Response ID ANON-X4N1-QV9Z-5

Submitted to The future of secure care and the single point of contact (SPOC) for victims in the Children's Hearings System
Submitted on 2026-04-16 16:54:24

Questions on secure accommodation criteria

Q1 Do you think the new criteria for authorising a child's placement in secure accommodation by a children's hearing are sufficient?

No

Please explain the reasons for your answer:

While the revised criteria represent an improvement in recognising psychological harm, the Royal College of Psychiatrists in Scotland does not consider the criteria to be sufficient in their current form.

The criteria remain too broadly framed and lack clearly defined thresholds relating to the severity, likelihood, and impact of harm. This creates significant scope for interpretation and contributes to the well established inconsistency in how secure care is used across local authorities. Without clearer thresholds, decisions may be driven by local risk tolerance, attitudes to secure care, service availability, or systemic pressures rather than by a consistent, child centred and proportionate assessment of need. It is important that any child can access the safety of secure care services irrespective of where they live.
For example, criteria such as "the child is likely to engage in self harming conduct unless the child is kept in secure accommodation" do not specify the degree of risk or seriousness of potential harm. This could encompass a very wide range of presentations, from low level self injury through to behaviour posing a high risk of significant injury or death.

We recommend that the criteria are strengthened by the inclusion of explicit thresholds, such as:
• The probability of the behaviour occurring (e.g. "highly likely" rather than "likely")
• The severity and consequences of the anticipated harm (e.g. risk of significant physical injury, serious psychological harm, or death)
• Consideration of whether the risk can realistically be managed through less restrictive alternatives, with clear justification where it cannot

Incorporating clearer thresholds would support more consistent decision making across Scotland, reduce unwarranted variation between local authorities and ensure that deprivation of liberty remains proportionate, evidence based, and truly a measure of last resort.

In addition, the criteria should more explicitly recognise the dual function of secure care, including both 1) safeguarding and welfare of the child and 2) public protection, particularly where a child has committed serious or violent offences.

We recognise that decisions to place a child in secure care may have to be made urgently and based on available information. However, where and when practicable, we recommend that all decisions to authorise secure care placements are supported by a structured best-interests assessment, aligned with Article 3 of the UNCRC, and informed by specialist mental health and risk assessment where appropriate.

Q2 Should the criteria for secure care be revised to include children who, while not posing an immediate risk to others, may still require intensive secure, or near secure, support, protection from self-harm, or stability in near-secure residential provision, including on premises currently registered and approved to deliver secure care?

No

Please explain the reasons for your answer:

The Royal College of Psychiatrists in Scotland does not support revising the criteria for secure care to include children who do not meet the established threshold for deprivation of liberty.

Secure care occupies a unique and clearly defined legal and ethical position within Scotland's care and justice system. The lawful deprivation of a child's liberty represents a hard legal threshold that should only be crossed where it is necessary, proportionate, and unavoidable in order to keep the child or the public safe. Broadening the criteria to include children who require intensive or near secure support, but who do not pose an immediate and significant level of risk, risks fundamentally undermining this safeguard.

Expanding secure care criteria in this way would blur the boundary between secure care, where deprivation of liberty is authorised and tightly regulated under statute, and other intensive residential or community based models of care, which do not involve deprivation of liberty and should be developed, commissioned and governed separately. Improved availability of 'step up and step down' provision would greatly support movement of children in and out of secure care.

There is a significant risk that widening the criteria would lead to net widening, whereby children are placed in increasingly restrictive environments not because they meet the legal threshold for secure care, but because suitable alternative provision is unavailable or under resourced. This would be contrary to both the principle of least restriction and the requirement under Article 37 of the UNCRC that deprivation of liberty is used only as a measure of last resort and for the shortest possible time.

The consultation proposes "near secure" or "flex secure" support as a way of meeting unmet need. The College's position is that: children who require intensive, highly supported care but who do not meet secure care thresholds should be supported through distinct, non secure models, with clear legal status and governance. These models should not rely on the infrastructure, procedures, or authorisation mechanisms of secure care and that deprivation

of liberty should not be incrementally introduced through changes in practice rather than through lawful authorisation.

Attempting to adapt secure care settings to meet a wide spectrum of risk and need risks creating environments that are neither safely secure nor appropriately non secure, particularly for children who present with high levels of aggression, violence, or serious risk. This may increase risk to other young people and staff and undermine the primary therapeutic function of secure care.

