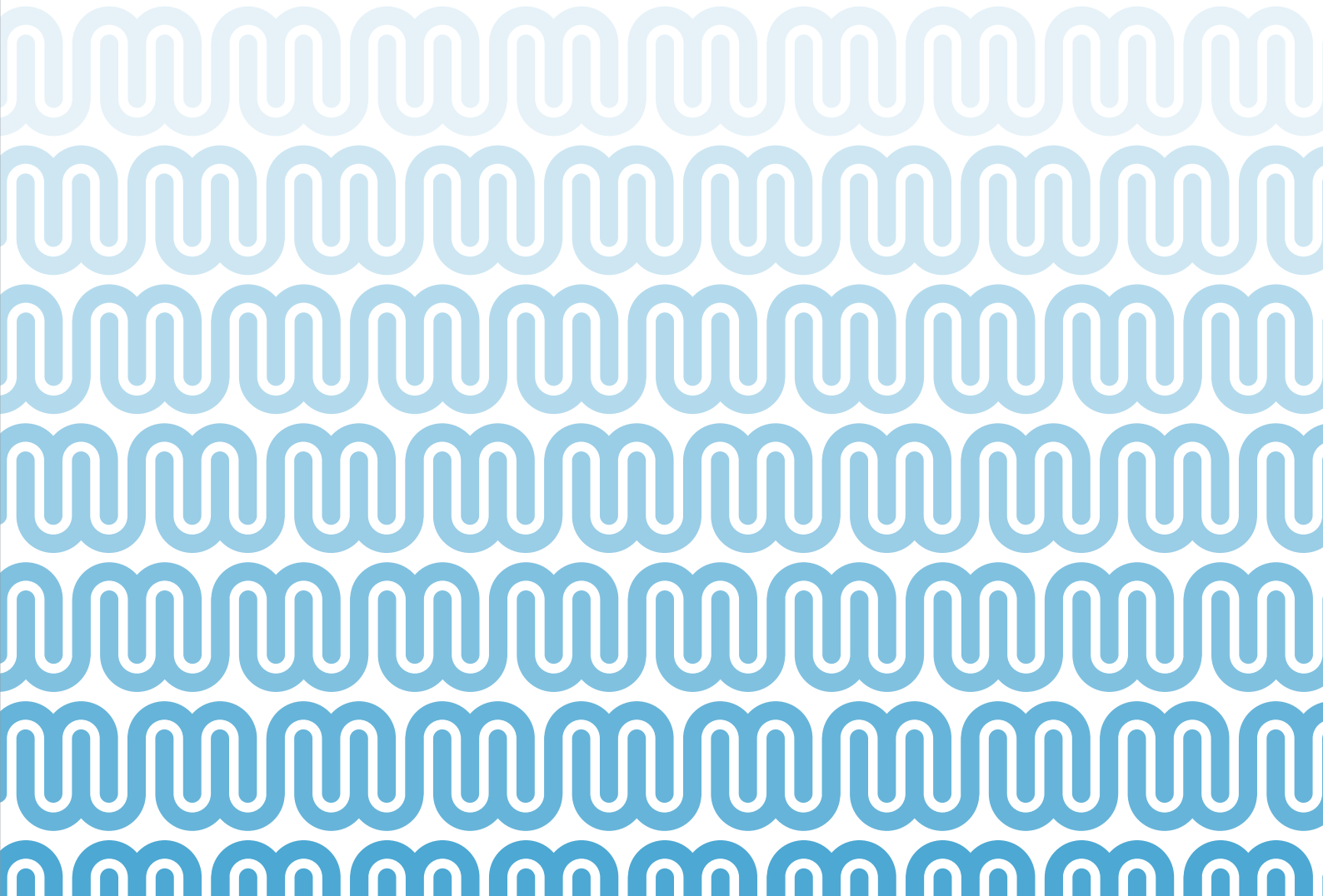
mental welfare commission for scotland

Young people monitoring report 2019-20

Statistical Monitoring

June 2021



Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

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

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

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What we do

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

We do this by:

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

Executive Summary

1. Under article 24 of the United Nations Convention for the Rights of the Child (UNCRC), children have a right to the highest attainable standards of health within available resources and, have a right to access health services for their care and treatment.

2. In its concluding observations to the fifth and latest periodic report from the UK[1] in 2016, the Committee on the Rights of the Child expressed concerns regarding the treatment of children (in Scotland and England) in hospitals far away from home, with inadequate provision of child-specific attention, support and placement in adult facilities. The CRC recommended that the prohibition of placement of children with mental health needs, in adult psychiatric wards, should be expedited while ensuring age appropriate mental health services and facilities were provided to children and young people.

3. The Mental Health (Care and Treatment) (Scotland) Act 2003 places a legal obligation on health boards to provide appropriate services and accommodation for young people admitted to hospital for treatment of their mental ill health.

4. In 2019-20, the number of young people under the age of 18 admitted to non-specialist hospital wards – primarily adult wards - for treatment of their mental health difficulties in Scotland was 103 admissions involving 88 young people. This is a slight fall from the 2018-19 figures which were 118 admissions involving 101 young people and appears to reflect a downward trend in admissions since 2013.

5. In a significant majority of instances where a young person needs inpatient care, this is provided within the regional or national specialist child and adolescent inpatient units. According to Public Health Scotland data, between1 April 2019 and 31st March 2020 30.6 % of overall admissions of children and young people under the age of 18 for care and treatment of their mental health were to non-specialist wards[2].

[1] Para 60c and 61c.
http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2FPPRiCAqhKb7yhskHOj6VpDS%2F%2FJqg2Jxb9gncnUyUgbnuttBweOlylfyYPkBbwffitW2JurgBRuMMxZqnGgerUdpjxij3uZ0bjQBOLNTNvQ9fUlEOvA5LtW0GL
[2] PHS (2021) Quality Indicator Profile for Mental Health
https://beta.isdscotland.org/find-publications-and-data/conditions-and-diseases/mental-health/mental-health-quality-indicator-profile/

6. Reasons for young people being admitted to adult wards include a shortage of specialist beds, and a lack of provision for:
    a. Highly specialised care for young people with learning disability,
    b. Young people who have offended due to mental health difficulties and require forensic care; and
    c. Young people who require intensive psychiatric care provided in specialised units.

7. In some instances it may be appropriate for a child or a young person to be admitted to a non-specialist setting if available alternatives would not be in their best interests. However the United Nations Convention of the Rights of the Child indicates the necessity of ensuring special safeguards for children and young people due to their stage of development.

8. The majority of admissions of young people to non-specialist wards continue to be short in length, however 41% remain on those wards (mostly adult) for over a week.

9. A positive finding is the specialist medical staff either supporting or available to support these admissions remains high – 57% of the doctors in charge of care or Responsible Medical Officers (RMO) were child specialists and in a further 28% of admissions a CAMHS consultant was available to give support, if needed.

10. Of all the young people admitted to non-specialist wards, 22% were care experience and looked after and accommodated by a local authority.

11. Access to specialist advocacy remains limited. We were disappointed to note that while 70% of young people had access to advocacy, only 20% had access to advocacy that specialised in the particular needs and rights of young people.

12. We are aware that CAMHS clinicians continue to provide support to young people in non-specialist inpatient wards, but over recent years the proportion of young people being able to access non-medical specialist CAMHS input whilst an in-patient on a non-specialist ward has not improved.

13. Action 20 of the Mental Health Strategy is a commitment to scoping the level of highly specialist mental health inpatient services for young people and act on the findings. The Commission notes the progress towards developing inpatient facilities for children and young people who require specialist forensic care and for those young people who have a learning disability.

14. The Commission is encouraged that, following a recommendation last year, work has begun once again to explore the needs of young people who require CAMHS specialised intensive psychiatric care unit (IPCU) support in Scotland. This has been a recommendation of ours for a number of years in annual monitoring reports, and we continue to emphasise the importance of this work and the need for it to be prioritised and brought to a conclusion. However we remain concerned that young people's access to intensive psychiatric care unit (IPCU) facilities have not been given similar prominence to Learning Disability and Forensic provision for the under 18s. We are aware of the complexity of this task and that previous initiatives to explore this question have been unsuccessful. We continue to emphasise the importance of addressing the need for IPCU facilities nationally for young people. It is important that any work looking at access to IPCU facilities is sufficiently supported by Scottish Government to be able to come to a conclusion that will have meaningful change for young people across Scotland in the delivery of intensive psychiatric services and accommodation.

Recommendations

Recommendation 1:

The Commission recommends that work to explore the accessibility and provision of intensive psychiatric care facilities (IPCU) for the under 18s in Scotland is sufficiently prioritised, resourced and supported by Scottish Government to ensure that its work can be brought to completion within an appropriate timescale and result in meaningful change nationally for young people having access to IPCU facilities that are age appropriate.

Recommendation 2:

Health Board Managers with a duty to fund and provide advocacy services for individuals with mental health difficulties in their area should review the availability of dedicated advocacy support for children and young people with mental health difficulties locally and ensure the resourcing and provision of any dedicated specialist advocacy service is sufficient to be able to meet the needs of young people with mental health problems and to support and protect their rights.

Recommendation 3:

Hospital managers should ensure that whenever a child or young person is admitted to a non-specialist ward that consideration and exploration of their educational needs and their right to education should be a standard part of care planning for the young person during their hospital admission.

Cases

The following composite cases illustrate the problems this report seeks to highlight. These are not real cases but are based on the information that Commission is aware of through our work.

JD is a 15 year old young person who is a secondary school student, and lives with their family. JD developed an episode of psychosis and required admission to a regional CAMHS inpatient unit located over fifty miles away from his home. Whilst there, as part of their illness, JD became paranoid about the staff and other young patients. This led to episodes of aggression, and the clinical team felt JD's care needs required more intensive psychiatric care. There are no IPCU facilities for young people in Scotland and the adult IPCU nearest to the regional CAMHS inpatient unit suggested JD would be better placed in the IPCU nearest to his home. However, JD's home IPCU said that they could not accept a 15 year old and advised them to speak to other IPCUs elsewhere. This lack of clarity was difficult for the young person, the family and JD's clinical team. JD remained on the adolescent unit whilst unwell but this had significant impact on JD and the other young people in the CAMHS unit. The lack of a specialised IPCU facility for young people and the lack of a clear protocol for how to progress the request for more support was unhelpful.

