mentalwelfare commission for scotland

dignity & rights ethical tre respect ca & equality

VISIT AND MONITORING REPORT

Visits to young people in secure care settings

Joint Mental Welfare Commission and Care Inspecorate visits to young people in secure care settings

The Mental Welfare Commission- Who We Are and What We Do

Our aim

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

Why we do this

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

Who we are

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

Our values

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

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

What we do

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

- We find out whether individual care and treatment is in line with the law and good practice

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

INTRODUCTION

The Commission visited young people in Scottish secure care settings who had identified mental health difficulties and who may be supported by or referred for assessment to specialist Child and Adolescent Mental Health Services (CAMHS). The visits were undertaken jointly with the Care Inspectorate and were completed in early 2014.

WHY WE VISITED

The Commission had been in discussions with the Care Inspectorate about the possibility of carrying out joint visits to areas where both organisations identified similar concerns and could see merit in a joint approach. This approach supports the duty of co-operation, as set out in the Public Services Reform (Scotland) Act 2010 section 114.[1] The area of secure care for young people was identified as a priority for such an approach as these young people are particularly vulnerable and their placement in a secure care environment places clear restrictions on their liberty.

The criteria for admission to secure care as detailed in S83(6) of the Children's Hearing (Scotland) Act 2011[2] are:

- The young person has previously absconded and is likely to abscond again and, if the young person were to abscond, it is likely that their physical, mental or moral welfare would be at risk, or
- The young person is likely to engage in self harming conduct or
- The young person is likely to cause injury to another person.

The visiting team from both the Care Inspectorate and the Commission agreed that the Care Inspectorate visitors would follow the format of their usual inspection visits and the Commission visitors would concentrate on the mental health care of the young people in the secure care settings.

For the purposes of this report only the Commission perspective will be documented as it is proposed that a joint report from the two organisations will be published in due course.

[1] Public Services Reform (Scotland)Act 2010 http://www.legislation.gov.uk/asp/2010/8/section/114
[2] Children's Hearing (scotland) Act 2011 http://www.legislation.gov.uk/asp/2011/1/data.pdf

THE POLICY CONTEXT

Since the early 2000s the need for improved mental health service for young people has been part of the strategic policy context. The mental health needs of looked after children have been recognised and well documented. It has been highlighted that young people in local authority care settings have a higher rate of mental health difficulties than the wider population[3]. This has been commented upon in the following documents:

- Scottish Needs Assessment Programme (SNAP) Report on child and adolescent mental health 2003[4]
- The mental health of children and young people: a framework for promotion, prevention and care 2005[5]
- The Scottish mental health strategy; Delivering for Mental Health 2006[6]
- Getting it right for every child 2006[7] (GIRFEC)
- The health of looked after and accommodated children and young people in Scotland 2006[8]
- Looked After Children and Young People: We Can and Must Do Better 2007[9].
- These are Our Bairns (2008)[10]

In 2009 the Scottish Government issued Guidance on health assessments for looked after children[11] (CEL 16). This was to clarify the implementation of action 15 of Looked After Children and Young People: We Can and Must Do Better 2007[9], that "Each NHS Board will assess the physical, mental and emotional health needs of all looked after children and young people for whom they have responsibility and put in place appropriate measures which take account of these assessments". In this

[3] Psychiatric disorder among British children looked after by local authorities, comparison with children living in private households. Ford et al. British Journal of Psychiatry 2007, 190, pp319-125.

[4] SNAP report, PUBLIC HEALTH INSTITUTE OF SCOTLAND (2003) Scottish Needs Assessment Programme (SNAP). NHS Scotland.

[5] The mental health of children and Young People: A framework for promotion, Prevention and Care, http://www.scotland.gov.uk/Resource/Doc/77843/0018686.pdf

[6] Delivering for Mental Health, http://www.scotland.gov.uk/Resource/Doc/157157/0042281.pdf

[7] Getting it right for every child 2006[7] (GIRFEC) http://www.scotland.gov.uk/Topics/People/Young-People/gettingitright

[8] The health of looked after and accommodated children and young people in Scotland 2006,http://www.scotland.gov.uk/Resource/Doc/128931/0030711.pdf

[9]Looked After Children and Young People: We Can and Must Do Better 2007, http://www.scotland.gov.uk/Publications/2007/01/15084446/6

[10] These are Our Bairns: A guide for community planning partnerships and being a good corporate parent 2008, http://www.scotland.gov.uk/Resource/Doc/236882/0064989.pdf

[11] Guidance on Health Assessments for Looked After Children in Scotland 2009 (CEL 16), http://www.sehd.scot.nhs.uk/mels/CEL2009_16.pdf

guidance there is clarity for health boards around ensuring mental health assessments are carried out and that responsibility lies with the person carrying out the assessment to ensure the resultant care plan is delivered. There is also reference made to Looked After Children Regulations(1996) updated (2009)[12] which stipulates that local authorities have responsibility for ensuring all background, health and mental and emotional development information on any child they are placing in residential care is given to the unit manager in writing. Part IX of the regulations state that the placing local authority has a responsibility to inform the health board local to the residential placement of the child or young person's placement.

In 2012 the Scottish Government emphasised their focus on this vulnerable group of young people in commitment 9 in its latest mental health strategy[13]. Commitment 9 specifically talks about the development of a Child and Adolescent Mental Health Services (CAMHS) balanced scorecard[14] to provide clearer information around the specialist mental health consultation and referral activity in general and importantly, includes looked after children. The clarity of the issues highlighted by the score card will inform future CAMHS development and will ensure that the needs of the looked after children population are included in these developments. In conjunction with this work during 2013, through the Protection Through Partnership Programme, the Scottish Government held a series of seminars for everyone involved in the life of looked after children, focussing on self harm and suicide in this vulnerable group. The intention was to develop further staff training in this area.

It is of note that the Royal College of Paediatrics and Child Health in conjunction with a number of other Royal Colleges and Faculties published healthcare standards for children and young people in secure settings in 2013[15]. These have been widely adopted in England and Wales but not in Scotland. The standards highlight the importance of assessing mental health needs as early as possible when children and young people are received into a secure care setting and of the necessity of ensuring appropriate access to healthcare beds when required. Scotland has developed its own guidance for health assessments for looked after children[16]. In regard to mental and emotional health the report refers to a 2004 report which looked at a total of 242 young people in local authority care highlighting that 45% of these young people were diagnosed with a mental disorder and 16% had been assessed as having emotional disorders. The report stresses the need to identify mental and emotional health needs as early as possible in a young person's care journey.