Broadening the criteria could result in increased variation between local authorities, with differing interpretations of what constitutes “near secure” need. This would exacerbate the existing inequities in access to secure care and undermine consistency and fairness in decision making.

The College recognises the challenges faced by children as they leave the safety of secure care and the efforts that have gone into developing frameworks and services which support and safeguard children in a variety of community setting.
An additional issue the College wishes to highlight is the need for greater clarity and consistency regarding the boundary between CAMHS inpatient units and secure care settings, and the pathways between them.

There is increasing concern about the number of children and young people being admitted to CAMHS inpatient units where the primary difficulty relates not to an acute mental disorder requiring hospital treatment, but to a breakdown in care arrangements in the community, particularly for children and young people with learning disabilities and complex needs. In such circumstances, hospital admission may be used as a holding placement rather than for its intended therapeutic purpose.

This can result in prolonged and inappropriate inpatient admissions, with children remaining in hospital after mental disorder has been excluded or adequately treated, simply because there is no suitable care placement available. This is not in the child’s best interests, is inconsistent with the principle of least restrictive care, and places additional pressure on already limited CAMHS inpatient capacity.

The College considers that there should be clearer operational links and pathways between CAMHS inpatient services, secure care, and alternative care settings, supported by agreed guidance and governance arrangements. Where a child is admitted to a CAMHS inpatient unit for assessment or treatment, there should be: early and active discharge planning from the point of admission, clear processes to determine when mental disorder has been excluded or sufficiently treated, timely consideration of transfer to an appropriate care setting.

Where the legal and clinical thresholds are met, this may include transfer to secure care. Where secure care thresholds are not met, suitably resourced non secure alternatives must be available. In all cases, decisions should be clinically informed, lawful, and based on the child’s assessed needs rather than on system pressures or gaps in provision.

Q3 Are there any factors or circumstances you think should be considered in potential future secure care criteria?

Please set out your suggestions below:

Public protection should be explicitly recognised within the criteria, alongside refinements to existing thresholds rather than the creation of new, overlapping categories.

Questions on secure accommodation definition

Q4 Do you agree the definitions of relevant children’s care services should be reviewed to include a new category of provision with adaptable levels of restriction which can be increased or decreased as required to contemplate necessary shifts between restriction of liberty to deprivation of liberty within the one setting, in the way envisioned by ‘flex secure’?

No

Please explain reasons for your answer and any situations where you think 'flex secure' could be used:

We do not support revising the statutory definitions of secure care to include a new category of provision with adaptable levels of restriction, as described under the concept of “flex secure”.

While the College recognises the complexity and fluctuating nature of risk and need among some children and young people, we have significant concerns that incorporating “flex secure” into secure care legislation would introduce conceptual, legal, and practical risks that undermine both children’s rights and safety.

Secure care is a clearly defined legal construct which permits the lawful deprivation of a child’s liberty, subject to strict statutory safeguards, thresholds, oversight, and review. Introducing a model that allows movement along a spectrum between restriction of liberty and deprivation of liberty within a single setting risks blurring this fundamental legal distinction. This may erode the clarity of safeguards designed to ensure that deprivation of liberty remains a measure of last resort.

While relational security may fluctuate over time, physical and procedural security are inherently difficult to adjust safely and rapidly. Attempting to do so risks creating uncertainty for both staff and young people, which may inadvertently increase distress, conflict, and violence. In particular, increases in restriction following incidents may be perceived by young people as punitive, rather than therapeutic, undermining trust and escalating risk.

The College is concerned that the flex secure concept is attempting to meet too broad a range of needs within a single model. Secure care and intensive non secure provision serve different functions and populations. Trying to amalgamate these functions risks creating a model that is neither sufficiently secure to safely manage young people who pose a high level of risk to others or the public, nor sufficiently non restrictive and therapeutic for those who do not meet the threshold for deprivation of liberty.

This is particularly concerning for children placed on justice grounds, where secure care also serves a public protection function. This function is not adequately recognised or addressed within the flex secure concept as described in the consultation.

There is also a significant risk of net widening, whereby children who would previously have been supported in non secure settings are placed within environments capable of deprivation of liberty due to system pressures, placement shortages, or risk aversion. This would be contrary to the principles of least restriction, proportionality, and Articles 3 and 37 of the UN Convention on the Rights of the Child.