SK is a 16 year old person who enjoys dancing and painting. She has diagnoses of autism and mood disorder. She developed an episode of mania and required an admission to a regional young people's inpatient unit. She was very distressed and hit out on several occasions at her support workers. This led to an admission to the local adult IPCU to ensure the level of care and support she needed. However this was on a ward with very unwell adults and adults involved in the criminal justice system and she was vulnerable. This required her to have staff placed with her constantly and she perceived this as intrusive and restrictive although she understood it was for her safety. The clinical team informed the Mental Welfare Commission of the admission of this young person to a non-specialist ward and the MWC collected information about her stay on the ward and access to CAMHS clinicians, education and age appropriate recreation. Despite the efforts of the CAMHS team, local adult mental health services, the admission was difficult for SK and her friends and family who were concerned about the environment in which she was placed.

Introduction

The United Convention on the Rights of the Child (UNCRC) is an international human rights treaty that comprehensively outlines a range of rights that are applicable to all children (a child is an individual who is younger than 18 years old in UNCRC). In 1991 the UK government ratified UNCRC and made a commitment to take steps to ensure that the rights described in UNCRC should apply to all children in the UK. The body responsible for monitoring compliance of states with UNCRC is the Committee of the Rights of the Child (CRC) which reviews and responds to the periodic submission of a report by the UK government which details the progress made in implementing UNCRC within the UK and describes areas of concerns and makes recommendations to the UK government or devolved administrations (where relevant mandates such as for example health in Scotland fall under their jurisdiction). On the 1st September 2020 the UNCRC (Incorporation) (Scotland) (Bill) was introduced to the Scottish Parliament and was passed unanimously on 16th March 2021. The Bill's main purpose is to bring UNCRC into Scots law with the aim for it to be passed before the end of the current parliamentary term.

The importance of children's mental health and access to appropriate mental health services is reflected in a number of UNCRC rights and these in turn have shaped existing mental health legislation:

Article 6 describes the right to life and maximum survival and development of any child and is one of the core principles of UNCRC.
Article 19 describes the rights of children to be protected from all forms of violence including mental or physical violence and also requires measures to be taken to help protect children from suicide and self-injury.
Article 24 describes the rights for children to attain the highest standard of health including mental and emotional health within available resources and includes the children's rights to access health services for treatment and rehabilitation of health. Article 24 also requires that states "strive to ensure that no child is deprived of his or her right to access health care services".
Article 37 requires that children deprived of their liberty are treated "in a manner that takes account of the needs of the person of his or her age" and goes to state that "every child deprived of their liberty shall be separated from adults unless it is considered in the child's best interests not to do so."

In addition to these health related rights children have a number of other rights which may be feature during admission to hospital. These include:

Article 12 which describes the rights of children who are capable of forming their view to be able to express them in all matters that affect them with due weight given to their views depending on their age and maturity. Advocacy is a right that all individuals with mental illness and related conditions have a right to under the Mental Health Act and access to specialist children's advocacy is an important mechanism by which children's rights can be protected.
Article 28 describes the right to equal access to education for children. Specialist child and adolescent units have access to educational facilities as a standard feature of inpatient provision.
Article 31 describes a child's right to recreational facilities, leisure and play and to take part in cultural activities.

In its concluding observations to the fifth and latest report periodic report from the UK[3] in 2016 the Committee on the Rights of the Child outlined concerns regarding the treatment of children (in Scotland and England) in hospitals far away from home, with inadequate provision of child-specific attention and support and placement within adult facilities. The CRC recommended that the prohibition of placement of children with mental health needs within adult psychiatric wards should be expedited while ensuring the provision of age appropriate mental health services and facilities to children and young people.

Since the implementation of the Mental Health (Care & Treatment) (Scotland) Act 2003 (the 'Act') in 2005 health boards in Scotland have had a legal duty to provide appropriate services and accommodation for young people who are under the age of 18 years and who are admitted to hospitals for treatment of their mental disorder (or mental illness, as we refer to it in this report).

The Code of Practice to the Act states "whenever possible it would be best practise to admit a child to a unit specialising in child and adolescent psychiatry "and that young people should be admitted to a non-specialist ward only in "exceptional circumstances"[4].

The Commission believes that admitting a young person to an adult ward should only be acceptable in rare situations. This would depend upon the individual needs and circumstances of the young person e.g. their maturity, the nature of mental health difficulties and the care they require and the distance to the regional unit and what is in their best interests. When an admission to a non-specialist ward does become unavoidable then every effort should be made to provide for the young person's needs as fully as possible.

Specialist adolescent units and wards designed to treat the needs of adults with mental illness differ in staff training and the ward environment and a young person's needs might not be fully met on an adult ward.

Since the inception of the Act, the Commission has monitored the admissions of young people to adult wards to ensure that their rights are respected, to identify and highlight any deficiencies in care, and to monitor and record the provision of age appropriate services under the Act. We publish our findings annually.

The most common non-specialist wards to which young people are admitted are adult mental health wards and adult intensive psychiatric care units (IPCUs). [5]

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[3] Para 60c and 61c.
http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2FPPRiCAqhKb7yhskHOj6VpDS%2F%2FJqg2Jxb9gncnUyUgbnuttBweOlylfyYPkBbwffitW2JurgBRuMMxZqnGgerUdpjxij3uZ0bjQBOLNTNvQ9fUIEOvA5LtW0GL
[4] Code of Practise Volume 1, chapter 1 paragraph 50.
https://www2.gov.scot/Publications/2005/08/29100428/04302
[5] Adult IPCU facilities are specialised psychiatry wards designed to provide a care setting for adults when they are very unwell and present with high levels of risk either to themselves or others.

Numbers of admissions can vary across the country. We have been told that approaches to try and reduce admission rates have included investing in and increasing the capacity of the specialist adolescent inpatient estate and promoting the development of CAMHS intensive services in the community to provide alternatives to admission and help reduce length of stay within adolescent units.

Although this goal has not been achieved completely across Scotland, in 2015-2016 and 2016-2017 we did see numbers of young people admitted to non-specialist wards fall substantially and admission figures have remained lower from that point. We welcome this development. Enquiries at the time suggested that the role of CAMHS community intensive treatment services has been a key contributory factor along with approaches to help co-ordinate and streamline admission and discharge procedures of the specialist inpatient units. Additionally the stability of staffing within the inpatient units and the expansion of capacity to deliver evidence based and intensive treatment in Tier III CAMHS within the community and thereby avoid the need for admission were also key.

The Scottish Government's current approach to mental health is outlined in In the Mental Health Strategy 2017-2027 which outlines a number of actions to further develop services across Scotland. Some of these actions are specific to Child and Adolescent Mental Health Services (CAMHS) with the aim of promoting and protecting children's and young people's mental health and wellbeing and improve their access to timely, evidenced based intervention and support[6].

As part of Action 19 of the Strategy the CAMHS Lead Clinician's Group was commissioned to develop a nationally agreed best practice guideline to ensure a clear protocol and standards for those occasions when a young person is admitted to a non- specialist ward. The Commission made a significant contribution to this activity which was published in June 2020 and our young person's monitoring data collection reflects a key number of these standards. [7]

Action 20 of the Mental Health Strategy 2017-2027 states plans to: "Scope the required level of highly specialised mental health inpatient services for young people and act on its findings." The services referred to in this action are those that would meet the needs of young people who also have learning disability or autism or who due to the nature of their illness may have committed offences that require care to be delivered in specialist child and adolescent psychiatric forensic care.

Currently Scotland does not have these inpatient facilities and the Commission has highlighted the continued lack of provision in these areas previously.

NHS Ayrshire and Arran has been chosen as the site for the building of a National Secure CAMHS Inpatient Facility (National Secure Adolescent Inpatient Service (NSAIS)) and encouragingly progress on the project has continued so that building work is anticipated to start in 2021 with an expectation that admissions should begin in 2022. This proposed development would meet the needs of those young people who require specialised forensic psychiatric care. The Commission has been involved

[6] Mental Health Strategy 2017-2027 published March 2017 http://www.gov.scot/Publications/2017/03/1750
[7] www.gov.scot/publications/best-practice-guideline-admission-adult-mental-health-wards-under-18s-mental-health-problems-adaptation-scotland/pages/2/

in supporting appropriate contingency planning for the unit to ensure that this respects and upholds young people's rights.

NHS Lothian has been chosen as the location for the development of a four-bedded unit for young people between the ages of 12 and 18 with a learning disability and facilities for the under 12s with a learning disability are to be developed within the National Child Inpatient Unit in Glasgow. Work on this project is continuing but is at a less advanced stage than the forensic unit NSAIS. The Commission has been involved in the planning of this unit to ensure that CAMHS management remains involved in the unit activity rather than the unit being managed under adult learning disability services.

In recent years the Commission has been highlighting the lack of IPCU provision for young people in Scotland and the impact that this has on young people and their families. The need for IPCU facilities is quite different from the forensic needs that NSAIS is designed for. Last year we again made recommendations about IPCU provision for young people in Scotland. Historically work has taken place by different parties and at different times to explore ways in which the needs of young people for IPCU care may be addressed in Scotland. Unfortunately these previous attempts have never been able to come to a conclusion and no solution has been found as to how best meet the needs of young people for IPCU in an age appropriate manner in a way that is practical, sustainable and accessible for the whole of Scotland.

Since our recommendations last year we are pleased to hear that that work has started to explore the need for IPCU provision for young people in Scotland. Young people's views are to be collected as part of this project and, although work to bring about changes in the ability of young people to access IPCU facilities nationally remains in the early stages we very much welcome this development.

Recommendation 1: The Commission recommends that work to explore the accessibility and provision of intensive psychiatric care facilities (IPCU) for the under 18s in Scotland is sufficiently prioritised, resourced and supported by Scottish Government to ensure that its work can be brought to completion within an appropriate timescale and result in meaningful change nationally for young people having access to IPCU facilities that are age appropriate.

Specialist Child and Adolescent Inpatient Services in Scotland

In Scotland, there are three NHS regional adolescent in-patient units for young people aged between 12-18. These units are:

Skye House is a 24 bedded specialist adolescent unit based in Stobhill Hospital, Glasgow. that receives admissions of young people from NHS Dumfries and Galloway, NHS Ayrshire and Arran, NHS Greater Glasgow and Clyde, NHS Lanarkshire and NHS Forth Valley (West of Scotland region).

The Young People's Unit in Edinburgh is a 12 bedded unit in the Royal Edinburgh Hospital campus and receives admissions of young people from NHS Lothian, NHS Borders and NHS Fife (East of Scotland region).

Dudhope House in Dundee is a purpose-built 12 bedded unit that receives admissions of young people from NHS Highland, NHS Grampian, NHS Tayside, NHS Shetland and NHS Orkney (North of Scotland region).

