Pushed into the shadows

Young people's experience of adult mental health facilities

OFFICE OF THE Children's COMMISSIONER

The Children's Commissioner for England

The Children's Commissioner for England was established under the Children Act 2004 to be the independent voice of children and young people - championing their interests and bringing their concerns and views to the national arena. Professor Sir Albert Aynsley-Green became the first Children's Commissioner for England on his appointment in July 2005.

YoungMinds

YoungMinds is the national children's mental health charity committed to supporting the mental health of children and young people and the development of appropriate services to meet the needs of those children and young people who experience mental health difficulties. The charity undertakes a wide range of activities to support children, young people and their families and the practitioners working with them in Child and Adolescent Mental Health Services (CAMHS), children's services and the voluntary sector. This includes a Parents' Information Service, Research, Policy and Information (including publications for a wide range of audiences), User Participation support and Training and Consultancy.

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Foreword

My job as the Children's Commissioner for England is to make sure that the views, needs and interests of children and young people in England are taken seriously and to help to ensure that their rights are recognised and upheld.

One in ten children and young people have a diagnosable mental health disorder. It is vital that we invest in services to meet the needs of this group, if we are to provide them not only with the support that they require to enjoy their childhood and become confident and competent adults, but also to prevent persistent long term consequences in later life.

A great deal has been achieved in England over the last four years as a result of the specific target set by Government for improving child and adolescent mental health services and the accompanying dedicated resources. However, despite the significant increases in capacity, we still have a long way to go before all children and young people are offered high quality, effective mental health services when and where they need them.

I commissioned this report to stimulate debate about the experience of a sometimes hidden and neglected group of young people with mental health difficulties, namely those young people who have to be admitted into adult facilities.

Developing a serious mental health problem requiring admission to hospital is a frightening experience for anyone - and particularly so for a young person. Their needs are very different to those of adults, and their management demands specialised skills in the staff caring for them, particularly in understanding what it is like to be a young person today and the impact a mental health problem has at a time of rapid physical and emotional development.

We cannot say that at present a young person should never be admitted to an adult psychiatric hospital facility. Some will, in some circumstances, prefer it, whilst there

will be little choice for others, for example those in need of emergency care who live some distance from the nearest adolescent facility. Too often, however, the reason for admission to an adult facility is that there are simply no suitable beds. The Government has said that eliminating the unacceptable use of adult wards for young people should be possible within a five year period. This is a welcome pronouncement, although I would hope to see much more rapid progress in all parts of the country, bearing in mind how damaging inappropriate care can be for a young person with a serious mental health problem.

This report recounts the real life journeys of young people who were admitted to adult in-patient wards. Having learned of the experiences of these young people, I remain convinced that our long term aim must be to ensure that the mental health services we offer to highly vulnerable young people are appropriate to their age and stage of development. We must recognise the rights of young people to receive age appropriate, effective treatment and care including continuing education.

Our thanks are due to YoungMinds for conducting this research, Camilla Parker for finalising the report and all those who have been involved in the writing and production. I am particularly grateful to the young people who have participated in this project. In many cases, their care in adult wards must have been harrowing, difficult and painful to recall, but all the young people who took part, did so in order to improve services for young people in the future. I am sure you will share my view that in sharing their stories, these young people made a powerful case for taking action now to ensure that all young people get the best care that is available in age-appropriate mental health care settings.

Professor Sir Al Aynsley-Green

Children's Commissioner for England

Executive summary

"Mental health is pushed into the shadows in this country and that's why there isn't enough money for services" Sam

Introduction

The Children's Commissioner for England commissioned this work because of serious concerns about the inappropriate use of adult mental health wards for young people, the slow rate of progress in phasing this out and the deficiencies in the quality of treatment and care provided to the young people placed on adult psychiatric wards.

This report is based on the findings of a consultation carried out by the Research Department of YoungMinds, the children's mental health charity, on behalf of the Children's Commissioner for England with young people who have been admitted on to adult in-patient mental health facilities. The report sets out their key areas of concern when describing and commenting on their involvement with adult mental health services. Comments from parents and staff are also included.

Report aims

- To draw attention to the continued practice of admitting children and young people to adult mental health facilities, despite the national policy objectives of ending such admissions;
- To highlight the experiences of those young people who have been admitted to adult mental health facilities, or have otherwise had some involvement with adult mental health services; and
- To make recommendations for addressing inappropriate admissions onto adult psychiatric wards and to ensure that adequate safeguards are in place where such admissions cannot be avoided.

Policy context: progress and challenges

Since the Mental Health Act Commission undertook its study of children and young people detained on adult wards (April 2002 – September 2003), there have been some significant developments in England. In 2004, the National Service Framework for Children, Young People and Maternity Services ('the Children's NSF') was published. In addition, the Government set a Public Service Agreement (PSA) target that a comprehensive child and adolescent mental health services (CAMHS) would be commissioned in all areas of England by the end of 2006. This has been facilitated by a considerable investment into CAMHS. Standard 9 of the Children's NSF, 'The Mental Health and Psychological Well-being of Children and Young People' (the CAMHS Standard), explains that a comprehensive CAMHS:

> 'means that in any locality, there is clarity about how the full range of users' needs are to be met, whether it be the provision of advice for minor problems or the arrangements for admitting to hospital a young person with serious mental illness'. [1]

The increased focus on CAMHS, along with additional resources and investment, is having a positive impact in a number of areas of service provision. This reflects the considerable efforts of many people at both national and local level. However, many of the changes have been focused on community-based provision and while this is welcome, it appears that in-patient resources are still inadequate in many parts of the country.

A recent report issued by the Department of Health on the implementation of the CAMHS Standard of the Children's NSF [2] confirms that there have been significant improvements in CAMHS. However, the report notes that service provision and access vary between different parts of the country and that, whilst CAMHS in general has improved, 'the slow rate of progress in some areas means that not all children and families are benefiting as they should'.

[1] Department of Health (DH) and Department for Education and Skills (DfES). 2004. National Service Framework for Children, Young People and Maternity Services, Standard 9, The Mental Health and Psychological Wellbeing of Children of Young People (The CAMHS Standard).
[2] Department of Health (DH). November 2006. Report on the implementation of Standard 9 of the National Service Framework (NSF) for Children, Young People and Maternity Services.

Key findings

The information gathered from the young people, parents and staff who took part in this consultation presents a mixed picture. Some young people experienced a good level of care and support on adult psychiatric wards. However, these positive examples are largely overshadowed by the more widespread negative experiences of young people. Many were left feeling isolated, bored, uninformed and uninvolved in decisions about their mental health care. Others had felt extremely unsafe, for example, some described how they had been at risk of aggression or sexual harassment from other patients.

Overall, the young people's experiences demonstrate that, despite the positive developments, access to in-patient Tier 4 CAMHS remains problematic in many parts of the country and young people are still being placed on adult wards. Furthermore, when they are placed on adult wards, the level of care offered to young people is – all too often - unsatisfactory, poorly planned and inadequately monitored.

Five key themes arose from the 'journeys' of those young people using adult mental health services:

1. Inadequate response to crises

Many young people end up as in-patients in adult psychiatric facilities as a result of a crisis to which CAMHS are unable to respond. Although often great efforts are made to avoid placing the young people on adult wards, this can result in young people being held in inappropriate settings, such as police cells or A&E wards. At other times, young people may find themselves being moved from one service to another, sometimes after a matter of hours. The lack of appropriate services for those aged between 16 and 18 was also raised by a number of young people and their parents.

2. Lack of information and involvement in care planning

Many of the young people commented on the lack of information about their general treatment and care - they did not know what was going to happen to them, what to expect on admission or when they might be discharged. This compounded their fear and confusion about being admitted to in-patient services. Young people were provided with very little explanation of their rights (in particular, regarding the use of sections of the Mental Health Act 1983) and only a very few were told about access to advocacy support. Even though many of them had been seriously unwell, the young people felt a strong need to be involved in their care and expressed a desire for the greater provision of independent advocates who could speak up on their behalf.

3. Nothing to do, no one to talk to

Over a third of the young people in this consultation described feeling isolated, lacking individual time with ward staff and 'wall-watching'. Many felt they were unable to develop friendships on the ward due to the age gap between them and other patients and some of the young people found it very difficult to keep in touch with their families and friends (due to distance and also due to some adult wards having policies which prevent under 18s from visiting). The lack of education provision was also highlighted.

4. Lack of safety, security or therapeutic care

While some young people's journeys provided examples of good practice such as offering young people designated rooms on their own, ensuring staff supervision at all times and providing more flexible visiting arrangements, these were far from the norm. Many of the young people felt a lack of safety and protection during their time on adult psychiatric units. The journeys also highlighted problems arising from a lack of staff in adult mental health services who had received training in, and/or experience of, working with children and adolescents. Often the staff appeared to lack interest or empathy with the young person's situation. In some cases, the young people had felt threatened and intimidated by staff. Some young people had been subject to harassment from other patients which appeared to have been inadequately dealt with, or ignored, by staff. In addition some of the young people

were able to engage in harmful practices such as misusing drugs or self-harming whilst on the ward.

5. Disorganised discharge arrangements

Young people reported having had little involvement in the planning of their discharge, in some cases describing rapid discharges, very often with little or no warning or preparation beforehand.

Young people's views

The young people involved in this consultation showed considerable insight into their difficulties and how some of their experiences on adult wards had served to heighten their anxiety, isolation and sense that no-one was listening to them. Alternatively, when things had worked well, they were able to draw out those factors which they thought had been instrumental in making the experience more positive. Two key factors were the availability of staff (and their ability and capacity to empathise with young people) and the beneficial effects of daily activities and structure (even when this felt quite demanding).

The young people were clear about what was needed to improve in-patient care and treatment for young people with mental health problem including:

- In-patient services with the capacity to respond immediately to crisis situations
- Respite resources that provide immediate support, for example, a place to stay and staff who can work with young people to sort out what is happening and what help they need.
- In-patient services that address the wide range of needs young people often have, including being able to offer a high level of security and being able to manage difficult or disturbed behaviour.
- The full and active involvement of young patients in their mental health care.
- The provision of information about all aspects of a young person's care, treatment and rights.

- The availability of independent advice and advocacy support to all young people who are admitted to in-patient facilities
- The opportunity to participate in structured daily activities.
- Services that offer young people the chance to meet and interact with other young people in similar circumstances and an end to the admission of young people into facilities where there are no other young patients.
- Allocated time to talk with staff with skills and training in working with young people.
- Improved visiting arrangements and the provision of dedicated space on wards in order to ensure that young people do not lose contact with their family and friends and are able to meet with them in comfort and privacy.
- If a young person does have to be admitted to an adult facility, he or she should not be the only young person on the ward.

Recommendations

The recommendations are divided into two categories:

- Measures aimed at preventing the inappropriate admission of young people onto adult psychiatric wards.
- Measures that must be taken to safeguard those young people who are admitted to adult wards.

Avoiding admission of young people onto adult psychiatric wards

End the use of adult wards for the treatment of under 18s

1. PCTs and mental health trusts should ensure that adult wards are not used for the care and treatment of under 16s and, wherever possible, adult wards should be avoided for 16 and 17 year olds unless they are of sufficient maturity and express a strong preference for an adult environment. The Department of Health should also monitor progress towards this nationally. The Healthcare Commission should also address this through one of its future annual health-checks of individual mental health trusts and PCTs.

Address the national shortage of emergency beds in Tier 4 CAMHS

2. Action must be taken by the Department of Health, mental health trusts and Primary Care Trusts (PCTs) to ensure that the Royal College of Psychiatrist's recommendations (that around 24 to 40 CAMHS beds are required per one million total population and a bed occupancy rate of 85%) are met consistently and geographical inequalities addressed. Tier 4 units must include both acute care provision (to be able to respond to the need for emergency admissions of young people who are acutely disturbed or high risk) and medium to long-term planned in-patient care.

Development of alternatives to 'traditional' in-patient provision

3. The Department of Health should ensure that there is a continued investment into CAMHS at local level, to support the development of both high quality responsive community teams and in-patient units that are closely linked to Tier 3 services. This should be backed by a commitment to develop a range of treatment interventions which adhere to the best available evidence and take account of children and young people's individual needs.

4. Through its topic selection process, the Department should commission a comprehensive range of appraisals and clinical guidelines on treatment for children and young people with mental health problems to inform evidence-based practice.

Meeting the needs of 16 and 17 year olds

5. As a part of the continued investment into CAMHS, support must be given by the Department of Health and the Care Services Improvement Partnership to the development of transition services that can support young people who require transfer to, and ongoing support from, adult services post-CAMHS. CAMHS should be commissioned and resourced to provide services to all young people up to their eighteenth birthday.

Safeguards for young people in adult psychiatric wards

Collection of data on the numbers of young people admitted to adult mental health beds

6. The Department of Health should arrange for the collection of information by an organisation such as the Mental Health Act Commission on the numbers of all children and young people (whether detained under the Mental Health Act 1983 or not) who are admitted to adult psychiatric facilities and the length of each admission. This should be monitored both nationally and locally to ensure that progress is being made to eliminate the use of adult beds as a matter of urgency and any unforeseen increases investigated through performance management and inspection.

Policies and protocols between CAMHS and adult services

7. Mental health trusts (CAMHS and adult mental health services) and PCTs should work together to ensure they have in place a joint policy and/or protocol to ensure the safety & protection of young people admitted to adult wards (including the provision of appropriately segregated sleeping and bathroom areas) and access to the expertise and support of CAMHS staff throughout their in-patient stay in line with the rights set out under the UN Convention on the Rights of the Child and the relevant national standards.

Involving children and young people and their families in care planning and discharge and in service design

8. Mental health trusts and PCTs should work together to ensure that health care professionals involve children and young people (and their families where appropriate) fully in all aspects of their mental health care. This should include children and young people being provided with comprehensive and accurate information about the medication that they are prescribed and administered, in a format that they are able to understand. Any decision-making about medication should involve the child or young person as an active partner.

9. The Department of Health and the Care Services Improvement Partnership, mental health trusts and PCTs should work together actively to involve young people in designing and planning services. Regional development workers

should ensure that there is increased participation in this area in line with other types of healthcare.

Access to appropriately checked and trained staff

10. All young people admitted to adult wards should have regular access to a named keyworker/lead professional who has received training in working with young people and who has responsibility for liaising with CAMHS and ensuring that young people's care is properly planned and they are fully supported throughout their stay.

11. PCTs and mental health trusts should ensure that all staff (including agency and other temporary staff) on adult wards admitting young people should have an appropriate and current Criminal Records Bureau (CRB) disclosure.

Ensuring adequate levels of staffing on adult in-patient wards

12. PCTs and mental health trusts should work to review and, where appropriate, to increase the level of supervision by staff on adult wards who are working with young people. All staff who are working with young people on adult wards should be trained in child and adolescent mental health.

Provision of rights information to young people and their families

13. On admission to an adult ward, all young people and their families must receive information (both written and oral) in an appropriate format about what will happen to them and about their rights (including how to complain and, where applicable, the provisions of, and their rights under, the Mental Health Act 1983).

Access to independent advocacy services

14. All mental health trusts should ensure that any young people admitted to adult in-patient mental health wards are advised of, and have access to, independent advocacy advice and support.

Care planning and discharge arrangements

15. Mental health care trusts and PCTs should ensure that all decisions are documented in a written Care Plan that has been discussed and written jointly with the young person and, if appropriate, discussed fully with their family/carers.

16. Mental health care trusts and PCTs should work towards using the Care Programme Approach (CPA) more consistently to ensure continuity of high quality treatment and care and, most importantly, better discharge planning. The CPA must be used when young people are discharged back to community CAMHS or to appropriate adult services.

Activities, education and therapeutic input

17. Mental health trusts and PCTs should ensure that any adult in-patient wards admitting young people under-18 should provide appropriate facilities and daily activities for young people including games, music, books, computer equipment and access to sports and physical exercise.

18. Mental health trusts and PCTs should ensure that all adult in-patient wards have resources in place to assess and respond to the educational needs of any young people under 18 admitted to the ward. It is important that action is taken to ensure that young people can continue with their education, especially those who are of compulsory school age. A named member of staff should have responsibility for ensuring that any links with a young person's existing place of education are maintained.