---

[12] Looked After Children (Scotland) Regulations 2009, http://www.legislation.gov.uk/ssi/2009/210/part/IX/made

[13] Mental health Strategy for Scotland; 2012-2015,pp22-23. Can be downloaded from http://www.scotland.gov.uk/Resource/0039/00398762.pdf

[14] CAMHS balanced scorecard: http://www.isdscotland.org/Health-Topics/Quality-Indicators/National-Benchmarking-Project/Child-and-Adolescent-Mental-Health/Balanced-Scorecard-Consultation-Feb-2011.pdf

[15] Healthcare Standards for Children and Young People in Secure Care Settings 2013, www.rcpch.ac.uk/cypss

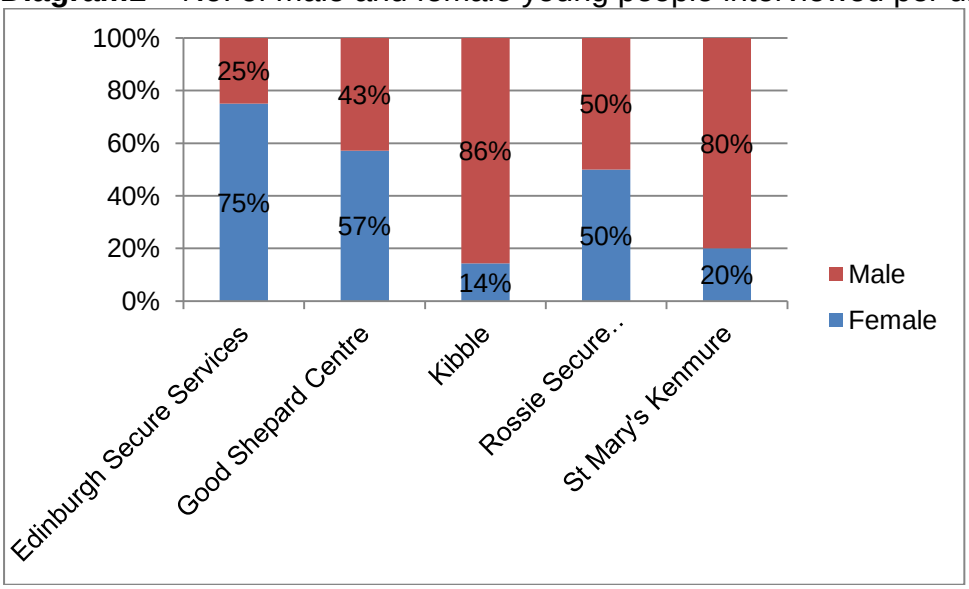
[16] Guidance on Health Assessments for Looked After Children and Young People 2014, http://www.scotland.gov.uk/Publications/2014/05/9977

Being aware of the vulnerability of this group of young people and the anecdotal evidence of secure services not feeling supported by CAMHS, one of our aims when visiting was to establish what CAMHS support was available to the young people directly as well as to staff. Of particular importance to us was to find out the perception of the young people of the support they did receive and how this impacted on their secure care stay.

HOW WE CARRIED OUT THE VISITS

There are 5 secure care establishments for young people in Scotland. For this themed visit we visited all 5 sites. At the time of our visit 65 young people were resident across the units. We spoke to 27 of the young people and examined an additional 8 records of young people who did not want to speak to us but who fitted our criteria. We completed a staff questionnaire at each site and, in addition, spoke to staff about each individual young person about whom we had gathered information.

Diagram1 – No. of male and female young people interviewed per unit



Prior to the visits Commission staff met with Care Inspectorate staff on 3 occasions to plan the visits and ensure both visit teams were able to carry out their particular functions with minimal disruption to the young people and services.

The Commission visit team devised questionnaires for direct contact with the young people as well as questions for staff about an individual young person. Some information was gathered from the young person's case records. We also developed a questionnaire for managers that explored the overall care and support provided to meet the mental health care needs of the young people in the units.

Prior to the visits taking place, a joint letter from ourselves and the Care Inspectorate was sent to all units explaining the planned visits. To ensure clarity for all unit

managers, representatives from the Commission and the Care Inspectorate held a meeting to talk through the planned visits and answer any queries.

Following the visits we made sure that any outstanding questions or concerns we had noted during the visit about a young person were taken forward with the unit staff and other agencies if necessary. This happened in 8 cases.

WHAT WE EXAMINED

When speaking with the young people themselves we were keen to hear about their overall contact with mental health supports, both prior to being received into secure care and while they were in placement. We did this to gain a clearer understanding of how they perceived the continuity of their mental health care and to hear from the young people about their understanding and participation in decisions regarding their mental health care. We were also interested to hear whether they had family and carers whose views were also considered in care decision making.

We also took the opportunity to ask staff how they shared information about a young person's mental health needs and care when they transitioned into and out of secure care settings. This led onto us looking at how information on a young person's mental health issues were communicated with the units from external agencies and then how this information was shared with care staff.

The visit team looked at crisis management and how medication, observation and restraint were utilised in each young person's care to see whether this was an appropriate response to their mental health or general behaviour presentation. In this context we asked young people what their understanding was about the use of these interventions as well as what supports they perceived were in place within the units for them in times of crisis.

An area of particular interest was professional mental health staff input to the young people's care whether directly or in support of care staff. We asked about care staff's understanding of mental health issues and any training they had either in-house or formal external training that helped them support young people with mental health issues in their care. Staff and young people were given the opportunity to tell the visit team if there were any supports they felt were working particularly well and if there were any suggestions they had for improvements to be made. In this context we also asked how young people perceived the support of CAMHS when they were involved.

We recognise the importance of discharge planning to ensure clarity for young people and their carers. With this in mind we looked at discharge planning and how services involved the young people as well as external agencies in their discharge processes.

KEY MESSAGES

1. Young peoples' understanding of why they were in secure care was consistent with the criteria for admission to secure care.

2. Young people may be in secure care settings for short periods of time but can experience a number of moves prior to admission to secure care, and this can impact on the provision of mental health services.
3. It is important to ensure young people are provided with continuity of care when they move into and out of secure care, or if they move between secure care services.
4. Sharing information about a young person between unit staff and any professionals providing care and treatment brings a number of benefits and can also assist young person/staff interactions in a positive way.
5. We found that young people were not as fully involved in their mental health care as they could be. The importance of the young person participating as fully as possible in any decisions being made about their mental health care and support needs to be prioritised on a more consistent basis.
6. Young people valued the supports available within units at times of crisis.
7. Young people valued the mental health care and support provided while in units, both by unit dedicated mental health staff and by CAMH services.
8. It is important that young people know how services to support their mental health care needs will be provided post discharge, and that wherever possible, they know and have had some contact with workers who will provide this support.
9. All young people in secure care settings should have access to independent advocacy services.

FINDINGS AND RECOMMENDATIONS

THEME 1: Journey into secure care and reasons for admission to secure care.

Key Messages:

Young people's understanding of why they were in secure care was consistent with the criteria for admission.

Young people may be in secure care settings for short periods of time but can experience a number of moves prior to admission to secure care, and this can impact on the provision of mental health services.

What we looked at

We asked all the young people what their understanding was about why they had been admitted to secure care.

What we expected to find

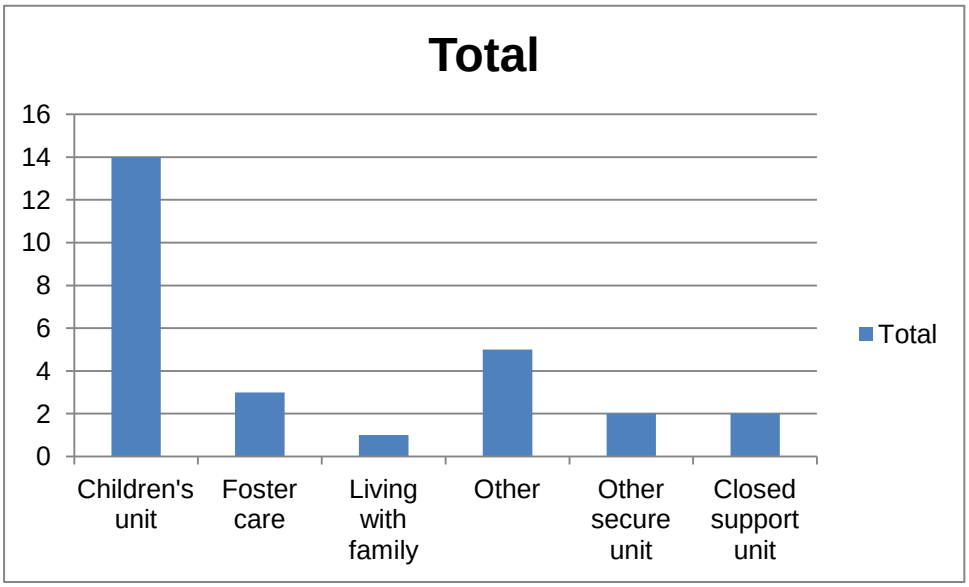
We expected to find that young people understood the reasons why they were placed in secure care, and that their understanding was consistent with the criteria for secure care placement.