In addition to these regional units for adolescents the National Child Inpatient Unit based in Glasgow receives admissions of children under the age of 12 years with mental health difficulties from across Scotland (6 beds).

In February 2019 the 10 bedded non-NHS Huntercombe Hospital in West Lothian which admitted patients between the ages of 12 and 18 closed.

The Young Person's Monitoring Process

The Commission collects information through notifications from health boards about the admissions of young people under the age of 18 years when they are admitted to wards for mental health care that are not in any of the units mentioned above. Information from mental health act forms also feed into this routine collection process and Commission staff are alerted to the admissions of young people to a non-specialist ward.

The Commission does not collect information on those admissions that are less than 24 hours in duration, are solely related to drug or alcohol intoxication or are solely for the medical treatment of self-harm.

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Once we have been notified about an admission we send out a questionnaire to the consultant in charge of the young person's care (or RMO) to find out further information about the admission.

In order to improve accuracy of our data collection in addition to the above routine process, every three months medical records staff from each Health Board area are required to submit details of any young person under the age of 18 who have been admitted to non-specialist wards in their Health Board area and who meet our criteria. Commission staff then cross reference this information with the admissions we have been notified about and chase ones that are missing from routine notification processes.

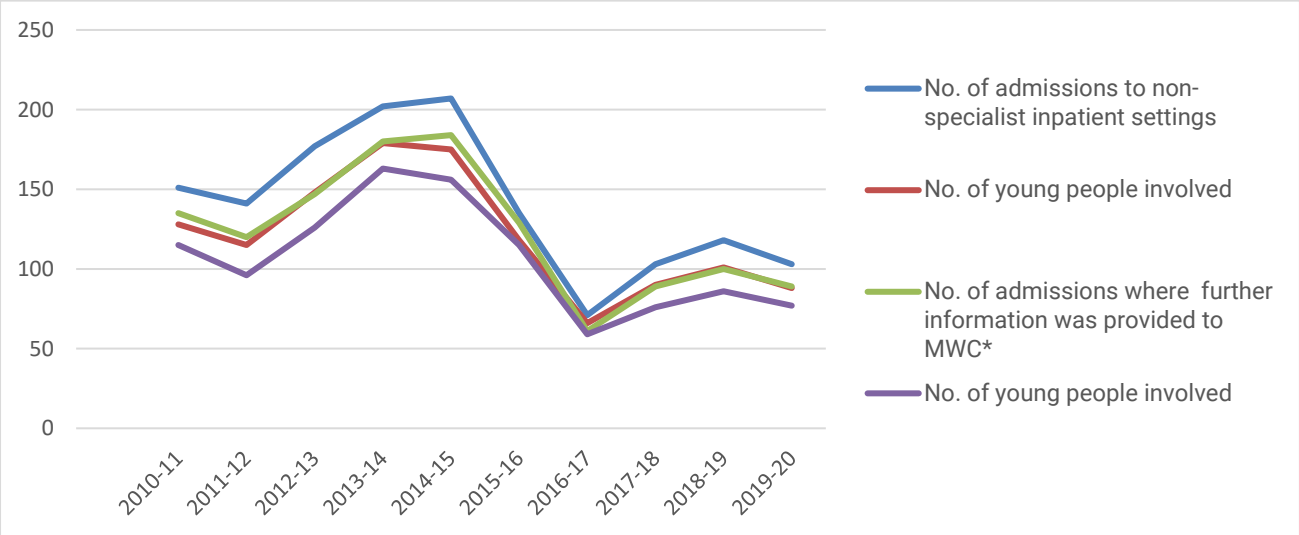
Young people (under 18) admitted to non-specialist facilities, by year 2010-2020

Table 1: Young people (under 18) admitted to non-specialist facilities, by year 2010-20

	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020
No. of admissions to non-specialist inpatient settings	151	141	177	202	207	135	71	103	118	103
No. of young people involved	128	115	148	179	175	118	66	90	101	88
No. of admissions where further information was provided to MWC*	135	120	147	180	184	129	61	89	100	89
No. of young people involved	115	96	126	163	156	115	59	76	86	77

*admissions where completed monitoring form returned to MWCS

Figure 1: Young people (under 18) admitted to non-specialist facilities, by year 2010-19



In 2019-2020 we were notified of 103 admissions to non-specialist wards which involved 88 young people. We received further information on 89 of these 103 admissions.

This is a slight decrease from last year when the figures had increased to 118 admissions involving 101 young people.

The lowest numbers were collected in 2016-2017 (71 admissions involving 66 young people).

This year's figures, however, remain an improvement on 2013-14 and 2014-2015 figures when admissions above 200 were recorded each year and also an improvement from figures before 2013 when admission numbers were higher than present levels. We welcome this development and are keen that ongoing review of the specialist adolescent inpatient estate in Scotland together with services that provide an alternative to admission remains ongoing to enable admissions of children and young people to non-specialist wards to be reduced further. This will be particularly important if specifications for CAMHS services in Health Boards which look after young people who are age 16 and 17 only if they are in full time education are altered which would likely increase demand for specialist adolescent inpatient provision.

Public Health Scotland (PHS) also collect information on admission to non-specialist wards using SMR04 (the name of a form) data completed by medical records staff at the time of discharge. We are keen to work with PHS colleagues to explore PHS and Commission data collection and review the processes to optimise the collection and reporting of children and young people to non-specialist admissions and intend to undertake a project with PHS in the near future to further our knowledge in this regard.

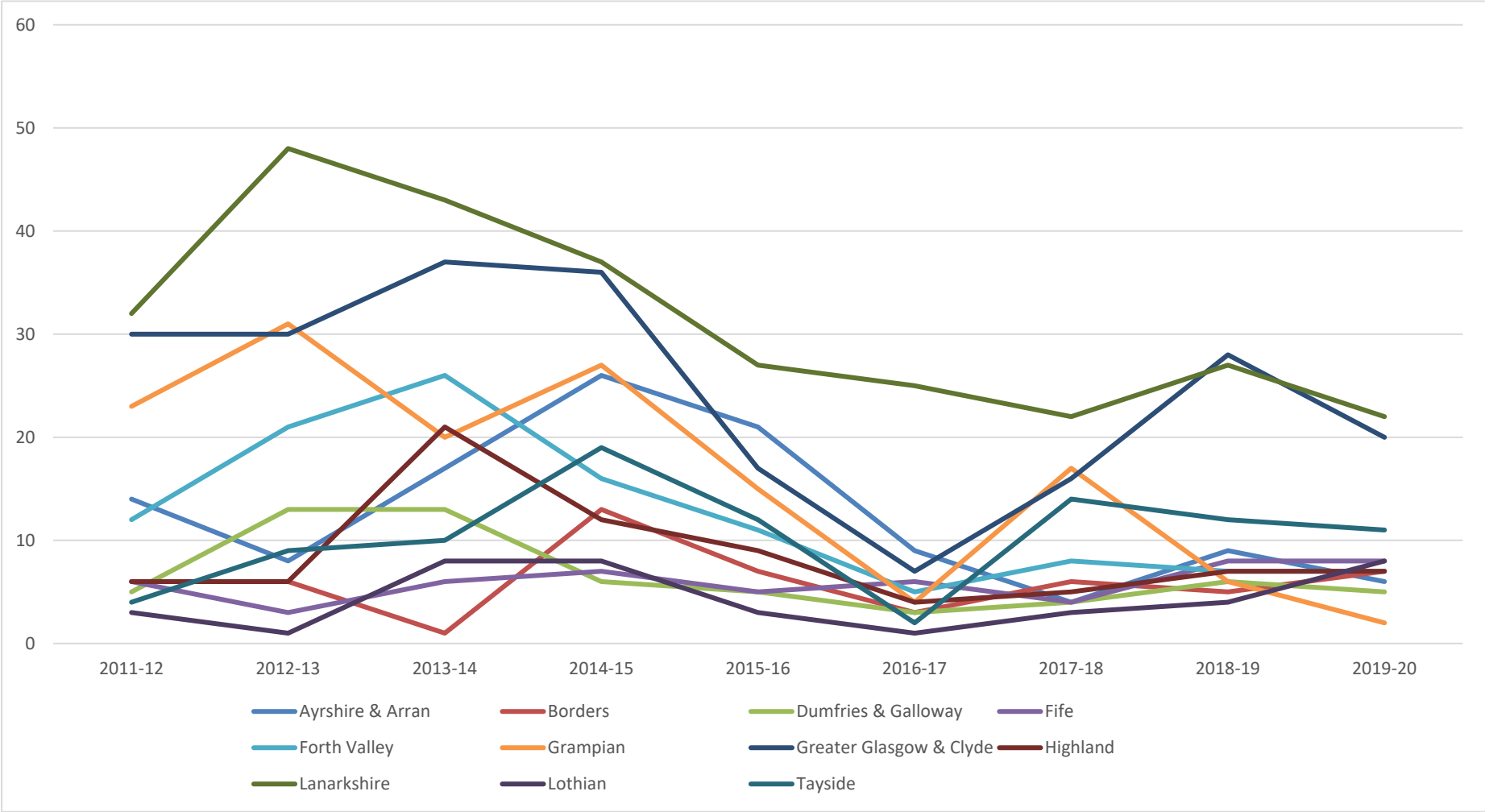
Young people admitted to non-specialist facilities by NHS board, by year 2012-2020

Table 2: Young people admitted to non-specialist facilities within an NHS board, by year 2012–2020

Health Board	2012 – 2013		2013 – 2014		2014 – 2015		2015 – 2016		2016 – 2017		2017 – 2018		2018 – 2019		2019 – 2020	
	Admissions	Young People Involved	Admissions	Young People Involved	Admissions	Young People Involved	Admissions	Young People Involved	Admissions	Young People Involved	Admissions	Young People Involved	Admissions	Young People Involved	Admissions	Young People Involved
Ayrshire & Arran	8	8	17	15	26	21	21	17	9	8	<5	<5	9	9	6	5
Borders	6	5	<5	<5	13	6	7	7	<5	<5	6	<5	5	<5	7	5
Dumfries & Galloway	13	10	13	9	6	6	5	5	<5	<5	<5	<5	6	<5	5	5
Island Boards*****	0	0	0	0	<5	<5	<5	<5	<5	<5	0	0	<5	<5	<5	<5
Fife	<5	<5	6	5	7	<5	5	5	6	6	<5	<5	8	6	8	6
Forth Valley	21	19	26	25	16	15	11	9	5	5	8	8	7	7	7	6
Grampian	31	22	20	17	27	23	15	12	<5	<5	17	14	6	5	<5	<5
Greater Glasgow & Clyde	30	24	37	34	36	30	17	16	7	7	16	14	26	23*	20	18
Highland	6	6	21	19	12	11	9	8	<5	<5	5	<5	7	7	7	<5
Lanarkshire	48	40	****43	****38	37	34	27	24	25	22	22	19	27	21*	22	18
Lothian	<5	<5	8	7	8	8	<5	<5	<5	<5	<5**	<5**	<5	<5	8	8
Orkney	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
State	<5	<5	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Tayside	9	9	10	9	19	17	12	11	<5	<5	14	12	12	10	11	10
Independent (Ayr Clinic)***	0	0	0	0	0	0	0	0	<5	0	0	0	0	0	0	0
Scotland	**177**	**148**	**202**	**179**	**207**	**176**	**135**	**118**	**71**	**66**	103	90	118	101	103	88

