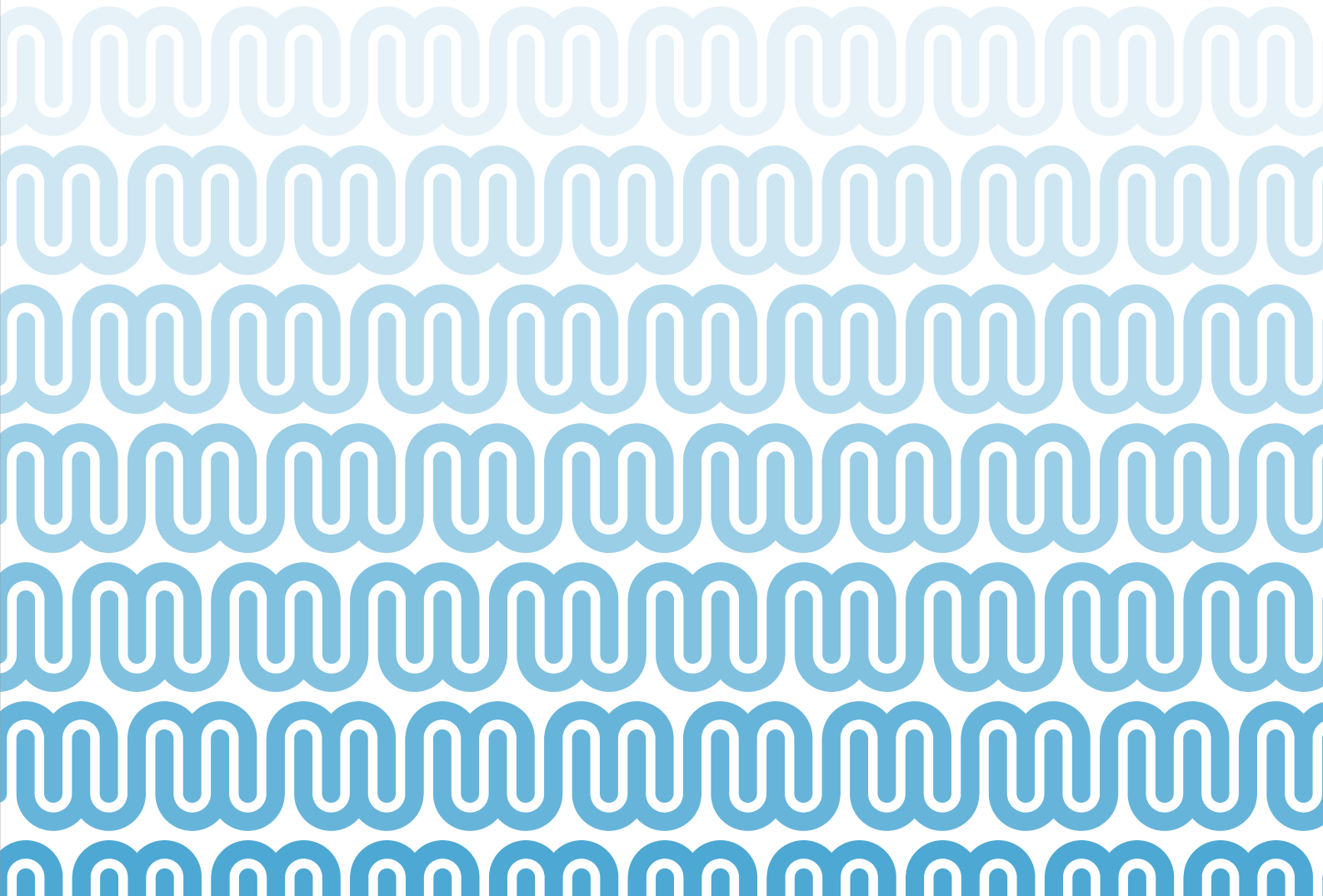
mental welfare commission for scotland

Young people monitoring report 2020-21

Admissions of young people under the age of 18 to non-specialist wards in Scotland 2020-21

October 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

Admissions of young people under the age of 18 to non-specialist wards in Scotland 2020-21

Contents

Foreword – Julie Paterson, chief executive

Every year we monitor and publish information on the number of young people under the age of 18 in Scotland who are admitted to non-specialist wards – usually adult wards – for treatment of their mental health difficulties.

We do this because, while there can be some instances when it might be in the best interests of a child or young person to be treated on an adult ward, this should only happen in rare situations.

Legislation recognises this, and under the Mental Health Act, health boards are obliged to provide appropriate services and accommodation for young people admitted to hospital for treatment for their mental health. This usually means one of Scotland's specialist adolescent units, designed to treat the needs of adolescents with mental illness.

The figures published in this report for the year 2020-21 show a fall from 2019-20, which in normal circumstances we would clearly recognise as a positive sign.

The numbers are however not directly comparable, and need to be understood against the backdrop of pandemic restrictions. Hospital wards and admissions and discharges across the country were adapted in 2020-21 to help cope with the pandemic, and this had an impact on bed availability and admissions.

The data published in this report nevertheless remains vital in understanding something of how services operated during that time. It also confirms that some of the issues we raised in the past as requiring attention continue to exist.

In these circumstances it is perhaps not surprising that our three recommendations for change are almost identical to the previous report's recommendations, except that this time we are asking that progress is made on identifying intensive psychiatric care facilities in Scotland for young people within one year.

Positive findings in the report include confirmation that a facility for young people who need forensic intensive psychiatric care is underway and is due to open in Ayr in November 2022.

We also welcome confirmation that national specialist facilities for young people with learning disabilities are being developed in Lothian area. This is good news for those young people who need this care and we look forward to hearing of the next stage.

Executive Summary

1. This year's report covers the year from 1 April 2020 to 31 March 2021. It describes admissions of young people under the age of 18 to non-specialist wards in Scotland. During this time there were major alterations to daily life for people living in the UK and many alterations made to hospital service provision both in response to the pandemic, and as a consequence of the impact of the pandemic on hospital staffing and the provision of care. As such this year's report covers a period of extraordinary circumstances and cannot be taken as a reflection of trends of activity outwith recent pandemic circumstances.
2. 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.
3. 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 (CRC) 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.
4. 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.
5. In 2020-21, 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 86 admissions involving 62 young people. This is a fall from the 2019-20 figures when there were 103 admissions involving 88 young people.
6. 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 the latest Public Health Scotland data, between 1 April 2020 and 31 March 2021 34 % 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]
7. 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 an learning disability,
    b. Young people who have offended due to mental health difficulties and require forensic care; and

[1] Para 60c and 61c.
http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2FPPRiCAqhKb7yhskHOj6VpDS%2F%2FJqg2Jxb9gncnUyUgbnuttBweOlylfyYPkBbwffitW2JurgBRuMMxZqnGgerUdpjxij3uZ0bjQBOLNTNvQ9fUIEOvA5LtW0GL
[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/

c. Young people who require intensive psychiatric care provided in specialised units.

8. 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.
9. The majority of admissions of young people to non-specialist wards continue to be short in length, however 48% remain on those wards (mostly adult) for over a week.
10. A continued positive finding is the specialist medical staff either supporting or available to support these admissions remains high – 60% of the doctors in charge of care or responsible medical officers (RMO) were child specialists and in a further 23% of admissions a child and adolescent mental health services (CAMHS) consultant was available to give support, if needed.
11. Of all the young people admitted to non-specialist wards, 16% were care experienced and looked after and accommodated by a local authority.
12. Access to specialist advocacy remains limited. We were disappointed to note that while 77% of young people had access to advocacy, only 13% had access to advocacy that specialised in the particular needs and rights of young people.
13. 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 specialist CAMHS input that is not medical whilst an in-patient on a non-specialist ward has not improved.
14. 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.
15. The Commission is encouraged that, following a number of recommendations in recent years, work has begun once again to explore the needs of young people who require CAMHS specialised intensive psychiatric care unit (IPCU) support in Scotland. We continue to emphasise the importance of this work and the need for it to be prioritised and brought to a conclusion. We are aware of the complexity of this task and that previous initiatives to explore this question have been unsuccessful in changing the landscape of inpatient provision for the under 18s. 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. From its work the Commission is aware that the young people who may need IPCU care often may also have a learning disability, they may be care experienced and/or may have a forensic history. It is important therefore that any work to develop IPCU facilities for young people regionally is sufficiently co-ordinated nationally between regional adolescent units and also with the work underway in relation to the proposed forensic and learning disability units being developed to ensure coherence in developing service provision.

Recommendations

Recommendation 1

To Scottish Government

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. This work should be brought to completion within one year to enable meaningful change nationally for young people having access to IPCU facilities that are age appropriate.

It is essential that any such work should not be undertaken in isolation but co-ordinated with other work-streams (such as relating to National Secure Adolescent Inpatient Service and Learning Disability unit development) to ensure that access to IPCU facilities is part of a cohesive integrated pathway between and within the various specialist adolescent inpatient services.

Recommendation 2

Health board managers with a duty to fund and provide advocacy services for individuals with mental health difficulties in their area should ensure 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 the Commission is aware of through its 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 provided within his home health board area.
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 regional 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 music and puzzles. 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 at her support workers on several occasions.
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 Commission 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 and 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

This year's report describes the admissions of children and young people under the age of 18 years to non-specialist wards in Scotland as a consequence of their mental illness between 1 April 2020 and 31 March 2021.