Q5 How could a model with adaptable levels of restriction within the one setting help protect and advance children's rights and ensure deprivation of liberty is always a last resort and for the shortest possible time, as required by Article 37 of the UNCRC and in accordance with Article 5 ECHR?

Please explain the reasons for your answer:

Any secure care placement must demonstrably be in the child's best interests, in line with Article 3 UNCRC. A formal best interest assessment should be an explicit part of all decision making processes.

Questions on models proposed in the 'Reimagining Secure Care' report

Q6 Do you support the concept of community-based hubs?

Yes

Please explain the reasons for your answer:

The College supports the concept of community based hubs in principle, recognising their potential role within a broader continuum of care aimed at preventing escalation to secure care and supporting children closer to their communities.

Community based hubs have the potential to provide early intervention and crisis response for children with complex needs, particularly where difficulties are primarily related to welfare, trauma, family breakdown, neurodevelopmental conditions, or unmet mental health needs. When appropriately designed and resourced, such models may help reduce placement breakdowns, support family engagement, and prevent unnecessary admission to secure care. These would require integrated access to CAMHS, including timely psychiatric assessment and treatment.

However, the College emphasises that community based hubs represent a distinct model of care and should not be incorporated into, or conflated with, secure care or secure care legislation.

It is essential that community hubs are not used as a substitute for secure care where a child meets the legal threshold for deprivation of liberty, nor should they become "near secure" placements by default due to pressure on secure care capacity. Such an approach would risk inappropriate restriction and blurred legal boundaries.

From a mental health perspective, the effectiveness of community based hubs will depend on:
• Integrated access to CAMHS, including timely psychiatric assessment and treatment
• Clear pathways into and out of specialist mental health services
• Robust multi disciplinary working, with defined roles and responsibilities
• Adequate workforce capacity, training, and clinical supervision

Community based hubs are also unlikely to be suitable for all areas, particularly in rural or geographically dispersed regions, and flexibility will be required to avoid creating new forms of postcode inequality.

Q7 Do you support the wider adoption of the concept of multi-disciplinary teams?

Yes

Please explain the reasons for your answer:

The wider adoption of multi disciplinary teams as a core component of services supporting children and young people who are in, or at risk of entering, secure care.

Children who require secure care almost invariably present with complex, overlapping needs, including mental disorder, neurodevelopmental conditions, intellectual disability, trauma, disrupted education, family distress, and, in some cases, criminogenic risk. No single profession or service is able to address these needs in isolation. MDTs are therefore essential to providing coordinated, formulation based, and proportionate support.

However, successful implementation of MDTs requires more than endorsing the concept. The College has several key considerations:

Equity of access
There is currently significant variation across Scotland in access to specialist MDT input, particularly forensic CAMHS expertise. Some secure care services and local authority areas benefit from well developed multi disciplinary input, while others have little or no consistent access. Without a national approach to workforce planning and specialist provision, wider adoption of MDTs risks reinforcing existing inequities rather than addressing them.

Clarity of structure and remit

The consultation does not clearly articulate:
• Where MDTs would be based (e.g. within secure care settings, community based hubs, or across both)
• How MDTs would interface with existing CAMHS, education, and social work structures
• How continuity of care would be maintained as children move between community settings, secure care, and onward placements
• The crucial role of nursing within secure care to provide a link with NHS primary and secondary care
From a clinical perspective, MDTs must be structured to support continuity across a child's pathway, rather than existing as isolated teams tied to a single setting.

Specialist mental health input
MDTs supporting children in secure care must include access to appropriately trained child and adolescent psychiatrists, particularly those with forensic expertise. This is essential to accurate assessment of mental disorder and risk, differentiation between mental illness, neurodevelopmental conditions, trauma response, and criminogenic behaviour; safe, proportionate decision making regarding restriction, treatment, and placement.

Without embedded specialist mental health leadership, MDTs risk focusing primarily on containment and behaviour management rather than treatment and recovery.

Governance and accountability
MDTs must operate within clear governance arrangements, with defined roles, responsibilities, and accountability across agencies. This includes clarity about: decision making authority; escalation processes where risk cannot be safely managed; and accountability when services are unable or unwilling to deliver agreed interventions.

Workforce capacity and sustainability
Wider adoption of MDTs will require investment in workforce development, including training, recruitment, and ongoing clinical supervision. Without this, MDTs risk existing in name only, with limited capacity to deliver meaningful multidisciplinary input.

Questions on mental health provision

Q8 What further actions could be taken to integrate secure care and mental health services?

