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Consulting children and young people who have been admitted to child and adolescent mental health in-patient units

A report for the Mental Welfare Commission for Scotland

by
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September 2005

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Acknowledgements

With thanks to all those who contributed to this project, including:

Children and young people who were interviewed

Children and young people, parents and practitioners who attended the seminar and took part in the group discussions

Staff in many organisations for their support and assistance during the consultation process, especially the child and adolescent mental health inpatient units in Glasgow, Edinburgh and Dundee.

Research Group

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The Research Group would like to thank all those individuals, groups and organisations who have contributed to this consultation. Without your knowledge, cooperation and enthusiasm this project could not have taken place.

Consulting children and young people who have been admitted to child and adolescent mental health in-patient units

1. Introduction

In 2004, the Scottish Development Centre (SDC) was commissioned by the Mental Welfare Commission for Scotland to consult young people about their experiences of in-patient admission. This was considered to be timely in view of the on-going implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003 and the current re-design of Child and Adolescent Mental Health services in Scotland lead by the Scottish Executive's Child Health Support Group (CHSG).

Article 12 of the United Nations Convention on the Rights of the Child (1989) gives children the right to express their views freely in all matters affecting them and states that these views will be given due regard. In Scotland the principles of the UNCRC were incorporated in the Children (Scotland) Act (1995) by giving children a right to express views in a range of decisions.

Young people have made it clear that the benefits to young people of being given an opportunity to express their views, and to be heard, outweighs the potential for distress. Young people have consistently stated that they wish to be asked about their experiences and specifically on issues concerning mental health (Public Health Institute for Scotland 2003).

Feedback from the service user consultation seminars convened by the Mental Welfare Commission in 2003 also confirms this viewpoint.

2. Background

In 2003, the Mental Welfare Commission for Scotland ran a series of service user consultations at which two groups of young people discussed a number of issues and raised some matters of concern. Among their comments were:

Consultation
Participants would like the Mental Welfare Commission to involve young people regularly in consultation and information sessions specifically for children and young people. These sessions would involve a wide network of organisations and include underrepresented groups with a geographical spread across Scotland.

Information
Participants thought that accessible information needs to be developed about young people's rights while in hospital. This should be available for children, young people and staff working with young people, their families and carers.

Resources for young people

Young people participating in the 2003 seminars suggested that resources should be developed to cover a range of requirements, including:

- Resources for young people visiting adult wards.
- Resources for children and young people near their homes - young people are being admitted to adult wards because of too few age appropriate in-patient units in Scotland
- Resources for young people with mental health problems and drug or alcohol problems.

3. Aims of the consultation with children and young people who have been admitted to child and adolescent mental health in-patient units

The consultation aimed:

- To consult children, young people, practitioners and family members on their experience of the young people being admitted to in-patient units
- To work with them to develop good practice guidelines for children and young people who may be voluntarily or compulsorily admitted
- To consider how to link their views into the ongoing process of re-designing child and adolescent mental health services.

4. Consultation process

Children and young people with experience of being admitted to mental health in-patient units were consulted on what constitutes good practice from their point-of-view. Existing in-patient units were approached and SDC consultants worked with staff at the units to arrange three sessions: at the Young People's Unit, Royal Edinburgh Hospital; the Adolescent Module, Gartnavel Royal Hospital, Glasgow; and the In-Patient Unit for Child and Family Psychiatry at Yorkhill Hospital. The Dundee Unit was not approached as the unit had only recently re-opened.

4.1 Interviews and discussions

11 children and young people were interviewed, three individually, one pair and one group of six. Individual time was offered to everyone but most preferred to be seen together. They were aged 12, 14, 15 (4 young people), 16 (4 young people) and 18 years. There were ten girls and one boy. Ten participants had been admitted to units for young people, and one to a unit for children. There were some difficulties in arranging interviews with the younger participants and interview dates were changed several times. Nine current in-patients stays ranged from two days to 14 months and two young people had extensive experience of acute and long-term in-patient care. Their life-experiences and mental health difficulties varied but included significant disorders, self-harm and drug dependency.