During this period much of Scotland was affected by lockdown as a result of the Covid-19 pandemic which saw substantial alterations made to daily life for the whole of the population in an attempt to minimise the impact of the virus on everyone[3]. Movement and travel was heavily restricted for long periods, social interaction and opportunities curtailed, people worked from home or their jobs were furloughed and schools were temporarily closed in an attempt to limit opportunities for the virus spreading. At the same time hospital inpatient wards and admission and discharge processes across the country were adapted which impacted on bed availability and admission pathways. This year's report figures should be understood with this backdrop in mind.

One of the Commission's duties is to monitor the use of the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Act') and each year the Commission produced a report that describes the number of children and young people who are admitted to non-specialist wards for treatment of their mental health difficulties. Section 23 of the Act places a legal duty on health boards 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 the Commission refers to it in this report). The most common non-specialist wards to which young people are admitted are adult mental health wards and adult intensive psychiatric care units (IPCUs).[4]

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"[5]. Specialist adolescent units are designed to treat the needs of adolescents with mental illness and differ in staff training and the ward environment so that a young person's needs might not be fully met on an adult ward.

The Commission believes that admitting a young person to an adult ward should only happen in rare situations. This would depend upon the individual needs and circumstances of the young person e.g. the nature of their 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.

It is important to bear in mind that the Section 23 duties on health boards reflect a number of rights outlined in the United Convention on the Rights of the Child (UNCRC) which is an international human rights treaty that outlines a comprehensive range of rights that should be available to all children. (Under the UNCRC a child is defined as an individual who is younger

[3] https://www.publichealthscotland.scot/media/2999/the-impact-of-covid-19-on-children-and-young-people-in-scotland-10-to-17-year-olds_full-report.pdf
[4] 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.
[5] Code of Practice Volume 1, chapter 1 paragraph 50.
https://www2.gov.scot/Publications/2005/08/29100428/04302

than 18 years old.) 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 what progress has been made in implementing UNCRC within the UK. The CRC describes any 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) for their attention. In its concluding observations to the fifth and latest periodic report from the UK[6] in 2016 the CRC 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.

The importance of children's mental health and access to appropriate mental health services is described in a number of UNCRC rights. These in turn reflect areas that the Commission explored in its routine monitoring process relating to an admission to a non-specialist ward:

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 12 describes the rights of children who are capable of forming their view to be able to express this 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, whether compulsorily treated or not and access to specialist children's advocacy is an important mechanism by which children's rights can be protected.

Article 19 describes the rights of children to be protected from all forms of violence including mental or physical violence and also includes 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 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.

[6] Para 60c and 61c.
http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2FPPRiCAqhKb7yhskHOj6VpDS%2F%2FJqg2Jxb9gncnUyUgbnuttBweOlylfyYPkBbwffitW2JurgBRuMMxZqnGgerUdpjxij3uZ0bjQBOLNTNvQ9fUIEOvA5LtW0GL

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 on 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." This may be an important consideration when young people are admitted to adult IPCUs.

On the 1 September 2020 the UNCRC (Incorporation) (Scotland) (Bill) was introduced to the Scottish Parliament and was passed unanimously on 16 March 2021. The Bill's main purpose is to bring UNCRC into Scots law and to ensure all legislation is compatible with it. Due to the fact that some areas within the UNCRC bill are not within the powers devolved to the Scottish parliament, a judgement from the UK's Supreme Court was delivered on Wednesday 6 October in relation to those matters which will be required to be revisited in the near future.

In recent years the Commission had seen that numbers of admissions to non-specialist wards can vary across the country and year to year. We have been told about a number of approaches to try and reduce admission rates which 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.

In 2015-16 and 2016-17 the Commission did see the numbers of young people admitted to non-specialist wards fall substantially and thereafter admission figures have remained lower from that point onwards. We welcome this development and are keen that there is ongoing investment in services to ensure that alternatives to admission are available at the point of need and that comprehensive support is available from a range of CAMHS professionals whenever there is an admission to a non-specialist ward of any duration.

In recent months Scottish Government has made available money to support further specialist CAMHS development across the country in line with the recent publication of the CAMHS national services specification in February 2020[7]. The service specification is an ambitious document that outlines a comprehensive range of specialist CAMH services which Scottish Government expects every health board should develop and provide, either individually or through jointly in conjunction with other boards. Services described include intensive home treatment capacity to help support more young people with more complex needs be looked after within community treatment rather than requiring an inpatient stay and also CAMHS support for out of hours emergency presentations of children and young people to contribute to the care and treatment of young people in crisis. In the coming years it will be interesting to see how this further development of CAMHS services will impact on non-specialist bed use.

Implementation of the CAMHS service specification is one strand of activity amongst others that are currently ongoing with the aim of improving availability and access to specialist mental health services for those children and young people who need them. Action 20 of the current Mental Health Strategy 2017-27[8] describes 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 inpatient needs of young people who have learning disability or autism or who due to the nature of their illness may

[7] https://www.gov.scot/publications/child-adolescent-mental-health-services-camhs-nhs-scotland-national-service-specification/
[8] Mental Health Strategy 2017-2027 published March 2017 http://www.gov.scot/Publications/2017/03/1750

have committed offences that require their care to be delivered in specialist child and adolescent psychiatric forensic services.

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 the National Secure Adolescent Inpatient Service (NSAIS) otherwise known as Foxgrove which is being designed to help meet the needs of those young people who require specialised forensic psychiatric care. Due to involvement in the ASSURE programme[9] to support development standards the building of the unit has been delayed for 6 months with the hope that the unit will be open and able to receive its first inpatients in November 2022. The Commission has been involved in supporting appropriate contingency planning for the unit.

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 the learning disability project is continuing but overall has been at a less advanced stage than the forensic unit NSAIS. The Commission has had involvement in the planning of the Lothian unit to ensure that the Lothian unit lies within the remit of CAMHS management structures rather than 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 the Commission 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 not been able to come to a conclusion and no solution has been found as to how best to 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.

We recognise that work is once again underway to explore the need for IPCU provision for young people in Scotland. In the Scottish Government's most recent letter to health boards announcing further mental health recovery funding, a funding allocation has been made to all three regional specialist adolescent inpatient units towards the development of IPCU provision regionally. This progress is very welcome.

However, due to the complexity of interfaces that any IPCU facilities might be expected to establish and, given that pathways into and out of any such facilities is likely to intersect with other existing and developing pathways (into NSAIS or the Learning Disability unit for example), it is crucially important that this work in developing IPCU capacity is sufficiently integrated with existing and developing streams of inpatient provision. It is vital that all the various specialist adolescent inpatient services are integrated and cohesive and IPCU development must not occur in isolation.

[9] https://www.sehd.scot.nhs.uk/dl/DL(2021)14.pdf

Given the nature of any IPCU provision and that the number of young people requiring such provision across the country is small at any one time, the care and accommodation planned and provided must comprehensively reflects the young people's needs, mental health or otherwise. This must support their rights to be protected from any inhumane or degrading treatment with sufficient planning to minimise the use of seclusion and restraint and support integration with other adolescent service activity whenever possible.

Recommendation 1

For Scottish government

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. This work should be brought to completion within one year to enable meaningful change nationally for young people having access to IPCU facilities that are age appropriate.

It is essential that any such work should not be undertaken in isolation but co-ordinated with other work-streams (such as relating to National Secure Adolescent Inpatient Service and Learning Disability unit development) to ensure that access to IPCU facilities is part of a cohesive integrated pathway between and within the various specialist adolescent inpatient services.

Covid-19 pandemic and lockdown

Over the timescale of this report the country was facing the challenges of the Covid-19 pandemic. Activities of everyday life in Scotland and the rest of the UK were significantly affected. As the months have passed increasing awareness has been paid to the impact that the pandemic has had on the mental health and wellbeing of individuals, and children and young people in particular. A number of reports about the impact of the pandemic are now available[10,11].

Due to the lethality of the Covid-19 virus, high levels of anxiety were experienced within the population as a whole, including children and young people, and many experienced far reaching changes in their daily routines and activities. Hospital and health services were affected by measures designed to try and limit the impact of the virus on the health of the population, and at the same time hospitals and health services were affected by altered staffing levels as a result of the pandemic, which had then to be managed.

Some of the changes put in place following the first lockdown in March 2020 remain. It is worth noting that not all the changes have been reported as negative and the pandemic has accelerated the use of virtual appointments in a way that could not previously have been imagined and some people report this has been helpful.

At present there is no widely available overview providing information across the country about how mental health services were affected by the pandemic. However, from work the Commission undertook during the first lockdown (between spring 2020 and autumn 2020), the Commission had been able to gather some information about some of the changes that took place in hospitals as wards and services reorganised to enable Covid wards to be created (to care for those in need of inpatient mental health care who also had contracted the virus). Alterations were made to admission and discharge processes, visiting arrangements and to practice around patients leaving ward for recreational purposes.

