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Mentally disordered young offenders in transition from child and adolescent to adult mental health services across England and Wales

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Keywords:	young offenders, mental health problems, transition, mental health services, care pathway, forensic services

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Journal of Forensic Practice

YOUNG OFFENDERS IN TRANSITION

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Abstract

Purpose - This paper provides an overview of transitions across forensic child and adolescent mental health services in England and Wales. The aim of this paper is to delineate the national secure services system for young people in contact with the youth justice system.

Approach- This paper reviews findings from the existing literature of transitions across forensic child and adolescent mental health services, drawing attention to present facilitators and barriers to optimal transition. We examine the infrastructure of current services and highlight gaps between child and adult service continuity and evaluate the impact of poor transitions on young offenders' mental health and wellbeing.

Findings- Young offenders experience a broad range of difficulties, from the multiple interfaces with the legal system, untreated mental health problems, and poor transition to adult services. Barriers such as long waiting lists, lack of coordination between services and lack of transition preparation impede significantly smooth transitions.

Research implications- We need to develop, test and evaluate models of transitional care that improve mental health and wellbeing of this group.

Practical implications- Mapping young offenders' care pathway will help to understand their needs and also to impact current policy and practice. Key workers in forensic services should facilitate the transition process by developing sustainable relationships with the young person and creating a safe clinical environment.

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Originality/value- Transition of care from forensic child and adolescent mental health services is a neglected area. This paper attempts to highlight the nature and magnitude of the problems at the transition interface in a forensic context.

Keywords: young offenders, mental health problems, transition, mental health services, care pathway, forensic services

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Journal of Forensic Practice

Background

Young offenders comprise a large proportion of the prison population and are at high risk of experiencing mental health disorders (Prison Reform Trust, 2012). In 2009, offenders under 21 made up 14% of the overall prison population in England and Wales (Bradley KJCB, 2009). The Bradley Commission reported that 1,323 children aged between 10 and 18 years were detained, excluding those in secure hospitals (Snodgrass and Preston, 2015). Up to 81% of young people within criminal justice agencies are known to present with mental health problems (Hagell, 2002), while a UK study identified 95% of young offenders aged 16 to 20 years as having a mental health disorder (Lader *et al.*, 2003).

Young offenders with mental health problems undergo several transitions between and within the health, social care and criminal justice systems that can negatively affect their psychological health (Campbell *et al.*, 2014). The transition from child and adolescent to adult mental health services has been described as poorly planned, poorly executed and poorly experienced (Singh *et al.*, 2010). A poor transition may adversely affect young people's health, wellbeing and successful integration into the community (Champion and Clare, (Vyas *et al.*, 2015). However, there is limited evidence with regards to transition processes within forensic psychiatric services. Even less is known about long-term outcomes of those transitioned from forensic mental health adolescent hospitals to the community (Harrington *et al.*, 2005).

A UK study of adolescent patients from a medium secure hospital showed that nearly half of them were discharged to the community (Hill *et al.*, 2014). These findings

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1
2
3 highlight the importance of the need for substantial investment in preparing young
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5 people's transition to community settings. Returning to the community might be
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7 especially difficult if they lack supportive networks. Moving to independent living brings
8
9 additional challenges such as risks of substance misuse and lack of appropriate
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11 housing and employment (DH, 2009). It is also known that the risk of reoffending
12
13 increases when community mental health services do not engage young people in
14
15 follow-up treatment (Hagell, 2002). There is a need for well-planned and organised
16
17 integrated community forensic teams to have a smoother community transition.
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24 *Who is the young offender in the UK?*

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26
27 There are several terms within legal and medical contexts to describe young people
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29 who have offended or are involved in the criminal justice system. According to UK law,
30
31 young offenders are those aged between 10 and 18 years who have committed an
32
33 offence. The UK Prison Service defines juvenile offenders as those between the ages of
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35 15 and 17 and young prisoners as those between the ages of 15 and 21 (Rickford and
36
37 Edgar, 2005). Detention under the Mental Health Act (MHA) 2007 may be considered if
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39 they have an emerging or established mental disorder and are at high-risk to
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41 themselves or others. Mentally Disordered Offenders (MDOs) may require a transfer
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43 from prison to secure inpatient units due to their need for urgent psychiatric care (Board
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45 NC, 2013).
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Forensic child and adolescent mental health services in England and Wales

Forensic child and adolescent psychiatric services across England and Wales are not standardised although attempts have been made to have a standard specification regarding service provision (Board NC, 2013). Effective liaison with youth courts, healthcare organisations and custodial settings are needed to develop tailored services (Nacro, 2006) leading to better transition outcomes.