* GGC total =23 as 1 YP also admitted to Lanarkshire. Some of these figures (<3) relate to young people looked after by Esteem. **We were informed that one admission to NHS Lothian was an out of area admission from NHS Greater Glasgow and Clyde (2017/2018).*** Ayr Clinic shown as independent rather than included in NHS Ayrshire and Arran figures. This admission followed a preceding admission to a non-specialist ward in Scotland. It is therefore not included in the individual data due to the young person being counted already elsewhere.**** We were informed that one admission to NHS Lanarkshire was an out of area admission from NHS Greater Glasgow and Clyde (2013/14).***** Island Boards comprise Eilean Siar (Western Isles) , Shetland and Orkney. The figures have been pooled in line with good practise relating to the publication of small numbers.

Figure 2: Graph showing Annual number of admissions within each Health Board area



The Mental Health Act places a clear legal duty on health boards in relation to the provision of child inpatient care and the Act has a clear principle that the child's welfare should be most important in framing service response The Commission's view is that when a young person requires in-patient treatment, their individual clinical needs should be given paramount importance.

When comparing admissions to non-specialist facilities by NHS board area, the Commission is looking to see whether there have been significant changes in the number of admissions within a specific area compared with the previous year.

There continues to be differences in the configuration of CAMHS across the country with varying eligibility criteria for young people for CAMHS versus Adult Mental Health services depending on their age and educational status. Some CAMHS provide mental health services for children and young people under the age of 16 years and only for young people between the ages of 16 and 18 years who are in full time education. Others provide mental health services for children and young people up to the age of 18 years. Importantly this difference in service configuration can affect the numbers of young people admitted to non-specialist wards. In the Commission's 2015-6 report an additional monitoring exercise[8] showed that young people aged between 16 and 18 who were not in full time education and were looked after ordinarily by general adult mental health teams in certain health boards were unlikely to access a specialist adolescent bed when admitted to hospital due to perceived continuity and consistency issues for the local adult psychiatric team. Recently published Scottish Government CAMHS specifications suggest that all CAMH services in Scotland should provide services for all children and young people up to the age of 18.[9]

Figures in Table 2 compare admissions to non-specialist in-patient mental health beds for young people up to the age of 18 years within an NHS board area from 2011-12 to 2019-20. This year, admission numbers for each NHS board areas in Scotland are mainly either similar to last year's figures or show some slight falls (Greater Glasgow and Clyde, Lanarkshire). Lothian figures showed a slight increase. We maintain the view that a single year's figures are difficult to interpret and several years of data collection is required in order to be able to make conclusions about trends with any confidence.

There does, however, appear to be a moderate but definite reduction in overall admission numbers from previous levels across the country since 2013 although there are regional differences in annual admissions figures and the number of admissions continue to affect the care and treatment of a sizeable number of children and young people.

[8]Young Person Monitoring 2015-2016. October 2016.
http://www.mwcscot.org.uk/media/343729/young_person_monitoring_report_2015-16.pdf
[9] National Service Specifications for CAMHS February 2020 https://www.gov.scot/publications/child-adolescent-mental-health-services-camhs-nhs-scotland-national-service-specification/

Length of stay in non-specialist wards, by year 2015 to 2020

We have been aware, from our monitoring activity and from our visits to young people that lengths of stay in non-specialist environments can vary considerably and a small but significant minority of young people are looked after for long periods of time on wards which are not designed for their needs.

The length of stay is the amount of time that a young person remained in a non-specialist ward during an admission.

We believe that length of stay together with standards of care provided while a young person is looked after in a non-specialist environment are important quality issues to keep in mind alongside the overall numbers of young people admitted to non-specialist wards nationally.

Table 3: Length of stay in non-specialist wards, by year 2016-2019

Length of Stay*	**2015/ 2016**	**%**	**2016/ 2017**	**%**	**2017/ 2018**	**%**	**2018/ 2019**	**%**	**2019/ 2020**	****%**
1-3 days	36	27%	25	35%	29	27%	35	30%	36	35%
4-7 days	28	21%	17	24%	23	22%	37	31%	25	24%
8-14 days 1-2 weeks	28	21%	8	11%	20	19%	13	11%	19	18%
15-21 days 2-3 weeks	13	10%	4	6%	10	9%	12	10%	9	9%
22-28 days 3-4 weeks	11	8%	7	10%	3	3%	6	5%	0	0%
29-35 days 4 weeks+	7	5%	3	4%	2	2%	5	4%	<5	1%
36 days or more 5 weeks +	12	9%	7	10%	19	18%	10	8%	13	13%
Total	**135**	**100%**	**71**	**100%**	106	100%	118	100%	103	100%
Mean (days)	15		19		23		16		21	

*The Commission collects data on admissions that are 24 hours and above. Totals are based on the total number of admissions for that year. ** Based on 103 admissions

The majority of admissions continue to be short in length (35% are between 1 and 3 days). However, sizable numbers of young people remain inpatients in a non-specialist environment for longer periods (41% last over 7 days, 23% last over two weeks and 13% lasted over 5 weeks).

When we looked into the admissions which were over five weeks in length many involved young people for whom there was no national provision of inpatient beds for their age group and/or mental

health needs. This often relates to young people who have learning disability and does again this year (see page 30/31). All 13 of the young people who were admitted to a non –specialist ward for over five weeks were either 16 or 17 years old. Five needed an IPCU admission as part of their hospital stay at some point and three were care experienced young people.

In longer admissions of young people to non-specialist wards, it is very important that the young person has access to a range of CAMHS specialist care relevant to their needs and provided by differing professional groups as appropriate.

While a small majority of admissions are less than one week in length, this still represents a considerable amount of time for young people in a non-specialist environment, many of whom have never been in hospital before.

Specialist health care provision for young people in non-specialist care, 2019/20

The Commission requests information as to whether specialist child and adolescent mental health support is available to a young person admitted to a non-specialist ward, to ensure that appropriate care and treatment is being provided to the young person, and that relevant guidance and support is available for staff in non-specialist units who will have less experience of providing treatment and support to young people.

Access to specialist child and adolescent services following admissions of a young person to an adult ward continues to vary across the country.

Table 4: Specialist health care for admissions of young people in non-specialist care, 2019/20

Specialist medical provision	Age 0-15	Age 16-17	All	*%
RMO at admission was a child and adolescent specialist	10	41	51	57%
CAMHS consultant available to give support other than as RMO	6	19	25	28%
Nursing staff with experience of working with young people were available to work directly with the young person	15	27	42	47%
Nursing staff with experience of working with young people were available to provide advice to ward staff	16	52	68	76%
The young person had access to other age appropriate therapeutic input	9	28	37	42%
None of the above	1	9	10	11%
Total admissions*	19	70	89	100%

* Total=89, all admissions where further information was provided; percentages may sum to more than 100% as more than one type of specialist medical provision might be provided at any one admission.

Once again in 2019-2020 there has been no substantial improvement in the percentages of young people receiving specialist care input from CAMHS staff during their admission to a non-specialist unit and the figures have now remained at a similar level over several years.

In some circumstances where an admission might be of very short duration, the provision of direct specialist clinical contact might not be as important in terms of provision of care as stays of longer duration.

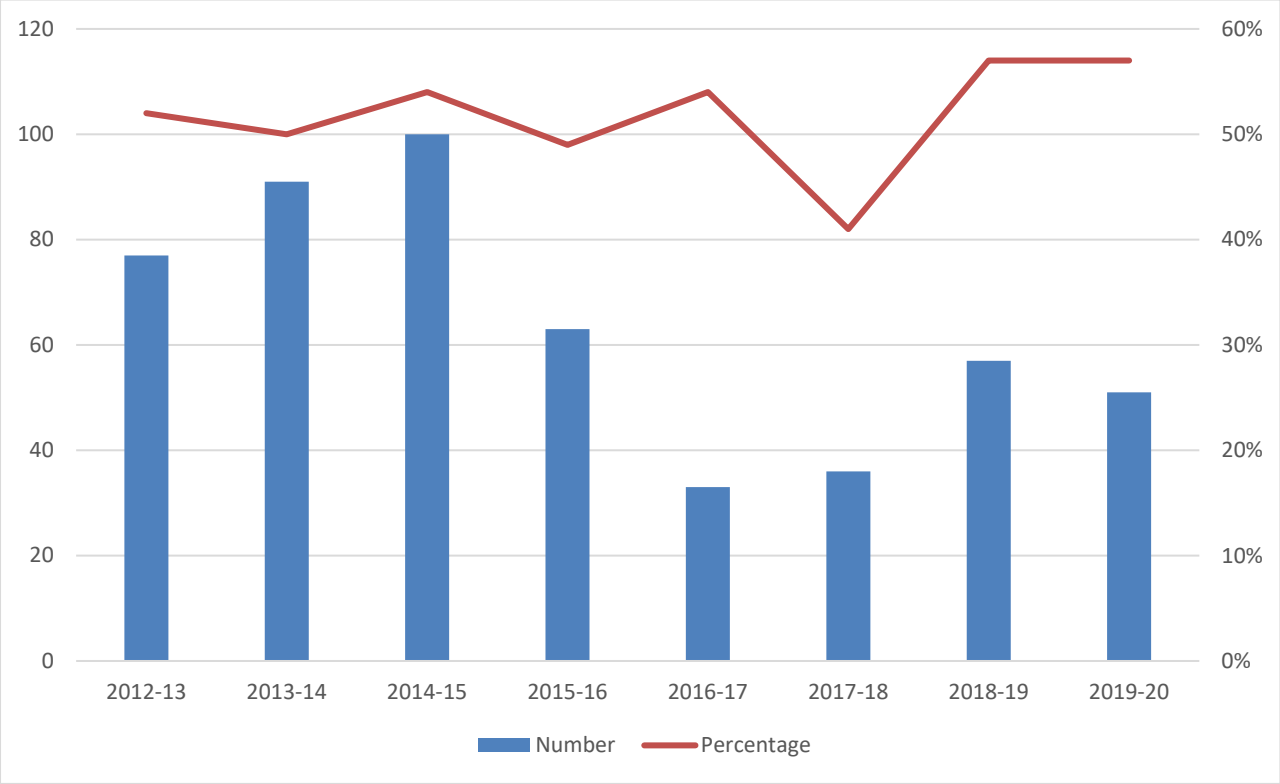
However, even in short admissions the task of liaison, communication and co-ordination of care around discharge and discharge planning is crucial for young people presenting in crisis.