Visiting on adult psychiatric wards

19. Mental health trusts and PCTs should ensure that where young people are admitted onto an adult ward, arrangements for their family and friends should be made, taking into account the need to safeguard the health and welfare of patients and visitors. This must include visiting areas in which they can meet with their families and friends (including those under 18) in private.

Safeguarding children and young people

20. Mental health trusts, PCTs and local authorities should ensure that they comply with the requirement in sections 85 and 86 of the Children Act 1989 to notify the local authority where a young person who had been living in their area is accommodated or is likely to be accommodated in hospital for three months or more.

All of these recommendations must be underpinned by a shift in mindset within mental health services away from crisis-driven reactive provision towards the greater involvement of children, young people and their families in the planning of mental health services and in determining the young person's own mental health care. In addressing the difficulties that lead to young people coming into contact with mental health services, professionals need to listen to young people and their families and draw upon their knowledge and experiences.

Introduction

“Mental health is pushed into the shadows in this country and that’s why there isn’t enough money for services”

Sam

This report is based on the findings of a consultation carried out by the Research Department of YoungMinds, the children’s mental health charity, on behalf of the Children’s Commissioner for England.

The function of the Children’s Commissioner, as set out in the Children Act 2004, is to promote awareness of the views and interests of children in England. An important part of the Commissioner's function is to consult children and in particular those children who have difficulty making their views known. This report makes a number of recommendations which are addressed to a range of bodies responsible for mental health services for children and young people. The Commissioner, on publishing this report, may under his powers require those responsible bodies to state what action they have taken or propose to take in response to those recommendations, and has requested these bodies to respond by 1 July 2007.

YoungMinds were asked to seek the views and experiences of those young people who have been admitted on to adult in-patient mental health facilities and, where possible, to seek the views of their families as well. The report sets out the key areas of concern identified by the young people in this consultation when describing and commenting on their involvement with adult mental health services. Comments from parents and staff are also included.

This work was commissioned because the Children's Commissioner for England was aware of the serious concerns about the inappropriate use of adult mental health wards for young people and the deficiencies in the quality of treatment and care provided to the young people placed on adult psychiatric wards. YoungMinds spoke to sixteen young people between the ages of 13 and 19 years, seven parents and five members of staff with experience of working with young people receiving adult mental health services. Whilst this kind of consultation inevitably means talking to small numbers of people and it cannot be assumed that everyone would have had the same kind of experiences, there is a high degree of consistency across the issues raised in this by the young people, from which much can be learnt.

The aim of this report is to:

- Draw attention to the continuing practice of admitting children and young people to adult mental health facilities, despite the national policy objectives of ending such admissions;

- Highlight the experiences of those young people who have been admitted to adult mental health facilities, or have otherwise had some involvement with adult mental health services; and

- In the light of the views of young people who have experienced adult mental services, make recommendations aimed at preventing inappropriate admissions onto adult psychiatric wards and, where such admissions cannot be avoided, to ensure that adequate safeguards are in place.

Why was this report commissioned?

Various reports over the last decade have raised concerns about the inappropriate use of adult mental health wards for young people, often prompted by the lack of beds in Child and Adolescent Mental Health Services (CAMHS). For example, the Royal College of Psychiatrists report, the National In-Patient Child and Adolescent

Psychiatry Study[3] identified problems with the general shortage of beds, the lack of emergency facilities available, the inadequate provision for young people with severe and high risk needs and the use of adult psychiatric beds for children and young people.

The YoungMinds' study, Whose Crisis?[4] identified particular problems with in-patient provision for young people aged 16-19, for young people with learning disabilities and mental health problems and for those with problems arising from drug and alcohol misuse. In 2003, Where Next?[5] reviewed developments within Tier 4 CAMHS and also highlighted concerns about the lack of CAMHS beds and the ongoing use of paediatric and adult psychiatry beds as an alternative.

In 2004, the Research Unit of the Royal College of Psychiatrists surveyed nine health authorities to gather information about admissions of young people to adult psychiatric and paediatric wards. (These health authorities were deemed to be representative of England and Wales in terms of their location, population, size and provision of mental health service in-patient wards.) The survey findings indicated that between 955-1266 young people are admitted to adult psychiatric wards every year, with over half of these admissions being considered inappropriate. This is a significant figure given that the average number of young people admitted to specialist CAMHS units each year is just over 2000 – in other words: "more than a third of all young people admitted for a mental illness are admitted to general psychiatric wards and paediatric wards."[6]

Apart from being aimed at an older client group, with different interests and needs, there are serious concerns about the adequacy and effectiveness of treatment and care for young people offered by adult psychiatric wards. For example, a report by the Mental Health Act Commission (Safeguarding children and adolescents

[3] O'Herlihy, A et al. 2001. National In-Patient Child and Adolescent Psychiatry Study (NICAPS). The Royal College of Psychiatrists.
[4] Street, C. 2000. Whose Crisis? Young Minds.
[5] Street, C and Svanberg. 2003. Where Next? Young Minds.
[6] Worrall, A; O'Herlihy, A; Bannerjee, S; Jaffa, T et al (2004) Inappropriate admission of young people with mental disorder to adult psychiatric wards and paediatric wards: cross sectional study of six month's activity. *British Medical Journal* **328** pp867).

detained under the Mental Health Act 1983 on adult psychiatric wards, 2004)[7] highlighted that:

- Very few staff in adult wards had received training in working with young patients.
- Child protection issues were not always appropriately addressed.
- There was a lack of education provision and limited access to advocacy, particularly advocates who had receive training in working with young people.
- Young people under 16 were found to be more likely to be placed on wards with seclusion facilities – that is, wards more likely to admit adult patients with high levels of disturbed behaviour.

The MHAC also found that 26.8% of the young people detained on adult wards were from ethnic minorities. Whereas Black Africans and Caribbeans make up just 2.7% of the youth population in England, they accounted for 13.1% of the young people detained on adult wards.

The National Service Framework for Mental Health ('the NSF for Mental Health'), which sets out national standards for adult mental health services in England, not only makes clear that children and young people should only be admitted to adult psychiatric wards in exceptional circumstances, but also requires measures for safeguarding the interests of the young person to be in place for when such admissions do occur. It states:

> 'If a bed in an adolescent unit cannot be located for a young person, but admission is essential for the safety and welfare of the user or others, then care may be provided on a ward for a short period. As a contingency measure, NHS Trusts should identify wards or settings that would be better suited to meet the needs of young people. A protocol must be agreed between the child and adolescent mental health services and adult services.

[7] Mental Health Act Commission. 2004. Safeguarding Children and Adolescent Detained under the Mental Health Act 1983 on Adult on Psychiatric Wards.

> Protocols should set out procedures that safeguard the patient's safety and dignity.'[8]

Although the NSF for Mental Health was published in 1999, the MHAC's report of 2004 found that fewer than half the service providers in the study met this part of the standard.

In the light of such concerns, the Children's Commissioner for England commissioned YoungMinds to explore the views of those young people who have been admitted on to adult in-patient mental health facilities and, where possible, to also seek the views of their families.

Although most of the young people who took part in this consultation were from England, a small number were from Wales. While the issues raised through this consultation are common across both countries, there are significant differences in the development of mental health policy in England and Wales generally, and in particular, in relation to CAMHS. Accordingly, in Appendix 2 of this report the Children's Commissioner for Wales sets out the policy background for Wales.

Policy Context: progress and challenges

Since the Mental Health Act Commission undertook its study of children and young people detained on adult wards, there have been some significant developments in England. In 2004, the National Service Framework for Children, Young People and Maternity Services ('the Children's NSF') was published. In addition, the Government set a Public Service Agreement (PSA) target that a comprehensive CAMHS would be commissioned in all areas of England by the end of 2006. This has been facilitated by a considerable investment into CAMHS.

[8] Department of Health. 1999. National Service Framework for Mental Health.

Standard 9 of the Children's NSF, 'The Mental Health and Psychological Well-being of Children and Young People' (Standard 9), explains that a comprehensive CAMHS:

> 'means that in any locality, there is clarity about how the full range of users' needs are to be met, whether it be the provision of advice for minor problems or the arrangements for admitting to hospital a young person with serious mental illness'.[9]

A recent report issued by the Department of Health on the implementation of Standard 9 of the Children's NSF ('the Department of Health CAMHS report') confirms that there have been significant improvements in CAMHS. However, the report notes that service provision and access vary between different parts of the country and that, whilst CAMHS in general has improved, 'the slow rate of progress in some areas means that not all children and families are benefiting as they should'.

The Department of Health CAMHS report notes that the 'distribution of beds across England remains inequitable'. Moreover, there is a continuing shortage of in-patient units. As a result, young people are still being admitted to adult wards (during 2005/6 29,306 'bed days' were spent by 16/17 year olds on adult wards, with 353 'bed days' spent by under 16 year olds) or are being cared for on paediatric wards. Information on the number of young people affected is not collected. Being cared for either on an adult ward or a paediatric ward both give rise to concern about the appropriateness of the therapeutic environment. Alternatively, young people may have to be cared for outside their local area because of a lack of local provision which 'disrupts family and social life and presents difficulties for the provision of mental health care when work with families is required'.

The report also notes that the number of beds for adolescents rose from 459 in 1999 to 625 in 2006, an increase of 36%[10]. However, the distribution is uneven across England and there are few dedicated in-patient CAMHS resources in Wales.

[9] Department of Health (DH) and Department of Education and Skills (DfES). 2004. Op cit.
[10] Department of Health (DH). November 2006. Op cit.

There has also been a welcome increase in the number of beds in Forensic Secure Units commissioned centrally for young people who are a danger to themselves or to others, or who have committed criminal offences.

There have been a number of developments that have stimulated positive change in mental health trusts. These include the development of Early Intervention for Psychosis Teams for 14-35 year olds as a key part of an overall strategy to reduce the stigma of psychosis and reduce the length of time young people remain undiagnosed and untreated. This may help to promote recovery during the early stages of illness and support the planned reduction in the use of adult in-patient beds by young people.

The increased focus on CAMHS, along with additional resources and investment, is having a positive impact in a number of areas of service provision. This reflects the considerable efforts of many people at both national and local level. Commissioning is the key driver in ensuring that these service improvements are planned and taken forward, though inspection and greater patient and user involvement also have a role to play.

Overview of the Findings

The information gathered from the young people, parents and staff who took part in this consultation presents a mixed picture. Some young people experienced a good level of care and support on adult psychiatric wards. However, these positive examples are largely overshadowed by the more widespread negative experiences of young people. Many were left feeling isolated, bored, uninformed and uninvolved in decisions about their mental health care. Even more worrying, it is clear that some of the young people had felt extremely unsafe in environments which were designed to provide security, treatment and care. For example, some of the young people described how they had been at risk of aggression or sexual harassment from other patients.

A number of the young people had been subject to sections of the Mental Health Act 1983 and had been provided with little or no explanation as to what this meant. Several of the young people had experienced restraint.

Financial constraints in England & Wales and Primary Care Trust (PCT) boundary arrangements in England appear to have played a role in a number of the journeys, with young people and parents giving examples of time-limited funding for admissions to independent units; young people being moved because they were in the 'wrong' hospital for their PCT or were about to turn seventeen, and young people not being able to take part in ward activities because they came from the wrong geographic area.

Overall, the different journeys demonstrate that, despite the positive developments, access to in-patient Tier 4 CAMHS remains problematic in many parts of the country and young people are still being placed on adult wards as a direct result. Furthermore, when they are placed on adult wards, the level of care offered to young people is – all too often - unsatisfactory, poorly planned and inadequately monitored.

Young people involved in this consultation

In total, 16 young people between the ages of 13 and 19 years and 7 parents were consulted. Five members of staff who were either working with one of the young people consulted or had supported other young people through an admission to an adult ward also shared their perspectives in this consultation process. As far as possible, the words of the young people themselves – and their parents, families and the staff working with them – have been used to describe their experiences and to illustrate the issues and concerns raised.

Most of the young people involved in this consultation were living in the community, many at home, following their admission to an adult facility which had happened some time during the previous 18 months. Only one young person was consulted whilst an in-patient on an adult ward. This is because, although several young people were identified whilst still in-patients on adult wards, they were not well enough to share their views with the project team until after they had left the hospital. Two of the young people consulted were contacted whilst they were in specialist therapeutic placements that had been organised for them on discharge from the adult in-patient ward.

Some very powerful messages emerge from the information gathered and whilst the total sample is not large, there was good geographic representation in that young people and families came from the North, North West, East, South West, South East and Midlands areas of England and both North and South Wales. Although it cannot be assumed that all young people would have had the same experiences, there was a high degree of consistency across the different journeys about certain key issues from which much can be learnt.

Participant profiles

Shaun	When Shaun was 10 his Dad died. Following this he had counselling, and then more counselling in his early teens. At 16, Shaun was arrested for shoplifting and drug possession. He spent the next two and a half years being admitted, discharged and readmitted to an adult psychiatric unit in his local area, during which time, on a number of occasions, he was placed on a section of the Mental Health Act 1983.
Sam	Sam was prescribed anti-depressants in his early teens. At 15 he experienced an acute psychotic episode. His local adolescent unit was full and since he was told that the only alternative was the local police station, Sam agreed to go to the acute adult facility. He was discharged four days later into the care of his mother while his CAMHS psychiatrist tried to find him a place in an adolescent unit. Sam was finally admitted to his local adolescent unit roughly 9 months after his first psychotic episode.
Jack	When he was 17, Jack began hearing voices and thinking that people were touching him. After a mental health assessment Jack was admitted to an adult unit about half an hour away from his home. This was because there was no room in the local young people's unit. After a month Jack was discharged but had to be readmitted 5 weeks later to another adult unit. He found this much more difficult than the first unit because the patients were much older and the staff did not seem to know how to talk to young people.
Amber	After episodes of violence and drug taking, Amber was expelled from her school at 14. Two weeks after being admitted to her local hospital, Amber attempted suicide and was admitted to an adult psychiatric unit. After two months, Amber tried to leave but was detained under Section 3 of the

	Mental Health Act 1983. After trying to run away, Amber was placed in a children's secure unit, and there followed a succession of placements. During her in-patient stays, Amber was often heavily sedated and at no point was she offered any education.
Tom	Tom spent most of one night in his local Accident and Emergency department after he had tried to kill himself since no adolescent in-patient bed could be found for him. He was 15 at the time and had no idea what was happening because no-one talked to him. The following day he was admitted to his local adult ward where he stayed for five days until it was possible to transfer him to an adolescent unit.
Mark	Mark's first admission was to his local adolescent unit was when he was 16. He remembers the unit as "really good" and he stayed for just over a month before being discharged to a community service offering intensive support. Unfortunately he then had another crisis and needed further in-patient care – however, because it was felt that he needed a high level of security and because he had just turned 17, the adolescent unit would not take him. Mark then spent nearly a day in his local police station before being admitted to the local adult unit.
Hattie	Hattie was first admitted to her local general hospital at the age of 16 when she was depressed, self-harming and misusing drugs and alcohol. She was transferred to an adolescent unit, which was followed by a three month period of stays in various hostels and hospitals culminating in her admission to the locked ward of a local adult unit. Hattie spent much of her time alone in her room on observation, during which time she observed staff openly disagreeing about her care.