The Commission knows from its work across the year that high levels of demand were experienced in parts of Scotland (different places experienced the upswing at different times) in relation to increased presentations of young people with eating disorders. This echoes the findings of other reports from across the UK which describe significant increases in referral rates of young people presenting with eating disorder over the course of the pandemic[12]. In the early months of the year that this report covers, Skye House, the regional adolescent unit in Glasgow, was able to develop increased bed availability such that it was able to take patients from the other two regional units in Dundee and Edinburgh where demand for a specialist bed had exceeded bed supply.

[10] https://www.publichealthscotland.scot/media/2999/the-impact-of-covid-19-on-children-and-young-people-in-scotland-10-to-17-year-olds_full-report.pdf
[11] https://www.gov.scot/publications/coronavirus-covid-19-children-young-people-families-evidence-summary-june-2021/pages/2/
[12] COVID-19 and eating disorders in young people - The Lancet Child & Adolescent Health

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 years. These units are:

Skye House which is a 24 bedded specialist adolescent unit based in Stobhill Hospital, Glasgow. Skye House 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 Melville Young People's Mental Health Unit in Edinburgh is a 12 bedded unit located within the newly built Royal Hospital for Children and Young People at Little France, Edinburgh. This unit now replaces the unit formally known as the Young People's Unit which was based at the Royal Edinburgh Hospital and which is now being repurposed. The Melville unit continues to receive 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 (six beds).

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.

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.

Once the Commission has been notified about an admission it sends 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 the Commission's 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 the Commission's criteria. Commission staff then cross reference this information with the admissions the Commission has been notified about and chase ones that are missing from routine notification processes.

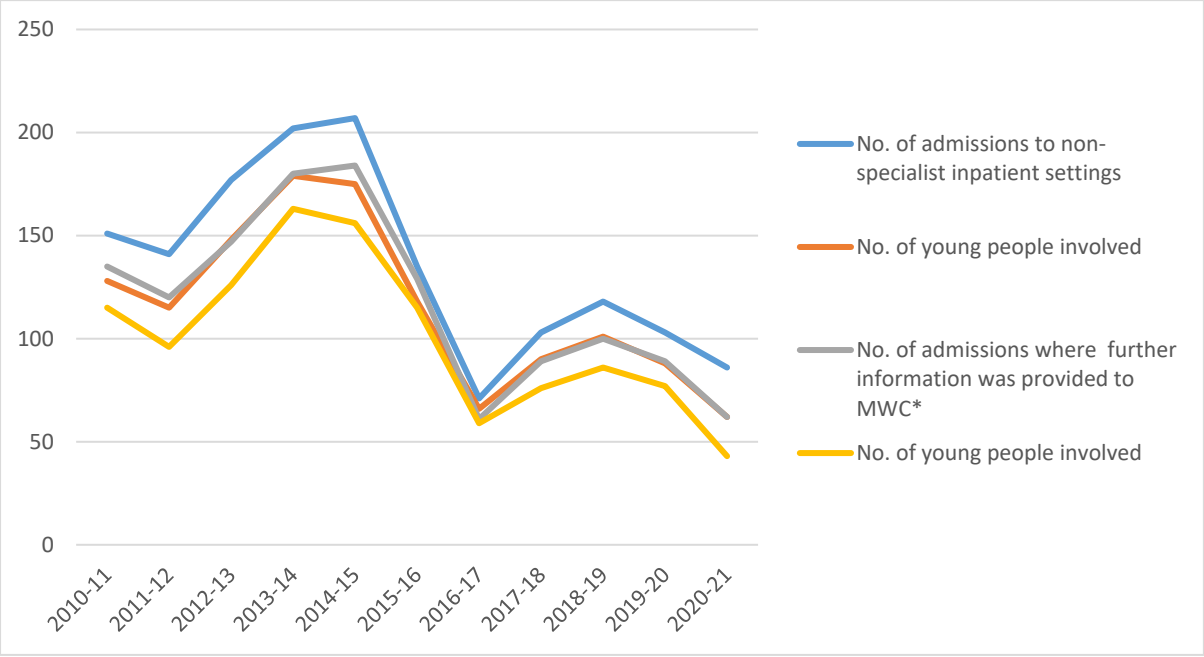
Young people (under 18) admitted to non-specialist facilities, by year 2011-21

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

	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021
No. of admissions to non-specialist inpatient settings	141	177	202	207	135	71	103	118	103	86
No. of young people involved	115	148	179	175	118	66	90	101	88	62**
No. of admissions where further information was provided to the Commission*	120	147	180	184	129	61	89	100	89	62
No. of young people involved	96	126	163	156	115	59	76	86	77	43

**admissions where completed monitoring form returned to the Commission.*
*** number of young people admitted to non-specialist facilities in Scotland over the course of the year.*

Figure 1: Young people (under 18) admitted to non-specialist facilities, by year 2011-21



In 2020-21 the Commission was notified of 86 admissions to non-specialist wards which involved 62 young people across Scotland as a whole. We received further information about the care provided for 62 of these 86 admissions.

This is a decrease from last year when the Commission obtained figures of 103 admissions involving 88 young people.

The lowest numbers of admissions were collected in 2016-17 when the Commission recorded 71 admissions involving 66 young people over the course of the year.

This year saw the lowest numbers of young people involved in the non-specialist admissions. As in previous years, a small number of young people were admitted multiple times to non-specialist wards over the course of the year. However, in 2020-21 the proportion of young people who were admitted multiple times was larger overall and over the course of the year the Commission saw a small number of young people who were admitted four or five times. Taken together these multiple admissions would seem to account for the lower numbers of individuals involved in the overall admission numbers over the course of this year.

In table 2 below the breakdown of admissions per health board area is provided. The figures relate to admissions of young people to non-specialist wards in that health board area. From table 2 many health boards describe similar figures to recent years with the exception of Greater Glasgow and Clyde which is striking in the scale of the reduction of admissions over the year. We are aware, from contact with the three specialist adolescent units during the lockdown, that for several months there was a lower demand on beds at Skye House such that Skye House was able to receive patients from the other health board areas where demand on adolescent inpatient care had substantially increased over that same period.

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 draw conclusions about trends with any confidence. This is particularly the case for figures relating to the pandemic lockdown when admissions to specialist and non-specialist beds were impacted by the pandemic lockdown.

When looking at this data it is also important to take into consideration the different sizes of population of health board areas and the differences in configuration of CAMHS across the country with varying eligibility criteria for young people for CAMHS versus adult mental health services depending on the young person's 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. The Commission knows from its work in previous years that this difference in service configuration can affect the numbers of young people admitted to non-specialist wards[13]. The CAMHS service specification suggests that all CAMH services in Scotland should provide services for all children and young people up to the age of 18 and the effect of this on figures in the coming years will be interesting to observe.[14]

[13] Young Person Monitoring 2015-16. October 2016.
https://www.mwcscot.org.uk/node/904
[14] National Service Specifications for CAMHS February 2020
https://www.gov.scot/publications/child-adolescent-mental-health-services-camhs-nhs-scotland-national-service-specification/

Young people admitted to non-specialist facilities by NHS board, by year 2012-21

Table 2: Young people admitted to non-specialist facilities within an NHS board, by year 2012–21

Health board	2012-13		2013-14		2014-15		2015-16		2016-17		2017-18		2018-19		2019-20		2020-21	
	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	Admissions	Young People Involved
Ayrshire & Arran	8	8	17	15	26	21	21	17	9	8	<5	<5	9	9	6	5	8	5
Borders	6	5	1	1	13	6	7	7	<5	<5	6	<5	5	<5	7	5	5	<5
Dumfries & Galloway	13	10	13	9	6	6	5	5	<5	<5	<5	<5	6	<5	5	5	8	<5
Fife	<5	<5	6	5	7	<5	5	5	6	6	<5	<5	8	6	8	6	<5	<5
Forth Valley	21	19	26	25	16	15	11	9	5	5	8	8	7	7	7	6	5	5
Grampian	31	22	20	17	27	23	15	12	<5	<%	17	14	6	5	<5	<5	9	7
Greater Glasgow & Clyde	30	24	37	34	36	30	17	16	7	7	16	14	28	24*	20	18	<5	<5
Highland	6	6	21	19	12	11	9	8	<5	<5	5	<5	7	7	7	<5	7	7
Lanarkshire*	48	40	*43	*38	37	34	27	24	25	22	22	19	27	21	22	18	16	12
Lothian	<5	<5	8	7	8	8	<5	<5	<5	<5	<5	<5	<5	<5	8	8	7	7
Tayside	9	9	10	9	19	17	12	11	<5	<5	14	12	12	10	11	10	18	11
Island Boards	0	0	0	0	<5	<5	<5	<5	<5	<5	0	0	0	<5	0	<5	0	0
Scotland	177	148	202	179	207	176	135	118	71	66	103	90	120	102	103	88	86	64******

