Mapping transitional care-pathways among young people discharged from adolescent forensic medium secure units in England

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Abstract

This study tracked young offenders transitioning from national adolescent forensic medium secure units to adult services in the UK within a six-month period. We used a mapping exercise to identify eligible participants moving during the study period from all national adolescent forensic medium secure units in England. Young people over 17.5 years or who had turned 18 years (transition boundary) and had been referred to adult and community services were included. Of the 34 patients identified, 53% moved to forensic adult inpatient services. Psychosis was the most prevalent symptom among males (29%) and emerging personality disorder symptomatology was commonly reported among females (18%) followed by learning disability (24%). The mean time for transition to adult mental health services and community settings was eight months. There were no shared transition or discharge policies and only two hospitals had discharge guidelines. The findings highlight the need for consistency between policy and practice among services along with the development of individualised care pathways. Future qualitative research needs to understand and reflect on young people's and carers' experiences in order to improve transition service delivery.

Keywords: transition, young offenders, age boundaries, forensic medium secure units

Introduction

The transition from adolescence to adulthood is a period of maximum risk for the emergence of mental health problems (1,2). However, service provision for young people with mental health problems is often inadequate, with the transition gap between child mental health services and adult mental health services being an area of significant concern (3,4,1). Young people with mental disorders usually experience poor transitions (5) with potentially adverse impact on several areas of their lives (e.g. education, employment, family). Transition is distinct from transfer in that is not a discrete event but should be a planned and purposeful process that addresses the psychological and medical needs of these young people (6,7,8,9).

Internationally, there is increasing evidence for the need to improve current transitional care provision (10,5). TRACK, one of the largest studies on mental health care transitions in the UK, was the first to identify the specific transition problems of young people with emotional and neurodevelopmental disorders (7). Hall et al., (11) also reported that young people with Attention Deficit Hyperactivity Disorder (ADHD) receive little support during the process and they lack readiness. Readiness is an extremely important component to facilitate transitions for challenging groups (12). Currently, the care-pathway of young people with ADHD and Autistic Spectrum Disorders (ASD) moving to adult services is not clear and there is no robust information about long-term outcomes (13, 14). The Department of Health (15) encourages transitions that are tailored to the developmental needs of young people disregarding rigid and arbitrary age criteria.

NICE guidance on transition from child to adult care has specifically identified transition in young offenders with mental health problems as a priority research area (16). Young people discharged from secure hospitals have particularly complex needs, including forensic history and contact with the youth justice system. Hence, they might need additional

support before, during, and after their transition focusing on transition preparation and management (17). However, very little is known about the nature and magnitude of transition-related problems in this group (18). Accordingly, to improve transition outcomes, we need to establish the relevant knowledge about current processes and policy.

UK Context and Setting There are six adolescent forensic medium secure units in England and Wales offering mental health services for young people below 18 years. These services are commissioned by the National Commissioning Group (NCG) and provide the highest level of security for adolescent inpatients (19). Adolescent forensic medium secure units admit young people with mental health problems and learning disabilities who offend or present high risk to others and are detained under the Mental Health Act (20). A young person might go through several pathways within the youth justice and mental health systems before ending up in a secure hospital either low or medium secure. Often prison services refer young people to secure hospitals if they are mentally unwell and need immediate care under section 47 or 48 (prison transfer)/ 49 (restriction order) or section 37 that is a court order (21). Adolescent psychiatric hospitals can also refer young people to secure hospitals if they present high risk and cannot be managed elsewhere (22, 23).

Transitions from adolescent medium secure units to adult services are still an overlooked area within the existing literature. Transition processes and outcomes from these services are not known and, therefore, we cannot address the barriers and facilitators to improve policy and practice. Previous findings point out that transition handover-planning from child and adolescent mental health services (CAMHS) to adult mental health services (AMHS) and liaison between services is problematic whilst transition plans are indistinct (24). More importantly, we lack evidence about young people's discharge placements and transition timelines at a national level. This study aimed to bridge this gap by mapping a national sample of young people across all adolescent forensic medium secure units.