Laura	Laura was admitted to her local adult ward when she was 15 as an emergency admission following a very serious episode of self-harm and feeling suicidal. She was told that she would only be on the adult ward for a few days but because no adolescent bed could be found, she ended up staying for a few weeks. Laura was discharged very abruptly from the ward in a taxi which was meant to take her to her local social services office, but then got lost on the way. Laura asked to be taken to a local youth project that she knew instead. Further in-patient stays followed before Laura was offered a year long therapeutic residential programme.
Helen	Following an overdose when she was 16, Helen was taken to her local Accident and Emergency Unit. The staff wanted to admit her but the only available beds were in the adult ward which refused to take her and so Helen had to return home. She was offered support from the local mental health crisis team for adults but did not find this helpful. Eventually after three months of pushing by her parents, a placement in an independent sector adolesent unit was agreed – however, this ended very suddently when she turned 17. A number of admissions to adult wards then followed. Helen experienced the use of restraint and seclusion and being detained under the Mental Health Act 1983. She stayed on one ward for over a year during which time she received no education and only limited access to activities due to staff shortages.
Louise	Louise visited her local A&E numerous times following incidents of self-harm and taking overdoses, however, although she was assessed on several occasions by the duty psychiatrist, she was not admitted to hospital. A journey involving multiple placements including a secure unit then followed. Finally, Louise was referred to her local forensic CAMHS and has been supported to take up a place in a

	college.
Gemma	Gemma experienced several attempts to admit to her to in-patient Tier 4 CAMHS services all of which were unsuccessful because she was deemed “not appropriate” although it was never really explained to her what this meant. At 17, Gemma was referred to her local community mental health team (CMHT) for community support. Gemma wanted to take part in this consultation because she has felt very isolated throughout her contact with mental health services and thinks that the care that she is now receiving is too adult-focused.
Mary	Mary began cutting herself and taking overdoses when she was about 7. Living in a very rural area, it was very difficult to see anyone from local health services and she remembers really only getting help when she went to university. Mary had her first admission to an adult mental health ward when she was 19 and found this a very unhelpful experience because the ward staff were always so busy that they had no time to talk to her and there was very little to do.
Charlotte	Charlotte was admitted to her local adult ward when she was 17. She was put on observation and because of her age, was given her own room and allowed flexible visiting times to ensure she could keep in touch with her family. Charlotte was discharged to the care of a team offering intensive community support with back-up from the adult in-patient ward. Charlotte is worried that as the ward has a waiting list if she does need a further admission, she will have to go a long way from her home because there are no other in-patient mental health beds in the area.

Themes arising from the young people's journeys

This chapter summarises the key themes raised by the young people and parents who took part in this consultation. Details of participants and the names of in-patient facilities have been changed to protect the confidentiality of the young people and their families.

The issues raised have been grouped into five areas of common concern:

1. Inadequate response to crises
2. Lack of information and inadequate involvement in care planning
3. Nothing to do, no one to talk to
4. Lack of safety, security or therapeutic care
5. Disorganised discharge arrangements

"...it seems like they (mental health and social services) wait until there is a crisis and then they say they can't cope"

Anne, parent

1. Inadequate response to crises

Many young people end up as in-patients in adult psychiatric facilities as a result of a crisis to which CAMHS are unable to respond, often due to a lack of emergency beds for adolescents. Six of the young people consulted began their journey through adult mental health services as an emergency presentation.

The point of admission to in-patient mental health facilities can be a frightening and traumatic experience. The lack of access to emergency CAMHS and insufficient coordination between services meant that many of the young people consulted experienced delays and uncertainty as to where they were being taken and this, understandably, exacerbated such feelings.

From the descriptions of some of the young people, it is clear that great efforts are often made by clinical staff and managers to avoid placing the young people on adult wards. However, this can result in young people being held in inappropriate settings, such as police cells or A&E wards. At other times, they may find themselves being moved from one service to another, sometimes after a matter of hours.

Waiting until a crisis point is reached

A number of the Journeys demonstrate missed opportunities for early intervention to help the young people and which would have avoided the situation reaching a crisis point. Comments from young people and parents illustrate the problems in getting help and the resulting frustration and anxiety:

> Louise **"Sometimes I would take myself to the hospital to ask for help… I thought I was going mad but the doctors wouldn't do anything…."**
>
> Anne, the mother of a young person with experience of multiple residential placements, including adult in-patient services: **"…it seems like they**

(mental health and social services) wait until there is a crisis and then they say they can't cope"

Louise's mother explained that when she first approached social services for help, as Louise's self-harming seemed to be getting more extreme, she was told that Louise didn't need them and that they had nothing to offer.

Elizabeth, mother of a young person with experience of adult mental health and secure provision: felt that she had not been taken seriously by her local mental health services when she first tried to seek help for her daughter who had just turned 14 and was being bullied at school and misusing drugs. She explained that her daughter's school had also tried to get help but without success. Later on, when her daughter took an overdose, it was recommended that the family should have some counselling, but this never happened due to the long waiting times for CAMHS appointments.

Lack of availability of age-appropriate facilities

Problems with local in-patient CAMHS being full or unavailable due to staffing shortages and a lack of age-appropriate emergency in-patient resources was one of the recurring themes arising from discussions with the young people.

Several of the young people were aware that they were placed on adult wards because of problems in getting them a place in an adolescent unit:

Jack (aged 17) was told that there was no room at the young people's unit. His mother was told that that the young people's unit only took young people who were still in education.

Tom was taken to the local A&E department at about 8.30pm at night. Tom stayed in A&E all night and at about 5.30am the following morning, he was admitted to the local adult mental health ward. Tom

learnt afterwards that the reason he stayed in A&E so long was that the staff were trying to find an adolescent bed or somewhere more suitable than the adult ward.

Sam agreed to his emergency admission to the local adult ward after being told that the only alternative was the local police station. His mother describes how the psychiatrist from their local CAMHS faxed an urgent request to the local Tier 4 unit for Sam to be admitted. The unit responded that they were full and that it would be two weeks before they would be able to offer an assessment. She remembers the psychiatrist then spending the next three hours on the phone trying to find Sam an adolescent bed but nowhere in the country had any spaces.

Charlotte talked about the need for services to be able to respond more promptly and made the comment that: **"worrying about whether there is a bed for you really makes it worse".**

The comments of several parents suggest that it was only by their being extremely vociferous in their demands for an in-patient bed for their child that any progress was made in securing an admission. In one case, this included a family organising and paying for an assessment and saying that they would pay for a bed in an independent unit. In another case:

Sam's mother: In her opinion, it is only because she made "a really big fuss" and "took things as high as she could" that Sam was later offered the two admissions to independent units. She remembers arguments at this time between her local CAMHS and social services, with the CAMH service saying that social services should offer something because of the local Tier 4 unit being full. She also learnt that the Tier 4 unit in question did have empty beds but could not accept any referrals because it was very short of staff – this is something she feels must be urgently addressed.

Sam also wanted to highlight that some things only happened because of people (his mother and his community psychiatrist) 'jumping up and down'.

Although the NSF for Mental Health makes clear that where admission on an adult ward is necessary, this should only be for a 'short period', Laura's and Helen's experiences show that the length of stay can be anything but 'short'.

Helen stayed on the ward for just over a year (much longer than any of the other patients).

Laura was told on admission that she would only be there for a few days but, because nothing else could be found, she ended up staying for a few weeks.

Specific problems for 16 & 17 year olds

Young people and parents identified particular problems for those aged between 16 and 18, including the lack of clarity over who is responsible for the treatment and care of this age group:

Louise feels that the major problem that affected her was the lack of appropriate services for young people between the ages of 16 – 18. She also commented that there is **"nowhere you can go to get help as a family".**

Mark a short while after his discharge from the local adolescent unit, Mark hit another crisis and this time it was felt that the adolescent unit could not offer him the security he needed. He had also just turned 17 and this seemed to be a problem too.

Gemma felt isolated and uncomfortable and that her care was too adult-focused and she was still only 17. She wanted to share her views about this

and about her experiences of mental health services in order to highlight the gaps between services for young people and services for adults: **"You need something in-between rather than just jumping from child to adult services….you need one specific person who will stick with you and not lots of different people who just pass you on the whole time…"**

Helen's mother felt that her daughter was in a very difficult situation due to her age (17): **"She was between a rock and a hard place, neither a child nor an adult, and they didn't seem to take account of that. They said she'd be better in the locked ward because there were only 6 of them there whereas in the open ward there were over 20 adults and a lot of self- defeating behaviour and she'd see too much. But neither was a good place for a young person. She ended up with another section because she couldn't cope."**

Charlotte's father expressed concern about the level of support that his daughter would be offered once she passed 18 but considered that this would be an improvement on the **"neither one thing nor the other age group of 16-18s"**

"Police cells should not be used to hold young people"

Mark was living at home and attending the local CAMHS service because he felt very depressed and had thought about killing himself. Mark's first in-patient admission was to the local adolescent unit when he was 16. He stayed for just over a month and was then discharged home and referred to a new local service offering intensive support in the community to try and reduce the need for young people to be admitted to hospital.

A short while after his discharge, Mark hit another crisis. He was now 17 and it was felt that the adolescent unit could not offer him the security he needed. He was taken to the local police cells in the back of a tiny van where he waited for over 12 hours. He thinks that his parents were not allowed to join him in the custody area.

After his eventual admission to an adult unit, Mark remembers having all his belongings taken from him and, although he was meant to have a key-worker, no arrangements were made for them to meet.

In the adult unit, Mark felt isolated as all the other patients were much older than him. He found it difficult to access a private space to see family or friends as the few rooms available had to be booked in advance.

Mark is now being supported by his local Community Mental Health Team (CMHT). In hindsight, Mark feels that he would have benefited from returning to the adolescent unit for his second admission as he felt staff there were more aware of his needs, he would not have felt so isolated and there was much more for him to do.

Mark feels strongly that police cells should not be used to hold young people waiting for admission to a mental health ward and that should be more places that can admit young people whatever the level of security they need. He would also have liked to have seen an advocate or someone independent who could explain what was happening and what his rights were.

Mark's journey

Commentary

The timely provision of care

Some of the young people and parents commented on the lack of help at an earlier stage, before a crisis point was reached. This was also an issue raised in Standard 9 of the Children's NSF. This document notes that young people who may require urgent treatment include, in addition to young people who are psychotic or suicidal, those who have become more urgent as a consequence of the more routine services having been unavailable to them when needed. Thus the CAMHS Standard suggests that one way of reducing the unpredicted out-of-hours demands would be to improve existing services and designing them to take account of views expressed by children, young people and their families.

Access to age-appropriate care

One of the ten markers of good practice in the CAMHS Standard is that:

> 'Children and young people who require admission to hospital for mental health care have access to appropriate care in an environment suited to their age and development.'

It is clear from this consultation that, in spite of this expectation, young people are still being admitted onto adult psychiatric wards. While some young people's experience was positive, this was not the case for others:

> Amber feels that her stay on an adult ward "mentally really hurt" and that it "isolated and damaged" her. She feels that her experience there became an integral part of the problems of her problematic past.

> Hattie was very clear that being on an adult ward had made things worse for her. It has had a bad effect and left her feeling that it has contributed to her problems, something she will need treatment for - **"treatment to get over her treatment"** she has commented. She

> feels that it has also led to her receiving a new diagnosis. Previously this was depression, now it is post traumatic stress disorder with borderline personality disorder.

It is unacceptable for young people to have been put through such traumatic experiences.

Elimination of use of adult wards

The Department of Health's report on the implementation of Standard 9 of the Children's NSF states that the:

> '…elimination of the unacceptable use of adult wards will take time to allow commissioners and providers to plan and develop alternative services. This should be possible within a five year period.'[11]

The report recommends that, in order to meet the NSF standard:

- CAMH Tier 4 services have adequate numbers of beds both for adolescents and for the smaller number of younger children who require in-patient treatment;
- Services and the environment are appropriate to the needs of older adolescents;
- No children under 16 are admitted to adult wards;
- All older adolescents requiring in-patient treatment are admitted to a specialist CAMHS unit unless, for reasons of maturity and independence, they prefer to be admitted to a ward specialising in treating young adults.

As Sam's mother points out, it is essential that there are sufficient numbers of staff working in CAMH Tier 4 services. Such staff must have the appropriate qualifications and experience.

Although it is inevitable that the elimination of the use of adult wards will take time, it is essential that plans are put in place to ensure that progress is made as rapidly as possible towards this and that those under the age of 16 are never admitted to adult wards.

[11] Department of Health (DH). November 2006. Op cit.

Services for 16 & 17 year olds

Another marker of good practice in the NSF relates to provision for 16 and 17 year olds:

> 'Child and adolescent mental health services are able to meet the needs of all young people including those aged sixteen and seventeen.'[12]

The Department of Health CAMHS report sets out a range of pointers for delivering good practice in relation to this age group. For those who are in need of in-patient treatment, the report makes clear that CAMH Tier 4 services must be closely linked with community and outreach services and that these must extend to 16 & 17 year olds.

Young people's recommendations

Young people involved in this consultation made the following recommendations regarding this theme:

- In-patient services need to be able to respond more immediately;
- Respite-type resources that provide immediate support should be available, for example, a place to stay and staff who can work with young people to sort out what is happening and what help they need;
- In-patient services for young people must be able to address the wide range of needs young people often have, including being able to offer a high level of security and being able to manage difficult or disturbed behaviour (several of the young people had been told that they were 'inappropriate' for their local CAMHS unit because their needs and/or behaviour were too challenging);
- There should be services that are age-appropriate, supportive, and that offer young people the chance to meet other young people who are having difficulties and to do things with them.

[12] Department of Health (DH). November 2006. Op cit.

“They just didn’t listen enough… my care plan was just a piece of paper that I signed.”

Shaun

2. Lack of information and involvement in care planning

The disregard of the need to inform the young people and take account of their views was evident on a number of fronts. Many of the young people who took part in this consultation commented that they did not know what was going to happen to them, what to expect on admission or when they might be discharged. This lack of information compounded their fear and confusion about being admitted to in-patient services. Crucially, the young people's comments and views highlighted that even though many of them had been seriously unwell, they had felt a strong need to be involved in their care. For example, a number of them described feeling remote from the decisions made about them and expressed a desire for the greater provision of independent advocates who could speak up on their behalf.

This section considers the following issues raised by the young people and their parents:

- Lack of information;
- Information provided inappropriately;
- Lack of involvement in care planning.

Lack of information

In addition to the inadequate information about their general treatment and care, many of the young people were given very little information about their rights (in particular, regarding the use of sections of the Mental Health Act 1983). Only a very few were told about access to advocacy support. For example:

> Amber does not remember anyone explaining to her about her rights to leave and how they could be overridden.

> Hattie when she arrived in a ward full of adult patients, she was not shown around nor were her rights explained to her.

Shaun was not told that he might be discharged until the meeting itself.

Laura was put on Section 2 of the Mental Health Act and remembers that she had no idea what this meant; when she was admitted, she was told that she had been put on "suicide watch" although it was not explained what this meant.

Helen wanted to emphasise that the only time anyone sat down with her to try and explain things was when she tried to leave the ward and had to be restrained. This was after she had been told at the ward round that the staff were thinking of putting her on a section.

Mark "**The only information that I got was that I was going to be put on a section and taken to the local adult ward**"

Helen **"Young people need information and this must be written down and talked through since "you can't take it all in at once, you needed to sit down and think about it."**

Many of the young people who took part in the consultation had used illicit drugs. Two of the young people commented that it would help to have more information on these issues:

Shaun felt that staff at the adult psychiatric unit could have done more to get the message across to him about how drugs and drink were a big part of making him ill rather than asking, what Shaun saw as: **"…lots of pointless questions - when you're ill, you want answers to your own questions first".**

Sam expressed concern that there is not enough information for young people about how misusing drugs can affect her mental health and that the Government should do a lot more to raise awareness of the harm that drugs can do.

Information provided inappropriately

The time and manner in which information is given is also of crucial importance. For example:

Jack commented that things were explained to him some days after he arrived. However, he would have liked this to have happened sooner, especially about times for taking medication and what it was for, what times people could visit and how many, the boundaries of where he could go and what activities were available.

Amber feels the staff could have been very much kinder and more respectful of her and they could have helped her when she felt scared. For example, when staff took her blood pressure, they could have explained things a lot more to her, especially when she was sedated and required information to be repeated so that she was able to understand it.

Lack of involvement in care planning

Many of the young people commented that they were given few opportunities to be involved in care planning:

Tom found the staff very nice and supportive, but his big problem was that he did not know what was going to happen next. He only found out that he was going to be moved to an adolescent unit on the morning of his transfer to that unit. Tom commented that it was really important that when working with young people, staff**: "…don't just make decisions, tell their parents and leave them out of it…"**

Shaun felt that in the year and a half that he had been in the adult psychiatric unit, staff had never been good at involving him in his care plan, he did not have much input into it at all. **"They just didn't listen enough…my care plan was just a piece of paper that I signed."**

The lack of involvement in care planning was also was raised by parents of the young people.