** GGC total = 23, as one 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 (2017-18).*

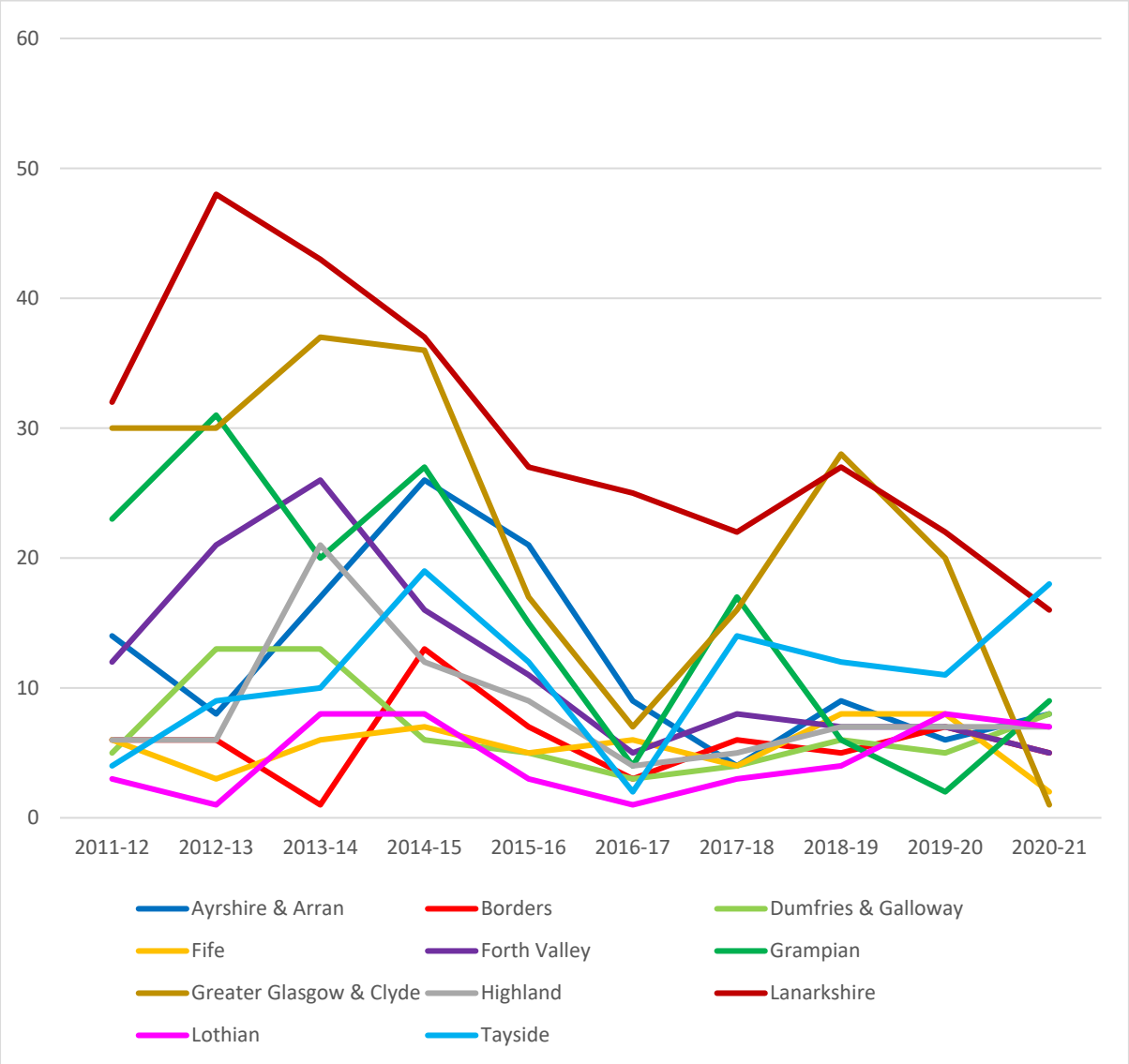
**** Ayr Clinic shown as independent rather than included in NHS Ayrshire and Arran figures. This admission followed a preceding admission to a non-specialist ward in Scotland. It is therefore not included in the individual data due to the young person being counted already elsewhere.*

***** 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.*

******* The sum of the number of young people admitted to each HB area is greater than 62 due to the fact that a small number of young people were admitted to different HB areas.*

Figure 2: Graph showing annual number of admissions within each health board area 2011-21



Length of stay in non-specialist wards, by year 2015 to 2021

In recent years the Commission had been aware, from its monitoring activity and from its visits to young people, that lengths of stay in non-specialist environments can vary considerably. 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 2015-21

Length of Stay*	2015-16	%	2016-17	%	2017-18	%	2018-19	**%	2019-20	%	2020-21	%
1-3 days	36	27%	25	35%	29	27%	35	30%	36	35%	34	40%
4-7 days	28	21%	17	24%	23	22%	37	31%	25	24%	19	22%
8-14 days 1-2 weeks	28	21%	8	11%	20	19%	13	11%	19	18%	10	12%
15-21 days 2-3 weeks	13	10%	<5	6%	10	9%	12	10%	9	9%	9	10%
22-28 days 3-4 weeks	11	8%	7	10%	<5	3%	6	5%	0	0%	4	5%
29-35 days 4 weeks+	7	5%	<5	4%	<5	2%	5	4%	<5	1%	3	3%
36 days or more 5 weeks +	12	9%	7	10%	19	18%	10	8%	13	13%	7	8%
Total	**135**	**100%**	**71**	**100%**	**106**	**100%**	**118**	**100%**	**103**	**100%**	**86**	**100%**
Mean (days)	15		19		23		16		21		23***	

** 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 86 admissions.*
**** Median = five days.*

This year, as in previous years, the majority of admissions continue to be short in length (40% are between one and three days). However, sizable numbers of young people remain inpatients in a non-specialist environment for longer periods (38% lasted over seven days, 26% lasted over two weeks and 11% lasted over four weeks).

In previous years when the Commission looked more closely at 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 including young people who have learning disability (see page 36-37). This was less evident this year with

seven admissions lasting over five weeks with many of the admissions relating to psychosis or other conditions with substantial risk presented. Only a very small number of the young people involved in these admissions were said to have a learning disability and all of the seven were either 16 or 17 years old (as in previous years).

Of these seven young people who remained in a non-specialist bed for over five weeks, almost half required IPCU admission at some point during their stay. This was similar to previous years, however, unlike previous years, none of the young people were described as care experienced young people. Approximately half of the admissions lasting over five weeks occurred in CAMHS services which do not provide care for all under 18 year olds.

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, 2020-21

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 admission of a young person to an adult ward continues to vary across the country.

Table 4: Specialist medical provision 2020-21

	Age 0-15	Age 16-17	All	*%
RMO at admission was a child and adolescent specialist	11	26	37	60%
CAMHS consultant available to give support other than as RMO	3	11	14	23%
Nursing staff with experience of working with young people were available to work directly with the young person	10	15	25	40%
Nursing staff with experience of working with young people were available to provide advice to ward staff	11	38	49	79%
The young person had access to other age appropriate therapeutic input	8	12	20	32%
None of the above	0	8	8	13%
Total admissions*	14	48	62	100%

** Total=62, 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 2020-21 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.

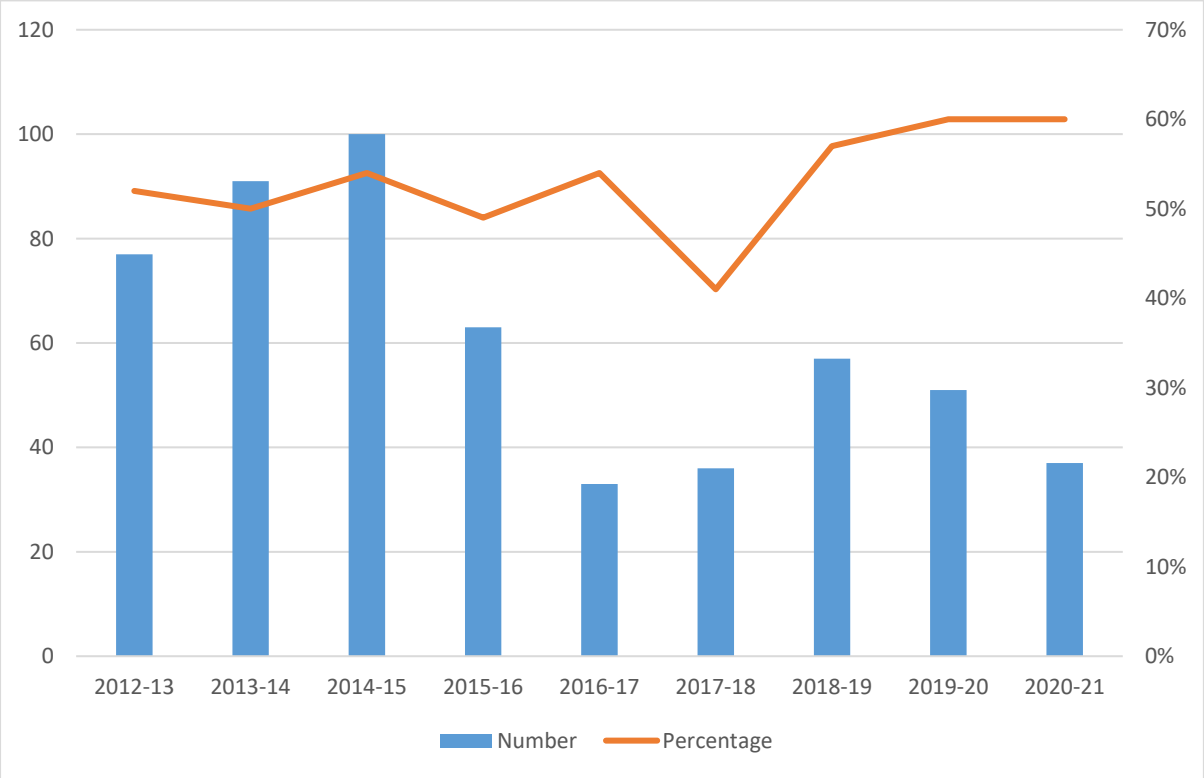
In some circumstances where an admission might be of very short duration, the provision of direct specialist clinical contact might not be as important in terms of provision of care as stays of longer duration.