Aims

This England based study aimed to:

(1) determine the number of young people transferring from medium secure units (annually to establish the team's caseload and within six months-the six month timeframe was used in order to follow-up young people post-discharge);

(2) establish the age transition boundary across medium secure units;

(3) examine demographics (gender, ethnicity and age), diagnosis, index offence, legal status, and discharge destination for this cohort;

(4) determine policy, guidelines and protocols for transitions across medium secure units;

(5) examine transition preparation and management to look at commonalities and differences in transition process across medium secure units;

(6) look at time from referral date to discharge date (waiting time) to determine whether transition delays occurred throughout services.

We included all national services funded by the National Commissioning Group (NCG) in London, Southampton, Northampton, Birmingham, Manchester and Newcastle. Ethical approval was received from the South Birmingham Ethics Committee in January 2016. This mapping exercise was part of a larger educational project and qualified as an NIHR CNS Portfolio study and was funded by NIHR CLAHRC West Midlands. The IRAS project ID number is 192731.

Methods

The sample

Our sample included young people who would reach or had reached 17.5 years and were eligible to be discharged from adolescent forensic medium secure units to adult services,

community, and custody, between May 30th 2016 and November 30th 2016. The minimum age threshold for including participants in the study was 17.5 years.

Mapping tool design

This tool was initially designed and successfully used in the TRACK project that examined transitions from the general child and adolescent mental health services to adult mental health services (5). Considering the forensic context of the current study some adjustments were made to meet the needs of this cohort. The tool was piloted and modified at the first participating medium secure unit prior to wider distribution and some questions were adjusted accordingly, following clinical input from the Lead Local Collaborator. One question was dropped-"Do you have a written closure policy?" None of the secure services had such policy. Index offence, Mental Health Act section and transition destination were added to the table of young people characteristics. The amendments were discussed with the two co-authors (SS and VF). We used this tool due to the lack of standardised and validated measures for transition outcomes in forensic mental health settings.

Data collection

The bespoke mapping tool was distributed to six medium secure units in different geographical areas across England. Initially, Local Collaborators were identified for each site and the study purpose was explained. Five consultant child and adolescent forensic psychiatrists and one consultant child and adolescent forensic psychologist agreed to complete the mapping tool. Multiple visits were arranged to each hospital to discuss in further detail the objectives of the project and to administer the mapping tool after giving instructions and guidance to the clinicians. Any queries regarding the tool were clarified either in person, via telephone or email. The clinicians had to return the form either electronically or during the researcher's next site visit. Additionally, clinicians were asked for patients' waiting time from

referral to discharge date to adult services and community. Returns were often delayed because respondents were uncertain about the patient's destination or transition date.

Data analysis

Descriptive statistics were used to estimate the number of young people transitioning within this six-month period, annual transition rates, ethnicity, age at the time of referral and age transition boundary, diagnosis, index offence, legal status and discharge destination. Responses from the mapping tool were analysed with STATA software to determine frequencies and percentages of annual rates. Where transitions protocols were identified, content analysis was performed. Thematic analysis was performed to explore the open-ended questions in the mapping tool.

Results

The results regarding demographics, diagnosis, index offence, and Mental Health Act section are summarised in Table 3. Figure 1 and Figure 2 demonstrate diagnostic characteristics and discharge destinations for young people being discharged from six medium secure units across England. The results of the open-ended question about transition preparation are displayed in Table 2. All respondents described in the text the services they represented, as forensic CAMHS and national services. Five Local Collaborators were consultant forensic child and adolescent psychiatrists and one was a consultant clinical forensic psychologist.

Number of referrals

We identified 34 patients eligible for transfer to adult services and community within May - November 2016. The average numbers of referrals to all medium secure units during the previous calendar year (June 1st 2016 to May 31st 2016) was 11.2 (*SD*=3.4) among the six medium secure units. The mean number of current open cases at the time was 9.2 (*SD*=3.9). The average number of accepted referral cases to adult services, community teams and custody

(for those reaching the age transition boundary) per year over the last three years among the six services was 9.9 (*SD*=9.1).