The discussion groups and individual interviews were recorded and draft good practice guidelines developed on the basis of the views expressed. Issues included approaches to working with children and young people, the provision of information, admissions, treatments, and access to community resources. Draft guidelines were then circulated to those who were consulted and to prospective seminar participants.

4.2 Seminar

Following the write-up of the interviews, a seminar was organised in August 2004 for approximately 30 people. Organisations working with children and young people and their families were approached and asked to suggest young people and family members who would be interested in participating in the seminar. Participants included:

- young people who have been consulted
- young people who have been in in-patient units in Scotland
- practitioners
- family members of those with experience of in-patient admission.

The seminar aimed to enable participants to reflect on the draft guidelines, to suggest additions and amendments and to explore how the guidelines might be used to best effect to inform practice and to improve the experience of children and young people, their families and carers. All four in-patient units for children and young people across Scotland were represented at the seminar. Following the seminar, the Mental Welfare Commission requested that the information in the guidelines, together with information from the research interviews, be written up as a research report with conclusions.

5. Feedback from the individual and group interviews

The interviews were conducted in June and July 2004 within three units and lasted between 45 and 75 minutes. All of the young people appeared motivated, engaged and open in discussion of their experiences and made insightful, meaningful contributions.

5.1 Accessing community resources

Children and young people displayed well-defined and accurate understanding of problems which required mental health service provision – eating disorders, anxiety, depression, severe behavioural problems, psychosis, poor self-image or self esteem or lack of social skills and abilities.

They had different experiences of services prior to in-patient admission. Six young people described out-patient appointments as disappointing or unhelpful. One young woman indicated they were too indirect and gentle in terms of her presenting eating disorder and she considered she required more straight-talking or a ‘sharp shock’. She suggested that out-patient clinicians did not adequately confront her denial and, consequently, her health deteriorated and she required admission. Another described attending out-patient

appointments for a year, which had not helped. Four young people considered that in-patient admission should have happened much sooner.

Drug counselling was perceived as very helpful for one young person who considered the drugs and sexual health education and information that she had received to be excellent. Another young woman had thought about approaching school guidance\counselling but did not pursue this as she wanted to keep her school life separate:

'I didn't want to talk to my guidance teacher as she also taught me geography and that didn't feel right'.

Overall, young people wanted responsive services to be readily available and to be listened to in a sensitive, non-judgemental way. In different ways they all considered that community based or out-patient services were not intensive enough to meet their needs and at least half found it a shock to move from these services to in-patient care:

'Everyone knew I was having problems and that they were getting worse …. no one did anything and before I knew it I was in hospital'.

Young people indicated that they did not think in-patient admission would have been necessary if there had been more easily available and intensive local services.

5.2 Experiences of acute or emergency admission

Nine of the children and young people had several experiences of crisis which merited emergency treatment and admission. Sometimes they had initially come to police attention and their perception of this varied. They considered some police officers to be responsive, caring and understanding – giving them time to express feelings and describe their situation (one talked about being taken for a drive until she was less upset) and involving them in discussions about 'what next'. At other times, they felt police had not understood, had 'made jokes', treated them as if they had done something wrong and contained or restricted them in an unhelpful way. Two described being 'left' in bare police cells for 'hours' with no one to talk to or nothing to do, one while feeling distressed, one delusional and experiencing hallucinations. They were aged 13 and 15 years at the time. They also had varying experiences of accident and emergency treatment. Several indicated paramedics were 'excellent' at dealing with and responding to self–harm. Sometimes A&E staff were caring and gentle and had time to listen, but at other times they were dismissive, 'didn't care…. saw me as a time waster' and ignored or treated only their physical injuries. They remembered staff calling them 'attention-seeking' or 'junkie' and being left alone with no one to talk to. One young person thought that even the physical care of a cut was poor, leaving unnecessary scarring.

