Mental Welfare Commission for Scotland

Report on announced visit to:

Royal Hospital for Children and Young People, The Melville Young People's Mental Health Unit, 50 Little France Crescent, Edinburgh, EH16 4TJ

Date of visit: 23 and 24 March 2026

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

The Melville Unit at the Royal Hospital for Children and Young People (RHCYP) is a 12-bedded specialist tier 4 inpatient service, designed for children and young people with mental ill health, aged 12 to 17 years (inclusive). On the day of our visit, there were eight young people on the unit.

Beds in the unit are primarily intended for children and young people from the Lothian region, although there are specific agreements in place for individuals from Fife and the Scottish Borders. There is also an agreement to take patients from other Scottish health boards on an emergency basis.

The Commission last visited the service in May 2025, along with Healthcare Improvement Scotland (HIS) as part of a series of enhanced, unannounced visits/inspections across all three young people units in Scotland and the separate children's in-patient psychiatric unit in Glasgow.

A joint report was subsequently published, with the Commission identifying eight key findings from the enhanced visit. These findings included concerns over the use of restraint, particularly in relation to nasogastric tube (NGT) feeding. The Commission highlighted that authority to treat young people must be in place in accordance with the Mental Health (Care and Treatment) (Scotland) Act, 2003 (Mental Health Act). Concerns in relation to multidisciplinary team (MDT) dynamics, lack of meaningful activity, poor quality care planning and insufficient communication with young people and families were identified. Environmental issues were also highlighted, with improvements required to ensure the safety of both staff and young people.

Prior to the enhanced visit, we last completed an unannounced local visit to Melville in July 2024 . We made nine recommendations and highlighted concerns that since April 2022, the Commission had undertaken four visits to Melville Unit, made 23 recommendations, many of which had been repeated and were concerned that there was little evidence of improvements being made.

This visit was intended as a follow up to the enhanced visit of May 2025. The multidisciplinary team of Commission visitors were in the unit for two days to meet with as many of the young people who were willing to meet with us and to review all of the care records for those in the unit at the time of our visit.

We also wanted to follow up on the previous recommendations/findings, meet with as many families and staff as possible and to hear their views and experiences of how care and treatment was being provided on the unit.

Who we met with

We reviewed the care records of eight people, six of whom we met with in person. We also met/spoke with four relatives.

We spoke with the general manager, chief nurse, clinical nurse manager (CNM), senior charge nurse (SCN), bed manager, specialist medical trainee, physician associate, nurse consultant, nursing staff, activity manager, occupational therapists (OT), psychology staff, and the family and systemic psychotherapist.

In addition, we contacted the advocacy service, AdvoCard, mental health officers (MHOs), and City of Edinburgh social work managers.

We attended various groups and meetings during the visit, including the ward MDT meeting, the development meeting, the community meeting, a ‘seize the day’ group and an art activity group.

Commission visitors

Kathleen Liddell, social work officer

Dr Juliet Brock, medical officer

Lesley Paterson, senior manager, practitioners

Claire Lamza, executive director (nursing)

What people told us and what we found

Comments from young people

The young people we met with told us that staff were “nice to me” and “available to talk to me when I needed support.” Young people also spoke positively about members of the MDT, describing their approach to care as “compassionate,” “empathetic,” and “positive.” One young person commented that the MDT approach had been “dynamic,” which they felt had supported their recovery.

Some of the young people reported that the unit had at times been short staffed, and that staff had appeared “stressed” at these times. Some of the young people told us that bank staff had often been used to cover staffing shortages, however they felt that bank staff had not always been aware of their individual care plan needs and they preferred it when permanent staff were on shift.

The young people told us that they had been aware of their care plans and had been involved in their completion. We heard that some of the young people felt involved in their care and were able to provide their views to staff during one-to-ones. We also heard that although young people had initially been aware of what was recorded in their care plans, as their admission progressed and their care and treatment goals and needs changed, they became less involved and less aware of the updated care plan goals. This led to some anxiety in relation to expectations around what was required to achieve increased pass time out with the ward and ultimately, discharge.

We heard that there had been improvements in relation to increased and more consistently provided activity in the unit. We heard that this had had a positive impact on the young people’s wellbeing and recovery as it provided a constructive focus for the day. Some young people commented that the introduction of a new activity manager had been positive, as activities had become more person-centred and there had been greater opportunities for off-ward activities at the HUB, which many of the young people had enjoyed.

However, young people also reported that there had still been periods of time, particularly at weekends, when there had been a lack of activity provision. We heard from them that periods of inactivity had contributed to increased boredom, anxiety and low mood. While young people were aware of plans to recruit an additional activity manager, they told us that more activities were needed across the day and week; this would then ensure a consistent delivery of meaningful activity across the day, seven days a week. We look forward to seeing the development of the dedicated activity staff team on our next visit.