Age transition boundary

Whilst transition planning started in all six units before the young person turned 18 years, they are allowed to keep the young person until they reach their 19th birthday (25). One clinician stated that if the patient could be treated in a hospital until their 19th birthday, then, services continue providing care to avoid additional transitions to same security level adult hospitals before final community discharge. Young people, however, cannot stay beyond their 19th birthday and an adult placement has to be identified.

Transition delays

Some participants were not discharged until almost a year after their transition time. The mean average discharge waiting time –from the time of referral to adult service to discharge date- for 29 patients was eight months, with nine patients waiting between nine to thirteen months. Please see Figure 3 for additional information. Three patients out of the total 34 were referred to adult services from the point of admission and the precise waiting time could not be estimated. All of them were discharged to community services. Two patients out of the 34 - a White British female with emerging borderline personality disorder (BPD) and a Black British male with schizoaffective disorder and ASD both who had reached 18 years- had not moved to adult services by the study's end date December 2017. Both of these patients were referred to adult medium secure units. There were concerns about the young female's safety in the adult placement due to her developmental needs and severe self-harming. However, bed availability accounted for these delayed transitions to adult medium secure units. The young male had a learning disability along with ASD and multiple neurodevelopmental

needs. All young people transferred to adult secure hospitals experienced transition delays due to bed shortage and commissioning issues.

Transition policy and practice across medium secure units

There was no shared protocol about discharge or transition among the six medium secure units. Two units provided a protocol with discharge guidelines and one of these stated that they followed NICE guidelines for patients in transition to adult services (22). This document included several aspects of young people's care from the point of referral to adolescent forensic medium secure units to discharge. The section referring to discharge included a pre-discharge meeting or Care Programme Approach (CPA) review according to the Mental Health Act and Section 117 (mandatory after-care) that should be attended by the responding adult service or adult community mental health team. The other hospital followed similar guidelines for discharging young people. They also provided a discharge checklist involving administrative tasks, risk assessments, a discharge pack with the patient's history and medical conditions and care-coordinator to plan discharge according to section 117. The discharge document also aimed for parental involvement in line with the CPA plan.

Each Local Collaborator elaborated on several components of the transition process and they highlighted similar and different aspects. They all referred to the CPA discharge meeting. Please see Table 1 for additional information. When they were asked to elaborate on the transition process, they responded:

One clinician stated:

The referral process starts at least 3 months prior transition. First, the case is discussed over the phone with the responsive services and then the required documents are sent over (e.g. risk assessment, offence, last CPA meeting).Usually, young people discharged to the community or CMHTS transition faster than those who are moving to adult forensic services, such as low and medium secure units.

Another clinician highlighted:

The transition process is highly dependent on a number of factors, sometimes the preparation is not possible because individual commissioners may insist on a rapid transition to an adult inpatient service even if an individual patient is on track to achieve a move into the community.

Discussion

Statement of principal findings

This mapping tool has elicited important information about national transition processes and outcomes regarding transition pathways followed by adolescent forensic medium secure units. Key findings from this study concerned transition delays and care trajectories based on clinical and risk characteristics.

Strengths and weaknesses of the study

This study comprised a national sample and is the first attempt to map young people in transition of care from medium secure units using a scoping exercise. We included all national adolescent forensic medium secure units which allowed for comparisons across units. The patients were identified in a consecutive manner; yet, during follow-up with the hospitals, there were no additional eligible people for transfer to adult services.

However, the time frame of six months is short and might not represent future cohorts. Young people in secure hospitals are a relatively small group. Hence the number transitioning from medium secure units is much lower compared to those moving from general CAMHS and would explain the low number of individuals moving to adult services. Yet, this group of young people presents with the most complex set of needs and comorbid mental disorders alongside high risk.

Strengths and weaknesses in relation to other studies

Age transition boundaries

The findings suggest that transition delays are common in spite of having 18-year-olds waiting for their transition for more than one year. Young people often move to adult wards once they turn 18 years where they are surrounded by much older patients who have been hospitalized in forensic services for long periods. Hence, young people can be exposed to intimidating peers or may be subject to bullying. Wheatley and colleagues (24) found that young patients newly admitted to adult inpatient settings described their older peers as aggressive. The findings from the Wheatley study (24) point out that the adult ward climate can have a huge impact on young people's transition experience.

Clinical characteristics of young people and available services

Young males admitted to secure hospitals are diagnosed with psychosis much more often than females (22). Psychosis was quite prevalent in this group and, particularly among males in contrast to the current literature whereas psychosis among detained young offenders is relatively low (26,27). However, these findings are not surprising, as, in fact, medium secure units admit the most severe cases in terms of mental illness and risk presentation and show that their clinical needs are well accommodated (21).

The results draw the attention to emerging personality disorders and, specifically BPD within young females, and the risk of self-harming. However, emerging BPD might not explain self-harming symptoms which can be related to developmental trauma, as many of these young people have been abused or neglected (19). Nevertheless, attachment styles and past trauma are often aetiologically important in understanding the development of borderline personality traits (30). While personality disorders are not diagnosed before the age of 18 years according to clinical criteria, there is a caveat in DSM-5 that allows BPD diagnosis before 18 years unlike other personality disorders (31). Sixty percent of the female sample in this mapping exercise presented with persistent personality traits indicative of BPD and only 2% of

the male population had emerging personality disorder traits. Transitions are even more distressing, for young people with BPD, as relationship instability is part of their symptomatology. Therefore, one, of the units, that mostly accommodates young female patients with BPD symptoms has built an attachment and trauma model based on their needs (32).

Neurodevelopmental problems and learning disabilities were common in two hospitals that specialise in these kinds of difficulties and provide supportive care for this group of young people. Previous research has found that young people with ASD and learning disabilities and comorbid mental disorders belong probably to the most vulnerable group of justice-involved youth in transition of care. Notably, 20 percent of the male population in this sample had a learning disability and/or a neurodevelopmental problem compared to 6% of females with such difficulties. The lack of services for specialised treatment (32) and the lack of readiness for moving to adult services could exacerbate their current problems. Lamb and Murphy (32) highlight that readiness in terms of developmental versus chronological age should be looked in more depth and implement policy across services accordingly. One American study measuring readiness for transition among young people with ASD and impaired cognitive functioning found that this group was less developmentally prepared for such a transition (33). Nevertheless, we need more studies assessing readiness among vulnerable young people to tailor transitions on a person-need basis.

Transition care-pathways

Overall, a few transition patterns emerged for different groups. Fifty percent of the male sample was discharged to an adult medium secure unit compared to 20% females. Although young females presented with severe self-harming history, they were mostly referred to community placements and open units. However, it is a concern whether these young people who stepped down would be able to manage a more independent lifestyle successfully without

the supportive structure of adolescent medium secure units considering developmental level and complexity of needs. Of the male population, 25% had psychotic symptoms. Eighty four percent of male patients with neurodevelopmental problems and/or learning disabilities were transferred to adult secure hospitals either high, medium or low security. Majority was moved to an adult medium secure unit. Perhaps, males were more likely to present with violent incidents while accommodated at medium secure units and they were not eligible to step down security level. Additionally, as one clinician mentioned, commissioners' pressure on rapid transitions may explain these transition outcomes. Seventy-five percent of young people from a white ethnic background were transferred to an adult medium or low secure unit whilst 75 percent from a black ethnic background were referred to Early Intervention Services (EIS) since they were all diagnosed with psychosis.

Transition delays

The key finding from this study was that transition timelines depended highly on bed availability. Accordingly, lack of beds in receiving adult secure hospitals significantly disrupted transition processes. The Joint Commissioning Panel for Mental Health (35) pinpoints that administrative delays should be avoided during transition and commissioning parties should manage to collaborate for timely transitions. Transition outcomes clearly depended on waiting time in between services. Therefore, it is imperative that commissioners and clinicians from both child and adult services make joint decisions facilitating the transition process (32). It looks that young people transitioning to adult secure hospitals experienced longer waiting than those moving to community services. Although all units reported that young people have to be moved by the time they reach 19 years, at the time of data collection (between May and November 2016), three young people were 19 years and were still in adolescent medium secure units. Two were males and one was a female and all three had been diagnosed with psychosis. The young female was referred to an adult low secure unit and the

two males to EIS and community services. Community placements are often reluctant in taking over young people presenting with high risk and high vulnerability and, this could explain transition delays (12).

A good example of multiple transitions and poor outcomes is illustrated in this sample with a young girl who experienced four transitions until she was admitted to an adult medium secure unit. The main reason for these transitions was that community and low secure services could not manage her symptoms and risk along with her young age. She waited 10 months to be placed in a community setting where the young person encountered major difficulties in managing an independent lifestyle and returned to the adolescent medium secure unit until she was discharged to an adult low secure unit from where she was transferred to an adult medium secure unit due to risk management issues.

Discharge management and preparation

In line with TRACK'S results, it is evident that rigid age criteria, the complexity of cases, transitional delays, long waiting lists and lack of uniform transition protocols lead to poor transition outcomes. While all respondents reported that young people are prepared for their transitions, there was no shared protocol explaining how this goal is achieved and what practices are in place to prepare emotionally young people leaving child services apart from CPA meetings.

All clinicians reported that handover planning to adult services, parental involvement and preparing the young person for the next therapeutic relationship are essential elements of the pre-discharge process. Yet, these goals might not be successfully achieved. This is not surprising taking into account that AMHS use different models of care than CAMHS and there is a split between the two services. Child services integrate attachment theory into their care model considering that majority of these young people have not formed early secure

relationships with parental figures, whilst adult services do not follow such theories in their care approach (36).

Implications for clinicians and policymakers

There have been frequent calls to establish 12 to 25-year-old services to serve adolescents and young adults (4,13). The aim of these age-appropriate services is to reduce the number of transitions young people are experiencing at the moment. Taking into account the findings of this mapping tool, and the difficulties embedded in transferring young people from adolescent forensic medium secure units, the option of a distinct care pathway for this group should be considered. To date, we lack knowledge in evidence-based transition care-models and interventions for young people with complex needs as those in medium secure units. However, at the time of data collection changes had just started taking place across secure services in order to improve transition outcomes and by now services might respond better to the transition needs of young people discharged from medium secure units.

The findings highlight the need for consistency between policy and practice among services along with the development of individualised care pathways. Priority should be given to young people with neurodevelopmental disorders, emerging BPD and comorbid mental health problems in order to identify appropriate responding adult secure hospitals and community services. We need more unified care-schemes across services that will go beyond transition handover planning and will prepare young people through clinical interventions and therapeutic approaches based on their needs. Considering the increasing numbers of BPD traits amongst young females, CAMHS and medium secure units should include in their transition planning agenda appropriate care-pathways for young people with emerging BPD. The NICE guidelines on BPD emphasize that child health care providers should plan extremely carefully this group's transitions when they are terminating relationships and child services should liaise with receiving adult services. Joint working in these cases is of paramount importance for

young people's care trajectory. However, existing adult services do not provide specialised care for young people with emerging personality disorders and high-risk presentation (32). The gap on care models between child and adult services might account for future relapse. When young people move to adult and/or community supported accommodation, they lose all their attachment relationships with previous healthcare professionals and peers which may result in relapse.

There is a limited number of current reports from adolescent forensic medium and low secure units. Therefore, a national standardised database for secure hospitals would facilitate coordination between services (10). More research is necessary to understand where services stand transition-wise and what processes they follow to protect young people from poor transition outcomes, future relapse, and reoffending.

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- **Data sharing statement** All relevant data are contained in the paper.