What we found

Young people explained to us in their own words what their understanding was of why they were in secure care. They were all able to give us a clear explanation of why they felt they had been admitted. No-one referred to their mental health difficulties as the primary reason why they thought admission had been deemed necessary. Thirteen young people spoke about putting themselves, and sometimes other people, at risk, because of their behaviour. Many of them also associated risks with factors such as absconding from previous placements, drug misuse, and/or self harming behaviour. Nine young people spoke about contact with the criminal justice service, for example, a court having sent them, having been convicted of offences, or having been charged by the police. All the young people were clear that there were specific reasons for being admitted to secure care, and their explanations were consistent with the criteria for admission in the children's hearing legislation.

When looking at the details of the 27 young people we interviewed we were struck by the complexity of some of their journeys into secure care. Fourteen of the 27(52%) had been resident in a residential unit immediately prior to secure unit admission, only 4 (15%) had been previously living in their homes or in foster care, 4 (15%) young people had been resident in either another of Scotland's secure units or Close Support Units and 5 (18%) had been resident in either medium secure forensic units, general adult psychiatric wards or residential schools.

Diagram 2 – Residency prior to secure care.



A sizeable minority of young people had been in secure care previously (9, 33%) and the previous secure unit was not necesarily the unit in which they were currently placed.

We did not to go into detail about the precise pathway of the young persons' journey into secure care and the number of transitions and changes in placement that had occurred along the way. We did try to identify, however, the region from which a young person originated and compare that with the region in which the secure unit in which they were currently placed. Most secure units are concentrated around the central belt of Scotland but receive young people from all over Scotland and parts of England. We were interested in this question because of the impact that moves might have on the young person and on social work and mental health services attempting to provide continuity and consistency of care. Gathering this data proved difficult largely because of the number of moves that any young person could have experienced prior to their admission to secure care and the wide geographical spread over which these transitions took place. We found that a small minority of young people who had been placed in Scottish secure units had come from England and these, together with young people who had been placed in secure care away from their original health board area on this admission, comprised nearly half of the total (13/27, 48%).

Transitions represent challenges to services in providing consistency for the young person at the time of and following admission. They can also generate particular obstacles in discharge planning on those occasions when the young person is in need of specialist services that a Health Board is required to fund. An example of this can be when a young person is assessed as requiring placement in a medium secure forensic facility, which can only be accessed in England at the present time. In these cases identifying the Responsible Commissioner is required prior to any commissioning of services and we were told that this can be a complex process at times. There has been recent Scottish Government guidance on how to establish the Responsible Commissioner for Health Boards which states clearly that this process should not disrupt timely treatment for an individual.[17]As a consequence, any lack of agreement about which Health Board is responsible for commissioning services for a young person should not unduly disrupt the young person's mental health care.

THEME 2: Contact with mental health supports prior to being received into secure care, and while in the placement.

Key message: It is important to ensure young people are offered continuity of care when they move into secure care, or if they move between services on transition.

What we looked at

[17] Esatblishing the Responsible Commissioner: Guidance and Directions for Health Boards. March 2013.CEL 067 http://www.sehd.scot.nhs.uk/mels/CEL2013_06.pdf

We asked all the young people we met if they had been in contact with CAMHS before their admission, and, if so, if this contact had continued. If contact had not continued we asked if they understood why not

We also asked staff the same questions, to clarify if there had been CAMHS involvement with the 8 young people who did not want to meet us.

What we expected to find

A number of reports and research studies have looked at the mental health needs of looked after children, and of young people in secure care. These have consistently highlighted that young people in residential care have a higher rate of mental health difficulties and diagnosable mental health problems than in the wider population. We therefore expected to find that a significant proportion of the young people in secure care units at the time we visited were in contact with CAMHS before admission.

Young people should not be disadvantaged in relation to having access to mental health care and treatment if they have been admitted to secure care. We expected to find a strong emphasis on ensuring consistency and continuity of care where services had been provided to meet identified mental health needs prior to admission. We also expected to see that young people who were not receiving support from CAMHS prior to admission had access to a CAMH service where appropriate, and that secure care units had arrangements in place with their local CAMHS to achieve this.

What we found

Thirty five young people were identified to us as either having a diagnosable mental health disorder or were in follow-up from CAMHS for mental health difficulties. CAMHS involvement is a major part of the ongoing care package for this group of young people. We were able to interview and gather further information about their experience of receiving support for their difficulties directly from 27 of these young people.

Of the 27 young people we spoke with the number who reported to have had contact with CAMHS immediately prior to admission was 22 (81%). A small number of young people had an identified mental health disorder and had had CAMHS contact in the past but had been discharged prior to their secure placement and were no longer in follow up by CAMHS . Following admission, the number of young people either in contact or referred to CAMHS was 25 (93%). Of these young people, 23 (85%) knew that unit staff were also in contact with CAMH services. The number of young people who had experienced a transition from one CAMHS service to another during the period of admission was 15 (56%). These included 6 young people (22%) who were receiving CAMHS input both from their home area CAMHS service and from the CAMH service in the secure unit's health board area. This proportion of young people experiencing transition of their mental health care from one service to another

appears large although, given the geographical relocation that can occur upon secure unit placement, it is not suprising. We did not look at the proceses of transition for these young people in more detail but in our review of cases we noted several examples of good transition arrangements whereby the home CAMHS team remained involved in the young person's care until it was clear that the young person would not return to that area and to their care in the future. We did however, observe difficulties with the transition process at times and this was also an area of concern raised by a number of secure unit staff during our visits.

Example of complexity of services trying to ensure consistency and continuity of care in the face of geographical disclocation.

We were told about a young person who was placed in a secure unit far removed from their home area and from their existing CAMHS team. The young person required ongoing mental health care from CAMHS on a *routine basis but the home area CAMHS team could not undertake this role due to the distance involved. As a consequence a referral was made for the young person to the CAMHS team in the secure unit's area. However, whilst the secure unit area CAMHS team were able to provide emergency care for the young person, they were reluctant to accept referral for routine ongoing care until it was clear that the young person would be remaining in the secure unit for a period of time. At the same time, the Social Worker involved in the case could not make recommendations to the Children's Panel about the duration and appropriateness of the young person's placement in the secure unit until there was a greater understanding of the young person's needs. A fuller understanding of the young person's needs could not be attained without additional CAMHS input.*

Our review found that all five secure units are able to access CAMHS from the local Health Board area and all five units are able to access CAMHS for emergencies.

All secure units reported some experience of accessing CAMHS located out-with their health board area but the arrangements for how this was achieved varied across the secure units. Access to CAMHS on a routine basis frequently took the form of both consultation meetings held on a regular basis with unit staff and/or individual contact with the young person by CAMHS clinicians based on the identified needs of the young person.