Some of the young people we met with had attended the school in the hospital and had found this experience to be positive.

We heard from a number of young people that we met with that they had not always felt safe on the ward. We heard that some young people in the unit had been experiencing high levels of stress and distress, which at times led to violence and aggression towards staff and, on occasion, other young people. Some described feeling “scared and unsafe” at times, which they felt had a negative impact on their mental health and recovery. We were pleased to hear that young people had felt able to tell staff how they were feeling although they did not always feel that sufficient action had been taken to ensure their safety in the unit.

Comments from parents/carers

The parents/carers we met/spoke with provided mixed views about the care and treatment their child had received. We heard a consistent view that staff were “very nice”, “caring” and “supportive” and that in general their child was receiving good care.

We heard positive feedback from parents/carers regarding the MDT in the Melville Unit, particularly the input from psychology and family therapy. Parents/carers described a “holistic approach” to their loved one’s care, which they felt supported recovery and provided strategies to help maintain progress following discharge.

We heard more about the improvements in the activity available in the unit. Parents/carers whose child had previously been in the unit commented that the introduction of activity manager post had been positive and had supported increased and more consistent meaningful activity both on and off the ward, which they felt was benefiting their child. However, similar to comments from young people, parents and relatives reported that there were still periods of time when activity was limited, which they felt negatively impacted their child’s mood.

Most parents/carers that we spoke with raised concerns about communication and involvement in their child’s care and treatment. They reported that communication was largely instigated by themselves, with inconsistent information provided by different members of the MDT. Some described receiving “conflicting information,” which caused confusion regarding care and treatment. Examples were shared of decisions about home pass arrangements being made without prior discussion, leaving parents/carers feeling excluded from these types of important decisions.

Parents/carers highlighted that, although they completed feedback forms prior to MDT meetings to share their views, it was not always clear whether these were taken into account during MDT decision-making. One parent described the form as “tokenistic,” adding that their view and input was not consistently reflected in the MDT’s decisions.

Parents/carers consistently emphasised that being actively involved in decisions about their child's care was important to support their understanding, engagement and confidence in the care provided.

We heard that there had been improvements to support communication, including the introduction of a Padlet providing general carer information, a weekly parent group and a new quarterly "meet the charge nurse" session. The service also outlined plans for regular family meetings, psychoeducation sessions and family/carer bulletins. These initiatives will be welcome and will, in future, help with the concerns raised with us by those parents/carers who reported to us that the information provided often did not include details specific to their child, which was the information they most needed.

At the end of the visit, we raised the parent/carer feedback with the service, highlighting that the issue of communication had been raised in previous reports and in the joint Commission/HIS visit last year. We discussed the Commission's expectations regarding communication and emphasised that it was essential the service addresses these issues urgently to ensure that families are consistently informed, involved, and supported in their child's care and treatment.

Recommendation 1:
Managers and the MDT must ensure parents and carers are consistently informed, involved, and supported in their child's care, building on existing engagement initiatives.

A number of the parents and carers that spoke with us raised concerns regarding safety in the unit, reporting that their child had been subject to physical aggression from other young people or that they had witnessed staff being assaulted. While the parents/carers recognised that the young people involved in these incidents were struggling with their own mental health challenges, they felt that not enough action was being taken by the service to protect and safeguard their child. We heard that parents and relatives raised their concerns with members of the MDT but did not always feel reassured that sufficient action had been taken to ensure safety.

During the visit, we spoke with young people who had either witnessed or been subject to violence and aggression. While this was often linked to the complexity and acuity of mental health difficulties, the actions required to manage this did not always reassure young people or their families, who continued to express concerns about safety. We discussed safety with various members of the MDT and the management team and were encouraged to hear that the safety of young people is taken seriously and was a priority.

Nevertheless, based on information provided by young people and a review of care records documenting harm, we were of the view that the MDT need to ensure that all safeguarding processes are consistently followed and that all available options to safeguard young people are considered. The Commission recognises that at times, the use of restrictive measures may be required to safely manage care and treatment for an individual or need to be put in place for the safety of those in the environment. We were concerned that the option to use these measures, particularly in relation to the use of seclusion, were not considered for young people experiencing acute periods of stress and distress on the day of the visit.

Appropriate use of seclusion, in line with local and national guidance, can support the safety of both the young person and others on the ward, provide space for de-escalation and ensure that interventions remain proportionate, therapeutic and least restrictive.