Helen's mother talked in considerable detail about the long and difficult journey her daughter and the whole family had experienced over a three year period. She made the point that, whilst appreciating the need for confidentiality, a major problem for parents as prime carers is that information is not shared with them and their views are not taken on board. **"They didn't tell us that she was huddled in tears in a corner and that she was sectioned."** In trying to support her daughter, Helen's mother commented: **"We were seen as pushy parents, wicked even, I'd say. Because I'd go in twice a day, to make sure she got up and to help her look after herself and be clean. I got others to visit her and got people to write to her, so she didn't feel alone or abandoned."**

Elizabeth, another parent described the feeling of being **"completely on your own"** when young people are discharged home from placements. In her opinion, neither she or her daughter were ever properly involved in discussing the possible treatment options and it was also clear that there was no communication between the various agencies who were involved from time to time. Elizabeth concluded that things could have been very different if the local services had listened to her worries and addressed her daughter's problems when she first started to withdraw from school.

Amber commented on the failure of staff to involve her mother. She feels that little attempt was made to explain to her mum what was happening. The unit also refused to involve her mum in her care and

treatment and there was no financial or emotional support offered to her.

“It’s like walking a tightrope never being sure what would happen next.”

Helen took an overdose when she was 16. She was taken to her local A&E where the staff wanted to admit her to hospital. However, the only beds available were in the adult ward which refused to take her. Helen was sent home and referred to the local crisis team for adults.

After about three months of searching for an appropriate place, Helen’s parents managed to organise and pay for an assessment at an independent adolescent unit. Helen was offered a bed and it was agreed that the Primary Care Trust would pay.

Helen stayed at this unit for about three months. She remembers her discharge from the unit as being sudden without explanation. Helen felt as though staff packed her bags as she was about to turn 17.

Helen was at home for 3 - 4 months before she took another overdose and was admitted to an adult ward in a hospital outside her Primary Care Trust (PCT). After 24 hours, she was transferred to another adult ward in her area.

Helen stayed on this ward for a further week. She had no idea where she was and walking into the ward, the only people she saw were patients in their 40s and 50s. During this time, she remembers no input from any staff apart from when she was called into the ward round and told by three male staff, who she had never seen before, that they were thinking of sectioning her under the Mental Health Act. As a result, Helen tried to leave, she was restrained and taken to the locked intensive care where a member of staff sat with her and explained the meaning of Section 2. This was the first time that anyone had tried to explain what was happening to her.

After some time, Helen was discharged but she found the move from a contained environment to her home difficult, she overdosed several times and was admitted to an adult psychiatric ward on a section of the Mental Health Act.

Helen described waking up in a “huge room all on my own.” Still aged 17, she stayed on this ward for just over a year during which time, she experienced further use of restraint and seclusion. At no point were Helen’s educational needs discussed with her and she received no education. Due to staffing shortages on the ward, there was only very limited access to activities.

Helen was eventually discharged to a therapeutic placement. The programme is part in-patient and part day-patient and lasts for twelve months. Helen is now in the day patient part of the programme and living independently in a flat during the week. She said that her current programme is “hard but wonderful’ and that she has been fully involved in all the planning throughout.

Helen’s Journey

Commentary

Information and involvement in care planning

The lack of information provided to the young people in this consultation, inadequate steps to ensure that information is given in an appropriate manner and the failure to involve young people in their care planning is a cause for serious concern which must be addressed.

The provision of adequate information to young people and involving them in their care planning is a core feature of expected good practice. Point 1 of the 'Markers of Good Practice, Standard 3 of the Children's NSF', Child, Young Person and Family-centred Services states:

> 'Every child, young person and parent is actively involved in decisions about the child's health and well-being, based on appropriate information.'[13]

Similarly, Standard 9 states:

> 'The views of service users are systematically sought and incorporated into reviews of service provision.'[14]

The need to respect the views of children and young people is also enshrined in the United Nation's Convention on the Rights of the Child to which the UK is a signatory:

> 'States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child'.[15]
>
> **(Article 12(1))**

[13] Department of Health (DH) and Department of Education and Skills (DfES). 2004. Op cit.
[14] Ibid
[15] UNCRC Article 12(1).

It is therefore essential that young people are involved in planning their own care and know what to expect at every stage in line with the principles of the care programme approach. There was little evidence that this was the case for the young people we interviewed.

Involving young people in decisions on their medication

Keeping young people informed about the medication they are taking is also key - several of the young people alluded to the fact that they did not know what medication they were taking, what it was for and how it would affect them. Standard 10 of the Children's NSF, Medicines for Children and Young People, makes it clear that:

> 'Children, young people and their parents/carers receive consistent, up-to-date comprehensive, timely information on the safe and effective use of medicines.'
>
> 'In all settings, professionals enable parents, young people…to be active partners in the decisions about the medicines prescribed for them…'[16]

The draft Illustrative Code of Practice to the Mental Health Act 1983 (November 2006) that has been introduced alongside the Mental Health Bill ('the draft Code') states:

> 'Children and young people should always be kept as fully informed as possible, and should receive clear and detailed information concerning their care and treatment'.[17]

Furthermore, the draft Code points out that children and young people have the right to share in making decisions about their care and treatment.

[16] Department of Health (DH) and Department of Education and Skills (DfES). 2004. National Service Framework for Children, Families and Maternity Services Standard 10, Medicine for Children and Young People. Page 5.
[17] Department of Health (DH) 2006. The Draft illustrative code of practice to the Mental Health Act 1983.

Thus there should be shared decision-making between the young person and the professionals responsible for prescribing and administering the medication, with the young person being an active partner in the discussion about medication. Such discussions should include a review of the risks and benefits of the treatment proposed. This does not appear to have been the case for many of the young people who took part in this consultation. Since young people with severe and enduring mental health problems may well be using medication for many years, it is essential that they are encouraged to participate in these decisions and to learn to assume responsibility for their medication.

A multi-disciplinary approach to care planning

Some of the young people had been party to arguments about whether their care was the responsibility of social services or mental health services. It is not clear in what circumstances such discussions were held, but at the very least this indicates a failure to understand that both agencies are likely to have a role in providing support to the young person concerned. Both the CAMHS standard and the care programme approach emphasise the importance of a multi-disciplinary approach in order to meet the range of health, social care, housing, education and other support needs of each individual. The CAMHS Standard states:

> 'The lack of understanding of the respective roles, duties and responsibilities and organisation of the different agencies and professionals of their different language, may lead to poor communication, misunderstandings and frustration. Effective partnership working can improve children and young people's experience of services and lead to improved outcomes.'[18]

The poor levels of communication and co-ordination and the lack of agreement between services was probably the most prominent theme running through the information gathered from the five members of staff who took part in this consultation. They commented that this often left young people and families unclear about what was happening and that it often resulted in an absence of discharge planning and post-discharge support. In relation to young people who may be

[18] Department of Health (DH) and Department of Education and Skills (DfES). 2004. Op cit.

placed in secure provision, staff highlighted particular concerns about the lack of agreed protocols for involving staff from CAMHS and forensic CAMHS services.

Planning and developing services

As well as participating fully in decisions over their own care, it is government policy that service users in the NHS should be engaged in planning and developing services generally, not only in relation to their own individual care. Until relatively recently, parents' views were used as proxies for those of their children but there is increasing recognition of the contribution that children can make to service development[19]. This is intended to improve the level of services and to make sure that services are being designed around the needs of patients. This applies to patients who are children and young people as much as it does to adults. Whilst there has been considerable progress in achieving this in recent years in some clinical areas following implementation of the National Service Frameworks and the NHS Plan (partly in response to the report on the Bristol Royal Infirmary Inquiry (2001)[20]) which found services were not designed to meet the needs of children and young people - there is little evidence that young people are being involved locally in designing CAMHS and this should be addressed. Guidance is available for those seeking to involve young people in this way[21] (Lightfoot and Sloper: 'Having a say in health: guidelines for involving young patients in health services development', University of York, September 2002).

Confidentiality and sharing information

Ensuring respect for young people's right to confidentiality is important since some may not wish their parents to be given information about their treatment and care. Where the young person does not want such information to be disclosed to their parents or others involved in their care, mental health professionals must consider and act in accordance with their duty of confidentiality. The consequences of

[19] Lightfoot, J and Sloper P. 2003. Having a say in health: involving young people with a chronic illness or physical disability in local health services development; Children and Society volume 17. pp 277-290.
[20] The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-85, TSO
[21] Lightfoot and Sloper. September 2002. 'Having a say in health: guidelines for involving young patients in health services development', University of York.

withholding information should be explained to the young person. However, even where the young person does not wish confidential information to be disclosed, this does not prevent mental health professionals listening to, and taking account of, the views of his or her parents and others that provide care and support.

Young people's recommendations

The young people involved in this consultation recommended that all young people undergoing mental health treatment should:

- Be involved in their mental health care rather than having decisions made for them.
- Be given information about all aspects of their care, their treatment and their rights. This includes information about illicit drugs and how this can affect their mental health; about how their particular illness may affect them; about what will happen on an in-patient ward, medication and treatments and about discharge procedures.
- Have access to independent advice and advocacy support – this must be made available to all young people who are admitted to in-patient facilities.

"...praying for the future, to have an activity or a meal there is nothing to do, just wait for the clock to go by..."

Sam

3. ‘Nothing to do, no-one to talk to’

A strong sense of isolation, a lack of structure and little or no therapeutic input or care in adult units is evident from many of the descriptions offered by the young people. There was also an absence of education provision resulting in the serious disruption to some of the young people’s studies. Difficulty in making friends and problems with keeping in touch with their family and friends were also common.

Lack of activities

Over a third of the young people in this consultation described feeling isolated, lacking individual time with ward staff and ‘wall-watching’. For example:

> Sam described being in shock when he was admitted – “I had no idea such places existed.” The staff were very good and stayed with him all the time due to his age (he was 15) but the major problem was that there was nothing to do.
>
> Shaun said most of his time on the ward was spent in his room listening to music and staring at his wall, walking the corridors, eating, sleeping, smoking and drinking tea. He was not offered the opportunity to take part in any activities, even though there were many on offer for patients. It emerged that despite living only half an hour’s drive away from the unit, Shaun did not come from the right area of the county to be able to access the unit’s activities that involved trips away from the ward. Shaun believes that not having anything to do, and being denied the opportunity to take part in unit activities contributed massively to how low he felt while being a patient at the adult psychiatric unit.
>
> Jack’s typical day consisted of watching the wall, smoking cigarettes, eating and sleeping. After being there a while he took part in some activities – playing pool, artwork and gardening. However, activities were only available 1 day a week. For the other six it was back to the wall-watching. His family

were able to visit regularly and they could always meet in private. He did not wish to see his friends as they all took drugs.

Hattie spent a lot of time to begin with on 24/7 observation and up to 22 hours a day in her room. Hattie describes it as a month **"without sunlight or sky"**. Sometimes the only time she would be allowed out of her room was when the staff, who were responsible for observing her, wanted to watch something on TV. The ward did not have ready access to any grounds or open spaces. Hattie spent a month inside before she was allowed outside the ward. On a typical day Hattie would spend her time playing pool, smoking and talking to a spider in her room that she had made friends with. Every other day there would be a group run where they played board games and listened to music with an activities nurse.

Helen's mother commented that the locked hospital ward was wrong for her daughter as an adolescent - there was nothing to do, they provided only medication, not stimulation and it was a desensitising place. There was no structure - they wouldn't get Helen up, there were no activities to get up for, just a TV in the corner and some games with bits missing. There was no encouragement to wash or look after herself. There was no routine at all. They could take or leave meals. She went on to explain that the lack of care, the lack of activity, the lack of shower facilities, and of being on a mixed ward with others who brought in razors which she used to cut herself with, had all left Helen bitter about her experience.

A number of young people, who had also spent some time on an adolescent unit, were generally more positive about their experiences on such units, as compared to adult psychiatric wards. For example:

Tom moved from an adult ward to an adolescent unit where he stayed for three months and received medication, help with anger management and occupational therapy. He found the atmosphere more relaxed and there was a lot more to do than on the adult ward.

Mark's first in-patient admission was to the local adolescent unit when he was 16 and he remembers the care being really good. He stayed for just over a month and was then discharged home and referred to a new local service offering intensive support in the community to try and reduce the need for young people to be admitted to hospital. Mark remembers lots of activities and groups, that it was easy for his family and friends to visit and this was encouraged.

Laura felt that her experience on the adolescent unit was far better than on the adult ward – it was only when she went to the adult ward as an emergency that she realised 'how bad a place could be'. In her view, the adolescent unit had many more activities, education, better daily routines and more staff who could relate to young people whereas in the adult ward, she felt unsafe with nothing to do and no one to talk to. Best of all though is her current therapeutic residential placement where "you have to get involved – you are not allowed to stay in bed asleep all day" - but where everyone gets a lot of support and "you feel fully involved in anything that is being planned."

Anne has experience of her 15 year old son being in both an adolescent unit and an adult ward. In her opinion, the adolescent service was much better since there were more activities on offer and the young people could support one another. It also seemed like there were more staff about on the ward able to provide individual time with young people.

Charlotte (aged 17) felt that overall she preferred her experience on adult ward as they treated her as an adult whereas in the adolescent unit, **"you spent a lot of time sitting about with nothing to so – though they did offer a few good things like aromatherapy…**"

Difficulty in establishing friendships

Many of the young people found it difficult to strike up friendships on the ward due to the age gap between them and other patients:

Shaun commented that was always looking out to make friends but this wasn't possible in the way he wanted to as the other patients were all too old. In trying to make friends he started copying other patients.

Jack commented that the patients on the ward were harder to get on with as they were generally much older than him. Despite that, he found it helpful to talk to them as they were quite parental towards him, in a positive way.

Tom was the youngest on the ward by quite some margin – the next youngest person being about 35. The adolescent unit he was on had more staff than on the adult ward meaning there were more people available to talk with the young people. He found it much better to have other young people around him who had similar interests.

Mark felt very isolated as everyone else was much older.

Amber found it extremely difficult to make any friends after leaving the adult psychiatric unit because she was scared of being isolated again. This pattern contributed to a succession of placements that followed…"**It definitely still affects me now."**

Problems in keeping in contact with friends and families

Some of the young people found it very difficult to keep in touch with their families and friends.

Amber's mum lived half an hour away by bus and tried to visit regularly but her financial situation prohibited it from being more than once a fortnight (she had lost her child benefit when Amber was admitted into hospital). Occasionally a friend would come and visit her but this was hard to arrange as people under the age of 18 weren't meant to be allowed on the ward.

Mark commented that on the adult ward it was much harder to find a private space to see family or friends – the few rooms had to be booked in advance.

Jack however, commented that his family were able to visit regularly and they could always meet in private.

Lack of education

The lack of arrangements for young people on adult wards was highlighted by two young people involved in the consultation.

Amber was not offered any education during her seven month stay on the adult psychiatric ward despite being 14 at the time of her admission. She is doubtful that the unit could have offered her any schooling even if she had asked for it.

Helen (aged 17) stayed on an adult psychiatric for over a year. She received no education during this time and, due to staffing shortages on the ward, there was only very limited access to activities such as occupational therapy and pottery. Helen's perception was that the staff had no interest in her educational needs whatsoever.

"Being in a unit with people your own age is really important."

Jack was a child who lacked confidence and started smoking cannabis at age 11. At 17, he moved into a house where there were a lot of drugs around. After about four months Jack began hearing voices and feeling like people were standing around him, touching him. The voices would shout at him or tell him jokes and then shout at him if he didn't find them funny. Jack used to find himself on the floor, holding his head and hitting himself.

After three weeks of these symptoms, Jack told his Mum and she spoke to the duty doctor. The next day, Jack met with the local crisis team who carried out a mental health assessment and asked him to go to hospital. Jack was told that there was no room at the young people's unit (his mother was told that the unit only took young people who were still in education) and so he agreed to be admitted as a voluntary patient to an adult unit about half an hour's drive away from his home.

At 17, Jack was the youngest in the unit. It took a few days for Jack to be given information about his medication, visiting arrangements, boundaries of where he could go and what activities were available. Jack felt these should have been provided earlier.

