

## **The Clinical Profile of Young People Accessing a Low Secure Adolescent Unit**

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### **Abstract**

The first NHS forensic low secure unit for adolescents, the Westwood centre, opened in 2004. In order to understand service utilisation and initial outcomes, the clinical profiles of young people admitted in the first 45 months were evaluated. This included demographics, locality, admission status, length of stay, medication use, presenting problem, diagnosis, previous and discharge destination. The profiles of young people accessing the low secure unit were then compared with young people accessing a neighbouring open adolescent unit.

Clinical profiles were ascertained from available healthcare records and service data. These were inspected and analysed using descriptive statistics. Thirty (54%) of the fifty-six Westwood young people were male, the mean age at admission was 16.3 years and mean length of stay was 202 days. Twenty-five (44%) young people had a discharge diagnosis related to psychosis, the remainder having primary problems relating to emotional and/or conduct problems. 26 (47%) were discharged to another hospital setting and 20 (35%) returned to their home of origin. Young people accessing the low secure unit were significantly older at admission and there was a trend for a higher proportion of females to be admitted to the open setting. In addition, the low secure unit had a greater proportion of young people with psychotic disorders and longer lengths of stay. Case examples illustrate a pilot of initial outcomes.

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## Introduction

The Westwood centre, located in Middlesbrough, became operational in July 2004. It is a specialist low secure mental health unit for young people aged between 12 and 18. Young people admitted to the Westwood centre are detained under the appropriate section of the Mental Health Act (1983; 2007) with referrals mainly arising from regional and national community and in-patient based Child and Adolescent Mental Health Services (CAMHS). Admissions are mostly funded by Primary Care Trusts. The unit development was guided by national initiatives and regional and locally identified needs. These have led to increased provision of low and medium secure CAMHS settings for young people by NHS and Independent providers. In particular, the Care Services Improvement Partnership (CSIP, 2007) reported concern about the shortage of inpatient beds for young people. Moreover, *Pushed into the Shadows* (Office of the Children's Commissioner, 2006) highlighted the plight of young people with mental health problems being inappropriately admitted to adult mental health units. As the Westwood centre was a unique NHS service, a clinical profiling exercise was undertaken in order to understand service utilisation and initial outcomes during the first 45 months of operation.

There is ever growing commitment for the improvement of services for children, young people and their families. As practitioners, we are concerned about the outcomes for young people moving through low secure services. Many of these have a history of poor outcomes such as prior inpatient admissions or secure placements, chronic developmental trauma, attachment difficulties, psychosis and often co morbidity. Hospital provision is an expensive resource and consistent with clinical governance (NHS Executive, 1999), a clinical profile of young people accessing a low secure unit compared to those accessing an open unit was used to develop a basis to consider outcomes for young people. Collated national outcomes for young people accessing secure hospital provision are not readily available. This would enable individual services to develop according to this. Many providers of secure hospital provision for young people do use various psychometric outcome measures and variables such as length of stay and incidents. Examples of these are the National Commissioning Group (NCG) for medium secure NHS forensic services for young people, Oakview, Huntercombe and St Andrews. A small proportion of general adolescent and eating disorder inpatient units also use Quality Network Inpatient CAMHS (QNIC) outcome measures.

The CAMHS Outcome Research Consortium (CORC) started in 2002 and expanded in 2004. This advocates routine outcome evaluation that can be used across a range of services to inform and develop good practice. Regarding inpatient services, QNIC (2007) in collaboration with CORC have developed parallel core outcome measures. The evaluation of outcomes for young people in low secure psychiatric care is in its infancy with largely an absent evidence base. Attention has tended to focus on the evaluation of specific treatment programmes or disorders (Fonagy, Target, Cotterell, Phillips & Kurtz, 2002). Many initiatives, especially through QNIC were developing around the time we were considering initial outcomes, which we required to be both meaningful and which could be used with practical ease.