The Commission's position is that young people have a right to feel safe in hospital and care must be provided in a safe, therapeutic and least restrictive manner, in line with the Mental Health Act; this includes protecting young people from harm while respecting their dignity and rights. Under the United Nations Convention on the Rights of the Child (UNCRC), children have a right to protection from violence or neglect (Article 19) to health and wellbeing (Article 24), to have their best interests as a primary consideration (Article 3), and to express their views on matters affecting them (Article 12). Ensuring safety on the unit is a legal obligation and the responsibility of the service, supporting young people's rights and recovery.

Recommendation 2:
Managers must ensure that all safeguarding processes are consistently followed and that all available options to manage risk are considered, including proportionate and therapeutic use of restrictive interventions where necessary, to maintain the safety of young people, staff, and others on the unit.

Care, treatment, support, and participation

We were told and saw that NHS Lothian had implemented a new person-centred care plan in April 2025. The new person-centred care plans reviewed on TRAKCare, the electronic patient information system in use in NHS Lothian, had various headings such as, mental health, stress and distress, meaningful activity, physical health, activities of daily living, discharge planning and family/carer involvement.

The Commission has made a number of recommendations in previous reports relating to care planning, reviews and audits processes. These were that there was limited evidence of the young people's involvement, as well as a lack of person-centred and personalised information being recorded in the care plans. The service's action plan outlined a proactive approach to improvement, including a care plan improvement project, training in relation to care planning and the auditing of the care plans.

We reviewed all care plans and were pleased to find improvement in the standard and quality of information recorded. We were encouraged to see contributions from different MDT members, supporting a more coordinated and collaborative approach to the care and treatment of young people in the Melville Unit.

On review of the care plans, we found that there was some variation across the different forms that were included as part of the individual’s documents.

Information was consistently recorded regarding the purpose of admission and included a robust assessment of need. Care plans were individualised, strengths-based, holistic and person-centred, addressing both mental and physical health needs.

However, information relating to the interventions required to achieve care plan goals and outcomes was not consistently comprehensive. In some instances, more clarity and specificity would be helpful, with interventions more clearly defined and aligned to SMART (specific, measurable, achievable, relevant and timely) objectives.

We were encouraged to see improved involvement and participation of young people in care planning. The use of documents such as ‘what matters to me’, ‘brain dump’, ‘today’s mental reset’ and ‘communication passport’ supported young people to express their views and preferences. We also saw evidence of child-friendly documentation, including the use of signs and symbols, which further supported accessibility and meaningful engagement. This demonstrated a rights-based approach to care, supporting young people’s participation in decision-making in line with UNCRC principles.

We were unable to find a consistent approach to involvement of parents/carers when reviewing care plans. While we saw that a parents/carer involvement care plan was in place, the information recorded mainly reflected the young person’s views of their family and did not include the perspectives of parents or carers themselves. As many of the young people we met valued the views and support of their families, we were concerned that the absence of parent/carer input into the care plan could impact on the achievement of care goals and outcomes, particularly in supporting effective discharge planning.

We were pleased to find that care plans were reviewed regularly although the template used to record reviews did not consistently support a clear, summative evaluation of outcomes. There was limited information on whether care plan goals were being achieved and where this was not the case, the interventions required to support progress and recovery were not always clearly defined. We raised this with the service on the day of the visit and discussed how staff could be more specific if changes were to be made, along with the importance of robust audit processes in supporting consistency and quality. The senior management team attending for the end-of-visit feedback session acknowledged that the quality of reviews, using the relevant template required further improvement. This would then support clear evaluation of outcomes, along with any changes required to the care plan goals.

The Commission has published a good practice guide on care plans[1]. It is designed to help all members of the MDT create person-centred care plans for people with mental ill health, dementia, or learning disability.

Recommendation 3:
Managers must ensure care plans are regularly reviewed and include a clear summative evaluation, recording the effectiveness of interventions and any additional actions required to support progress and recovery.

We were encouraged to note that discharge planning was considered from the early review meeting, following admission. Discharge planning discussions continued through regular MDT meetings, included community services and was discussed at most weekly MDT meetings. The discharge care plans that we reviewed did not consistently reflect the updated decisions, and the various discharge-related documents did not always align. This lack of consistency reduced clarity for staff, young people and families, impacting the effectiveness of discharge planning and continuity of care.

We reviewed all risk assessments and found them to be mainly of a good standard. They contained clear and concise information on current risks, including protective factors, triggers and stressors and all included a risk management plan; there were inconsistencies in the quality of these plans. Some contained detailed information on how risks should be managed and the interventions required, while others lacked this level of detail which was necessary given the complexity of the young people and associated risks.

In addition to the risk assessment, we saw supporting risk documentation, such as ligature and self-harm assessments.

Care records
Information on the young people's care and treatment was held electronically on TRAKCare; we found this easy to navigate. The care records were recorded on a pre-populated template with headings aligned to the person-centred care plans, helping to ensure consistency and continuity in achieving care, treatment and support outcomes.