In 2019-2020 the consultant in charge of a young person's care (or RMO) was a child and adolescent specialist in 51 out of 89 admissions (57%). This compares with 57% in 2018-2019, 41% in 2017-2018,

54% in 2016-2017, 49% in 2015-2016, 54% of admissions in 2014-2015, 50% in 2013-2014 and 52% in 2012-2013.

In 2019-2020 there were a further 25 admissions (28%) where a CAMHS consultant was available for advice for the admissions although was not the actual consultant in charge of care.

Figure 4a: RMO as Child Specialist



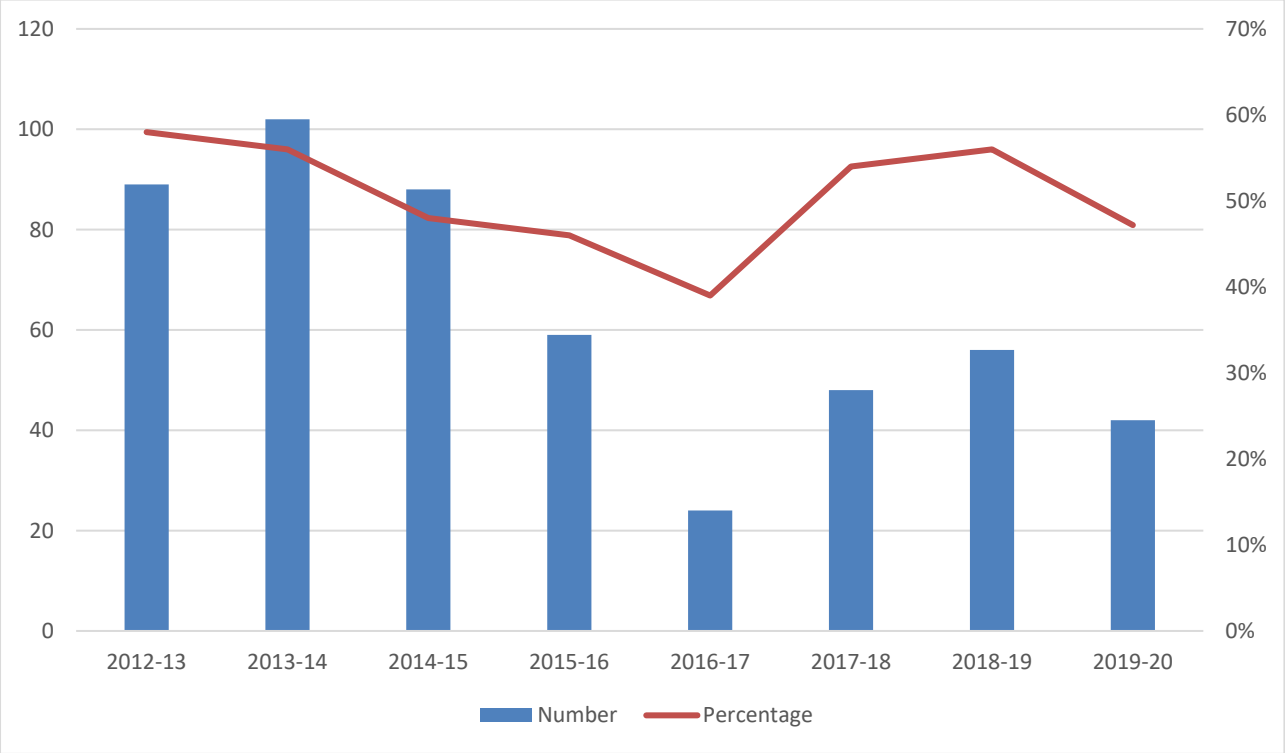
Data is based on the further information provided to the Commission (89 admissions) and reported on annually.

Once again in a large proportion of admissions there was no direct input from nurses experienced in working with children and adolescents.

In 2019-2020 42 out of 89 admissions (47%) experienced direct nursing care from child and adolescent experienced nurses.

This compares with 56% in 2018-2019, 54% in 2017-2018, 39% in 2016-2017, 46% in 2015-2016, 48% in 2014-2015, 56% in 2013-14 and 58% in 2012-2013. The percentage of admissions where there have been nurses available with relevant CAMHS experience to provide advice to ward staff also remains similar to previous years 68 admissions (76%). This compares with 80 out of 100 admissions (80%) in 2018-2019 85% in 2017-2018, 84% in 2016-2017, 78% in 2015-2016, 85% in 2014-2015, 80% in 2013-2014, and 76% in 2012-2013. This data reports the number of admissions when nurses with CAMHS experience were available for advice if needed but not whether that advice was ever sought.

Figure 4b: Direct Specialist Nursing Care provided



Data is based on the further information provided to the Commission (89 admissions) and reported on annually.

In 2019-2020 37 out of 89 admissions (42%) were able to access additional age appropriate therapeutic input.

This compares with 46% in 2018-2019, 41% in 2017-2018, 49% in 2016-2017, 38% in 2015-2016, 59% in 2014-2015, 51% in 2013-2014 and 88% in 2012-2013.

When looking at the information provided to the Commission in relation to the admissions of young people to non-specialist wards it is often not clear what factors influence whether a young person receives input from CAMHS whilst an inpatient.

For those health boards where adult mental health services provide services for some 16-17 year olds, such young people would not necessarily be expected to receive input from CAMHS while in hospital. Of the 10 admissions in which the young person received no input at all from clinicians specifically trained and experienced in child and adolescent mental health all but one admissions occurred in a health board whose CAMHS service does not included everyone under the age of 18 years.

Where admissions are very short or over a weekend, for example, specialist input may not be provided.

These factors do not explain many findings, however. This year, as in previous years, the provision of specialist care is inconsistent across non-specialist admissions.

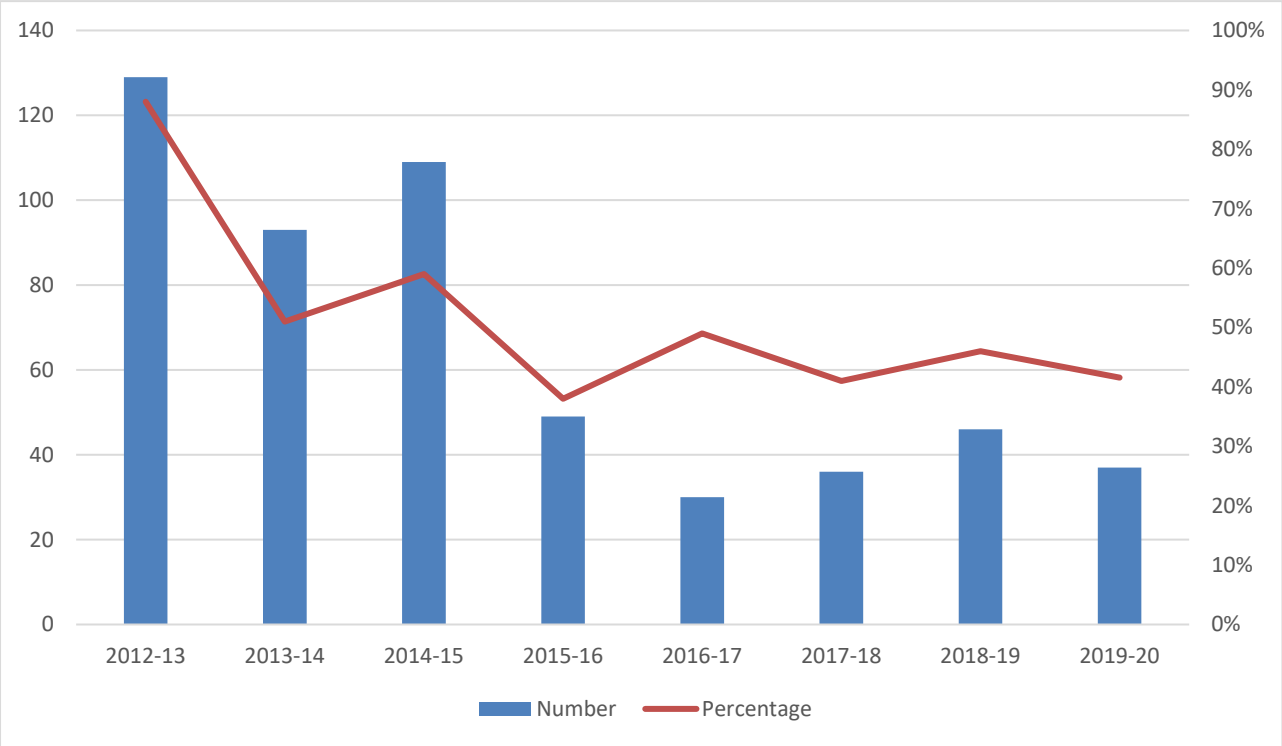
Concerningly in the 10 admissions which received no specialist input from child and adolescent clinicians during their hospital stay, 50% related to admissions lasting longer than one week and 20% lasted longer than 5 weeks. 2 of these 10 admissions also required IPCU admission at some point during their hospital stay.

Of the 13 admissions involving young people that lasted longer than 36 days, a high percentage ten (77%) had either a consultant in charge of their care who was a child specialist or a CAMHS consultant available for advice if needed. Only six of these 13 admissions had direct CAMHS nursing provision provided to the admission (46%) and only 7 (54%) had other age appropriate therapeutic intervention provided.

Of the 89 admissions that we obtained additional information about, 36 neither received direct specialist nursing support or specialist therapeutic input (40%) during their stay. Of these 36 admissions, 14 lasted between 1-3 days (39%), 10 lasted between 4-7days (28%), five lasted between 8-14days (14%), two lasted between 15-21 days (6%) and five lasted longer than 36 days (14%).