Overall, when asked, the Unit staff described the accessibility of CAMH services differently and said that accessibility of services for young people could change over time.

"At present it is working well. It can be difficult at times as it is not always available. It's a very busy service."

" At times it is hard to identify who will be responsible for care on an ongoing basis."

“it can depend on cross charging/commissioning arrangements between health boards.”

One unit described the local CAMH Service as “accessible” and valued the regular contact of CAMHS through consultation. However, the same unit also described drawbacks of the consultation model in use because young people could not be referred to the full CAMH service until the young person had been discussed at the consultation meeting first. This requirement was felt to delay timely access on occassion to more in-depth CAMHS input for some young people.

One secure unit described high levels of contact with the local CAMHS Looked After and Accommodated Children’s (LAAC) nurse citing communication about young people in the unit’s care occurring several times a week by telephone or email. Another service explained that when a particular specialist CAMH service was involved with a young person in addition to the local CAMHS, the specialist CAMHS involvement had helped ensure the local CAMH service was “prompt and regular” which had been a problem in the past.

“ They are very accessible and will discuss every admission. They also facilitate links with out of area CAMHS teams”

A closely associated topic to the question of perceived availability of CAMHS was the question regarding the frequency of CAMHS input. When describing the Unit’s satisfaction with the frequency of CAMHS input, again reponses varied widely.

Some secure units said they were satisfied overall with the frequency of CAMHS input:

“There is a good response and within an appropriate timescale.”

“CAMHS staff encourage unit staff’s input so working feels collaborative”

“Prompt response from CAMHS in general but getting written reports can be problematic”

“We are satisfied based on the service mainly provided by a specific CAMH service and based on knowledge of what other secure units receive”

Other secure units were not very satisfied with the overall frequency of CAMHS input:

Of those who were not very satisfied one service still praised the input from a specialised CAMH service which the unit felt was *“responsive.”* This differed, though, to their comments in relation to their experience of the local CAMH service:

“There is very little direct work done with the young person. Often just consultation was provided.”

One unit commented that in response to questions they might present about a young person there could be a confusion about roles and expectations and they could be told by health professionals *'you are the experts'*. Dedicated mental health staff in one unit also described it as being a confusing experience for secure unit staff to know what can be provided by CAMHS for young people in their care and this lack of clarity could cause problems. One unit that expressed dissatisfaction with the current frequency of CAMHS input clarified that this was following the end of a project which had previously enabled CAMHS psychiatric input to be provided on a more frequent basis.

The staff in one unit said that input from specialist CAMH services seemed to vary from service to service and, within services, between individual to individual practitioners without any clear rationale behind this and not clearly in response to differing needs between individual young people.

As referred to in this report's introduction, CEL 16 issued guidance about health assessments undertaken with looked after children and young people. It recommended that each Health Board should appoint a Board Director who takes corporate responsibility for the Looked After and Accomodated children and young people within the Health Board's area. It also recommended that this Board Director should ensure that every child or young person is offered not just a mental health assessment but that the person undertaking that health assessment should then take responsibility for ensuring that those young people with identified mental health needs should have their mental health care plans delivered and co-ordinated. Given CEL 16's recommendations then, the comments that we received from secure unit staff do raise a number of questions. It would appear that, despite the recommendations being in place for some time, the experience of staff working in secure units across Scotland remains mixed in relation to their experience of CAMHS accessibility and also of their experience of care packages for children being co-ordinated. Some units report good working relations with their local general CAMHS service whilst others are less satisfied. Many secure units reported positive experience of certain specialist CAMH services but the reason behind why the experience of contact with CAMHS overall is reportedly so variable was beyond the scope of this piece of work and remains unclear. Importantly we did not ask CAMH services about their experience of attempting to provide mental health services to this group of young people and the challenges that they face. This would be an important next step in order to gain a fuller understanding of why the variability of CAMHS access across the country exists.

It was also beyond the scope of these visits to explore in great detail the mental health care and treatment provided to young people in secure care, or to establish whether the young people experienced additional barriers to accessing CAMHS compared with young people who were not resident in secure care. We did become aware though, of some of the real challenges to providing appropriate mental health care to this group of young people. A period of secure care can provide an

important window of opportunity to collate information about a young person and promote engagement with services, while the young person is resident in a secure environment. However, it also presents challenges in deciding when it is appropriate for a young person to participate in certain therapeutic interventions which could require sustained therapeutic input from a single clinician or team, when their stay in secure care is transitory and might be of uncertain duration.

Recommendations:

Scottish Government should work with health boards and local authorities to develop a standardised care pathway to ensure clarity and continuity of provision of mental health care when young people make the transition into and between secure care settings. This should draw on the assessment pathway detailed in the Guidance on Health Assessments for Looked After Children and Young People in Scotland (2014).[16]

The Scottish Government should work with health boards to ensure there is equal access to specialist CAMH services, focussing on the needs of each young person in secure care settings across the country in line with CEL 16 (2009) and Guidance on Health Assessments for Looked After Children and Young People (2014) .

THEME 3: How is information about a young person's mental health care needs communicated between external agencies and secure care units, and shared with care staff within units.

Key message: Sharing information assists young person/staff interactions in a positive way.

What we looked at.

When we spoke with the young people we asked about their past and present contact with CAMHS, and if they knew whether staff in the unit were in contact with CAMHS. We also asked the young person if they felt that staff were aware of their mental health needs, and if they felt it was helpful if staff had access to information about their mental health problems.

What we expected to find.

The Looked After Children (Scotland) Regulations 2009[18] sets out a statutory requirement for every looked after young person should have their needs assessed and a young person's plan created. This plan should should set out any immediate and long term needs and how these will be met.

We expected to find that information about a young person's mental health care needs is available at the time of entry to secure care, and that relevant information about these needs and about supports and interventions provided to meet these needs is shared with staff working with the young person in the unit. We also expected to find that information is shared effectively, so that the young person is not asked repeatedly to give the same information to different workers.

What we found.

The young people were asked a general question about whether staff and peers were aware of their mental health problems. Five people said no, or did not answer, but all the rest felt that staff were aware of their problems. A few said that their peers were also aware, but several said explicitly that they did not want their peers to know about their problems. A couple of young people said that they felt staff could be more wary of them because they knew about their problems, but most felt that awareness affected positively how staff interacted with them;

"*they will understand if I am worked up.*"

We asked further questions, about whether young people felt that specific information about their mental health was shared with staff. Four young people either did not comment or said that this was not shared or they were not sure. A very small minority of young people felt it was not helpful if information was shared, and again the comment was made by one person that "*it makes them wary of me*" if information is shared. Twenty four (89%) young people though said that it was helpful if

information is shared and staff in the units are made aware of their mental health problems. A number of reasons were given for this being helpful; for example, it meant that they did not need to repeat information,

"*I don't need to tell them*."

The over-riding reason young people gave was that they felt staff would know them and understand them better because of shared information;

"*they know I have got psychosis and my thoughts are a bit mixed up*" and "*they know why I might be acting up*."

Admissions to secure care have varying degrees of urgency which affects the time available for information to be passed to Unit staff. Some young people are placed in secure care with little information relating to their mental health needs.This might be because the placement in secure care was arranged in an emergency. We generally found, however, that information about a young person is gathered before and in the days following a young person's admission.

Good practice example

In one case of a young person with complex mental health needs, admission to secure care was anticipated well enough in advance for the unit staff to be able to prepare an initial detailed behaviour support plan for the young person for their admission to secure care. This was able to guide staff in supporting and managing the young person prior to a more comprehensive assessment being undertaken in the unit.