The care records identified that there were high levels of mental health clinical acuity in the Melville Unit, with periods of significant distress, violence and aggression. We were encouraged to see that the MDT consistently adopted a compassionate and

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[1] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

empathetic approach to young people during these challenging situations, especially when staff themselves were at risk of or had experienced injury. We were also able to see regular and comprehensive reviews of young people's mental health by the consultant psychiatrist and specialist trainee doctor. These reviews included detailed assessments of mental state, risk and treatment planning. We were encouraged to see an active MDT approach to supporting young people at these times, with a focus on maintaining therapeutic relationships.

The care records we reviewed were of very good quality, containing person-centred, strengths-based, outcome and goal focussed information. We saw regular observations from the MDT of the young person's mental state and how they presented during the day. The information recorded areas of challenge and what interventions were required by the MDT to support the young person at these times.

We saw comprehensive recording from all members of MDT which detailed therapeutic interventions, activity and occupation the young people had engaged in throughout the day. These care record entries included assessment, reflected the views of the young people and where appropriate, family members. The records included an action plan detailing ongoing intervention and the support required to meet care plan goals and objectives. Information recorded in the care records promoted a holistic and recovery-based approach to the care of the young people in the unit.

We saw that the young people engaged in regular one-to-one interventions with the MDT. These care records recorded the young person's views, thoughts and feelings demonstrating a rights-based and participative approach to their care as well as supporting their right to express their views and have these meaningfully considered, in line with UNCRC principles.

We were pleased to observe that physical health needs were being appropriately addressed and followed up by the physician associate and medical staff. This was particularly evident for young people with an eating disorder, where regular physical health checks were undertaken. When health concerns were identified, there was prompt action and timely review of the physical health care plan.

We saw regular contact with professionals and parents/carers in the care records, although we were aware of the views that contact with parents/carers was often instigated by them rather than by the service, reflecting feedback received from families. This highlighted a continuing need for improvement, with the service required to take a more proactive and consistent approach to engaging parents and relatives.

Multidisciplinary team (MDT)

Care and treatment in the Melville Unit was provided by the MDT and consisted of one full-time consultant psychiatrist, one speciality trainee doctor, one higher trainee, physician associate, nursing staff, OT, OT assistant, dietician, two clinical psychologists (1.5 WTE) , a music and drama psychotherapist (sessional) and a systemic psychotherapist (0.4 WTE).

We heard that there had been reduced provision of social work input into the MDT following a review of the role by City of Edinburgh social work department. While we were informed by the chief social work officer that there were no plans to remove the CAMHS social worker as part of the service review, in practice, the MDT reported a reduction in social work presence at MDT meetings.

We contacted the City of Edinburgh social work department senior management team and were informed that arrangements remained in place to access social work input through consultation and referral pathways. However, there was a lack of consistent and embedded social work involvement in the MDT. We observed that this contributed to uncertainty regarding roles and responsibilities and that this risked delays in accessing social work support for care planning, safeguarding, and discharge. Given the complexity of the young people in the unit, we would expect clearer and more consistent social work involvement, aligned with national standards and best practice.

The Commission had previously raised concerns regarding the inconsistent attendance of nursing staff at weekly MDT meetings. We were pleased to see that MDT meeting arrangements had been reviewed, resulting in nursing staff attending alongside all disciplines. This supported a more cohesive MDT approach to discussion and decision-making during these meetings.

MDT meetings took place weekly on the ward and were recorded using a structured template. We found the quality of documentation to be variable. In some instances, records contained detailed accounts of discussions and clear rationale for decision-making. However, in other cases, documentation lacked sufficient detail, making it difficult to ascertain how decisions had been reached.

We saw from review of the records that parents/carers had completed feedback forms in advance of the MDT meeting. We have since been advised that these forms are available to all MDT members and stored on the electronic system, SCI Store. The Commission did not find that the views of the parents that had been recorded on the feedback form were consistently recorded in the MDT meeting template. We would expect that the views of parents/carers are clearly documented and demonstrably considered when decisions regarding their child’s care and treatment are made.

We also contacted some MHOs, who provided positive feedback regarding their involvement in MDT discussions and decision-making, particularly in relation to statutory detention procedures. MHOs noted that they felt actively included in discussions and that their professional input was valued. They did inform us that some parents/carers of young people had expressed dissatisfaction with aspects of care and treatment and were considering a more formal process to express their views.

The Commission had previously highlighted in reports the need for ongoing work to address interprofessional conflict in the Melville Unit. The joint visit in 2025 had a key finding that there was limited evidence of progress in improving MDT team dynamics.