It is not clear if capacity issues in community CAMHS staff impacts negatively on the availability of nursing and other clinical staff to support non-specialist admissions of young people.

Figure 4c: Other specialist therapeutic care provided



Data is based on the further information provided to the Commission (89 admissions) and reported on annually.

Admissions of care experienced young people and social work provision for admissions of all young people to non-specialist care, 2019/20

Table 5: Social work provision for admissions of young people to non-specialist care, 2019/20

Social work provision	Age 0-15	Age 16-17	All	*%
Young person was looked after and accommodated by the local authority	7	13	20	22%
No information	1	3	4	4%
Young person had access to social work	16	47	63	71%
No information	3	17	20	4%
Total	19	70	89	100%

*Total=89, based on all admissions where further information was provided to the Commission.

Many young people admitted to a non-specialist facility will have had no prior involvement with social work services, but our expectation would be that if social work input is felt to be necessary at the time when an admission is being considered, or after admission, there should be clear local arrangements to secure that input.

The Commission is particularly concerned about vulnerable groups of individuals and is interested in the provision of services to care experienced or "looked after" children[10]. A young person is described as being 'looked after 'if, under the provisions of the Children (Scotland) Act 1995, they are under the care of their local authority and either subject to voluntary or statutory measures and looked after at home, or looked after away from home in foster or kinship care, a residential care home, a residential school or secure young people unit.

There is evidence that such children generally experience poorer mental health and there is an established national requirement that NHS boards ensure that the health care needs of care experienced or 'looked after' children are assessed and met, including mental health needs[11]. The Guidance on Health Assessments for Looked after Children and Young People[12] emphasises that

[10] Children and young people looked after by the local authority or young people leaving care wish to be known collectively as care experienced. For this report we retain the use of the term 'looked after and accommodated' to describe a specific group of children and young people who are care experienced and are accommodated by the local authority.
[11] Action 15 Looked After Children and Young people: We can and must do better. January 2007 https://www2.gov.scot/resource/doc/162790/0044282.pdf
[12] The Scottish Government (28 April 2009) CEL16 http://www.sehd.scot.nhs.uk/mels/CEL2009_16.pdf
The Scottish Government (2014) *Guidance on Health Assessments for Looked After Children and Young People in Scotland* http://www.gov.scot/Resource/0045/00450743.pdf

mental health problems for care experienced young people are markedly greater than for their peers in the community.

In the recent Mental Health Strategy 2017-2027[13] Action 5 addresses particular issues "for young people on the edges of and in secure care" and seeks to ensure mental health needs are considered in the pathway of care for these children and young people.

We have been collecting information about young person's admissions to non-specialist wards and whether they are 'looked after and accommodated' since 2014. We would assume that any 'looked after' young person admitted to a non-specialist facility should have an identified social worker.

Twenty (22%) of the admissions for which we received further information involved young people who were described as being 'looked after and accommodated'. This compares with 21% in 2018-2019, 16% in 2017-2018, 13% in 2016-2017, 13% in 2015-2016 and 13% of young people in 2014-2015. Of the twenty admissions of young people this year, seven were admissions of young people under the age of 15 or and 13 related to admissions of young people aged 16 to 17 years. In terms of length of stay, three of the admissions (15%) lasted longer than five weeks, four were longer than two weeks (20%) and eight (40%) were longer than one week. A similar number of admissions to 2018-2019 involving young people who were "looked after and accommodated "also had an identified learning disability (three out of twenty admissions 15%).

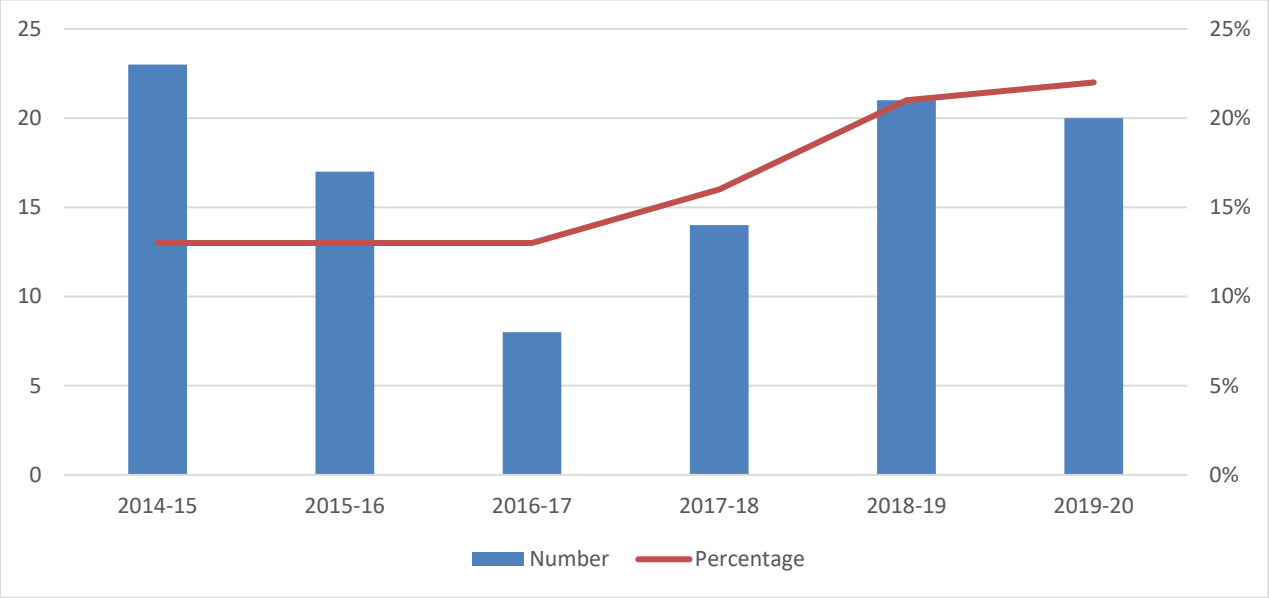
There were fifteen IPCU admissions of young people in 2019-2020 and five of these involved young people who were for looked after and accommodated.

A small number of young people who are 'looked after' accommodated by a local authority are admitted to non-specialist wards at a time of crisis and breakdown of their care placement. At times there are substantial concerns about the young person's mental health at this time and these admissions are entirely appropriate. However, we are aware of other occasions when it appears that a lack of suitably available and/or suitably adapting care provision appears to be the important factor behind admission and the young person is admitted as a result of a need of a place of safety rather than for assessment or treatment of mental health difficulties.

In 2019-2020 63 out of 89 admissions (71%) had access to a social worker. This compares with 71% in 2018-2019, 64% of the admissions we were given additional information about in 2017-2018, 77% in 2016-2017, 71% in 2015-2016, 74% in 2014-15, 76% in 2013-2014, and 74% in 2012-2013.

[13] Mental Health Strategy. March 2017. http://www.gov.scot/Publications/2017/03/1750

Figure 5: Admissions involving Care Experienced Young People



Data is based on the further information provided to the Commission (89 admissions) and reported on annually

Supervision of young people admitted to non-specialist care 2019/20

The Commission asks for specific information about the supervision arrangements for young people admitted on non-specialist facilities to monitor whether the need for increased observation is being carefully considered.

In previous reports the Commission has reported that young people report feeling lonely and bored due to intense supervision that might be in place on a ward on which they might be more vulnerable than they might be if on a ward with peers of a similar developmental age.

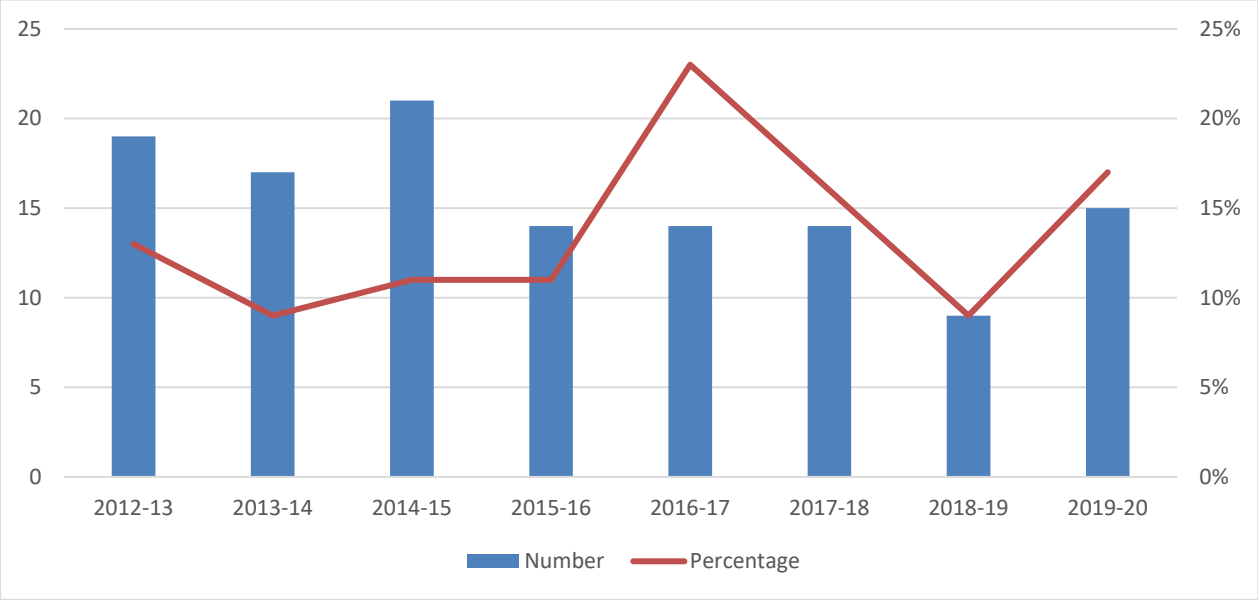
Table 6: Supervision of young people admitted to non-specialist care, 2019/2020

Supervision arrangements	**Age 0-15**	**Age 16-17**	**All**	**%****
Transferred to an IPCU or locked ward during the admission*	<5	13	15	17%
Accommodated in a single room throughout the admission	19	64	83	93%
Nursed under enhanced observation	18	48	66	74%
Constant observation because of ward policy	11	42	53	60%
Constant observation following an individual assessment of the young person	15	40	55	62%
Total**	19	70	89	100

*This is taken from information recorded on the forms.

**Total=89, based on all admissions where further information was provided to the Commission; percentages may sum to more than 100% as more than one of the above arrangements may apply.