The five units had different processes for gathering information about a young person's mental health needs. In some units we were told it was the clearly identified role of only the LAAC nurse to source data about a young person. One unit reportedly had a policy of the LAAC nurse undertaking a 'courtesy call' to CAMHS in the event of an admission to ensure CAMHS were aware of the admission of the young person and to request background relevant information. In other units different staff members undertook the task of sourcing mental health information following admission of different young people. We discovered a small number of cases when there was poor communication at the admission stage as information about the young person had not been sourced from the relevant CAMHS. We also found an example where an important letter from CAMHS had been sent to a unit staff member but was not disseminated through the network of unit staff involved in supporting the young person with mental health needs. All of the examples occurred in units were there was no clearly defined single point of contact between the unit and CAMHS.

Recommendations:

More focussed work needs to be done to support continuity of provision of mental health care when young people make the transition into secure care settings. To facilitate this local authorities should regularly audit the information flow between themselves and secure care establishments.

Units should consider whether having one person to have the role of data collection who would be the point of contact for CAMHS in liaising with the unit would facilitate and support communication between CAMH services and the secure unit.

Case holding social workers should consistently provide comprehensive information to secure units, at the point of admission, about mental health service input prior to the transfer.

Secure care unit managers should ensure that appropriate information about a young person's mental health difficulties and treatment being provided is shared with residential care staff, and unit managers should audit files to ensure this is happening.

THEME 4: How are young people involved in decisions about their mental health care and support.

Key message: We found that young people were not as fully involved in their mental health care as they could be. The importance of the young person participating as fully as possible in any decisions being made about their mental health care and support needs to be taken into account more consistently.

What we looked at

We asked all the young people we talked with specific questions about whether they were asked to consent to any mental health assessments or interventions that they were receiving. We asked if treatment options had been explained, and if the young person had been given information about any medication that had been prescribed for mental disorder. We asked if they had access to advocacy services. We also asked if any family members or paid carers were involved in the care and support being provided while they were in secure care.

What we expected to find.

A focus on the active participation of the young person in decisions about their mental health care and support would be consistent with the principles built in to mental health legislation, and with the GIRFEC approach to working with children and young people in a way which places their views at the centre. It would also be consistent with Article 12 of the UN Convention on the Rights of the Child

(UNCRC)[18] which focuses on respect for the views of the child or young person, and on young people having the right to have their opinions taken into account. We therefore expected to find that young people are listened to, and involved in decisions about their mental health care and support. We expected that when a young person's mental health needs are being assessed, and when interventions are being planned, consent is sought from the young person and is reviewed on a regular basis. We expected that any care plans to meet identified needs had been developed in collaboration with the young person. Finally, we expected to see that young people had access to advocacy supports, as advocacy is seen as a core service in ensuring that young people's rights are upheld.

What we found.

The mental health difficulties of the young people we met were wide ranging and complex with the majority of the young people we visited having more than one disorder or difficulty identified. A small number of the young people had a diagnosed Learning Disability and a small number had a diagnosis of Autistic Spectrum Disorder. Many young people were receiving a number of interventions aimed at alleviating or addressing their mental health difficulties. These could be provided by specialist CAMHS staff, dedicated trained secure unit staff or health professionals contracted by the units for particular interventions not readily available elsewhere. During our visits the young people we spoke to shared some positive experiences about how involved they felt in making decisions about their mental health care and support. However, their comments did also raise anumber of issues about how they were given information about, and how they were asked to consent to, the interventions and treatments being provided.

Consent to treatment for young people under the care of the local authority can be a complex area at times. The Age of Legal Capacity (Scotland) Act 1991 clearly recognises the capacity of young people under the age of 16 in Scotland to consent to medical treatment on their own behalf in certain circumstances. For those young people under the age of 16 who are not recognised as having sufficicient capacity to consent to medical treatment, consent for any intervention/ treatment could then be provided by individuals who posses parental authority for the young person or child. The legal basis for consenting to treatment is not affected as a consequence of a young person being received into care but it can make the situation a little more complex, however, when the individuals possessing parental authority for a child or young person have not been clearly identified upon admission to secure care or when there are a number of individuals with parental authority and there is a lack of clarity about who is best placed to provide consent to treatment on the young person's behalf.

[18] UNICEF Convention on the Rights of the Child, http://www.unicef.org/crc/

Out of the 27 young people we spoke with, 13 (48%) said they had been asked whether they wanted specialist CAMHS input, 8 (30%) could not remember being asked and 4 (15%) were unsure if they had been asked or not. Several young people spoke about how they were given good information about therapeutic interventions:

"*the psychologist explained what the focus of 1:1 work would be,"* and "*the (specialist) CAMHS have explained the purpose of sessions."*

We also heard a number of comments from young people about the information they were given about prescribed medication, with possible side effects being explained, and with some young people saying clearly they were given clear information verbally and/or in writing about medication:

"the doctor just spoke to me ...he explained it well."

In relation to medication and therapeutic modalities, 16 of the 27 young people (59%) reported to have been asked to give consent to the treatment, 3 (11%) denied having been asked and six (22%) were unsure. Thirteen of the 27 young people (48%) said that treatment options had been explained to them, five (19%) were unsure and seven (26%) said that they had not been given any explanation.Ten young people (37%) were being prescribed medication at the time of our visit. Eight (30%) reported they had been given the option not to take medication. Several young people had actually made the decision that they did not want to continue taking medication, and medication had been stopped, with one comment that "*I know it is up to me whether I take medication."* One young person did tell us, though, that they felt not taking medication was not an option, as they felt this could delay any move on from secure care for them.

All young people should be able to access advocacy support while in secure care. Advocacy is identified by the Scottish Government in Do the Right Thing[19] the Scottish Government's response to the 2008 concluding observations from the UN Committee on the Rights of the Child. Advocacy is regarded as a core service helping to ensure that the views of young people are central in any interventions in their lives, and that their rights are upheld. The Do the Right Thing document also recognises that the quality of the advocacy relationship is one of the most important supports for young people

Only seventeen of the young people (63%) reported having access to advocacy services and 14 (52%) found this helpful. Specific mention was made by several young people to contact with children's rights workers, or workers from Who Cares, and there were a number of comments about why this support was helpful:

"*They are helpful. They will listen and follow up anything you discuss with them*,"

"*they will support me at reviews,"*

[19] Do the right thing, http://www.scotland.gov.uk/Publications/2012/05/3593

"*I can phone Who Cares when I want to speak to someone. I know they will follow anything up*."

Recommendation:

Secure care unit managers and CAMHS should ensure that information about therapeutic interventions is provided to the young person in the form that is most likely to be understood and is most appropriate to their developmental stage and mental health needs.

Secure care unit managers should ensure that there are policies in place in relation to consent to mental health interventions undertaken by unit staff. The process by which consent to intervention may be obtained for a young person should be clearly outlined to ensure that a young person's right to be involved and consent to treatment is fully respected and that there is clarity about who should provide consent for a young person when that young person is not able to give to consent due to their immaturity or incapacity. Consent should be reviewed for each individual young person on a regular and ongoing basis.

Secure care unit managers and their health and social work colleagues should ensure that each young person in secure care with a mental healy, learning disability or related disorder has access to independent advocacy services.

THEME 5: Appropriate crisis management to ensure that young people with mental health difficulties remain safe at times when their behaviour is stressed and agitated.

Key message: Young people valued the supports available within units at times of crisis.

What we looked at.

We asked young people if they knew who they could speak to in a crisis, and if they felt that staff in the units responded quickly and positively in such situations. We also asked young people if they had been supported in isolation, or about whether special observation arrangements had been put in place during their admission in secure care. These specific questions were asked to try to identify if special measures were used at times when a young person was experiencing a mental health crisis.

In addition we asked staff to tell us who had been admitted to hospital from the units over the previous eighteen months, for mental health related care.

What we expected to find.

We expected to find that young people were given information about the support they could expect to receive at times when they were agitated or stressed or distressed, and that supports were responsive to any immediate needs. We also expected to see that when a young person was identified as being at risk of harm to themselves or others, because of mental health difficulties, appropriate action was planned and taken to safeguard the young person.

What we found.

Twenty three young people (85%) told us they knew who they could speak to in crisis. Keyworkers in units were generally identified as staff most young people would talk to, but many young people did tell us that they felt they could speak to other staff, but that there would be specific staff they would feel comfortable talking to, and that there would be some individual staff they would not approach to talk to.

Twenty young people (74%) told us that when they had spoken to someone in a crisis they were either very happy (12) or fairly happy (8) with the speed of response. One young person did say though that they would not approach staff because of a fear that they would have their possessions removed and be closely watched;

"*they will see you as being at risk and remove your possessions and put you on observation*."

There were a number of very positive comments from young people about the support they received from staff in units when they felt in crisis:

"*even if they are busy they will come and see you as soon as they can.*"

"*no problems getting to see the staff, they are always around*."

"*they always listen when I need them*."

All Units reported being able to access CAMHS in a crisis. Comments about the experience of this service included:

"At times crisis response has been good especially if known to services both locally and in home areas."

We also asked managers in units for information about how many young people had been admitted to hospital from the units over the previous 18 months for treatment of mental disorder. This did not include young people who might have been admitted to a general hospital or taken to A&E for treatment of physical difficulties relating to their mental health difficulties. In total we were told that five young people had experienced mental health difficulties of such a degree that they had had to be admitted to psychiatric hospital from the units. This information was provided solely on the basis of recall when speaking to managers and not from gathering information from unit records. As a consequence there may inaccuracies present in the reporting of this data.

All five of the units were able to receive CAMHS input for behaviour support plans for young people where that young person had a mental disorder. This varied in depth from case to case. Staff reported that in the 35 young people three (9%) were currently on some form of special observations and none were placed in isolation at time of visit. Seven of the 35 young people (20%) had received CAMHS input into their behaviour support plan and one young person was awaiting input. Staff reported that 23 of the 35 young people (66%) had undergone a restraint procedure for containment of behaviour during their admission and of these, CAMHS had given advice on four young people (11%). Staff said that all of the 23 young people who had been involved in some form of restraint had received a post incident debriefing. Information gathered at these interviews generally informed the young person's behaviour support plan/crisis management plan on an ongoing basis. All of the five units told us that they share information with the young people about the units policies relating to behaviour management at various stages in the young person's admission.

We asked the 27 young people we interviewed for their views about the use of physical restraint. Ten (37%) of them did not make any comments, seven (26%) only spoke about the circumstances in which restraint had been used. However, the other 10 (37%) all mentioned that there had been some discussion or de-briefing with staff after the event:

"*staff sit and talk with you after you have calmed down*,"

"*there is always discussion*."

Four of the five units reported the use of isolation as a means of intervention for young people. This often comprised ‘time out’ in an activity room or in a young person’s bedroom.

All 5 units had various levels of observation of the young people in their care and clear policies on the use of different observation levels. We heard from 24 of the 27 young people that they had been subject to special observation during admission although for some of these young people this was a routine process following admission rather than following a crisis. Four (15%) of the young people we questioned believed they were currently on some form of special observation, three (11%) young people either weren’t sure if they were or didn’t comment and 20 young people (74%) were not.

THEME 6: The importance of supportive services, both internal and external, focussing on the mental health needs of the young people in their care.

Key message: Young people valued the mental health care and support provided while in units, both by unit dedicated mental health staff and by CAMH services.

What we looked at.

We looked at information in case files about services being provided to meet mental health needs by CAMHS and by staff working within the units.

We asked each young person to tell us what supports they were currently receiving from CAMHS and unit staff, in relation to their mental health needs. We asked them for their perspective on their care and treatment, and whether they felt the support/interventions could be improved or could be provided differently. We also asked them to share their experience and to tell us what they thought generally about the mental health care and treatment they were receiving.

What we expected to find.

We were aware that often young people in secure care settings have complex backgrounds and have a range of life experience which can often include trauma. Managing this complexity of need can sometimes be difficult for staff and young people who may only be in a secure unit for a short period of time. Young people in secure care settings should have access to the same level and range of mental health care and support while in secure care as they would do if they were living in the community. This would be consistent with Article 24 of the UNCRC, which refers to children and young people having the right to the best health care possible[19].

All looked after and accommodated young people must have a young person's plan which includes information about immediate and long term needs and how these can be met (as set out on the Looked After Children Regulations 2009)[18]. We therefore expected to see clear information about identified mental health needs, and to see staff in units contributing to supporting and improving the mental health and well being of young people while they were in secure care.

GIRFEC established the role of the lead professional as a key role in relation to looked after children. The lead professional for most looked after children will be their social worker, and the lead professional has a pivotal role pulling together the multi-agency young person's plan, monitoring how this is working, amending this where necessary, and ensuring support is provided through transitions. During these visits we did not look in great detail at the overarching young person's plan, but we did expect to see interventions being recorded clearly, and need for further action identified.

What we found.

During the visits we asked the young people themselves about the supports they were receiving, and we gathered information from staff, both about the specific supports provided to individuals, and about the links between the units and CAMH services generally. Young people were given the opportunity to give us their overall view of the mental health care and support they were receiving. Four young people chose not to comment, and three were negative about their support. In these cases though, the reasons for their views were very specific, as the young people felt that they were not receiving the very specific treatment and support they had requested and felt was particularly appropriate.

The other young people who gave us their views about their mental health supports were positive about the supports they were receiving. Sometimes the young people were non-committal initially when asked for views and would say “OK” or “Alright”, but would then be more forthcoming and more positive in further discussions about their support later in the interview. Comments ranged from *‘fine’* through to detailed observations about why they felt supports were very good.

“I think support is good. I see (my CAMHS worker) every two weeks. I do programme work...anger management, in the unit. This is good as well.”

Where young people did give very positive comments this was often linked with specific, focussed interventions, for example to help with anger management, or bereavement issues, and with having 1:1 time to talk about issues. One young person talked about how support helped them feel more in control -*“I would really act up before...”* while another young person described the support they received helping them manage their distress and agitation –*“(workers) talk to me and listen and help when I get angry or upset.”*

We asked young people if, in relation to their mental health care and support, they would want anything done differently. Only three young people said yes. We asked young people and staff for specific details about the mental health supports being provided by CAMHS and by staff in the unit, and we reviewed care files to gather information as well. We did not ask young people any specific questions about whether they felt supports were well co-ordinated or about joint working between unit staff and CAMHS workers.

During our programme of visiting the five units we noted from the care files that a number of the young people in secure care had disclosed experiences of abuse before their admission. This information would be clearly recorded, as was the need in future for specific support and intervention designed to reduce trauma induced mental health symptoms be made available to the young person. At the time of our visits few of the young people were assessed as being ready to engage in this type of work and it was also clear that it was often seen as inappropriate to begin indepth interventions when the young person may be in secure care for a short period of time only. In one case we reviewed, the unit’s psychologist had recorded that they would

consider starting trauma focussed work in the future if the young person was to be in the secure unit for a lengthy period of time.

Mental health support is provided to young people by dedicated mental health staff in four of the five units. This type of support varied from unit to unit depending on staff training and could vary from psychological work including various types of assessment to a range of interventions including, for example, cognitive behavioural therapy, relaxation, and anger management. In addition, three units source input for their young people from independently provided mental health services. This work again varied depending on the needs of the young person and could comprise clinical or forensic psychological assessments, independent psychiatric reports and trauma informed consultation support for unit staff.

In one unit we saw a very clear example of good co-ordinated working between specialist mental health staff in the unit, and the local CAMH service. This ensured that the young person was receiving supports from staff working collaboratively to meet their mental health needs.

Good practice example:

A young person had been in contact with the local CAMHS before admission to a secure unit in the same area. Following admission a file review showed that information about the young person's mental health needs had been shared well, with the CAMHS worker attending all reviews. It was agreed and clearly documented that the CAMHS worker and the unit worker would each deliver specific interventions. It was also clearly recognised that there could be an overlap between the focus of these interventions and that the CAMHS worker was the identified lead professional. There was also clear evidence of good liason between the two workers, by phone, by e-mail, and by discussion at regular reviews, to ensure that there was a collaborative approach to delivering the appropriate mental health supports to this young person.

According to staff, of the 35 young people within the secure units 33 (94%) were receiving some form of mental health support from the unit's own dedicated mental health staff. Two young people were also receiving mental health input from an independent source.

When asked what staff thought the unit did well in meeting mental health care needs comments included:

"1:1 Keyworker time is good, it allows private space to be listened to."

The unit staff thought they made referrals promptly and their dedicated mental health team liaised with CAMHS well to ensure they were working appropriately to support young people waiting to be seen by CAMHS.

Another unit said;

"we provide support and emotional stability and calm to young people by nurturing and patient staff. We have a good understanding of risk and work well with young people in relation to risk"

One service described having;

"strong relationships with other services. Our dedicated mental health team have an appropriate skill mix that complements CAMHS" and described itself as being *"very pro-active in closing loopholes known to exist and we are dogged in chasing up information on young people".*

A further service described its dedicated mental health staff as being well trained and able to undertake robust assessments on admission and able to advocate well for the young person in their contact with CAMHS. They spoke positively of their care planning and review system and valued its encouragement of participation of the young people.

Finally one service described its strengths as;

" We offer care and individual support. We have an experienced group of staff that know the young people well."

When asked about barriers in the way of meeting young people's health care needs, units said that the fact that CAMHS staff have to come to the unit to see a young person can be difficult for them and can result in a reliance on CAMH services able to provide outreach.

One secure unit was concerned more about the breakdown of care once a young person left secure care. Another unit highlighted CAMHS waiting times as a barrier to accessing timely input into a young person's care.

One Unit thought an important barrier to meeting young peope's needs was the lack of accessibility of clinical input from CAMHS psychiatrists in particular. Others felt that the models health professionals sometimes used to understand the complex mental health needs of a young person in secure care could be overly restrictive and limiting at times.

Another unit cited a lack of CAMHS resources as a barrier in addition to the absence in Scotland of secure adolescent inpatient beds and the limited number of specialist adolescent inpatient beds available across the country. The Commission is aware of the small number of young people in Scotland who continue to require placements in specialist mental health units in England because of a lack of available facilties in Scotland. We are also aware that the Scottish Government commissioned a working group to look into this issue in 2013. The final report generated from this group led to work to establish a national implementation group to develop detailed proposals for

secure adolescent in-patient care in Scotland. The Commission continues to be concerned about the lack of specialist secure in-patient care for young people in Scotland and to have an interest in this issue. We look forward with interest to the outcomes from this implementation group in the hope that it will promote the range of resources available within Scotland to better meet the mental health needs of its young people.

Finally in relation to barriers to meeting the mental health needs of young people in secure care, one unit highlighted the difficulties that many young people have in agreeing to engage with services in the first place and the negative impact that the peer influence in a secure care unit can have at times on young people.

Recommendation:

Due to the complexity of the mental health needs of young people in secure care and the varying lengths of their stay, services should ensure any therapeutic intervention or work (including trauma focussed work) is enagaged in by appropriately trained and sufficiently experienced staff based on the clinical need of the individual young person within a robust supervisory framework to ensure quality of delivery of intervention. The timing of any mental health intervention is an important consideration and should be aimed at supporting the best outcome for the young person.

The lead professional should ensure that any intervention regarding a young person's mental health is clearly documented highlighting both met and unmet need. This should then become part of the transitional information that accompanies a young person on their journey though the care system.

THEME 7: The interaction of unit staff with young people and external agencies in the planning of and providing support on discharge.

Key message: It is important that young people know how services to support their mental health care needs will be provided post discharge, and that wherever possible they know and have had some contact with workers who will provide this support.

What we looked at.

We looked at whether discharge planning had started for each young person. We asked each young person as well as unit staff who they saw as being involved in discharge planning, to meet mental health needs. We also asked the young person if they knew what supports would be available after discharge, and if any workers who would be providing post discharge support in relation to their mental health needs were in contact with them.

What we expected to find.

We know that the best outcomes occur when care and support arrangements after leaving secure care correspond with the young person's needs. We expected to see that discharge planning processes ensure that mental health needs requiring follow up on discharge were clearly identified, that information was being shared effectively, and that appropriate arrangements for follow up after discharge were being put in place. We also expected to see young people being fully involved in discussions about mental health supports to be provided after they moved on from secure care, and that advocacy support was available to facilitate involvement.

What we found.

During the visits we asked young people and staff separately about discharge planning arrangements.

Eleven (41%) of the 27 young people we saw told us that discharge planning had started and that they knew they would be moving on. One young person was waiting to move to a specialist unit in England, a small number expected to move in the near future when criminal justice proceedings had been completed, and some young people knew that they were going to move to close support units within the same service where they were currently placed. Five (19%) young people said that placements were in the process of being identified and that planning meetings to finalise moves were coming up. Several of the other 16 young people were unsure about discharge plans but told us that the issue was being discussed at their review meetings.

Of the 11 young people who told us they were definitely moving on only one person said they didn't feel involved in the process -"*this is all done by workers*." The other 10 young people spoke about discussions at reviews and there were several positive comments about discharge planning:

"I feel very involved and am pleased with plans to move on within the service,"

"I got the choice (of where to move to) This was talked about at weekly care planning meetings."

Eight of the eleven young people knew what general supports were being arranged post discharge. However, in relation to specialist supports for mental health problems, only four young people said they knew who would be providing this support from CAMH services. Three of the four were young people who were going to move to another unit within the same service. The rest of the young people were unsure how or by whom support would be provided, although several expected to re-engage with CAMHS staff from their home area.

We asked young people who had been in secure care before their current admission if arrangements were made for CAMHS contact after their previous discharge. Three

young people in this group one said that CAMHS support had been arranged at the time when they were discharged from secure accommodation.

In some units nurses were heavily involved in the discharge planning process, chasing referrals and transfer arrangements by phone if necessary. In other units keyworkers took on this role. Other individuals involved in the discharge planning varied from case to case but could include unit staff, current CAMH service, and CAMH service where young person was to be discharged to family and SW .

The units' experience of the support provided after discharge by CAMHS varied. Two units commented that CAMHS will participate in discharge planning reviews if they have been actively involved. Another unit reported that CAMHS were involved in the discharge planning process:

"Depends on the circumstances. Some CAMHS are very reluctant to take some young people"

Units were able to give several examples of positive engagement by CAMHS teams. We were told about CAMHS services which supported transitions well, communicated well with the units and attended meetings even when units were some distance away geographically. Comments were made about CAMH services being;

"*very supportive in a recent case*,"

about CAMHS clinicians attending reviews and discharge discussions;

"*they started seeing the young person before discharge so handover went smoothly*,"

and about services being;

"*very good at maintaining contact with young people known to them who get admitted to the unit. Also for new referrals they will arrange post discharge appointments*".

However, examples of less positive engagement were also described. Concerns largely centred around CAMH services showing a reluctance to accept referrals and engage with the discharge planning process and this was said to have hampered the discharge planning process on occasion.

Recommendations:

The Scottish Government should develop national guidance about discharge planning processes, with a focus on ensuring continuity and identifying responsibility for provision of mental health care, in conjunction with the development of a standardised discharge care pathway.

Secure care services should ensure that young people are fully involved in discharge planning processes in relation to their mental health care and treatment, and that there is appropriate communication with external agencies who will provide support, including CAMHS and primary health care services.

CONCLUSIONS AND FURTHER ACTION

CONCLUSION

When we embarked on these visits we were aware of anecdotal information from services that there was limited support available to secure units from CAMH services and that often staff in the secure care settings were left to deal with young people who were mentally unwell and struggling to cope.

On carrying out our visits and having had the opportunity to speak with both staff and young people with varying mental health issues, we found that the picture was not as bleak as we at first envisaged. We were heartened to hear that young people had a good understanding of why they had to be cared for in secure settings and that they were on the whole engaging with supports being offered to them.

We found that young people benefit from continuity in their care and from not having to repeat their issues everytime they have to move through the care system. We found that those young people who were coping best had support from staff groups who shared information well. Continuity in how information is managed and shared across the services is basic good practice and should be seen as an achievable goal for all services and agencies involved in caring for these vulnerable young people.

The young people informed us of varying degrees of involvement in their mental health care planning and decisions. Our view is that young people should be encouraged to participate as fully as possible in such care planning and decision making and that information should be presented in an understandable format to ensure engagement. All agencies involved in providing support and care and treatment for young people's mental health needs should strive to ensure this practice in embedded in their care approach.

Overall we were pleased to hear that young people had clarity regarding who to turn to for support within units when in crisis. It was also good to hear that CAMHS provision, when this was in place, was enabling the young person to have support. However, we did note that CAHMS input in non urgent situations is provided in many forms from consultation for staff to therapeutic intervention with young people in the secure unit setting and that this can be variable across the country. We feel that there is a need for the development of nationally agreed, robust care pathways. Clarity from Scottish Ministers in this regard will ensure equality of access to CAMHS for this vulnerable group of young people across Scotland.

We are concerned to hear that transition and discharge planning can leave the young people feeling uncertain as to whether their mental health care will continue, have to be restarted with new staff or stop all together. This is an area that requires further attention from all agencies involved in the young people's lives as they move into and through the care system. We also noted the complexity of the mental health

difficulties of the young people in secure care and that a significant number of the young people we had contact with had also experienced significant trauma in their lives. Given the complexity of any individual's mental health needs it might not always be appropriate to undertake certain therapeutic interventions, such as trauma focussed work for example, while the young person is in secure care because the length of stay there might only be brief. We feel it is important that any unmet mental health need should be clearly recorded, and that this information should follow the young person through transitions between services so that therapeutic interventions with appropriately trained staff, can be provided whenever this is clinically appropriate as soon as possible.

These visits were undertaken by the Commission jointly with the Care Inspectorate and served to provide a baseline of understanding and recording on a fairly broad range of issues relating to the mental health care of young people in Scottish Secure care settings. Although the number of young people we visited was not large and the visits occurred in a short time frame, our findings were supplemented by staff interviews that broadened out the scope and the findings of the visits. It is the Commission's intention in the future to explore further the issues raised in the visits, either by extending the range of enquiry relating to the mental health care of young people in secure care or by exploring in more depth some of the careas of concern in more detail. The precise format and timings of future inquiriy have yet to be confirmed.

Our recommendations highlight areas where we feel further interagency work, both local and national could provide a more supportive, cohesive and smoother experience for the young people with mental ill-health who find themselves journeying through secure care settings.

RECOMMENDATIONS

For Local Authorities and Health Services

More focussed work needs to be done to support continuity of provision of mental health care when young people make the transition into secure care settings. To facilitate this local authorities should regularly audit the information flow between themselves and secure care establishments.

Case holding social workers should consistently provide comprehensive information to secure units, at the point of admission, about mental health service input prior to the transfer in line with GIRFEC principles.

Due to the complexity of the mental health needs of young people in secure care and the varying lengths of their stay, services should ensure any therapeutic intervention or work (including trauma focussed work) is engaged in by appropriately trained and sufficiently experienced staff based on the clinical need of the individual young person within a robust supervisory framework to ensure quality of delivery of

intervention. The timing of any mental health intervention is an important consideration and should be aimed at supporting the best outcome for the young person.

The lead professional should ensure that any intervention regarding a young person's mental health is clearly documented highlighting both met and unmet need. This should then become part of the transitional information that accompanies a young person on their journey though the care system.

Secure Units

Units should consider whether having one person in the role of data collection and point of contact for CAMHS in liaising with the unit would facilitate and support communication between CAMH services and the secure unit.

Secure care services should ensure that young people are fully involved in discharge planning processes in relation to their mental health care and treatment, and that there is appropriate communication with external agencies who will provide support, including CAMHS and primary health care services.

Secure care unit managers should ensure that appropriate information about a young person's mental health difficulties and treatment being provided is shared with residential care staff, and should audit files to ensure this is happening.

Secure care unit managers should ensure that information about therapeutic interventions is provided to the young person in the form that is most likely to be understood and is most appropriate to their developmental stage and mental health needs.

Secure care unit managers should ensure that there are policies in place in relation to consent to mental health interventions undertaken by unit staff. The process by which consent to intervention may be obtained for a young person should be clearly outlined to ensure that a young person's right to be involved and consent to treatment is fully respected and that there is clarity about who should provide consent for a young person when that young person is not able to give to consent due to their immaturity or incapacity. Consent should be reviewed for each individual young person on a regular and ongoing basis.

Scottish Ministers

Scottish Government should work with health boards and local authorities to develop a standardised care pathway to ensure continuity of provision and identify responsibility of mental health care when young people make the transition into and between secure care settings .This should draw on the assessment pathway detailed

in the Guidance on Health Assessments for Looked After Children and Young People in Scotland (2014).[16]

The Scottish Government should work with health boards to ensure there is equal access to specialist CAMH services, focussing on the needs of each young person, in secure care settings across the country in line with CEL 16 (2009)[11] and Guidance on Health Assessments for Looked After Children and Young People (2014) .

The Scottish Government should develop national guidance about discharge planning processes, with a focus on ensuring continuity and identifying responsibility for provision of mental health care, in conjunction with the development of a standardised discharge care pathway.

mentalwelfare
commission for scotland

Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE
Tel: 0131 313 8777
Fax: 0131 313 8778
Service user and carer
freephone: 0800 389 6809
enquiries@mwcscot.org.uk
www.mwcscot.org.uk

Mental Welfare Commission (10/14)