During this visit, we were encouraged to hear from the service that targeted action planning had been undertaken to address concerns regarding MDT dynamics. This included workshops held between August 2024 and August 2025 focusing on a formulation-based approach to team functioning, the introduction of structured ‘clinical pauses’ to enable reflective decision-making and the availability of reflective practice sessions for staff. We heard from a number of staff that these sessions were supportive, particularly when working with young people with complex needs.

Psychology staff described their role in supporting the implementation of an adaptive mentalisation-based integrative treatment (AMBIT) informed approach to decision-making, and the management team reported that these initiatives had helped all disciplines contribute their professional perspectives and feel more involved in decisions. Informal opportunities, including a weekly ‘tea and cake’ session, were also introduced to promote staff engagement in a less formal setting.

While we heard from some staff who reported to us about improvements in team dynamics and opportunities to contribute to decision-making, others described a sense of “disconnect” with the management team and felt that challenging decisions sometimes resulted in a “critical or unsupportive response”, leaving them feeling “undervalued and unsupported”.

We discussed these concerns with the management team who acknowledged the challenge of balancing an environment where staff could appropriately challenge decisions, with the need to provide guidance and make final decisions in complex situations which were in the best interests of young people.

We felt that these staff views suggested that, although positive steps had been taken to improve team dynamics, further work was required to ensure that all staff felt consistently supported, able to contribute their professional views and confident and confident that their input will be heard, while maintaining safe and effective decision-making.

Recommendation 4:
Managers must ensure that a culture of psychological safety is embedded across the MDT, where all staff feel able to appropriately challenge decisions and contribute their professional views without fear of negative consequences. This should be balanced with maintaining timely and effective decision-making in the best interests of the young people.

Use of mental health and incapacity legislation

On the day of the visit, six young people were detained under the Mental Health Act.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. This includes the requirement for a second opinion by an independent designated medical practitioner (DMP) for certain safeguarded treatments (such as artificial nutrition) and the authorisation of medications prescribed beyond two months, when the individual does not consent to the treatment or is incapable of doing so. Treatment must be authorised by an appropriate T3 certificate, or a T2 certificate if the individual is consenting.

We reviewed the prescribed medication for all young people in the unit, as well as the authorisation of treatment for those subject to the Mental Health Act.

Medication was recorded on the hospital electronic prescribing and medicines administration system (HePMA). T2 and T3 certificates authorising treatment were stored separately on TRAKCare. We found on previous visits that navigating both electronic systems simultaneously could be a practical challenge and suggested a paper copy of a T2 and T3 certificates should be kept in the dispensary, so that the nursing and medical staff had easy access, and an opportunity to review them. We were pleased to see that progress had been made in this area, with a folder containing copies of all T2 and T3 certificates available in the dispensary.

We have previously made recommendations in relation to legal authority to treat the young people in the Melville Unit. The joint visit in 2025 highlighted limited progress, with ongoing concerns that lawful practice and understanding of roles and responsibilities had yet to be embedded in the Melville Unit.

The service informed us that improvement work had been undertaken, including the introduction of weekly checks on T2 and T3 documentation by nursing staff, overseen by charge nurse team. On review of the folder containing T2 and T3 certificates, we were pleased to see that these checks were being completed.

On cross-checking the prescriptions for each young person, we found one young person was receiving medication beyond two months and an appropriate T3B certificate was in place to authorise this treatment. There was a note on HePMA stating that treatment was being given under the Mental Health Act, with the date that the certificate had been uploaded to the individual's electronic health record. We also found a T3B in place for artificial nutrition for a young person who was receiving NGT feeding under the Mental Health Act. Although there were not many young people requiring T2 or T3 certificates, we were encouraged by the progress made by the service, particularly in relation to the review processes in place to support lawful practice.

We noticed that a new consent to treatment form (T2B) for one young person had been incorrectly completed by a junior member of the medical team. While it appeared this had been done with the best of intentions while the responsible medical officer (RMO) was on leave, the Commission would expect that the RMO completes the T2 certificate. If they are unavailable, hospital managers have responsibility for deciding who acts as the RMO. Other medical practitioners in the team who are approved medical practitioners (e.g. experienced trainees, speciality doctors) can only undertake RMO duties if appointed to do so by hospital managers.

Anybody who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a named person had been nominated, we found this documentation recorded and easily located in TRAKCare.

On review of care records, we found examples where harm had been identified and appropriate safeguarding procedures were being considered and actioned by the MDT. This included child protection referrals being made to the child protection HUB and discussions regarding safety planning, as well as decisions about whether ongoing child protection measures were required.

