**MEDIUM SECURE MENTAL HEALTH CARE FOR YOUNG PEOPLE: DECISIONS TO DETAIN**

**Shortened running title:** Decisions to Detain

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**CONFLICT OF INTEREST**

The authors declare no conflict of interest.

**DATA AVAILABILITY STATEMENT**

The data sets generated during and/or analysed during this study are available from the corresponding author on reasonable request

**ETHICS STATEMENT**

This service evaluation was registered and approved as a service evaluation by the Clinical Effectiveness and Audit Department of West London NHS Trust. Informed consent from patients or their families was not required as the data used in the study were routinely collected clinical data that was fully anonymised.

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**INTRODUCTION**

Adolescent Medium Secure Units (MSU) are small, expensive, hospital based services that are part of Child and Adolescent Mental Health Services (CAMHS) inpatient care providing treatment for young people (YP) with severe mental disorders who pose significant risk issues to themselves and others. In England, these developed organically from one unit in 1985 to a national network of six units in 2006 initially comprised of three mixed units and three male only units. The units had a regional remit and the sites of units were chosen to facilitate family contact. All six units shared the same service specification. The admissions to these units were scrutinised in a weekly national admission panel and commissioned initially via NHSE specialised commissioners. These have been supplemented by low secure services and Psychiatric Intensive Care Unit beds, which, in sum, constitute the hospital element of secure provision for YP in England and Wales (see Figure 1) allowing for the detention of YP under diverse legislation in facilities overseen by several national agencies. Consistent guidance promotes the least restrictive option for inpatient care (Mental Health Code of Practice, 1983) for YP with physical and procedural security measures that are commensurate with the risks they pose. Despite existing for over 35 years, scrutiny to date of these units leaves many questions unanswered (Bailey 2022).

 Insert Figure 1 here

The Wells Unit, the subject of this paper, was one of two London components of the national medium secure service. The unit opened in 2006 and closed in September 2020. Over the history of the unit, commissioning of the national network changed as other services for YP in contact with justice services developed. The Bradley report (Department of Health, 2009) recommended improvements in diversion away from custody for those needing hospital treatment, especially YP. In 2012 the other unit in London closed. Initially commissioned for 10 beds, the number of commissioned beds was reduced to 7.8 (average occupancy) in 2013, as the low secure network of units grew, and then to 6.7 in 2017 following the establishment of both a low secure network (with a national referral meeting) and fully embedded Youth Justice Liaison and Diversion services (which started in 2015).

The limited literature analysing admissions to adolescent secure hospital units is almost entirely English in origin. International comparisons in adolescent secure care are intrinsically difficult, despite the existence of some similar units (Kaltiano-Heino 2014) and philosophies of care (Berg et al 2011), because of differences in service structures ([Barendregt](https://www.tandfonline.com/author/Barendregt%2C%2BCS) et al 2015**,** Souverein et al 2022). Characteristics of patients referred to and/or admitted to medium secure adolescent units across England (Bailey et al 1994; Hill et al 2014; 2015; 2019; 2020; Hales et al 2018) have been described. However, Wheatley and colleagues’ (2004) question of whether the units’ admissions meet the acceptance criteria for medium secure wards published as part of the national service specification (Hoare, T & Wilson, J (2010) (see Table 1) has not been addressed, nor has the differences of usage over the lifetime of the medium secure network. Given the financial cost of these units (NHS Benchmarking for CAMHS 2019) and increasing availability of alternative, less secure facilities (Warner et al 2018), this is an important outstanding question. Insert Table 1 here

The purpose of this paper is to:

* describe the demographic, offending and clinical characteristics of those admitted to the Wells Unit;
* examine their previous pathways of care and fit with referral criteria to consider extent of unit compliance with its intended remit

**METHOD**

***Design and Sample***

This was a retrospective cohort study of consecutive patients admitted to the Wells Unit. The unit was for young male patients aged between 12 and 18. Patients described in this paper were all admitted between January 2007 and September 2020. Data were collected for 149 admission periods for 133 young men. There were some missing data as data were collected retrospectively.