There are several independent and public sector organisations providing forensic mental health services for young offenders under the age of 18 in England and Wales, covering prison in-reach, outpatient and hospital based care (Hoare and Wilson, 2010).

The National Secure Forensic Mental Health for Young People service (SFMHSYPs) provides in-patient services to young offenders with complex needs (Dimond and Chiweda, 2011) until they reach the age of 19 in line with CAMHS, Adult Mental Health Services (AMHS) and the criminal justice system (Board NC, 2013).

In England and Wales, there are currently six medium secure hospitals for adolescent young offenders with mental health problems, based in different geographical locations.

Young offenders aged between 12 and 18 years who meet pre-established eligibility criteria are referred to medium secure adolescent units from custodial settings (Board NC, 2013). Behavioural and emotional disorders concurrent with substance use is the predominant diagnosis although (Dimond and Chiweda, 2011) some present with psychotic illnesses. A diagnosis of an emerging personality disorder is common among young female offenders (Hill *et al.*, 2014). However, emerging personality disorder symptoms have to co-occur with another diagnosis to ensure transfer to hospital. A

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2
3 significant number of female offenders are likely to present with unstable mood and
4
5 severe self-harm (Hill *et al.*, 2014) that might imply an emerging personality disorder. It
6
7 is hypothesised that these symptoms could be a result of significant abuse and trauma
8
9 during periods of development and maturation (Dimond and Chiweda, 2011).
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12
13 Young people with learning difficulties can be referred to specialist mental health units
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15 that focus on their particular disability needs. Legally, young offenders with learning
16
17 disabilities cannot be detained under the Mental Health Act unless they present with
18
19 violent behaviour, as merely a diagnosis of mental impairment does not suffice for
20
21 detention in hospital (Dimond and Chiweda, 2011).
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25 ADHD is also commonly diagnosed among young people within the criminal justice
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27 system. The TRACK project, the largest study on transitions across mental health
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29 services in the UK, identified that 23.5% of young individuals with ADHD and Autism
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31 Spectrum Disorders were not accepted by adult services at the point of transition (Khan
32
33 and Wilson, 2010). A possible explanation is that health-care providers lack the training
34
35 to treat individuals with ADHD (Hall *et al.*, 2013; Swift *et al.*, 2013). Therefore, services
36
37 should tailor the transition process according to the needs of special populations, such
38
39 as young people with ADHD. Designing specific care pathways for ADHD groups should
40
41 be a priority for adult services.
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48 **Transitions from forensic child and adolescent to adult mental health services**

49 *Transitional age boundaries*

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53 Transitional age boundaries are problematic in the UK as it is unclear at what age adult
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55 services start being accountable for young people (Singh *et al.*, 2010b). Child mental
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3 health services provide care for young people until they reach the age of 18. Age is the
4
5 only criterion for transferring young people to adult care disregarding factors such as
6
7 self-independence and readiness for transition (Singh *et al.*, 2010a). However, the Joint
8
9 Commissioning Panel for Mental Health (2012), recommended that commissioners
10
11 should tailor transfers according to the needs of the most vulnerable groups including
12
13 children with learning difficulties and young offenders. It follows that using age, as the
14
15 only criterion for transitioning young people to adult services should be reconsidered.
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18 The only argument for adhering to age cut-off criteria is that age boundaries aid
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20 organisational and structural purposes within services (Inspection CJJ, 2012).
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25 Adult services are structured differently to child services with the latter providing more
26
27 routine-based milieus (Singh *et al.*, 2010a). The Barrow Cadbury Commission (2005)
28
29 suggested using a *life course approach* integrating both adolescents and young adults,
30
31 as it is unlikely that their needs significantly change once they turn 18. Although these
32
33 recommendations refer to young adults in the criminal justice system, they can be
34
35 extended to young people moving from forensic child to adult services considering that
36
37 reaching a chronological age of 18 does not ensure entering to adulthood at a
38
39 developmental level.
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44 Davies (2003) explains that developmental transitions occur in the 16-25 age group and
45
46 many of these young people are not ready for adulthood due to the complexity of their
47
48 emotional needs. For example, young people diagnosed with learning disabilities and
49
50 autistic spectrum disorders (Swift *et al.*, 2013) are not developmentally ready for such a
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52 transition. However, we currently lack empirical research on transitions of young people
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54 with learning disabilities in contact with forensic services.
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Factors influencing the transition process

A recent systematic review on transition models, which included studies from the USA and Europe, highlighted that the most substantial difficulty in the transition process is inefficient communication between CAMHS and AMHS (Paul *et al.*, 2014)

Transitional Delays

The *Managing Transitions from Secure Settings* project followed-up six young people from secure settings in the UK (Hart, 2009). The findings showed that factors, such as housing and education, should be ensured for the young persons' return to their communities. Transition looked the most discouraging factor since young individuals were notified about their placement even a day before their transition (Hart, 2009). Delays in transition within the youth justice system and lack of proper planning in regards to new placements concurred with lack of coordination among services. The report illustrates that transitions within and across the justice system are rarely planned and usually occur in short notice lacking young person's proper transition management (Hart, 2009). Knowing the transition destination might be a protective factor for young people (Swift *et al.*, 2013) to avoid feelings of distress and insecurity. The findings highlight that young people need to have an active role in shaping their transitions, as they can acknowledge their own needs more efficiently. Therefore, it is essential that they be informed timely about their transition placement (Kane, 2008; Swift *et al.*, 2013). One of the common reasons that accounts for transition delays is lack of bed availability in secure hospitals. As a result, long waiting lists turn transition into a confusing and frustrating experience for young people. Bed shortage along with services infrastructural

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3 weaknesses can severely interrupt the transition process. When an initial placement
4 has been identified and responding services cannot provide a bed at the time of referral,
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6 new referrals and discharge plans have to take place resulting in additional transition
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8 delays (Kane, 2008). Meanwhile, young people's mental health might exacerbate and
9
10 new problems arise, such as risk; the young person might become more aggressive and
11
12 the level of security they were referred to might not be appropriate anymore. An
13
14 effective and structured post-discharge plan necessitates prior knowledge about the
15
16 post-transition placement and failing to provide such information impedes young
17
18 persons' commitment to future plans.
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Family involvement and sustained relationships

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26 The role of the family throughout the transition process has been discussed multiple
27
28 times in the current literature (Swift *et al.*, 2013). Families should be an integral part of
29
30 transitions and their involvement is significantly important. Most young persons are
31
32 attached to their families and the young persons' recovery sometimes partially relies on
33
34 the family's role (Kane, 2008). As Swift and colleagues (2013) highlight, parental
35
36 involvement might be necessary at the early stages of transition to adult mental health
37
38 services. However, the case might be different for certain cohorts of young people and
39
40 young offenders, in particular. Young people involved in the youth justice system often
41
42 come from families lacking secure attachment and, parents refuse to be involved.
43
44 Further, many young offenders are looked after children and have spent time in foster
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46 care. As Kane (2008) reports, relationships with staff and health-care professionals in
47
48 inpatient hospitals might be the only sustained relationships young people ever had.
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3 The transition to adult services might perpetuate the pattern of inconsistent
4 relationships in these young people's lives. Accordingly, attachment is a key element in
5 the transition process, as previous research has addressed (Kane, 2008). Abrupt
6 transitions where the young person loses relationships with staff and attachment to
7 places can severely interrupt a smooth transition. Adult hospitals do not rely on
8 attachment theory similarly to child services (Kane, 2008). Therefore, transferring to
9 adult hospitals can potentially traumatise young people, as they have to cope with new
10 care models. Child services should liaise with adult care and work collaboratively on
11 managing effectively attachment, loss, and transition.
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Continuity of care

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30 The concept of continuity of care should be understood differently for young people
31 moving to the community than those transferring to forensic adult inpatient services.
32 Those returning to the community are diverted from the justice system and need
33 different care than young people remaining in the forensic system. The dynamics of
34 transition depends heavily on the new placement. Presumably, transition for young
35 people moving in between secure hospitals is smoother. Young people placed in
36 community settings from inpatient services need the involvement of multiple services' to
37 ensure community integration. However, for young individuals moving to adult medium
38 or high secure hospitals issues surrounding hope should be examined given that their
39 detention in such services might be prolonged.
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54 A recent study conducted by Campbell and colleagues (2014) using a small sample of
55 young people from different tiers of the justice system in the UK confirmed the
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3 shortcomings of transitional care. Continuity of care was cited several times predicting
4 less trusting relationships between service providers and young offenders. Harrington
5 and colleagues (2005) found that only 30% received support from services. The study
6 concluded that services were unable to provide support with regards to relationships,
7 education, and mental health. These factors should be addressed before discharge to
8 the community to enhance autonomy (NICE, 2015) and reduce the risk of reoffending.

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10 Only one study included young females who had moved from adolescent medium
11 secure units to adult medium or low secure units in the UK (Wheatley *et al.*, 2013). This
12 group involved eight patients who had experienced transition during an 18-month
13 period. Yet, only those moved to lower secure units seemed to have positive
14 experiences while others felt intimidated by the aggressive behaviour of older patients.
15 Potentially, moving young people from child inpatient services to an adult ward with
16 older patients might exacerbate their mental health symptoms. Young people present
17 with different needs than older patients who have been in the system for a while and
18 might not compose role models for newly admitted patients.

19 Findings from the same study suggested support from key workers was an emerging
20 theme that is common in other transition studies (Campbell *et al.*, 2014; Young Minds,
21 2013). More research is necessary to explore the experiences of young offenders
22 moving to adult services in distant geographical areas (e.g. far from home or from
23 forensic child services).

24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 **Conclusions**

52 The transition from forensic child and adolescent health services entails numerous
53 difficulties that can severely distress young individuals. Young people in contact with
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forensic mental health services experience a broad range of challenges, from multiple interfaces with the legal system, untreated mental health problems leading to poor transition outcomes. They also struggle with lack appropriate housing, non-existent family support networks and lack of employment opportunities. Psychological problems per se do not compose the only factor contributing to poor mental health (Young Minds, 2013). Therefore, multidisciplinary collaboration across services may significantly help young people to overcome the inherent transition difficulties (Swift *et al.*, 2013). Attention should focus on providing standardised care irrespective of funding sources.

As identified above, there are gaps in the transition literature with regards to child and adolescent forensic psychiatric populations, such as continuity of care and discharge outcomes. To date, only one study has considered issues surrounding forensic child and adolescent mental health services while the current literature acknowledges the adverse consequences of poor transitions across adult mental health services in community populations.

More evidence-based research is needed to understand service users' and carers' experiences and expectations of the transition process. Additionally, there is paucity in long-term outcome research of young people discharged from secure hospitals. There is urgent need to map out young people's care pathways and examine guidelines and policies underpinning these transitions.

Implications

- Young offenders with learning disabilities and ADHD need specialised care pathways in community rehabilitation settings with well-trained staff.

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- Continuity of care includes different models of care for young people moving to the community and for those transferring to secure hospitals.
- Family involvement might facilitate the transition process and outcomes in a positive manner.
- Young offenders should be dynamically involved in their transitions and be part of decision making.
- Long waiting lists in adult services impact dramatically the mental health of young offenders awaiting transition.
- Attachment, loss, and transition should be integral elements of transition preparation and management.

Declarations**Ethics approval and consent to participate**

Not applicable

Consent for publication

Not applicable

Availability of data and materials

This paper does not include any raw data.

Competing interests

The authors declare that they have no competing interests.

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YOUNG OFFENDERS IN TRANSITION

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