Please explain the reasons for your answer:

Integration of secure care and mental health services to be fundamental to any effective reform of the secure care system. Children and young people who enter, or are on the edge of, secure care frequently present with complex and enduring mental disorders, neurodevelopmental conditions, intellectual disability, trauma related difficulties, and high levels of emotional and behavioural dysregulation. These needs must be assessed and treated as core components of care, not as secondary considerations.

A key priority is addressing the inequity of access to specialist mental health provision, particularly forensic CAMHS expertise, across Scotland. At present, access to specialist assessment, formulation, and treatment varies significantly by geography, with some areas having little or no access at all. The network of Forensic CAMH services should continue to develop across the country, ensuring that all secure care services and placing authorities can access consistent, high quality specialist mental health input regardless of location.

Further actions should include:
• Nationally commissioned secure care provision, ensuring consistent psychiatric assessment, diagnosis, treatment planning, and medication management within all secure settings.
• Clear, standardised care pathways linking community CAMHS, forensic CAMHS, secure care, and inpatient mental health services, to reduce fragmentation and delays.
• Expand primary care provision within secure care, including access to nursing care 7 days per week. This could be supported by stronger links with NHS and sharing nursing provision across different providers.
• Strengthen role of Looked After Children nurses in providing oversight of children's mental and physical health and development as they move across placements.
• Early mental health input for children on the edge of secure care, enabling timely intervention that may prevent escalation to more restrictive placements.
• Investment in workforce development, including specialist training and ongoing clinical supervision for CAMHS staff to build and sustain forensic competencies across Scotland.
• Robust clinical governance arrangements, ensuring clarity about responsibility for decision making in relation to risk, treatment, and placement, and avoiding situations where mental health input is advisory only and insufficiently embedded in care planning.

Q9 How can these systems work together to ensure that children and young people - both within secure settings and those on the edge of admission - receive trauma-informed, holistic support that prioritises wellbeing alongside safety?

Please explain the reasons for your answer:

As above in answer to Q8.

CAMHS remit is the assessment and treatment of mental disorders, not general wellbeing. Collaboration requires clarity of roles and appropriate commissioning of complementary services. Child and Adolescent Mental Health Services are specialist services commissioned to assess and treat mental disorders. While CAMHS should of course practice in a trauma informed way, the broader concept of "wellbeing" sits across multiple systems, including social care, education, youth justice, and third sector provision. Expecting CAMHS alone to deliver holistic wellbeing risks overstretching services and diluting their specialist function.

Systems can work together most effectively where:
• Mental health needs are clearly identified and treated by appropriately skilled CAMHS professionals, including access to forensic CAMHS where risk and offending behaviour are relevant
• Trauma informed practice is shared across all agencies, with secure care staff, social work, education, and justice services trained to understand trauma responses and their impact on behaviour and risk
• Each service understands what it is responsible for delivering, and what it is not, reducing fragmentation and unrealistic expectations
• Care planning is formulation based, bringing together mental health, psychosocial, educational, and relational factors to inform proportionate and safe interventions
• Whereas CAMHS and specialist neurodevelopmental services have a role in the assessment, formulation, diagnosis and in some instances treatment (e.g. ADHD) of some neurodevelopmental conditions, the care, education and wellbeing of affected young people must be the responsibility of all professionals and services involved.

For children on the edge of secure care, early access to specialist mental health assessment and intervention is essential, but this must be accompanied by appropriately resourced social care, family support, and education provision. For those within secure care, mental health treatment should be integrated into the care plan, while responsibility for daily wellbeing, safety, and relational support remains shared across the secure care workforce.

Particular attention is needed at transition points, including admission to secure care and discharge back to the community or onward placements. Poor coordination at these points can undermine both safety and therapeutic gains.

Q10 What improvements in information sharing across services are needed to ensure we fully understand and meet the health and wellbeing needs of children and young people?

Please explain the reasons for your answer:

Information transfer at admission and discharge is inconsistent and often poor. A national standardised protocol would improve continuity of care, reduce duplication of assessments, and avoid delays. Allowing nurses in secure care access to NHS information systems would support this.

The role of Looked After Children nurses is key in supporting information sharing as children move between placements.

Questions on prevention, alternatives, community based support and transitions

Q11 In your experience, which alternative care and support options are currently most effective in preventing the need for secure care placements, particularly on welfare grounds?