We identified one situation where a young person had experienced repeated physical harm from the same individual. While a review of the care plan had taken place and adjustments made through MDT risk assessment and safety management planning to manage the identified risk, safeguarding procedures had not been considered. We raised this with the senior management team during the visit, who were of the view that the risk assessment and management plan were sufficient to manage the risk, however the service have since advised that a referral to the child protection HUB was progressed after the Commission had highlighted the case.

We would advise that, in all instances where harm is identified, safeguarding legislation and local processes must be followed. This ensures that all incidents of harm are appropriately escalated, investigated and addressed, providing oversight, accountability and additional protection for young people, alongside MDT-informed risk management.

Additionally, consistent adherence to safeguarding processes supports the rights of young people to protection from abuse, in line with the United Nations Convention on the Rights of the Child (Article 19) and reinforces the legal and ethical responsibilities of the service to maintain a safe environment.

Rights and restrictions

The Melville Unit continued to operate a locked door, commensurate with the level of risk identified with the individuals on the unit.

Of the young people we met with, we found that they had a mixed understanding of their rights, whether detained under the Mental Health Act or admitted informally. We found letters to the young people who were detained under the Mental Health Act that provided information on the order they were subject to and information on how to exercise their rights. We were pleased to find that all young people had access to advocacy services, although some had chosen not to use this service. Many young people had also instructed legal representatives and were actively exercising their rights in relation to appealing their detained status.

We were pleased to see improvements made by the Melville Unit in promoting rights and delivering rights-based care in line with the Mental Health Act and the implementation of UNCRC legislation. We heard that initiatives to support rights-based care included approximately 80% of staff having completed rights-based training, the imminent introduction of a Padlet providing information on young people’s rights and the development of person-centred care plans to support young people’s participation and inclusion of their views.

We were able to see evidence of the implementation of these initiatives in practice, particularly in care planning, which reflected the views of the young person and demonstrated consideration of family life. We also observed that one-to-one interactions with staff supported a rights-based approach, with staff engaging young people in a respectful and supportive manner. This indicated that elements of rights-based care were being embedded in day-to-day practice.

The Melville Unit held a weekly community meeting, facilitated by members of the MDT, which aimed to provide a reflective space for young people to discuss what was working well in the unit and identify areas for improvement. We attended a community meeting during the visit and observed that it provided a safe and supportive environment. Young people were encouraged by staff to share their views about their care and experiences in the unit and were able to do so openly.

During the joint visit in 2025, we identified the safe and proportionate use of restraint, as a measure of last resort, as a significant issue in the Melville Unit. This was particularly relevant, although not exclusively, for young people with a diagnosed eating disorder requiring NGT feeding. At that time, we noted that restraint practices lacked detail in anticipatory care planning, with incomplete recording following incidents and inconsistent completion of DATIX, the electronic incident reporting system. A key finding from the joint report was that the approach to restraint required further enquiry and improvement by the service.

The service improvement action plan in response to the visit in 2025 outlined a range of actions to address these concerns, including enhanced staff training, a review of the DATIX system for recording restraint, development of a standard operating procedure (SOP) for NGT feeding, the introduction of workplace trainers, and the implementation of post-restraint physical health checks.

During the visit, the senior management team presented a report that evidenced the use of restraint had reduced by 84%. We were advised that training and the introduction of the SOP had supported the MDT to adopt a more person-centred and rights-based approach to managing challenging situations, where restraint may previously have been used.

On review of care records, we found that restraint was being used for several young people. We were pleased to see that, where restraint was required, a restraint risk assessment had been completed. This document outlined the rationale for restraint, the legal framework authorising its use, alternatives to restraint, and a clear plan of intervention, including the techniques to be used, the number of staff required, and review timescales. We also saw restraint care plans which demonstrated the involvement of young people, including their preferences regarding restraint.

However, we identified two cases where restraint had been used for those who required treatment in relation to an eating disorder at the time of their admission, with limited evidence of less restrictive alternatives were considered or attempted. While it was evident that the service had made progress overall, we were concerned that there were situations where the application of restraint required further review to ensure that all appropriate alternatives had been explored.

We were able to identify instances of restraint recorded in care records although a number of the records we reviewed lacked detail regarding the restraint and post-restraint care, as this information was recorded in the DATIX reports; the Commission did not have access to this. We heard that the service had recently introduced a post-restraint care record in TRAKCare to improve the level of detail recorded, which we welcomed.

Recommendation 5:
Managers must ensure all restraint incidents are fully recorded in care records, including rationale, legal authorisation, techniques used, observations, and follow-up actions, to promote accountability and a rights-based approach.

The Commission would expect that all instances of restraint are comprehensively documented in the care records, including the rationale for use, legal authorisation, techniques used, staff involved, duration, the young person's response, post-restraint observations and any follow-up actions or review plans. This ensures transparency, accountability, and supports a therapeutic, rights-based approach to care.