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 2020-21 the consultant in charge of a young person's care (or RMO) was a child and adolescent specialist in 37 out of the 62 admissions (60%). This compares with 57% in 2019-20, 57% in 2018-19, 41% in 2017-18, 54% in 2016-17, 49% in 2015-16, 54% of admissions in 2014-15, 50% in 2013-14 and 52% in 2012-13 (figure 4a).

In 2020-21 there were a further 14 admissions (23%) 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 2020-21



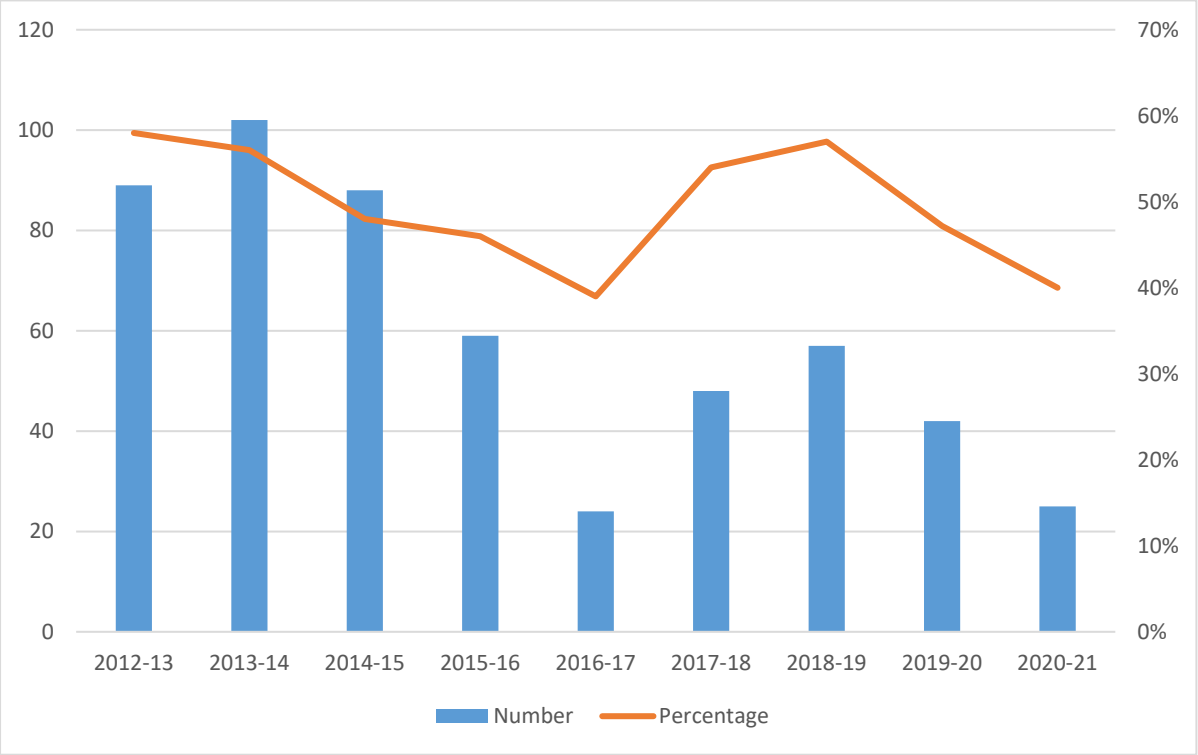
Data is based on the further information provided to the Commission (62 admissions) and reported on annually.

This year, as in previous years, in a large proportion of admissions there was no direct care provided from nurses experienced in working with children and adolescents.

In 2020-21 only 25 out of the 62 admissions (40%) experienced direct nursing care from child and adolescent experienced nurses during their stay. This compares with 47% in 2019-20, 56% in 2018-19, 54% in 2017-18, 39% in 2016-17, 46% in 2015-16, 48% in 2014-15, 56% in 2013-14 and 58% in 2012-13 (figure 4b).

The percentage of admissions where there have been nurses available with relevant CAMHS experience to provide advice to ward staff remains similar to previous years, 49 out of 62 admissions (79%).This compares with 76% in 2019-20, 80% in 2018-19 85% in 2017-18, 84% in 2016-17, 78% in 2015-16, 85% in 2014-15, 80% in 2013-14, and 76% in 2012-13. 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 2020-21



Data is based on the further information provided to the Commission (62 admissions) and reported on annually.

In 2020-21 only 20 out of the 62 admissions (32%) were able to access additional age appropriate therapeutic input. This might be input provided by CAMHS psychologists, CAMHS allied health professionals or family therapists. This compares with 42% in 2019-20, 46% in 2018-19, 41% in 2017-18, 49% in 2016-17, 38% in 2015-16, 59% in 2014-15, 51% in 2013-14 and 88% in 2012-13.

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 eight admissions in which the young person received no input and where no advice was available at all from clinicians specifically trained and experienced in child and adolescent mental health all but one admission occurred in health boards whose CAMHS service does not include everyone under the age of 18 years as a CAMHS patient.

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 remains inconsistent across non-specialist admissions.

Of the 62 admissions that the Commission obtained additional information about, 30 (48%) neither received direct specialist nursing support nor specialist non-medical therapeutic input during their stay. Of these 30 admissions, 18 lasted under one week (48%), four lasted

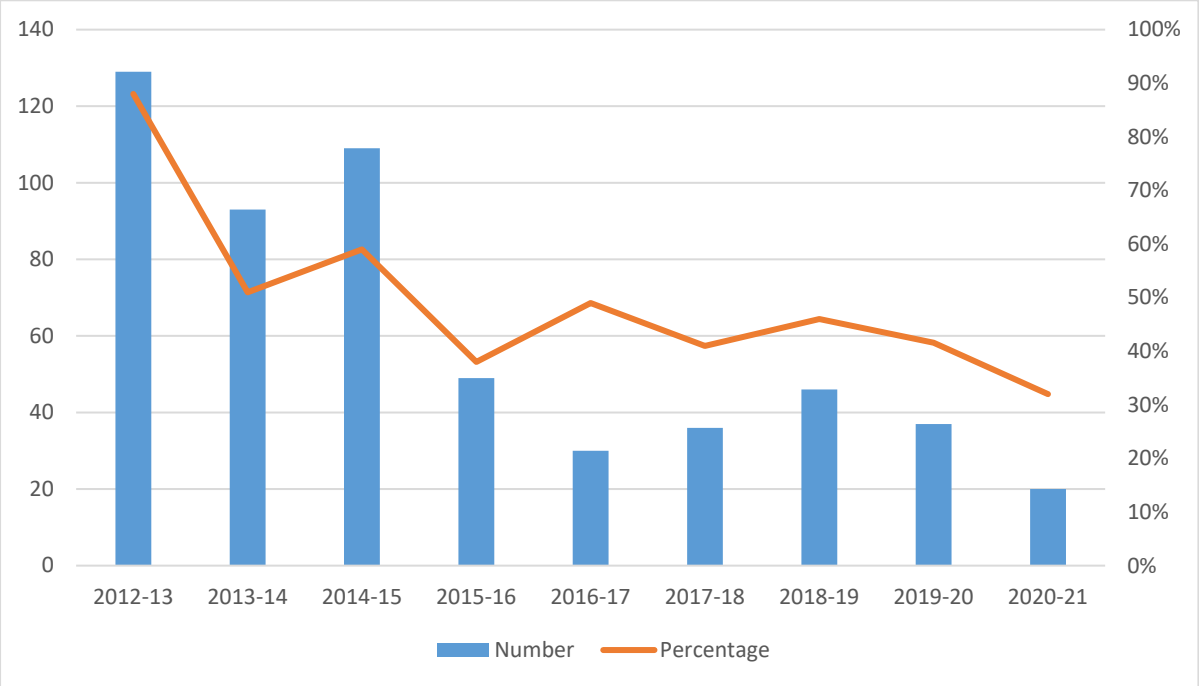
between 8-14 days (13%), and six lasted more than 21 days (20%) including three which lasted over 57 days (10%).

As in previous years, of the 19 admissions which received neither direct specialist nursing or therapeutic input from child and adolescent clinicians and whose RMO or consultant in charge was not a child and adolescent psychiatrist during their hospital stay, 42% related to admissions lasting longer than two weeks and 21% lasted longer than four weeks. 21% of these 19 admissions also required IPCU admission at some point during their hospital stay.

Of the seven admissions involving young people that lasted longer than 28 days and for whom the Commission received additional information about, 72% had either a consultant in charge of their care who was a child specialist or a CAMHS consultant available for advice if needed. Only three of these seven admissions had direct CAMHS nursing provision provided to the admission (43%) and only two (29%) had other age appropriate therapeutic intervention provided.