On a typical day in the unit, Jack said that he watched the walls, smoked cigarettes, ate and slept. He did begin to take part in some activities such as playing pool, artwork and gardening but these were only available one day a week. His family visited regularly and they could always meet in private, but Jack did not wish to see his friends as they all took drugs.

After about a month, Jack felt that he was OK and took the initiative to discharge himself. He was assessed by a doctor who decided not to section him. Jack declined the doctor's offer of help and returned home to his Mum's house.

At home, Jack kept experiencing severe mood swings and five weeks later, he threatened to kill himself. He agreed to go to hospital voluntarily and was admitted that same day. It was not to the same unit he had been to before and Jack was not told why. He would have preferred to have been with familiar people. He also felt the staff in the second unit didn't quite understand him because they were used to dealing with older adults and that the patients were harder to get on with. After a couple of weeks, Jack stopped having negative thoughts and was discharged on the understanding that would continue taking his medication and keep seeing the EI (Early Intervention) worker every fortnight.

Two months after being discharged, Jack decided that didn't need to see the EI worker anymore. Looking back, Jack feels that being in the units helped him as they got him off drugs and the voices stopped. He wanted to emphasise the need for more activities and information to be available on the wards and stressed the importance of being amongst other young people.

Jack's Journey

Commentary

Lack of activities

The lack of activities and resulting isolation and boredom is a striking – and very worrying - feature of many of the young people's time on adult wards. The need to ensure that wards are able to provide an appropriate environment and facilities for young people was one of the recommendations made by the Mental Health Act Commission (MHAC) in its 2004 report [22].

For care to be age-appropriate, it is essential that young people are occupied to the extent that they are able to cope with at any particular time.

Lack of education

The lack of education for young people on adult wards is of serious concern. This was also highlighted by the MHAC. It found that there were often no arrangements for the continuation of education for young people detained on adult wards, even for those below 16 years old and of compulsory school age. A failure to provide such education risks contravention of Article 28 of the United Nations Convention on the Rights of the Child (UNCRC) which gives young people the right to education wherever they are located. This was the case for Amber who spent seven months on an adult ward, having been admitted when she was 14, with no attempt to make any arrangements for her education.

Guidance issued by the Department for Education and Skills makes clear that children and young people admitted to psychiatric units retain their entitlement to education and that they should be able to access 'suitable and flexible education appropriate to their needs'[23]. The guidance states that a child or young person who is unable to attend school because of medical needs should have their educational needs identified and receive educational support quickly and effectively.

[22] Mental Health Act Commission (MHAC). 2004.'Safeguarding children and adolescents detained under the Mental Health Act 1983 on adult psychiatric wards'.
[23] Department for Education and Skills. November 2001. 'Access to Education for Children and Young People with Medical Needs'.

Furthermore, the 'Draft Illustrative Code of Practice to the Mental Health Act 1983 (November 2006) that has been introduced alongside the Mental Health Bill, states that:

> all 16 and 17 year olds 'who wish to continue their education should not be denied access to learning merely because they are receiving medical treatment for a mental health condition'.

It is important that action is taken to ensure that young people can continue with their education, especially those who are of compulsory school age.

Visiting arrangements

Facilitating visits with families and friends is of crucial importance. The problem with arranging visits for young people on adult units was raised by the staff involved in this consultation. They commented that often wards have policies prohibiting child visitors which can mean that young people are not allowed to have any visits from their friends/peers or indeed their siblings. The need to address this problem was also highlighted by the MHAC. It is recommended that there should be appropriate visiting areas available for families, including siblings and other children and young people.

Young people's recommendations

The young people recommended that:

- Young patients are given the opportunity to participate in daily activities.
- Visiting arrangements are improved and dedicated spaces on wards are provided in order to ensure that young people do not lose contact with their family and friends and are able to meet with them in comfort and privacy.

"no one knew what to do with me and nothing really happened, nothing was offered to me"

Mary

4. Safety, security and therapeutic care

Many of the young people felt a lack of safety and protection during their time on adult psychiatric units. While some young people's journeys provided examples of good practice such as offering young people designated rooms on their own, ensuring staff supervision at all times and providing more flexible visiting arrangements, these are still far from the norm. In addition, some of the information provided by the young people indicates that they had been subject to harassment from other patients which appeared to have been inadequately dealt with, or ignored by staff. In some cases, staff were threatening or verbally abusive. Some of the young people were able to engage in harmful practices such as misusing drugs or self-harming whilst on the ward and several young people had personal property stolen from them.

The journeys also highlight the problems arising from a lack of staff in adult mental health services with training in, and/or experience of, working with children and adolescents. Furthermore, many of the young people described difficulties with staff on adult psychiatric wards. Often the staff appeared to lack interest or empathy with the young person's situation. A number of young people had problems with other patients but found that staff were not willing to take steps to resolve matters. In some cases, members of staff were threatening and/or abusive towards the young person.

Lack of staff engagement with young people

The unwillingness of staff to engage with them was a common experience among the young people admitted to adult wards:

> Amber found staff hard to talk to and was frustrated that they seemed to spend most of their time moaning at her or reading magazines. Amber describes witnessing "a lot of aggression between patients and staff", that she thought resulted from staff's lack of empathy for the patients.

Shaun found that although staff were sometimes helpful and open to talk to on other occasions, when he was supposed to be on one-on-one observation, they were not very good at listening and talking with him.

Mary found that it was really hard to find staff with the time to talk to her – sometimes at night, the nursing staff might be free, but in the day-time, the ward was just too busy.

Jack feels that staff did not understand him was because they were more used to dealing with older adults.

Mary **"An alternative to hospital …would have been good…just somewhere/someone to talk to who can communicate at our level - someone who is willing to change the way they work rather than expecting that we communicate in their way."**

Some of the young people commented on the lack of therapeutic input from staff:

Helen commented that she would have liked more time to talk – more therapeutic input – and she feels that had she received help of this type it might have prevented her first overdose and all the difficulties that followed.

Helen's mother described her frustration with the lack of activities and therapeutic input available to her daughter: **"They said occupational threrapy was available, but there's a gap between what's on paper and the reality. People were off sick and there'd be no cover, or the room was being used for something else. I'd say she was lucky if she had it once a week… they called it the intensive care ward and it's meant for short sharp stays but she went there because there was nowhere else and they said they understood her problems. But there was no talking therapy and the care was only as good as the staff on duty. I felt it made her problems worse."**

Mary felt that **"no-one knew what to do with me and nothing really happened, nothing was offered to me…I hate the 'label' and the fact that it is going to follow me around for life now and dictate all that I can and cannot do".**

Mark was meant to have a key worker but did not manage to meet with them.

Young people who had experience of both adolescent wards and adult wards had differing views on their experiences.

Mark expressed the view that the staff on the adolescent unit really seemed to know how to talk to young people whereas on the adult ward, there was less staff and **"they just seemed to be there to stop things going wrong…"** He also commented that on the adolescent unit, the doctors seemed to be around and talking to everyone but that on the adult ward, you only saw them at the ward round.

Helen stayed on an independent adolescent unit for about three months and whilst having nothing to compare it against, Helen describes feeling that she was older than everyone else (she was nearly 17) and that as a result, the staff expected her to be an adult. She was put on medication but does not remember being offered much else in terms of therapy. However, when later admitted to an adult psychiatric ward, she describes being made to feel like **"I was an attention-seeking child"**

However, Charlotte had a different perspective:

Charlotte described the adult ward as being **"very old, dirty and smelly"**, but preferred it to the CAMH ward because the staff **"treated me like an adult and not a child… they tried to get to know me and didn't just talk about my problems.**

Problem of negative staff attitudes

Some young people described some negative experiences with staff, and in some cases felt threatened and intimidated by staff. For example:

> Shaun when he challenged one member of staff about something the staff member response was **"Watch it, I know a lot about you!"**
>
> Amber feels that staff could have been much kinder and more respectful towards her. She felt they did not understand her and failed to reassure her when she felt scared or, adequately explain what was happening to her (particularly as she was often sedated and required things repeating in order to understand). Amber found staff hard to talk to and was frustrated that they seemed to spend most of their time moaning at her or reading magazines. Amber describes witnessing **"a lot of aggression between patients and staff**", that she thought resulted from staff's lack of empathy for the patients.
>
> Hattie felt that there were only a couple of members of staff who were at all kind to her, the rest she found to be ambivalent, patronising, unkind or cruel. She describes how she was threatened with having her clothes removed by a male member of staff if she did not agree to a strip search and being sworn at by staff.
>
> Helen's mother commented: **"If they'd listened it could have saved so much distress. The system was so very negative. She has lost 3 years. I know she'll move on but the scars won't go. She has written to the doctor to say make sure others don't experience what I had. The problem is she's quite bitter, though perhaps it's cathartic to have written. They shouldn't have been so intent on finding a mental illness. She's a great kid and this shouldn't have happened."**

A number of the young people commented on the staff's unwillingness or inability to ensure that their belongings were kept safe:

Jack said that there was one staff member who used to mess about with his and other patient's belongings when they weren't around.

Amber was on a dormitory attached to an office for two months so that she could be seen. During this time, an old woman called Mary wouldn't leave Amber alone and would regularly take her teddy bear along with the duvet and pillows from her bed. Staff were unable to stop this from happening.

Shaun had lots of items stolen from him. Sometimes his property (such as CDs, clothes and tobacco) would be moved while he was on leave and would then go missing. Shaun feels that staff did not respect his belongings.

Inadequate protection of the health, safety and wellbeing of young people

Many of the young people have felt unsafe on the adult psychiatric wards.

Laura **"Whilst the ward might have been physically safe, it didn't feel it"**.

Helen comparing her experiences of the adolescent unit and the adult wards, Helen noted that the adolescent unit felt much safer and it was cleaner, more comfortable and homely – "**which is important in helping young people to feel that they want to get better…"**

Louise's mother considered that a number of the units where her daughter was placed were highly unsuitable, not least because they were staffed by young inexperienced and unqualified staff. When Louise was in the secure unit, her mother made a complaint about the excessive use of physical restraint. Later on, because Louise's mother was so concerned about the much older residents, the lack of staff support and the amount of drug misuse

in the adult mental health hostel, she discharged Louise from the care of social services and took her home.

Hattie recalled that although the ward was kept locked due to her being considered a high risk patient, one day it was left unlocked and she managed to walk out. This was despite the fact that she was meant to be on one-on-one observation. The police found her later and returned her to the ward. On another occasion, when the deputy ward manager was accompanying her to the gym, Hattie walked off intent on leaving the hospital. The deputy manager simply waved Hattie goodbye. The police found her later on.

Sam's mother said that when Sam was admitted to the adult ward, he was very frightened. He was put in a room on his own because of his age which was good – however, one of the other patients tried to attack Sam and because this patient was 'a paranoid schizophrenic', the ward staff had been told not to tackle him. It took fifteen minutes for the police to arrive to deal with the situation.

Two young women described being sexually harassed while an in-patient, despite being on one-to-one observation at the time:

Hattie was 'hit upon' by male patients.

Laura was touched up by a male patient even though she was meant to be on one to one, 24 hour watch at the time. She commented that she was also able to cut herself when on one to one observation.

There was also one example of a young man engaging in sexual relationships with woman while on the ward:

Shaun had sex a few times with women in their late 20s while he was there. He did not use any contraception and contracted the sexually transmitted disease, Chlamydia. Although recalling that he was not well at the time he

accepts that it this was his choice, however, on reflection, he felt that he should have used condoms.

Availability of drugs and alcohol

Some of the young people had access to alcohol or illicit drugs while an in-patient.

Shaun recalls how there was a lot of drinking on the ward and that he took drugs on the wards that he got from other patients.

Jack was regularly offered cannabis when he was on the adult ward, although he was never threatened with buying or taking drugs. He observed another patient taking some speed or similar substance one day. Searches were never carried out on the unit.

Hattie was able to smoke cannabis (sometimes witnessed by staff), and consume spirits. She had been dosed with GHB (Gammahydroxybutrate, a dangerous drug with sedative and anaesthetic effects) by another patient and allowed to take alkyl nitrites (staff did not realise what they were).

Use of restraint

Two of the young people involved in the consultation described their experience of being restrained when on an adult ward:

Amber remembers being restrained by “old-fashioned police methods” after trying to leave the ward.

Helen recalled how she tried to leave the ward round when she was told about being placed on a section of the Mental Health Act. She was restrained and taken to the locked intensive care where a member of staff then sat with her and explained what a Section 2 meant. Helen emphasised that this was the first time anyone had tried to explain what was happening. Helen

commented that during the time she stayed on an adult psychiatric ward (just over a year) she was restrained and secluded.

"I need treatment to get over my treatment"

At the age of 16, Hattie was depressed, self-harming and was misusing drugs and alcohol. She was admitted to general hospital and transferred to an adolescent unit. She was discharged after 4 months. A three-month period of being moved around to various hostels and hospitals followed until Hattie finally arrived in a unit full of adult patients.

Hattie's rights were not explained to her, nor was she shown around. She took a number of overdoses and initially spent much of her time on 24/7 observation and up to 22 hours a day in her room. Hattie spent a month inside before she was allowed outside the ward.

The ward was meant to be kept locked due to her being considered a high risk patient. However, one day it was left unlocked though and despite being on one-on-one observation she managed to walk out. Police found and returned her later on.

Hattie found herself in a number of vulnerable situations where she ended up in fights, witnessed acts of violence, and was 'hit upon' by male patients, even when on 1-1 observation. Hattie was also threatened with having her clothes removed by a male member of staff if she did not allow a strip search. Finding herself abused verbally and physically, Hattie felt that staff were unable to protect her. Her primary nurse screamed at her to **"Get the fxxx out of my face"** with other staff present.

Hattie was able to smoke cannabis (including when witnessed by staff), consume spirits, be dosed with GHB by another patient and allowed to take alkyl nitrites (staff did not realise what they were).

During her five months on the ward, she was been abused verbally and physically, came to feel neglected and untrusting of the professionals responsible for her, and was able to abscond.

Hattie thinks that being on the adult ward had a negative effect on her and contributed to her problems. Hattie says she needs “treatment to get over her treatment”.

Hattie’s journey

Commentary

Serious concerns about young people's health and safety

The young people's descriptions reveal some extremely serious concerns about the environment on adult wards, with some very worrying incidents where young people's health and safety were put at risk, including young people engaging in unsafe and inappropriate sexual relations with other patients and having access to illicit drugs. Many of the problems seem to be caused by a lack of staff with the necessary training and/or experience in working with young people. However, of particular concern are the incidents in which young people have been intimidated or threatened by staff.

Staff interviewed as part of this consultation made the following comments about the environment on adult wards:

- On some wards, the average age of the patients is 60 and staff are not equipped to deal with adolescent behaviour or to provide activities likely to be of interest to younger people.
- Young people can be "**scarred by the experience… as young people, they can feel alienated as the only adolescent there**…"
- That young people can find admission to an adult ward a boring, lonely and frightening experience.
- There can be safety issues for young females placed on adult wards that can mean that they need supervision on a 24/7 basis.

Such comments and the experiences of the young people in this consultation highlight the need for urgent action to put in place the necessary safeguards to protect the interests of young people on adult wards.

The United Nations Convention on the Rights of the Child requires governments to ensure:

> '… that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by

competent authorities particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision'.[24]

Furthermore, governments must:

> '…take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse while in the care of parent(s), legal guardian (s) or any other person who has the care of the child.'[25]

Point 1 of the Markers of Good Practice, Standard 9 of the Children's NSF, The Mental Health and Psychological Well-being of Children and Young People states:

> 'All staff working directly with children and young people have sufficient knowledge, training and support to promote the psychological well-being of children, young people and their families and to identify early indicators of difficulty.'[26]

The Department of Health's report on the implementation of Standard 9 of the Children's NSF[27] states that where children and young people are admitted to adult wards, the key concerns are that:

- The beds have been specifically set aside for such use and are single sex;
- The staff are Criminal Bureau (CRB) checked and have support and training available to them from child mental health professionals;
- The Local Safeguarding Children Board is satisfied with the measures in place;
- Adult mental health staff and CAMHS work closely together to plan the care, discharge and after-care, utilising the Care Programme Approach;

[24] UNCRC. Article 3(3). http://www.ohchr.org/english/law/crc.htm
[25] UNCRC. Article 19(1) http://www.ohchr.org/english/law/crc.htm
[26] Department of Health (DH) and Department of Education and Skills (DfES). 2004. Op cit.
[27] Department of Health (DH). November 2006. Op cit.