We were also informed that to support a more therapeutic approach, the service had introduced a safety pod. This provided a low-stimulation environment to support de-escalation and emotional regulation, offering a less restrictive alternative to restraint and contributing to a reduction in incidents.

When reviewing care records, we saw that a some of the young people were subject to continuous intervention (CI). On review of continuous intervention care plans, we found that while associated care records were of good quality and provided a clear account of care and interventions, the care plans themselves often lacked sufficient detail. In particular, they tended to focus on deficits and risk, with limited evidence of a strengths-based approach or inclusion of the young person's individual preferences and therapeutic needs. We would expect CI care plans to be more comprehensive, clearly outlining the rationale for intervention, therapeutic engagement strategies, and a personalised, strengths-based approach to supporting the young person. We raised this with the service during the visit and they acknowledged our concerns, agreeing that a review of CI care plans would be undertaken.

When we are reviewing individuals' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. We did not find any advance statements in the records reviewed. Some young people spoken with were aware of advance statements and one expressed an interest in completing one. There was little evidence that the service was consistently promoting advance statements in care planning. We raised this with the service, who advised that, as part of ongoing rights-based work, one of the charge nurses was involved in promoting advance statements. We will look forward to reviewing the outcomes of this work on our next visit.

Advocacy support in the Melville Unit was provided by Advocard. We contacted Advocard prior to the visit and met with an advocacy worker during the visit. CAMHS continued to have a dedicated CAMHS link advocate who attended the ward. We were told that the advocate received regular referrals from the MDT and during visits to the unit, observed that staff were often very busy but remained professional and supportive of advocacy. Advocacy support was reported to be helping some young people, as well as parents/carers, with concerns regarding care and treatment. We were also informed that a previous 'drop-in' service had been discontinued, as it was not well attended and that individual advocacy was considered more effective in meeting the needs of young people.

The Commission has developed *Rights in Mind.*[2] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

Since the last visits in July 2024 and May 2025, changes had been made to the provision of activities in the Melville Unit. Previous visits highlighted a lack of activity and occupation and made recommendations that activities should be offered in line with young people's care plans and the unit's activity planner. The service's action plan outlined recruitment of two activity managers to support this. On the day of the visit, we were pleased to see that one full-time activity manager was in post and a second had been recruited and was due to start imminently, supporting the provision of activities seven days a week.

We met with the activity manager, who reported that data analysis had been completed to identify which activities best supported young people's care, treatment, and recovery. Young people were involved in this process, and the findings were used to inform the current weekly activity planner. The activity manager highlighted the importance of embedding activity into the young people's care plans and daily routines, noting that previously activity had often been viewed as an addition rather than integral to the care plan.

We heard that supporting young people's engagement in activity remained challenging in the Melville Unit however, data collected by the serviced indicated improvement, which was positive to see. There was recognition that further progress would take time, but a clear commitment to developing activity and occupation in the unit was evident.

We were encouraged to hear that links were being developed with 'The Hub', 'RHCYP Charity' and other community organisations to support activities outside the ward and promote young people's connection with the wider community.

We heard about the importance of the activity manager working collaboratively with all members of the MDT, particularly the OT staff, who played an active role in providing activities, and the psychology team, who supported psychoeducational, cognitive behaviour therapy-informed and skills-based activities.

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[2] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

We were pleased to see that all young people had a meaningful activity care plan in place, developed collaboratively with the young person and the activity manager. On review, these care plans were person-centred and reflected the young person’s interests, preferences and hobbies. It was evident that young people had been actively involved in creating these care plans. We also saw evidence of regular review, with updates made to the care plans to reflect changes in the young person’s needs and engagement.

A range of activities was available both on and off the unit, delivered in group and one-to-one settings. Group activities included weekly Therapet sessions, OT groups, aromatherapy, ‘seize the day,’ ‘brain dump’, evening wind-down sessions, drama therapy, and sessions facilitated by Edinburgh Children’s Hospital Charity. One-to-one activities included OT and music therapy sessions, individual support with the activity manager and access to community resources, such as Edinburgh leisure facilities.

Feedback from the young people we met with regarding activity varied. Most young people reported improvements in the choice, availability and consistency of activities in the unit. However, they also described ongoing periods of inactivity, particularly at weekends, when there was limited activity available. We heard from the service that the planned introduction of a second activity manager was expected to support the provision of more consistent activity, including during evenings and weekends.

The physical environment

The Melville Unit is located in the RHCYP. We have made recommendations in previous reports regarding outstanding environmental issues and had remained concerned about the limited progress made. The joint visit in 2025 again highlighted concerns in relation to the maintenance of the environment to ensure the safety of young people and staff.

The service action plan outlined several measures to support improvements, including fortnightly environmental meetings between senior management, health and safety, and estates teams, monthly environmental walkarounds involving the SCN and estates department and plans for repairs, cleaning and redecoration. The service also reported involvement in ‘peace pathway’ work, which included reviewing and, where necessary, modifying the environment to reduce sensory overload and support communication.

We were pleased to find that there had been improvements made to the environment, including the replacement of damaged doors, the installation of protective wall coverings in young people’s bedrooms (with colours chosen by the young people) and the completion of the sensory room, with equipment ordered and imminently due for delivery. On the day of the visit, a number of items of furniture had been removed as part of the cleaning schedule.

The repairs and redecoration of the unit supported a more homely environment. The unit was clean and artwork and displays created by the young people were visible throughout, promoting a more child-centred and welcoming atmosphere. This contributed positively to the overall environment, supporting young people’s wellbeing, sense of belonging and engagement in their care.

Given the complexity of the young people within the unit and the potential for incidents of violence and aggression during periods of stress and distress, it is likely that further environmental damage may occur. It is therefore important that the service sustains and maintains ongoing improvement work to ensure the environment remains safe and therapeutic.

All young people had their own individual bedrooms with en-suite facilities, which were personalised with their own belongings. We observed that one young person was being supported in the enhanced nursing suite, located at the end of the corridor where the bedrooms were situated. While this environment was less personalised, it aligned with the clinical needs of the young person and had been informed by risk assessment and safety considerations.

For the majority of the time of our visit, the environment was calm. However, there were periods when young people became increasingly distressed, requiring additional staff support to manage the situation. These episodes highlighted how some young people could find such situations overwhelming and anxiety-provoking, reinforcing the importance of maintaining safety and a supportive environment to promote wellbeing.

We noted there had been little improvement to the outdoor space, which continued to be underutilised due to its design and associated risks. We heard that the service action plan included a scoping exercise with young people and families, which had taken place prior to Christmas, to gather their views on how the garden area could be developed.

We were advised that further work was required to determine how the space could be safely improved and made more accessible. The service also reported that the Green Health Project, an Edinburgh hospital charity, had been approached for funding to support the development of the garden area. We will review progress in relation to the development of the outdoor space on future visits.

Any other comments

We were pleased to see that the Melville Unit had made notable progress since the previous visit, including promoting rights-based, child-focused, and person-centred care, improved MDT functioning, reflective practice, AMBIT-informed decision-making, improved arrangements in relation to authority to treat young people and enhanced care records.

We saw that young people were increasingly engaged in decisions about their care through one-to-one sessions, involvement in care planning, community meetings and meaningful activities, while physical health monitoring and environmental improvements supported their wellbeing and safety.

We observed that ongoing areas for development included ensuring the safety and wellbeing of all young people and staff, variation in social work involvement in the MDT, limited parent/carer communication, improvements to the psychological safety for staff to challenge decisions, the need for more detailed, strengths-based continuous intervention care plans and improved recording of restraints in care records. Continued focus on these areas is essential to uphold young people's rights, support their participation in care, and provide safe, high-quality, and child-focused services.

Further work is also required to promote advance statements and fully utilise activity and outdoor spaces. Continued focus on these areas is essential to uphold young people's rights, ensure their voices are heard, and provide safe, high-quality, and inclusive care in line with UNCRC principles.

Summary of recommendations

Recommendation 1:
Managers and the MDT must ensure parents and carers are consistently informed, involved, and supported in their child's care, building on existing engagement initiatives.

Recommendation 2:
Managers must ensure that all safeguarding processes are consistently followed and that all available options to manage risk are considered, including proportionate and therapeutic use of restrictive interventions where necessary, to maintain the safety of young people, staff, and others on the unit.

Recommendation 3:
Managers must ensure care plans are regularly reviewed and include a clear summative evaluation, recording the effectiveness of interventions and any additional actions required to support progress and recovery.

Recommendation 4:
Managers must ensure that a culture of psychological safety is embedded across the MDT, where all staff feel able to appropriately challenge decisions and contribute their professional views without fear of negative consequences. This should be balanced with maintaining timely and effective decision-making in the best interests of the young people.

Recommendation 5:
Managers must ensure all restraint incidents are fully recorded in care records, including rationale, legal authorisation, techniques used, observations, and follow-up actions, to promote accountability and a rights-based approach.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

A copy of this report will be sent for information to Improvement Scotland.

Claire Lamza
Executive director (nursing)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The Commission is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards.

When we visit:

- We find out whether an individual's care, treatment, and support are in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia, and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice, and guidance to people we meet with.

Where we visit a group of people in a hospital, care home, or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports, and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line, and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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