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 particularly during the pandemic. However given that these figures remain similar to previous years it remains a concern that direct input into inpatient care by nursing staff or other therapeutically trained staff with specialist knowledge and experience in caring for the under 18s is not provided routinely when admissions are longer than a week in duration.

Figure 4c: Other specialist therapeutic care provided 2020-21



Data is based on the further information provided to the Commission (62 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, 2020-21

Table 5: Social work provision for admissions of young people to non-specialist care, 2020-21

	Age 0-15	Age 16-17	All	*%
Young person was looked after and accommodated by the local authority	3	7	10	16%
No information	0	1	1	2%
Young person had access to social work	11	36	47	76%
No information	1	2	3	5%
Total	14	48	62	100%

**Total=62, based on all admissions where further information was provided to the Commission.*

The Commission is particularly concerned about vulnerable groups of individuals, and in reflection of its corporate parenting[15] duties the Commission is interested in the provision of services to care experienced or "looked after" children[16]. 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 increasing evidence that care experienced children and young people experience poorer mental health than their peers 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[17]. The Guidance on Health Assessments for Looked after Children and Young People[18] emphasises that mental health problems for care experienced young people are markedly greater than for their peers in the community.

[15] Corporate Parenting duties are defined by the Children and Young People (Scotland) Act 2014 https://www.gov.scot/policies/looked-after-children/corporate-parenting/#:~:text=The%20Children%20and%20Young%20People,young%20people%20and%20care%20leavers%22

[16] 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.

[17] 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

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

We have been collecting information about young person's admissions to non-specialist wards and whether the young persons 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.

In 2020-21 ten (16%) of the 62 admissions that the Commission received further information on related to admissions of young people who were described as being 'looked after and accommodated'. This compares with 22% of the admissions in 2019-20, 21% in 2018-19, 16% in 2017-18, 13% in 2016-17, 13% in 2015-16 and 13% of young people in 2014-15 (figure 5).

Of the ten admissions of young people this year, seven were admissions of young people aged 16-17 years and three were young people either 15 years or younger. This is similar to previous years where the majority of admissions of young people who were care experienced were 16-17 years old.

The admissions lengths of young people who were care experienced were shorter this year than in previous years. Seven of the admission were seven days or less and the remaining three were over 15 days. Once again, as in previous years, a small number of young people who were care experienced also had a learning disability (this year 20% (two out of the ten)).

Once again as in previous years there was a high level of representation in young people who are care experienced who required IPCU care during their stay. In 2020-21 five out of the ten young care experienced young people who were admitted to a non-specialist environment required IPCU at some point during their admission (50% of admissions of young people who were care experienced). There were fifteen IPCU admissions of young people in 2020-21 and five of these involved young people who were looked after and accommodated (one third of IPCU admissions).

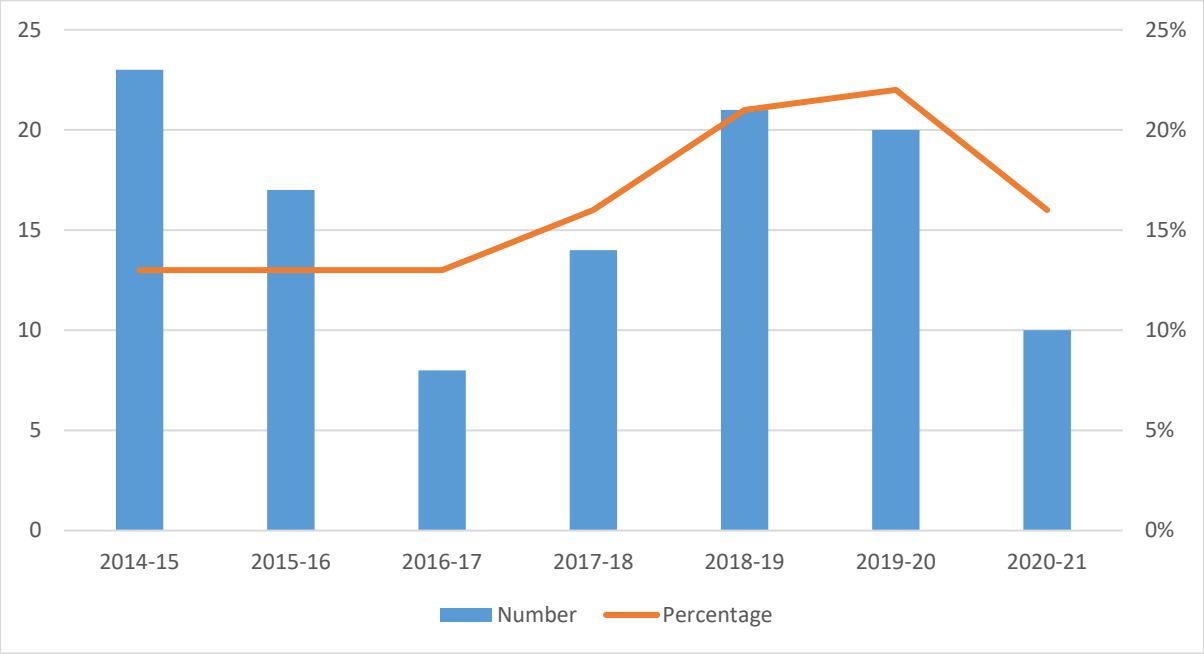
A small number of young people who are looked after by a local authority are admitted to non-specialist wards at a time of crisis and breakdown of their care placement. At times there are substantial concerns about the young person's mental health at this time and these admissions are entirely appropriate. However, the Commission had been told of other occasions when it appears that a lack of suitably available and/or suitably adapting care provision appears to be an 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.

Many of the young people admitted to a non-specialist facility will have had no prior involvement with social work services, but the Commission's 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.

In 2020-21 47 out of the 62 admissions (76%) the Commission obtained further information about confirmed there had been access to a social worker. This compares to 71% in 2019-20, 71% in 2018-19, 64% of the admissions the Commission was given additional information about in 2017-18, 77% in 2016-17, 71% in 2015-16, 74% in 2014-15, 76% in 2013-14, and 74% in 2012-13.

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

Figure 5: Admissions involving care experienced young people 2014-21



Data is based on the further information provided to the Commission (62 admissions in 2020-21) and reported on annually.

Supervision of young people admitted to non-specialist care 2020-21

The Commission asked for specific information about the supervision arrangements for young people admitted to 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.

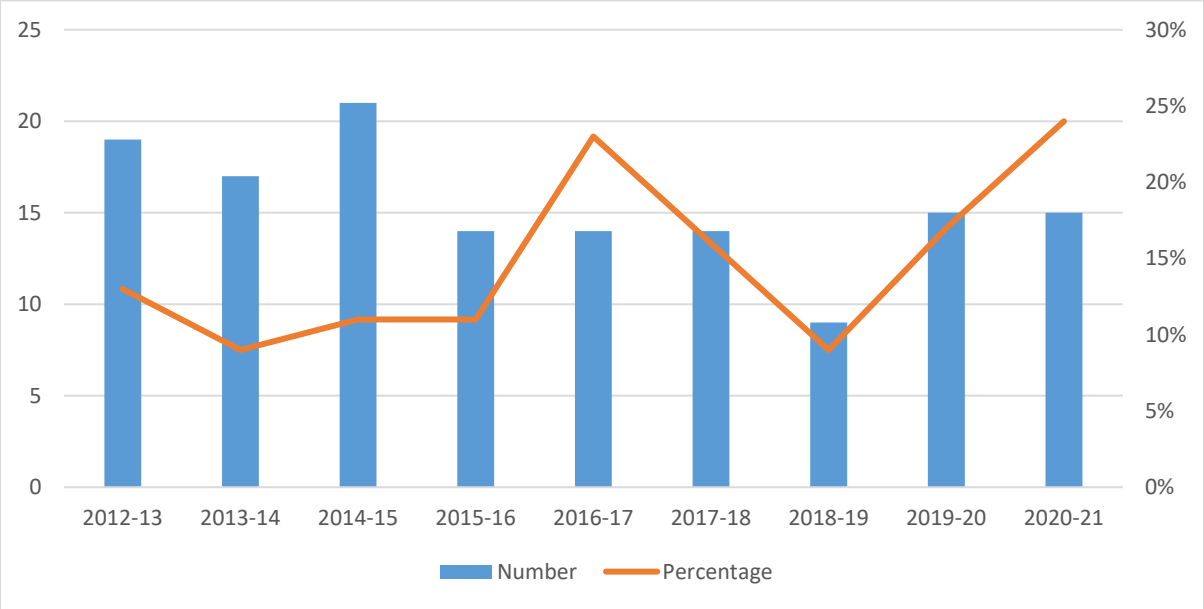
Table 6: Supervision of young people admitted to non-specialist care, 2020-21

Supervision arrangements	**Age 0-15**	**Age 16-17**	**All**	**%****
Transferred to an IPCU or locked ward during the admission*	<5	11	15	24%
Accommodated in a single room throughout the admission	12	42	54	87%
Nursed under an enhanced level of observation	12	34	46	74%
Enhanced observation because of ward policy	12	26	38	61%
Enhanced observation following an individual assessment of the young person	10	22	32	52%
Total**	14	48	62	100%

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

***Total=62, 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 2012-21



Data is based on the further information provided to the Commission (62 admissions in 2020-21) and reported on annually.