Figure 6: IPCU admissions



Data is based on the further information provided to the Commission (89 admissions) and reported on annually.

This year fifteen of the 89 admissions (17%) where further information was supplied to the Commission were cared for in an IPCU or locked ward at some point during their hospital stay. during admission.

This contrasts with 9% of 100 admissions in 2018-2019, 16% of admissions in 2017-2018, 23% of admissions in 2016-2017 , 11 % in 2015-2016, 11% in 2014-2015, 9% of admissions in 2013-2014 and 13% of admissions) in 2012-2013.

In 2019-2020 two young people under the age of 16 were admitted to an IPCU (13% of IPCU admissions). In previous years the proportion of the young people admitted to an IPCU or locked ward under the age of 16 has been around 25% of those admitted to an IPCU overall and in 2017-2018 this figure rose to 36%.[14]

The lack of specialist adolescent IPCU service provision and the lack of clear pathways around access to adult IPCU facilities that are equipped to cater to the needs of younger people can add significant difficulties for the young person, their family and their clinical team when a bed for the young person within a secure hospital environment is required. Clinicians continue to inform the Commission that this is particularly difficult for young people under the age of 16 and for female young people in general requiring IPCU care.

We are also concerned that, because of the lack of any IPCU some young people have to be cared for with significant restrictions in place in an attempt to manage risk on an open ward; a situation which may prove to be unsuitable for the young person and the other patients on the ward.

[14] MWCS Young Person's Monitoring report 2017/2018 www.mwcscot.org.uk/publications

The figures we report are likely to underrepresent the number of young people whose care needs indicate the need for IPCU facilities as the lack of IPCU provision means that clinicians have to try to manage these needs in other ways.

In last year's report the Commission once again highlighted the importance of the lack of provision of IPCU facilities for young people under the age of 18 in Scotland and the lack of established and co-ordinated process and protocols to ensure that young people requiring IPCU facilities have access to appropriate provision when needed. We welcome the news that work has again begun to look at the issue of IPCU for young people in Scotland.

Other care provision for young people, 2019/20

Table 7: Other care provision for young people, 2018/19

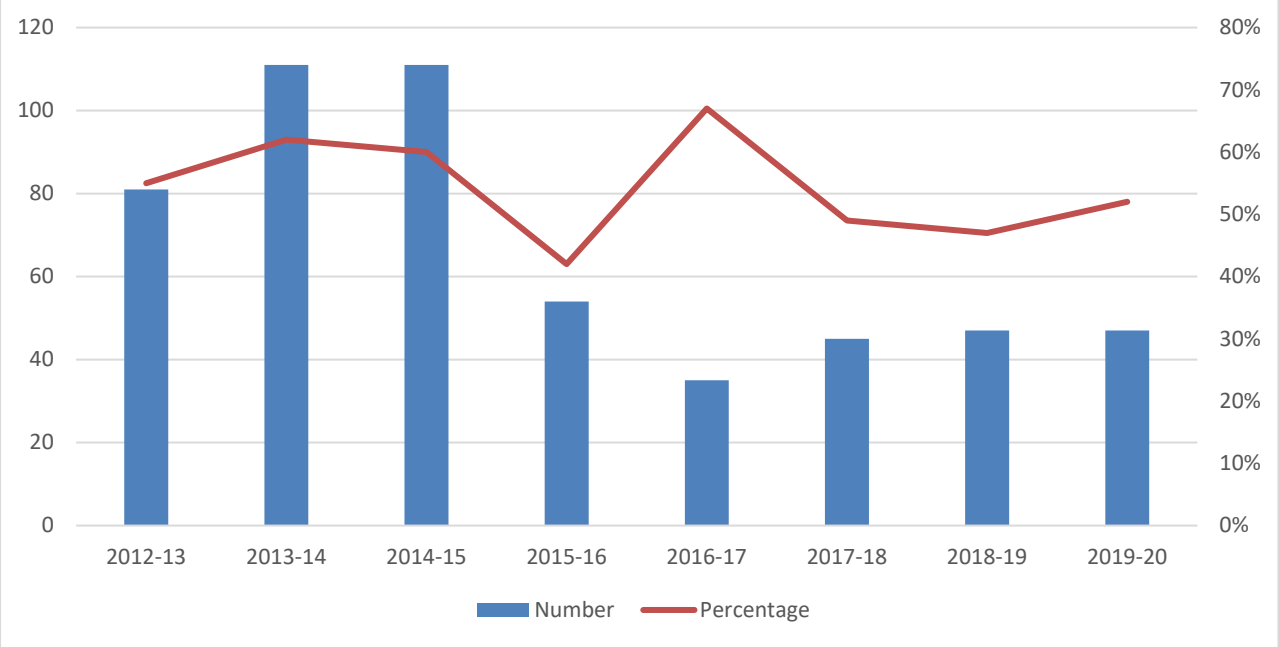
	Age 0-15	Age 16-17	All	*%
Access to age appropriate recreational activities	6	41	47	52%
Appropriate education was provided	2	3	5	6%
Access to advocacy service	9	53	62	70%
Has access to specialist advocacy service	3	15	18	20%
Total*	19	70	89	100%

*Total =89 admission where further information provide to the Commission

As part of our monitoring the Commission asks about access to other provisions to develop a clearer picture of how NHS boards are fulfilling their duty to provide age-appropriate services to young people. The importance of access to age-appropriate recreational activities and consideration of access to education becomes more important as the length of stay in the non-specialist environment increases.

In 2019-2020 the proportion of admissions where a young person was described as having access to age-appropriate recreational activity rose slightly to 52% (47 out of 89 admissions). This compares to 47% in 2018-2019, 49% in 2017-2018, 67% in 2016-2017, 42% in 2015-2016, 60 % in 2014-2015, 62% in 2013-2014 and 55% in 2012-2013.

Figure 7: Access to Age Appropriate Activity



Data is based on the further information provided to the Commission (89 admissions) and reported on annually.

Every year we ask for information about the activities that young people are able to access while they were receiving care and treatment as in-patients. Many young people are reported to have access to electronic games, their phones and to music and DVDs. Some young people are reported to be able to access gym facilities. In previous reports we have suggested that, even when admitted for a relatively short space of time, staff looking after the young person should give sufficient attention to structuring daily activity for young people with clear documentation regarding decisions made regarding appropriate activities available to a young person (involving the young person's views) and how these can be provided[15].

Article 12 of UNCRC describes the rights of all children to express their views freely in all matters that affect them and have their views "given due weight in accordance with their age and maturity. " A key way in which this right can be promoted relates to the accessibility and availability of independent advocacy services for children. In our monitoring process we enquire whether independent advocacy services are readily available which is a right that anyone with a mental disorder has in being able to access this service. In the 2015 amendments to the 2003 Mental Health Act, health boards were given new responsibilities to demonstrate how they are discharging their legal responsibilities in relation to the provision of advocacy.

In 2019-2020, 70% of young people (52 out of 89 admissions in which further information was provided to the Commission) had access to advocacy. This compares with 76% of young people in 2018-2019, 67% in 2017-2018, 61% in 2016-2017, 65% in 2015-2016, 72% in 2014-2015, 65% in 2013-14 and 70% in 2012-2013.

Of the young people who had access to advocacy during the admission, 18 of the 89 admissions (20%) had access to advocacy which specialised in the particular needs and rights of young people. This result remains disappointing and compares with 2017-2018 data of 18%, 20% in 2016-2017, 17% in 2015-2016 and 29% in 2014-2015.Our data does not provide information about whether the young people accessed advocacy during their admission, only that advocacy services might have been available should they have wished to have used them.

We expect advocacy support to be available and to be routinely offered to young people. It may be that during a very brief admission there is no time to involve advocacy to support a young person. However, the findings from our monitoring project described in 2016 raised concerns about the accessibility of advocacy supports during young people's admissions to non-specialist wards. [16]

Recommendation 2: Health Board Managers with a duty to fund and provide advocacy services for individuals with mental health difficulties in their area should review the availability of dedicated advocacy support for children and young people with mental health difficulties locally and ensure the resourcing and provision of any dedicated specialist advocacy service is sufficient to be able to meet the needs of young people with mental health problems and to support and protect their rights.

[15] Young Person Monitoring 2015-2016. October 2016.
http://www.mwcscot.org.uk/media/343729/young_person_monitoring_report_2015-16.pdf
[16] Young Person Monitoring 2015-2016. October 2016.
http://www.mwcscot.org.uk/media/343729/young_person_monitoring_report_2015-16.pdf

Article 28 of the UNCRC gives rights to children to access education and this applies whether the child is in hospital or not. In its general comments in 2007 the CRC stressed that "every child of compulsory school age has the right to education suited to his/her needs and abilities "[17].As part of our monitoring activity, we ask for information about whether education has been considered for and discussed with the young person and, if not, to give reasons why. If education has been considered for a young person, we ask whether education has been provided.

In 2019-2020 twenty two out of the 89 admissions in which further information was provided to the Commission were reported to have had a discussion regarding access to education during their inpatient stay (25%) and five young people had educational materials provided to them during their admission. These figures are comparable to previous years. The remaining young people were described as being either too unwell to access education, their admission was too short or the young person either was no longer in education or had not been in education due to their mental health difficulties. Of the nineteen admissions during 2018-2019 which involved young people who were under the age of sixteen and therefore of statutory school age, education was discussed in only six admissions and in only two was educational material provided.

It may not always be appropriate or relevant to discuss access to education or learning if an admission is for a very short period of time or during a weekend or school holidays or when the young person is no longer in education.

However, we are aware from previous reports[18] that access to education remains a fragile area of service provision when a young person has been admitted to a non-specialist facility. Education authorities have a duty to arrange for the education of young people who cannot attend school because of prolonged ill-health. We do think it is important that education needs are considered when a young person is admitted to an adult ward for a sustained period and remain concerned that staff in adult wards may not know how to access education services should that be appropriate while a young person is in hospital.

Recommendation 3: Hospital managers should ensure that whenever a child or young person is admitted to a non-specialist ward that consideration and exploration of their educational needs and their right to education should be a standard part of care planning for the young person during their hospital admission.