Short term admissions

Short-term admissions involved stays of up to 14 days in paediatric or adult acute wards. One young woman was admitted to neonatal care as her

behaviour and presentation may have been too distressing for other children and she could not be admitted to an adult ward for security reasons (people she was not to have contact with may have found her). Her experience of this is that she was cared for by staff who had little understanding of her circumstances:

'It was a serious overdose attempt and so some of my memories are all a blur…. but I do remember being hungry, I had not been eating and I was very thin. There was only baby milk on this ward and so I had nothing until about 8 o'clock at night'.

'There was no privacy, you couldn't discuss things, there was no time… everyone was too busy. I shared a room with babies and toddlers, it was really noisy … a nightmare'.

She considered that staff were 'moody' with her as they did not understand what she had done and they 'weren't used to it' and did not know what to do.

Two (younger) girls found paediatric wards safe and reassuring and the staff kind and helpful. They enjoyed opportunities to interact and play with others, for example, in games and arts and crafts.

Other young people's experience of paediatric wards was poor:

'Staff didn't want me there…. my condition was rare and took a while to be diagnosed…. They didn't believe me and thought I was making it up.'

One young person described staff ignoring hallucinations and fits as they did not know what to do. Several recalled being scared, as staff could seem either confused or hostile and judgmental. Individual members of staff made time to listen, which was helpful, but staff were busy and the young people recognised that it was difficult for staff to find time to spend with them.

Children and young people with eating disorders on paediatric wards described their physical care as good but general responses inappropriate to their needs.

'I was given hospital food (no choice) and had no idea what was in it…. I hardly ate at all …. Maybe if I had been given choices or fresh fruit I would have tried more'.

'They (paediatric staff) didn't have any experience of mental health issues'.

Admission to adult psychiatric wards also presented some difficulties:

'People are there for lots of different reasons …. some were drunk and that'

'Staff on adult wards couldn't be bothered…. They don't like you or treat you right. Mostly they spent all their time with adult (patients) and ignored me'.

Young people were not sure whether children's or adult's wards were best for them – in both they appeared to feel out of place either as a result of age or reason for admission. One of the consequences of this was that they were either treated like a child (having little or no say) or an adult (left to look after themselves) with an apparently poor understanding of their developmental and age-appropriate needs.

Practical problems

Practical problems included ward routines, access to clothes, money, phone calls and friends

'Why did I have to get up so early, I'd overdosed the night before and wanted to sleep … it was because that was the time they made the beds'.

'I'd self-harmed and couldn't wear my clothes, I had a hospital gown and no dignity'.

'I had no money and wasn't allowed to use my mobile or the ward phone'.

'None of my friends were allowed to visit, which I can understand as they weren't good for me but I wanted to see my best friend and that would've been ok'.

5.3 In-patient admission to Child or Adolescent Unit

Participants' responses differed depending on which unit they had been admitted to. Some young people's replies were positive, reflecting the therapeutic approach and apparent stability of their environment. Others were more critical, referring to constant crisis or pre-occupation with behavioural problems. Clearly units varied in terms of resources and physical environment, of staff cohesion and approach and of the group of resident young people.

Children and young people were aware that they were distressed or at a point of crisis when they were admitted. On reflection, they could see that their presentation was a response to this and they did often behave in very difficult and confrontational ways. Some were extremely positive of staff's initial responses to them, even at times when they required containment.

Information

Their individual experiences of admission were different. For example, one young person had known for a couple of weeks that admission was possible, and had met with a consultant from the unit who joined an out-patient appointment and explained what might be offered. They were given a (helpful) leaflet and introductory visit the week before and overall, found this process useful, reassuring and informative.

Another young person considered things happened 'too quick':

'I was seen on Thursday and offered a place for Friday' (eventually delayed to the following Tuesday).