- Education, recreational facilities and advocacy services are available to children and young people. Advocates are trained to work with children and young people and in mental health legislation; and
- Local authority and voluntary social care, vocational and housing services are part of the network supporting the young people.

The Children Act 1989 provides a specific safeguard for children and young people who are accommodated in hospital for over three months. The NHS Trust or independent hospital must inform the appropriate local authority (usually the authority in which the child or young person was living before being admitted into hospital) which is then required to take steps to ensure that the child or young person's welfare is safeguarded. This should include making visits to the child or young person. Furthermore, section 116 of the Mental Health Act 1983 requires local authorities to arrange for visits to be made to a child or young person who has been admitted into hospital and is subject to a care order and to take 'such other steps' as would be expected of the child or young person's parents.

Young people's recommendations

Young people recommended that all young mental health patients should:

- Be given time to talk with staff who have skills and training in working with young people.
- Not be admitted to an adult facility where they are the only young person on the ward.

“…high suicide watch and then suddenly I was on my own”

Laura

5. Disorganised discharge arrangements

Many of the young people involved in this consultation found themselves repeatedly moved from service to service. This was unsettling and hampered their recovery. For example, Sam was finally admitted to his local adolescent unit roughly nine months after his first psychotic episode. Sam expressed the view that it would have much better if he could have been admitted to this unit in the first place.

The chaotic circumstances under which the young people entered the mental health services, was mirrored for some in the arrangements for their discharge from hospital. Unprepared and, often unready, the young people reported having had little involvement in the planning of their discharge and varying levels of post-discharge support.

Rapid discharges

The young people described rapid discharges, very often with little or no warning or preparation beforehand.

> Amber was told, after seven months on an adult ward, that she would be discharged in two days time to a foster placement. She was not invited to attend any discharge meeting. She was taken to visit her prospective new home. Two days later she was moved there. At the time Amber did not realise that she was being fostered and what this meant. No alternatives to the foster placement were offered, and no other sources of support or help.

> Laura was very suddenly discharged from the adult ward which she found very frightening. She remembers being put in a taxi on her own by ward staff. The taxi was meant to take her to social services but got lost and in the end, Laura got the driver to take her to a local youth project that she knew. She described how scary she found her discharge - having been on “high suicide watch and suddenly I was on my own”.

Helen remembers her discharge from the adolescent unit as being very sudden – it seems as if the staff just packed her bags as she was about to turn 17.

Sam was admitted to the acute adult facility but, after four days the ward discharged him even though he was still unwell. They said that they would not keep him for longer because of his age. He returned home to the care of his mother whilst the CAMHS psychiatrist tried to find him a place in an adolescent unit. However, the local Primary Care Trust (PCT) would only agree to funding a place for 6 weeks. Sam experienced further problems on discharge from the unit and was admitted to another independent unit shortly afterwards. He suggested that one of the problems was that because he lived so far away from the unit, when he was discharged the outreach workers from the unit could not visit him to offer any support after discharge.

Planned discharge

Some of the young people's discharge was planned and discussed in advance of the leaving date:

Charlotte was allowed to go home to attend a school concert, after the psychiatrist had talked to her parents. The psychiatrist also promised Charlotte that she could come back to the ward whenever she needed to. Charlotte returned to the ward for a further week after the school concert so that plans could be made to support her back in the community.

Helen was discharged from the adult ward to a therapeutic placement. However, she feels that this only came about because of luck and the persistence of one of her Community Psychiatric Nurses (CPNs). The programme only takes young people from the age of 18 or so, Helen is one of the youngest – with the other patients ranging from mid 20s up to mid 50s in age. The programme is part in-patient and part day-patient and lasts for

twelve months. Helen is now in the day patient part of the programme and living independently in a flat, she returns to her parents' home at weekends.

Mark commented that the planning of discharge from the adult ward was better than his discharge from the adolescent unit. He thought that the adult service has better links with his local community mental health team (CMHT) who are now supporting him.

Support post-discharge

The young people's experience of support on leaving the ward varies greatly; for example:

Charlotte was referred to her local CAMHS (after her discharge from an adult ward) and to a new service offering intensive community support. She also has the back-up from the adult ward if she needs it – though the ward currently has a waiting list. This worries her since she knows of other young people who have ended up much further away from home because of this situation and the lack of any other beds in the area.

Helen describes her therapeutic placement as **'hard but wonderful'.**

Helen's mother comments: **"It's saved her really. It's a great place. They are quite strict and there's structure, there are things to do and they have to get up and show each other respect and take group decisions. They give people responsibility and Helen is organising outings. In hospital they told her "you have to take responsibility" but then take away all ways of doing that so you come out unable to cope. The notable feature has been that she has felt that the staff have stuck with her no matter what and that she has been fully involved in all the planning throughout."**

Gemma is currently under the care of her local community mental health team (CMHT) and receiving weekly visits from a community psychiatric nurse (CPN). Whilst this support has managed to keep her out of hospital, Gemma

feels isolated and uncomfortable since she feels her care is too adult focused and she is still only 17.

Sam was discharged home after a stay in an adolescent unit and about 10 months later he was referred to a mental health rehabilitation unit. Although this was for adults, he has found it helpful in teaching him independence skills. He is now 19 and living in a supported hostel.

"It would have been better to have stayed and got to 100% first"

Shaun's dad died when he was 10. By the age of 16, Shaun was drinking, smoking, taking pills and staying out late. He started selling pills and was arrested for shoplifting and possession of cannabis. Shaun was 'kicked out of home' by his mother and his resulting behaviour led to him being arrested and charged with criminal damage. After further violent incidents his mother asked him to see a doctor.

Shaun was admitted to an adult psychiatric unit half an hour away from his home as an informal patient experiencing psychosis. A week later, after trying to leave, he was sectioned.

Most of his time on the adult ward was spent in his room listening to music and staring at his wall, walking the corridors, eating, sleeping, smoking and drinking tea. Shaun was not offered the opportunity to take part in any activities, even though there were many available to patients. Despite living only half an hour's drive away from the unit, Shaun did not come from the right area of the county to be able to access the unit's activities including trips away from the ward. Shaun was, however, able to complete a Duke of Edinburgh Award.

Shaun wanted to make friends but found it difficult as the other patients were too old. He was given drugs by other patients and lots of items were stolen from him. Sometimes Shaun's property would be moved and possessions would go missing and he was regularly asked to change rooms with little explanation. Shaun had sex a few times with a number of women in their late 20s while on the ward, he did not use any contraception and contracted Chlamydia.

Shaun was not involved in the discharge process from his first period in the adult ward. Just fifteen days later he was readmitted. On his second stay, Shaun was not informed of his potential discharge until the discharge meeting itself. Though unprepared, he agreed to leave as he just wanted to be out of the unit. He was soon readmitted and after six weeks was placed under Section 3 of the Mental Health Act for the third time. In retrospect he feels that on both occasions "It would have been better to have stayed and got to 100% first". Shaun had a much greater involvement in his third and last discharge. During his time in adult mental health services, Shaun did not feel he was involved in his care plan – "they just didn't listen enough" says Shaun, "my care plan was just a piece of paper that I signed."

Shaun's journey

Commentary

Importance of discharge planning

Planning for discharge from hospital is of crucial importance, as is made clear by point 10 of the Markers of Good Practice, Standard 9 of the Children's NSF, The Mental Health and Psychological Well-being of Children and Young People:

> 'When children and young people are discharged from in-patient services into the community and when young people are transferred from child to adult services, their continuity of care is ensured by the "care programme approach'[28]

Despite such clear guidance, this is not being implemented across the country. The Care Programme Approach itself is currently under review, with proposals that the CPA focuses on individuals with the highest care coordination and most complex needs. However the principles of the CPA, such as partnership working between health and social care professionals and other relevant organisations will apply to all those receiving mental health care.

Staff involved in this consultation commented that adult wards lack experience in handling the discharge of adolescents and fail to understand their needs which can result in a young people being misplaced. The lack of appropriate placements for young people leaving secure provision with ongoing mental health problems was also raised by staff as a serious area requiring attention at a national level. Two of the staff interviewed highlighted how difficult it was to secure funding for longer-term therapeutic placements and were concerned that PCT financial pressures were limiting the options considered for young people.

The Department of Health's report on the implementation of Standard 9 of the Children's NSF (Report on the Implementation of Standard 9 of the NSF for Children, Young People and Maternity Services November 2006) highlights the

[28]Department of Health (DH) and Department of Education and Skills (DfES). 2004. Op cit.

importance of adult mental health staff and CAMHS working 'closely together to plan the care, discharge and after-care, utilising the Care Programme Approach'.[29]

Further work must therefore be taken to ensure that such guidance is disseminated, understood and put into practice.

Young people's recommendations

Young people highlighted the importance of:

- involving them in discharge planning and decisions; and
- providing them with information about discharge procedures.

[29] Department of Health (DH). November 2006, Page 33.

Conclusions and recommendations

In many parts of the country, it is clear that efforts are being made to avoid the use of adult wards and, as outlined in the introduction to this report, the development of new services and ways of working are having a positive impact. However, as the young people's descriptions of their experiences show, the current configuration of both CAMHS and adult mental health services means services are often unable to respond appropriately and sensitively to young adolescents who present in a crisis or emergency with an acute mental health problem.

The findings of this consultation, echoing previous reports, raise particular concerns about the adequacy of provision of mental health care for young people around the ages of 16 and 17 and even younger. Some young people in this age group are at high risk, acutely disturbed or have a need for security which exceeds that which many Tier 4 in-patient CAMHS offer. Others have a level of maturity which is beyond CAMHS but are too young for 'typical' adult in-patient wards. As the comments from those involved in this consultation show, such young people are currently poorly-served.

The young people who took part in this consultation showed considerable insight into their difficulties and how some of their experiences on adult wards had served to heighten their anxiety, their isolation and their sense that no-one was listening to them. Alternatively, when things had worked well, the young people were able to draw out those factors which they thought had been instrumental in making the experience more positive. Two key factors were the availability of staff (including their ability and capacity to empathise with young people) and the beneficial effects of daily activities and structure (even when this felt quite demanding).

This report's recommendations seek to incorporate the young people's views and are divided into two categories:

- Recommendations aimed at preventing the inappropriate admission of young people onto adult psychiatric wards.
- Recommendations on measures that must be taken to safeguard those young people who are admitted to adult wards.

Avoiding admission of young people onto adult psychiatric wards

Despite the guidance in the National Service Framework (NSF) for Mental Health and Standard 9 of the Children's NSF, it is clear that young people under the age of 18 are still being inappropriately admitted onto adult wards. For some of the young people in this consultation, their length of stay was months and, in some cases, over a year. Such a failure to make separate provision for young people may also amount to a breach of Article 37(c) of the United Nations Convention on the Rights of the Child which states:

> 'every child deprived of liberty, shall be separated from adults unless it is considered in the child's best interest not to do so'.[30]

End the use of adult wards for the treatment of under 18s

Recommendation 1

PCTs and mental health trusts should ensure that adult wards are not used for the care and treatment of under 16s and, wherever possible, adult wards should be avoided for 16 and 17 year olds unless they are of sufficient maturity and express a strong preference for an adult environment. The Department of Health should monitor progress towards this nationally. The Healthcare Commission should also address this through one of its future annual health-checks of individual mental health trusts and PCTs.

Address the national shortage of emergency beds in Tier 4 CAMHS

One of the key factors giving rise to children and young people who are in need of in-patient care being admitted to adult psychiatric wards is that there are insufficient

[30] UNCRC. Article 37(c). http://www.ohchr.org/english/law/crc.htm

specialised CAMHS in-patient units and the existing units have too high an occupancy rate. In adult units, there is evidence of a lack of appropriately trained staff. Of particular concern is the inability of services to respond to emergency situations which can also result in the inappropriate use of police cells as a short-term holding facility. The Royal College of Psychiatrists recommends that the number of beds for a given population must be based on a comprehensive, multi-agency needs assessment, with around 24 to 40 CAMHS beds being required per one million total population[31]. Available data shows that, as at 2003, this recommendation was not being met in many parts of the country. The same report also notes that the optimal maximum number of beds for an adolescent in-patient unit is in the region of 10 to 12 and that to ensure availability for emergency beds, the recommended bed occupancy rate should be 85%.[32]

Recommendation 2

Action must be taken by the Department of Health, mental health trusts and Primary Care Trusts (PCTs) to ensure that the Royal College of Psychiatrist's recommendations (that around 24 to 40 CAMHS beds are required per one million total population and a bed occupancy rate of 85%) are met consistently and geographical inequalities addressed. Tier 4 units must include both acute care provision (to be able to respond to the need for emergency admissions of young people who are acutely disturbed or high risk) and medium to long term planned in-patient care.

Development of alternatives to 'traditional' in-patient provision

In addition to addressing the shortage of in-patient Tier 4 beds, the evidence base is growing with regard to the effectiveness of other forms of specialist CAMHS that may provide an 'alternative' to in-patient care and this knowledge must be disseminated more effectively as it becomes available. Likewise, around the country, there are models of provision that 'wrap around' in-patient units and work to facilitate more effective pathways into and out of Tier 4 units These include:

[31] York, A. and Lamb, C. 2005 Building and Sustaining Specialist CAMHS
[32] Corrigall, R. and Mitchell, A. 2002. Service Innovations: Rethinking inpatient provision for Adolescents. A report from a new service. *Psychiatric Bulletin* 26, pp.388-392

assertive outreach teams, home treatment, services that can facilitate the early identification of mental health disorders, new crisis or respite services such as multi-agency short-term 'crash pads' (residential provision offering immediate access for a short, time-limited period) and new therapeutic interventions (such as Multi-Systemic Therapy though further evidence is required of its effectiveness in young people people). The National Institute of Health and Clinical Excellence has a key role in producing evidence-based appraisals and guidelines, some of which are produced in association with the Social Care Institute for Excellence.

Recommendation 3

The Department of Health should ensure that there is a continued investment into CAMHS at local level, to support the development of both high quality responsive community teams and in-patient units that are closely linked to Tier 3 services. This should be backed by a commitment to develop a range of treatment interventions which adhere to the best available evidence and take account of children and young people's individual needs.

Recommendation 4

Through its topic selection process, the Department should commission a comprehensive range of appraisals and clinical guidelines on treatment for children and young people with mental health problems to inform evidence-based practice.

Meeting the needs of 16 and 17 year olds

The particular needs of young people in 'transition' between services for children and those for adults have been highlighted in many reports over the last decade, with Standard 4 of the Children's NSF, Growing-Up into Adulthood[33], emphasising the need for high quality, multi-agency support. Inevitably, many adolescents using mental health services will continue to need them into adulthood. In 2005, the Social Exclusion Unit ('*Transitions: Young Adults with Complex Needs*')[34] estimated that up

[33] National Service Framework for Children, Families and Maternity Services Standard 4, Growing-Up into Adulthood.
[34] The Social Exclusion Unit. 2005. 'Transitions: Young Adults with Complex Needs'.

to 20 per cent of 16-24 year olds have mental health problems. Furthermore, due to CAMHS age boundaries and the limitations within many Adult Mental Health Services (AMHS) to adequately assess and treat young adults, some young people find that at 17, they cannot get any mental health support at all.

Recent requirements for all CAMH services in England to increase their upper age limit to 18 (instead of 16 in many areas) will, it is hoped, in time bring improvements in the access to mental health support for those aged 16-18. However, this consultation has revealed that right now, many young people in this age band experience particular difficulties accessing services, or are subjected to disjointed and inadequate planning. This left some of the young people in this consultation with the sense of being constantly passed on by 'lots of different people'.