Please explain the reasons for your answer:

Given the significant regional variation, it is difficult to identify best practice. A national or international review of alternative models and their outcomes is required.

Q12 Where alternatives to secure care are available, what factors most strongly influence whether they are used in practice (for example, workforce confidence, secure care placement availability, commissioning arrangements, risk)?

Please explain the reasons for your answer:

Q13 What gaps currently exist in the availability of alternatives to secure care across Scotland?

Please explain the reasons for your answer:

Q14 How can learning from local authority practice approaches to alternatives be shared and scaled across Scotland?

Please explain the reasons for your answer:

Q15 Is there scope for sharing and pooling of resources to support specialist alternatives to secure care on a multi-authority basis?

Please explain the reasons for your answer:

Q16 What role should health, education, and justice services play in supporting children with complex needs?

Please explain the reasons for your answer:

No one service will be able to meet the needs of a young person. There needs to be a clearer understanding of the role and function of each service and the need which they are meeting. This should be regularly reviewed and there should be accountability when services do not deliver.

Q17 How can we measure the effectiveness of community-based supports in meeting the needs of children and young people?

Please explain the reasons for your answer:

A standardised national dataset should be used across all services, including secure care, to track pathways, outcomes and adherence to standards.

Q18 What support should be in place to ensure successful transitions, including to Young Offenders' Institutions, and reintegration for children and young people leaving secure care into their communities, including as they transition into adulthood and more independent living?

Please explain the reasons for your answer:

Questions on national co-ordination of secure care placements

Q19 How can we improve access to secure accommodation placements to ensure that children who cannot legally be placed elsewhere (e.g. those remanded or sentenced by the courts) are always accommodated appropriately?

Please explain the reasons for your answer:

Robust national data collection would allow accurate modelling of capacity and bed requirements.

Q20 Do you agree there should be nationally-funded facilities whereby there is guaranteed access to fulfil court orders and do you think that would be sufficient to build confidence in decision makers?

Not Answered

Please explain the reasons for your answer:

National commissioning of secure care could improve access to beds.

Q21 Do you agree Scotland should introduce a single national system for co-ordinating secure care placements for children?

Yes

Please add your comments in the box below:

Functions should include bed management, data collection, and governance embedded within secure care standards. The system should operate consistently regardless of legal route into secure care.

Please add your comments in the box below:

The system should operate consistently regardless of legal route into secure care.

Please add your comments in the box below:

Q22 When creating a new national system to coordinate secure care placements for children, which type of model do you think Scotland should look at and take ideas from?

Please explain the reasons for your answer:

NHS Scotland commissioning of national services, including existing Forensic ID medium secure and child mental health inpatient services, has worked well for some time.

Q23 Beyond the specific models referenced in this section, please share any other proposals or comments you have in relation to national co-ordination.

Please explain the reasons for your answer:

NHS bed management systems provide a relevant comparator.

Questions on national co-ordination and secure care placement allocation

Q24 If Scotland were to establish a Multi-Agency Panel to make decisions about secure care placements, similar to Northern Ireland's model, which professionals do you think should be part of that panel? Do you also think that care experience should be represented on the panel?

Please explain the reasons for your answer:

All relevant agencies must be represented, including mental health. Advocacy and the voice of the child should be integral. Care experienced perspectives would enhance understanding of impact. An appeal mechanism would be essential, and clarity is needed on whether the panel would have legal authority. If secure care placement is not agreed there would be a need to understand the local options available for care which would be difficult on a national level.

A local multiagency model would work effectively. Local authority secure care screening panels should include senior clinicians/managers from local CAMHS to enable shared decision-making at all stages in the process. It would also support access to mental health care for children being considered for secure care.

Questions on the nationalisation of secure care

Q25 Do you support the concept of the wholesale nationalisation of secure care provision in Scotland so it is run as a national service in the future?

Yes

Please explain the reasons for your answer:

Secure care fulfils a statutory function and would benefit from national governance. Nationalisation could reduce unwarranted variation, improve equity, and support closer inter service collaboration. It should also remove unwarranted variation in care and improve equity of access.

Questions on assessing impact

Q36 What, if any, do you see as the data protection related issues that you feel could arise from the proposals set out in this consultation?

The following data protection issues may arise from the proposals set out in this consultation :

Q37 What, if any, do you see as the children's rights and wellbeing issues that you feel could arise from the proposals set out in this consultation?

The following children's rights and wellbeing issues may arise from the proposals set out in this consultation :

There are no details about young people's views of these changes which would be important to know and understand. It is crucial that they have access to independent advocacy.

Q38 What, if any, do you see as the main equality related issues that you feel could arise from the proposals set out in this consultation?

The main equality related issues which may arise from the proposals set out in this consultation are :

Any other comments

Q39 Please share any other views you have about this consultation, or any other issues you feel it raises.

Please share any other views you have about this consultation and/or any other issues it raises:

Main points
1. Overall, RCPsychIS recognises the invaluable role of secure care in supporting the healthy development of children in safe, secure conditions. Any developments should support secure care continuing as a key part of care and education provision in Scotland.

2. The proposed "flex secure" model requires further careful consideration. As currently described in the consultation, there is a risk that it could inadvertently increase levels of violence. In particular, increases in security following incidents may be experienced by young people as punitive rather than therapeutic.

3. It is important to clearly distinguish between two separate concepts:
o Secure care, which involves the lawful deprivation of liberty; and
o Flex secure, as described in the paper, which appears to be an intensive, patient centred model of care. This should be supported by ongoing evaluation of outcomes of secure care.
These represent fundamentally different models designed to meet different needs. Attempting to combine them risks creating an approach that aims to meet all needs simultaneously. This is unlikely to maintain safety when providing care to young people who present with high levels of risk.

4. The consultation places significant emphasis on children and young people admitted to secure care on welfare grounds, with limited consideration given to criminogenic needs or the public protection function of secure care. While some children may present with both welfare and justice needs, in practice they are admitted under distinct legal frameworks that serve different purposes.

5. The current regional forensic CAMHS network requires a national remit. There remain several areas of Scotland where there is no access to specialist forensic CAMHS expertise. This longstanding inequity in access to care persists and requires urgent attention.

6. The consultation appears to conflate wellbeing with specialist mental health care. CAMHS is a specialised service focused on the assessment and treatment of mental disorders. Service planning must be informed by a clear understanding of young people's actual psychiatric and psychological needs, rather than by broader or less clearly defined wellbeing concepts.

Broader comments on the consultation document

Page 8
The consultation estimates a 40% increase in secure care capacity, raising the projected requirement to between 85 and 120 beds. It is unclear how this expansion could be delivered in practice without substantial investment in a national capital building programme.

Page 10

The concept of “flex secure” requires further scrutiny. Security within secure care comprises three core elements:
• Physical security (for example, secure perimeters and locked doors),
• Procedural security (such as routines, searches, and accounting for items), and
• Relational security (the quality of relationships between staff and young people).

Physical and procedural security elements are inherently difficult to adjust flexibly. Altering procedural security may increase the risk of violence if staff and young people are unclear or inconsistent about processes and expectations.

Page 11
The paper refers to the effectiveness of community based hubs; however, no evidence is presented to support this claim.

Page 12
The potential benefits of providing care within a single setting under a flex secure model are highlighted, but this discussion is not balanced by an assessment of the associated risks outlined above.

Page 13
While the definition of secure care correctly references the restriction of a child’s liberty, it does not adequately recognise its dual function:
• safeguarding and welfare of the child; and
• protection of the public where serious offending has occurred.

Page 14
The more detailed description of secure care does not explicitly address its public protection role, particularly in cases involving serious or violent offending.

Page 15
The criteria for secure care do not specify thresholds relating to the severity or likelihood of harm. For example, the criterion:
“The child is likely to engage in self harming conduct unless the child is kept in secure accommodation”
could be strengthened by specifying seriousness, such as:
“The child is highly likely to engage in self harming conduct resulting in significant injury unless the child is kept in secure care.”
Clearer thresholds of this kind may help reduce the current variation in how different local authorities apply criteria for secure care placements.

It is crucial that all young people involved have access to suitable education, training and equitable health care and we also emphasise the importance of families and carers having access to independent advocacy.

About you

What is your name?

Name:
Jane Gordon

Are you responding as an individual or an organisation?

Organisation

What is your organisation?

Organisation:
Royal College of Psychiatrists in Scotland (RCPsychiS)

Further information about your organisation's response

Please add any additional context:

The Scottish Government would like your permission to publish your consultation response. Please indicate your publishing preference:

Publish response with name

Do you consent to Scottish Government contacting you again in relation to this consultation exercise?

Yes

What is your email address?

Email:
jane.gordon@rcpsych.ac.uk

Where did you hear about this consultation?

If other, please say where::