights to access education based on the agreements with the local authority they lived whilst at Skye House. This lack of parity is a concern and we have raised this with Scottish Government.

Care planning and documentation

Across and within Dudhope Unit, Skye House and Melville Unit, care planning processes varied considerably, with notable gaps in consistency, completeness, and person-centred approaches. That said, there were some care plans that were detailed and good quality. This was consistently the case on Ward 4 where care plans generally evidenced high-quality recording, detailed care plans which included the views of the multidisciplinary team, the young person and their family member. Care plans were also combined and converted to a ‘child friendly’ version, dependent on the age and development stage of the young person, using pictures and symbols as appropriate.

The templates and electronic systems used in Skye House and Melville Unit seemed to add to care planning challenges as they were not easy to navigate, with pockets of information held across different areas leading to a lack of a cohesive plan for staff to use to plan assessment, care, treatment and discharge from.

The Scottish Government has produced clinical process guidance for young people moving between Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services which was developed in consultation with CAMHS users to further Action 21 of the Mental Health Strategy: 2017-2027. Where discharge planning involved the significant transition to adult services, the use of this guidance was not evidenced as we would expect to ensure continuity of care.

Findings in relation to care planning and documentation led to requirements for improvement across Skye House, Dudhope and Melville Units. Among them are actions to ensure all documentation is accurately and consistently completed and reviewed, including activity plans, nasogastric bolus charts, risk assessments, and nutritional fluid charts and care plans. An additional area of improvement included having a system in place to identify young people if they are unable to confirm their name and date of birth themselves during medication administration.

Fire Safety

Fire safety concerns were identified in three sites, Skye House, Dudhope Unit and Ward 4. These include measures to support the assurance of a safe healthcare environment through the timely completion of actions within fire risk assessments. Other areas of improvement included maintenance and testing of fire safety equipment, maintenance of the care environment and staff training in fire evacuation procedures.

Infection Prevention and Control

Standard infection control precautions should always be used by all staff to minimise the risk of cross infection. These include patient placement, hand hygiene, the use of personal protective equipment (such as aprons and gloves) and linen and waste management. Practising good hand hygiene helps reduce the risk of the spread of infection. Other standard infection control precautions such as linen, waste and sharps management minimise the risk of cross infection. Sharps boxes should be stored in a safe, locked area whilst awaiting uplift and should have temporary closures in place. Sharps boxes should be labelled as per guidelines. Three areas for improvement in relation to infection prevention and control were highlighted across three visits/inspections, Skye House, Dudhope Unit and the Melville Unit. These requirements were in relation to the safe disposal of sharps, staff compliance with the safe management of linen, appropriate wearing of jewellery and adequate oversight and cleaning schedules of window grills.

Incident reporting

As part of each visit/inspection, we asked NHS boards to provide evidence of any adverse event or near miss incidents reported by staff for the six months prior to our onsite visit/inspection. Adverse event reviews help to identify whether the potential harm, or actual harm, associated with the adverse event was avoidable. The Healthcare Improvement Scotland ‘A national framework for reviewing and learning from adverse events in NHS Scotland’ highlights the expectations, guidance and timeframes for adverse event review.

The level of the review will be determined by the category of the event and is based on the impact of harm, with the most serious requiring a significant adverse events review.

We noted from these reports that incidents relating to attempted self-harm, restraint, and violence and aggression towards staff by young people, accounted for the highest number of reported incidents. We also noted some incidents relating to missed nutrition by nasogastric tube.

We recognise that a high number of reported incidents/near misses can indicate a culture of transparency and openness in reporting incidents and near misses to enable lessons to be learned and promote a safe delivery of care.

A significant adverse event is an event which caused or could have caused significant harm. Significant adverse event reviews are essential to ensure key learning and reduce the risk of future harm. We saw from evidence provided that across the four sites, there were five significant adverse events under review. We recognise the commissioning of a significant adverse event review is good practice to ensure lessons are learned and essential to continually improve safe and effective care. Skye House had three significant adverse events under review, two of which remained open after six and 12 months. A further two significant adverse events were under review at Melville Unit and remained open after 14 and 18 months although we were advised development plans were in place. This is not in line with Healthcare Improvement Scotland 'A National Framework for Reviewing and Learning from Adverse Events in NHS Scotland' which recommends that significant adverse events are commissioned, reviewed and an improvement development plan are completed in 140 days.

Across the four visits/inspections, two requirements were made to support timely review and implementation of lessons learned from reported incidents including significant adverse events. These were at Skye house and the Melville Unit.

Safe maintenance of care environment

Seven requirements regarding the physical care environment were issued across our four unit visit/inspection programme. These ranged from a specific area of the environment being used by young people because it is less visible to staff being added to an environmental risk register, to steps to ensure timely reporting and completion of maintenance requests.

Governance

Following the Skye House and Ward 4 visits/inspections, evidence provided by NHS Greater Glasgow & Clyde included a number of policies and procedures which were overdue their review date or in draft form awaiting ratification. Requirements were given to NHS Greater Glasgow and Clyde to support improvements in assuring that effective and appropriate governance approval and oversight of policies and procedures are in place to ensure the most up to date guidance is in use.

Conclusion

This summary report is the conclusion of the programme of joint visits/inspections by the Mental Welfare Commission and Healthcare Improvement Scotland to the four children and young people's units across Scotland during 2025.

Melville Unit (NHS Lothian), National Child Psychiatry Inpatient Unit (Ward 4) (NHS Greater Glasgow and Clyde), Skye House (NHS Greater Glasgow and Clyde) and Dudhope Unit (NHS Tayside) have all confirmed actions that they plan to take to address the individual service specific recommendations and requirements made towards improvement in response to our joint findings. Progress on stated actions will be followed up with each health board to ensure that they are embedded.

When a child or young person is admitted to one of Scotland's national or regional mental health units, it is because they require assessment and treatment for complex mental health needs. They are at their most vulnerable and they, and their families, have a right to the highest quality, compassionate care in a safe, clean, welcoming environment. We found that this was the experience of some but not all of those we met with. This is not good enough, all have the same right, irrespective of where the care is provided and by whom.

Recommendation

Our overarching recommendation therefore is to: ensure that learning takes place across all four of the children and young people's units across Scotland. This will assist identified good practice being understood and replicated in areas where improvement is identified and will support equitable access to high-quality, compassionate, safe, care and indeed education.

However, the right resources, the right staffing, the right staff attitudes and the right culture demand the most effective leadership which listens and responds. Where we found this, staff were able to do their jobs to the best of their abilities. Children, young people and their families felt included as partners in care with trust and confidence in those caring. Leadership therefore must underpin learning.

A final point relates to content within the BBC Documentary about Skye House. We heard that young people may not feel able to express their views or concerns about treatment and care to those around them whilst in receipt of that care or may not know what 'good care' looks like. Other families have also come forward to tell us similarly in relation to other settings.

We hope that the learning and leadership noted above helps to improve this. In conclusion, we end this review report by providing contact details for the Mental Welfare Commission advice line for anyone to contact at any time.

Mental Welfare Commission for Scotland telephone advice line:

91 Haymarket Terrace

Edinburgh

EH12 5HD

Telephone: 0800 3896809 Monday to Friday 9am-12noon and 1pm-4pm (calls are free and can be anonymous)

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