Recommendation 5

- As a part of the continued investment into CAMHS, support must be given by the Department of Health and the Care Services Improvement Partnership to the development of transition services that can support young people who require transfer to, and ongoing support from, adult services post-CAMHS. CAMHS should be commissioned and resourced to provide services to all young people up to their eighteenth birthday.

Safeguards for young people in adult psychiatric wards

The Department of Health's report on the implementation of Standard 9 of the Children's NSF[35] states that it should be possible to eliminate the use of adult wards within a five year period. Despite the imperative to prevent their admission to adult wards, there will inevitably be some young people admitted to adult wards during this period. The following recommendations are intended to ensure that these young people receive the highest standard of care and that their rights are recognised and met.

[35] Department of Health (DH) and Department of Education and Skills (DfES). 2004. Op cit.

Collection of data on the numbers of young people admitted to adult mental health beds

There is a lack of national data about the numbers of young people admitted to adult wards which to some extent masks the scale of this problem, and makes it very difficult to monitor any progress in addressing the issue. Across the country, there are considerable variations in the way that data is collected, with Department of Health data currently being based on occupied beds days and not numbers of admissions. As highlighted in the introduction to this report, in 2004, the findings of a Royal College of Psychiatrists survey indicated that 955 or more young people are admitted to adult psychiatric wards every year[36], with more recent work by YoungMinds also suggesting an annual figure of 900 admissions or more[37]. These figures suggest therefore that the use of adult psychiatric beds by young people is far from rare.

Recommendation 6

- The Department of Health should arrange for the collection of information by an organisation such as the Mental Health Act Commission on the numbers of all children and young people (whether detained under the Mental Health Act 1983 or not) who are admitted to adult psychiatric facilities and the length of each admission. This should be monitored both nationally and locally to ensure that progress is being made to eliminate the use of adult beds as a matter of urgency and any unforeseen increases investigated through performance management and inspection.

Policies and protocols between CAMHS and adult services

Some of the experiences related by the young people who took part in this consultation raise serious concerns about unacceptable practices and serious human rights abuses. For example, the descriptions of some of the young people suggest a failure to take appropriate measures to protect them from violence, injury

[36] Worrall, A et al. 2004. Inappropriate admission of young people with mental disorder to adult psychiatric wards and paediatric wards: cross sectional study of six months' activity British Medical Journal 328, pp867.
[37] Street, C et al. 2005. Benchmarking of Tier 4 Services in the Eastern Region.

or abuse (including suicide and self-harm) (Article 19 of the UN Convention on the Rights of the Child)[38] and a failure to ensure that they are treated with humanity and respect (Article 37 UN Convention on the Rights of the Child).[39]

In addition, the NSF for Mental Health recommends that protocols are agreed between CAMHS and adult services which set out the procedures that safeguard the child/young person's safety and dignity. NHS Trusts are expected to identify wards or settings that would be better suited to meet the needs of young people. Standard 9 of the Children's NSF states that when children or young people are placed on adult psychiatric wards, adult mental health and CAMHS professionals should work together towards the joint aim of ensuring *'…*a timely and appropriate placement, if required, in a child and adolescent in-patient unit'.[40]

There are some excellent examples of such protocols and shared working arrangements in England and Wales. These need to be more widely disseminated and implemented across the country. [41]

Recommendation 7

- Mental health trusts (CAMHS and adult mental health services) and PCTs work together to ensure they have in place a joint policy and/or protocol to ensure the safety & protection of young people admitted to adult wards (including the provision of appropriately segregated sleeping and bathroom areas) and access to the expertise and support of CAMHS staff throughout their in-patient stay in line with the rights set out under the UN Convention on the Rights of the Child and the relevant national standards.

Involving children and young people and their families in care planning and discharge and in service design

Despite clear guidance on the importance of involving children and young people and their families in decisions that affect their care, this was not the experience of many of the young people involved in this consultation. Mental health professionals

[38] UNCRC. Article 19. http://www.ohchr.org/english/law/crc.htm
[39] UNCRC. Article 37. http://www.ohchr.org/english/law/crc.htm
[40] Department of Health (DH) and Department of Education and Skills (DfES). 2004. Op cit.
[41] http://www.camhs.org.uk/

need to listen to what young people and their families are saying, draw upon their insights and knowledge and explore their strengths so that they can work with mental health professionals in addressing the difficulties that brought them into contact with services in the first place. Similarly, young people should be involved as users or potential users in service design and planning to ensure that the services delivered are appropriate and relevant.

Recommendation 8

- Mental health trusts and PCTs should work together to ensure that health care professionals involve children and young people (and their families where appropriate) fully in all aspects of their mental health care. This should include children and young people being provided with comprehensive and accurate information about the medication that they are prescribed and administered, in a format that they are able to understand. Any decision-making about medication should involve the child or young person as an active partner.

Recommendation 9

- The Department of Health and the Care Services Improvement Partnership, mental health trusts and PCTs should work together actively to involve young people in designing and planning services. Regional development workers should ensure that there is increased participation in this area in line with other types of healthcare.

Access to appropriately checked and trained staff

All staff should treat patients with respect, whatever their age. It is of vital importance that staff working with children and young people are appropriately trained and can support the young people throughout their admission and planning for discharge. This is highlighted by the Mental Health Act Commission report which notes:

> "If the ward is designated to admit young patients between the ages of 16 and 18 years on a regular basis, ensure at least some of the ward staff are

provided with specialist training in the care of adolescents with mental health needs."[42]

Recommendation 10

- All young people admitted to adult wards should have regular access to a named keyworker/lead professional who has received training in working with young people and who has responsibility for liaising with CAMHS and ensuring that young people's care is properly planned and they are fully supported throughout their stay.

National policy in other areas of public service provision (e.g. education and social care) requires all staff with access to children and young people to have a police check to ensure that they have no past record of offences against children and young people. It is thus a serious anomaly that this protection is not required for young people when they are placed in the often daunting environment of an adult mental health ward.

Recommendation 11

- PCTs and mental health trusts should ensure that all staff (including agency and other temporary staff) on adult wards admitting young people should have an appropriate and current Criminal Records Bureau (CRB) disclosure.

Ensuring adequate levels of staffing on adult in-patient wards

The young people in this consultation reported that they were exposed to harmful activities including inappropriate approaches from adult patients whilst on an adult ward, with incidents such as illicit drug-taking going unnoticed by ward staff. In addition, several of the young people had absconded/gone missing from the ward when they were meant to be under the direct supervision of staff. Where additional staff are brought in to provide care for the young people, only those who have training in child and adolescent mental health should be employed for this purpose.

[42] Mental Health Act Commission. 2004. Safeguarding Children and Adolescent Detained Under Mental Health Act 1983 on Adult Psychiatric Wards.

It is also essential that any allegations from a young person that he or she has been subjected to any form of harassment or abuse should be fully investigated and appropriate child protection procedures applied.

Thus urgent action is required to address the inadequate safeguards for children and young people on adult wards.

Recommendation 12

- PCTs and mental health trusts should work to review and, where appropriate, to increase the level of supervision by staff on adult wards who are working with young people. All staff who are working with young people on adult wards should be trained in child and adolescent mental health.

Provision of rights information to young people and their families

The provision of information is crucial for both young people and their families, not least if they are to feel involved in their treatment and care and enabled to make their views about their needs and wishes known. The lack of timely and sufficiently detailed information about all aspects of their care when placed on an in-patient unit was raised by many of the young people and parents involved in this consultation and echoes other consultations with young people about what they want from CAMHS and mental health services.

Recommendation 13

- On admission to an adult ward, all young people and their families must receive information (both written and oral) in an appropriate format about what will happen to them and about their rights (including how to complain and, where applicable, the provisions of, and their rights under, the Mental Health Act 1983).

Access to independent advocacy services

A number of the young people stressed how helpful it would have been if they had received independent advice and support. Section 12 of the Health and Social Care

Act 2001 requires arrangements to be put in place so that independent advocacy services are made available to support people in making a complaint. These services are delivered by Independent Complaints Advocacy Services (ICAS) and should be available to children and young people. However, the findings from this consultation would suggest that very few young people were made aware of their rights (including procedures for making a complaint) or were offered such support, despite a number of them indicating that they had been unhappy with the care they were receiving or their experiences on the adult ward. The Department of Health's report on the implementation of Standard 9 identifies the availability of advocacy as a key concern. More specifically it comments:

> 'Advocates are trained to work with children and young people and in mental health legislation'.[43]

Recommendation 14

- All mental health trusts should ensure that any young people admitted to adult in-patient mental health wards are advised of, and have access to, independent advocacy advice and support.

Care planning and discharge arrangements

Despite the emphasis placed on involving young people and their families in their care planning and discharge, this did not happen for most of the young people in this consultation. Many of the journeys were characterised by poor or non-existent discharge planning, including rapid discharges from units with no prior warning and without adequate post-discharge support arrangements in place – which clearly, increases the likelihood of readmission. Where effective discharge planning did take place, this not only involved the young people fully but it also started at an early stage in their in-patient stay. However, this was only noted in one or two of the journeys, and even then, seemed to reflect the investment and interest of a particular member of staff working with the young person, rather than being an approach that was routinely in place.

[43] Department of Health (DH). November 2006. Op cit.

Recommendation 15

- Mental health care trusts and PCTs should ensure that all decisions are documented in a written Care Plan that has been discussed and written jointly with the young person and, if appropriate, discussed fully with their family/carers.

Although the guidance on the Care Programme Approach (CPA) (October 1999) is focused on adults of working age it states that the principles of the CPA are relevant to the treatment of younger people. It also notes that the transfer from CAMHS to adult services is critical and that services should have in place clearly identified plans and protocols for meeting the needs of younger people moving from one service to the other. The Department of Health's report on the implementation of Standard 9 identifies the CPA as a factor in delivering good practice, the CPA is 'modified to meet the needs of younger people, is used to plan transition, and transition is supported by agreed protocols'.[44]

Recommendation 16

- Mental health care trusts and PCTs should work towards using the Care Programme Approach (CPA) more consistently to ensure the continuity of high quality treatment and care and, most importantly, better discharge planning. The CPA must be used when young people are discharged back to community CAMHS or to appropriate adult services.

Activities, education and therapeutic input

Over a third of the journeys presented were characterised by young people feeling isolated, lacking individual time with ward staff and 'wall-watching'. Although some young people described positive experiences of being supported and attempts to tailor provision to better fit their needs, these examples of good practice appear to be far from the norm. The need for age-appropriate activities and the provision of education was stressed by both the young people and the parents involved in this consultation. This was also highlighted by the Mental Health Act Commission in its

[44] Department of Health (DH). November 2006. Op cit.

report[45]. The following recommendations re-state the need for this matter to be addressed.

Recommendation 17

- Mental health trusts and PCTs should ensure that any adult in-patient wards admitting young people under-18 should provide appropriate facilities and daily activities for young people including games, music, books, computer equipment and access to sports and physical exercise.

Recommendation 18

- Mental health trusts and PCTs should ensure that all adult in-patient wards have resources in place to assess and respond to the educational needs of any young people under 18 admitted to the ward. It is important that action is taken to ensure that young people can continue with their education, especially those who are of compulsory school age. A named member of staff should have responsibility for ensuring that any links with a young person's existing place of education are maintained.

Visiting on adult psychiatric wards

A number young people indicated that they found it difficult to maintain contact with their friends and families (due to distance and also due to some adult wards having policies which prevent under 18s from visiting). One young person mentioned that it was difficult to find a private space as the few rooms available had to be booked in advance. The importance of young people not losing these important sources of support – people who are likely to play a vital and continuing role in a young person's life once they are discharged – cannot be over-stated.

Recommendation 19

- Mental health trusts and PCTs should ensure that where young people are admitted onto an adult ward, arrangements for seeing their family and friends should be made, taking into account the need to safeguard the health and

[45] Safeguarding children and adolescents detained under the Mental Health Act 1983 on adult psychiatric wards, Mental Health Act Commission. 2004. Op cit.

welfare of patients and visitors. This must include visiting areas in which they can meet with their families and friends (including those under 18) in private.

Safeguarding children and young people

Local authorities have a general duty to promote and safeguard the welfare of children in their area. In order to comply with this requirement, under the Children Act 1989, local authorities must be notified if children and young people who had been living in their area are being accommodated in hospital for three months or more. The NHS Trusts or independent hospital providing the accommodation should notify the relevant local authority. However concerns have been raised about the failure to comply with this notification requirement.

Recommendation 20

- Mental health trusts, PCTs and local authorities should ensure that they comply with the requirement in sections 85 and 86 of the Children Act 1989 to notify the local authority where a young person who had been living in their area is accommodated or is likely to be accommodated in hospital for three months or more.

All of these recommendations must be underpinned by a shift in mindset within mental health services away from crisis-driven reactive provision towards the greater involvement of children, young people and their families in the planning of mental health services and in determining the young person's own mental health care.

Mental health professionals need to listen to what young people and families are saying, draw upon their knowledge and explore their strengths so that young people and their families can work alongside mental health professionals in addressing the difficulties that lead to their contact with mental health services in the first place. Such an approach is clearly endorsed by the wide array of government policy and guidance about developing service user participation – in other words, this is something that all professionals working with children, young people and families in the mental health field must work towards.

Appendix 1

Methodology

The aim of this project was to explore in-depth the experiences of young people using adult in-patient mental health services, encompassing a range of different situations including young people with different diagnoses, different ages and types of unit. Gathering such information requires a flexible, qualitative, 'young-person friendly' approach and the following methodology was devised with this in mind.

Initially, the issue of Research Ethics Approval (REC) was checked with the London Multi-Centre Research Ethics Committee (MREC). The Chairman of London MREC confirmed that the proposal to undertake a consultation with young people, families and staff about the use of adult in-patient psychiatric wards by means of an open invitation letter and information sheet to be widely distributed via services working with young people did not constitute research and thus did not require REC review. However, in certain areas of the country, YoungMinds was asked to complete local service evaluation application forms and/or Research and Development (R&D) protocols, and in line with usual REC requirements, detailed information sheets and consent forms for young people and parents were developed for the project. These explained: who was working on the project; what information was being sought; how information would be used and who it would be shared with; confidentiality and how young people's identities would be protected and their rights to withdraw from the consultation at any time. In recognition for their time, it was also explained that young people would be offered a £20 High Street voucher.

Young people and their families were invited to take part in the consultation over a six month period spanning the summer and autumn of 2006. The invitation letter and information sheet which was widely distributed to services in the North, North West, East, South, South East and Midlands areas of England and both North and South Wales. These included Children and Adolescent Mental Health Services (CAMHS), adult mental health services, youth services and voluntary sector agencies known to be working with young people with mental health problems. In addition, the YoungMinds Parents' Information Service and some National CAMHS

Support Service Regional Development Workers disseminated information about the consultation and information was also posted on the Royal College of Psychiatrist's FOCUS email noticeboard.

Young people, parents and staff were offered a range of ways for sharing their views with the YoungMinds team including face-to-face meetings, via the telephone, via email and by post. Most chose to meet in person, at a venue already known to them – these included their homes, local CAMHS service and, for two young people, their specialist therapeutic placement. They were also invited to have someone they knew and trusted with them if they wished – including the member of staff who had initially informed them of the consultation - though most did not take up this offer and preferred to meet one of the YoungMinds team on their own.

All young people, parents and staff were subsequently sent a write-up of the information that had been recorded about their experiences for them to check its accuracy and to add any further comments if they wished.

Child and adolescent mental health services (CAMHS) in Wales

The United Nations Convention on the Rights of the Child

The United Nations Convention on the Rights of the Child (UNCRC) was ratified by the UK government in 1991. The last report submitted by the UK, to the United Nations Committee on the Rights of the Child about progress in implementing the articles of the UNCRC, was in 1999. In their *Concluding Observations* report[46], published in 2002, the UN Committee said that they remained:

> '…concerned that many children suffer from mental health problems and that rates of suicide among young people are still high.'

They recommended that the UK government:

> ' (c) take all necessary measures to strengthen its mental health and counselling services, ensuring that these are accessible and sensitive to adolescents, and undertake studies on the causes and backgrounds of suicides;'

The very fact that children and young people are still admitted to adult psychiatric wards, without being offered a choice in the matter is evidence that there has been little, if any, progress since 1999, to ensure that services are sensitive and accessible to the needs of adolescents.