[17] UN Committee of the rights of the child, general comment no 10 (2007) Children's rights in juvenile justice, para 89.
[18] Visits to young people who use mental health services: Report from our visits to1 young people using in-patient and community mental health services in Scotland 2009 (2010) http://www.mwcscot.org.uk/media/53171/CAMHS_report_2010.pdf

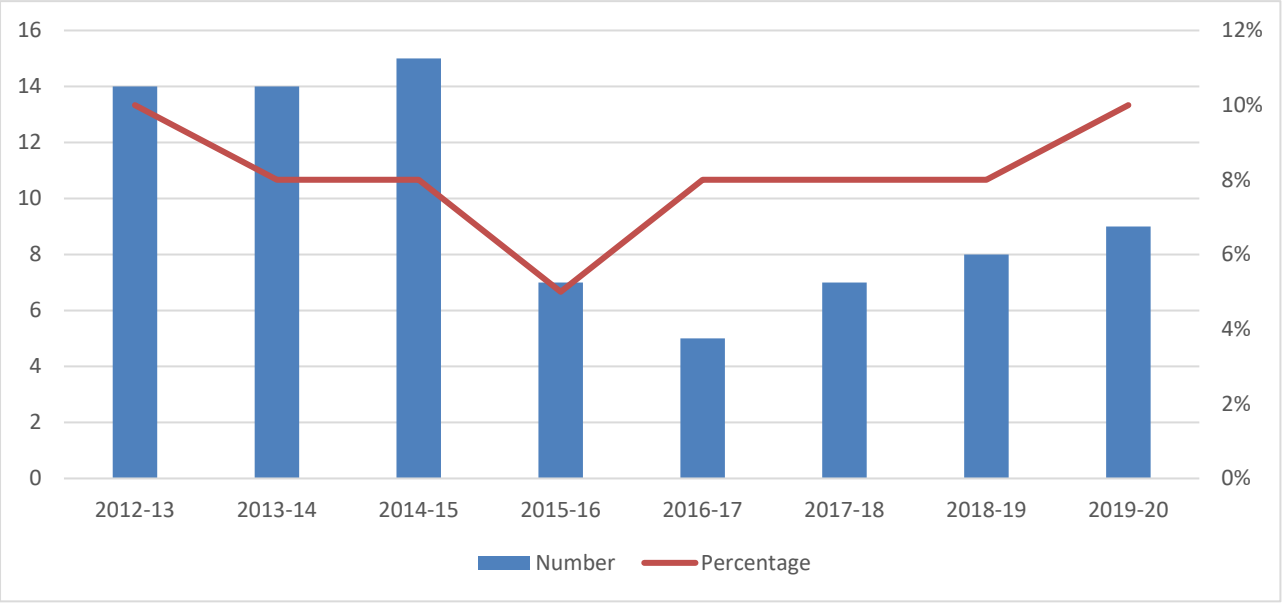
Young People with a Learning Disability 2019/20

Table 8: Admissions involving a Young Person with a learning disability

	Age 0-15	Age 16-17	All	*%
Young person has a learning disability	<5	7	9	10%
Total *	19	70	89	100

Total = 89 admissions where further information was provided to the Commission

Figure 8: Admissions involving a Young Person with a learning disability



Data is based on the further information provided to the Commission (89 admissions) and reported on annually.

The number of admissions to non-specialist settings where additional information was provided and the young people was described as having a learning disability in 2019-2020 was nine out of 89 admissions (10%). This is similar to previous years in terms of percentages: 8% in 2018-2019, 2017-2018 and 2016-2017, 5% in 2015-2016; 8% in 2014-2015 and 2013-14 and 10% in 2012-2013.

Of the nine admissions this year only four (44%) were for less than seven days and three for more than five weeks (33%).

Three of the fifteen admissions to an adult IPCU (20%) in 2019-2020 involved individuals with a diagnosed learning disability, In 2019-2020 three of the nine admissions of young people with a learning disability were also looked after and accommodated by their local authority (33%).

Age and gender 2019/20

We are interested in the age and gender of young people admitted to non-specialist settings to identify trends that develop over time that might indicate particular unmet needs.

In 2019-2020 there were ten children aged 14 years or younger who were admitted to a non-specialist environment. Half of these were admitted to a paediatric ward in the local hospital.

In 2019-2020 the proportion of 16 and 17 year old young people admitted to a non-specialist environment was comparable with previous years (67 out of 88 young people in total, 76%). In 2018-2019 the proportion of 16 and 17 year old young people admitted was 75%, 72% in 2017-2018, 82% in 2016-2017 and in 2015-2016 , 69% in 2014-15, 65% in 2013-14 and 62% in 2012-13.

The higher rates of admissions of young people in the 16-17 year age range reflects current understanding of the prevalence and the types of mental health difficulties affecting young people in this age group in particular.[19]

Table 9: Age of young person by gender

	2016-2017			2017-2018			2018-2019			2019-2020		
Age (yrs)	**F**	**M**	**Total**	**F**	**M**	**Total**	**F**	**M**	**Total**	**F**	**M**	**Total**
15	<5	<5	6	9	<5	12	10	<5	13	5	6	11
16	10	6	16	12	12	24	16	8	24	17	3	20
17	20	18	38	21	20	41	28	24	52	27	20	47
Total*	**37**	**29**	**66**	**51**	**39**	**90**	**62**	**39**	**101**	**56**	**32**	**88**

*Total describes all individuals admitted over the year, including where no further information was supplied to the Commission. The data for young people 14 years and under is included in this total but not provided in the table due to the low numbers. F=Female. M=Male

[19] https://dera.ioe.ac.uk/32622/1/MHCYP%202017%20Summary.pdf https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017 Mental Health of Children and Young People in England 2017.

Figure 9a: Young people admitted to non-specialist wards by gender (number of individuals), by year 2008-2018

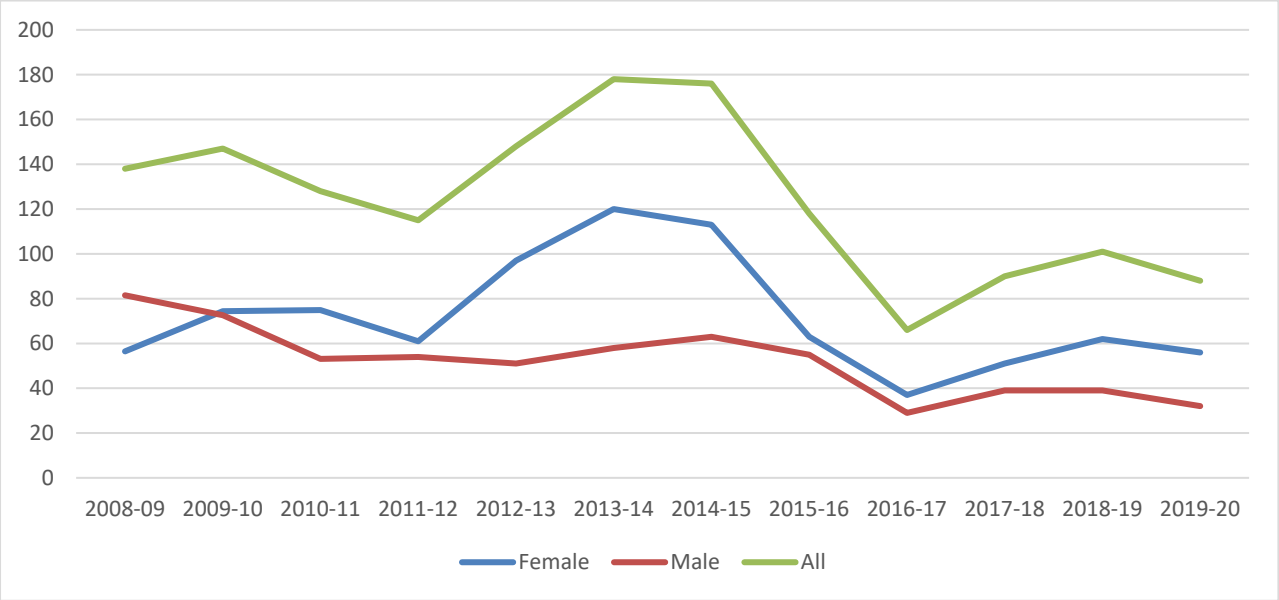
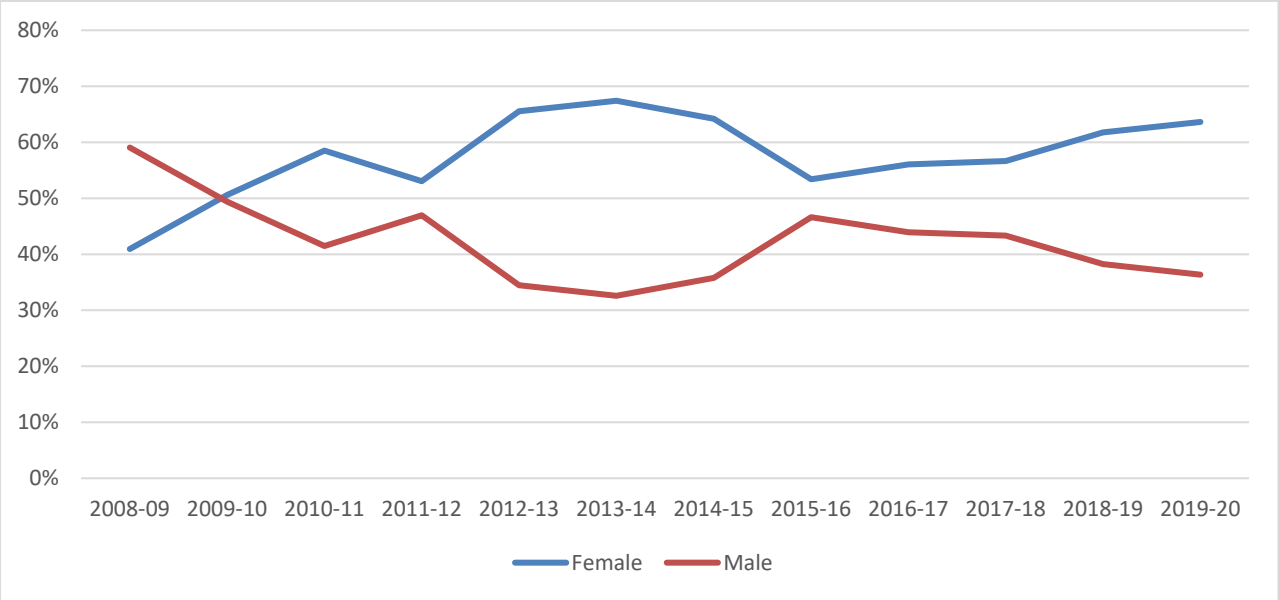


Figure 9b: Young people admitted to non specialist wards by gender (%), by year 2008-2018



Mental Welfare Commission for Scotland
Thistle House,
91 Haymarket Terrace,
Edinburgh,
EH12 5HE
Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk