Child and Adolescent Mental Health Services

FBS Advocacy

Consulting with Young People and Professionals: The need for a young person’s advocacy service within mental health services North Lanarkshire

Summary:
At any one time, around 10% of children and young people in Scotland have mental health problems which are viewed as having a negative affect on their thoughts, feelings, behaviour, and relationships on a day to day basis (SNAP, 2003). In some cases, this leads to the young people requiring treatment by mental health teams such as the child and adolescent mental health service (CAMHS) but are also referred to as Child and Family Clinics. For this report, this group will be referred to as CAMHS. Their treatment can either be in the community (outpatient) or in a mental health ward (inpatient). For those young people whose mental health needs require inpatient care, there are a number of rights that must be upheld. One of these is the right to be put in a ward with people of a similar age. The Mental Welfare Commission in 2008 published statistics which showed that 134 young people in Scotland were currently in adult acute psychiatric wards, placing them with dangerous adults without adequate thought to their safety, with 21 of these young people having no specialist care (i.e. a psychiatric team who specialised in child and adolescent mental health).

A number of pieces of legislation protect the rights of children and young people whilst they are in the care of the health service. The Mental Health (Care and Treatment) (Scotland) Act 2003 stated that the child’s welfare should be paramount in making decisions about their treatment, and that advocacy could be used to state a person’s wishes.

Key Findings
There was some disagreement amongst mental health professionals as to how involved advocacy should be, with some believing advocacy could be vital to developing CAMHS in Lanarkshire, whilst others believed advocacy should only be used sparingly when a disagreement between practitioner and the young person arise.

Other mental health advocacy groups found a number of difficulties in establishing their group as another force within the health service. These included gaining the trust of CAMHS practitioners and therefore gaining referrals, communicating what advocacy is and what it can do and also building a relationship with young people.

Whilst two of the young people had used advocacy to help with tribunals, but were assigned advocates. They found having someone there for them, to ask questions and also to help them prepare was very supportive. They mentioned if they needed someone on their side again, they would ask an advocacy service and recommended that more young people should use advocacy. One young person had not heard of advocacy, but believed that it would be useful if any issue came up that they were not able to talk to CAMHS about.

Recommendations for the development of FBS Advocacy as a young people’s mental health advocacy service are as follows:
1. Advocacy awareness meetings should be set up. FBS should go into hospitals, child and family centres and social work departments and explain what advocacy is and how it can help young people in psychiatric wards.

2. Advocacy should work closely with CAMHS practitioners from point of referral, to ensure that when advocacy is needed the foundations have already been put in place.

3. Based on the experiences of other advocacy services, there should be ward rounds or a drop in room for young people to approach an advocate. This way advocacy can be explained and young people will get to know advocates before any work needs to be done.

4. As there are no official inpatient facilities for Lanarkshire, it is important to create links with other advocacy groups to ensure that if a child from North Lanarkshire is being treated in Glasgow or Edinburgh, they have the option of working with a North Lanarkshire advocate as either an inpatient or as an outpatient.

5. As young people spoke about the importance of trusting an advocate, and other advocacy groups spoke about the difficulties in building a rapport and mutual working relationships with young people, it is important to identify advocacy workers as having easily identifiable roles. This could mean whilst one worker does ward rounds, another worker is knowledgeable about mental health legislation. This will give young people a sense of continuity in the service.
Introduction

Definitions

Independent advocacy, as defined by the Scottish Independent Advocacy Alliance, is concerned with standing up to injustice and aims to help people by supporting them to express their own needs and make their own informed decisions. The role of an independent advocate is to support people to gain access to information and explore and understand the options which are available to them. Advocacy is also viewed as having an especially important role within the mental health service. Many young people who are receiving treatment for mental disorders may find that they have lost some control over their lives when they have entered an inpatient ward, due to the young people perceiving professionals “taking control” of their treatment and working towards the young person’s best interests without consulting with the young person themselves. For this consultation, mental health difference/disorder will be used to cover any personality disorder, learning difficulty or behavioural issue as described by the Mental Health (Treatment and Care) (Scotland) Act 2003. Advocacy’s job therefore is to empower these young people, allowing them to take control of the situation that they find themselves in and find a voice for themselves behind the label of mental disorder/difference.

Consulting with Young People

White and Bennet (2005), in a report by the Mental Welfare Commission, stated “young people have made it clear that the benefits to young people of being given the opportunity to express their views, and to be heard, outweigh the potential for distress”. Consulting with young people, and to take their views into account, is in line with the Scottish Government (2004)’s Charter for Protecting Children and Young People and also article 12 of the United Nations’ Convention of Rights for the Child- which states that in matters which affect the child, they have a right to give their thoughts and feelings on decisions which will be made.

It is seen to be in the best interest of Child and Adolescent Mental Health Service (CAMHS) to consult with young people and to develop a service which takes on board young people’s opinions on what constitutes good practice and treatment which affects their lives, especially at a time where CAMHS is developing a new service plan (White and Bennet, 2005; Worrell-Davies, 2008).

However, the structure of consultation with children and young people on these psychiatric wards would need to take account of their various stages of development. (Worrell-Davies, 2008). This is to account for the differing socio-emotional stages of the children and young people who could range from 0-18, as well as their differing physical and mental development. (Ansley-Green et al (2000)). The importance of respecting these young people’s views regardless of age is seen as crucial for young people, who often believe that adults perceive them as trouble makers (Brown and Ferguson, 2000) and not old enough to form a view on these matters.

Advocacy in Mental Health Services

One of the important roles of an advocate whilst working with children and young people in the NHS is ensuring their identity as a young person is not diluted whilst they are being treated as a patient of the NHS (Ansley-Green et al (2000)). Under the United Nation’s
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Convention for Rights of the Child (ratified by UK in 1991), they have a right to have a say in any decision that affects them, which includes treatment for mental health differences.

Advocacy has had a number of challenges within this area. Pithouse and Crowley (2007) reported that many young people appeared ambivalent towards any help offered by an advocate. They believed this is part of the “help seeking process”, as asking a young person who is already in a vulnerable situation to participate in a mutual relationship with an advocate may be perceived as losing some element of control. This is especially relevant because young people are in a situation where they have already lost a considerable degree of independence and control.

In addition to this, Pithouse and Crowley also found that children and young people were not aware of advocacy services unless they had been directly involved in advocacy themselves. In focus groups of young people between the ages of 9 to 21, ideas for raising the profile of advocates included using media such as posters, adverts in local newspapers and having young people friendly websites. They also mentioned meeting more young people face-to-face, for example going to local youth clubs.

As well as young person centred challenges, there are also challenges working within large organisations. Dalrymple (2003) stated that an advocate working in a large organisation (like the health service or with social work) could be seen as threatening the power of other decision makers and professionals. This is especially so if the advocate is challenging a decision made by, for example, a psychologist who believes that it is in the best interest of the child to detain them under the Mental Health Act. However, if the communication between the independent advocate and the health care professionals is open, advocacy could be viewed as a way for health care professionals to get around increasing bureaucracy of their workplace (Dalrymple, 2004).

Statistics

The Mental Welfare Commission recently published Scottish national statistics which show that, this year alone, there were 142 admissions of 122 young people to adult psychiatric wards. They said that this was a 24% drop in admittance, but more had to be done. Out of these 142, 21 young people had not received any specialist psychiatric help (i.e. psychiatrists who specialise with young people) and also had not received any educational support. Due to the lack of inpatient services, eight of these were from Lanarkshire.

In North Lanarkshire, children and young people are being admitted to Monklands and Wishaw General Hospitals. In Wishaw, ward one is an adult psychiatric ward. However, there were eight admissions of children under the age of 16 between July 2007 and July 2008. In Monklands, between adult psychiatric wards 24 and 25, 11 young people were admitted. The youngest was 16.

All children and young people admitted to a psychiatric ward should be seen by an RMO with relevant specialism. In North Lanarkshire over the same period (July 07 to July 08), 8 children and young people were seen by specialist RMOs and 8 were not. This information was not recorded for 3 children and young people.
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A concern was raised in a 2007 report by North Lanarkshire Council’s Children’s Rights Officer that CAMHS Lanarkshire stopped at 16 years. This left many young people falling through the gaps between the ages of 16 to 18 years. The main concern is that, at this age, they are no longer given side wards or age appropriate leisure opportunities. The Children’s Commissioner for England made a promise that no under 16’s would be placed in adult psychiatric facilities by 2010, however young people between 16 and 18 would be placed in these beds if this is seen as the right course of treatment. Unlike this, the target for the Scottish NHS is to half the number of young people placed in adult acute psychiatric facilities by 2009. This would mean that if there were a shortage of beds, placing young people in adult wards would still be an option for NHS boards throughout Scotland.

In the past 10 years, the number of inpatient beds available to children and young people on psychiatric wards has fallen. In 1998, the number of adolescent beds was 44, whereas now it is 35 (16 in Glasgow, 12 in Lothian and 7 in Tayside). However, with the inpatient unit at Gartnaval moving to Stobhill later this year, this number is likely to rise to 42, as a further 6 beds become available. The Child Health Support Group in 2004 called for an investigation into the lack of adolescent facilities in the Highlands. For children, the only facility available to them is in Glasgow, which allows for 10 beds. The Child Health Support Group believed that this small number is acceptable as “children with a psychiatric disorder are best treated within their family environment wherever possible” unless it is not in the child’s best interests.

Government and NHS policy

One of the most important pieces of legislation referring to the care of children in Scotland has been the Mental Health (Care and Treatment) (Scotland) Act (2003). This has made special provisions for children and young people who have been affected by mental health issues. In their ten guiding principles, one specifically mentioned that the welfare of any child with a mental disorder should be paramount in any intervention that may be imposed on the child. A child, under NHS guidelines, is any young people under the age of 18. This welfare principle dictates that all reasonable and practical steps should be taken to minimise harm to the parent-child relationship, and that the two parties should be in close contact throughout the child’s treatment.

Although any young person under 18 is defined as a child under the Act, young people aged 16 to 18 are given the right to chose a “named person” who, unlike those who are under 16 years, is not their care giver, or someone in their immediate family. A named person is someone who has to be consulted when certain things, relating to detention or treatment, change. This named person is similar to an advocate, but can hold their own opinion on what is best for the child (whereas an advocate works with what the child wants).

The Mental Health Act also gives young people of every age the right to draw up an advance statement. This is done when the young person first enters hospital and outlines the way in which they wish to be treated if they become unwell and therefore lose the capacity of decision making. This is a written statement and is signed by both the patient and a healthcare professional (nurse, doctor, psychiatrist, mental health officer (MHO) etc). Although it is
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not a legally binding statement, it must be taken into account when decisions are being made about care/treatment.

Based on the directives of the Mental Health Act, the Scottish Government drew up a framework in 2005 for “Promotion, Prevention and Care” to be followed by NHS boards. Similarly to the Mental Health Act, they defined mental disorder has any mental illness, personality disorder or learning difficulty. This definition related to people of any age or gender. It stated that treatment for disorders should be dependent on the age of the young person, so whilst two young people have the same treatment needs, they can be offered very different services that are tailored to their socio-emotional development. The framework warned that, due to differing cut-off ages in various CAMHS services (some stopping at 16 whilst others offer care until 18), there is a risk of many young people “falling between the stools”. They stated that at this crucial stage, they would be perceived as too old for CAMHS but too young for adult acute services, leading to the young person receiving no care or the wrong level of care. It recommended that if the manifested disorder threatened to carry onto adulthood from adolescence (for example psychosis or an eating disorder), there should be a clear pathway in place for the young person to make the transition from adolescent services to adulthood.

Similar to the Mental Health Act, the framework also highlighted the need to involve children and young people in decisions that will affect them. It stated that health care professionals have a duty to respect the views of young people and allow them to feel that their view is listened to and valued.

Outline of consultation

Based on these findings, the need for advocacy within the mental health services of NHS Lanarkshire is very clear. The Mental Health act and the NHS Scotland framework both stress the importance of including young people in their own treatment and also highlight the importance of advocacy in this process.

Mental health professionals will be met with and their views about the usefulness of advocacy will be noted as well as how they would facilitate advocacy within their service. In addition to this, other independent advocacy teams from different districts will be interviewed to assess how their service operates within the NHS, and what hurdles they can identify in offering such a service. Finally, young people’s views will be taken into account, especially focusing on how they would use advocacy, and if having an advocate with them would help their journey through the mental health system easier. Each of these participants will be consulted with individually and, using a semi structured interview format, their views on the need for advocacy in the mental health sector will be elicited.
**Methods**

**Advocacy Teams**

Three advocacy teams who specialise in child and adolescent mental health advocacy were contacted by telephone. Hear 4 U in Ayrshire, Circles Advocacy in Edinburgh and Partners in Advocacy in Glasgow all agreed to meet with me in person to discuss their opinions and experiences working with the NHS to better represent young people’s views. All three advocacy teams had very different experiences and opinions on what approach was best for engaging with young people.

All three advocacy teams were interviewed using a semi-structured style, with questions surrounding how the teams received referrals, what type of work they are involved with (group or one to one advocacy) and what their biggest challenges were. All three teams were met at their own offices. Notes were taken throughout the interview.

Interview questions:

1. Describe the type of work you do (day to day work, what type of advocacy has worked for you, how have you built relationships within an NHS setting)

2. How do you get referrals (at what point in the treatment do you get involved, who communicates the need for advocacy with you, how have you advertised your services)

3. What have your main challenges been (challenges with referrals, challenges with staff, challenges communicating with young people)

**Mental Health Professionals**

In order to gain a better understanding of how NHS mental health services work in North Lanarkshire, I telephoned various professionals within the mental health services to ask if they would be interested in meeting with me to discuss how mental health provisions for the under eighteen age group is negotiated and how advocacy could fit in with these provisions.

4 mental health professionals agreed to meet with me: Richard Burgon (General Manager for North Community Health Partnership) Duncan Clark (Lead Clinician, NHS Lanarkshire) Ann McCormick (Mental Health Officer) and Beverley Adams (Child and Adolescent Mental Health Clinician).

**Young people**

As FBS advocacy (as well as advocacy in general) is concerned with giving a voice to vulnerable children, it was important therefore to discuss advocacy needs with young people. This was especially so as it would be with these young people that any future work would be done.

Both Coatbridge and Motherwell CAMHS teams were approached to request participants for this consultation. Practitioners approached young people to explain the consultation, if the young person wished to be included, a standard letter explaining the work would be posted. The letter stated that participation was voluntary and they did not have to take part. The letter included a contact telephone number and also a stamped address envelope if they wished to reply by letter. An initial phone call was then made after I had received a reply,
Methods: Young people

explaining more fully what I would be asking them to do. If the young person agreed to take part, a time and day for meeting would be set up.

One young person (16 years) was identified from Motherwell Child and Family Clinic, and two young people (aged 16 and 18 years) were identified from Coatbridge Child and Family Clinic.

Two of the young people interviewed had been detained in hospitals for eating disorders; one of these had been detained on more than one occasion. Both had experience working with an advocate. The other young person was being seen due to family issues, and had never had any advocacy experience.

Two young people agreed to meet in the FBS offices, a conference room was booked. One young person wished to meet in a cafe in Bellshill as this was somewhere she knew well.

Three main questions were asked

1. What were your experiences of CAMHS/the mental health service

2. Do you feel as though they listened to your opinions?

3. Do you think an advocate could have helped you?

As the interview started, notes were taken on the young person’s responses.
Results: Advocacy Teams

Hear 4 U

“People give advocacy either too much or too little power with young people”

1. Describe the work you do

Hear 4 U is a branch of children’s UK charity Barnardo’s, working within South Ayrshire with children under the age of 20. Hear 4 U mainly offers individual advocacy to children and young people. Their office is in a main community centre of Ayrshire, which is often used as a family room.

Hear 4 U’s work takes a number of different forms, as they respect that children and young people all have different strengths and preferences in how to express themselves. Some activities include activity books, role-play, poetry books and self esteem building. These different activities often have a common goal, to allow the young people the confidence to express themselves, but have a different process.

They report having only four referrals in the past three years from CAMHS, therefore most of their work takes on a more preventative direction, working with young people who are at risk of developing a mental health issue at a later date.

2. How do you get referrals

Hear 4 U received referrals from a number of different sources. For example school nurses, school health visitors, guidance staff, parents, MHOs and the local CAMHS team where Hear 4 U is represented in on their monthly meetings. They also advertised their service by displaying posters in the community, by going into secondary schools to give talks about children’s rights and their details are displayed on advocacy websites and also on the NHS website.

3. What have your challenges been

The two main issues that have arisen from working within the NHS as an advocacy team have been the lack of referrals and also many organisations ignorance of what advocacy is and what it offers.

In the three years that the Mental Health Act has been functioning, Hear 4 U has only received two referrals from the CAMHS team and only two from MHOs. This is in part due to the young people who are voluntarily in wards and not detained formally, so professionals do not perceive it as a situation where advocacy needs to be involved. For those young people who have been contacted, it often takes a long time for a mutual working relationship to be built up as many young people find it hard to trust that the advocate is working for them. This is often very time consuming, and happens at a time where the advocate can see there are things within the treatment that should be challenged- but the young person is not ready to confide in the advocate about them.

Hear 4 U have also experienced issues working with the CAMH service. Many professionals are perceived to have put up barriers, and find an advocate has challenging their authority.
**Results: Advocacy Teams**

One challenge Hear 4 U has experienced is that the health care professionals forget that the advocate is working for the young person, and any complaint about the service is based on the young person’s experience. Instead, they believe that the advocate is interfering in their work.

In the past, some groups have misunderstood the role of the advocate. They often believe that advocacy is about being a support worker for the young people, and that advocacy can provide an assessment of the young person’s situation. In addition, they wish to speak to the advocate without the child present, or openly say that they believe that children have too many rights and believe that adults should be allowed to decide all aspects of their care.

**Circles Advocacy**

“Advocacy in mental health is about helping young people make their journey their own, not leading them through it”

1. Describe the work you do

Circles advocacy has been running for three years, and has 1.5 advocates each having a caseload of 50 young people at any one time. They have an office in the Royal Infirmary in Edinburgh, but stay independent. Their remit is for inpatient and day patient cases.

Circles advocacy has found that, in their experience, young people perceived one to one advocacy on the wards as daunting. The young people felt vulnerable in their new environment and discussing their issues with an adult that they did not know on a one to one basis to talk to may increase this feeling of vulnerability. Circles’ therefore runs a number of group advocacy activities where young people can meet their peers on the ward, or will arrange to meet young people in a less clinical setting, where they feel they can be more open and safe.

Circles also offers transition groups up to the age of 25, which is useful for young people who have acute mental health issues, who are facing the prospect of moving into an adult ward where they will be placed in an open ward with many threatening adults and also, for the first time, will have a say over their treatment. In the transition groups, an advocate acts as an anchor- being a constant person talking through their changes. It also helps to gain a retrospective account of what CAMHS is like.

2. How do you get referrals

Referrals were commented as being one of the most difficult and challenging hurdles faced by Circles, at the start of their involvement with NHS Lothian, referrals were only given in severe cases where advocacy was seen as the last resort or when they felt they needed to involve advocacy as an obligation (for example with detention orders).

Referrals can be given by clinicians and nurses, but also by advocates walking around child and adolescent wards introducing themselves and explaining what type of work they can do.
**Results: Advocacy Teams**

When they receive a referral, it could take weeks to build a working rapport with a young person, as often the young person is reluctant to trust adults within the clinical setting.

3. **What have your main challenges been**

The main issue working within the NHS was the staff not understanding the role of an advocate, the clinicians and nurses perceived the advocates as an enemy of the service, someone who would argue and interfere with any decision which is being made. This negative experience was resolved when presentations were given to staff about the role of the advocate and to raise awareness of the service. They said that it was through increased use of advocacy, that the staff began to become more aware of what happens.

Another issue which Circles is constantly faced with is that of confidentiality. Some young people talk to their advocate about suicidal thoughts, and if the young person is in immediate danger it becomes the advocate’s duty to tell someone within the ward about this and therefore break confidentiality. To solve this, the advocate could involve the young person in the decision to tell someone, therefore reinstating their feeling of control.

**Partners in Advocacy**

“**You have to explain to them, advocacy can do things that you can’t**”

1. **Describe the work that you do**

Due to the statutory obligation of NHS Glasgow to provide independent advocacy to their patients, Partners in Advocacy is funded by the NHS to advocate on inpatient units in both Yorkhill and Gartnaval hospital. At this time, Partners in Advocacy employ two full time workers who currently with 20 young people each. Although the NHS funds them, they are still independent, and have to give quarterly reports to the funding body on numbers of children and young people who are using their services and how long they used it for.

Due to the personal details being shared, Partners in Advocacy mainly work on a one to one basis with young people, which allows for greater confidentiality and sharing of information. Also, it is easier to build a rapport if there is only the young person and advocate. This is especially useful if the young person has actively asked for advocacy himself or herself. As well as working within the inpatient units, they also work within the community working from referrals from the NHS. They help advocate with school-refusers, young people with additional support needs and also working with the adolescent deliberate self-harm unit.

2. **How do you get referrals**

As well as receiving referrals from clinicians at Yorkhill and Gartnaval hospitals, advocates also do outreach work. This requires the advocate to go to the child and adolescent wards and talk with the young people about what they do and what kind of help they could offer each young person. Partners in Advocacy believe it is important to allow the young person to...
**Results: Advocacy Teams**

know what the advocates look like and have a chance to discuss their advocacy needs before any direct advocacy takes place.

3. **What have your challenges been**

‘Partners in Advocacy’s main challenge working within the NHS has been the negative attitudes that many healthcare professionals hold towards advocates. The clinicians believed that advocates would interfere with their decisions surrounding treatment of young people. To overcome this hurdle, they tried to raise awareness about advocacy through attending CAMHS meetings and presenting their work there. They also found it useful to take time to get to know any new member of staff and explain what advocacy could do to work with them.

A general challenge for advocacy has been the lack of appropriate facilities in Scotland as a whole. The main eating disorder clinics are all in central Scotland, with young people from the Highlands having to travel down to Glasgow to receive treatment. In addition this, there is no specific mental health secure unit for children and young people in Scotland. Young people who require this type of care have to travel to Newcastle. Young people also face travelling to England if there are no available beds in Scotland.
Results: Mental Health Professionals

Understanding of Mental Health Advocacy

The mental health professionals I spoke to were all aware of advocacy as an important force within their area. Different ways of awareness included working with advocates in past work, working as an advocate themselves in a previous job or through the Scottish Government's framework “Promotion, Prevention and Care” where advocacy was explicitly mentioned, and the benefits of working with an independent advocate were stressed.

How advocacy could fit in with services with Lanarkshire received differing opinions. Having an advocate for young people was spoken about as a way of raising the agenda for developing child and youth mental health services within Lanarkshire, a way of making the NHS framework a working reality for young people, a different way of communicating with young people who did not feel comfortable in their service, and also as a way of raising cooperation and understanding of their treatment options with young people. One person mentioned that advocacy would not be needed frequently as the CAMHS team works closely with the young people and they feared having another adult, not from CAMHS, would interrupt the young person’s treatment and therefore not be beneficial.

The professionals also differed with their opinions on what young people could access advocacy. Opinions ranged from giving FBS information leaflets at the same time as the initial letter from the NHS; introducing advocacy after the young person has started treatment and may need extra support; waiting until the young person came across an issue that they may need advocacy with; waiting for the CAMHS team to try every option available to them before giving FBS the young person’s details; and also working with families where a detention order is imminent, to work with the family to ensure the young person’s views are being heard.

How we could fit in with other services

Similarly to opinion from other advocacy teams within NHS Scotland and also previous research with advocacy in a healthcare setting, advocacy fitting in with other services has a number of options. Although the professionals understood that advocacy is beneficial in some, if not all cases, for their work with children and young people; they had separate notions of how advocacy could fit in with their service.

One professional believed that advocacy should be used sparingly due to worries about the advocate interrupting the young person’s agreed treatment plan. Another said that advocates should work closely with the CAMHS team but maintain a working tension, so although both teams understand the others role, there is a sense of professionalism where both groups can work independently to do what is best for the young person. Another stated that advocates should be introduced at the start but stay separate from the CAMHS team, maintaining advocacy’s independence.

Issues that could arise

One issue that was highlighted by one professional is the difference between voluntary admission and a detention order, and how the advocate’s job may change as a result of this. The main difference is that, in principle, a young person could be free to leave the hospital
Results: Mental Health Professionals

at any time under a voluntary admission, but under a detention order they have to stay there. Advocacy, in the case of detention, must make the young person aware of their rights for treatment and allow their voice to be heard in tribunals.
Results: Young People

1. What were your experiences of CAMHS/the mental health service

   “You end up getting defeated by them and doing what they want”

   “They just spoke a lot, they didn’t really do anything”

Feelings about CAMHS and the mental health service were mixed. Person A felt as though CAMHS had a positive effect on her life and she enjoyed that she got to work as a family group but also get time on her own.

Person B felt CAMHS did not focus on an area of her life she wanted to talk about, and instead spoke about wider problems. She felt that this led her issues to reach a crisis point that she was admitted as an inpatient for. Person B felt if more work had been done investigating this issue, then she would not have been detained.

Person C felt that the CAMHS clinician she spoke to was not specialised enough to deal with her issues. Similar to person B she felt that her issue was only dealt with when it had reached a crisis level. Person C felt that, whilst CAMHS was honest with her, that some facts were not shared. An example of this was that as a voluntary inpatient, she had the right to leave.

2. Do you feel as though they listened to your opinions?

   “They’re always asking how I’m feeling when decisions are being made”

   “The therapist spoke at me, not with me”

Person A said that at every stage of working with CAMHS, her opinion if sought. She feels as though this helps her understand what is going on and feels that she is a part of the process. She said there are a few issues with school that no one listens to, but as this is not an issue with CAMHS, she does not think they have to help.

Person B felt that her view was not taken into account, and CAMHS preferred speaking with her parent leading to poor advice in how to cope with her issues in a home setting. This led to a strained parent-daughter relationship, which CAMHS seemed to be more interested in that the initial issue.

Person C also felt as though CAMHS preferred talking with her family rather than consulting with her. When CAMHS did speak with her, they would tell her their opinion without waiting for her reply. Person C felt as though CAMHS were more interested in solving the physical effects of her issue before dealing with the mental cause.
Results: Young People

3. Do you think an advocate could have helped you?

“When I was detained, I thought everyone hated me. It was good having someone on my side”

“More people should know about advocacy, it really helped me”

Person A had never heard of advocacy. When it was explained to her, she felt that it would be good to have someone else to talk to, and thought that if she had an issue that she could not raise with CAMHS, perhaps she could with advocacy.

Person B received an advocate due to her detention order. Her MHO found a young person’s advocacy team in her area (FBS Advocacy). Her advocate worked with her to prepare for tribunals, but she also found it was useful to have an advocate to ask questions about medication and the length of her stay.

Person C also found advocacy useful when preparing for tribunals. She said that having someone there who was solely on her side was comforting when everyone else seemed to be against her. She said that although the advocate visited once or twice a week, on the run up to a tribunal, the advocate would visit more.
Conclusions and Recommendations

Professionals

Similar to previous research conducted into the area of advocacy in professional sectors such as health care, the findings from the consultation showed a variety of experiences and opinions. These could be identified as broadly as “negative” (where health care practitioners are non inclusive of advocacy staff and the hurdles faced by advocates are vast) and also “positive” (where health care professionals are inclusive of advocacy staff and they find it easy to work together in order to do what is best for young people). Negative opinions and experiences included health care practitioners believing that advocacy should only be used in matters of emergency, or when CAMHS had exhausted all other avenues, so advocacy was a last resort. Also, the belief that as CAMHS is a multi-agency service, they would be able to advocate within their own service. Whilst many professionals may be trained in consulting with young people about their treatment, the need for an independent advocacy team is still apparent. This is especially so if there is an aspect of their treatment by CAMHS that the young person wishes to discuss.

Another negative experience was the experience of the Ayrshire advocacy group, in which health care professionals misunderstood the role of an advocate, believing that they were a befriending/support network. Although work had been done to raise their profile, this misunderstanding was stopping the advocates from doing their job. Whilst offering some level of support is part of advocacy, an advocate’s main role is to listen to the views of young people and then explain this to health care professionals; standing in on tribunals and writing letters to appropriate bodies if necessary. If the health care professional does not understand this, then any work done will not yield the results that the young person wants.

Finally, the last negative experience was one of time. All advocacy groups mentioned that when working on a mental health advocacy case, it often takes time to get to know the young person and build up some level of trust. If, during this time, their rights as young people are being challenged, the advocate must wait until the young person confides this in them. This allows the young person to see that they are in control of the situation, and that the advocate would only work for what they want.

Positive opinions and experiences included some health care professionals stating that information about advocacy should be sent out with initial contact letters, to ensure that every young person is given the opportunity to access advocacy. Advocacy groups in Glasgow and Edinburgh also ensured that advocacy’s message was heard by going around inpatient wards and making themselves known to young people. The need to advertise advocacy’s services in North Lanarkshire is important, as if a service is set up, it will not be a success unless young people know about FBS Advocacy.

Another positive experience that came out of this consultation was the different ideas about how to work with young people. Glasgow, Edinburgh and Ayrshire all had different opinions on how best to work with young people. These included working in small groups where all young people had similar problems and so were working towards a feeling of collective advocacy. In addition to this, one advocate spoke about using art and creative writing as a way of safely exploring difficult emotions and situations that an advocate may have to help with. A final suggestion was working on a one to one basis, but trying to meet in a separate
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area which would appear neutral, so if there are problems with treatment, the young person would not feel self conscious about discussing this.

Young People

Although this consultation was about the need for advocacy in the health service, two of the young people used it as an opportunity to discuss their treatment retrospectively. Whilst two of the young peoples’ experiences were negative, this shows the need for advocacy before the point of tribunal. Taking examples from their interviews, one young person felt as though the clinician preferred speaking with their parents than with them. An advocate would be able to ensure that the young person’s views of treatment were taken into account. One young person found that their clinician did not share all the relevant information about what a voluntary admission was. An advocate could have informed the young person about this process and supported them through out their stay.

Similar to previous research, one young person said that during their first few weeks of being on the ward, they did not talk to anyone. This included the advocate. The young person described how the advocate did not give up, but maintained a low profile on the wards, just saying hello and asking if everything was okay. The young person said that this allowed her to be in control of the situation, and spoke to the advocate when she felt ready.

The two young people who used advocacy stated that having an advocate there meant having someone on their side through a difficult time in their life, and the young person who did not use advocacy said that they felt advocacy would be good if they needed someone to speak on their behalf.

The young person who had not used advocacy thought that advocacy would be useful in schools. This could mean that the advocate who is working with CAMHS could perhaps also have tie-ins with education, leading to a more organic advocacy experience.

Issues

As this was a short term consultation, the issue of recruitment was a serious one. The idea of forming a steering group to assist and advise with problems was rejected as many health care professionals were too busy to meet, but were eager to offer help through emails and help with recruitment by asking colleagues.

As the sample group I was aiming to consult with were young people with some element of mental health difficulty and had been receiving inpatient or outpatient psychiatric care, the issue of their well being was paramount. Many young people that were identified were deemed unsuitable because their lives were too chaotic, they were currently detained, or they were “not well enough” to talk about their past issues. Due to this, only three young people were recruited, two of these were 18 and had finished working with CAMHS so their stories were retrospective. Another was 16 but was receiving care due to family issues rather than mental health needs.

In addition, because North Lanarkshire does not have any inpatient beds (although they do have beds designated for them in Glasgow), it was difficult to find mental health professionals who had relevant experience working with young people.
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If a consultation such as this was to be done again, it would be useful to involve individuals from Lanarkshire CAMHS teams and also work closer with child and adolescent inpatient units in Greater Glasgow to identify young people who are currently being treated. Based on reading past consultancies in this area, it would be useful to work with focus groups as well as individual young people to get a broader range of experiences. Questionnaires surrounding advocacy and how it would be used could also be passed to different services for a more qualitative look at young people’s opinions.

It is important to note that the aim of this consultation was not to attack or point out the perceived failings of the existing services. As this consultation was small, their views may not be representative of all young people who use services in Lanarkshire. However, from their responses, it is clear that advocacy could be used to help young people like them. For services and advocacy to move forward, working in a collaborative way would ensure that young people feel listened to and respected throughout their treatment.

Recommendations

Based on this consultation, a number of recommendations could be made.

1. Advocacy awareness meetings should be set up. FBS should go into hospitals, child and family centres and social work departments and explain what advocacy is and how it can help young people in psychiatric wards

2. Advocacy should work closely with CAMHS practitioners from point of referral, to ensure that when advocacy is needed the foundations have already been put in place.

3. Based on the experiences of other advocacy services, there should be ward rounds or a drop in room for young people to approach an advocate. This way advocacy can be explained and young people will get to know advocates before any work needs to be done.

4. As there are no official inpatient facilities for Lanarkshire, it is important to create links with other advocacy groups to ensure that if a child from North Lanarkshire is being treated in Glasgow or Edinburgh, they have the option of working with a North Lanarkshire advocate as either an inpatient or as an outpatient.

5. As young people spoke about the importance of trusting an advocate, and other advocacy groups spoke about the difficulties in building a rapport and mutual working relationships with young people, it is important to identify advocacy workers as having easily identifiable roles. This could mean whilst one worker does ward rounds, another worker is knowledgeable about mental health legislation. This will give young people a sense of continuity in the service.
References


Mental Health (Care and Treatment) (Scotland) Act 2003


Worrell-Davies, A. (2008) Barriers and Facilitators to Children’s and Young People’s Views Affecting CAMHS Planning and Delivery. Child and Adolescent Mental Health 13 (1) p16-18