She did not feel she had time to prepare for admission and declined an introductory visit.

Overall, young people saw planned admissions as being better for them with apparent benefits in meeting staff and introductory visits. Poorer experiences involved two young women admitted from paediatric wards at some distance from the unit. They were advised of admission by their out-patient consultant and told very little about what it would be like:

'Even when it was or what it looked like … what other people would be there, what help I would get or what the daily routine was… I knew absolutely nothing'.

Both had been in paediatric wards for two weeks and so introductions could have been possible. They thought that the distance unit staff would have had to travel was a problem. Suggestions for information to be made available about units included:

- Photos of the buildings
- A video
- Information about unit approach, age of young people etc
- a web-page with information and descriptions.

One young person specifically suggested an introductory leaflet to explain the daily routine 'so it's not so much of a surprise'. She described admission as:

'hell….I refused to stay and had several tantrums, I didn't want help'.

At least two young people were unhappy they had been admitted directly from another ward:

'I wasn't even allowed to go home and pack'.

For some, the introductions provided were perceived positively. One young person liked that she was able to choose her room; another was disappointed she could not choose even although several were empty. Young people were very aware of the need for safety on admission – that they were in different ways a risk to themselves. However, one found getting her bag searched 'embarrassing'. Nine young people found constant observation difficult. They were able to say it was more helpful when staff were there but not necessarily 'watching my every move', for example, allowing shower curtains to be drawn rather than open. They all liked having a key-worker identified at the point of admission, although one thought her key worker could have been more available early on.

In terms of material and practical arrangements, some were fairly positive about visiting arrangements, including those for dogs; access to telephones and personal belongings. They considered staff to be approachable and welcoming, patient and caring. Others described feeling alienated and terrified,

having mobile phones and personal belongings removed with little explanation of why or what would happen next.

5.4 Perceptions of treatment and care

Participants were positive about their experiences within the units for children and young people. They found staff to be receptive, skilled and helpful. All could identify changes which they directly attributed to interventions received. One young person described staff as being firm, but flexible:

'I was upset and frightened …. They stayed with me, you know, just nearby… not arguing with me or rushing, just waiting until I stopped'.

'The dietician's brilliant, she'll listen to what I have to say, get information and make sure the food I like is available'.

It was thought useful to join groups soon after admission. Young people in one unit found community\group meetings intense and challenging but helpful:

'They can be intimidating but I know that staff there will make sure they're safe and it won't get out of hand'.

In another unit young people were less positive:

'Group time is a waste of time …. It's not a therapeutic group, only occasionally do we look at anything useful'.

They considered that the quality or value of group time depended on what had been happening in the unit and which staff were involved. Young people suggested that some staff:

'are just not interested and don't want to be there … they'll tell you that. I asked someone the other day "who'll be doing the group?" and she said "hopefully not me". What can you say?'

Others were described as motivated and committed, keen to be there, relaxed and gentle:

'Making sure you talk if you want to'.

When available, 1:1 time was seen as helpful, although it could be hard to talk at 'set times'. The young people felt they responded well to the predictability and routine provided by the ward environment and group activities:

'I may not have liked it but, looking back, it was the best thing for me'.

Treatment

Some young people considered that they had been consulted about their admission and treatment. However, two-thirds expressed concern (at different levels) about their perceived lack of information and involvement. Young

people would have liked more information and discussion about mental illness and about the different types of treatment and approach.

There were some criticisms of the treatment young people had received. One young person considered her medication had been mismanaged and she had spent time 'walking about like a zombie' before it was changed. She expressed a concern that the consultant had not pursued a second opinion. Others felt ill-informed about their medication:

'I've no idea what I'm on or what it's for… it keeps changing'.

'I've been on and off Prozac for three years, it makes no difference to how I feel… I still get told to take it'.

Those receiving anti-psychotic medication considered it helped reduce symptoms significantly:

'I'm much better, I can concentrate and do things without being distracted'.

'At least I don't see Jesus any more'.

but were concerned about side-effects:

'I shake all the time'.

'I can feel really woolly, like I'm not here, things blur'.

Two young people described the units' approach to self-harm (cutting) as unrealistic and punitive. They suggested it was not possible to stop 'immediately' and that staff finding out and raising it at community meetings simply made them feel worse and more secretive. Whilst they clearly said self-harm was not acceptable they also wanted to be able to cut in a safe, contained, clean way and to be able to share this with staff without criticism.

Activities

Young people felt they benefited from a structured day. Many were extremely positive about school and teaching staff, helping them achieve their potential, although were conscious they would not do as well as they might have done in mainstream school. At least three thought they would not achieve the qualifications they had hoped for, due to lack of opportunity. They were conscious of restrictions or of missing out on normal, everyday activities and bed-times were seen as restrictive:

'Would you go to bed at 10.30 if you were 16?'

Young people in one unit described hospital food as 'awful' and those with eating disorders found it particularly frustrating to have little choice or:

'To choose something and a completely different meal arrives'.

One young person wanted her personal stereo to help her sleep at night (it had been removed). At least half wanted access to the internet and e-mail to keep in touch with friends or family. Most wanted televisions in their rooms and to be allowed to watch films which others their age could. One missed going horse-riding and her pets. Some wanted to go walks, shopping, swimming, to the cinema. There was a lengthy discussion about young people with eating disorders not taking part (linked to their treatment programme) in some activities – for example, swimming - and whether this was 'fair'. Current activities seen as enjoyable include going for drives, walks, outings, arts and crafts, cooking and using the garden or hospital grounds.

There were issues around access to mobile phones. Most young people wanted to phone or text friends or family. In one unit access to a private phone was relatively easy, in another they suggested the pay-phone was not always working and did not allow any privacy in a busy hallway. This was considered particularly important for those who lived further away from the unit.

Staff shortages

Young people felt strongly that staff shortages were impacting on day-to-day life in the unit and on staff morale:

'They get tired and grumpy if they miss breaks or have to work late'.

'Everyone's down – staff complain, we complain… it affects everyone'.

There was also a sense that staff are often involved in crisis management and staff shortages were thought to impact on outings and activities:

'I'm really missing home just now, I need to talk to someone and might've last night but someone 'kicked off' and so I didn't get a chance'.

'That's right, if you're quiet or upset around here you get no attention, only if you're making a fuss'.

All but one young person indicated there was too much free time or not enough to do:

'There's too much time to think, it makes me feel worse'.

Safety, distress and friends

Two young people expressed fears for their safety:

'When you see a member of staff who has lots of skills and can use restraint come out of a room hit and bleeding (apparently assaulted by a patient)… it makes me wonder what could happen to me in here'.

Others reflected on the problems of meeting others with various difficulties:

'My eyes have been opened to all sorts of things …. people's distress, we've had one young person hang themselves'.

‘I’d never heard swearing like it, or seen people so angry’.

They also described positives:

‘Sometimes I think I get most help from other young people … they know what it’s like’.

‘I’ve made great friends … life-long friends, I’ll never forget this place’.

Regional differences
Young people were aware that some beds within units are for certain regions and so you may have to wait longer for a ‘Midlothian’ bed, for example, even if there were others vacant. One young person considered she had to wait unnecessarily for education until ‘funding was sorted out’. Another young person did not have a visit from family for the first four months which was considered to be because they lived ‘too far away’. Clearly the distance between young people’s homes and in-patient location is sometimes a difficulty. One young person tearfully described:

‘home-sickness is worse to deal with than my eating problems’.

Addressing concerns
Older young people with experience as former in-patients discussed why their issues of concern were not addressed at the time. They thought that staff would listen and take concerns seriously but they also suggested that when they were in-patients they were more distressed and reactive – ‘moaning about everything’ - and so it would be hard for themselves and for staff to see which concerns were legitimate (open to change) and which were a response to the therapeutic process. Current in-patients who had concerns did not think they would be taken seriously or else staff would be too busy to respond.

6. Feedback from the seminar

Participants in the seminar were given an introduction to the work of the Mental Welfare Commission and a presentation on the themes arising from the consultation.

Individual group discussions were then held with family members, young people and practitioners. In the morning, the discussion focussed on people’s experience of services as reflected in the draft paper and in the afternoon on what information was needed and how this should be made available.

6.1 Key issues for young people

Access
Most would have liked to know more about other resources. One young person had accessed an eating disorder self-help group ‘by chance’ and found it helpful. They had found it difficult to get information and advice, for example in

school, and put this down to the stigma that is attached to discussing mental health issues.

Safety and care
Within units, staff were viewed as excellent, being committed, dedicated and helpful but staff shortages led to long working hours without breaks and constraints on treatment and care (only one hour-long outing for young people over the long summer holidays). Several young people referred to dangerous and demanding behaviour by others which took up staff time and was clearly frightening and distressing.

Younger children
Young people at the seminar felt that they could offer from their own experience some suggestions for younger children in in-patient units:

- Make more units so people don't have to travel so far but keep units small
- Higher ratio of staff to children
- Develop ways that you can communicate with the children without making them sit down and listen, ways that would get through to them
- Family (especially parents) allowed to stay overnight to give sense of security
- Separate therapy groups - younger children may have different issues or be ill for different reasons
- 'Hands on' recovery/therapy because it can have 'fun' aspects.

6.2 Key issues for parents

Information
Parents said that they often felt lost and needed information about danger signs – what to look out for when children and young people are in difficulties. They thought that GP practices should have an expert in mental health to advise families and that information should be available in a variety of formats including a web site, a video and leaflets in GP surgeries.

Support for families
Most participants had experienced difficulties in getting an initial referral from a GP for a child or young person with a serious mental health problem. Once a referral is made, it may be six months before a place is available in an in-patient unit. Community services were seen as unable to cope with seriously ill young people.

Parents and carers talked about falling ill with stress, and needing assistance with understanding the system and organising services for their children. Parents felt that have to stay sane themselves or decisions about their children may be taken out of their hands. Travel expenses are needed and acknowledgement of the distances some families must travel would be welcomed.

In-patient units
Parents appreciated the continuity offered within units, particularly that offered by charge nurses. In-patient units with services all available on one site were seen as offering the best possible support for parents and families. This cuts down on travel times and time spent managing the system.

6.3 Key issues for practitioners

Younger children
Although the numbers of younger children in the consultation was too small to draw firm conclusions, the following points emerged. It was seen as important to involve children and their families in giving their views of the in-patient unit for children and their experiences of using other services. Children and their families need to know about what they can expect of the unit and about education facilities, time for play and resources for younger children.

Information
Practitioners thought that information about local services is needed, for example about counselling services. This information needs to be communicated to children and young people, their families and carers, especially to those from outside the area covered by an individual in-patient unit. Information is also needed for younger children and their families who use child and adolescent mental health (CAMH) services as a resource.

Advocacy and rights to services
Practitioners identified the importance of children and young people knowing how to access independent and age appropriate advocacy. They also have the right to a CAMH services worker if a young person is admitted to a paediatric ward, to working age adult wards, or to an accident and emergency ward. Practitioners wanted to know how they could ensure that young people who are admitted informally have the same rights as those admitted under the Mental Health Act.

7. Conclusions

These conclusions are written primarily for staff in in-patient units. However, as in-patient units are one of a range of resources helping children and young people in crisis and with the current emphasis on mainstreaming mental health and making the well-being of children and young people the responsibility of all staff who are in touch with them, the conclusions are also relevant for:

- G.Ps
- Medical professionals especially in paediatric wards, working age adult wards, accident and emergency units
- Families
- Friends and other young people
- Counsellors
- School guidance staff
- Mental Welfare Commission for Scotland
- Scottish Executive.

It may seem to staff that you already carry out the tasks outlined in the conclusions. Some of the experiences that children and young people have described, however, suggest that there are still inconsistencies in working practices which participants would like to see addressed.

7.1 Approach to working with children and young people: all staff

The statements on the left in bold are from the Children's Charter, which outlines what children and young people need and expect from people whose job it is to keep them safe. The statements on the right are based on the consultation.

Get to know us	Please take time to understand our individual circumstances, strengths, problems and views about solutions.
Take us seriously	We have a lot to contribute to decisions and want to be involved and given reasonable choices in relation to our health, lifestyle and care.
Respect our privacy	We are often distressed or at a point of crisis when admitted and understand there are concerns about our safety and well-being. However we need private time and places to think or talk.
Think about our lives as a whole	Our everyday needs, thoughts, interests and contributions should be incorporated into our care plans.
Put us in touch with the right people	We use other services and find them helpful, for example, drugs counselling and education. It would be useful to know about local services to help prevent us being admitted again or to support us at home.
Use your power to help	In-patient staff can be "experts" in terms of their understanding of mental health problems, issues and solutions. We would like staff to use their expertise, and their individual knowledge of young people, to influence others to help us.
Help us be safe	In-patient units can be safe places to make changes and improvements. The unit's environment should reflect our need for safety and support. There should be space for reflection and support when we want to

	try to make changes in our lives.

7.2 Emergency or short-term admissions: Medical professionals especially in paediatric wards, working age adult wards, accident and emergency units

In emergency or short term admission, consideration should be given to children and young people's need for:

- Practical assistance – clothes, food, personal items, money and access to phone-calls
- Access to family and friends – many feel intensely isolated. Younger children in particular need family and carers allowed to stay overnight to give a sense of security.

Neither paediatric nor adult acute wards were considered ideal settings for children and young people and further exploration of the appropriate (short-term) setting is required. If paediatric and adult wards are to continue to be used, then a more flexible response in terms of ward routines is required.

7.3 Admission to psychiatric in-patient units for children and young people – unit staff

Units should offer as part of the admission procedure:

- Introductory discussions with the unit consultant and staff, the child/young person and their family to explain what can be expected on admission as soon as admitting a child or a young person becomes an option
- Information on what is expected, like rules and commitment
- Written information for children, young people and parents, such as leaflets and web pages
- Introductory visits and, where possible, choice of room
- Time to adjust, plan and pack for admission
- Explanations about routines, containment and activities on arrival
- Early introduction of key worker
- Potential for young people in a unit to offer peer induction and orientation.

7.4 Younger children under 12: staff in services used by younger children

Although the numbers of younger children in the consultation was too small to draw firm conclusions, the following points emerged:

- Admission to an in-patient unit under the age of 12 is relatively rare. The principles of working with children are similar to those for working with young people, but must be adjusted to take account of the developmental needs of the age of the child and the role of families and carers. Services used by children under the age of 12 must take account of the different needs of younger children

- It is important that younger children and their families are involved in giving feedback on their experiences of using services.
- Young people wished to have separate therapy groups provided for younger patients, which would communicate in ways that would get through to them - ‘hands on’ therapy with ‘fun’ aspects.

7.5 Activities within psychiatric in-patient units – unit staff

- Routines and planned activities within the units are good but there is sometimes not enough to do, especially in school holidays. In-patient units should offer a range of individual and group therapeutic activities with extra activities during school breaks and holidays.
- Children and young people wish to be asked about which activities interest them. Young people want information on developing spiritual resilience
- Activities should fit the age group of the child or young person and include links with outside agencies and leisure services; access to phones and the internet; access to TVs and DVD players.

7.6 Care and treatment within units – unit staff

- Young people sometimes lack information about their illness and treatment\management options. Simple, clear information about this should be available. They and their parents and carers should be given clear information about disorders, treatments and prognosis, which should include discussion with staff.
- Young people did not always feel consulted about their care and treatment plan, particularly in relation to medication. They should be involved in this process.
- A consideration of current responses to self-harm and, in particular, cutting is required.

7.7 Safety within units – unit staff

- ‘Lockdown’ – all doors locked in a unit – following admission of someone who may be violent is frightening for young people and families. Dangerous and demanding behaviour by others takes up staff time and is clearly distressing to young people. Staff need to let children and young people know that they can keep them safe.

7.8 Information: Unit staff and Mental Welfare Commission

- Parents would like information in a range of formats, including a video, to prepare them for their child’s admission. Parents sometimes find it impossible to take in spoken or written information
- Not all young people are able to talk through problems – some may go several weeks without talking. Ways of enabling children and young people who are not speaking to giving and receive information should be considered

- Concerns or complaints from children and young people were not always acknowledged or given a response. The Public Services Ombudsman now has a role in considering complaints about services. Information about this role should be made available to children, young people and their families.

7.9 Advocacy services: unit staff and the Advocacy Safeguards Agency

- Children and young people need to know how to access independent and age-appropriate advocacy. The Advocacy Safeguards Agency disseminates information about national advocacy resources. Units should hold and make available to children, young people and their families information about relevant local and national resources.

7.10 Access to community resources: GPs and community-based Child and Adolescent Mental Health services

- Children and young people did not often access young people's counselling or support services. They require information about local services which should be available in school, at out of school activities and through local staff
- Children and young people thought they waited too long for an out-patient appointment and would have benefited from shorter waiting times
- Some children and young people thought they were seen as an out-patient for too long and would have benefited from prompt in-patient admission
- All considered that out-patient services were not intensive enough to meet their needs and some thought better out-patient services would have prevented admission
- Where young people had to travel to in-patients units they felt isolated and disadvantaged (in terms of contact with friends and family). Further consideration needs to be given to the availability of community-based intensive support and/or in-patient services in rural areas.

7.11 Support for families and carers within units: unit staff

- More space and accommodation for parents, carers and families is needed, especially when they have travelled long distances. Younger children in particular need family and carers to stay overnight to give a better sense of security.
- More consistent acknowledgement of cultural issues for children and young people, their families and carers is required. For example there should be choice of food available eg vegetarian options, halal food

7.12 Support for families in their own area: unit staff and local Child and Adolescent Mental Health services

Out of area families need extra support. For example, people attending in-patient units out of their area may need extra support to find and link with outpatient or day support in their own area.

8. Additional information

www.mwc.scot.org.uk The Mental Welfare Commission for Scotland (MWC) has a statutory duty to protect the interests of people with mental illness or a learning disability. A range of information is available, including the Annual Report which contains practice guidance and a range of leaflets for the new the Mental Health (Care and Treatment) (Scotland) Act 2003.

The Advocacy Safeguards Agency www.advocacysafeguards.org has information on national advocacy resources.

The Public Health Institute for Scotland (2003) published Needs Assessment Reports on Child and Adolescent Mental Health and on Consulting Children, Young People and Parents.
www.phis.org.uk/pdf.pl?file=publications/CAMH1.pdf
www.phis.org.uk/pdf.pl?file=publications/CAMH2.pdf

The Public Services Ombudsman www.scottish**ombudsman**.org.uk has a role in considering complaints about services.

Scottish Association for Mental Health www.samh.org.uk has leaflets on 'Know your rights'.

Scottish Executive (2004) Protecting children and young people: The Charter
A downloadable version of the Children's Charter is available at
www.scotland.gov.uk/library5/education/ccel.pdf

www.youngminds.org.uk has leaflets and information for young people and parents and Young Minds Parents' Information Service can be contacted on 0800 018 2138).