[46] Available at: www.crae.org.uk/cms/dmdocuments/uncrc%20concluding%20obs%202002.pdf

Everybody's business: child and adolescent mental health strategy in Wales

The child and adolescent mental health strategy in Wales was published under the title 'Everybody's Business' in 2001[47]. It was welcomed as a comprehensive strategy that would, if properly resourced, make Wales a leader in this area of services.

As one would expect of a strategy, 'Everybody's Business', considers the whole range of CAMHS, provided by both statutory and voluntary agencies, and, as is often the case, the whole is more than the sum of its parts. Successful implementation also depended on co-operative planning and commissioning, and service delivery by both the local authority, and the NHS in Wales.

The CAMHS implementation group, set up by the Welsh Assembly Government, estimated that an additional £10m per year would be needed for the first three years of delivering on the strategy outlined in 'Everybody's Business'. In the Foreword to 'Everybody's Business', a financial commitment was made by Jane Hutt AM then Minister for Health and Social Services (and Minister for Children):

> **"Many of the reforms we want to see will be achievable through better planning and organisation. However, full implementation will require additional funding. The National Assembly has made mental health a priority and has supplied extra funding to support this. I want to see results from this injection of hard won cash and I expect to see CAMHS receive its fair share of it."**

However, despite this commitment, made in 2001, CAMHS provision is in crisis across Wales largely due to lack of investment.

This state of affairs is disappointing, and difficult to understand, particularly as the Carlile Report – 'Too Serious a Thing', published in 2002 made over twenty

[47] Available at: www.wales.nhs.uk/publications/men-health-e.pdf

recommendations about CAMHS, several of which pertain to the issue of children and adolescents requiring in-patient treatment at Tier 4 level.

Carlile Report – 'Too serious a thing'[48]

The Carlile Review panel was convened by the Minister of Health and Social Services, (and Minister for Children) in September 2000 in the aftermath of the publication of the Waterhouse Report – Lost in Care[49]. The review was asked to make recommendations so that proper safeguards could be in place wherever a child had contact with the NHS. Lord Carlile comments as follows about the admission of young people to wards for adult patients with a mental illness:

> '14.40 As we recognise in Chapter 4, a matter of ever-active concern in CAMHS provision is the use of adult wards for children and young people who present as emergency admissions, or are in an area of Wales where separate facilities are not available. This is not a problem peculiar to CAMHS services, but can be particularly serious in the mental health field.
>
> 14.41 As a general principle, whenever possible children and adolescents should not be placed in adult wards save when it cannot be avoided, and even then in a side room with appropriately qualified and experienced nurses. Staff who are not police checked or trained in child protection procedures should not have any involvement with this group of patients when they are in adult wards. Our findings and the principles derived from them resonate with the recurrent concerns and recommendations of the Mental Health Act Commission.'

Later Lord Carlile commented on the practice of admitting young people to adult mental health wards:

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[48] Too Serious a Thing – The Carlile Review – The Review of Safeguards for Children and Young People Treated and Cared for by the NHS in Wales, National Assembly for Wales

[49] The report of an inquiry into the abuse of children in care in the former county council areas of Gwynedd and Clwyd since 1974. The report is available at: http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPAmpGBrowsableDocument/fs/en?CONTENT_ID=4097884&chk=i/ffIL

'Children admitted to adult wards can find the experience upsetting and intimidating, especially if the ward contains very sick and often elderly patients displaying distressing symptoms. Nursing and other staff on adult wards may have no expertise in the care of children, and will not have gone through the appropriate employment checks or training in child protection.'

Children and Young People Rights to Action

Children and Young People Rights to Action – was published by the Welsh Assembly Government in January 2004[50], and follows on from a previous publication in July 2002, Framework for Partnership[51]. These publications set out the strategic direction and policy framework for children's services provision in Wales. The latter publication sets out the commitment from the Assembly Government to adopting and implementing the United Nations Convention on the Rights of the Child. To that end, seven core aims were established. The Assembly Government promised to ensure that all children and young people have:

- A flying start in life
- A comprehensive range of education, training and learning opportunities
- The best possible health free from abuse, victimisation and exploitation
- Access to play, leisure, sporting and cultural activities
- Children and young people are treated with respect and have their race and cultural identity recognised
- A safe home and community that supports physical and emotional wellbeing
- Children and young people not disadvantaged by poverty

Several of the core aims support children and young people's emotional wellbeing, however the commitment to promoting their emotional wellbeing is explicit at core aim 6. The publication also contains the admission, on page 40, that:

[50] Available at: www.wales.gov.uk/assemblydata/N000000000000000000000000016990.pdf
[51] http://new.wales.gov.uk/topics/childrenyoungpeople/publications/policyguidance/childframeworkpartnership?lang=en

> ‘When the Assembly Government came into office we recognised that mental health services for children and young people had been neglected for a very long time. Mental health services remain largely hidden from public view, coming to political and media attention only at a time of crisis.’

This would lead one to expect a commitment from National Assembly for Wales to ensuring that there would be adequate and appropriate level of funding to implement the much applauded CAMHS strategy.

The National Service Framework for Children, Young People and Maternity Services in Wales

The National Service Framework for Children, Young People and Maternity Services in Wales (the Welsh Children’s NSF) was published in 2004. It is a ten-year programme setting out eleven standards for health and social care that authorities must achieve by 2014. The Welsh Children’s NSF contains 203 key actions of which 82 were flagged as core key actions for delivery by the end of March 2006. The remainder are to be delivered over the 10 years of the NSF programme.

Chapter 4 deals with children and young people with mental health problems and disorders but disappointingly, of the twenty key actions listed in this chapter, only five were flagged for early delivery. Chapter 2 deals with universal actions, and the following key action is flagged:

> ‘NHS trusts Chief Executives, Local Authority Chief Executives and Directors of Social Services are aware of the outcome of the audit of their services following the publication of the Assembly’s response to the recommendations of the Laming Report, and Carlile Review, and ensure that they have implemented their action plan.’

It is difficult to understand how the Local Health Boards and the NHS Trusts as well as the local authorities are supposed to implement the recommendations in the Carlile review without dedicated and specific funding streams and the direction for

this contained within the Service and Financial Framework (SaFF) Document. Key action at paragraph 2.18 of the Welsh Children's NSF refers specifically to the placement of children on adult wards, and is disappointing in its content, in that it would have been preferable to have recommended that children and young people are not admitted to adult settings. However, the standard requires that there be systems in place to protect children and young people from harm when placed in adult settings – which bears out the comments made by Lord Carlile.

Not all the targets that were flagged in the Children's NSF have been achieved. However, instead of reinforcing a commitment to achieve the targets set by the Welsh Assembly Government in their Service and Financial Framework Document, those targets are now dropped for the next financial year. Indeed the SaFF contains no targets for achieving the standards laid down within the Welsh Children's NSF. It is unclear how exactly, if there is no financial commitment, implementation will be achieved,

Additional Funding for CAMHS

In March 2004, the Health and Children's Minister's announcement of an additional £700,000 for CAMHS but this is proving totally inadequate in the face of the continuing crisis in provision. The Children's Commissioner for Wales is being told how the absence of proper mental health support is undermining real progress in all areas of service for children. Timely intervention is crucial for these children, and its absence will mean some of them will struggle far into their adult lives unecessarily. The piecemeal allocation of relatively small amounts of money towards aspects of the strategy is not likely to be as effective or efficient a remedy as careful consideration of the funding and budgetary implications of 'Everybody's Business' as a whole.

The Welsh Assembly Government has now required that Local Health Boards and Trusts develop costed plans, but children in Wales are still left as the poor relations to their peers in England where, starting in 2002, almost £300 million has been invested over a three year period, the development of a comprehensive CAMHS by

2006 has been identified as an aim and a team of nine CAMHS Regional Development Workers has been recruited to provide guidance and assistance to local staff.

Overview of the situation in Wales

The current situation is that Wales has fewer adolescent mental health beds per head of population than anywhere else in the UK. There are no dedicated children's beds and no hospital facilities for young people with eating disorders. Nor is there a forensic psychiatric service for mentally disordered young offenders.

It remains the case that children and young people with mental health problems have to be placed so far from home, out of Wales, and usually detained under the Mental Health Act 1983 in order to receive treatment, therapy and services. Many children who normally receive education through the medium of the Welsh language are unable to do so in most placements. Those children with mental health problems who are placed so far from their normal sources of support are probably the most vulnerable in Wales and yet are probably the least safeguarded.

The commissioning of Tier 4 placements in Wales is the responsibility of the Welsh Assembly Government body – the Health Commission Wales. This is because in the view of Welsh Assembly Government, services at Tier 3 and 4 must be considered on an all-Wales basis as they are very specialised and low in volume. However, progress in commissioning a sufficient number of emergency placements in Wales has been slow, and the Children's Commissioner for Wales is aware of children and young people who have received treatment on adult wards.

We are also aware that some children are admitted to paediatric wards because of a physical medical need but who are also assessed as having a mental health problem. These children often spend several weeks in the paediatric ward before an appropriate CAMHS bed can be found for them.

The Welsh Children's NSF has identified a major cause of this problem:

> ‘Confusion in defining mental health problems and disorders can lead to tension and disputes about access to services, and which organisations are responsible for the provision of those services.’

At present there are specific concerns around access to appropriate services for 16-18 year olds since CAMHS is commissioned for children and young people up to 16 years of age unless they are still in full time education. Adult Mental Health Services are commissioned for 18 years and over, resulting in a gap in mental health services for many 16-18 year olds and patchy and problematic provision. CAMHS should be commissioned and resourced to provide services to all young people up to their eighteenth birthday.

The Children’s Commissioner for Wales is aware of cases in which the Health Commission Wales has refused to fund some placements that local CAMHS professionals considered to be appropriate for children’s needs. Young people in dire need of specialist treatment are experiencing weeks of delay before they are admitted. Adolescents are also being treated on adult mental health wards, which are not attuned to providing services for this age group and where the experience can be a frightening and damaging one for young people.

Despite all of this, it has been remarked that “Wales seems to do more with what it has” and there have also been some very positive developments and there is some innovative and good practice. Many health settings now recognise children’s rights and welfare to a greater extent. Examples of such positive developments are as follows:

- Early identification work is being developed through Primary Mental Health Workers undertaking preventative work. Three primary health workers per 100,000 children would ensure that children’s mental wellbeing is safeguarded.
- The development of a forensic consultation and treatment service (FACT) for young people.

- Projects that aim to tackle the issue of self-harm and 'hidden harm' are being developed. These are short-term projects which may only last for a few years and in some cases are being funded by Lottery money. The National Assembly for Wales must end this situation whereby important services are being run with short term funding.

Healthcare Inspection Wales and the Wales Audit Office have announced an intention to inspect and review CAMHS in Wales. We welcome this review, and are hopeful that the outcome will reopen the debate about the funding and provision of CAMHS service for the children of Wales.

The United Nations Convention on the Rights of the Child

Introduction

Recognising the need for a comprehensive and legally binding statement on children's rights, the General Assembly of the United Nations adopted the Convention on the Rights of the Child (UNCRC) in 1989. It sets out a range of human rights - economic, social, cultural, civil and political rights - that apply to all children and young people under the age of 18. (Accordingly in this appendix, reference to 'child' or 'children' applies to children and young people under the age of 18.) These rights apply to children of every background and encompass:

> '…the basic human rights that children everywhere have: the right to survival; to develop to the fullest; to protection from harmful influences, abuse and exploitation; and to participate fully in family, cultural and social life…
>
> … Every right spelled out in the [UNCRC] is inherent to the human dignity and harmonious development of every child. The [UNCRC] protects children's rights by setting standards in health care; education; and legal, civil and social services.' [52]

[52] UNICEF, www.unicef.org/crc/

General obligations on State Parties

The UNCRC has been ratified by 192 of the 194 members of the United Nations. In ratifying the UNCRC, States (referred to as 'State Parties') undertake to respect, protect and promote the rights set out in this treaty. This includes adopting or changing laws and policies to implement the provisions in the UNCRC. There is no hierarchy of rights. They are indivisible and interrelated and the focus is on the child as a whole. When making decisions in relation to any one right, Governments must take account of all the other rights in the UNCRC. Governments must also ensure that all adults and children know about and understand the rights set out under the UNCRC.

State Parties must submit regular reports to the Committee on the Rights of the Child (CRC), the body responsible for monitoring the implementation of the UNCRC. States must report two years after having ratified the UNCRC and thereafter every five years. The CRC examines each report and addresses its concerns and recommendations to the State Party in the form of 'concluding observations'.

The United Kingdom (UK) ratified the Convention on the Rights of the Child (UNCRC) on 16 December 1991 although it has not incorporated the convention into UK law. It is due to submit its third periodic report to the CRC in 2007.

General principles

The UNCRC enshrines four general principles which are intended to assist in its interpretation and guide national programmes of implementation:

- **Non-discrimination:** all the rights guaranteed by the UNCRC Convention must be available to all children without discrimination of any kind (Article 2)
- **Best interests of the child:** the best interests of the child must be a primary consideration in all actions concerning children (Article 3)
- **The views of the child:** children's views must be considered and taken into account in all matters affecting them (Article 12)
- **The right to life, survival and development:** in this context the term 'development' is interpreted broadly, it includes physical, mental, spiritual, moral,

psychological and social development. (Article 6).

The rights set out in the UNCRC are described as falling within the three broad categories of participation (for example, respect for the views of the child and freedom of expression); provision (for example, the right to education and the right to health) and protection (for example, protection from sexual exploitation and protection from drug misuse.[53].

Safeguarding children and young people admitted to mental health in-patient facilities

In considering what constitutes the interests of children and young people, the Children's Commissioner for England must have regard to UNCRC.

While all the rights set out in the UNCRC will apply to children and young people with mental health problems, there are a number of rights that will be of particular relevance to those who are placed in mental health in-patient facilities. These are set out below.

When States ratify the Convention they can enter reservations in relation to specific provisions that are not acceptable to them. The main reservations made by the UK Government are to article 37 on juvenile justice, allowing young offenders to be detained in adult prisons, and article 22 on asylum and immigration.

The reservation in relation to Article 37 concerns paragraph (c) of this article. This makes specific provision for the protection of children and young people who have been detained and includes a requirement that 'every child deprived of liberty, shall be separated from adults unless it is considered in the child's best interest'. The UK government has reserved the right not to apply this provision where there is a lack of suitable accommodation or adequate facilities. However, this is in relation to juveniles within the youth justice system. The reservation does not refer to those

[53] See for example, Scotland's Commissioner for Children and Young People: www.sccyp.org.uk/webpages/cypr_uncrcexplained.php

children in need of in-patient mental health care.

Examples of rights under the UN Convention on the Rights of the Child [54]

- **Best interests of the child (Article 3):** 'In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration' (Article 3(1))
- **Respect for the views of the child (Article 12):** this requires States to assure that children who are capable of forming their views have the right to express those views freely in all matters affecting them and their views are 'given due weight in accordance with the age and maturity of the child'.
- **Right to privacy (Article 16):** this covers not only the physical environment (such as private space and the design of bathrooms) of facilities in which the child is living but also privacy of the child's relationships and communications with others (such as visiting and 'phone calls) and confidentiality of their personal records.
- **Right to protection from all forms of violence (Article 19):** this requires States to take measures to protect children from 'all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse' while in the care of parents or others. This will include the requirement to take measures to protect children from suicide and self-harm.
- **Rights of disabled children (Article 23):** this right recognises that 'a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community'.

[54] For more information on the UN Convention on the Rights of the Child, see UNICEF, Implementation Handbook on the Convention on the Rights of the Child*,* UNICEF, 2002

- **Right to education (Article 28):** this requires states to ensure that there is equal access to education. It applies to all children, including disabled children and those in detention.
- **Protection for children deprived of their liberty (Article 37(c)):** 'Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons his or her age. In particular, every child deprived of liberty, shall be separated from adults unless it is considered in the child's best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstance.

For more information on the UN Convention on the Rights of the Child, see UNICEF, Implementation Handbook on the Convention on the Rights of the Child, UNICEF, 2002]