This year 15 of the 62 admissions (24%) 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 17% of admissions in 2019-20, 9% of admissions in 2018-19, 16% of admissions in 2017-18, 23% of admissions in 2016-17, 11 % in 2015-16, 11% in 2014-15, 9% of admissions in 2013-14 and 13% of admissions in 2012-13(figure 6).

In 2020-21 four young people under the age of 16 were admitted to an IPCU (26% of IPCU admissions). In previous years the proportion of the young people admitted to an IPCU or locked ward under the age of 16 had been around 25% of those admitted to an IPCU and in 2017-18 this figure rose to 36%.[19]

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.

[19] Mental Welfare Commission for Scotland: Young Person's Monitoring report 2017-18 https://www.mwcscot.org.uk/node/905

The figures the Commission reports 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 recent years the Commission has highlighted the importance that the lack of provision of IPCU facilities has 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 and funding has been allocated to each regional specialist adolescent unit to develop IPCU provision.

However, given the fact that many young people who are admitted to IPCU facilities may have a learning disability and often may be care experienced, it is important that any work to develop IPCU facilities is properly supported and co-ordinated nationally and properly integrated with the ongoing work to develop pathways and operating procedures for the NSAIS and the national inpatient learning disability provision. Also, given the challenge of providing appropriate and comprehensive facilities across the country for small numbers of young people with intense need at any one time and given the importance of ensuring there are appropriate safeguards around the use of seclusion and/or restraint due to the human rights concerns associated with their use, it is important that any IPCU provision is developed using a rights based approach to ensure that the comprehensive needs of any child or young person remain paramount in any service development.

Other care provision for young people, 2020-21

Table 7: Other care provision for young people, 2020-21

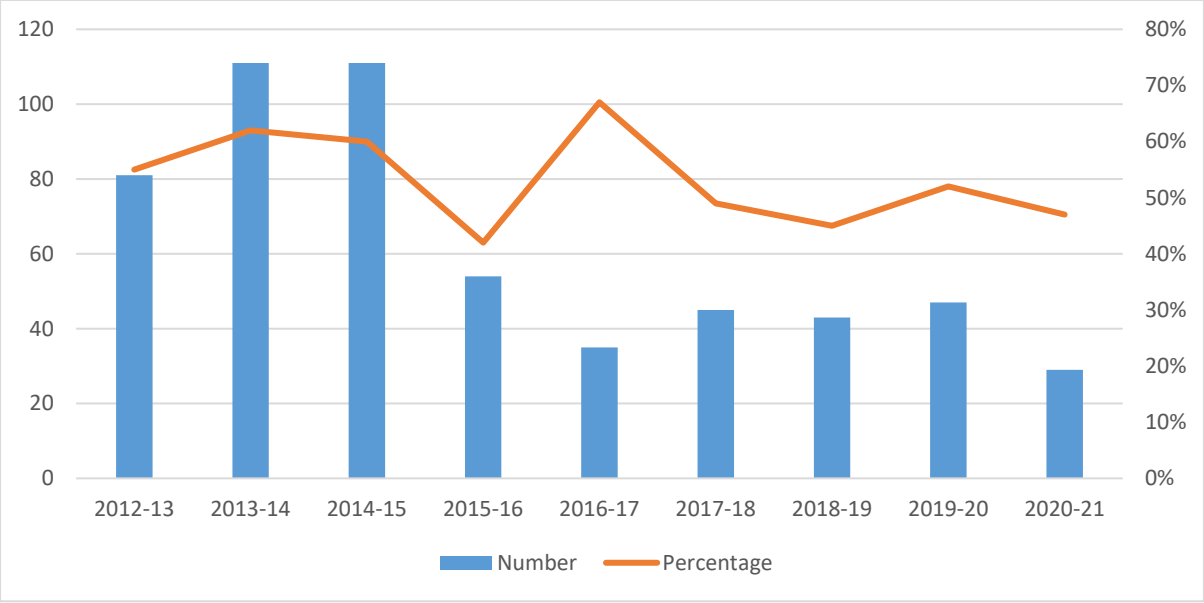
	Age 0-15	Age 16-17	All	*%
Access to age appropriate recreational activities	9	20	29	47%
Appropriate education was provided	0	6	6	10%
Access to advocacy service	10	38	48	77%
Has access to specialist advocacy service	5	3	8	13%
Total*	14	48	62	100%

**Total =62 admissions where further information provide to the Commission*

As part of its monitoring the Commission asked 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 2020-21 the proportion of admissions where a young person was described as having access to age-appropriate recreational activity remained at similar levels (29 out of 62 admissions) 47%. This compares to 52% of admissions in 2019-20, 47% in 2018-19, 49% in 2017-18, 67% in 2016-17, 42% in 2015-16, 60 % in 2014-15, 62% in 2013-14 and 55% in 2012-13.

Figure 7: Access to age appropriate activity 2020-21



Data is based on the further information provided to the Commission (62 admissions) and reported on annually.

Every year the Commission asks for information about the activities that young people are able to access while they were receiving care and treatment as in-patients. Normally many young people are reported to have access to electronic games, their phones and to music and DVDs. Some young people in the past have been reported to be able to access gym facilities. Due to social distancing related to lockdown restrictions some access to activities were curtailed. In previous reports the Commission had 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[20].

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 its monitoring process the Commission enquired 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 2020-21 78% of young people (48 of the 62 admissions in which further information was provided to the Commission had access to advocacy. This compares with 70% of young people in 2019-20, 76% of young people in 2018-19, 67% in 2017-18, 61% in 2016-17, 65% in 2015-16, 72% in 2014-15, 65% in 2013-14 and 70% in 2012-13.

Of the young people who had access to advocacy during the admission, eight of the 62 admissions (13%) had access to advocacy which specialised in the particular needs and rights of young people. This result is lower than recent years (2019-20 data of 20% of admissions, 18% in 2017-18, 20% in 2016-17, 17% in 2015-16 and 29% in 2014-15). 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 wherever they are admitted, whether informal or detained or whether from a care experienced background or not. It may be that during a very brief admission there is no time to involve advocacy to support a young person. From gathering information from hospital wards during the pandemic lockdowns the Commission learned that many advocacy services were making use of technology to undertake virtual meetings with children and young people once this was available. Due to the time required to develop this facility the findings of lower levels of advocacy support this year may reflect that the impact that social distancing measures had on visiting people in hospital. The findings from the monitoring project described in 2016, however, raised concerns about the accessibility of advocacy supports during young people's admissions to non-specialist wards. In last year's report the Commission recommended that those who have duties to fund and provide advocacy services for people with mental ill health should review the availability of specialist advocacy for children and young people. We are aware that agencies such as Who Cares Scotland are commissioned to provide advocacy for

[20] Young Person Monitoring 2015-16, October 2016.
https://www.mwcscot.org.uk/node/904

children and young people who are care experienced in many areas across the country but that, in contrast, specialist advocacy services for children and young people who have mental health difficulties is not provided comprehensively. Given the impact of the pandemic on activity and priorities the Commission repeats the recommendation again this year that the provision of specialist advocacy services for children and young people with mental ill health should be reviewed and prioritised.

Recommendation 2

Health board managers with a duty to fund and provide advocacy services for individuals with mental health difficulties in their area should ensure 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.

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."[21] As part of its monitoring activity, the Commission asked 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, the Commission asked whether education has been provided.

In 2020-21 nineteen out of the 62 admissions (31%) in which further information was provided to the Commission were reported to have had a discussion regarding access to education during their inpatient stay 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 where education was discussed, five related to young people aged 15 years and younger and therefore of statutory school age. Of the nineteen admissions in which education was discussed six young people were provided with educational materials during the course of their admission. All were 16 or 17 years old.

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. Of the five young people with whom education was discussed but none was provided four of the five admissions were under two weeks in duration but one extended beyond four weeks. In 2020-21 there were 17 admissions which related to young people 15 years and younger. In only five of these was education discussed. One of these admissions lasted longer than seven weeks and no education was provided.

[21] UN Committee of the rights of the child, general comment no 10 (2007) Children's rights in juvenile justice, para 89.

We are aware from previous reports[22] 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. Last year the Commission made a recommendation regarding education and repeats it here.

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.