Other models of service evaluation such as user involvement satisfaction have been widely used to evaluate outcomes. Boylan (2004) refers to common issues around communications, environment, access and involvement. Priory Healthcare (2009/10) offer a useful example of routinely gathering patient satisfaction across various aspects of care for services provided, including secure service users and those in complex care. We similarly send out satisfaction questionnaires, although there are few nationally available comparisons for young peoples secure hospital provision. Tullock's (2008) report on the costs, outcomes and satisfaction for inpatient child and adolescent psychiatric services for 403 young people accessing general adolescent and eating disorder units (NHS and independent sector) showed favourable outcomes for inpatient care for those without psychosis, with an emotional disorder and more severe psychopathology within the context of good family functioning and an absence of family psychopathology. Longer lengths of stay were associated with better outcome along with completing an organised treatment programme, planned discharge and continuation of therapy post discharge.

## **Method**

### *Clinical Profile*

The study was carried out in accordance with clinical governance and audit protocols within the employing NHS Trust. The first 56 admissions to the low secure unit in its first 45 months were selected. These included two re-admissions. Young people on the unit received individualised comprehensive assessments, care and therapeutic interventions from a multidisciplinary team comprising of psychiatry, clinical psychology, social work, nursing and education. Intervention models commonly utilised were Behavioural Therapy, Cognitive Behavioural Therapy, therapeutic milieu, Integrative Psychotherapy and family work.

Health care records were used to collect information retrospectively and interviews with experienced clinicians involved in young peoples' care were utilised to clarify gaps in information. Diagnosis was made by the young person's Consultant Psychiatrist through records and retrospective collection. Categories were identified following consultation with 2 senior clinicians external to the unit, experienced in working within adolescent forensic services, 4 senior clinicians within the service and 2 managers. The categories included demographics (age, gender, and ethnicity), locality, admission status, length of stay, medication use, and primary presenting problem at admission, diagnosis, previous placement and discharge destination. Further categories of general cognitive ability, history of abuse (emotional, sexual, physical, neglect), schooling (special support, exclusions), forensic history, care history, parental history (alcohol and substance dependency, mental illness, criminality), and level of risk at admission (self, other and absconson) are not presented here but are reported in an unpublished in-service profile document (2008). Descriptive statistics were used to summarise information.

#### *Comparison to open unit*

38 young people accessing the Westwood low secure unit were compared to 51 young people accessing the open Newberry unit (a neighbouring 12 bedded NHS mental health provision for adolescents) during a 31 month period. Young people at the open unit also received individualised comprehensive assessments, care and therapeutic interventions from a multidisciplinary team comprising of psychiatry, clinical psychology, social work, nursing and education. This included Behavioural Therapy, Cognitive Behavioural Therapy, therapeutic milieu and systemic family therapy. Specialist work in early intervention for psychosis and eating disorders were also a feature. Young people accessing the units were compared in terms of age, gender, length of stay and proportion with a psychotic disorder. Variables such as clear differences in diagnosis in the open unit having more young people with eating disorders and fewer detained under the Mental Health Act were not compared. A Kruskal-Wallis test was used to consider differences in age and length of stay. A Chi-squared test was used to compare gender and psychotic symptoms.

#### *Case Illustrations*

Using case study methodology, a pilot of initial outcomes was carried out over a six month period for 16 young people. The NHS Trust ethical guidelines for the audit of routine outcomes were followed in conducting the pilot. All young people's written informed consent was sought. The cases presented here are anonymous. They were assessed at admission and discharge in terms of the HoNOSCA and severity of symptoms (using a 4 point Likert scale of absent, mild, moderate and severe). These were routinely

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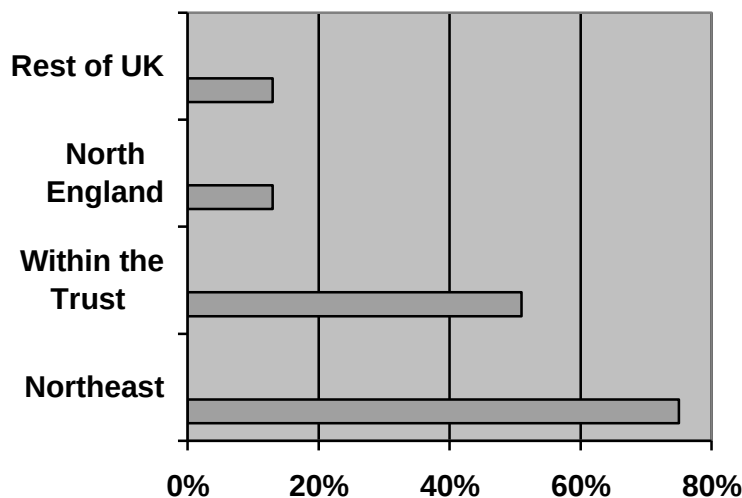
assessed by a psychiatrist in collaboration with the nursing team. Frequency of risk behaviours were assessed through weekly nursing reports. Admission and discharge qualitative semi-structured interviews considered young peoples' perception of their main difficulties, severity, expectations, perceived progress and unhelpful/helpful aspects. Two random cases are used to illustrate the pilot.

## Results

### *Socio-demographic Characteristics*

54% (N=30) of young people accessing the low secure unit were male and 46% (N=26) were female. The mean age at admission was 16 years, 4 months (16.34, range 12.75 to 18.33 years). The mean age at discharge was 16 years, 10 months (16.86, range 12.75 to 19.58 years). 87% (N=49) of young people were white British ethnic origin. 5% (N=3) were black African, 4% (N=2) white other, 2% (N=1) was of mixed white and black Caribbean and 2% (N=1) mixed white and Asian origin.

**Figure 1 - Geographical Areas**



75% (N=42) of young people accessing the low secure service came from the North East of England. 51% (N=29) of these came from within the geographical area of the Tees, Esk and Wear Valley NHS Foundation Trust. A further 13% (N=7) came from the North of England. Other young people came from Scotland, Wales and the South of England. Invariably, young people were detained under the Mental Health Act. 11% (N=6) were admitted from court settings with a hospital order, including several with a restriction order.

### *Length of Stay*

The mean length of stay was over 6 months (202 days). This ranged from 9 days to 956 days. Pearson Correlations were used to consider the strength of relationship between length of stay and factors such as gender, presenting problems, diagnosis, previous placement and discharge destination (See Table 1).

Table 1

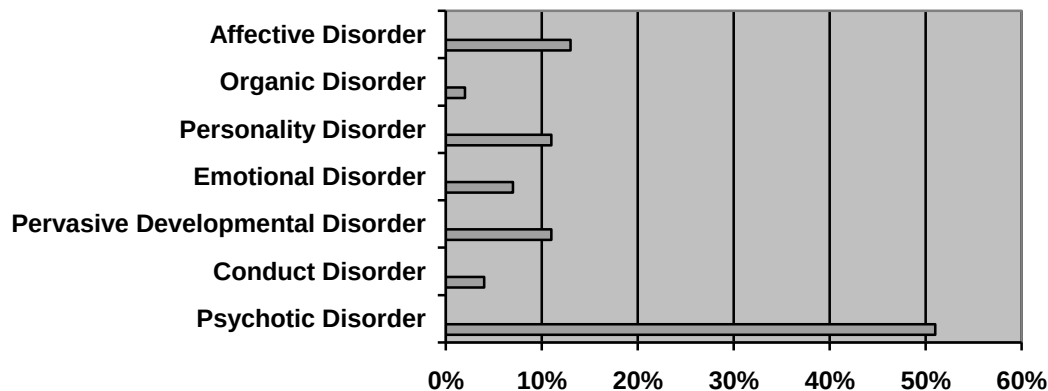
**Table 1 illustrates the correlation between length of stay and gender, previous placement, primary presenting problems, and discharge destination.**

| Factor                        | Length of stay |
|-------------------------------|----------------|
| 1. Gender                     | 0.127          |
| 2. Previous placement         | 0.066          |
| 3. Discharge Destination      | 0.25*          |
| 4. Primary presenting problem | 0.092          |
| 5. Diagnosis at discharge     | 0.113          |

\* $p < 0.07$

As shown in table 1, the correlation between length of stay and the others factors did not reach the level of statistical significance. The magnitude of the relationship between length of stay and factors in table 1 was low. However, as numbers were low, this impacts the power of the correlation to show relationship. The relationship of length of stays and discharge destination approached 95% level of significance at  $p = 0.063$

### **Figure 2 -Diagnosis at admission**



### *Diagnosis at discharge*

Figure 2 shows the primary discharge diagnosis for young people accessing the low secure service based upon psychiatric assessment, using ICD-10. 44% (N=25) were categorised as experiencing a schizophrenic, schizotypal or delusional disorder (Psychotic Disorders). 32% (N=18) were experiencing a mood/affective disorder (F90-98) or behavioural/emotional disorder.

### *Medication use*

60% (N=34) of young people were on psychotropic medication at admission and discharge. 19% (N=11) were discharged without medication (4%; N=2 of these were taken off medication during admission). 21% (N=12) were not on medication at admission but were at discharge.

### *Previous Placement*

65% (N=36) of young people came from open psychiatric hospital placements (such as adult intensive care, young people's unit). This figure increased to 74% (N=41) when all hospital settings of secure hospital provision, accident & emergency and general hospital wards were included. 11% (N= 6) came from secure accommodation via local authority secure units or medium secure hospital provisions and 9% (N= 5) came from community placements outside of the family home. 4% (N=2) came directly from the courts. Only 5% (N=3) came from their family home.

### *Discharge Destination*

35% (N=20) of young people were discharged to community placements, including their family home. 31% (N=17) were discharged to open hospital provision, (usually a young

person's open unit) and 16% (N=9) were transferred to other secure hospital provisions. This represents a reduction in young people receiving hospital provision from 74% (N=41) at admission to 47% (N=26) at discharge. Other placements included supported living, foster care and specialist residential placements provided by the independent sector.

#### *Comparison to open unit*

Table 2 shows the differences in age, length of stay and presence of psychosis in young people accessing the low secure and open unit using a Kruskal-Wallis test. An assumption of non-normality was made for all variables considered. The proportion of gender and psychotic symptoms was considered using Chi-square.

Table 2

**Table 2 illustrates the differences in age and length of stay across the two units.**

|                            | <i>Mean Age</i>        | <i>Mean Length of Stay (days)</i> |
|----------------------------|------------------------|-----------------------------------|
| <i>Low Secure Westwood</i> | 16.4 (sd 1.3; p 0.02)* | 172 (sd 143; p 0.09)              |
| <i>Open Unit Newberry</i>  | 15.8 (sd 1.2; p 0.02)* | 127 (sd 123; p 0.09)              |

Table 3

**Table 3 shows the proportion of males Vs females and those presenting with psychotic symptoms or not across the two units.**

|                               | <i>Gender</i>          | <i>Psychotic Disorders</i> |
|-------------------------------|------------------------|----------------------------|
| <i>Low Secure Westwood</i>    | Males N=23             | Psychotic N=23             |
|                               | Females N=15           | Non psychotic N=23         |
| <i>Open Unit Newberry</i>     | Males N= 20            | Psychotic N=21             |
|                               | Females 31             | Non psychotic N= 30        |
| <i>Chi Square proportions</i> | $\chi^2$ 3.96 (p 0.05) | $\chi^2$ 3.26 (p0.07)      |

#### *Case Illustrations*

Two random case examples were used to illustrate a pilot of initial outcomes.

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## *Sarah*

This 17 year old was admitted from an open NHS adolescent unit due to an increase in chaotic risk taking behaviour, aggression toward others and self harming behaviour. She was experiencing difficulties regulating her affect, voicing paranoid ideas and experiencing auditory and visual hallucinatory symptoms. She had difficulties in her attachment with her main carer and idealised a grandparent. Discharge was planned, back to her admitting open NHS adolescent unit. Her HoNOSCA score was 32 at admission and 14 at discharge. (HoNOSCA is a routine outcome measurement tool that assesses the behaviours, impairments, symptoms, and social functioning of children and adolescents with mental health problems). The HoNOSCA provides a global score. Symptoms at admission were rated severe in terms of mood instability, emerging borderline personality disorder, verbal and physical aggression and difficulties relating to past traumas. Moderate symptoms were experienced in relation to social difficulties, substance misuse and psychotic experiences. At discharge her symptoms were rated severe in terms of emerging borderline personality disorder, moderate in terms of mood instability, and mild in terms of verbal/physical aggression, dealing with past trauma, social difficulties and psychotic symptoms. Substance misuse was absent.

Weekly frequencies of risk behaviours showed that Sarah tended to exhibit verbal, physical aggression (toward property/others) and self harming behaviour together. A peak in self harming occurred during a breakthrough in reported visual and auditory hallucinatory symptoms and paranoid thoughts.

Sarah viewed her main difficulties as depression, hearing voices and risky behaviour, such as walking in front of cars. She rated her difficulties as moderate overall. She wanted help to stay safe when depressed or hearing voices and wanted to be able to control and manage the voices she experienced on her own. She feared becoming well as she had experienced problems for so long that she did not know what it would be like to be well. At discharge she continued to rate her difficulties as moderate. She expressed that learning to control her anger and stress levels was beneficial and therapeutic. She viewed the saw her assessments and interventions to have had a slight benefit. She reported that going on leave had been most useful in helping her socialise and providing contact time with nursing staff. She described staff trying to support her, talk and to staff to manage her stress least useful, as it did not help consistently.

## *Jade*

This 17 year old had also been admitted from an open NHS adolescent unit, due to an increase in suicidal behaviour, self harming behaviour, eating difficulties and low mood. She had a history of complex trauma, multiple abuse and attachment difficulties. Discharge was planned to her referring open adolescent unit. Her HoNOSCA score at admission was 22 and 8 at discharge. Her symptoms at admission were rated severe in terms of emerging borderline personality, suicidal thought and actions, emotional attachment difficulties, difficulties with past trauma and eating disorder. Substance misuse and post traumatic stress symptoms were rated moderate and mood symptoms were considered mild. At discharge, borderline symptoms were rated the same, emotional attachment difficulties were rated moderate. Post Traumatic Stress Disorder symptoms, difficulties with past trauma, suicidality and eating disorder symptoms were considered mild.

Weekly frequencies of risk behaviours, showed Jade presented one or two episodes of risky behaviour a week, predominantly self harm. Two ligatures were also observed during her admission, which were linked to contact from father and initial access to leave. Her risky behaviours were lower than she presented within the open unit.

Jade rated her difficulties as mild overall at admission. She viewed the main difficulties and risks to herself to be, absconsion, low mood, flashbacks and nightmares which caused her to self harm and hurt her self. She wanted to find different ways of managing stressful situations, distress and the anxiety she experienced. She also wanted to go back to the open unit. Her main fears were being on her own, remembering her past, “living but still hurting” and feeling pain. At discharge she rated her difficulties as mild. She reported that the practice of coping skills, distraction techniques, self soothing, grounding techniques, alongside talking to and support from staff to have been therapeutic and of benefit. Coping and distraction skills were found most useful. She also reported that some of the work in therapeutic sessions had been useful. She described liking the safety of a locked unit when she needed it and the support from staff. However, she noted that some of the work completed in sessions had felt unhelpful at the time. Being locked in and restricted in what she could and could not do was also described as being unhelpful.

## **Discussion**

A similar mixture of females and males accessed the low secure unit, and they tended to be older than the young people accessing the neighbouring open unit. The average age on the open unit was similar to those reported in other adolescent units (Tulloch, 2008). There was a trend toward more females accessing the open unit and for the low secure

unit to have more people with psychotic disorders and longer lengths of stay, although this did not reach statistical significance. The open unit has specialist provision for people with eating disorders and some young males in the low secure unit were on restriction orders for sexual offending, to largely account for these trends. Most young people were of white British origin, largely consistent with the local population. 75% of young people came from the North East region and just over a half from the local population, which is encouraging as it is consistent with the recommendations from *Together We Stand* (HAS, 1995), provision of local inpatient CAMHS services (CSIP, 2007) and minimising inappropriate admissions to adult mental health units or paediatrics (*Pushed into the Shadows*, 2006).

The average length of stay in the low secure unit was over 6 months. This compared to an average of 79 days for open young peoples' units (Tullock, 2008). There was large variation in length of stay in low secure which was not found to be associated with gender, presenting problems, diagnosis, previous placement or discharge destination. However, previous placement and discharge destination both approached the level of significance. When considering young people with the shortest and longest stays, there were no particular clinical indicators beyond those on a restriction order for sexual offences staying longer and generally moving onto hospital provision. Unfortunately, small numbers and statistical power limit a clearer understanding of length of stay. It would be useful to compare these with national findings across secure hospital provision for young people.

The most common primary presenting problem was a psychotic disorder (51%; N=29), with diagnosis at discharge becoming more defined, alongside the use or stopping of psychotropic medication. This illustrates careful review of medication according to need.

74% (N=41) of young people came from hospital provisions and 11% (N=6) from secure settings. Only 9% (N=5) came from their family or community home. This compares to 83% of young people coming from their family homes and 9% from hospital accommodation in general young peoples' units (Tullock, 2008). This illustrates the already adverse circumstances for many of the young people accessing this low secure provision. An improvement in outcome was evident for some with a reduction of 47% (N=26) being discharged to a hospital setting. For the majority still requiring a hospital provision, this was in an open setting. 40% (N=22) moved to community settings with their family, supported living, specialist community placements or foster care. This shows a progression for many into less restrictive settings.

Our findings offer support, for older adolescents in a restrictive secure mental health setting, in terms of Sunseri's (2005) finding from a sample of 8933 children and adolescents admitted to residential treatment facilities in California, that high level intensive residential programmes enabled greater placement stability (reduced care associated with greater instability and moves) and planned discharges to home and community settings. This is interesting as many young people had experienced failure in less intensive settings than they may have otherwise, due to professionals balancing decisions about need, the least restrictive alternative, cost and resources. Similarly, Bates, English & Kouidou-Giles (1997) conclude in their review of residential treatment, family preservation services, treatment foster care and individualised services that whilst residential care is often viewed negatively, empirical evidence does not suggest differential levels of effectiveness compared to non residential alternatives. 16% (N=9) were moved to secure hospital provision. Sunseri (2001) notes the importance of unplanned discharge from residential care adversely affecting future outcomes. It would be useful to routinely separate planned and unplanned discharges in future evaluations as many of our unplanned discharges related to an increase in behavioural dysregulation, risk and difficulty containing this. Although not common, this often resulted in transfer to further secure provision.

The clinical profile formed a basis on which to identify clinical priorities for young people accessing the unit and therapeutic needs that required staff development to improve confidence and therapeutic competencies in the service. Investment in training a team of staff to provide a Dialectical Behaviour Therapy service for suicidal young people with repeated self harming behaviour and psychological trauma focussed interventions such as Eye Movement Desensitisation and Restructuring (EMDR). Initial outcomes gave some useful experience in using and incorporating routine measures in to general practice, such as frequencies of behaviour, symptom ratings, qualitative interviews and HoNOSCA. Although some measures were useful in considering outcomes for individuals they did not easily compare across young people. The HoNOSCA ratings illustrated improvements, (i.e. HoNOSCA scores on those who had been discharged were significantly lower than on admission;  $t=5.346$ ,  $df=10$ ,  $p<0.001$ , two tailed). Hunt & Wheatley (2009) and Yates, Kramer & Elena (2006) also discuss the clinical utility of the HoNOSCA for adolescents in a secure psychiatric unit. Similarly, Priority Healthcare (2009/2010) shows improvement in a sample of 76 young people using HoNOSCA ratings.

There are methodological limitations to our findings. Comparisons to the open unit were over a shorter time period than available for the wider clinical profile of young people

accessing the low secure unit. However, this does not impact on the validity of findings as proportions were used. Beyond this, the retrospective use of health care records and interviews with clinicians are vulnerable to bias in interpretation compared to information that we were able to prospectively collect. The use of both qualitative and quantitative information to consider initial outcomes enriched the quality of feedback and took into account differing perspectives from the young people, clinicians and observed frequency of risk behaviour. Validity was considered by categories for the wider clinical profile being ascertained by experienced clinicians. Experienced psychiatrists assessed symptoms but this could have also had potential problems in consistency and bias. Scales such as the Paddington Complexity Scale as used by Yates *et al* (1999) could help improve biases in demographic data and assessing the nature and severity of psychiatric disorder. As numbers are small there are limits to the generalisability of our findings, with a need to relate these to young people accessing other secure hospital settings as well as similarities and differences to adult secure hospital provision, general adolescent units and other secure provision for young people. However, detailing clinical profiles and approaches to initial outcomes can easily be compared and replicated by other services.

As frequencies in risk behaviour are changeable within and across individuals over time, average summaries over specific time periods would enable changes in outcomes to be reported. Following our initial clinical profile of young people accessing the low secure unit, comparison with the open unit and consideration of initial outcomes, we have been able to focus improvements and resources to enable us to use core measures outlined by CORC and QNIC, whilst continuing to measure the frequency of risk behaviour. These measures will enable us to focus more attention on family views to further shape quality and therapeutic care provided. This is particularly relevant as Sunseri (2004) reported that family functioning was associated with most outcomes for children from residential settings including education, behaviour, and moves to less restrictive settings.

Knowing what happens to young people after they leave a service is necessary to consider pathways of young people and long term outcomes. Only then can we begin to understand the relevance of a low secure service, to whom they benefit and how to improve poor outcomes. Davies, Clarke, Hollin & Duggan (2008) considered available outcomes from adult medium secure care. In their study of 595 admissions over a 20 year period, 10% had died (32% of those by suicide, a 6 times risk of death compared to general population). Almost half of those discharged were reconvicted and almost two-fifths were readmitted to secure care. High readmission rates (75%) were also found by

Maden, Rutter, McClintock, Friendship & Gunn (1999), in outcomes from an adult medium secure psychiatric unit. Some excellent longitudinal studies are also available such as Farrington's (1995) Cambridge study of the development of offending and antisocial behaviour. Similar studies are needed for young people accessing secure accommodation to help strategies to improve outcomes. This enables improved outcomes and better mental health in line with recommendations from the Bradley report (Lord Bradley, 2009) through outcomes of diversion from custody for young people with mental health problems or learning disabilities who have offended or are at risk of offending.

#### *Implications for Practice*

- 1 *Clinical profiling useful as a basis to consider clinical outcomes, pathways, utilization of a service, service/training needs and development.*
- 2 *Comparisons between inpatient units provide further evidence to the areas above and help dispel myths that may otherwise guide decisions e.g. about which diagnoses or gender affecting length of stay.*
- 3 *Most young people progress positively from the low secure service onto open or community settings.*
- 4 *Improving future outcomes for young people such as through diversion from custody, length of admission, reduced symptoms/risks and planned progress to suitable community placements or home*

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