***Approval***

The West London NHS Trust Audit Committee agreed that this was a service evaluation and hence no additional ethical approval was required.

***Data Collection***

Clinical notes (electronic patient records) were retrospectively reviewed and collected using a data collection form designed to record demographic and clinical information. Index offences for which they were charged (rather than convicted) prior to admission were captured with the most serious for each individual classified under the categories of ‘serious violence’ (attempted murder, GBH, homicide, and sexual assault), ‘moderate violence’ (arson, ABH, kidnapping, robbery and firearm, threats, and weapons), ‘minor offence’ (criminal damage, drug and alcohol, and theft and burglary) or ‘none’. For those patients with multiple admissions, one form was completed per admission period.

***Statistical Analysis***

Descriptive data is presented using frequencies (percentages) and means (Standard Deviations (SD))/medians (inter-quartile ranges) for categorical and continuous variables, respectively. Chi-square and Fisher’s exact tests were employed to compare categorical between-group data and mid-p McNemar tests (Fagerland et al., 2013) were used for within-group comparisons (e.g., from admission to discharge). Mann-Whitney U and the Kruskal-Wallis H tests were administered to compare continuous data. The criterion for statistical significance was set at *P* < 0.05. All statistical analyses were completed with the SPSS (IBM, Version 27.0),

**RESULTS**

**Characteristics of patients admitted to the unit**

Characteristics of the 149 patient admission episodes are described in Table 2 and 3.

 Insert Table 2 here

In summary, the majority of admissions were aged 17, of Black ethnic origin and had a history of violence towards others. Two fifths had a previous hospital admission and 1/10 were admitted to the unit in the past. Most were admitted from custody but 7 admissions were directly from the community. Those under a forensic section were more likely to be linked with offences classified as moderate or serious violence. The commonest primary concern on admission was psychotic symptoms with a high proportion of conduct disorder diagnoses (with numbers reducing on discharge).

 Insert Table 3 here

A small proportion of patients had two admissions to the unit. Comparing their first admission with those who only had one admission, readmitted patients were disproportionately younger, more likely to have been admitted from the community, had a shorter unit stay on their first admission (median length of admission; 90.5 versus 154.0 days) and less frequently had a mental health section change from admission to discharge on their first admission.

**Evaluation of cohort against admission criteria (Table 1)**

The referral criteria require referrers to address 4 items. The first two, age at referral and mode of detention are categorical and available. The third criterion relates to “significant risk”, normally viewed as an assessment of the likelihood of a future event, in this case taken solely from evidence of historical behaviour with or without criminal charges. The criteria refer to “serious violence” or, in the case of those in “custodial care”, “a serious risk of suicide and/or severe self-harm” (Hoare and Wilson, 2010). The fourth criterion demands that “serious consideration (and testing where appropriate)” of less secure facilities precedes admission. None of these terms are defined or formally operationalised. In sum, addressing these criteria requires both evidence that is unequivocal (the first two criteria) and evidence where subjective judgements, of a kind common in forensic practice, come into play (the last two criteria).

To address the suitability of admission we have taken the view that charges or convictions amounting to “serious violence” and “moderate violence” (as defined in Table 2) address the criterion of “significant risk”. The first category’s inclusion is self-evident, the second may be considered over inclusive as although it includes fire-setting behaviours and kidnap and false imprisonment, offences involving threats or weapons are harder to assess. This paper errs on the side of including potential individuals as suitable for admission rather than excluding them. Also of relevance to this issue “significant risk” is evidence of historical behaviour that did not lead to criminal conviction. The presence of “firesetting”, “sexually harmful behaviour” and/or “harm to children” in the individual’s clinical history (Table 2) was taken to represent evidence of “significant risk”. Clinical histories of “violence to others” were deemed insufficiently well documented (i.e. untested in court) to be included. A clinical history of “suicidal behaviour” (Table 2) was considered as “a serious risk of suicide and/or severe self-harm” but a clinical history of previous self-harm considered too heterogeneous to match the required criterion. To address the fourth criterion, pathways of care data evidence its consideration and testing prior to admission to medium secure care. However, the available data set may underestimate the extent to which “serious consideration” rather than “testing” occurred.