[22] Visits to young people who use mental health services: Report from our visits to young people using in-patient and community mental health services in Scotland 2009 (2010) https://web.archive.org/web/20180705090414/http://www.mwcscot.org.uk/media/53171/CAMHS_report_2010.pdf

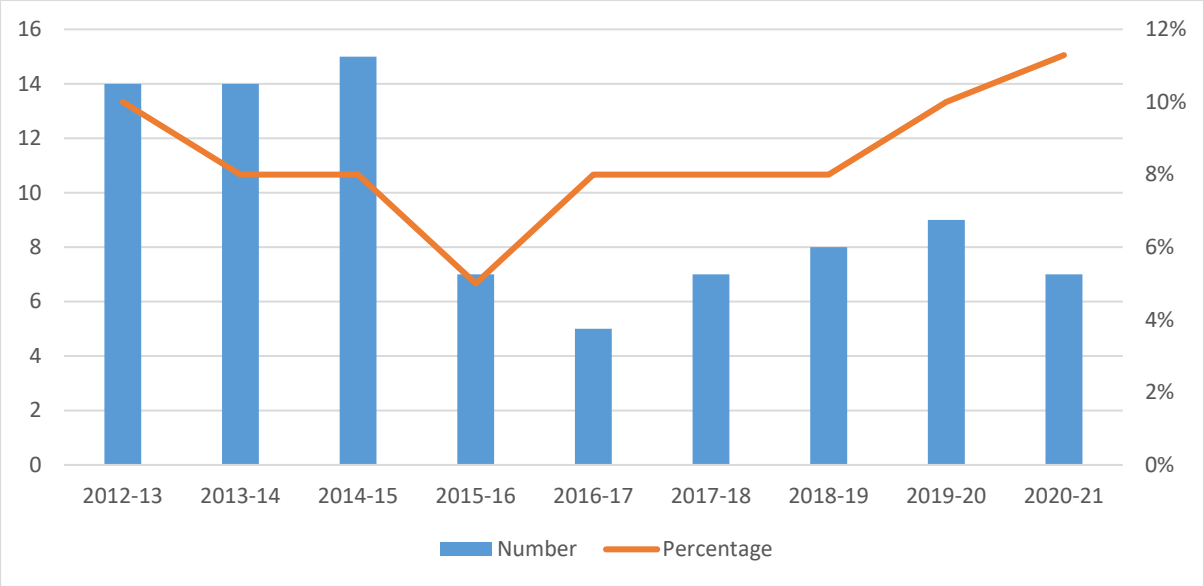
Young people with a learning disability 2020-21

Table 8: Admissions involving a young person with a learning disability 2020-21

	Age 0-15	Age 16-17	All	*%
Young person has a learning disability	<5	6	7	11%
Total *	14	48	62	100%

**Total = 62 admissions where further information was provided to the Commission.*

Figure 8: Admissions involving a young person with a learning disability 2012-21



Data is based on the further information provided to the Commission (62 admissions in 2020-21) 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 2020-21 was seven out of 62 admissions (11%). This is similar to previous years in terms of percentages: 10% in 2019-20. 8% in 2018-19, 2017-18 and 2016-17, 5% in 2015-16; 8% in 2014-15 and 2013-14 and 10% in 2012-13.

In previous years children and young people who have a learning disability have made up a substantial part of the admission which are lengthy. Last year a third of admissions of individuals with a learning disability were more than five weeks in length. In 2020-21 of the seven young people with a learning disability who were admitted to non-specialist care, four were admitted for less than one week (57%) and two were admitted for over four weeks (29%).

Unlike previous years where proportions were higher, only one of the fifteen admissions (7%) to an adult IPCU in 2020-21 involved children or young people with a learning disability. In 2020-21 two of the ten admissions of children and young people who were care experienced also had a learning disability (20%) which is slightly lower than in recent years.

Age and gender 2020-21

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 2020-21 there were six children and young people aged 14 years or younger who were admitted to a non-specialist environment. Two thirds of these were admitted to a paediatric ward in the local hospital.

In 2020-21 the proportion of 16 and 17 year old young people admitted to a non-specialist environment was comparable with previous years (66 out of 86 admissions in total, 77%). In 2019-20 the proportion of 16 and 17 year old young people admitted was 76%, 75% in 2018-19, 72% in 2017-18, 82% in 2016-17 and in 2015-16, 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[23].

Table 9: Age of young person by gender 2017-21

	2017-18			2018-19			2019-20			2020-21		
Age at last birthday (years)	**F**	**M**	**Total**	**F**	**M**	**Total**	**F**	**M**	**Total**	**F**	**M**	**Total**
15	9	3	12	10	<5	13	5	6	11	8	<5	11
16	12	10	22	16	8	24	17	3	20	18	9	27
17	20	20	40	28	24	52	27	20	47	26	16	42
Total*	**49**	**36**	**85**	**62**	**39**	**101**	**56**	**32**	**88**	**57**	**29**	**86**

**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. In 2020-21 there were six young people aged under 15 admitted to non-specialist wards.*
F=Female M=Male

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

Figure 9a: Young people admitted to non-specialist wards by gender (number of individuals), by year 2008-21

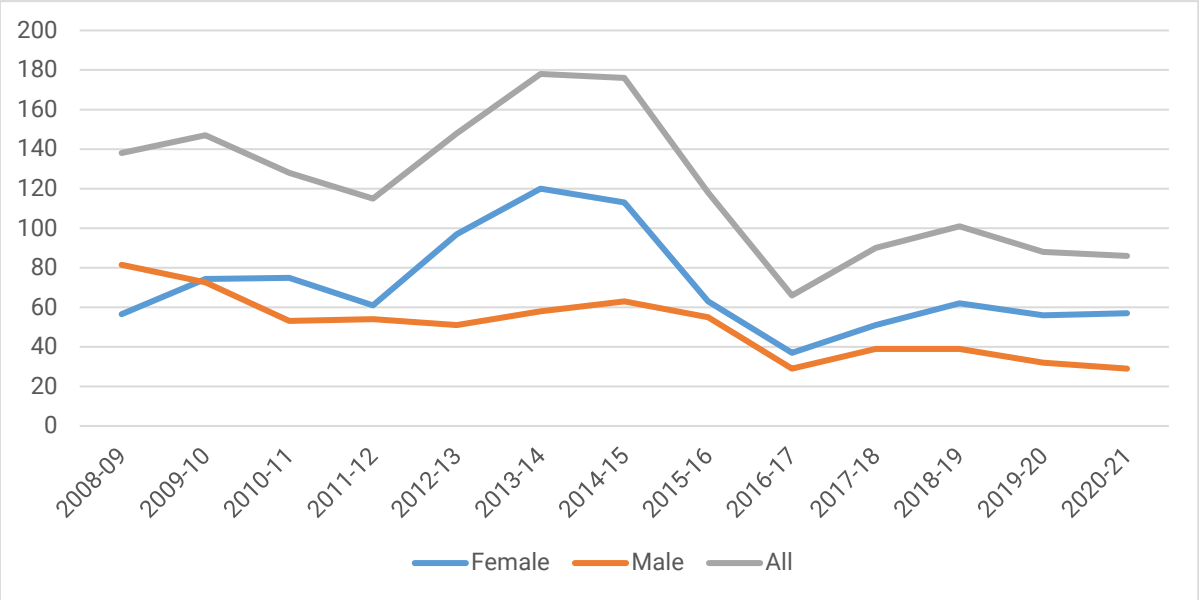
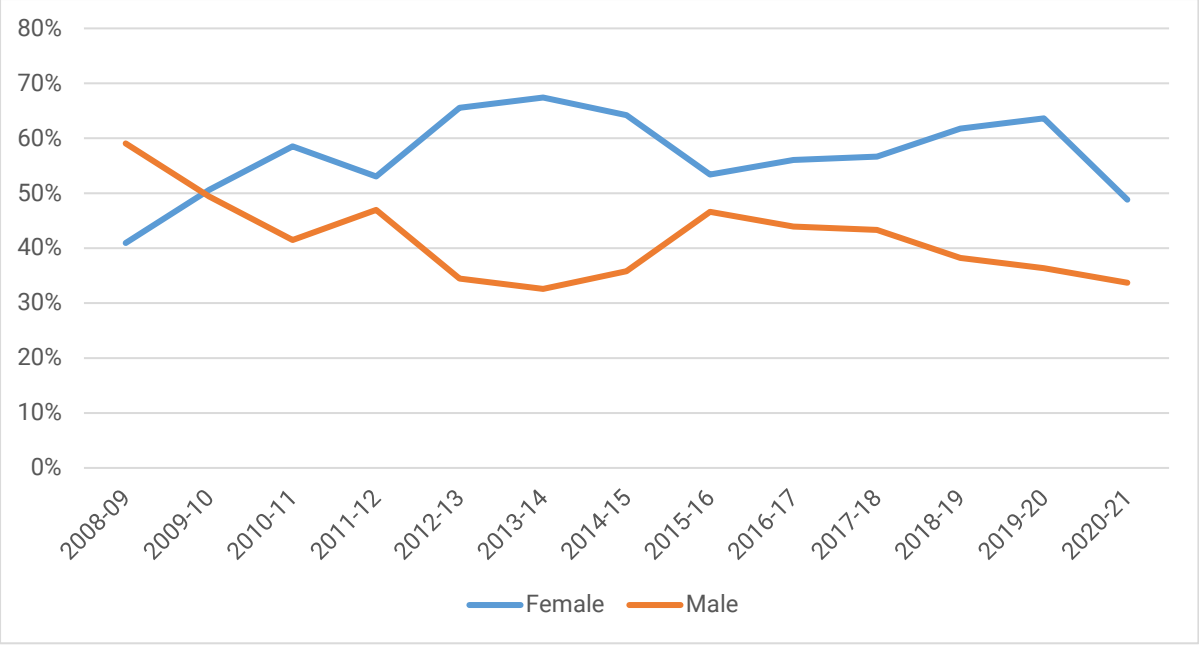


Figure 9b: Young people admitted to non-specialist wards by gender (%), by year 2008-21



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