 Insert Table 4 here

Results confirm that all patients admitted to the unit were under 18 years at the time of referral and all admissions were under the Mental Health Act (MHA) so 100% of admissions met the first two criteria. Using definitions of behaviour that would indicate a significant risk to others or where a young person is in custodial care and presenting a serious risk of suicide and/or severe self-harm, in total, 124 (83.2%) of admissions met the third criterion of “significant risk”. Fifty of the 149 admissions were from other hospital facilities. These will have been less secure than a MSU or will have been another MSU. Ninety-two admissions were from court/custody or a secure children’s home and our data provides no information on whether consideration was given to placement in less secure settings. However, guidance available on adolescents in youth justice settings (NHS, 2018) indicates that they should be referred to MSUs if likely to require admission under the MHA, where the referral will be considered, and it is unlikely they will be admitted to units with lower levels of security. These admissions were considered to meet the fourth criterion. Seven individuals were admitted from the community and we considered these did not meet the fourth criterion. We accept that although there is no information available in the data set as to whether open beds or low secure facilities were considered, these discussions may have occurred in various other fora.

To meet criteria for admission, an admission must meet all 4 criteria; the data suggests that 119 (79.9%) of the 149 admissions were likely to have been in line with guidelines for admission.

**DISCUSSION**

This paper defines the cohort of patients admitted to an Adolescent MSU over the duration of its lifespan and evaluates their suitability for admission against national guidance.

***Comparisons with other similar cohorts***

The young men admitted had had significant contact with mental health services; over half had a previous admission to a psychiatric hospital and just over two thirds had previous contact with a CAMHS service. Most had a major mental illness often complicated by conduct disorder. The majority had a history of violence to others and almost one in five were linked with very serious criminal offences at the time of admission.

Direct comparisons with other units described in the literature is difficult for a combination of reasons. Three papers (Bailey and colleagues 1994, Hill and colleagues 2019 and Kaltiano-Heino et al 2014) all describe a mixed cohort of both male and female adolescent patients. Wheatley et al (2004) also describe a mixed cohort but primarily concentrate on referrals to the service as opposed to admissions. Nadkarni et al (2012) describe the clinical profile of patients admitted to a low secure adolescent unit and whilst Hales and colleagues (2018) examined a national cohort in all types of secure care, different tiers of security in secure hospital were not distinguished.

Hill et al (2015) have described a male cohort admitted to their MSU. This cohort was of similar mean age at admission and all patients were detained under the MHA, with a similar length of stay. Differences include that the Wells Unit admitted more patients under a forensic section, had a minority of white patients and had far more young men diagnosed with a psychotic disorder. Hill et al (2019) describe the young men in their mixed cohort, in part a replication of data in their 2015 paper, noting similar proportions to the Wells Unit admitted under forensic sections as just over half were in some form of custody on admission. While rates of psychosis remained lower than the Wells Unit, it was the most frequent primary diagnosis.

Bailey’s (1994) earlier paper underlines changes over time. This described a younger admission cohort to the first MSU in England before the low and medium secure networks were established, some of whom were admitted from adult secure facilities, were mainly admitted under Section 21a (Children and Young Persons Act, 1969), which is no longer utilised. The cohort, which was three quarters male, had low rates of psychosis (13%) and 4 out of 5 had committed serious offences but over half were admitted from home or open facilities.

Kaltiano-Heino et al (2014) describe a young cohort of 98 boys in Finland admitted from child welfare or CAMHS services. Ninety two percent were admitted for severe physical violence and 29% with sexually aggressive behaviour but of these only 19% had court appearances, emphasising the varied practice that applies across jurisdictions.

***Adherence to Acceptance Criteria***

This is the first paper to consider the issue of suitability for admission into MSUs for YP. Guidance on admission provides 4 admission criteria that the individual must meet in order to be considered suitable. Four out of five Wells Unit admissions demonstrably did so. This raises important practical, ethical and cost-benefit questions both about admission processes and the adequacy of the criteria themselves.

Medium secure services are well resourced and offer, at their best, a holistic approach that can provide care to YP for longer than acute services, closely linked to both social services and education. This may well benefit a young person, even if they do not meet the acceptance criteria, and contribute to a more successful long term care plan, which can include protection from exploitation in the community. Conditions in custody and the availability of comprehensive treatment (Warner et al 2018), particularly for those with psychosis, may also contribute to a preference for admission over detention in custody, regardless of acuity and despite young men’s fear of mental health stigma and reluctance to access mental health services in custody (Mitchell et al 2016). Preference of unit may be based upon geographical location to be closed to family rather than level of security. Individuals readmitted may also benefit from a degree of continuity of care if they return to their unit of origin.

However, a fifth of these admissions are admitted to a level of secure care which, at least in terms of existing admission criteria, they appear not to warrant. Ethically, this is hard to defend, it is inconsistent with national guidance (Mental Health Code of Practice 1983) and possibly detrimental to the young person who may, in the words of Kaltiano-Heino and Eronen (2015) become constructed as a “high risk person”. They warn that the attribution of high risk to such a young person must not be seen as “permanent” but remain subject to alteration; it is therefore pertinent to note that length of stay in MSUs is often longer than in less secure units (Hales et al 2018). The 2018/19 NHS Benchmarking CAMHS Collection showed that the length of stay (excluding leave) for Secure CAMHS was almost four times higher than General Admission CAMHS (273 versus 62 days).

Secure CAMHS services (£285000 per bed p.a.) are also more expensive than General Admission CAMHS inpatient services (£219000 per bed p.a.) (NHS Benchmarking CAMHS, 2019). Perverse incentives based on commissioning priorities may also be relevant. If a unit must run at 100% of commissioned bed occupancy, as was the case for this unit, admissions may maintain the unit by admitting less risky YP.

Other UK studies have not examined their admission cohorts in relation to national acceptance criteria. Wheatley et al (2004) report admission criteria for a cohort of referrals to medium secure care but these are not the national criteria and they do not disaggregate referrals from admissions. Limited comparisons can be made with papers from Bailey (1994) and Hill (2015, 2019). Simple demographics such as age and MHA details can be easily found in all these papers but it is difficult to ascertain the risk on admission and the clinical thought process surrounding suitability for admission. Bailey (1994) has the most comprehensive risk data suggesting that 87% of admissions constituted a risk to others, 31% a risk to themselves and 29% had both risk to themselves and others. Current offences were committed by 82% of adolescents, of which sexual assaults constituted the largest single group. However, it is still unclear how that might translate when considered retrospectively against the admission criteria. Trials of less secure settings can be identified in part in other studies. At least 44% of the male and female admissions to the Gardner Unit came directly from community placements (Bailey 1994) and Hill (2015) reports 11% of male admissions coming from community placements and further reports (Hill 2019) 5% of male and female admissions coming directly from community placements. It appears these admissions did not involve a trial of a less secure hospital bed. No other study disaggregates the number of individual admissions who do or do not meet all the relevant criteria, ultimately constraining meaningful comparisons.

Given the restrictive nature of admissions, their length and cost, it should be easy to access information justifying admission. This would also be helpful to service providers auditing their own practice and for commissioners who are reviewing the function of the unit. We propose adoption of a template in which the admission criteria are formally considered as part of the assessment process. The process for admission in this study lacked this level of transparency. High rates of admission to medium security of YP from minority ethnic backgrounds has been noted previously (Chowdhury et al 2005) and are echoed in our findings. Given the source of admissions to the Wells Unit, this may be linked with the overrepresentation found in the Youth Justice Service (YJS) (Lammy 2016) reinforcing the need to improve understanding of clinicians’ decision- making processes.

***Suitability of National Acceptance Criteria***

Throughout this paper, we have used the acceptance criteria uncritically. We appreciate that the criteria were slightly updated in 2018 (NHS 2018). The criterion ‘the young person is in custodial care and presents a serious risk of suicide and/or severe self harm’, is no longer present. This study utilised the initial acceptance criteria as the majority of patients were admitted before the updated criteria were published. However, the criteria are open to further challenge and discussion. The grounds for challenge include: their largely unchanging nature when all around services and demand are altering; lack of suitability for easy use and audit; lack of congruence with clinical thinking; limited options for placement of those in custody.

Both our study and the existing literature indicate that the admission criteria should be regularly reviewed and amended to meet the changing needs of the patient population, developing treatment approaches (Dimond and Chigweda 2011) and altered service provision (Warner et al 2018). The Wheatley et al (2004) admission criteria excluded those with Learning Difficulties but this is not explicitly mentioned in the national criteria. Some units offer more specialised services due to the staff present and so an adaption of the national criteria may be appropriate for individual specialist units.

The acceptance criteria lack specificity and rely heavily on historical risk to others to indicate current significant risk. This is at odds with semi-structured clinical assessment and nuanced clinical judgement. Historical risk behaviours are important but there is no sense from the current criteria that admission be dependent on, for e.g. the length of time from such behaviours or other aspects of risk such as the imminence of repetition, likelihood of escalation to greater threat.

Finally, the automatic referral to MSUs of those in custody (NHS 2018) allows the detention of individuals charged or convicted of minor offences in MSUs, despite minimal risk to others. This seems disproportionate given the availability of low secure services now. Where the referral from custody was prompted solely by a serious risk of suicide and/or severe self-harm, rather than any perceived risk to others, the criteria seem even less ethically justified.

***Limitations***

Retrospective data collection from case notes limits the number of variables admissible to the study. Both missing data and unavailable variables limit its analytic power.

Furthermore, the nature of variables used in this study may not do justice to the depth of clinical thinking prior to admission. All referrals to this unit were discussed in the weekly national network meeting and notes from these meetings were not available.

**CONCLUSION**

This paper underlines the need for further information regarding the decision making process for admission to MSUs for adolescents in England and Wales. Such units have existed since 1985 (Bailey et al 1994) and are small scale but, despite the feasibility of conducting such a study, no longitudinal cohort study of all admissions, or discharges is published. The account we provide of the now closed Wells Unit has the merit of being in its own way comprehensive but also serendipitous.

We attempted to scrutinise admission practices rather than simply describe the cohorts as previous papers have done. While the admission criteria may run the risk of being parochial, the principle underpinning the interrogation is important and seemingly neglected. Transparency about practices of detention is protective of those detained, in this case YP with impaired and /or underdeveloped capacity. Actual decision making, responsive to demand, can be affected by organisational factors e.g. concerns about bed occupancy. That many YP need the kind of help they received is not really in doubt but we reiterate the need for revised admission criteria for low and medium secure units and greater transparency and documentation of the decision making process.

With the kind of small changes we suggest, an acceptable level of transparency around admissions is readily achievable. Such modest changes would make criteria more meaningful to clinicians and more amenable to being shared with commissioners and patients and their families alike.

Fewer medium secure beds may be needed, in line with the Wells Unit closure, with such beds being reserved for those YP within both custodial settings and other hospitals with complex mental health problems who pose significant, current harm to others.

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